Safeguarding Children Policy
Policy Title: SAFEGUARDING CHILDREN

Executive Summary: East Cheshire Trust is committed to the welfare and safeguarding of children. This policy details the safeguarding arrangements and responsibilities for all staff of East Cheshire Trust.

Supersedes: Safeguarding Children in East Cheshire Trust July 2015

Description of Amendment(s):
- Information and Guidance about the Mental Health Act (MHA) 1983 and the specific requirements when assessing whether to make an application under the MHA for children and young people under the age of 16yrs.
- The Management of Sexually active young people under the age of 18yrs.

This policy will impact on: The work of all employees and volunteers working at East Cheshire Trust.

Financial Implications: Non Known

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1. Introduction

East Cheshire NHS Trust as with all other NHS bodies has a statutory duty to ensure that it makes arrangements to safeguard and promote the welfare of children and young people that reflects the needs of the children they deal with.

In discharging these statutory duties/responsibilities account must be taken of statutory guidance on making arrangements to safeguard and promote the welfare of children under Section 11 of the Children Act 2004. (HM Government 2007); Working Together to Safeguard Children (HM Government March 2015); Statutory Guidance on Promoting the Health and Wellbeing of Looked after Children (DH March 2015); When to suspect child maltreatment (NICE Guidance July 2009); Looked after Children (NICE Guidance 28 October 2010) and the policies and procedures of the Local Safeguarding Children Boards (LSCB’s). Information sharing - Advice for practitioners providing safeguarding services to children, young people, parents and carers (HM Government March 2015)

This policy is mandatory and should be read in conjunction with the:

East Cheshire Trust Safeguarding Supervision Policy

East Cheshire Trust Domestic Violence and Abuse Policy

Cheshire Local Safeguarding Children Boards web based Procedures which can be accessed via the Infonet or Pan Cheshire Policies and Procedures
http://www.proceduresonline.com/pancheshire/

Cheshire East Practice Standards

Cheshire West Child Protection and cared for Children practice Standards

This policy applies to all employees of the East Cheshire NHS Trust including Locum, Bank and Agency Staff and volunteers.

It is recommended that this guidance is used by independent contractors.

2. Purpose

The aim of these policies/procedures/protocols is to set out a clear framework for East Cheshire Trust staff to work effectively with Children who are in need or at risk.

These policies / procedures and protocols should be used in conjunction with the two local Safeguarding Children Board Procedures

*HM Government Working Together to Safeguard Children March 2015 Inter-Agency Guidance*

*When to Suspect Child Maltreatment July 2009 National Institute for Health and Clinical Excellence*

*HM Government Statutory guidance on making arrangements to Safeguard and promote the welfare of children under section 11 of the Children Act 2004*
3.0 Responsibilities

In developing this policy East Cheshire NHS Trust recognises that safeguarding children is a shared responsibility with the need for effective joint working between agencies and professionals that have different roles and expertise if those vulnerable groups in society are to be protected from harm. In order to achieve effective joint working there must be constructive relationships at all levels, promoted and supported by:

1. the commitment of directors and senior managers to safeguarding children and vulnerable adults
2. clear lines of accountability within the organisation for work on safeguarding
3. service developments that take account of the need to safeguard service users, which is informed, where appropriate, by the views of service users
4. Learning and development and continuing professional education in order that staff understand their roles and responsibilities, and those of other professionals and organisations in relation to safeguarding children and vulnerable adults.
5. Safe working practices including recruitment, vetting and barring procedures
6. Effective interagency working, including effective information sharing

East Cheshire NHS Trust should ensure that systems are in place, which will enable all staff to comply with the two LSCB Procedures and the Children Act 1989 and 2004.

East Cheshire NHS Trust has a named senior manager to whom allegations of abuse against adults who work with children and young persons should be reported in line with the procedures. The head of Children and Families Division holds this responsibility.

East Cheshire NHS Trust has LSCB safe recruitment and selection practices in accordance with Safe Recruitment – A Guide for NHS Employers (NHS Employers 2010) NHS Employment Check Standards (NHS Employers 2014) and should ensure that appropriate Disclosure & Barring Service (DBS) checks are undertaken for new staff and volunteers including registered translators who have contact with children and vulnerable adults. Appendix 1 - Procedure to safeguard the service and staff.

East Cheshire NHS Trust will ensure the provision of training which meets the standards and objectives of and LSCB training requirements and has been accredited and endorsed by the LSCB training committee. All staff who are likely to come into contact with children or families in the course of their work, have access to and receive appropriate level of training, updating and access to professional advice and support.
In line with the trust’s statutory responsibilities under the Mental Health Act (MHA) 1983, the trust has arrangements in place to ensure appropriate legal requirements are complied with and the rights of patients who are detained are maintained. To support this and ensure adherence to the MHA Code of Practice (2015), the board has delegated authority to Cheshire and Wirral Partnership NHS Foundation Trust to formally receive applications for detention under MHA.

East Cheshire NHS Trust will promote a culture of listening and engaging in dialogue with children and young people in the formulation of all Trust policy options and proposals, consideration should be given to the impact on children.

Communicating with children will be appropriate to their age and understanding. When child abuse is suspected in a child admitted to East Cheshire NHS Trust the medical condition must be treated as a priority. The child, parents and carers must be afforded the same degree of sensitivity and respect as others.

East Cheshire NHS Trust will respond proactively to antenatal family concerns which may inhibit or detract from the welfare of the baby.

The Chief Executive

East Cheshire NHS Trust through the Chief Executive Officer and the Trust board have a duty under Section 11 of the Children Act 2004 and the Mental Health Act (1983) to ensure their functions are discharged with regard to the need to safeguard and promote the welfare of children and young people. Safeguarding children is an integral part of the Clinical Governance framework with a clear line of accountability within the organisation.

The Director of Nursing, Performance and Quality

East Cheshire NHS Trust has a Board Level Director who has executive responsibility for safeguarding children as part of their portfolio of responsibilities (Working Together to Safeguard Children, HM Government 2015) and is responsible for all aspects of safeguarding including PREVENT, Forced Marriage and arrangements for patients detained under the MHA (1983):

The Executive Director at East Cheshire NHS Trust holding this responsibility is the Director of Nursing, Performance and Quality

Engagement with the Local Safeguarding Children’s Board (LSCB) at strategic level is required of East Cheshire NHS Trust. The Trust is represented on the two LSCB’s by the Director of Nursing, Performance and Quality

Associate Directors

It is the responsibility of the Associate Directors to ensure that their areas of management and accountability deliver safe and effective services in accordance with statutory, national and local guidance for safeguarding children and that all service specifications, invitations to tender and service contracts fully reflect safeguarding requirements as outlined in this policy.

Senior Managers

It is the responsibility of managers to ensure that all their employees are aware of their responsibilities under this policy, and that it is fully implemented within their area of responsibility.

Managers have a responsibility to ensure that all staff, including administrative staff are given opportunities to attend local courses in safeguarding and promoting the welfare of children or ensure that safeguarding training is provided within the team.
Managers must ensure that staff in contact with children; in the course of their normal duties are trained and competent to be alert to the potential indicators of abuse or neglect, know how to act on those concerns in line with local and national guidance; ensure compliance with the statutory requirements of the MHA (1983).

Managers responsible for recruitment and selection decisions must ensure that all staff working with children apply for enhanced screening by the Criminal Records Bureau prior to appointment.

Managers must ensure that staff involved in child protection have access to advice and support. Clinical supervision should be available to all staff.

Where child abuse is suspected they must follow the LSCB guidance.

**Named Professionals**

All providers of NHS funded health services including NHS Trusts, NHS Foundation Trusts and public, voluntary sector, independent sector and social enterprises should identify a named doctor and a named nurse, and a named midwife if the organisation provides maternity services for safeguarding.

Named Professionals have a key role in promoting good professional practice within their own organization, and provide advice and expertise for fellow professionals. They should have specific expertise in children’s health and development, child maltreatment and local arrangements for safeguarding and promoting the welfare of children.

Named professionals should support the organisation in its clinical governance role, by ensuring that audits on safeguarding are undertaken and that safeguarding issues are part of the trust’s clinical governance system.

They also have a key role in ensuring a safeguarding training strategy is in place and is delivered within their organisation.

They are also responsible for providing effective support and supervision to staff within their organisation.

Named professionals are usually responsible for conducting the organisations internal management reviews, except when they have had personal involvement in the case when it will be more appropriate for the designated professional to conduct the review.

Named professionals should be of sufficient standing and seniority in the organisation to ensure that the resulting action plan is followed.

The named professional e.g. midwife, nurse or doctor as appropriate should be included in the induction of newly recruited staff to maternity, children’s ward and the emergency department.

**Responsibility of Consultant Paediatricians**

The consultant paediatrician is responsible for giving advice on health aspects of child abuse if approached by other health staff, social services, the police or other professionals.

They are responsible for ensuring that they update regularly on child protection.

Where child abuse is suspected they must follow the LSCB guidance.

**Responsibility of Paediatric Liaison Nurse**
The Paediatric Liaison Service is responsible for ensuring that written notification arrangements are in place at for notifying health visitor and school nurses of all visits by children aged less than 18 years to the Emergency Department at Macclesfield Hospital. All children who are highlighted by the Emergency Department staff to the Liaison Service as requiring input from community services will be notified by telephone in the first instance followed up in writing. This includes children who are non East Cheshire residents. Delays in the passage of information must be minimised.

Communication must take place between the Paediatric Liaison Service and the Named Professionals when a child presents with non-accidental injury or suspected non accidental injury.

Where child abuse is suspected LSCB procedures must be followed.

Responsibility of all Employees

All Health employees should be alert to the potential indicators of abuse or neglect for children and know how to act on those concerns in line with local guidance;

Be responsible for having knowledge of the LSCB Procedures. They should know how to contact Named and Designated Professionals for guidance and support and should be familiar with and follow their organizations policies/procedures for promoting and safeguarding the welfare of children in their area.

All health employees are responsible for accessing training relating to safeguarding children appropriate to their role so that they maintain their skills and are familiar with procedures aimed at safeguarding children;

To safeguard, uphold and advocate for the rights of patients detained under the Mental Health Act (1983) in line with the Code of Practice (2015).

All health employees should understand the principles of confidentiality and information sharing in line with local and government guidance and should contribute to, when requested, the multi-agency meetings established to safeguard and protect children.

All employees involved in direct child protection work should seek supervision and peer review that is provided by their employer.

Comprehensive and contemporaneous records of all concerns, discussions and decisions made including telephone conversations in relation to safeguarding children should be maintained in line with East Cheshire Trust policy on records and record keeping.

4.0 Processes and Procedures

DEFINITIONS

Children

In this policy, as in the Children Act 1989 and 2004, a child is anyone who has not reached their 18th birthday. ‘Children’ therefore means children and young people throughout.

Safeguarding Children is defined as:

1. All agencies with children, young people and their families take all reasonable measures to ensure that the risks of harm to children’s welfare is minimised
2. Where there are concerns about children and young people’s welfare all agencies take all appropriate actions to address those concerns, working to agreed local policies and procedures in partnership with other agencies.

INFORMATION SHARING

Effective information sharing underpins integrated working and is a vital element of both early intervention and safeguarding. It is important that frontline practitioners understand when, why and how they should share information and follow:

Sharing Information as Part of Preventative Services

Explain to children, young people and families at the outset, openly and honestly, what and how information will, or could be shared and why. And seek their agreement.
Information must be accurate and up to date, necessary for the purpose for which it is being shared and only shared with those people who need to see it.

Sharing Information to Protect a Child or Young Person

Remember that the Data Protection Act is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately.

In some circumstances the sharing of confidential information without consent would normally be justified in the public interest. These circumstances would be:

- When there is evidence that the child suffering or is at risk of suffering significant harm
- Where there is justifiable cause to believe that a child may be suffering or at risk of significant harm
- To prevent significant harm arising to children and young people including through the prevention, detection and prosecution of serious crime likely to cause significant harm to a child or young person

Information could also be shared without consent in the following circumstances:

- If the child or young person at greater risk
- If you or another health care professional is at risk
- If it would alert the perpetrator (in cases of sexual abuse or fabricated illness)
- If specific forensic evidence is needed

Consider the likely outcome of sharing or not sharing information

At all times the safety and wellbeing of the child or young person is paramount

Reasons for decisions to share, or not share must be recorded. Decisions require professional, informed judgment.

If in doubt this should be discussed with a designated / named professional for safeguarding children or you may need to seek advice from the Trust’s legal representatives.

Further guidance is available on the Trust website by following the links Safeguarding Children and then Information Sharing

Recording and Sharing of Information

It is extremely important that the recording of information about child concerns is written in a legible chronological order that reflect discussions with other professionals and agencies and complies with ECT record keeping Policies.

The Child’s Health records should retain child protection initial and review reports

Transferring information between health professionals and services for children within ECT.

When Transferring records within ECT for children whom have a child protection plan, who are requiring extra support or are Cared for Children see Guidance 1

For the transfer of Community Child Health Records out of area.

When transferring records for children who are Cared for Children, in pre adoptive placements, or for children who are subject to a child protection plan, a CAF, child in need plan or have been identified as vulnerable or requiring extra support see Guidance 2

CONFIDENTIALITY

Confidential information about a child or young person should never be used casually in conversation or shared with any person other than on a “need to know basis”.

There are some circumstances when employees may be expected to share information about a child, for example when child abuse is alleged or suspected. In such cases individuals have a duty to pass information on without delay in line with Local Safeguarding Board procedures. Disclosure should be justified in each case and guidance should be sought from the Designated or Named Professionals or the Trust’s legal representatives in cases of uncertainty. Employees must document when, with whom and for what purpose information was shared.

The main restrictions within the legal framework to disclosure are:

- Common duty of confidence
- Human Rights Act 1998
- Data Protection Act 1998

The storing and processing of personal information about children and young people is governed by the Data Protection Act 1998.

CONSENT

A young person under 16 years may consent to medical treatment if he/she is judged to be competent to give that consent. It is considered good practice for doctors and other health professionals to follow the criteria outlined by Lord Fraser in 1985, in the House of Lord’s ruling in the case of Victoria Gillick v West Norfolk and Wisbech Health Authority and Department of Health and Social Security. These are commonly known as the Fraser Guidelines: see Appendix --

For further guidance in relation to consent for children and young people up to the age of 18yrs the Cheshire East Trust Consent Policy can be assessed on the Trust Website

MENTAL CAPACITY ACT 2005 (MCA)

This law is designed to empower and protect any vulnerable person aged 16 and over, who is not able to make decisions at a particular time because of illness, injury, a disability or the effects of drugs or alcohol. For further information and guidance on the systems and processes in operation at the Trust to be used when the powers of the Mental Capacity Act are invoked The Cheshire East Mental Capacity Act 2005 Policy can be assessed on the Trust Website
ASSESSMENT UNDER THE MENTAL HEALTH ACT (MHA) 1983

The Mental Health Act 1983 Code of Practice (1999) sets out the guiding principles which underpin the administration of the Act which state that people should:

- Receive recognition for their basic human rights under the European Convention of Human Rights.
- Be given respect for their qualities, abilities and diverse backgrounds as individuals.
- Have their needs taken fully into account, though it is recognised that, within available resources, it may not always be practicable to meet them in full.
- Be given any necessary treatment or care in the least controlled and segregated facilities compatible with ensuring their own health or safety or the safety of other people.
- Be treated and cared for in such a way as to promote the greatest practicable degree their self-determination and personal responsibility, consistent with their own needs and wishes.

