NHS
Somerset
Clinical Commissioning Group

SAFEGUARDING CHILDREN POLICY

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VERSION CONTROL

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DOCUMENT CHANGE HISTORY		
Version	**Date**	**Comments**
1	June 2017	Amalgamation of the following policies: Safeguarding Children and Young People in general practice. 2016 Policy and procedure around the recording, flagging and sharing of information in general practice about patients who are known to be at risk of domestic abuse. 2016
2.0	March 2019	The CCG Safeguarding Children Policy includes details of procedural and operational practice required for the management of safeguarding and promoting the welfare of children alongside associated local, regional and national safeguarding children policies, procedures and guidance. It was originally devised in 2017 and has been updated in line with Working Together to Safeguard Children 2018. Revisions include: • Updated reference, definitions and guidance from WT 2018 (previously 2015) • Updated guidance for GPs on flags and alerts using national SNOMED coding • Updated SSCB links to various protocols (e.g. Resolving professional differences protocol) • Clearer guidance for making a child protection referral • Updated child exploitation section

Equality Impact Assessment (EIA) Form OR EIA Screening Form completed. Date:	

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SAFEGUARDING CHILDREN POLICY

1 INTRODUCTION

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

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

- NHS England Safeguarding Policy 2015
- South West Child Protection Procedures
- HM Government. Working Together to Safeguard Children 2018
- Information sharing advice for practitioners providing safeguarding services to children, young people, parents and carers, 2018
- Somerset Safeguarding Children Board Resolving Professional Difference Protocol, 2016
- Somerset Safeguarding Children Board Pre Birth Protocol
- Safeguarding Children Board Effective Support for Children and Families in Somerset

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

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

2 POLICY STATEMENT

2.1 Somerset CCG recognises that all children have a right to protection from abuse and neglect, and accepts its responsibility to safeguard the welfare of all children. The purpose of this policy is to assist all staff, both clinical and non-clinical, to understand their roles and responsibilities in relation to safeguarding children. It provides a framework for safe and effective practice in relation to vulnerable children, children in need and child protection. A child is defined as anyone who has not yet reached their 18th birthday.

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

Scope

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

Safeguarding

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

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

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

3 BASIC PRINCIPLES

3.1 This policy seeks to emphasise the following principles:

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

[1] Working together to safeguard children

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

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

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

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

4 WHAT IS ABUSE AND NEGLECT?

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

4.2 Abuse is a form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others. Abuse can take place wholly online, or technology may be used to facilitate offline abuse. Children may be abused by an adult or adults, or another child or children.[4]

4.3 There are four main categories of childhood abuse: neglect; physical abuse; sexual abuse and emotional abuse.

5 CATEGORIES OF ABUSE

Neglect

5.1 The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal

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

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

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

Physical Abuse

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

Sexual Abuse

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

Emotional Abuse

5.5 The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

6 FABRICATED OR INDUCED ILLNESS IN A CHILD (FII)

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

6.2 There are four main ways of the carer fabricating or inducing illness in a child:

- fabrication of signs and symptoms, including fabrication of past medical history
- fabrication of signs and symptoms and falsification of hospital charts, records, letters and documents and specimens of bodily fluids
- exaggeration of symptoms/real problems. This may lead to unnecessary investigations, treatment and/or special equipment being provided
- induction of illness by a variety of means

6.3 The above four methods are not mutually exclusive.

6.4 Once a health practitioner has suspicions that fabricated or induced illness is being presented, the CCG safeguarding children team should be contacted for specialist advice.

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

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

6.7 Relevant policies and procedures:

- South West Child Protection Procedures http://www.proceduresonline.com/swcpp/somerset/p_fab_ind_illness.html?zoom_highlight=FII
- Safeguarding Children in whom illness is fabricated or induced https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277314/Safeguarding_Children_in_whom_illness_is_fabricated_or_induced.pdf
- NICE CG89 guidance provides a summary of clinical features associated with child maltreatment (alerting features) that may be observed when a child presents to healthcare professionals. The alerting features in this guidance have been divided into two, according to the level of concern, with recommendations to either 'consider' or 'suspect' maltreatment.

7 DOMESTIC VIOLENCE AND ABUSE

7.1 Domestic Violence and Abuse is defined as: *"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family*

members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

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

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

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

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

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

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

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

7.8 Domestic violence and abuse is a complex issue that needs sensitive handling by a range health and social care professionals. This routinely includes Primary Care staff in the following way:

- The practitioner referring a family to MARAC for consideration is required to include the family's GP details and if there are children in the family, their schools details.

- The MARAC point of contact will contact the family's GP (using the generic practice email) to inform them that their patient has been referred to MARAC and request relevant information, to be returned in a timely way.

- The family's GP will be asked to either attend or dial in to the MARAC meeting, when their patient is to be discussed.

- Information provided by the family's GP is considered as part of the MARAC meeting. The family's GP will then be notified of the outcome of the MARAC.

