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Clinical Commissioning Group

SAFEGUARDING CHILDREN POLICY

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Version	**Date**	**Comments**
1.1	June 2017	Amalgamation of the following policies: Safeguarding Children and Young People in general practice. 2016 Policy and procedure around the recording, flagging and sharing of information in general practice about patients who are known to be at risk of domestic abuse. 2016

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SAFEGUARDING CHILDREN POLICY

1 INTRODUCTION

1.1 Somerset Clinical Commissioning Group is fully committed to promote and safeguard the wellbeing of children, in accordance with our duty under Section 11 of the Children Act 2004. This policy outlines the legislation, principles and values that inform the safeguarding practice of all staff.

1.2 This policy must be operated in conjunction with the following local, regional and national policies, procedures and guidance:

- NHS England Safeguarding Policy 2015
- South West Child Protection Procedures
- Working Together to Safeguard Children, 2015
- Information sharing advice for practitioners providing safeguarding services to children, young people, parents and carers, 2015
- Somerset Safeguarding Children Board Resolving Professional Difference Protocol, 2016
- Somerset Safeguarding Children Board Pre Birth Protocol
- Safeguarding Children Board Effective Support for Children and Families in Somerset

1.3 Additional information and resources in relation to safeguarding children in Somerset is available on the following websites:

- Somerset Professional Choices
- Somerset Safeguarding Children Board
- Somerset Direct

2 POLICY STATEMENT

2.1 Somerset CCG recognises that all children have a right to protection from abuse and neglect, and accepts its responsibility to safeguard the welfare of all children. The purpose of this policy is to assist all staff, both clinical and non-clinical, to understand their roles and responsibilities in relation to safeguarding children. It provides a framework for safe and effective practice in relation to vulnerable children, children in need and child protection.

2.2 Somerset CCG must ensure that staff use professional and clinical knowledge and understanding of what constitutes child maltreatment to identify any signs of child abuse and neglect. The CCG must also be assured that staff then know how to act on their concerns, to fulfil their responsibilities in line with local and national policies and procedures, and legislation, in relation to safeguarding children.

Scope

2.3 This document applies to all staff within Somerset Clinical Commissioning Group (CCG) working with unborn babies, children, young people, adults and their families. This document also applies to agency staff and other staff not employed directly by the Trust e.g. volunteers.

Safeguarding

2.4 The term safeguarding and promoting the welfare of children is defined in Working Together to Safeguard Children[1] as:

- protecting children from maltreatment
- preventing impairment of children's health or development
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- taking action to enable all children to have the best outcomes

2.5 Child Protection refers to the activity that is undertaken to protect specific children who are suffering or at risk of suffering significant harm.

3 BASIC PRINCIPLES

3.1 This policy seeks to emphasise the following principles:

- The welfare of the child is paramount.
- It is the responsibility of all staff to safeguard and promote the welfare of unborn babies, children and young people. Safeguarding and promoting the welfare of children is defined in section 2.4 of this policy.
- All staff should work in an open and transparent way with children, young people, adults and their families.
- All staff, both clinical and non-clinical, should:
  - be aware of their responsibilities for safeguarding children
  - be aware of the signs and symptoms of potential and actual abuse
  - understand how to respond to actual or suspected abuse of a child
  - know who to contact for advice and support in relation to safeguarding and promoting the wellbeing of unborn babies, children and young people
- All staff understand the need to share appropriate information in a timely way and in accordance with current legislation and guidance, including responding to information requests relating to the need to safeguard a child.
- All staff should actively contribute to multi-agency working in safeguarding children from abuse, neglect or exploitation whatever their:
  - Race, religion, first language or ethnicity;

[1] Working together to safeguard children

- Gender or sexuality;
- Age;
- Health or disability;
- Location or placement;
- Criminal behaviour;
- Political or immigration status[2].

3.2 Every assessment should be focused on outcomes, deciding which services and support are required to deliver improved welfare for the child.

3.3 Children and their families are able to share concerns and complaints and there are mechanisms in place to ensure these are heard and acted upon. For further information see http://www.somersetccg.nhs.uk/contact-us/pals/

3.4 Organisations must have safe recruitment practices (through Human Resources processes) including safe whistle blowing processes, and appropriate use of the Disclosure and Barring Service.

4 WHAT IS ABUSE AND NEGLECT?

4.1 Child abuse is any action by another person – adult or child – that causes significant harm to a child. It can be physical, sexual or emotional, but can just as often be about a lack of love, care and attention. We know that neglect, whatever form it takes, can be just as damaging to a child as physical abuse. An abused child will often experience more than one type of abuse, as well as other difficulties in their lives. It often happens over a period of time, rather than being a one-off event. And it can increasingly happen online[3].

4.2 Abuse is 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 (e.g. via the internet). They may be abused by an adult or adults, or another child or children.[4]

4.3 There are four main categories of abuse in relation to children: neglect; physical abuse; sexual abuse and emotional abuse.

5 CATEGORIES OF ABUSE

Neglect

5.1 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:

[2] UN Convention on The Rights of the Child (1998)
[3] https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/
[4] http://www.proceduresonline.com/swcpp/somerset/p_respond_abuse_neg.html#def_ch_abuse

- 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 or inadequate care givers)
- ensure access to appropriate medical care or treatment

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

Physical Abuse

5.3 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.

Sexual Abuse

5.4 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 include physical contact, including assault by penetration (e.g. rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Emotional Abuse

5.5 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.

6 FABRICATED OR INDUCED ILLNESS IN A CHILD (FII)

6.1 Fabricated or Induced Illness is a condition whereby a child suffers harm through the deliberate action of her/his main carer and which is attributed by the adult to another cause. FII is relatively rare, and is potentially lethal.

6.2 There are four main ways of the carer fabricating 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 fluids

- exaggeration of symptoms/real problems. This may lead to unnecessary investigations, treatment and/or special equipment being provided

- induction of illness by a variety of means

6.3 The above four methods are not mutually exclusive.

6.4 Once a health practitioner has suspicions that fabricated or induced illness is being presented, the named doctor or associate safeguarding nurse should be contacted for support and advice, but if unavailable, the designated doctor/nurse should be contacted.

6.5 Health practitioners should not normally discuss their concerns with the parents / carers at this stage.

6.6 If any professional considers their concerns about fabricated or induced illness are not being taken seriously or responded to appropriately, they should discuss these with their local named or designated doctor or nurse.

6.7 Relevant policies and procedures:

- South West Child Protection Procedures http://www.proceduresonline.com/swcpp/somerset/p_fab_ind_illness.html?zoom_highlight=FII

- Safeguarding Children in whom illness is fabricated or induced https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277314/Safeguarding_Children_in_whom_illness_is_fabricated_or_induced.pdf

- NICE CG89 guidance provides a summary of clinical features associated with child maltreatment (alerting features) that may be observed when a child presents to healthcare professionals. The alerting features in this guidance have been divided into two, according to the level of concern, with recommendations to either 'consider' or 'suspect' maltreatment.

7 DOMESTIC VIOLENCE AND ABUSE

7.1 Domestic Violence and Abuse is defined as: *"Any incident or pattern of incidents of controlling, coercive or 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. This can encompass but is not limited to the following types of abuse:*

- *Psychological;*

- *Physical;*

- *Sexual;*

- *Financial;*

- *Emotional.*

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

7.3 *Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim." Domestic Abuse is 'Any incident or pattern of incidents of controlling, coercive or threatening behavior, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: Psychological Physical, Sexual, Financial, and Emotional*."