Specific Requirements when assessing whether to make an application under the Mental Health Act for Children and Young People under 16 years

At Least one of the people involved in assessing whether a child or young person should be detained under the Mental Health Act one of the two medical practitioners or the approved mental health professional (AMHP) should be a Child and Adolescent Mental Health Services (CAMHS) professional. Where this is not possible, and admission to hospital is considered necessary, the AMHP should have access to an AMHP with experience of working in CAMHS and the medical practitioners should consult with CAMHS clinician as soon as possible. In cases where the child or young person has complex or multiple needs, other clinicians may need to be involved, for example, a learning disability CAMHS consultant where the child or young person has learning disability,

As part of the assessment process the AMHP should consult with Children’s Social Care to request that any relevant information about the child or young person is provided to inform the assessment. The AMHP should consider whether a representative from Children’s social care should attend the assessment. The AMHP should identify who has parental responsibility for the child and young person.

Further information:

Independent Mental Health Advocates (IMHA)

IMHAs are independent advocates who are trained to work within the framework of the MHA (1983) to support people to understand their rights under the Act and participate in decisions about their care and treatment. Advocacy can make a positive difference to the relationship between patients and professionals. Staff have a duty to ensure anyone who is eligible can have access to IMHA services and are provided with information on their rights and where required appropriately referred on via the trust’s MHA Administration Service.

DISAGREEMENT BETWEEN PROFESSIONALS OR AGENCIES

Designated professionals should be made aware of any professional or interagency disagreements. If the matter cannot be resolved by mediation then the LSCB Escalation Policy must be used.

Guidance 3

REQUEST FOR A CHANGE OF WORKER
Occasions may arise where relationships between parents’, or other family members, are not productive in terms of working to safeguard and promote the welfare of their children. In such circumstances, organisations should respond sympathetically to a request for a change of worker, provided that such a change can be identified as being in the interest of the child who is the focus of the concern.

See Guidance 4

**ALLEGATIONS OF ABUSE MADE AGAINST A WORKER AND ANY SERIOUS UNTOWARD INCIDENT AGAINST A CHILD**

Allegations of this nature should be reported to the Head of Women’s and Children’s services as soon as possible. The senior manager will then liaise with the Allegations Officers within the Local Authority Children’s Safeguarding Unit. The management of such an allegation should follow the procedures set out in East Cheshire Trusts Disciplinary Procedures.

**CONFIDENTIAL COUNSELLING SERVICE**

Where a staff member is aware of any circumstances in their private life which may adversely affect their ability to undertake their role within this health care organisation any such difficulties or problems that may affect their working relationships and their ability to safeguard children should be discussed with their line manager so that appropriate support can be provided.

Staff Counselling is provided by the Staff Counselling Service Team at East Cheshire NHS Trust. Referrals can be made confidentially by the member of staff themselves or by their line manager or through occupational health by ringing the service directly on 01625 661972 or by e-mailing ecn-tr.staffcounselling@nhs.net. Information leaflets about the service and self help information is also available on the Cheshire HR Intranet site.

**CATEGORIES OF ABUSE AND VULNERABLE CHILDREN**

**Abuse of children:**

For children’s safeguarding, the definitions of abuse are taken from *Working Together to safeguard Children* (HM Government, 2015)

**Abuse and neglect:** A form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others (e.g. via the internet). They may be abused by an adult or adults, or another child or children.

**Physical Abuse**

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

**Neglect**

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

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

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

Working with Families where neglect is a concern can be challenging for further Guidance re the use of the Graded Care Profile, Neglect Screening tools and the Neglect Strategy see the LSCB websites.

Cheshire East

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

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

Child sexual exploitation
Child sexual exploitation is a form of child sexual abuse. Sexual abuse may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. It may include non-contact activities, such as involving children in the production of sexual images, forcing children to look at sexual images or watch sexual activities, encouraging children to behave in sexually inappropriate ways or grooming a child in preparation for abuse (including via the internet).

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

CSE can affect any child or young person (male or female) under the age of 18 years, including 16 and 17 year olds who can legally consent to have sex;

- can still be abuse even if the sexual activity appears consensual;
- can include both contact (penetrative and non-penetrative acts) and non-contact sexual activity;
- can take place in person or via technology, or a combination of both;
- can involve force and/or enticement-based methods of compliance and may, or may not, be accompanied by violence or threats of violence;
Child sexual exploitation is a complex form of abuse and it can be difficult for those working with children to identify and assess. The indicators for child sexual exploitation can sometimes be mistaken for ‘normal adolescent behaviours’. It requires knowledge, skills, professional curiosity and an assessment which analyses the risk factors and personal circumstances of individual children to ensure that the signs and symptoms are interpreted correctly and appropriate support is given. Even where a young person is old enough to legally consent to sexual activity, the law states that consent is only valid where they make a choice and have the freedom and capacity to make that choice. If a child feels they have no other meaningful choice, are under the influence of harmful substances or fearful of what might happen if they don’t comply (all of which are common features in cases of child sexual exploitation) consent cannot legally be given whatever the age of the child.

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

One of the key factors found in most cases of child sexual exploitation is the presence of some form of exchange (sexual activity in return for something); for the victim and/or perpetrator or facilitator. The exchange can include both tangible (such as money, drugs or alcohol) and intangible rewards (such as status, protection or perceived receipt of love or affection). It is critical to remember the unequal power dynamic within which this exchange occurs and to remember that the receipt of something by a child/young person does not make them any less of a victim. It is also important to note that the prevention of something negative can also fulfil the requirement for exchange, for example a child who engages in sexual activity to stop someone carrying out a threat to harm his/her family.

**Who is vulnerable to child sexual exploitation?**

**Any child, in any community:** Child sexual exploitation is occurring across the country but is often hidden so prevalence data is hard to ascertain. However, areas proactively looking for child sexual exploitation are uncovering a problem. All practitioners should be open to the possibility that the children they work with might be affected.

**Age:** 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.

**Gender:** Though child sexual exploitation may be most frequently observed amongst young females, boys are also at risk. Practitioners should be alert to the fact that boys may be less likely than females to disclose experiences of child sexual exploitation and less likely to have these identified by others.
Ethnicity: Child sexual exploitation affects all ethnic groups.

Heightened vulnerability factors:

Sexual exploitation can have links to other types of crime. These include:
- Child trafficking;
- Domestic abuse;
- Sexual violence in intimate relationships;
- Grooming (including online grooming);
- Abusive images of children and their distribution;
- Drugs-related offences;
- Gang-related activity;
- Immigration-related offences; and
- Domestic servitude.

Potential indicators of child sexual exploitation

The following vulnerabilities are examples of the types of things children can experience that might make them more susceptible to child sexual exploitation:
- Having a prior experience of neglect, physical and/or sexual abuse;
- Lack of a safe/stable home environment, now or in the past (domestic violence or parental substance misuse, mental health issues or criminality, for example);
- Recent bereavement or loss;
- Social isolation or social difficulties;
- Absence of a safe environment to explore sexuality;
- Economic vulnerability;
- Homelessness or insecure accommodation status;
- Connections with other children and young people who are being sexually exploited;
- Family members or other connections involved in adult sex work;
- Having a physical or learning disability;
- Being in care (particularly those in residential care and those with interrupted care histories); and
- Sexual identity.

Not all children and young people with these vulnerabilities will experience child sexual exploitation. Child sexual exploitation can also occur without any of these vulnerabilities being present.

All agencies should be alert to the risks of sexual exploitation and be able to take action and work together when an issue is identified.

Referral

Where there are concerns about CSE a Pan Cheshire CSE Risk Assessment Tool should be completed with the young person


The Bichard checklist has been adapted for use within the Accident and Emergency Department to aid in the identification of CSE risk factors.
See Appendix 2

Where concerns have been identified a referral must be made to Children’s Social Care.

Where it is suspected or it is known that a criminal offence has taken place there should be discussion with Children’s Social Care and the Police

Practitioners should also refer concerns relating to adults and their involvement with children and young people where they believe that CSE may be a concern and any premises/venues which they believe may be associated with CSE to the Police

eastern.ppu@cheshire.pnn.police.uk

For Further information re the Pan Cheshire Strategy and the Pan CSE campaign see the LSCB websites

East Cheshire

West Cheshire
http://cheshirewestlscb.org.uk/professionals/child-sexual-exploitation/

Advice and support can be sought from the Children's Safeguarding team or the CSE Nurse Specialist

**Fabricated or Induced Illness**

Fabricated or induced illness (FII) is a complex issue and individual suspected cases typically require a lot of consideration and discussion before they are to be regarded in child protection terms.

The characteristics of fabricated or induced illness are a lack of the usual corroboration of findings with symptoms or signs, or – in circumstances of proven organic illness – lack of the usual response to proven effective treatments.

There are three main ways of fabricating or inducing illness in a child. More than one may be evident in individual cases: fabrication of signs and symptoms, including fabrication of past medical history fabrication of signs and symptoms and falsification of hospital charts and records, and specimens of bodily fluids. This may also include falsification of letters and documents inducement of illness by a variety of means.

The signs and symptoms require careful medical evaluation for a range of possible diagnoses. Parents should be kept informed of findings from any medical evaluation, but at no time should concerns about reasons for child’s signs and symptoms be shared with the parents if this information would jeopardize the child’s safety.

For guidance on the Management of Children in whom illness is fabricated or induced refer to the LSCB procedures.

**Female Genital Mutilation (FGM)**

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

There are four types of FGM, ranging from a symbolic prick to the vagina to the fairly extensive removal and narrowing of the vagina opening. In the UK all forms of FGM are prevalent. FGM is also sometimes known as ‘female genital cutting’ or ‘female circumcision’. However,
circumcision is not an appropriate term. Communities tend to use local names for referring to this practice including “sunna”.

It is known that the number of communities affected by FGM in the UK is growing with the increase in migration from countries where FGM is widely practiced. There are 28 countries in Africa, and also parts of the Middle East and Asia where FGM is commonly practiced. The highest prevalence rates are found in Somalia, Sudan, Egypt, Guinea and Sierra Leone. Although Cheshire East does not have a high population of these communities, staff must remain vigilant and be aware of any girls who may be at risk.

Health professionals, particularly GPs, Midwives, School Nurses, Sexual Health Staff and Gynaecologists, are in a key position to identify female children in a family where women or girls have already undergone FGM.

Health staff particularly school nurses and nurses working in vaccination clinics are in a key position to identify girls who may be visiting overseas and may be at risk of FGM.

FGM is considered child abuse in the UK and a grave violation of the human rights of girls and women. In all circumstances where FGM is practised on a child it is a violation of the child’s right to life, their right to their bodily integrity, as well as their right to health. The UK Government has signed a number of international human rights laws against FGM, including the Convention on the Rights of the Child.

Female Genital Mutilation is illegal in the UK under the Female Genital Mutilation Act 2003. The Act also makes it an offence for UK nationals and those with permanent UK residence to be taken overseas for the purpose of female circumcision, to aid and abet, counsel, or procure the carrying out of Female Genital Mutilation.

Practice points:
- ‘aiding, abetting and counselling applies to those who assist or persuade a girl to perform FGM on herself even though it is not itself an offence for that child to carry it out on herself.
- ‘Girl includes woman’ (Female Genital Mutilation Act, 2003) although not an offence for a girl or young woman to perform FGM on herself, consideration should be given to whether such self-harm is a safeguarding issue where the action may be the result of adult pressure.
- Midwives need to note that it is illegal to reinfibulate a woman following the birth of her baby.

This is crucial.
Midwives and Obstetricians may become aware that FGM has taken place when treating a pregnant woman. This should trigger concern for any female child of the family and should be reported to the Safeguarding Children Team.

All incidents of FGM must be recorded on the patients records and notified via the Datix system

What to do if you suspect a child may be at risk of undergoing FGM
- Be aware that FGM is child abuse and that you must take action
- Discuss your concerns with the Safeguarding Team
- Follow Cheshire East LSCB (Local Safeguarding Children Board) procedures
- Refer to Children’s Social care/Police

This Guidance should be read in conjunction with East Cheshire Trust FGM Policy (available on the Trust infonet) and the Pan Cheshire FGM
Forced Marriage and Honour Killing

Definitions

Arranged Marriage
In arranged marriages the families of both spouses take a leading role in arranging the marriage but the choice of whether or not to accept the arrangement remains with the prospective spouses.

Forced Marriages
“Forced Marriage is an abuse of human rights”

Universal Declaration of Human Rights Article 16 (2)

A forced marriage is where one or both people do not (or in cases of people with learning or physical disabilities, cannot) consent to the marriage and pressure or abuse is used.

- Hundreds of young people, some as young as 13, are taken abroad each year and forced into marriage
- Forced marriage can involve child and sexual abuse including abduction, violence, rape, enforced pregnancy and enforced abortion.
- Rejection can place a young person at risk of murder, also known as “Honour Killing”.
- Forced marriage is not sanctioned within any culture or religion.

Young people rarely feel able to disclose their feelings about forced marriage. However there are some warning signs that may indicate the possibility of an impending forced marriage:

- extended absence from school/college, truancy, drop in academic performance, low motivation, excessive parental restriction and control of movements, and history of siblings leaving education early to marry
- poor attendance in the workplace, poor performance, parental control of income and limited career choices
- evidence of self-harm, treatment for depression, attempted suicide, social isolation, eating disorders or substance abuse
- evidence of family disputes/conflict, domestic violence/abuse or running away from home

A young person demonstrating any of the above may not be necessarily at risk, but if you feel concerned about a potential forced marriage you should contact Children’s Social Care.

“Honour” Based Violence

Honour based violence is where the person is being punished by their family or their community. They are being punished because of a belief, actual or alleged that a person has not been properly controlled enough to conformity and thus this is the “shame” or “dishonour” of the family.

Health practitioners working with victims of forced marriage and honour based violence need to be aware that they may only have one chance to speak to a potential victim and may only have one chance to save a life.

Health practitioners should try to create opportunities to see victims on their own so that the following questions can be asked:

- How are things at home?
- Do you get out much?
- Can you choose what you want to do and when you want to do it such as seeing friends, working or studying?
- Do you have friends and family locally who can provide support?
- Is your family supportive?

If a disclosure is made health professionals should provide information about specialist advice and services or assist by referring to the Police, Social Care, Support Groups, and Counselling Services.
There may be occasions when the level of concern or the imminence of marriage requires referral to Social Services.

Within East Cheshire NHS Trust the named person with lead for supporting staff is the Head of Safeguarding.

Accurate records must be maintained at all times documenting what has been said and done.

National Contact Numbers:
Forced Marriage Unit – 0207 608 0151
Honour Network – 0800 5999 247
National Domestic Helpline – 0808 2000 247

Modern Day Slavery/ Child Trafficking and Unaccompanied Asylum Seeking Children

The Modern Slavery Act, 31 July 2015 consolidates and updates the existing criminal legislation on human trafficking, slavery, forced labour, cannabis farming, organ harvesting, forced begging and domestic servitude.

Modern day slavery comes in many forms it is abuse and must be acted upon. It can and does have a devastating and lasting impact on victims, children and families in countries all over the world, including our own. It is by its nature a largely hidden crime, but the Government recently estimated that between 10,000 and 13,000 people are currently being subjected to some form of modern slavery in the UK - and, although some may be more vulnerable to exploitation than others, it is an issue unrestricted by age, gender or background.

The term ‘Modern slavery’ captures a whole range of types of exploitation, many of which occur together.

Trafficking in persons means the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion for the purposes of exploitation. The recruitment, transportation, transfer, harbouring or receipt of a child for the purpose of exploitation is considered ‘trafficking in persons’ even if this does not involve the threat or use of force or other forms of coercion.

Most children are trafficked for financial gain. This can include payment from or to the child’s parents. In many situations, parents part with their children believing that they will be offered a better life or opportunities in the place they are being taken to. In most cases, the trafficker also receives payment from those wanting to exploit the child once in the UK. Some trafficking is carried out by organised gangs. In other cases individuals traffic children for their own personal gain. Children may be trafficked for:

- Sexual exploitation
- Domestic servitude
- Sweatshop, restaurant and other catering work
- Agricultural labour, including tending plants in illegal cannabis farms
- Benefit fraud
- Involvement in petty criminal activity
- Organ harvesting
- Drug mules, drug dealing or decoys for adult drug traffickers
- Illegal inter-country adoption.

