Child Protection Policy and Procedure

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Related policies:

- Child Protection Training Policy
- Cornwall and Isles of Scilly Our Safeguarding Children Partnership multi-agency Safeguarding Children Procedures

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Part A

1. Introduction

NHS Kernow Clinical Commissioning Group (NHS Kernow) has a statutory responsibility for safeguarding children and young people under the children Act 1989 and 2004. Section 11 of the Children Act 2004 places clinical commissioning groups (CCGs) under a statutory duty to ensure that in discharging their functions they have regard to the need to safeguard and promote the welfare of children. In order to fulfil its responsibilities effectively, NHS Kernow promotes the following general principles as set out in ‘Working Together to Safeguard Children’ HM Government 2013 and 2015:

- Ensure that all affected children receive appropriate and timely therapeutic and preventative interventions;
- Professionals who work directly with children should ensure that safeguarding and promoting the child’s welfare forms an integral part of all stages of care they offer;
- Professionals who come into contact with children, parents and carers in the course of their work also need to be aware of their safeguarding responsibilities. It is paramount that all health professionals can recognise risk factors, contribute to reviews, enquiries and child protection plans, as well as planning support for children and providing ongoing promotional and preventative support through proactive work; and
- Safeguarding children’s standards should be included in all clinical contracts.

This policy supports national legislation and guidance, together with local policies and procedures. It should be read in conjunction with the multi-agency electronic Child Protection Procedures which can be found on the Cornwall and Isles of Scilly Our Safeguarding Children Partnership (CIOSOSCP) website.

This policy is divided into two sections: Part A highlights the statutory role for NHS Kernow (appendix 1a) whilst Part B includes the practical management of safeguarding concerns. These are combined in one policy to reflect the legal requirements to co-operate and improve the wellbeing of children (Section 10, Children Act 2004) and ‘safeguard and promote the welfare of children’ (Section 11, Children Act 2004).

2. Purpose

The purpose of this policy is to enable NHS Kernow to demonstrate how it meets its corporate accountability for safeguarding children, demonstrating that it follows national guidance, promotes best practice and reflects just how well NHS Kernow works effectively with its partner agencies.

Who this policy applies to
The scope of this policy therefore includes all staff employed by NHS Kernow who work with families and children, either directly or indirectly, or commission services for children or parents/carers of children and young people.

The policy is also applicable to contractors and volunteers working within the organisation, including celebrity or fundraising volunteers.

It is expected that all providers of health services should have their own Safeguarding Children Policy, if they do not, then they should adhere to this Safeguarding Children Policy.

All service providers who have safeguarding children’s standards included in their contracts must comply with the annual and/or quarterly returns of performance information as appropriate to their contract. It is the responsibility of the contract manager to monitor compliance and inform the designated safeguarding children’s professionals of any problems. The designated professionals will then discuss these issues with the providers and work with them to ensure they address them in conjunction with the escalation process contained within the contract.

This policy applies to the unborn child (in relation to child protection concerns about the pregnant mother) and all children up to 18 years of age, regardless of nationality, culture or religion. If the child has learning difficulties/disabilities or is a care leaver their needs may extend to their 21st birthday (Section 9 Children Act 2004). The term ‘children’ will be used throughout this policy to refer to children and young people. Staff working with vulnerable young people must consider the safe transition to Safeguarding Adults services. Staff must not close any case until this transfer has been agreed by the client and the receiving service. The CCG defer to the Cornwall Local Authority policy and systems for safeguarding adults.

The children may be service users in their own right or children cared for by adults who are receiving services from a provider. It also covers other children in the wider community that come to the attention of staff in the course of their work e.g. children educated at home, children on holidays, travellers, asylum or migrant children or families not registered with GPs.

The principles in this document will provide support, advice and guidance to NHS Kernow in discharging its full safeguarding responsibilities. It will alert staff to their safeguarding responsibilities for children through early identification and appropriate information sharing and referral. As such this policy should be read by all staff and will be referred to in the level one safeguarding training delivered as mandatory training to all employed staff upon induction.

All providers of services commissioned by NHS Kernow must have a Safeguarding Children Policy as a requirement of their contract; this is now incorporated into national contracts for acute services, ambulance services and mental health services. Working Together to Safeguarding Children (2013 and 2015) particularly highlights independent contractors. These groups can use this document as good
practice guidance to support their own policy and practice development.

NHS Kernow will work closely with the NHS England), who have the statutory duty and responsibility to work with independent providers i.e. GPs, dentists, opticians, pharmacists and Children’s Hospice to safeguard and protect children and to ensure that Kernow residents receive a service that appropriately safeguards children.

Key principles

- The welfare of the child is the paramount consideration.
- Wherever possible, children should be brought up and cared for within their own families.
- Parents with children in need should be helped to bring up their children themselves. This help would be provided as a service to the child and his/her family and should:
  - Be provided in partnership with the parents.
  - Meet each child’s identified needs.
  - Be appropriate to the child’s race, culture, religion and language.
  - Be open to effective independent representations and complaints procedures.
  - Draw upon effective partnership between the local authority and other agencies, including voluntary agencies.

Legal considerations

- The Children Act 1989
- Section 11 and Section 13 of The Children Act 2004

Definitions

Working Together to Safeguard Children 2013 and 2015 recognises four categories of abuse; these are: physical, emotional, neglect and sexual, and it also provides definitions for the levels of support children can experience moving through the safeguarding agenda. Appendix four has these full definitions.

Safe recruitment

NHS Kernow’s recruitment policies and procedures must comply with all relevant legislation and guidance relating to staff working with children. This will include information on ‘Managing allegations of abuse against a member of staff’.

Practical details on how to manage this will also be in Part B (appendix two) of this policy.

All staff working with children and families will be checked by the Disclosure and Barring Service. Any exceptions to this will be flagged to the Designated Nurse and CCG Governing Body Executive Lead for safeguarding.
3. Policy governance

Roles and responsibilities

NHS Kernow has a broad range of safeguarding children responsibilities as detailed in ‘Safeguarding children and young people: roles and competences for health care staff’ (Intercollegiate document 2014) which are to be exercised through the Chair, Chief Executive officer, Executive Director and Non-Executive Director as described below.

Working Together to Safeguard Children (2013 and 2015) sets out the roles and responsibilities of all organisations with regard to safeguarding children, and provides the statutory guidance for all health organisations as described below.

Appendix 1a shows the organisational structure for NHS Kernow and Appendix 1b summaries the key safeguarding roles and responsibilities of the CCG. These are divided into corporate and lead professional responsibilities as summarised below.

Organisational responsibilities

The Chair
- The chairs of commissioning bodies are responsible for the effective operation of the Board with regard to safeguarding children and young people;
- Key responsibilities for chairs;
- To ensure that the role and responsibilities of the NHS organisation board in relation to child protection and looked after children are met;
- To ensure that the organisation adheres to relevant national guidance and standards for child protection and looked after children;
- To promote a positive culture of safeguarding children across the board through assurance that there are procedures for safer recruitment; whistle blowing; appropriate policies for child protection and looked after children and that these are being followed; and that staff and patients are aware that the organisation takes child protection and looked after children’s issues seriously and will respond to concern about the welfare of children;
- To ensure that there are robust governance processes in place to provide assurance on child protection and looked after children; and
- To ensure good information from and between the organisation board or board of directors, committees, council of governors where applicable, them, the membership and senior management on child protection and looked after children.

Chief Officer
- The Chief Officer of commissioning bodies must provide strategic leadership, promote a culture of supporting good practice with regard to Safeguarding within their organisations and promote collaborative working with other agencies.
Key responsibilities of the Chief Officer

- To ensure that the role and responsibilities of the NHS board in relation to child protection and looked after children are met
- To ensure that the organisation adheres to relevant national guidance and standards for child protection and looked after children
- To promote a positive culture of safeguarding children to include: ensuring there are procedures for safer staff recruitment, whistle blowing; appropriate policies for child protection and looked after children (including regular updating); and that staff and patients are aware that the organisation takes children’s safeguarding seriously and will respond to concern about the welfare of children
- To appoint an Executive Director lead for safeguarding
- To ensure good safeguarding practice throughout the organisation
- To ensure there is appropriate access to advice from Named and Designated professionals (Child protection and looked after children)
- To ensure that operational services are resourced to support/respond to the demands of child protection and looked after children effectively
- To ensure that an effective child protection, looked after children training and supervision strategy is resourced and delivered
- To ensure and promote appropriate, safe, multiagency/interagency partnership working practices and information sharing practices operate within the organisation

Executive Director

There should be a nominated Executive Director board member who takes responsibility for children’s safeguarding issues – this role is fulfilled by the Chief Nursing Officer. The Executive Director lead will report to the NHS Board on the performance of their delegated responsibilities and will provide leadership in the long term strategic planning for child protection and looked after children’s services for children across the organisation supported by the Named and Designated professionals.

Boards should consider the appointment of a Non-Executive Director (NED) board member to ensure the organisation discharges its safeguarding responsibilities appropriately and to act as a champion for children and young people.

Key responsibilities of the Board Executive Director Lead for safeguarding children

- To ensure that child protection and looked after children is positioned as core business in strategic and operating plans and structures
- To oversee, implement and monitor the on-going assurance of child protection and looked after children’s arrangements
- To ensure adoption, implementation and auditing of policy and strategy in relation to child protection and looked after children
- Within commissioning organisations to ensure the appointment of Designated Professionals (Child protection and looked after children)
- Within commissioning organisations to ensure that provider organisations are
quality assured for their safeguarding arrangements

- Within both commissioning and provider organisations to ensure support of named/designated lead professionals across primary and secondary care and independent practitioners to implement safeguarding arrangements
- To ensure that there is a programme of training and mentoring to support those with responsibilities for child protection and looked after children
- Working in partnership with other groups including commissioners/providers of health care (as appropriate), local authorities and police to secure high quality, best practice in child protection looked after children
- To ensure that serious incidents relating to safeguarding are reported immediately and managed effectively

**Non-executive Director Board lead**

- To ensure appropriate scrutiny of the Organisation’s safeguarding performance
- To provide assurance to the Board of the Organisation’s safeguarding performance
- This role is fulfilled by the NHS Kernow lay Member for Governance

**Designated professionals responsibilities**

‘Working Together to Safeguard Children 2013 and 2015 states that each CCG is responsible for identifying a designated nurse and a designated doctor for safeguarding and Looked After Children.

