

Safeguarding Policy for Children and Young People Aged 0 – 18 Years

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Name and designation of originator/ author (Lead Officer):	Sue Thompson, Named Nurse Safeguarding Children
Name of responsible committee/ individual:	Healthcare Governance Committee/ Clare Hawkins
Name of executive lead:	Clare Hawkins, Director of Quality & Governance
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Safeguarding Policy for Children and Young People Aged 0 – 18 Years
Policy No: CP46 0915

Version: 3
Lead Author: Sue Thompson
Lead Director: Clare Hawkins
Who is this document applicable to:
All staff working with Children for or on behalf of Hertfordshire Community NHS Trust (HCT).
Date ratified:

Scope: This policy is applicable to all staff working for, or on behalf of the Trust (HCT) which includes all bank, agency and volunteer staff
Purpose: to assist professionals within the Trust to play an active role in safeguarding children and young people and understand their on-going roles and responsibility in regard to vulnerable children and young people according to statutory guidance, professional codes of practice and Trust policy.

Key component/main content of the Policy:
An understanding of the whole safeguarding children process which also includes:

- Roles and responsibilities when there is a concern about children and young people.
- Pathways to follow to safeguard children
- The referral process to the statutory agency and other support agencies.
- Multi-agency partnership working to safeguard or identify risks to children.

Other policies that this policy should be read in conjunction with:

- HCT Procedures are complementary to the Hertfordshire Safeguarding Children Board Procedures Hertfordshire Safeguarding Children Board Procedures and Southend, Essex, Thurrock Child Protection Procedures Manual 2015 (SET Procedures) and should be used in conjunction with them.
- This policy needs to be read in conjunction with the following HCT policies, guidance and documents/ forms listed on page 7 (1.6) and are available via HCT intranet:

General Procedure guidance
All staff working within for, or on behalf of the Trust must act within the procedures.

Specific procedure for individual group:
Procedures detailed in the policy apply equally to Children’s Services and teams.

Specific training info for staff:
Policy provides procedural information.

Governance & Escalation:
If you require any guidance about the policy itself contact Named Nurse for Safeguarding Children

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1. Introduction

- 1.1 Health professionals are in a unique position to offer help and support to vulnerable children, young people, their families and carers. They are often the first practitioners to become aware that individuals and families are struggling with care. It is important that staff are able to recognise and respond when a child or young person's welfare or safety may be at risk either from their carers, individuals or a group known to them, via the internet, or by placing themselves at risk by their behaviour. Working Together to Safeguard Children (2015)¹ identifies all health professionals working with children and young people should ensure that safeguarding and promoting their welfare forms an integral part of all elements of care. Practitioners who work with children, young people and their families should be able to:
- Understand risk factors and recognise children and young people in need of support and/or safeguarding
 - Recognise the needs and capacity of parents who may need extra support with their children, and know where to refer to for help and the use of early help strategies to access support as appropriate for them
 - Recognise the risks of abuse and neglect to the unborn child
 - Communicate effectively with children and young people and stay focused on their safety and welfare
 - Liaise closely with other agencies, including other health professionals, and share information as appropriate
 - Plan and respond to the needs of children and their families, particularly those who are vulnerable; contribute to child protection conferences, family group conferences and strategy discussions
 - Help ensure that children who have been abused or neglected and parents under stress have access to services to support them
 - Be alert to the strong links between adult domestic violence, substance misuse and child abuse, recognising when a child is in need of help, services or at potential risk of suffering significant harm
 - Where appropriate play an active part in the Child Protection Plan (CPP), Child in Need (CIN) or Early Help agenda in keeping children safe; generally safeguarding children and young people by providing on-going promotional and preventative support, through proactive work with children, families and expectant parents
 - Where appropriate contribute to child death, Serious Case Reviews (SCR), Domestic Homicide Reviews (DHR) and the implementation of lessons learned
- 1.2 The identification of safeguarding issues should be approached in the same rigorous manner as any other health issue. This is very important because effective intervention can improve or save a child's life, protect siblings, the child's wider friendship group or children in the Community. Early intervention may prevent serious disability, and promote healthy development. Failure to recognise that a child may have been abused, neglected or at risk can have serious long-term consequences, including death or disability.
- 1.3 Therefore all staff employed by Hertfordshire Community Trust (HCT) who come into contact with children or adults who care for them should not only be able to recognise and know how to act upon indicators that a child's welfare or safety may be at risk but also play an active part in protecting children in co-operation with other statutory agencies.
- 1.4 The policy clarifies the roles, responsibilities and processes for staff with regard to safeguarding children and young people.
- 1.5 The policy will enable all staff to promote the welfare of and safeguard children and young people who are or may be at risk of significant harm, this responsibility starts as soon as employment commences.

¹https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf.

- 1.6 This policy needs to be read in conjunction with the following HCT policies, guidance and documents/ forms available via [HCT intranet](#):
- [Access to Health Records](#)
 - [Allegations and Suspicions of Child Abuse against Staff](#)
 - [Safeguarding Supervision](#)
 - [Freedom of Information \(FOI\) Requests to HCT](#)
 - [FAX Guidance](#) for Sharing Confidential and Personal Information
 - [Interpreting Service](#) information for staff
 - [Lone Worker Policy](#)
 - [Transfer Records Guidance](#)
 - [Conference Report](#) & Guidance
 - [Child protection referral form](#) (Hertfordshire)
 - [Child Protection - Transfer of Health Care Records](#)
 - [Domestic Abuse Guidance](#)
 - [Children's Services Referral Guidance](#) and single service request Form - Hertfordshire
 - Family Operations Request for Support (FORS) [Form](#) – West Essex - (this has replaced the ECC999 interagency referral form)
 - [Recording Safeguarding Children Information on SystemOne](#)
 - [Single Service Request Form](#)
 - Southend Essex and Thurrock Safeguarding and Child Protection Procedures ([SET Procedures](#))
- 1.7 This version supersedes any previous versions of this document.

2. Purpose

- 2.1 The purpose of this policy is to assist professionals within the Trust play an active role in safeguarding children and understand their on-going roles and responsibility in regard to vulnerable children and young people according to statutory guidance, professional codes of practice and Trust policy.
- 2.2 HCT Procedures are complementary to the Hertfordshire Safeguarding Children Board Procedures [Hertfordshire Safeguarding Children Board Procedures](#) and Southend, Essex, Thurrock Child Protection Procedures Manual 2015 ([SET Procedures](#)) and should be used in conjunction with them.
- 2.3 All Trust staff must abide by the above Safeguarding Children Board Procedures, Professional Codes of conduct and the Hertfordshire Community NHS Trust guidelines and policies for their own speciality. This Policy has been created in accordance with the requirements of The Children Act 1989 and 2004. Working Together 2015. It has also utilised learning and recommendations from Local and National Reviews. The policy refers to and links to other Hertfordshire Community NHS Trust policies and guidelines, Hertfordshire Safeguarding Children Board, SET Procedures and other nationally recognised guidance.

3. Scope

- 3.1 This policy is applicable to all staff working for, or on behalf of the Trust (HCT) which includes all bank, agency and volunteer staff.

4. Explanation of Terms and Definitions

- 4.1 **Child** - In this document, as in the Children Acts 1989 and 2004:7, a 'child' is anyone who has not yet reached their 18th birthday. The fact that a child has reached 16 years

of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate for children and young people, does not change his/her status or entitlement to services or protection under the Children Act 1989 (Working Together HM Government 2015).

4.2 **Vulnerable Child** - A vulnerable child includes but is not exclusively Children in Need, Children subject to a Child Protection Plan and Looked After Children. Vulnerability is defined as the risk that a young person might be harmed in some way either through their own behaviour or because of the actions or omissions of others (Department of Education 2013: 35)².

4.3 **Safeguarding Children** is defined (in Working Together 2015) as:

- protecting children from maltreatment
- preventing impairment of children's health or development
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care and
- taking action to enable all children to have the best outcomes including Assessment, planning and review, enquiry, referral

4.4 **Child in need** - Section 17 of the [Children Act 1989](#) defines a child as being in need in law if:

- He or she is unlikely to achieve or maintain or to have the opportunity to achieve or maintain a reasonable standard of health or development without provision of services from the LA;
- His or her health or development is likely to be significantly impaired, or further impaired, without the provision of services from the LA;
- He or she has a disability.

The critical factor to be taken into account in deciding whether a child is in need under the Children Act 1989 is what will happen to the child's health or development without services, and the likely effect the services will have on the child's standard of health and development.

4.5 **Significant Harm** - The [Children Act 1989](#) introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children, and gives local authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering or likely to suffer, significant harm.

Decisions about significant harm are complex and should be informed by a careful assessment of the child's circumstances and discussion between the statutory agencies and with the child and family.

4.6 **Section 47** - Section 47 of the [Children Act 1989](#) places a duty on LA's to investigate and make inquiries into the circumstances of children considered to be at risk of 'significant harm' and, where these inquiries indicate the need, to decide what action, if any, it may need to take to safeguard and promote the child's welfare. The investigation will form a core assessment, which is an in-depth assessment of the nature of the child's needs and the capacity of his or her parents to meet those needs within the wider family and community context.

The results of that assessment will form part of the LA's evidence if it commences proceedings for a Care or Supervision Order.

4.7 **Strategy Meeting** - Also referred to as a strategy discussion. This is initiated by Social

² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417669/Archived-Working_together_to_safeguard_children.pdf

Care where there is reasonable cause to suspect the child is suffering or likely to suffer significant harm. The purpose is to agree whether to initiate enquiries under section 47 of the Children Act and to plan a core assessment. It also identifies the tasks and time scales for each professional and agency involved and to agree what further help and support is necessary.

- 4.8 **Core Assessment** - This is an in depth assessment carried out under section 47 of the Children Act that addresses the central or most important aspects of the needs of a child and the capacity of the parents or caregivers to respond appropriately to these needs within the wider family and Community context.
- 4.9 **Case Conference** - This is a meeting chaired by Social Care and attended by all professionals directly or indirectly involved with the child and family. The conference will decide whether the child is at continuing risk of significant harm and whether they need to have a Child in Need (CIN) plan or Child Protection Plan put in place. Trust staff must prioritise Case Conferences in their work planning. Regular reviews will be held to ensure that the plan that the conference puts in place is working to protect the child
- 4.10 **Looked after Children (LAC)** - The term Children Looked After (Children in Care) has a specific legal meaning based on the Children Act 1989. A child is looked after by a local authority if he or she has been provided with accommodation for a continuous period of more than 24 hours, in the circumstances set out in sections 20 and 21 of the Children Act 1989, or is placed in the care of a local authority by virtue of an order made under part IV of the Act. This can happen voluntarily by parents struggling to cope or through an intervention by Children's Services because a child is at risk of significant harm. There are also other guardianship orders and agreements which do not mean that the child is in the care of the local authority, if you are unsure please discuss this with your safeguarding supervisor.
- 4.11 **Multi-Agency Safeguarding Hub (MASH)** - This is a multi-agency hub which brings professionals from partner agencies together to deal with safeguarding concerns. Within MASH information from partner agencies is collated to assess risk and decide what action to take. As a result, the agencies will be able to act quickly, in a coordinated and consistent way, ensuring that vulnerable children and families are kept safe from harm.
- 4.12 **SEARCH** - Police led Multi-Agency Sexual Exploitation meetings. The purpose of the SEARCH meetings is to share information and intelligence on individual cases; including information of children, who go missing, are at risk of sexual exploitation, identify trends and to provide a strategic response to child sexual exploitation locally.
- 4.13 **Abuse and Neglect** - A person may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children and young people may be abused in a family or in an institution or community setting, by those known to them or, more rarely, by a stranger. They may be abused by an adult or adults, or another child or children.
- Staff need to be sensitive to race, ethnicity, culture, disability and family values. Differences in upbringing should be respected; but staff should challenge behaviour which may be abusive or likely to put a child or young person at risk of significant harm. Child Abuse is broken down into four distinct categories (Physical, sexual, emotional and neglect) which are defined in Working Together to Safeguard Children (2015) as below.
- 4.14 **Physical abuse** may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child, including by fabricating the symptoms of, or deliberately causing ill health to a child.
- 4.15 **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. This 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 or groups of individuals.

Children under sixteen years of age cannot lawfully consent to sexual intercourse, although in practice may be involved in sexual contact to which, as individuals, they have agreed. **A child below thirteen years of age is considered in law incapable of providing consent to sexual intercourse.**

- 4.16 **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.

- 4.17 **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 and clothing, shelter, (including exclusion from home or abandonment,);
- protect a child from physical and emotional harm or danger,
- Ensure adequate supervision; (including the use of inadequate care-takers) ensure access to appropriate medical care or treatment.
- May also include neglect of, or unresponsiveness to, a child's basic emotional needs.

- 4.18 **Domestic Violence and abuse** is described as 'Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse (psychological, physical, sexual, financial, or emotional) between those aged 16 or over who are or have been intimate partners or family members, regardless of gender or sexuality' <https://www.gov.uk/domestic-violence-and-abuse>.

5. Ownership, Roles and Responsibilities

The generic statement of roles and responsibilities of The Trust Board, Designated Committee, The Executive Team, Chief Executive Officer, Lead Executive Director, Lead Officer, Deputy Directors/ General Managers, Line Managers, All Staffs, Policy Lead and Communication Lead applicable to all the HCT policies/ procedural documents are in line with the HCT (Trust) [GR1 0114 V.3](#). Roles and responsibilities specific to this particular policy are defined below.

5.1 Board Sub Committee (Designated Committee)

- 5.1.1 'Patient Safety & Experience Group' (PSEG) is the Designated Committee for this policy.

5.2 Lead Executive Director

- 5.2.1 The 'Director of Quality & Governance/ Chief Nurse' is the identified Lead Executive Director for this policy.

5.3 Lead Officer

- 5.3.1 The identified Lead Officer for this policy is the 'Named Nurse Safeguarding Children'.

5.4 General Managers

- 5.4.1 General Managers and through their line managers as appropriate, are responsible for ensuring that their staff comply with this document and that any evidence of non-compliance (individually or collectively) is reported to the Lead Officer and Lead Director taking such action to ensure compliance. Action may include:

- access to training
- use of personal development/ appraisal process
- providing clear instructions and/or briefings to individuals or groups
- In extreme cases, use of performance management/ disciplinary procedures.

5.5 Line Managers

- 5.5.1 Line Managers are responsible for:
- attend or undertake any training in respect of this document as identified by their Line Manager or safeguarding supervisor
 - raise with their Line Manager any issues or concerns they may have in respect of this document, including their understanding or ability to comply with their responsibilities; report in confidence known breaches of this document by others to their Line Manager or professional adviser and the Trust encourages this. If for some reason this is not possible, staff should contact any non-executive Director, Director, the Chief Executive or any senior manager who is independent of their concerns requesting a confidential meeting.
 - Report/ investigate where any breaches have presented or may present a risk of significant harm or loss to patients, staff, the public or the organisation as a whole.