Child victims of trafficking may enter the UK in a variety of ways:

- As unaccompanied asylum seeking children. Children may be told to ask for asylum on arrival in the country. They then become looked after and at a later date
are removed or abducted by their traffickers; often the children make contact with
the traffickers as they have been instructed.
- As students or visitors
- Brought in by an adult as dependents or be met by an adult who claims to be a
  relative.
- Via internet transactions
- As a private fostering arrangement for the purpose of benefit claims
- As domestic staff which is tantamount to slavery. There is thought to be
  considerable exploitation of children in situations of domestic service
- Bogus marriage for the purpose of forced prostitution

Trafficking may also take place within the UK mainly for the purpose of sexual exploitation.

Spotting the signs of Modern Day Slavery:
It’s important that people are aware of how to spot the signs of someone who may have been
trafficked and is being exploited.

Victims may:
- Look malnourished or unkempt
- Be withdrawn, anxious and unwilling to interact
- Be under the control and influence of others
- Live in cramped, dirty, overcrowded accommodation
- Have no access or control of their passport or identity documents
- Appear scared, avoid eye contact, and be untrusting
- Show signs of abuse and/or have health issues

If an agency or a professional suspects that a child is the victim of Modern Day
Slavery/trafficking, the Police or Children’s Social Care must be informed. Child victims of
trafficking are by definition children in need of protection and the arrangements for safeguarding
and promoting their welfare will be applied as for all children with the additional considerations
as apply to asylum seeking children or sexually exploited children.

An unaccompanied asylum seeking child is an asylum seeking child under 18 years who is not
living with their parent, relative or guardian in the UK.

All unaccompanied asylum seeking children are by definition children in need and will receive
assessment and provision of services. Most unaccompanied asylum seekers will qualify for
provision of accommodation under Section 20 Children Act 1989, there being no person who
has parental responsibility/being lost or abandoned/the person who has been caring for him
being prevented (whether or not permanently, and for whatever reason) from providing him with
suitable accommodation and or care. If the child is assessed to be at risk of significant harm,
consideration may need to be given to legal action to protect the child.

Child Abuse linked to Spirit Possession and Witchcraft

The belief in ‘possession’ and ‘witchcraft’ is widespread although the number of known child
abuse cases linked to accusations of ‘possession’ or ‘witchcraft’ is small.

In ‘possession’ cases the parent/carer views the child as ‘different’, attributes this to the child
being ‘possessed’ and attempts to exorcise the child. The reasons for being ‘different’ may be
disobedience, independence, bedwetting, nightmares, illness or disability. The attempt to
exorcise may involve beating, burning, starvation, cutting/stabbing and/or isolation within the
household.

‘Witchcraft’ is the belief that a child is able to use an evil force to harm others. There is a range
of terminology connected to such beliefs – black magic, kindoki, ndoki, the evil eye, djinns,
voodoo, obeah, and child sorcerers. In all known cases, families, carers and the children can
hold genuine beliefs that evil forces are at work. Families and children can be deeply worried by the evil that they believe is threatening them. There may also be an element of the adult gaining some advantage through the ritualistic abuse of the child which may even result in the death of the child.

Belief is not confined to particular countries, cultures or religions. Nor is it confined to new immigrant communities in the UK.

While the number of known cases of abuse related to spiritual or religious belief is small, agencies should be alert for possible indicators, and apply basic safeguarding children principles to prevent it. Where it occurs, the impact on the child is substantial, distressing and the child is at risk of significant harm. It is also possible that a significantly large number of cases remain undetected.

Key considerations are:

- Child abuse is never acceptable in any community or culture, under any circumstances.
- Child abuse linked to a belief in spirit possession usually stems from a child being used as a scapegoat, the underlying reasons for the abuse often being due to factors such as family stress, deprivation, domestic violence, substance abuse and or mental health problems
- Links, where they exist, between individual cases of such child abuse and wider belief, faith or community practices should be identified. Where connections are identified and appropriate action taken, the risk that other children will be similarly abused can be greatly reduced.
- Standard child safeguarding procedures apply and must be followed in all cases where abuse or neglect is suspected including those that may be related to a belief in spirit possession or witchcraft
- Practitioners need to have an understanding of religious beliefs and cultural practices in order to help gain the trust of the family or community. Practitioners should seek advice if dealing with a culture or set of beliefs that are unfamiliar.

Ref: DCSF Safeguarding Children from Abuse Linked to a Belief in Spirit Possession

‘Good Practice for Working with Faith Communities – Spirit Possession & Abuse (Churches Child Protection Advisory Service)

GOOD PRACTICE GUIDANCE:-

Indicators of abuse linked to belief in spirit possession, which may also be common feature

- a child’s body showing signs or marks, such as bruises or burns, from physical abuse;
- a child becoming noticeably confused, withdrawn, disorientated or isolated and appearing alone amongst other children;
- a child’s personal care deteriorating, e.g. through a loss of weight, being hungry, turning up to school without food or lunch money, or being unkempt with dirty clothes
- it may be directly evident that the child’s parent or carer does not show concern for or have a close bond with the child;
- a child’s attendance at school becoming irregular or the child being taken out of school altogether without another school place having been organized, or a deterioration in a child’s performance at school;
a child reporting that they are or have been accused of being ‘evil’, and/or that they are having the ‘devil beaten out of them’.

If any professional has concerns about Child Abuse linked to Spirit Possession and Witchcraft then a referral should be made to children’s social care and advice sought from the safeguarding team.

Abuse of Disabled Children

Children with special needs may be especially vulnerable to abuse because they may:
- they have fewer outside contacts than other children
- they receive intimate personal care, possibly from a number of carers which may both increase the risk of exposure to abusive behaviour, and make it more difficult to set or maintain physical boundaries
- have impaired capacity to resist or avoid abuse
- have communication difficulties which make it difficult to tell others what is happening
- be inhibited about complaining for fear of losing services they are especially vulnerable than other children to abuse from their peers

Guidance regarding sources of stress for children and families that may require extra support and supervision

- All unborn children identified by midwife or where there has been a pre birth planning meeting or a pre birth assessment
- Prematurity
- Failure to thrive
- Children looked after by the local Authority
- Sexual Exploitation
- Fabricated or Induced illness
- Female genital mutilation
- Frequent Accident and Emergency attendances
- Children living in prisons
- Forced marriage
- Young unsupported parents
- Impaired Parenting Capacity
- Mental ill health of parent or carer
- Substance misuse
- Domestic abuse
- Social exclusion – adverse environmental factors
- Parental exclusion difficulty
- Concealed pregnancy


The management of children and families requiring extra support
See Guidance 5

The Management of Sexually Active Young People under the Age of 18

This guidance has been devised with the understanding that most young people under the age of 18 will have a healthy interest in sex and sexual relationships. It is designed to assist those working with young people to identify where these relationships may be abusive and the young people may need the provision of protection or additional services.
All young people, regardless of gender, who are believed to be engaged in, or planning to be engaged in, sexual activity should have their needs for health education, support and /or protection assessed.

In order to determine whether the sexual activity presents a risk to the young person, the following factors should be considered:

- Whether the young person is competent to understand, and consent to, the sexual activity they are involved in
- The nature of the relationship between those involved, particularly if there are age or power imbalances as outlined above
- Whether overt or covert aggression, coercion or bribery was involved including misuse of substances as a dis inhibitor
- Whether the young person’s own behaviour, for example through misuse of substances, places them in a position where they are unable to make an informed choice about the activity
- Any attempts to secure secrecy by the sexual partner beyond what would be considered usual in a teenage relationship
- Whether the sexual partner is known by the agency as having other concerning relationships with similar young people
- Whether the young person denies, minimises or accepts concerns
- Whether methods used to secure compliance and /or secrecy by the sexual partner are consistent with behaviours considered to be ‘grooming’ as per sexual exploitation
- The attitude of anyone who acts in a parenting capacity for the young person
- That the young person targeted for sexual exploitation may believe they are in a relationship

Where there are concerns that a young person is being sexually exploited (See 11.1.5 Child Sexual Exploitation of this Policy) or where a criminal offence is taking place, then a referral should be made to the Police (Public Protection Referral Unit) and children’s social care for further discussion and an agreed way forward.

Process

In working with young people, it must always be made clear to them at the earliest appropriate point, that absolute confidentiality cannot be guaranteed, and that there will be some circumstances where the needs of the young person can only be safeguarded by sharing information with others.

On each occasion that a young person is seen, consideration should be given as to whether their circumstances have changed or further information is given which may lead to the need for referral or re-referral.

In some cases urgent action may need to be taken to safeguard the welfare of a young person. However, in most circumstances there will need to be a process of information sharing and discussion in order to formulate an appropriate plan. There should be time for reasoned consideration to define the best way forward. Anyone concerned about the sexual activity of a young person should initially discuss this with their manager, and with the Safeguarding Children team. There may then be a need for further consultation with Children’s Social Care or the Police (Public Protection Referral Unit). A discussion with Children’s Social Care does not constitute a referral to social services, but they may offer advice on the necessity or otherwise of making a referral.

All discussions should be recorded, giving reasons for action taken and who was spoken to, as support for the professional decisions made. It is important that all decision making is undertaken with full professional consultation, never by one person alone.

Children under the age of 13yrs

Under the Sexual Offences Act 2003 children under the age of 13yrs cannot legally give their consent to engage in any form of sexual activity. Sexual activity in someone under the
age of 13yrs should always be considered a cause for concern. Advice should always be sought from the Safeguarding team and a discussion with Children’s social care at the earliest opportunity. This also applies to where it becomes apparent that although the young person is now 13yrs the sexual activity commenced prior to this.

**Children and Young People under the age of 16 years**

It is well understood, that whilst the legal age of consent is 16, some young people become sexually active before that age. It was not however the intention of Sir Michael Bichard or of the Sexual Offences Act 2003 to prosecute consensual teenage sexual activity between two young people of a similar age and understanding.

Nevertheless all sexual activity by young people under the age of 16 needs to be taken seriously by all agencies involved both from a sexual health point of view and also in ensuring that the young person is not being abused or exploited.

Whenever a sexually active young person under the age of 16 comes to the attention of an agency or professional, that worker must undertake a risk assessment to establish the level of risk, if any, to that young person and what type of support and intervention might best meet their needs, including a possible referral to the police.

The Teenage Pregnancy Unit has produced a checklist to assist in the assessment, and the checklist is reproduced in Recommendation 13 of Sir Michael Bichard’s Report. See Appendix 3

**Young People Aged 16 to 18**

Even though the age of consent is 16 and sexual activity in itself is no longer an offence over the age of 16, young people under the age of 18 are still offered the protection of Child Protection Procedures under the Children Act 1989. It is still important to protect 16 and 17 year olds from abuse and exploitation. Young people aged 16 and 17 fall within the LSCB Child Protection Procedures and there are particular measures within the Sexual Offences Act 2003 to protect them from prostitution, pornography and abuse by family members and those in positions of trust. Good practice would therefore indicate that the checklist be used to inform the risk assessment of a young person’s sexual relationship

If assessment indicates that a young person over 16 but under 18 may be at risk of significant harm, or that sexual activity is with an adult in a position of trust or a family member, there must be a discussion with Children’s Social Care. Referral to the Police (Public Protection Referral Unit) must be considered.

**Confidentiality and Information Sharing**

Practitioners may be concerned that disclosing information about under-age sexual activity may be breaching the confidentiality rights of the child or young person in question, or equally, that the child or young person may not be forthcoming with information if they feel that it is going to be shared with others. However, it is important to remember that if there is a child protection concern of any kind, information about the child or young person must be shared. Equally, it will usually be essential that further information is sought or shared in order to make a sound assessment of whether there is a child protection concern in the first place.

The level of response will depend on how practitioners assess the level of risk. The response, and level of information shared, will be different depending on whether there is a child protection concern or whether there are other concerns for the well-being of the young person.
The overriding principle should be that the confidentiality rights of children and young people should be respected unless there is a child protection concern.

If the practitioner has assessed that the sexual behaviour is consensual teenage sexual activity where there are no concerns of abuse, coercion or exploitation, the practitioner should uphold the confidentiality rights of the young person and provide practical assistance and advice as required.

If there are concerns that the young person might be at risk of harm, if the practitioner is concerned that the young person's behaviour, or the nature of the sexual behaviour and/or relationship, could indicate that the young person is at risk of harm, the practitioner should:

- seek guidance from a line-manager and the safeguarding children's team
- inform the young person about the need to speak to other practitioners, where required, and seek their consent if possible
- if required, seek advice from other services and agencies to assist in this decision-making
- share appropriate information with other practitioners about the young person
- share information with the Police if there are concerns about the young person's sexual partner

If the practitioner is aware that the young person has experienced, or is experiencing, harm as a result of their sexual activity or behaviour, the practitioner should:

- where appropriate, speak with the child and young person prior to passing on the child protection concern – every reasonable effort should be made to seek their agreement;
- share the child protection concern with Police and/or Social Work Services
- If agreement is not reached, the professional should share the child protection concern and inform the child and young person that this will be the course of action.

There are certain circumstances in which practitioners should automatically share child protection concerns with the investigating agencies:

- if the child is, or is believed to be, sexually active and is under 13
- if the young person is currently 13 or over but sexual activity took place when they were 12 or under
- if the child is aged 13yrs and under 16yrs and has been subject to rape, including non-consensual sexual activity, or a serious sexual assault.
- if there is evidence or indication that the young person is involved in pornography or prostitution
- if there is evidence or indication that the young person is involved in child sexual exploitation
- if the 'other person' is in a position of trust in relation to the young person
- if the young person is perceived to be at immediate risk

Sharing Information with Parents

Decisions to share information with parents will be taken using professional judgement and in consultation with the Child Protection Procedures. Decisions will be based on the child's age, maturity and ability to appreciate what is involved in terms of the implications and risks to themselves. This should be coupled with the parents’ ability and commitment to protect the young person. Given the responsibility that parents have for the conduct and welfare of their children, professionals should encourage the young person, at all points, to share information with their parents where ever safe to do so.

This policy is written on the understanding that those working with this vulnerable group of young people will, naturally, want to do as much as they can to provide a safe, accessible and
confidential service whilst remaining aware of their duty of care to safeguarding them and promote their well-being.

Alerts re missing unborn/children/families
Missing families are when an outside Trust/Local Supervising Authority or children’s social care etc. contacts the Safeguarding Team via email regarding a family who has gone missing from their area for whom there are safeguarding concerns.

The Named Nurse will oversee that the following actions are undertaken:
- Check if the family are or have been known to the trust and respond to the alerting agency.
- If it is a child with no previous links to the trust the printed email is filed in a Missing Children’s folder and kept for 12 months

When Children go missing
See Guidance 6

Private fostering.
A private fostering arrangement is essentially one that is made privately (i.e. without the involvement of a local authority) for the care of a child under the age of 16, under 18 if disabled, by someone other than a parent or close relative for 28 days or more, in the carer’s own home.

- Under the Children Act 1989, private foster carers and those with parental responsibility are required to notify the local authority of their intention to privately foster; or to have a child privately fostered, or where a child is privately fostered in an emergency. East Cheshire Trust Employees should notify the local authority of a private fostering arrangement that comes to their attention where they are not satisfied that the local authority has been, or will be, notified of the arrangement.

