SAFEGUARDING CHILDREN POLICY

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• July 2013 updated to reflect new Working Together and other Local and National Changes.  
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## Associated documents

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<td>Safeguarding and Child Protection Supervision Policy</td>
<td>Child Protection Supervision Policy- BHT Pol 174 (this is the old policy – new one about to be ratified)</td>
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Section A. SUPPORTING STATEMENT – this policy should be read in conjunction with the following statement – Please print, display and keep in an easy accessible place:

SAFEGUARDING IS EVERYBODY’S BUSINESS

Ultimately, effective safeguarding of children can only be achieved by putting children at the centre of the system, and by every individual and service playing their full part, working together to meet the needs of our most vulnerable children

All Buckinghamshire Healthcare NHS Trust employees have a statutory duty to safeguard and promote the welfare of children and young people, including:

- **Keeping the child’s needs paramount**: the needs and wishes of each child, be they a baby or infant, or an older child should be put first, so that every child receives the support they need before a problem escalates and the right solution can be found for each child;
- **Being alert** to the possibility of abuse and neglect through observation or by professional judgment made as a result of information gathered about the child/young person/family member;
- **Knowing how to deal with a disclosure or allegation** of abuse/neglect;
- **Undertaking training and supervision** as appropriate for their role and keeping themselves updated;
- **Being aware of and following the local policies and procedures** they need to follow if they have a concern;
- **Sharing appropriate information** in a timely way;
- **Discussing any concerns** about an individual, ensuring appropriate advice and support is accessed either from managers, trust’s safeguarding teams or with local authority children’s social care;
- **Participating in multi-agency working** to safeguard the child/young person/family member;
- **Ensuring contemporaneous records are kept** at all times and record keeping is in strict adherence to Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;

CHILDREN HAVE SAID THAT THEY NEED

- **Vigilance**: to have adults notice when things are troubling them
- **Understanding and action**: to understand what is happening; to be heard and understood; and to have that understanding acted upon
- **Stability**: to be able to develop an on-going stable relationship of trust with those helping them
- **Respect**: to be treated with the expectation that they are competent rather than not
- **Information and engagement**: to be informed about and involved in procedures, decisions, concerns and plans
- **Explanation**: to be informed of the outcome of assessments and decisions and reasons when their views have not met with a positive response
- **Support**: to be provided with support in their own right as well as a member of their family
- **Advocacy**: to be provided with advocacy to assist them in putting forward their views
1.0. INTRODUCTION

1.1 This document is based on Working Together to Safeguard Children (HM Government 2015a) policy document which covers the legislative requirements and expectations on individuals and organisations to promote the welfare of children. Section 11ii of the Children Act (2004) (published in August 2005) states that health organisations have a duty to cooperate with social services under section 27 of the Children Act (1989). The policy also reflects the principles contained within the European Convention of Human Rights, in particular Articles 6 and 8 and the United Nations Convention on the Rights of the Child (ratified by the UK in 1991) which states that children live in a safe environment and be protected from harm. These duties are an explicit part of NHS employment contracts, with Chief Executives having responsibility to have in place arrangements that reflect the importance of safeguarding and promoting the welfare of children within organisations.

1.2 This policy sets out how Buckinghamshire Healthcare NHS Trust (BHT) will work to safeguard and promote the welfare of children. Fundamentally, it remains the responsibility of every NHS funded organisation and each individual healthcare professional working in the NHS to ensure that the principles and duties of safeguarding children are holistically, consistently and conscientiously applied, with the well-being of those children and their families at the heart of what we do. There is a need for a shared responsibility and effective joint working between agencies and professionals that have different roles and expertise if children are to be protected from harm and their welfare promoted.

1.3 All NHS organisations need to ensure that there is sufficient capacity in place to fulfil their statutory duties and should regularly review their arrangements to assure themselves that they are working effectively. Organisations need to come together to mitigate risks and develop workable local solutions based on local need. Some of the issues that must be considered include the size, geography and deprivation of the population served and the numbers of children in need, evidence from inspections, reviews, audits and case reviews of safeguarding. The views of the Safeguarding Children’s and Adults Boards and Health and Wellbeing Boards should be considered in the assessment of capacity.

1.4 Buckinghamshire Safeguarding Children Board (BSCB) is the key statutory mechanism for agreeing locally how relevant organisations will co-operate to safeguard and promote the welfare of children, and for ensuring the effectiveness of what they do. The local authority and the other board members owe to each other reciprocal duties of co-operation specifically in relation to the establishment and operation of the BSCB (Section 13 Children Act 2004). The BSCB must commission serious case reviews where abuse or neglect of a child is known or suspected, the child has either died or been seriously harmed, and there is concern over how agencies and service providers have worked together (Section 14 Children Act 2004).

1.5 The Buckinghamshire Safeguarding Children’s Board and its sub-committees engage in numerous activities to establish what is working well and what needs improvement. Their Learning and Improvement framework provides an opportunity to make the required links between the identification of what needs to improve and the various mechanisms available to the Board to achieve those improvements. Please see links: http://www.bucks-lscb.org.uk/wp-content/uploads/About/BSCB_Learning_and_Improvement_Framework.pdf
1.6 This policy **must be used in conjunction with**:

Associated guidance/ pathways for safeguarding children, maternity and paediatrics http://swanlive/

**Also:**

- The BSCB multiagency guidance and procedures [www.bucks-lscb.org.uk](http://www.bucks-lscb.org.uk)
- NICE: When to suspect child maltreatment [http://www.nice.org.uk/guidance/CG89](http://www.nice.org.uk/guidance/CG89)
- Other relevant national and BHT policy and guidance as listed or referenced in this policy and available on the intranet [http://swanlive/](http://swanlive/)

**Additionally the following are useful good practice documents:**

- GMC Guidance for all doctors: [0–18 years: guidance for all doctors](http://www.gmc-uk.org/guidance/0-18-years/) and [Protecting children and young people](http://www.gmc-uk.org/guidance/0-18-years/)

2.0. **POLICY STATEMENT**

- The Trust will comply with the principles outlined in ‘Working Together 2015’ and will actively work to recognise signs of vulnerability and maltreatment, and work to promote the welfare and safety of children.
- The Trust has a responsibility and duty to safeguard the children who access the organisation. This includes the children of those adults and carers who use the Trust’s services on a daily basis. This duty is reinforced through “The Children Act 2004”.
- Children are best protected when professionals are clear about what is required of them individually and how they work together.

3.0. **PURPOSE**

The purpose of this policy is to set out clearly the safeguarding roles, duties and responsibilities of the organisation.

- Identify and clarify how relationships between health and other systems work at both strategic and operational levels to safeguard children, young people and adults at risk of abuse or neglect.
• To set out the legal framework for safeguarding to support the Trust in discharging its statutory requirements to safeguard children.
• Ensure that all staff are aware of their individual duties to safeguard children from abuse and neglect.
• Outline principles, attitudes, expectations and ways of working that recognise that safeguarding is everybody's business and that the safety and well-being of those in vulnerable circumstances is at the forefront of our business.
• Ensure staff are aware of what constitutes child maltreatment and have recognition of the key indicators.
• Ensure all professionals understand information sharing processes so that appropriate information is shared in a timely manner and understand the need to discuss concerns about a child with colleagues and social care as appropriate.
• To introduce and provide signposting to procedures and guidance on what to do if a staff member has concerns within BHT, who to contact for advice and support and how to make a referral to Children’s Services this is via First Response in Buckinghamshire other areas may have different arrangements
• To introduce the training and supervision requirements for staff.

4.0. SCOPE OF THE DOCUMENT

4.1. The definition of safeguarding is necessarily broad as there is a wide range of risks of abuse or neglect that can result in harm to children (see section 7.0.). Effective safeguarding arrangements seek to protect individuals from harm caused by abuse or neglect occurring regardless of their circumstances. The arrangements set out within this policy will apply whenever a child is at risk of abuse or neglect, regardless of the source of that risk. The policy applies to all staff working for Buckinghamshire Healthcare NHS Trust and agents of other employers providing healthcare on behalf of the Trust.

4.2. Ultimately, effective safeguarding of children can only be achieved by putting children at the centre of the system, and by every individual involved playing their full part, working together with a child-centred approach with services based on a clear understanding of the needs and views of children, failings have too long been the result of losing sight of the needs and views of the children or placing the interests of adults ahead of the needs of children.

4.3. No single professional can have a full picture of a child’s needs and circumstances and if children and families are to receive help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking appropriate action.

5.0. LEGAL FRAMEWORK

5.1. There are no specific mandatory regulations in the UK requiring professionals to report suspicions to authorities (accept FGM – please see section 15.4.) but there are expectations and responsibilities for safeguarding which are enshrined in legislation and national guidance which
are set out in this policy. Safeguarding is everyone’s responsibility. The legislation and guidance relevant to safeguarding and promoting the welfare of children includes the following:

- Safeguarding children and young people: roles and competences for health care staff, intercollegiate document (updated 2014).

