East London
NHS Foundation Trust

Safeguarding Children Policy

Version number :	7.1
Consultation Groups	Key safeguarding leads
Approved by (Sponsor Group)	Safeguarding Committee
Ratified by:	Quality Committee
Date ratified:	16 October 2019
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Implementation Date :	October 2019
Last Review Date	August 2019
Next Review date:	April 2023

Services	Applicable
Trustwide	x
Mental Health and LD	
Community Health Services	

Version Control Summary

Version	**Date**	**Author**	**Status**	**Comment**
ELFT (Mental Health) Safeguarding Children Policy Final	May 2006	Jan Pearson Associate Director for Safeguarding Children	Final	
ELFT (Mental Health) Safeguarding and Promoting the Welfare of Children Policy Final	October 2008	Jan Pearson Associate Director for Safeguarding Children	Final	
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
ELFT Safeguarding Children Policy	May 2016	Jan Pearson, Associate Director for Safeguarding Children & Agnes Adentan, Named Nurse for Safeguarding Children	Final	Updated with reference to new ELFT services and procedural documents.
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.
ELFT Safeguarding Children Policy	August 2019	Agnes Adentan, Associate Director for Safeguarding Children & Gurinder Lall, Named Professional for Safeguarding Children	Final	Updated with additional guidance.
7.1	September 2022			Extended for 6 months

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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

- 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 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 has a duty to investigate where it has reason to suspect that a child is suffering or likely to suffer significant harm.

- The Children Act 2004 requires each local authority, health and partner agencies to make arrangements to promote cooperation between each of the authority's relevant partners. The arrangements are made to promote the wellbeing of children in their area which includes protection from harm.

- 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 17 of the Children Act 1989 considers the provision of services for Children in Need, their families and others; so far as is consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of services appropriate to those children's needs.

- 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.

- Under Section 20 of the Children Act 1989, children may be accommodated by the local authority if they have no parent or are lost or abandoned or where their parents are not able to provide them with suitable accommodation and agree to the child being accommodated.

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 (2018);
- 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 – Intercollegiate Framework (2019);
- Looked After Children: Knowledge, Skills and Competences of Health Care Staff - Intercollegiate Role Framework (2015);
- Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework. NHSE /I 2019
- Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework. NHSE /I 2019
- The London Child Protection Procedures, London Safeguarding Children Board (2018). http://www.londoncp.co.uk/;
- Pan Bedfordshire Child Protection Procedures, Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Boards (2018) http://bedfordscb.proceduresonline.com/index.htm

4.1 The Children Act 2004 (section 11) places duties on a range of organisations and individuals to ensure their functions and any services that they contract out to others, are discharged with regard to safeguard and promote the welfare of children. These statutory duties require the Trust to have:

a. A clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children;

b. A senior board level lead with the required knowledge, skills and expertise or sufficiently qualified and experienced to take leadership responsibility for the organisation's safeguarding arrangements;

c. A culture of listening to children and taking account of their wishes and feelings, both in individual decisions and in the development of services.

d. Clear whistleblowing procedures, which reflect the principles within Sir Robert Francis' Freedom to Speak Up Review and a culture that enables issues about safeguarding and promoting the welfare of children to be addressed;

e. Clear escalation policies for staff to follow when their child safeguarding concerns are not being addressed within their organisation or by other agencies;

f. Arrangements which set out clearly the processes for sharing information, with other practitioners and with Safeguarding Partners;

g. Designated Named Professionals for Safeguarding Children. Their role is to support other professionals in their agencies to recognise the needs of children, including protection from possible abuse or neglect. Professionals should be given sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively;

h. Safe recruitment practices and ongoing safe working practices for individuals whom the organisation will permit to work regularly with children, including policies on when to obtain a criminal record check;

i. Appropriate supervision and support for staff, including undertaking safeguarding training;

j. Creating a culture of safety, equality and protection within the services they provide.

In addition:

- 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 practitioners should have regular reviews of their own practice to ensure they have knowledge, skills and expertise that improve over time.
- Working Together Safeguard Children (2018) 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 The Children Act 2004, as amended by the Children and Social Work Act 2017 places new duties on key agencies in the local area i.e. the Police, Clinical Commissioning Groups and the Local Authority.

Working Together 2018 defines **'**Safeguarding and promoting the welfare of children' as:

- 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
- Taking action to enable all children to have the best outcomes.

5.2 Child

A child is defined in the Children Act 1989 and Working Together to Safeguard Children 2018 as any person from birth who has not yet reached their 18th birthday. 'Children' therefore means 'children and young people' throughout this policy. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the Armed Forces, is in hospital, in prison or in custody in the secure estate, does not change their status or entitlement to services or protection.

5.3 Voice of the Child

Children may be vulnerable to neglect and abuse or exploitation from within their family and from individuals they come across in their day-to-day lives.

A child centred approach is fundamental to safeguarding and promoting the welfare of every child. A child centred approach means keeping in focus when making decisions about their lives and working in partnership with them and their families. All practitioners should follow the principles of the Children Acts 1989 and 2004 - that state that the welfare of children is paramount and that they are best looked after within their families, with their parents playing a full part in their lives, unless compulsory intervention in family life is necessary.

5.4 Assessment of Needs / Management of Risk

Prevention of harm to children and young people is the purpose of child protection work. To determine if children or young people are at risk or likely risk of harm requires the systematic collection of information to inform a balanced risk assessment. Sound risk assessment assists practitioners to explore more explicitly with children and families what needs to change, especially with regard to the safety and welfare of a child. In the identification of both 'need' and 'risk' staff should build upon family strengths whilst keeping the needs of the child central. The Framework for the Assessment of Children in Need and their Families (2000, Appendix iii) provides a systematic basis for collecting and analysing information to support professional judgments about how to support children and families in the best interests of the child.

5.5 The Concept of Significant Harm

The Children Act 1989 introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children/young people, and gives local authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child/young person who is suffering, or likely to suffer, significant harm. A child is at risk of significant harm as a result of maltreatment, abuse or neglect. Decisions about significant harm should be informed by careful assessment of the child's circumstances and discussions between Local Authority Children's Social Care and the child and family.

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.

Child in Need

Children who are defined as being in need under section 17 of the 1989 Children Act are those whose vulnerability is such that they are unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or

development without the provision by the local authority services. This includes a child whose health or development is likely to be significantly impaired, or further impaired, without the provision of such services. This includes children with disabilities.

Children with Disabilities

Any child with a disability is by definition a 'child in need' under Section 17 of the Children Act 1989. The Disability Discrimination Act 2005 (DDA) and the Equality Act 2010 define a disabled person as someone who has:

"a physical or mental impairment which has a substantial and long term adverse effect on his or her ability to carry out normal day to day activities"

The Equality Act 2010 makes it unlawful to discriminate against a disabled person in relation to the provision of services. This includes making a service more difficult for a disabled person to access or providing them with a different standard of service

Research suggests that children with a disability may be generally more vulnerable to significant harm through physical, sexual, emotional abuse and / or neglect than children who do not have a disability. Disabled children may be especially vulnerable to abuse for a number of reasons e.g. they may be at increased likelihood of being socially isolated with fewer outside contacts than non-disabled children.

Where there are concerns about the welfare of a disabled child, they should be acted upon in the same way as with any other child.

Young Carer

A young carer is a person under 18 who provides or intends to provide care for another person (of any age, except generally where that care is provided for payment, pursuant to a contract or as voluntary work). They carry out on a regular basis, significant or substantial caring tasks and assume a level of responsibility, which would usually be associated with an adult. The person receiving care is often a parent but can be a sibling, grandparent or other relative who is disabled, has some chronic illness, mental health problem or other condition connected with a need for care support or supervision.

Parent or Carer

A parent or carer is usually someone aged 18 or over who provides practical and emotional support to someone with whom the person has parental responsibility. They could be a child with disability or mental health problem. The parent or carer may or may not live with the person they have parenting responsibility for.

5.6 Child Abuse

Abuse is defined as a form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others. Abuse can take place wholly online, or technology may be used to facilitate offline abuse. Children may be abused by an adult or adults, or another child or children. (Working Together to Safeguard Children 2018) Please see page 37 for guidance on referral to children social care.

Categories of Abuse

5.6.1 Emotional Abuse

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children.

These may include interactions that are beyond a child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the 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.

5.6.2 Neglect

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

- Provide adequate food, clothing and shelter (including exclusion from home or abandonment)
- Protect a child from physical and emotional harm or danger
- Ensure adequate supervision (including the use of inadequate caregivers)
- Ensure access to appropriate medical care or treatment
- It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

5.6.3 Physical Abuse

Physical abuse is a form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

5.6.4 Sexual Abuse

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

5.6.5 Allegations of Non Recent (Historical) Abuse

It is not unusual for people to disclose experiences of physical, sexual and / or emotional abuse and / or neglect which constitute significant harm only when they reach adulthood.

Adults may disclose they or others in their family were abused in childhood. Response to allegations by an adult of abuse experienced as a child must be of as high a standard as a response to current abuse because of the likelihood that the perpetrator has continued to abuse children and may be doing so now, criminal prosecution may be possible if sufficient evidence can be collated.

Professionals must inform the adult of the professional duty to safeguard children and try to establish whether the past abuser is in contact with children who could currently be at risk of harm which may need to be referred to children's social care or police.

The adult who has disclosed should be asked whether they want a police investigation and must be reassured that the police are able and willing to progress an investigation.

How to deal with this is included within the Pan London, Bedfordshire and other National Child Protection procedures:

https://www.londoncp.co.uk/chapters/historical_abuse.html#intro

https://bedfordscb.proceduresonline.com/chapters/p_historical_abuse.html

The guidance states that:

- 'When an adult discloses childhood abuse, the professional receiving the information should record the discussion in detail. If possible, the professional should establish if the adult has any knowledge of the alleged abuser's recent or current whereabouts and contact with children.

- In view of the potential continuing risk the alleged abuser may pose to children, the professional should make a referral promptly to Local Authority children's social care

- The adult who has disclosed should be asked whether they want a police investigation and must be reassured that the police are able and willing to progress an investigation even for those adults who are vulnerable as a result of mental ill health or learning disabilities.'

For further information, please refer to:

'Guidance document on the management of disclosures of non-recent (historic) child sexual abuse' (The British Psychological Society 2016) https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/Guidance%20on%20the%20Management%20of%20Disclosures%20of%20Non-Recent%20(Historic)%20Child%20Sexual%20Abuse%20(2016).pdf

Operation Hydrant - Victim Reporting Factsheet a leaflet for people who would like to speak to the Police http://napac.org.uk/wp-content/uploads/2016/12/Operation-Hydrant-Factsheet-Victim-Reporting-Dec-2016.pdf.

