Southern Health NHS
NHS Foundation Trust

SH CP 56

Safeguarding Children Policy

Version: 4

Summary:	This policy relates to the statutory safeguarding and looked after children responsibilities for Southern Health NHS Foundation Trust to ensure effective discharge of their duty to safeguard and promote the welfare of children and young people in accordance with legislation, guidance and standards.	
Keywords	Safeguarding Children Safeguarding, children and young people, Child protection, Allegations, Missing, Exploited, Trafficked Children Child Sexual Exploitation Female Genital Mutilation Prevent	
Target Audience:	All staff employed by Southern Health NHS Foundation Trust who have contact with children and/or young person's up to age eighteen years or their parents or carers. All Volunteers and Students working within Southern Health NHS Foundation Trust	
Next Review Date:	March 2018	
Approved and ratified by:	Safeguarding Forum/ Safeguarding Quality Workstream Meeting (Virtually)	**Date of meeting:** March 2017
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Version Control
Change Record

Date	Author	Version	Page	Reason for Change
12.06.14	Barbara Goff	2	All pages	Updating with new guidance and policies
12 06.14	Tim Coupland	2	Section 5.2	Enhancement of the section on risk and assessment processes
12.06.14	Oliver White	2	4.8 page 8	Grammatical errors and Insertion of section on Named Doctor responsibilities
12 06.14	Karen Rudland	2	Section 2.1	Section on scope and the addition of the flowchart for management of serious case reviews
12 06.14	Claire Goodridge	2		Reference new 4LSCB guidance on honour based violence, section on profession responsibilities
19.06.14	Caz Maclean	2	all	Updating of titles and areas on roles and responsibilities
05.10.15	Tina Scarborough	3	all	Enhancement of Professional dissent section. Reference new Working Together 2015. General updating and correction of grammatical errors. Section added regarding referrals to LADO
18.12.15	Tina Scarborough	3	Appendix 6	Section added on Mandatory reporting of FGM
23.12.15	Karen McGarthy	3	Appendix 5	Section updated to include Serious Crime Act and Modern Day Slavery Act
23.12.15	Karen McGarthy	3	6.1.1	Enhancement of the managing safeguarding children allegations against staff and keeping LADO informed.
30.12.16	Karen McGarthy	4	1	Review and update of summary and keywords
30.12.16	Karen McGarthy	4		Previous A7, A8, A9 Bluebird, Leigh House, Melbury Perinatal Mother and Baby Unit removed. Safeguarding Children Policy – the overarching policy and references units, but own policy/guidance for units to be maintained, updated and reviewed within own service and to reflect overarching safeguarding children policy. A statement on page 3 highlights changes and units to have own policy/guidance under overarching safeguarding children policy.
30.12.16	Karen McGarthy	4	6	Additional information added to 'legal definition of a child'
30.12.16	Karen McGarthy	4	5	1.6 changes added/removed
30.12.16	Karen McGarthy	4	7	Definitions of categories of abuse added
24.02.17	Karen McGarthy	4	8-11	Review and update of FGM, CSE in appendices 5 and 6 and moved to definition section under 'other forms of child abuse and child protection concerns.' Section added on radicalisation and e safety and Fraser guidelines.
24.02.17	Karen McGarthy		13-14	Identifying children and families who would benefit from early help replaces Vulnerability Guidelines
30.12.17	Karen McGarthy	4	15-16	Attending Child protection conference and core groups – added detail of expectations for staff
24.02.17	Karen McGarthy	4	16	5.2.1 additional information added on impact on children
24.02.17	Karen McGarthy		16	5.4 CP-IS added
24.02.17	Karen McGarthy	4	19-20	Additional information on managing safeguarding children allegations against staff. Added Allegations against Trust staff and the role of the SAMA
24.02.17	Karen McGarthy	4	Appendix 4	includes FGM reporting duty flowchart for children and risk assessment for children
24.02.17	Karen McGarthy	4	Appendix 5	Includes SERAF and CSEQR4 and matrix as to who should complete this
28.02.17	Karen McGarthy	4	Appendix 4	Protocol for handling historic abuse allegations, moved to page 17

Reviewers/contributors

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Safeguarding Quality Work stream Meeting	Senior staff of Safeguarding Quality Workstream Meeting	Version 4

Quick Reference Guide

For quick reference, this page summarises the actions required by this policy. This does not negate the need to be aware of and to follow the further detail provided in this policy.

The purpose of this policy is to ensure all Southern Health NHS Foundation Trust staff are compliant with statutory requirements to safeguard children and adults.

It provides the safeguarding framework for the safe and effective delivery of all services.

Section 3 Provides definitions of safeguarding and explains the difference between safeguarding and child protection. It includes the categories of abuse and other forms of child abuse and child protection concerns.

Section 4 Outlines individual responsibilities, including board members, and outlines the roles of each member of staff in safeguarding children.

Section 5 Provides the main policy context and includes assessment and referral processes – including a 'Think Family' approach, CP-IS, historic abuse allegations, resolving professional disagreements (escalation procedure), confidentiality and sharing Information, dissent at child protection conferences.

Section 6 Outlines the process of managing safeguarding children allegations against staff.

Section 7 Provides a clear definition of the safeguarding training requirements for staff.

Appendix 1 Provides the Training Needs Analysis.

Appendix 2 Includes the Equality Impact Analysis Screening Tool.

Appendix 3 includes the process for Learning Disability, Mental Health and Substance Misuse Services who are working with adult parents.

Appendix 4 includes the FGM Reporting Duty Flowchart for children and risk assessment for children.

Appendix 5 includes tools to assess CSE Risk.

Contents

Safeguarding Children Policy

1. Introduction

1.1. Southern Health NHS Foundation Trust, hereafter known as the Trust, provides a range of services including integrated community health, mental health and learning disability services. The Trust covers a large geographical area within Hampshire, and Southampton, Oxford as well as some regional services i.e. Mental Health Forensic.

1.2. The Trust has a statutory duty to safeguarding and promote the welfare of children and young people (the Children Act, 2004). This Safeguarding Children Policy outlines corporate and individual responsibilities in accordance with legislation, guidance and standards.

1.3. Section 11 of the Children Act (2004) places a legal duty on all health organisations to ensure that in discharging their functions, they have regard to the need to safeguard and promote the welfare of children.

1.4. The Trust's duty under Section 11 is, therefore, wider than child protection. To be effective it requires staff members to acknowledge their individual responsibility for safeguarding and promoting the welfare of children as well as the commitment of Trust management to support them in this. The Trust will ensure that all staff have access to expert advice, support and training in relation to safeguarding children.

1.5. It is the responsibility of NHS Trusts to make sure all staff are aware of their role in identifying children in need of protection and know how to act upon their concerns.

1.6. Safeguarding children and young people is a multiagency activity and is dependent upon partnership working with other statutory and non- statutory agencies. It is essential therefore that this policy is read in conjunction with:

- Southern Health NHS Foundation Trust Safeguarding Adult Policy
- Hampshire, Isle of Wight, Portsmouth and Southampton Safeguarding Children Boards 'Child Protection Procedures' http://4lscb.proceduresonline.com/
- Oxfordshire Safeguarding Children Board Procedures Manual 2012 available at: http://oxfordshirescb.proceduresonline.com

2. Who Does This Policy Apply To?

2.1. This Policy applies to all staff working for the Trust regardless of their role or place within the trust, and must be brought to their attention and read by them. The Policy is also applicable to Agency staff, Bank staff and staff from NHS Professionals. Reference is made here to the Trust's Safeguarding Adult Policy that gives guidance in relation to adults at risk.

2.2. Leigh House, Bluebird House, Perinatal Mental Health Services and Melbury Lodge Mother and Baby Unit have local safeguarding practice guidance and procedures for staff working in these units which should be read in conjunction with the Safeguarding Children Policy.

2.3. Safeguarding children is everyone's responsibility; for services to be effective each professional and organisation should play their full part (Working Together to Safeguard Children, 2015). This Policy applies to all children from unborn up to 18 years of age

whether the children are service users of the Trust's in their own right or children cared for by service users who are receiving services from the Trust. It also applies to other children in the wider community that come to the attention of Trust staff in the course of their work. The legal definition of a 'child' applies to those under 18 years of age. The Policy applies to all children who may access adult services provided by the Trust.

3. Definitions

3.1. **A Child:** In this document, as in the Children Acts, 1989 and 2004, **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.

3.2. **Safeguarding and promoting the welfare of children** is defined (in Working Together, 2015) as;

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

3.3. **Child Protection** is part of safeguarding and promoting welfare and refers to the activity which is undertaken to protect specific children who are suffering or are likely to suffer significant harm.

3.4. **Effective safeguarding arrangements in every local area should be underpinned by two key principles:** (Working Together, 2015)

- safeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their full part; and
- a child-centred approach: for services to be effective they should be based on a clear understanding of the needs and views of children

3.5. **Children in Care**

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.

3.6. **Definitions of categories of abuse:** (HM Government, 2015)

- **Physical abuse** a form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms or deliberately induces illness in a child.
- **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 a child that they are worthless or unloved, inadequate or valued only insofar as they meet the needs of another person. It may include not

giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children and young people. These may include interactions that are beyond the child's 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 and young people to feel frequently frightened or in danger, or the exploitation or corruption of children and young people. Some level of emotional abuse is involved in all types of maltreatment of a child though it may occur alone.

- **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 include physical contact, including assault by penetration (for example rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also involve non-contact activities such as involving children and young people in looking at, or in the production of sexual images, watching sexual activities, encouraging children and young people 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 and young people.
- **Neglect** is the persistent failure to meet a child's basic physical and /or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to;
    - Provide adequate food, clothing and shelter (including exclusion from home or abandonment);
    - Protect a child from physical and emotional harm or danger;
    - Ensure adequate supervision (including the use of inadequate care-givers); or,
    - Ensure access to appropriate medical care or treatment
    - It may also include neglect of or unresponsiveness to a child's basic emotional needs

3.7. Some other forms of child abuse and child protection concerns with definitions include:

- **Female Genital Mutilation (FGM)**

Female Genital Mutilation (FGM) is a procedure where the female genital organs are deliberately cut or injured, but where there is no medical reason for this to be done. FGM can be carried out on girls of all ages but may be more common between the ages of 5 and 10.

