Document Control

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B. Document Details

Classification:	Safeguarding Children Policy
Author and Role:	Bronwyn Job- Practice Manager Somerset ICB- Safeguarding Team
Organisation:	Park Medical Practice
Current Version Number:	1.0
Current Document Approved By:	Dr Will Kenny-Levick
Date Approved:	28/07/2025

C. Document Revision and Approval History

Version	Date	Version Created By:	Version Approved By:	Comments
1	28/7/2025	Bronwyn Job	Dr Will Kenny-Levick	

SAFEGUARDING CHILDREN POLICY

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SAFEGUARDING CHILDREN POLICY

VERSION CONTROL- ICB Information

Document Status:	**Final**
Version:	**4**

DOCUMENT CHANGE HISTORY		
Version	**Date**	**Comments**
1.0	June 2017	Amalgamation of Safeguarding Children and Young People in general practice and Policy and procedure around the recording, flagging and sharing of information in general practice about patients who are known to be at risk of domestic abuse
2.0	March 2019	Updated in line with Working Together to Safeguard Children 2018. Revisions include: • Updated reference, definitions, and guidance • Updated guidance for GPs on flags and alerts using national SNOMED codes • Updated links to various SSCB protocols (e.g. Resolving professional differences protocol) • Clearer guidance for making a child protection referral • Updated child exploitation section
3.0	November 2019	Updated to include: • Child protection supervision information for healthcare staff (appendix 5) • SNOMED codes for adult safeguarding. • New wording for CSPRs (formally SCRs)
4.0	January 2023	Updated to include: • New safeguarding guidance e.g., Child Was Not Brought, Pre-Birth Protocol and Perplexing Presentations /FII • Statutory duties associated with Domestic Abuse Act 2021 and Serious Violence Duty • Strengthened section on supervision Structure changed to better support staff in quickly accessing sections on What to do if they are concerned about a child.

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Document Reference:	

KEY SAFEGUARDING CONTACTS FOR PARK MEDICAL PRACTICE

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Practice Manager- Bronwyn Job- 01749 334386

Safeguarding Administrators- Rachael Brake, Carol Mullins, Pam Betsworth

The Family Front Door Somerset- 0300 123 2224

Somerset ICB Safeguarding Team- somicb.safeguardingandcla@nhs.net

Somerset Domestic Abuse Helpline- 0800 69 49 999

SAFEGUARDING CHILDREN POLICY

1 INTRODUCTION

1.1 Section 11 of the Children Act 2004 places Integrated Care Boards (ICBs) under a statutory duty to make arrangements to ensure that in discharging their functions they have regard to the need to safeguard and promote the welfare of children.

1.2 This policy must be operated in conjunction with the following local, regional, and national policies, procedures and guidance:

- South West Child Protection Procedures (Somerset Safeguarding Children Partnership Procedures)
- Somerset Safeguarding Children Partnership (SSCP) Local Protocols and Guidance
- BaNeS, BNSSG and Somerset Safeguarding Adults Multi – Agency Policy
- Somerset Safeguarding Adults Board (SSAB) local practice guidance and protocols
- Care and Support Statutory Guidance issued under the Care Act 2014
- Promoting the health and well-being of looked-after children (2015)
- Working Together to Safeguard Children (2018)
- DfE Information sharing advice for practitioners providing safeguarding services to children, young people, parents and carers (2018)
- Adult Safeguarding Roles and Competencies for Health Staff (2018)
- Intercollegiate Document: Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019)
- NHS England and Improvement Safeguarding Policy 2019
- Intercollegiate Role Framework: Looked after children: knowledge, skills and competences for health care staff (2020)
- Revised Prevent Duty Guidance: for England and Wales (2021)
- NHSE Safeguarding Children, young people and adults at risk in the NHS: Safeguarding Accountability and Assurance Framework (2022)
- Home Office Domestic Abuse Statutory Guidance (2022)
- Serious Violence Duty: statutory guidance (2022)
- Modern Slavery Statutory Guidance for England and Wales (2023)

1.3 This policy complies with statutory duties associated with all relevant safeguarding legislation, including but not limited to the following:

- The Children Act 1989
- The Children Act 2004
- Mental Capacity Act 2005
- Care Act 2014
- Children and Families Act 2014
- Serious Crime Act 2015
- Counter Terrorism and Security Act 2015
- Modern Slavery Act 2015
- Children and Social Work Act 2017
- UK General Data Protection Regulation (UK GDPR), tailored by the Data Protection Act 2018
- Mental Capacity (Amendment Act) 2019
- Domestic Abuse Act 2021
- Police, Crime, Sentencing and Courts Act 2021

1.4 Additional information and resources in relation to safeguarding children in Somerset is available on the following websites:

- Somerset Integrated Care Board Safeguarding Adult and Children
- Somerset Safeguarding Children Partnership
- Somerset Safeguarding Adults Board
- Safer Somerset Partnership
- Professional Choices

1.5 This policy outlines how Park Medical Practice will deliver its statutory duty to safeguard and promote the welfare of its population, including the legislation, principles and values that inform the safeguarding practice of all staff. In addition, this policy supports the Safeguarding Partnership and Board arrangements across Somerset.

1.6 This policy will be amended to reflect changes to legislation and the development of the Integrated Care System as appropriate to maintain assurance on the delivery of safeguarding children arrangements.

2 PURPOSE AND SCOPE

2.1 The purpose of this policy is to assist all staff, both clinical and non-clinical, to understand their roles and responsibilities in relation to safeguarding children. A child is defined as anyone who has not yet reached their 18th birthday.

2.2 All Practice staff must be aware of their responsibility to safeguard children and should be able to recognise indicators of abuse and know how to act upon concerns, fulfilling their safeguarding children responsibilities in line with local and national policies, procedures, and legislation.

2.3 This policy applies to all staff within Park Medical Practice working with unborn babies, children, young people, adults and their families. This policy also applies to agency staff and other staff not employed directly by the practice e.g., volunteers.

2.4 The term safeguarding and promoting the welfare of children is defined in Working Together to Safeguard Children[1] as:

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

3 WHAT TO DO IF YOU ARE CONCERNED ABOUT A CHILD

If you are concerned that a child may be at risk of, or may be suffering, significant harm you must contact Somerset Direct (Children Social Care) immediately to discuss the best way to meet those needs on **0300 123 2224**.

3.1 **Assessing levels of need for a child and their family**: The Effective Support for Children and Families in Somerset guidance provides a framework for professionals so they can identify if a child, young person or family might need help and support. Understanding when children, young people and families might need support can ensure they are given **"the right support, in the right place, at the right time"**.

Early Help –	
Children with additional needs which can be met by a single practitioner or agency or where a coordinated multi-agency response is needed. Providing early help is more effective in promoting the welfare of children	**What you need to do -** For an Early Help Assessment to be effective it should be undertaken with the agreement of the child and their parents or carers, involving the child and family as well as all the practitioners who are working with them.

[1] Working together to Safeguard Children

and their families by providing support as soon as a problem emerges. Completion of an Early Help Assessment (EHA) can be used to guide and support you in working with children, young people and their families.	It should take account of the child's wishes and feelings wherever possible, their age, family circumstances and the wider community context in which they are living. If concerns escalate the EHA provides information from which statutory services can make a better assessment of needs/risks, which may include working with other staff / services working with the child and their family, starting with a Team Around the Family (TAF) meeting. Other multi-agency information forums in place such as the Team Around the School (TAS) meetings should also be used.
Complex Early Help	
If there is a clear rationale **for targeted provision for children with multiple issues or complex needs where a coordinated multi agency response is needed** you can request the involvement and support of the **Family Intervention Services (FIS)**, to support you and the rest of the Team Around the Family working with the unborn baby /child and their family.	**What you need to do:** • Establish which other agencies are working with the family to triangulate information. • Complete the EHA and Child Protection Form and refer the child / family to FIS. Please note - A referral to FIS must be undertaken with the consent of the child and their parents or carers and take account of the child's wishes and feelings wherever possible, their age, family circumstances and the wider community context in which they are living.
Acute needs (Child in Need and Child Protection)	
The child has a high level of unmet and complex needs or is in need of protection and requires support from statutory services. This will include support provided by children's services, maybe via a Child in Need Plan or a Child Protection Plan, or the child may need to be cared for outside their immediate family full time.	**What you need to do -** All practitioners wishing to request involvement of children's social care in relation to Child in Need or Child Protection must complete an EHA and Child Protection form and submit this to: **SDinputters@somerset.gov.uk**

3.2 **Consent:** All staff should aim to gain consent to share information but should be mindful of situations where to do so would place a child at increased risk of harm. Information may be shared without consent if staff have reason to believe that there is good reason to do so, and that the sharing of information will enhance the

safeguarding of a child in a timely manner. See Section 5 of this Policy for further guidance on Information Sharing.

3.3 Advice and support for staff who are concerned about a child:

Early Help - The Early Help Advice Hub (EHA Hub) is part of Somerset's Family Front Door and offer support to all practitioners who work with children, young people and families living in Somerset. The EHA Hub provides an **Advice Line 01823 355803** which is open **Monday to Friday 9:00am until 4:00pm**. You can speak with a Customer Service Assistant or an Early Help Assessment Coordinator who can offer:

- Support and guidance in completing and submitting an Early Help Assessment **via option 1**.
- Advice on assessing levels of need for Early Help according to the Effective Support for Children and Families in Somerset Guidance **via option 2**. This option is for **organisations safeguarding leads only**.
- Triage requests for involvement made to Somerset County Council's Early Help Services (prevention services).

Please note - The Early Help Advice Line is not an alternative pathway to access Early Help Services, it is an advice service.

Child Protection - Children's Social Care provide a consultation line for Safeguarding Leads and all GPs. The line is staffed by qualified social workers from the First Response Team. The child/ren and family being discussed will remain anonymous. GPs can phone the consultation line if they are unsure whether or not to make a Acute Needs / Child In Need / Child Protection referral. **GP and Children's Safeguarding Leads Consultation Line** (9.00 to 4.30 Mon to Thurs, 9.00 to 4.00 Fri) on 0300 123 3078.

If you would like to speak to a social worker outside of office hours please phone the Emergency Duty Team (EDT) on **0300 123 23 27**

Safeguarding advice and support from the ICB strategic safeguarding team - The team can provide advice and support in relation to safeguarding concerns that staff may have about a child / family, when staff are unclear what action to take to safeguard the child, or where staff have completed a referral and need some support in escalating the response they've had. You can contact the ICB safeguarding team on **01935 381999** between 9am to 5pm Monday to Friday.

3.4 Resolving Professional Differences:

There will be times when there are differences of opinions about how best to support a child and family, and the intervention required by different agencies. In the first instance, this should be resolved within agencies as this will achieve the best outcome, and if agreement is not reached and cases become 'stuck' then the staff who disagreed with the outcome should notify their manager, who in turn should consult and use the Resolving Professional Differences protocol. If staff would like advice about a difficult safeguarding children situation, or are unhappy about the outcome of a referral, you can contact the ICB Safeguarding team for advice and support on **01935 381999**.

