Southern Hampshire
PRIMARY CARE ALLIANCE

Safeguarding Children & Young People Policy

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This policy document is SHPCA-agreed policy, applicable to all clinicians and staff working in SHPCA services as well as official visitors to the premises, and it represents the means by which SHPCA intends to keep children safe. The policy is detailed and lengthy but is no substitute for staff – clinical as well as administrative – ensuring they are aware of local and national procedures and maintaining their up-to-date training.

Under the 1989 and the 2004 Children Acts a child or young person is anyone under the age of 18 years.

Safeguarding Children refers to the activity that is undertaken to protect specific children who are suffering or at risk of suffering significant harm. All agencies and individuals should be proactive in safeguarding and promoting the welfare of children.

SHPCA recognises that all children have a right to protection from abuse and SHPCA accepts its responsibility to protect and safeguard the welfare of children with whom staff may come into contact. This policy is underpinned by the following basic principles:

Safeguarding Basic Principles

- The welfare of the child is paramount (Children Act 1989).
- It is the responsibility of all adults to safeguard and promote the welfare of children and young people. This responsibility extends to a duty of care for those adults employed, commissioned or contracted to work with children and young people.
- Adults who work with children are responsible for their own actions and behaviour and should avoid any conduct which would lead any reasonable person to question their motivation and intentions.
- Adults should work and be seen to work, in an open and transparent way.
- The same professional standards should always be applied regardless of culture, disability, gender, language, racial origin, religious belief and/or sexual identity.
- Adults should continually monitor and review their service and ensure they follow the guidance contained in this document and elsewhere.

To deliver this SHPCA will:

- Respond quickly and appropriately where abuse is suspected or allegations are made.
- Provide both parents and children with the chance to raise concerns over their own care or the care of others.
- Have a system for dealing with, escalating and reviewing concerns.
- Remain aware of child protection procedures and maintain links with other bodies, especially the CCG-appointed contacts.
- Ensure that all staff are trained to a level appropriate to their role, and that this is repeated on an annual refresher basis. New starters will receive training within 6 months of start date.

Staff can refer to government guidance on what to do if abuse is suspected: HM Government What to do if you suspect a child is being abused and local guidance for the Hampshire Isle of Wight, Portsmouth and Southampton (HIPS) Partnership: https://www.hampshirescp.org.uk/report-a-concern/

(Also See ANNEX 1 for SHPCA Statement of Intent).

Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting; by those known to them or, more rarely, by a stranger.

There are usually said to be **four types of child abuse** (with a fifth recognised in Scotland)

1. **Physical** Abuse
2. **Emotional** Abuse
3. **Sexual Abuse**
4. **Neglect**
5. Non-organic Failure to Thrive (Scotland only)

Female Genital Mutilation is also a form of abuse, please refer to section **g)** below regarding this.

General Indicators

The risk of Child Maltreatment is recognised as being increased when there is:

- Parental or carer drug or alcohol abuse;
- Parental or carer mental health disorders or disability of the mind;
- Intra-familial violence or history of violent offending;
- Previous child maltreatment in members of the family;
- Known maltreatment of animals by the parent or carer;
- Vulnerable and unsupported parents or carers;
- Pre-existing disability in the child, chronic or long-term illness.

(NICE CG89: When to suspect Child Maltreatment, July 2009)

Physical Abuse

Definition: Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child, including by fabricating the symptoms of, or deliberately inducing illness in a child. (*Working Together July 2018).*

Alerting features:

Abrasions	Eye Injuries	Lacerations	Spinal Injuries
Bites (human)	Fractures	Ligature marks	Strangulation
Bruises	Hypothermia	Oral Injuries	Subdural haemorrhage
Burns or scalds	Intra-abdominal injuries	Petechiae	Teeth marks
Cold injuries	Intra-cranial injuries	Retinal haemorrhage	
Cuts	Intra-thoracic injuries	Scars	

Or consider:

- Child with hypothermia and legs inappropriately covered in hot weather [concealing injury]
- For fabricated illness discrepancy in the clinical picture with one or more of the following:
  - Reported signs or symptoms only in the presence of the carer;
  - Multiple second opinions being sought;
  - Inexplicably poor response to medication or excessive use of aids;
- Biologically unlikely history of events even if the child has a current or past physical or psychological condition.

Definition: Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development.

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

Alerting features:

Persistent harmful parent or carer – child interactions	Hiding or scavenging for food without medical explanation	Precocious or coercive sexualised behaviour

Or consider:

Responsibilities which interfere with normal daily activities (such as school)	
Physical / mental / emotional developmental delay	Drug/solvent abuse
Low self-esteem	Self-harming/mutilation
Changes in behaviour or emotional state without explanation	Secondary enuresis or encopresis
Extremes of emotion, aggression or passivity	Running away
School refusal	

Sexual Abuse

Definition: Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening.

The activities may involve physical contact, including penetrative (e.g. rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing.

They may also include non-contact activities, such as involving children in looking at sexual images or grooming a child in preparation for abuse (including via the internet).

Women can also commit acts of sexual abuse, as can other children.

Alerting features:

Ano-genital symptom in a girl or boy that is associated with behavioural change	Hepatitis B or C in under 13s
Sexually transmitted infection	Pregnancy in under 13s

Or consider:

Persistent unexplained ano-genital symptoms	Ano-genital warts (see CG89)
Sexually transmitted infection in 13-15 year olds	Marked power differential in relationship
BEHAVIOUR CHANGES: Sudden changes Inappropriate sexual display Secrecy, distrust of familiar adult, anxiety left alone with particular person Self-harm mutilation / attempted suicide	Unexplained or concealed pregnancy

Neglect

Definition: Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development.

Neglect may occur during pregnancy as a result of maternal substance abuse.
Neglect involves failing to:

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

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

Alerting features:

Abandonment	Repeated injuries suggesting inadequate supervision	Failure to seek medical help appropriately
Repeatedly not responding to child or young person	Persistently smelly or dirty	

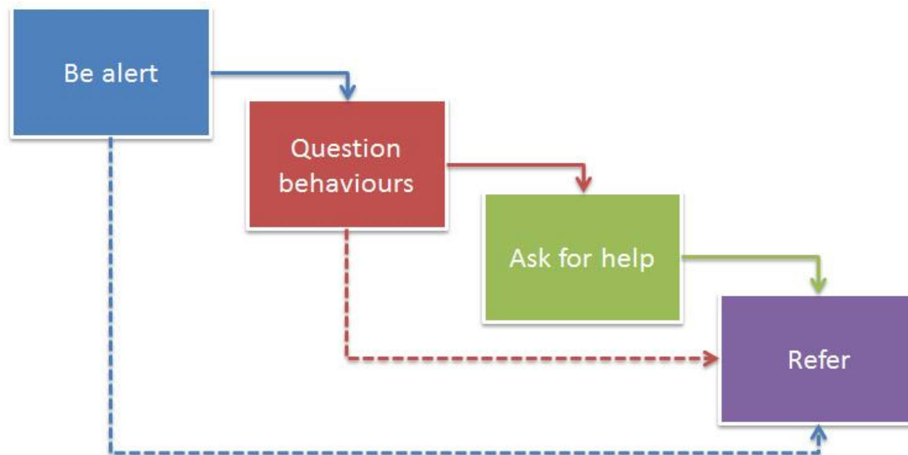
Or consider:

Poor personal hygiene, poor state of clothing	Untreated tooth decay	Poor attendance for immunisations
Frequent severe infestations (scabies, head lice)	Repeated animal bites, insect bites or sunburn	Low self-esteem
Faltering growth (due to poor feeding)	Treatment for medical problems not being given consistently	Lack of social relationships; children left repeatedly without adequate supervision
Parents failing to engage with healthcare, attend appointments (service or wider health professional) and / or use A&E / Out-of-Hours services frequently.		