7.4 This definition includes 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

7.5 Where there is domestic violence and abuse, the wellbeing of the children in the household must be promoted and all assessments must consider the need to safeguard the children, including unborn child/ren. They are at increased risk of physical, emotional and sexual abuse in these environments.

7.6 When carrying out a risk assessment of domestic violence using the Safelives-DASH Risk Identification Checklist, staff may determine that a child / adult / family is at high risk as a result of the domestic violence and abuse disclosed. In this case all staff should consider completion of a referral to Somerset Multi Agency Risk Assessment Conference (MARAC).

7.7 MARAC is a victim focused meeting where information is shared between partner agencies on the highest risk cases of domestic abuse and violence. A risk focused, coordinated safety plan is then drawn up to support the victim and his / her family. Cases discussed at MARAC will be shared with relevant services, if there needs to be further advice and support provided by that service. In light of the existence of high risk of domestic violence and known risks and vulnerability factors disclosed at MARAC, the expectation is that each service will review the family's needs and in accordance with the additional needs identified, provide an appropriate follow up service.

7.8 Further information regarding MARAC, the referral process and additional resources in relation identification of and response to domestic violence and abuse can be found on Somerset Survivors website.

7.9 Relevant policies and procedures:

- South West Child Protection Procedures: http://www.proceduresonline.com/swcpp/somerset/p_dom_viol_abuse.html?zoom_highlight=domestic+abuse#Definition

- Domestic violence and abuse: Professional guidance. DoH 2013 https://www.gov.uk/government/publications/guidance-for-health-professionals-on-domestic-violence

- Responding to Domestic Abuse: a resource for health professionals. DoH. 2017 https://www.gov.uk/government/publications/domestic-abuse-a-resource-for-health-professionals

- Domestic Violence and Abuse NICE Guidance QS116: https://www.nice.org.uk/guidance/qs116

8 SEXUALLY ACTIVE CHILDREN

8.1 A child under 13 is not legally capable of consenting to sexual activity and sexual activity with a child under 13 years of age is a criminal offence / classed as statutory rape. Any offence under the Sexual Offences Act 2003 involving a child under 13 indicates significant harm to the child and requires a child protection referral. Sections 9-13 of the Sexual Offences Act 2003 clarifies that any sexual activity involving consenting children under 16 is unlawful, but Home Office guidance is clear that there is no intention to prosecute teenagers under the age of 16 where both mutually agree and where they are of a similar age.

8.2 It is considered good practice for workers to follow the Fraser guidelines and Gillick competence when discussing personal or sexual matters with a young person under 16. It became lawful to provide contraceptive advice and treatment to girls under the age of 16, subject to certain guidelines (Fraser guidelines). In certain circumstances a child under the age of 16 can give consent to treatment in their own right ('Gillick competence').

8.3 Although sexual activity in itself is no longer an offence over the age of 16, young people under the age of 18 are still offered protection under the Children Act 1989 and consideration still needs to be given to issues of sexual exploitation and abuse.

8.4 Young people over the age of 16 and under the age of 18 are not deemed able to give consent if the sexual activity is with an adult in a position of trust or a family member as defined by the Sexual Offences Act 2003.

8.5 Professionals are required to identify where children and young people's sexual relationships may be abusive and the children and young people may need protection, or the provision of additional services.

8.6 Relevant Policies and Procedures

- SWCPP (Underage sexual activity) http://www.proceduresonline.com/swcpp/somerset/p_underage_sexual_act.html?zoom_highlight=sexually+active+children

8.7 Tools and resources

- Gillick competence and Fraser guidelines: https://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines/

9 CHILD SEXUAL EXPLOITATION (CSE)

9.1 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.[5]

9.2 Like all forms of child sexual abuse, child sexual exploitation:

- can affect any child or young person (male or female) under the age of 18 years, including 16 and 17 year olds who can legally consent to have sex;
- can involve force and/or enticement-based methods of compliance and may, or may not, be accompanied by violence or threats of violence;
- can be perpetrated by individuals or groups, males or females, and children or adults. The abuse can be a one-off occurrence or a series of incidents over time, and range from opportunistic to complex organised abuse;

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

9.4 Assessment tools and resources:

- A useful quick guide to CSE for Somerset health care practitioners has been developed.
- Somerset Safeguarding Children Board has produced an initial screening tool for CSE intended to assist the exercise of professional judgment by assisting professionals to consider the risk of harm to a child.[6] On completion of this tool, staff are then required to consider whether or not an Early Help or Safeguarding referral is required.
- The CSE section of the local safeguarding children board website: http://sscb.safeguardingsomerset.org.uk/working-with-children/cse-protocols/

9.5 Relevant policies and procedures

- Child sexual exploitation: Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/591903/CSE_Guidance_Core_Document_13.02.2017.pdf
- South West Child Protection Procedures: http://www.proceduresonline.com/swcpp/somerset/p_ch_sexual_exploit.html?zoom_highlight=child+sexual+exploitation
- Child sexual exploitation: Advice for Healthcare Staff. A pocket guide to provide practical information to healthcare staff to safeguard children and young people

[5] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/591903/CSE_Guidance_Core_Document_13.02.2017.pdf
[6] http://sscb.safeguardingsomerset.org.uk/working-with-children/cse-protocols/

10 MODERN SLAVERY (INCLUDES HUMAN TRAFFICKING AND THE EXPLOITATION OF CHILDREN)

10.1 Modern slavery is a form of organised crime in which individuals including children and young people are treated as commodities and exploited for criminal gain. Traffickers and slave drivers trick, force and/or persuade children and parents to let them leave their homes. Grooming methods are used to gain the trust of a child and their parents, e.g. the promise of a better life or education, which results in a life of abuse, servitude and inhumane treatment.

10.2 Child trafficking or child modern slavery is identified as child abuse which requires a child protection response. It is an abuse of human rights, and all children, irrespective of their immigration status, are entitled to protection under the law[7].

10.3 The National Referral Mechanism[8] is a framework for identifying victims of human trafficking and ensuring they receive appropriate care. It was set up in 2009 as part of the UK's implementation of the Council of Europe Convention.

10.4 Resources

- Unseen Website http://www.unseenuk.org/ and Modern Slavery Helpline 08000 121 700
- Anti-slavery partnership. Includes government leaflets setting out support for victims of modern slavery in 11 languages. http://www.aspartnership.org.uk
- Unchosen website. Includes films and printable posters and leaflets. http://unchosen.org.uk
- The NSPCC has a Child Trafficking Advice Centre for staff who work with children or young people who may have been trafficked into the UK, contact our specialist service for information and advice. Call 0808 800 5000 or email help@nspcc.org.uk for more information. https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/child-trafficking

10.5 Relevant policies and procedures

- SWCPP (Modern Slavery) http://www.proceduresonline.com/swcpp/somerset/p_modern_slavery.html?zoom_highlight=MODERN+SLAVERY
- For further details see Safeguarding children who may have been trafficked, practical guidance.

11 FEMALE GENITAL MUTILATION (FGM)

11.1 FGM comprises of all procedures involving partial or total removal of the external female genital organs or any other injury to the female genital organs for non-medical reasons. FGM is most often carried out on young girls aged between

[7] http://www.proceduresonline.com/swcpp/somerset/p_modern_slavery.html?zoom_highlight=MODERN+SLAVERY
[8] http://www.nationalcrimeagency.gov.uk/about-us/what-we-do/specialist-capabilities/uk-human-trafficking-centre/national-referral-mechanism

infancy and 15 years old. It is often referred to as 'cutting', 'female circumcision', 'initiation', 'Sunna' and 'infibulation'[9].