- Recording the information from the MARAC (Multi Agency Risk Assessment Conference) will help ensure that domestic abuse is considered when patients next attend an appointment

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

7.10 Relevant policies and procedures:

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

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

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

- Resources for general practitioners who come into contact with victims of domestic abuse http://www.safelives.org.uk/gp

8 SEXUALLY ACTIVE CHILDREN

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

8.2 It is considered good practice for workers to follow the Gillick competence and Fraser guidelines when discussing sexual health with a young person under 16. It became lawful to provide contraceptive advice and treatment to girls under the age of 16, subject to Fraser guidelines .In certain circumstances a child under

the age of 16 can give consent to treatment in their own right ('Gillick competence').

8.3 Although sexual activity over the age of 16 is lawful, under 18s are still offered protection under the Children Act 1989 and consideration still needs to be given to issues of sexual exploitation and abuse.

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

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

8.6 Relevant Policies and Procedures

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

8.7 Tools and resources

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

9 CHILD SEXUAL EXPLOITATION (CSE)

9.1 Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.[5]

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

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

[5] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/591903/CSE_Guidance_Core_Document_13.02.2017.pdf

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

9.4 Assessment tools and resources:

- A useful quick guide to CSE for Somerset health care practitioners has been developed, which is accessible in the resources section of the local safeguarding children board website.

- Somerset Safeguarding Children Board has produced an initial screening tool for CSE intended to assist the exercise of professional judgment by assisting professionals to consider the risk of harm to a child.[6] This is accessible in the tools section of the local safeguarding children board website. On completion of this tool, staff are then required to consider whether or not an Early Help or Child Protection referral is required.

- The CSE section of the local safeguarding children board website can be accessed here: http://sscb.safeguardingsomerset.org.uk/working-with-children/cse-protocols/

9.5 Relevant policies and procedures

- Child sexual exploitation: Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/591903/CSE_Guidance_Core_Document_13.02.2017.pdf

- South West Child Protection Procedures: http://www.proceduresonline.com/swcpp/somerset/p_ch_sexual_exploit.html?zoom_highlight=child+sexual+exploitation

- NHS England Child sexual exploitation: Advice for Healthcare Staff is a pocket guide to provide practical information to healthcare staff to safeguard children and young people

10 WIDER CHILD EXPLOITATION (INCLUDING CRIMINAL EXPLOITATION, MODERN SLAVERY, HUMAN TRAFFICKING, COUNTY LINES)

10.1 **Contextual Safeguarding** is where children may become vulnerable to abuse or exploitation from outside of their families:

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

[6] http://sscb.safeguardingsomerset.org.uk/working-with-children/cse-protocols/

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

10.1.2 Relevant policies and procedures

- County Lines and Child Criminal Exploitation are both set out in the Serious Violence Strategy, published by the Home Office: https://www.gov.uk/government/publications/serious-violence-strategy

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

10.3 **Modern slavery** is a form of organised crime in which individuals including children and young people are treated as commodities and exploited for criminal gain. Slavery is an umbrella term for activities involved when one person obtains or holds another person in compelled service. Modern slavery is identified as child abuse which requires a child protection response. It is an abuse of human rights, and all children, irrespective of their immigration status, are entitled to protection under the law[7]. For further information please refer to the Modern Slavery Act 2015.

10.2.1 Resources

- Unseen Website http://www.unseenuk.org/ and Modern Slavery Helpline 08000 121 700

- Anti-slavery partnership. Includes government leaflets setting out support for victims of modern slavery in 11 languages. http://www.aspartnership.org.uk

- Unchosen website. Includes films and printable posters and leaflets. http://unchosen.org.uk

10.2.2 Relevant policies and procedures

- SWCPP (Modern Slavery) http://www.proceduresonline.com/swcpp/somerset/p_modern_slavery.html?zoom_highlight=MODERN+SLAVERY

10.4 **Human trafficking** is the movement of people by means such as force, fraud, coercion or deception, with the aim of exploiting them. It is a form of modern slavery and a crime. Trafficking involves the transportation of people in order to exploit them by the use of force, violence, deception, intimidation or coercion. It does not always involve international transportation and can be transportation just within the UK. This exploitation includes commercial, sexual and bonded labour. Trafficked people have little choice in what happens to them and often suffer abuse due to violence and threats made against them or their families. In effect, they become commodities owned by traffickers, used for profit. The

[7] http://www.proceduresonline.com/swcpp/somerset/p_modern_slavery.html?zoom_highlight=MODERN+SLAVERY

National Referral Mechanism[8] is a framework for identifying victims of human trafficking and ensuring they receive appropriate care.

10.3.1 Resources

- The NSPCC has a Child Trafficking Advice Centre for staff who work with children or young people who may have been trafficked into the UK, contact our specialist service for information and advice. Call 0808 800 5000 or email help@nspcc.org.uk for more information. https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/child-trafficking

10.3.2 Relevant policies and procedures

- SWCPP (Child victims of Trafficking or Modern Slavery) https://www.proceduresonline.com/swcpp/somerset/p_ch_from_abroad.html?zoom_highlight=human+trafficking#part2

- DfE Safeguarding children who may have been trafficked, practical guidance.

