East London NHS
NHS Foundation Trust

Safeguarding Children Policy

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Newham PCT (incorporating Community Health Newham) Child Protection Policy	December 2009	Anne Morgan, Nurse Consultant, Designated Nurse for Safeguarding Children Newham Primary Care Trust	Final	
ELFT Safeguarding Children Policy	October 2013	Jan Pearson, Associate Director for Safeguarding Children & Sue Nichols, Named Nurse for Child Protection	Final	New policy format separating policy from procedures
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ELFT Safeguarding Children Policy	September 2016	Jan Pearson, Associate Director for Safeguarding Children & Agnes Adentan, Named Nurse for Safeguarding Children	Final	Updated with additional guidance.

Contents

Part A
Legal and Organisational Framework

1.0 Introduction

East London NHS Foundation Trust, as a public sector organisation, has an overall duty to:

- Take all reasonable measures to ensure that the risks of harm to the welfare of children are minimised and
- Take appropriate actions to address child protection concerns, by working to agreed local policies and procedures, in full partnership with other agencies.

If any member of staff requires advice and support about what action to take having read this policy, they should contact a member of the Safeguarding Children Team.

2.0 Purpose

The purpose of this policy is to ensure there is an infrastructure in place to equip and support all staff to fulfil their responsibilities for safeguarding and promoting the welfare of children confidently, safely and effectively. This is within the context that risk cannot be completely eliminated.

3.0 Legal Framework

- The major duty for the Trust is enshrined in Section 11 of the Children Act 2004 which places a statutory duty on the Trust to make arrangements to ensure that it has regard to the need to safeguard and promote the welfare of children in exercising its functions.

- Section 10 of the Children Act 2004 reinforces and updates the Trust's existing duty (under the Children Act 1989) to co-operate and share information with local authorities in order to improve children's well-being and promote positive outcomes for children.

- Section 27 of the Children Act 1989 provides that a local authority may request help from any NHS Trust (and other bodies).

- Section 47 of the Children Act 1989 places a duty on any NHS Trust (and other bodies) to help a local authority with its enquiries in cases where there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, unless doing so would be unreasonable in all the circumstances of the case.

4.0 The Trust's Statutory Duties

The Trust's duties and responsibilities are set out in:

- *Section 11 of the Children Act 2004*;

- *Working Together to Safeguard Children*, HM Government Statutory Guidance (2015);

- *Promoting the Health and Well-being of Looked After Children*, DfE & DoH Statutory Guidance (2015)

- *Safeguarding Children and Young People: Roles and Competences for Health Care Staff – Inter-collegiate Framework* (2014)

- *Looked After Children: Knowledge, Skills and Competences of Health Care Staff - Intercollegiate Role Framework* (2015)

- *The London Child Protection Procedures*, London Safeguarding Children Board (2016). http://www.londoncp.co.uk/

- *Pan Bedfordshire Child Protection Procedures*, Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Boards (2015) http://bedfordscb.proceduresonline.com/index.htm

4.1 Section 11 Requirements as set out in Working Together 2015

The Trust has a statutory duty to have:

- A clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children;
- A senior board level lead to take leadership responsibility for the organisation's safeguarding arrangements;
- A culture of listening to children and taking account of their wishes and feelings, both in individual decisions and in the development of services;
- Arrangements which set out clearly the processes for sharing information with other professionals and with the Local Safeguarding Children Board;
- Named Professionals for Safeguarding Children. Their role is to support other professionals in their agencies to recognise the needs of children, including rescue from possible abuse or neglect. Professionals should be given sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively;
- Safe recruitment practices for individuals whom the organisation will permit to work regularly with children, including policies on when to obtain a criminal record check;
- Appropriate supervision and support for staff, including undertaking safeguarding training;
    - Employers are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role;
    - Staff should be given a mandatory induction, which includes familiarisation with child protection responsibilities and procedures to be followed if anyone has any concerns about a child's safety or welfare; and

- All professionals should have regular reviews of their own practice to ensure they improve over time.

- Clear policies in line with those from the Local Safeguarding Children Board (LSCB) for dealing with allegations against people who work with children. An allegation may relate to a person who works with children who has:
    - Behaved in a way that has harmed a child, or may have harmed a child;
    - Possibly committed a criminal offence against or related to a child; or
    - Behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

In addition Working Together makes reference to additional guidance for health services including guidance from the Royal College of Nursing (RCN), General Medical Council (GMC) and the NHS Commissioning Board.

5.0 Definition of Safeguarding Children and Child Protection

5.1 *Working Together to Safeguard Children* states that '**safeguarding and promoting the welfare of children'** means the process of:

- Protecting children from maltreatment (i.e. abuse or neglect) and
- Preventing impairment of children's health and development and
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care and
- Undertaking that role so as to enable children to have optimum life chances and to enter adulthood successfully.

5.2 **'Child Protection'** is part of safeguarding and promoting welfare. The term 'child protection' refers to the activity which is undertaken to protect specific children who are suffering, or at risk of suffering, significant harm.

6.0 Scope

6.1 This policy applies to the following children and young people up to their 18th birthday:

- Unborn children of service users who are pregnant or who have a pregnant partner;
- All children and young people who are service users of CAMHS and Children's Community Health Services and their siblings;
- Children of service users whether living in the same household or not;
- Children who are related to service users – e.g. as grandchildren, nephews, nieces, siblings, step-children, foster children;
- Children who live in households shared with, or visited by, service users;
- Any child who may have contact with a perpetrator about whom a service user has disclosed past abuse;
- Any other children not covered above who may be at risk from a service user e.g. service users in contact with children through paid employment or voluntary work;
- Children of staff members who have child abuse allegations made against them.

6.2 The fact that a child has become 16 years of age, is living independently, is married, is in further education, is a member of the armed services, is in hospital or in custody

in the secure estate for children and young people, does not affect his or her status or entitlement to services or protection under the Children Act 1989.

7.0 Responsibilities

7.1 The Trust Board

The Trust Board has responsibility for ensuring that there is an effective framework in place for assisting staff to safeguard children and for ensuring contractors are aware of their responsibilities.

7.2 The Lead Director for Safeguarding

The Trust has identified the Director of Nursing as the Executive Lead for Safeguarding Children on the Trust Board, as required by Working Together to Safeguard Children, HM Government 2015. The Lead Director has overall responsibility for the effective implementation of this policy.

7.3 The Operational Lead Director for Safeguarding

The Trust has identified the Deputy Director of Nursing to provide professional leadership and, in liaison with managers and safeguarding leads in locality services, to provide operational oversight of safeguarding children activity and the work of the Safeguarding Children Teams.

7.4 The Associate Director for Safeguarding Children

This specialist post, along with the Named Nurse for Safeguarding Children in Newham, is responsible for providing a strategic lead for safeguarding children and promoting a co-ordinated approach to implementing relevant national guidelines and standards in respect to safeguarding children. This entails liaising with the Associate Director for Safeguarding Adults and Domestic Abuse where there are overlapping issues.

7.5 Clinical and Service Directors

Borough and Service Directors and Clinical Directors are responsible for ensuring their services meet safeguarding children requirements. This should occur through an identified operational lead manager for safeguarding children in each directorate, working closely with the Safeguarding Children Team.

They have responsibility for ensuring that all their clinical practitioners are adequately trained and skilled in incorporating safeguarding children considerations into assessment, care planning and care management and that they have fulfilled their minimum training requirements as specified in the Training Needs Analysis. In addition to this, service directors are responsible for ensuring that clinical staff are receiving regular supervision and oversight of their clinical work and that this includes monitoring of compliance with the principles and requirements of this policy and any associated documentation.

7.6 Clinical Practitioners

All practitioners are responsible for ensuring that they are adequately trained and skilled to incorporate safeguarding children considerations into assessment, care planning and care management and have fulfilled their training requirements as specified in the Training Needs Analysis. Practitioners also have a duty to ensure

they carry out clinical risk assessments and management planning as part of their clinical work, in line with the principles contained within this policy and using the Trust's most up-to-date tools and templates available on the intranet.

7.7 Named Nurse/Doctors/Professionals for Safeguarding Children

Government statutory guidance requires the Trust to employ Named Nurses, Named Doctors and Named Professionals for Safeguarding Children. The Trust has a number of staff fulfilling these responsibilities within the Safeguarding Children Team. Community Health Services in Newham have a Named Nurse, a Named Doctor and Advisor posts. Mental health services have the Associate Director for Safeguarding Children and five Named Professional posts with direct lines of communication with specific boroughs. The Associate Director and Named Nurse report to the Operational Lead for Safeguarding Children and have access to the Lead Director for Safeguarding Children.

7.8 The Role of the Safeguarding Children Team

The role of the Safeguarding Children Team includes:

- Ensuring the Trust is kept up-to-date about safeguarding children issues;
- Working with all clinical and corporate services to promote a joined-up Trust approach to safeguarding children;
- Delivering a monthly in-house training programme at Induction and regular training for clinicians at Level 2 and Level 3;
- Providing advice and support to staff;
- Providing child protection supervision to community health clinicians and other services as appropriate;
- Carrying out regular checks on Electronic Patient Record Systems as to whether service users are involved in multi-agency child protection or domestic abuse processes;
- Working with partner agencies, particularly Children's Social Care, to strengthen interface arrangements and resolving difficulties;
- Working with the Assurance Department on the management of reviews, audits and performance data;
- Following up incidents;
- Working with the Caldicott Guardian and Information Governance Manager regarding information sharing and information governance arrangements;
- Contributing to the work of Local Safeguarding Children Boards (LSCBs);
- Carrying out and contributing to LSCB Serious Case Reviews and Local Learning Reviews;
- Overseeing and leading Trust involvement in multi-agency case audits;
- Updating information on the Trust intranet;
- Contributing to coroners inquests as required;
- Advising HR on staffing matters that have a safeguarding children component, including child protection allegations against staff;
- Providing performance information to the Trust Board and Commissioners.

7.9 Human Resources

The Human Resources Department is responsible for:

- Ensuring Job Descriptions include a statement regarding safeguarding children;

- Carrying out Safe Recruitment as set out in the London Child Protection Procedures and the Pan Bedfordshire Child Protection Procedures;
- Ensuring Disclosure and Barring Scheme (DBS) checks are carried out in line with national and statutory guidelines;
- Ensuring allegations against staff regarding the welfare of children, at work or in personal life, are addressed in accordance with national/statutory guidelines;
- Ensuring all HR policies incorporate safeguarding children requirements where necessary.

7.10 Representation at Multi-Agency Bodies

The Trust has a responsibility to ensure it is represented at an appropriate level at the following bodies:

- Local Safeguarding Children Boards – including sub groups
- Multi-Agency Public Protection Panels (MAPPP) – regarding offenders
- Multi-Agency Risk Assessment Conferences (MARAC) – regarding domestic abuse
- Multi-Agency Sexual Exploitation (MASE) Panels
- Any other panels as are convened.