11.2 From the 31st October 2015, regulated professionals in health and social care and teachers in England and Wales have a duty to report 'known' cases of FGM in under 18s to the police. Professionals who initially identified the FGM (you) calls 101 (police) to make a report. Where concerns about the welfare and safety of a child or young person have come to light in relation to FGM a referral to Children's social care should be made in accordance with the local safeguarding referrals procedure.

11.3 Professionals must take into consideration that by alerting the girl's or woman's family to the fact that she is disclosing information about FGM may place her at increased risk of harm and professionals should therefore take sufficient steps to minimise this risk.

11.4 Assessment tools and resources:

- FGM resource pack: https://www.gov.uk/government/publications/female-genital-mutilation-resource-pack/female-genital-mutilation-resource-pack#effective-practice-and-resources
- NHS England has produced a helpful pocket guide about FGM for Health Care Professionals.
- The NSPCC has a 24 hour helpline to provide advice and support to victims of FGM, or to anyone who may be concerned a child is at risk - call the helpline on 0800 028 3550 or email fgmhelp@nspcc.org.uk

11.5 Relevant policies and procedures:

- SWCPP (Female Genital Mutilation) http://www.proceduresonline.com/swcpp/somerset/p_fem_gen_mutil.html?zoom_highlight=fgm
- Multi-agency statutory guidance on female genital mutilation. 2016 https://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation

12 SAFEGUARDING CHILDREN AND YOUNG PEOPLE AGAINST RADICALISATION AND VIOLENT EXTREMISM / PREVENT

12.1 Radicalisation is defined as the process by which people come to support terrorism and extremism and, in some cases, to then participate in terrorist groups.

12.2 "Extremism is vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs. We also include in our definition of extremism calls for the death of members of our armed forces, whether in this country or overseas" (HM Government Prevent Strategy 2011).

12.3 Prevent is one part of the United Kingdom's counter-terrorism strategy (CONTEST) and aims to stop people from being exposed to extreme ideologies

[9] https://www.england.nhs.uk/wp-content/uploads/2016/12/fgm-pocket-guide-v5-final.pdf

and becoming radicalised. The CONTEST strategy is divided up into four priority objectives:

- Pursue – stop terrorist attacks
- Prepare – where we cannot stop an attack, mitigate its impact
- Protect – strengthen overall protection against terrorist attacks
- Prevent – stop people becoming terrorists and supporting violent extremism

12.4 It is an approach that involves many agencies and communities, to safeguard people who may be at risk of radicalisation.

12.5 Since the publication of the Prevent Strategy, there has been an awareness of the specific need to safeguard children, young people and families from violent extremism[10]. There have been attempts to radicalise vulnerable children and young people to develop extreme views including views justifying political, religious, sexist or racist violence, or to steer them into a rigid and narrow ideology that is intolerant of diversity and leaves them vulnerable to future radicalisation.

12.6 Keeping children safe from these risks is a safeguarding matter and should be approached in the same way as safeguarding children from other risks. Children should be protected from messages of all violent extremism.

12.7 To report a concern contact the Regional Police Prevent Team:

- Phone: 01179 455 536
- Email: channelsw@avonandsomerset.pnn.police.uk

12.8 Relevant policies and procedures:

- SWCPP (Safeguarding Children and Young people against Radicalisation and Violent Extremism) http://www.proceduresonline.com/swcpp/somerset/p_sg_ch_extremism.html?zoom_highlight=prevent
- Revised Prevent Duty guidance for England and Wales. https://www.gov.uk/government/publications/prevent-duty-guidance

12.9 Tools and resources:

- eLearning available through the home office: https://www.elearning.prevent.homeoffice.gov.uk/
- Somerset County Council Prevent toolkit: http://www.somerset.gov.uk/EasySiteWeb/GatewayLink.aspx?alId=114670
- To access Prevent training available in Somerset email: Prevent@somerset.gov.uk

10 http://www.proceduresonline.com/swcpp/somerset/p_sg_ch_extremism.html?zoom_highlight=prevent

13 PRIVATE FOSTERING

13.1 A private fostering arrangement is essentially one that is made 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 for 28 days or more.

13.2 Privately fostered children are a diverse and sometimes vulnerable group which includes:

- 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.

13.3 Under the Children Act 1989, private foster carers and those with Parental Responsibility are required to notify the local authority of their intention to privately foster or to have a child privately fostered, or where a child is privately fostered in an emergency.

13.4 All health care professionals should notify Children's Social Care of a private fostering arrangement that comes to their attention, where they are not satisfied that the arrangement has been or will be notified.

13.5 Relevant policies and procedures:

- SWCPP (Private Fostering) http://www.proceduresonline.com/swcpp/somerset/p_ch_living_away.html?zoom_highlight=private+fostering#priv_fost
- Somerset Direct: http://www.somerset.gov.uk/childrens-services/adoption-and-fostering/private-fostering/

14 SAFEGUARDING CHILDREN AFFECTED BY GANG ACTIVITY AND YOUTH VIOLENCE

14.1 Defining a gang is difficult. They tend to fall into three categories: Peer Groups, Street Gangs and Organised Crime Groups[11]. It can be common for groups of children and young people to gather together in public places to socialise. Although some Peer group gatherings can lead to increased antisocial behaviour and youth offending, these activities should not be confused with the serious violence of a street gang.

14.2 Children may be involved in more than one 'gang', with some cross-border movement, and may not stay in a 'gang' for significant periods of time. Children

[11] http://www.proceduresonline.com/swcpp/somerset/p_ch_affected_gang_act.html?zoom_highlight=court+reports#Definition

rarely use the term 'gang', instead they used terms such as 'family', 'breddrin', 'crews', 'cuz' (cousins), 'my boys' or simply 'the people I grew up with'.

14.3 Safeguarding should focus on young people who are /vulnerable of making the transition to gang involvement as well as those already involved in gangs. Practitioners should be aware of particular risks to young people involved in gangs from violence and weapons; drugs and sexual exploitation.

14.4 Relevant policies and procedures:

- SWCPP (Children affected by gang activity and youth violence) http://www.proceduresonline.com/swcpp/somerset/p_ch_affected_gang_act.html?zoom_highlight=court+reports#Definition

- Safeguarding children and young people who may be affected by gang activity. 2010 https://www.gov.uk/government/publications/safeguarding-children-and-young-people-who-may-be-affected-by-gang-activity

15 SAFEGUARDING DISABLED CHILDREN

15.1 The Disability Discrimination Act 2005 (DDA) defines 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". By definition, any child with a disability should also be considered as a child in need under s17 of the Children Act 1989.[12]

15.2 This means that the needs of children and young people with long term illnesses such as leukaemia, diabetes, cystic fibrosis, or sickle cell are addressed. They may not usually be thought of as disabled, but their vulnerabilities may be similar. The key issue is the impact of abuse or neglect on a child or young person's health and development and how best to support them and safeguard their welfare.

15.3 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.

15.4 The national guidance Safeguarding Disabled Children - Practice Guidance (DCSF 2009) provides a framework collaborative multi-agency responses to safeguard disabled children.

15.5 The available UK evidence on the extent of abuse among disabled children suggests that disabled children are at increased risk of abuse, and that the presence of multiple disabilities appears to increase the risk of both abuse and neglect. Disabled children may be especially vulnerable to abuse for a number of reasons. These can include the following:

- Many disabled children are at an increased likelihood of being socially isolated with fewer outside contacts than non-disabled children;

- Their dependency on parents and carers for practical assistance in daily living, including intimate personal care, increases their risk of exposure to abusive behaviour;

[12] http://www.proceduresonline.com/swcpp/somerset/p_disabled_ch.html?zoom_highlight=safeguarding+disabled+chidlren

- They have an impaired capacity to resist or avoid abuse;
- They may have speech, language and communication needs which may make it difficult to tell others what is happening;
- They often do not have access to someone they can trust to disclose that they have been abused; and/or
- They are especially vulnerable to bullying and intimidation.