Their key responsibilities are also defined within NHS England’s Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework:

The Designated Professional’s role is to work across the local health system to support other professionals in their agencies on all aspects of safeguarding and child protection. Designated Professionals are clinical experts and strategic leaders for safeguarding and as such are a vital source of advice and support to health commissioners in CCGs, the local authority and NHS England, other health professionals in provider organisations, quality surveillance groups (QSG), regulators, the Local Safeguarding Children Partnership (LSCP) and the Health and Wellbeing Board. Whatever arrangements are in place for securing the expertise of Designated Professionals it is vital that CCGs enable and support Designated Professionals to fulfil their system-wide role.

The Designated Professional must have direct access to the Executive (Board level) Lead to ensure that there is the right level of influence of safeguarding on the commissioning process. The CCG Chief Officer (or other executive level nominee) should meet regularly with the Designated Professional to review child safeguarding.

- Designated professionals are responsible for undertaking serious case reviews/case management reviews/significant case reviews on behalf of health commissioners and for quality assuring the health content.
- Be involved in the appointment of named professionals and support named
professionals in fulfilling their role as appropriate.

- Advise on appropriate training for health personnel as dictated within the Intercollegiate Framework document and participate in its provision as required.
- Advise on practice, policy, guidance and ensure health components are updated; ensure expert advice is available on safeguarding policy and procedure and on day-to-day safeguarding management of children and families’ concerns.
- Liaise with other designated nurses and doctors, both nationally and regionally, to bench-mark safeguarding work.
- Attend relevant regional and national forums and maintain their competencies as laid out in the intercollegiate document.
- Ensure robust assurance/governance systems are in place within all provider organisations commissioned by the CCG.
- Provide leadership to the CCG on the safeguarding children’s agenda and children looked after and care leavers, to ensure the organisation discharges its responsibilities effectively and appropriately.
- Provide advice and support to GP practice members and named professionals in each provider organisation.
- May provide supervision to Named and Lead safeguarding staff within provider organisations.
- Provide specialist advice and guidance to the Governing Body and Executives of the CCG on all matters relating to safeguarding children including regulation and inspection.
- Be involved with commissioners, providers and partners on direction and monitoring of safeguarding standards and to ensure that safeguarding standards are integrated into all commissioning processes and service specifications.

**Named professionals**

Will focus upon safeguarding within their organisation as they:

Provide support and advice to staff in the day-to-day management of safeguarding practice.

- Promote good practice in safeguarding work.
- Provide advice to support their own organisation’s governance arrangements for safeguarding children.
- Develop a safeguarding children training strategy.
- Develop the safeguarding children training programme and ensure its delivery meets the required standards.
- The designated Nurse will provide support to the Named Nurses / Midwives to achieve the above.

**Head of nursing**

- Deputises for the Chief Nursing Officer / Board Executive Director
- Assists in the fulfilment of the key responsibilities of the Board Executive Director Lead for Safeguarding Children as listed above.
• Line manages the Designated Nurses Safeguarding and Looked After Children and Designated Nurses Safeguarding Adults

All staff - including managers

• This policy is designed to support staff in their safeguarding and child protection duties and to ensure managers take responsibility for the actions of their entire staff.
• Managers within the CCG are responsible for ensuring that practice reflects the standards laid out within this policy, particularly Section 2, and that staff are given adequate resources and support to comply with them.
• All staff are responsible for ensuring that they are aware of the requirements to safeguard children incumbent upon them and for ensuring that they comply with these.
• All staff involved in the commissioning of services must consider this policy when they develop and commission services and must include the safeguarding children standards in all contracts that have contact with adults or children.
• All staff have a responsibility to inform senior managers or the safeguarding team of any child protection or safeguarding concerns. Managers have a responsibility to ask staff about their child protection /safeguarding workloads, to ensure safe working.
• Managers must ensure that Safeguarding Children Policy practices are in place within the organisation. They must also escalate any concerns about resources or staffing impacting on implementing safeguarding procedures. (Laming Inquiry 2003)
• Managers are responsible for ensuring that staff are aware of and can access this policy and the multi-agency safeguarding procedures CIOSOSCP website. If staff do not have access to the internet then they should have access to a hard copy of “What to do if you’re worried a Child is Being abused” flowchart (Appendix 3)

Safeguarding structures

The Chief Nursing officer is accountable for the organisation’s overarching safeguarding responsibilities; this includes assuring the Governing Body that the organisation is fulfilling its duties.

Collaboration and partnership working is the key factor in securing successful outcomes for safeguarding children and promoting their welfare.

The Children Act 2004 places a duty on key agencies, which includes all CCGs to:

• Co-operate to improve the wellbeing of children (Section 10).
• Make arrangements to safeguard and promote the welfare of children. (Section 11).
• To work with the CIOSOSCP through joint procedures, training and funding, and engage in joint inspections of children’s services.
4. National context

Safeguarding continues to have a high national priority and this has been escalated following recent events, with even greater scrutiny of the way in which organisations execute their safeguarding responsibilities. This Safeguarding Children Policy supports the legislation and guidance in:

- Health and Social Care Act (2012).
- Protecting children and young people: The Responsibility of All Doctors-GMC (2012)
- The Victoria Climbie Inquiry (SH 2003).
- Female Genital Mutilation Act 2003.
- When to suspect child maltreatment: Quick reference guide, NICE clinical guideline 89 (July 2009).
- The Adoption and Children Act 2002.
- Intercollegiate Document Children in Care 2015.

This is not an exhaustive list of all safeguarding legislation, policies and procedures, but directs staff to the key publications they may wish to reference in their work.

5. Commissioning arrangements

- Ensure commissioning arrangements work in co-operation with Local Authority, NHS England and link to the priorities of the CIOSOSCP.
- Ensure there is a senior commissioning lead for children and young people to ensure their needs are at the forefront of local planning and service delivery.
- Ensure that clinical governance arrangements are in place to assure the quality of services commissioned by the CCGs.
- Commission secondary health care for Looked After Children (LAC), including those placed outside of the county.
Contract monitoring

- Ensure through contracts with commissioned services that health services and healthcare workers contribute to multi-agency safeguarding work.
- Include the requirement for sharing information with CCGs and LSCPs regarding Safeguarding arrangements and Outcome Frameworks in all commissioning arrangements, contracts and/or service level agreements.
- Ensure that Designated Professionals have been consulted on all relevant contracts and service level agreements.

Partnership working

- Work with Local Authorities to commission co-ordinated and, where possible, integrated safeguarding services.
- Statutory membership of the CIOSOSCP is required of NHS Commissioning Board, CCGs, and local NHS Trusts / Foundations Trusts whose hospitals and other facilities are within Cornwall.
- Work in collaboration with the NHS England to ensure that safeguarding children arrangements are in place across the health economy.
- Co-operate with the local authorities in fulfilling duties towards children in care, including health assessment and planning.

Responsibilities of employees

- All employees of the CCG’s partner practices and contracted support services must be mindful of their responsibility to safeguard children. Therefore, all staff must be up-to-date with the appropriate level of safeguarding children training as set out in the Intercollegiate Document (2014) – further detailed information about safeguarding training requirements are included in the CCG Safeguarding Children Training Policy (2018)

Primary Medical Care

- GP practices must have a lead for safeguarding children who must work closely with the CCG Named GP / Executive Lead Professional and Designated Professionals to address quality issues in relation to safeguarding
- GP practices must maintain an up-to-date list of staff training in relation to safeguarding.
- GPs must ensure that they contribute effectively to children in need of support or protection, including provision of reports for child protection conferences.

6. Annual reporting

The CCGs and all NHS trusts or foundation trusts are required to publish annual reports for Safeguarding and Looked After Children. These reports can incorporate:
7. Safe recruitment and employment

The CCG undertakes its recruitment procedures and practices in accordance with current employment legislation and guidance, which includes the Safeguarding Vulnerable Groups Act (2006) and Safer Recruitment (2006).


The CCG will carry out thorough checks on all new employees working with children or families or acting in a safeguarding role. This will include:

- Disclosure and Barring checks which includes an enhanced check if required.
- Recognising and discussing gaps in work history.
- All interview panels involved in the appointment of staff who will work with children will include at least one member who has undergone CIOSOSCP Safer Recruitment Training and understand their responsibility to safeguard children through the safer recruitment process.

All staff employed or subcontracted to work for the CCG, any volunteers, celebrities and visitors, should conduct themselves in an appropriate manner and adhere to their own professional codes of conduct, which includes being polite, consistent, honest, and trustworthy.

Staff working with children and families in their own homes or the community should think about their own personal safety and be able to undertake risk assessments as required. If any member of staff feels it is unsafe to work with a family or attend a home with children in it, they must consider the safeguarding issue for the children in the home. They should discuss their concerns with their line manager and/or the designated nurse for safeguarding children or their own safeguarding lead.

8. Managing allegations of abuse made against
Working Together to Safeguard Children (2013 and 2015) highlights the statutory guidance placed on the CIOSOSCP to manage allegations of abuse made against staff. Each member organisation of the CIOSOSCP must follow these guidelines if a report is received about an allegation or a concern that a professional has:

- Behaved in a way that has harmed a child, or may have harmed a child, or possibly committed a criminal offence against or related to a child, or behaved in an inappropriate way towards a child, which may indicate that he or she is unsuitable to work with children.
- CIOSOSCP Local Authority Designated Officer (LADO) Procedures must then be followed. A link to the LADO process is located in Appendix 5. The CCG’s Nominated Safeguarding Senior Officer (NSSO) for reporting professional allegations to is the Chief Nurse.
- Additionally these procedures may be used if: there are concerns about the person’s behaviour towards their own children or children unrelated to their employment or voluntary work, and there has been a recommendation from a strategy discussion that consideration should be given to the risk posed to children they work with and / or when an allegation is made about abuse that took place some time ago and the accused person may still be working with or having contact with children.