7.11 Training

Mandatory training requirements are set out in the Safeguarding Children Training Needs Analysis which has been developed in accordance with the Safeguarding Children and Young People: Roles and Competences for Health Care Staff, Inter-collegiate framework, revised 2014 and with the UK Core Skills Training Framework, Skills for Health 2013.

As part of the Trust Training Needs Analysis and depending on role, staff have been mapped to Level 1, Level 2 or Level 3 as appropriate.

- All staff are required to undertake the Trust Induction which includes information about Safeguarding Children arrangements in the Trust.
- Non-clinical staff attend classroom Level 1 at Induction and are required to maintain Level 1 competence and refresh no longer than every 3 years.
- Selected clinical staff are required to undertake Level 2 Training. These are clinical staff who have some degree of contact with children and young people and/or parents/carers. New staff are booked onto classroom Level 2 immediately they start working in the Trust. They are required to maintain Level 2 competence and refresh no longer than every 3 years.
- Clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns are required to be competent at Level 3. New staff are booked onto classroom Level 3 (incorporating Level 2) immediately they start working in the Trust. They are required to maintain

competence and refresh no longer than every 3 years. To maintain competence at Level 3 staff should attend Local Safeguarding Children Board multi-agency training or other relevant multi-agency training or activity.

- Safeguarding Children Named Professionals/Nurses/Doctors/Advisors are required to attend Level 4 Training and maintain competence and refresh no longer than every 3 years.

- Selected clinical staff are required to attend Safeguarding Adults Training which incorporates domestic abuse and impact on children and radicalisation and Prevent.

- Other training may be required from time to time in the light of Government priorities.

Staff and managers are responsible for keeping a record of individual training requirements and attendance in their Personal Development Plan. The Training Department keeps a corporate record of attendance at safeguarding children training and provides a monthly compliance report to managers. Compliance with training requirements is closely monitored by the Service Delivery Board.

8.0 Internal Monitoring, Compliance and Review

8.1 Safeguarding Committee

The Trust Safeguarding Committee meets bi-monthly and oversees all issues relating to the Trust's statutory responsibilities for safeguarding children, safeguarding adults and domestic abuse. It communicates and makes links with other committees and groups in the Quality Framework. The Safeguarding Committee is accountable to the Safety Committee.

It is chaired by the Deputy Director of Nursing who is the delegated operational Lead for Safeguarding Children, the vice-chair is the Deputy Medical Director (Named Doctor for Safeguarding Children – adult mental health) and its safeguarding children work is led by the Associate Director for Safeguarding Children and the Named Nurse for Safeguarding Children for Newham Community Services.

Each service directorate has a senior clinical/management lead for safeguarding children who is a member of the committee. This individual is responsible for ensuring that safeguarding children is raised at appropriate directorate committees, for taking up operational issues with managers and staff and for ensuring that action plans from serious case review recommendations are implemented.

The Safeguarding Committee receives a quarterly performance report which includes information on:

- Training compliance;
- Reported incidents;
- Trust Serious Incident Reviews;
- LSCB Serious Case Reviews and Local Learning Reviews.

8.2 Reporting to the Trust Board

The Trust Board receives an Annual Report and Work Plan from the Safeguarding Committee. The Annual Report is also submitted to the Local Safeguarding Children Boards and to the Clinical Commissioning Groups.

8.3 Training Compliance

Compliance with mandatory training is closely monitored by the Service Delivery Board via a regular Performance Report. Service managers receive monthly mandatory training compliance figures.

8.4 Incident Reporting and Monitoring

The electronic incident report form has five compulsory fields asking for information regarding children, parents and pregnant women.

These are:

- Was a person under 18 years old directly involved/indirectly affected?
- Was any action necessary to ensure the safety and wellbeing of a person under 18 years old?
- Is the primary person involved in this incident a service user with parenting responsibilities?
- Was a pregnant woman involved?
- Was a referral made to, or information shared with, Children's Social Care?

If any of the fields are completed the form is automatically forwarded to the Safeguarding Children Team for follow up where necessary.

Incident categories can also flag up children at risk, missing children and child deaths.

Type: **Children at Risk**	
Category	**Sub category**
Child or young person has suffered actual harm	Adult service user is alleged perpetrator
	Child service user is alleged perpetrator
	Child victim has parent who is a service user
	Child victim is a service user
	Child victim is sibling/other relative of service user
Child or young person has suffered actual harm from FGM	Adult service user is alleged perpetrator
	Child service user is alleged perpetrator
	Child victim has parent who is a service user
	Child victim is a service user
	Child victim is sibling/other relative of service user
Child or young person identified as at immediate risk of harm	Adult service user is alleged perpetrator
	Child at risk has a parent who is a service user
	Child at risk is a service user
	Child at risk is sibling/other relative of a service user
	Child service user is an alleged perpetrator
Child or young person identified as at immediate	Adult service user is alleged perpetrator
	Child at risk has a parent who is a service user

risk of harm from FGM	Child at risk is a service user
	Child at risk is sibling/other relative of a service user
Child or young person under 18 has made an allegation against staff	Allegation not resulting in report to LADO (allegations against staff would usually be reported to the LADO, a rationale may be sought if this is not done)
	Allegation resulting in report to LADO
Missing Child	Child is a service user
	Child of a service user
	Child of service user's partner or significant other – e.g. relative

Type: **Death**	
Category	**Sub category**
Death of a Child	Expected - As a result of diagnosed life limiting illness/condition
	Expected - In receipt of palliative/end of life care
	Suspected Suicide - Burning
	Suspected Suicide - Drowning
	Suspected Suicide - Jumping from height / into danger
	Suspected Suicide - Laceration
	Suspected Suicide - Method Unknown
	Suspected Suicide - On road
	Suspected Suicide - On tube/railway
	Suspected Suicide - Overdose of illicit drugs
	Suspected Suicide - Overdose of medication
	Suspected Suicide - Self-poisoning
	Suspected Suicide - Shooting or stabbing
	Suspected Suicide - Strangulation
	Suspected Suicide - Suffocation
	Unexpected - Cause known
	Unexpected - Cause unknown

8.5 Serious Incident Review Monitoring

Serious Incident and Serious Case Review action plan monitoring is carried out at service level governance committees, the Trust Safeguarding Committee and the Trust Serious Incident Committee.

8.6 Clinical Audit

The Trust carries out audits relating to safeguarding children in a number of ways:

- Through involvement in Local Safeguarding Children Board thematic audits where staff are involved in auditing identified cases and attending multi-agency case discussions;
- Through audits carried out by the Safeguarding Children Team regarding Trust involvement in child protection, child in need and early help processes;
- Through Directorate audits into clinical practice which impacts on identifying risks to, and needs of children.

They are used as a measure of compliance with the principles in this policy and associated procedures and action plans are developed in response to areas in need

of development. Audit results and action plans are monitored by Clinical teams and Service Directorate governance groups, the Safeguarding Committee and the Quality Committee.

8.7 Supervision

The Trust's Supervision Policy requires safeguarding children issues to be addressed in supervision using the Trust's performance management processes. The Safeguarding Children Team provides advice and support to staff and supervision to agreed groups of staff.

8.8 Complaints

Feedback, including complaints, from partner agencies including Child Protection Conference Chairs and Children's Social Care is followed up and acted upon.

9.0 External Monitoring, Compliance and Review

9.1 Commissioners

The Trust submits quarterly performance reports (dashboards) to local and specialist commissioners. The Safeguarding Children Named Professionals are supervised by the Designated Nurses in the Clinical Commissioning Groups (CCGs).

9.2 Local Safeguarding Children Board Section 11 Organisational Audit

Local Safeguarding Children Boards (LSCBs) have a statutory duty to monitor the arrangements that member agencies make for safeguarding children under Section 11 of the Children Act 2004. The Trust will complete and submit Section 11 audits to the LSCBs for City & Hackney, Newham, Tower Hamlets, Bedford Borough, Central Bedfordshire and Luton as required and will provide information to other LSCBs if necessary.

9.3 Care Quality Commission (CQC) Inspections and Review

The Trust is inspected by the CQC in relation to a wide range of standards which may include safeguarding children as part of an inspection or as a single issue inspection or review.

9.4 Ofsted Led Safeguarding and Looked After Children Inspections

In addition to single agency inspections of health trusts by the CQC, the Government has developed multi-inspectorate inspections of borough wide partnership arrangements for safeguarding children. The inspections are led by the Office for Standards in Education, Children's Services and Skills (Ofsted), and also include the Care Quality Commission (CQC), HM Inspectorate of Constabulary (HMIC) and HM Inspectorate of Probation (HMIP). The Trust is inspected, alongside all other relevant agencies in each of our seven local boroughs, and other local authority areas if required, in relation to single and multi-agency safeguarding children arrangements.

9.5 LSCB Multi-Agency Case Audits and Case Reviews

The Trust takes part in LSCB multi-agency case reviews and case audits which are monitored by LSCB Quality Assurance Sub-Groups.

10.0 References

- The Children Act 1989
- The Protection of Children Act 1999
- The Adoption Act 2002
- The Children Act 2004
- The Children and Families Act 2014

- Statutory Guidance: Working Together to Safeguard Children, HM Government 2015

- London Child Protection Procedures and supplementary guidance, London Safeguarding Children Board, 2015

- Pan Bedfordshire Child Protection Procedures, Bedford Borough, Central Bedfordshire and Luton LSCBs 2015

- When to Suspect Child Maltreatment, NICE Clinical Guideline July 2009

- Safeguarding Children and Young people: roles and competences for health care staff, Intercollegiate document, March 2014

- UK Core Skills Training Framework Subject Guide, Skills for Health 2013

- Refocusing the Care Programme Approach: Policy and Positive Practice Guidance, Department of Health 2008

- Care Programme Approach Briefing: Parents with Mental Health Problems and their Children, Department of Health and Social Care Institute for Excellence, 2008

- Parents as Patients, Royal College of Psychiatrists, 2011

- Hidden Harm: responding to the needs of problem drug users, Advisory Council on the Misuse of Drugs, 2003

- Bottling it Up: the effects of alcohol misuse on children, parents and families, Turning Point 2006

- Swept Under the Carpet: children affected by parental alcohol misuse, Alcohol Concern and The Children's Society, 2010

- Think Child, Think Parent, Think Family: a guide to parental mental health and child welfare, Social Care Institute for Excellence, 2009

Part B
Minimising Risk and Promoting Welfare of Children as Part of Routine Clinical Practice and the CPA Process

1. Introduction

1.1 Staff are required to consider the needs of children and the support needs of their parents on a routine basis. The starting point is talking to the service user about their children and family situation – i.e. Think Family. This should occur whether or not there are immediate and obvious child protection concerns. Part B covers how staff can do this as part of their day-to-day work with service users. Part C will highlight key actions that may need to be taken if staff have child protection concerns that warrant the involvement of Children's Social Care.