11 FEMALE GENITAL MUTILATION (FGM)

11.1 FGM comprises of all procedures involving partial or total removal of the external female genital organs or any other injury to the female genital organs for non-medical reasons. FGM is most often carried out on young girls aged between infancy and 15 years old. It is often referred to as 'cutting', 'female circumcision', 'initiation', 'Sunna' and 'infibulation'[9].

11.2 From the 31st October 2015, regulated professionals in health and social care and teachers in England and Wales have a duty to report 'known' cases of FGM (Female Genital Mutilation) in under 18s to the police. Professionals who initially identify FGM must call 101 (police) to report.

11.3 If you are worried about a girl under 18 who is either at risk of FGM or who you suspect may have had FGM, you should share this information immediately with Children's social care or the police. Where a child appears to be in immediate danger of mutilation, children's social care and the police will urgently consider the need for a Female Genital Mutilation Protection Order, an Emergency Protection Order or a Prohibited Steps Order. Practitioners should make it clear to the family that they will be breaking the law if they arrange for the child to have the procedure.

11.4 Assessment tools and resources:

- FGM resource pack: https://www.gov.uk/government/publications/female-genital-mutilation-resource-pack/female-genital-mutilation-resource-pack#effective-practice-and-resources

- NHS England has produced a helpful pocket guide about FGM for Health Care Professionals.

[8] http://www.nationalcrimeagency.gov.uk/about-us/what-we-do/specialist-capabilities/uk-human-trafficking-centre/national-referral-mechanism

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

- The NSPCC has a 24 hour helpline to provide advice and support to victims of FGM - call the helpline on 0800 028 3550 or email fgmhelp@nspcc.org.uk

11.5 Relevant policies and procedures:

- SWCPP (Female Genital Mutilation) http://www.proceduresonline.com/swcpp/somerset/p_fem_gen_mutil.html?zoom_highlight=fgm

- Multi-agency statutory guidance on female genital mutilation. 2016 https://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation

12 SAFEGUARDING CHILDREN AND YOUNG PEOPLE AGAINST RADICALISATION AND EXTREMISM

Extremism goes beyond terrorism and includes people who target the vulnerable – including the young – by seeking to sow division between communities on the basis of race, faith or denomination; justify discrimination towards women and girls; persuade others that minorities are inferior; or argue against the primacy of democracy and the rule of law in our society.

12.1 Extremism is defined in the Counter Extremism Strategy 2015 as the vocal or active opposition to our fundamental values, including the rule of law, individual liberty and the mutual respect and tolerance of different faiths and beliefs. Working Together 2018 also regard calls for the death of members of our armed forces as extremist.

12.2 Prevent is one part of the United Kingdom's counter-terrorism strategy (CONTEST) and aims to stop people from being exposed to extreme ideologies and becoming radicalised. The CONTEST strategy is divided up into four priority objectives:

- Pursue – stop terrorist attacks

- Prepare – where we cannot stop an attack, mitigate its impact

- Protect – strengthen overall protection against terrorist attacks

- Prevent – stop people becoming terrorists and supporting violent extremism

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

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

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

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

12.6 **To report a concern contact the Regional Police Prevent Team:**

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

12.7 Relevant policies and procedures:

- SWCPP (Safeguarding Children and Young people against Radicalisation and Violent Extremism) http://www.proceduresonline.com/swcpp/somerset/p_sg_ch_extremism.html?zoom_highlight=prevent

12.8 Tools and resources:

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

13 PRIVATE FOSTERING

13.1 A private fostering arrangement is essentially one that is made without the involvement of a Local Authority for the care of a child under the age of 16 (under 18 if disabled) by someone other than a parent or close relative for 28 days or more.

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

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

13.3 Under the Children Act 1989, private foster carers and those with Parental Responsibility are required to notify the local authority of their intention to

privately foster or to have a child privately fostered, or where a child is privately fostered in an emergency.

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

13.5 Relevant policies and procedures:

- SWCPP (Private Fostering) http://www.proceduresonline.com/swcpp/somerset/p_ch_living_away.html?zoom_highlight=private+fostering#priv_fost

- Somerset Direct: http://www.somerset.gov.uk/childrens-services/adoption-and-fostering/private-fostering/

14 SAFEGUARDING DISABLED CHILDREN

14.1 The Disability Discrimination Act 2005 (DDA) defines a disabled person as someone who has: "A physical or mental impairment which has a substantial and long term adverse effect on his or her ability to carry out normal day to day activities". By definition, any child with a disability should also be considered as a child in need under s17 of the Children Act 1989.[11]

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

14.3 Research suggests that children with a disability may be generally more vulnerable to significant harm through physical, sexual, emotional abuse and / or neglect than children who do not have a disability.