When a Child Dies.
The Pan Cheshire Overview Panel.
The Pan Cheshire Child Death Overview Panel is a Sub Group of the LSCB and has a statutory responsibility to review all deaths of children and young people from 0–18 years of age who would normally reside within the LA area, this includes any infant who was registered as a live birth from 22 weeks of life (reviews of deaths following a planned termination under the abortion Act 1967 will not be carried out by the Pan Cheshire CDOP).

The Pan Cheshire CDOP panel has representatives from the key organisations, ie, Police, Social Services, Education, Midwifery, Paediatricians, LSCB, CDOP Nurse, Public Health and a lay member. Other specialists may be co-opted to contribute as required.

Every child’s death is a tragedy for the family and for the wider community. It is hoped that by joint agency working and analysis of collated information the Pan Cheshire CDOP will:
- Where possible establish a cause or causes of death.
- Identify possible contributory factors.
- Ensure that ongoing support is provided to bereaved families.
- Identify lessons learnt in order to reduce the risks of child deaths by taking appropriate action to improve both the safety and well being of children in the area.

The overarching goal of this process is to reduce the number of child deaths. The review aims to ensure that there is a full understanding of the events leading to the child’s death. The recommendations arising from a review should lead to improved services for children and their families, both at local and national level.

When a Child Dies
There are two categories of death
Anticipated or Expected, with no additional complicating factors. (ie, children dying at home, hospice or another setting who have been undergoing end of life care, these children will not usually be considered to have died unexpectedly so a rapid response to such deaths is rarely indicated).

or

Sudden Unexpected Death In Infant or Child (SUDIC) – The Pan Cheshire LSCB Guidelines for The management of Sudden Unexpected Death in Infants and Children (2013) should be followed. This includes the Rapid Response Process which is an immediate comprehensive, multi-disciplinary review of unexpected child deaths which takes place within 72 hours and is initiated by the Senior Investigating Officer. Unless death is unexpected but explained, ie, in a road traffic collision and a satisfactory explanation has been determined.

Professionals need to consider:

- Is the death expected/unexpected?
- Should social care be informed?
- Is safeguarding of any other children required?
- Are suicidal thoughts or extreme grief/guilt reactions being experienced?
- What Family support is available?
- Have there been any concerns about the child/family expressed by professionals?
- Has an appropriate professional been identified to provide bereavement support?
- Notification of death - the deaths of all babies / children under 18 years resident in Cheshire, regardless of where the death took place, should be notified. Deaths of children not normally resident in the Cheshire area and who die here should also be notified; this information will be passed onto the relevant Panel who will then coordinate the information.

Notification of Child Death

Notification of death - the deaths of all babies / children under 18 years resident in Cheshire, regardless of where the death took place, should be notified. Deaths of children not normally resident in the Cheshire area and who die here should also be notified; this information will be passed onto the relevant CDOP Panel who will then co-ordinate the information (for Sudden Unexpected Deaths refer to SUDIC Guidelines 2013 Appendix 6 Child Death Notification.

For all Child Deaths unexpected or expected the Dfe Form A Notification doc is to be completed.

Form B must be sent out to all agencies involved with a child and family. This is an essential process for the CDOP, as the information gathered is used to safeguard and promote the welfare of children and for strategic planning purposes to support effective service delivery.

Policies, Guidelines, Notification forms A and B and additional resources for Professionals are available via East Cheshire LSCB and East Cheshire Trust Infonet


Key Operational Documents
Working together to Safeguard Children (2015) - DoH
The Management of Sudden Unexpected Death in Infants & Children Guidelines (2013) - Pan Cheshire LSCB

Transition from children’s services to adults
Robust joint arrangements between children’s and adult services will ensure that the medical and psychological needs of children moving into adulthood will be addressed.

Young people who have been looked after by local authority as a child will remain the responsibility of the local authority until they are 21. However, where someone is 18, still receiving children’s services and a safeguarding issue has been raised; the matter should be dealt with as a matter of course by adult safeguarding.

Health transition to adult services will start before the age of 16 and should be completed by 16 in the majority of cases. Some young people with learning disabilities or other chronic illnesses such as cystic fibrosis or endocrine disorders may take up to 18 years of age to transition fully and this will be assessed individually as part of their transition process. The care needs of the young person should be at the forefront of any support planning and require a coordinated multi-agency approach.

Assessments at this stage should include issues of safeguarding and risk. Care planning needs to ensure that the young adult’s safety is not put at risk through delays in providing services they need to maintain their independence and wellbeing and choice. However it must be noted that not all children who receive a service from children’s services will be eligible for a service from adult social care.

To facilitate the transition process where safeguarding issues have been raised the Children’s safeguarding team will share information with the Adult safeguarding team.

The following should be considered:

• Supporting effective transition processes
• Acknowledging that dangers for a child can translate into risks for the adult.
• Managing risks as a phased process with awareness of the psychological and emotional issues in relation to the young person.
• Managing family and carer expectations (being clear about the level of support and resources available through adult services).
• Taking time to get to know the young person, family and carers, especially if they have communication difficulties.
• Acknowledging the rights of the young adult to take more responsibility for their decisions.
### TRAINING FRAMEWORK

All training is in line with the recommendations of the *Safeguarding Children and young people: Roles and Competencies for Health Care Staff (Intercollegiate Document March 2014)* and *Working Together to Safeguard Children Guidance March 2014*.

<table>
<thead>
<tr>
<th>Level 1 training</th>
<th>Target Group</th>
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<tbody>
<tr>
<td>This level is equivalent to basic safeguarding/child protection training</td>
<td>All staff/volunteers of East Cheshire Trust. This includes, for example, Board level Executives and non executives, lay members, receptionists, administrative, caterers, domestics, transport, porters, community pharmacist counter staff and maintenance staff, including those non clinical staff working for independent contractors within the NHS such as GPs, optometrists, contact lens and dispensing opticians, dentists and pharmacists, as well as Volunteers across health care settings and service provision.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Learning Outcomes</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>• Demonstrates an awareness and understanding of child maltreatment</td>
<td></td>
</tr>
<tr>
<td>• Demonstrates an understanding of appropriate referral mechanisms and information sharing i.e. Knows who to contact, where to access advice and how to report</td>
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</table>

<table>
<thead>
<tr>
<th>Method of Delivery and Frequency</th>
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</thead>
<tbody>
<tr>
<td>All staff will complete Level 1 training as part of the induction programme</td>
<td></td>
</tr>
<tr>
<td>Level one staff will then continue to update this training three yearly via e- learning</td>
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</tr>
<tr>
<td>Over a three-year period, staff at level 1 should receive refresher training equivalent to a minimum of 2 hours.</td>
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<tr>
<td>An annual written update will be circulated to staff by the Safeguarding team</td>
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<table>
<thead>
<tr>
<th>Level 2</th>
<th>Target Group</th>
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</thead>
<tbody>
<tr>
<td>All non-clinical and clinical staff who have any contact with children, young people and/or parents/carers. This includes administrators for looked after children and safeguarding teams, health care students, clinical laboratory staff, phlebotomists, pharmacist, adult orthodontists, dentists dental care professionals audiologists, optometrists, contact lens and dispensing opticians, adult physicians, surgeons, anaesthetists, radiologists, nurses working in adult acute/community services (including</td>
<td></td>
</tr>
<tr>
<td>Target Group</td>
<td>Level 3 (Core)</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------</td>
</tr>
<tr>
<td>All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns</td>
<td></td>
</tr>
<tr>
<td>This includes GP, urgent and unscheduled care staff adult learning disability staff, learning disability nurses, specialist nurses for safeguarding, looked after children’s nurses, paediatric allied health professionals, sexual health staff, school nurses, health visitors, all children’s nurses, midwives, obstetricians, all paediatricians, lead anaesthetists for safeguarding I and child protection paediatric intensivists, paediatric orthodontists and dentists with a lead role in child protection.</td>
<td></td>
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</tbody>
</table>
### Learning Outcomes

- As outlined for Level 1 and 2
- Demonstrates knowledge of patterns and indicators of child maltreatment
- Demonstrates knowledge of the function of LSCBs
- Demonstrates understanding of appropriate information sharing in relation to child protection and children in need
- Demonstrates an ability to assess risk and need and instigates processes for appropriate interventions
- Where role includes conducting detailed assessments of child abuse and neglect, demonstrates ability to assess, examine children for suspected abuse and neglect, provide a report and an opinion
- Where undertaking forensic examinations as part of their role, demonstrates an ability to undertake forensic procedures and demonstrate how to present the findings and evidence to legal requirements.
- Demonstrates knowledge of the role and responsibilities of each agency, as described in local policies and procedures
- Demonstrates critical insight of personal limitations and an ability to participate in peer review

### Method of Delivery and Frequency

Mandatory annual requirement to attend an in house single agency update session
Interagency training via the LSCB can be attended in addition

Over a three-year period, professionals should receive refresher training equivalent to a minimum of 6 hours (for those at Level 3 core this equates to a minimum of 2 hours per annum)

At level 3 this could also for example include attendance at a HealthWRAP/prevent workshop where appropriate.
Organisations should consider encompassing safeguarding/child protection learning within regular multi-professional and/or multi-agency staff meetings, vulnerable child and family meetings, clinical updating, clinical audit, reviews of critical incidents and significant unexpected events, and peer discussions.

An annual written update will be circulated to staff by the Safeguarding team.

Staff requiring level 3 training will not be required to complete level 2 safeguarding children training but must repeat level 1 training 3 yearly.
<table>
<thead>
<tr>
<th>Level 3 (Additional Competences)</th>
<th>Target Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>This group includes midwives, Paediatric Nursing and Paediatricians, Paediatric nurse specialists, Paediatric learning disability staff, Health Visitors and School Nurses</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Learning Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• As outlined for Level 1 and 2</td>
</tr>
<tr>
<td>• Demonstrates knowledge of patterns and indicators of child maltreatment</td>
</tr>
<tr>
<td>• Demonstrates knowledge of the function of LSCBs</td>
</tr>
<tr>
<td>• Demonstrates understanding of appropriate information sharing in relation to child protection and children in need</td>
</tr>
<tr>
<td>• Demonstrates an ability to assess risk and need and instigates processes for appropriate interventions</td>
</tr>
<tr>
<td>• Where role includes conducting detailed assessments of child abuse and neglect, demonstrates ability to assess, examine children for suspected abuse and neglect, provide a report and an opinion</td>
</tr>
<tr>
<td>• Where undertaking forensic examinations as part of their role, demonstrates an ability to undertake forensic procedures and demonstrate how to present the findings and evidence to legal requirements.</td>
</tr>
<tr>
<td>• Demonstrates knowledge of the role and responsibilities of each agency, as described in local policies and procedures</td>
</tr>
</tbody>
</table>

Demonstrates critical insight of personal limitations and an ability to participate in peer review.

<table>
<thead>
<tr>
<th>Method of Delivery and Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Agency health training update.</td>
</tr>
<tr>
<td>Interagency training delivered in a multi agency setting in conjunction with the LSCB</td>
</tr>
</tbody>
</table>

Professionals should receive refresher training equivalent a minimum of 12-16 hours (for those at Level 3 requiring specialist knowledge and skill)

Mandatory annual requirement to attend an in house single agency update session
In addition to this the key areas: Health Visiting, School Nursing, Paediatrics and Midwifery, have an annual requirement to identify staff on a rolling programme to attend inter agency training.

Staff requiring level 3 training will not be required to complete level 2 safeguarding children training but must
### Level 4 training

**Target Group**

specialist roles - named professionals

This includes named doctors, named nurses, named health visitors, named midwives

**Learning outcomes**

As outlined for Level 1, 2 and 3

- Demonstrates completion of a teaching and assessment programme within 12 months of appointment
- Demonstrates an understanding of appropriate and effective training strategies to meet the competency development needs of different staff groups
- Demonstrates completion of relevant specialist child protection/safeguarding education within 12 months of appointment
- Demonstrates understanding of professional body registration requirements for practitioners
- Demonstrates an understanding and experience of developing evidence-based clinical guidance
- Demonstrates effective consultation with other health care professionals and participation in multidisciplinary discussions
- Demonstrates participation in audit, and in the design and evaluation of service provision, including the development of action plans and strategies to address any issues raised by audit and serious case reviews/internal management reviews/significant case reviews/other locally determined reviews
- Demonstrates critical insight of personal limitations and an ability to participate in peer review
- Demonstrates practice change from learning, peer review or audit.
- Demonstrates contributions to reviews have been effective and of good quality.
- Demonstrates use of feedback and evaluation to improve teaching in safeguarding.

**Method of Delivery and Frequency**

Named professionals should attend a minimum of 24 hours of education, training and learning over a three-year period. This should include non-clinical knowledge acquisition such as management, appraisal, and supervision training

- Named professionals should participate regularly in support groups or peer support networks for specialist professionals at a local and National level, according to professional guidelines (attendance should be recorded)
- Named professionals should complete a management programme with a focus on leadership and change management within three years of taking up their post
- Named Professionals responsible for training of doctors are expected to have appropriate education for this role
- Additional training programmes such as the newly developed RCPCH level 4/5 training for paediatricians should be undertaken within 1 year of taking up the post

Staff requiring level 4 training will not be required to complete level 2 and level 3 training but must repeat level 1 training 3 yearly

<table>
<thead>
<tr>
<th>Level 5</th>
<th>Target Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Designated professionals including lead paediatricians, consultant/lead nurses</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Learning Outcomes</th>
<th>As outlined for Level 1, 2 3 and 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Demonstrates advanced knowledge of national safeguarding practice and an insight into international perspectives</td>
</tr>
<tr>
<td></td>
<td>Demonstrates contribution to enhancing safeguarding practice and the development of knowledge among staff</td>
</tr>
<tr>
<td></td>
<td>Demonstrates knowledge of strategies for safeguarding management across the health community</td>
</tr>
<tr>
<td></td>
<td>Demonstrates an ability to conduct rigorous and auditable safeguarding/child protection support and peer review, as well as appraisal and supervision where provided directly</td>
</tr>
<tr>
<td></td>
<td>Demonstrates critical insight of personal limitations and an ability to participate in peer review</td>
</tr>
<tr>
<td></td>
<td>Designated professionals working within commissioning organisations in England also</td>
</tr>
<tr>
<td></td>
<td>Demonstrate knowledge of relevance of safeguarding to commissioning processes</td>
</tr>
<tr>
<td></td>
<td>Ensure a safeguarding focus is maintained within strategic organisational plans and service delivery</td>
</tr>
</tbody>
</table>

| Method of Delivery and Frequency | Designated professionals including lead paediatricians, consultant/lead nurses, should attend a minimum of 24 hours of education, training and learning over a three-year period This should include non-clinical knowledge acquisition such as management, appraisal, supervision training and the context of other professionals' work |
|---------------------------------|Designated professionals should participate regularly in support groups or peer support networks for specialist professionals at a local, regional, and national level according to professional guidelines (and their attendance should be recorded) |
|                                 | An executive level management programme with a focus on leadership and change management should be completed within three years of taking up the post |
- Additional training programmes such as the newly developed RCPCH level 4/5 training for paediatricians should be undertaken within 3 years of taking up the post.