<u>Types of Female Genital Mutilation</u>
FGM is classified into four major types. The World Health Organisation definitions are:

Type 1: Clitoridectomy: partial or total removal of the clitoris

Type 2: Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina)

Type 3: Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris

Type 4: Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area

The FGM mandatory reporting duty is a legal duty provided for in the FGM Act, 2003 (as amended by the Serious Crime Act, 2015) which requires all regulated healthcare professionals to report FGM in a girl under 18, either through disclosure by the victim or relative and/or are visually confirmed. This is no different from any other obligation on healthcare professionals to report abuse against children. FGM is child abuse so the healthcare professional must make a report to the Police.

Appendix 4 includes FGM reporting duty flowchart for children and risk assessment for children

3.8. Missing. Exploited and Trafficked children (MET)

3.8.1. Definition of Missing or being absent:
To ensure that the appropriate action to promote a child's safety is taken when police receive a concern about a child having gone "missing" the police apply the following categories

A 'missing' person is defined as:
"Anyone whose whereabouts cannot be established and where the circumstances are out of character or the context suggests the person may be subject of a crime or at risk of harm to themselves or another"

Those meeting this definition will be actively searched for, with a level of risk and assigned to each case.

An 'absent' person is defined as a:
"Person not at a place where they are expected or required to be"
People categorised as such should not be perceived to be at any apparent risk. Cases classified as 'absent' will be monitored by the police and escalated to the missing person category if risk increases.

3.8.2. Definition of exploited:
Revised statutory definition of child sexual exploitation
Child Sexual Exploitation (CSE) is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology (Working Together 2017)

Children aged 12-15 years of age are most at risk of child sexual exploitation, although victims as young as 8 have been identified, particularly in relation to online concerns. Equally, those aged 16 or above can also experience child sexual exploitation, and it is important that such abuse is not overlooked due to assumed capacity to consent. Account should be taken of heightened risks amongst this age group, particularly those without adequate economic or systemic support. Though child sexual exploitation may be most frequently observed amongst young females, boys are also at risk. Child sexual exploitation affects all ethnic groups.

It is important to remember that:-

- A child under the age of 13 is not legally capable of consenting to sex (it is statutory rape) or any other type of sexual touching; Sexual activity in older children (i.e. from 13 to 18 years) needs to be considered in relation to both *the giving, and the getting of consent*, with the promotion of mutual negotiation as the norm being an important aspect of preventative activity (Coy *et al*., 2013)
- Sexual activity with a child under 16 is an offence. Practitioners have a responsibility to undertake an assessment of young people aged 13 to 15 years who are engaged in sexual activity following Fraser competencies guidelines, to determine the risk of sexual and other forms of exploitation or coercion including trafficking. This assessment will inform the decision making process relating to the appropriateness of a referral to Children's Social Care and the Police. Risk assessment is a complex process and practitioners are encouraged to discuss concerns with a member of the Safeguarding Children Team whenever they are unsure about the appropriate course of action
- Those aged 16 and 17 years may be viewed by health professionals and others as being of 'the age of consent' in terms of the Sexual Offences Act (2003), but this age group are particularly vulnerable to CSE being missed precisely because of the legalities of sexual consent in this age group (Powell, 2016)
- It is an offence for a person to have a sexual relationship with a 16- or 17- year old if they hold a position of trust or authority in relation to them;
- Where sexual activity with a 16- or 17- year old does not result in an offence being committed, it may still result in harm, or the likelihood of harm being suffered;
- Non consensual sex is rape whatever the age of the victim; and
- If the victim is incapacitated through drink or drugs, or the victim or his or her family has been subject to violence or the threat of it, they cannot be considered to have given true consent and therefore offences may have been committed
- No individual, whatever their age, can give consent in a situation where there is intoxication, duress, violence, power imbalances and/or vulnerabilities through age differences, learning difficulties or mental health issues. A child under 18 years of age cannot consent to their own abuse through exploitation (Powell, 2016)

3.9. E-Safety

- Health professionals should be aware of the need to support parents to keep their children safe when using online, mobile technologies and to protect them from cyber bullying. Increasingly, it is recognised that solely attempting to block or rigorously control access to undesirable content is ineffectual and counter-productive, encouraging some young people to find ways round the rules and limiting the use of potentially valuable materials and activities to underpin learning and development
- Local procedures and training are accessible at http://4lscb.proceduresonline.com/

Further guidance is available on the Trust Safeguarding Intranet page and on Hampshire safeguarding children board website and 4LSCB procedures.

The new Working Together (2017) advice on CSE and the new definition is available at:
https://www.gov.uk/government/publications/child-sexual-exploitation-definition-and-guide-for-practitioners

3.10. Trafficking

Human trafficking is defined as a process that is a combination of three basic components:

- Movement (including within the UK)
- Control, through harm / threat of harm or fraud
- For the purpose of exploitation (UNHCR 2006)

The Modern Slavery Act (2015) requires public authorities to notify the Home Office when they encounter a potential victim of modern slavery or human trafficking, and for children this is generally done through a referral to the National Referral Mechanism (NRM). Unlike adults, consent is not needed from a child for this referral to be made.

- Children at risk of radicalisation (PREVENT)

Radicalization is defined as the process by which people come to support terrorism and extremism and, in some cases, to then participate in terrorist activity.
Extremism is vocal or active opposition to fundamental British values including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs.

Health care professionals may treat children who are vulnerable to radicalisation. The key challenge for the health sector is to ensure that, where there are signs that someone has been or is being drawn into terrorism, the health care workers can interpret those signs correctly, are aware of the support that is available and are confident in referring the child for further support (HM Government 2011).

Appendix 5 includes the assessment tools that should be used to assess children who may be at risk of child sexual exploitation and trafficking.

4. Duties / Responsibilities

4.1. The Trust's Chief Executive has the responsibility for ensuring that the health contribution to Safeguarding and promoting the welfare of children is discharged effectively across the whole local health economy through the services the Trust provides (Working Together HM Government, 2015). This responsibility is delegated to the Chief Nurse.

4.2. The Trust's Associate Director for Safeguarding and Strategic Lead for Safeguarding will ensure that there is an appropriate representation on Safeguarding Children Boards within the geography of the Trust. This representation is at an appropriate level of seniority with the ability to commit resources to the work of safeguarding children.
In line with statutory and organisational requirements, the Trust has appointed the following;

- Associate Director for Safeguarding
- Named Nurses for Safeguarding Children
- Specialist Nurses/Professionals and Practitioners for Safeguarding Children
- Specialist Nurse for Children in Care Team Leader
- Specialist Nurses for Children in Care
- Named Doctor for Safeguarding Children

4.3. The Trust recognises its responsibility to ensure that safe working systems are in place for staff working with children and families and staff working with adults who have children in their care, and adults who have contact with children.

4.4. The Trust accepts that Safeguarding Children is a challenging and complex area of work; difficult judgements have to be made.The Trust will ensure that any learning from such cases will be managed in a supportive and constructive way.

4.5. Associate Director for Safeguarding responsibilities include;

- Providing a strategic lead for safeguarding across the organisation and the provision of support to enable the operational development of this area of work
- Working with the designated professionals to ensure a strategic professional lead across the Trust
- Ensuring that there is a clear line of accountability and governance within the Trust and the provision of services designed to promote and safeguard the welfare of children
- Collaborating with Human Resources Department in order to ensure recruitment and human resources management procedures, including contractual arrangements, take account of the need to safeguard and promote the welfare of children and young people. This includes arrangements for appropriate employment checks on new staff and volunteers and the adoption of best practice in the recruitment of new staff and volunteers
- Ensuring that there are procedures for dealing with the allegations of abuse against members of staff and volunteers
- Leading the organisation to understand and embed learning from serious case reviews
- Attending the Local Safeguarding Children Boards (LSCB) that are within the boundaries of the Trust provider role
- Working collaboratively with partner organisations to grow business and ensure that the health economy is an equal partner in all safeguarding delivery

4.6. Named Nurses for Safeguarding Children responsibilities include;

- Ensuring support and supervision to promote good professional practice which safeguards and promotes the welfare of children and their families
- Promoting, influencing, developing and delivering the safeguarding training strategy
- Providing a vital source of professional advice on safeguarding and child protection matters to health professionals and links with partner agencies, for example: Local Authority Children's Services Departments and the LSCBs in the geographic boundaries of the Trust
- Conducting Individual Management Reviews as part of the Serious Case Review Process and ensuring the resulting action plans are actioned within provider services
- Supporting the Trust in its clinical governance role by ensuring safeguarding issues are part of the governance system
- Working together with other organisations, in accordance with LSCB guidance, to provide a rapid and coordinated response in the event of sudden and unexpected child death
- Attend and participate in the various LSCB Sub-groups

4.7. Specialist Nurse for Children in Care Team Leader responsibilities include;

- Raising awareness to all Trust employees that because children are in care they are not necessarily safe from harm and should be in fact be protected as with any other child
- Ensuring supervision and support to promote good professional practice specifically relating to children in care and their carers
- Promoting, influencing and participating in policy and procedure development ensuring it reflects the requirements of children in care and meeting statutory requirements
- Supporting the Trust in its clinical governance role to ensure services and issues regarding children in care are part of the governance system
- Ensuring that all Trust staff working directly with children in care and those who come into contact with them through their work are fully aware of their complex health needs, vulnerability and legal status
- Working in partnership with other statutory and third sector organisation who are responsible for meeting the needs of children in care
- Contributing to the training strategy for safeguarding to ensure children in care are an integral part