Professionals must:

- Report the allegation to the NSSO for allegations, as soon as possible.
- Make a signed and dated record of concerns, observations or the information they have received.
- Maintain confidentiality whilst an investigation is being conducted. The investigation must include a Human Resources representative.

Professionals must not:

- Attempt to deal with the situation themselves in isolation.
- Make assumptions or diminish the seriousness of the allegations or behaviour.
- Keep the information to themselves or promise confidentiality.
- Take any action which might undermine any future investigation or disciplinary procedure, such as interviewing the alleged victim or witnesses, or informing the alleged perpetrator or parents/carers.

The flow chart (appendix two) outlines the required actions and timescales.

9. **Access to advice and support for staff**

Staff can access advice and support from a range of sources, including:
• Designated Nurse or Doctor for Safeguarding Children;
• Named GP / Lead Professional or Named Nurse / Named Midwife;
• The Duty Child Protection Paediatrician at RCHT during working hours; and
• Duty Social Workers via the Multi-Agency Referral Unit (MARU).

Staff who are working frequently with children and parents must access regular supervision to help them reflect on their working practice and ensure they remain objective to the child’s needs for support and protection. This support can be group supervision or individual supervision and can be organised with the designated professionals. Details about supervision are contained in the CCG’s Safeguarding Supervision Policy (2018).

All staff are responsible for ensuring that telephone discussions concerning child protection are recorded including the action plans agreed. In addition, consideration should be given to sharing child protection concerns / referrals or significant information received with the child’s GP and other involved professionals on a need to know basis.

If staff are unable to contact the Designated Nurse for advice they can discuss cases prior to making a referral with a duty social worker at children services / MARU or with the on call Duty Paediatrician for Child Protection in keeping with CIOSOSCP procedures (See appendix three for contact details of the MARU, children services, the on call paediatrician and the police).

10. Recognising abuse or significant harm

The Children Act (1989) (2004) introduced the concept of Significant Harm as the threshold that justifies compulsory intervention in family life in the best interests of children. There are no absolute criteria on which to rely when judging what constitutes significant harm but consideration should be given to the following:

• The severity of ill-treatment, which may include the degree and extent of physical harm, including, for example, impairment suffered from seeing or hearing the ill-treatment of another.
• The duration and frequency of abuse and neglect.
• The extent of premeditation.

Child abuse and neglect is a generic term encompassing all ill-treatment of children, including serious physical and sexual assaults, as well as cases where the standard of care does not adequately support the child’s health or development.

Children may be abused or neglected through the infliction of harm, or through the failure to act to prevent harm.

Abuse can occur in a family or an institutional or community setting, regardless of social class. The perpetrator may or may not be known to the child.
Working Together to Safeguard Children (2013) (2015) sets out definitions and examples of the four broad categories of abuse which are used as a basis to determine whether or not a child should be subject to a Child Protection Plan:

- Physical abuse.
- Emotional abuse.
- Neglect.
- Sexual.

These categories overlap and an abused child does frequently suffer more than one type of abuse. Details about how children can become the subjects of a Protection Plan, have a Protection Plan amended or ended can be found in the CIOSOSCP Multiagency Child Protection Procedure.

Section 13 ‘Referring to Children’s Social Care’ provides details about how to refer child protection concerns and it is important to note the following principles:

‘Do Not Delay – Act on the same Working Day’

‘Children are not able to protect themselves. Children need you to see them, hear them and protect them. The difference between child abuse or child protection could be You’

**Part B**

**11. Risk indicators**

The factors described in this section are frequently found in cases of child abuse. Their presence is not proof that abuse has occurred, but must be regarded as indicators of the possibility of significant harm. The absence of such indicators does not mean that abuse or neglect has not occurred.

In an abusive relationship the child may:

- Appear frightened of the parent(s) / carer(s);
- Act in a way that is inappropriate to his/ her age and development;
- Engage in risk taking behaviour; or
- Not exhibit any definitive signs.

Staff need to be aware that the behaviour of children from different cultures or communities may not match the behaviour seen by the majority of children. Cultural issues, traditions or gender imbalance should not be used as an excuse for any form of abuse.
The parent or carer may:

- Persistently avoid services that support children and families or they may delay seeking appropriate treatment for a child if they are ill or need routine surveillance.
- Have unrealistic expectations of the child.
- Frequently complain about/to the child and may fail to provide attention or praise (high criticism/low warmth environment).
- Be absent physically or emotionally because of misusing substances, mental health problems or Domestic Violence.
- Persistently refuse to allow access on a home visit.

The Nice Guidance ‘When to suspect child maltreatment’ - July 2009: provides a comprehensive guide to recognising risks for children. There are some specific risks identified by reports into child deaths, these risks indicators are:

- Domestic violence in the family
- Parents who misuse drugs and alcohol
- Parental mental health issues, including those parents who perpetrate fabricated induced illness in children.
- Parents with learning difficulties.
- Disabled children.
- Parents who have been subject to child protection procedures when they were children.
- Teenage pregnancy
- Cultures that practice female genital mutilation, forced marriage or Honour Based Violence.
- Children who frequently miss health appointments.

This is not an exhaustive list but can support a professional in their assessment of the risk to a child.

Appendix five provides the professional with links to specific guidance produced by CIOSOSCP and the Department for Children, Schools and Families. Commissioners of services for children or families need to pay particular attention to the safeguarding arrangements of all providers.

**Children who access emergency services**

Appropriate action needs to be undertaken for children who access any of these services anywhere in the country:

- Emergency departments;
- Walk-in centres; and

*There are links in appendix five to the CIOSOSCP procedures about these matters*
• Out of hours services.

If a child attends any of these local services then the information is shared directly with the health visitor or school nurse and the GP. Where the service has access to the Child Protection - Information Sharing project (CP-IS) and is informed that the child is the subject of a Protection Plan the child’s social worker must be informed by the service; also if the child has a social worker because they are a Child in Need or Looked After then the health visitor / school nurse and / or GP should inform the social worker immediately regarding the child’s attendance. The CP-IS project is linking the IT systems used across health and social care and helping organisations to change business processes so this basic information can be shared securely between them. The information can only be accessed securely by trained professionals involved in a child’s care.

The provider of community children services must include these arrangements in their safeguarding policy, including timeframes for sharing information and reviewing / analysing cases where there have been frequent attendances within a given period. Minimum good practice guidance should recommend if there have been three or more attendances or communications from any of the emergency services listed above within a twelve month period then a formal review of children’s records should be undertaken. If analysis of the records / attendances indicates that there are concerns for the child’s welfare / care then advice must be sought from a member of the safeguarding team within one working day as it may be necessary to consider referring / referring to MARU / children’s social care.

If the child is in education in Cornwall or has accessed a service outside of Cornwall then the following points will be observed:

• The information will be shared with the child’s GP, the school nurse and/or health visitor employed by the provider of community services.
• The content of the information will be assessed and copied to the private schools registered health professional if they have one and if not appropriate information will be shared with the private school’s child protection leads.
• If the information is significant then the information will be shared with the duty social work team.
• If the child does not have a GP then a letter will be sent to the parent giving them details of local GPs and recommending they register with a GP. This letter will be copied into the local health visiting team or school nurses, with a request they make contact with the family to support them in registering with a GP.
• The information will be retained for five years and then shredded, as the primary source of information is held with the GP. The only exception is for families who have not registered with a GP and these records will be retained for 25 years.

If a member of staff has any safeguarding concerns about a child who attends one of the emergency services they should follow the child protection referral procedures on the CIOSOSCP web site. If staff have any safeguarding concerns when seeing a
child they may check with Cornwall’s Children’s Social Care team who can identify if a child is the subject of a child protection plan.

Appendix six is a simple flow diagram illustrating the steps you need to consider when you have safeguarding concerns for children.

12. Assessment

The assessment framework (2000) supports professionals working with children and families in their recognition of risks to the child. When this information is shared it also provides a common language for all agencies working to safeguard a child and their family.

Appendix seven has the assessment framework and appendix five includes a link to the referral form for making a referral to social care when safeguarding concerns have been recognised. Any staff employed by the CCG making a referral to the social work team must send a copy of the referral to the CCG Designated Nurse for Safeguarding Children.

Other providers using this policy should share their referrals with their child protection lead within their own organisation / practice. They should also share this referral with the child’s GP. The CCG Safeguarding team can help identify Children’s GP’s for practitioners.

Staff must use their professional judgement, knowledge and expertise when assessing potential risks within families. If needs are identified then these should be discussed with the parent/carer, unless to do so would jeopardise the safety of the child or any other person. An action plan, including timescales, should be agreed with the family to address the identified needs and the plan should be regularly reviewed.

It may be appropriate to complete a Common Assessment Framework (CAF) if the child or young person has additional needs which cannot be met by one agency but are below the threshold for child protection. Advice can be obtained from the designated nurse for safeguarding children or other members of the integrated working team (eg health visitors, school nurses, children centre managers, teachers, social care, etc). Staff who work regularly with children or parents should have access to the common assessment framework training. Parents must consent to a CAF assessment otherwise this cannot be undertaken as to take part is voluntary. If a parent / carer doesn’t take part / consent the practitioner will need to reassess the situation and consider whether the threshold for referral to Children’s Social Care is reached which does not require parental / carer consent.

The child must be the main focus of any assessment and the child’s views and wishes sought (in the light of their age and level of understanding), recorded and acted upon. A child’s feelings may be communicated through spoken word, written or body language and each element has equal importance.
It is especially important to assess the needs of children who are disabled or where English is not their first language. In these situations every effort should be made to have an independent person to communicate for the child together with the family’s interpretation of the child’s wishes.