5.7 Looked After Child

Children/young people who are looked after by local authorities have the same health needs as other children and young people, but their backgrounds and past experiences, and sometimes their experiences while they are "looked after", make them especially vulnerable. In particular, many Looked After Children have to cope with sadness, distress and trauma which may affect their mental health and cause them to behave in ways that put their health and safety at risk.

In England and Wales the term "looked after" is defined in law under the Children Act 1989.

Looked after children fall into four main groups:

- Children who are accommodated under voluntary agreement with their parents (Children Act Section 20)
- Children who are subject to a care order (Children Act Section 31) or an interim care order (Children Act Section 38)
- Children who are subject to emergency care orders for their protection (Children Act Section 44 and Section 46)
- Children who are compulsorily accommodated; this includes children remanded to the local authority or subject to a criminal justice supervision order with a residence requirement (Children Act Section 21)

The term also applies to children who are:

- Unaccompanied asylum seekers or those trafficked from abroad
- Children in family and friends placements
- Children where the agency has the authority to place the child for adoption

It does not apply to children who have been adopted or who are on a special guardianship order.

The Trust has a statutory role in ensuring that arrangements are in place to meet the health needs of Looked After Children. There is a community Looked After Children (LAC) team in Newham; the team work collaboratively with the Local Authority and the local CCG to fulfil the Trust's statutory responsibilities. The team is responsible for assessing and ensuring that the health needs of all looked after children and young people from Newham, whether they still live in the Borough or they have moved out of

the area, are met. The team is supported by Designated Professionals for LAC from the CCG. The Trust also has embedded LAC teams in Newham and Bedford CAMHS providing support for Looked After Children and Young people known to the service.

5.8 Transition Planning

The Care Act 2014 places a duty on Health and Social Care to conduct transition assessments for children, children's carers and young carers where there is a likely need for care and support after the child in question turns 18. The Care Act 2014 and the Children and Families Act 2014 capture the principles of personalisation, inclusion, participation and co-production in law.

The guidance states that in order to fully meet these duties, local authorities should consider how they can identify young people and carers who are not receiving children's services but are nevertheless likely to have care and support needs as adults. Practitioners working with young people requiring care and support needs should consider how to establish mechanisms and identify young people as early as possible in order to plan for or prevent the development of care and support needs and thereby fulfil their duty relating to 'significant benefit' and the timing of assessments

When planning any transition every effort should be made to put the service user and their family/carers at the centre of this process. Particular consideration should be given to the service user's developmental needs around this time.

5.9 Other Safeguarding Vulnerabilities

5.9.1 Contextual Safeguarding

Contextual safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. Contextual Safeguarding, therefore, expands the objectives of child protection systems in recognition that young people are vulnerable to abuse in a range of social contexts. As well as threats to the welfare of children from within their families, children may be vulnerable to abuse or exploitation from outside their families. These extra-familial threats might arise at school and other educational establishments, from within peer groups, or more widely from within the wider community and/or online. These threats can take a variety of different forms and children can be vulnerable to multiple threats, including: exploitation by criminal gangs and organised crime groups such as county lines; trafficking, online abuse; sexual exploitation and the influences of extremism leading to radicalisation. Extremist groups make use of the internet to radicalise and recruit and to promote extremist materials. Any potential harmful effects to individuals identified as vulnerable to extremist ideologies or being drawn into terrorism should also be considered.

Practitioners working with children and their families should consider whether wider environmental factors are present in a child's life and are a threat to their safety and/or welfare. Children who may be alleged perpetrators should also be assessed to understand the impact of contextual issues on their safety and welfare. Interventions should focus on addressing these wider environmental factors, which are likely to be a threat to the safety and welfare of a number of different children who may or may not be known to local authority children's social care. Assessments of children in such cases should consider the individual needs and vulnerabilities of each child. They should look at the parental capacity to support the child, including helping the parents

and carers to understand any risks and support them to keep children safe and assess potential risk to child.

5.10 Child Sexual Exploitation

Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology. Child sexual exploitation takes different forms - from a seemingly 'consensual' relationship where sex is exchanged for attention, affection, accommodation or gifts, to serious organised crime and child trafficking. Child sexual exploitation involves differing degrees of abusive activities, including coercion, intimidation or enticement, unwanted pressure from peers to have sex, sexual bullying (including cyber bullying), and grooming for sexual activity.

For further information, refer to:

Risk Assessment Tool in Appendix v

London Child Protection Procedures 2017, Part B3 Section 7 https://www.londoncp.co.uk/chapters/sg_sex_exploit_ch.html

Pan Bedfordshire Child Protection Procedure Section 1.5.1 https://bedfordscb.proceduresonline.com/chapters/p_safeg_sex_exploit.html#intro

5.10.1 Children Missing from Care, Home and Education

Children running away and going missing from care, home and education is a key safeguarding issue. Current research findings estimate that approximately 25% of children and young people that go missing are at risk of serious harm. There are particular concerns about the links between children running away and the risks of sexual exploitation. Looked After Children missing from their placements are vulnerable to sexual and other exploitation, especially children in residential care.

Children who go missing or run away from home or care may be in serious danger and are vulnerable to crime, sexual exploitation or abduction as well as radicalisation.

Healthcare professionals have a key role in identifying and reporting children who may be missing from care, home and school. Missing children access a number of services provided by a range of health providers, including, Urgent Care Units, Emergency Departments, Genito-Urinary Medicine Clinics (GUM) and Community Sexual Health Services.

Health professionals should have an understanding of the vulnerabilities and risks associated with children that go missing. Staff should be aware of their professional responsibilities and the responses undertaken by the multi-agency partnership.

5.10.2 Children exposed to Extreme Ideology (including PREVENT).

Extremism is defined in the Counter Extremism Strategy 2015 as the vocal or active opposition to our fundamental values, including the rule of law, individual liberty and the mutual respect and tolerance of different faiths and beliefs. Extremism goes beyond terrorism and includes people who target the vulnerable – including the young by seeking to sow division between communities on the basis of race, faith or denomination; justify discrimination towards women and girls; persuade others that minorities are inferior; or argue against the primacy of democracy and the rule of law in our society.

Children and young people can be radicalised in different ways:

They can be groomed either online or in person by people seeking to draw them into extremist activity. Older children or young people might be radicalised over the internet or through the influence of their peer network – in this instance their parents might not know about this or feel powerless to stop their child's radicalisation;

They can be groomed by family members who hold harmful, extreme beliefs, including parents/carers and siblings who live with the child and/or person(s) who live outside the family home but have an influence over the child's life;

They can be exposed to violent, anti-social, extremist imagery, rhetoric and writings which can lead to the development of a distorted world view in which extremist ideology seems reasonable. In this way they are not being individually targeted but are the victims of propaganda which seeks to radicalise.

A common feature of radicalisation is that the child or young person does not recognise the exploitative nature of what is happening and does not see themselves as a victim of grooming or exploitation.

The harm children and young people can experience ranges from a child adopting or complying with extreme views which limits their social interaction and full engagement with their education, to young children being taken to war zones and older children being groomed for involvement in violence.

PREVENT focuses on working with vulnerable individuals who may be at risk of being exploited by radicalisers and subsequently drawn into terrorism related activity. What is important, if you are concerned that a vulnerable individual is being exploited in this way, you can raise these concerns in accordance with the Trust's policies and procedures.

Contracts of employment and professional codes of conduct require all healthcare staff to exercise a duty of care to patients and, where necessary, take action for safeguarding and crime prevention. If you have a concern, discuss it with the Safeguarding team and they will advise you regarding your local referral pathway

For further information, please refer to:

London Child Protection Procedures 2017, Part B3 Section 6 http://www.londoncp.co.uk/chapters/sg_extremist.html/

Pan Bedfordshire Child Protection Procedures 2018, Section 1.4.13 https://bedfordscb.proceduresonline.com/

Or

contact your local Children's Social Care

5.10.3 Child Criminal Exploitation and County Lines

As set out in the Serious Violence Strategy (2018) published by the Home Office, where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18 into any criminal activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial or other advantage of the perpetrator or facilitator and/or (c) through violence or the threat of violence. The victim may have been criminally exploited even if the activity appears consensual. Child criminal exploitation does not always involve physical contact; it can also occur through the use of technology.

County Lines is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of 'deal line'. They are likely to exploit children and vulnerable adults to move and store the drugs and money, and they will often use coercion, intimidation, violence (including sexual violence) and weapons.

Potentially a child involved with a gang or with serious violence could be both a victim and a perpetrator. This requires professionals to assess and support his/her welfare and well-being needs at the same time as assessing and responding in a criminal justice capacity.

Professionals should always take what the child tells them seriously.

If a professional is concerned that a child is at risk of harm as a victim or a perpetrator of serious youth violence, gang-related or not, the professional should wherever possible, consult with their line manager or the Safeguarding Children Team and make an immediate referral to Children's Social Care.

For further information, refer to:

London Child Protection Procedures 2017, Part B3 Section 12
https://www.londoncp.co.uk/chapters/gang_activity.html#intro

Pan Bedfordshire Child Protection Procedures 2018, Section 1.4.10
https://bedfordscb.proceduresonline.com/chapters/p_safeg_gang.html

https://www.gov.uk/government/publications/criminal-exploitation-of-children-and-vulnerable-adults-county-lines

5.10.4 So Called Honour Based Abuse

Honour based abuse is the term used to describe incidents of violence, including murder ("honour killings") that have been committed in the belief that those actions will protect or defend the honour of the family and / or community. Such violence/abuse can occur when perpetrators perceive that a relative has shamed the family and / or community by breaking their honour code.

The victims of such off incidents are predominantly women, perceived to have behaved immorally and deemed to have breached the honour code of a family and / or community, causing shame. For young victims it is a form of child abuse and a serious abuse of human rights.

It can be distinguished from other forms of violence/abuse, as it is often committed with some degree of approval and/or collusion from family and/or community members. Women, men and younger members of the family can all be involved in the abuse.

The Metropolitan Police definition of so-called honour based violence is: 'a crime or incident, which has or may been committed to protect or defend the honour of the family and/or community.

This type of violence and abuse includes physical, emotional, financial and sexual abuse of the victims. Professionals should respond in a similar way to cases of honour violence as with domestic abuse and forced marriage (i.e. in facilitating disclosure, developing individual safety plans, ensuring the child's safety by according them confidentiality in relation to the rest of the family)

For further information, refer to:

London Child Protection Procedures 2017, Part B3 Section 23
https://www.londoncp.co.uk/chapters/honour_base_viol.html

Pan Bedfordshire Child Protection Procedures 2018, Section 1.4.2
https://bedfordscb.proceduresonline.com/chapters/p_hon_bas_abuse.html

5.10.5 Forced Marriage

A forced marriage is one where either or both parties do not (or in cases of people with learning disabilities, cannot) consent to the marriage and pressure or abuse is used against them. Forced marriage, as distinct from a consensual 'arranged' one, is a marriage conducted without the full consent of both parties and where duress is a factor. Duress cannot be justified on religious or cultural grounds. It is recognised in the UK as a form of violence against women and men, domestic/child abuse and a serious abuse of human rights. In 2004, the UK Government's definition of domestic abuse was extended to include acts perpetrated by extended family members as well as intimate partners.