15.6 Looked after disabled children are not only vulnerable to the same factors that exist for all children living away from home, but are particularly susceptible to possible abuse because of their additional dependency on residential and hospital staff for day to day physical care needs. These factors can be present for both LAC disabled children and disabled children:

- Force feeding;
- Unjustified or excessive physical restraint;
- Rough handling;
- Extreme behaviour modification, including the deprivation of liquid, medication, food or clothing;
- Misuse of medication, sedation, heavy tranquillisation;
- Invasive procedures against the child's will;
- Deliberate failure to follow medically recommended regimes;
- Misapplication of programmes or regimes;
- Ill-fitting equipment (e.g. callipers, sleep board that may cause injury or pain, inappropriate splinting);
- Undignified age or culturally inappropriate intimate care practices.

15.7 Safeguards for disabled children are essentially the same as for non-disabled children. Particular attention should be paid to promoting a high level of awareness of the risks of harm and high standards of practice, and strengthening the capacity of children and families to help themselves. Measures should include:

- Making it common practice to help disabled children make their wishes and feelings known in respect of their care and treatment;
- Ensuring that disabled children receive appropriate personal, health, and social education (including sex education);
- Making sure that all disabled children know how to raise concerns, and giving them access to a range of adults with whom they can communicate. Those disabled children with communication impairments should have available to them at all times a means of being heard;
- An explicit commitment to, and understanding of disabled children's safety; and welfare among providers of services used by disabled children;

- Close contact with families, and a culture of openness on the part of services;

- Guidelines and training for staff on good practice in intimate care; working with children of the opposite sex; handling difficult behaviour; consent to treatment;

- Anti-bullying strategies; and sexuality and sexual behaviour among young people, especially those living away from home; and

- Guidelines and training for staff working with disabled children aged 16 and over to ensure that decisions about disabled children who lack capacity will be governed by the Mental Health Capacity Act once they reach the age of 16.

15.8 Where a disabled child has communication impairments or learning disabilities, special attention should be paid to communication needs, and to ascertain the child's perception of events, and his or her wishes and feelings.

15.9 Relevant policies and procedures:

- SWCPP (Disabled Children) http://www.proceduresonline.com/swcpp/somerset/p_disabled_ch.html?zoom_highlight=safeguarding+disabled+children

- Safeguarding Disabled Children: Practice Guidance. 2009. https://www.gov.uk/government/publications/safeguarding-disabled-children-practice-guidance

16 CHILDREN LOOKED AFTER

16.1 This term applies to children currently being looked after and/or accommodated by local authorities / Health and Social Care Trusts, including unaccompanied asylum seeking children and those children where the agency has authority to place the child for adoption.

16.2 Most children become looked after as a result of abuse and neglect. Although they have many of the same health issues as their peers, the extent of these is often greater because of their past experiences. For example, almost half of children in care have a diagnosable mental health disorder and two-thirds have special educational needs. Delays in identifying and meeting their emotional well-being and mental health needs can have far reaching effects on all aspects of their lives, including their chances of reaching their potential and leading happy and healthy lives as adults.

16.3 Children living away from home are particularly vulnerable to being abused by adults and peers. Limited and sometimes controlled contact with family and carers may affect a child's ability to disclose what is happening to them. Given that many young people live away from home because of concerns about their home conditions, it is particularly important that their welfare is protected when they are being cared for by another agency or institution.

16.4 The Royal College of Nursing and the Royal College of GP developed a framework for healthcare staff to understand their role and responsibilities for meeting the needs of looked after children. It sets out the required knowledge, skills, attitudes and values required with the ultimate aim of improving life

experiences for some of the most vulnerable children in society[13].This can be located on the Royal College of Paediatrics and Child Health website: http://www.rcpch.ac.uk/improving-child-health/child-protection/looked-after-children-lac/looked-after-children-lac

16.5 Relevant policies and procedures:

- Promoting the health and wellbeing of children looked after. 2015 https://www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-looked-after-children--2

- Children Living and Staying Away from Home including Private Fostering http://www.proceduresonline.com/swcpp/somerset/p_ch_living_away.html

17 WHO TO CONTACT FOR ADVICE AND SUPPORT

17.1 If you are worried about a vulnerable child and would like help, please don't stay silent.

17.2 Early Help Advice Hub on **01823 355803** - an advice line for professionals to discuss families who may need Early Help support

17.3 If you are worried about a child or young person who could be in danger please contact Children's Social Care on **0300 123 2224** by email at childrens@somerset.gov.uk or the police.

17.4 You can contact the police directly by dialling 101 and they will discuss with Children's Social Care what action should be taken. **In an emergency** always contact the police by dialling **999**.

17.5 If you would like to speak to a social worker outside of office hours please phone the Emergency Duty Team (EDT) on **0300 123 23 27**

17.6 Consultation line for Safeguarding Leads and GPs on **0300 123 3078**- Children's Social Care provide a consultation line for Children's Safeguarding Leads and all GPs. The line is staffed by qualified social workers from the First response Team within Children's Social Care. The child/ren and family being discussed will remain anonymous. You should phone the consultation line if you are unsure whether or not to make a Level 4 referral to children's social care (see definition of Level 4 of the Threshold Document: http://sscb.safeguardingsomerset.org.uk/effectivesupport-documents/).

17.7 Somerset Safeguarding Children Team - Contact details for the CCG Safeguarding children team are available on the CCG website: http://www.somersetccg.nhs.uk/about-us/how-we-do-things/safeguarding-children/

18 ADDITIONAL RESOURCES FOR ADVICE, SUPPORT AND INFORMATION RELATING TO SAFEGUARDING CHILDREN

18.1 Effective Support for Children and Families in Somerset Guidance (Threshold Document)

18.2 The guidance aims to make existing levels of need clearer for professionals so you can identify if a child or family might need some help and support.

[13] Looked after children knowledge skills and competences for all health care staff. 2014. RCPCH

Understanding when children and families might need support can ensure they are given the right service, in the right place, at the right time.

18.3 This document outlines in detail the four thresholds, and will help you to identify what threshold your concerns meet. This document guides you as to what kind of specific information is required from you, when referring a child to the Early Help hub or Somerset Direct. The most up to date version of this document can be found on the safeguarding children board webpage.

Somerset and Avon Rape and Sexual Abuse Support

18.4 SARSAS are a specialist support service for people in Bath and North East Somerset, Bristol, North Somerset, Somerset, or South Gloucestershire, who have experienced any form of sexual violence, at any point in their lives.

18.5 SARSAS offer a confidential helpline, regular support sessions, counselling, and email support to individuals, as well as supporting the friends and family of people affected by sexual violence. They also offer training and advice to professionals.

- SARSAS confidential helpline for Women and girls: **0808 801 0456**.
- Open Monday & Friday 11.00am to 2.00pm, and Tuesday, Wednesday and Thursday 6.00pm to 8:30pm.
- SARSAS confidential helpline for Men and boys: **0808 801 0464**.
- Open Monday 11.00am to 2.00pm and Tuesday 6.00pm to 8:30pm.

Somerset Professional Choices

18.6 You can find family information, advice and guidance on the Somerset Professional Choices website.

Somerset Safeguarding Children Board

18.7 The Somerset Safeguarding Children Board (SSCB) is the statutory, multi-agency partnership with responsibility for coordinating, monitoring and challenging all activity relating to safeguarding children and young people living in Somerset. Safeguarding Children Board's were set up as a result of the 2004 Children Act and are regulated by that law.