Any practitioner who feels that their personal safety might be compromised when visiting a family must undertake a risk assessment. They must contact their line manager at the earliest opportunity to arrange safe contact arrangements for the family. The risk assessment should include the actual or potential risk to the child in each situation and arrangements made for this to be reviewed.

13. Referring to Children’s Social Care Multi-Agency Referral Unit (MARU)

It is not necessary to obtain consent for a child protection referral. It is, however, good practice, with few notable exceptions, when it would be detrimental to the child, or any resulting investigations, to share your concerns with the child/young person or family and inform them of the referral – please see the exceptions in section 16.

All telephone referrals to the MARU should be followed up in writing within 48 hours using the CIOSOSCP Multiagency Referral Form (MARF). Any correspondence related to the referral should be sent by secure e-mail to multiagencyreferralunit@cornwall.gcsx.gov.uk or registered post. All communication should be marked as ‘confidential’ and it is the sender’s responsibility to ensure the information has arrived.

A copy of the child protection referral form should be:

- Retained in the child’s records.
- Sent to the designated nurse (if you are an employee of the CCG).

Consideration should also be given to sharing the referral information with the GP and any other professionals working with the family on a need to know basis.

If the health practitioner has not been informed of the outcome of the referral within three working days they should contact the social care team to find out themselves.

Appendix five has a link to the CIOSOSCP referral form.

Remember:

- ‘Do not delay – act on the same working day’
- ‘Children are not able to protect themselves. Children need you to see them, hear them and protect them. The difference between child abuse or child protection could be you’
14. Child protection supervision

The National Service Framework core standard 5 (NSF Standard 5-14, p170) recommends that ‘agencies provide direct supervision to staff working with children where there are concerns about harm, self-harm or neglect of a child. This includes regular supervision and a review of the child’s records’.

Staff who are working regularly with children need to arrange child protection supervision with the designated professionals. The supervision can be either individual or group. Further details about the arrangements for this are in the CCG’s Child Protection Supervision Policy (2018)

Supervision will be recorded using an appropriate form at the time of supervision and this will be signed by both the supervisor and the supervisee (see the Safeguarding Supervision Policy (2018) . The supervision process should include a revision of cases, the practitioner’s emotional wellbeing, any challenges in practice related to child protection and the employee’s compliance with maintaining their safeguarding children’s training.

The Designated Doctor provides supervision for the named doctors. The Named Doctor is supported to provide group supervision to the designated safeguarding GPs in each Practice. In the absence of the Named GP/ Lead Professional, the Designated Nurse can be contacted for advice.

The Designated Nurses may provide child protection supervision to the Named Nurses / Named Midwives in the local health providers and CCG.

The Designated professionals will receive child protection support from the Governing Body Executive Lead for safeguarding and formal supervision paid for by the CCG. This would be one hour every six to eight weeks as a minimum.

15. Record keeping

Staff must ensure that they adhere to the NHS Records Management Policy and any professional codes of record keeping.

At first point of contact a full set of information about a child must be recorded, including names, dates of birth of each child, details of the parent(s)/carer(s), any new partners and names of those who may provide support in child care, eg: grandparents, etc. The information should also include any day care or schools and name of GP. This information should be reviewed and updated where necessary at every contact or new assessment.

If you are working with a child then a chronology of any significant events that happen to the child or the family must be maintained.
It is good practice to maintain a Genogram. Appendix 8 gives an example of how to create one. You must also retain copies of any communication with other agencies in these records.

16. Information sharing

Sharing information amongst professionals working with children and their families is essential for the purpose of safeguarding and promoting the welfare of children. It is often only when information is shared that a child can be seen to be in need or at risk of serious harm. Professionals must use their judgement but should also be aware that failure to pass on information that might prevent abuse or a tragedy could expose them to criticism in the same way as an unjustified disclosure.

Professionals work in partnership with parents / carers and it is therefore good practice to inform them, however, if in specific circumstances informing the parent(s)/carer(s) that information is to be shared with other agencies would be likely to put a Child(ren) at risk then informing the parent(s)/carer(s) can at that stage be discounted. Section 16.5 highlights some examples when parents should not be told about information sharing until there has been a formal strategy meeting to review the concerns and risks to the child.

There are some legal controls to the disclosure of information and these include:

- Common Law of Confidentiality.
- Data Protection Act 1998.

The law will not prevent you from sharing information with others if:

- Consent has been obtained.
- The public interest in safeguarding the child’s welfare overrides the need to maintain confidentiality.
- Information is being shared to inform an assessment being undertaken by social services. The Children Act places an obligation on health professionals to share information when an assessment is being undertaken.
- Disclosure is required under a court order or other legal obligation.

There is a useful guide to support professionals in understanding how a range of sources is put together and when they should share information which can be found here.

The key factor in deciding whether or not to disclose information is proportionality; is the disclosure a proportionate response to the need to protect the welfare of the child? The ‘need to know’ rule will apply to such information to ensure that the number of people to whom it is disclosed is no more than strictly necessary.

Information should not be shared with parents in cases of fabricated and induced
illness or if the sharing of information would be likely to contaminate evidence in further investigations of the case such as sexual abuse, female genital mutilation or forced marriage.

Further guidance on information sharing can be found in ‘What to do if you’re worried a child is being abused’ (HM Government 2006 – See Appendix 3)

Professionals must always seek advice from the Safeguarding team if they are in any doubt as to whether information needs to be shared. If staff are asked to make an official statement relating to safeguarding concerns to any outside agencies (e.g. the police, local authority or private solicitors, CAFCAS), they should seek support and advice from the safeguarding children team, their line manager or the Head of Information Governance.

17. Child protection inspections and reviews

There are many types of reviews and inspection that the CCG may be involved in, including:

- Joint Area Reviews (Children Act 2004).
- Serious Case Reviews (SCR).
- Child Death Reviews.
- Public Inquiries.
- Serious Incident.
- Domestic Homicide Reviews (DHR).
- Internal Management Reviews.
- Peer Reviews.
- Ofsted and Care Quality Commission (CQC) Inspection,

The CCG will support all these official investigations by following good practice.

As appropriate the child, parent or carer should be informed of these inspections and a request for consent considered as appropriate / agreed by the CIOSOSCP.

The safeguarding lead for the CCG must be informed of any investigation into child protection issues.

When any local health provider is asked to complete an Individual Management Review (IMR) for any Serious Case review (SCR) then they must inform the Safeguarding Lead in the CCG and ensure the report is quality assured by the safeguarding executive lead at the CCG before it is submitted to the Serious Case Review Overview Panel for the CIOSOSCP. Quality assurance can be negotiated with the CCG if this is being done in another area, but the CCG must be involved in the process, negotiation and outcome of any IMR / SCR that affects a local provider. It is the provider’s responsibility to inform the CCG and complete a Serious Incident (SI) for each case that meets the SI criteria.
The terms of reference and standards for each serious case review and individual management review are the responsibility of the CIOSOSCP who investigates the incident. The provider must include these terms of reference in their initial correspondence with the CCG informing them of their involvement in a serious case review.

All major incidents related to children where there are safeguarding concerns that meet the SI criteria must be reported through the Serious Incident (SI) process. The CCG Quality Team will monitor and track the progress of these cases. They will inform the Governing Body Executive Lead for safeguarding children, the commissioner for children’s services and the designated nurse of all these cases.

Staff involved in any investigation must be supported by a member of the safeguarding children team or their line manager.

The CCG has a duty to cooperate in these investigations under The Children Act 2004, Section 11.

If staff are aware of any child death, whether expected or unexpected, this must be reported to the designated nurse for safeguarding children, in line with the clinical incident reporting process and the child death review process.

If staff are made aware of any parental deaths this should be reported to the practitioner's line manager via the clinical incident reporting process. If there are child protection concerns then the line manager should inform the designated nurse for safeguarding children and agree who will be responsible for reporting any concerns to the Strategic NHS England and the Care Quality Commission.

18. Child protection training

Child protection/safeguarding training are mandatory for all CCG employees. All commissioned services must ensure all staff complete a minimum of level one child protection training as recommended by the Intercollegiate Document 2014.

All commissioned services must have a training matrix in their safeguarding policy or follow the recommendations for safeguarding training in the CCG ‘Child Protection / Safeguarding Training Strategy’ (2018). The child protection training requirements (appendix nine) highlights the level of training and commitment different staff groups must adhere to.

There are several routes through which staff can access child protection training or demonstrate their knowledge and competencies around safeguarding children and these are some examples:

- E-Learning package.
- Child protection updates for single or multi-professional groups.
- Multi-agency training through the CIOSOSCP. This training is free for CCG staff.
Details are on the CIOSOSCP web site.

- Specialist child protection training can be arranged through the CCG Safeguarding Children department.
- Any courses that have been agreed by the designated professional as compliant with the correct level of safeguarding children training for the employee’s workload.
- Team supervision sessions, or case management reflections.

The Safeguarding Lead will be happy to advise any member of staff on the best training option to meet their needs. All staff MUST have a child protection/ safeguarding children update every three years (minimum). The Intercollegiate document 2014 recommends an annual update. Those working directly with children or parents will have annual training as indicated in the CCG ‘Child Protection / Safeguarding Training Strategy’ (2018).

19. Domestic abuse

If practitioners are notified of a domestic violence incident reported to the police where there are children in the household.

The practitioner will be required to use professional judgement in each individual case as to what intervention is required. Consideration should be given to the severity, nature and number of incidents that have occurred.

The information should be recorded chronologically in the records, ensuring the nature and seriousness of the domestic violence are entered e.g. verbal, common couple violence, influenced by alcohol, weapons used, escalation of violence, number of previous incidents over a given timeframe and any outcomes e.g. referrals or hospital attendances, etc.

GPs should follow the NSPCC Safeguarding Toolkit guidance on ‘Scanning of sensitive information; safeguarding children, domestic violence and sexual offences’.