5.2. A full exposition of statutory provisions relating to children’s safeguarding can be found in appendix B of the statutory guidance document Working Together to Safeguard Children (HM Government 2015a). This document focuses on those which are relevant to Buckinghamshire Healthcare NHS Trust as an NHS organisation.

5.3. There are fundamental differences between the legislative framework for safeguarding children and that for adults which stem from who can make decisions. When children, or those with parental responsibility for them, reject measures that could save them from significant harm, their wishes can be overridden. This is part of the statutory principle that makes the welfare of the child the paramount consideration (Children Act 1989 section 1(1)), subject to this, decision-making power relating to children lies with those who have parental responsibility for the child. However, when a child understands fully the choice to be made and its consequences, based on the Gillick competency, the child’s decision prevails (Gillick v West Norfolk and Wisbech AHA [1986] AC 112). Parents and carers should still be fully involved (Children Act 2004 section 10(3)) unless the criteria set out in the Fraser guidelines apply Gillick v West Norfolk and Wisbech AHA [1986] AC 112, R (on the application of Sue Axon) v Secretary of State for Health EWCA 372006 (Admin) (and see http://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines/)

5.4. The Mental Capacity Act covers and empowers children aged 16 and 17 (‘young persons’). A young person has capacity unless it is established he or she lacks it (Mental Capacity Act 2005 section 1 Principle 1). If a young person lacks capacity because of an impairment of, or a disturbance in the functioning of, the mind or brain, the Mental Capacity Act will apply in the same way as it does to adults (people aged 18 or over). However if the young person is unable to make a decision for another reason, for example, because he or she is overwhelmed by its implications the common law principles set out in Gillick will apply (Mental Capacity Act 2005 Code of Practice, HMG, 2005, 12.13.)

5.5. Professionals who fail to report cases of abuse or neglect do not currently face criminal penalties for on-reporting; however they may be subject to professional disciplinary proceedings or held to account through serious case reviews of professional negligence cases.

6.0. DUTIES, ROLES AND RESPONSIBILITIES

Broadly:

- All public sector agencies providing services to children, including local authorities and all NHS bodies, “must make arrangements for ensuring that their functions are discharged having regard to the need to safeguard and promote the welfare of children” (Section 11 Children Act 2004).
Effective safeguarding arrangements should be underpinned by:

- That it is essential practice that all agencies recognise that **safeguarding is everyone's business**. ‘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’ (HM Government, 2015b).

- It is a **child centered approach**: for services to be effective they should be based on a clear understanding of the needs and views of children (see section 8.0).

6.1. **Responsibilities of Healthcare Provider Organisations**

Health professionals and organisations have a key role to play in actively promoting the health and well-being of children. Section 11 of the Children Act 2004 places a duty on all Statutory Health Care Bodies to make arrangements to ensure that in discharging their functions they have regard to the need to safeguard and promote the welfare of children.

Health professionals are in a strong position to identify welfare needs or safeguarding concerns regarding individual children and where appropriate, provide support. This includes understanding risk factors, communicating effectively with children and families, liaising with other agencies, assessing needs and capacity, responding to those needs and contributing to multi-agency assessments and reviews.

As a trust and through this policy we ensure that there is/are:

- Clear priorities for safeguarding and promoting the welfare of children explicitly stated.
- A clear commitment by senior management to the importance of safeguarding and promoting children’s welfare.
- A clear line of accountability within the organisation for work in safeguarding and promoting the welfare of children.
- Recruitment and human resources management procedures that take into account the need to safeguard and promote the welfare of children and young people including arrangements for appropriate checks on new staff and volunteers.
- Procedures for dealing with allegations of abuse against members of staff and volunteers.
- Arrangements to ensure that all staff undertake appropriate training to equip them to carry out their responsibilities effectively, and keep this up to date by refresher training at regular intervals; and that all staff, including temporary staff and volunteers who work with children are made aware of the establishment's arrangements for safeguarding and promoting the welfare of children and their responsibilities for them.
- Policies in place for safeguarding and promoting the welfare of children, including a child protection policy, and procedures that are in accordance with guidance from the local authority and locally agreed inter-agency procedures;
- Arrangements in place to work effectively with other organisations to safeguard and promote the welfare of children, including arrangements for sharing information.
- A culture of listening to and engaging in dialogue with children – seeking their views in ways appropriate to their age and understanding, and taking account of those both in individual decisions and the establishment or development of services.
• Appropriate whistle blowing procedures and a culture that enables issues about safeguarding and promoting the welfare of children to be addressed.

6.2. **Trust Board**
The Trust Board is statutorily responsible for safeguarding and promoting the welfare of children in its care, and is committed to meeting these obligations. Implementation of the Trust Board’s strategies for the purpose is delegated to the Chief Executive Officer, who has designated the Chief Nurse and Director of Patient Care Standards as the Executive Lead for child protection and arrangements for safeguarding children. BHT Safeguarding Organisational Chart and list of key personnel for Safeguarding within BHT can be found on the Trust internet Safeguarding page under the Staff Resources tab [http://swanlive/](http://swanlive/).

6.3. **The Chief Executive**
The Chief executive has accountability for ensuring the provision of high quality, safe and effective services within the Trust. He/she has overall responsibility and is accountable for safeguarding children, young people and vulnerable adults accessing services delivered by Buckinghamshire Healthcare NHS Trust.

6.4. **The Chief Nurse and Director of Patient Standards**
The Chief Nurse and Director of Patient Standards is the board level executive director lead for safeguarding. He/she is responsible for ensuring the provision of high quality, safe and effective services and ensuring the voice of the child is central within the safeguarding children services and throughout the Trust. He/she exercises accountability through the chairing of the Buckinghamshire Healthcare Safeguarding Forum which reports to the Trust Board on Safeguarding matters. He/she also sits on the Buckinghamshire Safeguarding Children’s Board.

6.5. **Safeguarding Lead – Director Level**
This post holder represents the Chief Nurse and Director of Patient Safety on the Bucks Safeguarding Adults Board and Bucks Safeguarding Children Board as required. She/he ensures that safeguarding standards are integral to the Trust governance and quality arrangements within all Divisions and that these support the delivery of safe and effective services in accordance with statutory, national and safeguarding policies. She/he supports the Chief Nurse and Executive Board as required in the strategic leadership of all aspects of the health service contribution to safeguarding children and adults across Buckinghamshire.

6.6. **Duties of the Chief Nurse and Director of Patient Standards Safeguarding Lead – Director Level**

- Ensuring that the Trust has policies and procedures that reflect the commitment of the Board in all the aspects identified in ‘Working Together to Safeguard Children’ (2015).’
- Liaising as appropriate with the Designated Doctor and Designated Nurse appointed by the CCG
- Ensuring the appointment of named professionals with a key role in promoting good professional practice, and providing advice and expertise for fellow professionals.
• Ensuring that the trust’s training strategy meets the need of staff to be competent and confident at each level in carrying out their responsibilities for safeguarding and promoting the welfare of children.
• Ensuring the establishment and implementation of an appropriate child protection supervision structure that supports meeting the trust’s obligations.
• Ensuring appropriate staff attend and represent the trust on BSCB sub-committees.

6.7. **Named Professionals**

“Named” professionals within the Trust include the Named Doctors, Named Nurses and Named Midwife. They have specific safeguarding expertise and have a key role in promoting good professional practice within their organisation, supporting the local safeguarding system and processes, providing advice and expertise for fellow professionals, and ensuring safeguarding training is in place. They work closely with the Safeguarding Lead – Directorate level, Designated Professionals and the BSCB and are line managed by the Lead Named Nurse for Safeguarding Children.

6.7.1. Their work includes:

• To develop, implement and review safeguarding practice across the organisation and its networks;
• To provide specialist professional safeguarding children advice and effective supervision for a range of professionals and staff;
• To develop, implement and evaluate a safeguarding children training programme for all staff groups from induction to specialist courses;
• To undertake the co-ordination and management of Internal Management Reviews that contribute to Safeguarding Children Board's serious case review process;
• To facilitate safe and effective multi-professional communication and information sharing appropriately across a range of settings and agencies;
• To communicate highly complex, sensitive and emotive information in health service and multi-agency contexts about suspected or actual risks to vulnerable children and decisions and action plans to protect children and families;
• To foster effective working relationships in order to promote inter-disciplinary and multi-agency collaboration and be an active member of multi-agency safeguarding groups.

6.8. **Duties of Service leads and Managers**

6.8.1. Senior Managers throughout the trust have a duty to ensure that the approved strategies, policies and procedures of the trust for safeguarding and promoting the welfare of children in their care are understood and implemented in their own areas of responsibility. They are accountable in this regard directly to their own executive director.

6.8.2. Line Managers will have varying degrees of responsibility for services that directly or indirectly provide care for children. The general duty of all staff applies in all circumstances, along with their duty to the trust and accountability to their own senior managers.

6.8.3. Line managers also have responsibility
For ensuring that the duty to safeguard and promote the welfare of children is reflected in individual job descriptions
For ensuring that staff have appropriate access to training
For ensuring that the training needs of their staff are identified at induction, developmental reviews and in their personal development plans, and
For ensuring staff are aware of the supervision policy, including when and how to access supervision.

