Thinking Differently

NHS
Dudley
Clinical Commissioning Group

SAFEGUARDING AND LOOKED AFTER CHILDREN POLICY

(INCLUDING PRACTICE GUIDANCE)

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REVIEWERS
This document has been reviewed by:

NAME	DATE	TITLE/RESPONSIBILITY	VERSION
Pauline Owens	April 2013	Designated Senior Nurse Safeguarding	V1
Su Vincent	July 2014	Designated Senior Nurse Safeguarding	V2
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APPROVALS
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NAME	DATE	VERSION
Quality and safety Committee	April 2013	V1
Designated Senior Nurse Safeguarding	July 2014	V2
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NB: The version of this policy posted on the intranet must be a PDF copy of the approved version.

DOCUMENT STATUS
This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of the document are not controlled.

RELATED DOCUMENTS
These documents will provide additional information:

Contents

1.0 INTRODUCTION

1.1. Dudley Clinical Commissioning Group (CCG), as with all other NHS bodies, has a statutory duty to ensure that it makes arrangements to safeguard and promote the welfare of children and young people (including those looked after) that reflect the needs of the children they deal with. Section 11 of the Children Act 2004 places CCG's under a statutory duty to ensure that, in discharging their functions they have regard to the need to safeguard and promote the welfare of children. In order to fulfil its responsibilities effectively Dudley CCG promotes the following general principles as set out in 'Working Together to Safeguard Children' HM Government 2015:

- Ensure that all affected children receive appropriate and timely therapeutic and preventative interventions.

- Professionals who work directly with children should ensure that safeguarding and promoting the child's welfare, forms an integral part of all stages of care they offer.

- Professionals who come into contact with children, parents and carers in the course of their work also need to be aware of their safeguarding responsibilities, ensuring that all health professionals can recognise risk factors and contribute to reviews, enquiries and child protection plans, as well as planning support for children and providing on going promotional and preventative support through proactive work.

- Safeguarding children's standards should be included in all clinical contracts.

1.2 This Policy supports national legislation and guidance, together with local policies and procedures. It should be read in conjunction with the electronic Dudley Safeguarding Board Child Protection Procedures which can be found at http://westmidlands.procedures.org.uk/ .These multi-agency procedures should not be downloaded as the web-based site is constantly being reviewed to reflect current legislation and guidance.

2.0 PURPOSE

2.1 The purpose of the policy is to enable staff who come into contact with children and families to recognise and act on concerns for the welfare of a child. It should be read in conjunction with local multi-agency procedures in order to promote best practice and to reflect how well Dudley CCG works effectively with its partner agencies.

3.0 SCOPE OF THE POLICY

3.1 This policy applies to all CCG staff and private contractors including GP member practices and volunteers working within the organisation including celebrity or fundraising volunteers. Provider organisations may have their own safeguarding policies in place (as per the National Standard Contract and section 11 of the Children Act 2004) but can also refer to this policy for guidance.

3.2 The policy includes information regarding the practical management of safeguarding concerns for those members of staff who work with children and families.

3.3 All service providers who have safeguarding children's standards included in their contracts must comply with the annual and or quarterly returns of performance information as appropriate to their contract. It is the responsibility of the contract manager to monitor

compliance and inform the designated safeguarding children's professionals of any problems.

3.4 This policy refers to all children up to 18 years of age (including the unborn) regardless of nationality, culture or religion. If the child has 'learning disabilities' or is a care leaver' their needs may extend to their 21st birthday (section 9 children Act 2004). The term 'children' will be used throughout this policy to refer to children and young people'.

3.5 The children may be service users in their own right or children cared for by adults who are receiving health services. It also covers other children in the wider community that come to the attention of staff in the course of their work, e.g. children on holidays, travellers, asylum or migrant children, those privately fostered or families not registered with GPs.

3.6 The principles in this document will provide support, advice and guidance to staff regarding their safeguarding and looked after children responsibilities through early identification and appropriate information sharing and referral. As such this policy should be read by all staff and will be referred to in the Level 1 safeguarding training delivered as mandatory training to all employed staff upon induction.

3.7 Dudley CCG will work closely with the NHS England (NHSE) who will have the statutory duty and responsibility to work with independent contractors' i.e. GP's dentists, opticians and pharmacists to safeguard and protect children within the borough. This will include engaging with the Care Quality Commission (CQC) in the implementation of their '2009 guidance about compliance: essential standards of quality and safety 'specifically outcome 7. GP's dentists, opticians and pharmacists are also free to use this policy in the course of their work.

4.0 KEY PRINCIPLES

- ✓ The welfare of the child is the paramount consideration
- ✓ Wherever possible, children should be brought up and cared for within their own families
- ✓ Parents with children in need should be helped to bring up their children themselves; this help would be provided as a service to the child and his family and should:
    - Be provided in partnership with the parents;
    - Meet each child's identified needs
    - Be appropriate to the child's race, culture, religion and language
    - Be open to effective independent representations and complaints procedures
    - Draw upon effective partnership between the local authority and other agencies, including voluntary agencies.

5.0 RELEVANT LEGISLATION AND STATUTORY GUIDANCE

5.1 Safeguarding continues to have a high national priority and this has been escalated following recent events with even greater scrutiny of the way in which organisations execute their safeguarding responsibilities. This policy will govern how services are provided, managed and monitored and is directed by (but not limited to) the following:

- The Children Acts 1989 and 2004.
- HM Government 2007. Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004. London: DFES
- Working Together to Safeguard Children (DoE 2015)
- When to suspect child maltreatment NICE 2009.
- DFE (2015) Information Sharing: Guidance for practitioners and managers, London: DFE

- Data Protection Act 1998.
- RCPCH (2014) Intercollegiate Document: Safeguarding Children and Young People: Roles and competencies for healthcare staff
- Care Quality Commission Safeguarding Adults and Children standards
- Protecting Children and Young People: the responsibilities of all doctors. (GMC, 2012)
- Safeguarding Vulnerable people in the NHS Accountability and Assurance Framework (NHSE 2015)
- Adoption and Children Act 2002
- National Service Frameworks (2004) Standard 5
- Health and Social Care Act(2012)
- Safeguarding Children and Young People: roles and competencies for health care staff. Intercollegiate document (2014)
- Public Law Outline (2008)
- The Sexual Offences Act 2003
- Female Genital Mutilation Act 2003
- Human Rights Act 1998
- Safeguarding Vulnerable Groups Act 2006
- The Adoption and Children Act 2002.

6.0 DEFINITIONS

6.1 Working Together to Safeguard Children (2013) recognises 4 categories of abuse these are;

- Physical,
- Emotional,
- Neglect
- Sexual

6.2 It also provides definitions for the levels of support children can experience moving through the safeguarding agenda. **Appendix 1** has these full definitions.

7.0 SAFER RECRUITMENT

7.1 Recruitment policies and procedures must comply with all relevant legislation and guidance relating to staff working with children. All statutory and public organisations (including non-regulated activity) which employ staff and/or volunteers to work with or provide services for children have a duty to safeguard and promote the children's welfare. This includes ensuring that safe recruitment and selection procedures are adopted and that at least one member of the panel must have undertaken safe recruitment and selection training and one who is knowledgeable and experiences in safeguarding and child protection issues.

7.2 Further information can be found following the link below.
http://westmidlands.procedures.org.uk/pkplz/regional-safeguarding-guidance/recruitment-supervision-and-training/

Disclosure and Barring Service (DBS)

7.3 The (DBS) replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA). Their core purpose is to prevent unsuitable people from working or volunteering with children and vulnerable adults by providing a registration system with continuous updating of their criminal history information for the ISA.

7.4 The key changes to the disclosure and barring scheme include:

- abolishing registration and monitoring requirements
- redefining the scope of 'regulated activities' - those are the activities involving close work with vulnerable groups, including children, which a barred person must not do
- abolishing 'controlled activities'

7.5 A barring function will be maintained. The definition of a "regulated activity" in relation to children is narrowed and covers fewer job roles. **However Healthcare provision (including physical and mental health care) remains a regulated activity and staff will require a DBS check.** There is no statutory guidance on how often the checks have to be completed however best practice would suggests an annual self-disclosure from the staff member.

7.3 All staff working in a regulated position would require the DBS check at an enhanced level to include the barred list check. Any exceptions to this will be flagged to the Designated Nurses and CCG board lead for safeguarding. Members of the CCG should have a DBS check as appropriate to their role and the CCG Board will require an enhanced DBS. The Designated Senior Nurse and Safeguarding Lead must have an enhanced DBS with barred list check.

7.4 Further information can be found below
https://www.gov.uk/disclosure-barring-service-check/overview

- Under the Safeguarding Vulnerable Groups Act (2006), all employers must be registered with the Independent Safeguarding Authority (ISA) and comply with the vetting and barring scheme;
- There should be a system in place to ensure that managers who are interviewing for posts involving working with children and adults at risk have attended Safer Recruitment Training;
- All job descriptions should reflect requirements for staff to have due regard for safeguarding;
- A Named Senior Officer (NSO) must be identified who will lead on allegations against staff working with children. The NSO must ensure any allegations involving children in work or personal life are reported to Local Authority Designated Officer and Designated Nurse;
- There are transparent systems in place to enable staff, patients and families to raise concerns that impact on the welfare or safeguarding needs of individuals or groups. These should be clearly available to all who come into contact with the service.