4.8. Named Doctor for Safeguarding Children responsibilities include;

- Participating in the local Safeguarding Children Board activities which may include attending the Boards or sub-committees as appropriate
- Working collaboratively at a strategic level to ensure there is effective multi-agency liaison and cooperation
- Supporting and advising the Trust Board and Executive Team on safeguarding matters
- Providing advice and support to senior management, supervision and professional guidance to medical colleagues
- Playing a key role in ensuring staff are up to date with recent legislation, national documentation, latest guidance, best practice and evidence based research
- Supporting the Head of Safeguarding to advise the management teams concerning the Trust, including the Board
- Liaising with Clinical Commissioning Group colleagues
- Ensuring an appropriate supervision structure for medical staff including trainees

4.9. Divisional Heads and all Managers Responsibilities include;

- Ensuring that all staff are made aware of their roles and responsibilities in relation to this policy
- Ensuring that all staff have read the policy and are aware of what actions they need to take
- To identify any additional training and support needs required by their staff to enable them to perform their duties as defined in this policy
- Monitoring periodically staff awareness of their roles in relation to this policy

- Following other appropriate Trust procedures, simultaneously where necessary e.g. disciplinary procedures, complaints and incident reporting
- Ensuring appropriate Divisional representation at the Trust's Safeguarding Forum and Board
- Ensuring all staff receive adequate safeguarding supervision considering the vulnerabilities and risks for children

4.10. Individual Responsibilities

4.10.1. **All staff** should actively safeguard and promote the welfare of children

- All staff, including those in universal services and those providing services to adults with children, needs to understand their role in identifying emerging problems and to share information with other professionals to support early identification and assessment.
- All staff should, in particular, be alert to the potential need for early help for a child who:
    - is disabled and has specific additional needs;
    - has special educational needs;
    - is a young carer;
    - is showing signs of engaging in anti-social or criminal behaviour;
    - is in a family circumstance presenting challenges for the child, such as substance abuse, adult mental health problems and domestic violence;
    - has returned home to their family from care and/or
    - is showing early signs of abuse and/or neglect
- Professionals working in universal services have a responsibility to identify the symptoms and triggers of abuse and neglect, to share that information and work together to provide children and young people with the help they need. (Working Together, 2015)
- Concerns that children are at risk of, or suffering from, child abuse or neglect must be discussed with a senior member of staff. Reasons for the concern and actions taken should be documented in the electronic patient record (RiO) or equivalent record
- Any decisions taken not to share information with other agencies regarding a child potentially experiencing harm or neglect should be clearly documented in the electronic patient record (RiO).
- Seek safeguarding supervision when they have concerns for vulnerabilities and risks to children

4.10.2. **Following up concerns**

- Safeguarding Children Single Point of Contact (SPOC) provides responsive supervision, including safeguarding queries, during office hours, for all employees of the Trust on 023 9237 2780
- For staff working at Bluebird House, Leigh House and Melbury Mother and Baby Unit, the Identified Lead Social Worker can provide help and advice as well as SPOC
- Children's Services including out of hours

- If a decision is made that the threshold for child protection referral has NOT been reached, consideration should still be given for providing additional services to the child and family. Reasons for the decision and actions taken should be documented
- Hampshire County Council threshold chart assists staff to consider if the threshold has been met to refer children that fit the criteria set out as level 3 and level 4 in http://documents.hants.gov.uk/childrensservices/ThresholdChartJuly2015.pdf
- For other areas Local Safeguarding Children Board procedures will provide their own threshold charts
- A telephone call or email referral should be made in the first instance to Children's Social Care. This must be followed up in writing within 48 hours using the relevant Interagency Safeguarding Children Referral Form
- The reasons for referral should normally be discussed with the child and their parents unless it is considered that such a discussion would place the child, other children or adult at increased risk or there are concerns about possible Fabricated or Induced Illness (FII)
- 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 the local Early Help Hub via Children's Services. Staff working with adults should then liaise with health practitioners working directly with the child
- Individuals cannot delegate the referral to Children's Social Care to another professional/colleague (although they may need support to make the referral). Health Visitors and/or School Nurses should take the lead in Child Health Teams in making a referral
- Staff should be mindful that Health are not an 'investigating agency'; where there are issues concerning the welfare of children and young people there is a 'duty to inform'
- There is an ongoing 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
- Ensure record keeping complies with individual Professional Codes of Conduct and the Trust's Record Keeping and Documentation Policies and RiO Standard Operating Procedure

4.10.3. **Attending Child protection conference and core groups**

- Staff (whether working with the child or adult who is a parent /carer) who are invited to attend a Child Protection Conference/Professional meeting due to their professional involvement must ensure they attend when invited. Should an invited professional be unable to attend, apologies must be communicated and a suitable deputy found
- It is essential that a written report regarding their involvement with and knowledge of, the family, including identification of risk factors and protective practice should be prepared for the Conference. The report should identify current health status and any outstanding health need
- Information contained in the report should be routinely shared with family members prior to the conference. Any concerns about sharing information with parents or carers should be discussed with the conference chair prior to the conference taking place. If the health professional has not been able to share their report with the family, reasons for this should be clearly stated on the report before submission

- Where a practitioner is identified as a member of a core group for a child who is made subject to a child protection plan at the conference, they must prioritise attendance at core group meetings
- Additional advice and support can be provided by Named and Specialist professionals via Single Point of Contact

5. Main Policy Content

5.1. Assessment and Referral Processes

5.1.1. Throughout the Trust all services must follow the guidance of;

- Hampshire, Isle of Wight, Portsmouth and Southampton Safeguarding Children Boards: http://4lscb.proceduresonline.com/
- Oxfordshire Safeguarding Children Board Procedures Manual available at: http://oxfordshirescb.proceduresonline.com

Children's rights to be safeguarded are paramount. Assessments should measure the potential or actual impact of parental health on parenting, the parent/child relationship and the child, as well as the impact of parenting on the adult's health. Appropriate support and ways of accessing it should also be considered in the assessment

5.1.2. Practitioners working with adults must identify and record at the earliest stage:

- the adult's relationship with any children
- any parenting or caring responsibilities for children
- which other agencies they need to work with if they have concerns about unborn babies, children or young people (Joint Working Protocol, 2014)

5.2. Risk and Assessment Processes must adopt the "Think Family" approach. Documentation throughout the Trust will ask the following questions in the context of understanding the whole family (Joint Working Protocol Flowchart, 2014);

- If there are family members under 18 years old
- If family members under the age of 18 are receiving services from other agencies, if so which ones and what is their role?
- If Children's Services are involved, what is their involvement?
- Is the Child on a Child Protection Plan?
- Is the Child a Young Carer?
- Does the service user have contact with children through their network of family and friends?

5.2.1. If any of the above is identified a risk assessment must consider the impact on the child's emotional, social and physical wellbeing and if there are risks, what further actions are required to safeguard the child.

Appendix 3 Process for learning disability, mental health and substance misuse services who are working with adult parents assists staff to identify risks and how to respond.

5.2.2. If Trust staff have knowledge that a service user is working with children in a paid or voluntary capacity and there are concerns regarding risks to children, then contact Safeguarding Children Single Point of Contact for responsive supervision and to escalate to the Named Nurse Safeguarding Children and refer to the Local Authority Designated Officer (LADO).

5.3. Checking to See If a Child Has a Child Protection Plan

5.3.1. If Trust staff have concerns that a child may have a Child Protection Plan and need to check, then the Children's Services in the relevant area must be contacted to conduct the search.

5.3.2. For children outside the Trust area, the Children's Service office in the geographic area concerned should be contacted.

5.4. CP-IS

The Child Protection Information System (CP-IS) is a system dedicated to developing an information sharing process that will deliver a higher level of protection of children who visit NHS unscheduled care settings. It provides additional child protection information to staff, shares local authority information with the NHS and allows staff to deliver a higher level of child protection.

Sharing information effectively across health and care settings is vital in protecting vulnerable children and young people and preventing further harm.

CP-IS focuses on three specific categories

- Those subject to a child protection plan
- Those with 'looked after child' status (children with full and interim care orders and voluntary care agreements)
- Any pregnant woman whose unborn child has a pre-birth child protection plan

CP-IS has been implemented in the Minor Injury Units (MIU). If a child presents at MIU and CP-IS identifies that a child has an allocated social worker, the social worker should be informed of attendance. If CP-IS does not identify the above three categories, a full risk assessment is still required and actions to safeguard if concerns are identified. *More information on CP-Is is available on the Trust intranet.*

5.5. Historic abuse allegations

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.

Allegations of child abuse are sometimes made by adults and children many years after the abuse has occurred. There are many reasons for an allegation not being made at the time including fear of reprisals, the degree of control exercised by the abuser, shame or fear that the allegation may not be believed. The person becoming aware that the abuser is being investigated for a similar matter or their suspicions that the abuse is continuing against other children may trigger the allegation.

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. It is important to ascertain as a matter of urgency if the alleged perpetrator is still working with, or caring for children.

Action to Safeguard

The professional receiving the disclosure or the victim may not be aware of the perpetrators present circumstances and therefore are not able to assess whether they pose a current risk to a child, children or other adults at risk person.

Consideration must be given to whether the alleged perpetrator presents a current risk to children or vulnerable people through having contact within a family setting, as a professional or by their behaviour.

The professional to whom the disclosure was made should:

- Clarify whether there are any children who may currently be at risk from the alleged perpetrator
- If it has been ascertained that the alleged perpetrator has or may have contact with a known child/ children, a referral should be made to Children's Services
- If there are concerns that the alleged perpetrator has contact with children but the names of the children are not identifiable, the police should be contacted to enable further investigation
- If there are concerns that the adult making the disclosure is at risk, consideration to refer to adult social services and police will be required
- Advise and support the adult that they are able to make a formal complaint to the Police.
- Provide the victim with information about relevant support services
- Contact the Safeguarding Children Team via Single Point of Contact (SPoC) on 02392 372780 for further advice and support for safeguarding of children
- Contact the Safeguarding Adult Team via Single Point of Contact Adults (SPoCA) on 070100 44974 for further advice and support for safeguarding of adults

5.6. Confidentiality and Sharing Information

5.6.1 The decision to share or not to share information about a child/young person should always be based on professional judgement, supported by the cross-governmental guidance Information *Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers* (HM Government, 2015).