6.9. Human Resources
Have a responsibility to ensure:

6.9.1. Safe recruitment practices that take into account the need to safeguard and promote the welfare of children and young people including arrangements for appropriate checks on new staff and volunteers. There is a statutory scheme for vetting people working with children and adults at risk of abuse or neglect. It is administered by the Disclosure and Barring Service. The system provides for checks on people entering the workforce, and maintains lists of individuals who are barred from undertaking regulated activity with either children or adults at risk of abuse or neglect.
http://swanlive/sites/default/files/recruitment_policy_v8.1_jan_2012_0.pdf

6.9.2. Procedures for dealing with allegations of abuse against members of staff and volunteers are in place. All adults working with children place them in a position of trust. Where it is alleged that any staff member has:
- Behaved in a way that has harmed a child, or
- May have harmed a child or
- Possibly committed a criminal offence against or related to a child; or
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children

6.9.3. It is important that a decision is made about whether the information should be treated as an allegation or a complaint against a staff member. If in doubt it can be discussed with the Local Authority Designated Officer (LADO) who can be contacted via First Response (see section 11). Some allegations will be so serious as to require immediate referral to children’s social care / police for investigation. Others may be much less might not seem to warrant this consideration. However, it is important to ensure that even apparently less serious allegations are seen to be followed up, and that they are examined objectively by someone independent of the organisation concerned. Consequently, the LADO should be informed of all allegations that appear to meet the criteria above so that s/he can consult police and social care colleagues if appropriate. The LADO should also be informed of any allegations that are made directly to the police (which should be communicated via the police force designated officer) or to children’s social care. As soon as a staff member/ their manager becomes aware of an allegation (or potential allegation), either directly or via another agency, it should be reported immediately to the Named Senior Officer within the human resources and the Designated Senior Manager. They should immediately liaise with the LADO who can provide advice and support.
6.9.3 **Appropriate whistleblowing procedures** and a culture that enables issues about safeguarding and promoting the welfare of children to be addressed.

http://swanlive/sites/default/files/whistleblowing_procedure_v2.2_0.pdf  
http://swanlive/sites/default/files/whistleblowing_raising_concerns_policy_v2.2_0.pdf  

6.9.4. Additionally there are new legal requirements that board level appointments of NHS trusts, foundation trusts and special health authorities are “fit and proper persons”. This excludes individuals who have been involved in “any serious misconduct or mismanagement”. Clearly, safeguarding falls within that definition (Regulation 5, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).


6.10. **Duties of all Staff**

6.10.1. All staff working directly with children have a duty to ensure that safeguarding and promoting their welfare forms an integral part of all stages of the care they offer. Other health professionals who come into contact with children, parents and carers in the course of their work also need to be aware of their responsibility to safeguard and promote the welfare of children and young people. **This is important even when health professionals do not work directly with a child, but may be seeing their parent, carer or other significant adult.**

6.10.2. BHT staff who work with children and families have the following responsibilities:

- To identify children and families who would benefit from early help and recognise that early help is more effective in promoting the welfare of children than reacting later;
- To understand the risk factors and recognise children in need of support and/or safeguarding;
- To recognise the needs of parents who may need extra help in bringing up their children, and know where to refer for help;
- To recognise the risks of abuse to an unborn child;
- To contribute to enquiries from other professionals about children and their family or carers;
- To liaise closely with other agencies, including other health care professionals;
- To assess the needs of children and the capacity of parents/carers to meet their children’s needs including the needs of children who display sexually harmful behaviours;
- To plan and respond to the needs of children and their families, particularly those who are vulnerable;
- To contribute to child protection conferences, family group conferences and strategy discussions;
- To contribute to planning support for children at risk of significant harm e.g. children living in households with domestic violence or parental substance misuse [http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-Procedures/Children_Substance_Misusing_Parents.pdf](http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-Procedures/Children_Substance_Misusing_Parents.pdf) have access to services to support them;
To play an active part, through the child protection plan, in safeguarding children from significant harm;

As part of generally safeguarding children and young people, provide ongoing promotional and preventative support through proactive work with children, families and expectant parents;

To contribute to serious case reviews and the learning identified

To participate in child protection supervision.

6.11. Commissioners

6.11.1. Clinical Commissioning Groups (CCGs)

CCGs are statutory NHS bodies with a range of statutory duties, including safeguarding adults and children. They are membership organisations that bring together general practices to commission services for their registered populations and for unregistered patients who live in their area. CCGs are responsible for commissioning most hospital and community healthcare services.

Aylesbury and Chiltern CCGs as commissioners of Buckinghamshire local health services need to assure themselves that the Trust have effective safeguarding arrangements in place. They are responsible for securing the expertise of Designated Professionals on behalf of the local health system. The Designated Professionals undertake a whole health economy role and play an integral role in all parts of the commissioning cycle, if appropriate services are to be commissioned that support children at risk of abuse or neglect, as well as effectively safeguard their well-being.

Safeguarding forms part of the NHS standard contract (service condition 32) and commissioners agree with their providers, through local negotiation, what contract monitoring processes are used to demonstrate compliance with safeguarding duties. Aylesbury and Chiltern CCGs gain assurance throughout the year to ensure continuous improvement. Assurance currently consists of assurance visits, section 11 audits, the completion of a safeguarding dashboard and safeguarding assurance framework as well as attendance at provider meetings in particular the Buckinghamshire Healthcare NHS Trust Safeguarding committee.

6.11.2. Designated Professionals

The Aylesbury and Chiltern CCGs are responsible for securing the expertise of Designated Professionals on behalf of the local health system. The Designated Professional’s role is to work across the local health system to support other professionals in their agencies on all aspects of safeguarding and child protection. Designated Professionals are clinical experts and strategic leaders for safeguarding and as such are a vital source of advice and support to health commissioners in the CCGs, the local authority and NHS England, BHT health professionals, quality surveillance groups (QSG), regulators, the BSCB and the Health and Wellbeing Board.
6.11.3. Local authority commissioners

The commissioning of public health services for children is undertaken by local authorities and includes sexual health services, school nursing services, and, from October 2015, health visiting and family nurse partnership services. These health services have an integral role in safeguarding children and young people are clearly reflected within their relevant service specifications.

As commissioners of these health services, the local authority liaises with the relevant Designated Professional as part of their assurance process to ensure that effective safeguarding arrangements are in place. As with all organisations which are subject to the Children Act 2004 section 11 duty, local authorities are responsible for ensuring that their staffs receive appropriate supervision and support, including undertaking safeguarding training. This applies to professionals delivering public health services commissioned by local authorities.

7. DEFINITIONS

7.10. General

Safeguarding and promoting the welfare of children means:
- 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 best life chances.

7.10.1. A child is anyone who has not yet reached their 18th birthday (Children Act 1989 and 2004). 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 on an adult ward, prison or a young offender's institution does not change his or her status or entitlement to services or protection under the Children Act 1989. Young people who are in this category as well as younger adolescents often fall through the net of services, not seen as an adult but no longer a child; they are often very vulnerable. Whilst 'unborn children' are not included in the legal definition of children, intervention to ensure their future well-being is encompassed within safeguarding children practice.

7.10.2. Child Protection is part of safeguarding and promoting welfare; it refers to the activity taken to protect specific children who are suffering or are likely to suffer significant harm, as defined under Section 47 of the Children Act (1989)

7.10.3. Children in Need are children defined under Section 17 of the Children Act 1989, as those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development or their health or development will be significantly impaired, without the provision of services. It includes children who are disabled.
7.10.4. **Significant harm** is a concept introduced by the Children Act 1989 as the threshold which justifies compulsory intervention in family life in the best interests of the children. There are no absolute criteria to define significant harm; it may be a single traumatic event or more commonly a compilation of significant events. Consideration should be given to the severity of ill treatment, duration and frequency of abuse or neglect, extent of premeditation, and the presence of threat, coercion, sadism, and bizarre or unusual elements.

7.11. **Definitions of Abuse**

7.2.1 Abuse and neglect are forms 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 a stranger; for example, via the internet. They may be abused by an adult or adults, or another child or children.

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

7.2.3. **Emotional abuse**
Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child’s emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. 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 the 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.

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

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

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

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

For further information on defining child abuse and the signs and indicators of child abuse, please refer to the BSCB Inter-Agency Child Protection and Safeguarding Procedures [www.bucks-lscb.org.uk](http://www.bucks-lscb.org.uk)

8. **THE VOICE OF THE CHILD**

8.1. Children want to be respected, their views to be heard, to have stable relationships with professionals built on trust and for consistent support provided for their individual needs. This should guide the behaviour of professionals. Anyone working with children should see and speak to the child; listen to what they say; take their views seriously; and work with them collaboratively when deciding how to support their needs.