Patterns of Maltreatment

The previous sections reflect the increasing emphasis on the importance of observation of patterns of possible maltreatment, including the interaction between the parent or carer and the child or young person, as well as physical signs which are inconsistent with their developmental stage (not always the same as the age in months or years) or the explanation given.

There are four key steps all staff, regardless of role, should follow to help to identify and respond appropriately to possible abuse and/or neglect:



A receptionist may be alerted by abuse on the phone or observing altercations in the waiting room.

Providing inappropriate supervision (or none) leading to accidental injury or burns can also be forms of maltreatment.

In addition, there are a number of injury patterns that cause immediate concern in terms of child protection including:

- Multiple bruising, with unusual bruises of different ages;
- Bruising in nonmobile baby, particularly facial bruising;
- Baby rolls over at six months;
- Baby attempts to crawl at eight months.

Common presentations and situations in which child abuse may be suspected include:

- Disclosure by a child or young person;
- Physical signs and symptoms giving rise to suspicion of any category of abuse;
- The history is inconsistent or changes;
- A delay in seeking medical help;
- Extreme or worrying behaviour of a child, taking account of their developmental age;
- Accumulation of minor incidents giving rise to a level of concern, including frequent A&E attendances.

Some other situations which need careful consideration are:

- Disclosure by an adult of abusive activities;
- Girls under 16 presenting with pregnancy or sexually transmitted disease, especially those with learning difficulties;
- Very young girls requesting contraception, especially emergency contraception;
- Situations where parental mental health problems may impact on children;
- Parental alcohol, drug or substance misuse which may impact on children;
- Parents with learning difficulties;
- Violence in the family;
- Unexplained or suspicious injuries such as bruising, bites or burns, particularly if situated unusually on the body;

- The child says that she or he is being abused, or another person reports this;
- The child has an injury for which the explanation seems inconsistent or which has not been adequately treated;
- The child's behaviour changes, either over time or quite suddenly, and he or she becomes quiet and withdrawn, or aggressive;
- Refusal to remove clothing for normal activities or keeping covered up in warm weather;
- The child appears not to trust particular adults, perhaps a parent or relative or other adult in regular contact;
- An inability to make close friends;
- Inappropriate sexual awareness or behaviour for the child's age;
- Fear of going home or parents being contacted;
- Reluctant to accept medical help;
- Not attending medical appointments (Did Not Attend or 'Was Not Brought')
- Fear of changing for PE or school activities.

Female Genital Mutilation

The safeguarding agenda covers Female Genital Mutilation in children and handling concerns for both adults and children under the laws of this country. FGM is illegal in the UK and is an extremely harmful practice. FGM is child abuse, and employers and the professional regulators are expected to pay due regard to the seriousness of breaches of the duty to report.

The legislation required regulated health and social care professionals in England to make a report to the police where, in the course of their professional duties, they either:

- are informed by a girl under 18 that an act an act of FGM has been carried out on her; **or**

- observe physical signs which appear to show that an act of FGM has been carried out on a girl under 18 and they have no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth.

Reports should be made as soon as possible after a case is discovered, and best practice is for reports to be made by the close of the next working day. The only acceptable circumstances where this may be delayed according to official guidance is in exceptional cases where a professional has concerns that a report to the police is likely to result in an immediate safeguarding risk to the child (or another child, e.g. a sibling) and considers that consultation with colleagues or other agencies is necessary prior to the report being made. Failure to comply with the duty to report will be dealt with thorough SHPCA performance policy and procedures. **The FGM Lead for SHPCA is Dr Kathryn Bannell.**

The Government has produced information on FGM and this can be found at:

https://www.gov.uk/government/publications/female-genital-mutilation-resource-pack/female-genital-mutilation-resource-pack

The Royal College of Obstetrics & Gynaecology have produces useful guidelines for Health Professionals:

https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-53-fgm.pdf

This includes guidance on legal responsibilities and data reporting/medical recordkeeping.

Please also refer to the local Hampshire Strategy and guidelines at: https://hipsprocedures.org.uk/zkyysp/harmful-practices-linked-to-faith-or-culture/female-genital-mutilation

Mental Capacity Act 2005 for 16/17-year-olds

When making plans and care or treatment arrangements for 16- and 17-year-olds it is necessary to determine whether the young person (YP) has the capacity to consent to the arrangements that are being made for him/her.

This is essential as the safeguards and steps that need to be put in place may vary if the YP lacks capacity to consent. Practitioners and managers need to be aware of the inter-relationship between the Mental Capacity Act 2005 and other related legislation which include the Children Acts 1989 and 2004, the Children and Families Act 2014, the Human Rights Act 1998, the European Convention on Human Rights and the Mental Health Act. The MCA 2005 does not apply to under 16s but does apply to 16- and 17-year-olds.

The following are the key principles:

- A person (including a YP) is assumed to have capacity. It is not for the person to prove they have capacity but for others to provide evidence that they do not;
- A person must be given all practicable support to help make their own decision
- A person with capacity can make an unwise decision-- if a person understands the consequences of their decisions, it is theirs to make;
- Acts done on behalf of someone who lacks capacity must be in their best interests. When considering best interests it is important to check the. person's previously expressed wishes, feelings, beliefs and to consult with interested others eg family, friends, carers, professionals
- The acts must be done by the least restrictive means: before an act is done or a decision made, it must be considered whether it can be achieved in a way that is less restrictive of the person's rights or freedoms of action. The lack of capacity must arise as a result of an impairment or disturbance in the functioning of the brain or mind (a mental disorder) and may be temporary or permanent.

SPECIFIC RESPONSIBILITIES WITHIN SHPCA

SHPCA Managers	• Will be alert to the potential indicators of abuse or neglect of vulnerable children and know how to act on concerns • Attend relevant training and maintain the skills to recognise abuse, neglect or exploitation and how to report this as per policy. • Seek advice from the key responsible individual or CCG safeguarding team if unsure how to act in response to concerns about a vulnerable adults. • Keep contemporaneous records in accordance with professional and organisational policy. • Ensure staff have appropriate awareness • Temporary staff are aware of safeguarding policy & who to refer to should abuse or neglect be suspected.

