




Safeguarding Children and Young People Policy

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Policy context

- This policy and procedure is consistent with and is applied in conjunction with the national statutory guidance given by “*Working Together to Safeguard Children (2018)*” and with the Child Protection Procedures of the Local Safeguarding Children Partnership LSCP (LSCP) serving the area in which the child normally resides. For the majority of our service users this will be either Birmingham LSCP or Solihull LSCP.

Policy requirement (see Section 2)

- This policy applies to all staff and volunteers across all BSMHFT services working with children, young people and adult service users and carers. All staff and volunteers are required to be aware of regional and national policy and guidance on safeguarding and promoting the welfare of children and must follow such policy and guidance in all cases when the safety or welfare of a child or young person (including unborn children) may be compromised.
- All members of staff have an individual duty to safeguard and promote the welfare of children.

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1.0 INTRODUCTION

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

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

(Working Together to Safeguard Children, 2018)

1.1 Rationale

- 1.1.1 Section 11 of the Children Act (2004) places a statutory duty on organisations and individuals to safeguard and promote the welfare of children. Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) is committed to promoting the safety and well-being of Children and young people (0-18 years). This policy outlines the legislation, principles and values that inform the practice of mental health staff that come into contact with or deliver mental health services to children, young people and their parents/carers.

1.2 Scope

- 1.2.1 This policy applies to all BSMHFT staff, agency staff, volunteers and other staff who in the course of their duties have contact with children and their families or who acquire information in relation to any child and their family.

- 1.2.2 Children and Young People affected by this Policy:

This policy applies to all children and young people up until 18 years of age, and includes:

- children and young people receiving services from BSMHFT as an inpatient or outpatient
- children who are already supported by the local authority on Child Protection plans and those who are children in care
- unborn children of service users who are pregnant or expectant fathers;
- children of service users whether living in the same household or not;
- children who are related to service users e.g. grandchildren, nephews, nieces, siblings, step-children, foster children;
- children who live in households shared with, or visited by, service users;
- any child who may have contact with a perpetrator about whom a service user has disclosed past abuse;
- children involved in private fostering arrangements;

- any other children not covered above who may be at risk from a service user e.g. service users in contact with children through paid employment or children of staff members who have child abuse allegations made against them;
- any child that staff consider to be at risk.

1.2.3 This policy and procedure is consistent with and applied in conjunction with the national statutory guidance given by “*Working Together to Safeguard Children (2018)*” and with the Child Protection Procedures of the Local Safeguarding Children Partnership (LSCP) serving the area in which the child normally resides. For the majority of our service users this will be either Birmingham LSCP or Solihull LSCP. Within the West Midlands, there are nine local areas that collaborate with regards to child safeguarding procedures.

1.3 Principles

1.3.1 Safeguarding and promoting the welfare of children and young people is everyone's business.

1.3.2 BSMHFT has a statutory duty under section 11 of the Childrens Act 2004, to protect children from harm as part of the wider work of safeguarding and promoting the welfare of children.

1.3.3 BSMHFT has a duty of care to ensure robust arrangements are in place to ensure the safeguarding of children. BSMHFT works in partnership with LSCPs.

1.3.4 This policy is to be read in conjunction with BSMHFT safeguarding standards (please see Appendix 4) These standards provide a supporting framework which clarify safeguarding expectations).

1.3.5 BSMHFT is committed to ensuring best practice with regard to promoting the wellbeing and the protection of children.

1.3.6 All BSMHFT staff, who come into contact with children and young people, accept a shared responsibility to work jointly across agencies to achieve the best outcomes for children and young people.

1.3.7 All staff and volunteers must be aware that the right of a child to be protected from abuse or neglect will always override the needs or wishes of any adult. This duty takes precedence and will not be compromised by our responsibilities to any adult under our care.

1.3.8 All staff must be aware of their duty to manage the specific risks and issues that mental ill health and/or substance misuse and domestic abuse may present to children, when working with service users who are parents and carers. This would include ensuring that children’s welfare and development are considered

and safeguarded and this is included within adult assessments, risk management formulations and care plans.

1.3.9 All staff must take account of cultural and diversity issues relating to service users and their family and any impact this might have on any safeguarding concerns.

1.3.10 The organisation positively supports individuals with learning disabilities and ensures that no-one is prevented from accessing the full range of mental health services available. Staff will work collaboratively with colleagues from learning disabilities services and other organisations, to ensure that service users and that both child and adult carers have a positive episode of care whilst in our services. Information is shared appropriately to support this.

2.0 POLICY

2.0.1 Everyone has a responsibility to keep children and Young People Safe

The purpose of this policy is to ensure that all staff are aware of:

- their individual responsibilities in relation to the safeguarding of unborns, children and young people and parents
- key processes that must be followed when there are safeguarding concerns about a unborn, child or young person

2.0.2 BSMHFT will ensure robust arrangements are in place in respect of safeguarding children. This will be carried out in partnership with the Local Safeguarding Children Partnerships (LSCPs).

2.0.3 Think Family

Promoting the wellbeing and safeguarding service users and their families including children and siblings is integral to BSMHFT care provision and clinical practice: our duty of care. Neither adults or children exist in isolation and their mental health concerns exist within a context of wider vulnerabilities. This context can sometimes mean they or their family's well being is compromised or they are at risk of harm from other's outside of the family. It is essential to apply a whole-family approach. This consideration of the person within a wider context is called Think Family. This means:

- We ask our service users about their family and partners
- We talk to family members, friends and carers
- We consider the impact of mental illness on families
- we work in partnership with others to form a full picture of need
- we accept that an individual's issues exist within a context of wider vulnerabilities and are always curious about this

In doing so, we seek to open a door for our service users into a system of joined-up support and coordination between adult and children's services. Services working with both adults and children should take into account family circumstances and responsibilities.

2.1 Legislation and guidance

- 2.1.1 This policy is informed by the Children's Acts of 1989 and 2004, Children and Social Work Act 2017, Health and Social Care 2008 and the Care Act 2014.
- 2.1.2 The Children's Act 1989 introduced *significant harm* as the threshold that justifies compulsory intervention in family life to safeguard children. Where a child is suffering *or is at risk* of suffering significant harm, there is a legal duty to assess the needs of that child. Physical Abuse, Sexual Abuse, Emotional Abuse and Neglect are all categories of significant harm.
- 2.1.3 Section 10 of the Children Act (2004) requires each local authority, health and partner agencies to make arrangements to promote cooperation. These arrangements are made to improve the wellbeing of children in the authority's area. This includes protecting children from harm and neglect alongside other outcomes.
- 2.1.4 The Children's Act 2004 (section 11) states that NHS Trusts 'must make arrangements for ensuring that its functions are discharged having regard to the need to safeguard and promote the welfare of children':
- 2.1.5 'Working Together to Safeguard Children (2018) provides Government guidance on safeguarding children. BSMHFT is committed to the principles set out in this guidance and the policies and procedures of Local Safeguarding Children Partnerships (LSCPs).
- 2.1.6 Local Safeguarding Children Partnerships (LSCP) have been given statutory powers to ensure that agencies comply with statutory guidance. They also have a responsibility to co-ordinate and ensure the effectiveness of what their member organisations do individually and together. Within the West Midlands, there are nine local areas collaborating and sharing the same high-level inter-agency safeguarding policies and procedures.
- 2.1.7 The Local Authority in which the child normally resides is the lead body with a statutory duty to make enquiries when there is reasonable cause to suspect that a child is suffering from or is likely to suffer significant harm (Section 47 Children Act 1989). Under this section, employees of NHS Trusts and Local Authorities have a statutory duty to assist in such enquiries when required to do so and are expected to prioritise attendance at all statutory meetings such as child protection conferences, Child in Need meetings and core groups.

2.2 Training

- 2.2.1 Mandatory safeguarding children and young people training is incorporated into the organisation's Fundamental Training Programme (please refer to Fundamental Training Policy). This safeguarding training meets the requirements described in Safeguarding Children and Young People, Roles and Competencies for Healthcare Staff Intercollegiate Document (2019).
- 2.2.2 Safeguarding children and adult training is broken down into 3 levels (level 1, level 2 and level 3). Staff are required to attend the level of training assigned to them on their training traffic light. This will ensure they are maintaining competency and to be able to safeguard children. Staff are required to attend safeguarding training on a 3 yearly basis

2.3 Supervision

- 2.3.1 Working Together to Safeguard Children (2018) states that sound professional judgement is required to ensure that all children and young people are protected from harm. It is widely acknowledged that safeguarding children and young people can be demanding work that can also be distressing and stressful in nature. It is therefore recommended that all of those involved in this area of practice should have access to advice and support through Safeguarding Supervision.
- 2.3.2 Safeguarding supervision forms part of standard clinical supervision arrangements as set out in the Clinical Supervision policy 2022. Clinical Supervision must address safeguarding issues on a regular basis. Supervision should also challenge the supervisee to consider if there are safeguarding concerns that impact on the welfare of a child or vulnerable adult linked to the service user, and, if so, how these should be addressed. This includes a consideration of the welfare of children, young people or vulnerable adults who are not the primary client
- 2.3.3 The Named Nurse for Safeguarding Children and Young People and the safeguarding team provides group safeguarding supervision to those services which work directly with children and young people.
- 2.3.4 The Named Nurse for Safeguarding Children receives supervision from the Head of Safeguarding and the CCG, Designated Safeguarding Nurse
- 2.3.5 Specialist Safeguarding Supervision may be needed when the supervisee is confronted with a situation outside normal clinical practice and beyond the expertise of the original clinical supervisor. This may include access to specialist safeguarding advice and support provided by the safeguarding team. The need for specialist Safeguarding Supervision will be agreed between the clinical supervisor and the supervisee. It will complement rather than replace existing Clinical Supervision arrangements.

If a supervisee is working with a child/parent/carer where there is a Child Protection Plan in place, safeguarding supervision must happen on a 6 monthly basis as a minimum either by a clinical supervisor or a member of the safeguarding team.

- 2.3.6 All entries recording Clinical Supervision should be made in progress notes and should have the heading Clinical Supervision. This enables the search facility on the electronic patient record (Rio) to bring up all such entries which facilitates audit, after action reviews, complaint and SUI investigations etc.

3.0 PROCEDURES

- 3.0.1 The following outlines a procedure for recognising abuse, responding to concerns and record keeping.
- 3.0.2 To support this procedure safeguarding standards are available to aid staff and managers. The safeguarding *standards* are designed to support and strengthen safeguarding practice. They are focussed on core safeguarding activities. Clear instruction is provided alongside a rationale for the activity, and an expectation of the outcome for the child, family or adult.

3.1 Recognition of abuse

- 3.1.1 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 or through acts of omission. Children may be abused in a family, institutional or community setting by those known to them, or more rarely, by a stranger. They may be abused by an adult/s or by another child or children.
- 3.1.2 The abuse of a child may be physical, emotional, sexual or by neglect. More than one type of abuse may be present.

Physical Abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces illness in a child. This is known as Fabricated Induced illness (FII).

Non-accidental Injury (NAI) - Any serious or unusual injury with an absent or unsuitable explanation. The injury will not be consistent with the account of its occurrence.

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 in so far 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 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.

Sexual Abuse involves forcing or enticing a child or young person to take part in sexual activities, including sexual exploitation, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape, assault by penetration, oral sex) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet).

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

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger
- ensure adequate supervision (including the use of inadequate 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.

Child Criminal Exploitation - Where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18 into any criminal activity:

- in exchange for something the victim needs or wants and/or
- for the financial or other advantage of the perpetrator or facilitator and/or
- through violence or the threat of violence. The victim may have been criminally exploited even if the activity appears consensual

Child criminal exploitation does not always involve physical contact, it can also occur through the use of technology.