18.8 The work of the SSCB is broad and varied but includes:

- Developing multi-agency policies and procedures for safeguarding
- Participating in the strategic planning of children's services
- Communicating the need to safeguard and promote the welfare of children to professionals and the public
- Conducting Serious Case Reviews when a child dies or is seriously harmed and abuse or neglect is suspected
- Ensuring procedures to ensure a coordinated response to unexpected child deaths

- Collecting and analysing information about all child deaths that occur in the area to identify issues of concern

- Providing multi-agency training and development to staff on safeguarding children

18.9 The SSCB have developed a range of learning opportunities that have been informed by the Board's priorities, quality assurance activities and learning reviews, which aim to equip you in your tasks and enable you to work confidently alone and alongside others to keep children safe and promote their wellbeing. These training opportunities and a wide variety of information, advice, tools and resources is located on the website: http://sscb.safeguardingsomerset.org.uk/

Somerset Direct

- http://www.somerset.gov.uk/childrens-services/safeguarding-children/report-a-child-at-risk/

19 EARLY HELP AND SAFEGUARDING REFERRALS

19.1 Best practice is to inform parents/carers of your concerns and the next steps you plan to take unless to do so may put the child or yourself at risk. Lack of consent to share information or to refer should not prevent you from taking appropriate action if this is in the child's best interest.

19.2 When external authorities need to be contacted, the relevant details are below. You should contact Children's Social Care first unless the issue is more immediate and the child is in need of immediate medical attention or requires support from the Police. In these circumstances you should still inform Children's Social Care.

19.3 Consider what the level of need is – consult the Thresholds Guidance 'Effective support for children and families in Somerset'.

Early Help Assessment

19.4 The Early Help offer in Somerset is for children of any age, as problems can emerge at any point throughout childhood and adolescence. Early help is everyone's responsibility; with children, families, communities and agencies to work together so that families are assisted to help themselves and are supported as soon as a need arises.

19.5 Early Help is delivered by a wide range of agencies including health organisations, schools and colleges, district councils, housing associations and voluntary sector groups, as well as Somerset County Council.

19.6 Children, young people and their families may require some extra support or intervention in addition to what every child receives, to help them reach their potential. This may be short term, but requires a targeted service to support the child and their family.

19.7 It is possible for different agencies to provide a targeted service to different members of a family at this level, by talking to the family about completing an Early Help Assessment. Consent is required for the completion of an Early Help Assessment.

19.8 If you require any advice or support with completing an Early Help Assessment, please contact:

19.9 The Early Help Advice Hub email: EHACoordinator@somerset.gov.uk, or telephone: 01823 355803.

19.10 A Team Around the Child (TAC) meeting must take place to agree a coordinated response which will be detailed in an action plan. The TAC brings together a range of different practitioners from across the children and young people workforce to support an individual child or young person and their family. The members of the TAC develop and deliver a package of solution-focused support to meet the needs identified through the Early Help Assessment. The model does not imply a multidisciplinary team that is located together or who work together all the time; rather, it suggests a group of practitioners working together as needed to help a particular child or young person. You will need parental consent to share relevant information with other involved professionals.

Early Help Referral

19.11 The Getset Service is part of Somerset County Council's contribution to the Early Help landscape. Getset will:

- Support children, young people and families to help themselves and become more resilient
- Think 'family' and quickly identify children, young people and families who need extra help
- Act quickly with effective interventions as soon as they know help is needed
- Use assessments to make sure the response is appropriate to the identified need
- Collect and analyse data and performance information to make sure they monitor and evidence the impact of their work while striving to improve what they do

19.12 The Level 3 service which provides targeted support for families that are assessed to require support at Level 3 on the Safeguarding Children Board's 'Thresholds for Assessment' and meet at least two of the government's 'Troubled Families' criteria:

- Children with poor school attendance
- Worklessness and risk of financial exclusion
- Affected by domestic violence and abuse
- Parents and children with a range of health needs
- Involvement in crime or anti-social behaviour
- Children who need help

19.13 Level 3 referrals to Getset should be made using the Early Help Assessment form, with the informed agreement of family members concerned and emailed to

the Early Help Advice Hub on EHACoordinator@somerset.gov.uk. The current version of the EHA can be accessed at: http://professionalchoices.org.uk/eha/

19.14 There is a quick guide to completing the Early Help Referral using the EHA tool, which can be accessed on the Professional Choices website: http://professionalchoices.org.uk/eha/

Safeguarding (Level 4) referrals

19.15 If you are concerned that a child may be at risk of, or may be suffering significant harm you must complete a Level 4 safeguarding referral. Suspicions or allegations that a child is suffering or likely to suffer Significant Harm should result in a statutory Child and Family assessment incorporating a Section 47 Enquiry.

19.16 There are no absolute criteria on which to rely when judging what constitutes significant harm. Sometimes a single violent episode may constitute significant harm but more often it is an accumulation of significant events, both acute and longstanding, which interrupt, damage or change the child's development.

19.17 Professionals can complete a Level 4 safeguarding referral using the Early Help Assessment and identify within section 9 that it is a Level 4 safeguarding referral. Level 4 safeguarding referrals should be sent to SDInputters@somerset.gov.uk. If there is an immediate risk to a child please call 0300 123 2224

Escalation / Resolving Professional Differences

19.18 Concern or disagreement may arise over another professional or agency's decision, actions or lack of actions in relation to a referral, an assessment or an enquiry regarding a child. All staff should attempt to resolve differences through discussion and /or written communication with the professionals concerned, within a working week or a timescale that protects the child from harm (whichever is less). The safety and wellbeing of the child or young person is paramount, and should they be considered to be at risk of, or may be suffering significant harm Children's Social Care must be contacted (**0300 123 2224**).

19.19 In the majority of cases these issues are resolved by discussion and negotiation between the professionals concerned. The Resolving Professional Differences protocol provides a process for resolution. The protocol should not be used when there is a complaint about a specific professional. In such situations the relevant organisation's complaints procedure will apply. Any complaint should be made in writing to the professional's line manager and copied to the person with lead responsibility for child protection in their organisation.

19.20 Differences are most likely to arise in relation to:

- Criteria for referrals
- Application of the 'Effective Support for Children and Families in Somerset – Thresholds for Assessment and Services' guidance.
- Quality and outcomes of assessments (at all levels)
- Roles and responsibilities of workers
- Service provision

- Timeliness of interventions
- Information sharing and communication
- Decisions about the need for child protection conferences
- Decisions made at child protection conferences

19.21 If a practitioner remains concerned about a practice issue, despite attempts to resolve the matter, they should liaise with their manager. A meeting should be arranged as soon as possible so a formal note of the concern can be recorded. They should then consider a strategy to attempt to resolve the matter. This should include informing the 'challenged' agency representatives that they feel that if the matter cannot be resolved they will be escalating the issue.

19.22 The diagram shown in the Resolving Professional Differences Protocol outlines the complete process. It should be remembered that differences can be resolved at any stage in the resolution process.

19.23 The Resolving Professional Differences Form (Appendix One) should be completed once Step 3 has been reached. Please see Resolving Professional Differences Protocol 2016 on the safeguarding children board website: http://sscb.safeguardingsomerset.org.uk/working-with-children/local-protocols-guidance/

19.24 If you would like advice about a difficult situation, or are unhappy about the way a referral has been handled, please contact the Somerset CCG Safeguarding Children team. Contact details for the CCG Safeguarding children team are available on the CCG website - http://www.somersetccg.nhs.uk/about-us/how-we-do-things/safeguarding-children/

20 ALLEGATIONS AGAINST STAFF

20.1 All allegations of abuse of children by those who work with children must be taken seriously. Allegations against any person who works with children, whether in a paid or unpaid capacity, cover a wide range of circumstances.