	• Ensure appropriate agencies are made aware in the event of criminal activity ie police or Hampshire County Council via the multiagency safeguarding hub if abuse or neglect has or has suspicion of occurring. • Support any requests to respond to statutory reviews/enquiries e.g. Section 42 & Section 44. SHPCA will complete referrals or engage in SAR processes as appropriate with the support of the CCG/ICB. • Domestic Homicide Reviews (DHR) - SHPCA will engage in DHR process as appropriate with the support of the CCG/ICB.
General Practitioners	• Will be alert to the potential indicators of abuse or neglect of vulnerable children and know how to act on concerns • Take immediate steps to ensure the safety of an individual is paramount working within GMC guidelines. • Attend relevant training and maintain the skills to recognise abuse, neglect or exploitation and how to report this as per policy. • Seek advice from the key responsible individual or CCG safeguarding team if unsure how to act in response to concerns about a vulnerable children. • Escalates issues to senior managers or Local Authority/CCG safeguarding team should disagreement arise in relation to how a safeguarding issue is being handled. • Keep contemporaneous records in accordance with professional and organisational policy.

All staff will need to be aware of this policy and new staff will be made aware at induction. Staff also need to be aware of SHPCA Freedom to Speak Up/Whistleblowing Policy.

All Staff	• Will be alert to the potential indicators of abuse or neglect of vulnerable children and know how to act on concerns • Attend relevant training, supervision and maintain the skills to recognise abuse, neglect or exploitation and how to report this as per policy. • Seek advice from the key responsible individual or CCG safeguarding team if unsure how to act in response to concerns about a vulnerable children. • Escalates issues to senior managers should disagreement arise in relation to how a safeguarding issue is being handled. • Keep contemporaneous records in accordance with professional and organisational policy. • Make alerts to the MASH where there is a concern regarding abuse and neglect.

2. Action in response to suspected or alleged abuse

IMMEDIATE ACTION to be taken by staff member: Where abuse of any child or young person is suspected, the welfare of the patient takes priority.

If a child makes an allegation of abuse to you should:

- Stay calm; Listen carefully to what is being said and reassure the child that they have done the right thing by telling you;
- Find an appropriate early opportunity to explain that it is likely the information will need to be shared with others – do not promise to keep secrets;
- Allow the child to continue at his / her own pace;
- Ask questions for clarification only, and at all times avoid asking questions that are leading or suggest a particular answer;
- Tell them what you will do next and with whom the information will be shared;
- **Establish the basic facts**
- **Record in writing what has been said using the child's own words as much as possible** (See guidance at Annex 3)

Do not delay in discussing your concerns. In an emergency and if it is suspected a **child/young person is in immediate danger 999 should always be called. DO NOT put yourself unduly at risk of harm** and all staff should however remember that intervention in cases of assault wherever possible should be with utmost caution and with support from other staff and the Police.

IF YOU HAVE CONCERNS:

- **Discuss concerns without delay** with a peer at the hub where you are working, together you can **make an initial assessment** of the risk to the child/young person and decide if referral is needed to Multi Agency Safeguarding Hub and/or police. The clinician will be responsible for making the referral.

  Following making the referral - inform the on call clinical director of concerns and complete an Incident Form and send to **shpca.complaintsincidents@nhs.net** and to Kathryn.Banell@nhs.net

- **The Clinician should contact the Multi Agency Safeguarding Hub (MASH)** Worried about yourself or a friend - Portsmouth Safeguarding Children Board (portsmouthscp.org.uk)

If an alert is appropriate please call the Multi Agency Safeguarding Hub: 02392 688793.
Out of Office hours (5pm -8am weekdays, weekends and bank holidays) is: 03005 551373

The need for further investigation and enquiry will then rest with the local Children's Safeguarding team and all staff will co-operate with any subsequent enquiries and provide truthful and factual information on request. Non-clinical staff must not however provide any opinion or judgement for which they have no training or experience.

Please log any safeguarding concerns/issues on using SHPCA INCIDENT FORM (at Annex and sent to shpca.complaintsincidents@nhs.net and to Kathryn.Banell@nhs.net

Do not under any circumstances take any action, unless it is immediately necessary to prevent harm, which might alert the perpetrator that their actions have been noted and are in question or would lead to onward referral.

All organisations providing healthcare have a duty outlines in legislation to make arrangement to safeguard and to co-operate with other agencies to protect children and young people at risk from harm, abuse or neglect. In compliance with this the Alliance has the following:

NAMED DOCTOR: Dr Kathryn Bannell is the appointed service clinical safeguarding lead. In her absence Dr Steph Ma acts as deputy.

SHPCA Lead(s) for Safeguarding Children & Young People:

- Implements SHPCA child protection policy;
- Ensures that SHPCA meets contractual guidance;
- Ensures safe recruitment procedures in collaboration with SHPCA HR specialists;
- Engages SHPCA services to establish "You're Welcome" policies -
  (See RCGP Child Health Strategy 2010-2015; http://www.rcgp.org.uk/clinical-and-research/clinical-resources/child-and-adolescent-health.aspx)
- Supports reporting and complaints procedures;
- Advises staff members about any concerns that they have;
- Ensures that staff members receive adequate support when dealing with child protection;
- Leads on analysis of relevant significant events;
- Determines training needs and ensures they are met;
- Makes recommendations for change or improvements in service procedural policy;
- Acts as a focus for external contacts including the named GP;
- Attends CCGs GP Leads Meetings/Training
- Has regular vulnerable person's meetings with others in the primary healthcare team to discuss particular concerns.

Named Nurse: Lee Busher, Head of Governance & Quality. This Lead has a key role in promoting good professional practice within their organisation, providing advice and expertise for fellow professionals, and ensuring safeguarding training is in place.

These are not full-time functions, but instead complement the individual's daily duties. The responsibilities are detailed below.

We recognise that it is our role to be aware of maltreatment and share concerns, but not to investigate or to decide whether or not a child has been abused.

SHPCA will undertake a Risk Assessment of the need for anyone working in SHPCA to undergo a Disclosure and Barring Service (DBS) check based on the role they perform (as opposed to an assessment of the individual). The Risk Assessment will take into consideration any occasions where a staff member has access to children such as minding a child while a patient undergoes an examination or procedure as well as clinical contact.

Safe Recruitment

SHPCA must comply with safe recruitment practice including efficient use of the Disclosure and Barring system with a system in place to repeat the process on a three yearly cycle, including Criminal Records Bureau (CRB) checks for eligible staff and enhanced level checks where appropriate. The safeguarding adults and children responsibility is to be included within all staff job descriptions. As part of our commitment to safe recruitment we ensure that we:

- Detailed application forms
- Robust interviews that cover safeguarding, equality, and diversity knowledge and skills
- Reference checks
- A thorough induction process
- Verification of qualifications and experience
- Risk assessments where indicated

Staff Training

Those working with children and young people and / or parents should take part in clinical governance including holding regular case discussions, training and education. Learning opportunities should be flexible with a multi-disciplinary component.

They include e-learning but also personal reflection and scenario-based discussion, drawing on case studies and lessons from research, critical event analysis, analysis of feedback and complaints and included in appraisal.

All new members of staff will as a minimum undergo in-house training in how to recognise abuse and how to report it or other basic awareness training, including online training and any classroom sessions that may be organised either in-house or by the CCG or Local Authority.

All members of staff will undergo child protection training as part of induction and renewed annually, as follows:

- All Non-Clinical Staff must be at Level 1
- Reception Staff should be at Level 2
- Registered Nurses and HCAs must be at minimum Level 2, working towards Level 3;
- All GPs need to be trained to Level 3
- Named leads must be at Level 4

SHPCA Management team and directly employed clinical staff will ensure they are up to date with the appropriate level of training. All Clinical staff registered to work in SHPCA services on the workforce platform MUST ensure their appropriate level of safeguarding training is up to date, as do any other clinical staff such as GPs working on a Locum basis.