1.2 It is acknowledged that different services within the Trust are commissioned differently and may have different operational frameworks however all services have a responsibility to comply with statutory duties and to ensure that their work always considers the impact on children.

1.3 All staff, in whatever role or service, should:

- Be alert to potential indicators of abuse or neglect;
- Be alert to the risks of harm that individual abusers, or potential abusers, may pose to children;
- Prioritise direct communication and positive and respectful relationships with children, ensuring the child's wishes and feelings underpin assessments and any safeguarding activities;
- Share and help to analyse information so that an assessment can be made of whether the child is suffering or is likely to suffer harm, their needs and circumstances;
- Contribute to whatever actions are needed to safeguard and promote the child's welfare;
- Take part in regularly reviewing the outcomes for the child against specific plans; and
- Work co-operatively with parents, unless this is inconsistent with ensuring the child's safety.

Source: Working Together to Safeguard Children, HM Government 2015.

2. CPA and Service Users who are Parents

2.1 The CPA guidance entitled *Refocusing the Care Programme Approach*, *Department of Health March 2008* highlights adults with mental health problems who have parenting responsibilities as a key group who need to be identified consistently and provided with holistic assessments and support.

2.2 Supplementary to this guidance, the Department of Health (DH) and the Social Care Institute for Excellence (SCIE) have produced *Care Programme Approach (CPA) Briefing: Parents with mental health problems and their children, April 2008* which provides additional guidance as to how to ensure service users who are parents and their children receive the services they need. The briefing can be found on the Intranet Safeguarding Children page.

2.3 Government guidance and Trust CPA policy suggests that because parents are an identified key group, consideration should be given as to whether their parenting support needs indicate the need to be subject to CPA. If parents are not on CPA, the reasons should be recorded and the Trust Safeguarding Children Policy should still be followed in relation to the safety and welfare of children.

2.4 Where service users may pose a risk to children a consultant psychiatrist should be directly involved in all clinical decision making which may have an impact on children.

3. Processing Referrals

3.1 When making decisions about referrals received in mental health teams and case allocation staff should do the following:

Routinely record basic details about all service users' children whether or not they live with their children namely:

- First name and surname
- Gender
- Date of birth
- Relationship to service user
- Where children live if not resident with service user
- Expected date of delivery (EDD) for pregnant woman
- Health visitor name/team and contact details (for children under five)
- School/nursery name and contact details

3.2 Ask the service user what other agencies are involved with them and get consent for checks to be made with Children's Social Care as to whether children are currently known, or have been known, to Children's Social Care and whether they are subject to a Child Protection Plan or have in the past been on the Child Protection Register. The social worker's name and contact details should be recorded.

3.3 Check with local CAF Helpline or Early Help Services or Children's Social Care whether an Early Help Assessment or Common Assessment Framework (CAF) has been completed or is ongoing.

3.4 Consider whether there are any child protection concerns or family support needs that warrant Early Help or a referral to Children's Social Care or any other family support service run by another agency or organisation. If the child is at risk of significant harm a referral must be made direct to Children's Social Care and not be delayed by completing a CAF.

3.5 Consider whether the service user's illness is having a detrimental impact on their parenting capacity and whether this is taken into account when prioritising allocation of cases.

3.6 Consider whether the child/children are providing support to the service user, without which the service user's condition would be liable to deteriorate – e.g. children take on additional chores, interpreting, looking after younger siblings. don't bring friends home, don't attend school, accompany parents to appointments or activities. Children and young people may be entitled to a Carer's Assessment or Child in Need assessment.

4. Recording

- All key discussions within the clinical team regarding impact on children must be clearly recorded.
- Consultation and advice from the Safeguarding Children Team, Parental Mental Health Service, Perinatal Mental Health Service or other specialist staff must be recorded.
- Demographic data and other relevant information must be regularly checked for accuracy to keep it up to date.

When information is recorded:

- A strong viewpoint needs to be justified by evidence;
- Conclusions need to be based on analysis;
- Conclusions flow from the concerns identified;
- Distinguish between fact and opinion;
- Professional judgements are based on evidence and analysis.

Staff using RiO (mental health) should complete the relevant Form in the Safeguarding Section of RiO. CAMHS should use the Form for a Child or Young Person Client and Adult Mental Health Services should use the Safeguarding Children in the Adult Client's Network Form.

5. Risk Assessments

5.1 Staff should have honest discussions with service users about any potential risk to children arising from their illness or addiction. This applies to service users who are mothers, fathers, siblings, grandparents, step parents or in any way closely connected with particular children or a potential risk to children more generally. Consideration should be given to the level of insight service users have about the impact of the illness on their children including any actual or potential risk and how they apply that insight. Risks will vary according to the age of the child and research shows that children under four, especially infants, are particularly vulnerable. The potential impact of illness in the antenatal and postnatal period should be considered when working with pregnant women or women with infants. The impact on men who have recently become fathers should also be considered.

5.2 All risk assessments must include an assessment of any current or potential risk to children in the household and/or in the wider community. Protective factors should also be considered.

5.3 The London Child Protection Procedures states that a child at risk of significant harm or whose well-being is affected, could be a child who:

- *Features within parental delusions (NB This must be referred to CSC for a Section 47 child protection assessment);*
- *Is involved in his/her parent's obsessional compulsive behaviours;*
- *Has caring responsibilities inappropriate to his/her age;*
- *May witness disturbing behaviour arising from the mental illness (e.g. self-harm, suicide, disinhibited behaviour, violence, homicide);*
- *Is neglected physically and/or emotionally by an unwell parent;*

- *Does not live with the unwell parent, but has contact (e.g. formal unsupervised contact sessions or the parent sees the child in visits to the home or overnight stays);*
- *Is at risk of severe injury, profound neglect or death.*

Or an unborn child:

- *Of a pregnant woman with any previous major mental disorder, including disorders of schizophrenic, any affective or schizo-affective type; also severe personality disorders involving known risk of harm to self and/or others*

5.4 The London Child Protection Procedures identifies the following factors that may impact upon parenting capacity and increase concerns that a child may have suffered, or is at risk of suffering significant harm:

- *History of mental health problems with an impact on the sufferer's functioning;*
- *Unmanaged mental health problems with an impact on the sufferer's functioning;*
- *Maladaptive coping strategies;*
- *Misuse of drugs, alcohol or medication;*
- *Severe eating disorders; self-harming and suicidal behaviour;*
- *Lack of insight into illness and impact on child, or insight not applied;*
- *Non-compliance with treatment;*
- *Poor engagement with services;*
- *Previous or current compulsory admissions to mental health hospital;*
- *Disorder deemed long term 'untreatable' or untreatable within timescales compatible with child's best interests;*
- *Mental health problems combined with domestic abuse and/or relationship difficulties;*
- *Mental health problems combined with criminal offending (forensic);*
- *Non-identification of the illness by professionals (e.g. untreated post-natal depression can lead to significant attachment problems);*
- *Previous referrals to Children's Social Care for other children.*

Staff should also consider any effects on children from a service user responding to hallucinations and delusional ideas, social withdrawal and deteriorations in self-care.

5.5 Protective factors can include:

- Mild problems
- Short duration
- No family dysfunction
- Family remains together
- Presence of responsive other carer
- Good early attachment between parent and child/later onset of mental illness in parent
- Extended family support

5.6 Information must be clearly recorded in the risk assessment. Identified risk and relevant actions required must be reflected in the service user's Care or Management Plan.

5.7 If the service user lives apart from his or her children, staff must find out the extent of the contact he/she has with their children and whether it constitutes any risk.

5.8 If identified risks could lead to actual or potential significant harm to children warranting a child protection investigation under Section 47 of the Children Act 1989 staff must make a referral to Children's Social Care and provide full written information about the risks identified. A copy of the completed referral form must be uploaded to the service user's records. Staff using RiO (mental health) should complete the Record of Referral to Children's Social Care Form and update it as necessary when the outcome of the referral is known and in case of the need for escalation.

5.9 A referral to Children's Social Care must be made:

- If a service user expresses delusional beliefs involving their child

  and/or

- If a service user might harm their child as part of a suicide plan.

5.10 As part of history taking, staff should ascertain whether a service user had been 'in care' as a child and any childhood abuse which might have a bearing on the nature of next of kin involvement in the service user's care management. Staff should check historical records with Children's Social Care.

5.11 Partners of service users should be fully informed of any potential risk to their children so they can make informed decisions about how best to safeguard their own children. Assessments should be realistic about the capacity for partners or family members to manage identified risks. This should be discussed within the clinical team and with Children's Social Care and considered within a Carer's Assessment.

5.12 Staff should follow the NICE guidelines on When to Suspect Child Maltreatment.

5.13 Where service users may pose a risk to children a consultant psychiatrist should be directly involved in all clinical decision making which may have an impact on children.

6. Service Users who Disclose Abuse of Children

6.1 If a service user discloses that they have, or may have abused a child, or children, this must be taken seriously, should be clearly documented, discussed within the multi-disciplinary team and referred to Children's Social Care and/or the Police as appropriate. Staff can seek advice from the Safeguarding Children Team.

6.2 Children who perpetrate sexual abuse

In all cases where sexual abuse is perpetrated by a child/young person, the case must be referred to Children's Social Care and the case discussed with the Safeguarding Children Team.

7. Needs Assessments

7.1 Staff should consider service users' parenting support needs. Staff should discuss with the service user, the service user's own concerns about how his or her illness is affecting their confidence and functioning as a parent and any support they may need in their parenting role.

7.2 Staff should talk to service users about his or her perceptions of how their illness is affecting their children and in what ways. If the service user does not live with their child/ren, staff should discuss with them how they perceive this arrangement is affecting them and their child/ren.

7.3 Staff should be aware of relevant services that could provide parenting support for parents with children of all ages. There are a wide range of community services for pregnant women and service users who have children under five, such as those set up under the umbrella of Children's Centres. In addition, local areas may have services for children with caring responsibilities.

7.4 Staff should talk to the service user about whether he or she is receiving Early Help services support or would be interested in Early Help services for their children.

8. Contingency and Emergency Planning

8.1 Staff should ensure that they ask and clearly record full and accurate details of who will look after the children in case of emergency and what the service user wishes their children to be told. They should consider whether proposed arrangements will keep the children safe and well and discuss with Children's Social Care where appropriate.

8.2 Staff may wish to suggest that parents create a 'child's routine factsheet' with his or her children for times when their parents may be absent. It could describe the child's daily/weekly routine and their likes and dislikes. If other caregivers follow this guidance it can provide children with continuity and a sense of security. It can also enable parents to maintain control and keep contributing to their children's wellbeing when they are apart.

8.3 Staff should provide, as needed, information and support for alternative carers and children about what is happening to their parent/relative. If there are no appropriate family members available staff should engage in a joint planning process with Children's Social Care about arranging emergency foster care.

