

Safeguarding Children Policy

BHT Pol 149 Version 3 Issue 3

Once printed off, this is an uncontrolled document. Please check the intranet for the most up to date copy.

Version:	3
Issue:	3
Approved by:	Chief Nurse and Safeguarding committee
Date approved:	September 2019
Ratified by:	Executive Management Committee
Date ratified:	20 th September 2019
Author:	Lead Named Nurse for Safeguarding Children
Lead Director:	Chief Nurse
Name of Responsible Individual/ Committee:	Safeguarding committee / Chief nurse
Consultation:	Specialist services; Paediatrics, Children and young people's community services, sexual health and maternity Named professionals for child protection Safeguarding Committee – 9 th April 2018 BSCB - Policies and procedures subcommittee TPSG – May 2018
BHT Document Reference:	BHT Pol 149
Department Document Reference (if applicable):	N/A
Date Issued:	September 2019
Review Date:	September 2022
Target Audience:	Trust-Wide
Location:	Swanlive
Equality Impact Assessment:	Current April 2018

DOCUMENT HISTORY

Version	Issue	Reason for change
1	0	Merger of Child Protection Policy of Community Bucks Health and Guidelines of Buckinghamshire Hospitals NHS Trust
1	1	July 2013 updated to reflect new Working Together and other Local and National Changes.
1	2	July 2014 further updates from the BSCB Policy and Procedures Sub-committee.
1	3	August 2015 updated to reflect new Local and National policy.
2	0	February 2018 updated to reflect new Local and National policy.
3	0	GDPR & Information Sharing updated
3	1	Guidance on Assessing Potential Transfer of Risk to the Workplace Arising from Staff Involvement in Safeguarding Processes in their personal lives.
3	2	CYP first response email change – 31 st March 2020
3	3	July 2020 updated to include ‘Confidentiality and Information Sharing, including 3rd Party Information’ under section 15
3	3	September 2020 Updated First Response telephone number

Associated documents

BHT Ref	Title	Location/Link
BHT Pol 106 HR36	Induction policy procedure	Management of Corporate Local Induction Policy BHT Pol 106 Managers Guide to Corporate Local Induction
BHT Pol 174	Safeguarding and Child Protection Supervision Policy	http://swanlive/sites/default/files/bht_pol_174_-_safeguarding_child_protection_supervision_policy_v1.2_rvw_10_2018.pdf
BHT Pol 217	Safeguarding Children Learning and Development Policy	http://swanlive/sites/default/files/bht_pol_217_-_safeguarding_children_-_staff_learning_and_development_policy_v1.1_rvw_09_2018.pdf

BHT Pol 014	Policy For The Chaperoning Of Patients During Examination, Investigation Or Clinical Recording	http://swanlive/sites/default/files/policy_for_chaperoning_of_patients_during_examination_investigation_or_clinical_recording_bht_pol_014_-_final_jan_2018_0.pdf
Guidelines	Safeguarding children guidelines	http://swanlive/staff-resources/safeguarding
BHT Pol 266	Discharge Policy	http://swanlive/sites/default/files/guideline_266.pdf

Contents

Section A. SUPPORTING STATEMENT	5
QUICK REFERENCE GUIDE	6
1. INTRODUCTION	8
2. POLICY STATEMENT	10
3. PURPOSE	10
4. SCOPE OF THE DOCUMENT	11
5. LEGAL FRAMEWORK.....	11
6. DUTIES, ROLES AND RESPONSIBILITIES of NHS Employees	12
7 HUMAN RESOURCES	16
8 PROCEDURES FOR DEALING WITH ALLEGATIONS OF ABUSE AGAINST MEMBERS OF STAFF AND VOLUNTEERS ARE IN PLACE	16
9 GUIDANCE ON ASSESSING POTENTIAL TRANSFER OF RISK TO THE WORKPLACE ARISING FROM STAFF INVOLVEMENT IN SAFEGUARDING PROCESSES IN THEIR PERSONAL LIVES	17
10 DEFINITIONS	21
11 THE VOICE OF THE CHILD	23
12 INTERPRETER SERVICES.....	24
13 EARLY HELP.....	24
14 INFORMATION SHARING.....	25
15 CONSENT AND CONFIDENTIALITY	28
16 MAKING A REFERRAL TO BUCKINGHAMSHIRE COUNTY COUNCIL CHILDREN AND FAMILY SOCIAL CARE.....	30
17 ASSESSEMENTS UNDER THE CHILDREN ACT 1989	32
18 PREVENT.....	34
19 INFORMATION COMMUNICATION TECHNOLOGY (ICT) AND E-SAFETY	35
21 IMAGING	36
22 SUPPLEMENTARY GUIDANCE ON SAFEGUARDING AND PROMOTING THE WELFARE OF CHILDREN	36
22.1 Fabricated and induced illness.....	36
22.2 Children abused through sexual exploitation	37
22.3 Investigating complex (organised or multiple) abuse	37
22.4 Female Genital Mutilation (FGM).....	37
22.5 Forced Marriage	38

23	SAFEGUARDING AND PROMOTING THE WELFARE OF CHILDREN WHO MAY BE PARTICULARLY VULNERABLE	38
23.1	Children living away from home.....	39
23.2	Children and families whose whereabouts are unknown.....	39
23.3	Children of families living in temporary accommodation.....	39
23.4	Migrant and asylum seeking children (UASC).....	39
23.5	Child victims of trafficking.....	40
23.6	Private fostering.....	40
23.7	Children in hospital.....	40
23.8	Safeguarding Disabled Children (see section 12.6.)	41
23.9	Children who exhibit problematic / harmful sexual behaviour	42
23.10	Safeguarding Children Affected by Gang Activity	42
23.11	Bullying.....	43
23.12	Children whose behaviour indicates a lack of parental control	43
23.13	Race and racism.....	43
23.14	Domestic Abuse.....	43
23.15	Children of substance misusing parents.....	44
23.16	Safeguarding children from abuse linked to faith or belief	44
24	Child Protection - Information Sharing (CP-IS).....	45
25	ESCALATION, CHALLENGE AND CONFLICT RESOLUTION.....	45
26	SERIOUS CASE REVIEWS (SCRs) AND INTERNAL CASE REVIEWS	45
27	TRAINING.....	47
28	SUPERVISION	48
29	MONITORING AND AUDIT	49
30	REFERENCES	51
31	BIBLIOGRAPHY	52
	APPENDIX 1; Seven golden rules for information sharing	54
	APPENDIX 2; BHT SAFEGUARDING CHILDREN CONTACTS BUCKINGHAMSHIRE	55
	APPENDIX 3; Local Areas social care contacts	56
	APPENDIX 4; Assessing Gillick/Fraser Competence	58
	APPENDIX 5; Child Protection - Information Sharing (CP-IS)	59
	APPENDIX 6; NEW GUIDANCE Version Control.....	61
	Appendix A - Contact arrangements plan to be added to medical records	65
	Appendix B Flow chart of the procedure when a child or young person is admitted to hospital and there are safeguarding concerns.....	66

Section A. SUPPORTING STATEMENT

– this policy must 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 must 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

QUICK REFERENCE GUIDE

For quick reference the guide below is a summary of actions required. This does not negate the need for the document author and others involved in the process to be aware of and follow the detail of this policy

