

Safeguarding Children/Child Protection Policy

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1. INTRODUCTION

1.1. Purpose

The Children Act 1989 and 2004 and the statutory guidance Working Together to Safeguard Children (2015 and prior versions of this document) have set out the principles for safeguarding and promoting the welfare of children and young people (i.e. anyone who has not yet reached their 18th birthday). This policy reflects the principles outlined within this document, and is in accordance with safeguarding children policies and procedures of the following Local Safeguarding Children Boards:

- North Yorkshire
- City of York
- Darlington
- Middlesbrough
- County Durham

These can be accessed at:

North Yorkshire	http://www.safeguardingchildren.co.uk/
City of York	http://www.yor-ok.org.uk/
Darlington	http://www.darlington.gov.uk/education-and-learning/local-safeguarding-children-board/
Middlesbrough	http://www.teescpp.org.uk/
County Durham	http://www.durham-lscb.org.uk/

1.2. Scope

The Children Act 2004 emphasises that we all share a responsibility to safeguard children and young people and to provide for their welfare, and that all members of the community can help to do this. The most important messages are therefore that **safeguarding is everyone's responsibility, and the welfare of children is paramount.**

Harrogate and District NHS Foundation Trust (hereafter known as 'the Trust') has a duty to take reasonable care to ensure the services they provide are high quality. There is an expectation that the organisation demonstrates robust safeguarding systems and safe practice in line with the LSCB.

This policy and procedures document describes the roles and responsibilities within the Trust in relation to the safeguarding of children. It applies to:

- All children (including unborn babies) and young people under the age of 18 years.
- All staff who come into contact with children, young people and/or their parents or carers.

- All employees of the Trust, including locums, agency staff, students and learners, volunteers and independent contractors working for the Trust and across all sites.

This document sets out the actions that must be taken if you have concerns that any child may be being abused or neglected, during the course of your work.

This policy and associated procedures should also be read in conjunction with related Trust Policies, Procedures and Guidance, including:

- HDFT Child Protection Allegations against Staff Policy
- HDFT Trust Wide Domestic Abuse Guidance
- HDFT Child Protection Supervision policy
- HDFT Child Protection Education, Supervision and Training Strategy.
- HDFT Recruitment, Selection and Pre-Employment Checks Policy
- HDFT Disciplinary Policy
- HDFT Whistle Blowing Policy
- HDFT Corporate Records Management Policy/Significant Events
- Children Act (1989, 2004 HMSO)
- Working Together to Safeguard Children, Statutory guidance on inter-agency working to safeguard and promote the welfare of children (Department for Education, 2015)
- HM Government (2015). Information Sharing Advice for practitioners providing safeguarding services to children, young people, parents and carers
- Human Rights Act (1998, HMSO)
- Children and Social Work Act 2017
- Safeguarding Children and Adult procedures from local safeguarding boards

2. DEFINITIONS

THE FOLLOWING ARE DEFINITIONS FOR THE PURPOSE OF THIS POLICY AND SHOULD BE APPLIED THROUGHOUT THE DOCUMENT.

Child: A child is defined as anyone who has not yet reached their 18 birthday. The fact that a child has reached 16 years of age and is:

- Living independently
- In further education
- A member of the armed forces
- In hospital
- In custody
- In a secure estate for children and young people

Does **not** change his or her status as a child, or entitlement to services under the Children Act 1989. Additionally, a person aged between 18 and 24 years, who has been Looked After by the Local Authority (previously known as 'In Care') or who has a disability, also has protection under the Children Act 1989. You must also refer to your Local Safeguarding Adults Board policy where concerns are raised in relation to this age group. **REMEMBER**, when young people, aged 16-18 years, attend the Emergency

Department, are seen within the community services, or are admitted to any area/ward of the Trust, staff must still follow these Safeguarding Children procedures if there are safeguarding concerns

Significant Harm: There are no absolute criteria in which to rely on when judging what constitutes 'significant harm'. Consideration of the severity of the ill- treatment may include:

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

Each of these have been associated with the more severe effects on the child, alerting professionals to the greater difficulty in helping the child overcome the adverse impact of the maltreatment. Sometimes, a single traumatic event may constitute significant harm (for example a violent assault, suffocation, poisoning) but more often significant harm results from a compilation of incidents or events, both acute and long standing, which interrupt, change or damage the child's physical and/or psychological development. Some children live in family and social circumstances where their health and development are neglected. For them it is the corrosiveness of the long term emotional, physical or sexual abuse that causes the impairment, to the extent of constituting significant harm. In each case it is necessary to consider any child maltreatment alongside the child's own assessment of his or her safety and welfare, the family's strengths and supports (working together to safeguard children 2015).

Safeguarding and promoting the welfare of children: This is defined for the purposes of this document 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
- To enable those children to have optimum life chances and to enter adulthood successfully

Child Protection: This is a part of safeguarding and promoting the welfare of children and young people. Child Protection refers to that activity which is undertaken to protect specific children who are known to be suffering or at risk of suffering significant harm, as defined by the Children Act 1989, Section 47. (<http://www.legislation.gov.uk/ukpga/1989/41/contents>).

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

- What will happen to the child's health or development without services

being provided?

- The likely effect that the services will have on the child's standard of health and development (Working Together to Safeguard Children 2015).

Child Abuse: This is defined as a form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others (e.g. via the internet). They may be abused by an adult or adults, or another child or children. Abused children may present with signs and symptoms within a variety of settings. For example the emergency department with a physical injury, infection at dermatology, Fractures at orthopaedic clinics and a variety of genitor-urinary and behavioural symptoms to acute paediatric wards or children's outpatients.

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

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

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

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

- Provide adequate food, clothing and shelter (including exclusion from home or abandonment)

- Protect a child from physical and emotional harm or danger
- Ensure adequate supervision (including the use of inadequate care-givers)
- Ensure access to appropriate medical care or treatment

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

Private Fostering: This is when a child under the age of 16 years (or under 18 years, if disabled) is cared for by someone who is neither their parent nor a close relative (i.e. step-parent, grand-parent, brother, sister, blood uncle or aunt). This is via a private arrangement made between the carer and the child's parent. It is classed as a private fostering arrangement if it lasts for 28 days or more. NB: All instances of Private Fostering must be reported to Children and Families Service (CFS).

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

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

It is also possible to obtain PR in the following ways:

Biological Fathers: if a father is not married to the mother, and is not registered on a child's birth certificate, he will not automatically have PR. If he is registered on the child's birth certificate, but the birth certificate was issued before December 2003, he will also not automatically have PR. A biological father who does not have PR can get PR by:

- Re-registering the birth of the child (if the father's name is *not* on the original birth certificate and the mother agrees to this)
- By making a Parental Responsibility Agreement with the mother, which is witnessed by a Court Official
- Applying to the Court for PR through a Parental Responsibility Order
- Being granted a 'Residence Order' by the Court
- Marrying the mother and re-registering the child's birth

Married and Civil Partnered Step-Parents: a step parent will not automatically get PR by marrying or entering into a civil partnership with the mother. A step-parents can get PR by:

- Making a Parental Responsibility Agreement with the mother, which is witnessed by a Court Official
- Applying to the Court for PR through a Parental Responsibility Order

Others who are Not Parents: it is possible for other people who are not the child's

parent or step-parent to gain PR by:

- A **Care Order or Interim Care Order**. Here, the Local Authority shares PR with the mother and any other people with PR
- A **Residence Order**. This grants the applicant PR for the duration of that Order
- Being appointed as **Guardian** to a child automatically gives that person PR shared with any other people with PR
- Being appointed as a **Special Guardian** to a child automatically gives that person PR. The biological parent(s) will keep their PR, but they will not have equal PR to the Special Guardian who can override decisions made by the parent if there is an issue they disagree on
- **Adoption**, their adoptive parent(s) automatically get PR and the biological parent(s) will lose PR
- Testamentary guardians (i.e. a person who is appointed to care for a child after the death of a parent who has parental responsibility or the death of a special guardian)

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

Notifiable Incidents and Seriously Harmed, Involving Children: A notifiable incident is an incident involving the care of a child which meets any of the following criteria:

- A child has died (including cases of suspected suicide), and abuse or neglect is known or suspected
- A child has been “seriously harmed” and abuse or neglect is known or suspected
- A looked after child has died (including cases where abuse or neglect is not known or suspected); or
- A child in a regulated setting or service has died (including cases where abuse or neglect is not known or suspected)

Seriously harmed in the context of the above includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all of the following:

- A potentially life-threatening injury
- Serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development

This definition is not exhaustive. In addition, even if a child recovers, this does not mean that serious harm cannot have occurred. The Local Safeguarding Children’s Board (LSCB) will ensure that any decision making is informed by available research and evidence.

Staff: Staff are defined as senior managers and board members, paid staff, volunteers and contractors, locums, agency staff, students or anyone working on behalf of the Trust.

3. POLICY STATEMENT

3.1 Aims and Purpose

This document sets out the child protection/safeguarding children principles, structures and systems that the Trust has implemented to ensure that all children accessing the services of the organisation will receive the appropriate measures to ensure that they are safeguarded. The Trust will act to the best of its ability in respect of all child protection/safeguarding children issues.

The Trust believes that it is always unacceptable for a child or young person to experience abuse of any kind. It recognises its responsibility to safeguard the welfare of all children and young people, by a commitment to practice which protects them.

The Trust recognises that:

- The welfare of the child/young person is paramount
- All children regardless of age, disability, gender, racial heritage, religious belief, sexual orientation or identity, have the right to equal protection from all types of harm or abuse
- Working in partnership with children, young people, their parents, carers and other agencies is essential in promoting young people's welfare

This policy applies to all staff, including senior managers and board members, paid staff, volunteers and contractors, locums, agency staff, students or anyone working on behalf of the Trust.

The Trust will seek to safeguard children and young people by:

- Valuing them, listening to them and respecting them
- Providing child protection guidance through procedures for staff and volunteers
- Recruiting staff and volunteers safely, ensuring all necessary checks are made
- Sharing information about child protection and good practice with children, parents, staff and volunteers
- Sharing information about child protection concerns with agencies who need to know, and involving parents and children appropriately
- Providing effective management for staff and volunteers through supervision, support and training

It is the responsibility of **all staff** to take appropriate action when they know or suspect a child has been subject to abuse or neglect, or is at risk of being abused or neglected.

3.2 Background

Abuse and neglect are forms of maltreatment of a child. Someone may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Safeguarding children and

young people includes any work which aims to prevent abuse, or to protect those who may already be experiencing abuse.

Effective safeguarding depends on a culture of zero tolerance of abuse, and where concerns can be raised with confidence that action will be timely, effective, proportionate and sensitive to the needs of those involved. The Munro Review (2011) gave particular emphasis to the importance of effective, early intervention for vulnerable children and families.

The wide body of research into child abuse and maltreatment over the last 50 years, the Munro Review 2011, the reports of the public inquiries into the deaths of children (Brandon et al 2007, 2009 and 2011), plus the reports of the recommendations from local and national Serious Case Reviews, have shaped current and emerging legislation and guidance.

Of particular note are the high profile child death inquiry chaired by Lord Laming, "*The Victoria Climbié Inquiry*", in 2002, and his second report in 2009 following the death of Peter Connelly in Haringey. These reports highlighted ongoing themes reported in many other child death inquiries:

- Failures to intervene early enough, inadequate information sharing
- Poor record keeping
- A lack of accountability
- Poor management support
- A lack of child protection reflective supervision
- Poor training of workers and managers

Public awareness continues to improve and there is an increasing expectation that all health care providers have systems in place to identify early indicators of abuse and prevent abuse wherever possible. They are expected to act quickly and effectively, in partnership with other relevant agencies, to safeguard children and young people when it is discovered that they are, or may be, experiencing abuse or significant harm.

3.2 3.3 Safeguarding and promoting the welfare of children

Health professionals and organisations have a key role to play in safeguarding and promoting the welfare of children. The general principles that must be applied are:

- To aim to ensure that all abused or neglected children receive appropriate and timely restorative and therapeutic interventions
- Those professionals who work directly with children and young people should ensure that safeguarding and promoting their welfare forms an integral part of all stages of the care and involvement that they offer
- Those professionals who come in to contact with children and young people, parents and carers in the course of their work need to be aware of their safeguarding responsibilities
- Ensuring that all clinical health professionals can recognise risk factors and contribute to identification of abuse or neglect, case reviews, enquiries and Child Protection Plans, as well as planning support for children and

providing ongoing promotional and preventative support through proactive work with children, young people and their parents/carers

3.4 Impact upon Individuals with Protected Characteristics

This policy aims to safeguard all children and young people who are in receipt of services (or whose family members or carers are in receipt of services) from the Trust, and who may be at risk of abuse, irrespective of disability, race, religion/belief, colour, language, birth, nationality, ethnic or national origin, gender or sexual orientation.

All Trust staff must respect the alleged victim's (and their family's/carers) culture, religious beliefs, gender and sexuality. However this must not prevent action to safeguard children and young people who are at risk of, or experiencing, abuse.

All reasonable endeavours must be used to establish the child, young person and families/carer's preferred method of communication, and to communicate in a way they can understand. This will include ensuring access to a professional interpretation service where people use languages (including signing) other than spoken or written English. Every effort must be made to respect the person's preferences regarding gender and background of the interpreter.

4. ACCOUNTABILITY

4.1 Recruitment Procedures

All members of staff commencing employment within the Trust, and who will be working in any 'regulated activity' (as defined by the Disclosure and Barring Service) with children or vulnerable people, must have enhanced Disclosure and Barring Service clearance prior to commencing in post.

The following Safeguarding statement will be in every HDFT job description: "All employees have a responsibility to protect and safeguard vulnerable people (children and adults). They must be aware of child and adult protection procedures and who to contact within the Trust for advice and guidance. All employees are required to undertake Safeguarding Children Awareness Training and to undertake additional training appropriate to their role"

It is expected that all recruitment will follow the Local Safeguarding Children Board Safer Recruitment guidance:

North Yorkshire	http://www.safeguardingchildren.co.uk/
City of York	http://www.yor-ok.org.uk/service-detail.htm?serviceid=2041
Middlesbrough	http://www.teescpp.org.uk/
Darlington	http://www.darlington.gov.uk/education-and-learning/local-safeguarding-children-board/
County Durham	http://www.durham-lscb.org.uk/

4.2 Accountability of individuals

The success of this policy is dependent on a range of individuals being involved in the implementation of this document. The responsibilities on individuals in ensuring compliance with this document are detailed below:-

ROLE	RESPONSIBILITIES
Chief Executive	Overall responsibility for the implementation of this policy.
Chief Nurse	Is the board lead for safeguarding children and holds specific responsibility for ensuring children's safety and welfare is promoted within the Trust. The Chief Nurse also has delegated responsibility for keeping the Trust Board fully informed about any serious incidents linked to safeguarding children.
Head of Safeguarding Children	To provide robust leadership in the development of existing and new strategies, protocols, pathways and action plans to strengthen the management of safeguarding services across the Trust. There will be a focus on robust risk management systems to ensure safe, efficient, effective and timely management of the safeguarding agenda. Responsible for the ongoing professional development of registered nurses working in a Paediatric setting.
Medical Director	Caldicott Guardian for the organisation.
Named Nurses, Named Doctor and Specialist Nurses Child protection and Nurses for Looked after Children	Key role in promoting good professional practice across the organisation, supporting the local safeguarding system and processes, providing advice and expertise for fellow professionals, and ensuring safeguarding training is in place. Work closely with the board lead for safeguarding, Head of Safeguarding (Children), Adult Safeguarding Lead, Designated Professionals and the LSCBs. (NHS England, 2015)
Human Resources Department	Ensure systems are in place for safe recruitment practices, and arrangements for dealing with allegations against staff who work with children or young people. Support implementation and monitoring of compliance with organisational training requirements.
Line/Service/Ward Managers	Advise/seek advice and support for their staff members in dealing with the assessment and management of any concerns relating to potential or actual significant harm of children.
All Staff	To be aware of the requirements of this policy and act in accordance with it. To access training and supervision in line

	with organisational role.
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5. CHILD PROTECTION PROCEDURES

5.1 General Principles

Prompt action must always be taken to ensure the immediate safety of a child. Consideration must also be given to the safety of other children at the family home address, or who are part of the family.

The parent/carer should always be asked if the child has any siblings or if the parent has care of any other children or dependent adults, or if they are privately fostering any other children.

The parent or carer should also be asked, in routine history taking, about what job they undertake and where. **If such information gives rise to concerns about the ability for the parent/carer to undertake their work safely (e.g. if allegation is that father abused child, and father states that he is a teacher/nurse/social worker/doctor) then advice must be sought from the Safeguarding Children Team.**

If you **know or suspect** that a child is suffering, may be suffering or is likely to suffer significant harm, you have a **duty** to refer your concerns immediately to Children and Family Services (Children's Services) and/or the Police. The Duty Social Worker within Children and Family Services must be contacted at an early stage, by telephone, to report the concerns. This will be undertaken by a qualified member of staff in the HDFT /department where the concern has been raised. The verbal referral to Children and Family Services (Children's Services) must then be followed up in writing, using the agreed referral document, within 24 hours, to ensure that action is taken as appropriate to safeguard the child in question.

If you are referring a child to CFS (Children's Services) for concerns about **Child Protection**/significant harm, you **do not need consent** from the parent/carer to make that referral; it is however good practice to **inform** the child's parents/carers that you intend to refer the child to CFS (children's services), **unless you have reason to believe that so doing would increase the risk to the child.** However, if you are referring the child as a **Child in Need or Early Help** (i.e. a child who needs additional support, but for whom there are no concerns about abuse or neglect) **you must have consent** from the child's parent or someone with parental responsibility.