9. Private Fostering

9.1 Children's Social Care must be informed by law if alternative carers are not close relatives and the situation may constitute a private fostering arrangement.

9.2 A private fostering arrangement is one that is made privately by the family and not instigated by a local authority for the care of a child under the age of 16 (under 18, if disabled) by someone other than a parent or close relative, with the intention that it should last for 28 days or more.

9.3 A close relative (under the Children Act 1989) is a grandparent, brother, sister, uncle or aunt (whether of full blood or half blood or by marriage) or a step-parent.

9.4 Private foster carers may be from extended family such as a cousin or great aunt. A private foster carer may be a friend of the family, or the child's friend's parents or someone unknown who is willing to privately foster a child.

9.5 If it is an emergency placement such as in response to a Mental Health Act assessment, notification should take place within 48 hours. In all cases, the Children's Social Care must be notified within 6 weeks of the placement starting.

9.6 Staff should contact a member of the Safeguarding Children Team if they have any queries.

10. Pregnant Women

10.1 The needs of pregnant women and their unborn children must be considered at the earliest opportunity whether or not there are obvious child protection concerns.

10.2 All pregnant service users with mental health problems should be notified to a relevant local Perinatal Mental Health Service and discussions held about care arrangements during the pregnancy. If there are safeguarding children concerns, discussions can be held with the Safeguarding Children Team.

10.3 As pregnancy is a change in circumstances for all service users a multi-disciplinary/ multi-agency review and planning meeting must be held under the CPA arrangements.

10.4 There are three types of pre-birth planning meetings:

- Perinatal CPA Meeting convened by ELFT staff;
- Pre-birth Professionals/Strategy Meeting which may be convened by any agency;
- Pre-birth Initial Child Protection Conference convened by Children's Social Care.

10.5 If the service user is not engaging with services a professional perinatal plan must still be made which record contingency arrangements.

10.6 The meeting must include all agencies involved in the pregnant woman's maternity care and the parents-to-be must be invited and informed about its purpose. Check with Children's Social Care whether they are already involved with the family and whether a referral and invitation to the meeting is indicated.

10.7 The Perinatal Care Plan must ensure that the needs and safety of the unborn baby are considered early enough to arrange support.

10.8 The Perinatal Care Plan must ensure that the pregnant woman is offered appropriate support and advice during pregnancy and following birth.

10.9 If child protection concerns arise before, at or after the meeting then the London Child Protection Procedures or the Pan Bedfordshire Child Protection Procedures regarding pre-birth referrals and assessments must be followed.

10.11 If one or more of the criteria set out below are met staff should make a referral to Children's Social Care for them to instigate a pre-birth child protection assessment.

The criteria are:

- There has been a previous unexplained death of a child whilst in the care of either parent
- A parent or other adult in the household has committed an offence on the government list of offences posing a risk to children (formerly known as Schedule 1 offender)
- A sibling in the household is subject to a child protection plan
- A sibling has previously been removed from the household either temporarily or by court order
- Domestic violence is known to have occurred

- The degree of parental substance misuse is likely to significantly impact on the baby's safety or development
- The degree of parental mental illness/impairment is likely to significantly impact on the baby's safety or development
- There are concerns about parental ability to self-care and/or to care for the child – e.g. unsupported young or learning disabled mother
- Any other concern exists that the baby may be at risk of significant harm including a parent previously suspected of fabricated or inducing illness in a child

10.12 If there is a need for a Section 47 Child Protection Investigation there may need to be a Core Assessment and a Pre-Birth Initial Child Protection Conference. This is usually held around 10 weeks prior to the expected delivery date or earlier if a premature birth is likely.

11. Service Users with a Pregnant Partner

11.1 As pregnancy is a change in circumstances for all service users a multi-disciplinary/multi-agency review and planning meeting must be held under the CPA arrangements for service users with a pregnant partner.

11.2 Consideration should be given to the effect of the pregnancy and parenthood on expectant partners and risks and needs assessments should take account of the pregnancy. Staff should seek advice from the Safeguarding Children Team if necessary.

12. Outpatients Arrangements for Service Users with Children

12.1 Staff should consider the child care arrangements of service users when offering appointments. If service users need to take or collect children from school these times should be avoided if possible.

12.2 Staff should endeavour to find out whether a service user may need to bring a child with them to an appointment and have arrangements in place as to how to deal with this situation that are agreed and understood by all relevant staff.

12.3 If children are brought to an outpatient area consideration should be given as to the suitability and safety of the environment for children and clear onsite guidance provided about the supervision of children.

13. Mental Health Act Assessments

13.1 Consideration for the protection of other persons must include the impact on the welfare of any children if their parent is admitted to hospital. Children must not be left unsupported with caring responsibilities if the service user is not hospitalised. Staff should make a referral to Children's Social Care if the family needs additional support.

13.2 Where possible, the presence of children should be ascertained before the assessment and Children's Social Care involved in planning the assessment if there are likely to be childcare needs, whether or not the service user is hospitalised. It is good practice to take account of the views of children and any information that they may have about their parent's illness and relapse indicators. Research shows that service users and children benefit if children are given an explanation about their parent/relative's illness, the role of professionals, what is happening and what will happen next.

13.3. If a person does not meet the criteria for admission to hospital the Approved Mental Health Professional (AMHP formerly Approved Social Worker) will make arrangements for the individual's treatment and care in the community. This may include referral to the Crisis Service/Home Treatment Team who will offer treatment in the person's home. The AMHP must ensure appropriate arrangements are made for the welfare of the child.

13.4 Staff should ensure, with relevant family members or Children's Social Care that arrangements are in place for children to be collected from school, nursery or elsewhere.

13.5 If there is a delay in carrying out a Mental Health Act assessment staff must ensure, with relevant family members or Children's Social Care, that the welfare of children is not compromised and that they are safe and supported in the meantime.

14. Children Visiting Relatives in Hospital

14.1 Staff must comply with the Child Visiting Procedures for their inpatient site and draw up their own ward arrangements in order to comply.

14.2 Inpatient services must have suitable and safe designated space for visits by children to take place. This applies to services run by the Trust and those commissioned or bought from the private or independent sector.

14.3 Staff should ensure that any visits by children to inpatients are in the child's best interests. Inpatient staff should ensure that issues regarding patients' children are discussed within the team and at multidisciplinary team meetings as well as with the patient and family. Where appropriate, advice should be sought from the child's social worker, if there is one, or the parental mental health team or the safeguarding children team.

14.4 A Child Visiting Plan must be discussed and recorded in the service user's notes.

15. Leave Arrangements

15.1 Staff must be aware of where service users are going when on leave from hospital. The Leave Plan must consider the impact on children when the service user is on leave which must be clearly recorded in the service user's notes.

15.2 If a service user does not usually reside with his or her own or other children checks must be made with the service user and if necessary, Children's Social Care, as to whether they are likely to be visiting or staying in a household with children and whether this poses any risks or practical problems for the household.

15.3 Occasionally, multi-agency Child Protection Plans or other plans relating to the children's care, have conditions regarding an adult's contact with children. Staff should check if any conditions exist and should consult with Children's Social Care prior to allowing leave. Staff must ensure that leave arrangements comply with plans made at Child Protection Conferences or as part of Children's Services assessment plans.

15.4 Staff should ascertain from the service user what happened on leave and record any contact with children and the service user's perceptions of the leave.

15.5 If Children's Social Care are involved, staff should inform them immediately if a service user goes absent without leave (AWOL) so they can carry out any checks

into the safety of children that may be necessary. They should also be notified when the service user returns and provided with any information if known about what the service user did whilst absent and any contact with their own children.

16. Discharge Planning

16.1 Discharge arrangements must take account of any impact on children in the family or household and where appropriate, the wider community. There must be a clear Discharge Plan that evidences this.

16.2 Children's Social Care, if involved, must be consulted about discharge plans to give them an opportunity to put any necessary arrangements in place. A separate planning meeting should be held in advance of discharge to focus on the children and a written plan agreed. If impractical, the meeting should be held as soon as possible after discharge.

16.3 Discussions should take place with Children's Social Care staff, if they are already involved with the family, as to which agency is best placed to lead and organise the meeting. If there is a child under five, the health visitor should be invited. School nurses may also need to be informed of the discharge of a child's parent/carer. The plans for the children should be shared, with the service user's knowledge and agreement, with relevant health and social care children's professionals involved with the family.

17. Carer's Assessments (Young Carers)

17.1 If a service user has children under the age of 18 staff should discuss with the service user whether the children are carrying out any caring responsibilities towards their parent/s, siblings, grandparents or other relatives, whether or not they have been identified as the main carer or a 'Young Carer'. They are entitled to an assessment of their own support needs.

17.2 Staff should be mindful of the fact that a caring role may have an impact on a child/young person's own development, mental health, education, leisure activities and so on. Staff should assess this as part of their risk assessment in the usual way.

17.3 Children under 16 with caring responsibilities may be entitled to a Child in Need Assessment carried out jointly with Children's Social Care. Staff should discuss this option with the family and make a referral when required. Young people over 16 with caring responsibilities are entitled to a Carer's Assessment.

17.4 Staff should consider applying for Carer's Grants to support the children. They should also find out about local young carer's groups and offer to facilitate the child or young person to attend. Staff may also need to consider whether support may be required from CAMHS.

18. Closing or Transferring a Case

18.1 Before closing a case or transferring a case to another team, staff must consider any impact on the children or unborn child if the service discontinues contact with the family.

18.2 If Children's Social Care are involved in the case they must be invited to any transfer or closure/discharge meeting and be sent a copy of the discharge report. If children are subject to a Child Protection Plan, staff should ensure transfer or closure plans

are discussed first with the children's social worker, the Core Group and the Child Protection Conference Chair because this is a change to the Child Protection Plan.

18.3 Discharge letters should be copied, with the service user's knowledge and agreement, to relevant health and social care children's professionals involved with the family.

18.4 Staff should ensure that there are appropriate family/parenting support services in place if necessary.

19. Incident Reporting

SEE ALSO TRUST'S INCIDENT POLICY.

19.1 In addition to risk categories relating to children the Trust's electronic Incident Reporting Form on Datix includes five mandatory fields for briefly identifying whether children, pregnant women and service users with parenting responsibilities were involved in an incident and whether any action was necessary to safeguard a child and whether information was shared with Children's Social Care.

19.2 If any of these fields are completed, the form is automatically forwarded to the Safeguarding Children Team for follow up and to ensure that children are safe and their needs are being addressed.

19.3 The incident may have a practical or emotional impact on children – e.g. suicide or attempted suicide of parent, living in a household with violence.

19.4 Staff must ensure that children are safe after an incident. Where a pregnant woman is involved staff must ensure there is no risk to an unborn child. A maternity health check or midwifery assessment should be arranged if necessary.

