Safeguarding Children and Child Protection Policy

Version:	V3.0	
Summary:	The policy provides a framework for the identification and response to child abuse and neglect and is to be used as a reference point to inform professional decisions in specific situations. It must be read in conjunction with Local Safeguarding Children Partnership (LSCP) procedures.	
Ratified by	Policy Ratification Group	Date: September 2021
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Name of originator/author:	Head of Safeguarding	
Executive Director	Chief Nurse and Director of Clinical Quality and Professional Practice	
Name of responsible committee:	Safeguarding Committee	
Target audience:	This Policy applies to all colleagues, students and bank colleagues, contractors, temporary workers and other Third Parties (including volunteers/patients/clients)	
Date issued:	13th September 2021	
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Review and Amendment Log

Version No	Type of Change	Date	Description of Change
3.0	Full scheduled review		

Contents

1. Introduction

Locala Health and Wellbeing, hereafter known as Locala, provides a range of NHS funded services, that includes 0-19 and sexual health services, over a large geographical footprint across Kirklees, Bradford and Calderdale.

Locala has a statutory duty to safeguard and promote the welfare of children and young people (The Children Act, 2004). Section 11 of the Children Act (2004) places a legal duty on all providers of NHS health services, including social enterprises, to ensure that in discharging their functions, they have regard to the need to safeguard and promote the welfare of children.

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

Safeguarding children and young people is a multiagency activity and is dependent upon partnership working with other statutory and non-statutory agencies. This policy reflects the principles outlined in statutory guidance and is in accordance with safeguarding children policies and procedures of the following Local Safeguarding Children Partnerships:

Kirklees Safeguarding Children Partnership **Link**

Calderdale Safeguarding Children Partnership **Link**

Working Together to Safeguard Children - The Bradford Partnership **Link**

For the purposes of this policy, safeguarding and promoting the welfare of children is defined as:

- Protecting children from maltreatment;
- Preventing impairment of children's mental and physical health or development;
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and
- Taking action to enable all children to have the best outcomes.

(Working Together to Safeguard Children, 2018)

This policy applies to all children from unborn up to 18 years of age whether the children are users of Locala services in their own right, children cared for by other service users who are accessing our services or the children of Locala colleagues. It also applies to other children in the wider community that may come to the attention of Locala colleagues in the course of their work.

2. Purpose

The purpose of this policy is to ensure all Locala colleagues are compliant with statutory requirements to safeguard children. The policy provides a framework for the identification and response to child abuse and neglect and is to be used as a reference point to inform professional decisions in specific situations. It must be read in conjunction with Local Safeguarding Children Partnership (LSCP) procedures available @ http://westyorkscb.proceduresonline.com/index.htm

3. Target Population

This Policy applies to all colleagues, students and bank colleagues, contractors, temporary workers and other Third Parties (including volunteers/patients/clients)

Providers of services commissioned by Locala are expected to use this policy to inform their own safeguarding children practice and to review or develop their own policy accordingly.

4. Explanation of Terms

Child: a young person who has not yet reached their 18th birthday. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, in hospital or in custody in a secure estate for children and young people, does not change his/her status or entitlement to services or protection under the Children Act, 2004.

Child Abuse: is any action by another person, either adult or another child, which causes significant harm to a child. Children may be vulnerable to neglect and abuse or exploitation from within their family and from individuals they come across in their day-to-day lives. These threats can take a variety of different forms, including sexual, physical and emotional abuse; neglect; domestic abuse, including controlling or coercive behaviour; exploitation by criminal gangs and organised crime groups; trafficking; online abuse; sexual exploitation and the influences of extremism leading to radicalisation (full definitions and examples of each type of abuse can be found in Appendix A).

Child in Need: is defined under section 17 of the Children Act 1989. It relates to those children whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health or development will be significantly impaired, without the provision of services (Section 17(10), The Children Act, 1989). It includes disabled children. The critical factors to be taken into account when deciding whether a child is in need under the Children Act 1989 are:

- What will happen to the child's health or development if services are not provided?
- The likely effect that the services provided will have on the child's

standard of health and development

Child Protection is a part of safeguarding and promoting the welfare of children. It refers to that activity which is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm, as defined by in Section 47 of the Children Act 1989.

County Lines is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of 'deal line'. They are likely to exploit children and vulnerable adults to move and store the drugs and money and they will often use coercion, intimidation, violence (including sexual violence) and weapons (Home Office, 2018).

Female Genital Mutilation (FGM) is a procedure where the female genitals are deliberately cut, injured or changed, but there is no medical reason for this to be done. It's also known as **female circumcision** or cutting, and by other terms, such as sunna, gudniin, halalays, tahur, megrez and khitan, among others.

Looked after child/Child Looked After The term 'looked after children' is defined in law under the Children Act 1989. A child is looked after by a local authority if he or she is in their care or is provided with accommodation for more than 24 hours by the authority. Looked after children fall into four main groups:

- Children who are accommodated under voluntary agreement with their parents (section 20);
- Children who are the subject of a care order (section 31) or interim care order (section 38);
- Children who are the subject of emergency orders for their protection (section 44 and 46);
- Children who are compulsorily accommodated. This includes children remanded to the local authority or subject to a criminal justice supervision order with a residence requirement (section 21).

The term 'looked after children' includes unaccompanied asylum-seeking children, children in friends and family placements, and those children where the agency has authority to place the child for adoption. It does not include those children who have been permanently adopted or who are on a special guardianship order.

Missing in relation to child safeguarding is a term used when a child's whereabouts cannot be established and where the circumstances are out of character **or** the context suggests the child may be subject of a crime or is at risk of harm to themselves or others. Children who are reported as 'missing' will be actively searched for by the police, with a level of risk assigned to each case on police local authority databases.

Parental Responsibility (PR) is the legal rights, duties, powers, responsibilities and authority a parent has for a child and their property. A person who has PR for a child has the right to make decisions about their care and upbringing. Important decisions in the child's life, e.g. whether or not a child receives medical treatment **must be agreed with anyone who has PR.** The following people automatically have PR:

- The birth mother
- The father, if married to mother at the time the child was born
- The father, if not married to the mother but he is registered on the child's birth certificate, if the birth was registered after 2003
- Any civil partners of the mother registered as the child's legal parent on the birth certificate

Private Fostering is when a child under 16 (or 18 if disabled) is cared for by an adult, who is not a parent or close relative, where the child is to be cared for in that home for 28 days or more. Close relative is defined as "a grandparent, brother, sister, uncle or aunt (whether of the full blood or half blood or by marriage or civil partnership) or step-parent". In private fostering arrangements the parents retain full parental responsibility.

Significant Harm is harm, or a likelihood of harm, that is considered serious and is attributable to a lack of adequate parental care or control. There are no absolute criteria on which to rely when judging what constitutes significant harm. Sometimes a single violent episode may constitute significant harm but more often it is an accumulation of significant events, both acute and longstanding, which interrupt, damage or change the child's development. Consideration of the severity of the ill- treatment may include:

- The degree and extent of physical harm
- The duration and frequency of the abuse and neglect
- The extent of premeditation
- The presence or degree of threat
- Coercion

5. Duties

5.1 Individual colleagues

Colleagues are responsible for reading, complying with and maintaining up-to-date awareness of policies as laid down in job descriptions and contracts of employment and for undertaking training as appropriate to enable them to comply with policies relevant to their roles and as colleagues of Locala.

5.2 Managers

It is the responsibility of all line managers to ensure that they and the people they manage are conversant with this policy and its contents.

5.3 Responsible Committee

It is the responsibility of the safeguarding committee to monitor the implementation and effectiveness of this Policy.

5.4 Chief Executive

The **Chief Executive** has overall responsibility for the strategic and operational management of Locala including ensuring that the organisation's procedural documents comply with all legal, statutory and good practice requirements.

5.5 Chief Nurse, Director of Clinical Quality and Professional Practice

The Chief Nurse and Director of Clinical Quality and Professional Practice holds executive responsibility for safeguarding within Locala and is responsible for ensuring there are adequate safeguarding systems in place in order for Locala to meet its obligations to safeguard children and to ensure that there is a clear line of accountability and governance (See Appendix B).

5.6 Director of OD and People

The Director of OD and People is responsible for

- Ensuring that Locala has safe recruitment and speaking up (Freedom to speak up, raising concerns and whistleblowing) policies in place that comply with legal requirements and LSCP guidance
- Ensuring adherence to statutory guidance on disclosure and barring service
- Ensuring standard safeguarding responsibility statements are in all contracts.
- Ensuring reports for monitoring colleague compliance with safeguarding children learning requirements are produced and available to managers on a monthly basis.

5.7 Head of Safeguarding

The Head of Safeguarding holds responsibility for the overall strategic and operational management of Locala adult and child safeguarding arrangements and the safeguarding team to ensure that Locala meets its obligations under the Children Act 2004, Mental Capacity Act 2005 and Care Act 2014. Responsibilities include

- Membership of Kirklees and Calderdale Safeguarding Children Boards as delegated by the Director of Nursing, Allied Health Professionals and Quality
- The development and progression of safeguarding children work in Locala, in line with Government Safeguarding Children Policy and Legislation
- Ensuring that procedures, protocols, structures, systems and processes across all services are in place so that safeguarding activity is actively coordinated across Locala
- Ensuring appropriate use of available resources and that the required operational and quality safeguarding standards are achieved
- Ensuring learning from Safeguarding Practice review, Domestic Homicide Review and Learning Lesson findings are understood and embedded in professional practice.
- Provision of an annual safeguarding report for the Locala operational board and for commissioners.
- Provide robust leadership in the development of existing and new strategies, policies, protocols, pathways and action plans to strengthen the management of safeguarding services across Locala.
- Respond positively and professionally to any concerns raised associated with client safety, policies, processes and/or culture which impacts on the experience of colleagues and their potential to raise concerns.

5.8 Named Nurses

The Named Nurses have a key role in promoting good professional practice within the organisation which includes:

- Provision of expert advice when required for Locala colleagues
- Supporting Locala in its quality assurance role, by ensuring that audits on safeguarding are undertaken and that safeguarding issues are part of business unit meetings and other quality assurance systems and meetings as required.
- Attending adult and children safeguarding meetings and participation in the work of Local Authority safeguarding board subgroups.
- Working effectively in the Multi Agency Partnerships.
- Take the professional lead within Locala for conducting internal

case reviews with the support of other members of the safeguarding team as appropriate.

- Ensuring a programme of safeguarding learning opportunities and supervision is available for Locala colleagues.
- Take a lead in the development of robust internal safeguarding policies, guidelines and protocols.
- Respond positively and professionally to any concerns raised associated with client safety, policies, processes and/or culture which impacts on the experience of colleagues and their potential to raise concerns.