Information should only be shared on a need to know basis and if there are child protection or adult protection concerns; seek advice from the safeguarding children team if required and/or the Designated Nurse Safeguarding Adults.

Offer the non-abusing parent advice on support services and discuss effects for children even if they have not witnessed the violence. Offer on-going support and safety planning if required.

Consider if this is child protection issue and if a referral to social care is required.

Information regarding domestic violence must be managed proactively and safely; if you are not sure, always get advice.

If CCG staff receive information about more than three incidents of domestic
violence in a six month period, the family should be discussed with the designated nurse for safeguarding in the CCG. Any family can be discussed at any time if the employee has a concern.

Staff may be asked to contribute to the Multi-Agency Risk Assessment Conference (MARAC), which is co-ordinated by the police. Staff may be asked questions relating to their knowledge of the family who are the subject of the MARAC.

If you have concerns in respect of a case that you would like to be discussed at MARAC, liaise with the Designated Nurse Safeguarding Children, Named Nurse Safeguarding Children for Cornwall Partnership Trust / Royal Cornwall Hospital Trust (CPT / RCHT) Named Midwives and / or adult safeguarding lead.

20. Private fostering arrangements

Private fostering occurs when a child under 16 (or 18 if disabled) is cared for by an adult who is not a relative for more than 28 days, by private arrangements between the parent and the carer. This is different from children in the care of a local authority.

Should any member of the CCG become aware of a child who is privately fostered they must inform the designated officer within children and young people’s services /social care teams, to ensure the child and family receives the appropriate care and support. Details about Private Fostering can be found from the link in appendix 5.

21. Female Genital Mutilation (FGM)

There are a significant number of girls who come from communities where Female Genital Mutilation (FGM) has been traditionally practiced. FGM is a cultural practice which commonly takes place in at least 28 African countries and some countries in the Middle-East and Asia. FGM is an illegal practice which affects a girl’s genital area and it can impact on their emotional or physical wellbeing. It is also illegal to arrange for a child to be taken out of the country for the procedure. All health providers must report this data centrally to the Department of Health on a monthly basis. This is the first stage of a wider ranging programme of work in development to improve the way in which the NHS will respond to the health needs of girls and women who have suffered FGM and actively support prevention. The FGM Enhanced Dataset introduced in April 2015, applies to all Acute Trusts, Mental Health Trusts and GP Practices.

If staff are aware of any parent who has had FGM or who have daughters being at risk of FGM they must report this in line with the National Guidance to the police on 101 and discuss this with their manager or the designated nurse. A referral should always be considered if the child is at risk.

Children’s Social care should be informed and the information recorded if there are risks in the family and practitioners have not been provided with adequate
information to the effect that the family have agreed not to undertake FGM. This discussion must be documented.

Full guidance on how to manage these complex cases can be found on the CIOSOSCP website and there link to the guide to FII contained in appendix five. Any member of staff working with communities where FGM is practiced should have attended child protection training on FGM. There needs to be a clear agreement between staff and agencies about their individual child protection responsibilities before undertaking any work. A female interpreter should always be used when talking to these families.

National Helpline (NSPCC) for FGM is available for staff and the public to access for advice is 0800 028 3550.

22. Forced marriage

A ‘forced’ marriage (as distinct from a consensual ‘arranged’ marriage) is defined as one that is conducted without the valid consent of at least one of the parties and where duress is a factor. Duress cannot be justified on religious or cultural grounds, and forced marriage is an abuse of human rights.

Forced marriages of children must be regarded as a child protection issue. You would not contact the parents in this situation and you would make a referral direct to the Police on 101 who will then liaise with Children’s Social care.

Full guidance on how to manage these complex cases can be found on the CIOSOSCP website.

For further advice contact the Forced Marriage Unit, Tel: 020 7008 0151 or website: https://www.gov.uk/forced-marriage

23. Prevent

The government's Prevent Strategy, published in June 2011, highlights the emerging evidence that some institutional environments, such as universities and prisons, are places where a range of individuals may be vulnerable to radicalisation towards active support for violent extremism. While extremist views are not in themselves indicators that an offender is likely to commit terrorist offences, they may be warning signs that staff need to be aware of. It is, therefore, important that staff members are alert to the views of all offenders, irrespective of the offence they have committed.

Prevent aims to stop people becoming terrorists or supporting terrorism. The Department of Health has highlighted that in statistical terms the NHS has a high chance of interacting with someone who may be exploited for terrorism.

There is no single profile of a terrorist, neither is race, religion or ethnicity a factor but the exploitation of vulnerable people is. Those who may be exploited are often
young, socially excluded, use drugs and alcohol, have low self-esteem, have suffered a personal crisis, may have links to criminality and may be unemployed. Factors such as; propaganda, media, internet use.

Commissioner’s responsibility

- To monitor compliance towards Prevent by seeking assurance via the quality contract meetings.
- Through provider safeguarding assurance meetings attended by the CCG Prevent lead (Designated Nurse Adult Safeguarding).
- Via request of the Prevent Self-Assessments Tool for review by the Designated Nurse.
- NHS Kernow employees also have a duty to be aware of the Prevent agenda and implications for the organisation and be able to recognise if one of their fellow colleagues, a patient or carer, is possibly being radicalised.

24. Child sexual exploitation

The sexual exploitation of children (CSE) and young people is a form of child sexual abuse.

Definition of child sexual exploitation (CSE)

Child sexual exploitation is a form of sexual abuse that involves the manipulation and/or coercion of young people under the age of 18 into sexual activity in exchange for things such as money, gifts, accommodation, affection or status. The manipulation or ‘grooming’ process involves befriending children, gaining their trust, and often giving them drugs and alcohol, sometimes over a long period of time, before the abuse begins. The abusive relationship between victim and perpetrator involves an imbalance of power which limits the victim’s options. It is a form of abuse which is often misunderstood by victims and outsiders as consensual. Although it is true that the victim can be tricked into believing they are in a loving relationship, no child under the age of 18 can ever consent to being abused or exploited, (Barnardo’s 2012).

Child sexual exploitation can manifest itself in different ways. It can involve an older perpetrator exercising financial, emotional or physical control over a young person. It can involve peers manipulating or forcing victims into sexual activity, sometimes within gangs and in gang-affected neighbourhoods, but not always. Exploitation can also involve opportunistic or organised networks of perpetrators who may profit financially from trafficking young victims between different locations to engage in sexual activity with multiple men, (Barnardo’s, 2011).

This abuse often involves violent and degrading sexual assaults and rape. Experts agree that these types of abuse are particularly humiliating and controlling, and, as such, may be preferred by those who exploit vulnerable young people, (Berelowitz et al, 2012). Exploitation can also occur without physical contact when children are
persuaded or forced to post indecent images of themselves online, participate in non-contact sexual activities via a webcam or smartphone, or engage in sexual conversations on a mobile phone, (DfE, 2012).

Technology is widely used by perpetrators as a method of grooming and coercing victims, often through social networking sites and mobile devices, (Jago et al, 2011). This form of abuse usually occurs in private, or in semi-public places such as parks, cinemas, cafes and hotels. It is increasingly occurring at ‘parties’ organised by perpetrators for the purposes of giving victims drugs and alcohol before sexually abusing them, (Barnardo’s, 2012).

Identification

It is not possible to say exactly how many young people are victims of child sexual exploitation for a number of reasons. It is described as a ‘hidden’ form of abuse which leaves victims confused, frightened and reluctant to make any disclosures. Health Practitioners should be aware of the key indicators of children being sexually exploited, which can include:

- Isolation from family and friends
- Teenage parenthood
- Failing examinations or dropping out of education altogether
- Unemployment
- Mental health problems
- Suicide attempts
- Alcohol and drug addiction
- Aggressive behaviour
- Criminal activity (Berelowitz, 2012)

It is important to remember that:

A child under the age of 13 is not legally capable of consenting to sex (if they do so it is considered to be statutory rape) or any other type of sexual touching; cases involving children aged under 13 years should always be discussed with Children’s Social Care.

Sexual activity with a child under 16 is also an offence.

- It is an offence for a person to have a sexual relationship with a 16 or 17 year old if they hold a position of trust or authority in relation to them.
- Where sexual activity with a 16 or 17 year old does not result in an offence being committed, it may still result in harm, or the likelihood of harm being suffered.
- Non-consensual sex is rape whatever the age of the victim.
- 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.
Action to safeguard

Child sexual exploitation is child abuse, so child protection procedures must be followed if anyone suspects that a young person is a victim or is at risk of becoming a victim. Where child sexual exploitation, or the risk of it, is suspected, all health practitioners should:

- Discuss the case with a child protection lead for your service.
- The Safeguarding team can be contacted for advice and support via the CCG.
- If after discussion there remain concerns, local safeguarding procedures should be triggered, including referral to Children’s Services regardless of whether the victim is engaging with services or not.

Procedures can be accessed via the link below to the CIOSOSCP website.

25. Missing child guidance

The CIOSOSCP has guidance on how to manage cases where children go missing from their own home or a care home and there is a link to the CIOSOSCP procedure for doing so in appendix five.

26. Fabricated Induced Illness (FII)

Concerns may occur when the health and development of a child is significantly impaired by the actions of the parent or carer who has fabricated or induced an illness in a child.

Working Together to Safeguard Children 2013, and the NICE guidance on ‘When to Suspect Maltreatment’, give detailed descriptions on what to look for in cases, but three main indicators of fabricating or inducing illness are:

- Fabrication of past medical history.
- Falsification of medical charts, documents or letters.
- Induction of illness by a variety of means.

This is not an exclusive list, more detail for guidance can be found on the CIOSOSCP website.

Where a member of staff suspects a case of fabricated or induced illness they should recognise this as a safeguarding concern and seek support and make appropriate referrals. You should not raise your concerns with the parents until you have sought help from either a paediatrician or social care. The CCG is currently working with the Local Authority on the development of a Multi-agency FII policy following the recommendations from a local Serious Case Review. (Update the reference Safeguarding Children in whom illness is fabricated or induced – Department for children, schools and families – 2008). A link to the CIOSOSCP
guide to FII is contained in appendix five.