8.0 ROLES AND RESPONSIBILITIES

8.1 Working Together to Safeguard Children (2015) sets out the roles and responsibilities of all organisations with regard to safeguarding children, and provides the statutory guidance for all health organisations. The roles and responsibilities of CCG staff can be found at **Appendix 2**

8.2 All Staff - Including Managers

- This policy is designed to support staff in their safeguarding and child protection duties and to ensure managers take responsibility for the actions of their entire staff.
- Managers are responsible for ensuring that practice reflects the standards laid out within this policy and that staff are given adequate resources and support to comply with them.
- All staff are responsible for ensuring that they are aware of the requirements to safeguard children incumbent upon them and for ensuring that they comply with these.
- All staff involved in the commissioning of services must consider this policy when they develop and commission services and must include the safeguarding children standards in all contracts that have contact with adults or children.

- All staff have a responsibility to inform senior managers or the safeguarding team of any child protection or safeguarding concerns. Managers have a responsibility to ask staff about their child protection /safeguarding workloads, to ensure safe working.
- Managers must ensure that Safeguarding Children Policy practices are in place within the organisation. They must also escalate any concerns about resources or staffing impacting on implementing safeguarding procedures.
- Managers are responsible for ensuring that staff are aware of and can access this policy and the multi-agency safeguarding procedures via the following link http://westmidlands.procedures.org.uk/
- Staff should also have access to 'What to do if you're worried a child is being abused" (DFE 2015) https://www.gov.uk/government/publications/what-to-do-if-youre-worried-a-child-is-being-abused--2

8.3 All employees of the CCGs, partner practices and contracted support services e.g. CSU, must be mindful of their responsibility to safeguard children. Therefore, all staff must be up to date with the appropriate level of safeguarding children training as set out in the Intercollegiate Document (2014).

Primary Care

8.4 GP practices must have a lead and deputy lead for safeguarding who must work closely with the CCG Named GP and Designated Professionals to address quality issues in relation to safeguarding children. GP practices must maintain an up to date list of staff training in relation to safeguarding. GPs must ensure that they contribute effectively to children in need of support or protection, including provision of reports for child protection conferences.

9.0 MANAGING ALLEGATIONS OF ABUSE MADE AGAINST STAFF

9.1 Working Together to Safeguard Children (2015) highlights the statutory guidance placed on the Dudley MBC to manage allegations of abuse made against staff. Each member organisation of the Dudley Safeguarding Children Board must follow these guidelines if a report is received about an allegation or a concern that a professional 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 in an inappropriate way towards a child which may indicate that he or she is unsuitable to work with children.

9.2 Dudley Child Protection Procedures must then be followed.
http://westmidlands.procedures.org.uk/ykpzy/statutory-child-protection-procedures/allegations-against-staff-or-volunteers/#s579

9.3 Additionally these procedures may be used:

- If there are concerns about the person's behaviour towards their own children or children unrelated to their employment or voluntary work, and there has been a recommendation from a strategy discussion that consideration should be given to the risk posed to children they work with.
- When an allegation is made about abuse that took place some time ago and the accused person may still be working with or having contact with children.

Professionals Must:

- Report it to the Designated Officer for allegations, as soon as possible. In Dudley CCG these are the Designated Nurse for Safeguarding Children and the Chief Nurse who will

liaise with the Head of Organisational Development and Human Resources and refer the case to the Local Authority Designated Officer (LADO).

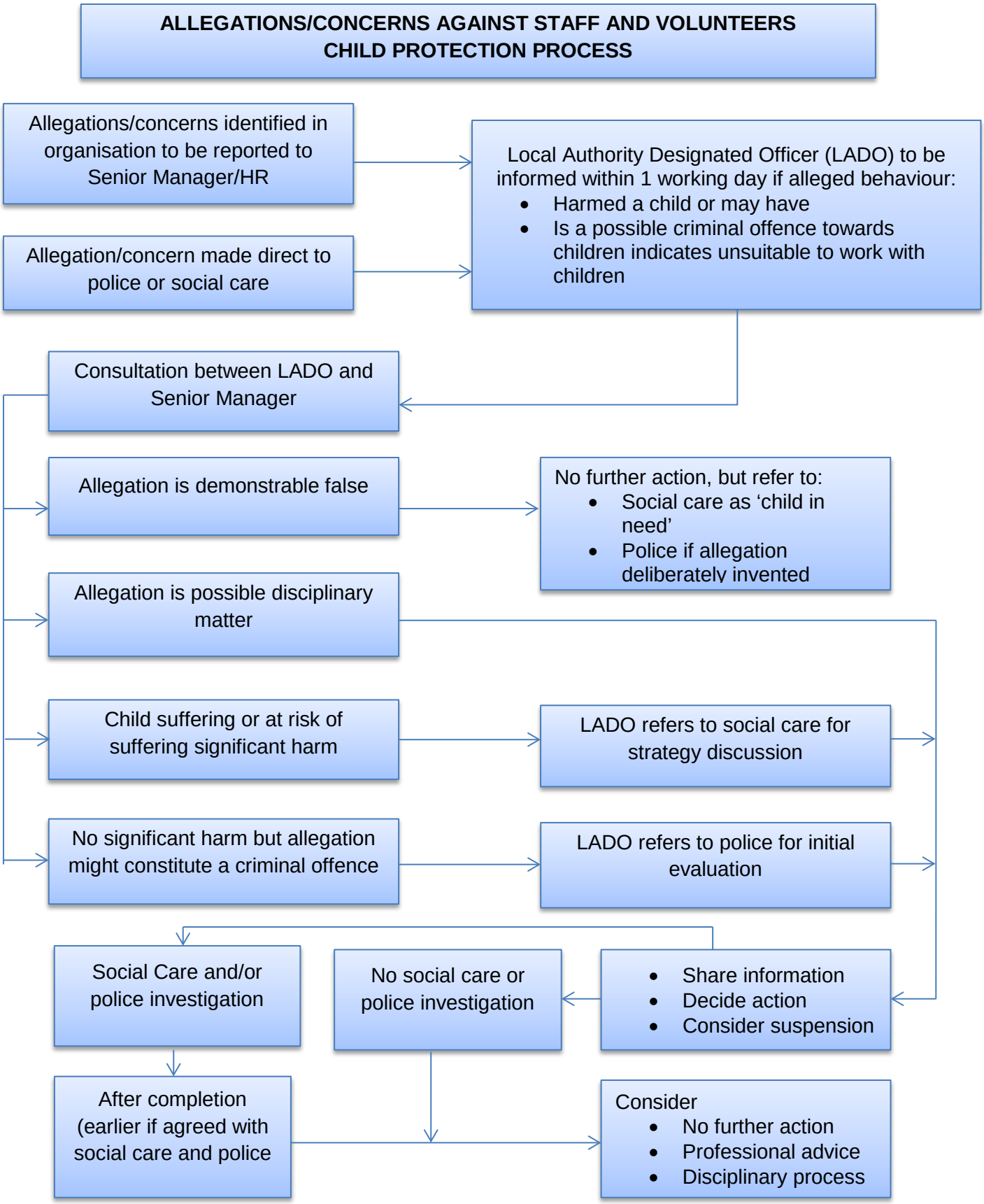
- Make a signed and dated record of concerns, observations or the information they have received.
- Maintain confidentiality whilst an investigation is being conducted. The investigation must include a Human Resources representative.

Professionals must not:

- Attempt to deal with the situation themselves in isolation.
- Make assumptions or diminish the seriousness of the allegations or behaviour.
- Keep the information to themselves or promise confidentiality.
- Take any action which might undermine any future investigation or disciplinary procedure, such as interviewing the alleged victim or witnesses, or informing the alleged perpetrator or parents/carers.

9.2 If the allegation is about the Designated Nurses or Doctor for Safeguarding Children then the allegation should be directed to the Chief Nurse who is the board lead for safeguarding Children.

9.3 The following flow chart outlines the required actions and timescales:


ALLEGATIONS/CONCERNS AGAINST STAFF AND VOLUNTEERS
CHILD PROTECTION PROCESS
Allegations/concerns identified in organisation to be reported to Senior Manager/HR
Allegation/concern made direct to police or social care
Local Authority Designated Officer (LADO) to be informed within 1 working day if alleged behaviour:
Harmed a child or may have
Is a possible criminal offence towards children indicates unsuitable to work with children
Consultation between LADO and Senior Manager
Allegation is demonstrable false
No further action, but refer to:
Social care as 'child in need'
Police if allegation deliberately invented
Allegation is possible disciplinary matter
Child suffering or at risk of suffering significant harm
LADO refers to social care for strategy discussion
No significant harm but allegation might constitute a criminal offence
LADO refers to police for initial evaluation
Social Care and/or police investigation
No social care or police investigation
Share information
Decide action
Consider suspension
After completion (earlier if agreed with social care and police
Consider
No further action
Professional advice
Disciplinary process

10.0 ACCESS TO ADVICE & SUPPORT FOR STAFF

10.1 Staff can access advice and support from a range of sources these include:

- Designated Nurse or Doctor for Safeguarding Children
- Named Professionals in provider organisations
- The on call Paediatricians (Contracted 24 hour cover 7 days a week)
- Duty social workers

10.2 Staff who are working frequently with children and parents must access regular supervision to help them reflect on their working practice and ensure they remain objective to the child's needs for support and protection. This support can be group supervision or individual supervision and can be organised with the Designated professionals. GP's can liaise with the Designated Nurses or Named GP for safeguarding children

10.3 The safeguarding children team will record details of any telephone discussion and action plans agreed. Staff must also record these action plans in any child or family records. Any child protection referrals or significant information received by a practitioner should also be copied to the child's GP.