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

The next few pages contain procedures for support and guidance when concerned about the welfare of a child. They are separated into areas of practice. Please pick the procedure which is applicable.

6. Procedures

5.2.1 Procedure for All HDFT employees, including those providing services under an SLA or Honorary Contract

If you suspect child abuse or neglect but are not sure, or if you require advice, contact the Safeguarding Children Team on **01423 55 77 88**.

Establish Parental Responsibility (PR) and explain your planned action with the parent(s)/carers of the child. Exceptions to this are:

- If you suspect sexual abuse
- If you suspect Fabricated or Induced Illness (previously known as Munchausen Syndrome by Proxy)
- If you consider that discussing your actions with parents would place the child (or yourself) in danger

If you are working on the premises of another agency (e.g. in a school), the relevant person must be informed of your concerns and the action to be taken, i.e. the Designated Teacher for Child Protection.

Children and Family referrals should be made to:

- The appropriate Customer Relations/Customer Advice Unit of Children and Family services (see Appendix 1 for contact details). (North Yorkshire and Middlesbrough)
- First Contact (Durham)
- First response (Darlington)

Out of hours referrals should be directed to the relevant Emergency Duty Team (Appendix 1 for contact details).

Any child protection medical examination should always be conducted/supervised or coordinated by a Consultant Paediatrician.

Record all events and actions taken. This should include conversations with other professionals and agreed outcomes, in accordance with trust policies and professional guidance.

Any unexplained marks or bruising noted on a child should always be recorded on a body/face map (Appendix 2 for body maps). See procedure for bruising in non-mobile babies North Yorkshire procedure 6; Durham <http://nww.hdft.nhs.uk/trust-wide/safeguarding/safeguarding-children/child-protection-policies-and-procedure/>

If you are unsure of what actions need to be taken, discuss/take advice from the Safeguarding Children Team (01423 557788) or Named Doctor for Child Protection (01423 885959). Out of hours, seek advice from the Local Authority Emergency Duty Team. See Appendix 1 or the Intranet for contact details

Notify your line manager/team leader of situation and action taken.

Follow up your telephone referral in writing within 24 hours using the agreed referral form, found at the Local Safeguarding Children Board website, or on SystemOne. Please

ensure your line manager quality assures the referral as per HDFT protocol (See Appendix 9 for the QA process and tool).

Community staff may encounter an emergency situation (e.g. where a child has been badly injured as a consequence of abuse or a young child has been left unattended in the home). In these circumstances, community staff should ring 999 and request assistance from the Police and any other appropriate service. This procedure should still then be followed.

5.2.2 Procedure for Staff Working In Emergency Department and Minor Injuries Unit

This guidance applies to **all** unborn babies, children and young people up to the age of **18 years** where there are actual or possible child protection concerns.

Ensure all fields are completed on an attendance card, including who is accompanying the child, GP, school/nursery, parental responsibility, and any temporary address. (See **Definitions** section for definition of Parental Responsibility’).

Admin Staff:

- Check CP-IS (or ask manager to arrange this for you) to ascertain whether there is a safeguarding alert re this child, and make senior nursing staff and relevant medical staff (i.e treating clinician) aware if alert/flag is present. This also includes unborn babies in the third trimester.
- Check hospital /clinical database for all previous attendances
- Retrieve previous records if available

Nursing/Medical Staff:

- Identify and document who is accompanying the child and their relationship to the child
- Identify who has parental responsibility
- Obtain clear history of events and document, including time scales of incidents and presentation in ED/MIU
- Ensure the CP-IS check has been undertaken by administration staff
- If you are unsure of what actions need to be taken, discuss/take advice from the Safeguarding Children Team (01423 557788) or Named Doctor for Child Protection (01423 889595). Out of hours, seek advice from the Local Authority Emergency Duty Team; see Appendix 1 for contact details.
- All children below age one year, or children who are not yet mobile, with fractures **must** be discussed with the Consultant Paediatrician on call, and the content and outcome of this discussion recorded in the patient notes. **Any unexplained marks or bruising noted on a child should always be recorded on a body/face map.** (see appendix 2) see Bruising in non-

mobile babies policy (North Yorkshire **procedure 6**)

- For Minor Injuries units please refer to the Protocol for the management of Under One year olds in Minor injuries units (See appendix 10).
- Parents should be informed that admission to the ward for children with fractures under the age of one year/pre-mobile children is usually routine. However, admission to the Children's Ward will be at the discretion of the Consultant Paediatrician on call.
- **All** children with suspected abuse should be seen by a Consultant Paediatrician (or Named Doctor for Child Protection) even if referred to another specialty.
- Discuss your plan of action with parents/carers. Exceptions are:
 - If you suspect sexual abuse, or
 - Fabricated or Induced Illness may be a possibility, or
 - If this would place the child or yourself in danger.
- Always consider the critically ill child may be the result of abuse and /or neglect.
- Establish the identities of accompanying adults and children, as well as any other family and household members. Record these in the child's records and share this information with Children and Families Service (CFS, Children's Services) when making a child protection referral.
- Notify the GP by A and E notification letter and send a copy of the referral also to the GP. Notify the 0-19 service by Paediatric Liaison of any referral to Children and Families Service (CFS, Children's Services), within the next working day.
- Any referral to Children and Families Service (Children's Services) should be followed up in writing, using the agreed form found in the Safeguarding Children intranet pages, or attached at Appendix 1 for City of York, North Yorkshire, Middlesbrough, Durham and Darlington Children and Families Service (Children's Services).
 - One copy of this form to be sent to Social Care Customer Relations/Advice Unit
 - One copy to be included in the clinical notes and uploaded on to SystemOne where applicable
 - One copy to the child's GP

North Yorkshire form <http://www.safeguardingchildren.co.uk/worried-about-child>

- Remember to ascertain and document the names and whereabouts of other children in the family, and consider their safety. Children and Families Service (Children's Service) need to be informed of these children.
- When handing over the patient to another staff member within the

department, document your name, who you have handed over to and time of handover, ensuring that you hand over the concerns and safeguarding information.

- If the child's name **is known** to be subject to a child protection plan or to be a Looked After Child (i.e. subject to a care order), even if the attendance is not of concern, you must:-
 - Inform Children and Families Service of the attendance and outcome. Document clearly on the ED/MIU/UCC (Urgent Care Centre) card that you have done so.
 - Notify other involved health practitioners e.g. GP and Health Visitor/School Nurse by sending a copy of the ED/MIU/UCC card or letter.
- If admission is required, it must be noted in the child's medical records that the child's name is subject to a child protection plan or that the child is a Looked after Child (also record the area in which the child resides).
- When **adults** present with problems related to:
 - Domestic abuse
 - Drug and alcohol misuse
 - Mental health or social care issues

It should be established whether they have any caring responsibility for children, where the children are and if they are safe. If there are immediate concerns that the children are/could be at risk of significant harm, a referral should be made to Children and Families Service. If you have concerns that are not immediate, seek advice from your line manager and/or the Safeguarding Children Team (**01423 557788**). If you are concerned about the vulnerability of the adult client please refer to Local Safeguarding Adults Board procedures.

5.

5.2.3 Procedure for All Staff on Children's Wards, Special Care Baby Unit, Children's Outpatients Department, and Maternity/Midwifery Staff

All staff must:

Inform the registered nurse/midwife/line manager in charge of the ward or department if you suspect child abuse or neglect.

The Registered Nurse/Midwife/line manager in charge will:

- Seek and record the following information:
 - Name of child(ren) and/or alleged perpetrator concerned
 - Address of child(ren) and/or alleged perpetrator concerned
 - Date of birth and NHS Number of child(ren) or alleged perpetrator concerned
 - Name of the informant
 - Nature of injuries/concerns. Any unexplained marks or bruising noted on a child should always be recorded on a body/face map (see Appendix 2). See Bruising in non-mobile babies protocol (North Yorkshire **see procedure 6**)
 - Date and time of receiving the information
 - General Practitioner and Consultant of the child(ren) and/or alleged perpetrator concerned
 - Establish Parental Responsibility (PR) if possible

NB: Failure to obtain any of the above **MUST NOT** delay action.

- Discuss your plan of action with parents/carers. Exceptions are:
 - If you suspect sexual abuse
 - Fabricated or Induced Illness may be a possibility
 - If actions would place the child or yourself in danger
- Inform and discuss with the Consultant Paediatrician and record the content and outcome of this discussion.
- Refer to Children's and Families Service Customer Relations/Advice Unit or Emergency Duty Team if outside of normal office hours. (see Appendix 1 for contact details). Discuss with Duty Social Worker (or Key Worker if it is an active case) and develop a plan of action. Make sure you have discussed the referral with the Consultant Paediatrician/Obstetrician. However, even if Consultant Paediatrician/Obstetrician does not agree to referral, if as a registered health professional you feel a child protection referral is necessary, you should make that referral. Advice can be taken from the Safeguarding Children's Team (01423 55 77 88)
- Record appropriately (see Trust Guidance on Record Keeping <http://nwww.hdfn.nhs.uk/document-search/?q=clinical+record+keeping&x=0&y=0>), including discussions taken place regarding the suspicions/incident, times child seen/discussed/referrals made, messages left, with whom and of what agency, advice received from those liaised with, decisions made and actions taken. All

records must be signed, dated and timed.

- Inform the child's GP and Health Visitor/School Nurse that you have referred the child to Children and Families Service. Please refer to the Antenatal Liaison Pathway.
- Follow up the telephone referral in writing on the agreed referral form within 24 hours. Ensure your referral is quality assured by your line manager as per HDFT Children and Families referral QA tool. Keep one copy in the child's medical record; upload one copy onto the child's electronic record where relevant.

North Yorkshire form: <http://www.safeguardingchildren.co.uk/worried-about-child>

NB: For all children admitted to the ward, details must be requested regarding any previous or current safeguarding concerns, or Children and Families Service involvement, for any family members.

- Chronologies of significant events re safeguarding are also to be kept in the child's notes, and all children with child protection plans will be flagged on SystmOne by the Safeguarding Children Team.
- Where there are known concerns regarding family members who may pose a risk to a child/children, these people will have restricted/supervised/no access to the ward, until further discussions with Children and Families Service (Children's Services), and/or Police have been held and safety plans made as appropriate. All employees must liaise with The HDFT Local Security Management Specialist (LSMS) to agree a risk management plan for the alleged perpetrator.
- Where a child has been an **in-patient exceeding 12 weeks**, the Local Authority (under Section 85 of the Children Act, 1989) has a responsibility to monitor the care and welfare of that child. Consequently, where a child or young person under 18 has been receiving in-patient services for 12 weeks or over, the Local Authority must be informed. On becoming aware HDFT staff are required to make a referral to Children and Families Service (Children's Services) in the relevant geographical area.

5.2.4 Procedure for All Staff Whose Main Work Is With Adults where there is a safeguarding children concern. (This includes staff who usually care for adults, but may also care for young people up to 18 years of age.)

Any member of staff who suspects or is concerned that child abuse or neglect is or may be taking place, or who is informed of this by a client/patient, **MUST** follow the following procedure.

- Discuss your concerns/the issues with your line manager and the HDFT Safeguarding Team, (01423 55 77 88) and agree an action plan. Collate all family information known to you including names, dates of birth and addresses (if known) of all children and young people within the family, any other household members, and of any known or suspected perpetrator of the abuse. Any unexplained marks or bruising noted on a child should always be recorded on a body/face map. (see appendix 2) See bruising in non-mobile babies'

protocol. North Yorkshire (**see procedure 6**)

- Refer to the appropriate Children and Families services in North Yorkshire or York (see Appendix 1 for contact details).
- **Out of hours referrals** should be directed to the Local Authority Emergency Duty Team (see Appendix 1 for contact details)
- Establish Parental Responsibility (PR) (See definitions section) and discuss your planned action with the parent(s)/carers of the child and/or the adult disclosing historic abuse. **See Procedure 11**. The exceptions to this are:
 - If you suspect sexual abuse.
 - If you suspect Fabricated and/or Induced Illness (previously known as Munchausen's Syndrome by Proxy).
 - If you consider that to discuss your actions with parents would place the child or yourself in danger.
- Any child protection medical examination should be conducted/supervised by a Consultant Paediatrician.
- Record all events and action taken in accordance with trust record keeping policies and professional guidance.
- Notify your line manager of the situation and action taken.
- Follow up your telephone referral in writing, within 24 hours, using the agreed referral form. One copy of this form should be sent to Children and Families services, one copy to be included in the clinical notes, one copy uploaded onto the child's electronic record where relevant and one copy to the GP.
- North Yorkshire form <http://www.safeguardingchildren.co.uk/worried-about-child>

5.2.5 Procedure for all staff where you suspect abuse of a child by a member of trust staff or volunteer

Please follow the Trust's Child Protection **Allegations against Staff Policy**.

<http://www.hdft.nhs.uk/trust-wide/safeguarding/safeguarding-children/child-protection-policies-and-procedure/>

It is **essential**, in order to safeguard vulnerable children, that **any concerns**, whether or not the concerns/allegations relate to current, recent or historical behavior, are shared promptly with the Senior Management Officer (SMO) See allegations against Staff policy. Where there are indications that a person has/may have:

- Behaved in a way that has harmed a child, or may have harmed a child
- Possibly committed a criminal offence against or related to a child; or
- Behaved towards a child or children in a way that indicates s/he may

pose a risk of harm to children

5.2.6 Procedure for Bruising in a non-mobile babies

For **Durham and Darlington** practitioners please refer to: - <http://www.durham-lscb.org.uk/wp-content/uploads/sites/29/2016/08/Bruising-in-Children-Pathway.pdf>

For **Middlesbrough** practitioners please see: - <http://www.teescpp.org.uk/>

For HDFT employees who work in the City of York please follow the HDFT North Yorkshire policy but referring into City of York CFS (Children's Services)

North Yorkshire

Introduction

Bruising is the most common presenting feature of physical abuse in children. Recent serious case reviews and individual child protection cases across the UK have indicated that clinical staff have sometimes underestimated or ignored the highly predictive value, for child abuse, of the presence of bruising in children who are not independently mobile. The definition of not independently mobile includes children not yet crawling, cruising or walking independently. As a result there have been a number of cases where bruised children have suffered significant abuse that might have been prevented if action had been taken at an earlier stage. The majority of children who are not independently mobile are babies, but it is important to also consider older children with a physical disability whom are also not independently mobile.

Indeed the National Institute of Clinical Excellence guidance (NICE) Clinical Guideline 89 (updated August 2012) states that bruising in any child not independently mobile, should prompt suspicion of maltreatment.

See: <http://www.nice.org.uk/guidance/CG89>

Bruising is the most common accidental injury experienced by children and research shows that the likelihood of a baby sustaining accidental bruising increases with increased mobility. It is extremely rare for a non-mobile baby to sustain accidental bruising. Therefore, all such bruising should be suspected by professionals to be an indicator of physical abuse and should be thoroughly investigated. A decision that the child has not suffered abuse must be a joint decision and must not be made by a single agency.

Aim

The aim of this protocol is to provide frontline staff with a knowledge base and action strategy for the assessment, management and referral of children who are Not Independently Mobile who present with bruising or otherwise suspicious marks. This protocol sets out when children should be referred for further assessment and investigation of potential child abuse.

In the light of the NICE guidelines "When to Suspect Child Maltreatment" (2009), this protocol is necessarily directive. While it recognises that professional judgement and responsibility have to be exercised at all times, it errs on the side of safety. It requires that staff should not be making decisions about the mechanism of the injury independently. However, information gathered in the investigation period should be shared with a GP and/or Paediatrician.

Definitions and Terminology

Front-line practitioners: in line with “Working Together to Safeguard Children” (2015) this includes: teachers, GPs, nurses, midwives, health visitors, school nurses, therapists, early years professionals, youth workers, police, accident and emergency staff, paediatricians, voluntary and community workers and social workers. Working Together 2006 introduced the concept that “safeguarding is everybody’s responsibility” and the 2015 update states that “Everyone who works with children or with adults who have children in the family has a responsibility to keep them safe and to share information in a timely way.” This should be actioned regardless of the seniority of the practitioner. When considering children with physical disabilities, front line practitioners include staff in specialist educational provision and Children’s nurses.

Not Independently Mobile: A child who is not yet crawling, bottom shuffling, pulling to stand, cruising or walking independently, this includes all children under the age of six months. Please note, however that some babies can roll from a very early age and this does not constitute self-mobility. Consideration should be given to children with physical disabilities whom are also not independently mobile.

Bruising: Is the extravasation of blood in the soft tissues producing a temporary, non-blanching discolouration of the skin. This can be faint or small and with or without other skin abrasions or marks. Colouring may vary from yellow through green to brown or purple. This includes petechiae, which are red or purple non-blanching spots, less than two millimetres in diameter and often in clusters.

Medical Bruising: bruising to very young babies may be caused by medical issues e.g. birth trauma, although this is rare. In addition, some medical conditions can cause marks to the skin in very young babies that may resemble a bruise. In all cases, unless the specific mark that has been identified is already confirmed as arising from a medical condition, this protocol should be followed to enable multi-agency assessment of the suspected bruise. An example of medical bruising is Mongolian blue spot, but this should be confirmed by a registered health professional and documented in the child’s records.