19.5 The Safeguarding Children Team should be consulted in all incident investigations that affect children or pregnant women namely SI Panels and Local Clinical Reviews.

19.6 Where the incident is also subject of a Serious Case Review instigated by an LSCB, the Safeguarding Children Team will provide the link between the Trust processes and the LSCB processes.

20. Court Proceedings concerning Children

20.1 If any service user is subject to any criminal, public or private family court proceedings concerning children, staff may wish to consult the Safeguarding Children Team and/or the Trust's Legal Manager. This will enable appropriate support and advice to be offered to staff in relation to their role and any potential court directions with which the Trust has to comply.

21. Working with Interpreters/Communication Facilitators

21.1 Family members or friends should not be used as interpreters, since the majority of domestic and child abuse is perpetrated by family members or adults known to the child. Children under 16 must not be used as interpreters. Service users should be strongly discouraged from using children as interpreters and should be offered assistance of a qualified interpreter or another appointment. Interpreting, particularly in health care setting is a serious responsibility and should not rest on a child. Staff should only ask a child for basic information in a case of emergency.

21.2 Staff should comply with the Trust's Interpreting and Translation Services Including Sign Language Policy. Staff should use one of the accredited interpreting services with which the Trust has a contract.

Staff should ensure that service users are seen with an interpreter within the same timescales for assessment or investigation as for any other intervention.

21.3 The use of accredited interpreters, signers or others with special communication skills must be considered when involved in enquiries regarding child protection involving children and families:

- For whom English is not the first language (even if reasonably fluent in English, the option of an interpreter must be available when dealing with sensitive issues);
- With a hearing or visual impairment;
- Whose disability impairs speech;
- With learning difficulties;
- With a specific language or communication disorder;
- With severe emotional and behavioural difficulties;
- Whose primary form of communication is not speech.

22. Young People who need Inpatient Care

22.1 In line with Government Policy the Trust will not have children and young people under eighteen on adult wards unless it is deemed more appropriate for particular young people approaching the age of eighteen. The Trust has the specialist Coborn Centre for adolescent mental health which provides inpatient and day services for young people with mental health problems.

22.2 As an emergency backup the Coborn Centre has an agreement with an adult mental health ward nearby at the Newham centre for mental health to provide beds for sleep over only. In such situations, the young person will have one to one staffing and attend the Coborn Centre during the day.

23. Service Users who Do Not Attend (DNA) Appointments

23.1 Incident reviews highlight that risk to children can be overlooked if adult service users or children do not engage with services, do not attend appointments or are not brought to appointments by their parents.

23.2 Staff must follow the relevant Trust DNA Policy.

24. Adults who Disclose Childhood Abuse

24.1 Adult service users who disclose to a clinician that they were subject to childhood abuse should be supported to consider and identify any current children who may be at risk from the same perpetrator.

24.2 The clinician will need to be part of a management planning meeting with Children's Social Care and the Police to plan how to proceed.

24.3 Advice can be sought from the Safeguarding Children Team.

25. Child Sexual Exploitation (CSE)

25.1 All Trust staff should be alert to the possibility that a child they are in contact with, may be being sexually exploited. Practitioners may already have concerns about the

child e.g. that s/he is missing school, frequently missing from home, misusing substances, is depressed or self-harming etc.

25.2 In all cases where a child/young person is identified to be at risk of sexual exploitation, the case must be discussed with the Safeguarding Children Team and a referral made to Children's Social Care. The young person may also need to be referred to their Borough's Multi Agency Sexual Exploitation Group (MASE).

25.3 Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where the young person (or third person/s) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities.

25.4 Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the internet/mobile phones without immediate payment or gain.

25.5 Violence, coercion and intimidation are common. Involvement in exploitative relationships is characterised by the child's or young person's limited availability of choice resulting from their social, economic or emotional vulnerability.

25.6 A common feature of CSE is that the child or young person does not recognise the coercive nature of the relationship and does not see themselves as a victim of exploitation.

25.7 Vulnerability factors in relation to child sexual exploitation

There are several vulnerability factors:

- **Sexual health and behaviour:** Evidence of sexually transmitted infections, inappropriate sexualised behaviour or pregnancy.

- **Absent from school or repeatedly running away:** Evidence of truancy from school, periods of being missing from care or from home.

- **Familial abuse and/or problems at home:** Familial sexual abuse, physical abuse, emotional abuse, neglect, as well as risk of forced marriage or honour-based violence; domestic violence; substance misuse; parental mental health concerns; parental criminality; experience of homelessness; living in a care home or temporary accommodation.
- **Emotional and physical condition:** Thoughts of, or attempted, suicide or self-harming; low self-esteem or self-confidence; problems relating to sexual orientation; learning difficulties or poor mental health; unexplained injuries or changes in physical appearance identify.

- **Gangs, older age groups and involvement in crime:** Involvement in crime; direct involvement with gang members or living in a gang-afflicted community; involvement with older individuals or lacking friends from the same age group; contact with other individuals who are sexually exploited.

- **Use of technology and sexual bullying:** Evidence of 'sexting', sexualised communication on-line or problematic use of the internet and social networking

sites.

- **Alcohol and drug misuse:** Problematic substance use.

- **Receipt of unexplained gifts or money:** Unexplained finances, including phone credit, clothes and money.

- **Distrust of authority figures:** Resistance to communicating with parents, carers, teachers, social services, health, police and others

25.8 CSE Risk Assessment Framework

There are 3 categories of sexual exploitation:

Category 1 (At Risk): a vulnerable child who is at risk of being targeted and groomed for sexual exploitation

Category 2 (Medium Risk): a child who is targeted for opportunistic abuse through the exchange of sex for drugs, accommodation (overnight stays) and goods, etc. The likelihood of coercion and control is significant

Category 3 (High Risk): a child whose sexual exploitation is habitual, often self-defined and where coercion/control is implicit.

26. Fabricated or Induced Illness

26.1 The term 'fabricated or Induced Illness' encompasses many different situations in which children are presented as 'sick' but where illness has arisen as a result of a parent/carers actions in inducing an illness or by fabricating an illness by telling a story of symptoms which lead health professionals to believe the child has an illness.

These include five key forms of parent/carer behaviour:

- Pretence of illness (e.g. feigning symptoms)
- Fabrication of illness or medical history
- Inducement of illness
- Exaggeration of genuine illness
- Enforced invalidism

26.2 Any concerns or suspicions regarding FII should be discussed with a Named Doctor for Safeguarding Children. These concerns MUST NOT be discussed with the family at this stage.

26.3 Further guidance is available in: Safeguarding Children in Whom Illness is Fabricated or Induced and Fabricated or Induced Illness by Carers: A Practical Guide for Paediatricians.

27. Female Genital Mutilation (FGM)

27.1 Female genital mutilation (sometimes referred to as female circumcision or cutting) refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. The practice is illegal in the UK. It is also illegal to

take a British national or permanent resident abroad for FGM or to help someone trying to do this. If you suspect or become aware that this is going to happen to a girl or young woman contact the Police on 101.

27.2 It has been estimated that over 20,000 girls under the age of 15 are at risk of female genital mutilation (FGM) in the UK each year, and that 66,000 women in the UK are living with the consequences of FGM. However, the true extent is unknown, due to the "hidden" nature of the crime.

27.3 The girls may be taken to their countries of origin so that FGM can be carried out during the summer holidays, allowing them time to "heal" before they return to school.

27.4 FGM is usually carried out on young girls between infancy and the age of 15, most commonly before puberty starts. The procedure is traditionally carried out by a woman with no medical training. Anaesthetics and antiseptic treatments are not generally used, and the practice is usually carried out using knives, scissors, and scalpels, pieces of glass or razor blades. Girls may have to be forcibly restrained.

27.5 Mandatory Reporting of FGM – Females Under 18

A ‘known’ FGM case is

- when a female under 18 has disclosed FGM themselves or
- FGM has been visually identified in the course of another examination or activity.

If you ‘know’ a female under 18 has undergone FGM you must:

- Discuss with the ELFT Safeguarding Children Team
- Phone the Police on 101 (within 48 hours, exceptionally within one month) - see below*
- Also make a referral to Children’s Social Care/MASH
- Complete a Datix Incident Reporting Form
- Complete the FGM Form on RiO
- Make a record of your actions, and record the Police reference number
- Make sure you or someone with access to all the information is available to discuss further with the police lead investigator.

***The information you as a Clinician need to give the Police 101 operator**

- Explain that you are making a report under the FGM mandatory reporting duty
- Your details:
    - name
    - contact details (work telephone number and e-mail address)
    - times when you will be available to be called back
    - role
    - place of work
- The details of the Trust’s Safeguarding Children Lead:

  - Associate Director for Safeguarding Children
  - Tel: 020 7655 4000
  - East London NHS Foundation Trust 9 Alie St, London E1 8DE

- The girl's details:
  - name
  - age/date of birth
  - address

- If applicable, you should confirm what safeguarding actions you have taken or plan to take.

27.6 Concerns about FGM – Females Under 18

Concerns may arise from what you are told by a young person themselves, another child or a parent or relative. Where there is a risk to life or likelihood of serious immediate harm, you should report the case immediately to the Police, including dialling 999 if appropriate.

If you do not 'know' that FGM has occurred but you have concerns you must:

- Discuss with the ELFT Safeguarding Children Team
- Make a referral to Children's Social Care/MASH
- Complete a Datix Incident Reporting Form
- Complete the FGM Form on RiO

28. Children & Young People Vulnerable To Radicalisation

28.1 Trust staff may in the course of their work, meet and treat people who may be vulnerable to being drawn into terrorism. Being drawn into terrorism includes not just violent extremism but also non-violent extremism, which can create an atmosphere conducive to terrorism and can popularise views which terrorists exploit.

28.2 If you have concerns that that a child or young person may be susceptible to radicalisation and or violent extremism, a referral must be made to Children's Social Care and the Channel Panel. The case must be discussed with the Safeguarding Children Team before the referral is made.

28.3 If your concerns relate to an adult service user or member of staff, the Safeguarding Adults Team must be informed. In these cases, consideration must be given to whether any children are at risk due to the behaviour of the adult either because they live in the family home or will come into contact with the adult during the course of their work. If so, the child will additionally need to be referred to Children's Social Care.

28.4 If you believe a child, young person, adult patient or member of staff is engaging in terrorist activity, the Police will also need to be informed and the Safeguarding Children/Adults Team must be contacted for advice. The Police have local Prevent leads who can be contacted for advice. See intranet for current details.

Further information can be found in: Prevent Duty Guidance for England and Wales**.**

29. Disabled Children

29.1 Disabled children can be particularly vulnerable and they are especially at risk of harm when they are living away from home. They may be particularly vulnerable to coercion due to physical dependency or because a learning disability or communication difficulty means that it is not easy for them to communicate their wishes or concerns to another person.