10.4 If staff are unable to access any member of the CCG safeguarding children team they can discuss cases prior to making a referral with a duty social worker at children services or the on call paediatrician. See below for contact details

Safeguarding Contact Details

Dudley CCG	
Designated Doctor for Safeguarding Children	01384 456111
Designated Nurse for Safeguarding Children	01384 321787
Black Country Partnership Foundation Trust (BCPFT)	
Named Nurse for Safeguarding Children	01384 366210
Specialist Nurse for Looked After Children	01384 366210
Safeguarding Lead BCPFT	01902 446609
Lead Nurse for Child Death Review	01384 366210
Lead Nurse, Domestic Abuse	01384 366210
Dudley Group of Hospitals Foundation Trust (DGOHFT)	
Named Nurse for Safeguarding Children	01384 456111
Dudley Walsall Mental Health Partnership Trust (DWMHPT)	
Vulnerable Adults & Children's Lead	01384 324592
Children & Young People's Service (Social Services)	

Single Point of Access	0300 555 0050
Emergency Duty Team (EDT)	0300 555 8574
CAF Team	01384 815266
Child Abuse Investigation Unit (CAIU) West Midlands Police	**101**
Consultant Paediatrician (Out of Hours) bleep paediatrician on call	**01384 456111**

11.0 RECOGNISING ABUSE OR SIGNIFICANT HARM

11.1 The Children Act 1989 introduced the concept of Significant Harm as the threshold that justifies compulsory intervention into family life in the best interests of children. There are no absolute criteria on which to rely when judging what constitutes significant harm but consideration should be given to the following:

- The severity of ill-treatment which may include the degree and extent of physical harm, including, for example, impairment suffered from seeing or hearing the ill-treatment of another.
- The duration and frequency of abuse and neglect.
- The extent of premeditation.

11.2 Child abuse and neglect is a generic term encompassing all ill treatment of children, including serious physical and sexual assaults, as well as cases where the standard of care does not adequately support the child's health or development.

11.3 Children may be abused or neglected through the infliction of harm, or through the failure to act to prevent harm.

11.4 Abuse can occur in a family or an institutional or community setting. The perpetrator may or may not be known to the child.

11.5 Working Together to Safeguard Children (2015) sets out definitions and examples of the four broad categories of abuse which are used as a basis to determine whether or not a child should be subject to a Child Protection Plan:

- Physical abuse
- Emotional abuse
- Neglect
- Sexual

11.6 These categories overlap and an abused child will frequently suffer more than one type of abuse. **See Appendix 1** for more comprehensive definitions

12.0 RISK INDICATORS

12.1 The factors described in this section are frequently found in cases of child abuse.

12.2 Their presence is not proof that abuse has occurred, but must be regarded as indicators of the possibility of significant harm. The absence of such indicators does not mean that abuse or neglect has not occurred.

12.3 In an abusive relationship the child may:

- Appear frightened of the parent/s
- Act in a way that is inappropriate their age and development
- Engage in risk taking behaviour
- Or they may not exhibit any definitive signs

12.4 Staff need to be aware that the behaviour of children from different cultures or communities may not match the behaviour seen by the majority of children. Cultural issues, traditions or gender imbalance should not be used as an excuse for any form of abuse.
The parent or carer may:

- Persistently avoid services that support children and families or they may delay seeking appropriate treatment for a child if they are ill or need routine surveillance.
- Have unrealistic expectations of the child
- Frequently complain about/to the child and may fail to provide attention or praise (high criticism/low warmth environment)
- Be absent physically or emotionally because of misusing substances, mental health problems or Domestic Violence
- Persistently refuse to allow access on a home visit

12.5 The Nice Guidance 'When to suspect child maltreatment'- 2009 and When to suspect Child maltreatment overview pathway 2014 provides a comprehensive guide to recognising risks for children. There are some specific risks identified by reports into child deaths, these risks indicators are:

- Domestic violence in the family
- Parents who misuse drugs and alcohol
- Parental mental health issues including those parents who perpetrate fabricated induced illness in children
- Parents with learning difficulties
- Parents who have been subject to child protection procedures when they were children.
- Disabled children
- Teenage pregnancy
- Cultures that practice female genital mutilation, forced marriage or Honour Based Violence/abuse
- Children who frequently miss health appointments.

12.6 This is not an exhaustive list but can support a professional in their assessment of the risk to a child.

https://www.nice.org.uk/guidance/cg89
https://pathways.nice.org.uk/pathways/when-to-suspect-child-maltreatment

13.0 CHILDREN WHO ACCESS EMERGENCY SERVICES

13.1 Appropriate action needs to be undertaken for children who access any of these services anywhere in the country:

- Emergency departments
- Walk in centres
- NHS 111

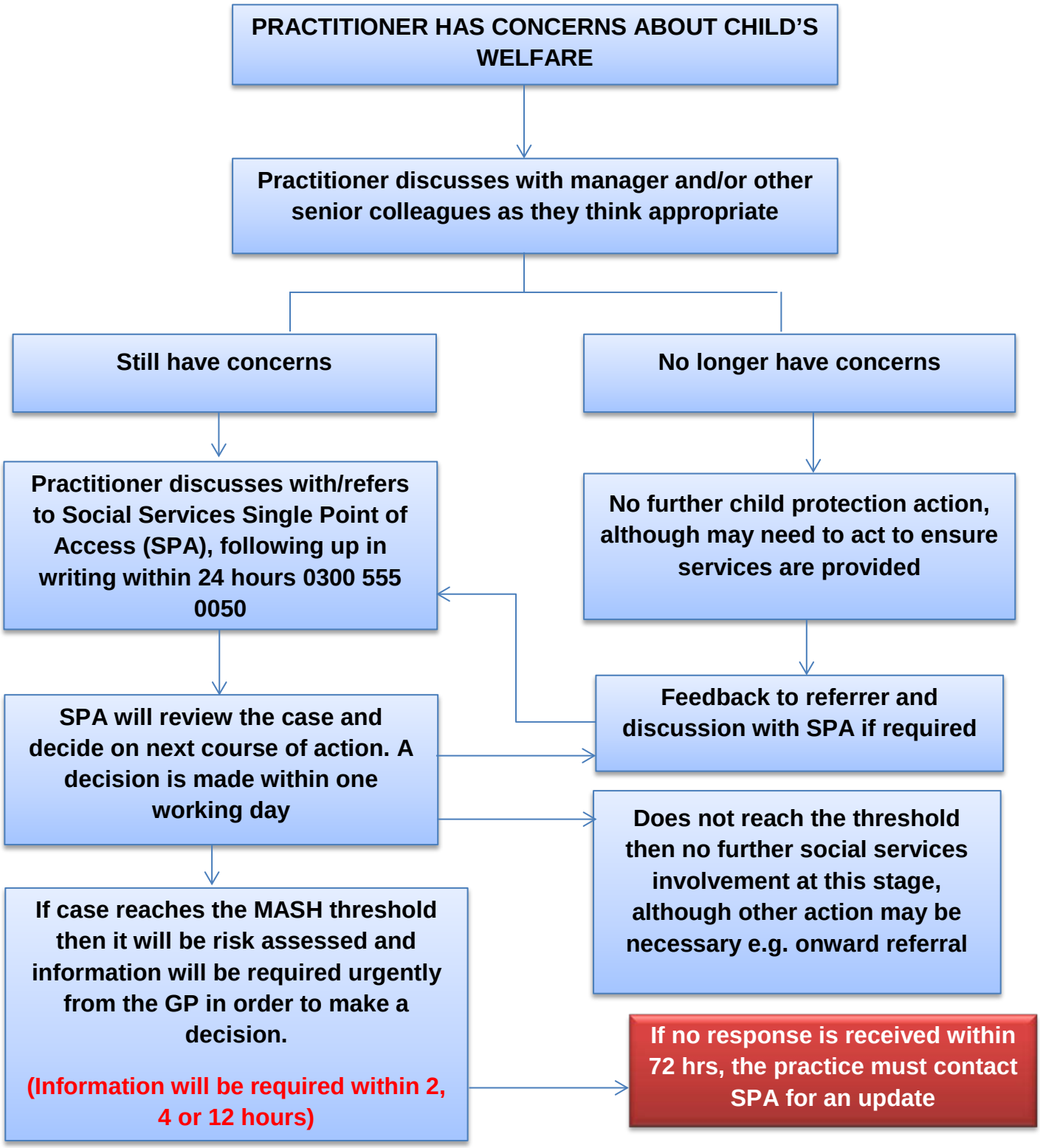
13.2 If a child attends any of these local services then the information is shared directly with the health visitor or school nurse and the GP. If the child has a social worker then the health visitor, school nurse and GP should inform the social worker immediately regarding the child's attendance.