For other examples of medical bruising see:

<http://www.core-info.cardiff.ac.uk/reviews/bruising/patterns/other-useful-references>

Research Base

Although bruising is not uncommon in older, mobile children, it is rare in infants that are immobile, particularly those under the age of six months. While up to 60% of older children who are walking have bruising, it is found in less than 1% of not independently mobile infants. Moreover, the pattern, number and distribution of innocent bruising in non-abused children is different to that in those who have been abused.

In mobile children innocent bruises sustained due to accidents such as a result of exploring their environment are more commonly found over bony prominences and on the front of the body but rarely on the back, buttocks, abdomen, upper limbs or soft-tissue areas such as cheeks, around the eyes, ears, and palms of the hands or soles of the feet.

Infants under 1 year are over three times as likely to have child protection plans for physical abuse as children over 1 year. Almost half of all serious case reviews involve a child less than 1 year old.

Patterns of bruising suggestive of physical child abuse include:

- Bruising in children who are not independently mobile
- Bruising in babies
- Bruises that are away from bony prominences
- Bruises to the face, back, abdomen, arms, buttocks, ears and hands
- Multiple or clustered bruising
- Imprinting and petechiae
- Symmetrical bruising

Also see:

<http://www.core-info.cardiff.ac.uk/reviews/bruising/patterns/patterns-and-sitesabused>

A bruise must never be interpreted in isolation and must always be assessed in the context of medical and social history, developmental stage, explanation given and this should be shared with an appropriately qualified medical practitioner. A full clinical examination and relevant investigations must be undertaken.

The younger the child, the greater the risk that bruising is non-accidental. While accidental and innocent bruising is significantly more common in older mobile children, professionals are reminded that mobile children who are abused may also present with bruising (Baby P, 2008). They should seek a satisfactory explanation for all such bruising, and assess its characteristics and distribution, in the context of personal, family and environmental history, to ensure that it is consistent with an innocent explanation.

Follow up of the Child (Community)

This protocol requires any front-line practitioner who identifies a bruise to a baby, who is not independently mobile, to make an assessment of:

- What happened, how it happened, when it happened
- If there were any witnesses and the extent of the injury
- The significant possibility that the bruising may have arisen as a result of abuse or neglect

When abuse is suspected in a seriously ill or injured child, that child should be referred immediately to hospital and transported by ambulance. A referral should be made as soon as possible to your local Children's Social Care (CSC) department.

Any bruising in a non-mobile child should raise suspicion of maltreatment and should result in an immediate referral to Children's Social Care and an urgent Paediatric opinion which will be arranged by the Social Worker. This referral is the responsibility of the first professional to learn of or to observe the bruising. A discussion should be held between the professional concerned and Children's Social Care as to the safe transport and escort of the child to hospital. The Duty Paediatrician should be contacted by the Social Worker at the hospital to which the child will be taken.

Prior to making the referral, the professional should ensure that they have sufficient information to assist Children's Social Care in responding. This would include basic details such as name, date of birth, address etc. as well as details of parents/carers and any other relevant background information that is known at the time. The parent, where it is safe to do so, must be aware of the referral although consent is not required.

If the family are already known to CSC then the front-line practitioner should inform the Social Worker as soon as is possible.

Follow up of child (Hospital)

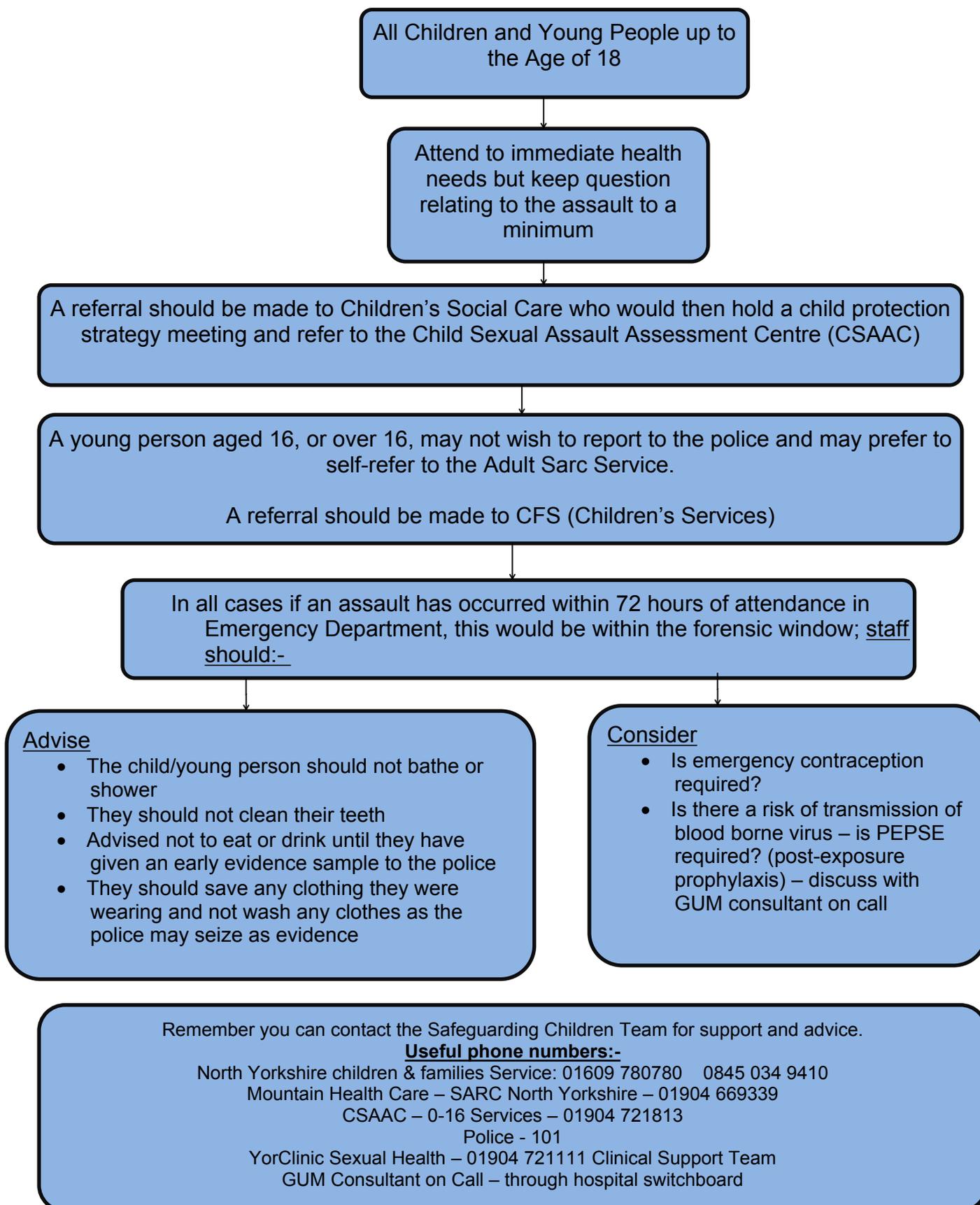
When concerns have been identified for children within Emergency Department, such children should be referred directly to the Paediatric Medical Team, who will comprehensively assess the child, incorporating consultant paediatrician and social care opinion.

References:

NICE clinical guidelines 89: When to suspect child mistreatment, July 2009 (SUSPECT means a serious level of concern about the possibility of child maltreatment but not proof of it)

Royal College of Paediatrics and Child Health (2013), Child Protection Companion 2013 2nd Edition

5.2.7 Procedure to follow when a Child or Young person discloses a Sexual Assault



5.2.8 Procedure for the Management of circumstances when parents and or carers fail to bring children and young people for health/medical appointments

Introduction

Following the death of baby Peter, the Care Quality Commission requires that all health services have a procedure in place to ensure there is a system to monitor vulnerable children or their parents who fail to attend any appointment with a health professional. The purpose of this is to identify children who may be experiencing significant harm.

Missing appointments for some children may be an indicator that they are at an increased risk of neglect and or abuse. There may be many innocent reasons why children miss appointments but numerous studies have shown that missing healthcare appointments is a feature in many Serious Case Reviews, including those into child deaths (DfE 2016).

Within Health there is now a move towards the concept of 'Was Not Brought' (WNB) rather than Did Not Attend (DNA) for children and young people. This is to acknowledge that it is rarely the child's fault that they miss appointments.

Repeated cancellation and rescheduling of appointments should be treated with the same degree of concern as repeated non-attendance, potentially harmful and possibly a feature of disguised compliance. Disguised compliance or apparently legitimate excuses for not attending appointments should not be accepted at face value. Professionals 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 (DfE 2016).

Harrogate and District Hospital NHS Foundation are only able to develop procedures for their own employees and consequently the role of GPs or health professionals from partner health agencies cannot be set out within this procedure. To prevent children 'falling through the gaps' this procedure attempts to promote timely communication with all partners

Definition

A vulnerable child is a child who is defined within the North Yorkshire Vulnerability check list as requiring more than universal services. A vulnerable child maybe a child who has greater social, developmental, educational or health needs than their peers. They may be at level 2, 3 or 4 in the vulnerability check list i.e. vulnerable, a child in need, a child in care or a child in need of protection.

Aim

This guidance has been developed to ensure that the circumstances and consequences of any child and/or young people failing to attend a health appointment are individually assessed and managed with consideration to their welfare.

The purpose of this procedure is to also promote appropriate information sharing and robust decision making with relevant health professionals such as the GP, Health Visitor and 5-19 Practitioners. The main health record for all adults and children is held by the GP and consequently the GP has a responsibility to consider the 'over-view' for the health care of an individual.

Procedure

The procedure details what to do in the event of a child or an adult (with difficulties that may impact upon parenting) failing to attend an appointment with a health professional. The procedure also states the actions to take upon receiving information that a child or adult (with the above difficulties) has failed to attend an appointment.

At any point, advice and support can be obtained from the HDFT Safeguarding Children Team on 01423 557788.

When a child fails to attend an appointment with a health professional:

Their case should be reviewed by the health professional whose appointment has been missed to assess the vulnerability of the child. The responsibility for deciding further action remains with this professional.

A joint decision should be made by the health professional whose appointment has been missed and the referrer as to whether another appointment is offered. It is advisable to consult the vulnerability check list at this stage.

The decision and rationale must be recorded in the child's record.

If the child is known to have a child protection plan the child's social worker as well as the child's health visitor/school nurse must be informed.

If a child is discharged, the referrer, the GP and Health Visitor or School Nurse should be notified by letter (with a copy to parent/carer) requesting further referral if necessary.

On receiving information that a child has failed to attend an appointment, the Health Visitor or School Nurse must;

- Add the details to the chronology of significant events in the child's records
- Review the information known about the child. Where the child is known to be vulnerable or there is little current information about the child, the professional from whom the information has come should be contacted. The health visitor/school nurse and the professional whose appointment has been missed should discuss the most appropriate action. This is an opportunity for both professionals to discuss the most effective method of engaging with the parent/carer to identify reasons for failing to attend the appointment.
- Either the health visitor/school nurse or the professional whose appointment has been missed should contact the parent/carer to discuss reasons for failure to attend and attempt to facilitate a more suitable appointment.
- If unsuccessful, the health visitor/ school nurse and professional whose appointment has been missed must communicate the outcome of the discussion with family. Then decisions can jointly be made about potential referral to other agencies, e.g. social care or the TAF process.
- Record all discussions with parents or carers or other professionals in the child's record.

When an adult with parental responsibilities who has difficulties that may impact upon parenting (e.g. mental ill-health, substance misuse, alcohol misuse, learning disabilities, domestic abuse) fails to attend an appointment with a health professional:

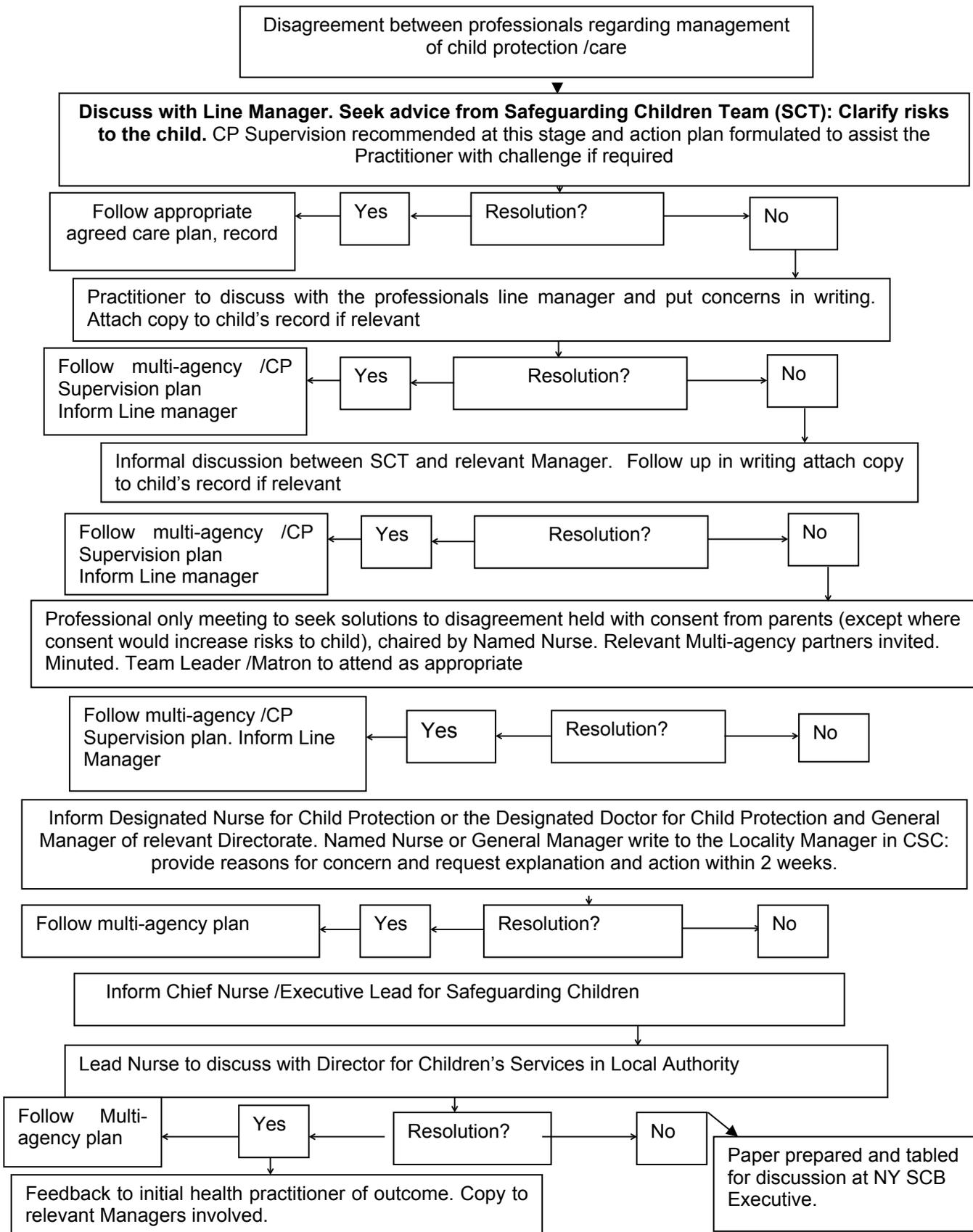
- Their case should be reviewed by the health professional whose appointment has been missed and the referrer. The responsibility for deciding the appropriate further action remains with the professional whose appointment has been missed.
- A decision should be made as to whether another appointment is offered.
- The decision and rationale must be recorded in the service user's record.
- If there are no plans to discharge the service user at that time but the service user has a child that is known to have a child protection plan the child's social worker as well as the child's health visitor/school nurse should be informed of the missed appointment. Consideration must be given to informing other professionals working with the service user. Unless it would place the child at greater risk, the service user must be informed that this information is being shared.
- If the plan is to discharge the service user from the service and the service user has a child that is known to have a child protection plan, the child's social worker as well as the referrer, the GP, the health visitor or school nurse and must be informed, requesting further referral if necessary. Consideration must be given to informing other professionals working with the service user. Unless it would place the child at greater risk, the service user must be informed that this information is being shared.
- If the plan is to discharge the service user from the service but a child is known to be vulnerable but does not have a child protection plan, the referrer, the GP and health visitor or school nurse should be notified by letter (with a copy to the service user) requesting further referral if necessary.
- If the service user is under the Care Programme approach (CPA), the CPA Care Co-ordinator must be informed. Consideration should be given to referring the service user to crisis/contingency planning.

On receiving information that an adult with difficulties that may impact on parenting (e.g. mental ill-health, substance misuse, alcohol misuse, learning disabilities, domestic abuse) has failed to attend an outpatient appointment, the Health Visitor or School Nurse must:

- Liaise with the health professional whose appointment they failed to attend to review the current information about the child and parents and discuss the most appropriate method to facilitate engagement with services.
- The most appropriate professional (this may be the health visitor or school nurse or CPA coordinator or key worker in another service already working with the adult service user) should contact the adult service user to discuss reasons for failure to attend and attempt to facilitate a more suitable appointment.

- If unsuccessful, a joint decision should be made about potential referral to other agencies, e.g. social care or the Team Around the Family process.