5.6 All Staff

- 5.6.1 All staff should actively safeguard and promote the welfare of children by:
- Being alert to the potential indicators of abuse or neglect in children and know how to act on those concerns in line with local guidance.
 - Taking part in training, including attending regular updates so that they maintain their skills and are familiar with procedures aimed at safeguarding children.
 - Understanding the principles of confidentiality and information sharing in line with local and government guidance.
 - Contributing to, when requested, the multi-agency meetings established to safeguard and protect children.
 - Discussing with their line manager/ Safeguarding Supervisor circumstances, difficulties or problems in their working life which may adversely affect their working relationships and ability to safeguard children. This should be discussed with their line manager so that appropriate support can be provided.
 - Ensuring record keeping complies with individual Professional Codes of Conduct and the Trust's Record Keeping and Documentation Policies.

5.7 **Specialist Group/ Individuals**

5.7.1 **Safeguarding Children's Team** - Responsible for ensuring there is provision of safeguarding support and guidance as required in accordance with these procedures. However it remains the responsibility of individual staff members and their line managers to ensure they are trained at the correct level for their role and that this training is up to date, in accordance to statutory guidelines, professional codes of practice and Trust Policy.

5.7.2 **Safeguarding support** - HCT have identified a Named Nurse and Named Doctor who are supported by Safeguarding Nurse Managers and Specialist Safeguarding Children Nurses. The team work closely with the board lead to ensure all services are aware of their responsibilities, trained and supported at an appropriate level and Safeguarding Policies and Procedures in place. They also work county wide with partner agencies and the CCG's to ensure that HCT are compliant with their statutory and contractual obligations.

The duties of named safeguarding nurse/ doctor include:

- Training- Strategy for all staff to access the appropriate level of training and ensuring
- staff are compliant
- Supervision – empowering staff to reflect on their practice in relation to safeguarding children
- Expertise and advice for all staff on safeguarding issues
- Support clinical governance arrangements through audit.
- Contribute to serious case reviews and/or serious incident reviews

The Safeguarding Team are available for additional specialist support and advice as Supervisors or through the duty safeguarding **urgent advice** line **07881 940233**. Any professional can contact the team, but should make a careful written note of advice given on the child's SystmOne record.

5.7.3 **Independent contractors** who deliver services directly to children, young people and their families should ensure that they:

- Access safeguarding children training in accordance with national and local guidance and competency frameworks.
- Act in accordance with Local Safeguarding Children Boards child protection procedures, policies and guidelines.

5.7.4 **Staff members employed or contracted who do not directly deliver services to individuals** - must ensure that they:

- Access safeguarding children training in accordance with national and local guidance and competency frameworks.
- Act in accordance with Local Safeguarding Children Boards child protection procedures, policies and guidelines.

5.7.5 **Volunteers** - must ensure that they:

- Access safeguarding children training in accordance with national and local guidance and competency frameworks.
- Act in accordance with Local Safeguarding Children Boards child protection procedures, policies and guidelines.

6. **Procedure for handling 'Children in Specific Circumstances' when Abuse is suspected or discovered**

6.1 If you consider a child to be in danger, action must be taken immediately. This may

require calling 999 for police assistance if a child's safety is threatened. If the child is in need of urgent medical care (e.g. when suspected to be home alone, where there are suspected fractures, bleeding, and/or loss of consciousness) an ambulance should be called. Where possible, staff should accompany the child to hospital; never leave the child unattended until they are in the care of another health professional e.g. paramedic, A&E staff. This should be followed by a referral to Children's Social care; the pathway in [Appendix 1](#) illustrates how to refer a child to Children's Social Care.

6.2 **Sexual Abuse:** Where there is a disclosure of sexual abuse, suspicion of sexual abuse or potential sexual exploitation, a practitioner should not ask any more questions than are necessary in the circumstances to take immediate action. Practitioners should avoid asking leading question to the child or family.

- Make a record of all that has been said as soon as possible, using verbatim quotes.
- If the disclosure has been made by a child then parents/carers should not be initially informed of contact with social care as this may increase the risk of harm.
- Contact Children's Social Care for the area the child lives in and agrees a plan of action. A strategy meeting arranged by Children's Social Care will decide whether a medical examination for forensic purposes is required.
- Complete a Child Protection referral form via [Incident reporting](#) (Datix) on the intranet and submit it immediately by e-mail to Children's Social Care for the area to where the child lives. Save the referral form to all health records of children in the household and document a plan of action. If the child lives out of County contact the safeguarding children team for advice.
- Ensure that the Child's GP is aware of the referral verbally and follow up in writing by sharing a copy of the referral form.
- Document on SystemOne regarding the GP liaison, and tick box under safeguarding template to record a referral has been made.
- Further local advice can be found in [HSCB procedures](#) and [SET Procedures](#). Please refer to [Appendix 8](#)

6.3 **Child Sexual Exploitation (CSE):** The National Working Group for Sexually Exploited Children and Young People (2010) developed the following definition of child sexual exploitation which is now used by Government and other organisations -

- 'The sexual exploitation of children and young people under 18 is defined as involving exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities In all cases, those exploiting the child/ young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/ economic and/or emotional vulnerability).'
- The local safeguarding boards all have multi-agency strategic groups to help practitioners identify and support children and young people either at risk from or exposed to sexual exploitation.
- Any child from any background may become a victim of sexual exploitation. However, there are a number of factors that may increase a child's vulnerability to CSE, including:
 - Living in a chaotic or dysfunctional household (including parental substance use, domestic violence, parental mental health issues, and parental criminality).
 - History of abuse (including familial child sexual abuse, risk of forced marriage, risk of honour-based violence, physical and emotional abuse and neglect).

- Recent bereavement or loss.
 - Gang-association either through relatives, peers or intimate relationships (in cases of gang-associated CSE only).
 - Attending school with children and young people who are already sexually exploited.
 - Learning disabilities.
 - Unsure about their sexual orientation or unable to disclose sexual orientation to their families.
 - Friends with young people who are sexually exploited.
 - Homeless.
-
- Lacking friends from the same age group.
 - Living in a gang neighbourhood.
 - Living in residential care.
 - Living in hostel, bed and breakfast accommodation or a foyer.
 - Low self-esteem or self-confidence.
 - Young carer.³
- [Appendix 2](#) and [Appendix 3](#) may also aid practitioners in the identification of child sexual exploitation and may assist with discussion with the safeguarding team.
 - Where child sexual exploitation, or the risk of it, practitioners should complete the risk assessment tool in [Appendix 4](#) and discuss the case with the Safeguarding Children Team for further advice and possible referral to HALO. A copy of the risk assessment tool should be scanned into the child's SystemOne record.
 - If after discussion there concerns remain, local safeguarding procedures should be triggered, including referral to Children's Services regardless of whether the victim is engaging with services or not. For further information for concerns relating to Child Sexual Exploitation refer to Hertfordshire Safeguarding Children's Board Procedures, [Chapter 6.6](#) or seek advice through **Hertfordshire Police** via **101 ask for HALO**.
 - Ensure the GP is aware of the referral.

6.4 **Suspected Physical Abuse or Neglect requiring Medical Attention:** Where there are bruising, bites and suspicious/unexplained marks in children, act in accordance with the local safeguarding policy where the child lives. For children living in Hertfordshire the [HSCB multi-agency protocol](#) for the management of bruising, bites and suspicious / unexplained marks in children can be found on the staff intranet.

For children living in West Essex, when there are physical injuries which are believed to be non-accidental or inconsistent with the history given, contact Children's social care and agree a plan of action. This may include a Child Protection Medical which will be arranged by Children's Social care. If it is agreed that attendance at Accident & Emergency is the most appropriate course of action, decide who will arrange this and inform the hospital. Decide who will check attendance and advise Children's social care of the outcome - if the child does not arrive at Accident and Emergency then Children's Social Care must be informed.

- Complete a Child Protection referral form via [Incident Reporting](#) (Datix) and submit immediately to Hertfordshire Children's or West Essex Social Care Inter-agency. Save the referral form to all health records of children in the household and document a plan of action. A record should also be made in the parents/carer's records. If unsure about whether injuries are significant, contact the Safeguarding Children Team to discuss further but do not delay acting if you are not able to access immediate advice.

³http://www.childrenscommissioner.gov.uk/sites/default/files/publications/If_only_someone_had_listened.pdf. (2013)

- Ensure that the Child's GP is aware of the referral verbally and follow up in writing by sharing a copy of the referral form.
 - Document on SystemOne regarding the GP liaison, and tick box under safeguarding template to record a referral has been made.
- 6.5 **Fabricated and Induced Illness:** There are three main ways of the carer fabricating or inducing illness in a child. These are not mutually exclusive and include -
- **Fabrication** of signs and symptoms. This may include fabrication of past medical history
 - **Falsification** of hospital charts and records, and specimens of bodily fluids. This may also include falsification of letters and documents
 - **Induction** of illness by a variety of means
 - When there are concerns that a parent or carer may be fabricating or inducing an illness in a child, guidance should be sought from the Safeguarding Children Team. In these cases, **do not** discuss your concerns with the family. Supplementary guidance can be sought from the Department for Children Schools and Families (2008) publication, [Safeguarding Children in whom Illness is Fabricated or Induced](#). Further information can be sought Chapter [4.6 HSCB](#) and [SET procedures](#), (chapter 19).
- 6.6 **Neglect:** When there are on-going concerns of Neglect to a child consider completing a [Graded Care Profile](#) and compiling a chronology.
- If any practitioner feels they are not making any progress with a family they are currently working with they should consider a joint visit, either with their Safeguarding Supervisor or another colleague in order that a 'fresh pair of eyes' can offer a new perspective. Consideration should also be given to the length of time that a practitioner has been working with a family; this should be discussed with the Safeguarding Supervisor and Team Lead.
- 6.7 **Domestic violence and abuse:** affects significant numbers of children and young people and their families causing immediate harm as well as damaging future life chances.
- Domestic violence and abuse [NICE Guidance](#) (2014) advises that front line staff in all health and social care services should be trained to recognise the signs of domestic violence and abuse and should be able to ask relevant questions to help people disclose their past or current experiences of such violence or abuse.
 - Routine enquiry or asking the question should be a routine part of good clinical practice even where there are no indicators of domestic violence or abuse. The enquiry should be made in private on a one-to-one basis in an environment where the person feels safe, and in a kind, sensitive manner.
 - If for any reason there is not an opportunity to discuss domestic violence or abuse, **this must be documented in the mother's record and the question asked at the earliest opportunity.**
 - For further guidance on Domestic violence and abuse refer to [Domestic Violence Guidelines](#).
- 6.8 **Domestic Violence Notifications to Health Visitors:** Following the receipt of a domestic violence liaison form from the police, HCT [Domestic Violence Guidelines](#) for Health Professionals working with children and families in identifying and responding to Domestic Abuse, must be followed. In all cases a copy of the police domestic violence notification must be sent to the family GP; a task sent to the School Nurse if there are children aged over 5-years within the household (for information only unless there are additional concerns known). [SystemOne guidance](#) needs to be followed to register and complete vulnerability icons to all involved. Advice and support can be obtained from your Safeguarding Supervisor or Team Lead.
- 6.9 **Female Genital Mutilation (FGM) & Cutting:** Female genital mutilation (FGM) is a form of child abuse and violence against women and girls. It involves procedures which include the partial or total removal of the external female genital organs for non-medical

reasons. The practice is extremely painful and has serious health consequences.

- The age at which girls undergo FGM varies enormously according to community. The procedure may be carried out when the girl is new-born, during childhood or adolescence, just before marriage or during the first pregnancy. However, the majority of cases are thought to take place between the ages of 5 and 8.
- In the United Kingdom FGM is illegal and is prohibited by the [Female Genital Mutilation Act 2003](#). The UK law states that “A person is guilty of an offence if s/he, excises, infibulates or otherwise mutilates the whole or any part of a girl's labia, labia majora, labia minora or clitoris except for operations performed on specific physical and mental health grounds by registered medical or nursing practitioners. It is also an offence to assist a girl to mutilate her own genitalia”. It is also illegal to assist a person to carry out FGM overseas.
- All professionals need to be aware of the possibility of FGM. Any female child born to a woman who has been subjected to FGM must be considered to be at risk, as must other female children in the extended family. Any information or concern that a child is at immediate risk of, or has undergone FGM must result in a child protection referral to Social Care. Social Care will investigate under Section 47 of the Children Act (1989). Please refer to Local Safeguarding Children's Board Procedures, [Chapter 6:14. SET Procedures](#), (Chapter 40.3, Page 556).
- **Health Visitors** need to ensure that they check a mother's discharge notification for FGM, if this is identified a clear note must be made on the mothers SystemOne record in conjunction with a note that indicates a conversation has occurred in regard to the protection of her daughter and a vulnerability icon placed on the child's SystemOne record.

6.10 **Honour Based Violence:** Honour' based violence (HBV) is a form of domestic abuse which is perpetrated in the name of so called 'honour'.

- The honour code which it refers to is set at the discretion of relatives/cultural group and those who do not abide by the 'rules' are then punished for bringing shame on the family. Infringements may include a partner rejecting a forced marriage; pregnancy outside of marriage; interfaith relationships; seeking divorce, inappropriate dress or make-up and even kissing in a public place.
- HBV can exist in any culture or community where males are in position to establish and enforce women's conduct, examples include: Turkish; Kurdish; Afghani; South Asian; African; Middle Eastern; South and Eastern European; Gypsy and the travelling community (this is not an exhaustive list).
- Males can also be victims, sometimes as a consequence of a relationship which is deemed to be inappropriate, if they are gay, have a disability or if they have assisted a victim.⁴
- For concerns relating to Honour Based Violence please refer to Hertfordshire Safeguarding Children's Board Procedures, [Chapter 4.5., SET Safeguarding and Child Protection Procedures](#), (Chapter 40.2.3, Page 551)

6.11 **Modern Day Slavery:** Modern slavery encompasses slavery, servitude, forced and compulsory labour and human trafficking. Traffickers and slave drivers coerce, deceive and force individuals against their will into a life of abuse, servitude and inhumane treatment. A large number of active organised crime groups are involved in modern slavery. But it is also committed by individual opportunistic perpetrators.⁵

- For concerns relating to Modern Day Slavery please refer to Hertfordshire Safeguarding Children's Board Procedures, [Chapter 6:4., SET Procedures](#).

⁴ <http://www.domesticviolencelondon.nhs.uk/1-what-is-domestic-violence-/17-honour-based-violence.html>.

⁵ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/383764/Modern_Slavery_Strategy_FINAL_DEC2015.pdf.