13.3 The provider of community children services must include these arrangements in their safeguarding policy including time frames for sharing information and reviewing cases were there have been frequent attendances within a given period. **Minimum good practice guidance should recommend if there have been three or more attendances or communications from any of the emergency services listed above within a 12 month period then a review of children's records should be undertaken.**

13.4 If a member of staff has any safeguarding concerns about a child who attends one of the emergency services then they should follow the child protection referral procedures on the DSCB web site http://www.proceduresonline.com/dudley/scb/chapters/p referrals.html .

13.5 If staff have any safeguarding concerns when seeing a child they may check with Dudley social care team who can identify if a child is the subject of a child protection plan or if there are other concerns.

13.6 Below is a simple flowchart illustrating the steps you need to consider when you have safeguarding concerns for children:


PRACTITIONER HAS CONCERNS ABOUT CHILD'S WELFARE
Practitioner discusses with manager and/or other senior colleagues as they think appropriate
Still have concerns
No longer have concerns
Practitioner discusses with/refers to Social Services Single Point of Access (SPA), following up in writing within 24 hours 0300 555 0050
No further child protection action, although may need to act to ensure services are provided
SPA will review the case and decide on next course of action. A decision is made within one working day
Feedback to referrer and discussion with SPA if required
Does not reach the threshold then no further social services involvement at this stage, although other action may be necessary e.g. onward referral
If case reaches the MASH threshold then it will be risk assessed and information will be required urgently from the GP in order to make a decision.
(Information will be required within 2, 4 or 12 hours)
If no response is received within 72 hrs, the practice must contact SPA for an update

14.0 ASSESSMENT

14.1 The assessment framework below supports professionals working with children and families in their recognition of risks to the child. When this information is shared it also provides a common language for all agencies working to safeguard a child and their family.

The Framework for the Assessment of Children in Need and their Families

'Assessment is the foundation for all subsequent planning and decision making for children in need and their families'

14.2 Other providers using this policy should share their referrals with their child protection lead within their own organisation/ practice and also with the child's GP. The CCG Safeguarding team can help identify Children's GP's for practitioners.

14.3 Staff must use their professional judgement, knowledge and expertise when assessing potential risks within families. If needs are identified then these should be discussed with the parent/carer, unless to do so would jeopardise the safety of the child or any other person. An action plan, including time scales, should be agreed with the family to address the identified needs and the plan should be regularly reviewed.

14.4 It may be appropriate to complete a common assessment framework (CAF) or Early Help Assessment (EHA) if the child or young person has additional needs which cannot be met by one agency but are below the threshold for child protection. Advice can be obtained from the designated nurse for safeguarding children or other members of the integrated working team (e.g. health visitors, school nurses, children centre managers, teachers, social care etc.). Staff who work regularly with children or parents should have access to the common assessment framework training. Parents must consent to a CAF/EHA assessment.

14.5 The child must be the main focus of any assessment and the child's views and wishes sought, recorded and acted upon. A child's feelings may be communicated through spoken word, written or body language and each element has equal importance.

14.6 It is especially important to assess the needs of children who are disabled or where English is not their first language. In these situations every effort should be made to have an

independent person to communicate for the child together with the family's interpretation of the child's wishes. Family members should not be used as interpreters.

14.7 Any practitioner who feels that their personal safety might be compromised when visiting a family must undertake a risk assessment. They must contact their line manager at the earliest opportunity to arrange safe contact arrangements for the family. The risk assessment should include the actual or potential risk to the child in each situation and the vulnerable child box of the CCG risk assessment should be ticked. All CCG risk assessments and clinical incident forms with the vulnerable child box ticked are seen and monitored by the designated nurse for safeguarding children and this information is reported in the CCG annual safeguarding children report.

15.0 REFERRING TO CHILDREN'S SOCIAL CARE

15.1 It is not necessary to obtain consent for a child protection referral. It is, however, good practice, **with few notable exceptions, when it would be detrimental to the child, or any resulting investigations, to share your concerns with the child/young person or family and inform them of the referral.**

15.2 All telephone referrals to Children's Social Care social services should be **followed up in writing within 24 hours**. Any correspondence related to the referral should be faxed or sent by post. All communication should be marked as **'confidential'** and it is the sender's responsibility to ensure the information has arrived.

15.3 A copy of the child protection referral form should be:

- Retained in the child's records
- Sent to the designated nurse (if you are an employee of the CCG)
- Shared with the GP and any appropriate professionals working with the family.

15.3 If the health practitioner has not been informed of the outcome of the referral **within three working days** they should contact the social care team to find out themselves.

15.4 The referral form used to make a safeguarding referral to Children's Social care is contained can be accessed below:

http://www.proceduresonline.com/dudley/scb/chapters/p_referrals.html

15.6 Any staff employed by the CCG making a referral to the social work team must send a copy of the referral to the CCG Designated Nurse for Safeguarding Children.

16.0 CHILD PROTECTION SUPERVISION

16.1 The National Service Framework core standard 5 (NSF Standard 5-14,p170) recommends that 'agencies provide direct supervision to staff working with children where there are concerns about harm, self-harm or neglect of a child. This includes regular supervision and a review of the child's records'. Effective professional supervision can play a critical role in ensuring a clear focus on a child's welfare. Supervision should support professionals to reflect critically on the impact of their decisions on the child and their family (Working Together 2015).

16.2 Staff who are working regularly with children need to arrange child protection supervision with the Designated or Named professionals. The supervision can be either individual or group dependent upon the staff group.

16.3 Supervision will be recorded using the appropriate form **(Appendix 3)** at the time of supervision and this will be signed by both the supervisor and the supervisee. The supervision process should include a revision of cases (if appropriate), the practitioner's emotional wellbeing, any challenges in practice related to child protection and the employee's compliance with maintaining their safeguarding children's training.

16.4 The Designated Doctor provides supervision for the Named Doctors. The Named GP will be supported to provide group supervision to the link safeguarding GP's in each Practice. In the absence of the Named GP, the Designated Senior Nurse can be contacted for advice.

16.5 The Designated Senior Nurse provides child protection supervision to the Named Nurses/Midwives and safeguarding leads and specialists within the local health provider organisations. Supervision may also be provided to other Named Nurses with prior agreement.

16.6 The Designated Professionals will receive child protection supervision out of area and will also have regular meetings with their Executive Safeguarding Leads.

17.0 RECORD KEEPING

17.1 Records should always factual, clear, accurate, accessible and comprehensive. Principles include:

- Recording all observations and discussions contemporaneously and avoid asking leading questions – allow the young person to tell their story
- Carefully recording any actions or decisions taken
- Including details and outcomes of health care contacts as well as follow-up arrangements
- Using good practice guidance on record keeping from the NMC (2010)
- Using a body map to identify specific anatomical marks or injuries
- Date and time all entries.

17.2 Guidance for health staff can be accessed below:

Record Keeping for Professionals Septem

17.2 Staff must ensure that they adhere to the NHS Records Management Policy and any professional codes of record keeping.

17.3 If you are working with a child then a chronology of any significant events that happen to the child or the family must be maintained.

17.4 It is good practice to maintain a genogram. **Appendix 4** gives an example of how to create one. You must also retain copies of any communication with other agencies in these records.

17.5 The DSCB Inter-Agency Case Recording Standards and Guidance can be accessed below: http://intranet.dudleyccg.nhs.uk/policies/Documents/Safeguarding%20Children%20-%20DSCB%20Inter-Agency%20Recording%20Standards%20Guidance.pdf

18.0 INFORMATION SHARING

18.1 Sharing information amongst professionals working with children and their families is essential for the purpose of safeguarding and promoting the welfare of children. It is often only when information is shared that a child can be seen to be in need or at risk of serious harm. Professionals must use their judgement but should also be aware that failure to pass on information that might prevent a tragedy could expose them to criticism in the same way as an unjustified disclosure.

18.2 Professionals work in partnership with parents/carer and it is therefore good practice to inform them if in specific circumstances informing the parent/care(s) that information is to be shared with other agencies would be likely to put a child(ren) at risk then informing the parents/ carer(s) can at that stage be discounted. Section 13.5 highlights some examples when parents should not be told about information sharing until there has been a formal strategy to review the concerns and risks to the child.

18.3 There are some legal controls to the disclosure of information and these include:

- Common law of confidentiality
- Human Rights Act 1998
- Data Protection Act 1998.

18.4 **The law will not prevent you from sharing information with others if**:

- Consent has been obtained
- The public interest in safeguarding the child's welfare overrides the need to maintain confidentiality
- Information is being shared to inform an assessment being undertaken by social services. The Children Act places an obligation on health professionals to share information when an assessment is being undertaken.
- Disclosure is required under a court order or other legal obligation.

18.5 The key factor in deciding whether or not to disclose information is proportionality; is the disclosure a proportionate response to the need to protect the welfare of the child? The 'need to know' rule will apply to such information to ensure that the number of people to whom it is disclosed is no more than strictly necessary.

18.6 Information **should not be shared** with parents in cases of fabricated and induced illness or if the sharing of information would be likely to contaminate evidence in further investigations of the case such as sexual abuse, female genital mutilation or forced marriage.