- 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, has a child of their own, 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.
- 2** Safeguarding children is widely acknowledged as 'Everyone's Responsibility' and this Operational/Practice Policy applies to all Buckinghamshire HealthCare NHS Trust (BHT) staff, both clinical and non-clinical, whether they work with children or with adults.
- 3** The *Children Act* (1989, s.27 and s.47) and (2004 s.11), places a duty on all agencies to work together to safeguard and promote the welfare of children. The statutory guidance, *Working Together to Safeguard Children* (2015), outlines the legislative requirements and expectations on individual services to safeguard and promote the welfare of children; and provides clear framework for Local Safeguarding Children Boards to monitor the effectiveness of local services. This policy outlines corporate and individual responsibilities in accordance with legislation, guidance and standards for Safeguarding Children.
- 4** The fundamental principle of the *Children Act* 1989 is that the welfare of the child is 'paramount' and is an important consideration in assessing parenting capacity and balancing the rights of parents with the child's right to be protected from harm. The *Care Act* 2015 (under the *Child and Families Act* 2014) aims to make care and support more consistent across the country and introduces the wellbeing principle and safeguarding as themes running through all aspects of care and support and is applicable to children & young people.
- 5** Parenting can be challenging and seeking help must be seen as sign of responsibility and not of failure. Health professionals have a key role in early intervention to support parents experiencing difficulties. Compulsory intervention in family life must be seen to be exceptional.

- 6 The Trust has a duty to ensure that **ALL** staff understand the importance of safeguarding children and to ensure that all health professionals be alert to potential indications of abuse or neglect in children, know how to act upon their concerns and who to contact in their organisation to express concerns about a child's welfare.
- 7 The Trust recognises the importance of multi-agency working in safeguarding children (child protection) and is committed to developing effective multi-agency practices.
- 8 Local authorities have overall authority for the investigation and management of safeguarding children cases. Police have overall authority for investigation and management of potential criminal offences. Trust staff is required to co-operate with the provision of timely, accurate responses to requests for information.

Further advice can be sought **internally** from the BHT Safeguarding Children Team on ext. **01296 566079**. **You will be directed to the Duty Named Nurse.**

External Advice Children's Social Care 1st Response 01296 383962

Out of Hours (Children's Social Care) on 0800 999 7677

Please consider and reference any adult safeguarding concerns or required referrals via this website:

Bucks Adult Safeguarding Board

<http://www.buckinghamshirepartnership.gov.uk/safeguarding-adults-board/>

1. 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 must 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 must 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](http://www.bucks-lscb.org.uk/wp-content/uploads/About/BSCB_Learning_and_Improvement_Framework.pdf)

[content/uploads/About/BSCB_Learning_and_Improvement_Framework.pdf](http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-)

<http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB->

[Procedures/BSCB_LI_Framework_Part_B.pdf](http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-)

<http://www.bucks-lscb.org.uk/>

1.6 This policy must be used in conjunction with:

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

<http://swanlive/corporate-information/safeguarding-adults>

Also:

- The BSCB multiagency guidance and procedures www.bucks-lscb.org.uk
 - Working Together 2015 to Safeguard Children: A Guide to Inter-Agency Working to Promote the Welfare of Children https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf
<http://www.workingtogetheronline.co.uk/index.html>
 - NICE: When to suspect child maltreatment. October 2017, NICE published a guideline on [child abuse and neglect](https://www.nice.org.uk/guidance/CG89). Recommendations relevant to both health and social care practitioners appear in this guideline and the child abuse and neglect guideline. Clinical features (including physical injuries) are covered in this guideline. <https://www.nice.org.uk/guidance/CG89>
- NICE guideline on [faltering growth](https://www.nice.org.uk/guidance/CG89). Recommendation 1.4.8 was also updated with information on Prader–Willi syndrome.
- Other relevant national and BHT policy and guidance as listed or referenced in this policy and available on the intranet <http://swanlive/>

Additionally the following are useful good practice documents:

- GMC Guidance for all doctors: [0–18 years: guidance for all doctors](https://www.gmc-uk.org/guidance/for-doctors/0-18-years-guidance-for-all-doctors) and [Protecting children and young people](https://www.gmc-uk.org/guidance/for-doctors/protecting-children-and-young-people)
- RCN Guidance for Nurses http://www.rcn.org.uk/_data/assets/pdf_file/0004/78583/004542.pdf

NHS England Practical Guidance on the sharing of information and information governance for all

NHS organisations specifically for Prevent and the Channel process

<https://www.england.nhs.uk/wp-content/uploads/2017/09/information-sharing-information-governance-prevent.pdf>

2. 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. 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. 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. Your single piece of information may make all the difference in the recognition and the referral of potential abuse.

5. LEGAL FRAMEWORK

- 5.1** There are no specific mandatory regulations in the UK requiring professionals to report suspicions to authorities (except 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:
- Children Act 1989 and 2004.
 - Working Together to Safeguard Children (2015a) – statutory guidance.
 - 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.) See appendix 4 Assessing Fraser Competency
- 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. DUTIES, ROLES AND RESPONSIBILITIES of NHS

Employees

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 must be underpinned by:
- That it is essential practice that all agencies recognise that **safeguarding is everyone's business**. 'No professional must 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 must 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 must be based on a clear understanding of the needs and views of children (see section 8.0).

6.1 Responsibilities of Healthcare Provider Organisations

Safeguarding Children Policy BHT Pol 149

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 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/>

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

The Chief Nurse is the board level executive director lead for safeguarding. 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. She exercises accountability through the chairing of the Buckinghamshire Healthcare Safeguarding Forum which reports to the Trust Board on Safeguarding matters. She also sits on the Buckinghamshire Safeguarding Children's Board.

6.5 Safeguarding Lead – Director Level

This post holder represents the Chief Nurse 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 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.

7 HUMAN RESOURCES

The Trust HR function has a central role in safeguarding people from abuse as follows:

- to ensure that safe and effective selection and recruitment procedures are in place that are able to identify candidates who may be unsuitable to work with vulnerable people in accordance with Home Office guidance as set out by the Disclosure and Barring Service (DBS);
- to ensure that appropriate disciplinary investigation and procedures are in place to deal appropriately with a member of staff who may act abusively towards a patient or other person;
- to provide advice on the management of staff/volunteers who have had allegations made against them - this may include providing advice on disciplinary processes as well as supportive measures available for the member of staff/volunteer concerned;
- to ensure that the appropriate local and national bodies are informed when staff are suspended or dismissed due to a safeguarding concern or allegation;
- to ensure that there is a policy in place which supports staff to raise concerns and that there is an agreed process to support staff reporting poor practice;
- to ensure a commitment to staff training at all levels.

8 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

It is important that a decision is made about whether the information will 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 serious and may not warrant consideration under this procedure (see link below to BSCB multi-agency procedure).

However, it is important to ensure that even apparently less serious allegations are followed up, and that they are examined objectively by someone independent of the organisation concerned. The LADO must be informed of all allegations that appear to meet the criteria above so that s/he can consult the police and social care colleagues if appropriate. The LADO must also be informed of any allegations that are made directly to the police (which must 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 from within the Trust or via another agency, it must be reported immediately to the Trust Designated Officer who is the Chief Nurse or to senior personnel in the Trust Safeguarding team in the absence of the Designated Officer. The Trust designated persons must immediately liaise with the LADO who will provide advice and support.