Part C
Inter-Agency Child Protection Procedures

1.0 Introduction

1.1 Trust staff who work in London must familiarise themselves, and comply, with the London Child Protection Procedures.

The London Procedures can be found at: http://www.londoncp.co.uk

1.2 Trust staff who work in Bedford Borough, Central Bedfordshire or Luton must familiarise themselves, and comply, with the Pan Bedfordshire Child Protection Procedures.

The Pan Bedfordshire and Luton Procedures can be found at:

http://bedfordscb.proceduresonline.com/index.htm

1.3 In both sets of procedures can be found:

- definitions of abuse and neglect
- guidance on acting on concerns and making referrals to Children's Social Care
- guidance on information sharing and consent
- guidance on resolving professional disagreements

1.4 In addition, the Local Safeguarding Children Boards have local guidance which can be found on their websites.

This includes local information about:

- How to make referrals to Children's Social Care and Multi-agency Safeguarding Hubs (MASH)
- Escalation processes
- Joint protocols
- Training courses

1.4.1 **Barnet** Local Safeguarding Children Board (BSCB)

https://www.barnet.gov.uk/bscb/

1.4.2 **City and Hackney** Local Safeguarding Children Board (CHSCB)

http://www.chscb.org.uk/

1.4.3 **Newham** Local Safeguarding Children Board (NSCB)

http://www.newhamlscb.org.uk/

1.4.4 **Redbridge** Local Safeguarding Children Board

http://www.redbridgelscb.org.uk/

1.4.5 Kingston & **Richmond** Local Safeguarding Children Board

http://www.kingstonandrichmondlscb.org.uk/

1.4.6 **Tower Hamlets** Local Safeguarding Children Board

http://www.childrenandfamiliestrust.co.uk/the-lscb/

1.4.7 **Bedford Borough** Local Safeguarding Children Board

http://www.bedford.gov.uk/health_and_social_care/children__young_people/safeguarding_children_board.aspx

1.4.8 **Central Bedfordshire** Local Safeguarding Children Board

http://www.bedfordshirelscb.org.uk/

1.4.9 **Luton** Local Safeguarding Children Board

http://lutonlscb.org.uk/

1.5 Multi-agency and single agency adherence to the procedures is monitored through the Local Safeguarding Children Boards (LSCBs). The Trust is represented on the LSCBs in Bedford Borough; Central Bedfordshire; Luton; City and Hackney; Newham; Tower Hamlets and sub-groups by representatives of ELFT.

1.6 The Children Act 1989 introduced the concept of *Significant Harm* as the threshold that justifies compulsory intervention in family life in order to safeguard children. The Local Authority's Children's Social Care (CSC) services has a duty to investigate where there is reason to suspect that a child is likely to suffer, or is suffering significant harm. See Appendix 2 for definitions of categories of abuse and Appendix 3 for possible indicators of abuse.

1.7 There is a wide range of more detailed national and regional supplementary guidance and procedures available on LSCB websites on issues such as children of families living in temporary accommodation, children and families who go missing, internet child abuse, child abuse linked to belief in 'possession' or 'witchcraft' or in other ways related to spiritual or religious belief, female genital mutilation, forced marriages, bullying, children living away from home, children in custody, children in hospital, sexually exploited children, trafficked and exploited children, and children affected by domestic violence.

2. Staff Involvement in Formal Child Protection Processes

Staff should:

- Refer concerns about significant harm or child in need to Children's Social Care (CSC)/Triage/MASH by phone and on the locally agreed Referral Form within 24 hours of verbal referral

- Co-operate and share information with Children's Social Care when they undertake a Children Act 1989 Section 47 Child Protection Investigation or a Section 17 Child in Need assessment;

- Contribute to assessment of parenting capacity (adult functioning), child's needs and family and environmental factors

- Attend and contribute to Strategy/Professionals Meetings, Child Protection Conferences, and Core Groups and provide written reports;

- Make a judgement about whether child should be subject of a Child Protection Plan and category – *neglect; emotional abuse; physical abuse; sexual abuse;*

- Continue to work jointly until joint decision is reached that this is no longer necessary.

3. Making a Referral to Children's Social Care

3.1 See hyperlinks to flowcharts. Click on relevant link for information about how to make a referral to:

- East London boroughs (City, Hackney, Newham, Tower Hamlets)
- Bedfordshire and Luton CSC (Bedford Borough, Central Beds, Luton)
- R3 North East London boroughs (Redbridge, Waltham Forest, Newham, Barking & Dagenham, Havering)


ELFT East London Flowchart Safeguardi


ELFT Beds&Luton Flowchart Safeguardi


ELFT R3 Safeguarding Childrer

3.2 Process:

- Telephone the relevant Triage Team/Children's Social Care/MASH
- Follow up immediately with relevant referral form for the borough (see Safeguarding Children page on intranet)
- Agree with the recipient of the referral:
  - ✓ what the child and parents will be told
  - ✓ by whom and
  - ✓ by when
- Children's Social Care should acknowledge your referral within one working day
- If you have not heard back within 3 working days, contact Children's Social Care again to find out if/how it is being acted upon
- If you are not happy that the response will safeguard the child and you are unable to resolve it, discuss with your manager or clinical lead

The Trust's Safeguarding Children Teams are available to support staff about making a referral or if concerns need to be escalated.

3.3 As part of their risk assessments of adults or children, staff should assess any risks to children and whether a referral should be made to Children's Social Care. Staff should use their clinical judgement regarding risk but there are some situations which must always be referred to Children's Social Care.

3.4 Referrals must be made to Children's Social Care if:

- A parent or other adult in significant contact with children has delusional thinking involving a child;

- A parent or other adult in significant contact with children has suicidal thoughts involving a child;
- There are concerns that a female under 18 has undergone or may undergo FGM;
- There are concerns a child or young person is at risk of Child Sexual Exploitation;
- There are concerns that a child or young person is at risk of radicalisation;
- There are concerns that a child may be subject of Fabricated or Induced Illness.

4. Ascertaining whether a family is known to Children's Social Care or subject of a Child Protection Plan

4.1 Staff can contact Children's Social Care to see if a child is known to Child Protection or Children in Need teams and if a child is subject to a Child Protection Plan or previously on the Child Protection Register.

4.2 If the child is known, or believed, to be resident in a borough outside the Trust's usual areas, staff should contact the appropriate local authority. The Safeguarding Children Team may be able to assist with this.

5. Record Keeping

5.1 The following records should all show that children have been considered and include relevant information about children and impact on children:

- Family and household composition including

  - non-resident children

  - pregnant service user with estimated date of delivery (EDD)

  - pregnant partner

- Risk assessments
- Needs assessments
- Contingency plans
- Leave arrangements
- Discharge arrangements
- Arrangements for children visiting service users in hospital
- Datix Incident Reporting Forms

5.2 When assessments show that a child is deemed to be vulnerable or at risk of harm information from these records should be shared with colleagues in Children's Social Care.

5.3 Staff dealing with cases where there is a child/children at risk of harm must keep full factual records of what is said by all parties, details of all findings and observations and record dates and times of all entries. It is helpful to keep a chronology of key events.

6. Information Sharing

6.1 It is recognised that information sharing is a thorny issue and that Trust staff can feel constrained from sharing information by their uncertainty about when they can do so

lawfully. It is best practice to discuss with service users, any concerns and any intention to share information, unless by doing so there would be increased risk to a child or children (or another person).

6.2 Legally, staff can share confidential information with the service user's consent (check the most recent Consent to Disclosure Form on file).

6.3 If the information is in the public interest it is legal to share without the service user's consent. Public interest considerations are covered in the list of exemptions in the Data Protection Act 1998. Risk to children is covered by the public interest exemption.

6.4 Government guidance on information sharing explicitly states that as well as applying to staff working mainly with children, it also applies to *practitioners who work in services provided for adults, for example mental health services and drug and alcohol services, as many of the adults accessing those services may have parenting or caring responsibilities.*

6.5 Six key points are:

- *You should explain to children, young people and families at the outset, openly and honestly, what and how information will, or could be shared and why, and seek their agreement. The exception to this is where to do so would put that child, young person or others at increased risk of significant harm or an adult at risk of serious harm, or if it would undermine the prevention, detection or prosecution of a serious crime (note 1 - see below for definition) including where consent might lead to interference with any potential investigation*.
- *You must always consider the safety and welfare of a child or young person when making decisions on whether to share information about them*. *Where there is concern that the child may be suffering or is at risk of suffering significant harm, the child's safety and welfare must be the overriding consideration.*
- *You should, where possible, respect the wishes of children, young people or families who do not consent to share confidential information. You may still share information, if in your judgement on the facts of the case, there is sufficient need to override that lack of consent.*
- *You should seek advice (note 2 below) where you are in doubt, especially where your doubt relates to a concern about possible significant harm to a child or serious harm to others.*
- *You should ensure that the information you share is accurate and up to date, necessary for the purpose for which you are sharing it, shared only with those people who need to see it and shared securely.*
- *You should always record the reasons for your decision – whether it is to share information or not.*

Note 1 – for the purposes of this guidance a serious crime means any crime which 6.6 causes or is likely to cause significant harm to a child or young person or serious harm to an adult.

Note 2 - Advice can be sought from your manager, members of the Safeguarding Children Team and the Trust's Caldicott Guardian (the Medical Director). The Caldicott Guardian is legally responsible for the Trust's compliance with information sharing guidance.

6.6 Where a member of staff has serious concerns about the immediate health and well being of an individual, or others that might come into contact with that person, then guidance on sharing personal information with another organisation without the individual's consent must be sought in the first instance from a line manager.

6.7 Where the risks to the individual or another person are considered so great, and/or the individual is either unwilling or unable to give consent to disclosure, then the member of staff or line manager, **acting in good faith,** should disclose this personal information to the relevant organisations immediately. **Failure to do so might be viewed as failure of the organisation that is aware of the risk to discharge its duty of care, particularly if there is resultant harm.**

6.8 Staff should always record on the service user's notes the reason for disclosing information and whether disclosure was with or without the service user's consent.

6.9 Written information likely to be shared with Children's Social Care or other services concerned with the child will be:

- Child Protection or Child in Need referral
- Reports for Child Protection Conferences
- Risk assessments and any other relevant parts of CPA documentation

6.10 Information shared with other agencies must be as factual as possible and provide evidence and sources of information. It should be discussed with the service user unless doing so would put a child at further risk of harm.

6.11 CHILD PROTECTION CONCERNS ALWAYS OVERRIDE

- CONFIDENTIALITY CONSIDERATIONS and
- WORRIES THAT STAFF MAY HAVE ABOUT POTENTIAL DAMAGE TO A THERAPEUTIC RELATIONSHIP

6.12 Staff may also be directed by the court to provide written reports in a range of court proceedings involving children – e.g. care proceedings, adoption proceedings, family proceedings regarding residence and contact arrangements. In such situations staff should notify, and seek advice from, the Safeguarding Children Team and Associate Director for Legal Affairs.