5.9 Safeguarding Practitioners

It is the responsibility of the safeguarding practitioners to:

- Take a lead in the delivery of learning opportunities that comply with the Intercollegiate Document; Safeguarding Children and Young People roles and competencies for health care staff (2019)
- Provide specialist safeguarding advice, support and guidance through training, supervision and advice calls to colleagues in Locala
- Contribute to the development of robust internal safeguarding/child protection policies, guidelines and protocols
- Contribute to safeguarding meetings and participate in subgroups of LSCPs as directed
- Support the Named Nurses with conducting internal reviews as appropriate.
- Support the Named Nurses and Head of Safeguarding in the delivery of the safeguarding agenda across Locala
- Respond positively and professionally to any concerns raised associated with client safety, policies, processes and/or culture which impacts on the experience of colleagues and their potential to raise concerns.

5.10 Named Doctor

The Named Doctor has a key role in promoting good professional practice within the organisation which includes:

- Working alongside the Head of Safeguarding and Named Nurses in promoting good safeguarding practice across Locala.
- Participation in LSCP subgroups as appropriate.

- Provision of advice and guidance to Locala medical colleagues and ensuring access to appropriate safeguarding children learning opportunities and supervision.
- Provision of support and advice to the Locala Board and Executive Management Group on medical safeguarding matters.
- Play a key role in ensuring medical registered practitioners across all Locala services and all other colleagues in Locala General Practices are up to date with recent legislation, national documentation, latest guidance, best practice and evidence based research in matters relating to safeguarding children.
- Respond positively and professionally to any concerns raised associated with client safety, policies, processes and/or culture which impacts on the experience of colleagues and their potential to raise concerns.

6. Safeguarding Children and Child Protection

6.1 General Principles

Effective safeguarding arrangements in every local area should be underpinned by five key principles: (Working Together, 2018).

A child centred approach is fundamental to safeguarding and promoting the welfare of every child. This means keeping the child in focus when making decisions about their lives and working in partnership with them and their families.

All practitioners should follow the principles of the Children Acts 1989 and 2004 – that state that the welfare of children is paramount and that they are best looked after within their families, with their parents playing a full part in their lives, unless compulsory intervention in family life is necessary.

Children may be vulnerable to neglect and abuse of exploitation from within their family and from individuals they come across in their day-to-day lives. These threats can take a variety of different forms, including; sexual, physical and emotional abuse; neglect; exploitation by criminal gangs and organised crime groups; trafficking; online abuse; sexual exploitation and the influences of extremism leading to radicalisation. Whatever the form of abuse or neglect, practitioners should put the needs of children first when determining what action to take.

Everyone who works with children has a responsibility for keeping them safe. No single practitioner can have a full picture of a child's needs and circumstances and, if children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking

prompt action.

In order that organisations, agencies and practitioners collaborate effectively, it is vital that everyone working with children and families, including those who work with parents/carers, understands the role they should play and the role of other practitioners. They should be aware of, and comply with, the published arrangements set out by local safeguarding partners.

6.2 Assessments

Practitioners working in both universal services and specialist services e.g. sexual health, children's expert team, have a responsibility to identify the symptoms and triggers of abuse and neglect, to share that information and provide children with the help they need.

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

To be effective, practitioners need to continue to develop their knowledge and skills in this area and be aware of the new and emerging threats, including online abuse, grooming, sexual exploitation, child criminal exploitation and radicalisation. Practitioners should also continue to develop their understanding of domestic abuse, which includes controlling and coercive behaviour from perpetrators of domestic abuse, and the impact this has on children.

Practitioners working with adults where safeguarding concerns may arise must identify and record at the earliest stage:

- The adult's relationship with any children.
- Any parenting or caring responsibilities for children.
- Which other agencies they need to work with if they have concerns about unborn babies, children or young people.

Colleagues should focus on conversations, assessments and plans where seeing and knowing about the day-to-day lived experience of the child are central; consider

- What is daily life like for the child?
- How is this situation impacting on them?

Assessment of risk outside the home (contextual safeguarding)

LSCP guidance on criteria for children's social care intervention is

accessible via the following links

Kirklees; Calderdale; Bradford

6.3 Early Help

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

All colleagues, including those in universal services and those providing services to adults with children, need to understand their role in identifying emerging problems and to share information with other professionals to support early identification and assessment.

An Early Help plan supports parents so that professionals can work together with them to make things better for the children. There must be a detailed closure summary documenting the reason for the closure of all Early Help plans, which must be available in the child/children's health record. In cases where there are ongoing concerns, and the early help plan has ended due to lack of parental compliance or withdrawal of consent, there must be a clear written process for what is to happen next e.g. refer to children's social care, school to monitor attendance for next month etc.

All professionals should be able to identify and respond early to the needs of **all** vulnerable children but should, in particular, be alert to the potential need for early help for a child who:

- Is disabled and has specific additional needs;
- Has special educational needs (whether they have a statutory Education, Health and Care Plan or not);
- Is frequently missing/goes missing from care or from home;
- Is at risk of modern slavery, trafficking or exploitation;
- Is at risk of being radicalised or exploited;
- Is a young carer;
- Is showing signs of engaging in antisocial or criminal behaviour, including gang involvement and association with organised crime groups;
- Is in a family circumstance presenting challenges for the child, such as substance abuse, adult mental health problems and domestic violence;
- Is misusing drugs or alcohol themselves;

- Has returned home to their family from care;
- Is a privately fostered child;
- Has a parent or carer in custody

Other factors that have been clearly established as placing children at an increased risk of abuse, neglect and exploitation include parents or carers who:

- Have a mental illness that is not adequately managed, including postpartum depression or psychosis.
- Are significantly misusing substances and/or alcohol.
- Experience/engaged in intimate partner violence.
- Have a history of criminal/antisocial behaviours.
- Lack knowledge about child development/developmental milestones or having unrealistic expectations about their children's developmentally appropriate behaviours.
- Have prior history of requiring child safeguarding or child protection services or have had a previous child become a looked after child.

In cases where agreement to an early help assessment cannot be obtained, practitioners should consider how the needs of the child might be met. However, practitioners should still inform individuals that their data will be recorded and shared, and the purpose explained to them. 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.

See individual safeguarding children partnership websites for the most up to date information and procedures. The latest information regarding the current Early Help arrangements can be found on LSCP websites Kirklees Calderdale Bradford.

6.4 When you are worried about a child

Only the Police have powers to intervene in emergency situations, such as where a child is believed to be at **immediate or imminent danger of significant harm. In such cases you should dial 999 and ask for the Police in your Local Authority area of work.**

If you know or suspect that a child is suffering, or is likely to suffer significant harm, you have a duty to refer your concerns immediately to Children's social care and/or the Police in the Local Authority area where you work. This must be done by a professional in the Locala

service where the concern has been raised. A verbal discussion/referral about your concerns with Children's Social Care **must** then be followed up in writing, using the agreed format, within 24 hours, to ensure that action is taken as appropriate to safeguard the child in question. Referral forms can be accessed directly from SystmOne for services accessed by children or on intranet (ELSIE) safeguarding page for adult services.

Be explicit in your referral to Children's Social Care about the concerns you have, what the needs and risks to the child are relating to your concerns and what the consequences may be for the child if the risk and concerns are not addressed.

It is essential that the same information discussed during your telephone referral/discussion is included in your written referral. It may be helpful to make some notes prior to a verbal conversation with social care in order to provide clear focused communication regarding the details of your concerns. Evidence to support your concerns should be provided within your referral. The preparation of a referral should not delay a referral for urgent cases.

Referrers should have the opportunity to discuss their concerns with a qualified social worker if required (**this is essential in Kirklees as referrals will not be accepted without a prior telephone conversation**). When a child is already known to children's social care and has an allocated social worker (this also applies to Looked after Children) the referral should be made directly to the allocated Social Worker or allocated Team Manager. If they are not available, the Duty Social Worker or Duty Team Manager should be contacted.

For information on **when to suspect child maltreatment** you can access NICE guidelines www.nice.org.uk/CG89

Guidance on information required for good quality referrals can be found in Appendix C

A copy of the referral form must be sent securely from a secure (@nhs.net) email account to a secure children's social care email account (@gov.uk) and a copy sent to the safeguarding team secure email account LCP.Safeguardingteam@nhs.net

Information for the specific details of how to make referrals to children's social care in the Local Authority area where you work can be found on the 'What to do if you are worried about a child' page on ELSIE Link

6.5 Consent

If you are referring the child for Early Help or as a Child in Need (i.e. a child who needs additional support, but for whom there are no concerns about significant harm) you must have consent from the child's parent,

the child themselves if age appropriate or someone with parental responsibility.

If you are referring a child to children's social care (Children's Services) for concerns about child protection or significant harm you do not need consent from the parent/carer to make that referral. However, it is good practice to inform the child's parents/carers that you intend to do so, whether this is to refer or to seek further advice, unless you have reason to believe that so doing would increase the risk to the child.

Consent status must be clearly documented within the record along with a clear rationale if a referral has been made without consent e.g. child assessed to be at risk of significant harm.

6.6 Gillick Competent and Fraser Guidelines

Children who have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention will also have the capacity to consent to that intervention.

A child of under 16 may be Gillick competent to consent to medical treatment, research, donation or any other activity that requires their consent.

The concept of Gillick competence is said to reflect a child's increasing development to maturity. Therefore, the understanding required for different interventions will vary considerably. (DOH 2009)

If your interaction with a child or young person involves touching them (for example, a medical examination) explain what you are going to do and ask for consent:

- From them if they are over 16 (follow the Mental Capacity Act 2005), or under 16 and Gillick competent

or

- From their parent or carer if they are under 16 and not Gillick competent.

If the child, young person or parent does not agree, respect their wishes unless touching them is essential to their treatment (seek legal advice first unless the need for treatment is immediate).

The Fraser guidelines refer to the guidelines set out by Lord Fraser in his judgment of the Gillick case in the House of Lords (1985), which apply specifically to contraceptive advice. Further information is available from NSPCC here

For further guidance on seeking consent see Locala Consent to Treatment Policy.

6.7 Burns, Bruises and Scalds

Burns bruises and scalds are unusual in a baby who is not mobile and should prompt professional curiosity and suspicion of abuse.

The Kirklees, Calderdale and Bradford multi-agency protocol for the assessment of bruising, burns or scalds requires any professional who identifies an actual or suspected bruise, burn or scald on a non-mobile baby to make a referral to Children's Social Care. This is regardless of the explanation given by the parent/carer because there is a wealth of evidence to suggest that there is a significant possibility that such injuries in non-mobile babies may have arisen as a result of abuse or neglect.

- The full protocol is available here LINK or alternatively in the procedures, guidance and process section of the safeguarding page on ELSIE.

6.8 Sexual Activity and Children

A child under the age of 13 is not legally capable of consenting to sex (it is statutory rape) or any other type of sexual touching. Sexual activity with a child under 13 is therefore a criminal offence and should always result in a child protection referral. When both children engaging in sexual activity together are under age 13 there will need to be a discussion with children's social care about both of them (if the details of both children are known).