5.6.2 Information sharing must be done in a way that is compliant with the Data Protection Act, the Human Rights Act and the common law duty of confidentiality. However, a concern for confidentiality must never be used as a justification for withholding information when it would be in the child/young person's best interests to share information. The Caldicott Principles set out in *Information: To share or not to share? The Information Governance Review* (*Caldicott 2 Review)*, March 2013, provide general principles that health and social care organisations should use when reviewing their use of client information and exemplify good practice.

5.7. Discharging a child and/or a parent/carer from your service when there are Safeguarding Child and/or adult concerns.

5.7.1 Trust Children's Services

It would not normally be anticipated that a child with safeguarding concerns would be discharged from the Health Visiting or School Nursing Service. There are occasionally exceptional circumstances where a parent makes an informed decision to withdraw from the service. In this situation or when the parent fails to engage in the service the Health Visiting or School Nursing Service should follow the Disengagement Guideline. Other Health Professionals working with the family e.g. GP, CAMH's Adult Health Services should also be informed

5.7.2 Trust Adult and Specialised Services

If an adult who is a parent/carer of a child or a child is discharged from Southern Health Services either because their episode of care is complete or they have disengaged it is important that other professionals including health professionals are informed. A letter outlining the diagnosis, treatment and safeguarding issues (if any) and reason for discharge should be sent to all professionals involved including the GP, Health Visitor or School Nurse, Social Worker for the adult and/or child and other adult or child health services involved. This could be the discharge letter that is normally sent. It is important to record in the patient record who has been informed of the discharge.

5.8. Resolving Professional Disagreements (Escalation Procedure)

Principle: At no time must professional dissent detract from ensuring that the child is safeguarded. The child's welfare and safety must remain paramount throughout

5.8.1 Differences of Opinion between Trust Staff Regarding Whether a Child Is at Risk of Deliberate Harm

If there is a difference of opinion between senior staff regarding whether a child is at risk of deliberate harm, the following process must be followed taking into account that the Trust is a secondary provider of services;

- The manager in charge of the team must be informed and included in the discussion
- Safeguarding Children Single Point of Contact should be contacted for advice and support. If the disagreement cannot be resolved at this point then the situation should be escalated to the Named Nurse for safeguarding Children for advice
- If there is still a difference of opinion, then the case must be referred to Children's Services

5.8.2 Disagreements over the handling of concerns by Children's Services

Disagreements over the handling of concerns reported to Children's Social Work Services typically occur when;

- The Referral is not considered to meet eligibility criteria for assessment by Children's Social Care Services
- Children's Social Care Services conclude that further information should be sought by the referrer before the referral is progressed
- There is disagreement as to whether child protection procedures should be involved

- If the professionals are unable to resolve differences through discussion and/or meeting within a time scale which is acceptable to both of them, their disagreement must be addressed by more experienced or more senior staff;
- Staff should contact Safeguarding Children team for advice and support
- Staff should follow the 4LSCB (Portsmouth, Southampton, Hampshire and Isle of Wight LSCB's) procedures regarding dissent

5.8.3 Dissent at Child Protection Conferences

If a Child Protection Conference Chair is unable to achieve a consensus as to the need for a Child Protection Plan, s/he will make a decision and note any dissenting views;

- The agency or individual who dissents from the Chair's decision must determine whether s/he wishes to further challenge the result
- If the dissenting professional believes that the decision reached by the Conference Chair places a child at (further) risk of Significant Harm, it is expected that s/he will formally raise the matter with their line manager and the Named Nurse for Safeguarding Children via Safeguarding Children Single Point of Contact

6. Managing Safeguarding Children Allegations Against Staff

The framework for managing allegations is set out in Working Together to Safeguard Children (2015). The framework applies to all who work with children and young people, including those who work in a voluntary capacity. When an allegation of child maltreatment is made against an employee of Southern Health NHS Foundation Trust, including agency staff, bank staff and staff from NHS Professionals it must be responded to and thoroughly addressed. There may be concern that a member of staff has;

- behaved in a way that has harmed, or may have harmed, a child
- possibly committed a criminal offence against, or related to, a child
- behaved in a way that indicates s/he is unsuitable to work with children

It is essential that any allegation of abuse made against a person is dealt with consistently, fairly, quickly and in a way that provides effective protection for the child and at the same time supports the person who is the subject of the allegation.

An integral part of the framework for managing allegations against staff is the role of the **Local Authority Designated Officer (LADO).** The LADO is responsible for the management and oversight of individual cases and must be informed of all allegations or concerns relating to staff or volunteers that fit the criteria above.

The LADO will provide advice and guidance to any agency or employer providing services for children. Where necessary they will liaise with Children's Social Care and other agencies, monitor the progress of cases and work to ensure that all allegations are dealt with appropriately.
It is essential that, following agreement with the LADO, managers ensure that they keep LADO informed of the ongoing investigation and at the closure share relevant reports relating to the investigation. Managers can seek advice from HR and the Named Nurse Safeguarding Children for further advice.

If there is an allegation of abuse or neglect by a member of staff, student or volunteer within the Trust, the Southern Health Safeguarding Children Team must be notified as soon as possible.

6.1 When to contact the LADO

All safeguarding allegations or concerns about a member of staff or volunteer should be discussed with Trust HR and the relevant LADO in the first instance who will liaise, as necessary, with social care and the police. The LADO needs to be informed within one working day of all allegations that come to an employee's attention or that are made directly to the police (Working Together, 2013) If appropriate you may be asked to complete a LADO referral form as a method of making a written referral.

6.2 Contacting the LADO

- **Hampshire**
  Contact telephone number – 01962 876364

- **Southampton**
  Contact Number via Central Business Support – 02380 915535

- **Oxfordshire**
  http://oxfordshirescb.proceduresonline.com

6.3 Allegations against Trust staff and the role of the SAMA

Each member organisation of the Local Safeguarding Adult Board (LSAB), including Southern Health, has a Safeguarding Allegations Management Advisor (SAMA) who is responsible for coordinating complex cases where concerns or allegations about the harm or abuse of an adult at risk are raised against a member of staff, volunteer or student within the organisation. Within Southern Health, the SAMA role is held within the Corporate Safeguarding Adults Team. Therefore, if there is an allegation of abuse or neglect by a member of staff, student or volunteer within the Trust, the Southern Health Safeguarding Adults Team must be notified as soon as possible. Please see the Southern Health Safeguarding Adults Policy for further information.

7. Training Requirements [Appendix 1]

7.1 All staff requires a minimum standard of Level 1 training and all frontline and/or clinical staff, a minimum of Level 2.

7.2 All new Trust employees will have their safeguarding training requirements reviewed and minimum level required identified

7.3 Previous training will be considered and reviewed by LEaD and if the core standards in terms of Skills for Health are met, this can be passported. However if these standards are not met level 1, 2 and 3 training would need to be completed, consummate to their role. This is for both e-learning and face to face training

7.4 A programme of mandatory and optional training courses will be available for clinical staff as part of their continuing professional development requirements.

8. Monitoring Compliance

The following table outlines the arrangements for monitoring compliance with this policy and its associated procedures.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Section 11 Responsibilities of the Children Act 2004	Safeguarding Forum	LSCB audit of arrangements	Annually	Safeguarding Forum
Duties and responsibilities of staff	Safeguarding Forum	Work plan	Quarterly	Safeguarding Forum
Basic record-keeping standards, which must be used by all staff	Clinical Records Steering Group	Clinical audit	Annual audit	Clinical Records Assurance Steering Group

The effectiveness of this policy will be assessed in a number of ways; through planned organisational and service level audits and through the investigation of serious incidents, complaints and allegations that are undertaken by Southern Health NHS Foundation Trust, LSCBs, or other authorised bodies. The policy will be amended as necessary in the light of learning from such reviews.

9. Policy Review

This policy will be reviewed annually.

10. Associated Documents

- SH IG 1 Clinical Information Assurance (Record-Keeping) Policy
- SH IG 18 Data Protection, Caldicott & Confidentiality Policy
- SH CP 15.2 Safeguarding Adults Policy
- SH IG 46 Information Sharing Policy
- SH CP 66 Notification of the Death of a Child Guidelines
- SH CP 72 Children's Community Public Health 0-19 Service Overarching Policy
- SH CP 88 Protocol for the Management of Bruising in Children who are not Independently Mobile
- SH CP 105 Child and Family Was Not Brought and Disengagement Guideline
- SH CP 106 Joint Working Protocol: Safeguarding Children and Young People whose Parents/Carers have problems with mental health, substance misuse, learning disability and emotional or psychological distress.
- SH CP 153 Maternity and Children's Services Unborn Babies Safeguarding Protocol
- RiO Standard Operating Procedure and Service Specific Guidance

11. Supporting References

- The Children Act, 1989
- The Human Rights Act, 1988
- The Data Protection Act, 1998
- The Children Act, 2004
- Home Office (2003) Hidden Harm. Responding to the needs of children of problem drug users. Executive summary of the report of an inquiry by the Advisory Council on the Misuse of Drugs
- NSPCC (2003) It Doesn't Happen to a Disabled Child
- HM Government (2007) Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004
- Coy, M., Kelly, L., Elvines, F., Garner, M. and Kanyeredzi, A. (2013). *"Sex without consent, I suppose that is rape": How young people in England understand sexual consent*. London: Office of the Children's Commissioner.
- Department for Children, Schools and Families (2009) Think Family Toolkit Improving support for families at risk Strategic overview
- Department for Education and Department of Health (2015) Promoting the Health and Wellbeing of Looked After Children
- Department for Education (2009) Safeguarding Disabled Children: Practice Guidance Care Quality Commission Essential Standards
- Royal College of Psychiatrists (2011) Parents as patients: supporting the needs of patients who are parents and their children. College Report CR164
- Department for Education (2017) Child sexual exploitation Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation
- Department of Health (2015) Working Together to Safeguard Children A guide to interagency working to safeguard and promote the welfare of children
- Department of Health (2017) Working Together to Safeguard Children A guide to interagency working to safeguard and promote the welfare of children
- Department of Health (2013) Information: To Share or not to Share – Government Response to the Caldicott Review
- Hampshire, IOW, Southampton and Portsmouth Safeguarding Adults Boards (2013) 'Honour' Based Violence, Forced Marriage and Female Genital Mutilation: Guidance A multi-agency guidance document for agencies and organisations to use with cases or suspected cases of Honour Based Violence in Hampshire, Portsmouth, Southampton and the Isle of Wight
- Hampshire, Isle of Wight, Portsmouth and Southampton Safeguarding Children Boards: http://4lscb.proceduresonline.com/
- Oxfordshire Safeguarding Children Board Procedures: http://oxfordshirescb.proceduresonline.com
- Powell, C (2016) 'Preventing Child Sexual Exploitation: taking action across Wessex - NHS England South (Wessex)