- 6.12 **Safeguarding Children from Abroad including children who are victims of Trafficking and unaccompanied Asylum Seeking Children:** For concerns relating to Safeguarding Children from Abroad including children who are victims of Trafficking and unaccompanied Asylum Seeking Children refer to Hertfordshire Safeguarding Children's Board Procedures, [Chapter 6:5](#) ; [SET Procedures](#) (Chapter 26 page 449)
- 6.13 **Trafficking:** For concerns relating to Children who are victims of Trafficking refer to Hertfordshire Safeguarding Children's Board Procedures, [Chapter 6:4](#); [SET Procedures](#) (Chapter 26 page 449)
- 6.14 **Private Fostering:** Private fostering is defined in the Children Act 1989 as a child under the age of 16 years (or under 18 years if disabled) who is cared for, and provided with accommodation, for 28 days or more by someone other than a parent or legal guardian, or close relative. Trust employees must report to children's social care if they are aware of any children being privately fostered children. It is a criminal offence not to do so. Children's social care has a duty to complete an assessment to establish the suitability and safety of the placement. Chapter [6.7](#) HSCB, [SET Procedures](#) (Chapter 26.15 page 457).
- 6.15 **Home Educated Children:** Parents have the right to educate their children at home; however practitioners should ensure that the needs of these children are being met and that there are no concerns in regard to the child's welfare.
- If during a term time visit a school age child is seen and they appear well, then the practitioner should enquire why they are at home and what school they go to. If they are informed that they are home educated then consideration should be given to the welfare of the child and ensuring the child's needs are being met, this is especially if the child has just been removed from school or is disabled. Practitioners should be aware of the possibility that the child may be privately fostered. If concerns are raised at any time then the practitioners should have a conversation with a member of the safeguarding team. Chapter [6.23](#) HSCB, [SET Procedures](#), (Chapter 21.7 page 422).
- 6.16 **Young Carers:** A young carer is a child who is responsible for caring on a regular basis for a relative (usually a parent, grandparent, sibling but occasionally a friend) Caring responsibilities can significantly impact on the child's health and development. Many young carers experience –
- Social isolation
 - Poor school attendance
 - Impaired development of identity potential
 - Low self esteem
 - Emotional or physical neglect
 - Conflict between loyalty to their family and having their own needs met
- If a practitioner feels that a child is acting as a young carer they should discuss their concerns with the safeguarding team as the young carer's needs should be assessed and appropriate action taken either through the early help agenda or a referral to children's social care. In all cases the young carer and the person they are caring for should have a referral to either children's or adult social care.⁶ Further advice can be found at [SET Procedures](#) (Chapter 31, page 490).
- 6.17 **Disabled children:** A disabled child will be more vulnerable to significant harm because of their additional needs. Risk maybe heightened because of:
- The need for practical assistance including intimate care from a number of carers
 - Lack of continuity of care meaning that a change in behaviour may go unnoticed

⁶ http://www.legislation.gov.uk/ukxi/2015/527/pdfs/ukxi_20150527_en.pdf

- Physical dependency with consequent reduction in the ability to be able to resist abuse
- An increase in the likelihood that the child is socially isolated
- Communication or learning difficulties preventing disclosure. Parents/ carers own needs and ways of coping may conflict with the needs of the child.⁷
- Safeguards for disabled children are essentially the same as for non-disabled children and should include enabling them to:
 - Make their wishes and feelings known
 - Receive appropriate personal, health and social education, including sex education
 - Raise concerns
 - Have access to more than one adult with whom they can communicate
- Practitioners must have:
 - An explicit commitment to, understanding of disabled children's safety and a culture of openness
 - Guidelines and training on good practice in intimate care, working with children of the opposite sex, handling difficult behaviour, consent to treatment, anti-bullying strategies, sexuality and sexual behaviour among young people, especially those living away from home.
- Refer to Chapter [6.13](#) HSCB and Chapter 18, [SET Procedures](#) (Chapter 27.4, page 469).

6.18 Parents who Misuse Drugs or Alcohol: Although there are some parents who are able to care for and safeguard their children despite their dependence on drugs or alcohol, parental substance misuse can cause significant harm to children at all stages of development. A thorough assessment is required to determine the extent of need and level of risk of harm for each child in the family.

- Where a parent has enduring and/or severe substance misuse problems, children in the household are likely to be at risk of, or experiencing, significant harm primarily through emotional abuse and neglect. The child/ren may also not be well protected from physical or sexual abuse.
- Misuse of drugs and/or alcohol is strongly associated with significant harm to children, especially when combined with other features such as domestic violence. For concerns relating to drug and alcohol misuse which is impacting on the wellbeing and safety of a child a referral to Children's Social Care should be considered. Refer to [Chapter 6:8](#) of the Hertfordshire Safeguarding Children Board procedures and Chapter 41.1 page 570 of the [SET Procedures](#)

6.19 Mental Health issues: For concerns relating to parental mental health which are impacting on the wellbeing and safety of a child, a referral to children's social care is essential; Chapter [6:12](#) of the Hertfordshire Safeguarding Children Board procedures and Chapter 41.2 page 572 of the [SET Procedures](#).

6.20 Learning Difficulties: For concerns relating to parental learning disabilities which are impacting on the well-being and safety of a child, a referral to Children's Social Care should be considered, [Chapter 6:11](#) of the Hertfordshire Safeguarding Children's Procedures and Chapter 41.3 page 575 of the [SET procedures](#)

6.21 Unborn Baby/ Antenatal causes of Concern: When there are concerns identified during the Antenatal period or where there is a history of concerns that require a risk assessment of the unborn baby, an information sharing form should be completed and sent to the maternity services. Consideration should be given to referring the unborn

⁷ <https://www.gov.uk/government/publications/safeguarding-disabled-children-practice-guidance>.

baby to Children's Social Care. Refer to the [HSCB Pre-Birth Assessment Policy 6.9. SET Procedures](#) (Chapter 2.6 page 28). In such cases a targeted Antenatal visit should be undertaken by the Health Visiting Team in accordance with Health Visitor Practice Guidance. There after regular communication between Health Visitor and Midwife should take place.

If concerns are noted by West Essex staff during consultation sessions then advice should be sought from the Safeguarding Team.

6.22 **Under aged sexually active young people:** If there is a concern about an under-age sexually active young person refer to flow chart in ([Appendix 5](#)) and discuss any concerns with the Safeguarding Children Team. The law clearly indicates when professionals have a responsibility to seek advice, refer a client to Children's Social Care or to the police. For guidance on the law refer to the Hertfordshire Safeguarding Children Board Child Protection Procedures Chapter [6.15](#) and Chapter 27 page 466 [SET procedures](#)

- A risk assessment should be performed on **all** under 16-year olds; this should be completed on the Under 16 year's sexually active young people's risk assessment form, [Appendix 6](#). If the Risk Assessment identifies concerns, the client must be informed of your concerns and the requirement for you to seek professional advice. Concerns can be discussed with either:
 - The Safeguarding Children's Team
 - Children's Social Care support consultation giving clients details
 - The Emergency Duty Team out of hour's service
 - The Police if Rape or Sexual exploitation is the concern
- If a referral is made to Children's Social Care a copy of the Risk Assessment Form, [Appendix 6](#) can be attached to the referral form via [Incident Reporting](#) (Datix) and attached to the client's record and their GP informed.

6.23 **Child Abuse linked to Spiritual or Religious Belief:** Belief in witchcraft, spirit possession and other forms of the supernatural can lead to children being blamed for bad luck, misfortune or disability and may subsequently increase the risk of them being abused. Fear of the supernatural is also known to be used to make children comply with being trafficked for domestic slavery or sexual exploitation.⁸ Young people are also susceptible to extremists' messages and at risk of being drawn into terrorism or supporting terrorism at a point in time.

- For concerns relating to Children who are at risk of Child Abuse linked to Spiritual or Religious Belief refer to Hertfordshire Safeguarding Children's Board Procedures, [Chapter 6.1.](#), [SET procedures](#) (Chapter 40, page 564)
- For concerns relating to young people and extremist views please contact the Safeguarding Children Team and refer to:
http://www.intranet.hct.nhs.uk/Library/staff-area/Polices_and_Guidance/Prevent%20Policy%20CP10%201114.pdf.

6.24 **Bullying and Cyber Bullying:** Bullying is behaviour by an individual or group, repeated over time that intentionally hurts another individual or group either physically or emotionally. Bullying can take many forms (for instance, cyber-bullying via text messages or the internet), and is often motivated by prejudice against particular groups, for example on grounds of race, religion, gender, sexual orientation, differences between children, or perceived differences⁹.

- For concerns relating to Bullying refer to Hertfordshire Safeguarding Children's

⁸ <https://www.gov.uk/government/publications/national-action-plan-to-tackle-child-abuse-linked-to-faith-or-belief>.

⁹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/444862/Preventing_and_tackling_bullying_advice.pdf.

Board, [Chapter 6.2, SET Procedures](#), (Chapters 25 & 33)

- For concerns relating to Children who at risk of Cyber Bullying refer to Hertfordshire Safeguarding Children's Board Procedures, [Chapter 6.3, SET Procedures](#), (Chapters 25 & 33)

6.25 **Children living away from home:** For concerns relating to Children living away from home refer to Hertfordshire Safeguarding Children's Board, [Chapter 6.7., SET Procedures](#), (Chapter 36)

6.26 **Children's visits to Specialists Hospitals/ Psychiatric Units:** For concerns relating to Children who visit Specialist Hospital/ Psychiatric Units refer to Hertfordshire Safeguarding Children's Board, [Chapter 6.18. SET Procedures](#), (Chapter 39).

6.27 **Children Visiting Custodial Settings:** For concerns relating to Children Visiting Custodial Settings refer to Hertfordshire Safeguarding Children's Board Procedures, [Chapter 6.17. SET Procedures](#) (Chapter 38).

6.28 **Children who are self-harming or have suicidal behaviour :** For concerns relating to Children who are self-harming or have suicidal behaviour refer to Hertfordshire Safeguarding Children's Board Procedures, [Chapter 6.19 SET Procedures](#), (Chapter 35).

6.29 **Non-attendance for health appointments, Children who are not brought to appointments (DNA):** Children and Young People failing to attend clinic appointments following referral from their General Practitioner or other professional may trigger concern, given that they are reliant on their parent or carer to take them to the appointment. Failure to attend can be an indicator of family's vulnerability, potentially placing the child's welfare in jeopardy.

- Each non-attendance must be recorded.
- The health professional should seek to establish the reason for non-attendance and assess any increased risk of significant harm to the child. Consideration needs to be given to the impact of non-attendance on a child's health and development
- Further appointments should be offered in line with individual's professional guidance.
- Any concerns should be discussed with the Safeguarding Children Team.
- If there are concerns that there may be an impact on the child's health/or development due to non-attendance the referral must not be closed until a discussion with the Safeguarding Children's Team has taken place.
- If the child is subject to a Child Protection Plan the information should be shared with the social worker and an action plan developed.
- Identification of all of the above can be complex, research shows that a good assessment is key in the identification and referral of issues [Appendix 7](#) may assist with this.

7. Difficulty in Accessing Families where there are Vulnerable Children

7.1 **Missing children who are known to be vulnerable or subject to a Child Protection Plan** - This group of children may also include Travellers; children in families who are seeking asylum, have recently entered the country or who are living in a refuge. The risk to this group is increased because of their transiency, lack of access to health and education, language and expectation barriers. Where there is a child protection plan in place, the child's social worker should be informed as soon as possible. Health professionals should contact the Safeguarding Children Team in all cases to formulate an action plan. Where appropriate they will share information with partner agencies and notify Designated Nurse to enable a national alert to be generated.

- 7.2 **No access to planned home visits for vulnerable children** - Prior to contacting the Safeguarding Children Team Practitioners should check the address with:
- The hospital where the child was born for the discharge address
 - Community Midwife
 - General Practitioner
 - Child Health
 - Housing Department
 - Registrar of births
 - National Spine via NHS portal
 - Visit the address to see if there is evidence the family are living there. Leave a contact note.
 - Any concerns should be discussed with the Safeguarding Children Team and a welfare check considered.
 - If the child is subject to a Child Protection Plan the information should be shared with the social worker and an action plan developed.
- 7.3 **Refusal of health services** - If there are known concerns about a child and the carer refuses health services offered this **MUST** be recorded in the child's health record and discussed with the Safeguarding Children Team.
- 7.4 **Unattended children** - If at any time you believe children who are of insufficient age, or understanding, are at risk due to lack of appropriate supervision, the police should be called.
- Dial 999 and stay with the child until an appropriate professional takes responsibility for their care
- 7.5 **Supporting vulnerable children across county boundaries** - Where healthcare is provided by Hertfordshire Community NHS Trust, the health professional(s) must ensure that they provide information to case conferences, core groups and other meetings and liaise with the relevant professionals, including the child (if appropriate).
- It is good practice to attend all relevant meetings and minutes taken should be requested and attached to the child's records.
 - If there are any doubts in regard to attendance then advice should be sought from the Safeguarding Children Team

8. Transfer of Care of Vulnerable Children (Children's Universal Services)

- 8.1 **The following should be read in conjunction with the [transfer procedures](#)**
- 8.2 **Transfer out of caseload** - A verbal handover should be provided to the new clinician by telephone or face to face. If difficulties arise with this, the Safeguarding Children Team should be notified. A summary should be documented in the child health records
- It is the current clinician's responsibility to ascertain the forwarding address. If a forwarding address is unknown, enquiries should be made to other professionals, e.g. social worker. If it remains unknown, a request should be made by the Health Visitor/ School Health Nurse to the GP surgery to put an alert on the child and carer(s) records to alert the clinician if records are transferred to another area. All actions and enquiries should be recorded in the child's health record. A high priority reminder should be added to all relevant family members' records on SystemOne.
 - If a child who is Looked After in Hertfordshire moves out of county the Children Looked after Team must be notified by Children's Universal Services and the child's health record transferred via Child Health.
- 8.3 **Transfer of records to a [SystemOne user](#) (including within Hertfordshire)** - Ensure

that SystemOne records are up to date including attachments

- Share the records in accordance with [SystemOne Guidance](#)
- Close care in accordance with [SystemOne Guidance](#)

8.4 **Transfer of records to a non SystemOne user –**

Complete the [Transfer of Health Records](#) Summary and attach to each family member's record

- Task Child Health to alert them that these children have a transfer summary attached.
- Records of parents /carers will need to be emailed to child health. If the child has been removed from parents/carers care then the adult notes should not be transferred.
- Ensure any pre SystemOne paper records are sent in a red bag.
- Close care in accordance with [SystemOne guidance](#)
- Specialist services should follow their local procedures.