Relevant policies, procedures, tools and resources in relation to 'What to do if you are concerned about a child':

- The EHA and Child Protection Form and associated documents can be found on the Professional Choices website.
- SWCPP - Responding to Abuse and Neglect
- What is Early Help section of the SSCP website
- Local Protocols and Guidance section of the SSCP website
- 'Early Help – A Quick Guide': a free bitesize cascade training presentation and session plan to raise awareness of Early Help support within Somerset. The package can be found on the training section by following this link.
- RCGP Libraries, Pathways and Toolkits
- CQC GP myth buster 25: Safeguarding adults at risk
- CQC GP myth buster 33: Safeguarding children

Snomed codes to be used in relation to safeguarding children (including Early Help, Complex Early Help, Child in Need and Child Protection):

Code	Classification on NHS Digital / SNOMED wording	Rationale for use of code in Primary Care
836881000000105	Child is cause for safeguarding concern (finding)	Use this code if discussing a child in CP meeting
1064961000000107	Child in family is safeguarding concern	Use this code if discussing sibling (of a child) in CP meeting
878111000000109	Unborn child is cause for safeguarding concern	Use this code if discussing an unborn baby in CP meetings. If using this code practitioner should refer to multi agency pre-birth protocol and Pre Birth SOP
1060581000000100	Early Help Assessment (procedure)	Use this code when completing an EHA / assessment of need – as a single or part of a multi-agency assessment.
1097361000000103	Signposting to Early Help Service (procedure)	Use this code when completing a Complex early help / Level 3 (child / family in need of support) referral to Family Intervention Service.
380491000000101	Referral to child protection service (procedure)	Use this code when submitting Complex Level 3 (in need of protection) and child protection / Level 4 referral to Children social care (irrespective of what format used for referral)
1047341000000106	Early Help Assessment Team	Use this code when attending a

	Around the Child meeting (procedure)	team around the child or family (TAC or TAF) meeting for a child / family.
762931000000105	Child protection strategy meeting (procedure)	Use this code when attending a strategy discussion or meeting
184062003	Patient not registered (finding)	Use this code when patient has a child that isn't registered at any other practice but has been seen with either parent since birth.
Child In Need		
836931000000102	Subject of child in need plan (finding)	Use this code to identify when a child has been designated as Child in Need
135890008	Child no longer in need (finding)	Use this code to identify when a child no longer becomes Designated as a CIN
1053651000000109	Child in Need meeting (procedure)	Use this code when attending a CIN meeting (Different to a TAC or TAF)

4 WHAT DOES SAFEGUARDING MEAN?

4.1 BASIC PRINCIPLES OF SAFEGUARDING CHILDREN

This policy seeks to emphasise the following principles:

- The welfare of the child is paramount.
- It is the responsibility of all staff to safeguard and promote the welfare of unborn babies, children, young people, adults and their families as defined in Section 2.4 above.
- All staff should adopt a child-centred approach which is fundamental to safeguarding and promoting the welfare of every child. A child centred approach means keeping the child in focus when making decisions about their lives and working in partnership with them and their families.
- All staff, both clinical and non-clinical, should:
    - be aware of the signs and symptoms of potential and actual abuse
    - understand how to respond to actual or suspected abuse of a child
    - know who to contact for advice and support in relation to safeguarding and promoting the wellbeing of unborn babies, children and young people
    - understand the need to share appropriate information in a timely way and in accordance with current legislation and guidance, including responding to information requests to safeguard a child.
- All staff should actively contribute to multi-agency working in safeguarding children from abuse, neglect or exploitation whatever their:
    - Race, religion, first language or ethnicity;

- Gender or sexuality;
- Age;
- Health or disability;
- Location or placement;
- Criminal behaviour;
- Political or immigration status[2].

Children and their families must be able to share concerns and complaints and there are mechanisms in place to ensure these are heard and acted upon. For further information see https://www.somersetICB.nhs.uk/get-involved/your-views/

4.2 ABUSE AND NEGLECT

Abuse is a form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others. Abuse can take place wholly online, or technology may be used to facilitate offline abuse. Children may be abused by an adult or adults, or another child or children[3].
There are four main categories of childhood abuse: neglect; physical abuse; sexual abuse and emotional abuse:

- **Neglect**: 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. It also includes neglect of, or unresponsiveness to a child's basic emotional needs. 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 or inadequate care givers)
  - ensure access to appropriate medical care or treatment
- **Physical Abuse**: A form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.
- **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. Sexual abuse can take place online, and technology can be used to facilitate offline abuse. Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children. Sexual abuse can include the following:

[2] UN Convention on The Rights of the Child (1998)
[3] South West Child Protection Procedures; Responding to Abuse and Neglect

- Activities may include physical contact, including assault by penetration (e.g. rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing.

- 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.

- **Emotional Abuse**: The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone. Emotional abuse can involve the following:

  - Conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person.

  - Not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate.

  - Age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction.

  - Seeing or hearing the ill-treatment of another.

  - Serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children.

4.3 CHILD DEATH REVIEW ARRANGEMENTS

When a child dies, in any circumstances, it is important for parents and families to understand what has happened and whether there are any lessons to be learned.

The responsibility for ensuring Child Death Reviews (CDR) are carried out is held by 'child death review partners', who, in relation to a local authority area in England, are defined as the local authority for that area and any clinical commissioning groups operating in the local authority area. Child death review partners must make arrangements to review all deaths of children normally resident in the local area and, if they consider it appropriate, for any non-resident child who has died in their area.
Senior leaders within organisations who commission or provide services for children, as well as relevant regulatory bodies, should follow the procedures set out in statutory Child Death Review guidance. All other professionals who care for children, or who have a role in the child death review process, are required to read and follow this guidance so that they can respond to each child death appropriately. This includes people working within:

- health services (across all sectors: acute, maternity, mental health, primary care and community)

- children's social care services
- police, including British Transport Police, and Royal Military Police
- coronial services
- education
- public health

The Pan Dorset and Somerset Child Death Overview Panel (CDOP) was established in 2019. In accordance with the Child Death Review statutory and operational guidance the purpose of this CDOP is to review all the deaths of children normally resident or registered with a GP in Dorset and Somerset, following the process defined in statutory child death review guidance;

- To progress local prevention agenda in respect of child death,
- To review the deaths of children and young people aged 0-17years
- To ensure a coordinated response to unexpected child deaths
- To collect and analyse information about child deaths in order to identify opportunities for the prevention of harm and child deaths that can be addressed locally, regionally and nationally.
- To professionally challenge to improve child outcomes
- To report data nationally as required to inform the national policy agenda
- Link with local LeDeR process for children above four years of age with a formal diagnosis

To notify the Pan Dorset and Somerset Child Death Review partners of a child's death, please follow the link below to complete a notification form:

- PANDorsetSomerset eCDOP

Relevant policies, procedures, tools and resources:

- Child Death Review: statutory and operational guidance (England)
- Chapter 5 of Working Together to Safeguarding Children: Child Death Reviews
- NHSE Learning from deaths: Information for families

4.4 CHILDREN LOOKED AFTER (CLA)

This term applies to children currently being looked after and/or accommodated by local authorities, including unaccompanied asylum-seeking children and those children where the agency has authority to place the child for adoption.

Most children become looked after as a result of abuse and neglect. Although they may have many of the same health issues as their peers, the extent of these is often greater because of their past experiences. For example, almost half of children in care have a diagnosable mental health disorder and two-thirds have special educational needs. Delays in identifying and meeting their emotional well-being and mental health needs can have far reaching effects on all aspects of their lives, including their chances of reaching their potential and leading happy and healthy lives as adults. Local authorities, ICBs, NHS England and providers of services should ensure that there are effective arrangements in place to share information about the health of a Child Looked After. These arrangements should balance the need to know with the sensitive and confidential nature of some information. Fear about sharing information should not get in the way of promoting the health of Looked After Children[4].

Children Looked After are particularly vulnerable to being abused by adults and peers. Limited and sometimes controlled contact with family and carers may affect a child's ability to disclose what is happening to them. Given that many children and young people live away from home because of concerns about their home conditions, it is particularly important that their welfare is protected when they are being cared for by another agency or institution.

All staff must understand their role and responsibilities for meeting the needs of looked after children. Where there is reasonable cause to believe that a Child Looked After has been harmed, a referral must be made to Children's Social Care in accordance with local procedure- see Section 3 of this policy for further details.

Relevant policies, procedures, tools and resources:

- SWCPP - Children Living and Staying Away from Home including Private Fostering
- HM Govt Promoting the Health and Wellbeing of Looked After Children
- HM Govt Looked After Children: detailed information
- RCGP Child Safeguarding Toolkit – Looked After Children
- RCPCH Looked After Children (LAC) - resources and guidance
- NICE guideline NG205 Looked After Children and Young People
- eLearning for Healthcare - Looked After Children

SNOMED codes to be used on EMIS in relation to Children Looked After (CLA):

764841000000100	Looked after child (finding)	Use this code to identify when a child has become looked after
764951000000107	No longer subject of looked after child arrangement (finding)	Use this code to identify when a child is no looked after

[4] Information sharing advice for safeguarding practitioners - GOV.UK (www.gov.uk)

764881000000108	Looked after child review meeting (procedure)	Use this code when attending a CLA review
764201000000104	Looked after child health assessment annual review (regime/therapy)	Use this code when you complete a review health assessment for a CLA

4.5 CHILD PROTECTION CONFERENCES (CPC)

A child protection conference (hereafter referred to as a 'CPC') brings together family members, the child/ren (where appropriate), supporters / advocates and those professionals most involved with the unborn / child and family to make decisions about the child's future safety, health and development. Depending on the circumstances there are several different types of child protection conferences:

- Initial conferences;
- Pre-birth conferences;
- Transfer in conferences;
- Review conferences

Staff invited to the child protection conference should attend if possible. The GMC (General Medical Council) in their guidance 'Protecting Children and Young People' states:

- *If you are asked to take part in child protection procedures, you must cooperate fully. This should include going to child protection conferences, strategy meetings and case reviews to provide information and give your opinion. You may be able to make a contribution, even if you have no specific concerns (for example, general practitioners are sometimes able to share unique insights into a child's or young person's family).*

All staff that receive an invite to a Child Protection Conference must prioritise this, particularly if the child and family are known to you and you have important information to share. A written report must be provided even if that report states that you have not had any recent contact with the child and / or their family. The Children Social Care (CSC) proforma for CPC reports should be used, completing as much of the template as possible, but recognising that there may be limits to the information you hold. The template will be sent as part of the invitation to the Child Protection Conference, which is based on the DoH Framework for the Assessment of Children in Need and their Families triangle:

- Child's developmental needs
- Parenting capacity
- Family and environmental factors

The CPC report you submit should include an interpretation from a health perspective of the risks to the child and seek to clarify to non-medical professionals the impact of any health-related conditions, including mental health, for all family members.

Sending copies of unredacted records e.g. GP medical records is not acceptable and is likely to be in breach of GDPR guidelines. It is the interpretation of what these notes mean to the child that is useful to the CPC members.

All Child Protection Conference (CPC) reports must be submitted in advance of the CPC to the conference administrator electronically. Contact details will be outlined in the CPC invitation. It is good practice to share the report with the parents/carers and child themselves if appropriate. Liaison with other health professionals who may also be working with the family is also recommended, particularly if you note they have not been included in the CPC invite list.

See separate practice process for Managing Child Protection Reports.

Staff invited to and attending Child Protection Conferences (CPC) will receive the minutes, the Child Protection (CP) plan and actions. Also included will be details of decisions made and whether the unborn baby or child/ren has been placed on a CP or Child in Need (CIN) plan. The CPC minutes, including the CP plan and Social Worker report / Child and Family Assessment must always be scanned and recorded within the child/ren's medical records and all named parties (in the case of an unborn baby with the mother's records). There is no need to scan and record third-party reports such as Education, Housing or Public health Nursing reports as these will be summarised within the CPC records you receive. This aligns with GMC guidance[5] which is clear that information or records from other organisations, such as minutes from Child Protection Conferences, must be stored with the child's medical record to ensure this information is available to all.

Staff will need to ensure that any actions required of them in relation to parent/carer or the child/ren's health are carried out and outcomes communicated to the allocated Social Worker. The GP safeguarding lead should ensure any actions for the Practice are undertaken. Parent/carer non-compliance with health care plans should be communicated to the allocated social worker as soon as discovered because this may be an important sign of increasing risk to the child.

Many electronic recording systems all have diaries, including EMIS. The date of the Review Case Conference is included within the CPC records you will receive. This serves as your invite to future conferences, so in order to plan ahead the details of the Review Case Conference should be added to the electronic diary when the CPC records are first received.