All clinical and non-clinical employed staff are expected to keep up to date with ELfH training and to access any face to face element of training required for their role.

All staff undergoing training will be expected to keep a learning log for their appraisals and or personal development. SHPCA should discuss and record at least one clinical incident each year involving safeguarding children and that discussion should involve as wide a number of roles within SHPCA as possible.

Staff training follows the recommend guidance in: *Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth edition: January 2019*

Whistleblowing – Freedom to Speak Up

Our service recognises the importance of building a culture that allows all our staff to feel comfortable about sharing information, in confidence and with a lead person, regarding concerns they have about a colleague's behaviour. In cases where that issue involves a child or young person, SHPCA recognise the difficulty staff may be placed in and would reinforce the degree of absolute discretion the whistleblowing policy requires.

This will also include behaviour that is not linked to child abuse, but that has pushed the boundaries beyond acceptable limits. Open, honest working cultures where people feel they can challenge unacceptable colleague behaviour and be supported in doing so, help keep everyone safe.

Where allegations have been made against staff, the standard disciplinary procedure and the early involvement of the Local Authority Designated Officer (LADO) may be necessary (*section 11 Children Act 2004*).

Complaints Procedure

SHPCA has a clear procedure that is capable of dealing with complaints from all patients (including children and young people), employee, accompanying adult or parent - *Please refer to SHPCA's 4Cs (Complaints) Policy.*

These guidelines are here to protect children and staff alike. The list below is by no means exhaustive and all staff should remember to conduct themselves in a manner appropriate to their position. Wherever possible, staff should be guided by the following advice. If it is necessary to carry out services contrary to it, you should only do so after discussion with, and the approval of, your service/line manager.

- You must not ignore unacceptable behaviour and should challenge it – accepting that there may be occasions when to do so directly may not be possible;
- Provide an example of good conduct you wish others to follow;
- Respect a young person's right to personal privacy and encourage children, young people and adults to feel comfortable to point out attitudes or behaviours they do not like;
- Involve children and young people in decision-making as appropriate;
- Be aware that someone else might misinterpret your actions;
- Don't engage in or tolerate any bullying of a child, either by adults or other children;
- Never promise to keep a secret about any sensitive information that may be disclosed to you, but do follow SHPCA guidance on confidentiality and sharing information;
- Never offer a lift to a young person in your own car;
- Never exchange personal details such as your home address with a young person;
- Don't engage in or allow any sexually provocative games involving or observed by children, whether based on talking or touching;
- Never display favouritism or reject any individuals.

Service Systems and Early Help

Good practice recommendations include:

- New child registrations – check names of parents or carers, school, social care involvement;
- Scan (and appropriately code) reports from other agencies into the child's notes;
- Follow-up repeated attendances at Accident and Emergency;
- Follow-up repeated missed appointments.
- See also 'recording information' Section.

Reactive Measures

While every precaution may be taken to prevent an incident from occurring, we recognise that thorough and professional reactive measures are necessary. The following procedures set out the steps to be taken with respect to any concerns relating to child protection.

Managing Disclosure of an Allegation of Abuse by a Person in Position of Trust

If a child makes allegations about abuse, whether concerning themselves or a third party, our employees must immediately pass this information on to the Clinical Lead and the Local Authority Designate Officer (LADO – see further information below) and follow the child protection procedures below.

It is important to also remember that it can be more difficult for some children to tell than for others. Children who have experienced prejudice and discrimination through racism may well believe that people from other ethnic groups or backgrounds do not really care about them. They may have little reason to trust those they see as authority figures and may wonder whether you will be any different.

Children with a disability, especially a sensory deficit or communication disorder, will have to overcome barriers before disclosing abuse. They may well rely on the abuser for their daily care and have no knowledge of alternative sources. They may have come to believe they are of little worth and simply comply with the instructions of adults.

When responding to a child making an allegation of abuse:

- Stay calm;
- Listen carefully to what is being said;
- Reassure the child that they have done the right thing by telling you;
- Find an appropriate early opportunity to explain that it is likely the information will need to be shared with others – do not promise to keep secrets;
- Allow the child to continue at his / her own pace;
- Ask questions for clarification only, and at all times avoid asking questions that are leading or suggest a particular answer;
- Tell them what you will do next and with whom the information will be shared;
- Record in writing what has been said using the child's own words as much as possible – note date, time, any names mentioned, to whom the information was given and ensure that paper records are signed and dated, and electronic subject to audit trails;

Do not delay in discussing your concerns and if necessary, passing this information on to SHPCA safeguarding lead and the Local Authority Designated Officer

Local Authority Designated Officer (LADO)

If you believe that a child has been harmed by a person in a position of trust, you should contact the Local Authority Designated Officer (LADO) on 01962 876364

The LADO should be advised of all cases where it is alleged that a person who works with children has:

- Behaved in a way that has harmed, or may have harmed, a child.
- Possibly committed a criminal offence against, or related to, a child.
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

A person in a position of trust includes anyone who works with children in the course of their employment or in a voluntary capacity.

Confidentiality

In order to do their jobs, members of staff need access to confidential (perhaps highly sensitive) information about children and young people. To effectively ensure that all relevant information is available to appropriate persons at all times, no records relating to child abuse or protection will be maintained separately from the main clinical record.

These details must be kept confidential within the clinical team at all times and only shared when it is in the interests of the child to do so and ensuring that – when domestic violence is involved – risk of harm to the non-abusive parent is not increased, and taking care to ensure that no humiliation or embarrassment is suffered by the child.

If an adult who works with children is in any doubt about whether to share information or keep it confidential, he or she should seek guidance from SHPCA safeguarding lead. Any actions should be in line with locally agreed information sharing protocols, and the Data Protection Act applies.

Whilst adults need to have an awareness of the need to listen and support children and young people, the importance of not promising to keep secrets or never requesting this of a child or young person must also be understood.

Additionally, concerns and allegations about adults should be treated as confidential and passed to a designated or appointed person or agency without delay.

In general, if a person decides to disclose confidential information without consent, they should be prepared to explain and justify their decision and they should only disclose as much information as is necessary for the purpose. The medical defence organisation will be consulted in all cases.

Physical Contact

A parent or carer should be present at all times, or a chaperone offered. Children should only be touched under supervision and in ways which are appropriate to, and essential for clinical care.

Permission should always be sought from a child or young person before physical contact is made and an explanation of the reason should be given, clearly explaining the procedure in advance.

Where the child is young, there should be a discussion with the parent or carer about what physical contact is required. Regular contact with an individual child or young person is normally part of an agreed treatment plan and should be understood and agreed by all concerned, justified in terms of the child's needs, consistently applied and open to scrutiny

Physical contact should never be secretive or hidden. Where an action could be misinterpreted, a chaperone should be used or a parent fully briefed beforehand, and present at the time.

Where a child seeks or initiates inappropriate physical contact with an adult, the situation should be handled sensitively and a colleague alerted.