Child Sexual Exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity in exchange for something the victim needs or wants, and/or) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual.

Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.

Female genital mutilation (FGM), also known as ‘female genital cutting’, ‘female genital mutilation/cutting’ or ‘cutting’, refers to ‘all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons’. FGM is child abuse and illegal. There are mandatory reporting duties for health professionals and a requirement for BSMHFT staff to complete a FGM NHS dataset form on Rio (please see Appendix 3 for more information)

- 3.1.3 **Impact of Mental Health and/or Substance Misuse.** The existence of a mental health problem or of problematic substance misuse in an adult living or working with children will not necessarily mean a child is at risk of significant harm. However, the nature of the problem may impact on the child’s welfare through physical or emotional abuse or neglect. This may also include risk of significant harm when an adult’s mental health or substance misuse impairs their ability to adequately keep a child safe from other potential abusers or from environmental risks. It is therefore necessary that an assessment be made of the actual or potential risk posed to children as either a direct or indirect result of adult service users’ mental health or substance misuse problems. Appropriate arrangements should then be put in place to ensure that children are protected.
- 3.1.4 At the point of assessment and on an ongoing basis the names and dates of birth of children and parental responsibility must be obtained and recorded on RiO for all of the children of service users and/or children they live with. This information should be recorded on the ‘children and siblings details’ form on RiO (found in the demographic section in RiO case records). If a service user refuses, or continuously evades providing this information, this must be recorded in progress notes and advice sought in supervision or from a line manager. (please see “Recording demographic standard” - Appendix 4)
- 3.1.5 When carrying out the assessment the following points should be considered:
- ability of the adult to meet child(ren)’s needs and promote the wellbeing of the child(ren);
 - attitude of adult to their mental health/substance use problem and its implications for their child(ren);
 - age, developmental stage and special needs of child(ren);

- the degree to which any chronic illnesses or other forms of ill health may affect the ability to cope with parenting;
- evidence of intra-family conflict or domestic abuse associated with the mental health or substance misuse problem;
- evidence of significant harm or emotional neglect or abuse;
- patterns of physical, emotional, neglect or abuse;
- presence or absence of another adult in household;
- availability of support from family and friends.

3.1.6 If professionals have concerns about the safety and well-being of a child. **All staff have a responsibility to raise concerns and make referrals.**

3.1.7 Concern or disagreement may arise over another professional's decision, action or lack of actions in relation to a referral, an assessment or an enquiry. In the event of a difference of opinion staff should follow the LSCP's dispute resolution procedure. These outline first steps of a discussion between professionals to resolve issues. If there is still a disagreement staff will escalate the concern to their line manager who will attempt to resolve the issue with the Children Services manager/team leader. If this fails, the issue should be escalated to the Named Nurse/Doctor for Safeguarding Children and Young People immediately to facilitate a resolution in the best interest of the child. (please see Appendix 4, "Professional challenge and dispute resolution standard").

3.2 Responding to a concern (see Appendix 2, for flow diagrams of the Local Authority referral and screening process)

3.2.1 All BSMHFT staff and volunteers have a responsibility to identify any concerns relating to children due to the impact of their parent/carers mental health/substance misuse issues. Although these concerns may not always be at a level which requires statutory intervention. Sometimes families may require Early Help support which will not always require a referral to the Local authority. (please see Appendix 4, "Identify the need for Early Help" standard).

3.2.2 As a partner agency to the LSCP all BSMHFT staff are required to support Early Help strategies Initiatives in line with 'Working Together to Safeguard Children (2018)'.

3.2.3 Effective working together to safeguard and promote the welfare of children relies on appropriate information being shared in a timely manner with relevant professionals (please see section 3.3). (also see Appendix 4, sharing information standard)

3.2.4 It is essential to obtain the consent of the parent and child (depending on age and level of understanding) to share confidential information and make a referral, unless you have evidence to suggest that to do so would increase the risk to the child. When it is believed the child is at immediate risk of harm consent is not needed.

3.2.5 When making a referral, it is important to have the following information available:

- name, date of birth, ethnic origin, gender of the child, address and telephone numbers;
- the reasons for your concern; including any disclosures the child may have made
- injuries and/or other indicators observed;
- the child's first language;
- details of any specific needs of the child e.g. disability etc;
- details of family members/other household members if known;
- other agencies and professionals involved;
- a description of the measures already taken to safeguard;
- a description of the role of the team member and the service provided.

3.2.6 Do not delay in making a referral about a child for whom there is concern if some of the above information is not readily available. The referral should normally be made to the Children and Families Services Department responsible for the area in which the child resides. Out of normal working hours referrals should be made to the Emergency Duty Team (see appendix 4, Making a referral standard).

3.2.7 A referral to local authority, Children Services cannot be made anonymously by a professional.

3.2.8 Allegations or concerns of abuse against staff (including BSMHFT staff): all allegations made against staff who work with children or whose work allows them access to children should be discussed with a senior manager and the safeguarding team. This may subsequently involve contacting the police, making a Local Authority referral and contacting the Local Authority Designated Officer (LADO), or lead for Position of Trust Concerns.

3.2.9 All allegations made against BSMHFT staff must be brought to the attention of the relevant senior manager and Human Resources immediately and advice sought from the safeguarding team and the local authority designated officer (LADO) with overall responsibility for ensuring LSCP child protection procedures are followed. The BSMHFT policy on managing safeguarding allegations concerning people in a Position of Trust policy must be followed. This includes the completion of an Eclipse incident form.

3.2.10 Where Children and Families Services have decided that no further action is required, but a concern remains about the safety of a child, further discussion with the MASH/CASS worker, social worker and if necessary, their manager should be sought. The support of BSMHFT safeguarding team should also be sought. (Please see dispute resolution section 3.15 and Appendix 4

Professional challenge standard). The concerns, discussion and any agreements made should be recorded in the patient's case record.

3.3 Sharing information and consent

- 3.3.1 Effective sharing of information between professionals and local agencies is essential for effective identification, assessment and service provision. Information sharing and exchange is crucial to the process of safeguarding children.
- 3.3.2 Early sharing of information is the key to providing effective early help where there are emerging problems. At the other end of the continuum, sharing information can be essential to put in place effective child protection services. A key factor identified in many Child Safeguarding Practice Reviews (CSPR) (formerly known as Serious Case Reviews) has been a failure by practitioners to record information, to share it, to understand its significance and then take appropriate action.
- 3.3.3 Fears about sharing information cannot be allowed to stand in the way of the need to promote the welfare and protect the safety of children. To ensure effective safeguarding arrangements, no staff member should assume that someone else will pass on information which they think may be critical to keeping a child safe. If a staff member has concerns about a child's welfare and believes they are suffering or likely to suffer harm, then they should share the information with local authority Children Services.
- 3.3.4 It is essential to always seek consent. Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so. However, if you believe that the child may be at risk of significant harm and that seeking consent may jeopardise a potential police investigation or increase the risk of harm to the child, **then consent may be dispensed with.**
- 3.3.5 There may be occasions where consent cannot be obtained or is withheld (for example, the person refusing consent may be the perpetrator of the abuse). In deciding whether there is a need to share information, the child's best interests must be the overriding consideration, including in cases of underage sexual activity.
- 3.3.6 Therefore, if there are concerns about a child being at risk of harm, and it is considered the sharing of information to be important in safeguarding that child, then information should be shared without parental consent to do so.
- 3.3.7 There may be situations when both the child is open to BSMHFT, CAMHS and the parent is also open to BSMHFT adult services. It is good practice to ask

parents, at the child's assessment and subsequently, if they are receiving support from other agencies, and if they disclose they are, to ask for their consent to liaise with their BSMHFT team and clinician. This would enable information sharing. Similarly, to ask for consent when they disclose their child is open to BSMHFT CAMHS for information to be shared to help with joint working. When there is a child safeguarding concern, there is a justification to access the record of a parent or child to ascertain contact details of the team involved in the care of the child/parent.

- 3.3.8 All CAMHS services including forensic CAMHS services do not need to apply the Gillick competency rule to determine whether to share or not share safeguarding information about a young person. A Gillick competency assessment determines the child's capacity to consent to treatment, not their capacity for information to be shared. Staff working with children need to consider how to balance children's rights and wishes about what information is shared about them with their responsibility to keep children safe from harm.
- 3.3.9 Restrictions on sharing information are embodied in the common law duty of confidence, the Human Rights Act 1998 and the General Data Protection Regulations (GDPR) 2018.
- 3.3.10 The law recognises that disclosure of confidential information without consent or a court order may be justified in the public interest to prevent harm to others. Generally, the amount of confidential information disclosed without consent should be no more than is strictly necessary to protect the health and wellbeing of a child.
- 3.3.11 In some situations to safeguard children "The duty to share information can be as important as the duty to protect patient confidentiality". (Caldicott 2 principle 7).
- 3.3.12 If any staff member is unsure whether confidential information should be disclosed the matter should be discussed with the Safeguarding team or the Caldicott Guardian.
- 3.3.13 BSMHFT's confidentiality policy, information sharing protocol and the information sharing safeguarding standard provide additional guidance. The document 'Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers Guidance for practitioners and managers (2018) provides guidance about sharing personal information on a case by case basis.
- 3.3.14 There is an expectation that as part of ongoing assessment, practitioners are considering the needs of the whole family, are explaining the Early Help approach, and outlining the organisation's approach to safeguarding children.

- 3.3.15 Community Mental Health Practitioners should inform the parent/carer of the need to share information. Therefore, practitioners should make every effort to positively engage service users in the process of routinely sharing information by explaining that as part of the treatment and care they deliver, BSMHFT services routinely share information with a range of health professionals including the GP, Health Visitor, School Nurse or midwife of their involvement.
- 3.3.16 In cases where service users are not willing to share information regarding children, they have regular contact with, the practitioner must discuss this with their manager and consider what steps may be taken.
- 3.3.17 Copies of letters for the purpose of sharing information can be shared with service users. Staff should always record the reason for disclosing information and whether disclosure was made with or without consent.
- 3.3.18 Child protection concerns always override confidentiality considerations and worries staff may have about potential damage to a therapeutic relationship.

3.4 Record keeping

- 3.4.1 At the point of assessment, and on an ongoing basis, the names and dates of birth of children and parental responsibility must be obtained and recorded on RiO for all of the children of service users and/or children they live with. This information should be recorded on the 'children and siblings details' form on RiO (found in the demographic section in RiO case records). If a service user refuses, or continuously evades providing this information, this must be recorded in the progress notes and advice sought in supervision or from a line manager (please see, Appendix 4, Recording family details standard).
- 3.4.2 Referrals to Local Authority, Children's Services Department should be recorded on RiO or other relevant service user integrated care records (ICR).
- 3.4.3 All referrals should be followed up in writing within 48 hours. Children's Services should tell the referrer what is happening within 24 hours of the referral being made. Where this does not happen the person making the referral has a duty to follow up the referral again within 72 hours.
- 3.4.4 Following making a referral an Eclipse Incident Report should be generated.
- 3.4.5 All referrals need to be uploaded onto RiO and attached to Eclipse Incident Forms.
- 3.4.6 If a child within the family is subject to a Child Protection Plan this needs to be entered on the Alert system of RiO and on the safeguarding section of the risk screen.

- 3.4.7 All conversations whether face to face or by telephone, regarding the welfare and safety of children must be accurately and contemporaneously documented within the adult service user's ICR. Documented material should be confined to matters of fact. Any opinion should be evidenced based and not speculation.
- 3.4.8 Safeguarding children should be routinely discussed as part of supervision and managerial or case management arrangements for all practitioners. Practice outcomes from the above should be recorded on RiO or other relevant service user ICR.
- 3.4.9 On occasion staff may be approached by a solicitor for information or be requested to provide a statement for court proceedings. In this event staff should seek advice and support from the Safeguarding Team and the BSMHFT Legal Department. Staff should be served a witness summons prior to attending court.