Relevant policies, procedures, tools and resources:

- SSCP website: Child Protection Conferences
- SWCPP – Child Protection Conferences
- RCGP Child Safeguarding Toolkit: Child Protection Case Conferences

SNOMED codes to be used on EMIS in relation to Child Protection Conferences:

Snomed code	Code description	When to use this code
375041000000100	Family member subject of child	Use this code for sibling / parent of

[5] GMC Protecting-children-and-young-people

	protection plan (situation)	a child, when a child becomes subject to a CP plan
375071000000106	Family member no longer subject of child protection plan (situation)	Use this code when a sibling / child (of a parent) is no longer subject to a CP plan
818901000000100	Unborn child subject to child protection plan (finding)	Use this code to log under mother that unborn child has become subject to a CP plan
1025431000000104	Unborn child no longer subject to child protection plan (finding)	Use this code to log under mother when unborn baby subject to CP plan has now been born / as code will be entered on child's record to show 'subject to a CP plan'.
342191000000101	Subject to child protection plan (finding)	Use this code to identify when a child becomes subject to a CP plan
342891000000105	No longer subject to child protection plan (finding)	Use this code to identify when a child is no longer subject to a CP plan
1036511000000100	Child protection conference report submitted (finding)	Use this code when **submitting a** child protection case conference **report**
408770006	Child protection case conference (procedure)	Use this code when recording **attendance** at a case conference for a child / adult
913841000000107	Child protection core group meeting (procedure)	Use this code when attending a CP core group meeting

4.6 CHILD SEXUAL ABUSE (CSA)

Working Together to Safeguard Children[6] defines Child Sexual Abuse as behaviour which 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.

Sexual abuse can take place online, and technology can be used to facilitate offline abuse. Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

[6] https://www.workingtogetheronline.co.uk/chapters/contents.html

Children from the age of birth onwards may be subjected to sexual abuse. Many children and young people do not recognise themselves as victims of sexual abuse – as a child may not understand what is happening and may not even understand that it is wrong especially as the perpetrator will seek to reduce the risk of disclosure by threatening them, telling them they will not be believed or holding them responsible for their own abuse.

Whenever a child reports that they are suffering or have suffered significant harm through sexual abuse the initial response from all staff should be to listen carefully to what the child says and to observe the child's behaviour and circumstances. Practitioners must:

- Clarify the concerns;
- Offer reassurance about how the child will be kept safe;
- Explain what action will be taken and within what timeframe.

The child must not be pressed for information, led or cross-examined or given false assurances of absolute confidentiality, as this could prejudice police investigations, especially in cases of sexual abuse.

Relevant policies, procedures, tools and resources

- SWCPP - Child Sexual Abuse in the Family Environment
- Home Office. Signs and Indicators – A template for identifying and recording concerns of child sexual abuse
- Home Office. Communicating with children - A guide for those working with children who have or may have been sexually abused

4.7 CHILD 'WAS NOT BROUGHT' (WNB)

Children, unlike competent adults, cannot assume personal responsibility and are dependent on their parents or carers to bring them to an appointment. Previously these children were considered under the adult nomenclature for missed appointments "did not attend" (DNA). However, this implies children can make an independent journey to their appointment. There is a movement away from this label substituting the more accurate "was not brought" descriptor – WNB for short.

Children should not be disadvantaged or put at risk if they are not brought to their appointments. There is a clear evidence-based link between children who are not brought to appointments and child abuse and numerous studies have shown that missing healthcare appointments is a feature of many Child Safeguarding Case reviews. Repeated cancellation and rescheduling of appointments should be treated with the same degree of concern as repeated non-attendance. Consideration must be given to neglect if parents or carers repeatedly fail to bring their child to follow-up appointments that are essential for their child's health and wellbeing[7].

[7] https://www.nice.org.uk/guidance/ng76/chapter/Recommendations#recognising-child-abuse-and-neglect

Staff need to be prepared to challenge excuses for non-attendance and where appropriate carry out relevant safeguarding assessments in order to establish any risk posed to the child. The responsibility for safeguarding the welfare of the child lies with staff / services to whom the child has not been brought. See Section 3 of this policy for further information on 'what to do if you are concerned about a child' that Was Not Brought to appointments / your service.

See Appendix 5 for the practice process on managing a child who was not brought to appointments in Primary Care and / or with other health professionals.

See separate Did Not Attend (DNA) Policy for further information.

Relevant policies, procedures, tools and resources:

- Rethinking 'Did Not Attend
- RCGP Child Safeguarding Toolkit: Recognition of child maltreatment in general practice
- NICE Clinical Guideline CG89: Child maltreatment: when to suspect maltreatment in under 18s
- NICE guideline NG76: Child abuse and Neglect

4.8 CHILD SAFEGUARDING CASE REVIEWS

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 set out the functions of LSCBs. Under the Children Act 2004, as amended by the Children and Social Work Act 2017, LSCBs set up by local authorities have been replaced.

In 2019, under the new legislation, the three safeguarding partners (local authorities, chief officers of police, and Integrated Care Boards) had to put in place multi-agency safeguarding children arrangements to work together with relevant agencies (as they consider appropriate) to safeguard and protect the welfare of children in Somerset. In Somerset, this is known as the Somerset Safeguarding Children Partnership (hereafter referred to as 'the SSCP'). The SSCP undertake reviews of serious cases in specified circumstances. Serious child safeguarding cases are those in which:

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

Working Together is clear that serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development and should also cover impairment of physical health, but this is not an exhaustive list[8]. When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this

[8] Chapter 4: Improving child protection and safeguarding practice (workingtogetheronline.co.uk)

is not immediately certain and even if a child recovers, including from a one-off incident, serious harm may still have occurred. Working Together goes on to outline three key stages in the process of learning from serious cases:

- Serious Incident (SI) Notification to the Panel (shared with Ofsted and the DfE): While the responsibility for notification of an SI rests with the local authority, there may be instances where safeguarding partners do not initially agree on whether there is a need to notify the Panel following a serious incident. In such instances discussion between safeguarding partners about cases and the decision to notify is crucial. Once a case has been notified, responsibility for the Rapid Review rests with the three safeguarding partners.

- Rapid Reviews: Safeguarding partners are required to promptly undertake a Rapid Review on all notified Sis (Serious Incidents). Review timescales are set out in the National CSPR Panel guidance[9]. Rapid Reviews should identify, collate, and reflect on the facts of the case as quickly as possible in order to establish whether there is any immediate action needed to ensure a child's safety and the potential for practice learning. Decisions around whether to proceed to an LCSPR, and the recommendations and action plans arising from rapid reviews and LCSPRs need to be agreed by senior representatives of each of the three partners.

- Local Child Safeguarding Practice Reviews (LCSPRs): It is for safeguarding partners to determine whether an LCSPR is appropriate, considering that the overall purpose of a review is to identify improvements to local practice and wider systems. Just because an incident meets the criteria for notification in Working Together 2018 does not mean there is an automatic expectation to carry out an LCSPR, particularly if improvements to local practice and wider systems have already been robustly identified through a Rapid Review.

Safeguarding partners can require a person or body to comply with a request for information, as outlined in section 16H of the Children and Social Work Act 2017 and section 14B of the Children Act 2004. This can only take place when the information requested is for the purpose of enabling or assisting the safeguarding partners to perform their functions. Any request for information to a person or body, should be necessary and proportionate to the reason for the request. Safeguarding partners should be mindful of the burden of requests and should explain why the information is needed.

The SSCP will as part of the Child Safeguarding Case Review, Rapid Review or LCSPR ask each relevant organisation to provide information in writing about its involvement with the children who are the subject of the review, and their families, using templates developed by the safeguarding partners.

Relevant policies, procedures, tools and resources:

- HM Govt Child Safeguarding Practice Review Panel guidance for safeguarding partners

[9] Child Safeguarding Practice Review Panel guidance for safeguarding partners (publishing.service.gov.uk)

- Local Child Safeguarding Practice Reviews and Learning Reviews section of the SSCP website
- SWCCP – Local Safeguarding Children Partnership – Role and Function
- Working Together to Safeguarding Children: Chapter 4 – Improving child protection and safeguarding practice
- RCGP Child Safeguarding Toolkit: Learning from Serious Case Reviews

4.9 COURT REPORTS AND WITNESS STATEMENTS

At times there may be a request by police for a witness statement and / or a request for a statement by the local authority or a court. The person requesting the report should make it clear what the grounds are for sharing this information. Requests for Police statements and Court reports must be made in writing, so that you know exactly what you are being asked to write about. Your statement should make clear what is fact and what is "professional opinion" and be discussed with your line manager and / or safeguarding lead prior to submission.

Relevant policies, procedures, tools and resources:

- GMC Guidance: acting as a witness in legal proceedings
- GMC Guidance: Doctors giving evidence in court
- RCN Advice Guides - Witness
- RCN advice: Statement and how to write them

4.10 DOMESTIC ABUSE

The Domestic Abuse Act 2021 creates a new definition of Domestic Abuse. Section 1 / Part 1 states that behaviour of a person "A" towards another person "B" is domestic abuse if "A" and "B" are each aged 16 years or over, are "personally connected" to each other and the behaviour is abusive[10]. Behaviour is "abusive" if it consists of any of the following—

(a) physical or sexual abuse;

(b) violent or threatening behaviour;

(c) controlling or coercive behaviour;

(d) economic abuse (see subsection 4);

(e) psychological, emotional or other abuse; and it does not matter whether the behaviour consists of a single incident or a course of conduct.

[10] https://www.gov.uk/government/publications/domestic-abuse-act-2021

This definition includes 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

Under the Domestic Abuse Act 2021, children are recognised as victims of domestic abuse in their own right, if they see, hear, or experience the effects of the abuse, and are related to the perpetrator of the abuse or the victim of the abuse[11]. Abuse directed towards the child is defined as child abuse. Where there is domestic violence and abuse, the wellbeing of the children in the household must be promoted and all assessments must consider the need to safeguard the children, including unborn children. They are at increased risk of physical, emotional and sexual abuse in these environments.

When carrying out a risk assessment of domestic violence using the ACPO-DASH Risk Identification Checklist, staff may determine that a child / adult / family is at high risk as a result of the domestic violence and abuse disclosed. In this case all staff should consider completion of a referral to Somerset Multi Agency Risk Assessment Conference (MARAC).

MARAC is a victim focused meeting where information is shared between partner agencies on the highest risk cases of domestic abuse and violence. A risk focused, coordinated safety plan is then drawn up to support the victim(s) and his / her / their family. In light of the existence of high risk of domestic violence and known risks and vulnerability factors disclosed at MARAC, the expectation is that each service will review the family's needs and in accordance with the additional needs identified, provide an appropriate follow up service.

Domestic violence and abuse is a complex issue that needs sensitive handling by a range health and social care professionals. This routinely includes Primary Care staff in the following way:

- The practitioner referring a family to MARAC for consideration is required to include the family's GP details and if there are children in the family, their schools details.

- The MARAC point of contact will contact the family's GP (using the generic practice email) to inform them that their patient has been referred to MARAC and request relevant information, to be returned in a timely way.

- The family's GP will be asked to either attend or dial in to the MARAC meeting, when their patient is to be discussed.

- Information provided by the family's GP is considered as part of the MARAC meeting. The family's GP will then be notified of the outcome of the MARAC.

- Recording the information from the MARAC (Multi Agency Risk Assessment Conference) will help ensure that domestic abuse is considered when patients next attend an appointment

[11] Domestic Abuse Act 2021 (legislation.gov.uk)

Further information regarding local MARACs, the referral process and additional resources in relation to identification of and response to domestic violence and abuse in Somerset can be found on the MARAC section of the Somerset Survivors website.

The challenge of managing and recording domestic abuse (DA) information in the electronic medical record (EMR) of people experiencing or perpetrating abuse and how to do this without increasing risk of harm to victims (adult and child) is addressed in the RCGP Guidance on recording domestic abuse in the EMR 2021. Principles relevant to all recording of domestic abuse information in EMR / Primary Care records is outlined in APPENDIX 1: GUIDANCE FOR RECORDING AND STORING OF SAFEGUARDING INFORMATION IN PRIMARY CARE.

For further information, please see the seperate NHS Somerset ICB Standard Operating Procedure For Responding To Domestic Abuse

Relevant policies, procedures, tools and resources:

- South West Child Protection Procedures / Domestic Abuse section
- Home Office Domestic Abuse Statutory Guidance (2022)
- Somerset Survivors 'Information for GP's and health professionals'
- SafeLives resources library for all professionals working with victims of domestic abuse and their families
- Responding to Domestic Abuse: A Resource for Health Professionals. DoH. 2017

SNOMED codes to be used on EMIS in relation to Domestic Abuse:

Snomed code	Code description	When to use this code
886201000000108	Assessment using Domestic Abuse, Stalking and Harassment and Honour Based Violence (2009) Risk Identification and Assessment and Management Model Checklist (procedure)	Use this code when completing a DASH RIC checklist with a patient, due to concerns about domestic abuse.
978091000000105	Referral to multi-agency risk assessment conference (procedure)	Use this code when referring a patient to MARAC for high-risk domestic abuse
758941000000108	Subject of multi-agency risk assessment conference (finding)	Use this code when receiving notification that a patient has been discussed at MARAC / You have called in or attended a MARAC regarding your patient
371772001	Domestic abuse (event)	Use this code for recording the disclosure of a domestic abuse incident / On all named person's record when police Domestic

		Abuse Incident Notifications (DAIT / Merlin report / Form 72 / Police notification) received, regarding a Domestic Abuse incident.