ATTITUDE OF PARENTS OR CARERS

Parental attitude may indicate cause for concern:

- Unexpected delay in seeking treatment; missed appointments;
- Denial of injury pain or ill-health;
- Incompatible explanations, different explanations or the child is said to have acted in a way that is inappropriate to his/her age and development;
- Reluctance to give information or failure to mention other known relevant injuries;
- Unrealistic expectations or constant complaints about the child;
- Alcohol misuse or drug/substance misuse;
- Violence between adults in the household;
- Appearance or symptoms displayed by siblings or other household members.

Records

Staff should be vigilant in the instance of multiple short-term temporary registrations for the same child, especially if consecutive. In the event of concern the permanent GP or practice should be contacted.

Medical Record

A record of the facts giving rise to the suspicion must be made and signed by the person reporting the issue as soon as possible and an alert placed on the clinical system. The original statement must be kept secure and a scanned copy placed on the clinical record.

This statement will constitute a third party reference and must not be disclosed to the patient or others not involved in the investigation should a subject access request ever be made.

The medical record relating to child protection issues may also include clinical photography / video recordings, and it is recommended that a significant event form be utilised within the medical record where a clinician identifies issues leading to increasing concern for the patient, or where an event occurs of particular note.

Other aspects which may be recorded are:

- Evidence of abuse;
- Criminal offences;
- A&E attendances;
- Child protection plan;
- Case Conferences;
- Meetings;
- Drug / substance abuse;
- Mental health issues;
- Non-attendance at meetings or appointments;
- Hostility or lack of cooperation;
- Cumulative minor concerns;

Where a safeguarding concern is raised for a child presenting at an SHPCA service, the registered practice of the child should also be informed within 24 hours. This is regardless of whether the information is recorded by the reporting individual directly into the practice clinical record on EMIS. Staff should be aware of Safeguarding alerts on records for Looked After Children and Children on CPP (Child Protection Plan).

Data Protection

Current guidance suggests that written records relating to child protection issues should be stored as part of the child's permanent medical records, either manually or on computer, or both - a change to previous guidance.

SHPCA should be alert to the fact that this guidance may be reviewed or amended in the future and must seek the guidance of the CCG and Child Protection staff of the Local Authority in all instances. SHPCA will have permanent access to the local child protection instructions as part of the routine CCG Safeguarding pathway procedures.

As a normal part of compliance with the data protection act it is likely that third party information will be stored within these records, and the normal duty of non-disclosure of this third party information may apply when information is to be released – it may be appropriate at such times to take advice.

Referral

In the first instance, and if the risk to the child is not increased by doing so (situations such as sexual abuse or fabricated & induced illness might increase risk; consult local guidance), the health professional or service lead for child protection will inform the child and accompanying carer / parent that you need to discuss or report your concern.

When the child concerned is not a patient of SHPCA, the policy is to speak to SHPCA lead, who should pass that information in accordance with the disclosure of information requirements.

Best practice is to inform parents/carers of your concerns and next steps unless to do so may put the child or yourself at risk. As a general rule, you should contact the child social care services first unless the issue is more immediate and the child is indeed of immediate medical attention or support from the police.

The contribution of GPs to safeguarding children is invaluable and priority should be given to attendance and sending a report wherever possible.

GPs may claim a fee for attendance at Child Protection Conferences, under the Collaborative Arrangements for Work for Local Authorities 1974, to defray their expenses – this is currently being considered in the HIPS area and GPs should refer to the CCG or Local Medical Committee for details. Consider liaising with your health visitor and school nurses in addition about your attendance.

No delay should occur in the provision of information while payment is sought. Even if attendance is not possible or judged necessary, the provision of the report, even to say that the child has not been seen, is essential. (*GMC Protecting children and young people 2011*).

General Points for Preparing Reports for Child Protection Conferences

The Assessment Framework Tool recommends a triangle model of assessment:

- Child's developmental needs;
- Parenting capacity;
- Family & environmental factors.

Consider:

Missed appointments with GP, service nurse and midwife	Parental mental health or substance abuse	Are both parents registered with your service?
Failed immunisations	Ability of the carer to parent [disability, physical or intellectual]	Who has parental responsibility?
Missed hospital appointments	Evidence of domestic violence	Sharing the report with the child if old enough and the parents where appropriate.
Education: discuss with school nurse or health visitor	Cruelty to animals in the family	

Recording Information

- Concerns and information about vulnerable children should be recorded in the child's notes and, where appropriate, the notes of siblings and significant adults. These should be recorded using agreed read codes. The GMC document 'Protecting children and young people: guidance for doctors', advises doctors to record minor concerns, as well as their decisions and information given to parents/carers.
- Concerns and information from other agencies such as social care, education or the police or from other members of the primary care team, including health visitors and midwives, should be recorded in the notes under a read code.
- Email should only be used when secure, [e.g. nhs.net to nhs.net] and the email and any response(s) should be copied into the record.
- Conversations with and referrals to outside agencies should be recorded under an appropriate read code.
- Case conference notes may be scanned in to electronic patient records as described below. This will usually involve the summary / actions, appropriately annotated by the child's usual doctor or service safeguarding lead.
- Records, storage and disposal must follow national guidance.
- If information is about a member of staff this will be recorded securely in the staff personnel file and in line with your own jurisdiction guidance.

Consideration should be given to recording the following information in the child record.

- Record of abuse in the child or any other child in the household;
- Record of whether the child or any other child in the household is or has been subject to a child protection plan;
- Observed and alleged harmful parent – child interactions;
- Basic family details (e.g. adults in the family, other siblings etc., including individuals who may not live at the address but who have regular contact with the child e.g. father, grandparents);
- Details of any housing problems;

- Details of significant illness or problems in the family, such as parental substance misuse or mental illness;
- History of domestic abuse in the household;
- House fires;
- Ante-natal concern;
- Multiple new registrations;
- Multiple consultations, especially emergencies.

Information can be sought and entered from:

- The new patient health checks on all children, including enquiry about family, social and household circumstances.
- Any contact with a potential carer – 'seeing the child behind the adult' – so that a patient with a substance misuse problem for example is asked about any responsibility they may have for a child, and that child's record amended accordingly, with a relevant code so that such families' progress can be reviewed.
- Opportunistic consultations:
  - Antenatal booking.
  - Postnatal visit.
  - 6 week check.
- Service team meetings, where regular discussion of all service children subject to child protection plans, or any other children in whom there may be concerns, should highlight safeguarding issues in children and their families.
- Correspondence from outside agencies, such as A&E/OOH reports and other primary and secondary care providers.

Case conference minutes frequently raise concerns because of their size and content (much of it about third parties). They should be processed and stored in the following way:

	Read code significant details	**Scan in summary**	**Scan in full minutes**
Child (subject of conference)	Yes	Yes	Yes*
Adults & other household members named in report	Yes	Yes	No

The minutes should be read by the relevant GP. If the minutes contain a majority of pertinent information that other professionals are likely to need to know, particularly where they are taking the case on cold (such as a locum, or GP receiving the patient on a transfer) then the full minutes can be scanned.

If there is little pertinent information, this should be entered as free text notes on the child's record. Following either the scanning, or entry of pertinent information, the paper copy should be securely disposed of (e.g. shredded).

Conference minutes should not be stored separately from the medical records because:

- They are unlikely to be accessed unless part of the record.
- They are unlikely to be sent on to the new GP should the child register elsewhere.
- They may possibly become mislaid and lead to a potentially serious breach in patient confidentiality.