Appendix 1 – LEaD (Leadership, Education & Development) Training Needs Analysis

Training Programme	Frequency	Course Length	Delivery Method	Facilitators	Recording Attendance	Strategic & Operational Responsibility
Safeguarding Children Level 1	Every 3 years	Combined Safeguarding Adults & Children Level 1 – 1.5 hours	Face to Face e-Learning e-Video/e-Assessment	Safeguarding children and adults specialists	LEaD	Strategic- Executive Director of Nursing & Allied Health Professionals Operational-Associate Director Of Safeguarding
Directorate	**Service**	**Target Audience**				
MH/LD/TQ21	Adult Mental Health	All non-clinical staff				
	Specialised Services	All non-clinical staff				
	Learning Disabilities	All non-clinical staff				
	TQtwentyone	All non-clinical staff				
ISD's	Older Persons Mental Health	All non-clinical staff				
ISD's	Adults	All non-clinical staff				
ISD's	Childrens Services	All non-clinical staff				
Corporate	All	All staff who are not required to complete Safeguarding Children Level 2 training.				

Training Programme	Frequency	Course Length	Delivery Method	Facilitators	Recording Attendance	Strategic & Operational Responsibility
Safeguarding Children Level 2	Every 3 years	Combined Safeguarding Adults & Children Level 2 – 7 hours	Face to Face e-Learning e-Video/e-Assessment	Safeguarding children and adults specialists	LEaD	Strategic- Executive Director of Nursing & Allied Health Professionals Operational-Associate Director Of Safeguarding
Directorate	**Service**	**Target Audience**				
MH/LD/TQ21	Adult Mental Health	All clinical staff				
	Specialised Services	All clinical staff				
	Learning Disabilities	All clinical staff				
	Tqtwentyone	All clinical staff				
ISD's	Older Persons Mental Health	All clinical staff				
ISD's	Adults	All clinical staff				
ISD's	Childrens Services	All clinical staff				
Corporate	All	All clinical staff working in the following services; Undergraduate Med Education team Director of Nursing Division Medical Directorate; MARC, Comprehensive Local Research Network Research & Dev, Focus Study, Trust Research & Development, PDSafe Research, Medical Directorate				

Training Programme	Frequency	Course Length	Delivery Method	Facilitators	Recording Attendance	Strategic & Operational Responsibility
Safeguarding Children Level 3	Every 3 years	Face to Face – 6 hours	Face to face	Safeguarding children and adults specialists	LEaD	Strategic- Executive Director of Nursing & Allied Health Professionals Operational-Associate Director Of Safeguarding
Directorate	**Service**	**Target Audience**				
MH/LD/TQ21	Adult Mental Health	All clinical staff who work in the following services; Mother & Baby Unit (Melbury Lodge); Perinatal Community Team and Early Intervention in Psychosis Teams (EIP)				
	Specialised Services	All clinical staff who work in the following services; Leigh House; Bluebird House (Stewart Ward, Moss Ward, Hill Ward, Bluebird House Medical, Bluebird House Nursing & Security, Bluebird House O.T & Bluebird House Psychology);				
	Learning Disabilities	Not Applicable				
	TQtwentyone	Not Applicable				
ISD's	Older Persons Mental Health	Not Applicable				
ISD's	Adults	All clinical staff who work in the following services; Outpatients & Minor Injuries-Petersfield; Minor Injury Unit at Lymington Hospital				
ISD's	Childrens Services	All clinical staff				
Corporate	All	Not Applicable				

Appendix 2 – Equality Impact Analysis Screening Tool

Equality Impact Assessment (or 'Equality Analysis') is a process of systematically analysing a new or existing policy/practice or service to identify what impact or likely impact it will have on protected groups.

It involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of your functions, policies or decisions. The form is a written record that demonstrates that you have shown *due regard* to the need to **eliminate unlawful discrimination**, **advance equality of opportunity** and **foster good relations** with respect to the characteristics protected by equality law.

For guidance and support in completing this form please contact a member of the Equality and Diversity team.

Name of policy:	Safeguarding Children's Policy
Policy Number:	SH CP 56
Department:	Corporate Safeguarding
Lead officer for assessment:	Karen McGarthy Named Nurse Safeguarding Children
Date Assessment Carried Out:	01.03.17

1. Identify the aims of the policy and how it is implemented.	
Key questions	**Answers / Notes**
Briefly describe purpose of the policy including How the policy is delivered and by whom Intended outcomes	This policy relates to the statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004 and links to compliance with Care Quality Commission: Standard 7 Safeguarding people who use services from abuse.

2. Consideration of available data, research and information

Monitoring data and other information involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of your functions, policies or decisions. It can help you to identify practical steps to tackle any negative effects or discrimination, to advance equality and to foster good relations.

Please consider the availability of the following as potential sources:

Demographic data and other statistics, including census findings
Recent **research** findings (local and national)
Results from **consultation or engagement** you have undertaken
Service user **monitoring data**
Information from **relevant groups** or agencies, for example trade unions and voluntary/community organisations
Analysis of records of enquiries about your service, or **complaints** or **compliments** about them
Recommendations of **external inspections** or audit reports

	Key questions	**Data, research and information that you can refer to**
2.1	What is the equalities profile of the team delivering the service/policy?	This policy applies to all staff employed by the Trust who have contact with children

		and/or young person's up to age eighteen years or their parents or carers. The Equality and Diversity team will report on Workforce data on an annual basis.
2.2	What equalities training have staff received?	All Trust staff have a requirement to undertake Equality and Diversity training as part of Corporate Induction (Respect and Values) and E-Assessment.
2.3	What is the equalities profile of service users?	The Trust Equality and Diversity team report on Trust patient equality data profiling on an annual basis.
2.4	What other data do you have in terms of service users or staff? (e.g. results of customer satisfaction surveys, consultation findings). Are there any gaps? **Key Research:** **1. Victoria Climbié Inquiry Report** *"The support and protection of children cannot be achieved by a single agency… Every Service has to play its part. All staff must have placed upon them the clear expectation that their primary responsibility is to the child and his or her family."* Lord Laming in the Victoria Climbié Inquiry Report, paragraphs 17.92 and 17.93. **2. Baby Peter in Haringey** In 2008 Lord Laming however was again commissioned by the Secretary of State for Children, Schools and Families to undertake a progress review of Every Child Matters following the death of Baby Peter in Haringey. Lord Laming's findings were published in March 2009. **3. Neglect:** *"Severe neglect of young children has adverse effects on children's ability to form attachments and is associated with major impairment of growth and intellectual development. Persistent neglect can lead to serious impairment of health and development, and long-term difficulties with social functioning, relationships and educational*	The Trust is preparing to implement the Equality Delivery System which will allow a robust examination of Trust performance on Equality, Diversity and Human Rights. This will be based on 4 key objectives that include: Better health outcomes for all Improved patient access and experience Empowered, engaged and included staff Inclusive leadership

	progress. Neglected children may also experience low self-esteem, feelings of being unloved and isolated. Neglect can also result, in extreme cases, in death. The impact of neglect varies and depending on how long children have been neglected, the children's age, and the multiplicity of neglectful behaviours children have been experiencing." 'Working Together to Safeguard Children' (2015)	
2.5	What internal engagement or consultation has been undertaken as part of this EIA and with whom? What were the results? Service users/carers/Staff	
2.6	What external engagement or consultation has been undertaken as part of this EIA and with whom? What were the results? General Public/Commissioners/Local Authority/Voluntary Organisations	

In the table below, please describe how the proposals will have a positive impact on service users or staff. Please also record any potential negative impact on equality of opportunity for the target:

In the case of negative impact, please indicate any measures planned to mitigate against this:

	Positive impact (including examples of what the policy/service has done to promote equality)	**Negative Impact**	**Action Plan to address negative impact**			
			Actions to overcome problem/barrier	**Resources required**	**Responsibility**	Target date
Age	The Safeguarding policy addresses the needs of all children and young people aged up to 18 yrs.	**Babies and toddlers** depend almost exclusively on their parents or carers for the provision of their basic physical and emotional needs. Generally, the younger the child, the greater the vulnerability and the more serious the potential risk will be in terms of either their immediate health or the longer-term emotional or physical consequences.	4LSCB Online Procedures: Local Safeguarding Children Boards			
Disability		Research indicates that disabled children face an increased risk of abuse or neglect yet	The Trust must ensure that staff are aware that disabled children			

		they are under-represented in safeguarding systems and less likely to be protected from harm (Ann Craft Trust, 2000). Research by Sullivan and Knutson (2000) indicates that disabled children are between 3 and 4 times more likely to be abused than their non-disabled peers. **People with a disability are more susceptible to abuse:** Many disabled children and young people have a communication impairment which creates barriers in reporting difficulties, worries or abuse. Children who use alternative means of communication are particularly vulnerable due to the limited number of people they can tell; in addition to this, many children are not taught or given the	and young people are more vulnerable to being abused than their non-disabled peers for a range of reasons. All reports that are written about a disabled child or young person should include their views, wishes and feelings, and how they have been ascertained. Any particular communication needs that they have must be met. 4LSCB Online Procedures: Local Safeguarding Children Boards			