20.2 This procedure should be applied when there is such an allegation or concern that a person who works with children, has

- Behaved in a way that has harmed a child, or may have harmed a child;
- Possibly committed a criminal offence against or related to a child;
- Behaved towards a child or children in a way that indicates he or she may pose a risk of harm to children.

20.3 These behaviours should be considered within the context of the four categories of abuse (i.e. physical, sexual and emotional abuse and neglect). These include concerns relating to inappropriate relationships between members of staff and children or young people, for example:

- Having a sexual relationship with a child under 18 if in a position of trust in respect of that child, even if consensual (see ss16-19 Sexual Offences Act 2003);

- 'Grooming', i.e. meeting a child under 16 with intent to commit a relevant offence (see s15 Sexual Offences Act 2003);

- Other 'grooming' behaviour giving rise to concerns of a broader child protection nature (e.g. inappropriate text / e-mail messages or images, gifts, socialising etc);

- Possession of indecent photographs / pseudo-photographs of children.

20.4 If concerns arise about the person's behavior to her/his own children, the police and/or children's social care must consider informing the employer / organisation in order to assess whether there may be implications for children with whom the person has contact at work / in the organisation, in which case this procedure will apply.

20.5 Allegations of historical abuse should be responded to in the same way as contemporary concerns. In such cases, it is important to find out whether the person against whom the allegation is made is still working with children and if so, to inform the person's current employer or voluntary organisation or refer their family for assessment.

20.6 As outlined in the Children Act 2004, the Local Authority Designated Officer (LADO) will be informed of all allegations against adults who work with children. A LADO is assigned by all Local Authorities and is required to:

- Be involved in the management and oversight of individual cases;

- Provide advice and guidance to employers and voluntary organisations;

- Liaise with the police and other agencies;

- Monitor the progress of cases to ensure that they are dealt with as quickly as possible consistent with a thorough and fair process.

20.7 Contact details for Somerset Local Authority Designated Officer (LADO) are via Somerset Direct as an initial referral: Telephone: **0300 123 2224.**

20.8 Relevant policies and procedures:

- SWCPP (Allegation against staff or volunteers) http://www.proceduresonline.com/swcpp/somerset/p_alleg_against_staff.html?zoom_highlight=ALLEGATIONS+AGAINST+STAFF

- Somerset Safeguarding Children Board website http://sscb.safeguardingsomerset.org.uk/working-with-children/allegations-management/

- Managing Safeguarding Allegations Against Staff Policy and Procedure. NHS England. 2014 https://www.england.nhs.uk/?s=safeguarding+allegations+against+staff&order-by=relevance

21 CHILD DEATH

The Child Death Review Process is outlined in Chapter 5 in 'Working Together to Safeguarding Children' (HM Government 2015)

21.1 The overall purpose is to understand how and why children and young people die, identify any interventions or improvements to services which may help to prevent future deaths and/or improve experiences for children and families receiving services. All professionals who are known to a child who dies will be asked to contribute to this statutory review process by providing information to the Child Death Overview Panel on a Form B and will be invited to share information at a subsequent multi-agency meeting prior to the CDOP.

21.2 For further information on the role and function of the Somerset CDOP see: http://sscb.safeguardingsomerset.org.uk/working-with-children/child-death-review

22 INFORMATION SHARING

22.1 In England and Wales, the Children Acts of 1989 and 2004 gave all staff a statutory duty to co-operate with other agencies if there are concerns about a child's safety or welfare.[14]

22.2 The Children, Schools and Families Act 2010 section 8 amends The Children Act 2004, providing further statutory requirements for information sharing when the LSCB requires such information to allow it to carry out its functions.[15]

22.3 The General Medical Council is clear that Doctors 'must tell an appropriate agency, such as your local authority children's services, the NSPCC or the police, promptly if you are concerned that a child or young person is at risk of, or is suffering, abuse or neglect unless it is not in their best interests to do so'.[16]

Concept of information sharing

22.4 Working Together to Safeguard Children 2015 states that:

- "*Effective sharing of information between professionals and local agencies is essential for effective identification, assessment and service provision.*
- *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.*
- *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*."

General Principles

22.5 The principles set out below are intended to help practitioners working with children, young people, parents and carers share information between organisations. Practitioners should use their judgement when making decisions on what information to share and when and should follow organisation procedures or consult with their manager if in doubt. The most important consideration is whether sharing information is likely to safeguard and protect a child.

[14] Children Act 2004 sections 10 and 11 http://www.legislation.gov.uk/ukpga/2004/31
[15] Children Schools and Families Act 2010 section 8 http://www.legislation.gov.uk/ukpga/2010/26
[16] Protecting children and young people: The responsibilities of all doctors (2012) http://www.gmc-uk.org/guidance/ethical_guidance/13257.asp

- **Necessary and proportionate:** When taking decisions about what information to share, you should consider how much information you need to release. The Data Protection Act 1998 requires you to consider the impact of disclosing information on the information subject and any third parties. Any information shared must be proportionate to the need and level of risk.

- **Relevant:** Only information that is relevant to the purposes should be shared with those who need it. This allows others to do their job effectively and make sound decisions.

- **Adequate:** Information should be adequate for its purpose. Information should be of the right quality to ensure that it can be understood and relied upon.

- **Accurate:** Information should be accurate and up to date and should clearly distinguish between fact and opinion. If the information is historical then this should be explained.

- **Timely:** Information should be shared in a timely fashion to reduce the risk of harm. Timeliness is key in emergency situations and it may not be appropriate to seek consent for information sharing if it could cause delays and therefore harm to a child. Practitioners should ensure that sufficient information is shared, as well as consider the urgency with which to share it.

- **Secure:** Wherever possible, information should be shared in an appropriate, secure way. Practitioners must always follow their organisation's policy on security for handling personal information.

- **Record:** Information sharing decisions should be recorded whether or not the decision is taken to share. If the decision is to share, reasons should be cited including what information has been shared and with whom, in line with organisational procedures. If the decision is not to share, it is good practice to record the reasons for this decision and discuss them with the requester. In line with each organisation's own retention policy, the information should not be kept any longer than is necessary. In some circumstances this may be indefinitely, but if this is the case there should be a review process.

22.6 Consent should be sought to share information unless:

- that would undermine the purpose of the disclosure (for example in suspected fabricated & induced illness and sexual abuse)

- action must be taken quickly because delay would put the child at further risk of harm

- it is impracticable to gain consent

- to do so would put the child or the staff member at risk

22.7 When asked for information about a child or family, staff should consider the following:

- identity, check identity of the enquirer to see if they have a genuine reason to request information. Call back via the switchboard if possible.

- purpose, ask about the exact purpose of the inquiry and the concerns.

- consent, does the family know that there are enquiries about them? Have they consented and if not why not? . Receiving a signed consent form from an agency does not imply consent given to you to share. If this doesn't cause harmful delay, you may also wish to seek consent from the family.

- need-to-know basis, give information only to those who need to know.

- proportionality, give just enough information for the purpose of the enquiry and no more. This may mean relevant information about parents/carers.

- keep a record, make sure that you record the details of the information sharing, including the identity of the person you are sharing information with, the reason for sharing and whether consent has been obtained and if not, why not.