NB *The records should be prepared for transfer. Forms and correspondence should be in chronological order, all duplicates and unnecessary paperwork should be shredded. The most recent records should be near the front of the records.*

8.5 **Transfer into caseload** - Relevant information must be accessed from other professionals involved with the family, including obtaining a verbal handover from the previous area if this has not occurred. *This is essential for children who are subject to a Child Protection Plan.* If you are unable to contact the previous professional notify the Safeguarding Children Team

- Register all relevant family members on SystemOne
- Request records from the previous area via Child Health, either paper or a share form a SystemOne user (including the parents records if these are used)
- It is expected that a practitioner will familiarise themselves with the child's health records prior to visiting. **This will include reading SystemOne records by overriding unshared records and summarising the information contained in them. Document that the records have been read.**
- If a child is subject to a child protection plan, notify the Safeguarding Children Team 01707 386866/7
- If a child is looked after in another area moves notify the Children Looked After Team
- Register all relevant family members on SystemOne

8.6 **Health Visitors** - Attempt to contact the family **within two working days** - all contacts/ liaison must be recorded and the child seen within **ten working days**

- If you are unable to contact the family the Safeguarding Children Team should be notified
- Face to face contact must be made with each child. Practitioners should be aware of the [Lone Worker Policy](#) when planning visits.

9. **Episodes of Care Performed by Other Professionals**

9.1 When a professional of any discipline, delegates an episode of care to another member of their team, a clear plan of action must be agreed between the professionals, taking into account the family and child's views as appropriate. This should be recorded in the child's records and should include the aim and duration of the agreed work. A final evaluation should be documented before the episode of care is closed.

10. **Interpreting Services**

10.1 Health professionals may be in a situation where communication is difficult for example, when English is not a client's first language or if signing is required. In these circumstances use of the interpreting service must be considered. Family members

should not be used as interpreters where there is any concern for a child's welfare and for screening purposes (i.e. asking the Question for Domestic Abuse and Maternal Emotional Screening). Children should NEVER be used as interpreters (except in a medical emergency).

The interpreting service should be requested via the practitioner's locality manager.

11. Looked After Children

- 11.1 The Looked After Children team (telephone: 01438 843004) should be notified of all movement within and out of area. The foster carer's address should not be disclosed on any reports or correspondence.

12. Identified Offenders and Others who may pose a Risk to Children

- 12.1 Where a health professional is concerned or has information that a person **may** pose a risk to children, a referral should be made to Children's Social Care in accordance with the Hertfordshire Safeguarding Children Board Procedures [5.1.](#), [SET Procedures](#), Chapter 13.

13. Responding To Allegations & Suspicion of Child Abuse against Staff

- 13.1 If staff have a concern about any staff member they should contact their Manager, Named Nurse for Safeguarding Children or the on call Manager if the incident happens out of hours for any allegations of abuse against [HCT staff](#)
- 13.2 All such incidents should be reported to the Local Authority Designated Officer (LADO) within one working day of all allegations to come to the attention of the Named or Designated Senior Officer.
- 13.3 If HCT removes an individual because the person poses a risk of harm to children, a referral must be made to the Disclosure and Barring Service. It is an offence to fail to make a referral without good reason.
- 13.4 Further information can be found [HSCB procedures](#) 4.1 and Chapter 7 [SET procedures](#)
- 13.5 If the child of a member of staff is subjected to a Child Protection Plan the Named Nurse for Safeguarding Children must be informed.

14. Historic Abuse

- 14.1 The term 'historical abuse' is commonly used to refer to disclosures of abuse that were perpetrated in the past. It is normally used when the victim is no longer in circumstances where they consider themselves at risk of the perpetrator and more commonly used when adults disclose abuse experienced during childhood.
- 14.2 Allegations of child abuse are sometimes made by adults and children many years after the abuse has occurred. Cases may be complex as the alleged victims may no longer be living in the situations where the incidents occurred or where the alleged perpetrators are also no longer linked to the setting or employment role. Such cases should be responded to in the same way as any other concerns. It is important to ascertain as a matter of urgency if the alleged perpetrator is still working with, or caring for children.
- 14.3 As soon as it is apparent an adult is revealing childhood abuse, the member of staff must avoid further questioning, record what is said and the responses given. This should be

followed by a conversation with the Safeguarding Children Team.

- 14.4 An adult reporting her/ his own experience of having been abused as a child should be asked whether (s)he wants a Police investigation and must be reassured that Police CAIU are able and willing to undertake such work even for those adults who are vulnerable as a result of mental health or learning disabilities. Consideration must be given to the therapeutic needs of the adult and reassurance given that, even without her/ his direct involvement all reasonable efforts will be made to look into what (s)he has reported. For further information please see [Section 4.11](#) HSCB. [SET procedures](#) Chapter 37 page 534.

15. Death of a Child under the Age of 18 years

- 15.1 The Safeguarding Children Team should be notified of all unexpected deaths which meet the Rapid Response criteria. The practitioner will be notified of the child's death by the Safeguarding administration team and will be invited to attend an information sharing meeting. This must be prioritised or a deputy sent.
- 15.2 Further guidance is available in the HSCB Rapid Response Guidance, [Chapter 9](#); (chapter 9 page 116). [SET procedures](#)

16. Making a Referral to Social Care

- 16.1 If a child is at risk of immediate, significant harm, the priority remains to move them to a place of safety. The police have the powers to remove a child to a place of safety without parental consent.
- 16.2 If you are concerned that a child is at increasing or significant risk of harm, contact Hertfordshire Children's Services by telephone on 0300 123 4043 or West Essex 0345 603 7627 (depending on where the child lives or goes to school). This should be followed up in writing with a referral form via [Incident reporting](#) (Datix), found on the intranet. Your concerns can be discussed with your safeguarding supervisor or through the urgent safeguarding advice line on 07881 940233, but this should not delay you making a referral.
- 16.3 The referral should be discussed with the child's carers or the young person and consent sought. However if this will place the child or other children at risk or consent is refused this should not stop the practitioner forwarding a referral to Social Care.
- 16.4 Never seek consent if your concern is in regard to sexual abuse or fabricated illness as this may place the child at increased risk. Always discuss your concerns with the safeguarding team.
- 16.5 The quality of information to inform the referral needs to be factual and objective to enable a comprehensive assessment to be undertaken by Children's Social Care. If you are unable to provide detailed information this should be clearly marked on the referral form. Once a referral has been made to Social Care, upload a copy to the child's records according to SystemOne guidance and send a copy to the GP. Document in SystemOne on all children's records, that this has been completed.

You should receive advice regarding action taken on the referral from social care:

- Within 2 working days
- Within 7 days for routine referrals

It is the referrer's responsibility to contact Children's Social Care within those

timescales if they do not receive information regarding the action taken following referral

- 16.6 If a decision is made that the threshold for child protection referral has NOT been reached, consideration should still be given to the need to provide additional services to the child and family. Reasons for the decision and actions taken should be documented
- 16.7 If a child is not at risk of significant harm but is vulnerable and would benefit from early intervention, staff should make a referral to local Early Help provision. Staff working with adults should then liaise with health practitioners working directly with the child.
- 16.8 Individuals cannot delegate the referral to Children's Social Care or to another professional/ colleague (although they may need support to make the referral).
- 16.9 There is an on-going responsibility to safeguard and protect children. Where the outcome of the referral is that the child is in need of support services rather than safeguarding, the child should be referred to the appropriate service with the parents'/carers' involvement and agreement.
- 16.10 [Appendix 8](#) shows the guidance for making referrals to Children's Social Care.

17. Procedure to Follow While Making a Referral to Social Care

- 17.1 **SAFER Communication Guidelines (Department of Health 2013)** - These are guidelines for communication between health and Local Authority Children's Social Care Teams using the **SAFER** process when a child may be suffering or is likely to suffer significant harm.
- All verbal communications can be carried out using the **SAFER** process.
 - The use of **SAFER** will ensure a uniform approach to communicating the level of risk to child/ children ([Appendix 9](#))
- 17.2 **Escalation of Concerns** - If you have contacted Children's Social Care with Child Protection concerns and they do not appear to have acknowledged the gravity of the concerns or acted within a reasonable timescale.
- Try to come to a mutually agreed plan of action that does not compromise the well-being or safety of the child.
 - Discuss with your line Manager/ Safeguarding Children Supervisor
 - If resolution cannot be reached then the Safeguarding team will support the use of HSCB [Chapter 7.2](#) procedures / SET Escalation [Procedures](#) (chapter 1, page 292).
 - All of the above must be done in a timely manner which should not place the child at further risk of harm.
 - Remember to document all the contacts
- 17.3 **Child Protection Conferences** - Staff who are invited to attend a Child Protection Conference/ Professional Meeting due to their professional involvement with the children and/or the adults involved, should prioritise their attendance at the meeting or provide a well briefed deputy. Advice and support can be provided by the Safeguarding Team.
- 17.4 **Initial Child Protection Conferences** - When an invitation is received, HCT staff should:
- Arrange to attend or to send a deputy and inform the Safeguarding Children Team which staff member will be attending
 - A member of the Safeguarding Children Team will attend a Child Protection Conference when requested, if the case is complex or to support the member of staff

attending

- Write a report as soon as possible giving an overview of your service's involvement on the HCT Child Protection [report template](#), unless you have agreed with the Safeguarding Children Team that this is not required at this stage.
- Send your report – combined Health Visitor/School Health Report - to your safeguarding supervisor for checking, finalising and forwarding to the chair **at least ten working days prior to the conference date.**
- If you do not have an allocated safeguarding supervisor please forward your report to Email: safeguardingchildren@hct.nhs.uk
- The report should be shared with the parent(s) and older children face to face (providing this does not increase any risks), at least 48 hours in advance of the Child Protection Conference, so that any factual inaccuracies are identified, amended and areas of disagreement noted.
- **At no stage should the report be posted to the parent(s)**
- Attach the agreed report to **all** the children's records in accordance with the [SystemOne guidance](#)
- **Ensure that all required icons are present**
- Children's Universal Services should complete all relevant information in the Safeguarding Children template on SystemOne both before and after the conference.
- Staff will be offered the opportunity to debrief by the Safeguarding team if they request it following the conference.
- The professional attending the conference must read and agree the minutes and document this on SystemOne before handing back to the named professional.
- If any professional becomes aware of the involvement of another health professional, they should ensure that they are added to the list of people to receive minutes and be invited to subsequent meetings and are included in groups and relationships
- Ensure that you note the date of the next Core Group and review conference as no further invitation will be sent
- If no HCT professional is able to attend the conference the Safeguarding Children's Team should be notified in advance to agree a plan of action and an [Incident Report](#) (Datix) should be completed.

17.5 **Review Child Protection Conferences - The School Nursing Team must refer to the School Nurse Prioritisation** (when there are no health needs for a child) [Appendix 10](#).

- Write a report giving an overview of your service's involvement on the HCT Child Protection [report template](#).
- Send your report – combined Health Visitor/ School Health Report to your safeguarding supervisor at **least ten working days prior to the conference date.**
- The report should be shared with the parent(s) and older children face to face (providing this does not increase any risks), at least 48 hours in advance of the Child Protection Conference, so that any factual inaccuracies are identified, amended and areas of disagreement noted.
- **At no stage should the report be posted to the parent(s)**
- Attach the agreed report to **all** the child/ren's records in accordance with the [SystemOne guidance](#)

NB: *The Safeguarding Children Admin Team will ensure that the post conference report is attached to all relevant children's record(s) on SystemOne*

17.6 **Child Protection Conference health reports for those unable to read English - The child protection report will need to be translated/ made available in audio format for the carers (and child, if appropriate)**

- To facilitate this, a request should be made to the Children's Universal Service manager in sufficient time for this to be actioned.

18. Guidelines for Sharing Information

- 18.1 The Children Act 1989 requires that “the child’s welfare is paramount”. In addition, the Children Act 2004 states that agencies have a statutory duty to cooperate to improve the well-being of and to safeguard children and promote their welfare.
- 18.2 Sharing of information for the purposes of safeguarding and promoting the welfare of children is critical. It is often when information is shared from a number of sources there is an indication that a child may be in need or at risk. Staff are sometimes anxious about the legal or ethical restriction on sharing information, particularly with other agencies.
- 18.3 As a health professional you should be aware of the law and comply with your code of conduct or other guidance applicable to your profession. Remember a failure to pass on information that might prevent a tragedy could expose you to a criticism in the same way as an unjustified disclosure.
- 18.4 The main restrictions on disclosure of information are below:

Common Law Duty of Confidence - The duty arises when a person shares information with another in circumstances where it is reasonable to expect that the information will be kept confidential. The duty is not absolute. Disclosure can be justified if:

- The information is not confidential in nature
- The person to whom the duty is owed has expressly or implicitly authorised the disclosure
- There is an overriding public interest in disclosure
- Disclosure is required by a court order or other legal obligation

The Data Protection Act 1998 - The data protection 1998 is not a barrier to sharing information but provides a framework to ensure that personal information is shared appropriately and proportionately. If you make a decision to disclose personal data you must comply with the Act and ensure your reasons for sharing are clearly documented.

This should not be an obstacle if:

- You have particular concerns about the welfare of a child
- You disclose information to Children’s Services or to another professional; and
- the disclosure is justified under the common law duty of confidence

In general the law will not prevent you from sharing information with other practitioners if:

- Those likely to be affected consent, or
- The public interest in safeguarding the child’s welfare overrides the need to keep information confidential, or
- Disclosure is required under a court order or other legal obligation.

Human Rights Act 1998 - If sharing information is justified under the common law duty of confidence and does not breach the data protection requirements or any specific legal requirements, it should satisfy Article 8.

- Should you have any concerns about sharing information contact the safeguarding team for advice.

- 18.5 **Principles to apply when considering whether to share information** (DoH, 2015):

- <https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice>.
- Remember that the Data Protection Act is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately
- Be open and honest with the person (and or their family where appropriate) from the outset about why, what, how and with whom information, will, or could be, shared, and seek their consent, unless it is unsafe to do so.
- Seek advice if you are in any doubt, without disclosing the identity of the person

where possible

- Share consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, that lack of consent can be overridden in the public interest. You will need to base your judgement on the facts of the case
- Consider safety and well-being: Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions
- Necessary, proportionate, relevant, accurate, timely and secure: Ensure that the information is necessary for the purpose for which you are sharing it, it is shared only with those who need to have it is accurate, up to date, is shared in a timely fashion, and is shared securely
- Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose
- Staff will be required to communicate with other professionals to maintain the safety of children. In accordance with Section 47 of the Children Act 1989 they have a duty to provide information and this will include co-operation with Hertfordshire Children's Social Care where there is a Child Protection investigation, Children and Family Court Advisory and Support Service (CAFCASS), police and court officials. This should be provided with guidance from the Trust's Safeguarding Children Team.
- Staff should work in partnership with families and obtain consent for any intervention or disclosure of information unless this is judged likely to put a child or young person at risk of significant harm. If staff are unsure about the appropriate action to take they should contact the Safeguarding Children Team for advice.
- When information is requested under Section 17 of the Children Act 1989 (Child in Need) staff must ensure that parental consent has been sought. However if consent is refused, consideration must be given to sharing relevant risk factors that may impact on a child's safety. Lack of consent should never be a barrier to ensuring the safety and wellbeing of a child.
- Sharing information even with consent with solicitors, police, CAFCASS and Children's Guardians must be discussed with the Safeguarding Children Team. Staff must not give any information, or agree to be interviewed without speaking to the Safeguarding Children Team first.
- Requests for a statement or a report for Court should be requested formerly in writing by the County Legal Department, CAFCASS or police and sent to the Safeguarding Children Team, email: safeguardingchildren@hct.nhs.uk or hcnt.safeguarding@nhs.net .
- Any statement or report must be seen by the Safeguarding Children's Team prior to it being sent to the relevant agency.
- Requests for access to a child's record where there are safeguarding issues should be discussed with the Safeguarding Children Team and the request managed in accordance with HCT [Access to Patient Record Management Policy](#).
- Requests for attendance at court should be discussed with the Safeguarding Children Team.