Sexual activity with a child under 16 is an offence. Practitioners have a responsibility to undertake an assessment of young people aged 13 to 15 years who are engaged in sexual activity following Fraser competencies guidelines (NSPCC, 2018), to determine the risk of sexual and other forms of exploitation or coercion including trafficking. This assessment will inform the decision making process relating to the appropriateness of a referral to Children's Social Care and the Police. Risk assessment is a complex process and practitioners are encouraged to discuss concerns with a member of the Safeguarding Team whenever they are unsure about the appropriate course of action.

Even where a young person is old enough to legally consent to sexual activity (age over 16), 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. (DfE 2017). Further information on consent in relation to sexual activity is available on the NHS choices 'What is consent' guide available Here.

Those aged 16 and 17 years may be viewed by health professionals and others as being of 'the age of consent' in terms of the Sexual Offences Act (2003), but this age group are particularly vulnerable to CSE being missed precisely because of the legalities of sexual consent in this age group (Powell, 2016);

- Where sexual activity with a 16- or 17- year old does not result in an offence being committed, it may still result in harm, or the likelihood of harm being suffered.
- Non consensual sex is rape whatever the age of the victim
- If the victim is incapacitated through drink or drugs, or the victim or his or her family has been subject to violence or the threat of it, they cannot be considered to have given true consent and therefore offences may have been committed.
- No individual, whatever their age, can give consent in a situation where there is intoxication, duress, violence, power imbalances and/or vulnerabilities through age differences, learning difficulties or mental health issues. A child under 18 years of age cannot consent to their own abuse through exploitation (Powell, 2016).
- It is an offence for a person to have a sexual relationship with a 16- or 17- year old if they hold a position of trust or authority in relation to them. **See section 6.10 – Allegations against people who work with children.**

6.9 Adults who Disclose Childhood Sexual Abuse

The term ‘historical disclosure’ is commonly used to refer to disclosures of abuse that were perpetrated in the past. It is normally used when the victim is no longer in circumstances where they consider themselves at risk of the perpetrator and more commonly used when adults disclose abuse experienced during childhood.

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

Cases may be complex as the alleged victims may no longer be living in the situations where the incidents occurred or where the alleged perpetrators are also no longer linked to the setting or employment role. It is important to ascertain as a matter of urgency if the alleged

perpetrator is still working with or caring for children.

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

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

The professional to whom the disclosure was made should:

- Clarify whether there are any children who may currently be at risk from the alleged perpetrator
- If it has been ascertained that the alleged perpetrator has, or may have, contact with a known child / children, a referral should be made to Children's Services (and the police in Kirklees).
- If there are concerns that the alleged perpetrator has contact with children, but the names of the children are not identifiable, the police should be contacted to enable further investigation
- If there are concerns that the adult making the disclosure is at risk, consideration on whether to raise a concern with adult social services or refer to the police will be required and discussed with the individual.
- Advise and support the adult that they are able to make a formal complaint to the police.
- Inform the victim of what and where information is going to be shared
- Provide the victim with information about relevant support services e.g. counselling
- Contact a member of the Safeguarding Team for further advice and support if required

NB If a disclosure of historic sexual abuse is made by a person under the age of 16 a discussion with children's social care must take place.

6.10 Allegations Against People Who Work with Children

All colleagues should be alert to the possibility that individuals employed by Locala or other organisations may pose a risk of causing harm to children.

It is **essential**, in order to safeguard vulnerable children, that **any concerns**, whether or not the concerns/allegations relate to current,

recent or historical behaviour, are shared promptly when there are indications that a person has/may have:

- Behaved in a way that has harmed a child, or may have harmed a child
- Possibly committed a criminal offence against or related to a child; or
- Behaved towards a child or children in a way that indicates s/he may pose a risk of harm to children
- Behaved or may have behaved in a way that indicates they may not be suitable to work with children

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

Please follow the Locala Managing Safeguarding Allegations against Staff Policy (LINK).

6.11 Information Sharing

All colleagues have a duty to be aware of their responsibilities following guidance in the Data Protection Act 2018, the Human Rights Act 1998, and the Common Law Duty of Confidentiality and Caldicott principles. They must protect all confidential information concerning patients and service users obtained in the course of professional practice and abide by their professional codes of conduct.

The Data Protection Act 2018 and General Data Protection Regulations (GDPR) do not prevent the sharing of information for the purposes of keeping children safe. Where children are at risk from abuse or neglect, maintaining client confidentiality or protecting the therapeutic relationship, are not justifiable reasons to prevent information sharing. Information sharing must be done in a way that is compliant with the Data Protection Act, the Human Rights Act and the common law duty of confidentiality. However, a concern for confidentiality must never be used as a justification for withholding information when it would be in the child/young person's best interests to share information.

The decision to share or not to share information about a child/young person should always be based on professional judgement, supported by the cross-governmental guidance *Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers* (HM Government, July 2018).

All clinical colleagues need to understand and apply good practice in sharing information. You can and should share confidential information

without consent when doing so is sufficiently in the public interest. The relevant public interest in relation to safeguarding children is the protection and welfare of children from being at risk of, or suffering significant harm, the prevention and detection of and/or prosecution of serious crime.

Procedures regarding the sharing of information can also be found within the West Yorkshire consortium procedures manual Section 2.4 westyorkscb.proceduresonline/information sharing

Further expert support and guidance can be sought from the Information Governance team, Safeguarding team or the Caldicott Guardian.

6.12 Record Keeping and Documentation

All colleagues must keep accurate, comprehensive and contemporaneous records in line with professional standards and the standards expected for the recording system used by the service.

When colleagues are contacted by another agency e.g. Children Social Care, to request information about a child or service user, the name of the professional, their role and the reason for the information request must be documented in the records. A record of the decision and the reasons for it – whether it is to share information or not must also be clearly documented. Any information that has been shared, with whom and for what purpose, must be clearly recorded within the health record of the individual concerned.

The information recorded should give other professional colleagues working with the child and family a clear outline of the work being undertaken with the family and any plans or actions taken by the professional.

Colleagues must ensure that all documentation in relation to Early Help, Child in Need or Child Protection processes, is available within the appropriate child or adult service user records if accessing adult services.

If minutes are not received follow the process outlined in Appendix D

Please see the Safeguarding SystmOne Guidance for specific safeguarding record keeping requirements within the electric health record platform SystmOne e.g. use of safeguarding node, safeguarding templates, significant events node, chronologies etc.

6.13 Child Protection - Information Sharing Project (CP-IS)

When a child is known to social services and is a Looked after Child or on a Child Protection Plan, basic information about that plan is shared

securely with the NHS. If that child attends an NHS unscheduled care setting, such as Locala Walk in Centre (WIC):

- The health practitioner team is alerted that they are on a plan and has access to the contact details for the social care team
- The social care team is automatically notified that the child has attended, and
- Both parties can see details of the child's previous 25 visits to unscheduled care settings in England

This means that health and social care staff have a more complete picture of a child's interactions with health and social care services. This enables them to provide better care and earlier interventions for children who are considered vulnerable and at risk. Locala WIC clinical colleagues should therefore access the CP-IS system as per departmental procedures to identify if the child is known to social care and to ensure information is shared.

6.14 Child Protection Processes

Locala expects all clinical case holder/manager colleagues working directly with children and/or their parents/carers (i.e. those requiring Level 3 safeguarding children competences) to contribute to safeguarding child protection meetings, that includes strategy meetings. Attendance at these meetings must be given priority **when there is active Locala intervention work with the family.**

Discussions should be held with line managers if colleagues are unable to attend in order that suitable cover can be arranged.

6.14.1 Strategy Meetings

Locala colleagues must prioritise attendance at strategy meetings. Strategy meetings within multi agency safeguarding hubs/teams the Front Door health practitioners will attend strategy meetings.

Strategy meetings convened by locality social work teams should be prioritised by Thriving Kirklees 0-19 service and Calderdale PHEYS (Public Health Early Years' Service).

6.14.2 Initial Child Protection Case Conference (ICPCC)

All Locala clinical colleagues must prioritise attendance at an ICPCC if they are actively working with a child and/or their parents and:

- Make available relevant information in a written report to the Conference and contribute to the discussion, assessment of risk and decision. Reports should also be

submitted to the safeguarding and Reviewing Unit, where possible, 3 working days in advance of the Conference.

- Inform the Safeguarding and Reviewing Unit if they are unable to attend and who will represent the service.
- Ensure that information to be presented by them at Conference is known to, and if possible shared verbally before the conference with the child (if old enough) and his/her parents.
- Ensure that their contribution is non-discriminatory
- In exceptional circumstances where confidential information cannot be shared with the child or parent(s) beforehand, guidance should be sought from the safeguarding team, or directly with the Conference Chair
- Ensure that information is communicated/translated in the most appropriate way taking account of the language and any sensory or learning difficulties of the child and/or parents
- Ensure that they are clear about their role within the Conference and the extent to which they have authority to make decisions on behalf of their agency.
- If the practitioner does not agree with a decision or recommendation made at a Conference, ensure their dissent will be recorded in the minutes of the Conference.
- If a practitioner concludes that a Conference decision places a child at risk, they must seek advice from the safeguarding team
- The safeguarding admin team in Locala child health are responsible for ensuring the child protection plan icon is entered onto the child's SystmOne record for children residing in Calderdale and Kirklees.
- In Kirklees the Safeguarding Hub will attend ICPCs if there is no current active work taking place with the child and/or family.
- **See Appendix I for Calderdale School Nursing Child Protection Process Pathway.**

6.14.3 Pre-Birth Conference

A pre-birth conference is an Initial Child Protection Conference concerning an unborn child and as such must be managed and prioritised in the same manner as an Initial Child Protection Conference.

6.14.4 Core Group Meetings

Practitioners that are members of the core group must:

- Prioritise attendance at the meetings when they are actively working with the child and/or parent. Core Group members must give adequate notice if unable to attend Core Group meetings or arrange a substitute colleague to attend if possible. If not, then along with their apologies, they must provide a summary of their involvement with the family since the last Core Group meeting;
- Provide specialist health advice which will inform the Child Protection Plan
- Provide the Lead Social Worker with written reports as requested;
- Communicate regularly with the Lead Social Worker about the progress of their part of the agreed Child Protection Plan (which may also be outside of core group meetings);
- Although the Lead Social Worker has the lead role, all members of the Core Group are jointly responsible for the formulation and implementation of the Child Protection Plan, refining the plan as needed, and monitoring progress against the planned outcomes set out in the plan.
- Ensure any health actions are recorded within the child/parent records.
- All colleagues who are members of core group meeting should ensure timely receipt of minutes of core group meetings are received and available in the child's records.

NB If the lead professional/social worker does not arrive at the core group meeting, consider continuing with the meeting in their absence. Agree with other colleagues at the meeting who will chair and who will minute the meeting.

Copies of the minutes will need to be sent to the social worker.