Staff requiring level 5 training will not be required to complete level 2 and 3 training or repeat level 1 training

<table>
<thead>
<tr>
<th>Level 6</th>
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<tbody>
<tr>
<td>Target Group</td>
</tr>
<tr>
<td>Board Level for Chief Executive Officers, Trust and Health Board Executive and non executive directors/members</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Learning outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates an awareness and understanding of child maltreatment</td>
</tr>
<tr>
<td>Demonstrates an understanding of appropriate referral mechanisms and information sharing</td>
</tr>
<tr>
<td>Demonstrates clear lines of accountability and governance within and across organisations for the commissioning and provision of services designed to safeguard and promote the welfare of children</td>
</tr>
<tr>
<td>Demonstrates an awareness and understanding of effective board level leadership for the organisations safeguarding arrangements</td>
</tr>
<tr>
<td>Demonstrates an awareness and understanding of arrangements to share relevant information</td>
</tr>
<tr>
<td>Demonstrates an awareness and understanding of effective arrangements in place for the recruitment and appointment of staff, as well as safe whistle blowing</td>
</tr>
<tr>
<td>Demonstrates an awareness and understanding of the need for appropriate safeguarding supervision and support for staff including undertaking safeguarding training</td>
</tr>
<tr>
<td>Demonstrates collaborative working with lead and nominated professionals across Agencies</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Method of Delivery and Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory 3 yearly update of level 1</td>
</tr>
<tr>
<td>Plus a tailored package to be delivered by the Head of Safeguarding to meet the additional skills and competences, as identified in the learning outcomes.</td>
</tr>
</tbody>
</table>

Reference: Safeguarding Children and Young People Roles and Competence for Health Care Staff – Intercollegiate Document March 2014
NON ATTENDANCE OF APPOINTMENTS AND NO ACCESS VISITS

The Commissioners for Healthcare Audit and Improvement recommend that Trusts monitor the number and types of Did Not Attend and No Access visits and pay particular attention to the reasons, if known. (CHI 2003, DoH 2005).

The Healthcare Commission audit on Safeguarding Children also highlighted that good practice should include a policy on taking action when a child/family fail to attend an appointment or the health professional fails to gain access to a family.

Serious Case Reviews both locally and nationally have frequently shown a history of DNA appointments and No Access visits for Health care. Clear guidelines, protocols and policies must be in place to ensure that all children receive the care and assessments they require.

Non-Attendance / No Access to Unborn Child / Children / Young Person

In the event that the young person has failed to attend, or the parent / carer has failed to bring the child to an appointment, please refer to the Flowchart for DNA and No Access Visits.

As a minimum the child should either be offered a further appointment or referred back to the referrer.

It is often difficult to quantify the likely risk to the child / young person / pregnant woman of non-attendance / no access. In view of this it is preferable to discuss this with the referrer, parent /carer and possibly other professionals who have knowledge of the family. In this way more information can be obtained, allowing for a more holistic assessment of the possible impact on the unborn child / child / young person from non-attendance / no-access.

Low / medium risk might be considered for children / young people / pregnant women with a stable condition / situation or where there are no known concerns. This may be considered for families who are known to engage with services generally. Each case will require individual consideration.

High risk will be all children / young people / pregnant women whom it is thought require assessment / intervention to prevent permanent or serious deterioration of their condition, or for whom there is a risk of significant harm as a result of non-attendance / no access (DOH 1999). It is essential to consider all children / young people / pregnant women who are known to Social Care and / or subject to a protection plan as high risk.

The Common Assessment Framework Pre-Assessment Checklist should be used when assessing risk. (Appendix 4)

Guidance for Healthcare Professionals

a) On the first Did Not Attend or No Access Visit

- Assess the reason for the non attendance or no access visit and assess the level of risk to the child’s health and well-being.
- Liaise with other professionals involved with the family.
- For No Access visits leave a written communication that you have called as arranged and record action to be taken in the child’s case notes.
• For DNA arrange another appointment if appropriate. A child must not be discharged from a service without the consent of the Consultant or the lead clinician.
• Where there are “High Risk” concerns it may be necessary to write to the parents to advise them of the concerns and to refer to Social Care. Advice should be sought from the Safeguarding team. (For guidance see What to do if you have concerns about the Welfare of a Child Flowchart Appendix 13)
• Document in case notes.

b) Second Did Not Attend or No Access Visit
• Assess the reason for the non attendance or no access visits and assess the risk to the child’s health and well-being.
• Liaise with other professionals involved with the family.
• For No Access visits leave a written communication that you have called as arranged and record action to be taken in the child’s case notes.
• Arrange another appointment if appropriate – it may be necessary to refer to Social Care or to send a letter to parents.
• For DNA arrange another appointment if appropriate. A child must not be discharged from a service without the consent of the Consultant or the lead clinician.
• Liaise with the referrer/and other professionals who may have knowledge of the family to obtain further information to assess the risk to the child/young person.
• Where there are “High Risk” concerns it may be necessary to write to the parents to advise them of the concerns and to refer to Social Care. Advice should be sought from the Safeguarding team. (For guidance see What to do if you have concerns about the Welfare of a Child Flowchart Appendix 13)
• Document in case notes the action taken.

c) Third Did Not Attend or No Access Visit
• Contact Social Care to establish if child/family known to their service. Refer to Social Care if there are significant risks to the child. (For guidance see What to do if you have concerns about the Welfare of a Child Flowchart Appendix 13)
• Advice should be sought from the Safeguarding team.
• Inform referrer of non attendance / No Access.
• Inform line manager.
• Document action in child’s health notes/child health records.

Please Note

Whilst the use of a letter is being cited as the standard form of communication with parents / carers in these situations additional methods of communications may be used where parents /carers circumstances would make this ineffective or inappropriate (for example, where there is a visual impairment, learning disability, low level of literacy or other factors affecting a carer's ability to read or understand the letters instructions).

See Appendix 5
Early Help and How we Work Together to keep Children Safe

Providing early help is more effective in promoting the welfare of children than reacting later. Early help means providing support as soon as a problem emerges, at any point in a child’s life, from the foundation years through to the teenage years.

Effective early help relies upon local agencies working together to:

- identify children and families who would benefit from early help;
- undertake an assessment of the need for early help; and
- provide targeted early help services to address the assessed needs of a child and their family which focuses on activity to significantly improve the outcomes for the child.

Local agencies should have in place effective ways to identify emerging problems and potential unmet needs for individual children and families. This requires all professionals, including those in universal services and those providing services to adults with children, to understand their role in identifying emerging problems and to share information with other professionals to support early identification and assessment.

For an early help assessment to be effective:

- the assessment should be undertaken with the agreement of the child and their parents or carers. It should involve the child and family as well as all the professionals who are working with them;
- if parents and/or the child do not consent to an early help assessment, then the lead professional should make a judgement as to whether, without help, the needs of the child will escalate. If so, a referral into local authority children’s social care may be necessary.
- If at any time it is considered that the child may be a child in need as defined in the Children Act 1989, or that the child has suffered significant harm or is likely to do so, a referral should be made immediately to local authority children’s social care.

(Working Together 2013)

Multi-Agency Risk Assessments/tool kits

It is vital that children and young people receive the right service at the right time and this is supported by the Working Together 2015. In order for this to happen, all professionals who have contact with children, young people and families have a duty of care to identify issues at the earliest opportunity and assess what intervention is required.

Assessment should be a dynamic process that identifies analyses and responds to the changing nature and level of need and/or risk faced by a child. A good
assessment will enable practitioners to intervene at the right time with the right level of support and to monitor and record the impact of any services delivered to the child and family. Continuous assessment is crucial in ensuring that the help and support being delivered is having the intended impact.

This multi-agency assessment toolkit has been developed to support practitioners to undertake effective assessments that enable them to accurately identify appropriate cases in need of early help or onward referral to Children’s Social Care. The tools included should also be used to review the effectiveness of the support plans that are in place and the outcomes for the child/ren.

Using the assessments early in intervention will hopefully support positive outcomes for children, meaning onward referral may not be required. However, should a case need referral, professionals will be expected to evidence why a threshold has been met despite appropriate intervention. The assessments included in the toolkit will provide a record of evidence for this purpose.

Cheshire West Tool Kit
http://cheshirewestlscb.org.uk/wp-content/uploads/2015/03/Multi-Agency-Assessment-Toolkit-FINAL.docx

Cheshire East Risk Assessments

Continuum of Need
The ‘windscreen’ model is used nationally to illustrate how children may move either way between different levels of need and the responses from support services they will require.

The four segments, from left to right, indicate Universal, Targeted, Complex, and Specialist levels of service provision in response to need.

The ‘windscreen’ illustrates the capacity for a child’s level of need to change throughout their childhood. Children will move between levels of the continuum as their circumstances change and at the same time they may be accessing both universal and targeted services. The model is not incremental; it is a continuum of needs and related responses.

Levels of Intervention (Cheshire East) - Common Assessment Framework (CAF)
To view the full Continuum of Need document for Cheshire East LSCB

Levels of Intervention (Cheshire West and Chester) – Team Around the Child (TAF)

15.1.2 THE COMMON ASSESSMENT FRAMEWORK (CAF) / Team Around the Child (TAF)

In analysing children’s needs it is important to identify both strengths (including resilience and protective factors) and difficulties (including vulnerabilities and risk factors) within the child’s family. Furthermore, the context in which children are living is as important as is considering how these factors are having an impact on the child's health and development.
The CAF/TAF is a tool to enable early and effective assessment of children and young people who need additional services or support from more than one agency. It is a holistic consent based needs assessment framework which records, in a single place and in a structured and consistent way, every aspect of a child’s life, family and environment.

For guidance on when to complete a CAF see appendix 4.

CAF/TAF documentation can be accessed via the Cheshire East and the Cheshire West Local Authority websites respectively.

**Neglect Graded Care Profile**
The Graded Care Profile (GCP) has been developed to help agencies identify neglect when working with families where there are concerns about the parental care provided for children.

Assessing and minimizing neglect within families is a complex and challenging area. The nature of neglect often has multiple features, long term needs without necessarily an event that triggers decisive intervention. Professional recognition and understanding of the situation is often very difficult and takes time to intervene. The greatest uncertainty is often in deciding how serious a situation is and identifying ways in which to help to safeguard and improve the outcomes for children.

The policy and tool outlined below is intended to provide a means of detailed assessment of potential neglect in order to respond in an effective way to identify needs, and promote children’s welfare at home via coordinated multi agency support. It also enables systematic review to track if sufficient progress has been made in reducing the impact on the child.

The GCP is a practical tool that gives an objective measure of the care of children across all areas of need.

The Assessment Tool can be accessed via the LSCB websites:

### 5.0 Monitoring Compliance with the Document

Compliance with the requirements of this policy will be monitored by the business units. Non compliance with this policy should be reported through the clinical incident reporting system. This may result in a multi-disciplinary incident review and action planning meeting.

Attendance at safeguarding children training will be recorded by learning and development and monitored by departmental managers. Knowledge and Skills relating to safeguarding children will form part of the KSF appraisal process and will be evidenced in personal performance plans where this is appropriate for the employee’s role.
Compliance with the requirements of the Victoria Climbié Enquiry (Laming 2006) will be monitored by an annual audit of case notes of those children where a safeguarding issue has been identified by the Named Nurse and Doctor for Safeguarding.

A further audit will be undertaken annually by the Named Midwife in relation to antenatal safeguarding.

The Safeguarding Team will contribute to all case audit requests made by the two LSCBs.

**Measuring Performance**

Key performance indicators identified relating to this policy are as follows:

- All staff will be provided with child protection information on commencement of employment
- All staff who have direct contact with children and families will attend basic awareness training (level 2) within 3 months of commencement
- All staff who to have direct contact with children and families will attend update training as defined within the policy i.e. either annually or every 3 yearly as defined by post.
- Annual audits of Safeguarding children / antenatal safeguarding will be undertaken in relation to this policy. These will be presented as part of the business units audit program.

An annual report on Safeguarding Children will review the key performance indicators for presentation to the Trust Board.

**Audit Standard**

The efficacy of this guideline will be audited annually.

These guidelines cannot anticipate all possible circumstances and exist only to provide general guidance on clinical management to clinicians.

### 6.0 References

In developing this Policy account has been taken of the following statutory and non-statutory guidance, best practice guidance and the policies and procedures of the Local Safeguarding Children and Adults Board.

Every Child Matters

The Protection of Children in England – A Progress Report

The Children Act 2004

Making Arrangements to Safeguard and Promote the Welfare of Children

Children Act 1989 and 2004
Information sharing - Advice for practitioners providing safeguarding services to children, young people, parents and carers (HM Government March 2015)

Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the children Act 2004

What to do if you’re worried a child is being abused

Working Together to Safeguard Children March 2015

Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2014

Statutory Guidance on Promoting the Health and Wellbeing of Looked after Children (DH March 2015);

When to suspect child maltreatment (NICE Guidance July 2009); Looked after Children (NICE Guidance 28 October 2010)
PRINCIPLES TO SAFEGUARD THE SERVICE AND STAFF

“Duty of Care”

All adults who work with, and on behalf of children are accountable for the way in which they exercise authority; manage risk; use resources; and safeguard children and young people. Whether working in a paid or voluntary capacity, these adults have a duty to keep children and young people safe and to protect them from sexual, physical and emotional harm. Children and young people have a right to be treated with respect and dignity. It follows that trusted adults are expected to take reasonable steps to ensure the safety and well-being of children and young people. Failure to do so may be regarded as neglect.

The duty of care is in part, exercised through the development of respectful and caring relationships between adults and children and young people. It is also exercised through the behaviour of the adult, which at all times should demonstrate integrity, maturity and good judgement.

Everyone expects high standards of behaviour from adults who work with children and young people. When individuals accept such work, they need to understand and acknowledge the responsibilities and trust inherent in that role.

Employers also have a duty of care towards their employees, both paid and unpaid, under the Health and Safety at Work Act 1974. This requires them to provide a safe working environment for adults and provide guidance about safe working practices. Employers also have a duty of care for the well-being of employees and to ensure that employees are treated fairly and reasonably in all circumstances.

The Human Rights Act, 1998 sets out important principles regarding protection of individuals from abuse by state organisations or people working for those institutions. Adults who are subject to an allegation should therefore be supported and the principles of natural justice applied.

The Health and Safety Act 1974 also imposes a duty on employees to take care of themselves and anyone else who may be affected by their actions or failings. An employer’s duty of care and the adult’s duty of care towards children should not conflict.

To fulfil the requirements of the “Duty of Care” East Cheshire Trust’s policies and reflect the Guidance for Safer Working Practice for Adults who Work with Children and Young People (March 2009)

Detailed guidance on safe working practices for adults who work with children is available on the DCSF website at

http://webarchive.nationalarchives.gov.uk/20100202100434/dcsf.gov.uk/everychildmatters/resources-and-practice/ig00311/
The general principles to safeguard the service and staff and to ensure professional integrity whilst working to safeguard children are:

1. East Cheshire NHS Trust has LSCB safe recruitment and selection practices in accordance with Safe Recruitment – A Guide for NHS Employers (NHS Employers 2010) and should ensure that appropriate Disclosure & Barring Service (DBS) checks are undertaken for new staff and volunteers including registered translators who have contact with children and vulnerable adults.

2. A recruitment procedure that includes the use of standard application forms, references, interview procedure and applicant declaration.

3. East Cheshire NHS Trust has clear E safety policies and guidance in place about access to and the use of the internet.

4. The Trust promotes a culture of listening and engaging in dialogue with children, seeking children’s views in ways that are appropriate to their age and understanding.

5. We encourage staff to raise concerns either directly or if they feel unable to do this through the Raising Concerns at Work’ (Whistleblowing) policy.

5. Ensuring the staff and managers follow procedures for managing allegations and concerns regarding the suitability of adults who work with children and young people in accordance with L.S.C.B. procedures for Cheshire and the guidance in Working Together to Safeguard Children 2013. Including having a nominated service manager who is the identified person to whom concerns regarding allegations of abuse against children are reported to in connection with his/her employment or voluntary activities. This is the Head of Children services.