14.4 The national guidance Safeguarding Disabled Children - Practice Guidance (DCSF 2009 (no update available since 2009) provides a framework collaborative multi-agency responses to safeguard disabled children.

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

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

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

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

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

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

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

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

14.8 Relevant policies and procedures:

- SWCPP (Disabled Children) http://www.proceduresonline.com/swcpp/somerset/p_disabled_ch.html?zoom_highlight=safeguarding+disabled+children
- Safeguarding Disabled Children: Practice Guidance. 2009. https://www.gov.uk/government/publications/safeguarding-disabled-children-practice-guidance

15 CHILDREN LOOKED AFTER

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

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

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

15.4 The Royal Colleges of Nursing and GPs developed a framework for healthcare staff to understand their role and responsibilities for meeting the needs of looked after children. It sets out the required knowledge, skills, attitudes and values required with the ultimate aim of improving life experiences for some of the most vulnerable children in society[12].This can be located on the Royal College of Paediatrics and Child Health website: http://www.rcpch.ac.uk/improving-child-health/child-protection/looked-after-children-lac/looked-after-children-lac

15.5 Relevant policies and procedures:

- Promoting the health and wellbeing of children looked after. 2015 https://www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-looked-after-children--2
- Children Living and Staying Away from Home including Private Fostering http://www.proceduresonline.com/swcpp/somerset/p_ch_living_away.html

16 WHO TO CONTACT FOR ADVICE AND SUPPORT

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

16.2 Early Help Advice Hub on **01823 355803** - an advice line for professionals to discuss families who may need Early Help support **(not for cases at child protection Level 4 threshold)**

16.3 If you are worried about a child or young person who could be in danger **(child protection Level 4 threshold)** please contact Children's Social Care on **0300 123 2224**.

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

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

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

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

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

17 ADDITIONAL RESOURCES FOR ADVICE, SUPPORT AND INFORMATION

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

17.2 **This guidance aims to make existing levels of need clearer for professionals so you can identify if a child or family might need some help and support.** Understanding when children and families might need support can ensure they are given the right service, in the right place, at the right time.

17.3 Effective Support outlines in detail the four thresholds, and will help you to identify what threshold your concerns meet. It also guides you as to what kind of specific information is required, when referring a child to the Early Help Hub or Childrens Social Care.

Somerset Professional Choices

17.4 You can find information, advice and guidance on the Professional Choices website. Somerset Professional Choices is a website that makes it easier for professionals to work together towards better outcomes for children, young people and their families, including vulnerable adults. All practitioners who work with children are encouraged to register.

Somerset Safeguarding Children Board

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

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

- Developing multi-agency policies and procedures for safeguarding

- Participating in the strategic planning of children's services
- Communicating the need to safeguard and promote the welfare of children to professionals and the public
- Conducting Serious Case Reviews when a child dies or is seriously harmed and abuse or neglect is suspected
- Ensuring procedures to ensure a coordinated response to unexpected child deaths
- Collecting and analysing information about all child deaths that occur in the area to identify issues of concern
- Providing multi-agency training and development to staff on safeguarding children

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

18 EARLY HELP AND CHILD PROTECTION REFERRALS

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

18.2 When external authorities need to be contacted, the relevant details are below. For Child Protection referrals Children's Social Care should be contacted first unless it is an emergency then call 999, followed by Children's Social Care. If a child requires a child protection medical assessment always contact the Consultant Paediatrician via the Hospital switchboard in conjunction with an urgent referral to Childrens Social Care. **A GP should never complete a child protection medical but advise the referrer to ensure this is undertaken by a Specialist Consultant Paediatrician.**

18.3 Remember - consider what the level of need is and consult the Thresholds Guidance 'Effective support for children and families in Somerset' (link in 18.1 above)

Early Help Assessment (EHA at Level 2/3)

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

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

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

18.7 It is possible for different agencies to provide a targeted service to different members of a family at this level, by talking to the family about completing an EHA. **Consent is required for the completion of an EHA at Level 2 or 3 but not for child protection referrals (Level 4).**

18.8 If you require any advice or support with completing an EHA (Level 2 or 3), please contact the Early Help Advice Hub email: EHACoordinator@somerset.gov.uk, or telephone: 01823 355803. http://professionalchoices.org.uk/eha/

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

Early Help Referral

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

- Support children, young people and families to help themselves and become more resilient
- 'Think family' and quickly identify children, young people and families who need extra help
- Act quickly with effective interventions as soon as they know help is needed
- Use assessments to make sure the response is appropriate to the identified need
- https://choices.somerset.gov.uk/025/getset-what-they-do/

18.11 The Level 3 service provides targeted support for families that are assessed to require support at Level 3 on the Effective Support 'Thresholds for Assessment' and that meet at least two of the government's 'Troubled Families' criteria (criteria on link above)

18.12 Level 3 referrals to Getset should be made using the EHA form, with the families' informed consent and emailed to the Early Help Hub on EHACoordinator@somerset.gov.uk. The current version of the EHA can be accessed at: http://professionalchoices.org.uk/eha/

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

Child Protection (Level 4) referrals

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

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

18.16 Professionals can complete a Level 4 child protection referral using the EHA and identify within section 7 that it is a Level 4 safeguarding referral. Level 4 child protection referrals should be sent to SDInputters@somerset.gov.uk. If there is an immediate risk to a child please call 0300 123 2224 as above in section 19.2.