3.5 Safeguarding children/young people and case management (Care Programme Approach (CPA) and Care Support)

- 3.5.1 National CPA guidance entitled. 'Refocusing the Care Programme Approach', (DH March 2008) and 'Care Programme Approach (CPA) Briefing: Parents with mental health problems and their children', (SCIE, April 2008), both highlight adults with mental health problems who have parenting responsibilities as a group who need to be identified consistently.
- 3.5.2 The National Patient Safety Agency (NPSA) distributed a Rapid Response Alert outlining Mental Health Trusts responsibilities in terms of Preventing Harm to children from parents with mental health needs.
- 3.5.3 All assessment, review, and discharge planning documentation and procedures must prompt staff to consider if the service user is likely to have or resume contact with their own child or other children in their network of family and friends, even when the children are not living with the service user.
- 3.5.4 If the service user has or may resume contact with children, this must trigger an assessment of whether there are any actual or potential risks to the children, including an illness or disorder including delusional beliefs involving them, or delusional beliefs which may impact on a child's welfare, and drawing on as many sources of information as possible, including compliance with treatment.
- 3.5.5 Staff must be mindful that there may be a range of other agencies involved with a family. Thought should be given to involving those agencies in the assessment process, and specifically if there is a need to work jointly with other agencies in relation to care planning, parenting ability and any other safeguarding issues.
- 3.5.6 Staff at all stages of assessment process must consider whether the service user's illness is having a detrimental impact on their parenting capacity and the

range of support and action that may need to be provided to ensure sufficient safeguards.

- 3.5.7 The Service users parenting capacity must always been considered and included as part of the care planning process and should always be considered in terms of discharge processes, both when an inpatient is being discharged back to their home environment and when a service user is being discharged from BSMHFT care.

3.6 Leave Arrangements for adult inpatients

- 3.6.1 Staff must be aware of where service users are going on leave from hospital. The leave plan must consider the impact on children when the service user is on leave which must be clearly recorded in the service user's notes.
- 3.6.2 If a service user does not usually reside with his or her own children, checks must be made with the service user and if necessary appropriate local authority Children's Services as to whether they are visiting or staying in a household with children and whether this poses any risk or practical problems for the household.
- 3.6.3 Occasionally multi agency plans or other plans relating to the care of children have conditions regarding the adults contact with children. Staff should check if any conditions exist and should consult with children services if necessary prior to allowing leave. Staff must make sure that leave arrangements comply with plans made at child protection conferences or as part of any children's assessment plans.
- 3.6.4 Service users who are inpatients on the perinatal suite and are having leave with/without their baby should inform all agencies involved prior to commencing leave and on their return as soon as possible.

3.7 Children in Care (CIC)/ Looked After Children (LAC)

- 3.7.1 The term Looked After Children (Children in Care) has a specific legal meaning based on the Children Act, 1989. A child is looked after by a local authority if he or she has been provided with accommodation for a continuous period of more than 24 hours, in the circumstances set out in Sections 20 and 21 of the Children Act, 1989, or is placed in the care of a local authority by virtue of an order made under part IV of the Act.
- 3.7.2 Local authorities are responsible for making sure a health assessment of physical, emotional and mental health needs is carried out for every child they look after, regardless of where that child lives.

- 3.7.3 BSMHFT staff must always contact services if a child returns to the care of a parent when they have been a Looked After Child. A joint assessment on parenting capacity should always be undertaken in this case.
- 3.7.4 Children living away from home: a child is determined as living away from home when they are in a local authority foster placement, a private fostering placement, a children's home, in hospital, in a residential school or in a custodial setting. Everywhere children live should provide the same basic safeguards against abuse, founded on an approach that promotes their general welfare, protects them from harm and treats them with dignity and respect.
- 3.7.5 Children living away from home are particularly vulnerable to being abused by adults and peers. Limited and sometimes controlled contact with family and carers may affect a child's ability to disclose what is happening to them. Given that many young people live away from home because of concerns about their home conditions, it is particularly important that their welfare is protected when they are being cared for by another agency or institution.
- 3.7.6 Staff should be alert to the risks of harm to children in the external environment from people prepared to exploit the additional vulnerability of children living away from home. Where there is reasonable cause to believe that a child has suffered, or is likely to suffer significant harm a referral must be made, in accordance with the referrals procedure to Children's Services this would include liaison with the allocated social worker in "open" cases.

3.8 Closing or transferring cases

- 3.8.1 Before closing a case or transferring a case to another team, staff must consider the impact on the children or unborn child if the service discontinues contact with the family.
- 3.8.2 Where a referral has been made to the Perinatal Service cases should not be closed until referral to the perinatal clinic have been confirmed by offer of an Out Patient Appointment.
- 3.8.3 If Children's Services, Family Support or Early Help services are involved in the case they must be invited to any transfer or discharge meeting and be sent a copy of the discharge summary. If a child is subject to a child protection plan staff should ensure the discharge plan is discussed first with the children's social worker and any other associated teams as this may be a change to the child protection plan.
- 3.8.4 Cases should not be declined or closed without the original referrer, and other key agencies, being advised that this is the proposed plan so that they can either question this decision or take over the responsibility for support and monitoring, where this is required. This is particularly important where a child is subject of a child protection plan or already known to Children's Services.

3.8.5 Discharge letters should be copied to any relevant health and social care children's professional involved with the family.

3.9 Children and families moving to reside across geographical boundaries

3.9.1 Formal arrangements are in place for transfer of responsibility for such children between authorities as set out in Working Together 2018 and the West Midlands Regional Safeguarding Procedures. These arrangements ensure that there is always one authority holding case responsibility.

3.9.2 Children's Services are normally provided by the local authority for **the area where the child is living or is found**. For these purposes, 'found' means the physical location where the child suffers, or is identified to be at risk of, harm or neglect.

3.9.3 However, where a child is currently receiving services, or is subject to a section 47 enquiry, formal transfer processes should be followed. Responsibility for safeguarding the child will remain with the local authority where the child was living (even though the child will have moved) until these transfer processes have been fully completed. In some cases, the local authority where the family previously lived will retain responsibility for the child.

3.9.4 Some families will move between authorities to avoid or divert professional contact where safeguarding or child protection concerns have been identified. Staff should be alert to this possibility.

3.9.5 When Children's Services are arranging a transfer to another Local Authority it is important that both CAMHS and adult mental health services also arrange for a transfer of care to a mental health service in the child/and or parent's new area.

3.9.6 In all cases the safeguarding team can be contacted for additional support or information

3.10 Missed Appointments

3.10.1 Staff must be aware if children are not brought to an appointment to consider any safeguarding issues before discharging from the service and document this in the records. Where adult service users fail to attend the impact on their children must be considered before discharging and good practice would include informing other involved agencies that the adult has not attended

3.10.2 If children are not brought to appointments or if discharge is considered because of missed appointments staff will inform the relevant agencies working with the child which may include the following: Health Visitor, midwife, social

worker, and/or school nurse of non-engagement, youth offending teams and paediatricians

3.10.3 CAMHS staff must follow the operational framework and 'was not brought policy' to ensure specific action is taken to follow up both in terms of informing the referrer of this missed appointment and any other relevant health professionals. Any child protection or child in need concerns must prompt the following of the responding to concerns procedure above (see section 3.2). Consideration of a child declining a service must also factor in safeguarding concerns when deciding not to offer a service. This must always include liaison with children services and other agencies.

3.10.4 Children and young people not attending health care appointments can raise concerns about potential neglect from parents/carers. The definition of neglect is the consistent failure to meet a child's needs, and this includes the failure to meet their child's health needs; including attendance to appointments. Not being brought to health care appointments can, in some cases, indicate neglect and other serious safeguarding concerns.

3.11 Domestic Abuse, MARACs and Mental Health Services

3.11.1 Staff should be aware of the interrelationship between domestic abuse and Safeguarding Children issues. Service users may be victims or perpetrators of domestic abuse.

3.11.2 If a service user discloses domestic abuse, checks must always be made if there are children in the household.

3.11.3 A referral should be made to Children's Services if a child lives in the household where domestic abuse is believed to be a factor as this could indicate that a child is in need of support and protection.

3.11.4 Consideration should always be given to the use of the MARAC (Multi Agency Risk Assessment Conference) process alongside a safeguarding child referral. Advice can be sought from the BSMHFT safeguarding team.

3.12 Planning and managing visits by celebrities, VIPs and media teams

3.12.1 To ensure appropriate safeguard arrangements are in place and working well for children and young people within in-patient settings when visited by celebrities, VIPs and media teams, please see VIP and Visitors policy.

3.13 Safeguarding issues attracting media interest

3.13.1 Any safeguarding issue that may attract media interest will be shared by Senior Managers or the Head of Safeguarding to the Head of Communications and Marketing and the Executive Director of Nursing.

3.14 PREVENT/ Radicalisation

3.14.1 Prevent is part of the UK's counter-terrorism strategy, CONTEST. Its aim is to stop people becoming terrorists or supporting terrorism. Parents and children/young people are likely to be facing multiple challenges in their life, of which exposure to terrorist-related influences is just one. Safeguarding concerns generally should be dealt with via our procedures for identifying and responding to safeguarding concerns. In addition, where concerns have been highlighted the BSMHFT Prevent Lead, who is part of the safeguarding team, should also be contacted for specific advice and guidance.

3.15 Dispute resolution and escalation

3.15.1 Situations arise when workers within one agency feel that the actions, inaction, or decisions of another agency do not adequately safeguard or promote the welfare of a child. Professional disagreements will sometimes arise over one professional's decisions, actions, or lack of actions in relation to a referral, an assessment or a plan which are considered not to be in the child's best interests. There can also be practical issues arising from not being invited to a multi-agency meeting or being sent minutes from meetings or other agencies not completing actions. (please see, Appendix 4, professional challenge and dispute resolution standard)

3.15.2 In such situations, staff are required to follow the local LSCP Resolution and Escalation Protocol (multi-agency) – in the area the child resides. All protocols require staff to try and promptly raise their concerns by sharing it with the professional they disagree with in the first instance and/or their manager. If no agreement can be reached the staff member should escalate to their team manager who will attempt to resolve the disagreement. If there is still a disagreement the issue should be taken to the BSMHFT Operational Service Manager and the BSMHFT Safeguarding Team who will escalate the issue further.

3.16 Child Safeguarding Practice Reviews (CSPR) and Child Death Reviews (CDR)

3.16.1 BSMHFT will participate in the CSPR and CDR processes via the Safeguarding Team. Participation in these processes will be overseen by the Head of Safeguarding. Reporting and learning will be taken to the Safeguarding Management Board. Specific action plans will be created by operational teams and progress reported through local clinical governance committee meetings.

3.16.2 To support the CSPR and CDR processes, information will be requested from the BSMHFT Named Nurse for Safeguarding Children, or a delegated other from the safeguarding team. All requests for information must be complied

with. The Named Nurse, or delegated other, will provide information, and individual clinical staff who have had involvement in the case may be required to participate in the review process and attend meetings where discussions will take place about the child and parents.

3.17 Associated policies:

- C08 Clinical supervision policy
- C50 VIP and Visitor policy
- R&S12 Children’s Visiting policy
- R&S26 Adult Safeguarding policy
- R&S32 PREVENT policy
- R&S03 Domestic Abuse policy
- IG01 Confidentiality policy
- CG06 Complaints and Concerns policy
- HR26 Recruitment and Selection policy
- HR37 PIPOT policy

4.0 RESPONSIBILITIES

Post(s)	Responsibilities	Ref
All BSMHFT staff, irrespective of discipline or role	All staff whether permanent, temporary or contracted have a duty to ensure that children and unborn babies are protected from harm and comply with the principles laid down in the legislation described in section 2.1. This means recognising and reporting concerns.	2.1
Service, Clinical and Corporate Directors	Operational managers and directors are responsible for making arrangements to safeguard and promote the welfare of children within their sphere of responsibility (Section 11 Children Act 2004) and ensuring that where contracted services are used that these services also have appropriate procedures in place for safeguarding children. Operational managers and directors are responsible for ensuring implementation of recommendations arising from Child Safeguarding Practice Reviews and incidents involving safeguarding children.	