6.14.5 Review Child Protection Case Conference (RCPCC)

All Locala practitioners involved with the child protection plan must:

- Make attendance at review conferences high priority;
- Make relevant information available in a written report to the Conference and contribute to the discussion, assessment of risk and decision regarding the level of risk. Reports should be submitted to the relevant Child Protection and Review Unit, wherever possible, 3 working days in advance of the Conference.
- Inform the Child Protection and Review Unit if they are unable to attend and who will represent the service.
- Ensure that information to be presented by them at Conference is known to the child and parents before the Conference
- Ensure that their contribution is non-discriminatory
- Ensure that information is communicated/translated in the most appropriate way taking account of the language and any sensory or learning difficulties of the child or parents;
- Ensure that they are clear about their role within the conference and the extent to which they have authority to make decisions on behalf of their agency.

6.15 Professional Challenge / Disagreements

There may be times when professionals have different opinions on a number of aspects or decisions in relation to the care or safeguarding arrangements for a child or young person, whether within the same or different agency, but are most commonly seen in relation to:

- Criteria for referrals;
- Outcomes of assessments;
- Roles and responsibilities of workers;
- Service provision; and
- Information sharing and communication.

At no time must professional dissent and disagreement detract from

ensuring that the child is safeguarded. The child's welfare and safety must remain paramount throughout. If the professionals are unable to resolve differences through discussion and/or meeting within a time scale which is acceptable to both of them, their disagreement must be addressed by more experienced or more senior practitioners.

Locala practitioners must be able to evidence their concerns with a chronology and analysis regarding the welfare of the child. Colleagues should discuss their concerns with a member of the Safeguarding team for support if initial discussions are unsuccessful in addressing the dissent as per the professional disagreements' flowchart **(see Appendix E).**

Further information on multi-agency professional challenge is available in the West Yorkshire Consortium Procedures Resolving Professional Disagreements

6.16 Children in Specific Circumstances

6.16.1 Female Genital Mutilation (FGM)

If you suspect that a female child is at risk of FGM being carried out, you must complete an FGM risk assessment. If it is decided that a child is at risk, you must make a referral to Children's Social Care Services without delay.

Mandatory Reporting

Locala healthcare professionals have a legal duty to report when FGM has been carried out on a girl under 18, whether this has been disclosed to them directly by the victim or a relative and/or this has been visually confirmed during an examination under the FGM Act, 2003 (as amended by the Serious Crime Act, 2015). This is no different from any other obligation on healthcare professionals to report abuse against children. FGM is child abuse and the healthcare professional must make a report to the Police using the FGM Mandatory Reporting Form.

Additional information, risk assessment tool and access to the FGM reporting form is available in the FGM section on the ELSIE **Domestic Abuse page.**

6.16.2 Domestic Abuse

Children's exposure to parental conflict, even where physical abuse is not present, can lead to serious anxiety and distress. Where there is domestic abuse, that includes controlling or coercive behaviour, the wellbeing of any children in the household must be promoted and all assessments must consider the need to safeguard the children.

Domestic abuse, can impact on children in many ways:

- Prolonged or regular exposure can have a serious impact on a child‘s development and emotional well-being, despite the best efforts of the victim parent to protect the child.
- During pregnancy, it can pose a threat to an unborn child as assaults on pregnant women often involve punches or kicks directed at the abdomen, risking injury to both the mother and the foetus. Older children may also suffer blows during episodes of violence.
- Children may be greatly distressed by witnessing the physical and emotional suffering of a parent. The effects may result in, but is not limited to, behavioural issues, absenteeism, ill health, bullying, and substance misuse, self-harm and anti-social behaviour.
- Children age 16-18 years may also be direct victims or perpetrators of domestic abuse and referrals for support in their own right may need to be considered.

The negative impact of domestic abuse on an adult victim’s parenting capacity is exacerbated when domestic abuse is combined with any form of substance misuse and/or mental health problems. Children may be drawn into the abuse or pressurised into concealing assaults. Children who are experiencing domestic abuse or conflict may benefit from a range of support and services; some may be at risk of significant harm.

If assessment indicates that a referral to children’s social care is required, you must make explicitly clear who in the family is aware that the referral has been made.

Further information about the management of concerns about domestic abuse is detailed in the Locala Domestic Abuse Policy

6.16.3 Private Fostering

Every Local Authority has a duty to satisfy itself that the welfare of children who are privately fostered within its area are being satisfactorily safeguarded and promoted.

Consequently, if any practitioner learns that a child is being Privately Fostered, including long holiday and ‘education guardian’ arrangements, they have a duty to inform children’s social care in the Local Authority area where the child is being fostered. The child and carers must be informed that this information will be shared.

Details of how to contact children's social care can be found in the what to do if you have concerns about a child in the Procedures, Processes and Guidance area on the safeguarding pages of the intranet HERE

6.16.4 Fabricated or Induced Illness (FII)

Fabricated or induced illness (FII) is a rare form of child abuse. It occurs when a parent or carer exaggerates or deliberately causes symptoms of illness in a child. It is important that the focus is on the outcomes or impact on the child's health and development and not initially on attempts to diagnose.

The common starting point for concern about Fabricated or Induced Illness (FII) is that the child's clinical presentation is not adequately explained by any confirmed genuine illness, and the situation is impacting upon the child's health or social wellbeing. In FII, the child suffers harm through the deliberate report or action of a parent/carer, so that the child is presented as ill when they are not ill, or more ill than is actually the case

The term 'perplexing presentation' (PP) is used at the early stages when a child first presents, or when other possibilities for the presentation are possible.

Colleagues who have identified concerns about a child's health should discuss these concerns with the child's GP or with a member of the safeguarding team. Parents should be kept informed of any medical assessments or investigations required, and of the findings, but at no time should concerns about fabricated or induced illness be shared with parents if this information would jeopardise the child's safety and compromise the child protection process and/or any potential criminal investigation. Additional information is available in the West Yorkshire Consortium Procedures Here

6.17 Risk of Abuse Outside the Home (Contextual Safeguarding)

As well as threats to the welfare of children from within their families, children may be vulnerable to abuse or exploitation from outside their families. These extra-familial threats might arise at school and other educational establishments, from within peer groups, or more widely from within the wider community and/or online. These threats can take a variety of different forms and children can be vulnerable to multiple threats, including exploitation by criminal gangs and organised crime groups such as county lines; trafficking; online abuse; teenage relationship abuse; sexual exploitation and the influences of extremism leading to radicalisation. Extremist groups make use of the internet to radicalise and recruit and to promote extremist materials. Any potential

harmful effects to individuals identified as vulnerable to extremist ideologies or being drawn into terrorism should also be considered.

Assessments of children in such cases should consider whether wider environmental factors are present in a child's life and are a threat to their safety and/or welfare. Children who may be alleged perpetrators should also be assessed to understand the impact of contextual issues on their safety and welfare (Working Together to Safeguard Children, 2018)

6.18 Complex Safeguarding Situations

The safeguarding children agenda is widening and increasingly complex. Section 1.4 of the West Yorkshire Consortium multiagency procedures provides guidance on a whole range of complex situations involving children living in specific circumstances. Practitioners should access the procedures when dealing with any of the circumstances below for the most up to date guidance and support.

The procedures are available via the follow link
https://westyorkscb.proceduresonline.com/contents.html

Children in Specific Circumstances:

- Abuse of Disabled Children
- Allegations of Harm Arising from Sexual Activity (including Underage Sexual Activity)
- Breast Ironing / Breast Flattening
- Bullying
- Child Abuse and Information Communication Technology
- Child Abuse Linked to Faith or Belief
- Child Exploitation: Policy, Procedures and Guidance
- Child Sexual Abuse in the Family Environment
- Children and Families Who Go Missing
- Children at Risk where a Parent has a Mental Health Problem
- Children from Abroad, including Victims of Modern Slavery, Trafficking and Exploitation
- Children Living Away from Home (including Children and Families living in Temporary Accommodation)
- Children Missing from Education - Updated
- Children of Alcohol Misusing Parents

- Children of Drug Misusing Parents
- Complex (Organised or Multiple) Abuse
- Concealed Pregnancies
- Dangerous Dogs and Safeguarding Children
- Deprivation of Liberty and Mental Capacity
- Domestic Abuse
- Elective Home Education - New
- Fabricated or Induced Illness
- Female Genital Mutilation (FGM) - Updated
- Forced Marriage
- Gang Activity and Youth Violence
- Harm to Animals and Possible Implications for Children
- Harmful Sexual Behaviour
- Interpersonal Violence and Abuse (IPVA) Young People's Relationships West Yorkshire Practice Guidance
- Intimate Care Good Practice Guidelines
- Male Circumcision – Bradford
- Missing Children
- Parents with Learning Disabilities
- Pre-Birth
- Self Harm
- Suicidal Behaviour
- So Called 'Honour' Based Violence
- Risks Posed by People with Convictions Against Children
- Children Visiting Psychiatric Wards and Facilities – Updated
- Children Visiting Prisons - Updated
- Cross-Border Child Protection Cases Under the 1996 Hague Convention
- Safeguarding Children who Move Across Local Authority Boundaries / Abroad

- Safeguarding Children and Young people against Radicalisation and Violent Extremism
- West Yorkshire Guidance for Families who are Relocating Due to Risk
- Working in Partnership with Families

Pathways and Good Practice Guidance

The Local Safeguarding Children Partnerships have locally developed good practice guidance and pathways that have been developed in response to local and national learning to support safeguarding practice e.g. working with non-engaging families, Good practice in working with parents who have learning difficulties.

The latest guidance and pathways can be accessed via the internet site for individual safeguarding partnerships.

Kirklees Safeguarding Children Partnership Link

Calderdale Safeguarding Children Partnership Link

Working Together to Safeguard Children - The Bradford Partnership Link

7. Safeguarding Children Incidents

It is vital to highlight where safeguarding children issues have not been dealt with in the optimal way and opportunities to learn from these incidents should not be missed. There are 3 different routes where safeguarding children incidents can be reviewed depending on the severity of the incident. Any lessons learnt from reviews or investigations are fed back to Locala and can form the basis for a policy change where needed.

Colleagues may be required to contribute to these processes if they have been involved in the care of the child or family.

7.1 Incident Reporting on Datix

Locala has a well-established Clinical Incident Reporting, Management and Investigation Policy. Incidents relating to safeguarding children must be reported if they fall within the criteria set below by a member of the safeguarding team. However, all incidents reported by colleagues indicated as a potential child safeguarding concern will be reviewed by the safeguarding team to ensure any safeguarding issue has been considered and addressed.

- Any case where there are initial indications that a child has sustained a potentially life- threatening injury which may be through abuse or neglect or serious sexual abuse or sustained serious and permanent impairment of health or development through abuse or neglect.
- Where a child dies (including death by suicide) and abuse or

neglect is known or suspected to be a factor in the child's death.

7.2 Child Death Review Processes

There are 2 statutory processes regarding deaths of children

Sudden and Unexpected Death in Infancy and Childhood (SUDIC).