8.2. A child-centred approach is supported by: the Children Act 1989 (as amended by section 53 of the Children Act 2004). This Act requires local authorities to give due regard to a child’s wishes when determining what services to provide under section 17 of the Children Act 1989, and before making decisions about action to be taken to protect individual children under section 47 of the Children Act 1989. These duties complement requirements relating to the wishes and feelings of children who are, or may be, looked after (section 22 (4) Children Act 1989), including those who are provided with accommodation under section 20 of the Children Act 1989 and children taken into police protection (section 46(3) (d) of that Act). A version of the Working Together to Safeguard Children (HM Government 2015a) guidance for young people is available for practitioners to share. [http://www.childrenscommissioner.gov.uk/publications/young-person-guide-working-together-safeguard-children](http://www.childrenscommissioner.gov.uk/publications/young-person-guide-working-together-safeguard-children)

8.3. The Equality Act 2010 puts a responsibility on public authorities to have due regard to the need to eliminate discrimination and promote equality of opportunity. This applies to the process of identification of need and risk faced by the individual child and the process of assessment. No child or group of children must be treated any less favourably than others in being able to access effective services which meet their particular needs.

8.4. The United Nations Convention on the Rights of the Child (UNCRC) is an international agreement that protects the rights of children and provides a child-centred framework for the
development of services to children. The UK Government ratified the UNCRC in 1991 and, by doing so, recognises children’s rights to expression and receiving information

9. EARLY HELP

9.1. Providing early help is more effective in promoting the welfare of children and sustaining positive outcomes than reacting at a later date when the child is at increased risk. This definition includes both help early in life (with young children including pre-natal interventions) and help early in the development of a problem (with children or young people of any age). It includes universal help that is offered to an entire population to prevent problems developing, and targeted help that is offered to particular children, young people and families with existing risk factors, vulnerabilities or acknowledged additional needs in order to protect them from developing problems or to reduce the severity of problems that have started to emerge.

9.2. Professionals should be alert to the potential need for early help and refer to appropriate services as necessary. Health based services such as health visiting; school nursing and the family nurse partnership provide early intervention and prevention work. Children’s centres are a particular effective source of early help for families with children under the age of 5 years. There is a range of other services within Buckinghamshire and the Buckinghamshire Family Information Service is the key information bank to obtain knowledge of these services; http://www.bucksfamilyinfo.org/kb5/buckinghamshire/fsd/home.page

9.3. Where there are multiple issues, additional support through a multi-agency coordinated approach is appropriate. In Buckinghamshire this is currently accessed through a referral to First Response via a Multi-agency referral form (MARF). The needs outlined in the referral are assessed through early help panels resulting in a plan put in place with a Team around the child / family approach with a lead professional. On-going support may also be provided by the Family Resilience service.

See further information within BHT Safeguarding children pages http://swanlive/policies-guidelines/safeguarding-children

10. INFORMATION SHARING


10.1. Sharing of information in cases of concern about children’s welfare will enable professionals to consider jointly how to proceed in the best interests of the child and to protect children generally. Often, it is only when information from a number of sources has been shared and is then put together that it becomes clear that a child is at risk or suffering harm. Early Sharing of information is 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 have shown how poor information sharing has contributed to the deaths and serious injuries of children.

10.3. Good partnership working is essential and individual practitioners should develop relationships and work closely with colleagues across their local health safeguarding systems to develop ways of working that are collaborative, enable learning and effective information sharing.

10.4. Consent and Confidentiality (section 5.0 above)
Confidential information can be shared if the person to whom it relates gives consent. However, where sharing of confidential information is not authorised, you may lawfully share it if this can be justified in the public interest; that is in the best interest of the child or to prevent crime. Seeking consent should be the first option, if appropriate.

10.3.1. The child’s best interests must be the overriding consideration in making any such decision on sharing information. The key factor in deciding whether or not to share confidential information without consent is proportionality, i.e. is the information you wish to, or are asked to share, a balanced response to the need to safeguard a child or young person? In making the decision you must weigh up what might happen if the information is shared against what might happen if it is not, and make a decision based on a reasonable judgment. Staff should record the rationale for their decision.

10.3.2. Access to Trust Policies relating to data protection and information sharing can be found within the Information Governance Document Store. Additionally there is a Buckinghamshire Information Sharing Protocol entitled Buckinghamshire Multi-Agency Data and Information Sharing Protocol for Children and Young People established between local agencies and organisations which assist staff in making decisions on information sharing. http://www.buckinghamshirepartnership.gov.uk/media/1024923/cop.pdf

10.4. Consent in cases of Fabricated or Induced Illness
In cases of suspected Fabricated or Induced Illness (FII) it may be detrimental to discuss initial suspicions with the parents or carers. Advice needs to be sought from safeguarding professionals when unsure.

10.4.1. Further advice and information can be obtained from the BSCB ‘Fabricated or Induced Illness’ Procedure (January 2013) http://www.bucks-lscb.org.uk/sites/default/files/Procedures/Fabricated_Illness_2013.pdf

And the Royal College of Paediatrics and Child Health ‘Fabricated or Induced Illness by Carers (FII): A Practical Guide for Paediatricians’ (2009)
10.4.2. The following guidance provides a national framework within which agencies and professionals at local level can draw up, and agree upon, their own more detailed ways of working together where illness may be being fabricated or induced in a child by a parent or carer who has parenting responsibilities.


10.5. **Handling of Requests for Patient Information by legal teams or the police**

It is accepted that all information provided by service users is confidential in nature. Information will not be disclosed to the police, social care or any other agency without the consent of the person concerned or a court order unless there are statutory grounds and an overriding justification for doing so. All requests for records need to go through the medico-legal department for the Trust; this includes any requests for notes or records following any strategy or professionals meeting on a ward or elsewhere. There are a range of legal proceedings and investigations that may be instigated by Buckinghamshire County Council’s Legal Department or the police. Staff may be asked to contribute to this process. Such requests should always be in writing with details of the case and guidance on what information is required and sent to the Safeguarding Children Team in the first instance, on buc-tr.bhtchildprot@nhs.net Trust protocol should be adhered to at all times to protect both the practitioner and the client about whom the information is requested. Named professionals will support practitioners with these requests. Police should in the first instance always contact the Head of Security for the Trust.

10.5.1. While staff will always provide statements and be willing to appear in court when the local authority is bringing care proceedings, this is NOT the case in private law proceedings (those not involving the Local Authority) under the Children Act (1989), they typically involve family disputes over contact or residence. If a staff member is approached by a family’s solicitor for information, they should refer the matter to his/her manager and draw their attention to this guidance.

See: Subject Access Request Policy v1.0 - BHT Pol 188

11. **MAKING A REFERRAL TO BUCKINGHAMSHIRE COUNTY COUNCIL CHILDREN AND FAMILY SOCIAL CARE**

11.1. If it is believed that a child or young person is being abused or neglected then those concerns must be referred to Buckinghamshire County Council (BCC) First Response Team. Referrals can be made 24 hours a day. If you believe a child is in imminent danger, has a significant injury or has disclosed or you highly suspect sexual abuse you can also contact the police.
11.2. Please note, if your concern relates to an allegation against a member of staff within the Trust or the wider children’s workforce, contact the LADO (Local Authority Designated Officer) – 01296 382070

11.3. Patients/children/carers can speak to someone in confidence by phoning ChildLine on 0800 1111. This service is free at any time and should be displayed in prominent areas.

11.4. If a child has experienced sexual or offensive chat that has made them feel uncomfortable or someone is trying to meet up with them, you can also report this directly to Child Exploitation Online Protection Agency. This may have happened in a chat room, message board, instant messenger or on a social networking site. It could be on a mobile phone, games console or computer. It could be messages, images or conversations over webcam. The important thing is that if you know that an adult is making sexual advances to children on the internet you report it on this link: Child Exploitation and Online Protection Centre (CEOP)

11.5. If a child is from a neighbouring local authority it will be necessary to contact the individual Social Care department to establish what systems they have in place and to whom to make a referral see appendix 2.

11.6. As a matter of good practice, professionals should seek to discuss any concerns with the parent/carer of the child/children. Where possible, seek their agreement to making a referral. However, if the referrer believes that seeking consent would place the child at increased risk of significant harm it would not be appropriate to discuss or inform the parents or carers of the referral. Depending on the child’s age and understanding it may be appropriate to discuss the concerns with them. (see sections 5 and 10.5).

11.7. If staff are uncertain about a situation they should discuss with their line manager. If they still require advice they can contact the appropriate named professional - Named Nurse, Doctor or Midwife (contact list on http://swanlive/ and appendix 1) or consult BCC Children & Family Social First Response Team by telephone for a discussion on a no-names basis.

11.8. The referral should be confirmed in writing within 24 hours using the Multi-agency referral form (MARF). This can also be down-loaded from http://swanlive/ or BSCB web-site www.bucks-lscb.org.uk The referral should always make reference to the BSCB Threshold document http://www.bucks-lscb.org.uk/professionals/thresholds-document/ The form should be sent to the
First response secure email address via an nhs.net email account. **A copy should always be sent to the safeguarding children team** buc-tr.bhtchildprot@nhs.net for monitoring purposes.