6. Providing and monitoring access to training to safeguard children in accordance to the statutory guidance in Working Together to Safeguard Children 2015. (Safeguarding Children Policy, Mandatory Training Policy)

7. Ensure that all those involved in safeguarding work should have access to clinical supervision and peer review/support. Advice should also be available from Named and Designated professionals. Supervision should scrutinize and evaluate work and case records to include key decisions reached during supervision. (See East Cheshire Trust Safeguarding Children Supervision Policy)

7. Medical examination of a child should be done in the presence of a chaperone to safeguard the child and the doctor, to assist the doctor and to make the child feel more at ease. The chaperone should be an experienced member of staff who is familiar with procedures and the special aspects of these examinations. The parents or the social worker should not be used as chaperones. (Child Protection Companion, Royal College of Paediatrics and Child health 2006)
8. If there are language difficulties or communication difficulties it is essential that a formal interpreter service is used. Other family members are not suitable interpreters. It is good practice for formal interpreters to have child protection training (Child Protection Companion, Royal College of Paediatrics and Child health 2006, Working Together to Safeguard Children, Chapter 10, H.M. Government 2006)

10. Staff must NOT:

- Engage in rough physical games with children and young people in their care, this includes horseplay.

- Touch a child in an intrusive or sexual manner or make sexually suggestive comments even as a joke, or to cause or incite that child to engage in or watch sexual activity

- Do things of a personal nature that the child or young person can do for themselves (Gain consent from the child, young person or parent before carrying out care, refer to the Consent Policy)

- Invite a child or young person into their home unless the reason for this has been firmly established and agreed with parents/ carers and senior managers or the home has been designated by the organisation or regulatory body as a work place.

- Give gifts or rewards to children or young people unless this is part of an agreed policy for supporting positive behaviour or recognising particular achievements. In some situations, the giving of gifts as rewards may be accepted practice for a group of children, whilst in other situations the giving of a gift to an individual child or young person will be part of an agreed plan, recorded and discussed with senior manager and the parent or carer.

- Communicate with children in a way that may result in possible misinterpretation of their motives or any behaviour which could be construed as grooming. They should not give their personal contact details to children and young people including email, home or mobile telephone numbers, unless the need to do so is agreed with senior management and parents/carers. E-mail or text communications between an adult and a child young person outside agreed protocols may lead to disciplinary and/or criminal investigations. This also includes communications through internet based web sites.

- Seek to have social contact with them or their families, unless the reason for this contact has been firmly established and agreed with senior managers. Where social contact is an integral part of work duties, e.g. pastoral work in the community, care should be taken to maintain appropriate personal and professional boundaries. This also applies to social contacts made through interests outside of work or through the adult's own family or personal networks.

11. Staff Must

- Be aware of the need to listen to and support children and young people, they must also understand the importance of not promising to keep secrets.
Neither should they request this of a child young person under any circumstances.

- Ensure they take care to ensure they are dressed appropriately for the tasks and the work they undertake in line with Cheshire East Cheshire NHS Trust Uniform Policy

- If a member of staff becomes aware that a child or young person is developing an infatuation, or where a child seeks or initiates inappropriate physical contact with a staff member this must be discussed this at the earliest opportunity with a senior manager or parent/carer so appropriate action can be taken to avoid any hurt, distress or embarrassment

- Ensure that children are not exposed to unsuitable material on the internet and ensure that any films or material shown to children or young people are age appropriate

- Follow Trust guidelines on IT usage

- Working with children and young people may involve the taking or recording of images. Any such work should take place with due regard to the law and the need to safeguard the privacy, dignity, safety and well being of children and young people. Informed written consent from parents or carers and agreement, where possible, from the child or young person, should always be sought before an image is taken for any purpose.

Ref: Guidance for Safer Working Practice for Adults who Work with Children and Young People (March 2009)

Detailed guidance on safe working practices for adults who work with children is available on the DCSF website at http://www.childrenengland.org.uk/upload/Guidance%20.pdf
## Appendix 2

### CSE (BICHARD) CHECKLIST

What to be alert to when discussing sex with young people
Should you tell the police and social services? Do any of the following apply:

| ☐ Is the Child under 13yrs of age. **Always discuss with ChECHS (Children’s Social Care)** |
| ☐ Age or power imbalances |
| ☐ Overt aggression, Low mood/ self-harm |
| ☐ Coercion or bribery |
| ☐ Injuries/bruises that are unexplained or not consistent with the explanation |
| ☐ The misuse of substances as a dis inhibitor |
| ☐ Does the child's own behaviour, because of the misuse of substances, place him/her at risk so that he/she is unable to make an informed choice about any activity? |
| ☐ Has any attempt to secure secrecy been made by the sexual partner, beyond what would be considered usual in a teenage relationship? |
| ☐ Is the sexual partner known by one of the agencies (NB. police)? |
| ☐ Does the child deny, minimise or accept concerns? |
| ☐ Are the methods used consistent with grooming? |
| ☐ Concerns about the presentation eg, time of day/night, Who are they with? |

Where there are concerns that a young person is being sexually exploited or where a criminal offence is taking place, then a consultation with children’s social care must take place.
# Working with under 16s: Seeking Sexual Health Advice

## FRASER GUIDELINES
Workers may give contraceptive advice and condoms to under 16s provided they are satisfied that the young person is ‘Fraser competent’:

- ☐ Understands the worker’s advice and has sufficient maturity to understand what is involved in terms of the moral, social and emotional implications.
- ☐ Has been encouraged to inform parent/carer
- ☐ Is likely to begin, or to continue having, sexual intercourse with or without contraceptive advice and/or condoms
- ☐ Without contraceptive treatment the young person’s physical or mental health or both would be likely to suffer.
- ☐ Providing advice and/or condoms (without parental consent) is in young person’s best interest

## BICHARD CHECKLIST
What to be alert to when discussing sex with young people

Should you tell the police and social services? Do any of the following apply:

- ☐ Is the Child under 13yrs of age. Always discuss with the Consultation team
- ☐ Age or power imbalances
- ☐ Overt aggression
- ☐ Coercion or bribery
- ☐ The misuse of substances as a dis inhibitor

- ☐ Does the child’s own behaviour, because of the misuse of substances, place him/her at risk so that he/she is unable to make an informed choice about any activity?
- ☐ Has any attempt to secure secrecy been made by the sexual partner, beyond what would be considered usual in a teenage relationship?
- ☐ Is the sexual partner known by one of the agencies (n.b. police)?
- ☐ Does the child deny, minimise or accept concerns?
- ☐ Are the methods used consistent with grooming?
Appendix 4

EAST CHESHIRE TRUST
THE PROCESS FOR UNDERTAKING A COMMON ASSESSMENT CAF/TAF

The Practitioner identifies child/young person has an additional need

Discuss identified need with the children/young person and/or their family as appropriate

During the discussion gain consent to complete the common assessment and to sharing information

Contact CAF/TAF co-ordinator to see if CAF already in place

Complete common assessment with the child/young person and/or their family as appropriate Use CAF/TAF form

Agree next steps with the family and record these on the delivery plan of the common assessment form

C – Assessment indicates additional support is required and multi-agency support is required

CAF/TAF review meeting convened

Services and actions initiated

Regular review and update of action plan

A – Assessment indicates no additional support is required. Current support with universal services can meet the needs of the child/young person. Agree no further action is required

B - Assessment indicates additional is required from another agency, single agency or service. Liaise with agency regarding provision of

If unclear whether a common assessment is required complete the pre-assessment checklist with the child/young person and/or their parent as appropriate

Check if there is an existing or previous common assessment

Check if a Lead Professional is already working with the family

If there is a CAF/TAF or Lead Professional identified contact the relevant practitioner

As part of the assessment contact other practitioners working with the family to discuss needs and share relevant information – based on consent given

Inform the family of these discussions

Agree with the child/young person and/or their the content of the assessment

Lead Professional is identified

Action plan is written and agreed

Review date is set

CAF is sent to the CAF support team at Sandbach House, 36 Crewe Road CW11 4NE

Copy of TAF is sent to the TAF mailbox

Copy of CAF filed in child’s records.
Flowchart for DNA and No Access Visits

NB: Record actions at each stage

1\textsuperscript{st} DNA/NO ACCESS VISIT

ASSESS REASON

MINIMAL RISK

Assess level of risk
(Consider the use of CAF
Assessment Framework
and or the CAF Pre-
assessment – Appendices
11 and 12)

RISK

HIGH RISK
Inform Line Manager. Refer to Social Care

LOW RISK
Send letter to Parents/liaise with referrer

2\textsuperscript{nd} DNA/NO ACCESS VISIT

ASSESS POSSIBLE RISK

MINIMAL RISK

No further appointment or
2\textsuperscript{nd} appointment/contact
depending on individual service specification.

HIGH RISK

LOW RISK

Assess level of risk

Inform Line Manager. Refer to Social Care

Send 2\textsuperscript{nd} letter to Parents –

3\textsuperscript{rd} DNA/NO ACCESS VISIT

ASSESS POSSIBLE RISK

MINIMAL RISK

No further appointment or
3\textsuperscript{rd} appointment/contact
depending on individual service specification. Liaise with referrer.

- Liaise with other agencies and referrer.
- Liaise/refer to Social Care if necessary.
- Inform manager of outcome.
- A meeting may be required.
- Keep GP informed.
- Letter to parent/carer and/or continue to try to access opportunistically.
ADMISSION OF A CHILD TO HOSPITAL

The ‘Children Act’ (2004), Carlile Review (2002) and Every Child Matters (2003) classify a child as up to the age of 18 years. This is not to say they should be accommodated within children’s wards but when 16-18 yr olds are admitted to the Hospital staff should be aware that there may be ongoing Child Protection issues relating to these young people and liaison with the Named Professionals within the Trust should be made relating to the admission of such young people where safeguarding concerns are identified.

PRINCIPLES OF CARE FOR WHEN A CHILD IS ADMITTED TO HOSPITAL AND ABUSE IS SUSPECTED

1. Medical conditions must be treated as a priority. The child, parents and carers must be afforded the same degree of sensitivity and respect as any other.

2. If English is not the family’s first language or the child requires additional support to be able to communicate and understand effectively then an appropriate interpreter or form of communication must be used. A source of interpreter should be identified by the trust.

3. Where a child has been treated at another hospital, those records should be obtained as soon as possible.

4. Details of the child including general practitioner and current school should be recorded in the child/young person’s medical/nursing notes.

5. Where child abuse is suspected, the admitting Consultant should be notified as soon as possible. If the admitting Consultant is not a Paediatrician then a referral should be made by the admitting Doctor to the on call Paediatrician and the child should be admitted jointly under the care of the Speciality Consultant and the Paediatrician. The Consultant Paediatricians role will be to ensure that appropriate guidance and management of the safeguarding Concern. This applies to all children under the age of 18yrs.

6. A full history and physical examination should be taken and recorded in an agreed form as soon as possible and within 24 hours unless there is a reason to delay, which has been recorded in the child/young person’s medical/nursing notes.

7. The examining doctor should consider taking a history directly from the child, if appropriate, even if parental permission is not forthcoming. The Responsible Consultant should make this decision.

8. If there are differences of opinion regarding the cause of harm to a child (for instance between doctors or nursing staff) this should be recorded in the medical/nursing record. The matter must be referred to the Named Professionals. If differences persist, the Designated Professionals should also be consulted. Any health professional with continuing concern should be able to raise concern with the Named/Designated Professionals.
8. No child/young person about whom there is concern should be discharged from hospital without the permission of the Consultant Paediatrician or Named Professional. This Policy should be read in conjunction with East Cheshire Trust Hospital Discharge Policy

9. A check to ascertain whether there is a child protection plan in place must be made before the child leaves hospital. This information is available through the Children's social services ChECS (Cheshire East Consultation Service) or the EDT (Emergency Duty Team) out of hours. See Guidance 12

10. Any concerns about a child at risk or a child’s welfare must be referred to Social Services according to the LSCB procedures and a documented plan of care agreed. For guidance see What to do if you have concerns about the Welfare of a Child Flowchart Appendix 13

11. If referral to social care is deemed necessary, a telephone referral to the ChECS (Cheshire East Consultation Service) team must be followed up with a completed referral form within 48 hours. Social Care should then be contacted in 72 hours to ensure that the referral has been received and to discuss social cares response. Referral forms must be photocopied and filed in the child’s records.

12. Future care plans must be agreed taking into account any information received from other Agencies or Health Personnel and evaluated by the responsible Consultant.

13 All cases of an infant/child death up to 18 years of age must be referred to the named professionals in line with Cheshire LSCB procedures.

When a child is referred to the Hospital for possible Child Abuse

Cases of possible child abuse referred by the Police, Social Services and/or other health professionals should be referred directly to the Consultant Paediatrician on call. Arrangements will be made as appropriate for the child to be seen in Paediatric Outpatients or the Children's ward, it is usual practice for the child to be accompanied by a Social Worker. The Trust Safeguarding Documentation should be used.

Discharge of a Child against Medical Advice

For Guidance regarding parents/guardians wishing to take their child’s discharge against medical advice where there are Safeguarding issues, see the East Cheshire Trust Hospital Discharge Policy

The Process for the Transfer of a Child from Hospital to Hospital when there is a Safeguarding Concern.

Transfer documentation must be completed that ensures that Nursing and Medical staff at the receiving Hospital is aware of the Safeguarding concerns and any ongoing support that the child/family are receiving. This may include information about CAF, Lead Professional, any Child Protection Plan and Named Social Worker.
This information should also be transferred via a telephone conversation with the receiving Medical and Nursing Staff.

If the child is an inpatient then the Senior Nurse must be informed.

The Nurse for Safeguarding Children at the receiving Trust must be informed.

The Paediatric Liaison Health Visitor must also be informed so that she can inform the local area Health Visitor and the liaison Health visitor in the receiving area.

The child’s Named Social Worker must also be informed.

If there is no current social care involvement and there is a Child Protection concern then a referral to social care must be made in line with ECT and LSCB Procedures.

All phone conversations must be documented in the patient notes and copies of referrals and transfer documentation filed in the patient’s records.

**Process for when a child is to be removed from the Hospital by Social Care into Foster Care.**

Regular contact should be maintained between the Named Nurse for Safeguarding Children and the Named Social Worker to ensure a safe and orderly handover of care.

In the case of a newborn Social care will be informed of the delivery of the baby by the midwife as soon as possible in order to initiate plans for the transfer of care.

Contact between Mother/Father will be allowed at all times if this is not considered to expose the baby /child to further Risk. In such cases contact will have to be supervised and agreed by Social Care.

If the child is a newborn then duplicate mementoes, cot cards, foot prints and identification bracelets should be made for use in the future if required.

Arrangements will be made for the Social Worker to attend the ward to discuss discharge planning with the mother and the medical and Nursing Staff.

When visiting the ward the Social Worker should introduce themselves on each occasion and show identification to the Nursing Staff prior to visiting Mother/Father and Child.

The Social Worker will provide details of the baby’s discharge address to the Nursing/Medical staff including foster carers names and, if possible, General Practitioner details.

It will be viewed as positive if the foster carers are able to visit the Child prior to discharge. This contact can be arranged through the named Social Worker.

On discharge the name of the Social Worker collecting the baby should always be known in advance and the Social Worker must present appropriate identification.

If foster carers are collecting the baby they should normally be accompanied by the Social Worker. Where this is not possible, prior notification will be provided to the
Nursing/Medical Staff with details of the foster carer. Identification **must** be produced on arrival.

A convenient date and time for the discharge of the baby should be agreed between the Nursing/Medical Staff and Social Worker.

Following discharge the Named Nurse for Safeguarding must be told of discharge details so that the Named Nurse for the area to which the baby has been transferred to can be made aware, and The Looked after Children's Nurse can be informed.

The Paediatric Liaison Health Visitor must also be informed so that the local Health Visitor can be informed.

If the child is being discharged from the Maternity Unit then the discharging Midwife must inform the Midwife in the area the baby is being transferred to of the baby's Address and the foster Cares details.

Midwifery care for the baby will continue in the home of the foster parents until hand over of care to the health visitor.