22.8 Relevant policies and procedures:

- SWCPP (Information Sharing) http://www.proceduresonline.com/swcpp/somerset/p_info_sharing.html?zoom_highlight=information+sharing

- Information sharing advice for practitioners providing safeguarding services to children, young people, parents and carers. 2015: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419628/Information_sharing_advice_safeguarding_practitioners.pdf

23 SERIOUS CASE REVIEWS

23.1 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1)(e) and (2) set out an LSCB's function in relation to serious case reviews, namely undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

23.2 For the purposes of paragraph (1) (e) a serious case is one where:

- abuse or neglect of a child is known or suspected; and

- either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

- "Seriously harmed" includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all of the following:

- A potentially life-threatening injury;

- Serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.

23.3 The LSCB will ensure appropriate representation in the review process of professionals and organisations involved with the child and family, establish

timescales for action to be taken, agree success criteria and assess the impact of the actions.

23.4 The LSCB may decide as part of the Serious Case Review to ask each relevant organisation to provide information in writing about its involvement with the child who is the subject of the review. The form in which such written material is provided will depend on the methodology chosen for the review.

23.5 In addition, the LSCB can require a person or body to comply with a request for information, under Section 14B of the Children Act 2004.This can only take place where the information is essential to carrying out LSCB statutory functions. Any request for information about individuals must be 'necessary' and 'proportionate' to the reasons for the request.

23.6 Relevant policies and procedures:

- SWCPP (serious case reviews) http://www.proceduresonline.com/swcpp/somerset/p_ser_case_rev.html?zoom_highlight=court+reports

24 COURT REPORTS AND WITNESS STATEMENTS

24.1 At times there may be a request by police for a witness statement and / or a request for a Court Statement by the local authority. Requests for Police statements and Court reports must be made in writing and discussed immediately with your line manager. The CCG's Legal Services can review and advise on reports once completed.

24.2 Relevant policies and procedures:

- Acting as a witness in legal proceedings. GMC. 2013: http://www.gmc-uk.org/guidance/ethical_guidance/21188.asp

25 CHILD PROTECTION CONFERENCES

25.1 All staff that are requested to attend a Child Protection Case Conference must provide a written report even if that report states that the professional concerned has not had any recent contact with the child and / or their family. The Children's Social Care proforma for Case Conference reports should be used, complete as much of the template as possible, but recognising that there may be limits to the information you have to share. The correct template will be sent as part of the invitation to the Case Conference.

25.2 All Case Conference reports must be submitted in advance of the Case Conference date to the Conference Administrator. Reports will be completed and submitted electronically to the relevant local Children's Social Care office. This address will be stipulated on the Case Conference Invitation. It is good practice to share the report with the child if old enough, and the parents/carers where appropriate. Liaison with other health professionals who may also be working with the family is also recommended.

General Points for Preparing Reports for Conference

25.3 The Assessment Framework Tool recommends a triangle model of assessment:

- child's developmental needs

- parenting capacity
- family and environmental factors

25.4 Areas to consider include:

- missed/was not brought to health appointments
- failed immunisations where there are known health risks to child
- education: discuss with School Nurse or Health Visitor (if under 5)
- parental mental health or substance abuse
- ability of the carer to parent [disability, physical or intellectual)
- evidence of domestic abuse
- cruelty to animals in the family
- if both parents/carers registered with a GP Practice and access wider health services
- who has parental responsibility

25.5 Relevant Policies and Procedures:

- Information Sharing Policy NHS England. 2016 https://www.england.nhs.uk/?s=information+sharing+policy

26 RECORD KEEPING

26.1 All staff have a duty to keep up to date with, and adhere to, relevant legislation, case law, and national and local policies relating to record keeping. Electronic and paper records should include a record of all contacts, planned or unplanned, and a concise summary of:

- Purpose of the contact: who, where, why
- What has been discussed and an analysis of the information shared, disclosed or assessed.
- Outcome of the contact: actions to be undertaken by the client and / or professional

26.2 There are clear policies, standards, procedures and guidance in place for staff in relation to record keeping and the management of health records.

26.3 Good recording systems can help build a fuller picture of a child's life, and help detect patterns that may be a cause for concern. Good practice recommendations include:

- new or review child/young person's assessments/registrations – check names of parents or carers (and link families), school, and social care/multi agency involvement

- scan (and appropriately code if used) reports from other agencies into the child's electronic record

- follow-up repeated attendances at Accident and Emergency/Minor Injury Units

- follow-up repeated missed appointments/repeated 'was not brought' to appointments

27 MANDATORY SAFEGUARDING CHILDREN TRAINING

27.1 All staff working in healthcare settings - including those who predominantly treat adults - should receive training to ensure they attain the competences appropriate to their role and follow the relevant professional guidance:

- Safeguarding Children and Young People: roles and competences for health care staff, RCPCH (2014); Safeguarding Children and Young People: Roles and Competences for Health Care Staff (Intercollegiate Document 2014).

- Looked after children: Knowledge, skills and competences of health care staff, RCN and RCPCH, (2012); Looked After Children Knowledge, skills and competences for healthcare staff

- Protecting children and young people: the responsibilities of all doctors, GMC (2012). Protecting children and young people: The responsibilities of all doctors

27.2 The competences and minimum requirements specifically needed by healthcare workers to safeguard and promote the wellbeing of children are described in detail in the above guidance.

27.3 Safeguarding competences are the set of abilities that enable staff to effectively safeguard, protect and promote the welfare of children and young people. They are a combination of skills, knowledge, attitudes and values that are required for safe and effective safeguarding children practice.

27.4 Different staff groups require different levels of competence depending on their role and degree of contact with children, young people, adults and families; the nature of their work, and their level of responsibility.

27.5 The Intercollegiate Document[17] identifies six levels of competence in Safeguarding Children and Young People, and gives examples of groups that fall within each of these. The levels are as follows:

- Level 1: Non-clinical staff working in health care settings.

- Level 2: Minimum level required for non-clinical and clinical staff that have some degree of contact with children and young people and/or parents/carers.

- Level 3: Clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.

[17] Safeguarding Children and Young People: Roles and Competences for Health Care Staff Intercollegiate Document 2014

- Level 4: Named professionals
- Level 5: Designated safeguarding professionals
- Board Level: Chief Executive Officers, Trust and Health Board Executive and non-executive directors / members, commissioning body Directors

27.6 In the South West a minimum of 2 hours per year/6 hours in 3 years safeguarding children training is required for all front line staff dealing with children / Level 3.[18]

27.7 Appropriate training must include a multi-agency element, for example as provided by Somerset Safeguarding Children Board.

27.8 Staff are responsible, along with their line managers, in ensuring that they continually monitor and review their practice, and follow the guidance contained in this document and elsewhere.

27.9 Somerset CCG must ensure that their staff are trained and competent to be alert to potential indicators of abuse or neglect in children and young people, and know how to act on their concerns. In order to fulfil their responsibilities in line with local and national policies, procedures, and legislation in relation to safeguarding children.

28 SUMMARY

28.1 Safeguarding children is a vital and often challenging part of our work with children and families. This policy aims to help clarify difficult areas, but it is recognised that there will still be situations where decision making is not straight forward. The child's needs are paramount, and at any stage advice should be sought as appropriate, with escalation to a more senior level.