	<p>Operational managers and directors are responsible for ensuring that no person is given access to service users, including researchers, temporary staff and locums, without evidence of engagement procedures and honorary contract issued by BSMHFT, HR or DBS checks, disclosure to professional training body for health professionals.</p> <p>Managers and supervisors of clinical staff must ensure management oversight of safeguarding concerns, this may include, case discussions, quality assurance of referrals, monitoring and evaluating the outcomes of the work to safeguard children and ensuring staff receive clinical and safeguarding supervision and training in relation to safeguarding children.</p> <p>Team managers are responsible for ensuring staff are aware of BSMHFT safeguarding children policy, other relevant policies and procedures, and are performance managed on their compliance with these and that staff have the appropriate level of DBS clearance. Team managers will have managerial oversight of the safeguarding practice within their multi-disciplinary team.</p> <p>The Associate Director of Human Resources is responsible for ensuring safer recruitment standards; meeting the requirements of the Disclosure and Barring Service (DBS) checks, disclosures, meeting safeguarding standards in job descriptions and that Position of Trust processes are in place.</p>	
<p>Policy Lead</p>	<p>The Head of Safeguarding is the strategic lead with responsibility for safeguarding children across the organisation and meeting its statutory functions. They are responsible for the</p>	

	<p>co-ordination, management, development, and implementation and monitoring of the safeguarding children policy on behalf of the Trust Board. They liaise with partner agencies and ensure the systems for safeguarding children include education and training, risk and assurance frameworks, annual board reporting are in place and responsive to relevant guidance. They will provide the Board with regular updates regarding Child Safeguarding Practice Reviews.</p>	
<p>Named Nurse for Safeguarding Children and Young People</p>	<p>The Named Nurse for Safeguarding Children and Young People is the professional lead within the BSMHFT for safeguarding children. The named nurse has a specific, statutory role and responsibility to ensure expected standards to safeguard children. They also provide supervision, advice, and expertise for all BSMHFT staff and professionals within other agencies.</p>	
<p>Named Doctor for Safeguarding Children</p>	<p>The Named Doctor for Safeguarding Children takes the statutory lead medical role for safeguarding children. The named doctor has expertise in children's health and development, safeguarding children and the local arrangements for safeguarding children and promoting their welfare. They have an educative role with all doctors and medical staff employed by BSMHFT. They provide supervision to all levels of medical staff when they are dealing with complex situations relating to safeguarding children.</p>	
<p>Executive Director</p>	<p>The Chief Executive on behalf of BSMHFT retains ultimate accountability for the health, safety and welfare of all patients, service users, carers, staff and visitors. However key tasks and responsibilities are delegated to individuals in accordance with the content of the policy.</p>	

	<p>The Chief Nurse is the Trust Board executive member with overall responsibility delegated from the Chief Executive for ensuring that effective systems and processes are in place to address the safeguarding children agenda and chairs the Safeguarding Management Board.</p>	
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4.1 Specialist services responsibilities

4.1.1 Perinatal services:

Particular attention needs to be paid to the needs of parents and their children who are in receipt of perinatal services in both the pre and post-birth period. Services must ensure they have comprehensive multi-agency risk plans; that coordination and information sharing between all agencies is established as early as possible and that appropriate pre-birth assessment is completed in conjunction with Children's Services where appropriate.

4.1.2 The perinatal service will ensure that they have appropriate policies and local protocols in place which reflect the specific needs of this client group.

4.1.3 CAMHS clinical staff:

CAMHS staff are required to understand the impact of abuse and neglect on child development and emotional well-being. CAMHS staff must be able to identify the signs of abuse in children, including the signs of physical, emotional, sexual abuse and neglect. Staff must understand the effects on children of domestic violence, parental mental illness and substance misuse.

4.1.4 CAMHS staff are required to be aware of children who are at risk of abuse or exploitation in the following ways: for example, bullying, child on child abuse, sexual violence against girls involved with gangs and other gang related violence, children who have been trafficked, children at risk of radicalisation and involvement in terrorist activity, children at risk of sexual exploitation or those at risk of grooming via social media and children at risk of female genital mutilation (FGM).

4.1.5 CAMHS staff are required to complete risk assessment and to regularly update to identify risk and potential need to involve other agencies.

4.1.6 If CAMHS staff are working with a young person who is pregnant or a parent, they are required to pay particular attention to the safeguarding needs of both the young person and their child and to complete the child in need and risk screen.

- 4.1.7 Safeguarding children must be at the centre of the care and treatment provided to all CAMHS service users and as such must be documented accordingly and referrals made to partner agencies in a timely and appropriate way.
- 4.1.8 The screening process for referrals received into CAMHS may include children whose needs are not suitable for mental health and emotional wellbeing services; however safeguarding concerns have been listed on the referral. On these occasions, CAMHS staff will liaise with the referring agency to ensure the safeguarding concern has been responded to and if not, will escalate that issue to both internal and external managers. When a child is assessed and not offered a service, the rationale for the decision making must include formulation of any safeguarding concerns and the plans to safely hand the child back to the referring agency and/or other agencies.
- 4.1.9 **CAMHS Secure in-patient unit services:**
The CAMHS forensic units must have operational policies, staff induction and patient and family information leaflets which reflect the need to safeguard children throughout their stay on the unit. Search, relationship, visiting and social media management policies must reflect the wider safeguarding needs of children.
- 4.1.10 Staff must ensure there is no unsupervised contact between external facilities contractors and children in CAMHS in-patient units. There is no unsupervised contact between any of the adult service users from separate services on the Ardenleigh site and children in the FCAMHS inpatient unit.
- 4.1.11 All staff on Secure CAMHS units, including bank or agency staff must have up to date DBS checks and receive safeguarding training as part of their induction to the unit.

5.0 DEVELOPMENT AND CONSULTATION PROCESS

Consultation summary		
Date policy issued for consultation	9.6.22	
Number of versions produced for consultation	1	
Committees / meetings where policy formally discussed	Date(s)	
Safeguarding Team/business Meeting	29.4.22	
Where received	Summary of feedback	Actions / Response
Email	Change to wording on professional disagreements (3.15.1) to remove word 'occasional'.	Text changed 'occasional' removed

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6.0 REFERENCE DOCUMENTS

Please access the Safeguarding Hub from a desktop for access to a range of safeguarding resources and information. The safeguarding behaviour profile and standards referenced in this policy and procedure is located here: [Safeguarding Hub](#)

Birmingham Safeguarding Children Partnership (BSCP)
<http://www.lscpbirmingham.org.uk/>

The Children Act 1989
<http://www.legislation.gov.uk/ukpga/1989/41/contents>

The Children Act 2004
<http://www.legislation.gov.uk/ukpga/2004/31/contents>

DOH.2008 'Refocusing the Care Programme Approach', (DH March 2008)

HM Government, DOE, 2018 *Working Together to Safeguard Children – a guide to interagency working to safeguard and promote the welfare of children*
<https://www.gov.uk/government/publications/working-together-to-safeguard-children--2>

HM Government (2018) *Information sharing guide for safeguarding practitioners*
<https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice>

HM Government 2011) *The Munro Review of Child Protection*
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/175391/Munro-Review.pdf

Home Office (2003) '*Hidden Harm – Responding to the needs of children of problem drug users*'
<https://www.gov.uk/government/publications/amcd-inquiry-hidden-harm-report-on-children-of-drug-users>

National Society for the Protection of Children (NSPCC)
<https://www.nspcc.org.uk/preventing-abuse/safeguarding/>

[Regional Child Protection Procedures for the West Midlands](#)
[West Midlands Safeguarding Children Group \(procedures.org.uk\)](#)

Royal College of Nursing (RCN)

Safeguarding Children and Young People, Roles and Competencies for
<https://www.rcn.org.uk/professional-development/publications/pub-007366>
Healthcare Staff Intercollegiate Document (2019)

Royal College of Psychiatrists (2002) *Patients as Parents: addressing the needs, including safety, of children whose parents have mental illness.*
https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr164.pdf?sfvrsn=79416179_2

Royal College of Psychiatrists (2004) *Child Abuse and Neglect: the role of mental health services*

Royal College of Psychiatrists (2014) Safeguarding Children and Young People: roles and competencies for health care staff. Intercollegiate document.
[http://www.rcpch.ac.uk/sites/default/files/page/Safeguarding%20Children%20-%20Roles%20and%20Competences%20for%20Healthcare%20Staff%20%2002%200%20%20%20\(3\)_0.pdf](http://www.rcpch.ac.uk/sites/default/files/page/Safeguarding%20Children%20-%20Roles%20and%20Competences%20for%20Healthcare%20Staff%20%2002%200%20%20%20(3)_0.pdf)

SCIE (2009) 'Think child, think parent, think family: a guide to parental mental health and child welfare'
<https://www.scie.org.uk/publications/guides/guide30/>

SCEI (2008) 'Care Programme Approach (CPA) Briefing: Parents with mental health problems and their children'
<https://www.scie.org.uk/publications/guides/guide30/files/CPAbriefing.pdf>

Solihull Local Safeguarding Children Partnership (LSCP)
<https://solihulllscp.co.uk/>

Local Child Safeguarding Practice Reviews, Regional Framework and Practice Guidance (April 2019),
[LCSPR Regional Framework and Practice Guidance 05 2019](https://www.procedures.org.uk/LCSPR_Regional_Framework_and_Practice_Guidance_05_2019)
([procedures.org.uk](https://www.procedures.org.uk))

7.0 BIBLIOGRAPHY

None

8.0 GLOSSARY

Abuse A form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others. Abuse can take place wholly online, or technology may be used to facilitate offline abuse. Children may be abused by an adult or adults, or another child or children.

Children - anyone who has not yet reached their 18th birthday. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate, does not change his/her status or entitlements to services or protection. This includes unborn children where pre-birth planning may be necessary to safeguard and promote welfare.

Child Safeguarding Practice Review - Child Safeguarding Practice Reviews (CSPRs) (formerly Serious Case Reviews (SCRs)) in England are undertaken when a child dies (including death by suspected suicide), and abuse or neglect is known or suspected. The purpose of a child safeguarding practice review is to explore how practice can be improved through changes to the system itself. Reviews should seek to understand both why mistakes were made and to comprehend whether mistakes made on one case frequently happen elsewhere and to understand why

Child Death Review and Child Death Overview Panel

The child death process covers all children and a child death review must be carried out for all children regardless of the cause of death. This includes death of any new-born baby (of any gestation) but does not include those (of any gestation) who are stillborn where there was medical attendance, or planned terminations of pregnancy carried out within the law. The CCG and Local Authority in the area where the child dies, will assume statutory responsibility for the review of the child death

Child Protection - part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm.

Contextual safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse.

Early Help Early help means providing support as soon as a problem emerges, at any point in a child's life, from the foundation years through to the teenage years. Early help can also prevent further problems arising; for example, if it is provided as part of a support plan where a child has returned home to their family from care, or in families where there are emerging parental mental health issues or drug and alcohol misuse.

Looked After Child/Child in Care

A child who has been in the care of their local authority for more than 24 hours is known as a looked after child. Looked after children are also often referred to as children in care, a term which many children and young people prefer.