18.7 Further guidance on information sharing can be found in "Information sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers" (HM Gov 2015)

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

18.7 Professionals must always seek advice from the Safeguarding team if they are in any doubt as to whether information needs to be shared. If staff are asked to make an official statement relating to safeguarding concerns to any outside agencies they should seek support and advice from either the safeguarding children team, their line manager or the head of Information Governance.

"Sharing of information has long been a problem in a multi-agency sense, but it is hard to believe that it should still present difficulties (even within the closed domain of the Health Sector). Yet in this case information was not accessed or shared ……. and part of the reason seems to be a misunderstanding of the data protection laws. '*Whilst the law rightly seeks to preserve individuals' privacy and confidentiality, it should not be used (and was never intended) as a barrier to appropriate* ***information sharing between professionals****. The safety and welfare of children is of paramount importance, and agencies may lawfully share confidential information about the child or the parent, without consent, if doing so is in the public interest*' (Laming, 2009). **There is no need for a full blown child protection concern to allow information sharing between professionals; a '*public interest*' has been interpreted as simply being '*the promotion of child welfare.*' (Laming, 2009)**

18.8 A number of issues have been raised historically around information sharing with Local Authorities and other agencies. A recent SCR from Northamptonshire (Child I: 2012) clarifies the importance of information sharing in order to protect vulnerable children:

19.0 CHILD PROTECTION INSPECTIONS & REVIEWS

19.1 The CCG may be involved in a number of reviews and inspections. These include:

- Serious Case Reviews (SCR)
- Child Death Reviews
- Public Inquiries
- Serious Incident.
- Domestic Homicide Reviews (DHR)
- Internal Management Reviews (IMR)
- Peer Reviews
- Ofsted and CQC Inspection

19.2 The CCG will support all these official investigations by following good practice.

19.3 As appropriate the child, parent or carer should be informed of these inspections/reviews and a request for consent considered if inspectors wish to meet with families.

19.4 The Designated Senior Nurse for the CCG must be informed of any investigation into child protection issues.

19.5 When the decision is made to undertake a SCR within Dudley, the Designated Senior Nurse will be informed via the DSCB SCR panel and sub group. All Individual Management Reviews (IMR's) undertaken by providers should be quality assured by their executive lead before being submitted to the SCR overview panel for the DSCB. Quality assurance can be negotiated with the CCG if the IMR is being completed for another area, but the CCG must be involved in the process, negotiation and outcome of any IMR/SCR that affects a local provider. It is the providers' responsibility to inform the CCG and complete a Serious Incident (SI) for each case.

19.6 The terms of reference and standards for each SCR and IMR are the responsibility of the DSCB who review the incident and these should be included in all correspondence with the CCG informing them of their involvement in a SCR if being conducted out of area.

19.7 All major incidents related to children where there are safeguarding concerns must be reported through the Serious Incident (SI) process. The Quality Team will monitor and track

the progress of these cases. They will inform the CCG Executive Board lead for safeguarding children, the Children's Commissioner and the CCG Designated Senior Nurse of all these cases.

19.8 Staff involved in any investigation must be supported by a member of the safeguarding children team /line manager/staff side and have the right to have Union Representation

19.9 The CCG has a duty to cooperate in these investigations under Section 11 of the Children Act 2004.

19.10 If staff are aware of any child death this must be reported to the CCG Designated Senior Nurse for safeguarding children in line with the clinical incident reporting process and the child death review process.

19.11 If staff are made aware of any parental deaths this should be reported to the practitioner's line manager via the clinical incident reporting process. If there are child protection concerns then the line manager should inform the Designated Senior Nurse for safeguarding children and agree who will be responsible for reporting any concerns to the Care Quality Commission.

20.0 CHILD PROTECTION TRAINING

20.1 Child protection/safeguarding training is mandatory for all CCG employees.

20.2 All commissioned services must ensure that all staff complete a minimum of level 1 child protection training as recommended by the inter-collegiate document 2014.

20.3 All commissioned services must have a training matrix in their safeguarding policy or follow the recommendations for child protection training in this policy. Dudley CCG's safeguarding children core competency framework highlights the level of training and commitment different staff groups must adhere to. The document can be accessed below

SAFEGUARDING
CHILDREN CORE COM

20.4 There are several routes through which staff can access child protection training or demonstrate their knowledge and competencies around safeguarding children including (but not exclusively);

- E-learning package
- Child protection updates for single or multi-professional groups
- Multi-agency training through the Dudley Safeguarding Children Board. This training is free for CCG staff. Details are on the DSCB web site.
- Scenario Based learning
- Case reviews
- Any courses that have been agreed by the designated professional as compliant with the correct level of safeguarding children training for the employee's workload.
- Team supervision sessions, or case management reflections.

20.5 Specialist child protection training can be arranged through the CCG Safeguarding Children department.

20.6 The safeguarding Lead will be happy to advise any member of staff on the best training option to meet their needs. All staff **MUST** have a child protection/ safeguarding children level 1 update on an annual basis. This can take the form of a written update. Those working directly with children or parents should receive training in line with the competency document.

21.0 DOMESTIC ABUSE

21.1 Multi Agency Rapid Response Team (DART) receives all Domestic Abuse incidents reported to the police where there are children in the household.

21.2 The team will send this information out to the child's health visitor and GP for all children aged 0-5 years**.** For children aged 5-16 who are in full time education the GP and School Health Advisor are informed. For children aged 16-18 the information is sent to the GP only as children out of school do not receive a school nursing service.

21.3 The practitioner will be required to use **professional judgement** in each individual case as to what intervention is required. Consideration should be given to the severity, nature and number of incidents that have occurred, using the Barnardo's risk assessment Tool below:

Barnardos Risk
Assessment Matrix.pd

21.4 The information should be recorded chronologically in the records, ensuring the nature and seriousness of the domestic violence are entered, e.g. verbal, common couple violence, influenced by alcohol, weapons used, escalation of violence, number of previous incidents over a given time frame and any outcomes, e.g. referrals or hospital attendances etc.

21.5 Information should only be shared on a need to know basis and if there are child protection or adult protection concerns seek advice from the safeguarding children team if required.

21.6 Consider contacting the non-abusive parent, considering their safety within any planned contact.

21.7 Offer the non-abusing parent advice on support services and discuss effects for children even if they have not witnessed the violence. Offer on-going support and safety planning if required. Services available in Dudley are available via the link below

Directory of Services
AYP Final Jan 2015.do

21.8 Consider if this is child protection issue and if a referral to social care is required.

21.9 Information regarding domestic violence must be managed proactively.

21.10 If staff receive more than three incidents of domestic violence in a six month period the family should be discussed with the designated nurse for safeguarding in the CCG. Any family can be discussed at any time if the employee has a concern.

21.11 Staff may be asked to contribute to the multi-agency risk assessment conferences (MARAC), which are co-ordinated by the police. This forum discusses all high risk cases of domestic abuse. Staff may be asked questions relating to their knowledge of the family who are the subject of the MARAC. If you have concerns in respect of a case that you would like to be

discussed at MARAC liaise with the Designated Senior Nurse or Adult safeguarding lead. Further information can be found in the DSCB procedures below
http://www.proceduresonline.com/dudley/scb/chapters/p_dom_viol_abuse.html

22.0 PRIVATE FOSTERING ARRANGEMENTS

22.1 Private fostering occurs when a child under 16 (or 18 if disabled) is cared for by an adult who is not a close relative and for more than 28 days, by private arrangements between the parent and the carer. This is different from children in the care of a local authority.

22.2 Should any member of the CCG become aware of a child who is privately fostered they must inform the designated officer within children and young people's services /social care teams, to ensure the child and family receives the appropriate care and support. Details of the designated officer and leaflets for carers and professionals can be found at http://www.dudley.gov.uk/resident/care-health/fostering-adopting-and-looked-after-children/private-fostering/

23.0 MISSING CHILDREN GUIDANCE

23.1 The DSCB have guidance on how to manage cases where children go missing. The link for this policy is:
http://www.proceduresonline.com/dudley/scb/search/search.html?zoom_query=missing

24.0 FEMALE GENITAL MUTILATION

24.1 Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

24.2 The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths. However, more than 18% of all FGM is performed by health care providers, and the trend towards medicalization is increasing. FGM is illegal in the UK. It is also illegal to arrange for a child to be taken abroad for the procedure.

24.3 If staff are aware of any parent who has had FGM or their girls being at risk of FGM they must discuss this with their manager or the designated nurse. A referral should always be considered if the child is at risk. From April 2014 NHS hospitals were required to record:

- if a patient has had FGM
- if there is a family history of FGM
- if an FGM-related procedure has been carried out on a women

24.4 All acute hospitals must report this data centrally to the Department of Health on a monthly basis. This is the first stage of a wider ranging programme of work in development to improve the way in which the NHS will respond to the health needs of girls and women who have suffered FGM and actively support prevention. The FGM Enhanced Dataset introduced in April 2015, will apply to all Acute Trusts, Mental Health Trusts and GP Practices.

24.5 Expansion of existing Acute FGM Prevalence returns will be.

1. Mandatory from June 2015 for GPs and MH Trusts where FGM prevalence exists locally.
2. Mandatory from October 2015 for all others.