5.2.9 **Escalating concerns where professionals disagree**



5.2.10 Notifiable Incidences

A notifiable incident is an incident involving the care of a child which meets any of the following criteria:

- A child has died (including cases of suspected suicide), and abuse or neglect is known or suspected
- A child has been “seriously harmed” and abuse or neglect is known or suspected
- A looked after child has died (including cases where abuse or neglect is not known or suspected); or
- A child in a regulated setting or service has died (including cases where abuse or neglect is not known or suspected)

Seriously harmed in the context of the above includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all of the following:

- A potentially life-threatening injury;
- Serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.

This definition is not exhaustive. In addition, even if a child recovers, this does not mean that serious harm cannot have occurred. The Local Safeguarding Children’s Board (LSCB) will ensure that any decision making is informed by available research and evidence.

Where a serious childcare incident occurs which meets the definition of a ‘notifiable incident’ as outlined in the Definitions section of this policy, the first step for any organisation is to ensure it takes appropriate action to ensure the immediate safety of the child or minimise the impact of any serious harm.

In all circumstances staff should consult with their Safeguarding Lead/Senior Manager and complete and submit a datix. Safeguarding Lead/Senior Manager should contact the relevant Local safeguarding Children Board Business Unit Manager to identify whether the criteria for notification has been met.

Where a child has suffered serious harm, the relevant practitioner will make a referral to the Children and Families Service

The Named Nurse must be informed of the incident. The Named Nurse will then inform the Head of Safeguarding Children for HDFT and executive lead, the Chief Nurse.

The Safeguarding Lead/Senior Manager within HDFT discusses and agrees with the Local safeguarding Children Board (LSCB) Business Unit manager that a notifiable incident has taken place

Where the child has died, the relevant practitioner must follow the Expected and Sudden Unexpected Death in Childhood policy <http://nww.hdfn.nhs.uk/trust-wide/safeguarding/safeguarding-children/child-protection-policies-and-procedure/>

5.2.11 Responding to ‘Historical’ Abuse (i.e. an adult disclosing about their own history of abuse in childhood)

When an adult discloses a personal history of abuse as a child, there are three elements that need to be taken in to consideration:

- The welfare of the adult who was abused as a child: this may entail referring the adult for counselling or other talking therapy;
- The welfare of any children who may currently have contact with the person who abused: it is of note that where an adult has been sexually abused during their childhood, it is likely that the abuser will continue to abuse other children. If the adult making the disclosure has any suspicions that their abuser may currently have contact with known children, a referral in relation to those children should be made to the relevant Children and Families Service (Children’s Services) department. Advice regarding this can be obtained from the Trust Safeguarding Children Team (see Appendix 4 for contact details).
- Prosecution of the perpetrator: the adult making the disclosure should be encouraged to speak to the Police Serious Crime Team, who will discuss with the adult the range of actions they could take and all implications of such actions. This will also include the protection of children who may currently be at risk of abuse by this alleged perpetrator. Advice regarding this can be obtained from the Trust Safeguarding Children Team (see Appendix 13 for contact details).

5.2.12 Standard Operating Procedure for recording Significant Events

SOP NUMBER: L 7 Version 2 **DATE:** 20/6/17

AUTHOR: Alyson Harker

REVIEW DATE: August 2020

OBJECTIVES	Facilitates recognition of risk or cause for concern Provides a chronological summary of key issues within a child and family's history Prevents significant events becoming 'lost' within records Aids practitioners' reflection and planning.
SCOPE	An out of the ordinary event that may impact on the health or well-being of the unborn baby/child/young person
TARGET GROUP	All staff within the health visiting and school nursing service.
EVIDENCE TO SUPPORT PROCEDURE	LSCB procedures Serious case reviews
CONTENTS	<ol style="list-style-type: none"> 1. Significant event record. 2. Completing the SER. 3. Applying the rule of 4 4. Transfer of care from health visitor to the school nurse. 5. Training. 6. Audit.

Rational	Additional Information
1. The Significant Event Record (SER) must be completed correctly and the information on it must be accurate and contemporaneous.	
2. Competing the SER	
2.1. A significant event must be recorded on the SER.	See Appendix 1 Significant event
2.2. All 0-5 attendances at A&E/ MIU will be scanned onto electronic system.	Clerk will task the named or duty health visitor
2.3. All attendances at A&E must be analysed by a health visitor or staff nurse and all significant attendances recorded on the SER	
2.4. School aged children attendances will be documented on the electronic SER	This will state the date and reason attended.

by the admin team	
<p>2.5. The admin team will scan the A&E form and refer the following to the school nurse or staff nurse</p> <ul style="list-style-type: none"> • <i>Deliberate self-harm</i> • <i>Overdose intentional or accidental</i> • <i>Intoxication / alcohol related</i> • <i>Recreational drugs / substance misuse</i> • <i>Frequent attendance of 3 or more in a year</i> • <i>If there rule of four is reached</i> 	The school nursing team are responsible for reviewing the attendance and considering the action required.
3.0 Applying the rule of four.	
3.1. Each time there are four events, or a multiple of four, supervision must be sought. The discussion must be logged in the electronic record	
3.2. Supervision can be requested from a colleague, supervisor or the child protection department at any stage	The purpose of supervision is to identify patterns of worrying trends that otherwise may not be identified and allow the practitioner time to reflect on the case.
4.0 Transfer of care from Health Visitor and School Nurse	School nurses will continue to record significant events as above and appendix 1 once care is transferred to them
5.0 Training All staff will be made aware of the procedure at induction.	
6.0 Audit Appropriate use of the documentation within the SER will be audited through peer, management record reviews.	Additional audits may take place within the Safeguarding department

Developed By:	AUTHOR TITLE (NAME)	JOB TITLE
	Alyson Harker	Locality Manager
	APPROVAL GROUP NAME	DATE
Approved By:	HCP Q&A Meeting	28/6/17

Significant Event Guidance

The significant events record must have the following documented

Events that may impact on the child's development needs:

- Premature / low birth weight
- Refusal of treatment that places a child at risk / refusal of immunisation
- Poor attendance or persistent non-attendance at health appointments or non-compliance with professionals
- Child Protection or Child in Need concerns / involvement with Children, Family and Learning / Social Care. A child in Looked After system or subject to a legal order. **(NOT core groups, network meetings and supervision)**
- Attendance at A&E (see earlier)
- Hospital admission / referrals
- Referrals to health professionals
- Family requiring frequent support
- Developmental delay / growth issues / behaviour issues
- Initial or closing meetings (CAF, Children and young people panel, Network or Child Wellbeing)
- No consent for screening procedure
- Serious or chronic illness in child e.g. allergy requiring Epipen, genetic disorder within family
- Teenage pregnancy / miscarriage
- Self-harm / anorexia / bullying / attendance at anxious unit
- School refusal / Excluded from education
- Identified young carer
- Home tuition
- Risk taking behaviour
- Child with an active Health Plan
- Educational Health Care Plan

Events that may impact on parenting capacity:

- Previous SID in close family
- Problems in current pregnancy
- Chronic and/or serious illness in family member / mental health issues in key family member / sudden onset or long-term depression in mother
- Learning disability of one or both parents
- Drug or alcohol misuse
- Lack of self-care
- Teenage pregnancy
- Eating disorder – recent or historical
- Poor parent/child relationship or interaction
- History of being in care.
- Poor childhood experience
- Removal of previous children.

Events that may impact on the family and environment

- DNA, No access or cancelled visits (2 or more). Also refer to 'no access protocol' for children subject to a protection plan or child in need and DNA pathway.

- Sibling with special needs
- Evidence of violence or criminal behaviour in the family/family member in prison
- Bereavement / separation or divorce / change in family structure / new sibling in family / change of partner / change in adults or children living in the family home
- Frequent change of address (i.e. months rather than years)
- Frequent change of school.
- Recent unemployment / financial problems / debt
- Unacceptable or deteriorating home conditions
- Risk assessment procedure carried out for either actual or potential aggression / violence towards staff.

This list is not exhaustive and there will be other information that should be added to the Significant Event Record.

5.2.13 Standard operating procedure for the follow up of ineffective visits and for the denial of access by Health Visiting and School Nursing Teams

Introduction

This standard operating procedure gives guidance to Health Visiting and School Nursing Teams across Harrogate and District Foundation Trust when visits/contacts are ineffective, or staff are unable to gain access to children and families, in order to ensure they receive service provision.

Purpose

This document sets out the Trust's standard operating procedure for follow up of ineffective visits/contacts by Health Visiting, School Nursing and Family Nurse Partnership Teams (0 -19 service). The document is intended to offer guidance to the above health professionals who require access to children and their families, in their own homes or community venues, to ensure health service provision. This guidance relates to **all** children and their families during the antenatal period and up to school leaver age. (0-19)

Practitioners have no legal right of access to a client's home. Families have the right to decline the 0-19 service. Parents may choose not to avail themselves of a home-based service but may wish to access services at a clinic, surgery or other venue.

Practitioners have a responsibility to request that children are presented for immunisations, routine child surveillance and development assessments in line with the agreed HDFT protocols/policies.

It has been determined that there are no specific training requirements associated with this protocol.

Scope

This standard operating procedure applies to the 0-19 service.

2. INEFFECTIVE CONTACTS

2.1 Definition

A contact can be a home visit or clinic /other setting.

An ineffective contact is either:

- A contact arranged by written appointment, face-to-face contact or telephone contact by a Health Visitor/School Nurse/Staff Nurse/ EYP (0-19 Practitioner) and there is no reply when the practitioner arrives at the pre-arranged time at the home or the family do not attend their appointment

Practitioners may visit without appointment to maximise the opportunity of making contact with the family. If the family are not in for the visit, this will not necessarily trigger this standard operating procedure.

- 2.2 Where a practitioner has made two pre-arranged, consecutive, ineffective contacts, with a family then the records will be reviewed. If there are no identified

concerns for the welfare of the child, the standard letter (**Appendix A1 or A2 see end of procedure**) should be sent.

2.3 Document on the significant event record.

2.4 If the proposed visit is a primary visit or a transfer-in visit then the standard operating procedure for Denial of Access to a Child will be followed regardless of whether any concerns have been identified. If a family persistently fails to keep appointments, including those for immunisation, then the Health Visitor/School Nurse will write to the family (**Appendix B, see end of procedure**). The Specialist Nurse Child Protection may be contacted where there are safeguarding concerns (01423 557788). The practitioner will record all failed appointments in accordance with significant events policy (See procedure 12)

3. DENIAL OF ACCESS

3.1 Definition

- Refusal of access to a child in any premises, to include home, GP surgery, school or any other setting.
- Access is gained to the home but the child is not seen either by direct refusal, or the child is deliberately not made available.
- Persistent ineffective pre-arranged contacts, where child/children are not being seen by other professionals.
- Persistent failure to keep appointments with the health visitor/school nursing service including appointments for Immunisations, where there are concerns for the child's wellbeing.
- Parent /carer declines the service when need is clearly identified, even if alternative Service is being accessed

4.0. REFUSAL OR DECLINE OR SERVICE.

4.1 Definition

- .A parent / carer refuse or decline to engage with the service verbally or in writing.

5.0 PROCEDURE FOR DENIAL OF ACCESS

5.1 If, at any time, the parent/carer refuses or declines the 0- 19 services the Line Manager must be informed immediately.

5.2 The Line Manager will write or telephone the parent/ carer offering an appointment to discuss the situation and advising them of alternative options e.g. clinic appointments. The Line Manager will explain the need to inform their G.P, Social Worker (if involved) and any other Health Professionals known to be involved

5.3 Where there are no risks to the child and following discussion either face to face or via phone with the parent / carer they continue to decline the service a letter will be sent (**Appendix C see end of procedure**)

5.4 The SER (Significant Event Record) will be updated to show decline of service

5.5 Where there are concerns discussion will take place with the safeguarding team.

6.0 PROCEDURE FOR INEFFECTIVE VISITS

6.1 Following 2 consecutive appointments/visits, if the practitioner has failed to gain access to the child the following information must be documented in accordance with the Significant Events Policy.

6.2 The practitioner will confirm the address with the GP practice and/or school, if the child is still resident at the address.

6.3 Where the practitioner has any concerns they may also consider

- Relevant information from child's GP
- Liaison with extended family or known associates. (maintaining confidentiality)
- The parent/carer has been informed of the need and reason for seeing the child.
- Discussing in supervision / with line manager or safeguarding team.

6.4 An ineffective contact letter (**Appendix A1 A2 or A3, see end of procedure**) will be sent. A copy will be retained on file and sent to the GP and other appropriate Health Professionals

6.5 All actions taken and discussions held will be recorded in full in the child's Health Record.

6.6 If access is gained at any time in the future the Health Professional will inform the child's General Practitioner and other appropriate Health Professionals.

7.0 PROCEDURE FOLLOWING FAILURE TO GAIN ACCESS, OR REFUSAL OF ACCESS, TO A CHILD WHO HAS A CHILD PROTECTION PLAN OR WHEN A NEED HAS BEEN CLEARLY IDENTIFIED WITH EITHER A PARENT/CARER OR CHILD OR YOUNG PERSON.

7.1 Following a no access visit or where access is gained but the child is not seen and the practitioner suspects the child may be at immediate risk then emergency action is needed.

7.2 Where assessment of the circumstances does not identify immediate risk the practitioner should:

- leave a call card with a follow up appointment within 2 working day where the child is subject to a plan
- leave a call card with a follow up appointment within 7 days where the child is identified as in need or there are high level concerns
- Carry out a second home visit as above.

7.3 Where at the second contact the child is unseen and the practitioner suspects the child may be at immediate risk then an immediate discussion is required.

7.4 The practitioner must review all information and where immediate risk is not obvious all relevant personnel should be informed and the appropriate action agreed with the key worker

7.5 The Key Worker must be informed of every failed access visit **within one working day**. If the Key Worker is unavailable the practitioner will attempt to

Speak to the Team Manager, if neither is available the practitioner will notify the Key Worker in writing within one working day.

7.6 Future courses of action will be discussed with and agreed by the Health Professional, Key Worker, Safeguarding nurse and other members of the Core Group.

8.0 PROCEDURE FOR REFUSAL OR DENIAL OF SERVICE WHERE A CHILD IS SUBJECT TO A PLAN

8.1 If, at any time, the parent/carer refuses or declines home visiting by the practitioner the Line Manager and / or Senior Nurse Child Protection must be immediately informed.

8.2 The practitioner will discuss with the parent/carer that the child's G.P, the Social Worker (if involved) and any other health professionals known to be involved will be informed.

8.3 If the parent/carer advises an alternative care giver is providing this service the health professional should liaise with the alternative care giver to ensure effective communication and evaluation of care.

8.4 The practitioner must document in the clinical records.

8.5 The practitioner or where necessary the line manager will contact the parent/carer in writing using Standard Letter (**Appendix C see end of procedure**). A copy will be filed /scanned in/onto the child's records and a copy sent to the child's Social Worker, General Practitioner and other appropriate Health Professionals. (Letter to be translated into appropriate language as required)

8.6 The practitioner should utilize every opportunity to review the care and monitor the progress of the identified need. If the needs are addressed by the alternative care giver, then the care should be ended and documented accordingly.

8.7 If the needs are not addressed and non-compliance is impacting upon the needs of the child or young person, then the practitioner should discuss with the line manager and senior nurse safeguarding and this should be actioned accordingly.

If at any time the Health Professional suspects a child is home alone the Police and Emergency Duty Team, must be contacted immediately. The Key Worker and Senior Nurse Child Protection will be informed within one working day. For any other causes for concern please refer to Child Protection Procedures and Related Guidance.

9.0 Monitoring compliance and effectiveness

9.1 Standards / Key Performance Indicators

Monitoring Criterion	Response School Visitor	Response Nurse/Health Family Nurse
----------------------	-------------------------------	--

Who will perform the monitoring?	CCCW	CCCW
What are you monitoring?	Number of ineffective care plans utilised on SystmOne or Number of ineffective letters sent to parents	Number of cancelled or attempted visits to clients
When will the monitoring be performed?	Audit Bi-Annually	Quarterly review
How are you going to monitor?	This will form part of the compliance audit for the healthy child programme audit.	Open Exeter Data Reports are analysed on a quarterly basis. Clients are discussed in 1-1 supervision
What will happen if any shortfalls are identified?	Discussed in caseload management	Data reports are discussed in 1:1 supervision and as a team learning activity. All measures identified in procedure will be implemented to try to re-engage client
Where will the results of the monitoring be reported?	Professional Practice, HCP Quality and Assurance Meeting	Number of cancelled or attempted visits are available for the FNP advisory board and annual review
How will the action plan be addressed and monitored?	Task and finish groups identified will report directly to the Professional Practice, Governance and Public Health Framework Group.	Continual learning and service improvement is included in the FNP work plan
How will learning take place	Via mandatory training, team meetings, professional forums bulletins.	All staff are aware of their role and responsibility with regard to ineffective visits. Agenda item at team meeting.

10. Associated documentation

This Standard Operating Procedure refers to the following HDFT Trust policies and procedures:

- Lone worker Policy
- Clinical Record Keeping Policy
- Local Safeguarding Procedures and Related Guidance

11.0 Appendices

Appendix A1 No further appointments offered

Appendix A2 Use of alternative service

Appendix A3 Denial of access

Appendix A 1

Standard Letter (A)

You matter most

NHS No: <NHS number>

0 - 5 Service
<Sender Address>

<Today's date>

Tel No: <Sender Details>

Parent/Guardian of
<Recipient Name>
<Recipient Address>

Dear Parent/Guardian

Re: <Patient Name> DOB: <Date of birth>
<Recipient Address>

Your (**Practitioner role**) has made two appointments to visit you and your child at home; unfortunately you were not at home when they visited.