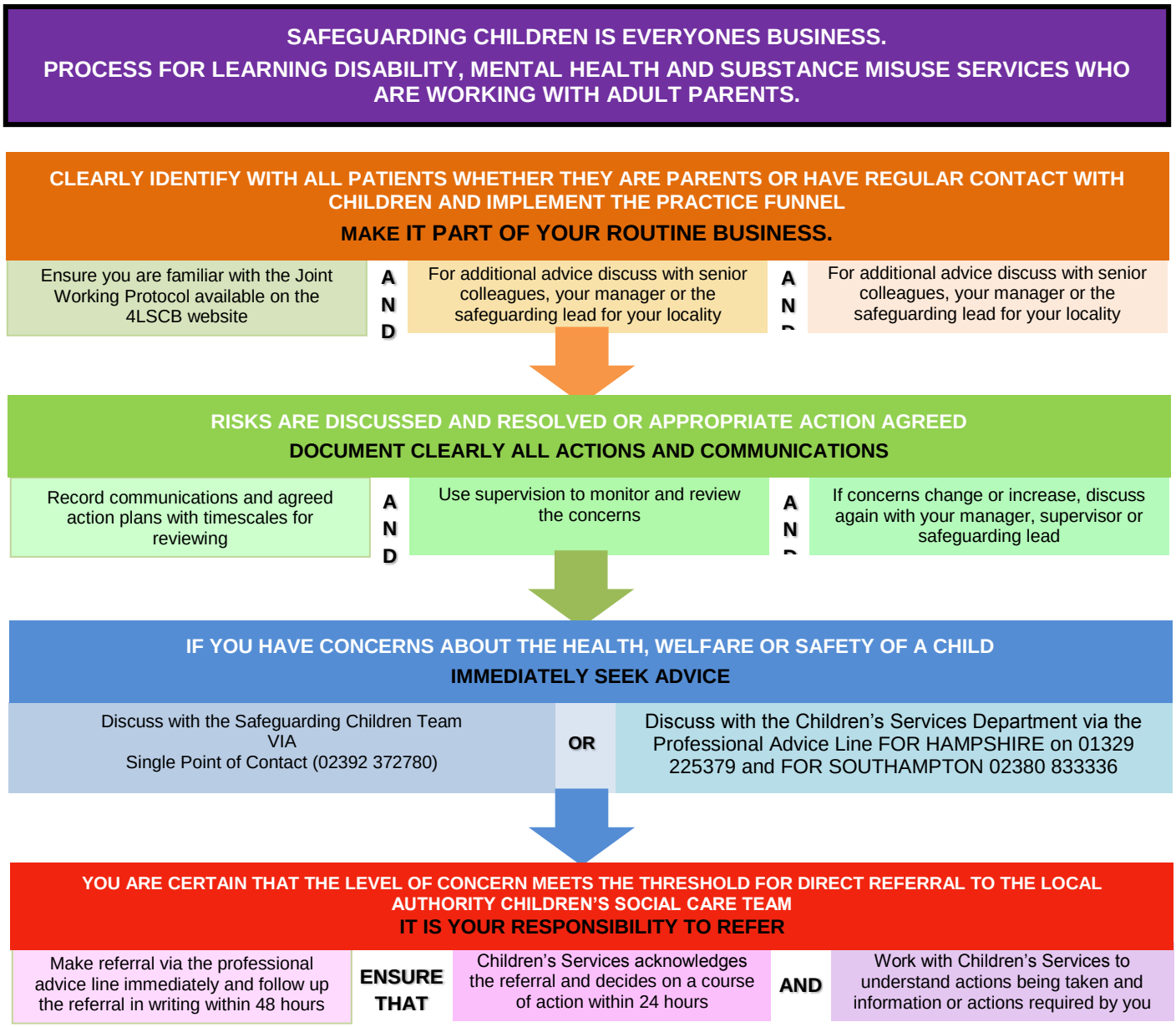
		words they need to disclose abuse.				
Gender Reassignment	Safeguarding services would apply to all people	No negative impacts identified at this stage of screening	4LSCB Online Procedures: Local Safeguarding Children Boards			
Marriage and Civil Partnership	Safeguarding services would apply to all people, irrespective of marital status	No negative impacts identified at this stage of screening	4LSCB Online Procedures: Local Safeguarding Children Boards			
Pregnancy and Maternity	The needs of the child are paramount if they conflict with those of the parents. Children Act 1989	The National Service Framework for Children Young People and Maternity Services (2004) recommends that: - *Maternity and Social Services have joint working arrangements in place to respond to concerns about the welfare of an unborn baby and its future, due to the impact of the mother's needs and circumstances.*	4LSCB Online Procedures: Local Safeguarding Children Boards The Maternity Services And Children's Social Care Joint Working Protocol To Safeguard Unborn Babies states that when risks have been identified, it is essential that professionals engage in early intervention and planning to optimise the outcomes and support for the			

			family.			
Race	The Trust will respond positively to request of information in alternative formats and provide access to interpretation and translation: Access to Communications	**Race, ethnicity, nationality and culture** are relevant where they affect language and communication: Poor communication may impact on parental understanding of the potentially serious issues impacting on the needs of their child. **Forced Marriage and Honour Crime**: In 2004 the Government's definition of domestic violence was extended to include acts perpetrated by extended family members as well as intimate partners. Consequently, acts such as forced marriage and other so-called 'honour crimes', which can include abduction and homicide, can now come under the definition of domestic	Every effort should be made to obtain the child's views or an understanding of their situation and to ensure that this is done in the child's first language or other relevant format if the child has a disability. Access to Communications Language Line for emergencies 4LSCB Online Procedures: Local Safeguarding Children Boards			

		violence. Many of these acts are committed against children.				
Religion or Belief	A family's religion and belief will always be considered, however the safeguarding children's guidelines are based on the rights of the child and when this is in conflict with religion or belief, the needs of the child will be paramount as per national guidance e.g. Children Act 2004	Children from all cultures are subject to abuse and neglect. In order to make sensitive and informed judgements about a child's needs, and parents' capacity to respond to their child's needs, it is important that professionals are aware of differing family patterns and lifestyles that vary across different racial, ethnic and cultural groups. At the same time professionals must be clear that child abuse cannot be condoned for cultural or religious reasons. Anxiety about being accused of racist practice must not prevent the necessary action being taken to safeguard and promote a child's	4LSCB Online Procedures: Local Safeguarding Children Boards			

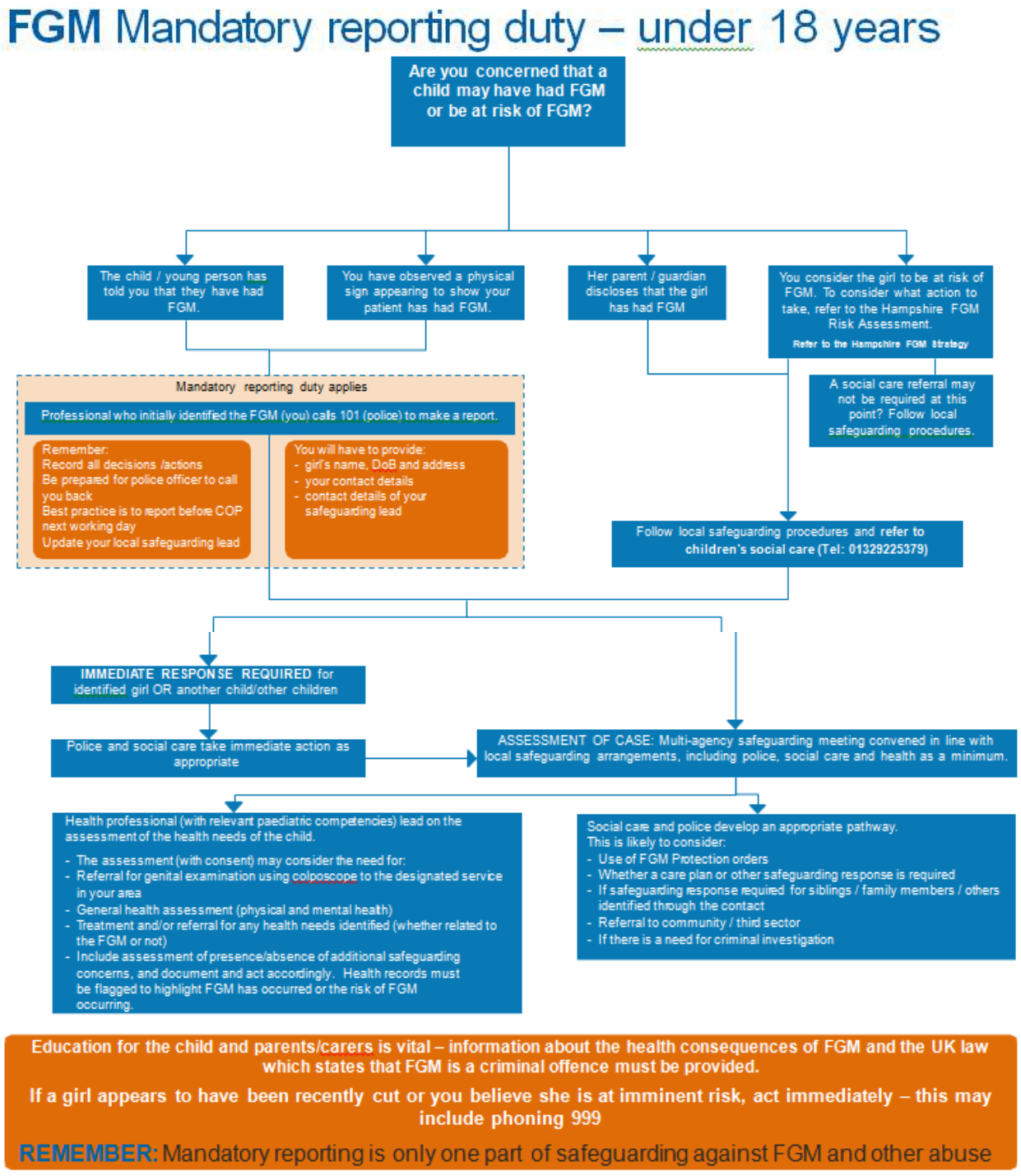
		welfare.				
Sex		**Female Genital Mutilation (FGM):** Some aspects of abuse are gender specific, e.g. female genital mutilation: Acknowledgement that FGM is performed largely in certain minority groups may be considered discriminatory	FGM is illegal practice in this country 4LSCB Online Procedures: Local Safeguarding Children Boards			
Sexual Orientation	The Trust acknowledges the needs of the child in any family are paramount. Sensitivity to parental and children and young people's sexual orientation is part of holistic working practices.	No negative impacts have been identified at this stage of screening.	4LSCB Online Procedures: Local Safeguarding Children Boards			

Appendix 3 – Process For Leaning Disability, Mental Health and Substance Misuse Services Who Are Working with Adult Parents



Appendix 4 – Protocol For Suspected Or Known Female Genital Mutilation (FGM)

This Guidance is intended for professionals working across Hampshire in all settings including; health, education and social care



Female Genital Mutilation (FGM) is child abuse and illegal.