19. Record Keeping

- 19.1 All professionals must follow their Professional Code of Conduct and Hertfordshire Community NHS Trust [Records Management Policy](#) and [SystemOne guidance](#).
- 19.2 When a child is referred to Specialist Children's Services, that service MUST request a share of the SystemOne records from Children's Universal Services and ensure records are reviewed by the practitioner where there is relevant Safeguarding information and a

full handover obtained.

- 19.3 **Key principles of record keeping** - Keep clear, accurate records of assessments, discussions, action plans agreed and review dates
- Complete records contemporaneously
 - Written records must be legible, dated and signed with your role identified
 - Electronic records must be clearly attributable to you (NMC 2015)

20. Duty to Protect

- 20.1 [Hertfordshire Safeguarding Children Board procedures](#) and [SET Procedures](#) are available to all staff via the [Intranet](#). [Appendix 11](#) gives information on organisations that may also offer help and advice.

21. Dissemination and Access to Ratified Policy

- 21.1 The final reviewed & ratified Policy will be published on the HCT website electronically and is available to print through the Trust website –'Intranet Policy section'.
- 21.2 All the Trust staffs will be made aware of the revised Policy once approved and ratified; electronically via the Staff Notice board.
- 21.3 Awareness of the policy will be made through mandatory safeguarding children training, staff team meetings and child protection supervision to ensure effective and consistent application.

22. Implementation and Safeguarding Children Training

- 22.1 The policy will be available for reference for all staff at all the times and the Trust (HCT) will ensure all staff implementing this policy has access to appropriate implementation tools, advice and training.
- 22.2 All HCT staff including agency, bank, staff sub contracted or volunteers who work within HCT are required to attend safeguarding children training relevant to their role. HCT have adopted the intercollegiate 2014 model for Safeguarding Children training for staff. It is the manager's responsibility to ensure that staff attend the appropriate level of training as described in the [Training pathway](#).

Training is also available from [Hertfordshire Safeguarding Children Board](#) and for teams working with Essex children, [Essex Safeguarding Children's Board](#).

If there are any difficulties in receiving training or supervision at the appropriate level it is the responsibility of the practitioner and their line manager to inform the safeguarding team to ensure that strategies are put in place to resolve this.

- 22.3 Please refer to Safeguarding Children training strategy for further information or the training pathways ([Appendix 12](#)). A quick guide is provided below:

Quick Reference Training Grid	Level 1	Level 2	Level 3
All staff clinical and non-clinical	X		
All Clinical staff who have any contact with children, young people, parents or carers	X	X	
All clinical staff working directly with children and young people	X	X	X

- 22.4 **Safeguarding Supervision** - Safeguarding Supervision is provided by the Safeguarding Children Team and is mandatory for any HCT employee who holds a caseload of children. A supervision contract must be signed annually by all employees who are required to undertake supervision. Please see Safeguarding [Supervision Policy](#)
- 22.5 **Individual supervision** - Is provided for Health Visitors, School Nurses and Community Paediatric Nurses: who require supervision with the Safeguarding Children Team at a minimum of **3-monthly**.
- 22.6 **Group Supervision** - Is for the following clinical staff who see children as part of their caseload but are not in the clinical group above. This professional group should undertake supervision **every 4 months**
- 22.7 **Safeguarding Children Nurses and Looked After Children Specialist Nurses** - Should have three-monthly peer group supervision. It is the responsibility of **ALL** staff to book and attend sessions in order to meet this requirement and inform their Manager or Safeguarding Supervisor at the earliest opportunity if this is not possible.
- 22.8 **All staff can access the safeguarding advice line for URGENT issues at 07881940233.**
- 22.9 The Safeguarding Children Nurses will ensure that the Policy is discussed within Safeguarding Supervision and when delivering Safeguarding training.

23. Monitoring Compliance and Effectiveness

- 23.1 Random audit of practitioner records will be undertaken at Safeguarding Children Supervision and reported quarterly to the Safeguarding Children subcommittee.
- 23.2 Compliance is monitored through the following processes by the Lead Officer in accordance with the timescales identified:
- Safeguarding Children Team Meetings
 - Complaints, Incidents and enquiries from clients, staff and other agencies
 - The annual safeguarding children audit programme
- 23.3 If new evidence finds the practice guidelines to be inaccurate they will be reviewed by the Safeguarding Children Team and then by the HCT Safeguarding Children Sub Committee.

24. Review and Revision Arrangements

- 24.1 The review, updating and archiving process for this policy shall be carried out in accordance with the Trust (HCT) [GR1 Policy for Procedural Documents, V.3](#) by the identified Lead Officer.
- 24.2 Minor revision and details of amendments are recorded as per [Appendix 13](#).

25. Document Control and Archiving Arrangements

- 25.1 The version control table as listed in [Appendix 14](#) enables appropriate control of the policy with listed personnel responsible for its implementation as well the date assigned/ approved/ circulated.

26. Equality Impact Analyses (EIA)

- 26.1 It is the responsibility of the Lead Officer to complete the EIA form ([Appendix 15](#)) before submitting the policy for ratification.

27. References

- 27.1 Berelowitz, S. et al (2012) "I thought I was the only one. The only one in the world." The Office of the Children's Commissioner's inquiry in to child sexual exploitation in gangs and groups: interim report (PDF). London: Office of the Children's Commissioner. http://dera.ioe.ac.uk/16067/1/FINAL_REPORT_FOR_WEBSITE_Child_Sexual_Exploitation_in_Gangs_and_Groups_Inquiry_Interim_Report_21_11_12.pdf.

Children Act 1989 www.opsi.gov.uk/acts/acts1989/ukpga_19890041_en_1

Children Act 2004 www.opsi.gov.uk/acts/acts2004/ukpga_20040031_en_1
Department of Schools and Families (2008). Safeguarding Children in whom illness is fabricated or induced <https://www.gov.uk/government/publications/safeguarding-children-in-whom-illness-is-fabricated-or-induced>.

Department of Health et al (2009) Statutory guidance on Promoting the Health and well-being of Looked After Children, Nottingham , DCSF publications http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108501

Department of Education (2012) What to do if you suspect a child is being sexually exploited <https://www.gov.uk/government/publications/what-to-do-if-you-suspect-a-child-is-being-sexually-exploited>.

Department of Health (2013) SAFER Communication between Health Visitor and Social Care. HMSO https://www.rcn.org.uk/_data/assets/pdf_file/0008/530657/NHS_Safer_tools.pdf.

Department of Health (2013) Information: To Share or not to Share – Government Response to the Caldicott Review. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251750/9731-2901141-TSO-Caldicott-Government_Response_ACCESSIBLE.PDF

Department of Health (2015) *Working together to safeguard Children* .London. HMSO https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf .

- DOH Information Sharing for Practitioners who are Working to Safeguard Children (2015) <https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice>.
- DH and Chanon Consulting (2014) Health impact of sexual exploitation on adolescents. http://www.nspcc.org.uk/inform/resourcesforprofessionals/sexualabuse/cse-introduction_wda97566.html#do.
- Hertfordshire Safeguarding Children Board (2015) *Child protection procedures* <http://hertsscb.proceduresonline.com/index.htm>.
- HM Government (2015) What to do if you are worried a child is being abused. A Guide for Practitioners. <https://www.gov.uk/government/publications/what-to-do-if-youre-worried-a-child-is-being-abused--2>.
- HM Government (2011) Multi-Agency Practice Guidelines: Female Genital Mutilation <https://www.fco.gov.uk/fgm>
- HM Government (2015) Working Together to Safeguard Children, Nottingham, DCSF Publications https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf.
- National Institute for Health and Clinical Excellence (2009) When to suspect child Maltreatment www.nice.org.uk/nicemedia/pdf/CG89FullGuideline.pdf.
- NHS Commissioning Board (2013) Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework. <http://www.commissioningboard.nhs.uk/wp-content/uploads/2013/03/safeguarding-vulnerable-people.pdf>
- Rogstad, K & Johnston G (2014) Spotting the Signs - A national proforma for identifying risk of child sexual exploitation in sexual health services. BASHH. Brook. <http://www.bashh.org/documents/Spotting-the-signs-CSE%20a%20national%20proforma%20April%202014%20online.pdf>
- Royal College of Midwives (2013) Tackling FGM in the UK – Intercollegiate recommendations for identifying, recording and reporting. http://www.equalitynow.org/sites/default/files/Intercollegiate_FGM_report.pdf
- Royal College Paediatrics and Child Health et al (2014) Safeguarding Children and Young people: Roles and Competencies for Health Care Staff. Intercollegiate Document supported by the Department of Health. https://www.rcn.org.uk/_data/assets/pdf_file/0008/474587/Safeguarding_Children_-_Roles_and_Compentences_for_Healthcare_Staff_02_0....pdf.
- Royal College Paediatrics and Child Health et al (2015) Looked after children: Knowledge, skills and competences of health care staff. Intercollegiate Role Framework http://www.rcpch.ac.uk/system/files/protected/page/Looked%20After%20Children%202015_0.pdf.
- Southend, Essex, Thurrock Child Protection Procedures Manual 2015 ([SET Procedures](#))
- Young London Matters. The London Continuum of Need – Threshold document. <http://www.younglondonmatters.org>

28. Appendices

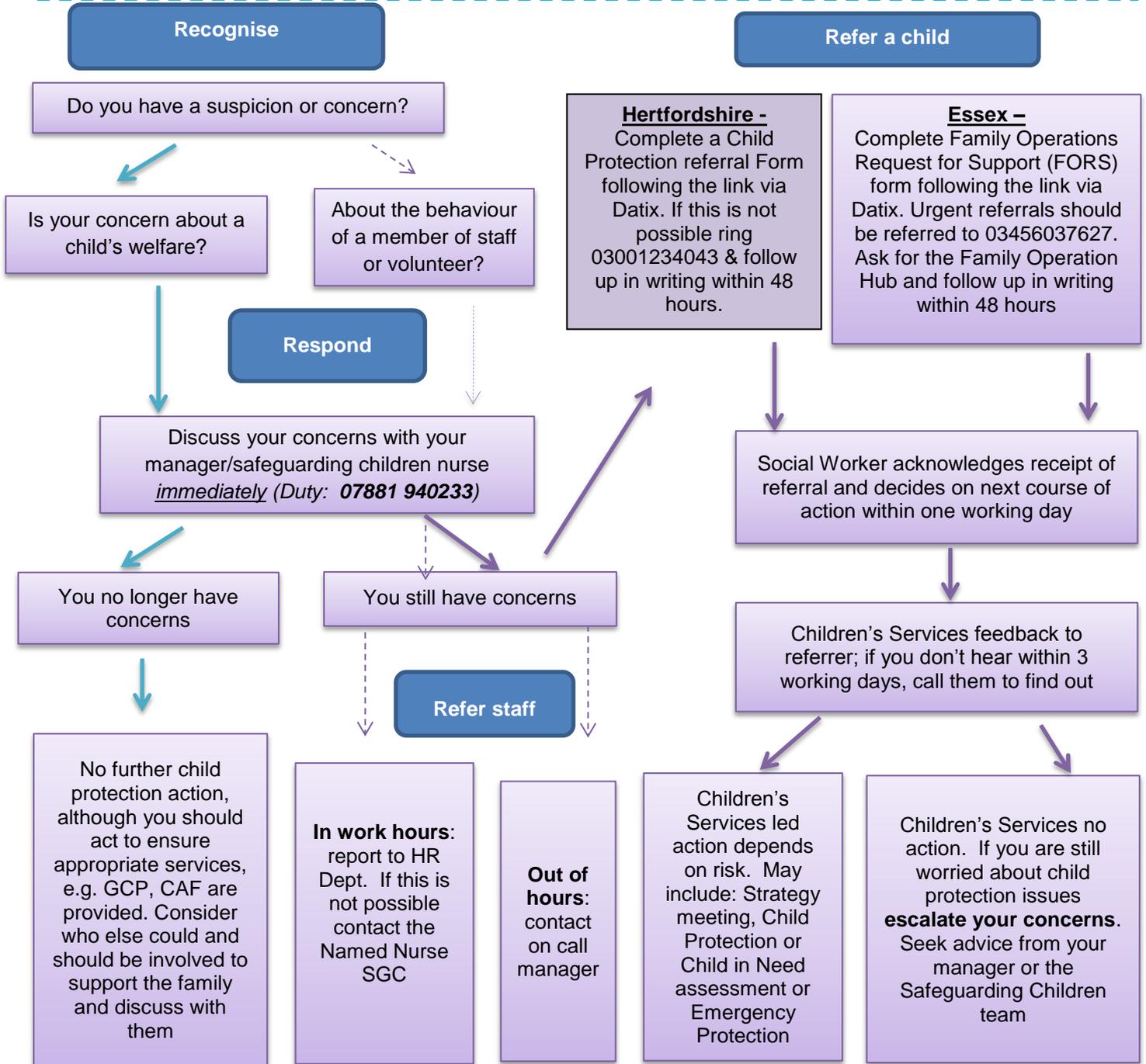
28.1 The following appendices are attached to support this policy:

- Appendix 1** – Safeguarding Children Flowchart for Referrals
- Appendix 2** – Indicators of Child Sexual Exploitation (CSE)
- Appendix 3** - CSE Analysis
- Appendix 4** – Sexual Exploitation Risk Assessment (SERA) Model
- Appendix 5** – Working with sexually active children & young people flow chart
- Appendix 6** – Under 16 years sexually active risk assessment form
- Appendix 7** – Guidelines on Assessment
- Appendix 8** – Guidance for making referrals to Children’s Social Care
- Appendix 9** – Safer Communication Guidelines
- Appendix 10** – Prioritisation of safeguarding work for School Nurses
- Appendix 11** – Helplines
- Appendix 12** – Safeguarding Children Training Pathway
- Appendix 13** - Amendment(s) Template for the Policy
- Appendix 14** - Version Control Table
- Appendix 15** - Equality Impact Analyses Form

APPENDICES

APPENDIX 1: Safeguarding Children Flowchart for Referrals

All staff can refer directly to social care.
However, as long as it does not delay the referral, staff are advised to discuss the issues with their Line Manager, or a Safeguarding Children (SGC) Nurse



REMEMBER
AT ALL STAGES OF THE PROCESS KEEP A RECORD OF YOUR ACTIONS

In an emergency situation call the police: 999

APPENDIX 2: Indicators of Child Sexual Exploitation (CSE)