28.2 All Somerset CCG and Primary Care staff are expected to read and follow this policy.

[18] http://www.gpappraisals.uk/safeguarding.html

APPENDIX 1 SAFEGUARDING CHILDREN INFORMATION SPECIFIC TO GP PRACTICES

GUIDANCE FOR RECORDING AND STORING OF CHILD PROTECTION INFORMATION FOR GP PRACTICES

Concerns and information about vulnerable children should be recorded in the child's records, and where appropriate the notes of siblings, other children in the same household, and significant adults. These should be recorded using agreed Read codes. The GMC document 'Protecting children and young people: The responsibilities of all doctors (2012)' advises doctors 'to record minor concerns, as well as their decisions and the information given to parents/carers'.

Concerns and information from other agencies such as social care; education; the police, or from other members of the Primary Care Team, including health visitors, school nurses and midwives, should be recorded in the notes under a Read code.

Consideration should be given to recording the following information in the child's record:

- Record of abuse in the child or any other child in the household
- Record of whether the child or any other child in the household is or has been subject to a child protection/child in need plan
- Observed and alleged harmful parent – child interactions
- Basic family details (e.g. adults in the family, other siblings etc., including individuals who may not live at the address but who have regular contact with the child e.g. father, grandparents etc.)
- Details of any housing problems
- Details of significant illness or problems in the family, such as parental
- Child's or family member's substance misuse or mental illness
- History of domestic abuse in the household
- House fires
- Ante-natal concerns
- Multiple consultations especially emergencies
- Where any safeguarding concerns or harmful parenting have been identified and recorded in the records, what action has been taken to address these should also be included in the records.

Information can be sought and entered from:

- any contact with a potential carer – 'seeing the child behind the adult' – (and conversely when children are seen, consider 'the adult behind the child')

- new patient health checks, including enquiry about family social and household circumstances – (a Climbié Inquiry recommendation[19])
- Antenatal booking
- Postnatal visit
- 6 week check
- Practice Team meetings, where regular discussion of all practice children subject to child in need or child protection plans, or any other children in whom there may be concerns, are discussed. This record should highlight any agreed actions to be taken as a result of the discussion.
- Correspondence from outside agencies, such as A&E/OOH reports, Domestic Abuse notifications, and other primary and secondary care providers[20]

When Child Protection documents are received they should be reviewed by the relevant GP. For example, a copy of an early help or safeguarding referral completed by another professional. This document should then be scanned to the relevant family member's electronic records.

CASE CONFERENCE SUMMARIES AND MINUTES

Scanning of Case Conference Summaries and Minutes into electronic records held by general practices is an area where practice has changed.

Case conference minutes frequently raise concerns because of their size and content (much of it about third parties). The table below refers to case conference summaries and minutes[21].They should be processed and stored in the following way:

	Read Code	Scan summary	Scan full report
Child(ren) –subject(s) of conference	Yes	Yes	Yes[32]
Adults & other household members named in report	Yes	Yes	No

The minutes should be read by the relevant GP. The GP should identify any pertinent information in the minutes and the full minutes can then be scanned and attached to the relevant family member's electronic record (as per above table).

Conference minutes should not be stored separately from the medical records because:

- they are unlikely to be accessed unless part of the record;
- they are unlikely to be sent on to the new GP should the child register elsewhere;
- they may possibly become mislaid and lead to a potentially serious breach in patient confidentiality.

Whilst GPs may have concerns about third party information contained in case conference minutes, part of the solution is to remove this information if copies of medical records are

[19] The Victoria Climbie Inquiry – report of an inquiry by Lord Laming Jan 2003, Recommendation 86
[20] Care Quality Commission 2009: Review of the involvement and action taken by health bodies in relation to the case of Baby P
[21] Safeguarding Children & Young People - A Toolkit for General Practice, RCGP & NSPCC 2011.

released for any reason, rather than not permitting its entry into the medical record in the first place.

CHILD PROTECTION READ CODES

When a Case Conference has been held, whatever the outcome, the Read code **3875** (Social Services Case Conference), should be added to the child's record as a major active problem.

For children subject to a Child Protection Plan, the Read code **13Iv** (subject to Child Protection Plan) should be added. A free text entry, visible in the summary page, should indicate the category of abuse, details of the next case conference and the contact details of the social worker.

The read code **13Iy** (Family member subject of Child Protection Plan) (**XaOtl)** should be recorded on the records for the adults named in the report, and any children not identified as subject to a child protection plan (See table and guidance above).

When the Child Protection Plan is ended, the Read code **13Iw** (**XaOtl**) should be added for the children subject to a child protection plan, and 13Iz for the family members.

All of the above highlighted Read codes should be entered as a priority 1 item (this is clinical system and practice dependant), and remain in the active problem list in the summary page.

The documents can be shredded once the usual practice protocol is followed. i.e. kept for a period of time, making sure the data has been backed up and the backup has been validated. There is no longer any need to retain the original paper copy. When patients leave the Practice list, any scanned Child Protection documents should be sent on to the Area Team in the normal way.

Social services case conference	3875
Subject to Child Protection Plan	13Iv
No longer subject to Child Protection Plan	13Iw
Family member subject of Child Protection Plan	13Iy
Family member no longer subject to Child Protection Plan	13Iz
Child in need	13IS
Child no longer subject to Child in Need plan	13IT
Looked after child	13IB1
Family is cause for concern	13Ip

ALERT MESSAGES

The notes of all children subject to a Child Protection or Child In Need Plan, and all members of the child's household, including siblings and adults, (especially if they have a different surname), should be clearly marked, for example by using an alert system on the computer. The child's status, and any other current or previous child protection concerns within the family, must be clear to anyone accessing the child's record, or those of a family member. A child who is Looked After should have an alert and read code attached to their record. Appropriate computer pop up messages or alerts would be:

	Alert message
Child with a CP plan	'subject of child protection plan'
Parent of child with CP plan	'Child or Children subject of child protection plan'
Other adults or children in household of	'Family/household member subject of

child with CP	child protection plan'
Child in need	'Child in need'
Parents, siblings, or others in household of child in need	'parent/sibling/family member of child in need'
Looked after child	'Looked after child'
Children of families of concern but no formal safeguarding plan in place	'Surgery concern'

ROLE OF GP SAFEGUARDING CHILDREN LEADS

Each Practice is required to have a named Safeguarding Children Lead and a Deputy. This is a necessary function complementing the individual's normal duties. The responsibilities are detailed below.

To ensure that their practice colleagues are aware of the need to hold regular meetings to discuss vulnerable children and families, seeking to involve other agencies in these meetings as appropriate and available, such as Health Visitors, Midwives, CAMHS, Integrated Therapy Services and School Nurses. This is to ensure early recognition of circumstances leading to abuse and neglect and identification of this can be addressed by the GP practice and other agencies.

The GP Safeguarding Children Leads are responsible for:

- ensuring the GP practice has an up to date child protection policy of their own, or has adopted the CCG child protection policy.
- ensures that the practice meets contractual guidance in relation to safeguarding and promoting the wellbeing of unborn babies, children and young people.
- ensures safe recruitment procedures.
- supports reporting and complaints procedures in relation to children and young people.
- advises practice members about any concerns that they have in relation to safeguarding children practice.
- ensures that practice members receive adequate support and advice when dealing with early help and safeguarding concerns.
- leads on analysis of relevant significant events in respect of safeguarding children.
- provides advice and support as to safeguarding children training requirements for all practice staff, as detailed in the Intercollegiate Document.
- identifies safeguarding children training resources and opportunities required for staff members in line with appraisal objectives.
- provides safeguarding children training to practice colleagues as when appropriate and available.
- makes recommendations for change or improvements in practice procedural policy.
- acts as a point of contact for the practice in relation to safeguarding children, including liaison with the CCG's safeguarding children team.

- act as a conduit for the practice in relation to cascading and dissemination of safeguarding children tools, newsletters, resources and learning opportunities.