<http://bscb.procedures.org.uk/skosz/adults-who-pose-a-risk-of-harm-to-children/managing-allegations-against-staff-and-volunteers-working-with-children>

9 GUIDANCE ON ASSESSING POTENTIAL TRANSFER OF RISK TO THE WORKPLACE ARISING FROM STAFF INVOLVEMENT IN SAFEGUARDING PROCESSES IN THEIR PERSONAL LIVES

Guidance must be followed whenever a member of Trust staff is subject to child protection or other safeguarding or Police procedures in relation to their **own family**, which are being managed by Buckinghamshire County Council Children's Services or another local authority Children's Services or Thames Valley Police or other Force. This may include Probation services.

In these circumstances it is always necessary for the organisation to assess whether there is any potential for risk to transfer to the workplace due to the staff member's work and role within the NHS. This risk may be regarding other staff members/client groups or Patients.

The Trust must also pay attention to any potential risk to the staff member's own health and well-being arising from their involvement in any Police or Children's Services procedures.

In a limited number of situations a risk assessment may be required. These situations include:

1. When staff has experienced Domestic Violence & Children's Services and/or agencies are actively involved.

2. When staff have been reported to BHT by the Police/Social Care as perpetrators of Domestic abuse
3. When staff have children that are subject to Child Protection Plans.
4. Where allegations have been made about a staff member such as the physical assault/sexual assault of a patient and or a member of staff.

If there is any doubt about whether to conduct a Transfer of Risk Assessment the Trust's Safeguarding Team (Adults or Children) must always be consulted.

The transference of Risk assessment concerns itself with the following areas, analysis of which will be conducted following direct communication with the Social Worker/ Police involved with the family if and when required.

1. **Volatile Emotions** are often expressed when people are under stress, this may potentially be expressed in the work place and amongst colleagues.
2. **Concentration levels** may also be affected by what is going on at home, thus interfering with work assignments and patient care. Being fit to practise requires a Nurse, midwife, Doctor or other professional to have the skills, knowledge, good health and good character to do their job safely and effectively. If during the course of the meeting it became apparent that there are other work related factors to be considered these will be addressed by the line manager.
3. **The personal views and perceptions of BHT as an organisation and other agencies**

(I.e. Children's Services /Police/another health department). If a family, who are working with Children's Services or the Courts perceive negative views of either their own or another external agency this may impact on their ability to believe that the agency in question would be of benefit to another family.

As a health professional working with children and families X's role would place him/her in direct contact with parents. Subsequently there is always the opportunistic chance discussion and conversation that may result in a personal view being put forward, this is especially the case when Children's Services are involved with families. This may result in a staff member advising that information about a child (or parent situation) must NOT be shared as Social Care will 'take your children away'.

[Swanlive/Policies and Guidelines/Policies & Strategies/Human Resources/Staff Policies](#)

9.1 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_poster_may_8_2014_v6.pdf

http://swanlive/sites/default/files/bht_pol_092_raising_concerns_policy_and_procedure_v3.0_rvw_07_2020.pdf

CEO Raising concerns blog (Aug 2017) <https://vimeo.com/229820747>

9.1.1 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).

See <http://www.bucks-lscb.org.uk/professionals/safer-employment/> and BHT policy/guidance for further information

9.2 Duties of all Staff

9.2.1 All staff working directly with children has 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.

9.2.2 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](#) 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.

9.3 Commissioners

9.3.1 Buckinghamshire Clinical Commissioning Group (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.

Buckinghamshire CCG 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. Buckinghamshire CCG's 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.

9.3.2 Designated Professionals

The Buckinghamshire 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.

9.3.3 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, since 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.

10 DEFINITIONS

10.1 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.

10.1.1 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, has a child of their own, 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.

10.1.2 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)

10.1.3 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.

10.1.4 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 must 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.

10.2 Definitions of Abuse

10.2.1 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.

10.2.2 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.

10.2.3 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.

10.2.4 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.

10.2.5 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

11 THE VOICE OF THE CHILD

11.1 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 concept must guide the behaviour of professionals. Anyone working with children must 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.

11.2 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>

- 11.3** 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.
- 11.4** 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

12 INTERPRETER SERVICES

INTERPRETER SERVICES Children and parents whose first language is not English, and who are not fluent in English must be interviewed / consulted with an interpreter who is not related to the child or a family friend. It must be an independent interpreter.

http://swanlive/sites/default/files/thebigword_best_practice_guidelines.pdf

http://swanlive/sites/default/files/interpreting_access_codes_for_the_interpreting_and_translation_service_-_telephone_interpreting_access_codes.pdf

The Accessible Information Standard

The standard (which became law in July 2016) aims to ensure that those with additional communication needs receive information that is clear, consistent and easy to understand so they can be fully informed and involved in the decisions about their care. This helps to maximise patient safety and good outcomes and minimise disadvantage as a result of impairment, disability or other communication needs.

Whether you are clinical or non-clinical YOU need to be aware of what this means for patients, carers and parents, yourself, quality of care and the Trust.

For more information and guidance:

<http://swanlive/corporate-information/accessible-information-standard>

13 EARLY HELP

- a. 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.
- b. Professionals must 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>
- c. 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.

14 INFORMATION SHARING

- a. The EU General Data Protection Regulation (GDPR) which forms part of the data protection regimen in the UK, came into force on 25th May 2018. The UK Data Protection Act 1998 was then revised and replaced by Data Protection Act 2018 (DPA 2018). The key theme of the new legislation are more rights for the individuals in relation to how their personal data is processed and more obligations for organisations that are processing personal data.
- b. The GDPR has introduced a principle of "accountability", requiring all organisations to demonstrate compliance. Confidential and client/staff data must be collected and stored in accordance with the GDPR and DPA 2018 principles and requirements
- c. Information sharing is vital to safeguarding and promoting the welfare of children and young people. A key factor identified in many serious case reviews (SCRs) has been a failure by practitioners to record information, to share it, to understand its significance and then take appropriate action.

- d. 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.
- e. 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.
- f. Good partnership working is essential and individual practitioners must 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.
- g. **Confidentiality and Information Sharing, including 3rd Party Information**

Professionals often share information about children with their professional partners, that is, a teacher may share information with a therapist who is working with the child at school. There are often occasions when one professional will witness behaviours in a child that another may not. When that happens it is important to be clear about your own professional responsibilities.

- What exactly is my professional responsibility in this situation?
- What is the immediate, presenting problem or concern?
- Who needs to know about this situation and who already knows? (the child's Social worker or just the person telling you)
- Could there be additional unmet need? Is an early support plan needed or already in place?
- Always verify and corroborate information with others either through face to face meetings or virtual meetings with all professionals involved in the child's care.
- Explore and understand what is happening within a family rather than making assumptions or accepting service users' versions of events or disclosures at face value. This is known as 'respectful uncertainty'.

Consider the information you are now aware of, does the information indicate that a child or young person is at risk? What has the person informing you done about this risk and is there any immediate action that should be taken. If you are not sure what to do, seek professional advice from your organisational Designated Safeguarding Leads, Police, Health or Social Care for their professional support immediately.

All parties should be reporting their concerns in a timely manner by various means:-

- With the social worker through their core group meetings if a child or young person is already on a child protection plan

- Their line manager/team lead or during supervision where valuable lessons can be drawn from prior experience of team members
- Through the independent scrutiny of a Safeguarding Supervisor/named Nurse

Professionals may at times appear reluctant to share such information wishing to protect the 'relationship' with the parent. It is natural for a practitioner to want to believe the best of a family and thinking the unthinkable does not mean assuming the worse. It means keeping an open mind, and being able to think objectively about the evidence presented. Always be prepared to accept information that does not fit with previous assumptions and assessments.