Somerset Direct (Childrens Social Care)

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

19 ESCALATION / RESOLVING PROFESSIONAL DIFFERENCES (RPD)

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

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

19.3 Differences most likely to arise may be:

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

- Roles and responsibilities of workers
- Service provision
- Timeliness of interventions
- Information sharing and communication
- Decisions about the need for child protection conferences
- Decisions made at child protection conferences

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

19.5 The diagram shown in the RPD Protocol Appendix 2 outlines the complete process. It should be remembered that differences can be resolved at any stage in the resolution process.

19.6 The RPD Form should be completed once Step 3 has been reached. Please see RPD Protocol 2018 that can be found here: http://sscb.safeguardingsomerset.org.uk/working-with-children/local-protocols-guidance/

19.7 If you would like advice about a difficult safeguarding children situation, or are unhappy about the outcome of a referral, please contact the CCG Safeguarding Children team. Contact details are available here: http://www.somersetccg.nhs.uk/about-us/how-we-do-things/safeguarding-children/

20 ALLEGATIONS AGAINST STAFF

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

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

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

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

- behaved in a way that has harmed a child, or may have harmed a child
- possibly committed a criminal offence against or related to a child
- behaved towards a child or children in a way that indicates they may pose a risk of harm to children

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

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

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

- Be involved in the management and oversight of individual cases;
- Provide advice and guidance to employers and voluntary organisations;
- Liaise with the police and other agencies;
- Monitor the progress of cases to ensure that they are dealt with as quickly as possible consistent with a thorough and fair process.

20.7 Referrals to the Somerset Local Authority Designated Officer (LADO) are via Somerset Direct (Childrens Social Care): Telephone: **0300 123 2224.**

20.8 Relevant policies and procedures:

- SWCPP (Allegation against staff or volunteers) http://www.proceduresonline.com/swcpp/somerset/p_alleg_against_staff.html?zoom_highlight=ALLEGATIONS+AGAINST+STAFF
- Somerset Safeguarding Children Board website http://sscb.safeguardingsomerset.org.uk/working-with-children/allegations-management/
- Managing Safeguarding Allegations Against Staff Policy and Procedure. NHS England. 2015 https://www.england.nhs.uk/?s=safeguarding+allegations+against+staff&order-by=relevance

21 CHILD DEATH

The Child Death Review Process is outlined in Chapter 5 in 'Working Together to Safeguarding Children' (HM Government 2018)

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

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

22 INFORMATION SHARING

22.1 In England and Wales, the Children Acts of 1989 and 2004 gave all staff a statutory duty to co-operate with other agencies if there are concerns about a child's safety or welfare.[13]

22.2 The Children, Schools and Families Act 2010 section 8 amends The Children Act 2004, providing further statutory requirements for information sharing when the LSCB requires such information to allow it to carry out its functions.[14]

22.3 The General Medical Council is clear that Doctors 'must tell an appropriate agency, such as your local authority children's services, the NSPCC or the police, promptly if you are concerned that a child or young person is at risk of, or is suffering, abuse or neglect unless it is not in their best interests to do so'.[15]

22.4 Working Together to Safeguard Children 2018[16] states that:

- "*Effective sharing of information between professionals and local agencies is essential for effective identification, assessment and service provision to keep children safe.*
- *Fears about information sharing must not be allowed to stand in the way of the need to promote the welfare and protect the safety of children which must always be of paramount concern"*
- Practitioners must have due regard to the relevant data protection principles which allow them to share personal information, as provided for in the Data Protection Act 2018 and the General Data Protection Regulation (GDPR). To share information effectively:
    - all practitioners should be confident of the processing conditions under the Data Protection Act 2018 and the GDPR which allow them to store and share information for

[13] Children Act 2004 sections 10 and 11 http://www.legislation.gov.uk/ukpga/2004/31
[14] Children Schools and Families Act 2010 section 8 http://www.legislation.gov.uk/ukpga/2010/26
[15] Protecting children and young people: The responsibilities of all doctors (2012) http://www.gmc-uk.org/guidance/ethical_guidance/13257.asp
[16] https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

safeguarding purposes, including information which is sensitive and personal, and should be treated as 'special category personal data'

- where practitioners need to share special category personal data, they should be aware that the Data Protection Act 2018 contains 'safeguarding of children and individuals at risk' as a processing condition that allows practitioners to share information.