27. **Children who do not attend / have not been brought to their health appointments**

When parents or children frequently miss health appointments then the professional must review their case and see if there are any issues of neglect or abuse.

The National Institute for Health and Care Excellence (NICE) guidance on ‘When to Suspect Child Maltreatment’ (2009), page 76 states, consider neglect if:

- A parent fails to administer essential prescribed treatment for their child.
- A parent fails to attend essential appointments or follow-ups that are necessary for their child’s health and wellbeing.
- A parent persistently fails to obtain NHS treatment for their child’s dental cavities (tooth decay).

If a child has missed a health appointment then staff should:

- Check the appointment was given to the correct person/address.
- Consider if there are any known safeguarding concerns, including neglect or patterns of missed appointments in the child or other family members records.
- Offer another appointment.
- Talk to a line manager.
- Consider a referral to social care.

The CCG expect all service providers to have a policy that address these issues. Each GP should develop practice guidance and procedures to manage children who miss appointment.

CIOSOSC published a Neglect Strategy in November 2017 along with some supporting documents (e.g. Neglect Toolkit / Practitioner’s Guide and a One Minute Guide). The aim of the strategy and supporting documents is to reduce the incidence of neglect by way of professional’s intervening at a much earlier stage before neglect becomes chronic and compromises the child’s health and development. A link to these neglect documents is contained in Appendix 5.

28. **Resolving cases where professionals have different opinions**

When a CCG employee is not happy with the outcome of a child protection or safeguarding referral, they can use the CIOSOSCP Escalation Policy.

Appendix five has a link to the Escalation Policy. There are five stages to the policy; the designated nurse/doctor should be informed when staff using this policy reaches
stage three. The five stages are:

1. Talk to your line manager about your concern.
2. Talk to the individual where there are disagreements.
3. Your manager will talk to the equivalent manager for the employee you disagree with.
4. The designated nurse/doctor will liaise with a senior manager in the agency where there is a dispute and report this to the service manager safeguarding and quality assurance.
5. The Chair of the CIOSOSCP will convene a panel to review the concerns and make a final judgement.

29. In the event of a child death

There are two inter-related processes for reviewing child deaths, (either of which can trigger a Serious Case Review):

- A rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child.
- The arrangements for this initial evaluation by key professionals which should take place within 24 – 48 hours and the process of evaluating all child deaths via the Child Death Overview Panel (CDOP) are described in the CIOSOSCP procedures in the chapter entitled: Rapid Response and Child Death Protocol for Unexpected Death.

Where there is known or suspected abuse as a factor in the child’s death, these cases are referred to a sub-panel of the CIOSOSCP for consideration for a Serious Case Review. Any professional or agency may refer a case to the CIOSOSCP if they believe that there are important lessons for intra-agency and/or inter-agency working to be learned from the case. (Working Together to Safeguard Children: DoH 2010: Chapter 8).

Each unexpected death of a child is a tragedy for his or her family, and subsequent enquiries/investigations should keep an appropriate balance between forensic and medical requirements and the family’s need for support. Children with a known disability or a medical condition should be responded to in the same manner as other children. A minority of unexpected deaths are the consequence of abuse or neglect, or are found to have abuse or neglect as an associated factor. In all cases, enquiries should seek to understand the reasons for the child’s death, address the possible needs of other children in the household, the needs of all family members, and also consider any lessons to be learnt about how best to safeguard and promote children’s welfare in the future. (Working Together to Safeguard Children: DoH 2010: 7.4)

When a child dies unexpectedly hospital staff will inform a number of agencies within two to four hours of the death including the child’s GP, the CDOP Office and the Safeguarding Children Partnership via the Partnership Manager. The Care Quality
Commission will be notified by the healthcare provider although providers may discharge this duty by notifying NHS England.

30. Management reviews

In the event of any incident leading to the death of a child, where child abuse is confirmed or suspected, there will be an investigation by the police and Children’s Social Care. Arrangements will be made to discuss the protection of any other children from the household. The CIOSOSCP will convene a Serious Case Review Panel to determine whether the death meets the criteria for a SCR or Local Case Review either of which outcomes may lead to the need for health agencies to undertake an Individual Management Review (IMR) as described in the CIOSOSCP Procedures and Working Together. The Designated Nurse Safeguarding Children will advise and support the Named Nurses / Midwives to complete an IMR within the agreed timescale and may produce an overview report depending on which type of review is going to take place as described in the CIOSOSCP Procedures.

31. References

- Children Act 1989
- Children Act 2004
- Female Genital Mutilation Act (2003)
- NHSE Guidance on FGM 2016
- What To Do If You’re Worried a Child is Being Abused DfES (2006 / 2015)
- Safeguarding Children in whom illness is fabricatated or induced – Department for children, schools and families – 2008
- Roles and Competences for Health Care Staff Intercollegiate Document (2014)
- Roles and Competences for Health Care Staff Intercollegiate Document for Looked after Children (2015)
Appendix 1: NHS Kernow organisational chart
Appendix 1b: Safeguarding roles and responsibilities

<table>
<thead>
<tr>
<th>Organisation/role</th>
<th>Summary of organisation/ role key safeguarding functions, roles and responsibilities and key safeguarding functions</th>
</tr>
</thead>
</table>
| Executive Lead / Chief Nursing Officer | - To be the CCG Governing Body Executive Lead for safeguarding children. This role includes:  
- Chairing the CCG safeguarding committee  
- Attending the CIOSOSCP as the lead for the CCG  
- Providing leadership to the CCG on the safeguarding children’s agenda  
- Managing the designated and named professionals employed by the CCG  
- Ensuring all commissioned services have safeguarding children’s standards in their contracts.  
- To liaise with the Safeguarding Children’s lead in the NHS CB ensuring independent health providers safeguarding work links with that of other providers  
- Ensuring safeguarding standards are maintained across commissioned health services and taking action if risks are identified |
| Head of Nursing            | - Deputises for the Chief Nursing Officer / Board Executive Director  
- Assists in the fulfilment of the key responsibilities of the Board Executive Director Lead for Safeguarding Children as listed above.  
- Line manages the Designated Nurses Safeguarding and Looked After Children and Designated Nurses Safeguarding Adults |
| Designated Professionals    | To provide:  
- Strategic professional lead on all aspects of health service contribution to safeguarding children across the CCG area.  
- Advice and support to named professionals in each provider organisation.  
- Professional advice to the CCG Governing Body to ensure the organisation discharges its responsibilities effectively and appropriately.  
- Co-ordination of the health elements of Serious Case Review process, including quality assuring the health elements.  
- To provide professional advice and expertise on health issues to the CIOSOSCP |
<p>| Provider                   | Co-operate with arrangements to safeguard children, share |</p>
<table>
<thead>
<tr>
<th>Organisation/role</th>
<th>Summary of organisation/ role key safeguarding functions, roles and responsibilities and key safeguarding functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisations</td>
<td>the responsibility for effective safeguarding arrangements. Ensure that they identify appropriate staff to undertake the functions of Named Professionals</td>
</tr>
</tbody>
</table>
| Named Professionals | • Will focus upon safeguarding arrangements within their own organisation by:  
  • Providing support and advice to staff in the day-to-day management of safeguarding practice.  
  • Promoting good practice in safeguarding work  
  • Providing advice to support their own organisations governance arrangements for safeguarding children.  
  • Developing a safeguarding children training strategy.  
  • Developing the safeguarding Children training programme and ensuring its delivery meets the required standards. |
| NHS England     | Performance management and support for development of safeguarding arrangements in the Local Area team. |
Appendix two: Allegations / concerns against staff and volunteers - child protection process

**ALLEGATIONS/CONCERNS AGAINST STAFF AND VOLUNTEERS CHILD PROTECTION PROCESS**

- Allegations/concerns identified in organisation to be reported to Designated Senior Manager
- Allegation/concern made direct to police or social care

Local Authority Designated Officer (LADO) to be informed if alleged behaviour:
- harmed a child, or may have
- is a possible criminal offence
- towards child/ren indicates unsuitable to work with children

Consultation between LADO and Designated Senior Manager

- Allegation is demonstrably false
- Allegation is a possible disciplinary matter
- Child suffering or at risk of suffering significant harm
- No significant harm but allegation might constitute a criminal offence

- LADO refers to social care for strategy discussion
- LADO refers to police for initial evaluation

Social care and/or police Investigation

- No social care or police investigation

- Share information
- Decide action
- Consider suspension

After completion (earlier if agreed with social care and police)

Consider:
- No further action
- Professional advice
- Disciplinary process
Appendix three:

What To Do If You’re Worried a Child is Being Maltreated

PRACTITIONER HAS CONCERNS ABOUT CHILD’S WELFARE

- Practitioner discusses with manager and/or other senior colleagues as they think appropriate
- Still have concerns
  - Practitioner refers to social services, following up in writing within 48 hours
- No longer have concerns
  - No further safeguarding action, although may need to act to ensure services provided
- No further social services involvement at this stage, although other action may be necessary e.g. onward referral
- Initial Assessment required
  - Concerns about child’s immediate safety
  - Acknowledge response and reply whether you are happy with the outcome/response. Seek advice if you are not happy.