A strict procedure for any unexpected death in childhood up to 18 years of age must be initiated by the SUDIC team based in acute settings.

Child Death Reviews

All deaths in children up to 18th birthday whether expected or not are reviewed by a multiagency panel. The purpose of the child death review process is to collect and analyse information from known agencies about the death of each child who normally resides in the area with a view to identifying any matters of concern affecting the health, safety, or welfare of children, or any wider public health concerns.

Any colleague working in a service where the child had been known to that service may be asked to complete a FORM B to inform the Child Death Overview Panel case discussion. Additional information about CDOP is available on ELSIE **HERE.**

In addition, there is also a requirement for health services providers to undertake reviews of deaths of those (including children and young people) to whom they are providing services to determine whether there is any specific learning for individual organisations, as outlined in the Locala Learning from Deaths Policy.

7.3 Safeguarding Children Practice Reviews

Multi-agency safeguarding children practice reviews are undertaken where:

- Abuse of a child is known or suspected **and**
- The child has died or been seriously harmed

The local safeguarding partners will consider the following criteria in determining whether a safeguarding practice review should be undertaken.

Does the case:

- Highlight or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified.
- Highlight or may highlight recurrent themes in the safeguarding and promotion of the welfare of children

- Highlight or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children

  Or

- is the case one which the Child Safeguarding Practice Review Panel have considered and concluded a local review may be more appropriate.

A Named Nurse, supported by other members of the safeguarding team, may be required to oversee a review of Locala involvement with the child and family. This may involve discussion and memory capture with colleagues working directly with the family. Colleagues may also be required to participate in a practitioner event to contribute to the overall learning.

A safeguarding practice review is not an investigation into the child's death; it is an opportunity to identify learning and where improvements can be made to safeguard and promote the welfare of children. Support will be given throughout the process by the safeguarding team. An action plan to address any learning points will be coproduced with operational services and approved by the Head of Safeguarding and the Safeguarding Children Operational meeting. All learning will be cascaded within Locala via the Safeguarding Children Operational meeting, Safety Summit and a variety of other learning opportunities.

7.4 Legal Statements

Colleagues may be required to support judicial processes relating to child welfare via the provision of a statement or may be required to give evidence in court. Please refer to the Standard Operating Procedures for writing legal statements and giving evidence in court in relation to child welfare (LINK).

8. Safeguarding Children Learning and Training

Child protection learning and training is mandatory for all colleagues at the level required by their role as set out in 'Safeguarding Children and Young People: Roles and Competencies for Health Care Staff'. Intercollegiate Document (2019).

The level assigned to the role will be shown in ESR.

All colleagues must have the required level of knowledge, skills and competences to recognise child maltreatment and to take effective action appropriate to their role.

Training and learning opportunities should draw upon lessons from research, case studies, critical incident reviews and analysis, and from local and national learning arising from serious safeguarding children incidents and

reviews. The emphasis is flexible and tailored learning opportunities, which must incorporate any role specific mandatory training requirements, to enable all individuals to acquire and maintain the required level of knowledge, skills and competences required.

There are essentially 4 different levels assigned to colleagues depending on their level of contact with children and/or their families. The level assigned will determine your safeguarding children learning and training needs.

Level	Staff Groups	Requirement
1	All colleagues including non-clinical managers and all those working in healthcare settings. This includes Board level Executives and non-executives, lay members, receptionists, administrative workers, non-clinical colleagues working within GP practices and volunteers across Locala service provision.	**Minimum of 40 minutes of safeguarding training or learning per annum.** *Equating to a minimum of 2 hours every 3 years.*
2	All non-clinical and clinical colleagues who have any contact with children and young people up to 18 years of age and/or adults who are parents/carers. This includes administrators for looked after children and safeguarding teams, health care students, phlebotomists, pharmacists, orthodontists, dentists, dental care professionals, nurses and allied health care practitioners working in adult community services (including practice nurses) and clinic receptionists.	**Minimum of 60 minutes of safeguarding training or learning activity per annum.** *Equating to a minimum of 3 hours every 3 years.*
3	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. This includes GPs, urgent and unscheduled care clinical colleagues, specialist nurses for safeguarding, looked after children's nurses, health professionals working in substance misuse services, youth offending team health advisors, paediatric allied health professionals, sexual health colleagues, school nurses, health visitors and all children's nurses.	**Minimum of 4 hours of safeguarding training and learning activity per annum.** *Equating to a minimum of 12 hours every three years*
4	Named Safeguarding Children Professionals	**Minimum of 8 hours of safeguarding training or learning per annum.** *Equating to a minimum of 24 hours every 3 years.*

The Safeguarding Children Training matrix (Appendix E) clarifies the safeguarding children training and learning requirements (including role specific mandatory training) that must be undertaken according to individual roles and the level of competence required.

Colleagues must identify their learning needs for the year (these may be specific knowledge gaps or aspects of safeguarding children where refreshers or updates would be beneficial) then undertake appropriate learning activities to meet the identified learning needs.

Evidence of the safeguarding children training and learning activities completed by all colleagues must be recorded and stored electronically on individual secure drive (OneDrive) to provide evidence of achievement of safeguarding competences during your annual appraisal. An annual self-declaration of achievement of competences must then also be completed on ESR. This data will be used to monitor compliance with policy requirements and will be included within the Locala Annual Safeguarding Report.

Information and guidance on resources and learning opportunities available to support colleagues to achieve their annual safeguarding children learning requirements is available and accessible via the safeguarding homepage on ELSIE HERE.

9. Safeguarding Children Supervision

Locala recognises that working in the field of Safeguarding Children involves making difficult professional judgements. It is demanding work that can be distressing and stressful therefore access to effective supervision must be available to all practitioners. Supervision is recommended for everyone involved in child protection work and has benefits for the colleague, for the organisation and most importantly for the child/children.

Supervision is a planned, accountable, two-way process, which should support, motivate and ensure all practitioners develop good practice. Effective supervision, supported by appropriately trained professionals, is key to delivering positive outcomes for children, young people and their families (Morrison 2005)

The purpose of Safeguarding Children Supervision is to:

- Support and colleagues in relation to decision-making, care planning and management of their concern in vulnerable/child protection/complex cases.
- Provide insight into complicated topics where the area of concern relates to multiple factors
- Enable and empower colleagues to develop knowledge and competence
- Explore new ways of working in response to changing need

- Promote and share best professional practice that will ensure that the welfare of the child is paramount, and risk is assessed and managed effectively
- Explore the impact of stress relating to safeguarding practice and provide staff with a forum to ventilate their feelings and views in relation to safeguarding children issues
- Identify any training needs

Safeguarding children supervision is most effective when it is planned and prepared for in advance by the supervisee and involves a retrospective review of a safeguarding case with an approved safeguarding children supervisor. The process provides a structured format that involves both reflection, learning and direction regarding case management and must be differentiated from advice and support. Case specific safeguarding supervision must be documented on agreed templates within all relevant electronic health records.

All individuals involved in direct work with children and/or their families (Level 3 practitioners) must seek and access formal safeguarding children supervision as set out in the Safeguarding Children Supervision Matrix (Appendix F). It is the responsibility of colleagues to ensure that they are compliant with the minimum required level of safeguarding children supervision.

9.1 Individual Safeguarding Children Supervision

Individual safeguarding children supervision is facilitated on a one to one basis and may be sought from an approved safeguarding supervisor or a member of the safeguarding team. Case managers should routinely access safeguarding supervision when working with complex cases or when they have concerns about a child's welfare that are not being addressed. Individual supervision is available on request to complement, but not replace, group supervision requirements.

Individual supervision from a member of the safeguarding team, or an approved safeguarding supervisor, **must** be sought by the case manager when a child becomes subject to a child protection plan as soon as feasible but must be done before the first review conference. However, professional judgement will need to be used if the assessment following the initial child protection conference is that there is no further role for health practitioners in the child protection plan or ongoing child protection processes. The analysis and rationale for not requiring supervision should be clearly documented in the child's records.

9.2 Group Safeguarding Children Supervision

Safeguarding Children Group Supervision is a planned group discussion that promotes reflection and learning on cases and/or other

safeguarding issues. Groups may be made up of professionals working in the same teams or from different teams/services and will also provide an arena for reflective learning, training and supporting newly qualified and inexperienced professionals.

Group supervision must be facilitated by an approved safeguarding supervisor.

Benefits of group supervision include the following –

- The diversity of the group widens perspectives
- It is a source of emotional support from peers
- It increases options, ideas, and innovations
- It expands the skills – pool and knowledge base.
- Key organisational safeguarding messages are disseminated during this forum

It is suggested that group supervision lasts no longer than 1 hour, and the group will have no more than 12 participants plus a facilitator/supervisor at each session.

NB It is the responsibility of the practice teacher to ensure that student specialist community public health nurses access group supervision whilst in placement. Attendance of students will not be monitored via mandatory reporting mechanisms.

9.3 Tri-partite Supervision

Family Nurses require a supervision framework that fits with their service operational framework. This process will be supported by tri-partite supervision facilitated by the safeguarding team.

9.4 Integrated Supervision

Integrated supervision is planned reflection on the same case by two or more professionals involved. It may be multi-disciplinary and/or multi-agency and in accordance with the Locala integrated supervision principles (Appendix G). **Integrated supervision must be requested in advance and facilitated by a member of the safeguarding team.**

9.5 Ad-Hoc Advice

It is recognised that colleagues will often require advice and support in relation to safeguarding children outside of the formal supervision session.

Advice and support should be sought in the first instance from a team leader or approved safeguarding children supervisor.

However, any colleague, irrespective of their role can access specialist safeguarding children advice by contacting a member of the safeguarding team by telephone or other virtual/electronic means.

Additionally, colleagues may require specialist supervision when they are dealing with stressful individual cases or serious child safeguarding incidents.

A list of approved safeguarding children supervisors can be found on the Safeguarding page on Elsie (LINK).

9.6 Supervision Records

All safeguarding children supervision must be documented on the approved safeguarding supervision templates available in SystmOne or in the supervision section accessible via the safeguarding home page on the intranet site ELSIE **HERE.**

Safeguarding supervisors must provide data to the safeguarding team of all safeguarding children supervision facilitated in the agreed manner upon completion of the supervision record.

10. Equality Impact Assessment

Locala Community Partnerships aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

An Equality Impact Assessment Tool is used during ratification processes to establish whether its policies and practices would further, or had furthered, the aims set out in the section 149 (1) of the [Equality Act 2010]. Any outcomes have been considered in the development of this policy.

11. Consultation Process

A consultation process was carried out with key stakeholders in the development of this policy. These stakeholders included all members of the Safeguarding Committee, Patient Safety Specialists and Operational Managers/Clinical Leads in Children and Sexual health services.

12. Dissemination and Implementation

12.1 Dissemination

The policy will be communicated through a colleague briefing and a targeted and comprehensive communication plan. It will be placed in the relevant section of the Policies site on SharePoint. Where a review is identified and any changes made, these will be communicated.