Those reluctant to share any new concerns with Children's Social Care must be actively encouraged to do so within a set time frame, 24-48 hours would be appropriate or earlier if required. If this does not happen and your concern for the child remains unchanged, then you should report those concerns yourself, stating when and where you heard the information. First-hand information is, in most instances, much more informative. Be clear in any referral that you make to Children's Social Care that the information is **third party** and you have informed that party of your intentions to complete a referral (eMARF) with their information as per policy. All issues discussed and actions taken must be documented in the RiO / Hospital records.

In the case of a member of the public giving you information about a child please advise them they can report safeguarding concerns anonymously to Children's Social Care, however unless it is unsafe to share this person's name etc the information about the concern should be shared with Children's Social Care as described above. Please discuss the individual situation with either the safeguarding team or your line manager.

Remember the reason we share information is to protect the welfare of a child or young person.

See appendix 1

Seven golden rules of information sharing

h. BSCB Multi-Agency Information Sharing Code of Practice

This Code of Practice outlines the principles and practice which govern the sharing of information between agencies, for the purposes of identifying, safeguarding and promoting the welfare and protection of all children and young people.

[Click here to download the Multi-Agency Information Sharing Code of Practice](#)

HM Government - Information Sharing Advice for Practitioners

This HM Government advice is non-statutory and has been produced to support practitioners in the decisions they take when sharing information to reduce the risk of harm to children and young people.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419628/Information_sharing_advice_safeguarding_practitioners.pdf

15 CONSENT AND CONFIDENTIALITY

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 must be the first consideration if deemed appropriate.

An overriding public interest would justify disclosure of the information (or that sharing is required by a court order, other legal obligation or statutory exemption). To overcome the common law duty of confidence, the public interest threshold is not necessarily difficult to meet – particularly in emergency situations. Confidential health information carries a higher threshold, but it must still be possible to proceed where the circumstances are serious enough. As is the case for all personal information processing, initial thought needs to be given as to whether the objective can be achieved by limiting the amount of information shared – does all of the personal information need to be shared to achieve the objective?

Not all information is confidential. Confidential information is information of some sensitivity, which is not public knowledge, and which has been shared in a relationship where the person giving the information understood that it would not be shared with others. For example, a teacher may know that one of his/her pupils has a parent who misuses drugs. That is information of some sensitivity, but may not be confidential if it is widely known or it has been shared with the teacher in circumstances where the person understood it would be shared with others. If, however, it is shared with the teacher by the pupil in a counselling session, for example, it would be confidential.

Confidence is only breached where the sharing of confidential information is not authorised by the person who provided it or to whom it relates. If the information was provided on the understanding that it would be shared with a limited range of people or for limited purposes, then sharing in accordance with that understanding will not be a breach of confidence. Similarly, there will not be a breach of confidence where there is explicit consent to the sharing.

Even where sharing of confidential information is not authorised, it may lawfully be shared if this can be justified in the public interest. Seeking consent must be the first option, if appropriate. Where consent cannot be obtained to the sharing of the information or is refused, or where seeking it is likely to undermine the prevention, detection or prosecution of a crime, the question of whether there is a sufficient public interest must be judged by the professional on the facts of each case. Therefore, where a professional has a concern about a child, he or she must not regard refusal of consent as necessarily precluding the sharing of confidential information.

A public interest can arise in a wide range of circumstances, for example, to protect children or other people from harm, to promote the welfare of children or to prevent crime and disorder. There are also public interests, which in some circumstances may weigh against sharing, including the public interest in maintaining public confidence in the confidentiality of certain services. The key factor in deciding whether or not to share confidential information is proportionality, i.e. whether the proposed sharing is a response in proportion to the need to protect the public interest in question. In making the decision, the professional 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

15.1 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 must always record the rationale for their decision.

15.2 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>

15.3 **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.

15.3.1 Further advice and information can be obtained from the **BSCB 'Fabricated or Induced Illness' Procedure (January 2013)**

<http://bscb.procedures.org.uk/qkqsy/children-in-specific-circumstances/fabricated-or-induced-illness-procedure-and-guidance>

And the Royal College of Paediatrics and Child Health '**Fabricated or Induced Illness by Carers (FII): A Practical Guide for Paediatricians**' (2009)

http://www.rcpch.ac.uk/system/files/protected/page/Fabricated%20or%20Induced%20Illness%20by%20Carers%20A%20Practical%20Guide%20for%20Paediatricians%202009_0.pdf

15.3.2 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.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/190235/DCSF-00277-2008.pdf

<http://webarchive.nationalarchives.gov.uk/20130401151716/https://www.education.gov.uk/publications/eOrderingDownload/DCSF-00277-2008.pdf>

15.4 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 Access to Health records 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 must 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 must 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.

15.4.1 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 must refer the matter to his/her manager and draw their attention to this guidance.

See: [Subject Access Request Policy v1.0 - BHT Pol 188](#)

16 MAKING A REFERRAL TO BUCKINGHAMSHIRE COUNTY COUNCIL CHILDREN AND FAMILY SOCIAL CARE

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.

BUCKINGHAMSHIRE SOCIAL SERVICES
FIRST RESPONSE TEAM
Telephone: 0845 460001
Local rate: 01296 383962
Out of hours – Emergency Duty Team – 0800 9997677
Secure email: secure-cyfirstresponse@buckinghamshire.gov.uk

- 16.1 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**
- 16.2 Patients/children/carers can speak to someone in confidence by phoning **ChildLine on 0800 1111**. This service is free at any time and must be displayed in prominent areas.
- 16.3 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, and 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)**
- 16.4 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 3.
- 16.5 As a matter of good practice, professionals must 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).
- 16.6 If staff are uncertain about a situation they must 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.
For more information and guidance:
http://swanlive/search/apachesolr_search/safeguarding%20children%20?filters=

- 16.7 The referral must be confirmed in writing within 48 hours using the Multi-agency referral form (MARF). This form can be down-loaded from <http://swanlive/staff-resources/safeguarding> or BSCB web-site www.bucks-lscb.org.uk. The referral must always make reference to the BSCB Threshold document <http://www.bucks-lscb.org.uk/professionals/thresholds-document/>. The form must be sent to the First Response secure email address via an nhs.net email account. **A copy must always be sent to the safeguarding children team** buc-tr.bhtchildprot@nhs.net for monitoring purposes.
- 16.8 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 Children's 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:
 - o If meets section 17 (Children Act 1989) threshold – Child in Need (CIN) transfer to CIN unit for assessment and the provision of services
 - o 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

17 ASSESSEMENTS UNDER THE CHILDREN ACT 1989

- 17.1 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.
- 17.2 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.
- 17.3 **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.

17.4 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 must be convened.

17.5 Initial child protection conference

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.

17.5.1 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.

17.5.2 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.

17.6 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 must be given sufficient recognition and priority in the assessment process. Further guidance:

Safeguarding Disabled Children - Practice Guidance (2009)

<https://www.gov.uk/government/publications/safeguarding-disabled-children-practice-guidance>

Recognised, valued and supported: Next steps for the Carers Strategy (2010)

<https://www.gov.uk/government/publications/recognised-valued-and-supported-next-steps-for-the-carers-strategy>

18 PREVENT

18.1 Radicalisation / Terrorism

18.1.1 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.

18.1.2 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.

18.1.3 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.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417943/Prevent_Duty_Guidance_England_Wales.pdf

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

19.1 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.