The pressure that is put on people to marry against their will may be physical (including threats, actual physical violence and sexual violence) or emotional and psychological (for example, when someone is made to feel that they are bringing shame on their family). Financial abuse (taking away a person's wages or not giving them any money) may also be a factor.

If a person does not consent or lacks capacity to consent to marriage, that marriage must be viewed as a forced marriage whatever the reason for it taking place. Capacity to consent can be assessed and tested but is time-and-decision specific. Professionals should respond in a similar way to forced marriage as with domestic violence and honour based violence (i.e. in facilitating disclosure, developing individual safety plans, ensuring the child's safety by according them confidentiality in relation to the rest of the family, completing individual risk assessments, etc.)

For further information, refer to:

London Child Protection Procedures 2017, Part B3 Section 24
https://www.londoncp.co.uk/chapters/forced_marriage_ch.html

Pan Bedfordshire Child Protection Procedure Section 1.4.1
https://bedfordscb.proceduresonline.com/chapters/pr_multi_age_force_marry.html

5.10.6 Female Genital Mutilation (FGM)

Female genital mutilation (FGM) is a collective term for procedures, which include the removal of part or all of the external female genitalia for cultural or other non-therapeutic reasons. The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life. The procedure is typically performed on girls aged between 4 and 13, but in some cases it is performed on new-born infants or on young women before marriage or pregnancy.

FGM is practised in at least 29 countries across Africa, parts of the Middle East and South East Asia. FGM is usually carried out on young girls between infancy and the age of 15, most commonly before puberty starts. It is estimated that 60,000 girls under 15 are at risk of FGM in the UK, and 137,000 women and girls in the UK have already been subjected to it.

Child protection procedures should be followed when there are concerns that a girl is at risk of, or is already the victim of, FGM. It comprises all procedures that involve partial or total removal of the external genitalia or other injury to the female genital organs for cultural or non-therapeutic reasons. The practice is medically unnecessary and is linked to a number of forms of physical and psychological distress.

There are also mandatory reporting procedures in place for health professionals in relation to FGM. The duty to report applies in specific situations:

Either:

A health professional is informed by a girl under 18 that an act of FGM has been carried out on her

Or

A health professional observes physical signs which appear to show that an act of FGM has been carried out on a girl under 18 and they have no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth

All Trust clinicians should refer to and familiarise themselves with the publication "Mandatory Reporting of Female Genital Mutilation – procedural information HM Gov. 2015

https://www.gov.uk/government/publications/mandatory-reporting-of-female-genital-mutilation-procedural-information

For further information, refer to:

FGM pathway – Appendix iii.

London Child Protection Procedures 2017, Part B3 Section 25

https://www.londoncp.co.uk/chapters/sg_ch_risk_fgm.html domestic abuse

Pan Bedfordshire Child Protection Procedure 2018 Section 1.4.8 https://bedfordscb.proceduresonline.com/chapters/p_fgm.html

5.10.7 E- Safety: Children Exposed to Abuse through Digital Media

Online / Information and communication technology (ICT) - based forms of child physical, sexual and emotional abuse can include bullying via mobile telephones or online (internet) with verbal and visual messages. Children can experience a wide range of upsetting things online. The most common upsetting experience was 'trolling' (defined as 'unkind comments or rumours circulated online'). However, 'a significant minority had received sexual messages, been encouraged to self-harm, or subjected to language which was violent or aggressive' (NSPCC, 2017).

The Trust has a responsibility to:

- Understand e-safety issues
- Know how to help children stay safe on line
- Have procedures in place to support those working with children in knowing how to respond when concerns arise

Staff must have an understanding of the risks, dangers and potential harm, and be aware of the mechanisms which are in place to mitigate any risks and potential dangers; staff are required to recognise, challenge and respond to e-safety concerns.

All Trust staff should conduct themselves in a professional manner, adhering to their professional codes of conduct and Trust policies at all times. This includes consideration in the personal use of social media and information technology.

For further information, refer to: London Child Protection Procedures 2017 Part B Section 16 http://www.londoncp.co.uk/chapters/bullying.html

Pan Bedfordshire Child Protection Procedures 2018
https://bedfordscb.proceduresonline.com/chapters/p_esafety_abuse.html

In addition to this please refer to the Trust's Social Media & Attributed Digital Content Policy on the Trust Intranet.

5.10.8 Fabricated or Induced Illness (FII)

Fabricated or induced illness is a condition whereby a child has suffered, or is likely to suffer, significant harm through the deliberate action of their parent and which is attributed by the parent to another cause.

There are three main ways of the parent fabricating (making up or lying about) or inducing illness in a child:

- Fabrication of signs and symptoms, including fabrication of past medical history
- Fabrication of signs and symptoms and falsification of hospital charts, records, letters and documents and specimens of bodily fluid
- Induction of illness by a variety of means

The above three methods are not mutually exclusive. Existing diagnosed illness in a child does not exclude the possibility of induced illness. The very presence of an illness can act as a stimulus to the abnormal behaviour and also provide the parent with opportunities for inducing symptoms.

Fabrication of illness may not necessarily result in a child experiencing physical harm, but there may be concerns about the child suffering emotional harm. They may suffer emotional harm as a result of an abnormal relationship with their parent and/or disturbed family relationships.

Please refer to the Safeguarding Children section on the Trust Intranet for 'what to do if you are worried a child is being abused' guidance.

Where fabricated or induced illness is suspected the parents/carers MUST NOT be informed as this could jeopardise the child/young person's safety and compromise any Section 47 (Children's act 1989/2004) enquiries.

If any concerns relate to a member of staff, please contact the Trust's Safeguarding Children Team for advice.

For further information, refer to: London Child Protection Procedures 2017, Part B3 Section 2

http://www.londoncp.co.uk/chapters/fab_ind_ill.html#intro

Pan Bedfordshire Child Protection Procedures 2018, Section 1.4.7
https://bedfordscb.proceduresonline.com/chapters/p_fab_ind_illness.html

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/277314/Safeguarding_Children_in_whom_illness_is_fabricated_or_induced.pdf

5.10.9 Private Fostering

A private fostering arrangement is essentially an arrangement between families/households, without the involvement of 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 (close relatives are parents, step-parents, siblings, siblings of a parent, and grandparents) for 28 days or more, Children Act 1989 and Children (Private Arrangements for Fostering Regulations 2005). http://www.legislation.gov.uk/uksi/2005/1533/contents/

Privately fostered children are a diverse, and sometimes vulnerable, group. Groups of privately fostered children include:

- Children sent from abroad to stay with another family, usually to improve their educational opportunities
- Asylum seeking and refugee children
- Teenagers who, having broken ties with their parents, are staying in short term arrangements with friends or other non-relatives
    - Children who stay with another family whilst their parents are in hospital, prison or serving overseas in the armed forces
    - Language students living with host families.

    Private Fostering can place a child in a vulnerable position because checks as to the safety of the placement will not have been carried out if the local authority is not advised in advance of a proposed placement. The carer may not provide the

child with the protection that an ordinary parent might provide. In many cases, the child is also looked after away from a familiar environment in terms of region or country.

Where there is reasonable cause to believe that a child in a residential setting has suffered or is likely to suffer significant harm, a referral must be made to Children's Social Care in accordance with the Trust's Safeguarding Children Policy; London Child Protection Procedures and the Working Together to Safeguard Children (2018).

The concerns may be related to bullying, children who exhibit harmful behaviour against other children, or allegations about the behaviour of practitioners or volunteers.

For further information, refer to London Child Protection Procedures 2017, Section 19.3 https://www.londoncp.co.uk/chapters/ch_living_away.html#private_fost

Pan Bedfordshire Child Protection Procedures 2018

https://bedfordscb.proceduresonline.com/chapters/p_priv_fost_policy.html

In addition, health care staff should confirm with carers and/or Children's Social Care that Children's Social Care is aware that a private fostering arrangement is in place.

5.10.10 Trafficking /Modern Day Slavery

The United Nations (Article 3 paragraph A of the Protocol to Prevent, Suppress and Punish Trafficking in Persons) defines Trafficking in Persons as the "recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs".

Most children are trafficked and exploited for financial gain. Some trafficking is by organised gangs, in other cases individual adults trafficked children to the UK for their own personal gain. Exploitation includes children being used for sex work, domestic servitude, sweatshop and restaurant work, drug dealing and credit card fraud, begging or pickpocketing, benefit fraud, drug mules or decoys for adult drug traffickers, forced marriage, trade in human organs, and, in some cases, ritual killings. There are a number of circumstances that could indicate a child may have been trafficked to the UK, and may still be controlled by the traffickers or receiving adults.

The National Referral Mechanism is a process set up by the Government to identify and support all victims of modern slavery following the implementation of the Modern Slavery Act (2015). the mechanism through which the **Modern Slavery and Human Trafficking Unit (MSHTU)** collects data about victims. This information aims to help build a clearer picture about the scope of human trafficking in the UK. https://www.ecpat.org.uk/national-referral-mechanism

For further information, refer to London Child Protection Procedures 2017, Part B3 Section 9 http://www.londoncp.co.uk/chapters/sg_trafficked_ch.html

Pan Bedfordshire Child Protection Procedures 2018

https://bedfordscb.proceduresonline.com/chapters/p_modern_slavery.html

In cases where a staff member suspects that a child may have been trafficked and exploited an immediate Multi-Agency Referral Form (MARF) or Multi-Agency Safeguarding Hub (MASH) referral must be completed and sent to Children's Social Care in the Local Authority where the child resides.

5.10.11 Spiritual, Cultural and Religious Beliefs

Where parents, families and the child themselves believe that an evil force has entered a child and is controlling them, the child is likely to suffer significant harm. The belief includes the child being able to use the evil force to harm others. This evil is also known as black magic, kindoki, ndoki, the evil eye, djinns, voodoo, and obeah. Children are called witches or sorcerers.

Parents can be initiated into and/or supported in the belief that their child is possessed by an evil spirit by a privately contacted spiritualist/indigenous healer, or by a local community faith leader. The task of exorcism or deliverance is often undertaken by a faith leader, or by the parents or other family members.