**Process for Children who spend more than 3 months in hospital**

Children who spend more than 3 months in hospital should be referred to Social Care, to trigger an assessment under the framework for the assessment of children in need and their families and to follow up their welfare needs. A telephone referral to the ChECS (Cheshire East Consultation Service) I-ART (Cheshire West Integrated - Assessment and Referral Team) must be followed up with a completed referral form within 48 hours. Social Care should then be contacted in 72 hours to ensure that the referral has been received and to discuss social cares response. Referral forms must be photocopied and filed in the child's records.

The Safeguarding Team must be informed so that the Clinical Commissioning Group can be notified via the Designated Nurse.
Bruising in Children who are not Independently Mobile

*Children who don't Cruise don't Bruise*

This Guidance provides all professionals with a knowledge base and awareness of their responsibilities in relation to children who are not independently mobile presenting with bruising or other suspicious marks.

Children with disabilities who are not mobile should also be considered within this guidance.

**KEY MESSAGES:** see also [http://www.core-info.cf.ac.uk/bruising](http://www.core-info.cf.ac.uk/bruising)

- Bruising is the commonest presenting feature of physical abuse in children.
- The younger the child the higher the risk that the bruising is non-accidental, particularly when the child is under 6 months old.
- Bruising in any child ‘not independently mobile’ should raise suspicion of maltreatment.
- Even apparently minor bruising may be an indicator that the infant or child is at risk of serious harm.
- There may be an underlying medical problem that will need attention.

**Children who don't Cruise don't Bruise**

**RECOMMENDED ACTION:**
For the majority of cases a referral to Social Care will be required. The child’s parents / carers should be informed* of the existence of this guidance and the reasons for the referral made clear.

Transfer to a Hospital is a priority if the child is obviously unwell and should be arranged via emergency ambulance where appropriate.

It is recognised that a small percentage of bruising in pre-mobile babies will have an innocent explanation or a medical cause. Nevertheless, because of the difficulty in excluding non-accidental injury, it is recommended that professionals seek advice immediately from Children’s Social Care and / or a consultant paediatrician.

These situations do need careful and detailed assessment and if the child is not referred, the person making that decision must take regard of:

1. Their competence to assess in this arena
2. The history of the injury
3. The fact that a full examination of the child is a requirement
4. The fact that there should be an assessment of the child’s circumstances and safety

Having considered all these, if a competent professional is confident to exclude Non Accidental Injury or underlying serious illness, then that decision and the reasoning should be clearly recorded in their notes. For all babies and non mobile preschool children the Health Visitor must be informed of the incident and decision.
MEDICAL ASSESSMENT

1. A bruise should never be interpreted in isolation and must always be assessed in the context of medical and social care history, developmental stage and the explanation given. The examining medical practitioner should obtain relevant information from all available sources e.g.: health visitor, GP, health records, social services, nursery etc.

2. A full clinical examination of the whole body of the child or young person should be undertaken. Haematological and biochemical studies including a clotting screen may be necessary to identify possible medical causes contributing to bruising. It is important to remember that a medical condition predisposing to bruising does NOT exclude the possibility of non-accidental injury.

3. Any child under 2 years presenting with unexplained bruising should have a full skeletal survey, including a CT Brain scan (see guidelines for requesting, repeating and reporting on skeletal surveys). Retinal examination by an experienced ophthalmologist is essential to exclude eye injury including retinal haemorrhages.

4. The potential need for a medical examination of all other children in the household should also be considered and discussed with Social Care as part of the assessment process.

Referrals to children’s social care are made by telephone to the ChECS (Cheshire East Consultation Service) in East Cheshire and the I-ART Integrated Assessment and Referral team) in West Cheshire. All referrals must be followed up with a completed referral form within 48 hours. Social Care should then be contacted in 72 hours to ensure that the referral has been received and to discuss social care response. Referral forms must be photocopied and filed in the child’s records.
**Appendix 8**

**PRINCIPLES OF CARE FOR WHEN A CHILD IS SEEN ACCIDENT AND EMERGENCY DEPARTMENT FOR WHO THERE ARE SAFEGUARDING CONCERNS**

(For AED Pathway see Appendix 6)

Children attending without referral or liaison with child protection concerns

In a medical emergency the needs of the child are paramount, and medical intervention must take priority over any other action.

The triage nurse who assesses a child initially will inform the nurse in charge and the A/E doctor if there is a suspicion that the child has been or is at risk of abuse or neglect.

The investigation and management of a child about whom there are concerns must be approached in the same systematic and rigorous manner as would be appropriate to any other potentially fatal disease.

The nurse or allied health professional will continue to manage the care of the child and family (including any siblings who may be present), under the supervision and co-ordination of the nurse in charge of Accident and Emergency Department.

The nurse in charge will take the appropriate action following this policy to inform/liaise with the relevant professionals and agencies.

If a nurse, allied health professional or doctor suspects, receives an allegation or disclosure, or has evidence of child abuse or neglect, the concern must be discussed with the senior A&E doctor with a view to refer to social care. The paediatrician on call is available for advice but only social care can refer a child for a "child protection examination" and the process starts with the emergency department referring to social care. If there is some concern about bruising vs medical cause that should be discussed with the paediatric consultant on call (please also refer to appendix 6 bruising in non-mobile infants).

If a child has a genital injury which is thought to be accidental, a senior A&E doctor should initially examine the child. If there are Safeguarding concerns then the child must be discussed with the on call Paediatrician. The paediatrician on call will examine the child if it suspected that there is an accidental injury but if there is a specific disclosure or accusation of sexual abuse the referral should be to children’s social care and they will arrange a child sexual assault examination at the SARC.

In a case of suspected deliberate harm the examining doctor should consider taking a history directly from the child. In the cases where English is not the child’s first language, the use of an interpreter should be considered. However, this must only be done if it is in the best interests of the child. This should be well documented in the notes.

Any concerns about a child at risk or a child's welfare must be referred to Social Services according to the LSCB procedures and a documented plan of care agreed.
If referral to social care is deemed necessary, a telephone referral to the ChECS (Cheshire East Consultation Service) team must be followed up with a completed referral form within 48 hours. Social Care should then be contacted in 72 hours to ensure that the referral has been received and to discuss social cares response. Referral forms must be photocopied and filed in the child’s records.

While professionals should seek in general, to discuss any concerns with the family and, where possible, seek their agreement to making referrals to Social Services, this should only be done where such a discussion will not place a child at increased risk of significant harm.

**Special Register in Accident and Emergency Department.**

Children who have a child protection plan or a Child Sexual Exploitation Plan in place in the Cheshire East area, or have been discussed at the Child Sexual Exploitation Operational meeting and are considered to be vulnerable to CSE will be highlighted on the Special Register in Accident and Emergency. Children who are frequent attenders at MDGH AED, or who have been discussed at the Multi Agency Risk Assessment Conference (MARAC) in relation to Domestic Abuse will be also be highlighted on the Special Register in Accident and Emergency.

Children living in other local authority social services areas will not have this facility. Therefore it is important not to assume that if they are not highlighted on the special register that the child is not at risk. There are more children at risk whose names are not on the register than on the register.

**If a child is recorded as having a Child Protection Plan in place**

- This should be reported to the doctor or ENP dealing with the case, as a significant family factor.
- If a child has a Child Protection Plan or a CSE Plan even if there are no safeguarding concerns in relation to this presentation Children’s Social care must still be informed of the child’s attendance. Staff should document who the child has attended the department with so that this information can be shared with the social worker
  - Should there be any child protection concerns on attending the A&E department then the guidance within this policy must be followed and Children’s social care must be informed
  - Where a child is flagged as being vulnerable to Child Sexual Exploitation information about this attendance must be shared with Children’s social care and the Safeguarding team. Staff should document who the child has attended the department
  - The nurse in charge must ensure that the Named Nurse for Safeguarding Children and the Liaison Health Visitor are informed of all children on the Special Register attending the A&E department, regardless of whether there have been child protection concerns.

**When an adult attends A&E with physical injuries, which are suspected to be inflicted personally or by another person or where there are concerns around substance misuse**
Staff must ask if any children live with them. If they do, then a referral must be made to the Liaison Health Visitor and consideration must be given to a referral to Children’s Social Care if there are concerns for the welfare of the child.
Emergency Department Guidance for Child Protection

Child Protection Concern Triggered: e.g.
- Physical Injury
- Neglect
- Sexual Abuse/assault/CSE
- Emotional Abuse (e.g. domestic violence)
- Carer incapacitated

If you have a serious concern about a child, and the carers threaten to take him away from the department before an assessment can be completed immediately discuss with the most senior Doctor available in the department.

Clinician to assess child and ensure they are receiving appropriate medical treatment. Must discuss with senior ED Doctor (Middle Grade or Consultant) and refer to children's social care or discuss with paediatric Middle Grade or Consultant as appropriate.

NB. Carefully document all communications. Sign and print name clearly.

Check whether the child is subject to a Child Protection Plan by checking CP-IS or telephoning Social Care. A positive CP-IS alert on the ED card means the child has CPP or CSE plan or is a Looked After Child (LAC). However, the absence of a CP-IS alert does not mean the child does not have a CPP or is a LAC. Triggering the CP-IS automatically informs Social Care that the child has attended ED. If concerns are raised due to this ED attendance then the SW should be contacted. For children with no CPP, and an SR alert means that there are safeguarding concerns registered on the PAS system. A receptionist will be able to access this information for you.

NB it is good practice to inform parents of referrals unless it is thought to put the child at a further risk – discuss with senior doctor.

SOCIAL CARE REFERRALS – DISCUSS WITH SENIOR ED NURSE OR DOCTOR
- Telephone the children’s social care Consultation Team or Child’s Social Worker if known
- Complete a MULIT AGENCY REFERRAL FORM and EMAIL to Children’s Social Care and copy to the safeguarding team. Ecn-tr.safeguardingmacclesfield@nhs.net
- Ensure all information including siblings is documented

LIAISON HEALTH VISITOR BOOK MUST BE COMPLETED

NB Ensure good communication with Primary Care by completing discharge letter immediately. Telephone contact with GP may also be required. Advice or feedback of cases is available from the Safeguarding Team 01625 661774. For further contact details for advice please see Trust “What To Do If You’re Worried A Child is Being Abused”. Referral Pathway
Appendix 10

Process for Children Attending Hospital Who Are Not Registered With a GP - or For When a Health Visitor or School Nurse becomes aware that a child is residing in this area who is not registered with a GP

If a child is not registered with a GP the parents/guardians should be advised to register the child immediately. Information regarding GPs accepting patients can be found on www.nhs.uk

Further assistance with the allocation of a GP can be provided by the FHSA Registration Department 01244 650 400

Hospital
If there are safeguarding concerns the child must not be discharged from Hospital until a GP has been allocated to the child.

The child's details will be shared with the Liaison Health Visitor who will share these details with the appropriate Health Visiting or School Nurse team so that the child can be followed up in the community and the Health Visitor/School Nurse can liaise as appropriate with any agencies involved.

Where there are no safeguarding concerns the child’s details will be shared with the Liaison Health Visitor who will share these details with the appropriate Health Visiting or School Nurse team.

Community
The health Visitor will contact the family to follow up that they have registered with a GP. If the family has moved to the area the Health Visitor will arrange a “Transfer in Visit” and request the Child’s child health records. If the family continue not to register with a GP or safeguarding concerns are raised advice should be sought from the Safeguarding Team.

The School Nurse will check the Child’s educational status. If the child’s educational status is not known and the child is not registered with a GP then the School Nurse will contact the family. If the child is new to the area the School Nurse will request the Child’s child health records. Where safeguarding concerns arise the school nurse will contact the safeguarding team and the Educational Welfare Officer as appropriate. (See Guidance 5)
Appendix 11

MATURETY SAFEGUARDING PRINCIPLES

1. The relationship that midwives foster with women provides an opportunity to observe attitudes towards the developing baby and identify potential problems during the pregnancy, birth and the child’s early care.

2. A holistic assessment of the mother should be undertaken, taking into account family and environmental factors, lifestyle choices, parenting capacity, the possible impact on the health and developmental needs of the unborn child or of any previous children. (Framework of Assessment – DOH 2000). This assessment should include any information from other agencies working with the family including the GP.

3. It is estimated that a third of domestic abuse starts or escalates in pregnancy; therefore every woman should be given the opportunity to have a private consultation with a midwife so that issue of abuse can be raised in a supportive and enabling environment.

4. To facilitate the assessment process and to enable disclosure of sensitive information where the woman’s first language is not English an interpreter as identified by the Trust must be used.

5. When the midwife identifies special circumstances/concerns they must commence a special circumstances form on the maternity shared drive. A copy the special circumstances form needs to be printed out and filed into the woman’s medical records and another copy sent to the woman’s named GP. Where there are safeguarding concerns raised the Named Midwife for Safeguarding Children must be notified using the Safeguarding Notification form. (See appendix 12) The Special Circumstances Form is to facilitate effective communication about any circumstances that may affect the women’s capacity to provide a safe/adequate environment for her baby and to detail any plans made throughout pregnancy and following delivery for ongoing care to minimize risks. The lead midwife taking the key responsibility would usually be the Team leader.

6. It is every midwives responsibility to update the Special Circumstances Form contemporaneously following each contact for the continuum of the maternity care.

7. On identifying concerns, liaison should take place with Health visitor, FNP, GP, Social Care and any other agencies as appropriate.

8. Supervision should be arranged with the Named Midwife for Safeguarding Children so that safeguarding issues can be discussed and a plan put in place.

9. The outcome may not always necessitate a referral to social care. It may be that the additional support can be met by the universal services. If additional support is being provided or required from specialist agencies then undertaking a CAF assessment should be discussed with the client. Where a CAF is undertaken the CAF process must be followed. (See appendix --). The CAF must be copied to the Named Midwife for Safeguarding Children and...
consent gained to share with the Health Visitor, GP to facilitate information sharing and working together. Supervision should be sought with the Named Midwife where safeguarding concerns have been highlighted to facilitate a CAF review meeting.

10. All young mothers (18 years of age and below) should be routinely offered a CAF to assess if there are any unmet not only for the unborn baby but also for themselves.

11. Where Clients require “Targeted” support from universal services but do not meet the requirements for a CAF or for those clients who have not consented to the CAF process where there are not safeguarding concerns should be offered a joint antenatal visit with the midwife and the Health Visitor so enhanced support can be put in place.

12. If referral to social care is deemed necessary, a telephone referral to the ChECS (Cheshire East Consultation Service) team must be followed up with a completed referral form within 48 hours. Social Care should then be contacted in 72 hours to ensure that the referral has been received and to discuss social cares response. Referral forms must be photocopied and filed in the child’s records and copied to the Named Midwife for Safeguarding Children and supervision must be sought. A referral to the Vulnerable Families Midwife (VFM) should also be undertaken (see Referral to the Vulnerable Families Midwife below)

13. Referral Criteria to Vulnerable Families Midwife

- There has been a previous unexpected or unexplained death of a child whilst in the care of either parent.
- A parent or other adult in the household is a person identified as presenting a risk, or potential risk, to children. This may be due to domestic abuse, violence, substance/alcohol abuse, mental health or learning difficulties.
- Children in the household / family currently subject to a child protection plan or previous child protection concerns.
- A sibling (or child in the household of either parent) has previously been removed from the household temporarily or by court order.
- Where there are serious concerns about parental ability to care for the unborn baby or other children.
- Where there are maternal risk factors e.g. denial of pregnancy, concealed pregnancy, avoidance of antenatal care (failed appointments), non-co-operation with necessary services, non-compliance with treatment with potentially detrimental effects for the unborn baby.
- Where female genital mutilation is disclosed or identified.
- Where there are concerns around child sexual exploitation.
- Any other concern exists that the baby may be at risk of significant harm.