Each UK nation has a slightly different definition of a looked after child and follows its own legislation, policy and guidance. But in general, looked after children are living with foster parents; living in residential children's home; or living in residential settings like secure units

Private fostering is an arrangement whereby a child under the age of 16 (or 18 if the child has a disability) (S.66 Children Act 1989) is placed for 28 days or more in the care of someone who is not the child's parent(s) or a 'connected person'. A connected person is defined as a 'relative, friend or other person connected with a child'. The latter is likely to include person(s) who have a pre-existing relationship with the child, for example, a teacher who knows the child in a professional capacity

Safeguarding and promoting the welfare of children is defined as -

Safeguarding is the action that is taken to promote the welfare of children and protect them from harm.

Safeguarding means:

- protecting children from abuse and maltreatment;
- preventing harm to children's health or development;
- ensuring children grow up with the provision of safe and effective care;
- taking action to enable all children and young people to have the best outcomes.

Significant Harm is the threshold that justifies compulsory intervention in family life in the best interests of children, and give local authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering or likely to suffer, significant harm.

9.0 AUDIT AND ASSURANCE

Audits relating to Child safeguarding are conducted by BSMHFT in a variety of ways which include:

- participation in Local Safeguarding Children Partnership thematic reviews where staff are involved in auditing identified cases and attend multi-agency discussions to facilitate joint learning.
- audits being completed as a specific action in a plan arising from a CSPR or learning review.
- as part of Joint Targeted Area Inspections, led by Ofsted, CQC, HM Inspectorate of Constabulary and HM Inspectorate of Probation.
- completion by the Named Nurse of Section 11 Audits as per statutory guidance.
- BSMHFT internal audits against the safeguarding standards

Audits are used as a measure of compliance with the principles and procedures in this policy.

Safeguarding governance is formally constituted within BSMHFT integrated governance structure. The Safeguarding Management Board (SMB) reports to the Trust Board via the Clinical Governance Committee (CGC) and the Quality, Patient Experience and Safety (QPES) committee. This reporting provides assurance of how BSMHFT is meeting its statutory obligations to safeguarding children and adults. This policy's implementation and training is monitored through the SMB which is responsible for maintaining and reviewing risk and assurance frameworks, audit, strategy implementation and reporting to the Board.

All reports and action plans from Child Safeguarding Practice Reviews, Child Death Reviews and serious incidents concerning safeguarding children issues will be monitored by the SMB. The SMB will take the lead on some actions that require an organisational response, for example child protection structures and arrangements, organisational wide policy, training programmes and systems.

Element to be monitored	Lead	Tool	Frequency	Reporting Arrangements
Process in place for discussion of any changes in Government Legislation or Local Safeguarding arrangements requiring policy amendments (sections 2.1.4, 2.3.1)	Head of Safeguarding	Standard agenda item on the Safeguarding Management Board meeting	Bi-monthly	Safeguarding Management Board
Nominated Trust Director, LSCP Board Member or deputy attends all LSCP meetings on a quarterly basis (sections 2.1.2)	Head of Safeguarding	Review of LSCP minutes to confirm BSMHFT attendance. Review of LSCP minutes	Quarterly	Safeguarding Management Board
Upon undertaking and completing any CSPR, associated recommendations and actions are monitored (2.3.2)	Head of Safeguarding	Standard agenda item on the Safeguarding Committee meeting	Bi monthly	Safeguarding Management Board

Safeguarding training is incorporated into the organisation's . Fundamental Training Programme. All staff must complete training commensurate with their job role (2.5)	Head of Safeguarding, Named Nurse for Safeguarding Children and Young People	Compliance report	Annual	Safeguarding Management Board
When safeguarding children concerns are identified a referral to Local Authority Children's Services is made without delay (3.2.5)	Named Nurse for Safeguarding Children and Young People	Audit against safeguarding standards (to include consideration of NICE benchmarking statements and compliance against, QS31, PH28; NG55 Harmful Sexual Behaviours; CG89 Child Maltreatment; Child abuse and neglect NG 197, QS179)	Annual	Safeguarding Management Board
Safeguarding children concerns are accurately and contemporaneously recorded within the ICR and when required through Eclipse incident reports (3.4)	Named Nurse for Safeguarding Children and Young People	Audit against safeguarding standards (to include consideration of NICE benchmarking statements and compliance	Annual	Safeguarding Management Board

		against QS31 (Looked after Children, QS31, PH28; NG55 Harmful Sexual Behaviours; CG89 Child Maltreatment; Child abuse and neglect NG 197, QS179)		
Participation in multi-agency working and child protection plans	Named Nurse for Safeguarding Children and Young People	Audit	Annual	Safeguarding Management Board

10.0 APPENDICES

Appendix 1

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
<http://connect/corporate/humanresources/managementsupport/Pages/default.aspx>

Title of Proposal	Safeguarding children and young people policy		
Person Completing this proposal	Ella Lutterodt-Quarcoo	Role or title	Named Nurse for Safeguarding Children
Division	Corporate - Safeguarding	Service Area	
Date Started	1.6.22	Date completed	9.6.22
Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.			
The policy details the responsibilities of BSMHFT to promote and safeguard the well-being of all children in line with legislation and statutory guidance.			
Who will benefit from the proposal?			
Service users and their families. BSMHFT staff and volunteers. The wider public (not BSMHFT service users).			
Do the proposals affect service users, employees or the wider community? <i>Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward</i>			
Service users, employees and the wider community			
Do the proposals significantly affect service delivery, business processes or policy? <i>How will these reduce inequality?</i>			
Does it involve a significant commitment of resources? <i>How will these reduce inequality?</i>			
Do the proposals relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)			
Impacts on different Personal Protected Characteristics – Helpful Questions:			

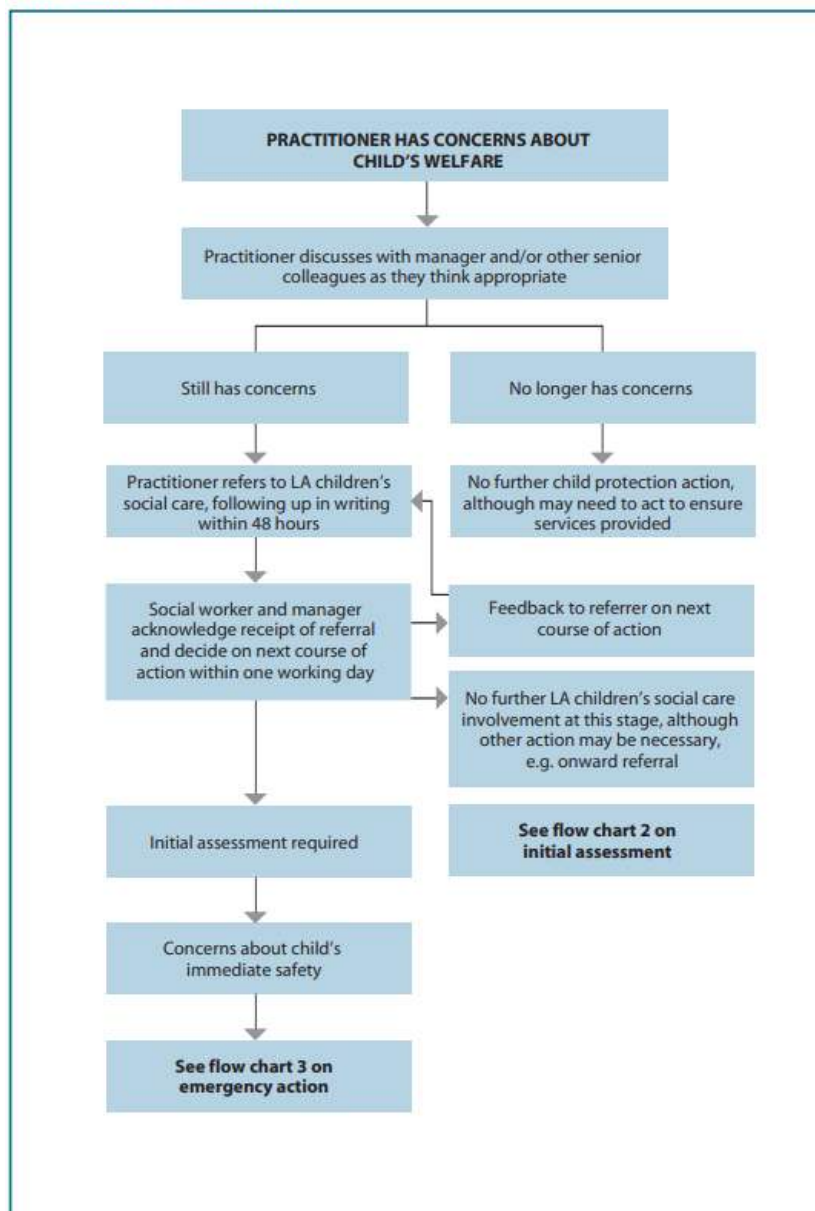
<p><i>Does this proposal promote equality of opportunity?</i> <i>Eliminate discrimination?</i> <i>Eliminate harassment?</i> <i>Eliminate victimisation?</i></p>				<p><i>Promote good community relations?</i> <i>Promote positive attitudes towards disabled people?</i> <i>Consider more favourable treatment of disabled people?</i> <i>Promote involvement and consultation?</i> <i>Protect and promote human rights?</i></p>
<p>Please click in the relevant impact box and include relevant data</p>				
Personal Protected Characteristic	No/Minimum Impact	Negative Impact	Positive Impact	Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.
Age			✓	The policy will have a positive impact on service users under the age of 18 by supporting staff to protect children from harm and promote their wellbeing
<p>Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups</p>				
Disability			✓	Children with disabilities are at greater risk of abuse and neglect compared to children without disabilities. The policy will have a positive impact on children by supporting staff to protect them from harm and helping to promote their wellbeing. The policy promotes the use of Think Family and Early Help strategies as this enables agencies to work with parents and carers before significant harm has taken place. The policy references Child In Need plans.
<p>Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?</p>				
Gender			✓	Although there is an equal gender distribution of children subject to child protection plans, girls are more susceptible to sexual abuse and child sexual exploitation than boys. The policy generally promotes the use of safeguarding procedures including Local Authority referrals when disclosures of sexual abuse are made. The policy will have a positive impact upon children of all genders by supporting staff to protect them from harm and help promote their wellbeing.
<p>This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?</p>				

Marriage or Civil Partnerships				
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity			✓	The policy will have a positive impact on unborn children, pregnant and post natal mothers by directing and supporting staff to protect them from harm and respond effectively to safeguarding risks
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity			✓	The policy will have a positive impact on children, of all races and ethnicities, by supporting staff to protect them from harm and respond effectively to any safeguarding risks. The policy raises awareness and addresses specific safeguarding risks associated with female genital mutilation.
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief			✓	The policy will have a positive impact on service users of all religions and beliefs and non believers under the age of 18 by supporting staff to protect them from harm and respond effectively to any safeguarding risks.
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation			✓	The lesbian, gay, bisexual and transgender community experience higher levels of abuse and discrimination when compared to the general population. It is estimated that they are 4 times more likely to be bullied than their peers, The policy will have a have a positive impact on children of all sexual orientations, by supporting staff to protect them from harm and respond effectively to any safeguarding risks.
Including gay men, lesbians and bisexual people				