The reason for the visit is: [**Reason**]

We are therefore unable to offer any further appointment. However if you would like to discuss any concerns or would like your child to be seen please contact the number above. Alternatively you can attend a local health clinic as listed in the enclosed leaflet.

A copy of this letter will be retained in your child's health records and a copy sent to your child's G.P for information.

Yours sincerely

<Sender Name>

Clinical Lead for 0-5 service (or similar)

Enc

Copy: <GP Name> - <GP Details>

Appendix A 2

Standard Letter (A2)

Harrogate and District 
NHS Foundation Trust

You matter most

NHS No: <NHS number>

0-5 Service
<Sender Address>

<Today's date>

Tel No: <Sender Details>

Parent/Guardian of
<Recipient Name>
<Recipient Address>

Dear Parent/Guardian

**Re: <Patient Name> DOB: <Date of birth>
<Recipient Address>**

The health visiting team offered you two appointments to review your child's development and growth. Child development is reviewed at key stages of a child's life and is a valuable opportunity to discuss any concerns you may have regarding your child's health and wellbeing.

Our records show that you have failed to attend these appointments. We are therefore unable to offer any further appointment for this review. However, if you would like your child seen or have any concerns currently or in the future please do not hesitate to contact us on the telephone number above. Alternatively you can attend a local health clinic as listed in the enclosed information.

Your child will be offered contact at their next development review.

A copy of this letter will be retained in your child's health record and sent to your General Practitioner for information.

Yours sincerely

<Sender Name>
Clinical Lead for 0-5 service (or similar)

Enc

Appendix A3

Standard Letter (B)

You matter most

Copy: <GP Name> - <GP Details>

NHS No: <NHS number>

Health Visiting Service
<Sender Address>

<Today's date>

Tel No: <Sender Details>

Parent/Guardian of
<Recipient Name>
<Recipient Address>

Dear Parent/Guardian

**Re: <Patient Name> DOB: <Date of birth>
<Recipient Address>**

Further to my visit / telephone contact on [Date] to discuss the service available from the 0-19 service for your child. I offered to provide support to you and your family during this time, however on this occasion you do not feel that you require our support.

Your child will be offered appointments for developmental reviews. Child development is reviewed at key stages of a child's life and is a valuable opportunity to discuss any concerns you may have regarding your child's health and wellbeing.

As discussed you are able to contact the service at any time for advice and support or attend a local health clinic details of which are enclosed.

A copy of this letter will be sent to your General Practitioner for information.

Yours sincerely

<Sender Name>
Clinical Lead for Health Visiting (or similar)

Enc

Copy: <GP Name> - <GP Details>

6. POLICY MANAGEMENT

6.1 Consultation, Quality Assurance and Approval Process

Consultation Process

Consultation has been undertaken with the Chief Nurse, Clinical Director, Head of Safeguarding Children, Children's Public Health Nursing, General Manager for the 0-19 Healthy Child Service, Matron for Paediatrics, Matron of Emergency Care; Named Nurse for Safeguarding Children; Named Doctor for Safeguarding Children; and all members of the HDFT Safeguarding Children Governance Group. See **Appendix 4**

Quality Assurance Process

The author has consulted with the following to ensure that the document is robust and accurate:

- Designated Doctor for Safeguarding Children, NHS in North Yorkshire and York
- Designated Nurses for Safeguarding Children North Yorkshire and York
- All members of the HDFT Safeguarding Children Governance group

Approval Process

The approval process for this policy complies with that detailed in the Policy Guidance.

The Checklist for Review and Approval has been completed and is included at **appendix 3**

6.2 Review and Revision Arrangements

The Trust Head of Safeguarding Children will be responsible for review of this policy in line with the timeline detailed on the cover sheet.

Subsequent changes to this policy will be detailed on the version control sheet at the front of the policy and a new version number applied. Subsequent reviews of this policy will continue to require the approval of the Trust Safeguarding Children Governance Group.

6.3 Dissemination and Implementation

The following table indicates the dissemination and implementation plan

Title of document:	Safeguarding Children Policy and Procedures
Date finalised:	17 May 2017
Previous document in use?	Yes
Dissemination lead	Named Nurses, and Midwife for Safeguarding Children; Named Doctors for Child Protection

Implementation lead	Named Nurses, and Midwife for Safeguarding Children; Named Doctor for Child Protection
Which Strategy does it relate to?	Safeguarding Children Strategy

Dissemination Plan	
Method(s) of dissemination	Team Brief; Email to all Directorate Leads for dissemination to staff; Specific email to Senior Sisters/Charge Nurses in ED, Maternity, Paediatrics, Unscheduled Care Directorate and Head of Midwifery and Midwifery Matrons to highlight changes in Procedures.
Who will do this	Operational Director; Communications Team; Head of Safeguarding;
Date of dissemination	Within 2 weeks of Trust Safeguarding Children Governance Group Approval
Format (i.e. paper or electronic)	Electronic
Implementation Plan	
Name of individual with responsibility for operational implementation, monitoring etc	Named Nurse, and Midwife for Safeguarding Children; Named Doctor for Child Protection
Brief description of evidence to be collated to demonstrate compliance	i) Verbal evidence collected at contacts with Team; ii) Quality of safeguarding children referrals; iii) Training attendance.

1. 6.4 Archiving Arrangements

Please refer to the [Policy Development Guideline](#) for detail

6.5 Retrieval of Archived Policies

Please refer to the [Policy Development Guideline](#) for detail

6.6 Standards/Key Performance Indicators

Staff awareness of the policy and procedures;

Adherence to the policy and procedures;

Attendance by staff at appropriate Safeguarding Children training;

Engagement with Care Quality Commission Inspections.

Approval and acceptance of Policy and Procedures by City of York, North

Yorkshire, Durham, Darlington and Middlesbrough Safeguarding Children Board

6.7 Process for Monitoring Compliance and Effectiveness

In order to fully monitor compliance with this policy and ensure effective review, the policy will be monitored as follows:-

Minimum requirement to be monitored	Process for monitoring	Responsible Individual/ committee/ group	Frequency of monitoring	Responsible individual/ committee/ group for review of results	Responsible individual/ committee/ group for developing an action plan	Responsible individual/ committee/ group for monitoring of action plan
a. Staff awareness of the policy and procedures.	Questioning of staff re awareness of new Policy and Procedures.	Safeguarding Children Team	12 month audit	Safeguarding Children Governance Group	Named Nurse and Midwife for Safeguarding Children	Safeguarding Children Governance Group
b. Adherence to the policy and procedures;	Reviewing of Child Protection Referrals to Children and Families Service (CFS (CHILDREN'S SERVICES) (CHILDREN'S SERVICES));	Named Nurse and Midwife for Safeguarding Children and Specialist Nurse Child Protection	At each receipt of a copy of a referral form until practitioner competent as per protocol	Safeguarding Children Governance Group	Team/Clinical Leads	Safeguarding Children Governance Group
c. Attendance by staff at appropriate Safeguarding Children training;	Review of Statutory and Mandatory Training Compliance Reports	Named Nurse and Midwife for Safeguarding Children	Quarterly	Safeguarding Children Governance Board	Safeguarding Children Lead for Training	Safeguarding Children Governance Group
d. Approval and acceptance of Policy and Procedures by City of York, North Yorkshire, County Durham, Darlington and Middlesbrough Safeguarding Children Board.	Policy and Procedures accepted by the five named Local Safeguarding Children Boards.	Head of Safeguarding Children	At each revision of Policy and Procedures	Safeguarding Children Governance Board	Head of Safeguarding	Safeguarding Children Governance Board

7. TRUST ASSOCIATED DOCUMENTATION

8. EXTERNAL REFERENCES

- 8.1. Children Act 1989
- 8.2. Children Act 2004
- 8.3. Working Together to Safeguarding Children (HMSO : 2013)
- 8.4. Safeguarding Children and Young people: roles and competences for health care staff (RCPCH: 2014)

9. APPENDICES

- Appendix 1 Area Contact Numbers and Links**
- Appendix 2 Body maps**
- Appendix 3 Quick guide to making a Child protection referral**
- Appendix 4 Checklist for Review and Approval**
- Appendix 5 Consultation Summary**
- Appendix 6 Policy Monitoring, Audit and Feedback Summary**
- Appendix 7 Attendance at Child Protection Meetings**
- Appendix 8 Attendance at Strategy Meetings**
- Appendix 9 Children and Families Referral QA tool**

APPENDIX 1

Area Contact Numbers and Links

North Yorkshire Children's and families services	01609 780 780
City of York Children's and Families Services	01904 551900
North Yorkshire Emergency Duty Team (EDT) (out of hours)	0845 0349417
Middlesbrough CSC	01642 726004
South Tees EDT (out of hours)	08702 402994
Darlington CSC	01325 406222
Darlington EDT (out of hours)	08702 402994
County Durham CSC	03000 267 979
County Durham EDT	03000 267 979

Hyperlink for the LSCBs

North Yorkshire	http://www.safeguardingchildren.co.uk/	
City of York	http://www.yor-ok.org.uk/service-detail.htm?serviceid=2041	
Middlesbrough	http://www.teescpp.org.uk/	
Darlington	http://www.darlington.gov.uk/education-and-learning/local-safeguarding-children-board/	
Durham	http://www.durham-lscb.org.uk/	

Contact details for Designated Nurses

North Yorkshire	Designated Nurse Elaine Wyllie	07917800793
City of York	Designated Nurse Karen Hedgley	07946337290
Middlesbrough	Designated Nurse Alison Ferguson	07826912417
County Durham	Designated Nurse Marie Baister	0191 3713655
Darlington	Designated Nurse Heather McFarlane	01325621414

Contact Details for Named Doctor

Dr Anna Linden Tel no: 01423 885959

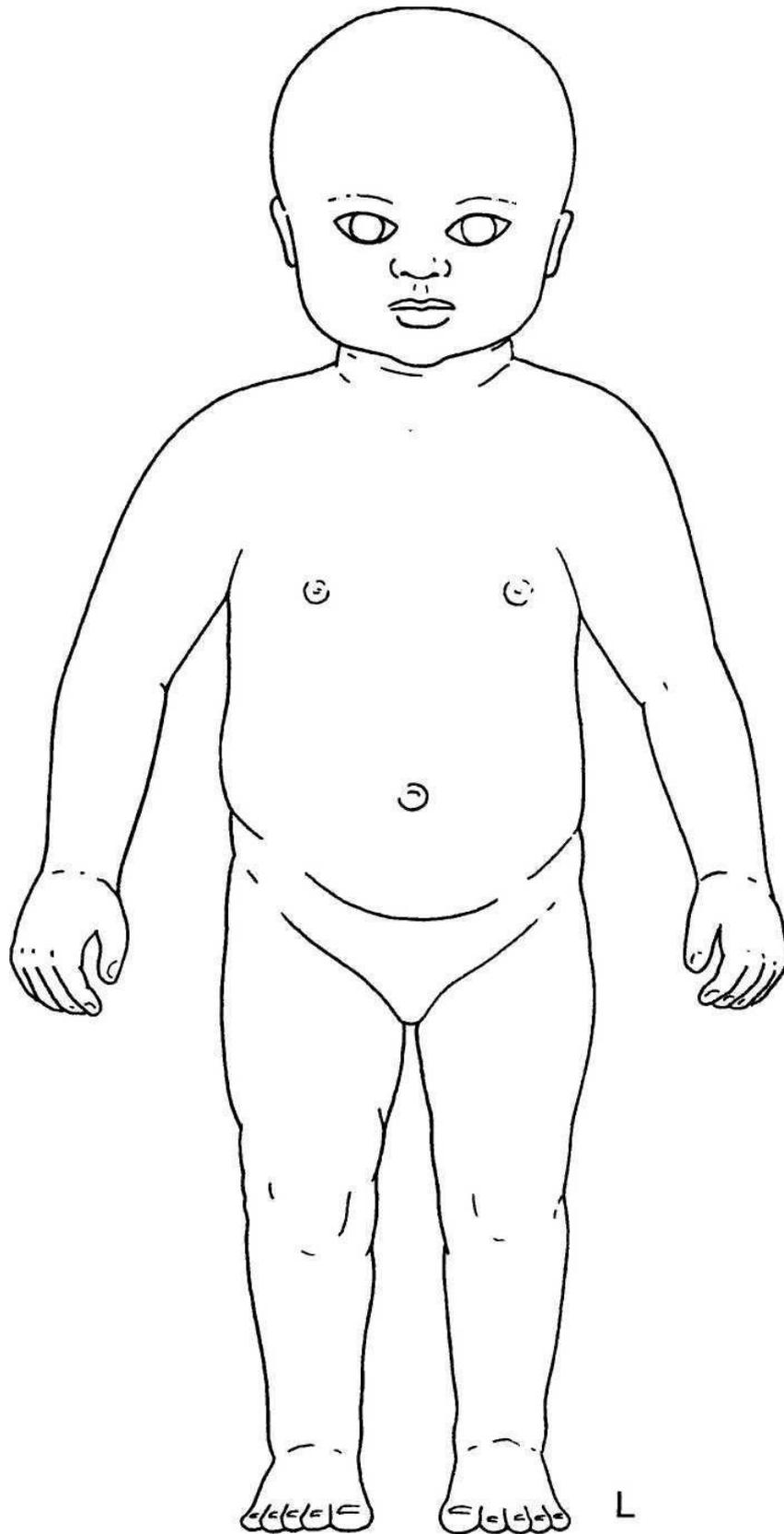
APPENDIX 2

Body Maps

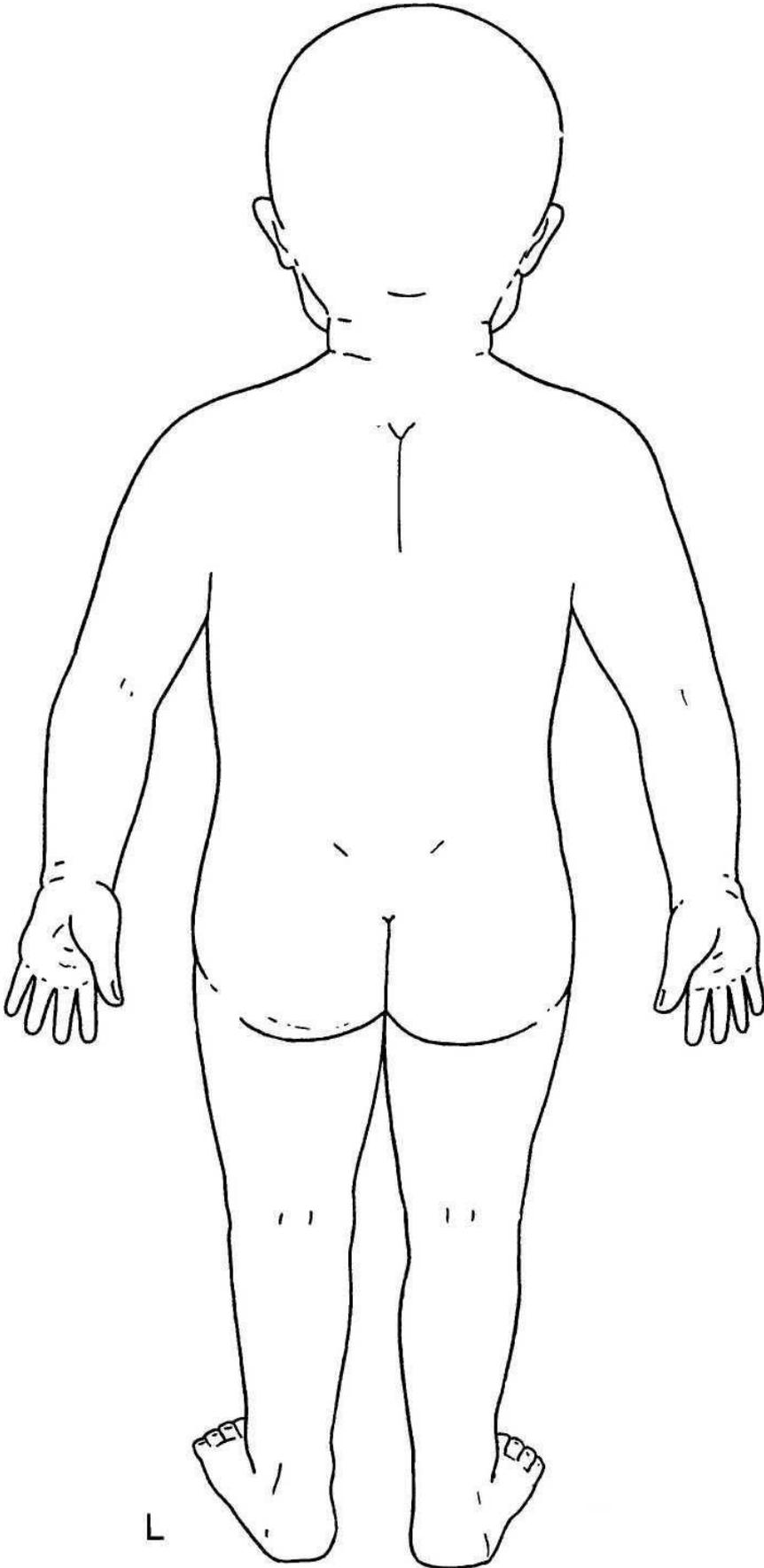
(NB: these are NOT to be used by medical staff for forensic/court reports)