A child may suffer emotional abuse if they are labelled and treated as being possessed with an evil spirit. In addition, significant harm to a child may occur when an attempt is made to "exorcise" or "deliver" the evil spirit from the child. Staff need to remember that while recognising that child rearing practices are highly diverse, and that all differences are to be valued and understood, it is also important that any judgements about the care and protection of children are based on objective assessment of facts. Sensitivity to parental behaviours, culture, religion, or ideology, whilst being important in the provision of care, must not mean that children from any background receive a lower level of care or protection.

For further information, refer to: London Child Protection Procedures 2017, Part A Section 1 http://www.londoncp.co.uk/chapters/responding_concerns.html

Pan Bedfordshire Child Protection Procedures 2018
https://bedfordscb.proceduresonline.com/chapters/p_ca_religion.html

5.10.12 Parenting Capacity and Mental Illness

Some situations cause additional stress within families, such as social isolation, poverty, homelessness and racial harassment. Parental factors such as mental health, substance misuse (drugs and alcohol), domestic violence, learning/physical disability or difficulty, and teenage parents may also have a negative impact on a child/young person's health, development and well-being, either directly, or because they affect the capacity of the parents to respond to the child/young person's needs. This is particularly the case when there is no other significant adult who is able to respond to the child/young person's needs.

Parental mental illness does not necessarily have an adverse impact on a child's developmental needs, but it is essential to always assess its implications for each child in the family. Many children whose parents have mental ill health may be seen as children with additional needs requiring professional support.

Where a parent has enduring and / or severe mental ill-health, children in the household are more likely to suffer significant harm; this could be through physical, sexual or emotional abuse, and / or neglect.

Adult mental health professionals must identify those service users who are pregnant and those who are parents or who have regular access to children, whether they reside with children or not. Professionals should consider the needs of all children as part of their **Care Programme Approach (CPA)** assessments. When adult mental health services and LA children's social care are both involved with a family, joint assessments should be carried out to assess the support parents need and the risk of harm to the child/ren.

The most effective responses to children and families affected by mental ill health comes through agencies adopting a "**Think Family"** approach. Whilst mental illness can be compatible with good parenting, some parents with severe mental illness are at risk of harming their children; very serious risks may arise if their illness incorporates delusional beliefs about the child, and/or the potential for the parent to harm the child as part of a suicide plan.

For further information, refer to:

London Child Protection Procedures 2017, Part B3 Section 30
https://www.londoncp.co.uk/chapters/par_cap_ment_illness.html

Pan Bedfordshire Safeguarding Children Procedures 2018 section 1.6.1
https://bedfordscb.proceduresonline.com/chapters/p_ch_par_ment.html

5.10.13 Parental Substance Misuse

Where a parent has enduring and / or severe substance misuse problems, children in the household are likely to suffer significant harm primarily through emotional abuse and neglect. The child/ren may also not be well protected from physical or sexual abuse.

Maternal substance misuse in pregnancy can have serious effects on the health and development of the child before and after birth. Many factors affect pregnancy outcomes, including poverty, poor housing, poor maternal health and nutrition, domestic abuse and mental health.

For further information, refer to:

London Child Protection Procedures 2017, Part B3 Section 29
https://www.londoncp.co.uk/chapters/par_misuse_subtance.html/

Pan Bedfordshire Safeguarding Children Procedures 2018 section 1.6.6
https://bedfordscb.proceduresonline.com/chapters/p_ch_misuse_subs.html/

5.10.14 Domestic Abuse

Domestic violence is the most frequent form of abuse among adults. However, it is known nationally that one in seven children and young people under the age of 18 will have lived with domestic abuse at some point in their childhood. Children can experience both short and long term cognitive, behavioural and emotional effects as a result of witnessing domestic abuse. There is an increased risk to children's welfare where there is domestic abuse, mental ill health and substance / alcohol abuse.

Domestic abuse has a devastating impact on children and young people that can last into adulthood. Children's responses to the trauma of witnessing domestic abuse may vary according to a number of factors, which may include, age, race, sex and stage of development.

The cross-government definition of domestic violence and abuse is:

"Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality."

Domestic abuse can co-exist with child abuse, through direct abuse of children in addition to their exposure to the abuse of their parent.

Abuse can take many forms such as:

- Psychological;
- Physical;
- Sexual;
- Financial;
- Emotional.

For further information, please see: Domestic Abuse Pathway – Appendix ii

The Trust Domestic Abuse and Harmful Practices policy is also available on the Intranet

6 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 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 Executive Lead for Safeguarding

The Trust has identified the Chief Nurse as the Executive Lead for Safeguarding Children on the Trust Board, as required by Working Together to Safeguard Children, 2018. The Executive Lead has overall responsibility for the effective implementation of this policy. He/ she is the Named Senior Officer and is responsible for the management of allegations against staff in the Trust.

7.3 The Operational Lead Director for Safeguarding

The Trust has identified a 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 Teams to ensure action plans are progressed and implemented.

7.4 The Associate Director for Safeguarding Children

The Associate Director for Safeguarding Children is responsible for providing a strategic lead for safeguarding children and promoting a co-ordinated approach to the development, implementation, management and monitoring of relevant national guidelines and standards in respect to safeguarding children. They ensure that the Trust systems for safeguarding children including education and training, risk and assurance frameworks, annual board report are in place and responsive to relevant guidance. This entails working closely with the Associate Director for Safeguarding Adults where there are overlapping issues. They are to be in regular communication with the Designated leads in the CCGs where ELFT has its footprints. The Associate Director report to the Operational Lead for Safeguarding Children.

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 Named Doctor, Safeguarding Children

The Clinical Director for Children Services is the Named Doctor for children safeguarding and the Medical Director has also been identified as the Named Doctor (children safeguarding) for Adult Mental Health Services. The function of Named Doctors includes:

- Promoting good practice and effective communication within and between Trust's and all agencies on matters related to the safeguarding and protection of children and young people
- Being a source of advice and expertise on safeguarding and child protection matters to all staff at the point of need
- Co-ordinating and monitoring medical input into cases of abuse and/or neglect
- Co-ordinating and participating in safeguarding training for medical staff
- Providing safeguarding supervision for medical staff (see Safeguarding Supervision Policy on the Trust Intranet)
- Participating and contributing to Internal Management and Serious Case Reviews
- Contributing to an effective system of child protection audits to monitor the application of agreed child protection standards
- Contributing to the work of Local Safeguarding Partners and attend relevant safeguarding board and committee meetings.
- Representing the Trust at the Child Death Overview Panels in the Boroughs the Trust serves when required.

7.7 Named Professionals for Safeguarding Children

The Trust has a number of staff fulfilling the statutory responsibilities of this role within the organisation. Named professionals have direct lines of communication with specific boroughs and are responsible for:

- Promoting good practice and ensuring the Trust is kept up-to-date about safeguarding children issues;
- Working with all clinical and corporate services to promote a 'Think Family' approach to safeguarding children;
- Delivering a regular Safeguarding Children training programme for clinicians at Level3.
- 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 for information sharing purposes;
- Working with partner agencies, particularly Children's Social Care, to strengthen interface arrangements and resolving difficulties;

- Working with the Governance and Risk Management Department on the management of Incident Reviews, audits and performance data;

- Working with the Caldicott Guardian and Associate Director of Governance and Risk Management regarding information sharing and information governance arrangements;

- Contributing to the work of Local Safeguarding Partners;

- Carrying out and contributing to Local Safeguarding Practice Reviews and Learning Reviews;

- Overseeing and leading Trust involvement in multi-agency case audits;

- Ensure that the Safeguarding information on the Trust intranet is up to date;

- Providing performance information to the Trust Board and Commissioners.

- Contributing to coroners' inquests as required;

- Advising HR on staffing matters that have a safeguarding children component, including child protection allegations against staff;

7.8 Named Nurse for Children in Care

- Raising awareness to all Trust employees that because children are in care they are not necessarily safe from harm and should be protected as with any other child;

- Providing appropriate advise and support to promote good professional practice specifically relating to children in care and their carers

- Promoting, influencing and participating in policy and procedure development ensuring it reflects the requirements of children in care and meeting statutory requirements;

- Supporting the Trust in its clinical governance role to ensure services and issues regarding children in care are part of the governance system;

- Ensuring that all Trust staff working directly with children in care and those who come into contact with them through their work are fully aware of their complex health needs, vulnerability and legal status;

- Working in partnership with other statutory and third sector organisation who are responsible for meeting the needs of children in care;

- Contributing to the training strategy for safeguarding to ensure children in care are an integral part.

7.9 The Director of Human Resources

Responsible for ensuring safer recruitment standards are maintained as set out in the London Child Protection Procedures and the Pan Bedfordshire Child Protection Procedures:

- Ensuring Job Descriptions include a statement regarding safeguarding children;
- 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 Trust policy and national/statutory guidelines;
- Ensuring all HR policies incorporate safeguarding children requirements where necessary;
- Ensuring Job Descriptions include a statement regarding safeguarding children.

7.10 All ELFT staff, irrespective of discipline or role

All staff whether permanent, temporary or contracted have a duty to ensure that children are protected from harm and comply with the principles laid down in the legislation (described above)

This includes recognising and reporting concerns and to always follow up oral communication in writing to ensure the message is clear. All clinical staff must ensure all relevant clinical documentation is completed and reviewed in order to ensure the on-going safeguarding of children.

All ELFT employees have a duty to undertake relevant mandatory safeguarding training.

For all staff, the welfare of the child is paramount. This implies that when there is actual, or potential, conflict between the needs of a child and adult (for example, an adult client of ELFT) the child's needs must be prioritised.

7.11 Clinical Practitioners – additional responsibilities

All practitioners have a responsibility for ensuring that they are adequately trained and skilled to incorporate safeguarding children considerations into assessment, care planning, 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.

Practitioners must be aware of local procedures for reporting concerns about a particular child and refer to local authority children's social care if there are signs that a child or unborn baby is experiencing or may already have experienced abuse or neglect or is likely to suffer significant harm in the future.

Must be able to recognise whether a child is in need of additional services (because they are unlikely to achieve or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services; or a child with disability) and make a decision about referral to children social care or early help services. This might include children whose parents are in hospital, prison and for asylum seeking children. Children and young people in receipt of CAMHS services or who have been admitted to hospital, should be considered children in need and might require additional services

Referrals to partner agencies should be coordinated so that the child and family experience a clear process and a single plan of action.

Practitioners must also consider:

The needs of parents/carers who may require additional support or extra help in caring for their children, and know where to refer for help.

The impact parents/carers condition and symptoms may have on their own or other children, and whether this merits referral to LA CSC. This includes risk of physical, emotional harm or neglect;

Identify young carers and provide information to them about their right to request an assessment of their own needs as a 'child in need' and as a carer.