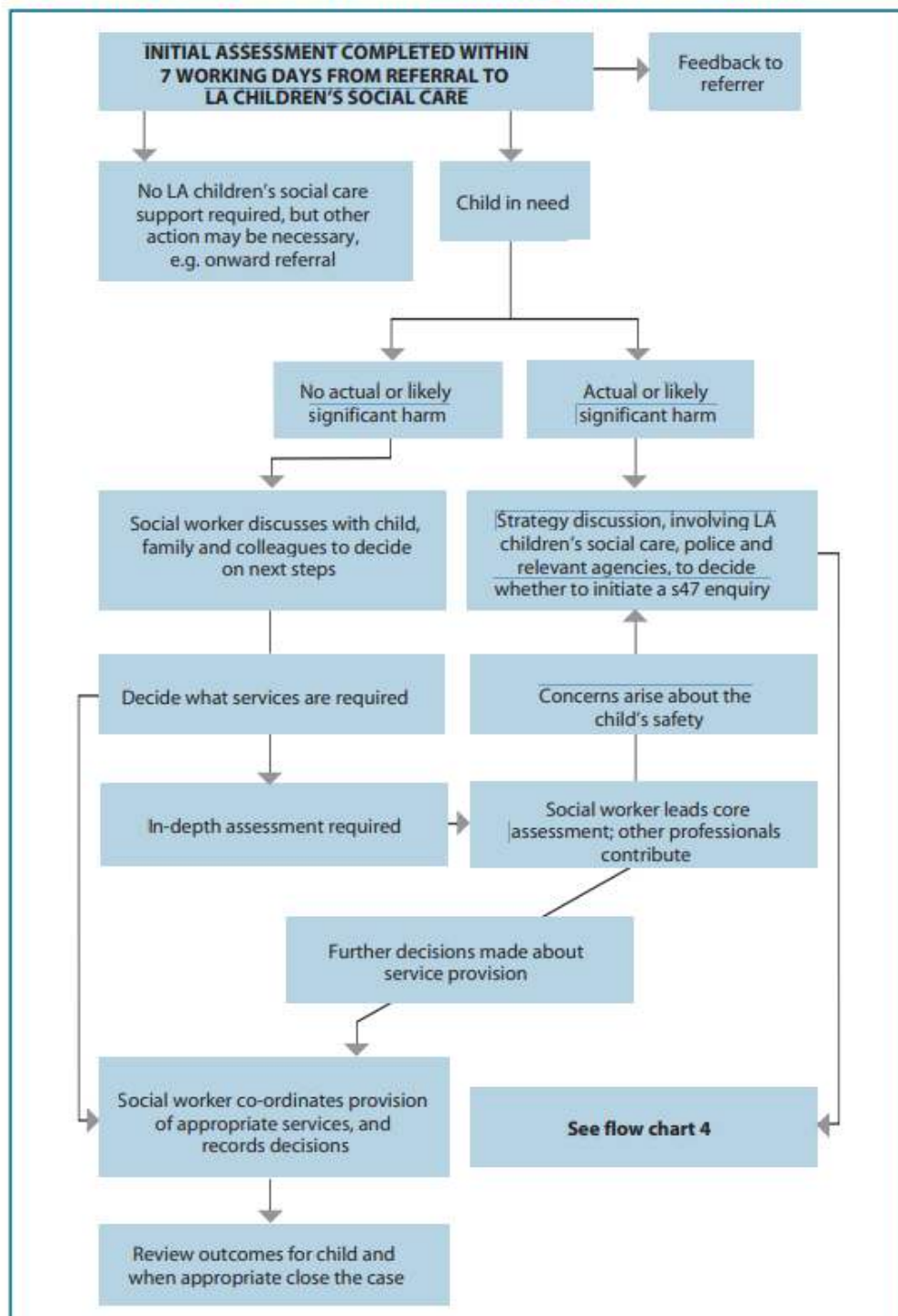
Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment			✓	The transgender community experience higher levels of abuse and discrimination. It is estimated that a transgender teenager is 8 times more likely to attempt suicide, than their peers. The policy will have a positive impact on transgender children, by supporting staff to protect them from harm and respond effectively to any safeguarding risks.
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights			✓	The European Convention on Human Rights and the United Nations Convention on the Rights of the Child enshrine the rights of every child in the world to survive, grow, participate and fulfil their potential. It sets standards for education, health care, social services and penal laws, and establishes the right of children to have a say in decisions that affect them. The policy will have a have a positive impact on children's rights, by supporting staff to protect them from harm, promoting their wellbeing and responding effectively to any safeguarding risks.
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				
	Yes	No		
What do you consider the level of negative impact to be?	High Impact	Medium Impact	Low Impact	No Impact
If the impact could be discriminatory in law, please contact the Equality and Diversity Lead immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required.				

<p>If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the Equality and Diversity Lead before proceeding.</p> <p>If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the Equality and Diversity Lead.</p>
Action Planning:
How could you minimise or remove any negative impact identified even if this is of low significance?
How will any impact or planned actions be monitored and reviewed?
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at bsmhft.edi.queries@nhs.net . The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis

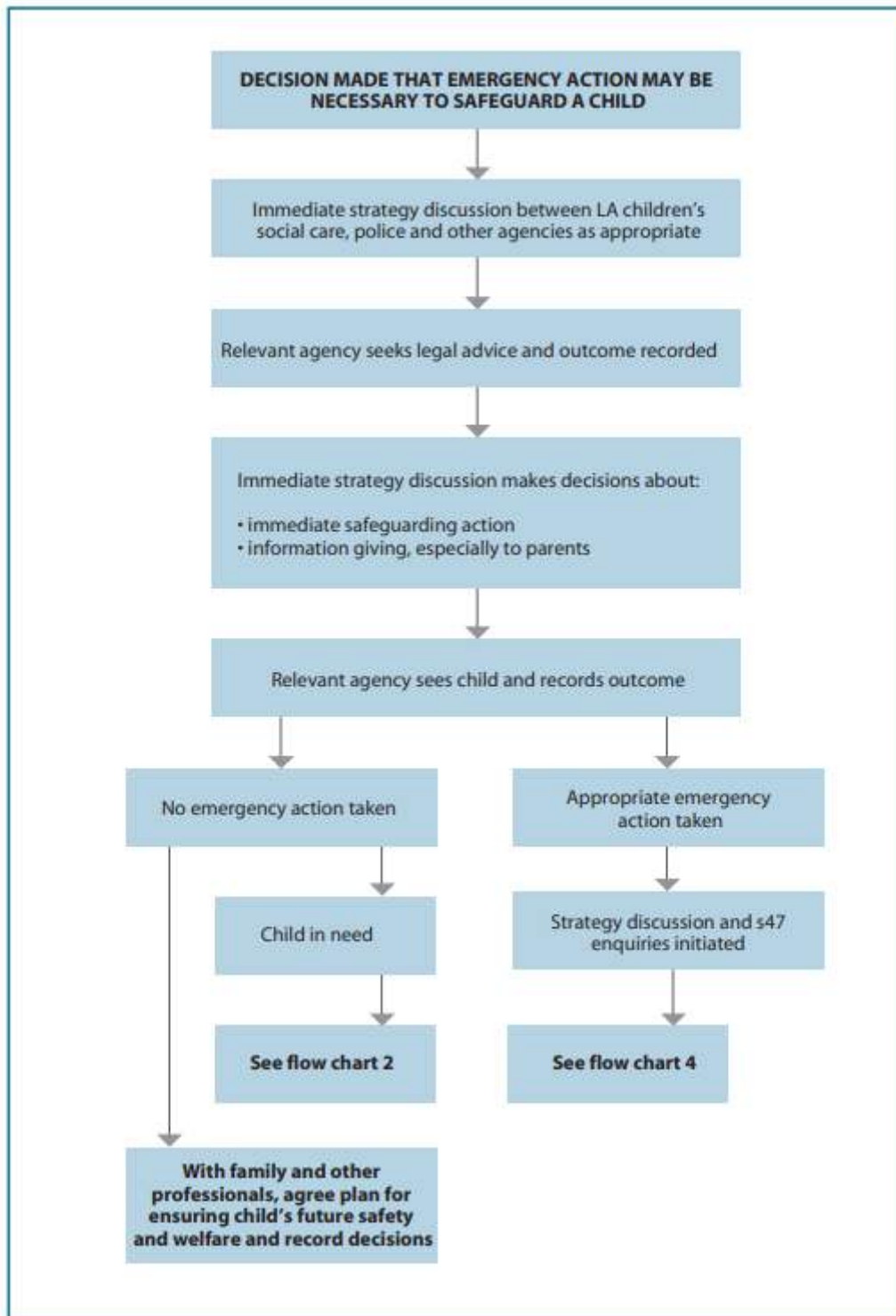
Flow chart 1 – Referral



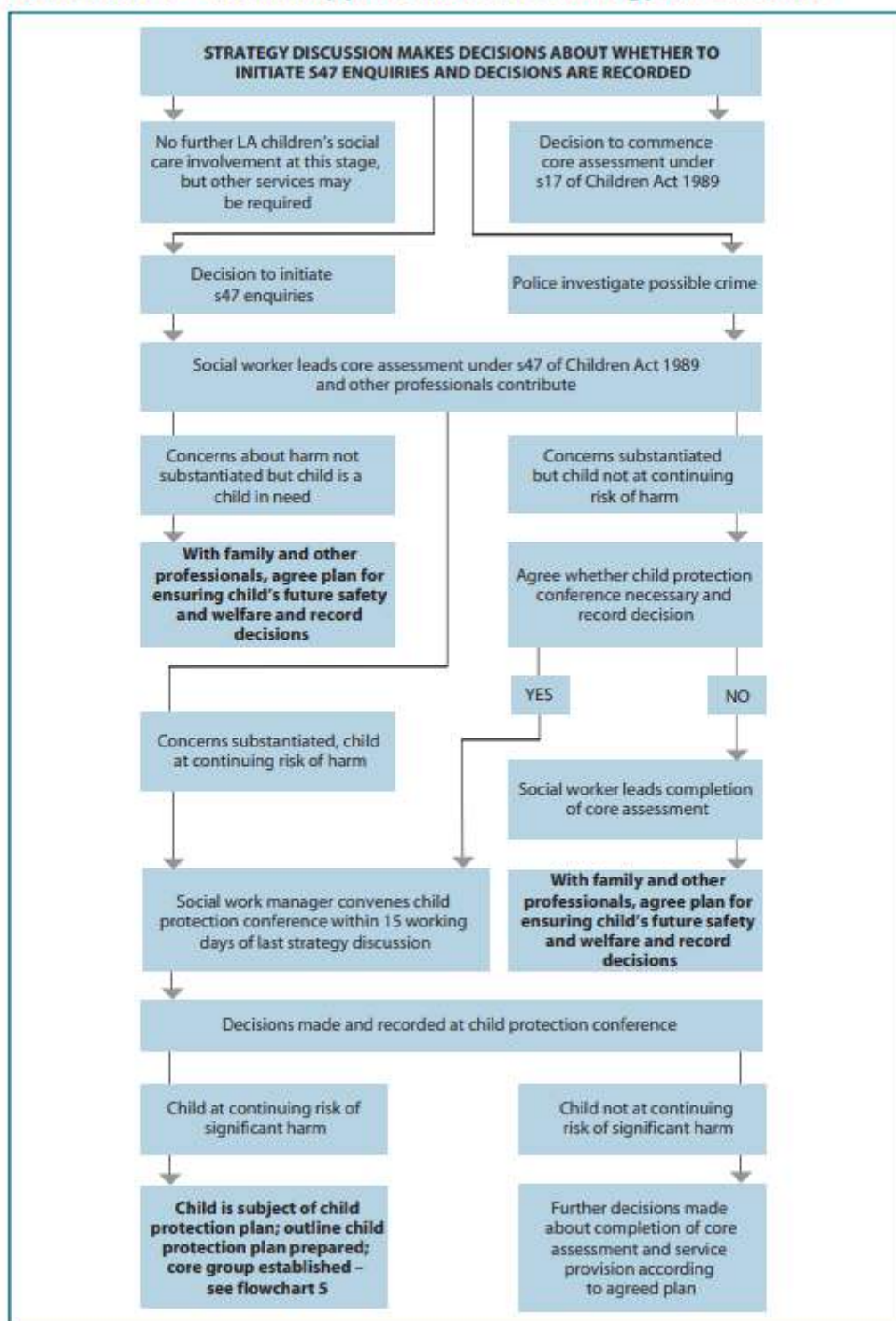
Flow chart 2 – What happens following initial assessment?