For advice prior to referral (9 – 5, Monday – Friday)

- Judy Mace
  Designated Nurse Safeguarding Children
  Tel: 01726 627517
- Jane Wilkinson
  Named GP Safeguarding Children (Vacancy)
- Dr Roger Jenkins
  Designated Doctor Safeguarding Children, KCCG.
  Tel: 01872 245514
- Dr Ellen Wilkinson
  Named Doctor Safeguarding Children, CPT.
  Tel: 01872 245514
- Wendy Perkin
  Named Nurse Safeguarding Children, RCHT.
  Tel: 01872 254551
- Bernie Dolan / Suzie Williams
  Named Midwives RCHT. Tel: 01872 254551
- Dr Simon Bedwani named Dr RCHT
  Tel: 01872 250000 (Switchboard)

After hours:
Contact ‘Consultant Paediatrician on-call’
01925 635911
Appendix 4: Defining child abuse

<table>
<thead>
<tr>
<th>Terms</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child</td>
<td>In this document, as in the Children Acts 1989 and 2004 respectively, a child is anyone who has not yet reached their 18th birthday. “Children” therefore means “children and young people throughout.”</td>
</tr>
<tr>
<td>Common Assessment Framework - CAF</td>
<td>The CAF is a tool to enables early and effective assessment of children and young people who need additional support from more than one agency. It is a holistic consent-based needs assessment framework which records, in a single place and in a structured and consistent way, every aspect of a child’s life, family and environment.</td>
</tr>
<tr>
<td>Child in Need Section 17</td>
<td>Children who are defined as being in need, under section 17 of the Children Act 1989, are those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services plus those who are disabled.</td>
</tr>
<tr>
<td>Significant harm Section 47 (Child Protection)</td>
<td>There are no absolute criteria on which to rely when judging what constitutes significant harm. Consideration of the severity of ill-treatment may include the degree and the extent of physical harm, the duration and frequency of abuse and neglect, the extent of premeditation, and the presence or degree of threat, coercion, sadism and bizarre or unusual elements.</td>
</tr>
<tr>
<td>Abuse</td>
<td>Abuse and Neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm. Children may be abused in a family or in an institutional or community setting, by those known to them or, more rarely, by a stranger for example, via the Internet. They may be abused by an adult or adults, or by another child or children.</td>
</tr>
</tbody>
</table>

Definitions of abuse - Working Together to Safeguard Children 2013 and 2015

What is abuse and neglect?
Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting, by those known to them or, more rarely, by a stranger for example, via the internet. They may be abused by an adult or adults, or another child or children. Medical examinations of children for the purpose of child protection must only be arranged by Children’s Social Care or the police as indicated in the CIOSOSCP procedures – a link to information about this is in appendix five.

Physical abuse
Physical abuse 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.

**Emotional abuse**

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child’s emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or ‘making fun’ of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children.

These may include interactions that are beyond the child’s developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

**Neglect**

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

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

It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs. CIOSOSCP has produced detailed practice guidance for staff concerned about child neglect and a link to it is in appendix five.

**Sexual abuse**

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.
Appendix 5: Links and specific guidance to issues related to child abuse and neglect

National guidance

This is a good link to the DFE website which reflects the most recent publications related to safeguarding children, these include:

- Safeguarding children and young people from sexual exploitation.
- Reviewing guidance and handling allegations of abuse about members of staff.
- Parental learning disability and children’s needs.
- Safeguarding children in whom illness is fabricated or induced.
- Safeguarding children who may have been trafficked.
- Safeguarding children from abuse linked to a belief in spirit possession.
- Statement on the duty of doctors and other professionals in investigating child abuse.

This link below can connect you to any other major guidance or legislation related to safeguarding and child protection:

- [https://www.nspcc.org.uk/Inform/research/briefings/child_protection_legislation_in_the_uk_wda48946.html](https://www.nspcc.org.uk/Inform/research/briefings/child_protection_legislation_in_the_uk_wda48946.html)

Local guidance

Links to CIOSOSCP website – if clicking any of the links doesn’t take you to the website then please copy and paste it into your web browser instead:


Information on the topics below may be accessed via these links:

- Domestic violence and abuse:
Escalation Policy:  

Fabricated or Induced Illness:  
http://www.proceduresonline.com/swcpp/cornwall_scilly/p_fab_ind_illness.html?zoom_highlight=fabricated+and+induced+illness

Female Genital Mutilation (FGM):  

Neglect:  

Private Fostering:  
http://www.proceduresonline.com/swcpp/cornwall_scilly/p_ch_living_away.html?zoom_highlight=private+fostering#priv_fost

CIOSOSCP Referral Form:  
http://www.safechildren-cios.co.uk/media/22715698/cornwall-inter-agency-referral-form.doc

Council of the Isles of Scilly Referral Form:  
http://www.safechildren-cios.co.uk/media/10982210/Isles-of-Scilly-Children-in-Need-Inter-Agency-Referral-Form.pdf
Appendix 6: Referral flow chart

Remember:
- ‘Do not delay – act on the same working day’
- ‘Children are not able to protect themselves. Children need you to see them, hear them and protect them. The difference between child abuse or child protection could be You’

Note: A link to the CIOSOSCP Referral Form can be found in appendix five. The website should always be checked to ensure the most up-to-date version of the form is being used. Once completed, please return this form to: CIOSOSCP MARU (Multi Agency Referral Unit) Phone: 0300 123 1116 / Out of Hours: 01208 251300 Email: multiagencyreferralunit@cornwall.gcsx.gov.uk
Appendix 7: Assessment framework
Appendix 8: Guidance on constructing and using genograms

GUIDANCE FOR CONSTRUCTING AND USING GENOGRAMS

Genograms can be a useful technique to show:
1. Family structure and composition
2. Exact dates of birth, separations, divorces, deaths
3. Details and descriptions of relationships and alliances

They can:
1. Provide information about a family’s lifestyle and highlight gaps
2. Highlight patterns and themes in previous and present generations
3. Provide a structure to obtain and share with a family
4. Be constructed in conjunction with families

NOTES

Common symbols and constructions/connections should be used and a key should be available to describe these. Staff can use the key below:

- Male
- Female
- Gender unknown e.g. pregnant
- Death
- Miscarriage or abortion
- Enduring relationship, e.g. marriage or cohabitation
- Separation
- Divorce
- Transitory relationship

A dotted line should be drawn around people who currently live in the same house e.g.

For example, the above diagram shows the genogram of a pregnant mother who lives with her three children, two of whom are from a previous relationship, which ended in divorce. One child also died and one was aborted. The twins are currently living with their father and stepmother.
Appendix 9: Child protection training requirements

This training matrix is a guide for CCG staff to identify their mandatory requirements to undertake child protection training to ensure safeguarding is recognised as everybody’s business. The matrix takes into account the training recommendations laid out in:

- Children Act 1989 and 2004;
- Working Together to Safeguard Children 2015; and
- Intercollegiate document 2014.

The safeguarding children training matrix is identified in six levels recommended in the Roles and Competencies for Healthcare Staff - Intercollegiate Document 2014.

The Intercollegiate document 2014 indicates the specific amount of time and knowledge the training must include and the competencies the student must acquire.

The matrix below indicates how staff can achieve and evidence their training.

All staff must complete induction safeguarding children’s training once and after that they must complete the level of training which is appropriate to their work. All jobs/employee must have a safeguarding training level recorded on their electronic staff records (ESR). It is the manager’s responsibility to ensure each post has a safeguarding training level allocated to it. No new post should be advertised without the correct level of safeguarding children’s training allocated.

Induction training - all new staff clinical and non-clinical

All new staff must attend Induction training, which includes a basic awareness of issues related to safeguarding children. This training is 45 minutes. You can also completed the safeguarding children E-Learning training on the core-learning unit

Level one

All Staff employed by the CCG - 30 minutes safeguarding children training is included in annual / three yearly mandatory training program.

Level two

Clinical and non-clinical staff that have regular contact with parents, children and young people

This is a training session, which is two to three hours long and must be repeated every three years. The designated nurse for safeguarding children delivers this training. The course includes: advocating for the young person, being clear about yours and others roles in safeguarding children, understanding the law and information sharing, your role in effective documentation and recognising how
parent's behaviours can impact of child safety –‘Think Family’. Some professional groups may have their distance learning or e-learning safeguarding training. The designated professionals can offer advice to senior managers or contract leads on the quality of training and its adherence to the intercollegiate document.

**Level 3**

All staff working predominately with children, young people and parents

This is training for staff that predominantly work with children / young people and / or their parents / carers and who may contribute to the assessment, monitoring and planning for child protection cases. To comply with this level you must attend CIOSOSCP multi-agency training, or a multi-agency training event related to safeguarding children. You must evidence you have completed an annual update on your level three multi-agency training. All GPs in their relevant practice staff should be trained to a minimum of level three for safeguarding children.

If staff have completed training delivered by providers outside of Kernow the Designated Safeguarding Children’s Professionals can quality assure the training and accredit the training if they receive the certificate of attendance, the name of the trainer / service provider and the aims and objectives of the training attended. Details about how to do this are contained in the Child protection / Safeguarding Children Training Policy 2018.

You must complete all your safeguarding training to ensure you meet the requirements of your KSF and mandatory training. Detailed information about the training required for CCG staff is contained in the Safeguarding Children Training Policy which includes a detailed training matrix as per the table below:
## Child protection training matrix

<table>
<thead>
<tr>
<th>Course</th>
<th>Frequency</th>
<th>Staff</th>
<th>Knowledge, Skills, Attitudes and values and Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Induction</td>
<td>Within six weeks of commencement of employment – 30 minutes</td>
<td>All Staff</td>
<td>See Intercollegiate documents for Safeguarding and Looked after Children</td>
</tr>
<tr>
<td>Level 1</td>
<td>Every three years for non-clinical staff – two hours</td>
<td>All CCG Staff</td>
<td>See Intercollegiate Documents as noted above</td>
</tr>
<tr>
<td>Level 2</td>
<td>Three to four hours over three year period</td>
<td>All staff whose work brings them directly into contact with children, young people and parents.</td>
<td>See Intercollegiate Documents as noted above</td>
</tr>
<tr>
<td>Level 3</td>
<td>12 – 16 hours over a three year period</td>
<td>Clinical staff working with children, young people, parents and carers. This includes GP’s and children continuing care team staff.</td>
<td>See Intercollegiate Documents as noted above</td>
</tr>
<tr>
<td>Level 4</td>
<td>24 hours over a three year period</td>
<td>Specialist Roles – Named Professionals</td>
<td>See Intercollegiate Documents as noted above</td>
</tr>
<tr>
<td>Level 5</td>
<td>24 hours over a three year period</td>
<td>Specialist Roles – Designated Professionals</td>
<td>See Intercollegiate Documents as noted above</td>
</tr>
<tr>
<td>Governing body</td>
<td>Every three years</td>
<td>Chair of the Governing Body; Chief officer; Directors and members</td>
<td>See Intercollegiate Documents as noted above (level one e-learning and specific face-to-face Governing Body Learning)</td>
</tr>
</tbody>
</table>
Equality Impact Assessment