4.11 EXPLOITATION (CHILD SEXUAL EXPLOITATION, CRIMIAL EXPLOITATION, MODERN SLAVERY, HUMAN TRAFFICKING, GANG ACTIVITY AND COUNTY LINES)

Child Sexual Exploitation: Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited *even if the sexual activity appears consensual*. CSE does not always involve physical contact; it can also occur through the use of technology.[12] It can be part of wider exploitation of the child and / or their family.

Like all forms of child sexual abuse, child sexual exploitation:

- can affect any child or young person (male or female) under the age of 18 years, including 16- and 17-year-olds who can legally consent to have sex;
- can involve grooming, force and/or enticement-based methods of compliance and may, or may not, be accompanied by violence or threats of violence;
- can be perpetrated by individuals or groups, males or females, and children or adults. The abuse can be a one-off occurrence or a series of incidents over time, and range from opportunistic to complex organised abuse;

CSE is never the victim's fault, even if there is some form of exchange, as all children and young people under the age of 18 have a right to be safe and should be protected from harm.

Criminal Exploitation is, where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18 into any criminal activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial or other advantage of the perpetrator or facilitator and/or (c) through violence or the threat of violence. The victim may have been criminally exploited even if the activity appears consensual. Child criminal exploitation does not always involve physical contact; it can also occur through the use of technology.

County Lines is a form of criminal exploitation and is a term used to describe the dedicated phone lines that gangs and organised criminal networks use to move illegal drugs around the UK. They are likely to exploit children and vulnerable adults to move and store the drugs and money, and they will often use coercion, debt bondage, intimidation, violence (including sexual violence) and weapons.

[12] DfE Child Sexual Exploitation - Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation

Modern slavery is a form of organised crime in which individuals including children and young people are treated as commodities and exploited for criminal gain. Slavery is an umbrella term for activities involved when one person obtains or holds another person in compelled service. Modern slavery is identified as abuse which requires a child protection response. It is an abuse of human rights, and all children, irrespective of their immigration status, are entitled to protection under the law[13]. For further guidance refer to the Modern Slavery Act 2015 and associated guidance outlined below.

As specified in Section 52 of the Modern Slavery Act 2015, public authorities in England and Wales have a statutory duty to notify the Home Office when they come across potential victims of modern slavery. This duty is discharged by either referring a child or consenting adult potential victim into the National Referral Mechanism (NRM), or by notifying the Home Office if an adult victim does not consent to enter the NRM. The National Referral Mechanism[14] is a framework for identifying victims of human trafficking and ensuring they receive appropriate care. Potential victims of modern slavery in the UK that come to the attention of authorised 'First Responder' organisations are referred to the NRM. Authorised 'First Responder' organisations include local authorities and police forces but not health organisations. Adults (aged 18 or above) must consent to being referred to the NRM, whilst children under the age of 18 are not required to give consent to be referred. Child victims must first be safeguarded and then referred into the NRM process. NRM referrals can also be made for individuals exploited as children but who are now adults.

Human trafficking is the movement of people by means such as force, fraud, coercion or deception, with the aim of exploiting them. It is a form of modern slavery and a crime. Trafficking involves the transportation of people in order to exploit them by the use of force, violence, deception, intimidation or coercion. It does not always involve international transportation and can be transportation just within the UK. This exploitation includes commercial, sexual and bonded labour. Trafficked people have little choice in what happens to them and often suffer abuse due to violence and threats made against them or their families. In effect, they become commodities owned by traffickers, used for profit.

Relevant policies, procedures, tools and resources

- SSCP quick guide to CSE for Somerset professionals which is accessible in the 'Resources for Professionals' section of the SSCP Child Exploitation webpage.
- SSCP initial screening tool for Child Exploitation (CE) is intended to support professional judgment by assisting professionals to consider the risk of harm to a child.[15] This is accessible in the 'Tools' section of the SSCP Child Exploitation webpage.
- SWCPP - Children from Abroad, including Victims of Modern Slavery, Trafficking and Exploitation
- SWCPP - Child Criminal Exploitation

[13] Modern Slavery Act 2015 (legislation.gov.uk)
[14] National referral mechanism guidance: adult (England and Wales) - GOV.UK (www.gov.uk)
[15] http://sscb.safeguardingsomerset.org.uk/working-with-children/cse-protocols/

- SWCPP - Child Sexual Exploitation
- SWCPP - Children Affected by Gang Activity and Youth Violence
- Home Office. Signs and Indicators – A template for identifying and recording concerns of child sexual abuse
- Home Office. Communicating with children - A guide for those working with children who have or may have been sexually abused
- DfE Child sexual exploitation: definition and guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation
- NHSE Child Sexual Exploitation: Advice for Healthcare Staff is a pocket guide to provide practical information to healthcare staff to safeguard children and young people
- Advice and Support for Modern Slavery Victims
- HM Govt Modern Slavery Statutory Guidance for England and Wales (2023)

SNOMED codes to be used on EMIS in relation to Child Sexual Exploitation:

919461000000108	At risk of sexual exploitation (finding)	Use this code when notified by Topaz that child is subject to discussion at Topaz for possible CSE
785101000000105	Victim of sexual exploitation (finding)	Use this code when notified by Topaz that child is subject to discussion at Topaz for actual CSE
1086791000000109	Child is cause for concern regarding sexual exploitation (finding)	Use this code when notified by Topaz that child is subject to discussion at Topaz for possible CSE

4.12 FEMALE GENITAL MUTILATION (FGM)

FGM comprises of all procedures involving partial or total removal of the external female genital organs or any other injury to the female genital organs for non-medical reasons. FGM is most often carried out on young girls aged between infancy and 15 years old. It is often referred to as 'cutting', 'female circumcision', 'initiation', 'Sunna' and 'infibulation'[16]. Under the Female Genital Mutilation Act 2003, **FGM is a criminal offence.** FGM causes significant harm, constitutes physical and emotional abuse, and is a violation of a child's right to life, their bodily integrity as well as their right to health**.**

It is a mandatory duty for a regulated healthcare professional to report any concerns they have about a female under 18 years and record when FGM is disclosed or identified as part of NHS healthcare. As FGM is illegal this should be reported to the

[16] https://www.england.nhs.uk/wp-content/uploads/2016/12/fgm-pocket-guide-v5-final.pdf

police via the 101 non-emergency number. Staff who initially identify FGM must call 101 (police) to report. If you believe that a victim or potential victim of FGM is in immediate danger, always dial 999. If you are concerned that a child is at risk you must make a referral to Children's Social Care (CSC) immediately. Where a child appears to be in immediate danger of mutilation, CSC and the police will urgently consider the need for an FGM Protection Order, an Emergency Protection Order or a Prohibited Steps Order. Staff should make it clear to the family that they will be breaking the law if they arrange for the child to have the procedure.

Relevant policies, procedures, tools and resources:

- SWCPP - Female Genital Mutilation
- HM Govt FGM resource pack
- NHS England has produced a helpful pocket guide about FGM for Health Care Professionals.
- CQC GP myth buster 80: Female Genital Mutilation (FGM)
- DoH Safeguarding women and girls at risk of FGM
- The NSPCC has a 24 hour helpline to provide advice and support to victims of FGM 0800 028 3550 or email fgmhelp@nspcc.org.uk
- RCGP resources - Female Genital Mutilation

4.13 MENTAL CAPACITY ACT AND CHILDREN

The Mental Capacity Act (2005) applies to all professions – doctors, nurses, social workers, occupational therapists, healthcare assistants, and support staff. All these staff and their employers have a duty to ensure they know how to use it. The Mental Capacity Act is intended to assist and support people who may lack capacity; it aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack capacity to make decisions to protect themselves. The Act is built on five principles that guide and inform decision making for people who may lack capacity for decision making in some aspects of their life including their health care. They are:

- Assume Capacity
- Help people have capacity in all practical ways before deciding they don't have capacity
- People are entitled to make unwise decisions
- Decisions for people without capacity should be in their Best Interests Decisions for people without capacity should be the Least Restrictive possible

Children under 16: The Act does not generally apply to people under the age of 16. There are two exceptions:

- The Court of Protection can make decisions about a child's property or finances (or appoint a deputy to make these decisions) if the child lacks capacity to make such decisions within section 2(1) of the Act and is likely to still lack capacity to make financial decisions when they reach the age of 18 (section 18(3)).
- Offences of ill treatment or wilful neglect of a person who lacks capacity within section 2(1) can also apply to victims younger than 16 (section 44).

Young people aged 16–17 years: Most of the Act applies to young people aged 16–17 years, who may lack capacity within section 2(1) to make specific decisions. There are three exceptions:

- Only people aged 18 and over can make a Lasting Power of Attorney (LPA).
- Only people aged 18 and over can make an advance decision to refuse medical treatment.
- The Court of Protection may only make a statutory will for a person aged 18 and over

Where a young person over 16 is found to lack capacity to make a particular decision, it is important that the best interests process under the Mental Capacity Act 2005 is followed and that young people are as involved as possible in decisions made on their behalf. In some cases, it will be possible for someone with parental responsibility to make a decision on behalf of the young person who lacks capacity. However, this will not always be appropriate. In these circumstances, the Mental Capacity Act Code of Practice should be followed to determine who should lead the best interests process.

In 2019 the Mental Capacity (Amendment) Act was passed, which means that the Liberty Protection Safeguards (LPS) will replace the Deprivation of Liberty Safeguards (DoLS). DoLS currently only applies to people aged 18 years and over, and any authorisation to deprive young people of their liberty must currently be made by a court. Whereas 16- and 17-year-olds will come within the LPS framework, which is designed to be a simpler, more streamlined system which puts the person being deprived of liberty at the heart of the decision-making process.

The Liberty Protection Safeguards will provide protection for people aged 16 and above who are, or who need to be, deprived of their liberty in order to enable their care or treatment and who lack the mental capacity to consent to their arrangements. LPS authorisations can apply to 16 and 17 year olds in settings such as:

- Social care settings including children's homes, short breaks and youth club provision
- Education settings including day and residential schools and colleges
- Hospitals, including inpatient mental health units

Effective safeguarding identification and processes must always be followed, with acute awareness necessary among staff about the more subtle forms of abuse such as coercion. Staff must always refer to local safeguarding procedures if concerned

about a child. See Section 3 of this Policy on 'What to do if you are concerned about a child' for further details.

Relevant policies, procedures, tools and resources:

- HM Govt Mental Capacity Act Code of Practice
- HM Govt Liberty Protection Safeguards (LPS) factsheets
- NHSE website – Mental Capacity Act
- RCGP Mental Health Toolkit
- CQC GP mythbuster 10: GPs and the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards
- NICE Quality Standard QS194: Decision Making and Mental Capacity
- NICE Guideline NG108: Decision-making and mental capacity Includes recommendations for best practice in assessing and supporting people aged 16 years and older with decision-making activities.
- BMA guidance Mental Capacity Act Toolkit

4.14 PERPLEXING PRESENTATIONS (PP) and FABRICATED OR INDUCED ILLNESS IN CHILDREN (FII)

There is no nationally agreed definition of Perplexing Presentations and Fabricated or Induced Illness. The most up to date definitions are from the RCPCH 2021 Perplexing Presentations and FII Guidance:

- **Fabricated or Induced Illness** is a clinical situation whereby a child is, or is very likely to be, harmed due to parent(s) behaviour and action, carried out in order to convince doctors that the child's state of physical and/or mental health and neurodevelopment is impaired (or more impaired than is actually the case). FII results in physical and emotional abuse and neglect, as a result of parental actions, behaviours or beliefs and from doctors' responses to these. The parent does not necessarily intend to deceive, and their motivations may not be initially evident.
- A **Perplexing Presentation** is when there are presence of alerting signs when the actual state of the child's physical/ mental health is not yet clear but there is no perceived risk of immediate serious harm to the child's physical health or life.