7. Children Who Live outside the Trust Area

7.1 If a child who is the subject of concern does not live in Hackney, Newham, Tower Hamlets, The City, Redbridge, Barnet, Richmond, Bedford Borough, Central Bedfordshire or Luton staff should contact the relevant Children's Social Care in the Local Authority area where the child lives. Their contact details should be available on the relevant Council website.

8. Out of Hours Child Protection Concerns

8.1 Out of hours child protection referrals should be made to the Emergency Duty Team (EDT) for the relevant borough. If the EDT worker is unavailable and the situation is urgent, staff should call the Police.

8.2 All out of hours concerns should be discussed with the Duty Nurse or Doctor. If the situation is serious the Duty Director should be informed. Staff must also consider whether an Incident Reporting Form should be completed.

9. Child Protection Conferences and Meetings

9.1 There are a number of types of conferences and meetings convened under child protection arrangements. These are:

- Child Protection Professionals Strategy Meeting
- Initial Child Protection Conference
- Initial Pre-Birth Child Protection Conference
- Review Child Protection Conference
- Child Protection Core Group Meeting

9.2 Staff invited to a Child Protection Conference MUST:

- Prepare a typed report, using the locally agreed Child Protection Report proforma including your assessment of risk;
- Upload the report to the service user records;
- Send report to the conference chair/administrator in advance;
- Share contents of your report with your service user in advance as he/she will be invited to the conference;
- Attend conference and take enough copies of your report or if unable to attend, send a colleague who you have adequately briefed;
- At the conference, verbally present your report;
- When asked by the Chair, express a view about whether the child should be subject of a Child Protection Plan;
- If a Child Protection Plan is agreed, join the Core Group if your service can play a part in implementing the Plan;

If required the Safeguarding Children Team can:

- Help staff prepare a report
- Help staff prepare for the conference and
- May attend the conference with staff if support is needed

10. Differences of Opinions and Escalation Processes

10.1 If staff remain concerned about the safety of a child and are not satisfied with the response from Children's Social Care they should seek further discussion with the social worker and their manager. Staff should involve their manager and if necessary one of the Safeguarding Children Team. In line with LSCB Escalation Policies staff should continue to escalate with senior managers until a satisfactory conclusion has been reached. Concerns, discussions and any agreements made should be recorded in the service user's notes.

10.2 If concerns remain, staff may, with the support of a member of the Safeguarding Children Team, formally request that Children's Social Care convene an initial child protection conference. In accordance with the London Child Protection Procedures, Children's Social Care must convene a conference where it is requested by one or more professionals, with the support of a senior manager and a Named Professional from the Safeguarding Children Team.

10.3 If this approach fails to achieve agreement or where differences of opinion across agencies occur about risk the procedures for resolution of conflicts in the London Child Protection Procedures or Pan Bedfordshire Child Protection Procedures should be followed.

10.4 Where differences of opinion occur within a Trust multi-disciplinary team advice should be sought from the Trust's Safeguarding Children Team. If necessary, the situation will be escalated with senior managers in the relevant Directorate.

11. Multi-Agency Public Protection Arrangements (MAPPA)

Staff may be working with a service user who is subject to, and monitored under MAPPA arrangements. These cover the management of individuals who pose a risk of harm to children. In these circumstances, staff should ensure that appropriate information is shared with the MAPPA panels.

12. Multi Agency Risk Assessment Conference (MARAC)

Staff may be working with a service user who is a victim or perpetrator of domestic abuse or a child in a family where domestic abuse occurs. Cases can be referred to MARACs for multi-agency plans to be agreed. The Trust is represented on MARACs and will check whether cases being discussed are known to ELFT and will share appropriate information with MARACs.

13. MASE (Multi Agency Sexual Exploitation)

The Trust is involved in Multi-Agency Sexual Exploitation arrangements whereby cases of concern can be discussed.

14. Channel Panel

Staff concerned about service users who are vulnerable to radicalisation should contact the Police Prevent leads and if necessary a referral to the Channel Panel will be made.

APPENDIX 1

SAFEGUARDING CHILDREN IS EVERYONE'S RESPONSIBILITY

ELFT Safeguarding Children Induction Pack – September 2016

1.0 Introduction

The Trust takes very seriously its responsibilities for safeguarding and promoting the welfare of children and all of us, whatever our role in the organisation, have a legal duty to uphold this commitment.

It is the duty of all staff, whether clinical or non-clinical and whether providing services to adults or children, to place the needs of the child first.

All East London NHS Foundation Trust (ELFT) employees, volunteers and Board members must strive to proactively safeguard and promote the welfare of children.

If you are in a non-clinical role you are less likely to come into routine contact with safeguarding children issues as part of your role, but you need to be aware of your responsibilities. You may be in a position to identify concerns and bring them to the attention of clinical colleagues.

2.0 Corporate Leads

Lead Director for Safeguarding

Jonathan Warren Director of Nursing

Tel: 020 7655 4000 jonathan.warren@elft.nhs.uk

Operational Lead for Safeguarding

Eirlys Evans Deputy Director of Nursing

Tel: 020 7059 6707 eirlys.evans@elft.nhs.uk

3.0 Safeguarding Children Teams

The Trust has a number of specialist staff who are here to help you with advice, support and information regarding safeguarding children. These staff run in-house training and work closely with partner agencies on the Local Safeguarding Children Boards.

You can email or phone the relevant team to help you with issues like:

- Risk assessments and information sharing;
- Decisions about referrals to Children's Social Care;
- Impact of domestic abuse on children;
- Risks relating to suicide plans or delusional beliefs involving children;
- Disclosures by adult service users of childhood abuse;
- Concerns about unborn children and pregnant women;

3.1 Mental Health Services (including IAPT and Drug & Alcohol Services)

The Safeguarding Children Team (Mental Health) can be emailed at:

TrustadviceMHsafeguardingchildren@elft.nhs.uk

Jan Pearson	Associate Director for Safeguarding Children
Tel: 020 7655 4136	jan.pearson@elft.nhs.uk
Mob: 07971 664232	
Linda Geddes	Named Professional for Safeguarding Children (Newham)
Mob: 07891 865051	linda.geddes@elft.nhs.uk
Alison Eley	Named Professional for Safeguarding Children (C&H)
Mob: 07891 862029	alison.eley@elft.nhs.uk
Gurinder Lall	Named Professional for Safeguarding Children (Tower Hamlets)
Mob: 07908 194436	gurinder.lall@elft.nhs.uk
Jones Korankye	Executive Assistant for Safeguarding
Tel: 020 7655 4276	jones.korankye@elft.nhs.uk
Dr Deji Oyebode	Deputy Medical Director/ Named Doctor (Adult Mental Health)
Tel: 020 7655 4000	deji.oyebode@elft.nhs.uk
Dr Georgina Hawkes	Consultant Child & Adolescent Psychiatrist/Named Doctor (East London CAMHS)
Tel: 020 7055 8400	georgina.hawkes@elft.nhs.uk
Isobel Sanderson	Named Professional for Safeguarding Children (Bedford and Mid Beds)
Tel: 07940 001239	isobel.sanderson@elft.nhs.uk
Mandy Penfold	Named Professional for Safeguarding Children (Luton and South Beds)
Tel: 07940 001247	mandy.penfold@elft.nhs.uk
Dr Hilary Gahan	Consultant Child & Adolescent Psychiatrist/CAMHS Named Doctor
Tel: 01582 708140	hilary.gahan@elft.nhs.uk

3.2 Newham Community Services (including Barnet SLT)

Agnes Adentan Tel: 020 7059 6584 Mob: 07930 618960	Named Nurse for Safeguarding Children agnes.adentan@elft.nhs.uk
Dr Fayrus Abusrewil Tel: 020 8250 7356/7359 Mob: 07984 278896	Named Doctor for Safeguarding Children fayrus.abusrewil@elft.nhs.uk
Patricia Marius Tel: 020 7059 6580 Mob: 07946 782332	Specialist Safeguarding Practitioner patricia.marius@elft.nhs.uk

Alberta Awotwi	Specialist Safeguarding Practitioner
Tel: 020 7059 6580 Mob: 07779 281511	alberta.awotwi@elft.nhs.uk
Lacey Swann	Specialist Safeguarding Practitioner
Tel No: 020 7059 6577 Mob: 07866 444189	lacey.swann@elft.nhs.uk
Mercy Maponga	Specialist Safeguarding Practitioner
Tel: 020 7059 6580 Mob: 07946 782273	mercy.maponga@elft.nhs.uk
Surjeet Kundi	Senior Administrator
Tel: 020 7059 6583	surjeet.kundi@elft.nhs.uk

3.3 Newham Community Service Duty Desk

Staff working in CHN can access ad hoc safeguarding children advice from the Safeguarding Children Team duty desk Monday to Friday 9:00 – 17:00.

The duty desk can be accessed via telephone: 020 7059 6583 or
via e-mail: elt-tr.safeguardingchildrenteam@nhs.net

4.0 What should you do if you are worried about a child?

- Do not minimise your concerns or assume someone else will do something;
- Do discuss your concerns with your manager or an appropriate colleague;
- If necessary, consult a member of the relevant Trust Safeguarding Children Team.

If you are a clinician you will need to consider whether to make a referral to Children's Social Care. In most circumstances you should seek the consent of the parent or child, if the latter is of sufficient understanding, to share information about concerns. Consent can be overridden if there are child protection concerns. Do not seek consent if this will put a child or a vulnerable adult at further risk of harm.

5.0 Information sharing

Remember that child protection concerns ALWAYS OVERRIDE:

- Confidentiality considerations;
- Any concerns about potential damage to a therapeutic relationship.

6.0 What if you are worried about a child outside of work?

If, in your personal life, you suspect that a child or young person is being abused, you can contact:

- Children's Social Care services in the relevant Council (see the Council's website)
- The Police on 999 (emergency) or 101 (non-emergency)
- NSPCC Child Protection Helpline

Tel: 0800 800 5000

Email: help@nspcc.org.uk

Text: 88858

Website: www.nspcc.org.uk/helpline

7.0 Managing your own feelings

Child abuse is distressing and disturbing. You may feel upset, shocked or angry. If you know the person involved, you may find it difficult to accept that it has happened. However, it is important to manage your own feelings so that you can respond appropriately.

You may find it helpful to talk over these issues with a colleague, friend or a Safeguarding Children Team member so that it is clear where responsibility sits and what contribution that you can reasonably be expected to make. Awareness of child abuse can often remind adults of painful situations in their own past. If this applies to you, you may wish to seek help from colleagues or professionals in dealing with your feelings.

8.0 Support for staff

If you need personal advice and support you may wish to contact the Trust's employee assistance scheme which includes counselling services and legal advice. Full details can be found on the Trust intranet.

Search for: *Employee Assistance Programme*.