24.6 Children's Social care should be informed and the information recorded if there are risks in the family but practitioners have provided adequate information and they believe the family have agreed not to undertake FGM at that time. This discussion must be documented.

24.7 Full guidance on how to manage these complex cases can be found below https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216669/dh_124588.pdf or on the DSCB website http://www.proceduresonline.com/dudley/scb/chapters/p_fem_gen_mutil.html

24.6 Any member of staff working with communities where FGM is practiced should have attended child protection training on FGM. There needs to be a clear agreement between staff and agencies about their individual child protection responsibilities before undertaking any work. A female interpreter should be offered to women when discussing FGM.

National Helpline for FGM is available for staff and the public to access for advice is **0800 028 3550**

25.0 FORCED MARRIAGE

25.1 A 'forced' marriage (as distinct from a consensual 'arranged' marriage) is defined as one that is conducted without the valid consent of at least one of the parties and where duress is a factor. Duress cannot be justified on religious or cultural grounds, and forced marriage is an abuse of human rights.

25.2 Forced marriages of children must be regarded as a child protection issue.

25.3 **You would not contact the parents in this situation and you would make a referral direct to the Police Child Abuse Investigation Unit on 101 who will liaise with social care.**

Full guidance on how to manage these complex cases can be found on the DSCB Website http://www.proceduresonline.com/dudley/scb/chapters/p_force_marriage.html

For further advice contact the Forced Marriage Unit on 020 7008 0230 or 020 7008 0151 or https://www.gov.uk/forced-marriage

26.0 FABRICATED INDUCED ILLNESS

26.1 Concerns may occur when the health and development of a child is significantly impaired by the actions of the parent or carer who has fabricated or induced an illness in a child.

26.2 "Safeguarding Children in whom illness is fabricated or induced: Supplementary guidance to Working Together to Safeguard Children (2008) and NICE guidance 89 on 'When to Suspect Child Maltreatment" (2013), gives detailed descriptions on what to look for in cases, but three main indicators of fabricating or inducing illness are:

- Fabrication of past medical history
- Falsification of medical charts, documents or letters
- Induction of illness by a variety of means

26.3 This is not an exclusive list and further guidance can be found at https://www.nice.org.uk/guidance/cg89/resources/guidance-when-to-suspect-child-maltreatment-pdf

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277314/Safeguarding_Children_in_whom_illness_is_fabricated_or_induced.pdf

26.3 Where a member of staff suspects a case of fabricated or induced illness they should recognise this as a safeguarding concern and seek support and make appropriate referrals. You should not raise your concerns with the parents until you have sought help from either a paediatrician or Children's Social Care.

27.0 CHILDREN WHO DO NOT ATTEND/ HAVE NOT BEEN BROUGHT TO THEIR HEALTH APPOINTMENTS

27.1 When parents or children frequently miss health appointments then the professional must review their case and determine if there are any issues of neglect or abuse.

27.2 The NICE guidance on 'When to Suspect Child Maltreatment' (2013) states, consider neglect if:

- A parent fails to administer essential prescribed treatment for their child
- A parent fails to attend essential appointments or follow-ups that are necessary for their child's health and well being
- A parent persistently fails to obtain NHS treatment for their child's dental caries (tooth decay).

27.3 If a child has missed a health appointment then staff should:

- Check the appointment was given to the correct person/address
- Are there any known safeguarding concerns including neglect or patterns of missed appointments in the child or other family members records
- Offer another appointment
- Talk to a line manager
- Consider a referral to Children's Social Care.

27.4 The CCG expect all service providers to have a policy that addresses these issues or to follow this policy. Each GP should develop practice guidance and procedures to manage children who miss appointments. An example of a DNA flowchart is available at **appendix 5**

28.0 RESOLVING CASES WHERE THERE IS PROFESSIONAL DISAGREEMENT

28.1 When a CCG employee is not happy with the outcome of a child protection or safeguarding referral then they can contact the Designated Senior Nurse or use the Dudley Safeguarding Children Board Escalation Process. Provider staff should follow their organisation's processes.
http://www.proceduresonline.com/dudley/scb/chapters/p_conflict_res.html

28.2 **Appendix 6** has a flow chart for this escalation policy. There are 5 stages to this policy. The Designated Senior Nurse/Doctor should be informed when staff using this policy reaches stage 3. The 5 stages are:

1. Talk to your line manger about your concern
2. Talk to the individual where there are disagreements
3. Your manager will talk to the equivalent manager for the employee you disagree with.
4. The designated nurse/ doctor will liaise with a senior manager in the agency where there is a dispute and report this to the service manager safeguarding and quality assurance

5. The Chair of the DSCB will convene a panel to review the concerns and make a final judgement.

29.0 CHILD DEATHS

29.1 There are two inter-related processes for reviewing child deaths (either of which can trigger a Serious Case Review):

- A rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child.
- An overview of all child deaths (under 18 years) in the LSCB area(s), undertaken by the Child Death Overview Panel (CDOP). (Working Together to Safeguard Children 2015)

29.2 Where there is known or suspected abuse as a factor in the child's death these cases are referred to a sub panel of the Safeguarding Children Board for consideration for a Serious Case Review. Any professional or agency may refer a case to the Local Safeguarding Children Board if they believe that there are important lessons for intra-agency-and/or interagency working to be learned from the case.

29.3 Each unexpected death of a child is a tragedy for his or her family, and subsequent enquiries/investigations should keep an appropriate balance between forensic and medical requirements and the family's need for support. Children with a known disability or a medical condition should be responded to in the same manner as other children. A minority of unexpected deaths are the consequence of abuse or neglect, or are found to have abuse or neglect as an associated factor. In all cases, enquires should seek to understand the reasons for the child's death, address the possible needs of other children in the household, the needs of all family members, and also consider any lessons to be learnt about how best to safeguard and promote children's welfare in the future. (Working Together to Safeguard Children 2015)

29.4 In the event of any member of staff becoming aware of such a case, they should notify the Child Health Department, the GP, the Designated Nurse/Designated Doctor for Safeguarding Children and the Dudley Local Safeguarding Board CDOP co-ordinator. Records pertaining to the child should be secured and held within the Safeguarding Children Team. These include records made by community nurses and GP patient records. Records of parents may also need to be secured from GPs.

29.5 The annual CDOP report is presented to the CCG Quality and Safety Committee.

30.0 SERIOUS CASE REVIEWS (SCR)

30.1 When a child dies from abuse or neglect, the local inter-agency group responsible for child protection conducts a review to identify how local professionals and organisations can improve the way they work together. Serious case reviews (SCRs) are undertaken by local safeguarding children boards (LSCBs) for every case where abuse or neglect is known - or suspected - and either:

- a child dies
- a child is seriously harmed and there are concerns about how organisations or professionals worked together to protect the child

30.2 The LSCB should aim for completion of an SCR within 6 months of initiating it. If this is not possible (for example because of potential prejudice to related court proceedings), every effort should be made whilst the SCR is in progress to:

- capture points from the case about improvements needed; and
- take corrective action.

30.3 Serious Case Reviews and other case reviews should be conducted in a way in which :

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisation involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings (Working Together 2015)

30.4 LSCBs may use any learning model which is consistent with the principles in Working Together 2013 including the systems methodology recommended by Professor Eileen Munro (Munro 2011). All staff may be involved in the SCR process and should be guided by the Designated professionals

31.0 PREVENT

31.1 The government's *Prevent* Strategy, published in June 2011, highlights the emerging evidence that some institutional environments, such as universities and prisons, are places where a range of individuals may be vulnerable to radicalisation towards active support for violent extremism. While extremist views are not, in themselves, indicators that an offender is likely to commit terrorist offences, they may be warning signs that staff need to be aware of. It is, therefore, important that staff members are alert to the views of all offenders, irrespective of the offence they have committed.

31.2 *Prevent* aims to stop people becoming terrorists or supporting terrorism. The Department of Health has highlighted that in statistical terms the NHS has a high chance of interacting with someone who may be exploited for terrorism.

31.3 There is no single profile of a terrorist, neither is race, religion or ethnicity a factor but the exploitation of vulnerable people. Those who may be exploited are often young, socially excluded, use drugs and alcohol, have low self-esteem, have suffered a personal crisis, may have links to criminality and are unemployed. Factors such as propaganda, media, internet use.

31.4 Commissioner's Responsibility to monitor compliance towards Prevent by seeking assurance via the quality contract meetings.

- Through provider safeguarding assurance meetings attended by the CCG Prevent lead (Designated Nurse Adult Safeguarding).
- Via request of the Prevent Self-Assessments Tool for review by the Designated Nurse.

31.5 Dudley CCG employees also have a duty to be aware of the Prevent agenda and implications for the organisation and be able to recognise if one of their fellow colleagues, a patient or carer is possibly being radicalised.