Staff must consider these issues at all stages throughout the episode of care and documentation and risk assessments should be regularly reviewed. There should be clear written evidence of consideration of the safeguarding needs of children. For example, GP discharge letters and ward summaries must address any actions taken or concerns expressed regarding the needs of children.

Staff must ensure that they seek information from relevant services about a service user's history. This needs to include information from other agencies such as children's social care and other health agencies especially if they have moved or recently transferred into the area.

All staff working with current service users must contribute to multi-agency assessments, child protection investigations and subsequent child protection conferences and reviews.

7.12 Responsibilities for staff working in all adult services: Think Family approach

The section below referring to parents include all adults, carers and siblings with responsibility for the care of children.

Parents with mental health problems and their children are a group with complex needs. Not all parents and children will need the support of health and social care services but those that do can find it difficult to get support that is acceptable, accessible and effective for the whole family. 'Think child, Think parent, Think family' (SCIE 2012) identifies what needs to change and makes recommendations to improve service planning and delivery, and ultimately to improve outcomes for families.

Parents with mental health problems need support and recognition of their responsibilities as parents. Their children's needs must also be addressed. Different services use very different language to describe the processes they follow for

assessing need and delivering support. However, essentially they all operate basic care pathway that involves making and receiving referrals, screening.

7.13 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 Partnerships including sub groups;
- Multi-Agency Risk Assessment Conferences (MARAC) – regarding domestic abuse;
- Multi-Agency Sexual Exploitation (MASE) Panels;
- Any other panels as are convened e.g. Channel Panel

7.14 Data Protection and Confidentiality (GDPR)

The Data Protection Act (2018) and the General Data Protection Regulation (GDPR) sets the legal framework by which the Trust can process personal information. It applies to information that might identify any living person. The common law duty of confidentiality governs information given in confidence to a health professional (about a person alive or deceased) with the expectation it will be kept confidential. The GDPR is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately.

The General Data Protection Regulations (GPDR), implemented through the Data Protection Act 2018 identifies:

"that it is no longer necessary to seek consent to share information for the purposes of safeguarding and promoting the welfare of a child (i.e. removing the distinction between information sharing for the purposes of assessing need or child protection). It does, of course, continue to be good practice to inform parents/carers that you are sharing information for these purposes and to seek to work cooperatively with them. Agencies should also ensure that parents/carers are aware that information is shared, processed and stored for these purposes."

It is therefore important to be open and honest with the child and their parents/carers where appropriate from the outset about why, what, how and with whom information will, or could be shared, and seek their informed consent, unless it is unsafe or inappropriate to do so.

The information shared should be necessary, proportionate, relevant, accurate, timely and secure. Ensure that the information shared is necessary for the purpose for which you are sharing, it is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely. Reference can be made to the Trust's Data Protection and Confidentiality Policy on the Intranet.

The child's best interest must be the overriding consideration in making any such decision of sharing information.

7.15 Information Sharing

"The duty to share information can be as important as the duty to protect patient confidentiality". (Caldicott 2 principle 7).

Effective sharing of information between professionals and local agencies is essential for safeguarding and promoting the welfare of children and young people. Early sharing of information is the key to providing effective early help where there are emerging problems. At the other end of the continuum, sharing information can be essential to put in place effective child protection services. Serious Case Reviews (SCRs) have shown how poor information sharing has contributed to the deaths or serious injuries of children (Working Together to Safeguard Children, 2018).

Fears about sharing information cannot be allowed to stand in the way of the need to promote the welfare and protect the safety of children. To ensure effective safeguarding arrangements:

No professional should assume that someone else will pass on information which they think may be critical to keeping a child safe. If a professional has concerns about a child's welfare and believes they are suffering or likely to suffer harm, then they should share the information with local authority children's social care.

Information Sharing: Guidance for practitioners and managers (2018) provides guidance about sharing personal information on a case by case basis.

Please refer to the Trust Trust's Data Protection and Confidentiality Policy on the Intranet provide additional support and guidance.

Where sharing concerns with parents could increase risks to a child, for example sexual abuse within the family when there is a danger of the parents silencing the child; you should make the referral without informing the parents and record this in the notes".

Children have a right to be told what is going on. They should not be given promises that cannot be kept. Their views and wishes should be taken into consideration, in accordance with their age and developmental status.

Clients and children should be made aware that confidentiality can never be absolute, as staffs have a duty to ensure they are protected from harm.

Information should be shared with parent or carer and with the child appropriate to their age and understanding. This includes all reports for child protection conferences and some planning meetings, which should always be shared with the family before any meeting.

There will be circumstances in which it will not be in the child's best interests for information to be shared immediately.

Nevertheless, health professionals should not disclose without consent, information obtained in confidence, unless it is necessary to ensure the protection of a child at risk, or is necessary as part of a multi-agency comprehensive assessment to determine the level of risk.

The welfare of a child should always be considered whenever a letter is sent, for example to the GP/ referrer, summarising involvement with a patient who is a parent

or carer. This may include copying the letter to the relevant Local Authority Children Social Care where there are concerns.
Cases should not be declined or closed without the original referrer, and other key agencies, being advised that this is the proposed plan so that they can either question this decision or take over the responsibility for support and monitoring, where this is required. This is particularly important where a child is subject of a child protection plan or already known to children social care.

Generally, if children social care request information as part of a section 47 (child protection) assessment, practitioners have a duty to pass on information with or without client/parental consent. If the request information is part of a section 17 (child in need) assessment, then information should only be given with service user or parental consent. Therefore, staff should clarify with children social care which section of the Children Act 1989 the assessment is being conducted under, in-order to know the level of client consent required.

Where a child in the family is subject of a child protection plan or where there are safeguarding concerns, services should ensure copies of letters sent to GPs summarising involvement in the case are copied to children's social care.

7.16 Data protection and the Caldicott Guardian

For further guidance on information sharing please contact the Trust Caldicott Guardian.
The Caldicott Guardian is a senior person responsible for protecting the confidentiality of a patient and service-user information and enabling appropriate information-sharing.

7.17 Consent

Children under the age of 16 can consent to their own treatment if they're believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment. This is known as being Gillick competent.

A child of under 16 may be Gillick competent to consent to medical treatment, research, donation or any other activity that requires their consent.
The concept of Gillick competence is said to reflect a child's increasing development to maturity. Therefore the understanding required for different interventions will vary considerably. (DOH 2009)

If your interaction with a child or young person involves touching them (for example, a medical examination) explain what you are going to do and ask for consent from them if they are over 16 (follow the Mental Capacity Act 2005) or under 16 but Gillick competent otherwise, someone with parental responsibility can consent for them.

This could be:

- the child's mother or father
- the child's legally appointed guardian
- a person with a residence order concerning the child
- a local authority designated to care for the child
- a local authority or person with an emergency protection order for the child

If the child, young person or parent does not agree, respect their wishes unless touching them is essential to their treatment (seek legal advice first unless the need for treatment is immediate).

For more guidance on seeking consent for medical examination in children and young people see the General Medical Council's 0-18 years: guidance for all doctors.

Please note - The Mental Capacity Act 2005 generally applies to people 18 and above, but it is applicable to children age 16 to 17 in certain circumstances. The Mental Capacity (Amendment) Act 2019 - Liberty Protection Safeguard) received Royal Assent in May 2019, but is not expected to come into force before October 2020.

7.18 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 (2019)

As part of the Trust Training Needs Analysis and depending on role, staff are mapped to their highest compliance level. Therefore, they are required to access appropriate training for their role.

- All staff are required to undertake the Trust Induction which includes information about Safeguarding Children arrangements in the Trust.

- Non-clinical staff are required to maintain Level 1 competence and refresh no longer than every 3 years.

- Non – clinical and clinical staff who in their role have contact (however small) with children, young people and/or parents/carers or adults who may pose a risk to children are required to undertake Level 2 Training. They are required to maintain Level 2 competence and refresh within every 3 years.

- All clinical staff working with children, young people and/or their parents/carers and or any adult who could pose a risk to children and who could potentially contribute to assessing, planning, intervening and or evaluating the needs of a child or young person and /or parenting capacity (regardless of whether there have been previously identified child protection / safeguarding concerns or not) are required to be competent at Level 3. They are required to maintain competence and refresh within every 3 years. To maintain competence at Level 3 staff should attend multi-agency training or other relevant activity and complete the **Refresher Evidence Form to log their training hours and submit to the Learning and Development team once the required hours are completed**.

- Safeguarding Children Named Professionals/Doctors are required to attend Level 4 Training and maintain competence and refresh within every 3 years.

- All staff are required to attend Safeguarding Adults Training which incorporates the impact on children within domestic abuse, radicalisation and PREVENT.

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

Staff and managers are responsible for keeping a record of individual training requirements and attendance in their Personal Development Plan. The Learning and Development team 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 Safeguarding Committee.

8 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 feeds into other committees and groups in the Quality Framework. The Safeguarding Committee is accountable to the Quality Assurance Committee.

It is chaired by the Director of Nursing who is the delegated operational Lead for Safeguarding Children, the vice-chair is the Medical Director (Named Doctor for Safeguarding Children – adult mental health) and its safeguarding children work is led by the Associate Director for Safeguarding Children. 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 issues are raised at appropriate directorate committees, for taking up operational issues with managers and staff and for ensuring that action plans from practice review recommendations are implemented.

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

- Training compliance;
- Reported incidents;
- Trust Serious Incident Reviews;
- Local Safeguarding Practice 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 review and follow up where necessary.

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

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, supervision and Referrals to Children's Social care and attendance at Child Protection Conferences. These themes may change to reflect local and national interests. 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 Safeguarding Supervision Policy (available on Trust Intranet) requires safeguarding children issues to be addressed in supervision. The Safeguarding Children Team provides advice and support to staff and safeguarding supervision to agreed groups of staff.

8.8 Complaints

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

8.9 Safer recruitment

The Trust has several policies in place relating to safe recruitment, including the Disclosure and Barring Policy and the Management of Allegations Policy. Please see Trust Intranet for further information.

8.10 Management of Allegations Against Members of Staff and Contractors

Allegations against members of staff and contractors may be a safeguarding children issue. When any such allegation is made the incident should be reported to their Line Manager and the Service / Borough Director.

If during a VIP/celebrity visit, the behaviour of a visitor or a member of their accompanying party gives cause for any concerns whatsoever, then this should be raised at the time with the manager who is supervising the visit or the Service / Borough Director.

The Service/Borough Director should report it to the Associate Director for Safeguarding Children (or in their absence the Chief Nurse) and both will ensure it is reported to the appropriate Local Authority Designated Officer (LADO) within one working day.