Flow chart 3 – Urgent action to safeguard children



Flow chart 4 – What happens after the strategy discussion?



Female Genital Mutilation (FGM)

FGM is practiced for a variety of complex reasons, usually in the belief that it is beneficial for the girl. Sometimes religious, social and cultural reasons are given to justify FGM, however it is a dangerous practice and can cause long-lasting health problems. FGM is a human rights violation and a form of child abuse, breaching the United Nations Convention on the Rights of the Child, and is a severe form of violence against women and girls. FGM is illegal in the UK under the Female Genital Mutilation Act 2003 and is child abuse.

Types of FGM (World Health Organisation Classification)

Type 1: Clitoridectomy – partial or total removal of the clitoris. Occasionally only the prepuce (clitoral foreskin) is removed;

Type 2: Partial or total removal of the clitoris and labia minora with or without excision of the labia majora;

Type 3: Infibulation – removal of the labia minora or labia majora with a seal being formed through healing of opposing wound edges. The clitoris may or may not be removed. A small hole is left to allow the passage of menstrual flow and urine;

Type 4: Any other harmful procedure on the female genitalia for non-medical purposes including piercing, scraping, pricking and cauterising.

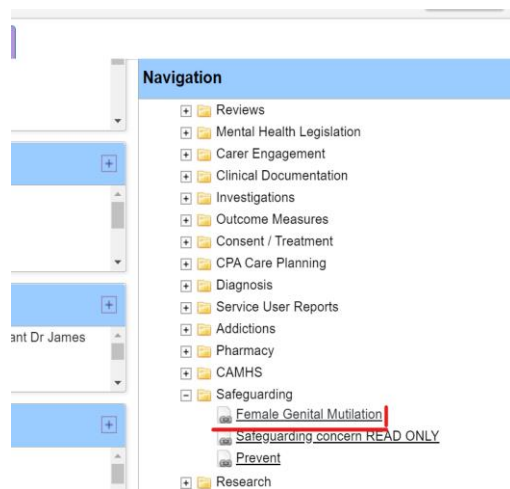
FGM is performed at different ages and can occur in early childhood (often between the ages of five and eight years), during adolescence, before marriage or during the first pregnancy. There is some evidence that the age is reducing in response to the increased awareness of statutory services and actions of these to prevent FGM.

Girls living in communities that practice FGM are at risk. It can happen in the UK or abroad. In the UK the Home Office identified girls and women from certain communities as being more at risk, including : Somali, Ethiopia, Sudan Nigeria, Yeman; Eritrea

The FGM mandatory reporting duty requires health professionals to report to the police (via telephone 101) any known cases of FGM in girls aged under 18 which they identify in the course of their professional work. However, if it is known that another professional has already made a report, there is no duty to make a second report. A case may be visually identified or verbally disclosed. Visual identification will generally be made in the course of another examination or while carrying out another task. There is no requirement for an examination to discover whether FGM has been carried out, nor for a full clinical diagnosis of FGM before a report is made. Verbal disclosure occurs when a girl discloses to you that FGM has been carried out on her. **The duty does not apply when another person – for example a parent, guardian or sibling – discloses that FGM has been carried out on a girl. However normal child protection procedures will still apply. The victim must be aged under 18 at the time of the**

disclosure – there is no duty to report cases in which an adult reports that FGM was carried out on her while she was still a child. The report should be made as soon as possible - it is generally best practice for reports to be made by the close of the next working day. The legal requirement is that the report must be made within a maximum timeframe of one month, and the expectation is that all reports will be made much sooner than this.

As part of BSMHFT staff mandatory reporting duty a form on Rio (under the safeguarding section) must be completed to add to the NHS Female Genital Mutilation Dataset. It is expected that where clinical staff identify FGM in the course of a consultation with a service user, a series of questions is asked and data is collected for the dataset.



Please follow this link for a flow diagram of the reporting process:
[FGM Mandatory reporting duty \(publishing.service.gov.uk\)](https://publishing.service.gov.uk)

Appendix 4

Safeguarding Standards:

- Making a Safeguarding Referral
- Record Family Composition
- Information Sharing in a Safeguarding Context
- Identify the need for Early Help
- Routine Enquiry
- Professional Challenge and Dispute Resolution
- Additional Reading



Safeguarding Standard
Making a Referral

The standards describe what is needed and what staff should be able to do to respond to safeguarding concerns. Safeguarding Standards describe core safeguarding activities. They benchmark good practice and allow staff to evaluate their own performance and identify any learning needs or other issues that get in the way.



Making a Safeguarding Referral

Overview

This standard is about making a safeguarding referral. Staff are required to make timely and effective referrals to access help and support for a child, adult or family when a safeguarding need has been identified.

Why this matters

Making a safeguarding referral helps keep children and adults at risk safe from abuse and maltreatment. This helps ensure that they have the best outcomes and are provided with safe and effective care. Safeguarding is everyone's responsibility, do not assume that another agency will keep a child or adult safe or that they will make a safeguarding referral.

A child, adult or family should be able to say: **"I get help and support to report abuse or neglect when I am in need of safeguarding"**

What you must be able to do

- Be clear that you have established that the child or adult requires a safeguarding response
- Access the Trust Safeguarding Hub for the referral form, relevant resources and information
- Discuss the referral with your manager, the Trust Safeguarding Team or Local Authority partners if you need to talk it through
- Gain consent for the referral if possible; if not possible provide a reason why
- Consider mental capacity to consent to referral and factors that may influence this, eg coercion
- Make a capacity assessment if necessary and document this on RiO
- Be specific about the safeguarding concern, give as much detail as possible
- Record all known demographic details about the person, their family and carers
- Advise what steps have already been taken to keep the child or adult safe
- Be clear about your role and how you are working with the child or adult
- Explain the type of team you are in and how you are involved in the care of the child or adult
- State the impact of the mental illness on the child, adult, their family and their carers
- Attach a copy of the referral to the BSMHFT eclipse form and ensure your manager is aware
- Follow-up the referral within 72 hours if there has been no response
- Make a record: document in the progress notes, add a safeguarding alert, update the risk assessment, upload the referral to the clinical documents file on RiO
- Maintain contact with the adult, child and family and keep them up to date with progress

How will you know this standard has been met?

Ask yourself:

- Has my referral been accepted by the partner agency?
- If my referral has been rejected am I clear why?
- Do I follow up on referrals and record the outcome?
- Do I maintain communication with my client and relevant professionals once I have made a referral?
- How can I demonstrate this?

Think about these questions and discuss them with your manager. Refer to the safeguarding behaviour profile for guidance. How confident do you feel about your safeguarding practice? Are there any gaps in your knowledge or skills? If so, what will you do next

Policy Statement

3.1.1 All employees have a responsibility to recognise, identify and respond to concerns about abuse, neglect or any safety concerns for service users and/or their families/carers (Policy No R&S 34)

3.1.6 Any identified adult safeguarding concern must also consider children's safeguarding (Policy No R&S 26)

1.3.7 All staff are expected to respond to possible and disclosed incidents of domestic violence and abuse as a safeguarding issue by ensuring an open and safe discussion, including an assessment of risk using the Domestic Abuse Stalking and Harassment risk screening tool. Also have considerations of raising a safeguarding concern with the local authority and or referring to the local Multi Agency Risk Assessment Conference (Policy No R&S 03)

This standard aligns to the following Think Family principle and BSMHFT policy requirement

- We work in partnership with others to form a full picture of need

Record Family Composition

Overview

This standard is about recording the details of family composition. Staff are required to request, receive and record family demographic details and information about significant others. This information must be accurate and regularly updated.

Why this matters

Effective assessments and safeguarding interventions rely on the sharing of accurate information about families and the context of relationships and caring responsibilities. If information is incomplete or out of date, the opportunity to provide timely and appropriate support to a child, adult or family may be lost. Registered staff are professionally accountable for the maintenance of detailed and reliable records and this information may be requested if a safeguarding response is required.

A child, adult or family should be able to say: "I am asked about my family and my caring responsibilities"

What you must be able to do

- Gather information from the point of assessment and at each episode of care
- Use the Children & Siblings form on RiO to record details of children's names and dates of birth, parental responsibility, and parenting arrangements.
- Record others involved in caring responsibilities and include their full names
- Establish which other agencies are involved with the family
- Inform other agencies involved of your role and your contact details
- Record that you have informed other agencies
- Keep adding to this form to record additional details e.g. parental responsibilities, Children Services' involvement, school details
- Always record the name of alleged perpetrators of abuse in progress notes. Don't use 'partner', 'ex-partner, 'husband'
- Be attentive to changes e.g. new partners. Update the record at each further contact
- Update the safeguarding section of the risk screen and the safeguarding risk alert on RiO if required

How will you know this standard has been met?

Ask yourself:

- Have I asked my client about any changes in their family situation?
- Do I know about their caring responsibilities and what this means for them?
- Do I routinely update records after each contact?
- Am I confident that my records are accurate and up to date?
- How can I demonstrate this?

Think about these questions and discuss them with your manager. Refer to the safeguarding behaviour profile for guidance. How confident do you feel about your safeguarding practice? Are there any gaps in your knowledge or skills? If so, what will you do next?

Policy Statement

3.1.4 At the point of assessment and on an ongoing basis the names and dates of birth of children and parental responsibility must be obtained and recorded on RiO for all the children of service users and/or children they live with (Policy No R&S 34)

3.1.5 It is important to always consider the wider family taking a "Think Family" approach. It is imperative that all assessments and on-going interventions include the context of family relationships, involve friends, carers and significant others (Policy No R&S 26)

3.1.3 All assessment, risk assessments and reviews should routinely enquire about the structure of the individual's family. The "Think Family" approach gives opportunity to look at all individuals' needs in the context of their life and the people around them including relevant children including all relational dynamics (Policy No R&S 03)

This standard aligns to the following Think Family principles and BSMHFT policy requirements

- We ask service users about their family and record the information
- We talk to family members, friends and carers

Information Sharing in a Safeguarding Context

Overview

This standard is about sharing information in the context of safeguarding when a need for help and support has been identified. Staff are required to share appropriate information promptly, securely and proportionately to promote welfare and safety. They should understand when consent to share information may not be necessary in a safeguarding context.

Why this matters

Information sharing is a key factor identified in many safeguarding reviews when there has been significant harm, or a person has died. In some situations, information sharing can be the difference between life and death (Department for Education 2018). It is also essential to enable early intervention and preventative work. A failure by practitioners to record information, to share it, to understand its significance and then take appropriate action leads to delay and increases risk. A child, adult or family should be able to say: **“I know that professionals treat my personal and sensitive information in confidence, only sharing what is helpful and necessary to promote my wellbeing and keep me and my children safe”**

What you must be able to do

- Recognise the need for further help and support
- Speak with the person about the identified need if it is safe to do so
- Base information sharing decisions on consideration of the safety and wellbeing of the individual, and others who may be affected by their action
- Seek agreement to share information if it is safe to do so
- Seek the agreement of parents to share information about their child/children
- Understand why parents may refuse consent and consider this in your risk assessment
- Balance children’s rights and wishes about what information is shared about them with the responsibility to keep them safe
- Understand the situations in which it is not necessary to gain consent to share information
- Ask for advice if you are unsure and avoid any delay in sharing information
- Consider mental capacity to consent and factors that may influence this, eg coercion.
- Make a capacity assessment if necessary and document this on RiO
- If you decide to make a safeguarding response without consent to share information, clearly state the reason for this on the relevant referral or request form
- Record your decision making and your actions on RiO

How you will know this standard has been met

Ask yourself:

- Do I recognise when information is personal and sensitive?
- Do I always consider the issue of consent when it is necessary to share this information?
- Do I know when to share information within and outside of my organisation?
- Do I routinely record my decisions about information sharing?
- How can I demonstrate this?