14. The Vulnerable Families Midwife (VFM) role is to caseload all unborn's currently on a Child in Need or a Child Protection Plan. Complex CAF’s with any potential safeguarding concerns will also be case loaded by the Vulnerable Families Midwife at her discretion. As well as providing Antenatal and Postnatal care for her caseload the VFM will plan, sign-post and co-
ordinate multi-agency involvement with the woman to ensure the health and development of their babies.

15. If social care are involved then the LSCB Multi Agency Pre - birth Assessment Pathway must be followed. Midwifery team leaders must prioritise the attendance at Child in Need, Core Group and Child Protection Case Conference meetings in the absence of the Vulnerable Families Midwife attendance. Midwifery Team Leaders, the Antenatal Clinic Manager and the Vulnerable Families Midwife will have 3 monthly supervision from the Named Midwife for Safeguarding Children.

16. When arranging CAF review meetings or antenatal planning meetings these must be arranged with the client in plenty of time for her to make arrangements to attend and bring someone to support her if desired.

17. It is the responsibility of the birth notification midwife to file in the baby’s records any case conference reports, Decisions and recommendations, Child Protection Plan, planning meeting reports or CAFs completed following delivery to facilitate information sharing. This will alert staff on further admissions to the hospital that there have been concerns identified and of any agencies involved.

18. Following the discharge of a mother and baby at 28 days where there have been Safeguarding concerns’ raised, a discharge planning meeting held or a CAF completed a summary of the postnatal period should be sent to the Health Visitor, GP and any other agencies involved in providing support to the family. For Summary Letter see appendix 13

It is also the responsibility of the discharging midwife to print off the completed Special Circumstances Form and to file in the Clients hospital records. The electronic copy should then be deleted from the maternity shared drive.

Following the Concealment of a Pregnancy.

See Guidance 8

A concealed pregnancy is when a woman knows she is pregnant but does not tell anyone or those who are told conceal the fact from all caring and health agencies. Consideration should also be given if a woman appears genuinely not aware that she is pregnant. Concealment may be an active act or a form of denial where support from appropriate carers and health professionals is not sought. In exceptional cases the mother may not reveal the delivery and may conceal the baby even if it has died.

Concealment of pregnancy may come to light late in pregnancy, in labour or following delivery. The birth may be unassisted whereby there are additional risks to the child and mother’s welfare and long-term outcomes.

For the purpose of this document, late booking is defined as presenting for maternity services after 24 weeks of pregnancy.

This Guidance should be read in conjunction with the LSCB policy for the Management of Concealed Pregnancy
Appendix 12

Referral Pathway to the Vulnerable Families Midwife (VFM)

Team Midwife identifies any cause for concern in the antenatal, intrapartum or postnatal period

Team Midwife to fully complete a Cause for Concern Form and save on the Maternity Shared Drive. The front cover of the Cause for Concern Form should also be printed out on Orange Paper and filed in Maternal Hospital Records.

If following completion of the Pre-CAF assessment section of the Cause for Concern Form there is an indication for a CAF assessment, then the Team Midwife has the responsibility to complete this.

If the concern is current domestic abuse then the Team Midwife will be expected to undertake a MARAC Risk assessment at the point of disclosure prior to referral to the VFM.

If Criteria for referral for vulnerable families Midwife are met:

For Criteria please see referral form

Complete the referral form and send via email or internal post within 48 hrs. ecn-tr.safeguardingmacclesfield@nhs.net

Internal mail should be sent to the Children’s Safeguarding Team, Arley Building, MDGH

The Vulnerable Families Midwife (VFM) will complete an Initial Assessment once a referral is received.

This assessment may include discussions with partner agencies therefore ensure that consent from the woman has been gained prior to referring to the VFM for these discussions to take place.

Following on from this initial assessment, if the threshold of need has NOT been met:

Inform Team Leader and manage under Team Midwifery

This Pathway should be used in conjunction with:

- Standard Operating Procedure for referral to the VFM
- Referral to the Vulnerable Families Midwife form
- ECNHST Safeguarding Children’s Policy/Domestic Abuse Policy.

Possible Outcomes:
- Active CAF with safeguarding elements
- Child In Need Plan
- Child Protection Plan
- Pre-Proceedings

If Criteria for Referral to Vulnerable Families Midwife are not met:

Inform Team Leader and manage under Team Midwifery

Following on from this initial assessment, if the threshold of need has been met then the referral will be accepted by the VFM. The Team Leader and Named Midwife will be informed.
# Notification to Safeguarding Midwife

<table>
<thead>
<tr>
<th>Women’s Details</th>
<th>This form is to be commenced at any point in the pregnancy or in the postnatal period when any safeguarding issues have been identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>The aim is to aid multidisciplinary communication and information sharing in line with Working Together and ECNHST Guidelines and Standards.</td>
</tr>
<tr>
<td>Number:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Telephone Number:</td>
<td></td>
</tr>
<tr>
<td>Consultant:</td>
<td></td>
</tr>
<tr>
<td>Midwifery Team/Footprint:</td>
<td></td>
</tr>
<tr>
<td>GP:</td>
<td></td>
</tr>
</tbody>
</table>

| Baby's details: | |
|-----------------| |
| Unborn Edd:     | Born Name & Dob |

<table>
<thead>
<tr>
<th>Safeguarding Issue Identified: (Please tick)</th>
<th>Referrals Made to other agencies: (Please tick)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs &amp; Alcohol misuse</td>
<td>• East Cheshire Children’s Social Care – Consultation</td>
</tr>
<tr>
<td>Domestic Abuse</td>
<td>• East Cheshire Children’s Social Care - Referral</td>
</tr>
<tr>
<td>Neglect</td>
<td>• MARAC RIC undertaken &amp;/or referred to MARAC/DAFSU</td>
</tr>
<tr>
<td>Previous/Current Social Care Involvement</td>
<td>• CAF Commenced</td>
</tr>
<tr>
<td>Mental Health Issue where Safeguarding concerns are identified</td>
<td></td>
</tr>
<tr>
<td>Poor engagement</td>
<td>Please send a copy of any referrals to the Named Midwife.</td>
</tr>
<tr>
<td>Late Booker</td>
<td></td>
</tr>
<tr>
<td>Concealed Pregnancy</td>
<td></td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td></td>
</tr>
<tr>
<td>Teenage Pregnancy</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Information Sharing</th>
<th>Further Notes or Identified Concerns:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification form to be filed in Maternal/Baby’s Records</td>
<td></td>
</tr>
<tr>
<td>Copy to be sent to:</td>
<td></td>
</tr>
<tr>
<td>Named Midwife for Safeguarding</td>
<td></td>
</tr>
<tr>
<td>Heather Millward</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Team</td>
<td></td>
</tr>
<tr>
<td>Silk House</td>
<td></td>
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<tr>
<td>MDGH</td>
<td></td>
</tr>
<tr>
<td>Or</td>
<td></td>
</tr>
<tr>
<td>e-mail <a href="mailto:h.millward@nhs.net">h.millward@nhs.net</a></td>
<td></td>
</tr>
</tbody>
</table>
# Summary Discharge Letter For Where There Have Been Safeguarding Concerns Raised in the Antenatal Period

<table>
<thead>
<tr>
<th>Clients Name</th>
<th>DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Date and type of Delivery</td>
</tr>
<tr>
<td>Baby's Name</td>
<td>Gravida/Parity</td>
</tr>
<tr>
<td>Midwifery Team</td>
<td>GP and Address</td>
</tr>
<tr>
<td>Health Visitor and Address</td>
<td>Social Worker and Address</td>
</tr>
<tr>
<td>Other Relevant Professionals</td>
<td>CAF Open/ Closed Name of Lead Professional and Address</td>
</tr>
</tbody>
</table>

**Reasons for requiring extra support**

**Summary of Postnatal period**

In line with statutory regulations the above woman will be/was discharged from midwifery care on the -------------------at ------------------days post partum

**Copied to:**  GP  HV  Social Worker  Family Support  Mental Health Team  
Drug and Alcohol Team.  CAF Team  School Health  Safeguarding Nurse  Other.

**Name and Signature of Discharging Midwife**  Date
What to do if you are worried a child is being abused

**PRACTITIONER HAS CONCERNS ABOUT CHILD’S WELFARE**

Practitioner discusses with the Safeguarding team, manager and/or other senior colleagues, as they think appropriate

- **Still has concerns**
  - Practitioner refers to Social Services via telephone and follows up with a completed referral form within 2 working days. All referrals must be copied to the Safeguarding team
  - Social worker and manager acknowledge receipt of referral and decide on next course of action within one working day
  - Combined assessment required
    - Concerns about the child’s immediate safety social care initiate section 47 procedures

- **No longer have concerns**
  - No further Child Protection action, although may need to act to ensure services provided
  - Feedback to referrer within 3 working days on next course of action.
    - If the practitioner has not had feedback they must contact Social Care to follow up outcome
  - No further Social Services involvement at this stage, although other action may be necessary, eg onward referral

**Out of Hours Duty Team**

- **East** 0300 123 5022
- **West** 01244 977277

**Cheshire Police**

Public Protection Unit
All calls via central referral line

0845 4580000

**Cheshire West & Chester Social Care**

Integrated Assessment and Referral Team

03001237047
I-ART@cheshirewestandchester.gcsx.gov.uk

**Cheshire East Social Care**

Consultation Service

0300 123 5012
checs@cheshireeast.gov.uk.cjsm.net

**Cheshire Police**

Public Protection Unit
All calls via central referral line

0845 4580000

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**Contact Information**

**Cheshire East Social Care Consultation Service**

0300 123 5012
checs@cheshireeast.gov.uk.cjsm.net

**Cheshire West & Chester Social Care Integrated Assessment and Referral Team**

03001237047
I-ART@cheshirewestandchester.gcsx.gov.uk

**Out of Hours Duty Team**

- **East** 0300 123 5022
- **West** 01244 977277

**Cheshire Police Public Protection Unit**

All calls via central referral line

0845 4580000

**Safeguarding Children Team 02/08/2016**
Equality Analysis (Impact assessment)

1. What is being assessed?

Safeguarding Children Policy

Details of person responsible for completing the assessment:

- Name: Mel Barker
- Position: Named Nurse for Safeguarding Children
- Team/service: Safeguarding Team

State main purpose or aim of the policy, procedure, proposal, strategy or service:

(usually the first paragraph of what you are writing. Also include details of legislation, guidance, regulations etc which have shaped or informed the document)

East Cheshire Trust as with all other NHS bodies has a statutory duty to ensure that it makes arrangements to safeguard and promote the welfare of children and young people that reflects the needs of the children they deal with.

In discharging these statutory duties/responsibilities account must be taken of statutory guidance on making arrangements to safeguard and promote the welfare of children under Section 11 of the Children Act 2004. (HM Government 2007); Working Together to Safeguard Children (HM Government March 2015); Statutory Guidance on Promoting the Health and Wellbeing of Looked after Children (DH March 2015); When to suspect child maltreatment (NICE Guidance July 2009); Looked after Children (NICE Guidance 28 October 2010) and the policies and procedures of the Local Safeguarding Children Boards (LSCB’s). Information sharing - Advice for practitioners providing safeguarding services to children, young people, parents and carers (HM Government March 2015)

This policy is mandatory and should be read in conjunction with the:

East Cheshire Trust Safeguarding Supervision Policy

East Cheshire Trust Domestic Violence and Abuse Policy

Cheshire Local Safeguarding Children Boards web based Procedures which can be accessed via the Infonet or Pan Cheshire Policies and Procedures

http://www.proceduresonline.com/pancheshire/

Cheshire East Practice Standards


Cheshire West Child Protection and cared for Children practice Standards

This policy applies to all employees of the East Cheshire NHS Trust including Locum, Bank and Agency Staff and volunteers.

It is recommended that this guidance is used by independent contractors.

2. Assessment of Impact

**RACE:**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, racial groups differently? Yes □ No x□

Explain your response: This document has no negative impact on any groups as it applies to Safeguarding Supervision and case management in relation to all children who have been identified as vulnerable or requiring additional support due to safeguarding concerns. It is recognised that children from minority groups maybe more vulnerable therefore staff have access to equality and diversity training and staff who work with children and families receive annual training in Safeguarding Children. Staff will follow the trust interpretation policy as required.

_________________________________________________________

**GENDER (INCLUDING TRANSGENDER):**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, different gender groups differently? Yes □ No □x

Explain your response: This document has no negative impact on any groups as it applies to Safeguarding Supervision and case management in relation to all children who have been identified as vulnerable or requiring additional support due to safeguarding concerns. Staff have access to equality and diversity training and staff who work with children and families receive annual training in Safeguarding Children. There is a transgender support policy available in the trust.

_________________________________________________________

**DISABILITY**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, disabled people differently? Yes □ No x□

Explain your response: This document has no negative impact on any groups as it applies to Safeguarding Supervision and case management in relation to all children who have been identified as vulnerable or requiring additional support due to safeguarding concerns. Children with special needs may be especially vulnerable to abuse and neglect. Staff are trained in LD awareness and staff who work with children and families receive annual training in Safeguarding children.

_________________________________________________________
AGE:
From the evidence available does the policy, procedure, proposal, strategy or service, affect, or have the potential to affect, age groups differently?  Yes  □  No  □  x

Explain your response: This document applies to all children as identified in the Children Act 1989 and 2004, a child is anyone who has not yet reached their 18th birthday. All paediatric and paediatric allied staff receive annual training on communicating with children, including children with learning difficulties and disabilities. There is a range of materials and specially trained play therapists to support this.

LESBIAN, GAY, BISEXUAL:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, lesbian, gay or bisexual groups differently?  Yes  □  No  □  x

Explain your response: Staff have access to equality and diversity training and therefore would be sensitive to the needs of children or parents with different sexual orientations.

RELIGION/BELIEF:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, religious belief groups differently?  Yes  □  No  □  x

Explain your response: This document has no negative impact on any groups as it applies to Safeguarding Supervision and case management in relation to all children who have been identified as vulnerable or requiring additional support due to safeguarding concerns. Staff have access to equality and diversity training and staff who work with children and families receive annual training in Safeguarding children.

CARERS:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, carers differently?  Yes  □  No  □  x

Explain your response: This document has no negative impact on any groups as it applies to Safeguarding Supervision and case management in relation to all children who have been identified as vulnerable or requiring additional support due to safeguarding concerns. Staff have access to equality and diversity training and staff who work with children and families receive annual training in Safeguarding children.

OTHER:  EG Pregnant women, people in civil partnerships, human rights issues.
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect any other groups differently?  Yes  □  No  □  x

Explain your response:
This document has no negative impact on any groups as it applies to Safeguarding Supervision and case management in relation to all children who have been identified as vulnerable or requiring additional support due to safeguarding concerns.

3. Safeguarding Assessment - CHILDREN

| a. Is there a direct or indirect impact upon children? | Yes ☐ No ☐ |

b. If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual children. As well as consideration of impact now or in the future; competing / conflicting impact between different groups of children and young people: The purpose of this policy to help support staff to recognise when a child may be at risk of abuse and to take appropriate action. This policy could therefore be said to have a positive impact.

c. If no please describe why there is considered to be no impact / significant impact on children

4. Relevant consultation

*Having identified key groups, how have you consulted with them to find out their views and that the made policy, procedure, proposal, strategy or service will affect them in the way that you intend? Have you spoken to staff groups, charities, national organisations etc?*

Yes . The policy has been updated and all relevant staff groups have been consulted. The policy was reviewed at the Quarterly Safeguarding Assurance meeting

5. Date completed: 12/06/17 Review Date: July 2018

6. Any actions identified: Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact?

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Date to be Achieved</th>
</tr>
</thead>
</table>

7. Approval – At this point, you should forward the template to the Trust Equality and Diversity Lead lynbailey@nhs.net

Approved by Trust Equality and Diversity Lead: 

Date: 3.7.17