Regulated health and social care professionals and teachers are required now to report cases of FGM in girls under 18s which they identify in the course of their professional work to the police.

How can I prepare?

- Full support pack: **www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare**
- FGM eLearning: **www.e-lfh.org.uk/programmes/female-genital-mutilation**
- Videos: **www.nhs.uk/fgmguidelines**
- FGM Multi-Agency Practice Guidelines: **www.gov.uk/government/publications/female-genital-mutilation-guidelines**
- **www.workingtogetheronline.co.uk**
- FGM Safeguarding guidance: **www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm**
- Search for guidance from Royal Colleges and regulators

Remember:

- This is a personal duty; the professional who identifies FGM / receives the disclosure must make the report.
- If a woman is over 18 when she discloses / you identify FGM, the duty does not apply and you should follow local safeguarding processes.
- Do not undertake a genital examination unless this is already part of your role.
- Complying with the duty does not breach data protection rules or other confidentiality requirements.
- Non-regulated healthcare staff should report through existing safeguarding procedures.
- This duty is about reporting a crime. NHS organisations continue to be responsible for collecting and recording data on FGM.

FAQs

A girl is using another term which I think is FGM. Do I need to report?
Yes. Whether she uses the term 'FGM' or any other term or description, e.g. 'sunna' or 'cut', the duty applies.

Does the duty apply to professionals in private education/healthcare?
Yes, if working as a regulated professional, the duty will apply.

Should you only report if you are certain that FGM has been carried out?
Yes. When you see something which appears to show in your opinion that a girl has FGM, you should make the report. A formal diagnosis will be sought as part of the subsequent multi-agency response.

I have identified a case but the patient is over 18, what should I do?
The duty does not apply in this case. You should signpost the woman to services offering support and advice. You may also need to carry out a safeguarding risk assessment considering children who may be at risk or have had FGM.

Some FGM is very difficult to notice. What if I did not notice signs when I was caring for a patient who is later identified as having had FGM?
If an allegation of failure to report is made, all relevant circumstances will be taken into account by the regulators, including your experience and what could reasonably have been expected.

I am treating a girl under 18 with a genital piercing / tattoo. What should I do?
You should make a report.

How quickly should I make a report?
The safety of the girl or others at risk of harm is the priority. You should report ASAP with the same urgency as for all other safeguarding cases. If you believe reporting would lead to risk of serious harm to the child or anyone else, contact your designated safeguarding lead for advice; you may need longer to take action, in exceptional circumstances.

Should I tell the girl / family about the report?
Yes, wherever possible you should explain why the report is being made and what it means. If you believe reporting would lead to risk of serious harm to the child or anyone else, do not discuss it but instead contact your local designated safeguarding lead for advice.

Following a risk assessment for a girl I've identified as being at risk of FGM, it isn't appropriate to refer to social care at this point. What should I do?
You should share information about the potential risk and your actions with your colleagues across health (GP, school nurse and health visitor as a minimum) and discuss next steps with your local safeguarding lead. A new system to support these cases from January 2015 is the FGM Risk Indicator System. See **www.hscic.gov.uk/fgmris** for details.

This guidance has been agreed by Hampshire Safeguarding Children Board's FGM Task and Finish Group – Guidance by NHS England and the Department of Health has adapted for local use across all agencies.

CONSENT – We work closely with other agencies, however we will only ever share information on a need to know basis. If we have concerns about the safety or welfare of anyone in the family we have a duty of care to disclose this to relevant agencies. This may include Children's Services & the Police.

RISK ASSESSMENT FOR FEMALE GENITAL MUTILATION/CUTTING

This checklist includes factors/indicators that can suggest an increased risk of FGM being performed. This checklist is not exhaustive and **professional judgement** is needed to fully assess the risk to the individual child. Consideration should be given to the suitability of completing this form with the parents and not just the mother/ Female carer.

	Please explain that the purpose of asking these questions is for the safety and protection of the individual concerned. **Tick if the factor is present, comments can be added below.** **If the information is provided by a third party please indicate source in right hand column.**	**Yes**	**Suspected**	**No**	Third party Source (clarify)
Score as HIGH RISK if answering 'YES' to any questions 1- 10 **Submit this risk assessment with a child protection (s47) referral to Children's Services**					
	Has the child disclosed that she has had FGM? Comments:				
	Has the child got symptoms which appear to show that she has had FGM? (do not examine genitalia if this is out of your professional remit)				
	Has the child disclosed that they are afraid of FGM/C or made a non-specific request for help due to concerns regarding personal safety, shame or dishonour to the family?				
	Has the child disclosed that they are having a special occasion, such as where they are going to 'become a woman'?				
	Has the child or family member informed someone that FGM/C is to be performed soon?				
	Is a family member/friend expressing concern that FGM/C may be performed when the child is born?				
	Have the child's siblings or close female minor relatives had FGM/C performed? How is this known and when was it performed? Comment:				

	Has deinfibulation/reinfibulation been performed or requested?				
	Does the mother or father have strong familial ties to a community where FGM/C is practised and are feeling pressurised by the family or community for FGM/C to be performed?				
	Have arrangements been made for the child to travel to a high-risk country where FGM/C is performed? (When, where, flight booked, any other details) Comment:				
Score as MEDIUM RISK if answering 'YES' to any questions 11-14		**Yes**	**Suspected**	**No**	Third party Source (clarify)
9	Has the mother or other significant female adult been subject to FGM/C? How is this known? (Who, when & what age?) Comment:				
11	Is an older female relative visiting from a country or community when FGM/C is commonly practised?				
12	Have other family members been forced to marry or reported missing? (Name, relationship, age, when & where?) Comment:				
13	Has the child had behaviour change (anxious, withdrawn, depressed mood) at school prior to a school holiday or known travel?				
Score as STANDARD RISK if answering 'YES' to any questions 15-25		**Yes**	**Suspected**	**No**	Third party Source (clarify)
14	Has the mother cancelled/not attended her own visits/appointments with a health professional on more than one occasion?				
15	Has the child not been brought to visits/ appointments with a health professional on more than one occasion?				
10	Is the mother or father originally from a high risk country where FGM/C is performed?				

	Do the parents avoid removing nappies etc during health appointments/visits? (when appropriate to do so)				
17	Has the child been presented to primary care with vague non-specific symptoms, obvious symptoms or anxiety?				
18	Has the child attempted to run away from home?				
19	Has the child been missing or reported missing?				
20	Has the child self- harmed or attempted suicide?				
21	Has the child been withdrawn from PSHE or PSE lessons?				
22	Does the mother/female carer feel safe and empowered to make decisions regarding the children?				
23	Are there any other risks or vulnerabilities that need addressing? Comment:				

Comments, professional judgement/family views
(For example does the mother understand/speak English, do the family socialise outside their own community or access non essential services in the mainstream community)

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RISK ASSESSMENT - OVERALL ASSESSMENT OF RISK OF FGM
When assessing the risk answers from the checklist should be considered alongside your professional judgement as this checklist is not exhaustive and may not cover the individual indicators of risk for the individual.

HIGH ☐ **Immediate child protection (s47) referral**

MEDIUM ☐ **Referral to children's services for multi-professional safeguarding care planning**

STANDARD ☐ **Routine health checks and monitoring as per NICE Guidance. Request consent to share information with Children's Services.**

Remember - FGM Mandatory reporting duty

You must phone the police on 101 if a girl under 18:

a) Tells you she has had FGM

b) Has signs which appear to show she has had FGM

The professional who identifies FGM must report it as soon as possible. **This is your personal legal duty**.

NEXT STEPS FOR ALL PROFESSIONALS

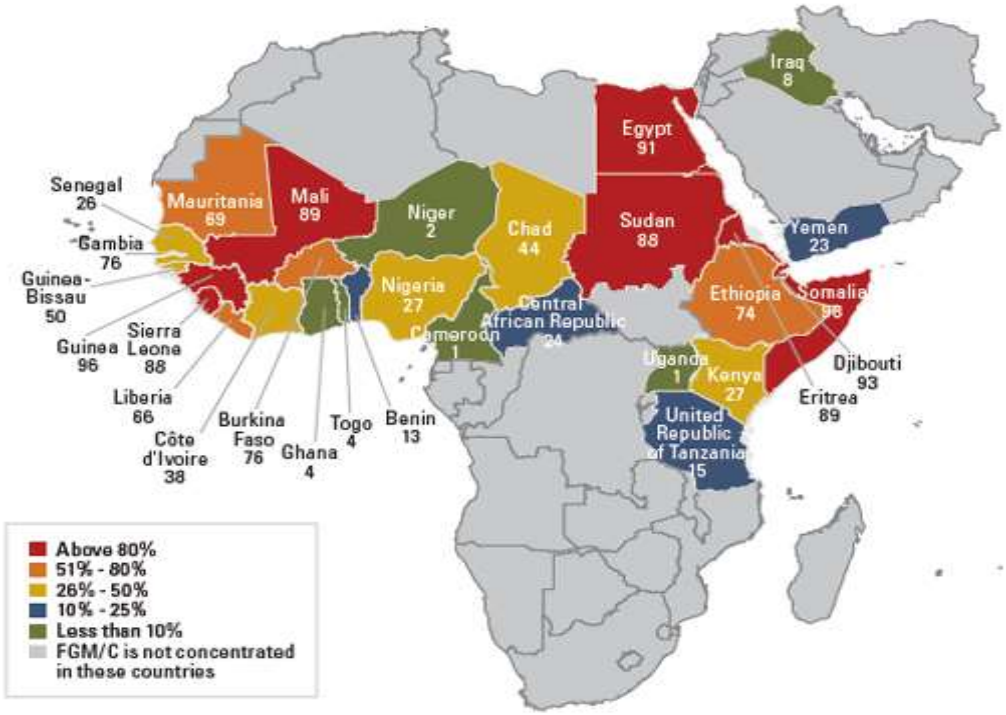
Please tick to indicate that you have provided the following information to the children & parent/carer

Informed that FGM is illegal in the UK	
Informed about the health consequences of FGM	
Advised where to access community support services	
Informed the GP or other relevant health care professionals such as HV or School Nurse	

Name of Professional	
Date	
Agency address & telephone number	
Discussed concerns with	
Date & time of discussion	

Prevalence of FGM

Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, by country (WHO, 2016).