12.2 Competence / Training

Prior to ratification of this policy the required education and training needs for ensuring effective implementation and compliance have been

reviewed.

Colleagues are required to undertake annual mandatory safeguarding children learning commensurate with their role.

13. Monitoring Compliance with the Document

13.1 Process for Monitoring Compliance

This can be statements or in a table format e.g. where reports will be presented or frequency of audits to check compliance.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Section 11 Responsibilities of the Children Act 2004	Head of Safeguarding	LSCB audit of arrangements	As per requested	Safeguarding Committee
Basic safeguarding record-keeping standards,	Named Nurses	Safeguarding Practice Audit	6 monthly audit	Safeguarding Committee and Audit and Effectiveness Group
Safeguarding practice	Safeguarding Team	Work Plan	Annual	Safeguarding Committee

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

13.2 Key Performance Indicators

Safeguarding Children Group and Individual Supervision Compliance (should not fall below 90%)

Safeguarding Children Annual learning compliance (should not fall below 90%)

14. References / Bibliography

Child sexual exploitation. Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation (2017) Department of Education.

Children Act, 1989; 2004.

HM Government ‘What to do if you’re worried a child is being abused’ (March,

2015)

Intercollegiate Document; Safeguarding Children and Young People roles and competencies for health care staff (RCHCP, 2019)

Staff Supervision in Social Care: Making a Real Difference for Staff and Service Users. Morrison, T (2005)

Powell, C (2016) 'Preventing Child Sexual Exploitation: taking action across Wessex. NHS England South (Wessex)

Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework: NHS England (2015)

United Nations Palermo Protocol

When to suspect child maltreatment NICE guidelines www.nice.org.uk/CG89

Working Together to Safeguard Children (2018) HM Government

15. Associated Policy Documentation

Mental Capacity Act 2005

Mental Capacity Act Code of Practice

Department of Health (2009) Reference Guide to Consent for Examination or Treatment. Second Edition.

Locala Clinical Record Keeping Policy

Locala Domestic Abuse Policy

Locala Incident Reporting, Management and Investigation Procedure

Locala Learning from Deaths Policy

Locala Managing Safeguarding Allegations against Staff Policy and Procedure

Locala Prevent Policy

Locala Safeguarding Adults at Risk Policy

Locala Speaking up: freedom to speak up, raising concerns and whistleblowing policy

Appendix A – Types and Categories of Child Abuse

Physical Abuse

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

Sexual Abuse

This 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. It 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.

Emotional Abuse

This is defined as 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.

Neglect

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

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

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

Child Sexual Exploitation (CSE)

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 in exchange for something the victim needs or wants, and/or 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.

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.

Children aged 12-15 years of age are most at risk of child sexual exploitation, although victims as young as 8 have been identified, particularly in relation to online concerns. Equally, those aged 16 or above can also experience child sexual exploitation, and it is important that such abuse is not overlooked due to assumed capacity to consent.

Account should be taken of heightened risks amongst this age group, particularly those without adequate economic or systemic support. Though child sexual exploitation may be most frequently observed amongst young females, boys are also at risk. Child sexual exploitation affects all ethnic groups.

The impact of CSE on young people can last well into adulthood and the potential impact on parenting must be considered when undertaking parenting capacity assessments on young people who become parents themselves.

Female Genital Mutilation (FGM)

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

FGM is classified into four major types. The World Health Organisation definitions are:

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

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

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

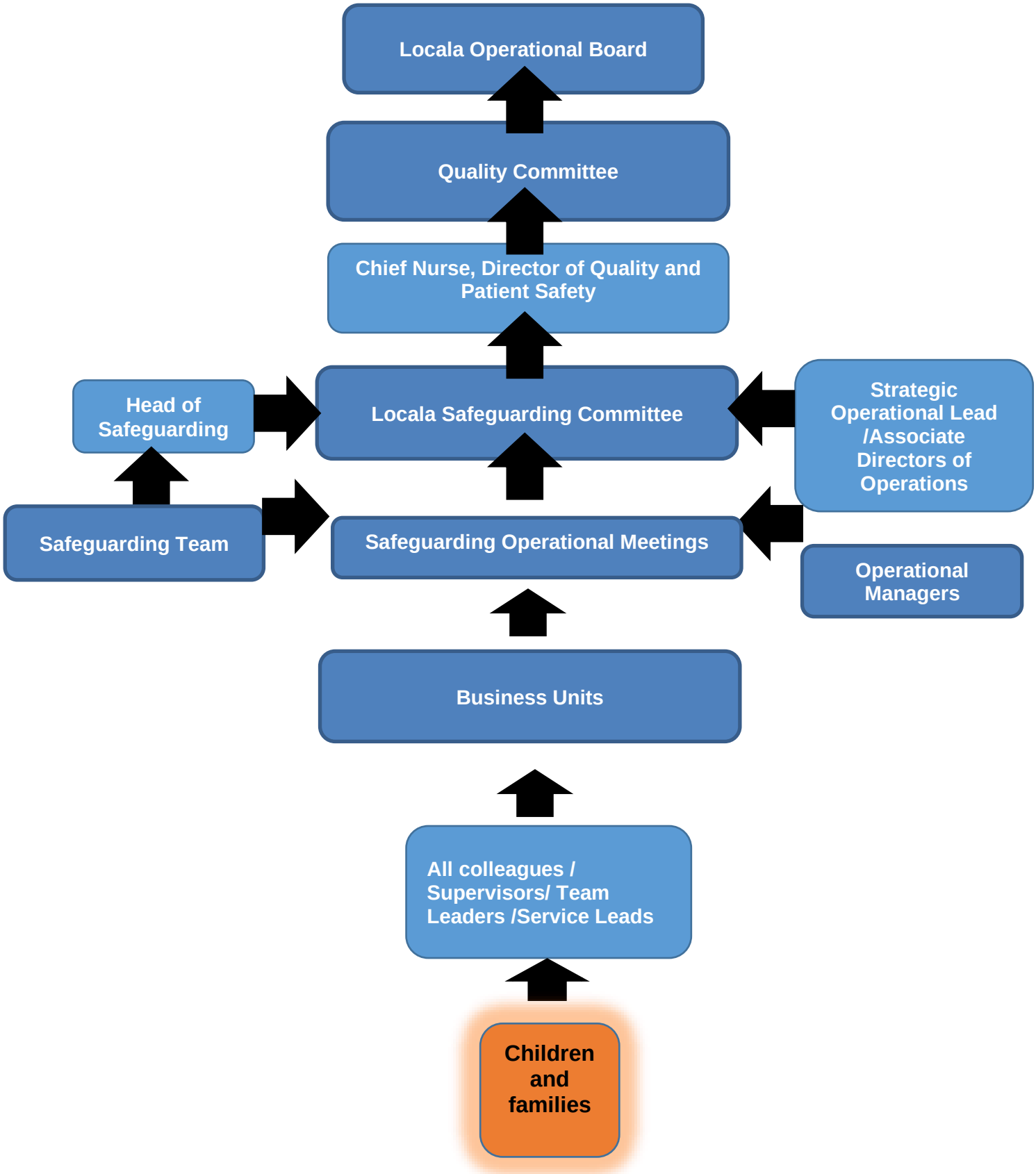
Type 4: Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area

Fabricated or Induced Illness (FII)

Fabricated or Induced Illness is a condition whereby a child suffers harm through the deliberate action of her/his main carer, and which is attributed by the adult to another cause. It is a relatively rare but potentially lethal form of abuse. Concerns will be raised for a small number of children when it is considered that the health or development of a child is likely to be significantly impaired or further impaired by the actions of a carer/carers fabricating or inducing illness. These concerns may arise when:

- Reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering; or
- Physical examination and results of medical investigations do not explain reported symptoms and signs; or
- There is an inexplicably poor response to prescribed medication and other treatment; or
- New symptoms are reported on resolution of previous ones; or
- Reported symptoms and found signs are not observed in the absence of the carer; or
- Over time the child is repeatedly presented with a range of symptoms to different professionals in a variety of settings; or
- The child's normal, daily life activities are being curtailed beyond that which might be expected from any known medical disorder from which the child is known to suffer.

Appendix B - Safeguarding Accountability and Governance Flowchart



Appendix C – Top Tips for making a high-quality referral to children's social care:

Contact Form/Referral Form

Ensure the details of the child and his/her family, including the names and dates of birth of everyone in the household or who is significant to the child, and their contact telephone numbers are documented. It is important that names, DOB, address and contact details are all spelt correctly.

Referrer details:

It is important that all the contact details of the person completing the form are included i.e. name, phone number, role and organisation so that additional information can be obtained if needed and the outcome of the referral can be shared.

Consent:

Consent must be obtained from the parent or carer unless to do so would place a child at risk of significant harm. Try and include the views of the person giving consent if possible. If consent has not been obtained you will need to provide a clear explanation why.

Documenting why Children's Social Care intervention is being requested

Robust decision making in Children's Social Care is dependent on high quality referral information that is accurate, specific, concise, and relevant. It is extremely important therefore the specifics about key risks and concerns for the child/children are explicit on the referral form.

What are the concerns? The reason for referral needs to clearly reflect what the nature of the concern is and an analysis of the risk and how that impacts on the child's physical health, emotional health and development. The reason for referral must include an account of any particular event, situation or specific information giving clear dates and times if known. All information known about the child's needs and the capacity of the child's parents or carers to meet those needs should be included. If possible, a summary of actions or interventions which have already taken place by professionals should be provided.

What have you witnessed?

What have you learned from discussions with a child/young person or family member?

Is this an existing or a past concern?

Is this information direct from your interactions/observations with a child/parent or is it second hand?

Which services are you requesting?

What results or outcomes do you want for the child?

Avoid using jargon, medical terms or acronyms which may not be readily understood.

Avoid being ambiguous or too generalised

Don't waffle – be specific.

REMEMBER: Poor quality referrals can cause undue delays for children. Therefore, check before making the referral whether you have included the most important details. Not including or missing out essential information can compromise a referral.

Appendix D - Process to follow when requesting minutes from early help, child in need and child protection meetings.

The West Yorkshire Consortium Procedures state:- *Core Group Meetings should be recorded and* ***Copies of the notes and written agreement must be circulated to Core Group members as soon as possible****.*

At the core group meeting :-

Establish with the lead professional/social worker an agreed date by when the minutes will be received.

The minutes need to be received prior to the next arranged meeting to ensure that they are checked for accuracy.