Perplexing presentations indicate possible harm due to fabricated or induced illness which can only be resolved by establishing the actual state of health of the child. Not every perplexing presentation is an early warning sign of fabricated illness, but professionals need to be aware of the presence of discrepancies between reported signs and symptoms of illness and implausible descriptions of illnesses and the presentation of the child and independent observations of the child

There are four main ways of the carer fabricating or inducing illness in a child, which are not mutually exclusive:

- fabrication of signs and symptoms, including fabrication of past medical history
- fabrication of signs and symptoms and falsification of hospital charts, records, letters and documents and specimens of bodily fluids
- exaggeration of symptoms/real problems. This may lead to unnecessary investigations, treatment and/or special equipment being provided
- induction of illness by a variety of means

Once ICB staff have suspicions of fabricated or induced illness of are seeing a Perplexing Presentation (PP), the ICB safeguarding children team should be contacted for specialist advice. Staff should not normally discuss their concerns about Fabricated or Induced Illness (FII) with the parents / carers at this stage.

If staff feel their concerns about FII are not being taken seriously or responded to appropriately by partner agencies, they should discuss these with the ICB Safeguarding Children Team.

Relevant policies, procedures, tools and resources:

- South West Child Protection Procedures - Perplexing Presentations / Fabricated of Induced Illness
- RCPCH Perplexing Presentations (PP) / Fabricated or Induced Illness (FII) in children guidance 2021
- NICE CG89 guidance provides a summary of clinical features associated with child maltreatment (alerting features) that may be observed when a child presents to healthcare professionals. The alerting features in this guidance have been divided into two, according to the level of concern, with recommendations to either 'consider' or 'suspect' maltreatment.

4.15 PREVENT – SAFEGUARDING CHILDREN AGAINST RADICALISATION AND EXTREMISM

The Prevent strategy, published by the Government in 2011, is part of the overall counter-terrorism strategy, CONTEST. The aim of the Prevent strategy is to reduce the threat to the UK from terrorism by stopping people becoming terrorists or supporting terrorism. In the Counter-Terrorism and Security Act 2015 this has simply been expressed as the need to "prevent people from being drawn into terrorism".[17]

Radicalisation is defined by the UK Government within this context as "the process by which a person comes to support terrorism and extremist ideologies associated with terrorist groups." Extremism goes beyond terrorism and includes people who target the vulnerable –including the young – by seeking to sow division between communities on the basis of race, faith or denomination; justify discrimination towards

[17] Revised Prevent duty guidance: for England and Wales - GOV.UK (www.gov.uk)

women and girls; persuade others that minorities are inferior; or argue against the primacy of democracy and the rule of law in our society.

Extremism is defined in the Counter Extremism Strategy 2015 as the vocal or active opposition to fundamental values, including the rule of law, individual liberty and the mutual respect and tolerance of different faiths and beliefs. Working Together 2018 also regards calls for the death of members of our armed forces as extremist[18].

Section 26 of the Counter-Terrorism and Security Act 2015 (the Act) places a duty on certain bodies (including the NHS) in the exercise of their functions, to have "due regard to the need to prevent people from being drawn into terrorism." The key challenge for the NHS is to ensure that, where there are signs that someone has been or is being drawn into terrorism, staff are trained to recognise those signs correctly and are aware of and can locate available support, including the Channel programme where necessary. Frontline staff who engage with the public should understand what radicalisation means and why people may be vulnerable to being drawn into terrorism as a consequence of it.

Keeping children safe from risks of radicalisation and extremism is a safeguarding matter and should be approached in the same way as other safeguarding concern. See Section 3 of this Policy for further details of what to do if you are concerned about a child.

Relevant policies, procedures, tools and resources in relation to Prevent:

- HM Govt Prevent Duty Guidance
- SWCPP - Safeguarding Children and Young People against Radicalisation and Violent Extremism
- Somerset County Council website – Prevent in Somerset
- Avon and Somerset Police dedicated Prevent Team (specially trained male and female officers) who can give advice or direct you to other support agencies. Phone **01179 455 536** or Email: channelsw@avonandsomerset.pnn.police.uk
- Prevent duty training: learn how to support people vulnerable to radicalisation

4.16 PRIVATE FOSTERING

A private fostering arrangement is essentially one that is made without the involvement of a Local Authority for the care of a child under the age of 16 (under 18 if disabled) by someone other than a parent or close relative for 28 days or more. Private fostering is not the same as fostering arranged by the local authority.

Privately fostered children are a diverse and sometimes vulnerable group which includes[19]:

[18] Glossary: Extremism (workingtogetheronline.co.uk)
[19] Children Living and Staying Away from Home including Private Fostering (proceduresonline.com)

- Children sent from abroad to stay with another family, usually to improve their educational opportunities;

- Teenagers who, having broken ties with their parents, are staying in short–term arrangements with friends or other non-relatives;

- Children who stay with another family whilst their parents are in hospital, prison or serving overseas in the armed forces;

- Language students living with host families.

Under the Children Act 1989, private foster carers and those with Parental Responsibility are required to notify the Local Authority of their intention to privately foster or to have a child privately fostered, or where a child is privately fostered in an emergency.

All staff should notify Children's Social Care of a private fostering arrangement that comes to their attention, where they are not satisfied that the Local Authority have been or will be notified. The local authority must also arrange to visit privately fostered children at regular intervals. All arrangements and regulations in relation to Private Fostering are set out in the Children (Private Arrangements for Fostering) Regulations 2005.

Relevant policies, procedures, tools and resources in relation to Private Fostering:

- SWCPP - Children Living and Staying Away from Home including Private Fostering

- Somerset Direct (Private Fostering)

- RCGP Child Safeguarding Toolkit: Private Fostering

4.17 REGISTERING CHILDREN WITH A GP

NHS England has established operating principles for GP practices for patient registrations that promote equality, human rights and public health and reduce health inequalities. For purposes of safeguarding children, the following should be considered whilst recognising that patients must still be registered in the absence of documentation and policies. This must be applied in a non- discriminatory manner. The practice should seek assurance through:

- Proof of identity and address for every child, supported by official documentation such as a birth certificate, (This helps to identify children who may have been trafficked or who are privately fostered.)

- An adult with parental responsibility should always be registered at the practice with the child[20] unless the child is looked after, in which case the practice should be clear who has parental responsibility and the contact details for any carer and social worker. Verifying the ID of the adult is essential as it can be matched to

[20] There may be legitimate exceptions to this, such as where both parents are serving in the armed forces and are registered with an 'armed forces' GP.

the birth certificate details. However, the practice should not refuse to register a child if there is no-one with parental responsibility who can register, as it is generally safer to register first and then seek advice from the Practice Safeguarding Children Lead or Practice Manager. (This situation may alert you to a private fostering arrangement which constitutes a safeguarding concern).

- Where there are safeguarding concerns identified it is good practice to offer each child a new patient registration health check as soon as possible after registration.

- Proof of parental responsibility or relevant guardianship agreements should be documented on the child's notes. A father automatically has parental responsibility if he's married to the mother at the time of the child's birth. An unmarried father will have parental responsibility if they are named on the child's birth certificate (from 15 April 2002). If not the practice will need to see proof that this has been granted (a letter from the mother stating this will suffice).

- Children who have been temporarily registered with the practice should be reviewed regularly and proceed to permanent registration as soon as possible and ideally within three months of initial registration.

- Children of parents or carers, who have been removed from the list for any reason, must not be left without access to primary care services and should be reregistered at a new practice together. The practice should ensure that the child has access to appropriate care in the interim.

- Where parents or carers have been removed from the list due to aggressive and or violent behaviour a risk assessment should be completed to identify any risk to their children and the appropriate referrals safeguarding made.

There is nothing to stop a parent deregistering their family and not registering again. It is not compulsory to be registered with a GP whether an adult or a child. If a practice is concerned about a family who is deregistering their children with no plan to register with another general practice, potential or actual safeguarding children needs must be considered in the context of information known about the family by the General Practice and other agencies also working with the family. Further action should be taken as necessary if there are safeguarding concerns. See section 3 of this policy for further guidance on this.

Relevant policies, procedures, tools and resources in relation to Registering a Child with a GP:

- NHSE Primary Medical Care Policy and Guidance Manual (PGM).
- BMA guidance on patient registration for GP practices
- HM Govt Parental Rights and Responsibilities
- CQC GP MythBusters 61: Patient Registration

4.18 SEXUALLY ACTIVE CHILDREN

A child under 13 is not legally capable of consenting to sexual activity. Sexual activity with a child under 13 years of age is a criminal offence and is classed as statutory rape. Any offence under the Sexual Offences Act 2003 involving a child under 13 indicates significant harm to the child and requires a child protection referral. Any sexual activity involving consenting children between 13 and 16 is unlawful, but the Sexual Offences Act 2003 is not used to prosecute two people under the age of 16 who engage in mutually consensual activity, whereby the activity is not part of one child exerting power over another. Sexually active young people in this age group will still have to have their needs assessed.

Although sexual activity over the age of 16 is lawful, under 18s are still offered protection under the Children Act 1989 and consideration still needs to be given to issues of sexual exploitation and abuse. Children over the age of 16 and under the age of 18 are not deemed able to give consent if the sexual activity is with an adult in a position of trust or a family member as defined by the Sexual Offences Act 2003. This applies even though they would normally be legally able to give their consent to sexual activity.

The sharing or viewing of sexual images of children is an offence even if they were originally sent by the child themselves (e.g., sexting). Staff should seek support from the police on 101 or 999, dependent on need and / or urgency, if they become aware of any such activity.

Staff are required to identify where young people's sexual relationships may be abusive and they may need protection, and/ or the provision of additional services. Where there are concerns that a child may be at risk of or are reporting child sexual abuse, a child protection referral should be made to Children's Social Care and where the situation is an emergency, the local police should be contacted immediately.

Relevant policies, procedures, tools and resources in relation to Sexually Active Children:

- SWCPP - Underage Sexual Activity
- The Sexual Behaviours Traffic Light Tool (developed by Brook) complements organisational safeguarding procedures by supporting professionals working with children and young people to identify, understand and respond appropriately to sexual behaviours.
- Training on the Sexual Behaviours Traffic Light Tool is available through Brook or the Somerset Safeguarding Children Partnership (SSCP). The training and accompanying tool equips staff to make consistent and informed decisions that neither stigmatise nor criminalise young people. For further information on the SSCP training opportunities, contact SSCP@somerset.gov.uk
- CQC GP Mythbuster 8: Gillick Competency and Fraser Guidelines

4.19 SAFEGUARDING DISABLED CHILDREN

The Disability Discrimination Act 2005 (DDA) defines a disabled person as someone who has: "A physical or mental impairment which has a substantial and long term adverse effect on his or her ability to carry out normal day to day activities"[21]. By definition, any child with a disability should also be considered as a child in need under s17 of the Children Act 1989.[22]

This means that the needs of children and young people with long term illnesses are addressed. They may not usually be thought of as disabled, but their vulnerabilities may be similar. The key issue is the impact of abuse or neglect on a child or young person's health and development and how best to support them and safeguard their welfare.

The available UK evidence on the extent of abuse among disabled children suggests that disabled children are at increased risk of abuse and vulnerable to significant harm through physical, sexual, emotional abuse and / or neglect than children who do not have a disability. The presence of multiple disabilities appears to increase the risk of both abuse and neglect. Disabled children may be especially vulnerable to abuse for a number of reasons. These can include but are not limited to the following:

- Many disabled children are at an increased likelihood of being socially isolated with fewer outside contacts than non-disabled children;
- Their dependency on parents and carers for practical assistance in daily living, including intimate personal care, increases their risk of exposure to abusive behaviour;
- They may have an impaired capacity to resist or avoid abuse;
- They may have speech, language and communication needs which may make it difficult to tell others what is happening;
- They often do not have access to someone they can trust to disclose that they have been abused; and/or
- They are especially vulnerable to bullying and intimidation.