11.9. The referrer will be informed of the outcome. However, if an outcome is not forthcoming, the referrer is required to contact the First Response Team within 3 days (or earlier if the referral was more urgent) to clarify the outcome. Referrals to BCC Children & Family Social Care First Response Team may have the following outcomes:

- No further action
- Signposting / referral to another agency if single agency response is required
- Early Help panel – if a multiagency response is needed but it does not meet social care threshold
- MASH enquiry/ assessment – for information to aid decision making:
  - If meets section 17 (Children Act 1989) threshold – Child in Need (CIN) transfer to CIN unit for assessment and the provision of services
  - If there reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm a Section 47 (Children Act 1989) inquiry is initiated for further assessment and the provision of services
- Or emergency action to safeguard and promote the welfare of the child

12. **ASSESSMENTS UNDER THE CHILDREN ACT 1989**

12.1. Under the Children Act 1989, local authorities are required to provide services for children in need for the purposes of safeguarding and promoting their welfare. Local authorities undertake assessments of the needs of individual children to determine which services to provide and what action to take as stated above.

12.2. Assessment is undertaken in accordance with the Framework for the Assessment of Children in Need and their Families (DH 2000). Information is gathered and analysed within the 3 domains of the Assessment Framework. All relevant information will be taken into account, including seeking information from relevant services.

12.3. **Strategy discussion / Meeting**

At any point in the process when there is reasonable cause to suspect that a child is suffering or likely to suffer significant harm, a strategy discussion involving Children's Social Care, the police and other agencies such as health will take place. Health professionals may be invited to a strategy meeting, their role is to share relevant information their involvement and the health and development of the child in question. The purpose is to decide whether Section 47 enquiries will be initiated or continued and plan how these will be handled, including action required immediately to safeguard the child.

12.4. **Section 47 enquiries**

The Children Act places a statutory duty on other agencies, including health, to help Children's Social Care with these enquiries. Section 47 enquiries may have the following outcomes:
• Concerns are not substantiated / Concerns are substantiated but the child is not judged to be at continuing risk of significant harm it is judged that those involved are willing and able to co-operate with actions to ensure the child's safety and well-being.

• Concerns are not substantiated / Concerns are substantiated but the child is not judged to be at continuing risk of significant harm - although they may still require support as a Child in Need (see section 7.10.3).

• Concerns are substantiated and child is judged to be at continuing risk of significant harm. In this case an initial child protection conference should be convened.

12.5. Initial child protection conference

12.14.1 This meeting brings together family members, the child (where appropriate) and those professionals most involved with the child and family.

Its purpose is to:

• Bring together and analyse in inter-agency setting information about the child's health and development, and the parents' capacity to ensure the child's safety and to promote their child's health and development.

• Make judgments about the likelihood of the child suffering significant harm in the future,

• Decide and plan future action needed to safeguard and promote the welfare of the child, along with intended outcomes.

Any health professional that has a (significant) contribution to make to the conference will be invited to attend. Attendance at conference needs to be considered as high priority and a written report provided.

12.5.1. If the decision of the conference is taken that the child is at continuing risk of significant harm then the child will become subject to a child protection plan under one or more of the following categories: physical abuse; sexual abuse; emotional abuse or neglect.

12.5.2. A range of tasks including appointing a key worker, the lead professional and identifying membership of the core group will be agreed. Identifying further assessments, outlining the child protection plan and a contingency plan, if agreed actions are not completed, or circumstances change, will be undertaken, and the date for the first review child protection conference, usually 3 months later, will also be agreed.

12.6. Disabled Children (see section 16.8)

Where a local authority is assessing the needs of a disabled child, a carer of that child may also require the local authority to undertake an assessment of their ability to provide, or to continue to provide, care for the child, under section 1 of the Carers (Recognition and Services) Act 1995 and section 6 of the Carers and Disabled Children Act (2000). The local authority must take account of the results of any such assessment when deciding whether to provide services to the disabled child. The specific needs of disabled children and young carers should be given sufficient recognition and priority in the assessment process. Further guidance:

Safeguarding Disabled Children - Practice Guidance (2009)
12.7. Radicalisation / Terrorism

12.7.1. The Office for Security and Counter Terrorism (OSCT) in the Home Office is responsible for providing strategic direction and governance on CONTEST. CONTEST is primarily organised around four key principles. Work streams contribute to four programmes, each with a specific objective:

• **PURSUE**: to stop terrorist attacks
• **PREVENT**: to stop people becoming terrorists or supporting terrorism
• **PROTECT**: to strengthen our protection against a terrorist attack
• **PREPARE**: to mitigate the impact of a terrorist attack.

12.7.2. The Health Service is a key partner in PREVENT and encompasses all parts of the NHS, charitable organisations and private sector bodies which deliver health services to NHS patients. The overall principle of health is to improve the health and wellbeing through the delivery of healthcare services while safeguarding those individuals who are vulnerable to any form of exploitation. PREVENT is also about protecting individuals.

12.7.3. PREVENT aims to protect those who are vulnerable to exploitation from those who seek to get people to support or commit acts of violence. Healthcare staff are well placed to recognise individuals, whether patients or staff, who may be vulnerable and therefore more susceptible to radicalisation by extremists or terrorists. It is fundamental to our ‘duty of care’ and falls within our safeguarding responsibilities.

See the Trust Prevent Strategy [http://swanlive/](http://swanlive/) (TBC)


13.0. INFORMATION COMMUNICATION TECHNOLOGY (ICT) AND E-SAFETY (See section 11.0.)

13.1. ICT (information and communications technology) is an umbrella term that includes any communication device or application, encompassing: radio, television, cellular phones, tablets, smart-phones laptops, computer and network hardware and software, satellite systems, as well as the various services and applications associated with them, such as videoconferencing and distance learning. The importance of ICT’s is in its ability to create greater access to information and communication.

13.2. Professionals working with children, adults and families should be alert to the possibility that:

• A child may already have been / is being, abused and the images distributed on the internet or by mobile telephone;
• An adult or older child may be grooming a child for sexual abuse, including for involvement in making abusive images. This process can involve the child being shown abusive images;
• An adult or older child may be viewing and downloading child sexual abuse images.
Further local information and guidance is available at:  
http://www.buckslscb.org.uk/professionals/e-learning/

Further information is available:  

http://www.ceop.police.uk/Publications/

14.0.  IMAGING

14.1.  For most children; parents, grandparents, other family members and friends are the guardians of safety and security. For some children these carers or others can be responsible for abuse and or neglect. During the course of normal activity children will sustain accidental injury; both groups of children require careful investigation which will or may include some form of clinical imaging. A child who may have suffered physical abuse, imaging may be essential if patterns of trauma that are consistent with Non-Accidental Injury (NAI) are to be detected.

Guidance on imaging in cases of concern of possible NAI can be found via BHT-intranet

See Trust 239.2 Guidelines for Imaging in suspected Non-Accidental Injury  
http://swanlive/sites/default/files/guideline_239.pdf

15.0.  SUPPLEMENTARY GUIDANCE ON SAFEGUARDING AND PROMOTING THE WELFARE OF CHILDREN

A number of documents have been published as supplementary guidance to Working Together to Safeguard Children (HM Government 2013), containing more detail to reflect the specialist nature of the particular issues covered. This list is not exhaustive and further information can be accessed from:  
http://www.buckslscb.org.uk/bscb-procedures/ additionally if any of the local links below are broken please use this link to take you through to the full list

Healthcare practitioners should be aware of these guidance documents and access them as required.

15.1.  Fabricated and induced illness (see section 10.4.)

Concerns may be raised when it is considered that the health or development of a child is likely to be significantly impaired or further impaired by a parent or caregiver. Fabricated and induced illness has no generally agreed definition but has been found to have four central features:

- Illness in a child which is fabricated or induced by a parent or carer.
- A child is presented for medical assessment and care, usually persistently, often resulting in multiple medical procedures.
- The perpetrator denies the aetiology of the child’s illness.
- Acute symptoms and signs cease when the child is separated from the perpetrator.

Local information and guidance is available at [www.bucks-lscb.org.uk](http://www.bucks-lscb.org.uk)

National guidance “Safeguarding Children in Whom Illness is Fabricated or Induced” (2009), is available for further information and can be found at


### 15.2. Children abused through sexual exploitation

The sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive something (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and / or others performing on them, sexual activities. Children at risk of or that are being sexual exploitation should be treated as victims of abuse, and their needs carefully assessed. They are likely to be in need of welfare services and – in many cases – protection under the Children Act (1989).

Local information and guidance if you suspect a child is at risk is available at [http://www.bucks-lscb.org.uk/professionals/child-sexual-exploitation-2/](http://www.bucks-lscb.org.uk/professionals/child-sexual-exploitation-2/)

Statutory guidance outlining how organisations and individuals should work together to protect young people from sexual exploitation:


National document - Step-by-step advice outlining actions to be taken if staff suspect that a child they are in contact with is being sexually exploited.


### 15.3. Investigating complex (organised or multiple) abuse

This is defined as abuse involving one or more abusers and a number of children. It may occur as part of a network of abuse across a family or community, or within institutions. The designated and named professionals within the Trust should be aware of these cases and would offer support to individual healthcare practitioners who may be involved.