TODDLER MAP

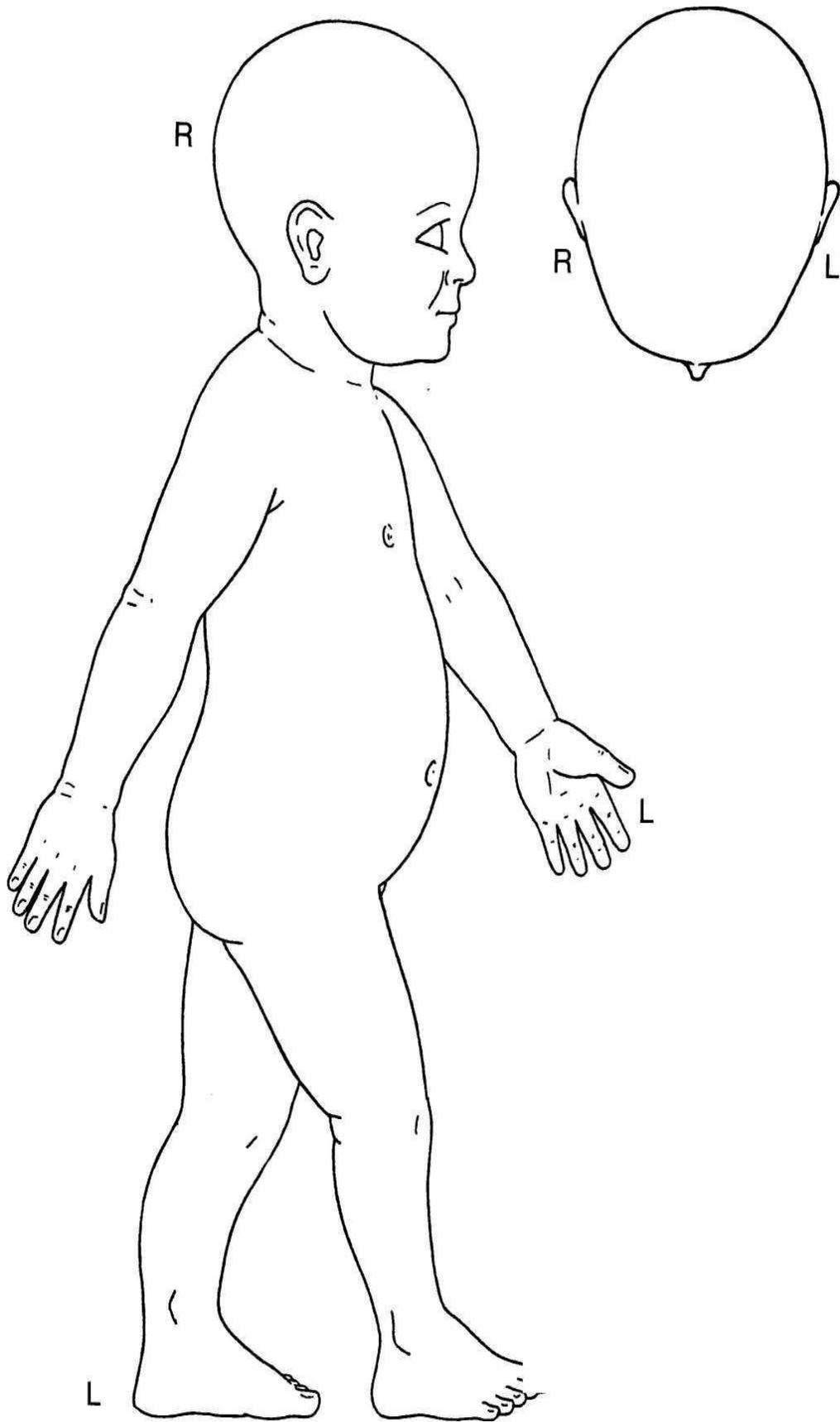
NAME
DATE



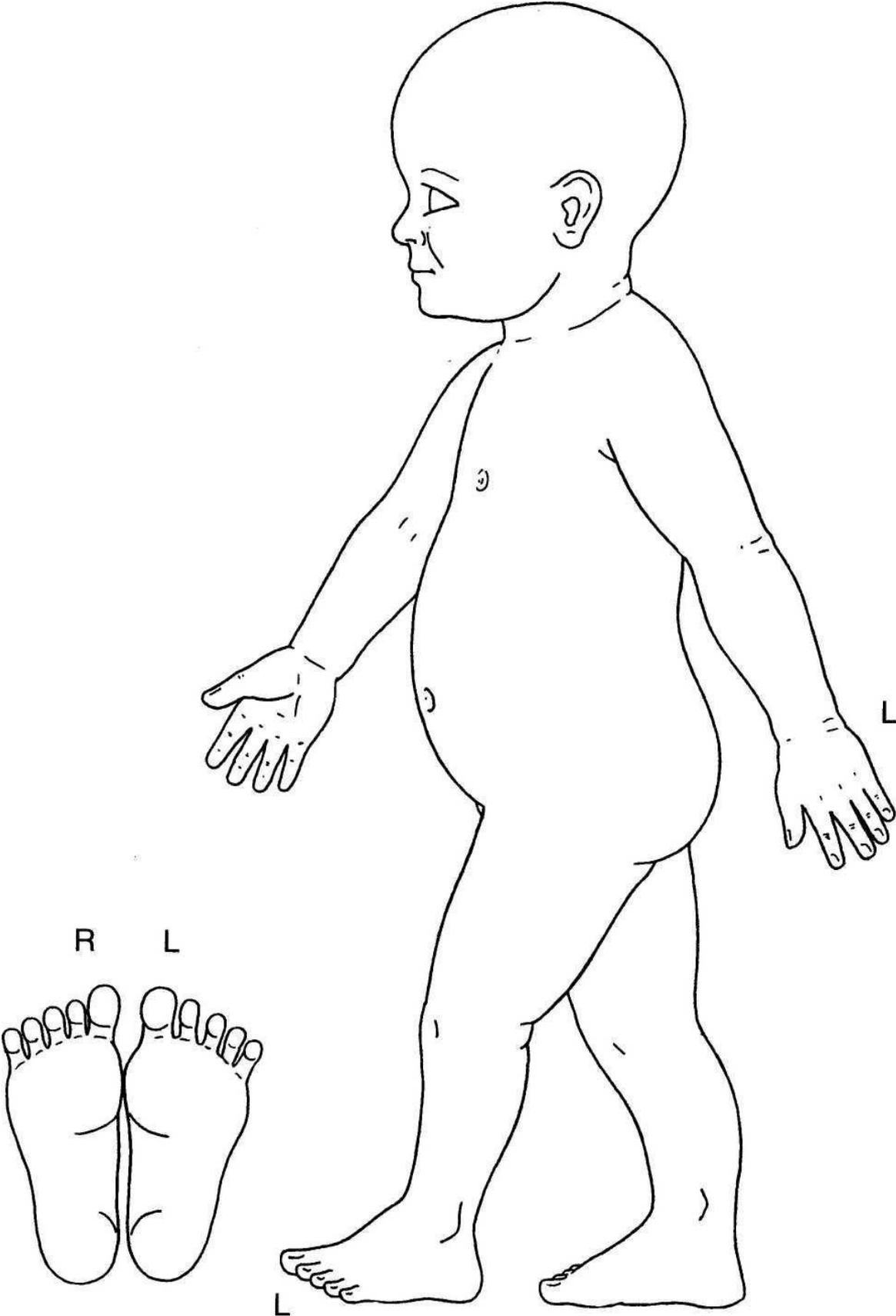
NAME
DATE



NAME
DATE



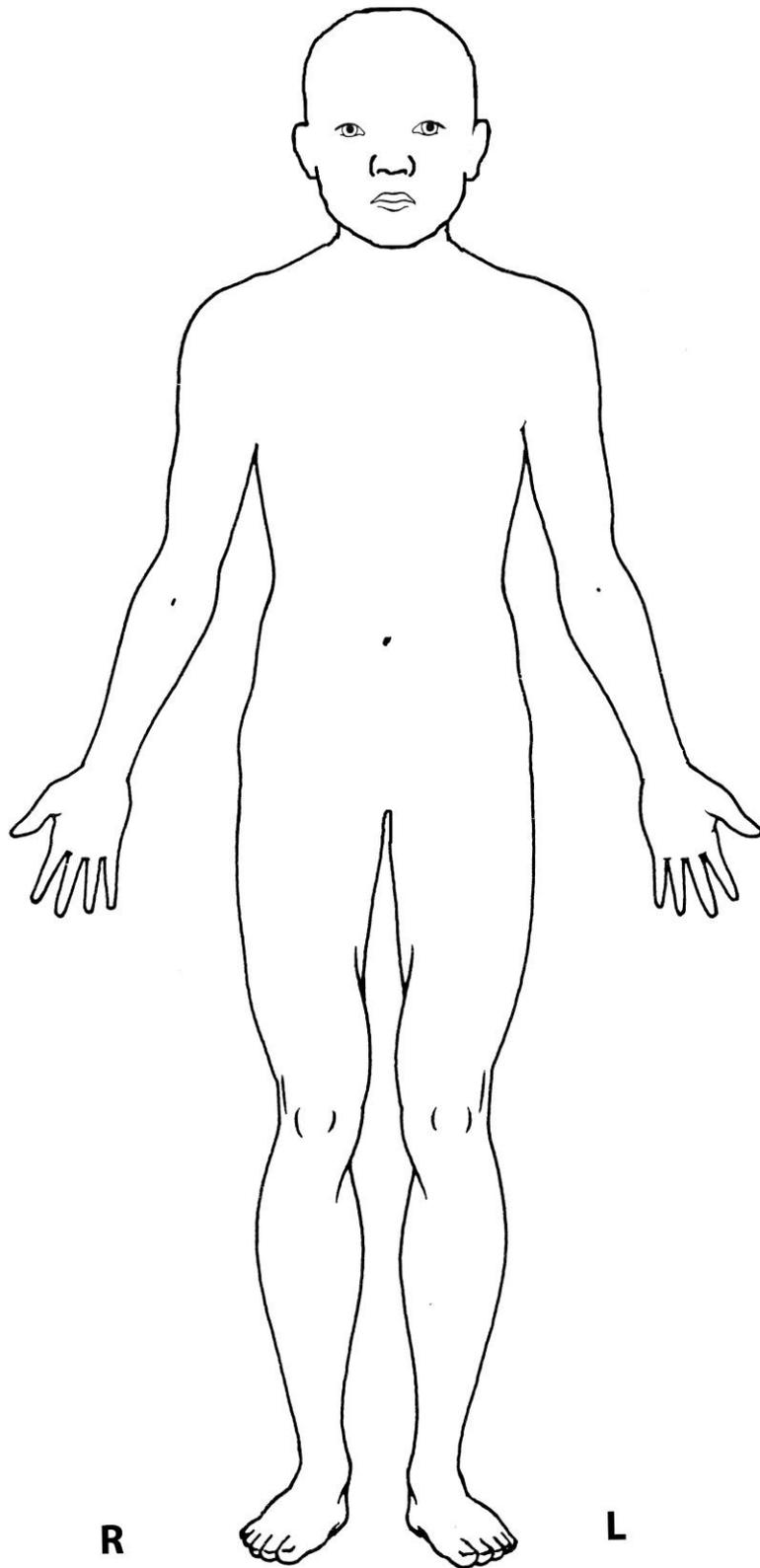
NAME
DATE



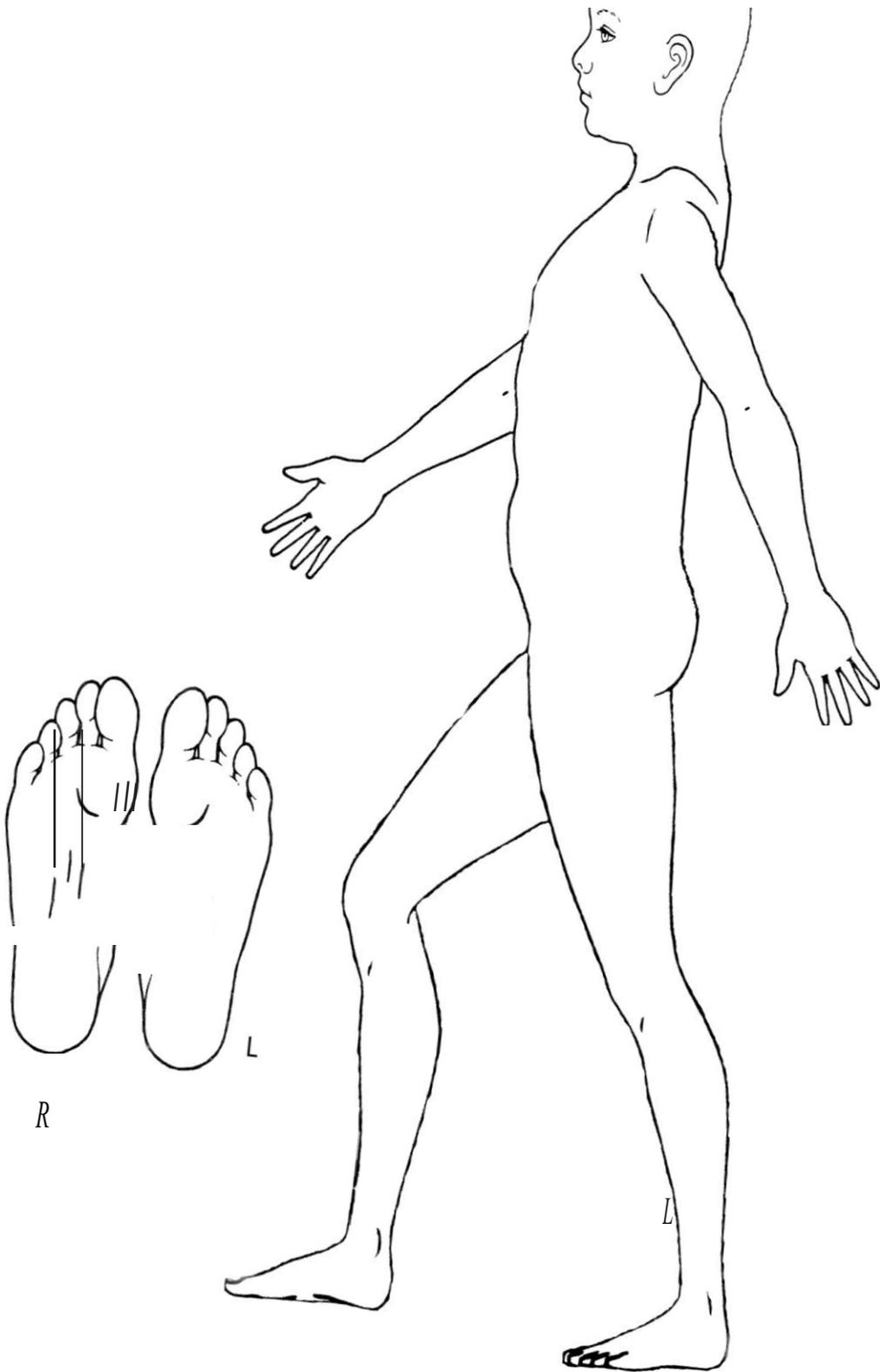
BODY MAP –SCHOOL AGED CHILD

NAME

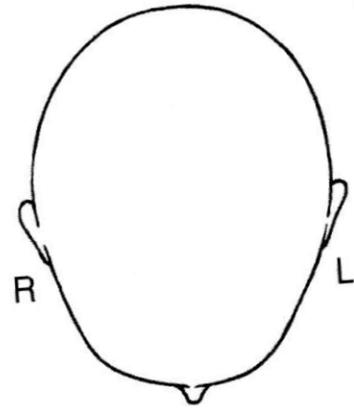
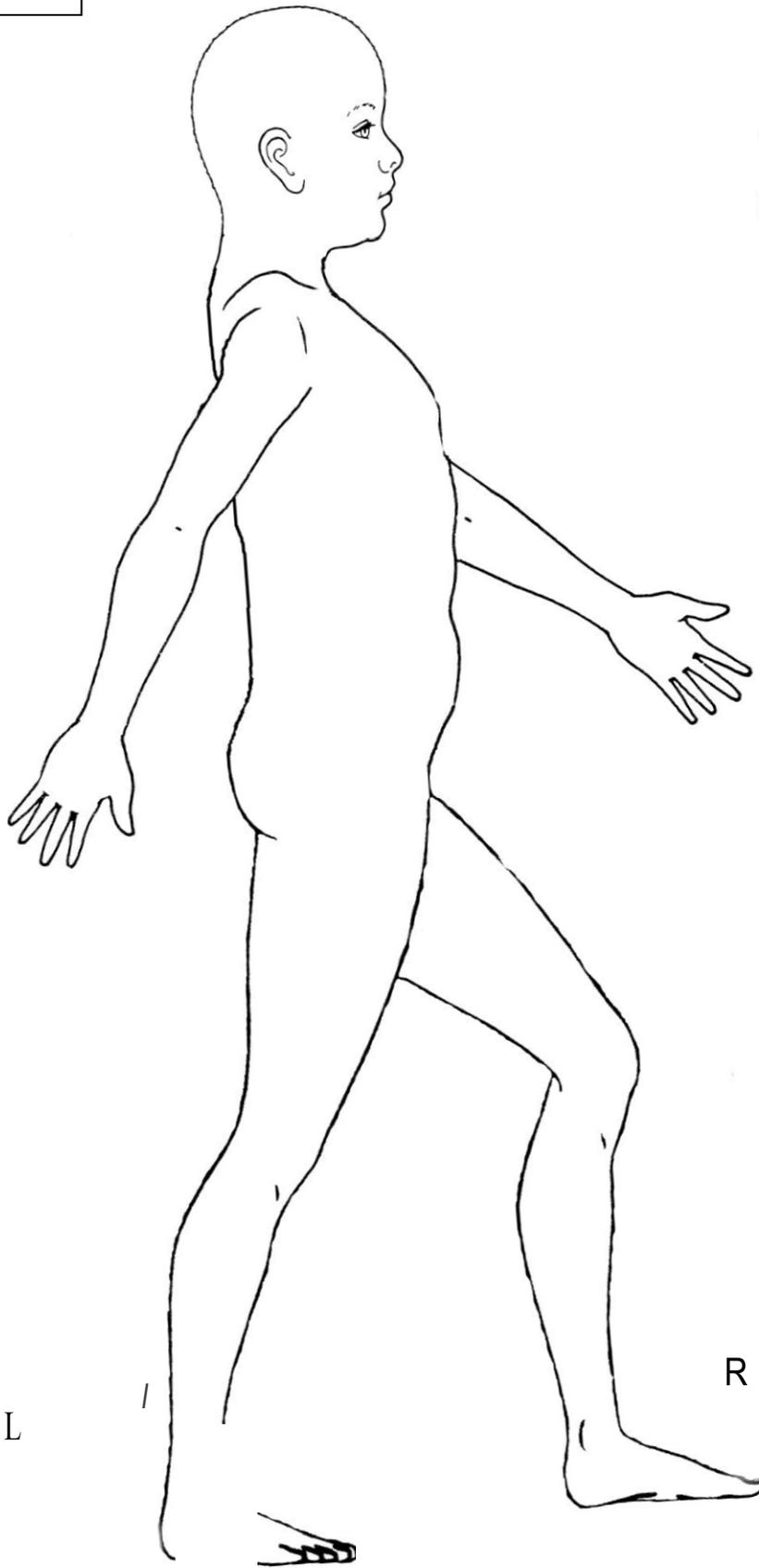
DATE