22.5 Consent should be sought to share information unless:

- that would undermine the purpose of the disclosure (for example in suspected fabricated & induced illness and sexual abuse)
- action must be taken quickly because delay would put the child at further risk of harm
- it is impracticable to gain consent
- to do so would put the child or the staff member at risk

22.6 Working Together 2018 is clear that practitioners can and should share information without consent, for the reason given above, in order to safeguard and protect the wellbeing of the child at risk.

22.7 When health professionals are asked for information about a child or family, they should verify the identity of the enquirer and clarify the grounds on which the information is being requested. The proportionality principle still applies, in that only information for the purpose of the enquiry is shared, not the full records held by the health professional or agency. This may mean relevant information about parents/carers needs to be shared, when the information request relates to a child.

22.8 Relevant policies and procedures:

- SWCPP (Information Sharing) http://www.proceduresonline.com/swcpp/somerset/p_info_sharing.html?zoom_highlight=information+sharing
- Information sharing advice for safeguarding practitioners: Guidance on information sharing advice for people who provide safeguarding services to children, young people, parents and carers. July 2018: https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice

23 SERIOUS CASE REVIEWS (SCR)

23.1 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. Under the Children Act 2004, as amended by the Children and Social Work Act 2017, LSCBs, set up by local authorities, will be replaced. Under the new legislation, the three safeguarding partners (local authorities, chief officers of police, and clinical commissioning groups) must make arrangements to work together with relevant agencies (as they consider

appropriate) to safeguard and protect the welfare of children in the area. This includes the requirement for LSCB / Multi-agency safeguarding partnership to undertake reviews of serious cases in specified circumstances.

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

- abuse or neglect of a child is known or suspected; and
- either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.
- "Seriously harmed" includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all of the following:
    - A potentially life-threatening injury;
    - Serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.

23.3 The LSCB / Multi-agency safeguarding partnership will ensure appropriate representation in the review process of professionals and organisations involved with the child and family, establish timescales for action to be taken, agree success criteria and assess the impact of the actions.

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

23.5 In addition, the LSCB / Multi-agency safeguarding partnership can require a person or body to comply with a request for information, under Section 14B of the Children Act 2004.This takes place as the information is essential to carrying out LSCB / Multi-agency safeguarding partnership statutory functions.

23.6 Relevant policies and procedures:

- SWCPP (SCRs) http://www.proceduresonline.com/swcpp/somerset

24 COURT REPORTS AND WITNESS STATEMENTS

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

24.2 Relevant policies and procedures:

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

25 CHILD PROTECTION CONFERENCES

25.1 All staff that receive an invite to a Child Protection Case Conference must prioritise this if the child and family are well known to you and you have important information to share

25.2 A written report must be provided even if that report states that the professional concerned has not had any recent contact with the child and / or their family. The Children's Social Care (CSC) proforma for Case Conference reports should be used, completing as much of the template as possible, but recognising that there may be limits to the information you have to share. The correct template will be sent as part of the invitation to the Case Conference which is based on the children and families triangle model of assessment:

- child's developmental needs
- parenting capacity
- family and environmental factors

25.3 All Case Conference reports must be submitted in advance of the Case Conference date to the Conference Administrator. Reports will be completed and submitted electronically to the relevant local CSC office. This address will be stipulated on the Case Conference Invitation. It is good practice to share the report with the parents/carers and child themselves if appropriate. Liaison with other health professionals who may also be working with the family is also recommended.

26 MANDATORY SAFEGUARDING CHILDREN TRAINING

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

- Safeguarding Children and Young People: roles and competences for health care staff, RCPCH (2018); Safeguarding Children and Young People: Roles and Competences for Health Care Staff (Intercollegiate Document 2018).
- Looked after children: Knowledge, skills and competences of health care staff, RCN and RCPCH, (2015); Looked After Children Knowledge, skills and competences for healthcare staff
- Protecting children and young people: the responsibilities of all doctors, GMC (2012). Protecting children and young people: The responsibilities of all doctors

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

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

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

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

- Level 1: Non-clinical staff working in health care settings.
- Level 2: Minimum level required for non-clinical and clinical staff that have some degree of contact with children and young people and/or parents/carers.
- Level 3: Clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.
- Level 4: Named safeguarding professionals (such as the CCG Named GP role)
- Level 5: Designated safeguarding professionals
- Board Level: Chief Executive Officers, Trust and Health Board Executive and non-executive directors / members, commissioning body Directors

26.6 A minimum of 2 hours per year / 6 hours in 3 years safeguarding children training is required for all clinical staff working with children / Level 3.[18]

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

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

27 SUMMARY

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

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

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

APPENDIX 1: GUIDANCE FOR RECORDING AND STORING OF SAFEGUARDING INFORMATION IN PRIMARY CARE

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

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

Safeguarding information received should be reviewed by the relevant GP and must be scanned and documented within all people named within the documents records. These records are as important as records of serious physical illness and should be recorded in the same way, with the same degree of permanence and not kept separately from the main record.