19.2 Professionals working with children, adults and families must 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.bucksiscb.org.uk/professionals/e-learning/>

Further information is available:

<http://webarchive.nationalarchives.gov.uk/20130401151716/https://www.education.gov.uk/publications/eOrderingDownload/ukccis%20advice%20on%20child%20internet%20safety.pdf>

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

20 SAFEGUARDING BABIES UNDER 1 YEAR

Babies are a particularly vulnerable group of children. Serious Case Reviews both locally and nationally identify this group as being at increased risk of significant harm and death due to non-accidental injury therefore it is particularly important that any injury to this group is considered carefully. Bruising in babies who are not independently mobile is rare and must raise suspicion of possible non-accidental injury requiring referral to Children's Services, a multi-agency strategy meeting and medical investigations including skeletal survey, CT head, ophthalmology review and blood tests for potential clotting disorders. It is also important to consider carefully the language used by parents and carers of this group. Comments such as "My baby bruises easily" or "I felt like shaking him" need further careful exploration with parents/carers as to what they meant. Comments such as this are of concern and could indicate that a parent has already harmed their child even if no injury is visible. If concerns remain after further exploration with parents/carers then consideration must be given to referral to Children's Services and/or further medical investigation. This must be discussed with the Named Doctor or Nurse wherever possible. When there are concerns regarding non-accidental injury in child under 1 year of age the parents/carers must be offered an information leaflet to explain what is happening and why.

21 IMAGING

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

Standards for Radiological Investigations of suspected Non-accidental injury (2008)

[https://www.rcpch.ac.uk/system/files/protected/news/StandardsforRadiologicalInvestigationsD\[1\].pdf](https://www.rcpch.ac.uk/system/files/protected/news/StandardsforRadiologicalInvestigationsD[1].pdf)

22 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.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.

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

22.1 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

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

<https://www.gov.uk/government/publications/safeguarding-children-in-whom-illness-is-fabricated-or-induced>

22.2 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 must 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/>

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

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/278849/Safeguarding_Children_and_Young_People_from_Sexual_Exploitation.pdf

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.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279511/step_by_step_guide.pdf

22.3 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 must be aware of these cases and would offer support to individual healthcare practitioners who may be involved.

Local information and guidance can be found at: http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-Procedures/March_2013_COMPLEX_PROCEDURES.pdf

22.4 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. From 31st 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 2).

See

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/469448/FGM-Mandatory-Reporting-procedural-info-FINAL.pdf

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>

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/>

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

National Guidance: <https://www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm>

22.5 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/>

The Government's Forced Marriage Unit produced guidelines and are available at www.adss.org.uk/publicaitons/guidance/marriage.pdf and www.homeoffice.gov.uk/comrace/race/forcedmarriage/index.html

23 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/> additionally if any of the local links below are broken please use this link to take you through to the full list.

23.1 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.

Local information and guidance can be found at: http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-Procedures/Children_Living_Away_From_Home.pdf

23.2 Children and families whose whereabouts are unknown

If a practitioner becomes aware of a family whose whereabouts is not currently known, they must make efforts to trace the family to ensure that any health needs are met. Liaison must 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.

Local information and guidance can be found at: http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-Procedures/Child_Families_whose_whereabouts_are_unknown.pdf

23.3 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.

Local information and guidance can be found at: http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-Procedures/Child_Families_living_in_temporary_accommodation.pdf

23.4 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 must 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

23.5 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 must 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>

23.6 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 must 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/>

National guidance:

http://www.privatefostering.org.uk/?gclid=CLvorZLL_qcCFUlkfAod9Tsatq and

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/274482/national_minimum_standards_for_private_fostering.pdf

23.7 Children in hospital

The National Service Framework for Children, Young People and Maternity Services (2004), sets out standards for hospital services.

- When children are in hospital this must 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, including Neonatal units. This will allow the LA to assess the child's needs and decide whether services are required under the Children Act 1989.

DISCHARGE FROM HOSPITAL –

A child about whom there are child protection concerns must not be discharged from hospital without the authorisation of the consultant paediatrician and the agreement of the social worker, who must be informed when discharge is being planned. On discharge, the discharge information form must be completed in full and the original filed within the records.

Children about whom there are child protection concerns must not be discharged until the social worker and health visitor/midwife have been informed as to when the child is to be discharged. This must be clearly recorded in the child's records.

Ideally children about whom there are child protection concerns must remain in hospital until the next working day so sufficient background information can be gathered. Discussions and the discharge arrangements must also be fully documented in the child's medical notes. When abuse or neglect is alleged, suspected or confirmed the child must not be discharged from hospital without a named GP. All children must have a discharge letter completed at the time of discharge on Evolve. – Obtain the child's discharge address. If the child is being fostered obtain the foster parents name and address or officer in charge if in residential home. Obtain the name and address of the foster parents GP. If the child is to be cared for by a member of the extended family obtain that person's name, address and GP. Ensure this information is kept confidential if the child is being fostered. The foster parents' address must be put on the system in "Postal address field". Contact ward clerk to do this. The following information must be included in the discharge plan: The names of the social worker (with contact telephone number), the school nurse and school, the health visitor and the children's community nurse, (if appropriate).

http://swanlive/sites/default/files/guideline_266.pdf

MISSED OUTPATIENT APPOINTMENTS – Children and Young People 0-18yrs

Children miss appointments for a variety of reasons. A letter must be sent to the parents, child/young person and GP to inform of non-attendance and the clinician will decide if another appointment is to be offered as per the Trust Access Policy. Should the child /young person not attend or not be brought in for a second time, then the consultant must make a decision to discharge or follow up through health visitor, school nurse or children's social services. If the child is subject to a Child Protection plan, then social services must be informed of non-attendance at appointments. If non-attendance at a hospital appointment impacts adversely on a child's health or development a referral must be made to Children's Social services. Discuss with the hospital safeguarding team if you have concerns that non-attendance to the appointment will have a negative impact on the child's health or if you require advice on referral.

23.8 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 must 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.

Local information and guidance can be found at: http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-Procedures/Abuse_of_Disabled_Children_Working_Together_to_Safeguard_Disabled_Children_Practice_Guidance.pdf

National Guidance: <https://www.gov.uk/government/publications/safeguarding-disabled-children-practice-guidance>

23.9 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 must always be taken as seriously as any abuse perpetrated by an adult. It must 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.

23.9.1 Work with children and young people who abuse others – including those who sexually abuse/offend – must 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 must be held responsible for their abusive behaviour, whilst at the same time be treated in a way that meets their needs whilst protecting others.

Local information and guidance can be found at: http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-Procedures/Children_who_Exhibit_Problematic_or_Harmful_Sexual_Behaviour.pdf

23.9.2 The Child and Harmful Behaviours Service (CAHBS) is a service for young people who sexually harm across Buckinghamshire and Oxfordshire. It is a high quality specialist service to children and young people across all sectors of care and agencies as part of the forensic child & adolescent mental health service. See link: <http://www.oxfordhealth.nhs.uk/children-and-young-people/bucks/child-and-adolescent-mental-health-services-camhs-tier-2-3/child-adolescent-harmful-behavioural-service-cahbs/>

23.10 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 must 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.

Local information and guidance can be found at: <http://www.bucks-lscb.org.uk/professionals/safeguarding-children-affected-by-gang-activity/>

National guidance <https://www.gov.uk/government/publications/safeguarding-children-and-young-people-who-may-be-affected-by-gang-activity>

23.11 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 must have in place rigorously enforced anti-bullying strategies.