Whilst GPs may have concerns about third party information contained in case conference minutes, part of the solution is to remove this information if copies of medical records are released for any reason, rather than not permitting its entry into the medical record in the first place.

These procedures are regarded as best practice, but as they may vary between UK jurisdictions, you are advised to consult local CCG / LMC policies for further details.

3. Sharing Information

The default position is that SHPCA will share information with Social Care as it recognises that not doing so maybe legally indefensible.

SHPCA will implement the following policy on sharing information in child protection cases:

- In England and Wales, GPs have a statutory duty to co-operate with other agencies (Children Act 1989 section 27, 2004 section 11) if there are concerns about a child's safety or welfare.

  CCGs (*section 47.9*) have a duty to assist local authorities (Social / Childcare Services) with enquiries; Named Doctors for child protection can be powerful advocates for this function.
- The Children, Schools and Families Act 2010 (section 8) amends The Children Act 2004 providing further statutory requirements for information sharing when the LSCB requires such information to allow it to carry out its function.

General principles for sharing information

1. The 'Seven Golden Rules' of information sharing as set out in the government guidance, *Information Sharing: Pocket Guide* is applicable to all professionals charged with the responsibility of sharing information, including in child protection scenarios:
2. ***The Data Protection Act is not a barrier to sharing information*** but provides a framework to ensure personal information about living persons is shared appropriately.
3. ***Be open and honest*** with the person/family from the outset about why, what, how and with whom information will be shared and seek their agreement, unless it is unsafe or inappropriate to do so.
4. ***Seek advice*** if you have any doubt, without disclosing the identity of the person if possible.
5. ***Share with consent where appropriate*** and where possible, respect the wishes of those who do not consent to share confidential information. You may still share

information without consent, if, in your judgement, that lack of consent can be overridden by the public interest. You will need to base your judgement on the facts of the case.

6. ***Consider safety and well-being***, base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.
7. ***Necessary, proportionate, relevant, accurate, timely and secure***, ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up to date, is shared in a timely fashion and is shared securely.
8. ***Keep a record of your concerns, the reasons for them and decisions*** - whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

General Medical Council Guidance

http://www.gmc-uk.org/guidance/ethical_guidance/13257.asp
http://www.gmc-uk.org/guidance/ethical_guidance/13382.asp

The General Medical Council offers guidance on recording of allegations and Confidentiality and Information Sharing which is regularly reviewed and advises that the first duty of doctors is to make the care of their patients their first concern:

- When treating children and young people, doctors must also consider parents and others close to them, but the patient must be the doctor's first concern.
- When treating adults who care for, or pose risks to, children and young people, the adult patient must be the doctor's first concern, but doctors must also consider and act in the best interests of children and young people.

Consent should be sought to disclosures unless:

- That would undermine the purpose of the disclosure [such as fabricated & induced illness and sexual abuse]
- Action must be taken quickly because delay would put the child at further risk of harm
- It is impracticable to gain consent

When asked for information about a child or family, Service staff should consider the following:

- Identity, check identity of the enquirer to see if they have a bona fide reason to request information. Call back the switchboard or ask for a faxed request on headed notepaper
- Purpose, ask about the exact purpose of the inquiry. What are the concerns?

- Consent, does the family know that there are enquiries about them? Have they consented and if not why not? Consent is not necessary if there is felt to be a risk of harm to the child from seeking it. Receiving a signed consent form from social services does not imply consent given to you to share. If this doesn't cause harmful delay, you may also wish to seek consent from the family
- Need-to-know basis, give information only to those who need to know
- Proportionality, give just enough information for the purpose of the enquiry and no more. This may mean relevant information about parents/carers
- Keep a record, make sure that you record the details of the information sharing, including the identity of the person you are sharing information with, the reason for sharing and whether consent has been obtained and if not why not.

GMC advice includes:

- Sharing information with the right people can help to protect children and young people from harm and ensure that they get the help they need. It can also reduce the number of times they are asked the same questions by different professionals. By asking for their consent to share relevant information, you are showing them respect and involving them in decisions about their care
- If a child or young person does not agree to disclosure there are still circumstances in which you should disclose information:
  a) When there is an overriding public interest in the disclosure.
  b) When you judge that the disclosure is in the best interests of a child or young person who does not have the maturity or understanding to make a decision about disclosure.
  c) When disclosure is required by law.

Restraint Policy also known as 'Positive Handling Policy'

Restraint is where a child is being held, moved or prevented from moving, against their will, because not to do so would result in injury to themselves or others, or would cause significant damage to property.

Restraint must always be used as a last resort, when all other methods of controlling the situation have been tried and failed.

Restraint should never be used as a punishment or to bring about compliance (except where there is a risk of injury).

Only employees who are properly trained in restraint techniques should carry it out.

A person should be restrained for the shortest period necessary to bring the situation under control.
The Prevent Programme is a national strategy which aims to stop people from becoming violent extremists or supporting terrorism. It is designed to safeguard people from extremism in a similar way to safeguarding processes to protect people from gang activity, drug abuse,

and physical and sexual abuse. Prevent aims to deal with all forms of extremism including Far Right racist extremism, animal rights extremism and religious extremism.

The Counter Terrorism and Security Act 2015 introduced a duty on the NHS in England. Healthcare staff will meet and treat people who may be drawn into terrorism. Further information is available here: http://www.hampshirepreventboard.org.uk/

If concerns are raised about the child or young person and radicalisation/violent extremism, the referral process should be followed. This can be found at https://hipsprocedures.org.uk/qkyylh/children-in-specific-circumstances/safeguarding-children-and-young-people-against-radicalisation-and-violent-extremism

See ANNEX 4 for Information on reporting concerns regarding radicalisation,

Channel is the process that supports people at risk of being drawn towards terrorism or violent extremism.

In law, the responsibility for ensuring that this Safeguarding Children and Young Persons Policy is reviewed and implemented belongs to the Directors.

SHPCA have decided to delegate this responsibility to:

Dr Kathryn Bannell

This policy has been reviewed and accepted.

Signed by: ____

Date: _____________________________

Signed: ____
on behalf of the

The aim of this document is to ensure that, throughout SHPCA, children are protected from abuse and exploitation. This work may include direct and indirect contact with children (access to patient's details, communication via email, text message / phone).

We aim to achieve this by ensuring that we are a child-safe service.

SHPCA follows the guidelines suggested in the revised version of the GMC document "*Raising and acting on concerns about patient safety*", effective 12 March 2012.

We are committed to a best practice which safeguards children and young people irrespective of their background, and which recognises that a child may be abused regardless of their age, gender, religious beliefs, racial origin or ethnic identity, culture, class, disability or sexual orientation.

As an organisation, we have a duty of care to protect the children we work with and for. Research has shown that child abuse offenders target organisations that work with children and then seek to abuse their position. This policy seeks to minimise such risks.

In addition, this policy aims to protect individuals against false allegations of abuse and the reputation of SHPCA and professionals. This will be achieved through clearly defined procedures, code of conduct, and an open culture of support.

We are committed to implementing this policy and the protocols it sets out for all staff and SHPCA will provide learning opportunities, and make provision for appropriate child protection training to all staff.

This policy will be made widely accessible to staff and reviewed annually.