Looked after disabled children are not only vulnerable to the same factors that exist for all children looked after but are particularly susceptible to possible abuse because of their additional dependency on care staff for day to day physical care needs. These factors can be present for both looked after disabled children and disabled children:

- Force feeding;
- Unjustified or excessive physical restraint;
- Rough handling;

[21] Disability Discrimination Act 2005 – Definition
[22] http://www.proceduresonline.com/swcpp/somerset/p_disabled_ch.html?zoom_highlight=safeguarding+disabled+chidlren

- Extreme behaviour modification, including the deprivation of liquid, medication, food or clothing;
- Misuse of medication, sedation, heavy tranquillisation;
- Invasive procedures against the child's will;
- Deliberate failure to follow medically recommended regimes;
- Misapplication of programmes or regimes;
- Ill-fitting equipment
- Undignified age or culturally inappropriate intimate care practices.

Safeguarding disabled children's welfare is everybody's responsibility and given that we know that disabled children are more vulnerable to abuse than non-disabled children, awareness amongst professionals about safeguarding disabled children and what constitutes best practice, is essential. Safeguards for disabled children are essentially the same as for non-disabled children, to ensure that disabled children at risk of or who have experienced abuse should be treated with the same degree of professional concern accorded to non-disabled children. Staff must report safeguarding concerns about a disabled child promptly and detailed information sharing is vital. Furthermore, it is crucial when considering whether a disabled child has been abused and/or neglected that the disability does not mask possible signs of abuse, or deter an appropriate investigation of child protection concerns

Relevant policies, procedures, tools and resources in relation to Safeguarding Disabled Children:

- SWCPP - Disabled Children
- SSCP Effective Support for Children and Young people with Special Educational Needs and Difficulties and their Families in Somerset
- HM Govt Safeguarding disabled children guidance
- CQC GP mythbuster 67: Reasonable adjustments for disabled people
- CQC GP mytbuster 53: Care of people with a learning disability in GP practices

4.20 SAFEGUARDING UNBORN BABIES

Young babies are particularly vulnerable to abuse, and work carried out in the antenatal period can help minimise any potential harm if there is early assessment, intervention and support, with an emphasis on clear and regular communication between staff working with the unborn baby, and their parents / carers / family.

Where staff become aware a woman is pregnant, at whatever stage of the pregnancy, and they have concerns for the pregnant woman, her partner, the unborn baby's welfare, or that of siblings, they must not assume that maternity services or

other services involved are aware of the pregnancy or the concerns held. When safeguarding concerns have been identified, it is important that staff work together with other professionals working with the unborn baby, siblings, the pregnant woman and their family. This is key to effectively safeguarding unborn babies, particularly as other professionals may have also identified vulnerability and risk indicators that will add context to the safeguarding concerns you have identified.

Partners / fathers play an important role during pregnancy and after. It is important that all agencies involved in pre and post birth assessment and support fully consider the significant role of partners / fathers and wider family members in the care of the baby, even if the parents are not living together, and where possible actively involve them in the assessment. The assessment should include the partner/ father's attitude towards the pregnancy, the mother and the unborn / new-born baby and his thoughts, feelings and expectations about becoming a parent. Information should also be gathered about fathers and partners who are not the biological father at the earliest opportunity to ensure any risk factors can be identified.

There is an agreed process for professionals in Public Health / Health Visiting, Midwifery and Primary Care in relation to communication in the Pre-Birth period, designed to ensure that all midwives, health visitors and GP's assess and communicate risk collectively and in a standardised format in relation to unborn babies and their families. The agreed process is outlined in the Pre-Birth Standard Operating Procedure which is aligned to the South West Child Protection Procedures.

There is also an agreed process in Somerset between all agencies (including health professionals and Children's Social Care) working with the unborn baby, pregnant woman and their family, which gives clear guidance on the planning, assessment and actions required to safeguard the unborn baby:

- The Somerset Pre-Birth Workbook is a new digital modular resource that has been produced collaboratively with practitioners from across the partnership to help you to work with new parents in the pre-birth period.

- The Somerset pre-birth planning toolkit has been designed for staff working with pregnant women and their families. The toolkit should always be used in conjunction with the SWCPP chapter on Safeguarding Unborn Babies to inform safeguarding decision making.

When risks have been identified in the Pre-Birth period, it is important that professionals work together to provide appropriate interventions and planning at the earliest opportunity to optimise the outcomes and support for the unborn baby and their family. See section 3 of this Policy for further guidance on What to Do if You are Concerned about a Child.

Relevant policies, procedures, tools and resources in relation to Safeguarding Unborn Babies:

- SWCPP – Pre-Birth (Safeguarding Unborn Babies)

- Pre-Birth Planning section of the SSCP website

- The Somerset Maternity Toolkit is designed to support parents / families from pre-birth, pregnancy, birth and beyond.

- An online training package "Improving Multi-Agency Pre-Birth Planning" has been developed for professionals in Somerset and is available free of charge.

- ICON - Babies Cry You Can Cope - advice and support
  I – Infant crying is normal
  C –Comforting methods can help
  O – It's OK to walk away
  N – Never, ever shake a baby

Snomed codes to be used in relation to safeguarding unborn babies:

Code	Classification on NHS Digital / SNOMED wording	Rationale for use of code in Primary Care
878111000000109	Unborn child is cause for safeguarding concern	Use this code if discussing an unborn baby in CP meetings. If using this code practitioner should refer to multi agency pre-birth protocol and Pre Birth SOP

5 INFORMATION SHARING

5.1 In England and Wales, the Children Acts of 1989 and 2004 gave all staff a statutory duty to co-operate with other agencies if there are concerns about a child's safety or welfare.[23]

5.2 The Children, Schools and Families Act 2010 Part 1 / Section 8 amended the Children Act 2004, providing further statutory requirements for information sharing when the Local Safeguarding Children Board requires such information to allow it to carry out its functions.[24]

5.3 The General Medical Council is clear that Doctors 'must tell an appropriate agency, such as your local authority children's services, the NSPCC or the police, promptly if you are concerned that a child or young person is at risk of, or is suffering, abuse or neglect unless it is not in their best interests to do so'.[25]

5.4 Working Together to Safeguard Children 2018[26] states that:

[23] Children Act 2004 sections 10 and 11 http://www.legislation.gov.uk/ukpga/2004/31
[24] Children Schools and Families Act 2010 Part 1 /Section 8
http://www.legislation.gov.uk/ukpga/2010/26
[25] GMC guidance - Protecting children and young people: The responsibilities of all doctors
http://www.gmc-uk.org/guidance/ethical_guidance/13257.asp
[26] https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

- "*Effective sharing of information between professionals and local agencies is essential for effective identification, assessment and service provision to keep children safe.*

- *Fears about information sharing must not be allowed to stand in the way of the need to promote the welfare and protect the safety of children which must always be of paramount concern"*

- Practitioners must have due regard to the relevant data protection principles which allow them to share personal information, as provided for in the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR).

- To share information effectively all practitioners should be confident of the processing conditions under the Data Protection Act 2018 and the GDPR which allow them to store and share information for safeguarding purposes, including information which is sensitive and personal, and should be treated as 'special category personal data'.

5.6 Under Schedule 1 Part 1 of the Data Protection Act 2018 Sub Paragraph 18 (1) a processing condition is provided that allows special categories of personal data to be shared for the purposes of "safeguarding of children and individuals at risk". This condition is met if –

(a) the processing is necessary for the purposes of—
(i) protecting an individual from neglect or physical, mental or emotional harm, or
(ii) protecting the physical, mental or emotional well-being of an individual,

(b) the individual is—
(i) aged under 18, or
(ii) aged 18 or over and at risk,

(c) the processing is carried out without the consent of the data subject for one of the reasons listed in sub-paragraph (2), and

(d) the processing is necessary for reasons of substantial public interest.

5.7 Under Article 6(1)(d) the UK General Data Protection Regulation (GDPR) a lawful basis is provided for processing personal data where: "processing is necessary in order to protect the vital interests of the data subject or of another natural person".

5.8 Consent should be sought to share information unless:

- that would undermine the purpose of the disclosure (for example in suspected fabricated & induced illness and sexual abuse)

- action must be taken quickly because delay would put the child at further risk of harm

- it is impracticable to gain consent

- to do so would put the child or the staff member at risk

5.9 It is important to note that GDPR and the Data Protection Act 2018 are not barriers to sharing information. The Information sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers guidance states "Where there are concerns about the safety of a child, the sharing of information in a timely and effective manner between organisations can improve decision-making so that actions taken are in the best interests of the child. The GDPR and Data Protection Act 2018 place duties on organisations and individuals to process personal information fairly and lawfully; they are not a barrier to sharing information, where the failure to do so would cause the safety or well-being of a child to be compromised. Similarly, human rights concerns, such as respecting the right to a private and family life would not prevent sharing where there are real safeguarding concerns."

5.10 When health professionals are asked for information about a child or family, they should verify the identity of the enquirer and clarify the grounds on which the information is being requested. The proportionality principle still applies, in that only information for the purpose of the enquiry is shared, not the full records held by the health professional or agency. This may mean relevant information about parents/carers needs to be shared, when the information request relates to a child.

Relevant policies, procedures, tools and resources:

- SWCPP - Information Sharing
- Information sharing advice for safeguarding practitioners
- RCGP Child Safeguarding Toolkit – Information Sharing
- RCGP Safeguarding Children and Adults- Information Sharing course

6 SAFEGUARDING CHILDREN TRAINING REQUIREMENTS

6.1 All staff working in healthcare settings - including those who predominantly treat adults - should receive training to ensure they attain the competencies appropriate to their role and responsibilities. Minimum safeguarding training requirements are set out in the following:

- Safeguarding Children and Young People: Roles and Competencies for Healthcare staff, RCPCH (2018)
- Looked after children: Knowledge, skills and Competencies of Healthcare Staff, RCN and RCPCH, (2020)
- Adult Safeguarding: Roles and Competencies for Healthcare Staff (2018)
- NHS Prevent Training and competencies framework, RCN, (2022)

6.2 The competences and minimum requirements specifically needed by healthcare staff to safeguard and promote the wellbeing of children are described in detail in the above guidance. Safeguarding competencies are the set of abilities that enable staff to effectively safeguard, protect and promote the welfare of children and young

people. They are a combination of skills, knowledge, attitudes and values that are required for safe and effective safeguarding children practice. Different staff groups require different levels of competence depending on their role and degree of contact with children, young people, adults and families; the nature of their work, and their level of responsibility.

6.4 The Intercollegiate Document[27] identifies six levels of competence in Safeguarding Children and gives examples of groups that fall within each of these. The levels are as follows:

- Level 1: Non-clinical staff working in health care settings.
- Level 2: Minimum level required for non-clinical and clinical staff that have some degree of contact with children and young people and/or parents/carers.
- Level 3: Clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.
- Level 4: Named safeguarding professionals (such as the ICB Named Professional for Safeguarding in Primary Care role)
- Level 5: Designated safeguarding professionals (such as the ICB Designated Nurse and Doctor)
- Board Level: Chief Executive Officers, Trust and Health Board Executive and non-executive directors / members, commissioning body Directors.

6.4 Further information available in relation to training requirements for staff at all levels, in line with all of the above documents, can be found on the Safeguarding Training section of the ICB safeguarding team's webpages.

6.5 Training must include a multi-agency element, particularly for staff identified as requiring level 3 and above. For example, as provided by Somerset Safeguarding Children Partnership (SSCP), the Association of Child Protection Professionals (AoCPP) and others.

6.6 Training delivered by all NHS organisations can encompass a blended learning approach to facilitate staff meeting their safeguarding training requirements. A blended approach to meeting safeguarding training competencies includes:

- Face to Face – including but not limited to , conferences
- Blended learning -including but not limited to eLearning, webinars, reflective practice, and safeguarding supervision.