Local information and guidance can be found at: <http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-Procedures/Bullying.pdf>

National guidance: <https://www.gov.uk/government/publications/preventing-and-tackling-bullying>

23.12 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 must be done on a multi-agency basis.

Local information and guidance can be found at: http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-Procedures/Children_whose_behaviour_indicates_a_lack_of_parental_control.pdf

23.13 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.

Local information and guidance can be found at: http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-Procedures/Race_and_Racism.pdf

23.14 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 children and families must 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 must 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>

23.15 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

23.16 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 must look for indicators and be able to identify children at risk of this type of abuse and intervene to prevent it. They must 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/>

National guidance: <https://www.gov.uk/government/publications/national-action-plan-to-tackle-child-abuse-linked-to-faith-or-belief>

24 Child Protection - Information Sharing (CP-IS)

The 'Child Protection - Information Sharing' System is a National project that will improve the way that health and social care services work together across England to protect vulnerable CP-IS links the IT systems of NHS unscheduled care to those used by social care child protection teams, so that information can be shared about three specific categories of child: those with a child protection plan those classed as looked after (i.e. children with full and interim care orders or voluntary care agreements) any pregnant woman whose unborn child has a pre-birth protection plan. All children who attend the hospital Emergency Department or Minor Injuries/Urgent care Centre are checked on the national spine to establish if they have a child protection alert. This is checked by the administrative staff at booking into ED. To provide backup for any systems failure and as a safety netting procedure nursing staff at triage also ask the question of whether a child or young person has a Social Worker. If a child has a child protection plan or is a looked after child, the Children's Social Care Department will be notified of all attendances. If any practitioner has a concern about the child both the out of hours and in hours phone numbers for that particular Social Care department will be on the CP-IS child care alert, Social Care must be contacted. In the event of a child who is on a Child Protection Plan presenting with an injury, contact must be made to the children's social care team prior to discharge to establish if a strategy meeting is needed to ensure the child's safety. (See appendix 5).

25 ESCALATION, CHALLENGE AND CONFLICT RESOLUTION

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 Climbié (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 must also follow these procedures.

See BSCB Procedure - Escalation, Conflict Resolution between Practitioners or Agencies <http://www.bucks-lscb.org.uk/>

See further information see within Safeguarding children pages and Safeguarding children procedures <http://swanlive/>

26 SERIOUS CASE REVIEWS (SCRs) AND INTERNAL CASE REVIEWS

26.1 Serious Case Reviews

26.1.1 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/>

26.1.2 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 must **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

26.1.3 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.

26.1.4 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.

26.1.5 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.

26.1.6 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.

26.1.7 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.

26.2 Internal Case Reviews

26.2.1 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.

26.2.2 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.

26.2.3 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.

26.2.4 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.

26.2.5 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 Quality and Governance Committee and the Board as appropriate. The designated professionals will monitor the implementation of the action plan.

27 TRAINING

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;

- 27.1 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.
- 27.2 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 must be obtained from the Designated Nurse within Buckinghamshire CCGs.
- 27.3 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 statutory and essential training undertaken for Trust employees to be maintained by the Education, Learning and Development Department.

Details for Education and Learning can be found on the Trust Intranet

28 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 must be seen to operate effectively at all levels of an organisation (Laming, 2003)

28.1 Definitions

28.1.1 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.

28.1.2 **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.

28.2 Working Together to Safeguard Children (HM Government 2015) states Effective professional supervision can play a critical role in ensuring a clear focus on a child’s welfare. Supervision must support professionals to reflect critically on the impact of their decisions on the child and their family.

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

See Trust policy for Safeguarding and child protection supervision

http://swanlive/sites/default/files/bht_pol_174_-_safeguarding_child_protection_supervision_policy_v1.2_rvw_10_2018.pdf

29 MONITORING AND AUDIT

The policy will be monitored through the following means:

What will be monitored and/or standard to be achieved	How/ Method	Frequency	Lead	Reported to	Deficiencies/ gaps recommendations and action plans followed up by	Implementation of any required change the responsibility of
Completion of MARF (referrals to social care) forms	Audit	6 monthly internally Annually with CSC	Safeguarding Children Team	Safeguarding Committee via Dashboard	For ED referrals discussion at ED/Paeds Solutions in Safeguarding group. Audit yearly with S/Care	Safeguarding Children Team
Completion of Safeguarding information sharing	Audit	Quarterly	Paediatric Liaison Nurse	Safeguarding children steering group Quality	Paediatric Liaison Nurse	Paediatric Liaison Nurse

forms				Committee (via the Quarterly / annual report)		
Training compliance for trust staff	Report from ESR / ELD	Monthly	Safeguarding children team	Safeguarding children steering group Safeguarding Committee via Dashboard Quality Committee (via the Quarterly / annual report)	Safeguarding children team	Learning and Development team
Safeguarding and child protection supervision compliance	Audit	Quarterly	Lead named nurse for safeguarding children	Safeguarding children steering group Safeguarding Committee Quality Committee (via the Quarterly / annual report)	Safeguarding committee	Safeguarding committee
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 Committee via Dashboard Quality Committee (via the Quarterly / annual report) BSCB	Safeguarding Directorate Lead & Lead Named Nurse for Safeguarding Children	Safeguarding Directorate Lead
----------------------	--------	---------	--	---	--	-------------------------------

30 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_in_formation-effective_clinical_supervision_for_publication.pdf

Carers Act (1995) London: HMSO <http://www.legislation.gov.uk/>

Carers and Disabled Children Act (2000) London: HMSO <http://www.legislation.gov.uk/>

Children Act 1989 London: HMSO <http://www.legislation.gov.uk/>

Children Act 2004 London: HMSO <http://www.legislation.gov.uk/>

Department of Health (2000) *Framework for Assessment of Children in Need and their Families*. London: The Stationary Office.

Equality Act (2010) London: HMSO <http://www.legislation.gov.uk/>

Health and Social care act (2008) London: HMSO <http://www.legislation.gov.uk/>

HM Government (2015a) *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children*. London: The Stationery Office

HM Government (2015b) *Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers*. London: The Stationery Office

Lord Laming (2003) *The Victoria Climbié Inquiry: Report of an Inquiry by Lord Laming*. London: The Stationary Office.

Mental capacity Act (2005) London: HMSO <http://www.legislation.gov.uk/>

NHS England (2015) Safeguarding Vulnerable People in the NHS – Accountability and Assurance <http://www.england.nhs.uk/wp-content/uploads/2015/07/safeguarding-accountability-assurance-framework.pdf>

RCPCH (2014) *Safeguarding Children and Young People: roles and competencies for health care staff: intercollegiate document* London: RCPCH.

United Nations Convention on the Rights (1989) http://www.unicef.org/crc/index_30177.html

31 BIBLIOGRAPHY

Department for Education (2011) *The Munro Review of Child Protection: Final Report A child centred system* Presented to Parliament by the Secretary of State for Education by Command of Her Majesty.

Department for Education and Skills, Department of Health (2004) *National Service Framework for Children, Young People and Maternity Services*. London: DH (Core Standard Five). <https://www.gov.uk/government/publications/national-service-framework-children-young-people-and-maternity-services>

General Medical Council (2012) *Protecting Children and Young People: The responsibilities of all doctors*. London: General Medical Council.

HM Government (2015) *What to do if you're worried a Child is being abused*. London: Department for Education and Skills.