### 15.4. Female Genital Mutilation (FGM)

Female genital mutilation (FGM) is a collective term for procedures which involve the removal of part or all of the external female genitalia for cultural or other non-therapeutic reasons. FGM has been a criminal offence in the UK since 1985. In 2003 the Female Genital Mutilation Act made it an offence for UK nationals or permanent UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where it is legal. It is sometimes known as ‘female circumcision’ or ‘cutting’. It is mostly carried out on young girls.
FGM procedures can cause severe bleeding, infection and problems with giving birth later in life. Form 31\textsuperscript{st} October 2015, the Female Genital Mutilation Act 2003 (as amended by the Serious Crime Act 2015) introduced a mandatory reporting duty for all regulated health and social care professionals and teacher in England and Wales. Professionals must make a report to the police on 101, if, in the course of their duties that are informed by a girl under the age of 18 that she has undergone an act of FGM or they observe physical signs that an act of FGM may have been carried out on a girl under the age of 18. Staff must also inform the safeguarding team by phone or email (contact details Appendix 1).


Additionally it is now mandatory to record FGM in a patient’s healthcare record, please see link for further information: [http://www.nhs.uk/NHSEngland/AboutNHSservices/sexual-health-services/Documents/FGMstatementNHSCDec2014.pdf](http://www.nhs.uk/NHSEngland/AboutNHSservices/sexual-health-services/Documents/FGMstatementNHSCDec2014.pdf)

If you are concerned someone may be at risk or victims please see the link below for guidance: [http://www.bucks-lscb.org.uk/professionals/female-genital-mutilation/](http://www.bucks-lscb.org.uk/professionals/female-genital-mutilation/)

Further information about the Act can be found in the Home Office Circular 10/2004 which is available on [www.hmso.gov.uk/acts/acts2003/20030031.htm](http://www.hmso.gov.uk/acts/acts2003/20030031.htm)


15.5. **Forced Marriage**

There is a clear distinction between a ‘forced’ marriage and an ‘arranged’ marriage. A ‘forced’ marriage is a marriage in which one or both spouses do not and/or cannot consent to the marriage and duress is involved. Duress can include physical, psychological, financial, sexual and emotional pressure. Duress cannot be justified on religious or cultural grounds. The Anti-social Behaviour, Crime and Policing Act 2014 make it a criminal offence to force someone to marry.

Local information and guidance can be found at: [http://www.bucks-lscb.org.uk/professionals/forced-marriage/](http://www.bucks-lscb.org.uk/professionals/forced-marriage/)


16.0. **SAFEGUARDING AND PROMOTING THE WELFARE OF CHILDREN WHO MAY BE PARTICULARLY VULNERABLE**

This section outlines the circumstances of children who may be particularly vulnerable. This list is not exhaustive and further information can be accessed from: [http://www.bucks-lscb.org.uk/bscb-procedures/](http://www.bucks-lscb.org.uk/bscb-procedures/) additionally if any of the local links below are broken please use this link to take you through to the full list.
16.1. **Children living away from home**
Revelations of the widespread abuse and neglect of children living away from home have done much to raise awareness of the particular vulnerability of children living away from home. Many of these have focused on sexual abuse, but physical and emotional abuse and neglect – including peer abuse, bullying and substance misuse – are equally a threat in institutional settings. Concern for the safety of children living away from home has to be put in the context of attention to the overall developmental needs of such children and a concern for the best possible outcomes for their health and development.

16.2. **Children and families whose whereabouts are unknown.**
If a practitioner becomes aware of a family whose whereabouts is not currently known, they should make efforts to ‘trace’ the family to ensure that any health needs are met. Liaison should take place with other agencies and professionals who have had involvement with the family e.g. education to determine whether they have more information on the families whereabouts and to alert them to the fact that you have ‘lost contact’ with them.

16.3. **Children of families living in temporary accommodation**
It is important that effective systems are in place to ensure that the children from homeless families receive services from health and education as well as any other specific types of services because these families move regularly and may be at risk of being disengaged from services.

16.4. **Migrant and asylum seeking children (UASC)**
Over recent years the number of migrant children in the UK has increased for a variety of reasons, including the expansion of the global economy and incidents of war and conflict. Safeguarding and promoting the welfare of these children must remain paramount with agencies in their dealings with this group. A UASC is an asylum seeking child under the age of 18 who is not living with their parent, relative or guardian in the UK. Based on this assessment, under the Framework for the Assessment of Children in Need and their Families (2000) local authorities have a duty to provide appropriate support and services to all UASC as these children should be provided with the same quality of individual assessment and related services as any other child presenting as being “in need”.
Local information and guidance can be found at: [http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-Procedures/Migrant_and_Unaccompanied_Asylum_Seeking_Children_UASC.pdf](http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-Procedures/Migrant_and_Unaccompanied_Asylum_Seeking_Children_UASC.pdf)

16.5. **Child victims of trafficking**
Trafficking in people includes the exploitation of children through force, coercion, threat and the use of deception and human rights abuses. Exploitation occurs through prostitution and other types of sexual exploitation, and through labour exploitation. It includes the movement of people
across borders and also the movement and exploitation within borders. The UK is a destination country for trafficked children and young people. Such children enter the UK through various means. Some enter as unaccompanied asylum seekers, or students or as visitors. Children are also brought in by adults who state that they are their dependents, or are met at the airport by an adult who claims to be a relative. If it is suspected that a child is the victim of trafficking, the police or children’s social care should be informed.

Local information and guidance can be found at: http://www.bucks-lscb.org.uk/professionals/trafficked-exploited-children-and-young-people/
National guidance: https://www.gov.uk/government/publications/safeguarding-children-who-may-have-been-trafficked-practice-guidance

16.6. Private fostering
A private fostering arrangement is essentially one that is made privately (that is to say 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. Under the Children Act (1989), private foster carers and those with parental responsibility are required to notify the local authority of their intention to private foster or to have a child privately fostered or where a child is privately fostered in an emergency. Health care professionals should notify the local authority of a private fostering arrangements that comes to their attention, where they are not satisfied that the local authority has been, or will be, notified of the arrangement.

Local information and guidance can be found at: http://www.bucks-lscb.org.uk/parents-carers/private-fostering/

16.7. Children in hospital

- When children are in hospital this should not in itself jeopardise the health of the child or young person further.
- The Local Authority where the hospital is located is responsible for the welfare of children in its hospitals.

Additionally, section 85 of the Children Act 1989 requires hospitals to notify the ‘Responsible Authority’ i.e. the Local Authority for the area where the child is ordinarily resident or where the child is accommodated if this is unclear – when a child has been or will be accommodated for 3 months or more for example, in hospital. This will allow the LA to assess the child’s needs and decide whether services are required under the Children Act 1989.

16.8. Safeguarding Disabled Children (see section 12.6.)
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 (see standard 5,7, and 8 of the National Service Framework for Children, Young People and Maternity Services). 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 them.


16.9. **Children who exhibit problematic / harmful sexual behaviour**

Children, particularly those living away from home, are also vulnerable to physical, sexual and emotional bullying and abuse by their peers. Such abuse should always be taken as seriously as abuse perpetrated by an adult. It should be subject to the same safeguarding children procedures as apply in respect of any child who is suffering, or at risk of suffering significant harm from an adverse source.

16.9.1. Work with children and young people who abuse others – including those who sexually abuse/offend – should recognise that such children are likely to have considerable needs themselves, and also that they may pose a significant risk of harm to other children. Such children and young people are likely to be children in need, and some will in addition be suffering or at risk of significant harm and may themselves be in need of protection. Children and young people who abuse others should be held responsible for their abusive behaviour, whilst being identified and responded to in a way which meets their needs as well as protecting others.


16.10. **Safeguarding Children Affected by Gang Activity**

Defining what constitutes a ‘gang’ can be difficult, partly because its characteristics are known to change over time and locality. Being part of a friendship group is a normal part of growing up and it can be common for groups of children and young people to gather together in public places to socialise. These groups should be distinguished from ‘gangs’ for whom crime and violence are a core part of their identity, although ‘delinquent peer groups’ can also lead to antisocial behaviour and youth offending.


16.11. Bullying
Bullying may be defined as deliberately hurtful behaviour, usually repeated over a period of time, where it is difficult for those bullied to defend themselves. The damage inflicted by bullying can frequently be underestimated. It can cause considerable distress to children, to the extent that it affects their health and development or, at the extreme, causes them significant harm (including self-harm). All health care settings in which children are provided with services or are living away from home should have in place rigorously enforced anti-bullying strategies.

16.12. Children whose behaviour indicates a lack of parental control
When children are brought to the attention of the police or the wider community because of their behaviour, this may be an indication of vulnerability, poor supervision or neglect in its wider sense. It is important that consideration is given as to whether these are children in need and are offered assistance and services that reflect their needs. This should be done on a multi-agency basis.

16.13. Race and racism
Children from black and minority ethnic groups (and their parents) are likely to have experienced harassment, racial discrimination and institutional racism. Although racism can cause significant harm it is not, in itself a category of abuse. The experience of racism is likely to affect the responses of the child and family to assessment and enquiry processes. Failure to consider the effects of racism will undermine efforts to protect children from other forms of significant harm.