Name of Young Person:

DOB:

Name of Person Completing:

Date:

Review Date:

Lower Level Indicators- one or more indicators identified	✓
Regularly coming home late or going missing	
Overt sexualised dress	
Sexualised risk taking including on internet	
Unaccounted for monies or goods	
Associating with unknown adults or other sexually exploited children	
Reduced contact with family and friends and other support networks	
Sexually transmitted infections	
Experimenting with drugs and/or alcohol	
Poor self-image, eating disorders, some self-harm	
Medium Level Indicators- any of the above and ONE or more of these indicators	✓
Getting into cars with unknown adults	
Associating with known CSE adults	
Being groomed on the internet	
Clipping i.e. offering to have sex for money or other payment and then running before sex takes place	
Disclosure of a physical assault with no substantiating evidence to warrant a S47 enquiry, then refusing to make or withdrawing a complaint	
Being involved in CSE through being seen in hotspots i.e. known houses or recruiting grounds	
Having an older boyfriend/girlfriend	

Non school attendance or excluded	
Staying out overnight with no explanation	
Breakdown of residential placements due to behaviour	
Unaccounted for money or goods including mobile phones, drugs and alcohol	
Multiple sexually transmitted infections	
Self-harming that requires medical treatment	
Repeat offending	
Gang member or association with gangs	
High Level Indicators- any of the above and ONE or more of these indicators	✓
Child under 13 engaging in sexual activity	
Pattern of street homelessness and staying with an adult believed to be sexually exploiting them	
Child under 16 meeting different adults and exchanging or selling sexual activity	
Being taken to clubs and hotels by adults and engaging in sexual activity	
Disclosure of serious sexual assault and then withdrawal of statement	
Abduction and forced imprisonment	
Being moved around for sexual activity	
Disappearing from the 'system' with no contact or support	
Being bought/sold/trafficked	
Multiple miscarriages or terminations	
Indicators of CSE in conjunction with chronic alcohol and drug use	
Indicators of CSE alongside serious self-harming	
Receiving rewards of money or goods for recruiting peers into CSE	

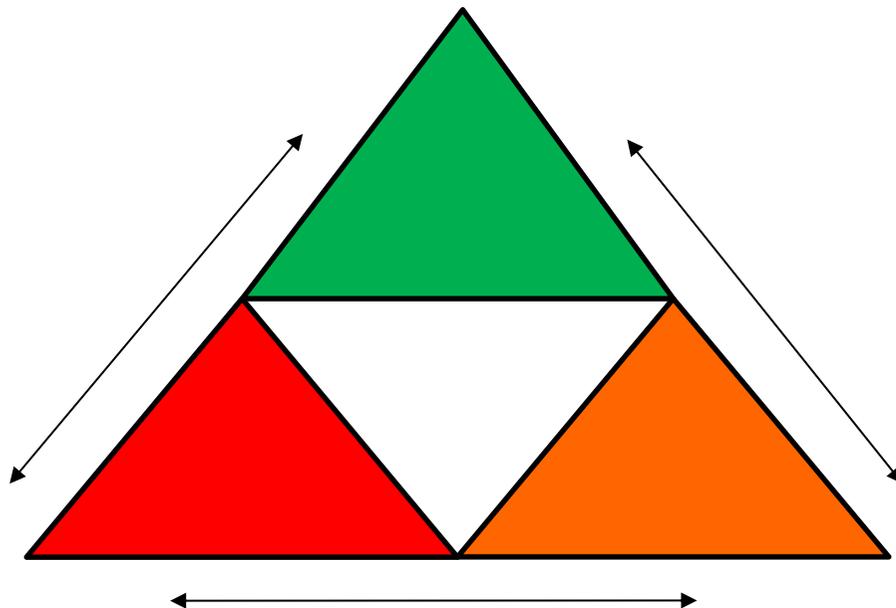
APPENDIX 3: Child Sexual Exploitation (CSE) Analysis

NAME OF YOUNG PERSON:		DOB:	
DATE OF ANALYSIS:			
YOUNG PERSON RISK TAKING BEHAVIOURS/ INDICATORS		ASSOCIATES/ ADDRESSES/ HOTSPOTS	
ALLEGED PERPETRATOR/S		POLICE ACTIVITY	

APPENDIX 4: Sexual Exploitation Risk Assessment (SERA) Model

Description of young person with risk indicators in level 1

Smaller number of risk factors identified or movement from levels 2 or 3. For example: sexualised risk taking behaviours, beginning to truant from school, occasionally going missing, going to know places of concern, early signs of problem drugs or alcohol use.



Description of young person with risk factors identified in level 3

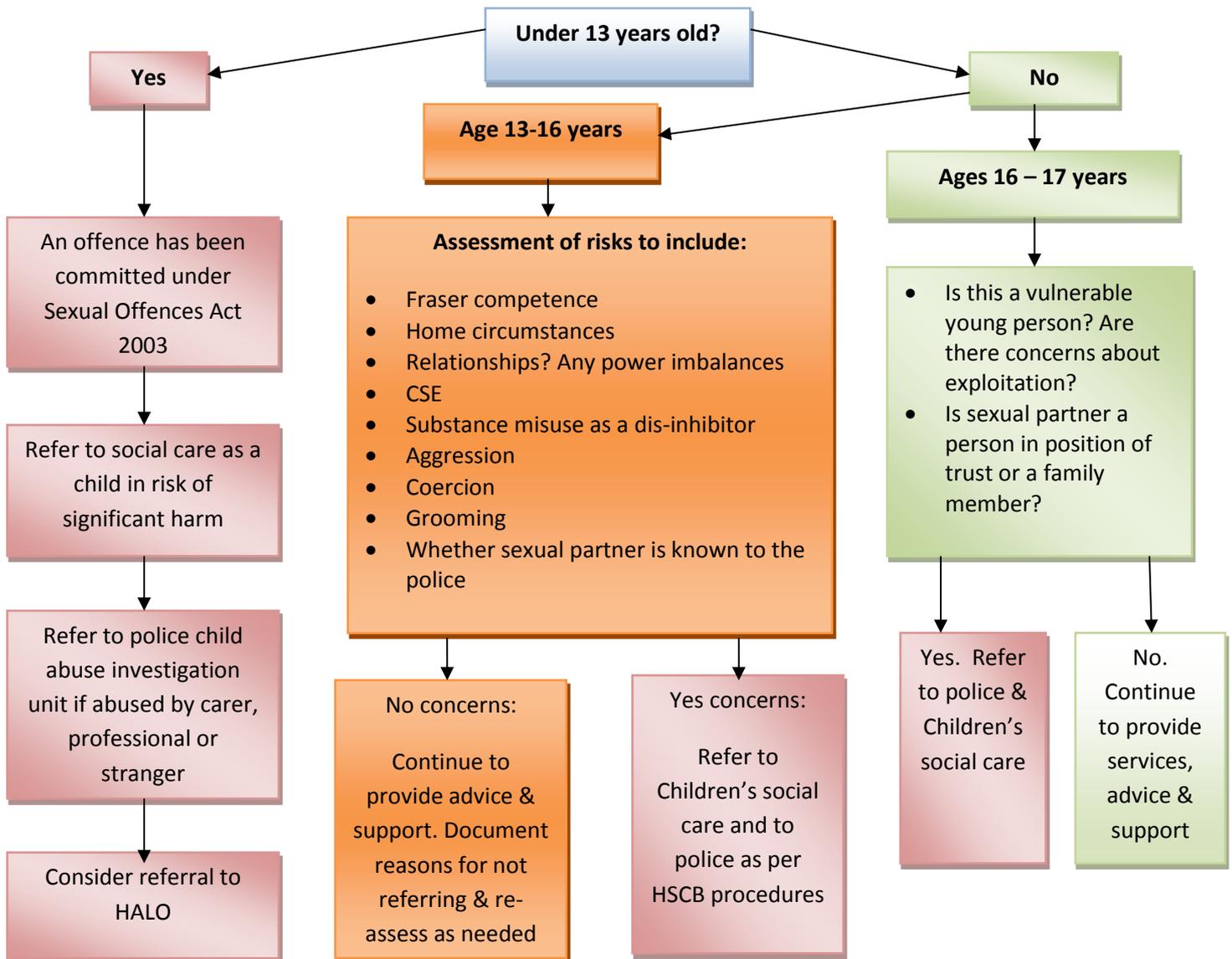
Multiple risk factors. For example: entrenched in one or more abusive relationships, contact with known perpetrators, going missing and running away from home regularly, problem alcohol and/or drug use, experience of violence, intimidation and fear.

Description of young person with risk factors in level 2

Fewer risk factors or signals (or reduction from level 3). For example: regularly going missing, swapping sex for goods, monies. Truancing regularly from school. Going to places of concern 'HOT SPOTS', involved with vulnerable peers, experiencing violence, intimidation and fear. Developing drug and alcohol use.

APPENDIX 5: Working with Sexually Active Children & Young People

The child's welfare is paramount. Any departure from protocol needs to be agreed with a member of the safeguarding team and reasons for doing so must be recorded. Wherever possible the child or young person should be encouraged to discuss the issues with a parent or person in a position of trust



REMEMBER
AT ALL STAGES OF THE PROCESS TO KEEP A RECORD OF YOUR ACTIONS

In an emergency situation call the police: 999

APPENDIX 6: Under 16 years sexually active risk assessment form

Risk assessment for all under 16 year olds where there are concerns in regard to sexual activity

Client's name:

Date of birth:

Fraser guidelines assessment: Yes No (please tick box see Appendix 12)

Date of assessment:

	YES	NO
Are there any concerns that your client has been forced to have sexual intercourse? (<i>This includes rape and sexual exploitation</i>)		
Are there any concerns that your client is being sexually abused?		
Are there any concerns that your client is in an incestuous relationship?		
Are there any concerns that there is a significant age difference between your client and your client's partner? (<i>Please consider an age gap of 4 years plus as a potential concern</i>)		
Has there been any disclosure from your client that leads you to be concerned?		
Are there concerns about your client's sexual health?		

If you answer **YES** to any of the above, please discuss your concern with your client and inform them that you need to seek advice.

Following the above Risk Assessment:

If concerns are identified obtain address and GP details for any future follow up/referral to Children's Social Care if appropriate.

	YES	NO
Have your concerns been discussed with your client?		
Have you discussed your concerns with a member of the Safeguarding Children's Team?		
Has your discussion with the Safeguarding Children's team led to a referral to Children's Social Care Referral?		

Name: **Signature:**

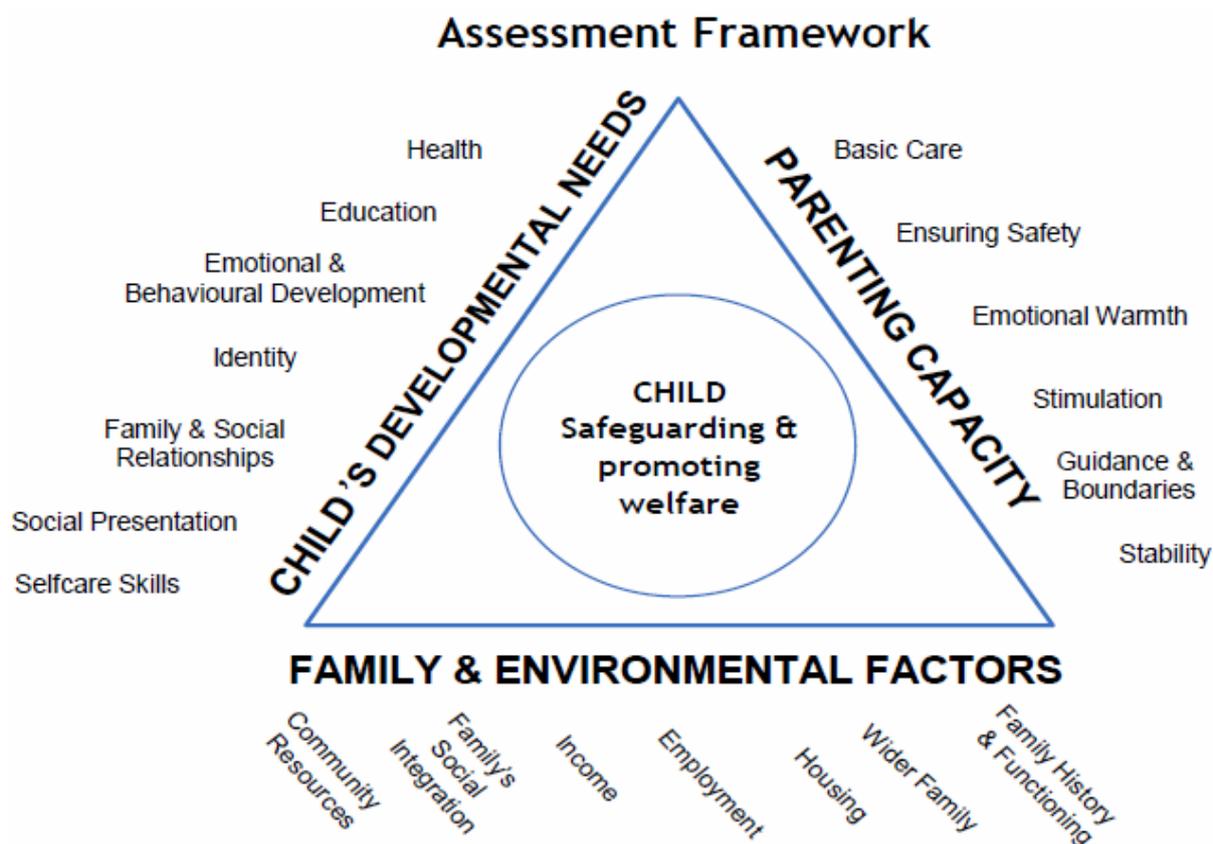
Designation: **Date:**

APPENDIX 7: Guidelines on Assessment

Research has shown that taking a systematic approach to enquiries using a conceptual model is the best way to deliver a comprehensive assessment for all children. A good assessment is one which investigates the domains below, the child's developmental needs, including whether they are suffering, or likely to suffer, significant harm; • parents' or carers' capacity to respond to those needs; and the impact and influence of wider family, community and environmental circumstances.

The interaction of these domains requires careful investigation during the assessment. The aim is to reach a judgement about the nature and level of needs and/or risks that the child may be facing within their family. It is important that:

- information is gathered and recorded systematically;
- information is checked and discussed with the child and their parents/carers where appropriate;
- differences in views about information are recorded; and
- the impact of what is happening to the child is clearly identified.



<http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/eOrderingDownload/Framework%20for%20the%20assessment%20of%20children%20in%20need%20and%20their%20families.pdf>. Please read in conjunction with When to suspect child Maltreatment www.nice.org.uk/nicemedia/pdf/CG89FullGuideline.pdf.

Thresholds: http://m.hertsdirect.org/docs/pdf/m/MTN_2014.pdf.