32.0 REFERENCES

Adoption and Children Act (2002)

Children Act 1989

Children Act 2004

Female Genital Mutilation Act (2003)

Information sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers (2015)

National Service Framework for Children, Young People & Maternity Services, DfES (2004)

Records Management: NHS Code of Practice Part 2, DH (2006)

Safeguarding Children in whom illness is fabricated or induced: Supplementary guidance to Working Together to Safeguard Children (2008)

Safeguarding Vulnerable Groups Act, DfES (2006)

Safer Recruitment - A Guide for NHS Employers, NHS Employers (2006)

Sexual Offences Act (2003)

Standards for Better Health DH (2004)

The NMC Code of Professional Conduct: Standards for Conduct, Performance & Ethics, NMC, London (2007)

Adoption and Children Act (2002)

What To Do If You're Worried a Child is Being Abused: HM Gov (2015)

When to suspect child maltreatment NICE (2014)

Working Together to Safeguard Children, H M Gov (2015)

Intercollegiate Document: Safeguarding Children & Young People: Roles and Competences for Health Care Staff. RCPCH 2014

APPENDIX 1 - DEFINITIONS OF ABUSE
Working Together to Safeguard Children 2013
What is abuse and neglect?

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.

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.

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.

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

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

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

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.

APPENDIX 2 – SUMMARY OF ROLES AND RESPONSIBILITIES

Organisation/ Role	**Summary of Organisation/Role Key safeguarding functions, Roles and Responsibilities and Key Safeguarding functions**
CCG/ Accountable officer	Has a duty to make arrangements to ensure that in discharging their functions they have regard to the need to safeguard and promote the welfare of children. Work with the Local Authority to commission and provide integrated services for children, uyoung people and families. Ensure that commissioning arrangements effectively incorporate safety and welfare issues across the health economy Should ensure they commission the services of a senior Doctor and Nurse to undertake the functions of Designated Professionals.
Executive Chief Nurse	To be the CCG Board lead for safeguarding children. This role includes • Chairing the CCG Safeguarding Forum • Attending the Dudley Safeguarding Children Board (DSCB) as the lead for the CCG • Providing leadership to the CCG on the safeguarding children's agenda • Managing the designated and named professionals employed by the CCG • Ensuring all commissioned services have safeguarding children's standards in their contracts • To liaise with the Safeguarding Children's lead in the NHS CB ensuring independent health providers safeguarding work links with that of other providers • Ensuring safeguarding standards are maintained across commissioned health services and taking action if risks are identified
Designated Professionals	To Provide: • Strategic professional lead on all aspects of health service contribution to safeguarding children across the CCG area • Advice and support to named professionals in each provider organisation • Professional advice to the CCG Board to ensure the organisation discharges its responsibilities effectively and appropriately • Co-Ordination of the health elements of Serious Case Review process, including quality assuring the health elements • To provide professional advice and expertise on health issues to the DSCB
Provider Organisations	Co-operate with arrangements to safeguard children, share the responsibility for effective safeguarding arrangements. Ensure that they identify appropriate staff to undertake the function of Named Professionals
Named Professionals	Will focus upon safeguarding arrangements within their own organisation by: • Providing support and advice to staff in the day-to-day management of safeguarding practice • Promoting good practice in safeguarding work • Providing advice to support their own organisations governance arrangements for safeguarding children • Developing a safeguarding children training strategy • Developing the safeguarding children training programme and ensuring its delivery meets the required standards
NHS CG	Performance management and support for development of safeguarding arrangements in the Local Area Team

APPENDIX 3 - SAFEGUARDING CHILDREN SUPERVISION RECORD (INDIVIDUAL)

NAME OF SUPERVISEE:

POST TITLE:

WORK BASE:

NAME OF SUPERVISOR:

DATE OF SUPERVISION SESSION:

VENUE:

DURATION:

TOPICS DISCUSSED:

OUTCOMES/ACTION PLANS:

EVALUATION: (HOW USEFUL WAS THE SESSION? WHAT WAS LEARNT?)

COMMENTS:

APPENDIX 4 - GUIDANCE FOR CONSTRUCTING AND USING GENOGRAMS

Genograms can be a useful technique to show:

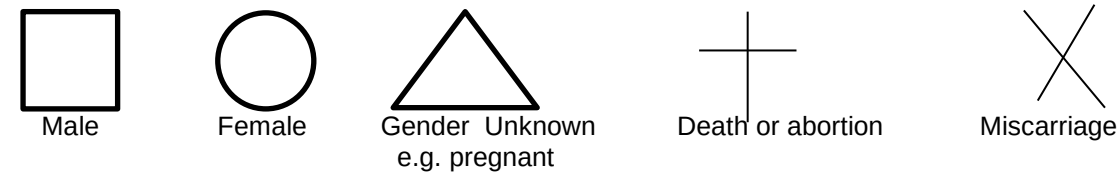
1. Family structure and composition
2. Exact dates of birth, separations, divorces, deaths
3. Details and descriptions of relationships and alliances

They can:

1. Provide information about a family's lifestyle and highlight gaps
2. Highlight patterns and themes in previous and present generations
3. Provide a structure to obtain and share with a family
4. Be constructed in conjunction with families

NOTES

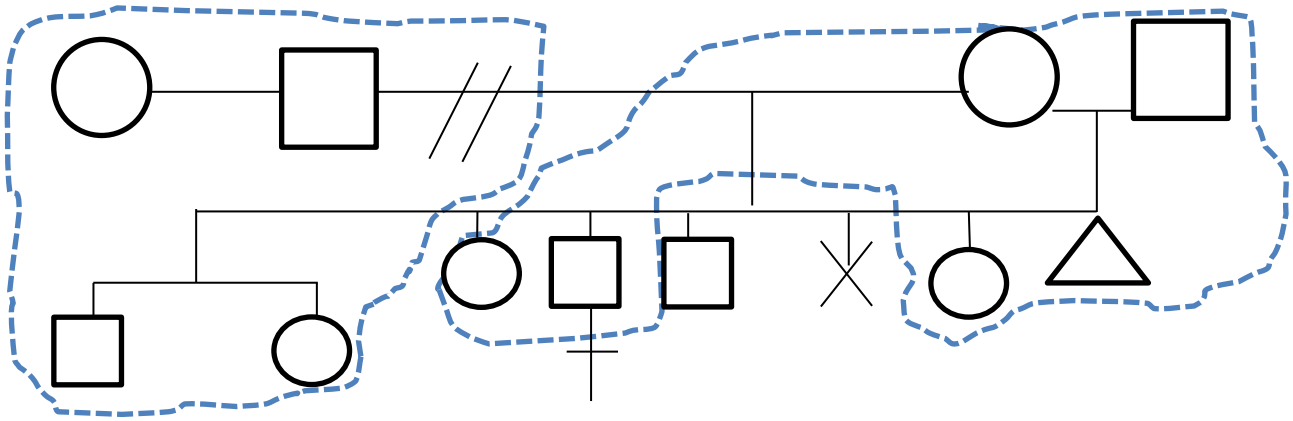
Common symbols and construction/unions should be used and a key should be available to describe these. Staff can use the key below