This policy addresses the responsibilities of all service employees and those with whom we have arrangements. It is the responsibility of SHPCA manager and safeguarding lead to brief staff on their responsibilities under the policy.

For employees, failure to adhere to the policy could lead to dismissal or constitute gross misconduct. For others (volunteers, supporters, donors, and partner organisations) their individual relationship with SHPCA may be terminated.

To achieve a child-safe service, employees and partners (independent contractors, volunteers, and the wider primary care team members) need to be able to:

- Describe their role and responsibility
- Describe acceptable behaviour
- Recognise signs of abuse
- Ensure service systems work well to minimise missing vital information or delay in communication
- Describe what to do if worried about a child or a pregnant woman or a family
- Respond appropriately to concerns or disclosures of abuse

- Minimise any potential risks to children
- Ensure that all information relating to Child Protection issues is regularly updated in the relevant patient record, with appropriate alerts being added to (and removed from) the records of the child/family member.

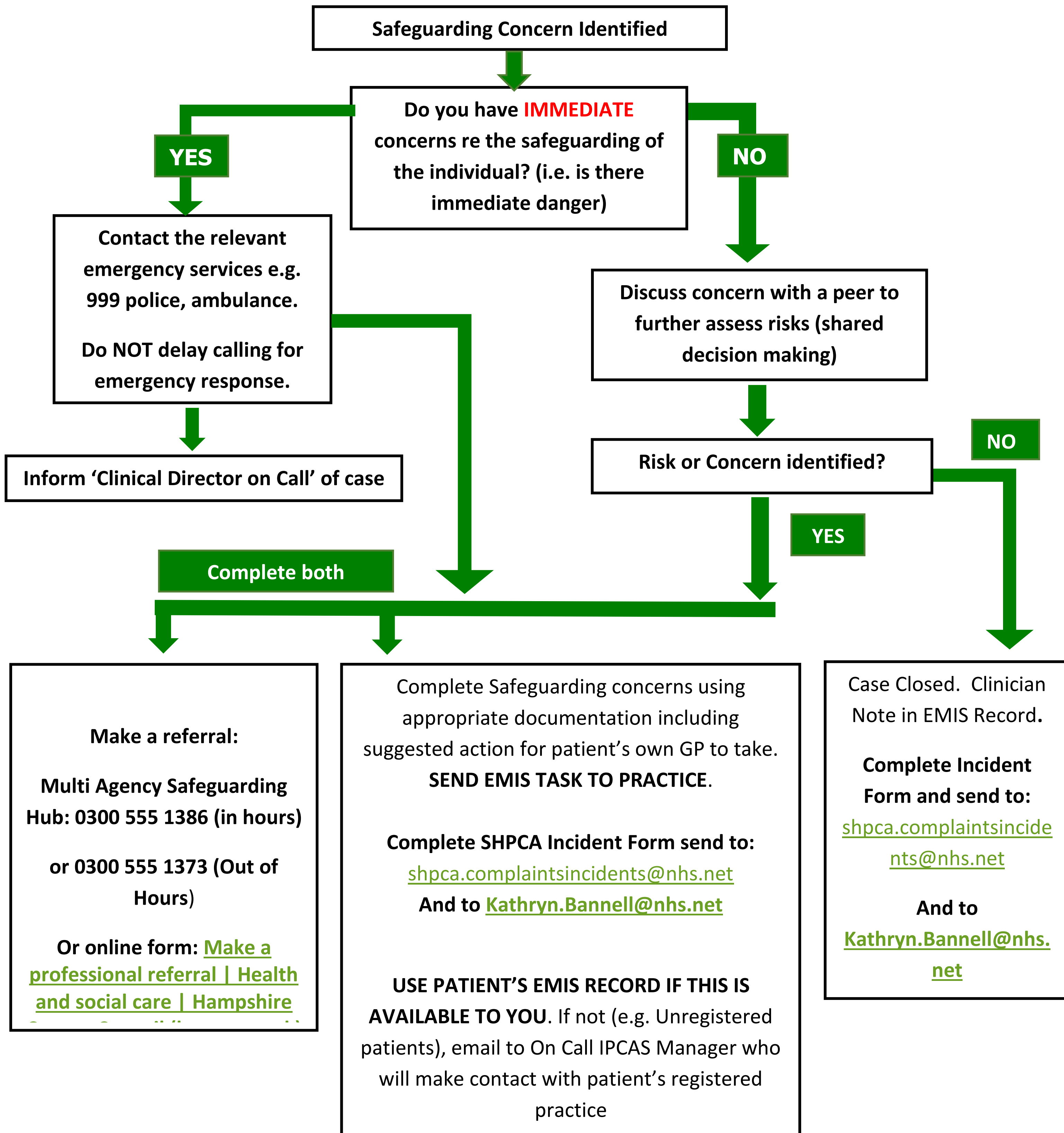
The Read Codes for alerts in use in SHPCA are:

13IS - Child in need
13Id - On Child Protection Register
13IV - Child is classed as a 'Looked after Child' (may still be living with a parent)
13IO - Child has been removed from the Register

The code **13IM** - Child on Child Protection Register will not be used on the record for the child (use **13Id** above); however it may be used on a parent's / guardian's record to indicate that they have a child who is on the register.

Note: reference in the Read Coding system to "Register" is assumed to identify children at risk under the recent guidance. These read codes may need to be reviewed and amended once SNOMED is adopted

ANNEX 2a - REPORTING CONCERN PROCESS



Southern Hampshire PRIMARY CARE ALLIANCE

ANNEX 2C – Incident Reporting Form

<table>
<tr><td colspan="2">SIGNIFICANT EVENT/INCIDENT REPORTING FORM
Reporting incidents is important to protect patients from avoidable harm by increasing opportunities for the SHPCA to learn and where we can make improvements to the services.</td></tr>
<tr><td colspan="2">Please use this form to record events and incidents. Please note this document is subject to confidentiality requirements and should be handled accordingly.
Please email completed form to shpca.complaintsincidents@nhs.net and copy in Head of Governance lee.busher3@nhs.net</td></tr>
<tr><td colspan="2">YOUR INFORMATION</td></tr>
<tr><td>Name:</td><td></td></tr>
<tr><td>Role:</td><td></td></tr>
<tr><td>Contact details:</td><td></td></tr>
<tr><td colspan="2">DETAILS OF EVENT/INCIDENT</td></tr>
<tr><td>Date of event/incident:</td><td></td></tr>
<tr><td>Location of event/Service involved:</td><td></td></tr>
<tr><td>NHS Number/Case number:</td><td></td></tr>
<tr><td>Patient's Registered GP:</td><td></td></tr>
<tr><td>Who was the event/ incident reported to:</td><td></td></tr>
<tr><td colspan="2">Outline of event (Box will expand):
(Describe what happened including names of other people involved, did the event/incident involve factors such as knowledge skills and performance, patient or staff safety, equipment, communication, partnership & teamwork)</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td>Please categorise the incident – please select the ONE that is most relevant</td><td>[ ] Patient or clinical.
[ ] Premises or working environment
[ ] Administration
[ ] Information Technology or telephony
[ ] Medical Device
[ ] Abusive aggressive behaviour
[ ] Documentation
[ ] Infection Control Incident
[ ] Medication or prescribing</td></tr>
<tr><td>What is the degree of harm or risk to patient(staff) Please use scoring matrix as below.</td><td>[ ] No harm / Near Miss
[ ]Minor [ ]Moderate
[ ]Major [ ]Catastrophic</td></tr>
</table>

(Likelhood X Level of Harm)	
Immediate Actions taken:	
Learning Points Identified: (Consider: what learning needs have been highlighted by the incident, what went well: what could have been done better?)	
Duty of candour: (Consider: Does this apply, who is responsible for taking action. has this been actioned?)	**Yes/No/Not Applicable**
Feedback to person who reported undertaken:	
Any other reflections on the event/incident:	
Signed by reporting person	
Date	
Signed by person closing incident	
Date	
(If applicable) was incident reported on Quasar? **Quasar reference no:**	

It is vital that a written record of any incident or allegation of abuse (or crime) is made as soon as possible after the information is obtained. Written records must reflect as accurately as possible what was said and done by the people initially involved in the incident. The notes must be kept safe as it may be necessary to make records available as evidence and to disclose them to a court.