6.7 Staff will need to keep accurate records of any type of education, training and learning that contributes to their compliance with their safeguarding training

[27] Safeguarding Children and Young People: Roles and Competences for Health Care Staff Intercollegiate Document 2019

requirements. This can be captured through completion of an Education, training and learning reflection record that includes each individual learning activity to be considered as part of the blended approach. Education, training and learning reflection records for safeguarding adult, safeguarding children and children looked after competencies can be found on the Safeguarding Training section of the ICB safeguarding team's webpages

Relevant policies, procedures, tools and resources:

- The Somerset Safeguarding Children Partnership (SSCP) website includes multiple training opportunities (using a blended approach) through
  - Highlighting learning from Child Safeguarding Practice Reviews locally and nationally cascaded via Newsletters and Bulletins
  - Somerset Safeguarding Children Forum weeks and associated recordings,
  - Multi-agency training

- The Somerset Safeguarding Adult Board (SSAB) website houses training and highlights learning from Safeguarding Adult Reviews locally and nationally is cascaded via Practice Guidance and Resources such as Webinars, which is incorporated into all aspects of multi-agency training.

- NHS England South West Safeguarding Training Framework 2022 to 2025

- E-learning for Healthcare - Safeguarding

- Prevent duty training: learn how to support people vulnerable to radicalisation

- SGPET: Somerset GP Education Trust

- SCIE Safeguarding training courses

7 SAFEGUARDING CHILDREN SUPERVISION

7.1 To effectively safeguard and promote the welfare of children, staff need to be confident and competent, and properly supported in their role. This means having strong structures in place that provide the opportunity for robust and regular supervision that enables constructive challenge and time to reflect on practice and develop skills. Local arrangements for supervision must be robust, meet the specific needs of staff in their area and demonstrate the effective discharge of statutory duties to safeguard children and promote their welfare, in accordance with local and national safeguarding guidance.

7.2 Safeguarding supervision is not the same as appraisal. Safeguarding supervision must be focused on the needs of the vulnerable child or adult with care and support needs and actions to be taken to keep the child or adult safe. In addition, safeguarding supervision includes the need to:

- Ensure that the supervisees and supervisors are clear about their roles and responsibilities.

- Assist in the supervisee's professional development.

- Be a source of support for the supervisee.
- Facilitate safe and effective practice through constructive feedback to a professional.
- Maintain a clear focus on the child's welfare and support the supervisee in reflecting on the impact of their practice, from a single and multi-agency perspective, on the child and their family.
- Understand how effectively the supervisee is working together with other professionals to safeguard the vulnerable child or adult with care and support needs, exploring relationships and interactions between those professionals.

7.3 The Intercollegiate Document 2019 states "It is the duty of healthcare organisations to ensure that all health care staff have access to appropriate safeguarding / child protection supervision and support to facilitate their understanding of the clinical aspects of child wellbeing and information sharing".

7.4 Working Together to Safeguard Children 2018 states that "Practitioners should be given sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively".

7.5 The ICB Strategic safeguarding team provide formal safeguarding supervision to safeguarding leads within the ICB, Primary Care and the NHS providers we commission. This can be on a one-to-one basis or in a group with peers. Participants receiving one to one safeguarding supervision are asked to read and sign a safeguarding supervision agreement which is reviewed on an annual basis. The ICB Safeguarding team also provide ad hoc safeguarding supervision as and when needed to all other staff within the ICB, Primary Care, NHS providers and partner agencies.

Relevant policies, procedures, tools and resources:

- SWCPP - Agency roles and responsibilities (including supervision)

8 SAFER RECRUITMENT

8.1 The ICB undertakes its recruitment procedures and practices in accordance with current employment legislation and guidance regarding Safer Recruitment. Safer recruitment means ensuring that the staff and volunteers who are hired to work with children, young people and vulnerable adults have been suitably checked to prevent any harm being done to the people in their care. This includes enhanced Disclosure and Barring Service checks (DBS) inclusive of agency staff, students and volunteers working with children. The ICB also requires assurance that all services commissioned by them have safe recruitment processes in place

8.2 All allegations of abuse of children by those who work with children must be taken seriously. Allegations against any person who works with children, whether in a paid or unpaid capacity, cover a wide range of circumstances. The South West Child Protection Procedures (SWCPP) should be applied when there is such an allegation or concern that a person who works with children, has

- Behaved in a way that has harmed a child, or may have harmed a child;

- Possibly committed a criminal offence against or related to a child;
- Behaved towards a child or children in a way that indicates he or she may pose a risk of harm to children.

8.3 If concerns arise about a person's behavior to her/his own children, the police and/or children's social care must consider informing the employer / organisation in order to assess whether there may be implications for children with whom the person has contact at work / in the organisation, in which case the SWCPP will apply.

8.4 Allegations of historical abuse should be responded to in the same way as contemporary concerns. In such cases, it is important to find out whether the person against whom the allegation is made is still working with children and if so, to inform the person's current employer or voluntary organisation or refer their family for assessment.

8.5 As outlined in the Children Act 2004, the Local Authority Designated Officer (LADO) will be informed of all allegations against adults who work with children. A LADO is assigned by all Local Authorities and is required to:

- Be involved in the management and oversight of individual cases;
- Provide advice and guidance to employers and voluntary organisations;
- Liaise with the police and other agencies;
- Monitor the progress of cases to ensure that they are dealt with as quickly as possible consistent with a thorough and fair process.

8.6 On being advised of an allegation which meets the criteria, staff should contact the LADO within 1 working day. Referrals to the Somerset LADO are undertaken through an Allegations Reporting Form (ARF) to Somerset Direct (Childrens Social Care): sdinputters@somerset.gov.uk. The ARF can be found on the SSCP website using the link below. Alternatively, you can phone Somerset Direct on **0300 123 2224** and request an ARF.

Relevant policies, procedures, tools and resources:

- SWCPP – Guidance for Safe Recruitment, Selection and Retention for Staff and Volunteers
- SWCPP - Allegation against staff or volunteers
- SSCP website - Procedures relating to Allegations Management
- NHSE Managing Safeguarding Allegations Against Staff Policy and Procedure
- NHS Employers: Employment standards and regulation

APPENDIX 1: GUIDANCE FOR RECORDING AND STORING OF SAFEGUARDING INFORMATION IN PRIMARY CARE

Legal duty: All providers and local authorities have a (legal) duty under the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 to ensure that any personal data they process is handled and stored securely. Further information on data security is available from the Information Commissioner's Office.

Where personal data is not properly safeguarded, it could compromise the safety of individuals and damage your reputation. Concerns and information about vulnerable children must be recorded in the child's records, and where appropriate the notes of siblings / other children in the same household, and parents / carers / significant adults.

The GMC guidance 'Protecting children and young people: The responsibilities of all doctors' advises doctors 'to record minor concerns, as well as their decisions and the information given to parents/carers'. This guidance came into effect in 2012. It was updated in 2018 to reflect the requirements of the GDPR and Data Protection Act 2018.

Safeguarding information: Safeguarding concerns and information from other agencies such as social care; education; the police, or other health colleagues, including Public Health Nurses and Midwives, should be recorded in the notes under the most appropriate SNOMED codes outlined in Appendix 2.

All contacts with any parties regarding any safeguarding children issues/concerns should be recorded on the patient's medical records and any necessary action taken immediately. This includes:

- Contact with staff from partner agencies as part of Child Protection / Section 47 investigations
- Attendance at multi-agency meetings i.e. Strategy meetings, Child Protection Conferences (CPC), Child In Need (CIN) meetings, Core Groups and Team Around the Family (TAF) meetings.
- Discussions held with staff from partner agencies at the Practice's Safeguarding / Child Protection meetings, where discussion of all children subject to child in need or child protection plans, or any other children/families where there are concerns are discussed. The record for each family member must highlight any agreed actions to be taken as a result of the discussion.

Safeguarding information received by the practice should be reviewed by the relevant GP and must be scanned and stored within the records of all people named within the documents. This can include but is not limited to the following:

- Child Protection Conference invites and minutes.
- MARAC referrals and information (on ALL named persons records)
- Police Domestic Abuse Incident Notifications (on ALL named persons records)
- Child Looked After health reviews
- Team Around the Family (TAF) invites and minutes

- A&E / MIU / Out of Hours reports
- Maternity Safeguarding Communication Form

These records are as important as those for serious physical illness and should be recorded in the same way, with the same degree of permanence and never kept separately from the main record. Consideration must always be given as to how Safeguarding information is stored within a patient's electronic record, and it may need to be saved in such a way that it cannot be seen online by the patient, particularly if to do so would increase the risks to the child(ren) and other adults in the household. Safeguarding information within a patient's electronic record may also need to be redacted if patients ask for a copy of their file.

SNOMED codes to be used on EMIS in relation to recording and storing of safeguarding information:

Records Management		
1077911000000105	Safeguarding (record artifact)	Use this code when receiving all safeguarding records related to a child: • Strategy meetings • Minutes from multi agency meeting regarding a child e.g. Child Protection Conference / CIN / CLA Review / core group • MARAC referrals • Police Domestic Abuse Incident Notifications (DAIT / Merlin / Form 72) (on all named persons records) • Child Looked After Health Assessment / Form C • Maternity Communication Form

Online visibility of Safeguarding information: In both SystmOne and EMIS, entries can be 'hidden' from online view both whilst writing your entry (before saving) and retrospectively after saving an entry. Entries become visible as soon as they are saved, if not hidden. If you think that an entry needs to be 'hidden', it is better to do this whilst creating the entry to prevent temporary visibility of the entry between saving it and retrospectively 'hiding' it. Please note: Hiding information from online visibility WILL NOT redact records when printed.

Safely managing and recording patient information is most relevant when considering how to store Domestic Abuse information on an individual's record, including the perpetrator. The challenges of managing and recording domestic abuse (DA) information in the electronic medical record (EMR) of people experiencing or perpetrating abuse and how to do this without increasing risk of harm to victims (adult and child) is addressed in the RCGP Guidance on recording domestic abuse in the EMR 2021.

Principles relevant to all recording of domestic abuse information include the following:

- ALL information in the EMR (Electronic Medical Record) about domestic abuse MUST be hidden from patient online access.

- Family records should be linked in practices where possible.
- The name of anyone accompanying a patient in a consultation should be documented
- The name of any alleged perpetrator/s should be included when documenting disclosure of Domestic Abuse (DA).
- Ensure that any reference to DA on a victim's records is not accidently visible to the perpetrator during appointments. The computer screen showing the medical record should never be seen by third parties (i.e. family or friends accompanying a patient). When providing a summary printout for a hospital admission for example, care should be taken that information about DA is not inappropriately included when printing out these summaries to give to patients, as the perpetrator may see this.
- Never disclose any allegation to the perpetrator or other family members.
- Ensure that any decision to record the information in the perpetrator's EMR is made with due regard to the associated risks.
- Ensure that any reference to DA in a perpetrator's record is redacted if provided to the perpetrator unless you are certain it is information that the perpetrator already knows. For example, the perpetrator has disclosed this information themselves to you, or there is a relevant conviction which the perpetrator has disclosed or is aware has been disclosed to you such as in Child Protection Conference minutes, when the perpetrator has been present at the conference and is aware this information is being shared.
- Be aware of the potential danger of the perpetrator having access to information about their abuse and to information in children's EMRs; this includes via online access to their own information and their children's information, as well as coercive access to the victim's EMR.

SNOMED codes to be used on EMIS in relation to Domestic Abuse:

886201000000108	Assessment using Domestic Abuse, Stalking and Harassment and Honour Based Violence (2009) Risk Identification and Assessment and Management Model Checklist (procedure)	Use this code when completing a DASH RIC checklist with a patient, due to concerns about domestic abuse.
978091000000105	Referral to multi-agency risk assessment conference (procedure)	Use this code when referring a patient to MARAC for high risk domestic abuse
758941000000108	Subject of multi-agency risk assessment conference (finding)	Use this code when receiving notification that a patient has been discussed at MARAC / You have called in or attended a MARAC regarding your patient
371772001	Domestic abuse (event)	Use this code on all named person's record when police Domestic Abuse Incident Notifications (DAIT / Merlin / Form 72) received, regarding a Domestic

		Abuse incident.