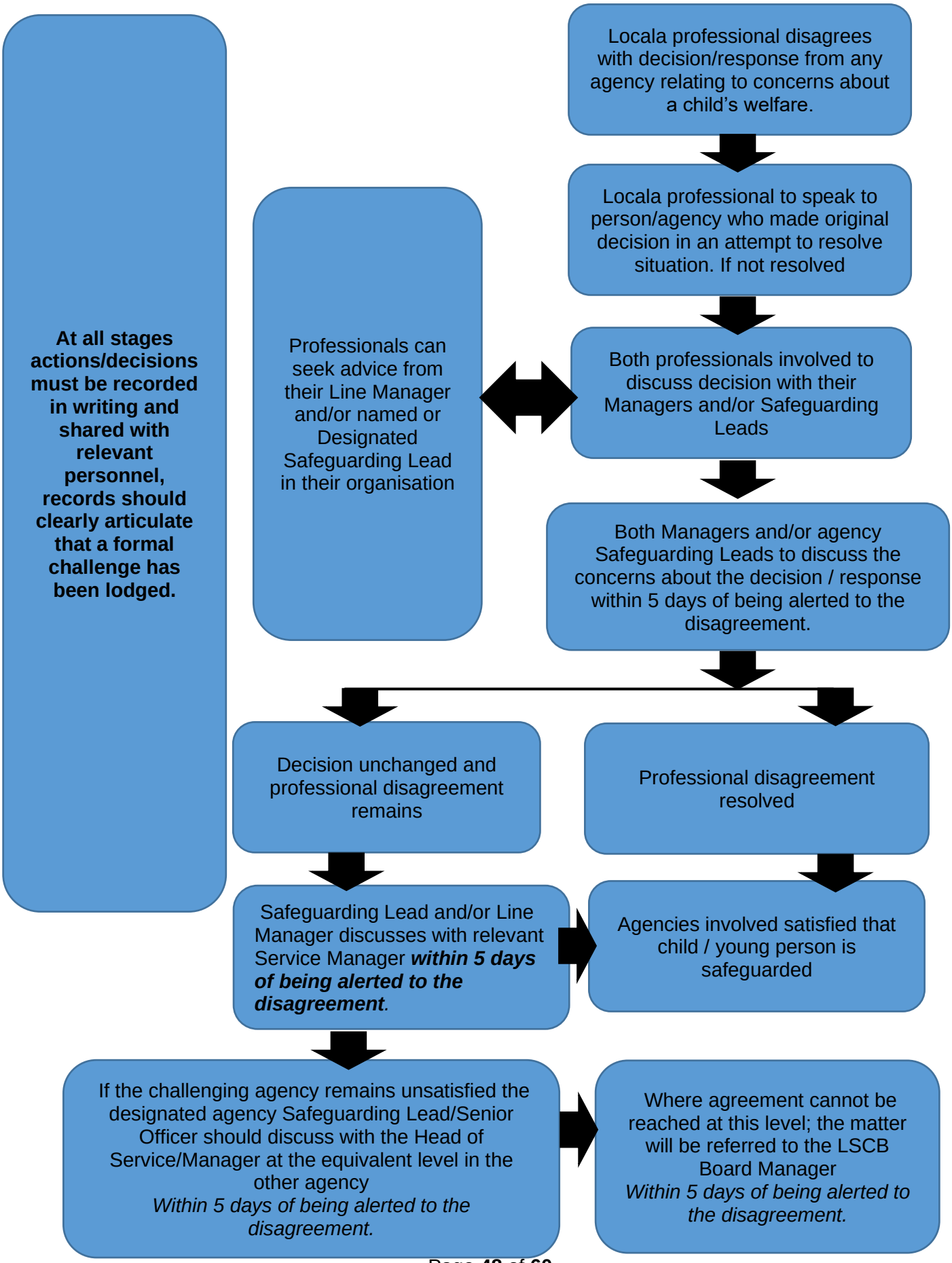
Minutes should be sent via secure accounts to a team generic NHS mail account and not to an individual's account.
If you are unable to attend the meeting you still need to establish with the lead professional/social worker when the minutes will be received.
After the meeting:-

- Document the agreed date and method of receipt In SystmOne.
- Create a scheduled task to chase the minutes (available on meeting templates).
- If the minutes do not arrive as expected, contact and discuss with the social worker and agree a new timescale - follow up the verbal discussion with an email.
- Create scheduled task to chase minutes.
- If minutes are not received, by the second agreed timescale **contact** the social worker's team manager to inform them of the missing minutes. Include the dates of the meetings and when requests were made. Agree timescale for receipt of minutes. Follow up the verbal discussion with email
- If minutes do not arrive following discussion with social work manager **complete** a Datix incident form including dates of meetings and to whom and how requests have been made. Mark as an external incident and potential safeguarding children concern.

- On receipt of the Datix the Safeguarding team will contact the Locality service manager directly to request minutes (the steps above need to have been completed and recorded in the Datix).

NB If the lead professional/social worker does not arrive at the core group meeting, consider continuing with the meeting in their absence. Agree with other colleagues at the meeting who will chair and who will minute the meeting. Copies of the minutes will need to be sent to the social worker.

Appendix E – Resolving Professional Disagreements Flowchart



Appendix F – Mandatory Safeguarding Children Training Matrix

INDUCTION			
STAFF GROUP	MANDATORY REQUIREMENTS	COMMENTS	LEARNING OUTCOMES
All new employees or volunteers will receive a basic awareness safeguarding update as part of the 2 day induction course upon commencing employment.	**Colleagues in a non-clinical role** to complete 000 Safeguarding Children and Young People Level 1 via NLMS e-learning NMLS e-learning 000 Safeguarding Children and Young People Level 1 or completion of Level 1 Safeguarding Children Workbook within 3 months of taking up post **Colleagues in a clinical role** to complete NMLS e-learning 000 Safeguarding Children and Young People Level 2a or Primary Care NMLS e-learning 000 Safeguarding Children and Young People Level 1 or completion of Level 2 Safeguarding Children Workbook within 3 months of taking up post.	This is a basic introduction to safeguarding arrangements within Locala and colleagues will still need to complete additional learning to self-declare competence	Know where to locate relevant safeguarding children policies and know what to do if concerns about child welfare arise. Working towards achieving learning outcomes of individual's assigned Level.

LEVEL 1 a minimum of 40 minutes of safeguarding children training/learning activity must be undertaken per annum		
STAFF GROUP	MANDATORY REQUIREMENTS	COMMENTS
Volunteers	Annual 40 minute face to face training delivered by member of the safeguarding children team.	No additional mandatory training or learning activity requirements
Managers of non-clinical teams or services, receptionists and administrative staff who do not have direct face to face contact with service users, non-clinical staff working in GP practices	NMLS e-learning 000 Safeguarding Children and Young People Level 1 or completion of Level 1 Safeguarding Children Workbook must be completed at least once in every three year period.	Other learning activities must be undertaken according to individual learning needs to achieve competences. Learning activities are available on the safeguarding children Level 1 resource area.
LCP non-executive and lay Board members	2 hour face to face learning activity delivered by member(s) of the safeguarding team delivered at least once in every 3 year period. NMLS e-learning 000 Safeguarding Children and Young People Level 1 or completion of Level 1 Safeguarding Children Workbook must be completed at least once in every three year period **NB** Additional independent learning activities are required to meet annual self-declaration requirements	Specific Locala board member competences are; Demonstrates an understanding of appropriate referral mechanisms and information sharing 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 Demonstrates an awareness and understanding of effective board level leadership for the organisations safeguarding arrangements Demonstrates an awareness and understanding of arrangements to share relevant information Demonstrates an awareness and understanding of effective arrangements in place for the recruitment and appointment of staff, as well as safe whistle blowing Demonstrates an awareness and understanding of the need for appropriate safeguarding supervision and support for staff including undertaking safeguarding training Demonstrates collaborative working with lead and nominated professionals across Agencies

LEVEL 2 – a minimum of 60 minutes of safeguarding children training/learning activity must be undertaken per annum		
STAFF GROUP	MANDATORY	COMMENTS
All pre-registration health care students; dentists, dental nurses, hygienists and therapists; all colleagues in a clinical role working in adult care services; practice nurses; adult therapists; Looked after Children and Safeguarding Children Administrators; Health care assistant clinical practitioners (Band 3) working in school nursing, health visiting and children's community nursing teams; managers of clinical services	NMLS e-learning 000 Safeguarding Children and Young People Level 2a Primary Care or completion of Level 2 Safeguarding Children Workbook at least once in every three year period CSE e-learning package	Additional learning activities must be undertaken to complete the 60 minute per annum requirements. Other learning activities should be based on individual learning needs to attain the required competences, knowledge and skills required and achieve the learning outcomes. Learning opportunities are available in the Level 2 learning resource area that includes other e-learning and face to face briefings
Receptionists in clinical areas	NMLS e-learning 000 Safeguarding Children and Young People Level 2a Primary Care or completion of Level 2 Safeguarding Children Workbook at least once in every three year period	

LEVEL 3 – a minimum of 4 hours of safeguarding children training/learning activity must be undertaken per annum that should incorporate multi-disciplinary and multi-agency learning. **At least ONE multi-agency learning activity must be undertaken in every three year period.**		
STAFF GROUP	MANDATORY & ROLE SPECIFIC	COMMENTS
Kirklees Walk in Centre registered nurses and advanced nurse practitioners (emergency and unscheduled care); sexual health service medical and nursing registered staff; Looked After Children nurses TB Nurses.	One off training Kirklees Safeguarding Children Partnership (KSCP) Multi-agency L2 'Working together to safeguard children' (or equivalent course in another area) within 1 year of commencing in post CSE e-learning package or other face to face training	Level 3 Safeguarding children training/learning activities undertaken should incorporate multi-disciplinary and multi-agency activities that can be delivered internal or external. A variety of learning opportunities are available on the safeguarding children Level 3 resource area accessible via the intranet. Other training, education and learning opportunities may include multi-disciplinary and scenario-based discussion drawing on case studies and lessons from research and audit appropriate to specialty and role. Safeguarding learning may be encompassed within regular, multiagency or vulnerable family meetings, clinical updating, clinical audit, reviews of critical incidents and significant unexpected events and peer discussions.
Kirklees Thriving Kirklees 0-19 practitioners, health visitors, school nurses; front door health practitioners; safeguarding hub nurses; registered children's community nurses, community nursery nurses/child development practitioners (Band 4); registered paediatric allied health professionals (therapists); health advisors in Youth Justice Service, Pupil referral unit; Looked after Children nurses	One off training KSCP 'Working Together to Safeguard Children' (within 12 months of commencing in post) or equivalent if undertaken in another area KSCP 'Making a Positive Contribution to Child Protection Conferences and Core Groups' (within 12 months of commencing in post) or equivalent if undertaken in another area CSE e-learning or other face to face training within 12 months of commencing in post	
Calderdale health visitors; school nurses; MAST health practitioners; Health advisor in Youth Justice Service; community nursery nurses; oral hygienists.	One off training CSCP Identifying and Responding to Vulnerable Children and Young People in Calderdale (within 12 months of commencing in post) CSCP Multi-Agency Assessment and Planning (Strengthening Families Approach to Initial Child Protection Conferences) (within 12 months of commencing in post)	