Appendix 5 – Protocol For Suspected Or Known Child Sexual Exploitation (CSE)

Southern Health NHS
NHS Foundation Trust

Matrix guide for staff who should complete the Full SERAF or CSERQ4

Agency	Full SERAF	CSERQ4
Southern Health NHS Foundation Trust	Health Visitors	Minor Injury Units
	School Nurses	iTalk
	Children in Care (CiC)	136 Suites
	Family Nurse Partnership	Adults Services
	Bluebird House	Learning Disability/Mental Health
	Leigh House	Older Person's Mental Health
	Perinatal Mental Health Service (if working with under 18s)	Perinatal Mental Health Service
	EIP (if working with under 18s)	EIP

This Matrix is a guide, staff identified to complete CSERQ4 are able to also complete the full SERAF. Further advice can be given by contacting SPOC and Training is available on LEaD

Believe in children
Barnardo's Cymru

SERAF Risk Assessment Form

Name of worker completing assessment (by phone or email)		**Name and contact details of referrer**	
Child's Name		**Local Authority**	
Known to social services since		**Date of SERAF Assessment**	
Age **Date of birth**		**Legal status** **Section:**	
		Migrant/Refugee/Asylum Seeker/Trafficked status Please specify & Complete Trafficking Risk Matrix:	
Ethnicity		**Gender**	
Physical/learning disabilities If yes see Section (x) of guidance		**Languages spoken**	
Have child protection procedures been initiated? (If yes provide date)	**Yes** ☐ **No** ☐ **If yes when:**	**Involvement with the youth justice system?**	**Yes** ☐ **No** ☐
Is the child receiving support or services from any other agency?	**Yes** ☐ **No** ☐	**If other agencies are involved please list them here e.g. CAMHS, Early Help etc.**	
Has sexual exploitation previously been identified as a specific issue for this child?	**Yes** ☐ **No** ☐ **If yes when:**	**Has the All Hampshire Safeguarding and Promoting the Welfare of Children who are at Risk of Abuse through Sexual Exploitation Protocol been used?**	**Yes** ☐ **No** ☐ **If yes when:**

Vulnerabilities	Please tick	**Vulnerabilities**	Please tick
Emotional neglect by parent/carer/family member	☐	Family history of mental health difficulties	☐
Physical abuse by parent/carer/family member	☐	Low self-esteem	☐
Sexual abuse	☐	Unsuitable/inappropriate accommodation	☐

Breakdown of family relationships	☐	Isolated from peers/social networks	☐
Family history of domestic abuse	☐	Lack of positive relationship with a protective/nurturing adult	☐
Family history of substance misuse	☐		

Moderate risk indicators	Please tick if present **on date of referral or during the past 3 months**
Staying out late	☐
Multiple callers (unknown adults/older young people)	☐
Use of a mobile phone that causes concern	☐
Expressions of despair (self-harm, overdose, eating disorder, challenging behaviour, aggression)	☐
Exclusion from school or unexplained absences from or not engaged in school/college/training/work	☐
Sexually Transmitted Infections (STIs), pregnancy/termination of pregnancy	☐
Drugs misuse	☐
Alcohol misuse	☐
Use of the internet that causes concern	☐
Living independently and failing to respond to attempts by worker to keep in touch	☐

Significant risk indicators	Please tick if present **between 3 and 6 months ago**	Please tick if present **on date of referral or during past 3 months**
Disclosure of sexual/physical assault followed by withdrawal of allegation	☐	☐
Peers involved in sexual exploitation/clipping (offering to have sex/ perform sexual acts and running off with payment before undertaking the sexual act)	☐	☐
Periods of going missing overnight or longer	☐	☐
Older 'boyfriend'/ 'girlfriend' relationship with controlling adult	☐	☐
Physical abuse by controlling adult / physical injury without plausible explanation	☐	☐
Emotional abuse by controlling adult	☐	☐
Entering/leaving vehicles driven by unknown adults	☐	☐

(**not** taking and driving away: car theft)		
Unexplained amounts of money, expensive clothing or other items	☐	☐
Frequenting areas known for on/off street sexual exploitation	☐	☐

SERAF Score		**In addition: Physical/Learning Disability: Score 1 Age under 13 and at least 1 significant risk factor present: Score 5**
Do you agree with this score?	Y/N	
Reason/ Rationale?		
Risk Category		
Have you considered whether this child been trafficked? Remember - movement for the purpose of exploitation = child trafficking	Yes / No / Suspected	
If Yes or suspected is this internally (i.e. moved within the UK) or from abroad?	Internally / abroad	
If Yes or Suspected- have you completed a NRM? (National Referral Mechanism form) **https://www.gov.uk/government/publications/human-trafficking-victims-referral-and-assessment-forms**	Yes/ No	

Vulnerabilities Identified: (if any of these have been ticked please detail why)
Emotional neglect by parent/carer/family member:

Physical abuse by parent/carer/family member:

Sexual abuse:

Breakdown of family relationships:

Family history of domestic abuse:

Family history of substance misuse:

Family history of mental health difficulties:

Low self-esteem:

Unsuitable/inappropriate accommodation:

Isolated from peers/social networks:

Lack of positive relationship with a protective/nurturing adult:

Moderate Risk Indicators Identified: (if any of these have been ticked please detail why)
Staying out late:

Multiple callers (unknown adults/older young people):

Use of a mobile phone that causes concern:

Expressions of despair (self-harm, overdose, eating disorder, challenging behaviour, aggression):

Exclusion from school or unexplained absences from or not engaged in school/college/training/work:

Sexually Transmitted Infections (STIs), pregnancy/termination of pregnancy:

Drugs misuse:

Alcohol misuse:

Use of the internet that causes concern:

Living independently and failing to respond to attempts by worker to keep in touch:

Significant Risk Indicators Identified: (if any of these have been ticked please detail why)
Disclosure of sexual/physical assault followed by withdrawal of allegation:

Peers involved in clipping/sexual exploitation:

Periods of going missing overnight or longer:

Older 'boyfriend'/ 'girlfriend' relationship with controlling adult:

Physical abuse by controlling adult / physical injury without plausible explanation:

Emotional abuse by controlling adult:

Entering/leaving vehicles driven by unknown adults (**not** taking and driving away: car theft):

Unexplained amounts of money, expensive clothing or other items:

Frequenting areas known for on/off street sexual exploitation:

Additional information:

August 2016

Child Sexual Exploitation Risk Questionnaire (CSERQ4)

Guidance Notes.

This form is to be used by agencies that have *'time limited'* contact with children under the age of 18, to help them quickly identify children at risk of sexual exploitation. For professionals not on the list below, it is expected that you use the full SERAF document:

http://www.hampshiresafeguardingchildrenboard.org.uk/user_controlled_lcms_area/uploaded_files/SERAF%20Risk%20Assessment%20Form%20UPDATED%20Sept%202015%20%282%29.doc

List

ED staff	***Opticians***	***Condom distributers***
Paramedics/ Ambulance service	***Dentists***	***GP's / OOH's service***
Pharmacists	***111 Service***	***Police***

If a child between the ages of 10 – 17 presents to your service with **one** or more of the following a short CSERQ4 needs to be completed (overleaf).

Contraception or STI testing / treatment (including emergency contraception / pregnancy testing)
Pregnancy
Drug or alcohol problems or overdose
Self-harm
Disclosure of sexual assault or sexual activity that raises concern
Domestic violence in the home

Please ask questions 1- 4 as a minimum. If you **are** able to complete the fuller risk assessment with the child, please do so.

You may like to introduce the questions: *"I would like to ask you some questions to check that you are safe and no one is harming you or pressurising you to have sex."*

*Children under 13 years of age cannot consent to sexual activity- refer to child protection procedures.

*Have you considered if the child has capacity to consent to sexual activity

Child Sexual Exploitation Risk Questionnaire (CSERQ4)

	CSER 4 Questions	Yes	No
1	Have you ever stayed out overnight or longer without permission from your parent(s) or guardian?		
2	How old is your boyfriend/ girlfriend or the person(s) you have sex with? Age of partner _____ Age of client/patient _____ Age difference _____ If age difference is 4 or more years then tick 'YES'		
3	Does your boyfriend/ girlfriend or the person(s) you have sex with stop you from doing things you want to do?		
4	Thinking about where you go to hang out, or to have sex. Do you feel unsafe there or are your parent(s) or guardian worried about your safety?		

OUTCOME

If the child has answered 'yes' to **one or more of questions 1-4** then a referral should be made to Children Services as this indicates that the child is at risk of, or experiencing child sexual exploitation.

Please note that to make a referral to Children Services you will need to obtain the child's name, DOB and address.

A referral can be made to Hampshire Children Services via telephone on 01329 225379 or email from a SECURE E-Mail e.g. NHS Mail to csprofessional@hants.gcsx.gov.uk, including a copy of this form.

Childs Name	Address	Date of Birth

Name and Designation of staff member completing this form

Name:	**Signature:**
Position: **Organisation:**	**Date:**
Address:	**Telephone Number:**