Staff should refer to Trust's Management of Safeguarding Children and Adults Allegations against Staff and Volunteers Policy available on the Trust Intranet for full details of the process to follow and who to contact.

Additional information is available within the London Child Protection Procedures 2017, Part A Section 7 http://www.londoncp.co.uk/chapters/alleg_staff.html/

Pan Bedfordshire Child Protection Procedures 2018
https://bedfordscb.proceduresonline.com/chapters/p_alleg_staff_wk_ch_yp.html/

9 External Monitoring, Compliance and Review

9.1 Commissioners

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

9.2 Local Safeguarding Children Partnership Section 11 Organisational Audit

Local Safeguarding Children Boards 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 completes and submit Section 11 audits to the City & Hackney,

Newham, Tower Hamlets, Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Boards as required.

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 Safeguarding and Looked After Children Inspections - Ofsted and Joint Targeted Area Inspection (JTAI)

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.

10 Child Was Not Brought / Did Not Attend

It is not acceptable to discharge a child/ young person from a service for non-attendance without a reassessment or liaison with the original referrer being undertaken.

For guidance and procedures to be followed when a child, young person and/ or family fail to attend/ was not brought to an appointment please refer to the management of non- attendance of health care appointments in Children, Young People and CAMHS services on the Trust intranet or on the embedded document below.

1234 DNAWNB
policy CYP-CAMHS 2

11 Making a Referral to Children's Social Care

11.1 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)
- Richmond

i.

ELFT East London Flowchart Safeguardi

ELFT Beds&Luton Flowchart Safeguardi

ELFT Richmond Flowchart Safeguarc

11.2 Process:

- Telephone the relevant Children's Social Care / MASH team;
- 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.

11.3 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.

11.4 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.

Following triage of the referral to children's social care, the outcome could be:

- Delegated to Early Help,
- 'Mash' process,
- Single Agency Statutory Assessment
  or
- Closed

12 Professional Conflict Resolution

It is important that all those working with children and families feel able to air their views and constructively challenge the decisions and actions, or lack of actions of others.

Concern or disagreement may arise over another professional's decisions, actions or lack of actions or lack of actions in relation to a referral, an assessment or an enquiry, the implementation of the child protection plan, including the timing, quoracy or decision-making of core group meetings, progress of the plan or professional practice.

There must be respectful challenge whenever a professional has concern about the action or inaction of another, or with regard to any response about concerns and referrals for children perceived to be at risk or in need.

This challenge should initially be the responsibility of the member of staff who has concerns, and the other agency or professional involved.

If the practitioner(s) are unable to resolve differences within an appropriate timescale, or anticipate they will be unable to do so, they should contact a member of the Trust's Safeguarding Children Team and follow the local Safeguarding Board conflict resolution procedures.

Escalation of concerns relating to any aspect of safeguarding or child protection work is essential; it is clearly stated within the:

London Child Protection Procedures 2017, Part B1 Section 11 http://www.londoncp.co.uk/chapters/profess_conflict_res.html/

Pan Bedfordshire Child Protection Procedures 2018, Section 4.6 https://bedfordscb.proceduresonline.com/chapters/p_resolution_disagree.html/ .

13 References and Associated Documents

The Children Act 1989

https://www.legislation.gov.uk/ukpga/1989/41/contents.htm

The Children Act 2004

https://www.legislation.gov.uk/ukpga/2004/31/contents

The Children and Families Act 2014

http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted

Education and Adoption Act 2015
https://services.parliament.uk/bills/2015-16/educationandadoption.html

Serious Crime Act 2015
http://www.legislation.gov.uk/ukpga/2015/9/part/5/crossheading/female-genital-mutilation/enacted

Children and Social Work Act 2017
http://www.legislation.gov.uk/ukpga/2017/16/contents/enacted.htm

HM Government (2018) Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, Crown Copyright

NICE Clinical Guidance (89) 2016: Child Maltreatment: When to suspect maltreatment in Under 18s

NICE Guidelines (NG76) 2017: Child Abuse and Neglect

RCPCH (2019) Safeguarding Children and Young people: roles and competences for health care staff, Intercollegiate document,

HM Government (2015), What to do if you're worried a child is being abused: advice for practitioners. Crown copyright

HM Government Guidance on Forced Marriage 2013 updated 2018

HM Government (2009), *The Right to Choose: multi-agency statutory guidance for dealing with forced marriage.* Forced Marriage Unit: London

HM Government (2008), *Safeguarding children in whom illness is fabricated or induced.* DCSF Publications
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/277314/Safeguarding_Children_in_whom_illness_is_fabricated_or_induced.pdf

National Audit Office (2015), Care Leavers' transition to adulthood https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/399649/CA1989_Transitions_guidance.pdf

Skills for Health (2013), UK Core Skills Training Framework Subject Guide

Trust-wide Care Programme Approach (CPA) Policy

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

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

Royal College of Psychiatry (2017), Parental mental illness: the impact on children and adolescents: for parents and carers,

The Government Drug Strategy (2017), Tackling the complex issue of drug misuse

House of Parliament Post note; Parental Alcohol Misuse and Children, February 2018

Social Care Institute for Excellence (2012), Think Child, Think Parent, Think Family: a guide to parental mental health and child welfare

14 Child Protection Procedures

Health professionals involved in the care of a child and young person are required to attend child protection case conferences or meetings and make specific contribution due to their knowledge of the child and family or their expertise relevant to the case.

For further information, see appendix iv (Guidance on preparation at a child protection conference and other child protection meetings)

14.1 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

14.2 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 Procedures can be found at:

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

14.3 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

14.4 In addition, the Safeguarding Children Boards in London and Bedfordshire have local guidance which can be found on their websites.

- This includes local information about:
- Threshold guidance
- How to make referrals to Children's Social Care and Multi-agency Safeguarding Hubs (MASH)
- Escalation processes
- Joint protocols
- Training courses

14.5 City and Hackney Local Safeguarding Children Board (CHSCB)

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

14.6 Newham Local Safeguarding Children Board (NSCB)

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

14.7 Tower Hamlets Local Safeguarding Children Board

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

14.8 Bedford Borough Local Safeguarding Children Board

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

14.9 Central Bedfordshire Local Safeguarding Children Board

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

14.10 Luton Local Safeguarding Children Board

http://lutonlscb.org.uk/

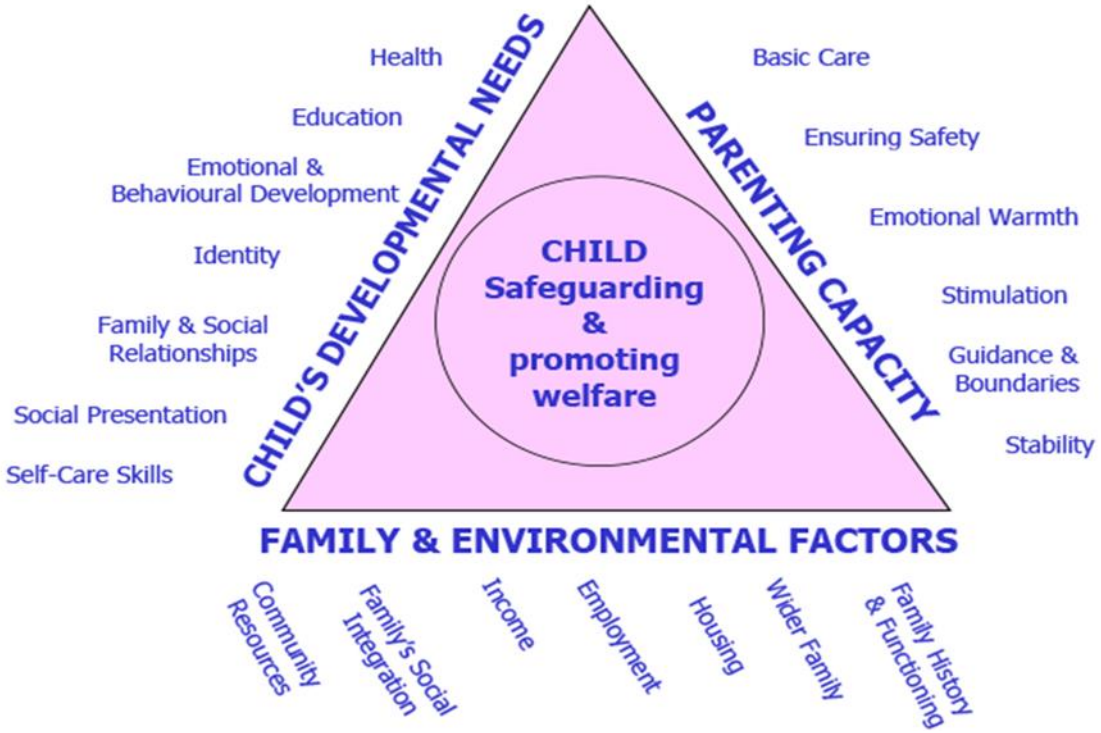
14.11 Kingston & Richmond Local Safeguarding Children Board

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

Appendix i

Assessment Framework Triangle for Children and Young People

Triangle chart for the Assessment of Children in Need and their Families



Appendix ii

Domestic Abuse Pathway

Ask the question

Document when you ask the domestic abuse question and the response

Disclosure of abuse

Or

Potential Indicators of abuse

Disclosure of domestic abuse and/or sexual violence

Explain the limits to confidentiality of the disclosure and what actions you may have to take

Consider and act if there are safeguarding adult issues. Refer to staff intranet to gain contact details

Are there any children?