	CSE e-learning or other face to face training within 12 months of commencing in post	
Bradford sexual health service medical and nursing registered staff	One off training BSCP Safeguarding Children – A shared responsibility (within 12 months of commencing in post) or equivalent if undertaken in another area CSE e-learning or other face to face training within 12 months of commencing in post	
LCP General Practice General Practitioners and Advanced Nurse Practitioners (ANPs)	One off training KSCP 'Working Together to Safeguard Children' or CSCP Identifying and Responding to Vulnerable Children and Young People in Calderdale (within 12 months of commencing in post) or equivalent if undertaken in another area or CCG provided multi-agency L3 safeguarding training CSE e-learning or other face to face training within 12 months of commencing in post	
Safeguarding Children and Adult at Risk Safeguarding Practitioners Level 3/4	One off training KSCP 'Working Together to Safeguard Children' (within 12 months of commencing in post) or equivalent if undertaken in another area. CSE e-learning or other face to face training within 12 months of commencing in post	Training and learning activities undertaken will be fully informed by individual, organisational and Local Safeguarding Partnerships learning needs to meet the learning outcomes. Training, education and learning opportunities may include multi-disciplinary and scenario-based discussion drawing on case studies and lessons from research and audit appropriate to specialty and role. Safeguarding learning may be encompassed within regular, multiagency or safeguarding children partnership meetings, clinical updating, clinical audit,

LEVEL 4 – a minimum of 8 hours of safeguarding children training/learning activity must be undertaken per annum **<u>At least ONE multi-agency learning activity must be undertaken per annum.</u>**		
STAFF GROUP	MANDATORY	COMMENTS
Head of Safeguarding; Named Nurses Safeguarding Children and Adults at Risk; Named Doctor	Named Nurse should complete a management programme with a focus on leadership and change management within three years of taking up their post	Training and learning activities undertaken will be fully informed by individual, organisational and Local Safeguarding Partnerships learning needs to meet the learning outcomes. Training, education and learning opportunities may include multi-disciplinary and scenario-based discussion drawing on case studies and lessons from research and audit appropriate to specialty and role. Safeguarding learning may be encompassed within regular, multiagency or safeguarding children partnership meetings, clinical updating, clinical audit, reviews of critical incidents and significant unexpected events and peer discussions.

Appendix G - Safeguarding Children Mandatory Supervision Matrix

Practitioner group	Individual safeguarding supervision	Safeguarding children group supervision	Comments
Kirklees 0-19 Practitioners, health visitors, school nurses; Pupil referral unit (PRU); children's community nurses; sexual health outreach workers who are working with young people; **Calderdale** School nurses; **Kirklees and Calderdale**; health advisors in youth justice service; Looked after children (LAC) nurses	A minimum of one **planned** session with an approved safeguarding children supervisor **or** a member of the safeguarding children team per annum.	A minimum of one session within a 90 period, that may be incorporated into team meetings	**In addition, planned individual or integrated Supervision from a member of the safeguarding team or an approved safeguarding children supervisor must be accessed when a child on individual practitioner caseload becomes subject to a child protection plan.** Professional judgement will need to be used if the assessment following the initial child protection conference is that there is no further role for health practitioners in the child protection plan or ongoing child protection processes. It is best practice to seek supervision when a child has been receiving multi-agency support under a Single Assessment, Early Help, Child in Need or child protection plan for 12 months and there are no plans for de-escalation and/or no progress is being made.
Calderdale Health Visitors; health practitioners working in the multi agency safeguarding team (MAST)	**Planned** three monthly face to face supervision with an approved safeguarding children supervisor **or** a member of the safeguarding team for complex cases.	A minimum of one session within a 90 day period, which may be incorporated into team meetings.	**The face to face planned supervision must include supervision for children/young people who have become subject to a child protection plan.** It should also include children who have been receiving multi-agency support under a Single Assessment, Early Help, Child in Need or child protection plan for 12 months and there are no plans for de-escalation and/or no progress is being made. Colleagues working in Local Authority front door services must also fulfil any mandatory supervision requirements specific to their other roles.

Kirklees Health practitioners working in Front Door services; Safeguarding Hub practitioners	As required available upon request from an approved safeguarding children supervisor or a member of the safeguarding team	A **minimum** of one session within every 90 day period with a member of the safeguarding team	Colleagues working in Local Authority front door services must also fulfil any mandatory supervision requirements specific to their other roles.
Kirklees Paediatric physiotherapists, occupational and speech therapists; community Nursery Nurse/ Child Development Practitioners (Band 4); immunisation nurses; TB nurses **Calderdale;** Community nursery nurses	Individual supervision should be accessed as required; available on request from an approved safeguarding children supervisor or a member of the safeguarding team for complex cases	A **minimum** of one session within every 90 day period that may be incorporated into team meetings.	Sessional clinicians may access safeguarding supervision as part of other roles Pro rata
Kirklees, Calderdale and Bradford; all registered medical and nursing colleagues in sexual health services, walk in centres and GP practices	As required available upon request from an approved safeguarding supervisor or a member of the safeguarding team for complex cases	A minimum of one session within every 90 day period that may be incorporated into team meetings.	Safeguarding supervision may be incorporated into team meetings and supervision may be case based or involve reflection on wider safeguarding children circumstances and issues relating to practice within the service. Sessional clinicians may access supervision as part of other roles. Safeguarding supervision requirements for sessional clinicians are pro rata and are to be determined at the discretion of service manager and agreed with Head of Safeguarding dependent on frequency and nature of sessions covered.
Colleagues in a clinical role in dental services; non- medical or non-registered colleagues in	As required available upon request from an approved safeguarding children	Attendance at group supervision is good practice but not mandated.	Safeguarding should remain a regular agenda item on team meeting agendas to discuss any safeguarding issues.

integrated sexual health services, Health care assistants in children's services (Band 3).	supervisor or a member of the safeguarding children team		
Family Nurses	Tripartite with FNP supervisor and nominated member of the safeguarding team at least once per quarter. As required from a member of the safeguarding team.	Once a month in team meetings	Family nurses have weekly supervision with FNP supervisor, monthly team meetings and regular safeguarding updates. All clients on the family nurse caseload are required to be discussed in individual supervision with the FNP supervisor. It is recommended that clients whose children become subject to a child protection plan are also reviewed in tri-partite supervision.
Safeguarding Children supervisors	At least one **planned** session with a member of the safeguarding team per annum	A **minimum** of one Safeguarding Supervisor Development' update session per annum.	Supervisors must also fulfil any mandatory requirements specific to their substantive role. **NB Supervisors who have not attended a minimum of one Safeguarding Supervisor Development within the last 12 months should not provide supervision until they have attended an update session.**
Named Nurses Named Doctor	1:1 meetings as per agreed with Head of Safeguarding and additional as required Additional external as required from an appropriate senior supervisor	A minimum of one session within every 90 day period with the safeguarding team	
Safeguarding practitioners	Monthly with a senior member of the safeguarding team.	A minimum of one session within every 90 day period with the safeguarding team.	
Head of Safeguarding	External supervision as required.	A minimum of one session within every 90 day period with the safeguarding team	

Appendix H - Integrated Safeguarding Supervision Principles

1. The purpose of integrated safeguarding supervision facilitated by a member of the safeguarding team is to
    - undertake reflective work together to increase our understanding of the child/ren's and/or family circumstances
    - to maintain a child focus and consider what life is like from the child's perspective
    - to inform and widen professional assessments of vulnerabilities
    - to provide clarity about the role and responsibilities of each colleague working with the family
    - to understand other colleagues views and perspectives
    - to improve coordination of services provided to the family
    - to plan and agree together any actions that need to be taken and who will be responsible for those actions
    - to provide mutual support

2. All supervisees must agree to actively participate in the supervision by sharing our personal knowledge and experience of working with the family and to listen to other colleagues' experiences and perspectives.

3. All supervisees must agree to accept and offer each other respectful challenge to ensure that alternative explanations and perspectives of the children's circumstances are considered to enhance the quality of our assessments.

4. All supervisees must agree that discussions that take place in integrated supervision will remain confidential but understand that the supervision session will be formally documented, and a record will be maintained in the relevant child's electronic health record and a copy will be sent to each supervisee.

5. All supervisees must agree that ownership and follow through on any actions agreed by consensus will be the shared responsibility of all colleagues actively working with the family.

6. All supervisees must agree to inform the relevant safeguarding leads and/or managers in their own service that supervision has been sought as per their own individual agency requirements.

Appendix I – Process for Initial Child Protection Conference (ICPC) Attendance by Calderdale School Nursing Team

Invite and report request received into duty via admin

Complete & return ICPC report to Gov.uk e-mail admin account.

- Allocate to School Nursing (SN) team colleague.
- Colleague to review records to determine if child/family known to service
- Colleague to make contact with Social Worker (SW) for update and to determine if any risks in contacting family and arranging Health Needs Assessment (HNA)
- HNA to be arranged with parents before ICPC after reviewing the SW report (see A) Completion of HNA is dependent on availability of SN/Parent, capacity of SN and appropriateness? (see B)
- If parents/child decline HNA see C
- If child consents but parent's do not, consider Gillick competence, discuss with SW.
- Decision to be made if attendance at ICPC is needed after reviewing records, reading SW report and completing the HNA (if this has been possible) attendance/non-attendance will need confirming.
- Clear documentation in SystmOne record with rationale for attendance/non-attendance. This should be recorded in the Tabbed Journal and Significant Events
- Supervision to be sought by Band 5 from Band 6 regarding decision making for attendance/non-attendance at ICPC

A

Reading the SW report prior to the HNA may help you in directing your questions/exploring any issues that may be apparent in the report that you would otherwise have no prior knowledge of.

B

Considerations for delaying HNA until after ICPC:

- If safety of contact has not been clarified and the family are not known to school nursing service
- If short timescales (less than 4 working days) for completion would compromise the quality of the assessment

- If the SW report was not received in a timely manner allowing opportunity to complete HNA beforehand

C

- If parents/child decline to give consent for HNA, SN to inform SW.

Guidance for Withdrawal from Future Core Groups and Review Conferences

If the HNA identified there is no school nursing intervention required:

- Where possible 1st core group to be attended by SN to share outcome of Health Needs Assessment and any recommendations for partner agencies
- If unable to attend 1st core group due to capacity, colleague to complete a non-core group member report template for sharing the HNA outcome using the strengthening families framework in order to analyse risk, complicating and protective factors, grey area and the voice of child. **This report needs to be sent via NHS Net to the Social Worker's Pod Coordinator (Pod contact details saved in SN share). SN to ring Pod admin to confirm receipt of report.**
- Clear documentation on report that should circumstances change and school health practitioner expertise is needed this can be requested by the Core Group/Child/Family by contacting School Nursing Duty
- Clear documentation in SystmOne records with rationale for opting out of the Core Group meetings
- Supervision to be sought by Band 5 staff nurse from Band 6/Safeguarding Team/Team Leader regarding decision making regarding opting off the core group
- A copy of this report to also be sent to Local Authority Child Protection Admin Team so the report is available for the review conference and will be sent to the review by the child protection admin team.