APPENDIX 2: SNOMED CODES FOR USE IN PRIMARY CARE

Code	Classification on NHS Digital / SNOMED wording	Rationale for use of code in Primary Care
836881000000105	Child is cause for safeguarding concern (finding)	Use this code if discussing a child in CP meeting
1064961000000107	Child in family is safeguarding concern	Use this code if discussing sibling (of a child) in CP meeting
878111000000109	Unborn child is cause for safeguarding concern	Use this code if discussing an unborn baby in CP meetings. If using this code practitioner should refer to multi agency pre-birth protocol and Pre Birth SOP
1060581000000100	Early Help Assessment (procedure)	Use this code when completing an EHA / assessment of need – as a single or part of a multi-agency assessment.
1097361000000103	Signposting to Early Help Service (procedure)	Use this code when completing a Complex early help / Level 3 (child / family in need of support) referral to Family Intervention Service.
380491000000101	Referral to child protection service (procedure)	Use this code when submitting Complex Level 3 (in need of protection) and child protection / Level 4 referral to Children social care (irrespective of what format used for referral)
1047341000000106	Early Help Assessment Team Around the Child meeting (procedure)	Use this code when attending a team around the child or family (TAC or TAF) meeting for a child / family.
762931000000105	Child protection strategy meeting (procedure)	Use this code when attending a strategy discussion or meeting
184062003	Patient not registered (finding)	Use this code when patient has a child that isn't registered at any other practice but has been seen with either parent since birth.
Child protection case conference		
375041000000100	Family member subject of child protection plan (situation)	Use this code for sibling / parent of a child, when a child becomes subject to a CP plan
375071000000106	Family member no longer subject of child protection plan (situation)	Use this code when a sibling / child (of a parent) is no longer subject to a CP plan
818901000000100	Unborn child subject to child protection plan (finding)	Use this code to log under mother that unborn child has become subject to a CP plan
1025431000000104	Unborn child no longer subject to child protection plan (finding)	Use this code to log under mother when unborn baby subject to CP plan has now been born / as code will be entered on child's record to

		show 'subject to a CP plan'.
342191000000101	Subject to child protection plan (finding)	Use this code to identify when a child becomes subject to a CP plan
342891000000105	No longer subject to child protection plan (finding)	Use this code to identify when a child is no longer subject to a CP plan
1036511000000100	Child protection conference report submitted (finding)	Use this code when **submitting a** child protection case conference **report**
408770006	Child protection case conference (procedure)	Use this code when recording **attendance** at a case conference for a child / adult
913841000000107	Child protection core group meeting (procedure)	Use this code when attending a CP core group meeting
Child In Need		
836931000000102	Subject of child in need plan (finding)	Use this code to identify when a child has been designated as Child in Need
135890008	Child no longer in need (finding)	Use this code to identify when a child no longer becomes Designated as a CIN
1053651000000109	Child in Need meeting (procedure)	Use this code when attending a CIN meeting (Different to a TAC or TAF)
Records Management		
1077911000000105	Safeguarding (record artifact)	Use this code when receiving all safeguarding records related to a child: • Strategy meetings • Minutes from multi agency meeting regarding a child e.g. Child Protection Conference / CIN / CLA Review / core group • MARAC referrals • Police Domestic Abuse Incident Notifications (on all named persons records) • Child Looked After Health Assessment / Form C
Domestic Abuse		
371772001	Domestic abuse (event)	Use this code on all named person's record when police Domestic Abuse Incident Notifications received, regarding a Domestic Abuse incident.
886201000000108	Assessment using Domestic Abuse, Stalking and Harassment and Honour Based Violence (2009) Risk Identification and Assessment	Use this code when completing a DASH RIC checklist with a patient, due to concerns about domestic abuse.

	and Management Model Checklist (procedure)	
978091000000105	Referral to multi-agency risk assessment conference (procedure)	Use this code when referring a patient to MARAC for high risk domestic abuse
758941000000108	Subject of multi-agency risk assessment conference (finding)	Use this code when receiving notification that a patient has been discussed at MARAC / You have called in or attended a MARAC regarding your patient
Children Looked After (CLA)		
764841000000100	Looked after child (finding)	Use this code to identify when a child has become looked after
764951000000107	No longer subject of looked after child arrangement (finding)	Use this code to identify when a child is no longer looked after
764881000000108	Looked after child review meeting (procedure)	Use this code when attending a CLA review
764201000000104	Looked after child health assessment annual review (regime/therapy)	Use this code when you complete a review health assessment for a CLA
Child Sexual Exploitation (inc Topaz)		
919461000000108	At risk of sexual exploitation (finding)	Use this code when notified by Topaz that child is subject to discussion at Topaz for possible CSE
785101000000105	Victim of sexual exploitation (finding)	Use this code when notified by Topaz that child is subject to discussion at Topaz for actual CSE
1086791000000109	Child is cause for concern regarding sexual exploitation (finding)	As above

APPENDIX 3: ROLE OF GP SAFEGUARDING LEADS

There is a contractual requirement for every practice to have a Named Safeguarding Lead. This is vital to the embedding of Safeguarding practices within the practice. In England, GP surgeries are expected to have a lead GP for safeguarding children and safeguarding adults.

Some practices may decide that a senior clinician will take on the role of Adult and Child Safeguarding Lead. If there are different Named Safeguarding Leads for Adult and Children, they should work closely together as there is much crossover between adult and child safeguarding. Effective safeguarding requires effective leadership, and the Named Safeguarding Lead(s) should be supported by practices to take on this role.

Practices should also recognise that in order to fulfil their additional competences the Named Safeguarding Leads are required to have more in depth knowledge, and have sufficient time allocated to supporting their colleagues.

The role of a Named Safeguarding Lead may include:

- Regular chairing of safeguarding meetings within the practice which can include other community healthcare team members such as district nurses, midwives, palliative care nurses, health visitors and school nurses.

- Ensuring a list is maintained of which patients are discussed. Maintaining oversight of attendance and appropriate record keeping. This will include monitoring effectiveness of new and previous actions agreed.

- Being available to offer advice and guidance to colleagues on safeguarding cases and signpost to additional areas of advice and support as required.

- Ensuring that systems are in place to respond to safeguarding concerns in a timely way, including raising awareness of alternative sources of support to staff (including locums, volunteers and temps) when the Named Safeguarding Lead is not available.

- Supporting staff who have been involved in safeguarding cases as these can be very challenging. This constitutes staff supervision and a record of this ***needs*** to be kept.

- Meeting regularly with the safeguarding administrator(s) in the practice regarding coding, summarising and other issues related to managing and storing of safeguarding information in patient records.

- Regularly attending Named Safeguarding Lead forums and events hosted by the ICB, including safeguarding training and supervision.

- Applying the lessons learned from safeguarding audits, Rapid Reviews, Local Child Safeguarding Practice Reviews (LCSPRs), Domestic Homicide Reviews (DHRs), Safeguarding Adult Reviews (SARs) and any other statutory reviews.

- Ensuring that requests for information for and attendance at strategy discussions is viewed in the same way as a medical emergency.

- Ensuring that systems are in place to respond to requests for child and adult case conference reports, supporting staff to complete them effectively, and where appropriate facilitate the attendance of a clinician.

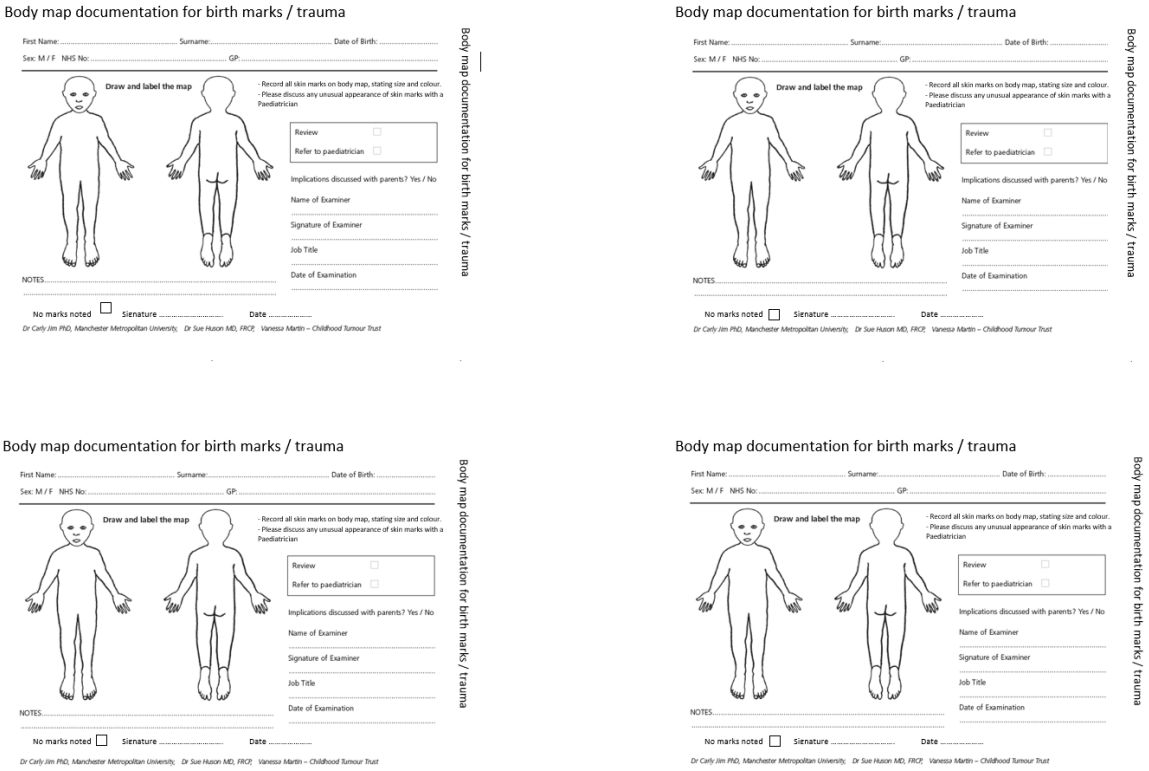
- Facilitating in-house staff safeguarding training and maintain oversight of the practice staff compliancy with statutory safeguarding training, in line with the three Intercollegiate Documents (see section 1.2 of this policy).

- Working closely with the practice manager and Caldicott Guardian to ensure the practice meets its statutory responsibility in relation to safeguarding adults and children, including information sharing.

- Notify the ICB safeguarding team via the Single Point of Contact (SPOC) somicb.safeguardingandcla@nhs.net when you come into post to ensure you are included in relevant invites for forums, training, events and information sharing.

- Working with practice staff to ensure you have an up to date Safeguarding policy

APPENDIX 4: BODY MAP ILLUSTRATION IN CHILD HEALTH RECORD



The latest versions of the Personal Child Health Record / children's 'red book' now has a new body map illustration inside them. This is placed in the first page of the "notes" section towards the back. Immediately following birth, any staff who examine the baby is required to identify on the body map illustration any marks, bruising or birth trauma with clear written documentation to accompany it.

The reason for this change in practice is because historically this information would be recorded in the baby's purple postnatal notes, which are sent back to the hospital following discharge by midwifery services. The Health Visiting service and GPs therefore have had very little information available to them when they take over the care of the family and are not easily able to confirm if marks or bruises they observe are new or pre-existing.

The red books are routinely issued at birth so that the midwife or paediatrician who performs the initial newborn check is able to document any marks or bruises observed from birth to point of discharge from hospital in the red book. The GP undertaking the 6 weeks check or other contacts in the newborn period should review the body map and add information as required.

It is imperative from a safeguarding children perspective but also clinically, that any practitioner who examines the baby is able to easily tell whether a mark or bruise is old or new. This new process will improve the communication between all agencies and assist in the diagnosis of medical conditions and the protection of children at risk of harm.

APPENDIX 5: WAS NOT BROUGHT (WNB) PRACTICE PROTOCOL

Child is not brought to appointment at surgery or GP practice receives notification that child "Was Not Brought" to an external appointment at another healthcare setting and no further action by provider has been taken regarding this.

Use SNOMED code "Child was not brought to appointment" on clinical system

- If child misses one appointment: Send text in Annex D of the Did Not Attend (DNA) Policy. Response should be saved in child's record.

- If a second appt is missed: Send letter in Annex E of the Did Not Attend (DNA) Policy. Response should be saved to child's record.

- If a third appt is missed: Send letter in Annex E of the Did Not Attend (DNA) Policy. Response should be saved to child's record.
- Safeguarding Lead should be made aware that child was not brought to two appointments
- If Safeguarding Lead is concerned normal safeguarding procedures should be followed.
- If the situation is escalated beyond the practice to an external agency, the parents should be informed.