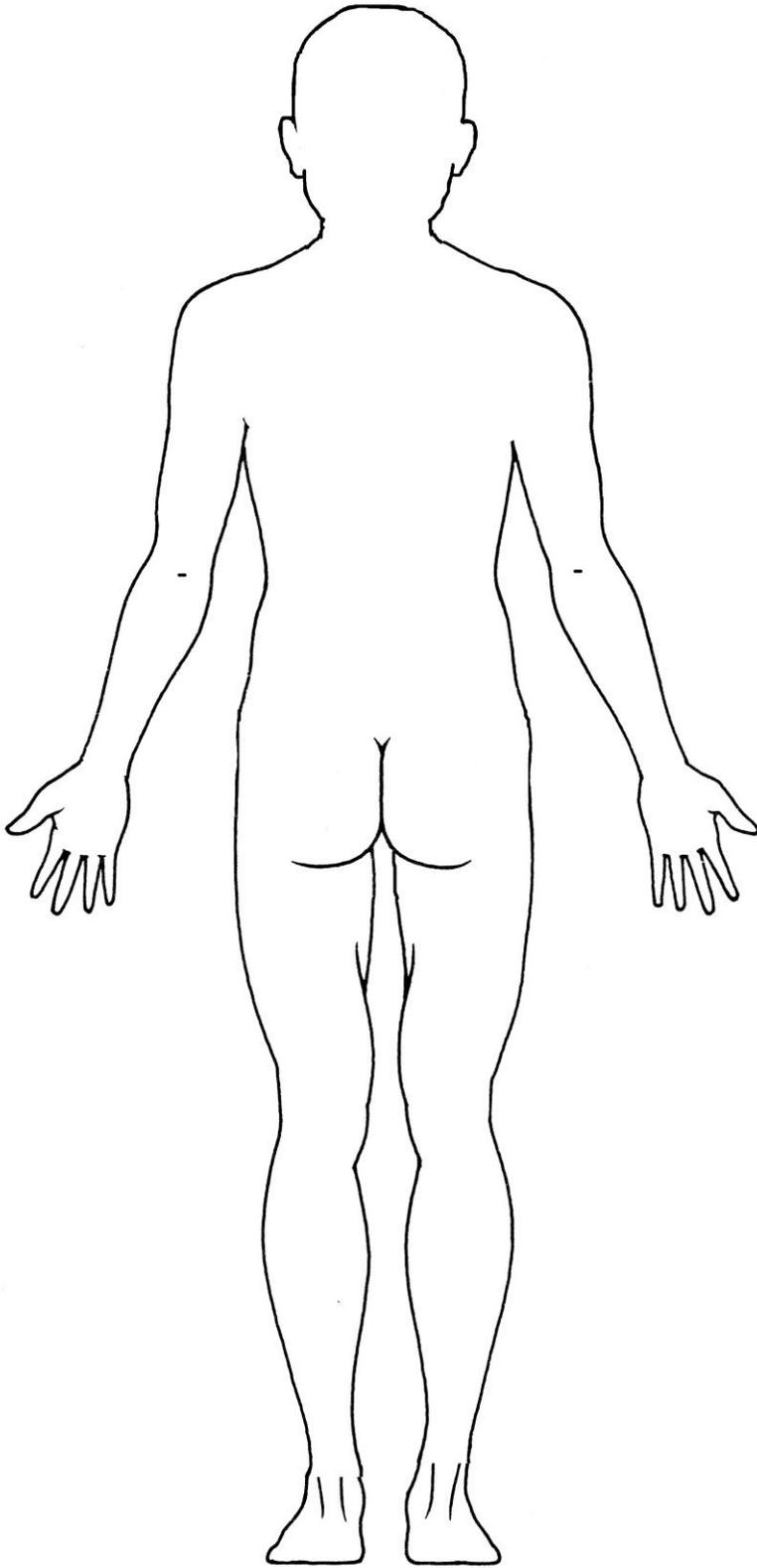
NAME
DATE



Name
Date



Name
Date



Appendix 3

Making a children and families referral – quick guide and checklist embedded

1. Clearly document concerns and collate any family information known to you – check the child's electronic record or CP-IS as per departmental procedure (or ring the Safeguarding Children Team if you do not have access to SystemOne or CP-IS) to see whether there is a safeguarding alert re this child.
2. If you are unsure how to proceed, seek advice from one of the following: line manager, HDFT Safeguarding Children Team (01423 558877), Children and Families Service (CFS Children's Services) or duty Paediatrician at Harrogate District Hospital.
3. If a child protection referral is required, contact Children and Families Service (CFS Children's Services) (Appendix 13)
4. Give all details/information regarding your concerns and confirm that you are making a child protection referral.
5. Follow verbal referral up in writing within 24 hours. Retain a copy of your referral for your reference, and send a copy to the HDFT Safeguarding Children Team. (Referral forms available on LSCB websites) North Yorkshire form: <http://www.safeguardingchildren.co.uk/worried-about-child>
6. Wherever possible, share your intent to refer with parents/carers of child (exceptions outlined on page 22).
7. Always follow the Safeguarding Children and Child Protection Procedures.
8. If you believe that a child is at risk of immediate harm, call the Police on 999, as an emergency.
9. Follow up your referral within 5 working days of making the initial telephone call.

Further information and multi-agency child protection procedures can be found on:

- City of York Safeguarding Children Board website (www.saferchildrenyork.org.uk)
- North Yorkshire Safeguarding Children Board website (www.safeguardingchildren.co.uk)
- East Riding Safeguarding Children Board web site (www.ercb.org.uk)
- Durham Safeguarding Children Board website (<http://www.durham-lscb.org.uk/>)
- Darlington Safeguarding Children Board website (<http://www.darlington.gov.uk/>)
- Middlesbrough Safeguarding Children Board website (<http://www.teescpp.org.uk/>)

Making a Referral to Children and Family Services (formerly known as Children's Social Care): Practitioner checklist

STEP 1 I have sought advice from one of the following:

- HDFT Safeguarding Children Team (SCT)
- Line Manager/Team Leader
- Named Doctor/Duty Paediatrician/Named GP
- Children and Family Services or their Emergency Duty Team
- Police

STEP 2 I plan to make a referral to

- Children and family Services.
- Police
- EDT (out of hours)

STEP 3 I have made a verbal referral to:

- Children and Family Services or
- Emergency Duty Team
- Police

STEP 4 I have documented in the patient health record:

- Full detail of the identified concern/s including the date and time of referral and who spoken to
 - For 0-19 practitioners - I have had the referral quality assured by my line manager/I have been signed off as having the required competency*
- *delete as appropriate

STEP 5 I have completed a written referral within 24 working hours of my verbal referral and completed the following actions:

- Sent the written referral securely to the Children and Families service
- Filed/saved copy in the electronic patient record

Appendix 4

Checklist for review and approval

Authors need to be confident that their policy meets all of the criteria identified below before submitting this to the appropriate Group/ Committee for approval. The Approving Group/Committee should also assure themselves that the document complies with the criteria below.

	Criteria	Yes/No	Comments
1.	Compliance with Policy Guidance		
	Is the title clear and unambiguous?	Y	
	Is the correct policy template used?	Y	Policy transferred to template by HDFT Policy Manager
	Does the style and format of the policy meet the requirements of section xx of the Policy Guidance	Y	Policy formatted by HDFT Policy Manager
	Does the policy contain a list of definitions of terms used?	Y	
2.	Rationale		
	Are reasons for the development of the document stated?	Y	
3.	Development Process		
	Is the reason for the development of the document identified?	Y	
	Do you feel that all of the relevant stakeholders have been consulted with?	Y	
	Does the document identify the individuals or groups consulted with?	N	Not appropriate
4.	Content		
	Is the document linked to a strategy?	N	Safeguarding Children Strategy development
	Is the objective of the document clear?	Y	
	Is the target population clear and unambiguous?	Y	
	Are the intended outcomes described?	Y	
	Is the content clear and unambiguous?	Y	
	Does it meet all of the requirements of external agencies/bodies where applicable?	Y	
5.	Evidence		

	Is the type of evidence to support the document identified explicitly?	??	
	Are supporting references cited in full?	Y	
	Are local/organizational supporting documents referenced?	Y	
	Are all associated documents listed and updated?	Y	
6.	Approval		
	If appropriate, have the staff side committee (or equivalent) approved the document?	N/A	
	Does the document identify which committee/group will approve it?	Y	
	Has the document been sent to the Policy Manager for proof reading immediately prior to submission to the Group/Committee for approval?	Y	
7.	Dissemination and Implementation		
	Does the dissemination plan identify how this will be done and is it clear?	Y	See Page 44
	Does the plan include the necessary training/support to ensure compliance?	Y	
	Does the policy detail what evidence will be collated to demonstrate compliance with it?	Y	
8.	Process for Monitoring Compliance		
	Are the Monitoring Compliance and Effectiveness table arrangements robust and achievable?	Y	
	Are there measurable standards or KPIs to support monitoring compliance of the document?	Y	
9.	Review Date		
	Is the review date identified?	Y	
	Is the frequency of review identified? If so, is it acceptable?	Y	
10.	Overall Responsibility for the Document		

	Is it clear who will be responsible for the operational implementation, delivery and monitoring of the policy?	Y	
11. Impact Assessment on other Corporate Departments			
A	Does the policy require staff to attend statutory training?	Y	
B	If the answer to the above is yes, have you discussed and agreed this with Workforce Development Please include date and outcome in comments box.	Y	Julia Bullock 22.12.2016
C	Could the introduction of this document have any impact on the following departments: - Procurement/SNS/ Information Governance/Risk and Legal Communications/Occupational Health/Estates and Facilities or Health and Safety? If the answer is yes, please contact the relevant department(s) and detail who you spoke with, the date and the outcome in the comments box.	Y	Angie Gillet, Deputy Director of Planning 22.12.2016 in terms of impact when procuring 0-19 services out with HDFT
D	Could there be any additional costs associated with the implementation of this policy, which are not supported by an approved business case?	N	
E	Does the document require any change in financial process arrangements (e.g. Payroll, Invoicing, Payments etc)	N	
F	If the answer to questions 11d and e are yes you should immediately seek the advice of the Deputy Director of Corporate Finance on extension 772 5039 and detail the outcome in the comments box.	N/A	

Policy Approval

Name of Group or Committee Approving the Policy	Safeguarding Children Governance Group
Name of Chair of Group or Committee	Lorraine Fox, Head of Safeguarding Children
Date of Approval	20 February 2015
Submission of Document for Logging and Publishing	
<p>Policy authors must obtain a copy of the minutes or an extract of the minutes of the approving group demonstrating approval of the document. This can be obtained from the relevant Group/Committee administrator.</p>	

Appendix 5

Consultation Summary

<p>Those listed opposite have been consulted and any comments/actions incorporated as appropriate.</p> <p>The author must ensure that relevant individuals/groups have been involved in consultation as required prior to this document being submitted for approval.</p>	<p>List Groups and/or Individuals Consulted</p>
	Jill Foster - Chief Nurse
	Natalie Lyth-Clinical Director
	Lorraine Fox - Head of Safeguarding Children
	Suzanne Lamb -Head of Children's Public Health Nursing
	Paul Simpson - General Manager for the 0-19 Healthy Child Service
	Julie Walker -Matron for Paediatrics
	Stephanie Davies -Matron of Emergency Care
	Named Nurses for Safeguarding Children
	Anna Linden -Named Doctor for Safeguarding Children
	All members of the HDFT Safeguarding Children Governance Group
	Elaine Wylie – Designated Nurse Safeguarding Children

Appendix 6

Safeguarding Children / Child Protection Policy Monitoring, Audit and Feedback Summary

KPIs	Audit / Monitoring required	Audit / Monitoring performed by	Audit / Monitoring frequency	Audit / Monitoring reported to	Concerns with results escalated to

Appendix 7

HDFT Attendance at Child Protection Meetings

Background for 5-19 attendance

Historically School Nurses have attended all Child Protection meetings (Child Protection Strategies, Initial Child Protection Conferences (ICPC), Review Child Protection Conferences (RCPC) and Core Groups). The role of the Specialist Nurse for Child Protection and/or Named Nurse has changed over recent years and 0-19 practitioners are encouraged to attend strategy meetings to share their information and build upon their skills in the analysis of and assessment of risk. Specialist Nurses for Child Protection and/or Named Nurses can support the child protection strategy meeting process by using their analytical skills to support the identification of the level of risk posed to a child or young person.

Role of the 5-19 Public Health Nurse/School Nurse

The 5-19 Practitioners (School Nurses) have a pivotal role in safeguarding. It is essential that children, young people, families and partner agencies all have a clear understanding of the role of the school nurse and their skills and competence

The School Nurse role is a degree level qualification as a Specialist Community Public Health Nurse (SCPHN). As a Public Health Nurse their specialism is in understanding the population health needs of children aged 5 – 19 years. There is national guidance on maximising the role of the Public Health School Nurse¹ which demonstrates the importance of universal prevention and health promotion through to targeted work to protect and safeguard children. In the words of Professor Sir Michael Marmot, proportionate universalism² should be applied to the role as there is a clear evidence base that providing universal primary prevention and earlier intervention will reduce the escalation of high need cases. The Healthy Child Programme encompasses health development reviews, immunisations, screening and health promotion interventions such as advice and guidance for young people on sex and relationships, drugs, alcohol and smoking as well as low level support around emotional health. The School Nurse should provide a leadership and coordination function within the school setting, supporting schools to have an up to date health profile of their pupils and to be able to proactively manage the health needs of their pupils.

Specialist Community Public Health Nurses contribution to safeguarding processes whether 0-5 or 5-19, should be purposeful and meaningful. PHE guidance published in January states their contribution should be *'where appropriate and the child or young person is known to the provider, senior team members will attend child protection conferences or meetings when they are **the most appropriate health representative** and there is a specific outcome to contribute towards'*

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/493622/Service_specification_CG2_FINAL_19jan2016.pdf

Safeguarding Children Board procedures require that 'professionals with significant knowledge of the child or with relevant expertise' contribute to the process and the contractual requirements of the service HDFT provides also reflects that position. The

¹ DH (2014) Maximising the school nursing team contribution to the public health of school aged children

² Marmot (2011) Fair society healthy lives

Healthy Child Service is a public health service and is a resource that we need to use in the most effective and efficient way and where they do not have significant knowledge or relevant expertise there is no sound reason why they should be the health representative.

Revised Pathway for all 0-19 Practitioners

HDFT will ensure that a Band 6 Specialist Community Public Health Nurse (SCPHN) will attend all child protection strategy meetings and if they are unable to attend will ensure their information is shared in a timely manner. Teleconferencing is being used in some areas to support this process.

HDFT will ensure that a Band 6 Specialist Public Health Nurse (SCPHN) will attend all Initial Child Protection Conferences and then make a decision after the completion of the holistic health assessment as to whether there is role for the School Nursing Service moving forward which may include the Band 5 Healthy Child Nurse taking a Lead role.

HDFT practitioners will ensure that the child or young person subject to the strategy discussion will have a holistic assessment undertaken if the last assessment was undertaken more than 3 months previously before the decision is made regarding current and/or ongoing involvement with the child, young person and/or family.

The holistic health assessment will be undertaken by the SCPHN as part of the assessment for the initial child protection conference and completed by the second core group. At this point a decision will be made as to whether ongoing input from the service is required if there are no any identified health needs.