16.14. Domestic Abuse
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. The abuse can encompass, but is not limited to; psychological, physical, sexual, and financial emotional abuse. Domestic abuse is an umbrella term, covering a wide spectrum of behaviour but the core element is a process through which power is exercised by an adult perpetrator in an attempt to control or dominate another. Domestic abuse can also be perpetrated by a child or young person e.g. a child abusing their parents. Children may suffer both directly and indirectly if they live in households where there is domestic violence as it is likely to have a damaging effect on their health and development of children, and it will often be appropriate for such children to be regarded as children in need of protection. Healthcare professionals working with women with children should be alert to the frequent inter-relationship between domestic violence and the abuse and neglect of children. Conversely, where it is believed that a child is being abused; those involved with the child and family should be alert to the possibility of domestic violence within the family.
BHT Domestic abuse pathway and guidance is available here Responding to Domestic Abuse Disclosure Pathway
Local information and guidance can be found at: http://www.bucks-lscb.org.uk/parents-carers/domestic-abuse/
National guidance and further information: https://www.gov.uk/guidance/domestic-violence-and-abuse

16.15. Children of substance misusing parents
It is important not to generalise or make assumptions about the impact on a child of parental drug and alcohol misuse. As with the general population, some parents who misuse drugs and alcohol are good parents whilst others are not. However, parental substance misuse can cause significant harm to children at all stages of development. The advisory council on the Misuse of Drugs (ACMD) report Hidden Harm – Responding to the needs of children of problem drug users, concludes that parental drug misuse can and does cause harm to the children (and young people) at every age from conception to adulthood, including physical and emotional abuse and neglect. A thorough assessment is required to determine the extent of need and level of risk of harm in every case.
Local information and guidance can be found at: http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-Procedures/Children_Substance_Misusing_Parents.pdf

16.16. Safeguarding children from abuse linked to faith or belief
The belief in “possession” and “witchcraft” is widespread. It is not confined to particular countries, culture or religions, nor is it confined to new immigrant communities in this country. Such abuse generally occurs when a carer views a child as being “different”, attributes this difference to the child being “possessed” or involved in “witchcraft”, and attempts to exorcise him or her. Health professionals should look for indicators and be able to identify children at risk of this type of abuse and intervene to prevent it. They should apply basic safeguarding children principles including: sharing information across agencies: being child-focused at all times: and keeping an open mind when talking to parents and carers.
Local information and guidance can be found at: http://www.bucks-lscb.org.uk/professionals/belief-in-spirit/

17.0. ESCALATION, CHALLENGE AND CONFLICT RESOLUTION
17.1. It may be appropriate to challenge a decision made by BCC Children & Family Social Care First Response Team in response to a referral, as stated in the Inquiry into the Death of Victoria Climbie (DH 2003), especially if it is to clarify that they have understood the nature of the concerns. If staff disagree with how concerns have been progressed there is an Escalation procedure in place that managers, with support from the named child protection professionals, can guide staff through. Additionally any disagreements in on-going cases, in relation to how they are progressed or managed between Trust staff and Social Care should also follow these procedures.
18.0. SERIOUS CASE REVIEWS (SCRs) AND INTERNAL CASE REVIEWS

18.1. Serious Case Reviews

18.1.1. The BSCB has to undertake reviews of serious cases in specified circumstances. The function requires; reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

See: http://www.bucks-lscb.org.uk/serious-case-review/

18.1.2. A serious case is one where:

(a) Abuse or neglect of a child is known or suspected; and
(b) 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. In addition, an SCR should always be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children’s home, or where the child was detained under the Mental Health Act 2005. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide

18.1.3. 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.

This definition is not exhaustive.

18.1.4. The purpose of serious case reviews is to:

- Establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard and promote the welfare of children;
- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and
- As a consequence, improve inter-agency working and better safeguarding and promote the welfare of children.
18.1.5. SCRs are not enquiries into how a child died or who is culpable. That is a matter for coroners and criminal courts respectively to determine. It is not about professional competence.

18.1.6. Any professional may refer a case to the LSCB if it is believed that there are important lessons for inter-agency working to be learnt from the case. For health professionals this should be done via the designated professionals for child protection.

18.1.7. If it is agreed by the LSCB that a serious case review will take place, then a serious case review panel will be established. This will include a health representative which may be a named professional or appropriate health manager/lead. The Named professionals will have a responsibility to review and evaluate the practice of all involved health professionals and providers within the organisation. This may involve reviewing the involvement of individual practitioners and Trusts, and also advising or completing reports, such as Internal Management Review (IMR) and chronologies, for the review panel. They also have an important role in providing guidance on how to balance confidentiality and disclosure issues.

18.2. Internal Case Reviews

18.2.1. Internal case reviews are case reviews that are carried out within “health” where it is believed there may be lessons to be learned from the management of a case by healthcare professionals and the case is not the subject of a Serious Case Review by the BSCB.

18.2.2. The purpose of internal case reviews is to:

- Establish whether there are lessons to be learned from the case about the way in which health professionals work together to safeguard children and promote the welfare of children;
- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result.

18.2.3. Internal case reviews are initiated when:

- There has been a serious untoward incident involving the safeguarding of a child; or
- The designated child protection professionals and the director responsible for safeguarding children believe that lessons can be learned from a case; or
- The chair of the BSCB, following a recommendation from the BSCB Strategic and serious case review sub group, requests one is undertaken.

18.2.4. The designated professionals will inform the named professionals that an internal case review is to be instigated. The same process will be followed as for individual management review.

18.2.5. The findings from internal case reviews will be collated by the designated professionals. The Trust directorate lead for safeguarding will take responsibility for ensuring recommendations and actions agreed are presented to the Healthcare Governance Committee and the Board as appropriate. The designated professionals will monitor the implementation of the action plan.
19.0. TRAINING

19.1. To protect children and young people from harm, all healthcare staff must have the competences to recognise child maltreatment and to take effective action as appropriate to their role. It is the duty of employers to ensure that those working for them clearly understand their contractual obligations within the employing organisation, and it is the responsibility of employers to facilitate access to training and education which enable the organisation to fulfil its aims, objectives and statutory duties effectively and safely. It remains the responsibility of the organisation to develop and maintain quality standards and quality assurance, to ensure appropriate systems and processes are in place and to embed a safeguarding culture within the organisation. It is also important to be aware of the role of external regulators such as CQC in monitoring safeguarding systems within organisations.

19.2. The purpose of training for inter-agency work at both strategic and operational levels is to achieve better outcomes for children and young people by ensuring:

- a shared understanding of the tasks, processes, principles, roles and responsibilities outlined in national guidance and local arrangements for safeguarding children and promoting their welfare;
- more effective and integrated services at both the strategic and individual case level;
- improved communication and information sharing between professionals, including a common understanding of key terms, definitions and thresholds for action;
- effective working relationships, including an ability to work in multi-disciplinary groups or teams;

19.3. The requirements for safeguarding children training are set out in the Intercollegiate Document Guidance Safeguarding Children and Young People: Roles and Competencies for Health Care Staff 2014. This guidance outlines that different groups of staff will have different training needs to fulfil their duties, depending on their degree of contact with children and young people and their level of responsibility.

19.4. Local processes for safeguarding children training with BHT are set out with the Safeguarding Children Learning and Development Policy available on the Trust intranet. All staff on joining the Trust are required to attend the corporate induction day which includes an introduction to child protection session. Staff are then advised to access the trust policy and identify with their manager at local induction what additional training is required. Managers are responsible for advising and identifying what level of training is appropriate for their staff and can seek advice from the Named Professionals for Child Protection to assist with this if unsure. For commissioned and contracted providers without a named professional, advice should be obtained from the Designated Nurse within Aylesbury and Chiltern CCGs.

19.5. E-learning is available within the Trust for mandatory training and updates for identified staff as per policy through the National Learning Management System (NLMS). Details of how to register and access on-line learning programme can be found on the Trusts intranet and by clicking on the NLMS icon on a Trust computer. The NLMS allows a database of all mandatory and essential
training undertaken for Trust employees to be maintained by the Education, Learning and Development Department.

See Trust policy for Safeguarding Children learning and development

20.0. SUPERVISION

Supervision as an accountable process which supports, assures and develops the knowledge skills and values of an individual group or team (Care Quality Commission, 2013). The requirement for Trust employees to have access to safeguarding and child protection supervision is laid down in Working Together to Safeguard Children (HM Government, 2015a). It is identified that supervision is the cornerstone of good practice and should be seen to operate effectively at all levels of an organisation (Laming, 2003)

20.1. Definitions

20.1.1 Clinical Supervision: Clinical Supervision is a term used to describe a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and to enhance consumer protection and the safety of care in complex clinical situations

The Trust recognises that Safeguarding and child protection supervision is integral to providing an effective child centred service. The Trust has a responsibility to provide clinical supervision for staff. Safeguarding children supervision is provided in addition to clinical supervision which it complements but does not replace. Thus Clinical Supervision is not within the scope of this policy.