'Think Family'

A Child's records should be linked in some way to parents even if not living at the same address, siblings and others in household by use of appropriate templates and codes. Child Protection/Safeguarding Read/SNOMED codes should be entered into notes of ALL individuals living at same address.

All contacts with any parties regarding any safeguarding children issues/concerns should be recorded on the patient's medical records and any necessary action taken immediately.

This includes:

- Child Protection investigations i.e. Strategy meetings, Child Protection Conference reports and minutes, Child In Need meeting plans and minutes, Core Group minutes.
- Child Protection Case Conference records.
- MARAC referrals and information (on ALL named persons records)
- Police Domestic Abuse Incident Notifications (on ALL named persons records)
- Child Looked After Health Reviews and information
- Team Around the Child/School information
- A&E/MIU/Midwifery Safeguarding notifications/ Out Of Hours GP reports
- Practice Child Protection Team meetings, where discussion of all practice children subject to child in need or child protection plans, or any other children/families where there are concerns, are discussed. The record for each family member must highlight any agreed actions to be taken as a result.

APPENDIX 2 CHILD PROTECTION CASE CONFERENCE PLANS AND MINUTES

- GPs will receive the full Case Conference (CC) minutes (with the CP plan and actions) which includes details of decisions made and whether the unborn baby or child/ren has been placed on a CP or Child in Need Plan. The CC minutes, including the Child Protection Plan and any health agency reports should always be scanned and recorded within the child/ren's medical records and all named parties (in the case of an unborn baby with the mother's records). NB there is no need to scan and record any third party reports such as Education or Housing reports as Childrens Social Care will store these.

- The Practice Safeguarding Lead will need to ensure that any actions required of the Practice in relation to parental/carer or the child/ren's health is carried out and outcomes communicated to the Social Worker via the Review Conference.

- Parent/carer non-compliance with health care plans should be communicated to the social worker as soon as discovered because this may be an important sign of increasing risk to the child.

- GP electronic recording systems all have diaries. The date of the Review Case Conference is included within the CP plan/minutes and this serves as your invite to future conferences in order to plan ahead. The details of the Review Case Conference should be added to the electronic diary when the CP plan and CC minutes are first received.

Case conference minutes frequently raise concerns because of their size and content (with some relating to third parties). The table below refers to case conference summaries and minutes[19]:

	Read/SNOMED Code	Scan summary / CP plan	Scan full Case Conference Minutes
Child(ren) –subject(s) of conference	Yes	Yes	Yes[32]
Adults & other household members named in report	Yes	Yes	No

You should store information or records from other organisations, such as minutes from child protection conferences, with the child's or young person's medical record. [20] Whilst GPs may have concerns about third party information contained in case conference minutes, part of the solution is to remove this information when copies of medical records are released for any reason, rather than not permitting its entry into the medical record in the first place.

[19] Safeguarding Children & Young People - A Toolkit for General Practice, RCGP & NSPCC 2011.
[20] GMC Protecting-children-and-young-people

APPENDIX 3: READ / SNOMED CODES FOR USE IN PRIMARY CARE

Code	Classification on NHS Digital / SNOMED wording	Rationale for use of code in Primary Care
836881000000105	Child is cause for safeguarding concern (finding)	Use this code if discussing in CP meetings but does not meet level 4 threshold
1064961000000107	Child in family is safeguarding concern	Use this code if discussing sibling (of a child) or child (of an adult) in CP meetings but does not meet level 4 threshold
878111000000109	Unborn child is cause for safeguarding concern	Use this code if discussing in CP meetings. If using this code practitioner should refer to multi agency pre-birth protocol
1060581000000100	Early Help Assessment (procedure)	Use this code when completing an EHA- for single / multi-agency assessment of need only. (Level 1 universal service only)
1097361000000103	Signposting to Early Help Service (procedure)	Use this code when completing a Level 2 / 3 (child / family in need of support) referral to Getset / other early help services listed on Professional Choices.
380491000000101	Referral to child protection service (procedure)	Use this code when submitting Level 3 (complex in need of protection) and 4 / child protection referral to Children social care (irrespective of what format used for referral)
1047341000000106	Early Help Assessment Team Around the Child meeting (procedure)	Use this code when attending a team around the child meeting for a child / family.
762931000000105	Child protection strategy meeting (procedure)	Use this code when part of a strategy discussion / when attending a strategy meeting
184062003	Patient not registered (finding)	Use this code when patient has a child that isn't registered any other practice but has been seen with either parent since birth.
Child protection case conference		
375041000000100	Family member subject of child protection plan (situation)	Use this code for sibling / parent of a child, when a child becomes subject to a CP plan
375071000000106	Family member no longer subject of child protection plan (situation)	Use this code when a sibling / child (of a parent) is no longer subject to a CP plan
818901000000100	Unborn child subject to child protection plan (finding)	Use this code to log under mother that unborn child has become subject to a CP plan
1025431000000104	Unborn child no longer subject to child protection plan (finding)	Use this code to log under mother when unborn baby subject to CP