Consider concerns about a child's safety, including unborn baby

Information sharing

Follow the Trust guidelines on the Intranet and LSCB guidelines

Discuss with safeguarding team and your manager

Inform service/user of the need to refer to social care (if appropriate and safe)

Consider MARAC referral

Give information safely

Women's Aid National 24 hour helpline:

0808 2000 247

Local Helpline Number: 999 in emergency

Open access to Trust and external training

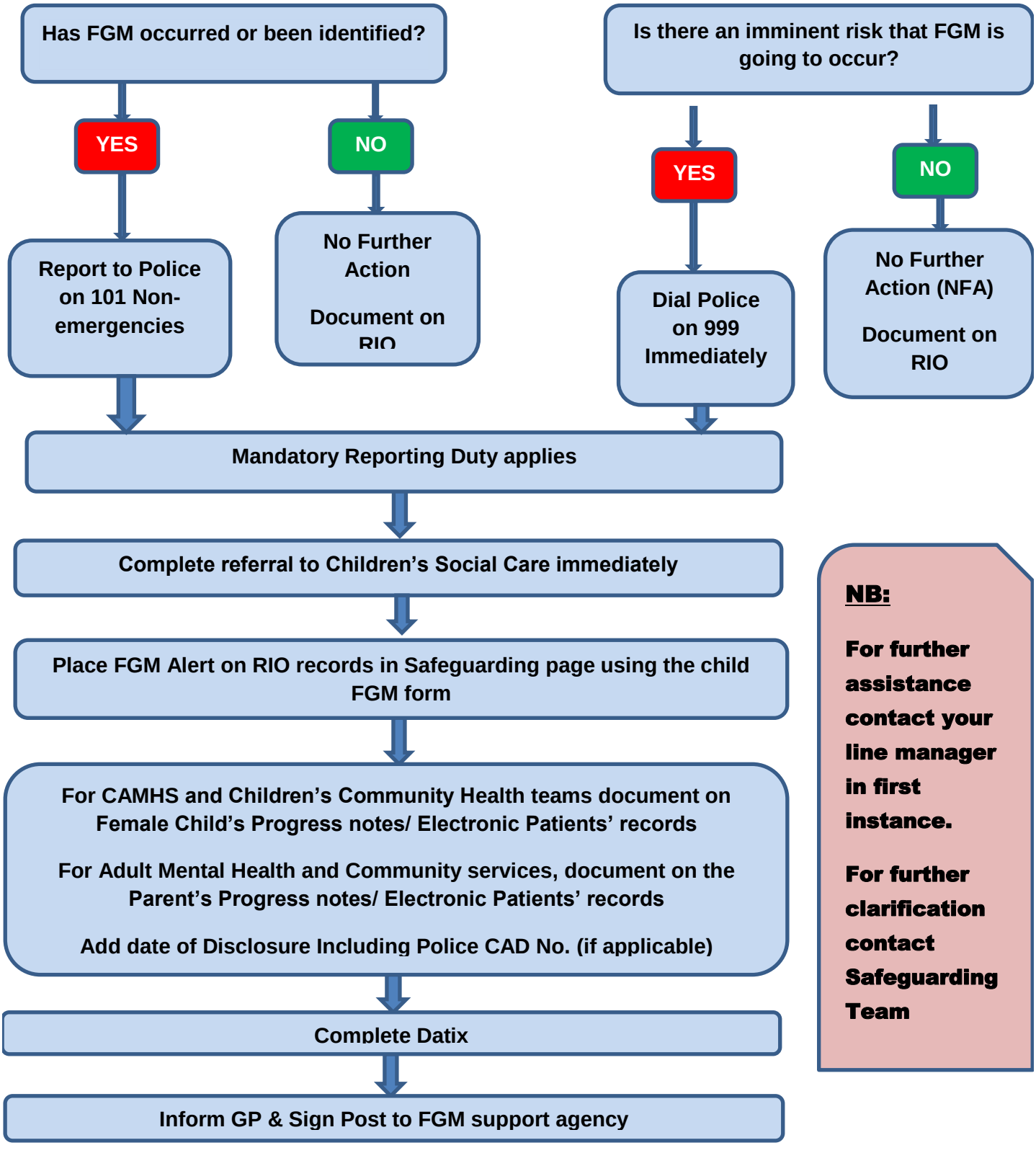
Best practice

Always talk to the victim alone

- Never pressure a woman to leave partner
- Discuss and ensure a safety plan is in place
- Reinforce options
- Explain the role of expert agencies
- Always use a professional interpreter. Never use family members or a client's friend if English is not his/her first language
- Always ensure complex domestic abuse cases are brought to supervision for discussion
- Document all contacts, when asking 'the question', disclosures, actions, observations, etc

Appendix iii

FGM PATHWAY



NB:

For further assistance contact your line manager in first instance.

For further clarification contact Safeguarding Team

Appendix iv

East London NHS Foundation Trust

Guidance for the preparation and attendance at Child Protection Conferences and other Child Protection meetings

Date: December 2018

1. Introduction

1.1 It is essential that information provided to the child protection conference and other meetings is relevant, useful and fulfils the requirement of the conference/meeting in order to safeguard the welfare of children. Therefore, all child protection conference/meetings must be attended by the key health professional who must also submit a report in the approved format.

1.2 All reports for child protection conferences and meetings submitted by health professionals must follow this agreed format. The only exception is medical examinations which will follow the report format for medical examinations.

2. Purpose

2.1 To support staff in their day to day work, improve communication and promote safe outcomes for children

2.2 To ensure that all Trust procedures conform to an agreed standard for preparation and attendance at child protection conferences and report writing

2.3 To establish clear standards against which the process of attendance at conference and written reports can be audited.

3. Objectives of the procedure

3.1 To outline the expected process and format for attendance at child protection conferences.

4. Responsibilities

4.1 Health professionals have a responsibility to adhere to this procedure.

4.2 Line managers and named safeguarding professionals have a responsibility to support supervisees in relation to this procedure, monitor practice and inform the practitioner's manager when there are areas for development identified.

5. Definitions

5.1 A child protection conference is a multiagency meeting which brings together the child, family and significant others, key professionals involved with the family in order to share information to:

- Make a judgement on the likelihood of the child/children suffering significant harm
- Decide what future action is needed to safeguard the child/children and promote their welfare.

6. Representation at Child Protection Conferences

6.1 Health representation must be made at all child protection conferences and meetings by key professionals who have a specific contribution to make due to their knowledge of the child and family or their expertise relevant to the case.

6.2 The aim of the discussion is to share and plan health input for the family. Subsequent case discussions would be organised in response to additional needs. Either practitioner could request this.

6.3 Core group meetings/review child protection conference:

6.4 The key health professionals will form the core group and review child protection plan, for the family and child/ren, unless he / she informs the chair and named social worker who will be replacing them providing name, job title and contact details. This will be recorded in the RiO progress notes for each child.

6.5 If there is no health representation, the chair of the conference will inform the Safeguarding Children Team who will raise the issue with the individual's line manager for action.

7. Preparation for Child Protection Conferences

7.1 If a health professional is unable to attend a child protection conference, they must ensure a colleague from their own service represents them and presents their report.

7.2 There may be occasions when a health professional may request support at a child protection conference due to the complexity of the case or inexperience of the health professional in attending conferences. The health professional should negotiate this with their line manager and/or their Child Protection Supervisor.

8. Writing Reports for Child Protection Conferences and other Child Protection Meetings (see Intranet page)

8.1 The report must be typed on the template sent from social care or in appendix 1

8.2 A separate report should be produced for each child within the family for which the professional has responsibility.

8.3 Where information in the report is either the assessment of other professionals or comes from another source, this must be clearly identified.

8.4 Where the health professional's client is an adult e.g. antenatal or in mental health, then their report will focus more on parenting capacity and family and environmental factors. The report should include an explanation of their condition and care where this has an impact on their ability to care for their children and/or outline what support they will require to care for their children.

8.5 Contents of the report must be shared with the parent/carer and child (depending on age and understanding) prior to the conference. The report must be sent to the chair of the conference at least 48 hours prior to the conference.

9. Heath Professionals' responsibility at a Child Protection Conference

9.1 All health professionals attending child protection conferences will share information about their involvement with family or children.

9.2 Health professionals will be expected to provide an opinion on whether child/ren discussed is in need of a child protection plan including which category is most suitable based on the information provided at the child protection conference.

10. Dissent to the decision regarding the need for a Child Protection Plan

10.1 When a health professional disagrees with the decision regarding the need for a Child Protection Plan, they must clearly state their dissent and request that this and their reason for dissent is documented in the minutes.

11. Record Keeping and Minutes

11.1 Attendance at a Child Protection Conference must be recorded in each child's records by the health professional that attended the conference and should include the following:

- Date, time and venue of the conference
- Type of conference attended (initial /review/transfer-in/pre-birth);
- The decision of the conference including the category if a child protection;
- Date, time and venue of the next conference (or child in need meeting);
- Date, time and venue of the Core Group Meeting, if relevant;
- The main issues/concerns;
- An outline of the health care plan and the health professional's responsibilities under the Child Protection Plan.

11.2 Child protection conference minutes must be checked for accuracy. If inaccurate they must be amended and returned to the conference chairperson within 7 days of receipt. Failure to do so will result in acceptance of minutes as a true reflection of conference.

11.3 Child protection conference minutes must be uploaded to RiO Documents for each child by the health professional. Where the health professional is working with the adults the conference minutes must be uploaded to the adult's records.

11.4 Failure to comply with the agreed child protection plan by any party should be notified to the social worker within 48 hours.

References

HM Government (2018) Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children Available on: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf [accessed on 24.12.18]

London Safeguarding Children Board, 2018 London Child Protection Procedures 2017. Available on: http://www.londoncp.co.uk/ [accessed on 24.12.18]

Pan Bedfordshire Safeguarding Children Board, 2018: Child Protection Procedures available at https://bedfordscb.proceduresonline.com/chapters/p_bedford_cp_conf.html#attend [accessed on 24.12.18]

East London NHS Foundation Trust

Appendix v

Protocol for safeguarding sexually active children and young people

Date: December 2018

1. Introduction

1.1 This document is based on the core principle that the welfare of the child is paramount and emphasises the need to accurately assess to what extent there may be a risk of significant harm when a child is engaging in sexual activity. The purpose of this document is to help health professionals identify where children and young people's sexual relationships may be abusive, and how to take the appropriate action.

2. Legal context

2.1 The Sexual Offences Act (2003) introduced a range of offences specifically focusing on the protection of children from sexual exploitation. This legislation prevents the following;

- Sexual activity with a child.
- Causing or inciting a child to engage in sexual activity.
- Engaging in sexual activity in the presence of a child.
- Causing a child to watch a sexual act.

2.2 The legal age of consent to sexual activity is16 years. The law is not intended to prosecute mutually consenting teenage sexual activity between two young people of a similar age unless there is evidence of abuse or exploitation.

2.3 A child under the age of 13 is not legally capable of consenting to sexual activity.

2.4 Young people under the age of 18 are protected under the 'Sexual Offences Act' from sexual abuse by adults who are in positions of trust or authority.

3. Indicators of risk

- In order to determine whether a relationship presents a risk of significant harm to a young person, the following factors should be considered:
- Whether the child/young person is competent to understand, and consent to, the sexual activity they are involved in (children under 13 are not legally capable of consenting to sexual activity);
- What the child or young person in the relationship's living circumstances are, whether they are attending school, whether they or their siblings are receiving services from LA Children's Social Care or another social care agency etc.;
- The nature of the relationship between those involved, particularly if there are age or power imbalances
- Whether overt aggression, coercion or bribery was or is involved including misuse of alcohol or other substances as a disinhibition;
- Whether the child/young person's own behaviour, for example through misuse of alcohol or other substances, places him/her in a position where he/she is unable to make an informed choice about the activity; and
- Any attempts to secure secrecy by the sexual partner beyond what would be considered usual in a teenage relationship;
- Whether methods used to secure a child or young person's compliance and trust and/or secrecy by the sexual partner are consistent with grooming for sexual exploitation.