Laming (2009) *The Protection of Children in England: A Progress Report*. <https://www.gov.uk/government/publications/every-child-matters>

Munro, E. (2011) *The Munro Review of Child Protection: Final Report A child-centred system* Professor Eileen Munro. London: TSO.

NICE clinical guideline 89: NHS National Collaborating Centre for Women's and Children's Health Clinical Guideline *When to suspect maltreatment* (2009) London: Royal College of Obstetricians and Gynecologists (RCOG). www.nice.org.uk/nicemedia/pdf/CG89FullGuideline.pdf

APPENDIX 1; Seven golden rules for information sharing

1 Remember that the Data Protection Act 2018 and human rights law are not barriers to justified information sharing, but provide a framework to ensure that personal information about living individuals is shared appropriately.

2. Be open and honest with the individual (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

3. Seek advice from other practitioners if you are in any doubt about sharing the information concerned, without disclosing the identity of the individual where possible.

4. Share with informed consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, there is good reason to do so, such as where safety may be at risk. You will need to base your judgement on the facts of the case. When you are sharing or requesting personal information from someone, be certain of the basis upon which you are doing so. Where you have consent, be mindful that an individual might not expect information to be shared.

5. Consider safety and well-being: Base your information sharing decisions on considerations of the safety and well-being of the individual and others who may be affected by their actions.

6. Necessary, proportionate, relevant, adequate, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those individuals who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely (see principles).

7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

APPENDIX 2; BHT 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.**  01296 566079
- **Paediatric Liaison nurse:**  01269 566079
- **Named Midwife for Child Protection Buckinghamshire Healthcare:**  01296 316217
- **Named Doctors Child Protection Buckinghamshire Healthcare**  01296 566079
- **Designated Nurse Child Protection/Safeguarding Lead Buckinghamshire CCG**
 01296 585916

Social Care

First Response	01296 383962
Emergency Duty Team (Countywide, Out of Office Hours)	0800 9997 677
General Enquiries	0845 370 8090

APPENDIX 3; 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

Safeguarding Children Policy BHT Pol 149

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**

APPENDIX 4; Assessing Gillick/Fraser Competence

Young people aged 16 years and over are presumed in law to be competent to consent to medical treatment. Under 16 years competence needs to be assessed in each case.

All children and young people must be involved in decisions relating to their care. For a young person under 16 years to be competent they must have:

- The ability to understand the choices and those choices have consequences
 - An understanding of the alternatives to the proposed intervention, and the risks attached to them
 - The ability to weigh the information and arrive at a decision
 - An understanding of the nature and purpose of the proposed intervention
 - An understanding of the proposed intervention's risks and side effects
 - An understanding of the alternatives to the proposed intervention, and the risks attached to them
 - Freedom from undue pressure
- Competent under 16 year olds is referred to as Gillick or Fraser competent. Health professionals who assess competence need to be skilled and experienced in interviewing young patients and eliciting their views without distortion. The treating doctor is often the most appropriate person.

Key guidance General Medical Council. 0-18 years: guidance for all doctors.

Available at www.gmcuk.org BMA.

Consent, rights and choices in health care for children and young people. Further information at www.bma.org.uk/ethic

APPENDIX 5; Child Protection - Information Sharing (CP-IS)

Every child/young person (0-18 years of age), who attend our Emergency Department will be checked against the NHS SCRa Spine Portal for any Child Protection Alerts:

Child care tab NOT visible on SCR search.



Consider the following:
Is the child out of area?



The child is not currently on a child protection plan and there are no concerns with the presentation.

Child Care Alert tab IS visible.
POSITIVE RESULT



Reception staff

- Print off CP information & secure to paper Cas cards.

Clinicians:

- Does this presentation require a call to Childrens social care?

Child Protection Information System (CP-IS)

CP-IS will share information for those who are:

- **Subject to a Child Protection Plan (CCP) with start date**
- **If CP plan has ended the information stays on for 365 days.**
- **Looked after Children (LAC)**
- **A pregnant woman whose unborn child has a CPP.**

A guide for clinicians:

What is the information telling you?

- CP plan is currently in place and an assessment of the presentation needs to be made.
- More direct/ relevant questions from family and/or the child around the current plan in place can be helpful.
- Has the CP plan recently been closed?
- Who is supporting the child at this time?
- Remember vulnerability when stepping down from CP.

LAC-or Unborn: These are some of our most vulnerable Women & children.

Some points to remember –

No NHS number match on Summary care record will return a message stating 'no patients match the information provided'- the information is generated by GP- have they registered?

Unscheduled care setting the CP-IS alert is visible, a notification is sent to the child's social worker within the local authority that the child originates from.

The system will automatically retain an audit of who has accessed the record, when this was done and from where. This information can also be viewed at each presentation – a record of any access can be seen at each booking within health settings.

re

APPENDIX 6

NEW GUIDANCE Version Control

Date	Version No	Summary of Changes	Changes Made by <i>(Name and Job Title)</i>
2017	V1.0	Initial Issue	Gerry Linke Lead Safeguarding Nurse Children Kate Bulbeck Lead Nurse Paediatrics
June 2017	V2.0	Social Care Initial Input	Sandra Carnall Practice Improvement Manager Children's Services
August 2017	V3.0	Add flow chart	Gerry Linke Lead Safeguarding Nurse Children
November 2017	V4.0	EIA	Gerry Linke Lead Safeguarding Nurse Children

1 Introduction

This protocol adheres to Working Together to Safeguard Children (2015) requirements, to ensure safety in cases where children are cared for in acute hospitals and there are safeguarding concerns relating to their contact with their parent /carers. All services working with children and their families have a responsibility to safeguard and promote their welfare. This guidance is informed by the requirements of The Children Act 1989 and 2004. It reflects the principles contained within the United Nations Convention on the Rights of the Child, ratified by the U.K. Government in 1991. The guidance takes account of the European Convention of Human Rights, particularly Articles 6 and 8, which was incorporated into UK domestic law on 02 October 2000 and Bucks Safeguarding child protection procedures: <http://www.bucks-lscb.org.uk/>

2 Purpose of this Guidance/Procedure

There is a need for a common understanding between agencies of how we can work together to reduce risk that accepts shared ownership of challenges and joint ownership of risk.

This protocol aims to provide guidance to be followed when a child or young person is admitted to hospital (either planned or emergency) where there is a need to supervise the contact they have with family members in order to keep them safe from harm.

All agreed contact with children and their parents and carers in the hospital environment, when risk is identified, is the responsibility of Children's Services and hospital staff cannot be used for social supervision purposes.

This guidance can be applied to any area where children are being cared for in including: paediatric wards, maternity units, high dependency units, neonatal intensive care baby units, and Emergency Departments and outpatient departments.

3 Principles

To promote contact with the child's family and carer when it is safe to do so.

To ensure the child's best interests and safety are always a priority.

It is acknowledged that safeguarding children is the responsibility of all agencies. To ensure the safety of all children within the hospital environment.

4 Scope

It is normally in the interests of a child to have contact with parent/carer/significant adult when in hospital. In some situations it is in the child's interests/safety to restrict or stop contact.

Situations where consideration needs to be given to contact arrangements being made include:

- i. Adult may pose a risk to a child.
- ii. There is evidence of significant harm to a child previously or currently.
- iii. Restriction indicated in a Child Protection plan that is in place.
- iv. Previous court orders limiting or detailing contact arrangements.
- v. Current Care Orders in place.
- vi. Direct contact is considered by agencies a risk to a child.
- vii. Adult carer's behaviour is considered inappropriate/dangerous and causing distress to the child.