Where a Band 5 Healthy Child Nurse or band 4 Early Years Practitioner is working with the family then the case would be overseen by an agreed Band 6 SCPHN.

It would be the responsibility for the Band 5 practitioner to attend all the Review Child Protection Conferences during the period of time she/he was working with the child and or family. This would be overseen by the agreed Band 6 SCPHN.

Where there is a role for a Band 4 Early Years Practitioner they could be asked to attend a review child protection conference but would not be expected to attend on their own.

Once the holistic assessment has been undertaken and there is no clearly identified role for the SCPHN then the practitioner will notify the IRO (Independent Reviewing officer), Social Worker (SW) and family that that he/she will no longer be involved in the process. The practitioner will ensure the electronic patient record is updated with the details of the person they have informed of this decision and to be removed from the invite list.

The SCPHN will make a clear record in the child's electronic patient record the outcome of the assessment and what their role in the child protection plan is (to include the actions/interventions they have agreed to undertake with associated timeframes) and if there is not a role and why.

If the child/young person refuses the assessment the practitioner will try and work creatively with the young person and family to have the opportunity to assess the health of the child and the benefits this will bring.

If there are any changes in the health needs of the child and or young person at any point during the child protection process the Lead Social Worker can request that the 0-19 service becomes involved in the process.

HDFT Specialist Nurses Child Protection Nurses will attend strategy meetings if:

- If there is an allegation against a member of staff
- The case is potentially sensitive and/or could cause media interest
- The case is a high risk FII/CSE case.
- There could be a potential impact on the reputation of the Organisation
- At the request of the Social Work Manager.

HDFT Specialist Nurses Child Protection will attend child protection conferences if:

- If the practitioner is newly qualified and wants/requires support
- If requested by the practitioner because of a potential challenge required
- The case is potentially sensitive and/or could cause media interest
- The case is a high risk FII/CSE case
- At the request of a Children's Social Care Manager or Independent Reviewing Officer (IRO).

Appendix 8

HDFT Attendance at Strategy meetings

Position Statement of: Lorraine Fox, Head of Safeguarding Children

Purpose of the Statement

The purpose of this statement is to provide assurance to the County Durham Safeguarding Children Board that HDFT will have appropriate representation at Child Protection Strategy meetings.

Background

Historically Specialist Nurses for Safeguarding Children and/or Named Nurses have attended child protection strategy meetings and have shared relevant health information held by Health Visitors and School Nurses.

Specialist Nurses for Safeguarding Children and/or Named Nurses support the Strategy meeting process by using their analytical skills to support the identification of the level of risk posed to a child or young person.

The role of the Specialist Nurse for Safeguarding Children and/or Named Nurse has changed over recent years and practitioners are encouraged to attend strategy meetings to share their information and build upon their skills in the analysis of and assessment of risk.

Current Position

HDFT will ensure that 0-19 practitioners will attend all child protection strategy meetings where practicable and if they are unable to attend will ensure their information is shared in a timely manner.

HDFT have signed up to strategy meeting teleconference pilot.

HDFT Specialist Safeguarding Children Nurses will attend strategy meetings if:

- If there is an allegation against a member of staff
- The case is potentially sensitive and/or could cause media interest
- The case is very high risk
- There could be a potential impact on the reputation of the Organisation

Monitoring and Quality Assurance

HDFT requires all practitioners to complete a Datix if they are unable to attend a strategy meeting or share relevant information in a timely manner.

HDFT will monitor attendance at strategy meetings over a three month period to assess attendance compliance.

Contact: Lorraine Fox
Email: lorraine.fox@hdft.nhs.uk

Appendix 9

Quality Assurance of Children & Family Referrals made by HDFT 0-19 Practitioners

To ensure referrals made by HDFT practitioners to Children and Family services have robust risk assessment and analysis to enable Social Workers to make informed decisions

Area of work:	Speciality:
Line Manager	Patient ID:
Auditor name:	Date:

Ref	Question	Y	N	NA	Comments
Situation					
1.	Was the Name and Job Title of the referrer documented?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
2.	Were contact details for the referrer documented?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
3.	If appropriate, has the Common Assessment Framework (CAF) section been completed if relevant?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
4.	Is the referrer working with the adult and/or child?				
5.	Has the referrer provided the date of birth, gender and address for the child and or children the subject of the referral?				
Services Involved					
6.	Are there any other agencies working with the child/family, have these been documented?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Consent					
7.	Has parental consent been asked?	<input type="radio"/>	<input type="radio"/>		
8.	If no has a reason why been documented?				
Reason For Concern For Child's Safety/Wellbeing					
9.	Are the referrers concerns clearly documented using?	<input type="radio"/>	<input type="radio"/>		
10.	Is there evidence of an assessment of risk and analysis?	<input type="radio"/>	<input type="radio"/>		
10a.	Does the information provided make it clear what the risks are?	<input type="radio"/>	<input type="radio"/>		
10b.	If no is any explanation/reason stated?	<input type="radio"/>	<input type="radio"/>		
11.	Is it clear if the referral is child protection?	<input type="radio"/>	<input type="radio"/>		
Comments:					

Family and environmental factors					
12.	Has the relevant Family Factors section been completed fully?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
13.	If available has appropriate information been shared in relation to other family members?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
14.	If available appropriate information been shared in relation to home situation?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
15	Are there details recorded relating to the home conditions?				
Expected response					
16.	Has the expected response section been completed?	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	
Recording					
17.	Have the details of the referral been recorded in the child's record and in the Safeguarding Children Clinical Tree?	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	
Additional evidence					
18.	Have any further evidence been submitted as required?	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>	

Appendix 10

Protocol for the Management of Children under the age of one year old presenting at Minor Injury Units

INTRODUCTION

Purpose

The purpose of this protocol is to aid the Urgent Care Practitioners(UCP) working within the Minor Injury Units(MIUs) managed by Harrogate District Foundation Trust(HDFT) to provide a safe accessible service for patients who present to the units, specifically children under 1 year old.

The MIU services are not commissioned to see patients attending with minor illness, however it is recognised that patients and their families may attend with a minor illness presentation. A small percentage of patients attending the units are outside the scope of the unit as there are no doctors on-site, but these patients must be re-directed safely and consistently to appropriate alternative services.

The following protocol provides a framework for managing all children under 1 year old attending a MIU.

Scope

This protocol applies to any Registered Professional working at any Minor Injury Unit provided by Harrogate District Foundation Trust.

Definitions

Assessment

Practitioners have access to “Manchester Triage” handbook 3rd edition, “Emergency Triage Telephone triage and advice” first edition , and paper copies of National Early Warning Score [NEWS], Paediatric Advanced Warning Scores [PAWS]and Modified Early Obstetric Warning Score [MEOWS] which will support their decision making in assessment and subsequent redirection of patients.

A to E Assessment

Airway, Breathing, Circulation, Disability, Exposure assessment

Urgent Interventions

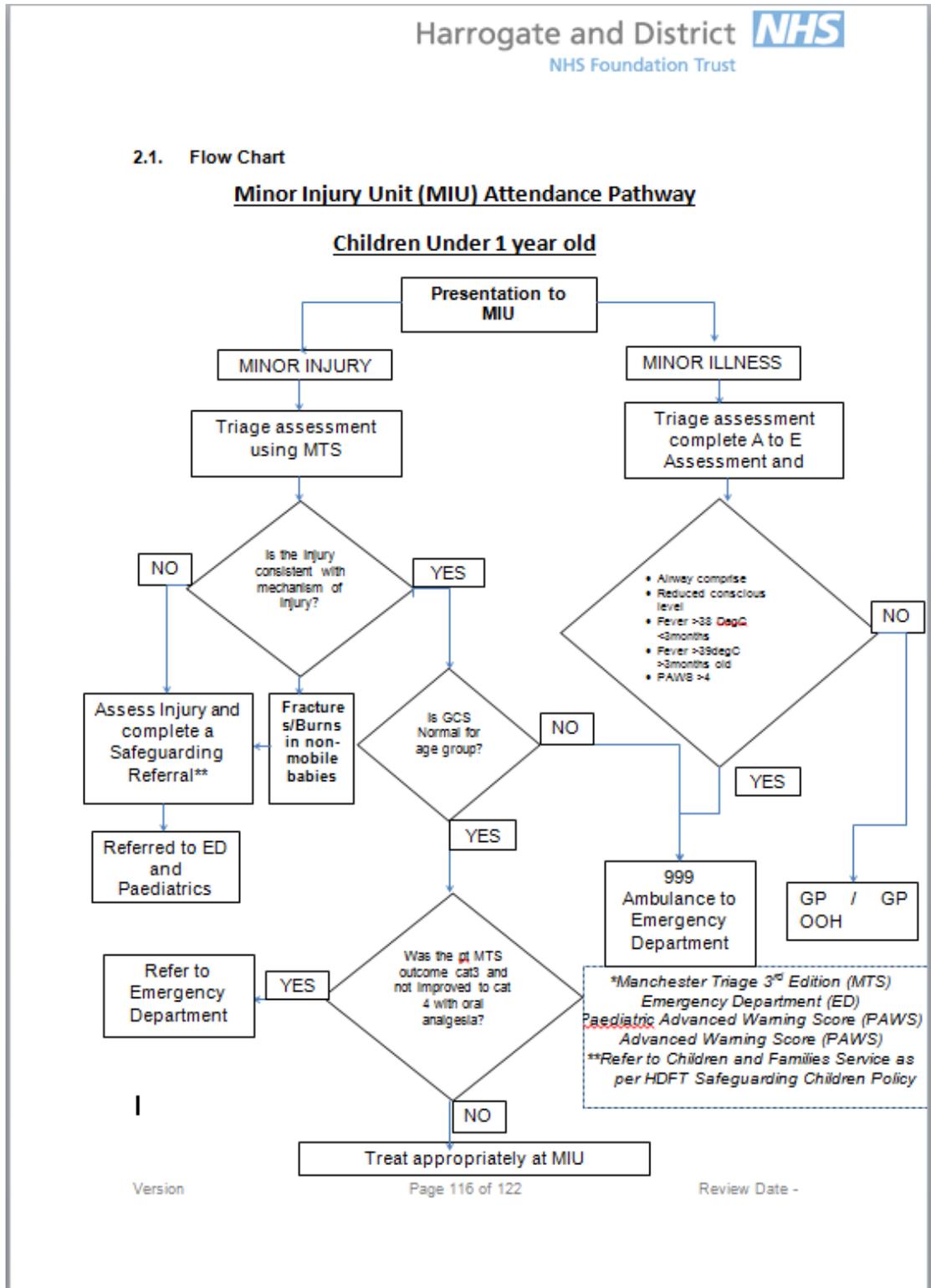
Oxygen, Basic Life Support (BLS), position change, analgesics, anti-pyrexics.

Protocol

Any critically unwell / seriously injured patient, adult or child, brought into the unit will be assessed and transfer arranged via ambulance to the nearest Emergency Department

(ED).

Children under the age of one year old attending the MIU with a minor illness complaint will be redirected to an appropriate service after an “A to E” assessment and appropriate corresponding urgent interventions. **Children under the age of 1 attending with a minor illness will not be definitively cared for in an MIU.**



Roles and responsibilities

Responsibilities for appropriate competence

Each UCP working at a MIU has responsibility for ensuring that:

- They are familiar with the assessment process, who and how to refer to services outlined and how to escalate any immediate concerns
- They are competent to treat any patient they choose not to refer to another professional or service.
- They are familiar with HDFTs safeguarding policies and procedures and that these are followed.
- They attend Paediatric Intermediate Life Support [PILS] training and updates
- They complete mandatory and essential training requirements, have an annual appraisal and maintain skills and competency for their role.
- Emergency equipment provided for basic life support as an initial intervention is maintained, they know where equipment is kept, they are competent in using this equipment and that appropriate checks on this equipment are completed in a timely way.

HDFT is responsible for ensuring that:

- All Practitioners are afforded time to attend mandatory and essential training required for their role, including Paediatric Intermediate Life Support [PILS] and Safeguarding Training
- Providing the Emergency equipment required to provide basic life support.

Responsibilities for ensuring compliance

The Clinical Services Manager at the MIU is responsible for ensuring that the audit of the attendance records of children under one year old is completed as outlined in section 4.2 below.

The Matron for Urgent & Emergency care is accountable for the completion of the audit and ensuring recommendations are actioned.

Monitoring compliance and effectiveness

Measure of compliance

Percentage of interactions where guidelines have been followed – 100% compliance

Method of Monitoring

Quarterly audit of MIU cards for all attendances for children under 1 year old

Consultation Process

Key Individuals Involved in the document development	
Dr Matt Shepherd	Clinical Lead for Emergency Medicine
Julie Walker	Matron for Paediatrics
Liz Eagin	Clinical Service Manager – Selby MIU
Circulated for Comments	
All Urgent Care Practitioner	
Tracy Campbell	Head of Nursing - LTUC
Andy Alldred	Clinical Director - LTUC

Reference Documents

- Manchester Triage handbook 3rd edition: Manchester Triage Group, BMJ
- Emergency Triage, Telephone triage and advice: Manchester Triage Group, 2016 BMJ
- NICE guidance Fever in under5's: assessment and initial management May 2013 nice.org.uk/guidance/cg160
- Royal College of Emergency Medicine, Quality in Emergency Care Committee Standard Consultant sign off (June 2016)

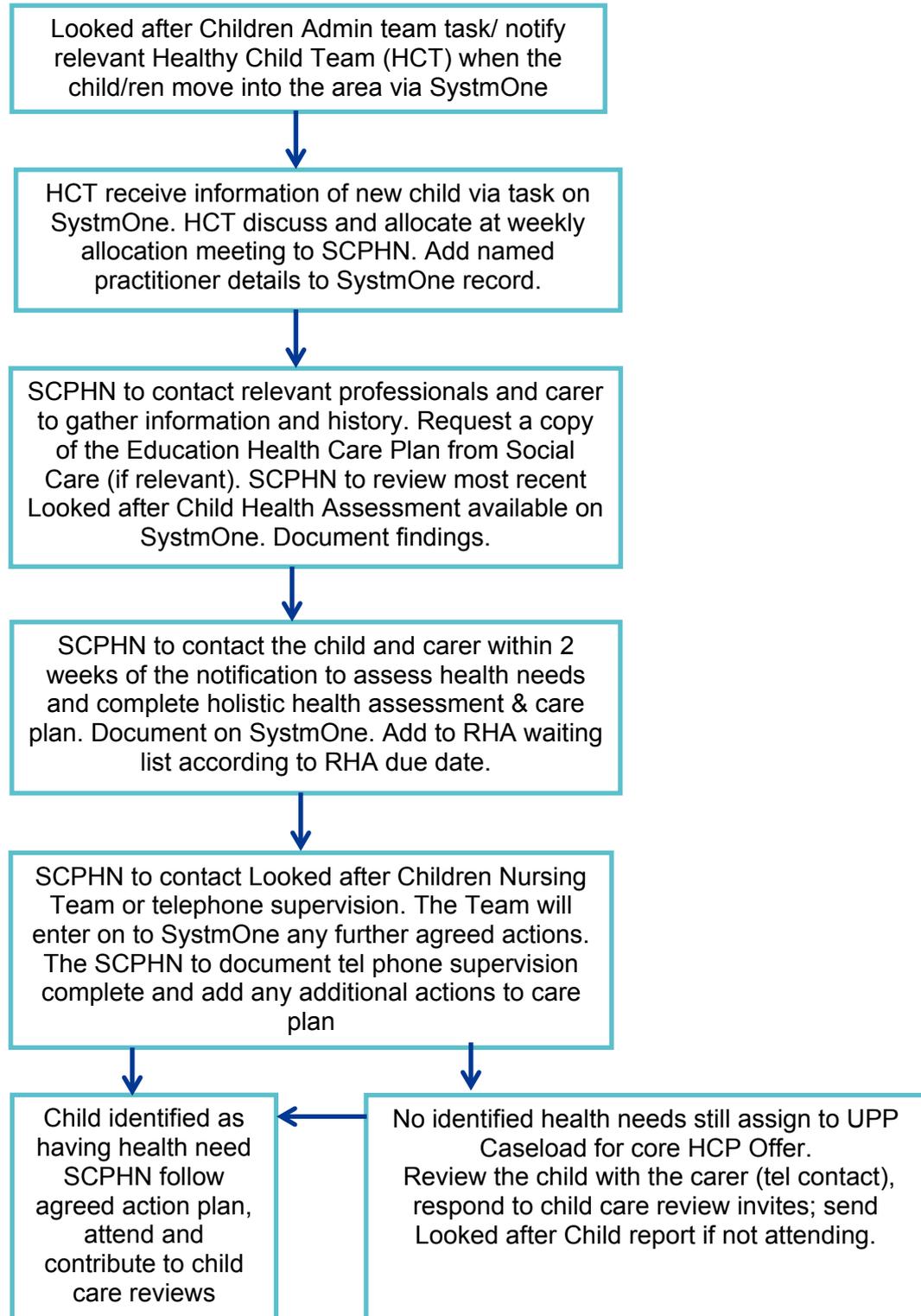
Paper copies of:

- National Early Warning Score [NEWS]
- Paediatric Advanced Warning Scores [PAWS]
- Modified Early Obstetric Warning Score [MEOWS]

- [HDFT Safeguarding Children Policy](#)
- [Children and Families Referral Form](#)
- [Bruising in Non-Mobile Babies Policy](#)

Appendix 11

Looked after Children movement into area pathway



Appendix 12

Was Not Brought Flow Chart