An accurate record should be made at the time, including:

- Date and time of the incident
- Exactly what the person at risk said, using their own words (their account) about the abuse and how it occurred or exactly what has been reported to you
- Appearance and behaviour of the person at risk
- Any injuries observed
- Name and details of any witnesses
- Any witness to the incident should write down exactly what they saw
- The record should be factual, but if it does contain opinion or an assessment, it should be clearly stated as such and be backed up by factual evidence
- Information from another person should be clearly attributed to them
- Name and signature of the person making the record.

A record of the facts giving rise to the suspicion must be made and signed by the person reporting the issue as soon as possible and an alert placed on the clinical system. The original statement must be kept secure and a scanned copy placed on the clinical record. This statement will constitute a third party reference and must not be disclosed to the patient or others not involved in the investigation should a subject access request ever be made.

The medical record relating to child protection issues may also include clinical photography / video recordings, and it is recommended that a significant event form be utilised within the medical record where a clinician identifies issues leading to increasing concern for the patient, or where an event occurs of particular note.

Other aspects which may be recorded are:

- Evidence of abuse;
- Criminal offences;
- A&E attendances;
- Child protection plan;
- Case Conferences;
- Meetings;
- Drug / substance abuse;
- Mental health issues;
- Non-attendance at meetings or appointments;
- Hostility or lack of cooperation;
- Cumulative minor concerns;

Where a safeguarding concern is raised for a child presenting at an SHPCA service, the registered practice of the child should also be informed within 5 working days. This is regardless of whether the information is recorded by the reporting individual directly into the practice clinical record

Hampshire Safeguarding Children Partnership (HSCP) is the key statutory body overseeing multi-agency child safeguarding arrangements across Hampshire (excluding Portsmouth, Southampton and the Isle of Wight, which have their own Boards). The work of the HSCB is governed by statutory guidance Working Together to Safeguard Children 2018.

Section 14 of the Children Act 2004 sets out the statutory objectives of Local Safeguarding Children Boards, which are:

- To coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
- To ensure the effectiveness of what is done by each such person or body for those purposes.

The Board's work is underpinned by two key principles:

- Safeguarding is everybody's responsibility – for services to be effective each professional and organisation should play their full part
- A child centred approach – for services to be effective they should be based on a clear understanding of the needs and views of the individual children whilst recognising the support parents and carers may require.

WEBSITE: https://www.hampshirescp.org.uk/

CONTACTING Hampshire Children's Services

Public phone number: 0300 555 1384

Professionals should complete the online interagency referral form. For urgent Child protection enquiries, Professionals can phone: 01329 225379

All immediate safeguarding concerns should be made initially by telephone to the Children's Services Professionals line 01329 225379 or by email to csprofessional@hants.gov.uk.

Calls to the Children's Services Professionals line number will be automatically redirected to the Out of Hours Service outside normal office hours.
Please have a completed referral form to hand. In circumstances where this is not possible a referral form should follow ASAP.

The 4LSCB safeguarding procedures will provide you with further guidance on your duty to refer.

Supporting Resources used/referred to when contacting Children's Services:

- HSBC Threshold Chart
- HSBC Neglect Thresholds Chart and Online Toolkit
- HSBC Unidentified Adults Toolkit

Southern Hampshire
PRIMARY CARE ALLIANCE

Preventing terrorism and radicalisation within our communities

What is Prevent?

Prevent is the name given to a national strategy which aims to stop people from becoming violent extremists or supporting terrorism. Channel is the process that supports people at risk of being drawn towards terrorism or violent extremism.

All forms of extremism

Prevent aims to deal with all forms of extremism including Far Right racist extremism, animal rights extremism and religious extremism.

By raising your concerns and making a referral, you can help someone who you believe is at risk of radicalisation get support, and can prevent them becoming involved in potentially violent activities, long before any criminal activity occurs.

Signs of possible radicalisation

- Notable changes in behaviour/mood
- May begin to express extreme political or radical views
- Appear increasingly sympathetic to terrorist acts
- Appearance may change
- Friends may change and may spend excess time on their own or on the internet

Making a referral

You can speak to your supervisor or Prevent lead about any concerns, or contact one of the numbers below. If the concern is about an individual, refer to the numbers below or in an emergency call the police on **999**.

Local safeguarding contacts

Portsmouth
Children: 0845 6710271
Adults: 02392 688613

Isle of Wight
Children: 01983 814545
Adults: 01983 814980

Southampton
Children: 02380 833336
Adults: 02380 833003

Hampshire
Children: 0300 5551384
Adults: 0300 5551386

Further information

Home Office
www.gov.uk/government/organisations/home-office

Prevent Board
www.hampshireiowpreventboard.org.uk

Anti-terrorism hotline 0800 789321

Crimestoppers 0800 555111

General Medical Council – Protecting Children & Young People - http://www.gmc-uk.org/static/documents/content/Protecting_children_and_young_people_-_English_1015.pdf

RCGP – Toolkit for General Practice- http://www.rcgp.org.uk/clinical-and-research/toolkits/the-rcgp-nspcc-safeguarding-children-toolkit-for-general-practice.aspx

CQC – Mythbusters and general guidance - http://www.cqc.org.uk/news/stories/cqc-updates-information-safeguarding-children-adults-england

http://www.cqc.org.uk/guidance-providers/gp-services/nigels-surgery-33-safeguarding-children

Royal College of Paediatrics and Child Health www.rcpch.ac.uk

ANNEX 3 – Reference list which contains key statutory guidance

- The Care Act 2014 (updated 2016 DOH)
- Local Government Documents – Making Safeguarding Personal (2014)
- GMC 2009 & NMC web Sites guidelines on confidentiality
- The Mental Capacity Act 2005 code of practise
- Children Act 1989 / 2004
- Working Together to Safeguard Children (2015)
- Promoting the Health and Well-being of Looked After Children (2015)
- 4LSAB Safeguarding Adults. Multi-Agency policy, guidance and toolkit. (Hampshire, Isle of Wight, Portsmouth and Southampton Safeguarding Boards) May 2015
- NHS England Prevent Training And Competencies Framework (2015)
- Safeguarding Policy NHS England (2015)
- NICE Guidance Looked After Children (2013)