Enduring relationship e.g marriage or cohabitation

Separation

A dotted line should be drawn around people who currently live in the same house

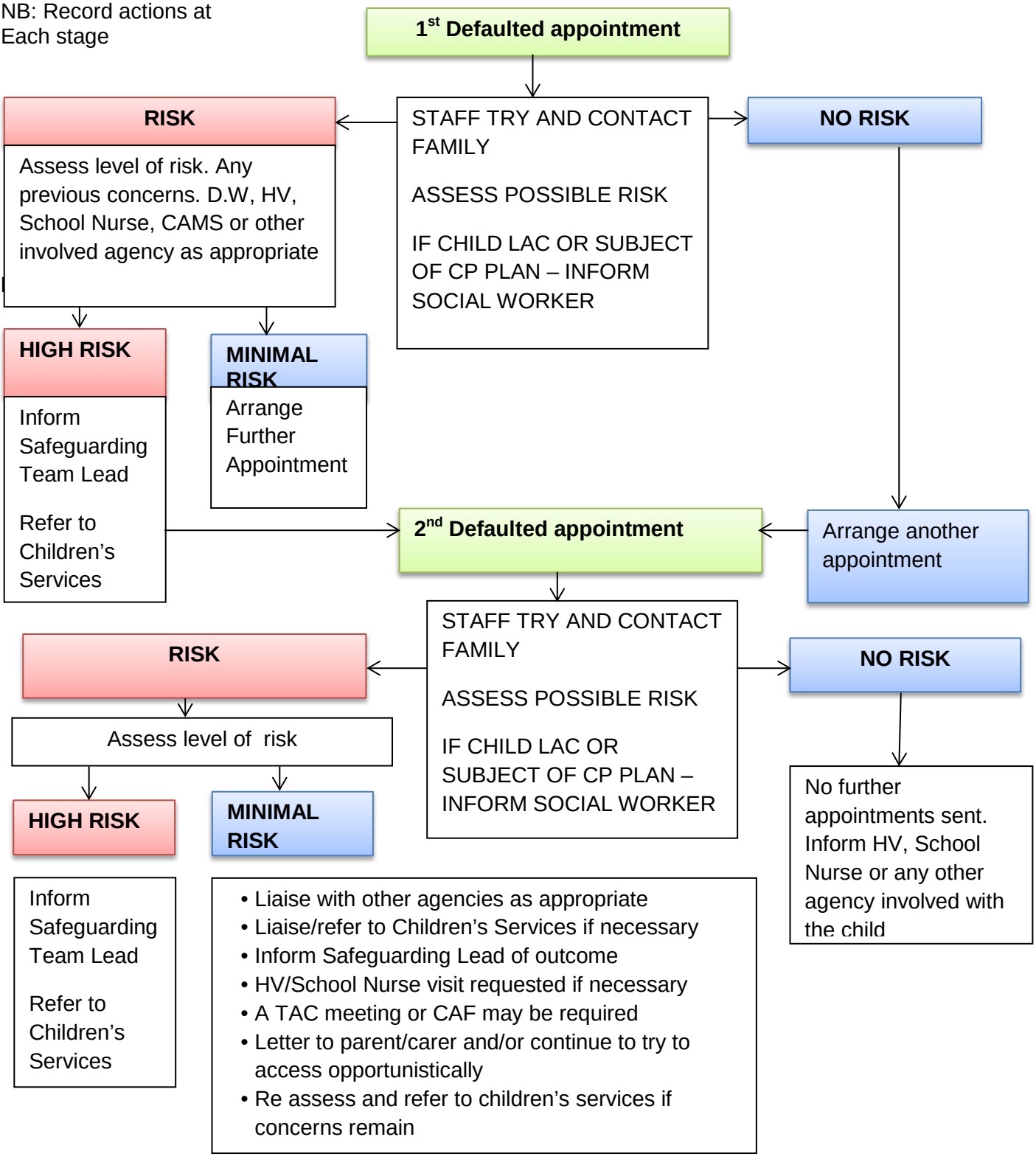


For example, the above diagram shows the genogram of a pregnant mother who lives with her three children, two of whom are from a previous relationship, which ended in divorce. One child also died and one was aborted. The twins are currently living with their father and stepmother

The genogram needs to be dated, timed and signed and the source of the information acknowledged e.g. case conference records Mrs Smith (Mother)

APPENDIX 5 - FLOW CHART FOR DNA OR NO ACCESS VISITS FOR CHILDREN

NB: Record actions at Each stage



Any concerns discuss with the safeguarding lead of safeguarding team.

APPENDIX 6 – ESCALATION POLICY
Resolution of Professional Disagreements in Work

Relating to the Safety of Children

1 Purpose

1.1 To provide a clear mechanism for the timely resolution of professional disputes in order to ensure the safeguarding needs of the child and young person

2.0 Introduction

2.1 Occasionally situations arise when workers within one agency feel that the decision made by a worker from another agency on a child protection or child in need case is not a safe decision. Disagreements could arise in a number of areas, but are most likely to arise around:

- Levels of Need
- Roles and responsibilities
- The need for action
- Communication

2.2 The safety of individual children is the paramount consideration in any professional disagreement and any unresolved issues should be addressed with due consideration to the risks that might exist for the child.

2.3 All workers should feel able to challenge decision-making and to see this as their right and responsibility in order to promote the best multi-agency safeguarding practice. This policy provides workers with the means to raise concerns they have about decisions made by other professionals or agencies by:

a) Avoiding professional disputes that put children at risk or obscure the focus on the child
b) Resolving the difficulties within and between agencies quickly and openly
c) Identifying problem areas in working together where there is a lack of clarity and to promote the resolution via amendment to protocols and procedures

2.4 Effective working together depends on an open approach and honest relationships between agencies. Problem resolution is an integral part of professional co-operation and joint working to safeguard children.

Resolution should be sought within the shortest timescale possible to ensure the child is protected. Disagreements should be resolved at the lowest possible stage however if a child is thought to be at risk of immediate harm discretion should be used as to which stage is initiated.

3.0 Stages of the policy

3.1 Stage One (professional resolution) Any worker who feels that a decision is not safe or is inappropriate should initially consult a supervisor/manager to clarify their thinking in order to identify the problem; to be specific as to what the disagreement is about; and what they aim to achieve. They should also be able to evidence the nature and source of their concerns and should to keep a record of all discussions.

3.2 Stage Two Initial attempts should be taken to resolve the problem at the lowest possible level. This would normally be between the people who disagree. It should be recognised that differences in status and/or experience may affect the confidence of some workers to pursue this unsupported.

3.3 Stage Three If the problem is not resolved at stage two the concerned worker should contact their Manager and/or Designated Nurse within their own agency who should raise the concerns with the equivalent manager in the other agency. The manager should also notify the Safeguarding Children's Board Manager who will keep a record of all on-going disagreements.

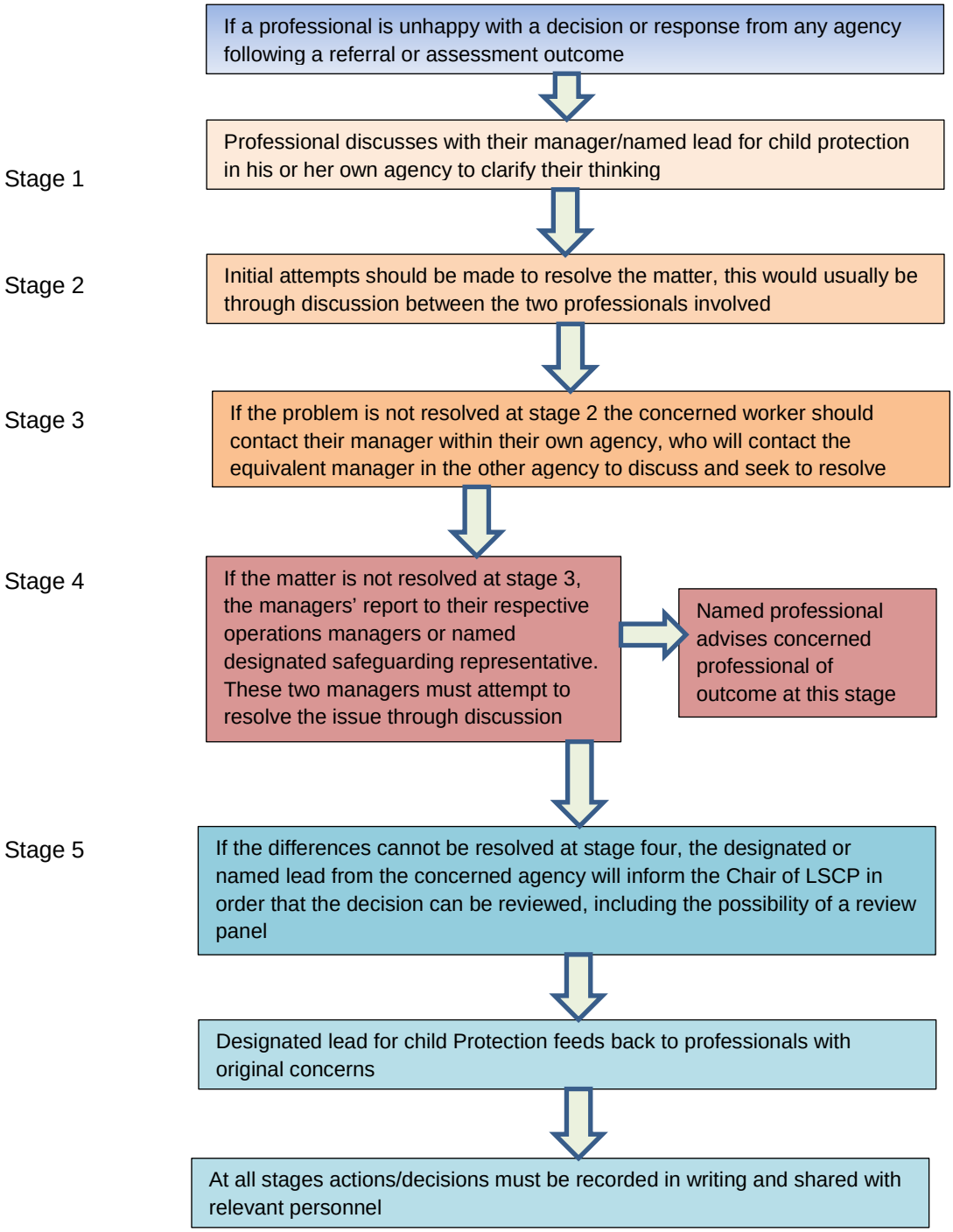
3.4 Stage Four If the problem is not resolved at stage three the supervisor/manager reports to their respective operations manager /designated safeguarding representative. These two managers must attempt to resolve the professional differences through discussion. Safeguarding Children's Board Manager should be advised of any outcome.

3.5 Stage Five If it has not been possible to resolve the professional differences within the agencies concerned the matter should be referred to the Chair of the Local Safeguarding Children Board, who may either seek to resolve the issue direct, or to convene a Resolution Panel.

- The panel must consist of LSCB representatives from three agencies (including the agencies concerned in the professional differences, where possible).

- The panel will receive representations from those concerned in the professional differences and make a decision as to the next course of action, resolving the professional differences concerned.

3.6 Timescales Some matters may be resolved very quickly, and this will be determined locally by the complexity of the issues. In all cases, the matter will be resolved as speedily as possible, and the primary focus will be on ensuring that the safety and welfare of the child concerned is assured whilst discussions take place.



Additional Notes

At all stages of the process actions and decisions must be recorded in writing and shared with relevant personnel, to include the worker who raised the initial concern. In particular this must include written confirmation between the parties about an agreed outcome of the disagreement and how any outstanding issues will be pursued.

It may be useful for individuals to debrief following some disputes in order to promote continuing good working relationships.