20.1.2. Child Protection Supervision is more focused in its approach and is concerned with issues to support staff members to ensure that they are competent to safeguard and promote the welfare of children.

20.2. Working Together to Safeguard Children (HM Government 2013) states “Effective supervision can play a critical role in ensuring a clear focus on a child’s welfare. Supervision should support professionals to reflect critically on the impact of their decisions on the child and their family.

20.3. Supervision for practitioners is an essential component for maintaining safe and effective practice. Organisations should ensure that a robust supervision model is available to all frontline staff and first line managers. Supervision should involve elements of reflection and case management.

See Trust policy for Safeguarding and child protection supervision
## 21.0. MONITORING AND AUDIT

The policy will be monitored through the following means:

<table>
<thead>
<tr>
<th>What will be monitored and/or standard to be achieved</th>
<th>How/Method</th>
<th>Frequency</th>
<th>Lead</th>
<th>Reported to</th>
<th>Deficiencies/gap s recommendatio ns and action plans followed up by</th>
<th>Implementation of any required change the responsibility of</th>
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<tbody>
<tr>
<td>Completion of MARF (referrals to social care) forms</td>
<td>Audit</td>
<td></td>
<td>Safeguarding Children Team</td>
<td>Safeguarding children steering group</td>
<td>Safeguarding children steering group</td>
<td>Safeguarding children steering group</td>
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<tr>
<td>Quantity</td>
<td></td>
<td>Monthly</td>
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<td>Safeguarding children steering group</td>
<td>Paediatric Liaison Nurse and Child Protection lead nurse for A&amp;E and MASH</td>
<td>Paediatric Liaison Nurse and Child Protection lead nurse for A&amp;E and MASH</td>
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<tr>
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<td></td>
<td>Quarterly</td>
<td>Safeguarding children team</td>
<td>Safeguarding children steering group</td>
<td>Safeguarding children team</td>
<td>Safeguarding children team</td>
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<tr>
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<td>Quarterly</td>
<td>Paediatric Liaison Nurse and Child Protection lead nurse for A&amp;E and MASH</td>
<td>Safeguarding children steering group</td>
<td>Safeguarding children steering group</td>
<td>Safeguarding children steering group</td>
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<tr>
<td>Training compliance for trust staff</td>
<td>Report from ESR / ELD</td>
<td>Monthly</td>
<td>Safeguarding children team</td>
<td>Safeguarding children steering group</td>
<td>Safeguarding children team</td>
<td>Safeguarding children team</td>
</tr>
<tr>
<td>Training compliance for:</td>
<td>Appraisals</td>
<td>Annual</td>
<td>Safeguarding Directorate Lead Quality Committee (via the Quarterly / annual report)</td>
<td>Safeguarding children steering group</td>
<td>Safeguarding children steering group</td>
<td>Safeguarding children steering group</td>
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<tr>
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<td></td>
<td>CP lead A&amp;E and MASH</td>
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<tr>
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<td>Named Midwife for child Protection</td>
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<td>Quarterly</td>
<td>Lead named nurse for safeguarding children</td>
<td>Safeguarding children steering group</td>
<td>Safeguarding committee</td>
<td>Safeguarding committee</td>
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<tr>
<td></td>
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<td>Safeguarding Committee Quality Committee</td>
<td>Safeguarding committee</td>
<td>Safeguarding committee</td>
</tr>
</tbody>
</table>
| Notifiable / serious incidents | Review | Monthly | Lead named nurse for safeguarding children | Safeguarding children steering group
Safeguarding Committee via Dashboard Quality Committee (via the Quarterly / annual report) BSCB | Safeguarding Directorate Lead | Safeguarding Directorate Lead |
|------------------------------|--------|---------|---------------------------------------------|------------------------------------------------------------------------------------|--------------------------------|--------------------------------|
| Serious case reviews         | Review | Monthly | Lead named nurse for safeguarding children | Safeguarding children steering group
Safeguarding Committee via Dashboard Quality Committee (via the Quarterly / annual report) BSCB | Safeguarding Directorate Lead | Safeguarding Directorate Lead |
| Attendance and providing a report for child protection case conferences | Audit  | Monthly | Head of children and young people’s services | Safeguarding children steering group
Safeguarding Committee via Dashboard Quality Committee (via the Quarterly / annual report) | Head of children and young people’s services | Head of children and young people’s services |
22.0. REFERENCES

Buckinghamshire Safeguarding Children Board - www.bucks-lscb.org.uk

Care Quality Commission http://www.cqc.org.uk/content/essential-standards

Care Quality Commission (2013) Supporting information and guidance: Supporting effective clinical supervision
http://www.cqc.org.uk/sites/default/files/documents/20130625_800734_v1_00_supporting_information-effective_clinical_supervision_for_publication.pdf


23.0. BIBLIOGRAPHY


SAFEGUARDING CHILDREN CONTACTS BUCKINGHAMSHIRE

Named Nurses for Child Protection base: 3rd Floor, 66 High Street, Aylesbury, Bucks HP20 1SD

Team e-mail address: buc-tr.bhtchildprot@nhs.net

- Named nurses for Child Protection Tel.no.: 01296 566080 / 566079
- Named nurse for Acute Services: Bleep No. 631
- Named nurse for A&E and MASH Tel.no.: 01296 316598 Bleep No. 564
- Paediatric Liaison nurse: 01296 316598
- Named Midwife for Child Protection Buckinghamshire Healthcare: Tel.no. 01296 316217
- Named Doctors Child Protection Buckinghamshire Healthcare
  - Community: Tel.no. 01296 566046
  - Acute: Tel.no. 01494 426186
- Designated Nurse Child Protection/Safeguarding Lead Buckinghamshire CCG Tel.no. 01296 585916

Social Care

<table>
<thead>
<tr>
<th>First Response</th>
<th>0845 4600 001</th>
</tr>
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<tbody>
<tr>
<td>Emergency Duty Team (Countywide, Out of Office Hours)</td>
<td>0800 9997 677</td>
</tr>
<tr>
<td>General Enquiries</td>
<td>0845 370 8090</td>
</tr>
</tbody>
</table>
APPENDIX 2

Local Areas social care contacts

**Bedfordshire**

**North Bedford**
Intake & Assessment and Family Support Team Children’s Services (Open 8.45am – 5.20pm Monday to Thursday, 8.45am – 4.20pm Friday) **01234 223599**

**Central Bedfordshire (including Luton)**
Intake & Assessment and Family Support Team Children’s Services (Open 8.45am – 5.20pm Monday to Thursday, 8.45am – 4.20pm Friday) **0300 300 8149**

**South, West and Mid Beds (including Dunstable, Leighton Buzzard and Biggleswade)**
Intake & Assessment and Family Support Team Children’s Services (Open 8.45am – 5.20pm Monday to Thursday, 8.45am – 4.20pm Friday) **01582 818499**

**Emergency Duty Team** (Open 5.00pm – 9.00am Monday to Thursday, Weekends: 4.00pm on Friday to 9.00am Monday) **0870 238 5465**

**Berkshire**

**West Berkshire**
Referral and Assessment Team - **(01635) 503090**

**Reading**
Office hours - **0118 937 3641**
Emergency Duty Team - out of hours **01344 786 543**

**Bracknell Forest**
Office hours 8.30am to 5.00pm Mon-Fri - Tel: **01344 352020**
Emergency Duty Team (5.00pm - 9.00am Mon-Fri, 24 hrs on weekends and bank holidays) Tel: **01344 786543**

**Windsor and Maidenhead**
Referral and Assessment Team (8.45am to 5.15pm Monday to Thursday, 8.45am to 4.45pm Friday) - **01628 683150**
Out of Hours Emergency Duty Team (5.00pm to 9.00am and weekends) - 01344 **786543**

**Slough**
Monday and Friday Office hours - **01753 690898** or **01753 875591**
Weekends and Out of Hours Service - **01344 786543**

**Wokingham**
Referral and Assessment Team: Monday and Friday Office hours - **0118 908 8002**
Out of office hours: **01344 786 543**
**Hertfordshire**

Children, Schools & Families (including out of hours): **0300 123 4043**

**Milton Keynes**

Referral and Assessment Team during office hours - **01908 253169/70**
Emergency Social Work Team; out of office hours - **01908 265545**.

**Northamptonshire**

Monday to Friday from 8:00am to 6:00pm - **0300 126 1000**
Secure email: cypsnccinitialcontact@northamptonshire.gcsx.gov.uk
Out of Hours Team phone **(01604) 626938**

**Oxfordshire**

Banbury Assessment Team: **01865 816670**
Oxford Assessment Team: **01865 323048**
Abingdon Assessment Team: **01865 897983**
Emergency Duty Team (outside office hours): **0800 833 408**

**Hillingdon**

Contact number: 01895 556644

**Harrow**

Duty and Assessment Team - Tel: **020 8901 2690**
Out of hours; weekends, bank holidays and between 5pm-9am weekdays - Tel: **020 8424 0999**