Early Help and Support

Example situations:

- Family socially isolated
- Limited play opportunities
- Unregistered with a GP
- Children not accessing school or pre-school regularly
- Pregnancy in a later teenager
- Children living in poverty
- Substance misuse habit has a significant negative impact on family income
- Planned change in drug/alcohol use that may impact on ability to parent
- Parental support may prevent relapse of mental ill health.

Example actions:

- Think with the family- who else could be involved to support them? GP, Health Visitor (HV), voluntary organisations, school, early intervention or family support from Children's Services
- Assess their needs- use the Common Assessment Framework (CAF) to help you or work with somebody else to do so.
- Refer the family to other voluntary or statutory services with their recorded verbal or written consent.

Vulnerable Children

Example situations:

- Domestic violence - child with a disability or under seven
- Medium level of domestic violence disclosed or suspected
- The parent has a physical, mental or substance misuse problem and the child has significant caring responsibilities
- The carer/parent is struggling to fulfil parenting role because of increasing mental or physical health needs.
- You think that a child may be privately fostered
- Child at high risk of sexual exploitation
- Pregnancy in an early teenager

Example actions:

- Speak to who else is involved with the family- GP, health visitor, social worker
- Discuss with the family; you don't need their permission to discuss with others or refer as you have concerns about the child's welfare but it is always better to do so.
- Refer to Children's Social Care and contribute to any assessment.
- Attend any Children in Need, or Team around the Child/Family meetings and contribute to plans.
- Make sure the child's details and needs are explicit in the notes.
- Consider the need for supervision.

Child Protection

Example situations:

You **must** always refer to Children's Social Care if you become aware of:

- Domestic abuse- women pregnant, child under one
- Any bruise in a pre-mobile child
- Sexually activity involving a child under thirteen
- A parent/carer expressing delusional thoughts about a child
- An adult who may harm a child as part of a suicide plan

You should refer if you become aware of:

- Any indication that the child **may** be at risk of significant harm from physical, emotional or sexual harm or neglect
- A disclosure of abuse or neglect from a child, young person or adult

Example actions:

- Always seek advice and support
- Refer to Children's Social Care by phone and follow up in writing (in 48 hours). Call them if you don't hear back.
- Discuss with the parent/carer. You do not need their permission to refer but it is better to do so unless you think that it will increase the risk.
- Ensure consultant psychiatrist is directly involved in clinical decision making for services users who may pose a risk to children.
- Contribute to the Children's Services led assessment
- Write a report for a child protection conference
- Attend the child protection conference and help to make a decision about the risk of significant harm.
- Contribute to the child protection plan
- Attend core group meetings
- Ensure that you have supervision

APPENDIX 8: Children's Services Referrals

*Early help, Targeted Youth, Thriving Families,
Young Carers, Disabled Children*

Child at risk of harm

Service Request (green form)-Hertfordshire
Family Operations Request for Support- West Essex
Link available on the intranet

Hertfordshire Child Protection (red form)

URGENT concerns/suspicious marks: ring **0300 123 4043** (written referral MUST then be completed within 24 hrs)

Essex Child Protection (Family Operations Request)

URGENT: ring **0345 603 7627** (written referral MUST then be completed within 24 hrs)

Complete all sections of the referral form
Additional information can be attached when sending

Access referral form via incident reporting (Datix) on the intranet
Complete Datix and ensure child's details are added

Save and send via email
Hertfordshire: **@hertscc.gcsx.gov.uk** (secure from an NHSMail account) or **@hertfordshire.gov.uk** (secure from an HCT account)
West Essex: **FOH@essex.gcsx.gov.uk**

Complete all sections on referral form
Please be aware the text boxes do not enlarge, the more you write the smaller the font becomes. If you have additional information this can be sent as an attachment with the referral

Save and send via email
Hertfordshire: **@hertscc.gcsx.gov.uk** (secure from an NHSMail account) or **@hertfordshire.gov.uk** (secure from an HCT account)
West Essex: **FOH@essex.gcsx.gov.uk**

Attach the referral form to the records of all children in the family

1. Attach the referral form to the records of all children in the family
2. Complete the Safeguarding template on SystemOne, ensuring the box is ticked under Children's Services tab, to record a referral has been made.
3. Tick the box to say you have received receipt of the referral
4. Document that a Datix has been completed

- Inform Universal Services (HV/SN) and any additional services currently working with the child/family
- Also Inform GP of referral, (if making a service request, please ensure parents are aware that this referral will be shared)
- Document all liaison on SystemOne.

**If in doubt, or you need any assistance, please contact the Safeguarding Children Team
Duty number: 07881 940233**

APPENDIX 9: SAFER Communication Guidelines

Communication Guidance (Department of Health 2013)

These are guidelines for communications between health and local authority children's social care teams using the SAFER process when a child may be suffering or is likely to suffer significant harm.

All verbal communications can be carried out using the **SAFER** process.

The use of SAFER will ensure a uniform approach to communicating the level of risk to a child/ children.

Section A: Prior to referral, ask yourself these questions:

- Have I assessed the child and documented my findings?
- Have I documented existing risk factors or issues?
- Is there any evidence of substance abuse, domestic abuse, mental illness, a chaotic lifestyle or missed appointments?
- Has a Common Assessment Framework (CAF) been followed?
- Has the situation been discussed with the child's parent(s)?
- Who else is in the household?
- Has the situation been discussed with the child's GP?
- Have I updated myself on the child's recent health history?
- Do I have knowledge of any siblings? May they be at risk of harm too?
- Is there a social worker already allocated? Have I discussed this referral with that social worker?
- Has the situation been discussed with a named nurse/senior colleague for safeguarding?

Prior to making a call, have the following available:

- The child's health record
- A list of recent events
- The evidence triggering the call.

Section B: Aide-memoire to support efficient and appropriate telephone referrals of children who may be suffering, or are likely to suffer, significant harm

Situation

- This is the Health Visitor/ School Nurse/ Allied Health Professional (give name) for (give your area). I am calling about ... (child's name(s) and address).
- I am calling because I believe this child is at risk of significant harm.
- The parents are/ aren't aware of the referral.

Assessment and actions

- I have assessed the child personally (and completed a CAF) and the specific concerns are ... (provide specific factual evidence, ensuring the points in Section A are covered).

- *or*: I fear for the child's safety because ... (provide specific facts – what you have seen, heard and/ or been told and when you last saw the child and parents).
- A CAF has/ hasn't been followed.
- This is a change since I last saw him/her (give no. of) days/ weeks/ months ago.
- The child is now ... (describe current condition and whereabouts).
- I have not been able to assess the child but I am concerned because.
- I have ... (actions taken to make the child safe).

Family factors

- Specific family factors making this child at risk of significant harm are ... (base on the Assessment of Need Framework and cover specific points in Section A).
- Additional factors creating vulnerability are
- Although not enough to make this child safe now, the strengths in the family situation are

Expected response

- In line with Working together to Safeguard Children, NICE guidance and Section 17 and/or Section 47 of the Children Act I recommend that a specialist social care assessment is undertaken (urgently?).
- Other recommendations.
- Ask: Do you need me to do anything now?

Referral and recording

- I will follow up with a written referral and would appreciate it if you would get back to me as soon as you have decided your course of action.
- Exchange names and contact details with the person taking the referral.
- Now refer in writing as per local procedures and record details and time and outcomes of telephone referral

If a child is at risk of immediate, significant harm, the priority remains to move them to a place of safety. The police have the powers to remove a child to a place of safety without parental consent.

APPENDIX 10: Prioritisation of Safeguarding Work for School Nurses

This prioritisation list originally was developed in April 2014 in response to a 60% increase in safeguarding work for school nurses (SN) during the previous 12 months and the school nursing vacancy levels in Hertfordshire. It was amended in December 2014 due to on-going time pressures and an audit of cases held by School Nurses.

The original prioritisation had been agreed with HCT Safeguarding Nurses Team, Head of Children's Universal Services Kay Gilmour and senior School Nurses. This has been approved by HCT Assistant Director for Quality Tricia Wren, LA Commissioners Elizabeth Biggs/Jane Banbury and Nicola Curley Children's Services Manager Hertfordshire County Council.

The amended prioritisation work for school nurses in December 2014 has been agreed by the head of child protection Hertfordshire County Council.

Essential safeguarding work for all school aged children

- Responding to S47 enquiries in a timely manner and providing information for telephone strategy discussions
- Writing reports for all Initial Child Protection Conferences (CPC) at the earliest opportunity. *NB: For children who are Out of School, Home Educated or attending private schools, the records must be checked and a report written or the chair informed that no information is held*
- Writing reports for all Review CPCs within the timeframe in the HCT Guidance. If there is no active involvement, the staff member should provide a brief report via the Safeguarding Children Team. The suggested text for the box "Why are you working with this child" is:
No current identified health needs or School Nurse involvement. The School Nurse will not be attending CPCs/ Core Groups. Please continue to send reports to enable regular reassessment.
- Sharing CPC reports with parents at a face to face contact where the school nurse is involved and documenting the reason when this is not possible. Parents could be asked to come to the practitioner's health base to view the report prior to conference
- Attending all Initial CPCs for Hertfordshire school children. *If not working at the time of the CPC another team member i.e. Health Visitor (HV) or School Nurse (SN) as appropriate must attend*
- Ensuring appropriate recording of all Safeguarding issues on SystemOne. *This includes documenting any non-attendance at meetings, with reasons*
- Entering Core Groups/ Reviews in the ledger of the appropriate staff member and alerting them to this
- Creating appropriate reminders to ensure that all reports are written in a timely manner

- Attending all first TAF and CiN meetings (unless the latter was as a result of the Step Down process) to allow them to assess health needs (physical and emotional) and agree the SN role (including no active involvement unless health needs are identified)
- Reviewing minutes of CPCs, Core Groups, Child in Need (CiN) meetings and Team Around the Family (TAF)s. Correcting inaccurate information, escalating lack of minutes and planning future care

Additionally, for children with identified health needs (physical or emotional)

- Attend Initial CPCs for children who are Out of School, Home Educated or attending private schools
- Attend all Review CPCs in Hertfordshire, *unless another SN or HV is attending, is briefed regarding your information and writes up the SystemOne record afterwards and ensures that this is shared promptly with the health professionals involved in the case*
- See children as detailed in the CP plan to assess/ review the identified health needs
- Attend Core Groups where SNs are the only CUS representative
- Attend all Child in Need (CiN) and Team Around the Family (TAF) meetings

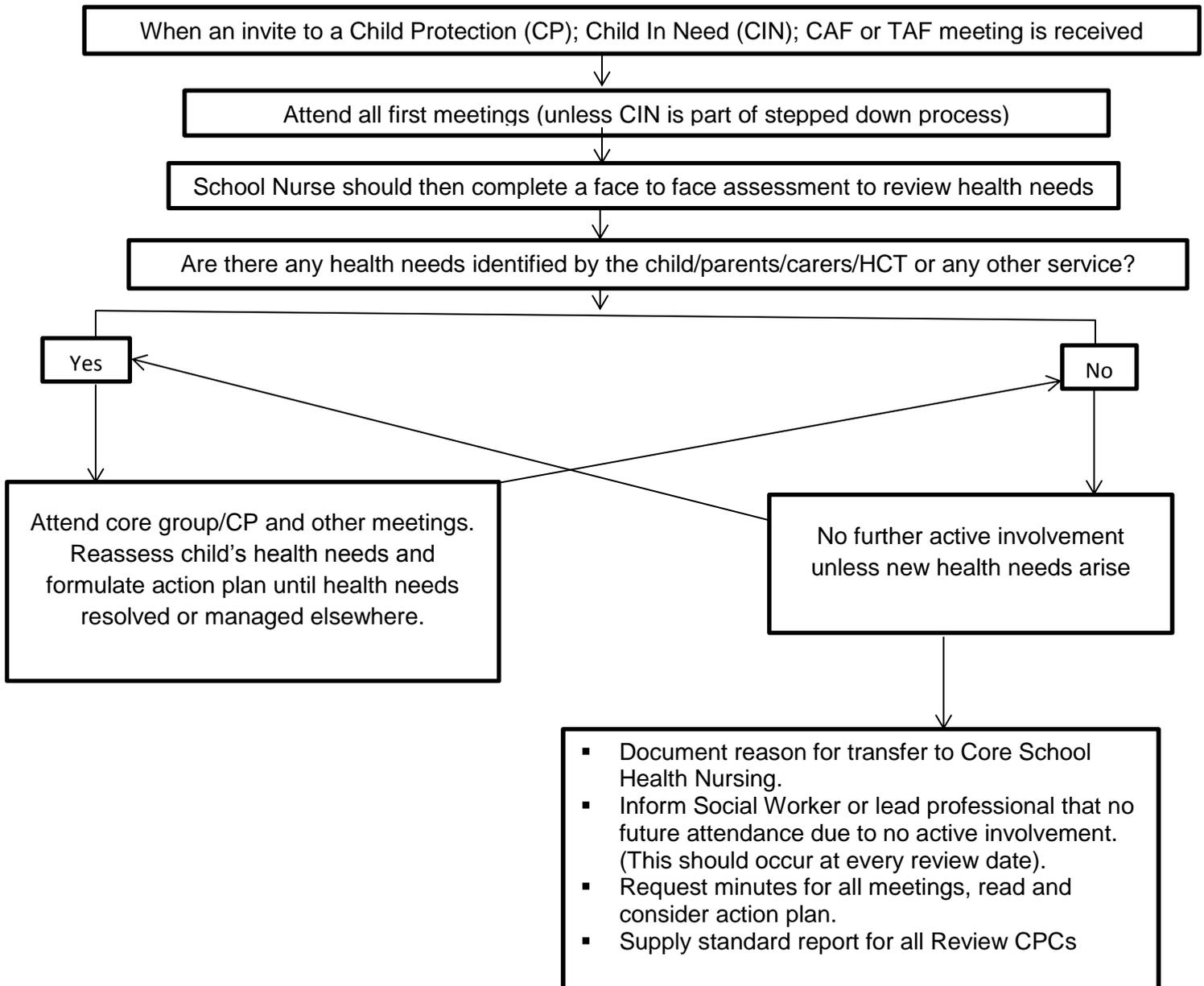
Children with no identified health needs

- If there are no identified health needs prior to the ICPC, the school nurse should attend the ICPC to confirm this. There is no need to see the child prior to ICPC. If there are no reported health needs at ICPC, School Nurse should complete own face to face assessment to confirm this.
- If there are no identified health needs the school nurse is not required to attend Review CPCs or Core Groups, and request minutes from these meetings. However, a report MUST be provided to all Review CPCs.
- If health concerns are raised to the school nursing team by parents or professionals, the child's needs should be reassessed and the action plan reviewed

Blanket statements that can be used for future reports/correspondence

No current identified health needs or School Nurse involvement. The School Nurse will not be attending CPCs/ Core Groups. Please continue/ensure reports are sent to enable regular reassessment.