		plan has now been born / as code will be entered on child's record to show 'subject to a CP plan'.
342191000000101	Subject to child protection plan (finding)	Use this code to identify when a child becomes subject to a CP plan
342891000000105	No longer subject to child protection plan (finding)	Use this code to identify when a child is no longer subject to a CP plan
1036511000000100	Child protection conference report submitted (finding)	Use this code when **submitting a** child protection case conference **report**
408770006	Child protection case conference (procedure)	Use this code when recording **attendance** at a case conference for a child / adult
229058001	Case conference (procedure)	Use this code when **invite** to child protection case conference is received.
913841000000107	Child protection core group meeting (procedure)	Use this code when attending a CP core group meeting
Child In Need		
836931000000102	Subject of child in need plan (finding)	Use this code to identify when a child has been designated as Child In Need
135890008	Child no longer in need (finding)	Use this code to identify when a child no longer becomes Designated as a CIN
1053651000000109	Child in Need meeting (procedure)	Use this code when attending a CIN meeting
Records Management		
1077911000000105	Safeguarding (record artifact)	Use this code when receiving all safeguarding records related to a child: • Strategy meetings • Minutes from multi agency meeting regarding a child e.g. Child Protection Conference / CIN / CLA Review / core group • MARAC referrals • Police Domestic Abuse Incident Notifications (DAIT / Merlin / Form 72) (on all named persons records) • Child Looked After Health Assessment / Form C
Domestic Abuse		
371772001	Domestic abuse (event)	Use this code on all named person's record when police Domestic Abuse Incident Notifications (DAIT / Merlin / Form 72) received, regarding a Domestic Abuse incident.
886201000000108	Assessment using Domestic	Use this code when completing a

	Abuse, Stalking and Harassment and Honour Based Violence (2009) Risk Identification and Assessment and Management Model Checklist (procedure)	DASH RIC checklist with a patient, due to concerns about domestic abuse.
978091000000105	Referral to multi-agency risk assessment conference (procedure)	Use this code when referring a patient to MARAC for high risk domestic abuse
758941000000108	Subject of multi-agency risk assessment conference (finding)	Use this code when receiving notification that a patient has been discussed at MARAC / You have called in or attended a MARAC regarding your patient
Children Looked After (CLA)		
764841000000100	Looked after child (finding)	Use this code to identify when a child has become looked after
764951000000107	No longer subject of looked after child arrangement (finding)	Use this code to identify when a child is no looked after
764881000000108	Looked after child review meeting (procedure)	Use this code when attending a CLA review
764201000000104	Looked after child health assessment annual review (regime/therapy)	Use this code when you complete a review health assessment for a CLA
Topaz / Child Sexual Exploitation		
919461000000108	At risk of sexual exploitation (finding)	Use this code when notified by Topaz that child is subject to discussion at Topaz for possible CSE
785101000000105	Victim of sexual exploitation (finding)	Use this code when notified by Topaz that child is subject to discussion at Topaz for actual CSE
1086791000000109	Child is cause for concern regarding sexual exploitation (finding)	Use this code when notified by Topaz that child is subject to discussion at Topaz for possible CSE

APPENDIX 4: ROLE OF GP SAFEGUARDING CHILDREN LEADS

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

The GP Safeguarding Children Leads are responsible for:

- ensuring the GP practice has an up to date child protection policy of their own, or has adopted this CCG safeguarding children policy.
- ensures that the practice meets contractual guidance and legislation in relation to safeguarding and promoting the wellbeing of unborn babies, children and young people.
- ensure that the practice hold regular meetings to discuss vulnerable children and families, seeking to involve other agencies in these meetings as appropriate and available, such as Public Health Nurses, Midwifery, CAMHS, Social Care etc. This is to ensure early recognition of circumstances leading to abuse and neglect and identification of this can be addressed by agencies.
- ensures safe recruitment procedures.
- supports reporting and complaints procedures in relation to children and young people.
- advises practice members about any concerns that they have in relation to safeguarding children practice.
- ensures that practice members receive adequate support and advice when dealing with early help and safeguarding concerns.
- leads on analysis of relevant significant events in respect of safeguarding children.
- provides advice, support and signposting to resources and opportunities for safeguarding children training to all practice staff, as detailed in the Intercollegiate Document (section 26).
- provides safeguarding children training to practice colleagues as when appropriate and available.
- makes recommendations for change or improvements in practice procedural policy.
- acts as a point of contact for the practice in relation to safeguarding and promoting the welfare of children, including liaison with the CCG's safeguarding children team.
- act as a conduit for the practice in relation to cascading and dissemination of safeguarding children tools, newsletters and resources.
- attendance and participation at the quarterly CCG Primary Care safeguarding children forum wherever possible.