9.0 Mandatory Training

Staff should use the personal development planning and appraisal process to monitor access to mandatory training, provided by the Trust or externally, and to identify any additional training needs. Please look at the details on the Safeguarding Children training pages as well as your OLM records so you are clear which training you should be looking for and booking onto.

All non-clinical staff should undertake the Trust's Level 1 Safeguarding Children course within three months of starting in the Trust.

All clinical staff will be required to undertake either a Level 2 Safeguarding Children course or go straight to a Level 3 course both of which will incorporate all relevant competences. This will be dependent on role.

There are different courses for community health clinicians and mental health clinicians (CAMHS and adult mental health services). Please check carefully that you book on to the relevant course. Courses are run in London and in Bedfordshire and Luton.

Full details of mandatory training requirements and courses can be found on the Trust's intranet Training section. This includes in-house courses run by the Safeguarding Children Teams as well as links to free of charge multi-agency courses run by the Local Safeguarding Children Boards in Barnet, Bedford Borough, Central

Bedfordshire, City & Hackney, Luton, Newham, Redbridge, Richmond, and Tower Hamlets.

Click on Safeguarding Children Training Courses then type Safeguarding Children into the Search box. LSCB Training Brochure links can be found on the Safeguarding Children Level 3 Refresher page.

10.0 Safeguarding Children and Domestic Abuse

Safeguarding children situations can often arise in the context of domestic abuse within the family or household. The Trust has a strategic lead for domestic abuse and there are information pages on the Trust intranet.

Strategic Lead

Janet Boorman Associate Director - Domestic Abuse and Safeguarding Adults
Tel: 020 7655 4240 janet.boorman@elft.nhs.uk

11.0 Trust Intranet – Documents and Resources/Clinical and Patient Care

There are a number of links to relevant information on the Trust Intranet *in Documents and Resources/Clinical and Patient Care* section.

These include:

- *Carers and Users Involvement* – for links to all Young Carers Projects;
- *Domestic Abuse* – for resources and guidance;
- *Parental Mental Health* – for a range of materials and information;
- *Safeguarding Children* – for a range of information.

The Safeguarding Children page on the Trust intranet contains links to a range of information including:

- full details of the members of the Trust Safeguarding Children Teams;
- information about making referrals to Children's Social Care;
- policies and procedures;
- training;
- Local Safeguarding Children Boards.

You can use the search function too.

APPENDIX 2

Safeguarding Children Level 1

Introduction

Welcome to the Safeguarding Children Level 1 briefing. This is provided to all new staff at Induction and also serves as a refresher for non-clinical staff. Reading and understanding this will ensure that non-clinical staff are compliant with their Level 1 refresher training. Clinicians should refresh at Level 2 or Level 3 dependent on role.

This briefing supports you in understanding what is meant by:

- safeguarding children and child protection;
- the different ways a child or young person may be abused or neglected;
- thinking about the potential impact of a parent/carers physical and mental health on the well-being of a child or young person; and
- what action you should take if you ever have concerns that a child is being harmed.

If anything in this briefing raises any issues for you please see the later sections entitled *Managing your own feelings* and *Support for staff*.

What are our responsibilities?

It is the duty of all staff, whether clinical or non-clinical and whether providing services to adults or children, to place the needs of the child first.

All employees, volunteers, lay members and Board members of East London NHS Foundation Trust (ELFT) must aim to proactively safeguard and promote the welfare of children.

If you are in a non-clinical role you may be less likely to come into routine contact with safeguarding children issues but you need to be aware of your responsibilities. You may be in a position to identify concerns and bring them to the attention of clinical colleagues.

SAFEGUARDING CHILDREN IS EVERYONE'S RESPONSIBILITY

What is safeguarding children?

Safeguarding and promoting the welfare of children is defined as:

- Protecting children (unborn - 18th birthday) from maltreatment;
- Preventing impairment of children's health or development;
- Ensuring children are growing up in circumstances consistent with the provision of safe and effective care;
- Taking action to enable all children to have the best outcomes.

It is important to consider the support needs of children and their parents/carers. There may be universal or specialist services that can help. The provision of additional support services or early help could prevent a situation needing child protection interventions.

What is child protection?

Child protection is a part of safeguarding and promoting welfare. It refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm. This requires agencies to work together and share information.

What is child abuse?

The term child abuse describes a range of ways in which people cause harm to, or fail to act to prevent harm to, children or young people (unborn -18th birthday). 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. Child abuse can be physical, emotional, sexual

or neglect. In many cases, children are subjected to a combination of types of abuse e.g. neglect and emotional abuse.

Definitions of abuse

There are four nationally recognised categories of abuse:

Physical abuse

Physical abuse is when physical harm is caused to a child by a parent or other person responsible for the child's care.

It may involve:

- Hitting
- Shaking
- Throwing
- Poisoning
- Burning or scalding
- Drowning
- Suffocating
- Any other way of causing physical harm.

- It may also be caused when a parent/carer fabricates the symptoms of, or deliberately induces, illness in a child. (Fabricated or Induced Illness - FII).

- It may also be in the form of female genital mutilation (FGM). This is illegal in the UK. It is also illegal to take a British national or permanent resident abroad for FGM or to help someone trying to do this.

- Children may also be injured if caught up in domestic abuse situations. The scope of domestic violence now also includes young people aged 16 and 17 who experience domestic abuse in peer relationships.

Emotional abuse

Emotional abuse is the persistent emotional ill-treatment to cause severe and persistent adverse effects on the child's emotional development.

It may involve or include:

- Conveying to children they are worthless, unloved, inadequate or valued only insofar as they meet the needs of another person;
- Not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate;
- Age or developmentally inappropriate expectations imposed on a child: e.g. interactions beyond child's developmental capability, overprotection and limitation of exploration and learning, preventing the child participating in normal social interaction;
- Seeing or hearing the ill-treatment of another – including living in a household where domestic abuse/violence takes place;
- Serious bullying (including cyber bullying);
- Causing a child frequently to feel frightened or in danger;
- Exploitation or corruption of children.

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

Sexual abuse

Child sexual abuse is forcing or enticing a child (up to aged 18) 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.

- Involving physical contact:
  - Penetrative acts – e.g. rape, oral sex, use of objects;
  - Non-penetrative acts - e.g. masturbation, kissing, rubbing and touching outside of clothing.

and/or

- Non-contact activities:
  - Involving children in looking at or in the production of pornographic materials, including online and with mobile phones;
  - Involving children in watching sexual activities;
  - Encouraging children to behave in sexually inappropriate ways or
  - Grooming a child in preparation for abuse (including via the internet).

Child sexual abuse can be perpetrated by adult males, adult females and children/young people.

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 section 5 of the Sexual Offences Act 2003.

Neglect

Child neglect is the persistent failure to meet a child's basic physical and/or psychological needs likely to result in the serious impairment of the child's health or development.

Neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect 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.

Neglect may occur during pregnancy as a result of maternal substance misuse, maternal mental ill health or learning difficulties, or a cluster of such issues. Where there is domestic abuse and violence towards a child's parent or carer, the needs of the child may be neglected.

What are the effects of child abuse?

The effects of abuse on children are wide-ranging and profound. The effects may include:

- Behavioural problems
- Emotional difficulties
- Educational problems
- Mental health problems
- Relationship difficulties
- Drug and alcohol problems
- Suicide or other self-harm
- Injury, and in extreme cases, death.

Many survivors comment that the emotional consequences are far more severe than the physical effects of abuse. Children who are abused can be helped.

What should you do if you are worried about a child?

- Do not minimise your concerns or assume someone else will do something;
- Discuss your concerns with your manager or an appropriate colleague;
- If necessary, consult a member of the Trust's Safeguarding Children Team.

If you are a clinician you will need to consider whether to make a referral to Children's Social Care. You should seek consent of the parent or child, if the latter is of sufficient understanding, to share information about concerns in most circumstances. Consent can be overridden if there are child protection concerns. Do not seek consent if this will put a child or a vulnerable adult at further risk of harm.

Information sharing

Remember that child protection concerns ALWAYS OVERRIDE:

- Confidentiality considerations
- Any concerns about potential damage to a therapeutic relationship

Child abuse allegations against staff

Occasionally, a member of staff may be subject to allegations that they have caused a child harm at work or in their personal life. Staff should inform their line manager if Children's Social Care or the Police have contacted them in relation to their personal life. See the Trust's Allegations against Staff Policy for more details.

What if you are worried about a child outside of work?

If, in your personal life, you suspect that a child or young person is being abused, you can contact:

- Children's Social Care services in the relevant Council (see Council website)
- The Police on 999 (emergency) or 101 (non-emergency)
- NSPCC Child Protection Helpline

  Tel: 0800 800 5000

  Email: help@nspcc.org.uk

  Text: 88858

  Website: www.nspcc.org.uk/helpline

Managing your own feelings

Child abuse is distressing and disturbing. You may feel upset, shocked or angry. If you know the person involved, you may find it difficult to accept that it has happened. However, it is important to manage your own feelings so that you can respond appropriately.

You may find it helpful to talk over these issues with a colleague, friend or member of the Safeguarding Children Team so that it is clear where responsibility lies and what contribution that you can reasonably be expected to make. Awareness of child abuse can often remind adults of painful situations in their own past. If this applies to you, you may need help from colleagues or professionals in dealing with them.

Support for staff

If you need personal advice and support you may wish to contact the Trust's employee assistance scheme which includes counselling services and legal advice. Full details can be found on the Trust intranet

Search for: Employee Assistance Programme.

Support for staff or service users

The NSPCC and NAPAC are charitable organisations that provide advice and support for children and adults who are being, or have been, abused.

NSPCC Child Protection Helpline

Tel: 0800 800 5000

Email: help@nspcc.org.uk

Text: 88858

Website: www.nspcc.org.uk/helpline

NAPAC (The National Association for People Abused in Childhood)

Tel: 0800 085 3330

Website: http://www.napac.org.uk/

The Trust Safeguarding Children Team

The Trust's Safeguarding Children Team is here to provide you with advice and support. Contact details can be found on the Trust intranet.

Further information

The Trust intranet contains information and links for a range of safeguarding children documents. Use the Search function or go to *Documents & Resources/Clinical & Patient Care/Safeguarding Children*

NATIONAL

Working Together to Safeguard Children, *HM Government 2015*

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

LONDON BOROUGHS - ALL

London Child Protection Procedures 2015, *London Safeguarding Children Board*

http://www.londonscb.gov.uk/procedures/

BEDFORDSHIRE & LUTON

Pan Bedfordshire Child Protection Procedures 2015

Bedford Borough, Central Bedfordshire and Luton Local Safeguarding Children Boards

http://bedfordscb.proceduresonline.com/index.htm

What you must do now:

- Check that you have understood what you have read;
- Confirm with your supervisor or line manager that you have read the briefing;
- Discuss any issues with your supervisor or line manager;
- Ensure your personal training record logs the date that you read the briefing;
- Sign and date below.