SCHOOL NURSE INVOLVEMENT FOR MEETINGS FOR SCHOOL AGE CHILDREN



APPENDIX 11: Helplines

Hertfordshire Area Rape Crisis and Sexual Abuse Centre

This is a free and confidential phone and face to face counselling and information service for women who have experienced rape, sexual assault or sexual abuse at any time in their lives.

The counsellors see women over the age of 16 either at the centre in Hatfield or in their own homes, by appointment.

The helpline on 01707 276512 is open on Thursdays from 7.30pm-9.30pm. This line has an answerphone at all other times. This is checked regularly and calls are normally responded to within a few hours.

Contact: Administrator
PO Box 256
Hatfield, Hertfordshire AL10 0NE

Phone: 01707 276512 (Helpline) 01707 276539 (Admin)
hertsrapecrisis@btconnect.com Web pages: <http://www.hertsrapecrisis.org.uk/>

SACCA (Sexually Abused Children's Counselling Agency) SACCA has been a charity since 1997 and is still dedicated to its original aim of promoting relief of the distress of those who have suffered childhood sexual abuse.

Clients may be self-refer or be referred by G.P's, Social Services/Children Schools and Families, Police, Victim Support or Community Mental Health Teams.

All counsellors are professionally trained and qualified, members of British Association of Counselling and Psychotherapy, and have experienced childhood sexual abuse themselves. We work with women, men, adolescents and children and offer individual counselling, group work, training and advice and consultancy.

P O Box 275
Hertford SG13 9DD
Phone: 05602 395396
Fax: 05602 395396 email: saccaa-info@hotmail.co.uk

Respond

Provides assessment and therapy to people with learning difficulties who have experienced sexual trauma, or who are perpetrators of abuse. Helpline for anyone aged 16+ who needs advice or emotional support on these issues.24-32 Stephenson Way, London NW1 2HD, 0808 808 0700 - Monday-Friday 1.30-5pm www.respond.org.uk

There4me

www.there4me.com

Email support service for young people between 12-16 years. There's on-screen advice about all sorts of things e.g. bullying, relationships, exams, drugs, difficulties at home, to name just a few. Or you can send an e-letter to Sam, their agony aunt. If you'd prefer a confidential private session, you can talk 1-2-1 in 'real time' with an NSPCC adviser, or email for reply within 24 hours. You don't have to say who you are - you stay in control.

Mosac

Mosac is a voluntary organisation supporting all non-abusing parents and carers whose children have been sexually abused. We provide advocacy, information and advice, befriending, counselling, play therapy and support groups following alleged child sexual abuse.

Mosac seeks to enable parents/carers to rebuild confidence, alleviate isolation and to assist both parents/carers and their children to achieve an improved quality of life.

Mosac will raise awareness of the needs of the families affected by sexual abuse by liaising within the community and with voluntary and statutory agencies involved with families.

You can call the national helpline from anywhere in the UK for support, advice and information.

Mosac

141 Greenwich High Road,

London SE10 8JA

National helpline 0800 980 1958

Sexual Assault Referral Centres (SARCs) 0808 178 4448 Cheshunt and Watford

VICTIMS of rape and serious sexual assault will now have access to an alternative range of support and medical services without the need to involve police.

The two Sexual Assault Referral Centres (SARCs) are places of safety and discretion for victims and provide real choices about how victims want to receive care and be dealt with. Even results of medicals undertaken with a doctor can be stored until a victim feels they are ready to proceed.

Equally if a victim seeks police assistance they will be offered the support of dedicated officers based within the forces Sexual Offences Investigation Team, which is located at Police Headquarters, Welwyn Garden City.

Specially trained volunteers from Victim Support are available to advise victims from the outset as part of the new service.

Rape Crisis www.rapecrisis.org.uk & www.truthaboutrape.co.uk

National Association for People Abused in Childhood

www.napac.org.uk

Support for women and children from multicultural backgrounds

Foreign and Commonwealth Office (support forced marriage and repatriation issues) - 020 7008 0230

www.fco.gov.uk

Forced Marriage unit - 020 7008 0151 www.gov.uk/forced-marriage www.gov.uk/forced-marriage

Southall Black Sisters - 020 8571 9595

Muslim Women's Helpline - 020 8904 8193 / 020 8908 6715 / www.mwhl.org

Jewish Women's Aid Helpline - 0808 801 0500 www.jwa.org.uk (Tina Hine – [Barnet/Hertsmere tina@jwa.org.uk](mailto:tina@jwa.org.uk))

Christian website <http://www.restoredrelationships.org.uk>

Somalian Women's Centre - 020 8752 1787

Newham Asian Women's Project - 020 8552 5524 www.nawp.org

Kiran - Asian Women's Aid - 020 8558 1986 www.rdlogo.com/cwp/kawa/

Chinese Information and Advice Centre - 020 7692 3697 www.ciac.co.uk

Black Association of Women Step Out - 029 2043 7390

Aanchal: 24 hour Helpline for Asian women experiencing domestic violence. Languages spoken include: Bengali, Hindi, Punjabi, Gujarati, Tamil and Urdu. Phone: 08454 512547

Support for men

Men's Advice Line

A confidential helpline for all men experiencing domestic violence by a current or ex-partner. This includes all men - in heterosexual or same-sex relationships. Offers emotional support, practical

advice and information on a wide range of services for further help and support. Freephone 0808 801 0327

Days and times of phone support vary. www.mensadvice.org.uk/mens_advice.php

Mankind 08707 944124 Male **perpetrator programmes**:

Respect

A confidential helpline for people who are abusive and/or violent towards their partners. Offers information and advice to support perpetrators to stop their violence and change their abusive behaviours. The main focus is to increase the safety of those experiencing domestic violence. Phone line Freephone 0808 802 4040

Days and times of phone support vary.

www.respectphoneline.org.uk

www.respect.uk.net

Historic Abuse

National Organisations

CIS'ters (Childhood Incest Survivors) surviving rape and/or sexual abuse during childhood Survivor Network for females 18+ who were raped and/or sexually abused and/or sexually exploited as female children/teens, by a member of their immediate or extended family.

Address: PO Box 119, Eastleigh, Hampshire, SO50 9ZF
023 80 338080 (Sat 10-noon; answer phone at other times) Fax 023 80 346536
Helpline Number 023 80 338080 (Sat 10-noon; answer phone at other times)
Helpline: Hours of operation 24 hour voicemail

NSPCC

Advice and Support Helpline for adults who were victims of child abuse or neglect who are experiencing emotional or psychological difficulties.
Free Helpline Service 0808 800 5000 – available 24 hours per day, 365 days per year.
Text 88858, email at help@nspcc.org.uk

NAPAC (National Association for People Abused in Childhood)

A registered charity, based in the UK, providing support and information for people abused in childhood.

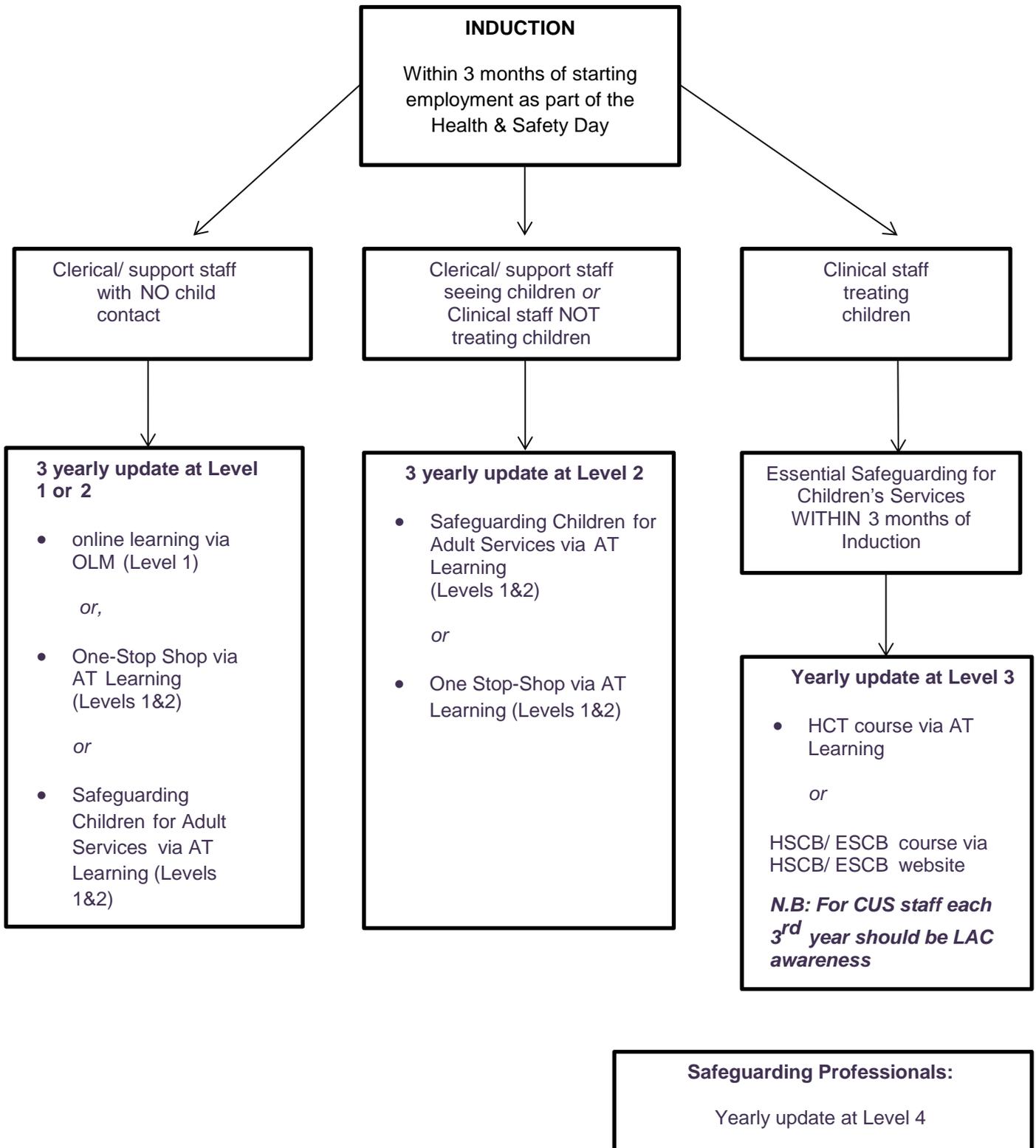
NAPAC provides a national Freephone support line for adults who have suffered any type of abuse in childhood.

The support line is staffed by trained volunteers, who can help with coming to terms with what happened and finding ways of repairing the harm.

The lines are open 10am till 9pm Monday to Thursday, 10am till 6pm on Friday and 10am till 4pm on Saturdays.

Call free on 0800 085 3330 from landlines, 3, EE, Vodafone and Virgin mobile phones.
Call free on 0808 801 0331 from O2, EE and Vodafone mobile phones.

APPENDIX 12: Safeguarding Children Training Pathway



APPENDIX 13: Policy Amendment(s) Template

To be completed and attached to any procedural document when submitted to the appropriate committee for ratification after doing Minor/ Technical revision(s).

Procedural Document Title: Safeguarding Policy for Children & Young People aged 0-18 years

Ref No: CP46 0915

Version: V.2

Date of Revision(s): tbc

Summary of Amendments:

Section Heading, Paragraph Number(s)	Description of Amendment(s)	Comments
All sections, paragraphs renumbered	Whole Document amended to meet new GR1 format	New GR1 procedural document revised in January 2014
Appendix 12	Safeguarding Children Training Pathway	New appendix inserted
Appendix 13	Amendment sheet	New appendix inserted
Appendix 14	Version Control table	New appendix inserted
Appendix 15	EIA form	New appendix inserted
Whole document	Whole document rewrite to convert previous Safeguarding Children and Young People Guidelines into a policy and update on recent changes in legislation.	<ul style="list-style-type: none"> ▪ CSE added ▪ FGM added ▪ Missing Added ▪ Children with disabilities added ▪ Home Educated added ▪ Historic abuse added ▪ Young carers added ▪ Risk assessments and flow charts added ▪ School Nurse prioritisation added
Whole document	Update to whole document regarding current policies and procedures	<ul style="list-style-type: none"> ▪ Appendix 8 amended ▪ Appendix 10 updated

APPENDIX 14: Version Control Table

Version No.	Status (Draft/ Approved)	Lead Officer (Author) Or, Identified Responsible Personnel	Date ratified (dd/mm/year) & reported Designated Committee	Comment (Key points of amendments)
V.1	Consultation draft	Safeguarding named nurse	Dec 2013	
V.1	Approved	Safeguarding named nurse	Jan 2014	
V.2	Consultation draft	Dee Harris, Safeguarding children's named nurse	April 2015	Guidelines revised and written as Policy
V.2	Consultation draft	Dee Harris, Safeguarding children's named nurse	August 2015	Sent to Safeguarding Committee members for comment
V.2	Consultation draft	Dee Harris, Safeguarding children's named nurse	Sep 2015	Final draft
V.2	Consultation draft	Dee Harris, Safeguarding children's named nurse	Oct 2015	6.4,6.21 amended 22.2 amended.

Historical Editions:

Edition/ Version and Date	Reason for archiving	Date for archiving & location
V.1 Jan 2014	Superseded by V.2 Sep 2015	<i>N:HCT/ Shared Secure/Archived Policies</i>

APPENDIX 15: Equality Impact Analyses Form

To be undertaken, completed and attached to any procedural document when submitted to the appropriate committee for consideration and ratification.

Function or Service	Safeguarding Policy for children & Young people			
Date of Equality Analysis	25.09.15			
Those involved in this analysis	Dee Harris			
Intended Outcomes	Human Rights Approach			
What are the Desired Outcomes? What are the benefits?	What are patients' core rights as part of this service/function? Are there any gaps identified? What are the risks? What action is needed to mitigate risk and/or close the gap?			
Children and Young people in receipt of HCT services receive safe, evidence based care Delivered by well-trained confident and competent staff who listens to their views and wishes as they have access to training relevant to their role and receive robust supervision.	To have care delivered by staff who understand the need to protection children using a variety of risk assessment and support methods. No risks identified through the policy			
Evidence	What are the Risks?			
What evidence is being used to support and develop the service/function?	What are the risks in providing an equitable service? How can these risks be reduced, managed or justified?			
Safeguarding legislation and national and local reviews and recommendations. Including evidence that is referenced in the policy.	Capacity is the only issue identified and this will have to managed on a local basis			
Who will be Affected?				
Identify issues in relation to each of the protected groups below:				
Race: None	Gender Reassignment: None			
Disability: None	Religion or Belief: None			
Gender: None	Maternity & Pregnancy: None			
Age: None	Marriage & Civil partnership: None			
Sexual Orientation: None				
What Workforce Issues included job role and design need to be considered?	Engagement and Involvement			
None	Who has been involved in this analysis? Dee Harris			

Actions Identified: None

S. No.	WHAT	WHO	WHEN	COST