<table>
<thead>
<tr>
<th>Name of policy to be assessed</th>
<th>Child Protection - Safeguarding Children Policy and Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Date of Assessment</td>
<td>20/03/2018</td>
</tr>
<tr>
<td>Officer responsible for the assessment</td>
<td>Charlie Whelan</td>
</tr>
<tr>
<td>Is this a new or existing policy?</td>
<td>New</td>
</tr>
</tbody>
</table>

1. Describe the aims, objectives and purpose of the policy.

To ensure that NHS Kernow Clinical Commissioning Staff comply with national and local guidance on safeguarding children and young people

2. Are there any associated objectives of the policy? Please explain.

Staff to be able to identify abuse or neglect
Staff to know where to access advice and support
Staff to know how to raise a safeguarding alert for children and young people

4. Who is intended to benefit from this policy, and in what way?

All NHS Kernow staff and contractors and the children and young people being provided with services by them

5. What outcomes are wanted from this policy?

All NHS Kernow Clinical Commissioning Group to comply with this policy and procedure and take the appropriate steps to protect children from abuse by reporting it when known / alleged in compliance with the policy.

6. What factors/forces could contribute/detract from the outcomes?
Not having access to the policy or being provided with training about it leading to staff not being aware of what to do when child abuse is known or alleged.

### 7. Who are the main stakeholders in relation to the policy?

| NHS Kernow Staff and Safeguarding team; Children at risk of abuse or neglect; Cornwall and Isles of Scilly Our Safeguarding Children Partnership (CIOSOSCP) |

### 8. Who implements the policy, and who is responsible for the policy?

| NHS Kernow via Head of Nursing in the role of Safeguarding Team Manager |

### 9. What is the impact on people from Black and Minority Ethnic Groups (BME) (positive or negative)?

Consider relevance to eliminating unlawful discrimination, promoting equality of opportunity and promoting good race relations between people of different racial groups. Issues to consider include people’s race, colour and nationality, Gypsy, Roma, Traveller communities, employment issues relating to refugees, asylum seekers, ethnic minorities, language barriers, providing translation and interpreting services, cultural issues and customs, access to services.

Not applicable as all people regardless of ethnicity will be treated fairly under safeguarding legislation (Care Act 2014)

**How will any negative impact be mitigated?**

N/A

### 10. What is the differential impact for male or female people (positive or negative)?

Consider what issues there are for men and women e.g. responsibilities for dependants, issues for carers, access to training and employment issues, attitudes towards accessing healthcare.

None  Not applicable as all people regardless of gender will be treated fairly under safeguarding legislation (Care Act 2014)
<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>How will any negative impact be mitigated?</td>
<td>N/A</td>
</tr>
<tr>
<td>11. What is the differential impact on disabled people (positive or negative)?</td>
<td>Consider what issues there are around each of the disabilities e.g. access to building and services, how we provide services and the way we do this, producing information in alternative formats and employment issues. Consider the requirements of the NHS Accessible Information Standard. Consider attitudinal, physical and social barriers. This can include physical disability, learning disability, people with long term conditions, communication needs arising from a disability. N/A Not applicable as all people regardless of disability will be treated fairly under safeguarding legislation (Care Act 2014)</td>
</tr>
<tr>
<td>How will any negative impact be mitigated?</td>
<td>N/A</td>
</tr>
<tr>
<td>12. What is the differential impact on sexual orientation?</td>
<td>Consider what issues there are for the employment process and training and differential health outcomes amongst lesbian and gay people. Also consider provision of services for e.g. older and younger people from lesbian, gay, bi-sexual. Consider heterosexual people as well as lesbian, gay and bisexual people. N/A Not applicable as all people regardless of sexual orientation will be treated fairly under safeguarding legislation (Care Act 2014)</td>
</tr>
<tr>
<td>How will any negative impact be mitigated?</td>
<td>N/A</td>
</tr>
<tr>
<td>13. What is the differential impact on people of different ages (positive or negative)?</td>
<td>Consider what issues there are for the employment process and training. Some of our services impact on our community in relation</td>
</tr>
</tbody>
</table>
to age e.g. how do we engage with older and younger people about access to our services? Consider safeguarding, consent and child welfare.

<table>
<thead>
<tr>
<th>N/A</th>
<th>Not applicable as all people regardless of age will be treated fairly under safeguarding legislation (Care Act 2014)</th>
</tr>
</thead>
</table>

**How will any negative impact be mitigated?**

N/A

14. **What differential impact will there be due religion or belief (positive or negative)?**

Consider what issues there are for the employment process and training. Also consider the likely impact around the way services are provided e.g. dietary issues, religious holidays, days associated with religious observance, cultural issues and customs, places to worship.

<table>
<thead>
<tr>
<th>N/A</th>
<th>Not applicable as all people regardless of religious belief will be treated fairly under safeguarding legislation (Care Act 2014)</th>
</tr>
</thead>
</table>

**How will any negative impact be mitigated?**

N/A

15. **What is the impact on marriage of civil partnership (positive or negative)? NB: this is particularly relevant for employment policies**

This characteristic is relevant in law only to employment, however, NHS Kernow will strive to consider this characteristic in all aspects of its work. Consider what issues there may be for someone who is married or in a civil partnership. Are they likely to be different to those faced by a single person? What, if any are the likely implications for employment and does it differ according to marital status?

| N/A | |
|-----||

**How will any negative be mitigated?**

N/A
<table>
<thead>
<tr>
<th>16. What is the differential impact who have gone through or are going through gender reassignment, or who identify as transgender?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider what issues there are for people who have been through or a going through transition from one sex to another. How is this going to affect their access to services and their treatment when receiving NHS care? What are the likely implications for employment of a transgender person? This can include issues such as privacy of data and harassment.</td>
</tr>
<tr>
<td>N/A</td>
</tr>
<tr>
<td>How will any negative impact be mitigated?</td>
</tr>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>17. What is the differential impact on people who are pregnant or breast feeding mothers, or those on maternity leave?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This characteristic allies to pregnant and breast feeding mothers with babies of up to six months, in employment and when accessing services. When developing a policy or services consider how a nursing mother will be able to nurse her baby in a particular facility and what staff may need to do to enable the baby to be nursed. Consider working arrangements, part-time working, infant caring responsibilities.</td>
</tr>
<tr>
<td>N/A</td>
</tr>
<tr>
<td>How will any negative impact be mitigated?</td>
</tr>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>18. Other identified groups:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider carers, veterans, different socio-economic groups, people living in poverty, area inequality, income, resident status (migrants), people who are homeless, long-term unemployed, people who are geographically isolated, people who misuse drugs, those who are in stigmatised occupations, people with limited family or social networks, and other groups experiencing disadvantage and barriers to access.</td>
</tr>
</tbody>
</table>
How will any negative impact be mitigated?

N/A

19. How have the Core Human Rights Values been considered in the formulation of this policy/strategy? If they haven’t please reconsider the document and amend to incorporate these values.

- Fairness;
- Respect;
- Equality;
- Dignity;
- Autonomy

The Core Human Rights are protected by this policy as it relates to protecting all children from abuse as they have the right to live a life free from harm, abuse or neglect.

20. Which of the Human Rights Articles does this document impact?

<table>
<thead>
<tr>
<th>The right:</th>
<th>Yes / No:</th>
</tr>
</thead>
<tbody>
<tr>
<td>To life</td>
<td>No</td>
</tr>
<tr>
<td>Not to be tortured or treated in an inhuman or degrading way</td>
<td>No</td>
</tr>
<tr>
<td>To liberty and security</td>
<td>No</td>
</tr>
<tr>
<td>To a fair trial</td>
<td>No</td>
</tr>
<tr>
<td>To respect for home and family life, and correspondence</td>
<td>No</td>
</tr>
<tr>
<td>To freedom of thought, conscience and religion</td>
<td>No</td>
</tr>
<tr>
<td>To freedom of expression</td>
<td>No</td>
</tr>
<tr>
<td>To freedom of assembly and association</td>
<td>No</td>
</tr>
<tr>
<td>To marry and found a family</td>
<td>No</td>
</tr>
</tbody>
</table>
- Not to be discriminated against in relation to the enjoyment of any of the rights contained in the European Convention | No
- To peaceful enjoyment of possessions | No

**a) What existing evidence (either presumed or otherwise) do you have for this?**

Safeguarding policies and procedures contain references to child care legislation / human rights to ensure fairness / equality for all.

**21. How will you ensure that those responsible for implementing the Policy are aware of the Human Rights implications and equipped to deal with them?**

They will be required to read and understand the policy and be aware of paragraph A above.

**22. Describe how the policy contributes towards eliminating discrimination, harassment and victimisation.**

It ensures that all children are protected from abuse regardless of their background details as described above.

**23. Describe how the policy contributes towards advancing equality of opportunity.**

N/A

**24. Describe how the policy contributes towards promoting good relations between people with protected characteristics.**

N/A

**25. If the differential impacts identified are positive, explain how this policy is legitimate positive action and will improve outcomes, services or the working environment for that group of people.**

N/A

**26. Explain what amendments have been made to the policy or mitigating actions have been taken, and when they were made.**

None

**27. If the negative impacts identified have been unable to be mitigated through amendment to the policy or mitigating actions, explain what your next steps are.**

N/A
Signed (completing officer): .................................................................

Date: ..............................................................................................

Signed (Head of Section): .............................................................

Date: ..............................................................................................

Please ensure that a signed copy of this form is sent to both the Policies Officer with the policy and the Equality and Diversity lead.