- Whether the sexual partner is known by one of the agencies as having or having had, other concerning relationships with children/young people (which presupposes that checks will be made with the Police);
- Whether the child/young person denies, minimises or accepts the concerns held by professionals.
- (London Child Protection Procedures, 2017).

4. Assessment tool

4.1 The process of assessment must be undertaken in a consistent and comprehensive manner by practitioners who have the relevant knowledge and skills.

4.2 The Risk Assessment Tool (See Appendix 1) is designed to assist practitioners to identify and assess the risk of abuse when delivering sexual health services to children and young people in order to identify the appropriate response.
Practitioners should also be familiar with the accompanying guidance in Appendix 2 prior to using the Risk Assessment Tool.

4.3 Once completed the Risk Assessment Tool should supplement any other records generated by the practitioner for the child/young person.

4.4 The Risk Assessment Tool is not substitute for the practitioner's professional judgement or supervision from their manager and/or from the Named Nurse or Doctor for Child Protection.

5. Referral to Children's Social Care

5.1 The decision whether or not to make a formal referral to Children's Social Care must be made within the supervision arrangements within an agency for making such a decision.

5.2 Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm a referral should be made to Children's Social Care of the Borough in which the child resides.

6. Where there are no concerns

6.1 Where the practitioner knows that a young person 13 or over is sexually active but the practitioner's assessment does not raise concerns that the young person's sexual relationship is abusive, the practitioner should continue to make arrangements for the young person to receive confidential advice and support.

7. Children under the age of 13

7.1 A child under 13 is not legally capable of consenting to sexual activity.

7.2 Under the Sexual Offences Act 2003, penetrative sex with a child under 13 is classed as rape. A referral should be made to Children's Social Care and be reported to the police. All cases involving under 13s should be fully documented, including giving detailed reasons where the decision is taken 'not' to share information.

8. Children aged 13 years to their 16th birthday

8.1 Young people below the age of consent have a right to access sexual health services and to have their rights to confidentiality respected (FPA 2016)

8.2 However, sexual activity with a child under 16 is also an offence. Where it is consensual, Practitioners should consider whether they should initiate a discussion with Children's Social Care about the risk of harm to the child and whether a referral should be made. Where a decision is made not to refer to Children's Social Care and /or the police has made the rationale for this decision, then this decision must be documented in the young person's records.

9. Young people from the age of 16 until their 18th birthday

9.1 Sexual activity involving a 16 or 17 year old, though unlikely to involve an offence, may still involve harm or the risk of harm. Professionals should still bear in mind the considerations and processes outlined in this document in assessing that risk, and should share information as appropriate.

9.2 It is an offence for a person to have a sexual relationship with a 16 or 17 year old if they hold a position of trust or authority in relation to them.

10. Record keeping

10.1 The completed Risk Assessment Tool should supplement any other records generated by the practitioner for the child / young person.

10.2 Any decision made by the practitioner with regard to potential risk of harm should be recorded in the child /young person's records accompanied by their rationale for that decision.

References

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Section a of Appendix v

Risk Assessment Tool

Risk Assessment (sexually active young person)					
Family name:	First name:		Date of birth: Age:	Address:	
School:	Clinic number:		NHS number:		
Age and competency				**Notes**	**Level of concern**
Is the child/young person competent to understand, and consent to, the sexual activity they are involved in?	No	Unsure	Yes		
Age of young person	Under 13 years	13-15 years	16-17 years		
Young person's circumstances				**Notes**	**Level of concern**
Are the living circumstances of the child or young person secure and supportive?		Yes	No		
Does the young person attend school?		Yes	No		
Does the young person live with their parents?		Yes	No		
Has the young person experienced domestic violence?		Yes	No		

Does the young person or their siblings receive services from local authority children's social care or another social care agency?	Yes	No		
Is the young person looked after by the local authority?	Yes	No		
Is the young person homeless, living in a hostel or staying temporarily somewhere?	Yes	No		
Is the child or young person in any way disabled or learning disabled or does s/he have a communication difficulty?	Yes	No		

Experience of sexual / intimate relationships				**Notes**	**Level of concern**
Age of first sexual experience?	Under 13 years	13-15 years	16-17 years		
Age of partner					
Relationship details					
Are you having sexual contact with anyone?					
How old is the person you are having sexual contact with?					
Where did you meet this person?					
How many people have you had sexual contact with in the past three months?					

Where do you spend time together?				
Is the age differential greater than 5 years?	Yes	No		
Is the relationship between those involved equal and consensual or are there power imbalances?	Yes	No		
Are coercion or seduction / bribery involved including misuse of alcohol or other substances as a disinhibitor?	Yes	No		
Has the sexual partner made attempts to secure secrecy beyond what would be considered usual in a teenage relationship?	Yes	No		
Are the methods used to secure a child or young person's compliance and trust and/or secrecy by the sexual partner consistent with grooming for sexual exploitation?	Yes	No		
Is the sexual partner known by one of the agencies as having or having had, other concerning relationships with children/young people?	Yes	No		
Does the child/young person deny, minimise or accept the concerns held by professionals?	Yes	No		
Does the child/young person's own behaviour, for example through misuse of alcohol or other substances, place him/her in a position where he/she is unable to make an informed choice about the activity?	Yes	No		
Plan (see guidance that accompanies this risk assessment tool)				

Staff name:	Signature	Date of assessment:

Appendix 2 – Practitioner Guidance for the Risk Assessment Tool for (sexually active child or young person)

1. The indicators for concern should be assessed using professional judgement and individually rated as HIGH, MEDIUM or LOW risk.
2. A single occurrence of HIGH would be sufficient to generate a referral to police and LA children's social care.
3. Two or more occurrences of MEDIUM would be sufficient to generate a referral to police and LA children's social care.
4. Assessments of risk below these thresholds may also be referred to the police and LA children's social care.
5. Confidentiality is never absolute and, in most cases, competent professionals will be able to articulate the need for information from the police in a manner that does not undermine the integrity of the agency.
6. Decisions not to refer to the police and LA children's social care must be made within the agency's supervision arrangements and at first line manager level or above.

Age and competency	Considerations for assessment		
Is the child/young person competent to understand, and consent to, the sexual activity they are involved in?	Competence is relative to the seriousness of the situation. The less a child or young person is able to appreciate the risks involved in their sexual relationship the less s/he is likely to be able to protect her/himself.	No	Seek advice from a Named Professional for safeguarding children
		Unsure	Document any concern and consider seeking advice from the safeguarding team
		Yes	Continue to provide a confidential service to the young person.
Age of young person	Children under 13 years old are not legally capable of consenting to sexual activity (Sexual Offences Act 2003). Where a practitioner is concerned that a child is involved with penetrative sex, or other intimate sexual activity, there will always be reasonable cause to suspect that a child, whether girl or boy, is suffering or is likely to suffer significant harm.	Under 13 years old	Seek advice from a Named Professional for safeguarding children regarding referral to children's social care and/or the police.
		13-15 years old	Document any concern and consider seeking advice from the safeguarding team.
		16-17 years old	Document any concern and consider seeking advice from the safeguarding team.

Young person's circumstances	Considerations for assessment	
Are the living circumstances of the child or young person secure and supportive?	Children and young people whose home / social / school circumstances are not robust are likely to have lower self-esteem and less resilience and are therefore more vulnerable to coercion. They are less likely to be able to resist forceful or seductive sexual advances.	Document, including level of concern and consider seeking advice from a Named Professional for Child Protection. A high level of concern should always result in consultation with a Named Professional for Child Protection.
Does the young person attend school?		
Does the young person live with their parents?		
Has the young person experienced domestic violence?		

Does the young person or their siblings receive services from local authority children's social care or another social care agency?		
Is the young person looked after by the local authority?		
Is the young person homeless, living in a hostel or staying temporarily somewhere?		
Is the child or young person in any way disabled or learning disabled or does s/he have a communication difficulty?	Disabled children and young people are more likely to be abused than non-disabled children.	

Experience of sexual / intimate relationships	**Considerations for assessment**	
Age of first sexual experience?	See section on age and competency	
Is the relationship between those involved equal and consensual or are there power imbalances?	These can result from differences in size, age, material wealth and/or psychological, social and physical development. In addition gender, sexuality, race and levels of sexual knowledge can be used to exert power. A large age differential could be a key indicator (e.g. 5 years or more) There can also be bullying present where the children and young people are in a similar age relationship. There may also be instances when the sexual predator is a woman or girl and the victim is a boy. A child or young person is considered unable to give consent if the sexual partner is in a position of trust or is a family member (Sexual Offences Act 2003; and/or any pre-existing legislation).	Document, including level of concern and consider seeking advice from a Named Professional for Child Protection. A high level of concern should always result in consultation with a Named Professional for Child Protection.
Is coercion or seduction / bribery involved including misuse of alcohol or other substances as a disinhibitor?	A child or young person may not see the activities of another as aggressive, coercive or seductive. Similarly they may be unaware and reluctant to recognise that drugs and alcohol are offered to facilitate sex or sexual exploitation.	
Has the sexual partner made attempts to secure secrecy beyond what would be considered usual in a teenage relationship?	Practitioners should seek advice and supervision about what would be considered a usual degree of secrecy in a teenage relationship, if they are unsure.	

Are the methods used to secure a child or young person's compliance and trust and/or secrecy by the sexual partner consistent with grooming for sexual exploitation?	Adults and young people who are paedophiles are extremely adept at presenting themselves as benevolent (gifts, help, money) and trustworthy (friend of the family or responsible older friend). Adults and young people who are pimps may develop the relationship with the young person first, including by offering them money or drugs, before coercing them into prostitution. Children and young people who begin taking illegal substances are likely to need protection irrespective of their views.	
Is the sexual partner known by one of the agencies as having or having had, other concerning relationships with children/young people?	In cases of concern, when sufficient information is known about the sexual partner/s, the agency concerned should check with other agencies, including the police, to establish whatever information is known about that person/s.	
Does the child/young person deny, minimise or accept the concerns held by professionals?	Protecting a child or young person from harm depends on a practitioner scrupulously assessing the child or young person's true position – rather than a possible position by the child or young person as a line of least resistance or in order to avoid the involvement of other agencies.	
Does the child/young person's own behaviour, for example through misuse of alcohol or other substances, place him/her in a position where he/she is unable to make an informed choice about the activity?	Anyone who takes advantage of a child or young person's temporary disinhibition or incapacity for sexual purposes, whether by accident or design, does so without consent. The sexual activity is always unlawful.	

Section b of appendix v - Safeguarding Sexually Active Children & Young People