5 Role of the Managers

Line managers are responsible for:

- Understanding their role and responsibilities to ensure the safety of children that are vulnerable in your care
- Have a working knowledge of Working Together to Safeguard Children (2015) and its implementation on their practice when safeguarding children.
- Demonstrates skills and knowledge to contribute effectively to the safeguarding process.
- Awareness and application of a range of local and national guidance and procedural frameworks when undertaking safeguarding activity.

- Ensure service users / carers are supported appropriately to understand safeguarding issues to maximise their decision making.
- Understand when to use emergency systems to safeguard children
- Maintain accurate, complete and up-to-date records

6 Children admitted to hospital with suspected non-accidental injury (NAI)

6.1 If it is felt that the child may have suffered harm or be at risk of suffering harm a strategy discussion/meeting must take place between the Children's Services, Police, Health and other relevant professionals as soon as possible following admission. Part of the strategy discussion/meeting is the consideration of the level of risk the family members may pose to the admitted child and the medical consent issues. Hospital staff must ensure that the outcome of the decision regarding supervision of the parents and the people carrying out the supervision is documented in the child's health record. There must be a contact plan (See appendix 1).

6.2 If the child's admission is outside of normal working hours this must not prevent the meeting from occurring. It is reasonable for this to be via telephone if appropriate. Hospital staff must ensure this conversation is documented in the child's health record if appropriate with the relevant out of hours service.

6.3 Until such time as the strategy discussion/meeting has taken place, hospital staff must follow the Trust's risk management procedures in ensuring the safety of the child. If the decision of the strategy discussion/meeting requires parents to leave the hospital then all the relevant medical and care information must be requested from the parents prior to them leaving, for example: medical factors such as known allergies, child care issues such as bedtime and feeding routine or any other special circumstance pertaining to the child.

6.4 If the decision of the strategy meeting/discussion is that supervision of the parents is necessary on the ward due to the risk they pose to the child then Children's Services are responsible for making the arrangements for that supervision. This could include the use of family members to supervise the contact if the strategy discussion/meeting deemed this to be safe. Hospital staff must not be used for the supervision purposes.

If appropriate supervision cannot be identified, it should be clearly understood that on some occasions a decision may be reached that the parent or relevant person may be unable to visit /have access to the child during the relevant period. The decision to do so is a serious one with potentially detrimental consequences to the child's immediate wellbeing and demeanour; however there are occasions when this is in the best safeguarding interests of the child.

6.5 All discussion and decisions must be clearly documented in the child's health record by health staff and on the relevant case management systems by all other agencies involved.

6.6 Children's Services are responsible for informing Health staff of any deviations from the agreed contract plan, any such changes must be put in writing to ward staff so that the ward have the full recorded facts and decisions. Both ward staff and Children's Services are expected to record these changes in their respective agency records.

7 Children requiring planned admission to hospital (when contact is already supervised in the community)

If a child is having supervised contact with their parent it is probable that the child is either looked after by the Local Authority or is being cared for by relatives/friends. This should be confirmed and discussed within the admission planning process

7.1 As far as is possible all planning for the admission needs to be carried out prior to admission taking place. This includes compilation of supervision plans. There must be an acceptance from all the specific agencies that if parents require supervised contact with their child outside of hospital then the supervision of contact should be put in place during hospital admission/attendance unless there is documented reason as to why this does not need to occur.

7.2 Prior to planned admission a multi-agency meeting or discussion must occur to provide a forum in which information about the family and the risks which they pose can be shared and any requirement for supervision will be discussed and agreed.

7.3 As far as possible parents should be kept informed of the supervision arrangements. The decision of the meeting will be relayed to the parents by the social worker.

7.4 Children's Services is responsible for making arrangements for supervision if it is necessary. This could include the use of family members to supervise contact if the strategy discussion/meeting deemed this to be safe. Hospital staff must not be used for supervision purposes.

8 Children requiring emergency admission to hospital (when contact is already supervised in the community)

8.1 It is acknowledged that the emergency admissions for children present an unknown risk and it may take some time to establish if the child is known to Children's Services.

8.2 When Health staff become aware there are child protection concerns regarding a child and family they must liaise with Children's Services or the child's Social Worker directly to establish what contact arrangements are in place.

8.3 If supervised contact agreements are in place in the community then it needs to be established how supervised contact will continue in the hospital.

9 Basic Principles of parental/carers supervised contact within the acute hospital setting

9.1 In emergency situations i.e. the child becomes acutely unwell/injured; Health staff must make immediate contact with parent/carers and inform the social worker or Emergency Duty Team as soon as possible. It is anticipated that in this instance a parent may wish to attend the hospital to see their child. Supervision between the child and parents must still occur but it may be appropriate for health staff to supervise for a short period and then ask the parents to leave. A Multi-agency discussion should take place to agree all aspects of the contact as soon as possible.

9.2 Any deliberation in relation to the contact between children and their families must consider what actions are in the child's best interests, ensuring that the child's needs are paramount as defined in the Children's Act (2004).

9.3 Where possible the wishes of the child should be considered and kept central to all discussions.

9.4 Children’s Services is responsible for making the arrangements for supervision if it is necessary. This could include the use of family members to supervise contact if the strategy discussion/meeting deemed this to be safe. Hospital staff must not be used for supervision purposes.

9.5 If at any point during the child’s hospital admission concerns are raised that the wellbeing of the child or ward environment is being jeopardised by the parents/carers, immediate protective steps must be taken to safeguard the child and the environment; for example removing the parents from the room to calm down or requesting they leave the ward area. If parents/carers fail to comply with requests then the Hospital security/police assistance should be considered. Health staff must inform Children’s Services of any incidents and action taken.

9.6 Immediate police assistance via 999 must be sought if a parent attempts to remove the child from the ward setting without agreement.

10 Glossary

Child	As defined in the Children Act (1989) a child is considered as being less than 18 years of age
Contact	For the purposes of this guidance contact is taken to mean the time that a parent/carer spends directly with their child
Supervision of Contact	When a third person constantly monitors the contact between a parent/carer and their child to ensure the child’s safety
Non Accidental Injury (NAI)	An injury that has been inflicted to a child and was not caused accidentally
S47	Section 47 of the Children’s Act (1989) place a duty of care on Local Authorities to investigate and make inquiries into the circumstances of children thought to be at risk of “significant harm” and where these injuries indicate the need, to safeguard and promote the child’s welfare
Strategy Discussion/Meeting	Children’s Services must hold a Strategy Discussion whenever there is a reasonable cause to suspect that a child has suffered or is likely to suffer significant harm . This may be following a <ul style="list-style-type: none"> • A referral (eMARF) • A Children’s and Families assessment • When a child is already receiving support services • If concerns about significant harm to the child emerge; any agency may request that Children’s Services convene a strategy discussion.

Appendix A - Contact arrangements plan to be added to medical records

Name of Child:	
Name of Social Worker:	
Contact details of Social worker:	

It is the responsibility of the Named Social Worker to inform Ward Staff of contact arrangements and Supervision planned and of any changes to these arrangements so that the plan can be updated.

Date and Time of Contact	People taking part in contact	People excluded from contact with the child	Supervisor

Appendix B Flow chart of the procedure when a child or young person is admitted to hospital and there are safeguarding concerns