Think about these questions and discuss them with your manager.

Refer to the safeguarding behaviour profile for guidance. How confident do you feel about your safeguarding practice? Are there any gaps in your knowledge or skills? If so, what will you do next?

Policy Statement

3.2.3 Effective working together to safeguard and promote the welfare of children relies on appropriate information being shared in a timely manner with relevant professionals (Policy No R&S 34)

3.1.1 All employees have a responsibility to recognise, identify and respond to concerns about abuse, neglect or any safety concerns for service users and/or their families/carers. (Policy No R&S 26)

3.2.2 You should share information in order to prevent a serious crime; a danger to a person’s life; a danger to others; danger to the community; danger to the health of the person (Policy No R&S 03)

This standard aligns to the following Think Family principles and BSMHFT policy requirements

- We work in partnership with others to form a full picture of need and risk

Identify the Need for Early Help

Overview

This standard is about identifying the need for early help. Staff are required to proactively identify when a child, adult or carer has an emerging need for help and support and take timely and appropriate action.

Why this matters

Prevention is a core principle of safeguarding children, families, adults and carers. Statutory Inquiries following child deaths have identified that if children and families get support as early as possible, problems may be prevented from escalating into more serious harm (Laming 2003, 2009). Working in partnership with adults to provide early access to specialist services can support the person to manage emerging risk and take steps to keep themselves safe and well.

A child, adult or family should be able to say: **“I am confident that my needs will be discussed with the right people at the right time”**

What you must be able to do

- Recognise the need for early help and support
- Understand the difference between a need for early help and for a statutory safeguarding response
- Use the relevant Local Authority threshold document to guide your assessment of need
- Ask the person about the identified need and what they want to happen
- Seek consent to take further action and share information
- Ask appropriate others for information to support your assessment of need
- Ask about any support already in place
- Identify where to obtain advice and support in partner agencies
- Understand how to access early help and support from partner agencies
- Speak to your Manager about your concerns and/or discuss with the MDT
- Contact the Trust Safeguarding Team for expert advice if required
- Make a timely and effective request for support or needs assessment if this is indicated
- Record your decision making and your actions
- Record your decision making if no further action is taken

How will you know this standard has been met?

Ask yourself:

- Do I routinely consider the wider needs of my clients in assessments and care planning?
- Do I establish relationships with agencies and professionals who may provide additional support?
- Am I aware of the barriers that stop me from seeking early help and support?
- Do my supervisory discussions include cases where early help may have averted a crisis?
- How can I demonstrate this?

Think about these questions and discuss them with your manager. Refer to the safeguarding behaviour profile for guidance.

How confident do you feel about your safeguarding practice? Are there any gaps in your knowledge or skills? If so, what will you do next?

Policy Statement

3.2.1 All BSMHFT staff and volunteers have a responsibility to identify concerns relating to children due to the impact of their parent/carers mental health/substance misuse issues in line with the “Think Child, Think Parent and Think Family” approach although these concerns may not be at a level which requires statutory intervention. Sometimes families may require Early Help support which will not always require a referral to the Local Authority. (Policy No R&S 34)

3.1.3 Staff must always promote the adult’s wellbeing within a safeguarding context. People have complex lives and being safe is only one of the things they may want (Policy No R&S 26)

3.1.6 Staff should always promote the adult’s wellbeing within a safeguarding context. People have complex lives and being safe for that individual may be about maintaining the status quo (Policy No R&S 03)

This standard aligns to the following Think Family principles and BSMHFT policy requirements

- We talk to family members, friends and carers
- We consider the impact of mental illness on families
- We work in partnership with others to form a full picture of need

Routine Enquiry

Overview

This standard is about routine enquiry to facilitate disclosure of domestic abuse. Staff are required to ask service users about their relationship history as a routine part of good clinical practice, even when there are no indicators of violence and abuse. They must ensure that this is done safely and in private without any third parties present (NICE 2014, 2018).

Why this matters

Victims of domestic abuse are often reluctant or feel unable to disclose what is happening to them. Safe, routine enquiry at each contact with the service user increases the likelihood of disclosure and the opportunity to take effective safeguarding action. Registered staff have a duty to recognise the indicators of domestic abuse and to respond sensitively and appropriately, according to Think Family principles.

A person or their family receiving care at BSMHFT should be able to say: "I am asked about my relationships in private whenever I see my health professional in a way that helps me to disclose abuse should this be necessary"

What you must be able to do

- Ask a service user about their current and past relationships as a regular and routine part of every clinical contact
- Recognise that this is a Think Family principle and an opportunity for a victim of abuse to disclose if they are ready to do so
- Always make sure that it is safe to ask about relationships. Do this in private with no third-party present, including children, and where you are sure that you cannot be overheard, especially if contact is made virtually or by phone.
- Use professional judgement to decide when to use direct or soft questions to explore relationships.
- Understand why victims may be reluctant or unable to disclose domestic abuse and consider this in your work with the service user
- Understand the dynamic of coercion and control and how this may impact on decisions made by a service user; factor this into clinical thinking, discussion and action
- Always validate a disclosure of domestic abuse with non-judgmental acceptance
- Only use professional interpreters
- Know who the specialist domestic abuse agencies are, who are able to provide information, advice, support and advocacy and signpost
- Understand your responsibilities if a service user is identified as a perpetrator of abuse, if unsure refer to the BSMHFT policy (appendix 4)
- Understand the impact of domestic abuse on children and your duty to respond
- Work with the service user to help them make decisions about what they want to happen next.
- If you think the service user is at risk but they are declining support and you are unsure what action to take next, seek advice from your manager and Trust Safeguarding Team
- Follow BSMHFT policy and interagency procedures if there is a disclosure of domestic abuse
- Keep good records of any discussions and interventions and update demographic and partner details where new information is discovered

How will I know I have met this standard?

Ask yourself:

- Am I able to recognise, identify and respond to concerns about domestic abuse?
- Do I ask about relationships routinely at each clinical contact ensuring this is safe?
- Do I understand my duty to respond if a service user is a perpetrator of abuse?
- Do I record and update relevant documents when I have asked about relationships?
- How can I demonstrate this?
- Do I work in partnership with other agencies and share relevant and proportionate information about domestic violence and abuse?

Think about these questions and discuss them with your manager. Refer to the safeguarding behaviour profile for guidance. How confident do you feel about your safeguarding practice? Are there any gaps in your knowledge or skills? If so, what will you do next?

Policy Statement

3.11.2 If a service user discloses domestic abuse, checks must always be made if there are children in the household (Policy No R&S 34)

3.1.5 It is important to always consider the wider family taking a "Think Family" approach. It is imperative that all assessments and on-going interventions include the context of family relationships, involve friends, carers and significant others (Policy No R&S 26)

1.3.5 All members of staff have an individual duty to recognise, identify and take action where domestic violence and abuse is being perpetrated by individuals receiving care and support, towards their carers, family or significant others (Policy No R&S 03)

1.3.6 All clinical staff are expected to routinely enquire about all experiences of violence and abuse (past and current) including specifically domestic violence and abuse. (Policy No R&S 03)

This standard aligns to the following Think Family principles and BSMHFT policy requirements

- We ask service users about their family and/or partner and record the information
- We accept that an individual's safeguarding issues exist within a context of wider vulnerabilities and are always curious about this

Professional Challenge and Dispute Resolution

Overview

This standard is about professional challenge and dispute resolution. Staff are required to respectfully challenge when they consider that the action or inaction of another professional or agency does not adequately safeguard or promote the welfare of a child or an adult. They should know the local dispute resolution procedures to help them to do this.

Why this matters

Each practitioner has a role to play in the safeguarding process and is accountable for their contribution. Situations may arise when there is dispute and these should be managed promptly and directly, keeping the focus on the wellbeing and safety of the child or the adult. Failure to professionally challenge and to resolve disagreement may lead to delay in seeking appropriate care and support. It may also mean that essential knowledge that you hold about the impact of mental illness is lost and desired outcomes are not achieved.

A child, adult or family should be able to say: “My care team challenge other colleagues and agencies when there is a disagreement about the response to mine or my family’s need for welfare and safety”

What you must be able to do

- Respond promptly if you consider that the action or inaction of another colleague or an agency fails to promote the welfare or adequately safeguard a child, adult or family.
- Raise the concern directly with the professional or team involved
- Escalate the issue to your Line Manager if no agreement can be reached
- Call a professionals meeting with relevant colleagues if a safeguarding response is required and there is dispute about this decision
- Raise the issue with the BSMHFT Operational Service Manager and the Trust Safeguarding team if there is still a disagreement
- Document that you have challenged and escalated a dispute
- Refer to the relevant local Safeguarding Board policies and procedures for dispute resolution and escalation
- Record all actions and decisions, including no action, contemporaneously and accurately

How will I know I have met this standard?

Ask yourself:

- Have I challenged a decision when I have not agreed with it? If not, why?
- Do I challenge when I am not asked to participate in multi-agency meetings or contribute to multi-agency decision making?
- Have I been assertive in following up when there has been a disputed decision? If not, what has stopped me?
- Have I felt supported by my manager when I have disputed a decision?
- How can I demonstrate this?

Think about these questions and discuss them with your manager. Refer to the safeguarding behaviour profile for guidance. How confident do you feel about your safeguarding practice? Are there any gaps in your knowledge or skills? If so, what will you do next

Policy Statement

3.15.1 Occasionally situations arise when workers within one agency feel that the actions, inaction, or decisions of another agency do not adequately safeguard or promote the welfare of a child. (Policy No R&S 34)

3.15.2 In such situations, staff are required to follow the local LSCP Resolution and Escalation Protocol (multi-agency) – in the area the child resides. (Policy No R&S 34)

3.2.14 If the referral does not meet the Local Authority criteria to open a safeguarding enquiry yet staff remain concerned, staff should hold a professionals meeting inviting all relevant agencies/partners so that risks can be considered and effective monitoring and intervention can be formulated. (Policy No R&S 26)

1.1.5 BSMHFT is committed to promoting the safety and wellbeing of all adults (and relevant children) where domestic violence and abuse is a feature of their lives and their experience (Policy No R&S 03)

This standard aligns to the following Think Family principles and BSMHFT policy requirements

- We work in partnership with others to form a full picture of need

Additional Reading

BSMHFT Safeguarding Children and Young People Policy No R&S 34
 BSMHFT Safeguarding Adults Policy No R&S 26
 BSMHFT Domestic Violence and Abuse Policy No RS 03

West Midlands Safeguarding Policies and Procedures (2019)

[West-Mids-Policy-and-Procedures-Nov-2109.pdf \(safeguardingworcestershire.org.uk\)](#)

Birmingham Safeguarding Adult Board

<https://www.bsab.org/>

Solihull Safeguarding Adult Board website

<https://www.ssab.org.uk/>

Solihull Safeguarding Adult Needs Assessment Form

[Solihull Adults Self-Assessment Tool \(openobjects.com\)](#)

Birmingham Safeguarding Children Partnership

[Home - Birmingham Safeguarding Children Partnership \(lscpbirmingham.org.uk\)](#)

Birmingham Safeguarding Children Partnership Threshold Guidance

http://www.lscpbirmingham.org.uk/images/BSCP/Professionals/RHRT_Feb_2020/Right_Help_Right_Time_Guidance_Feb_2020.pdf

Birmingham Safeguarding Children Partnership Guidance on filling in Request for Support

http://www.lscpbirmingham.org.uk/images/Request_for_Support_Quality_and_Compliance_Guide.doc

Solihull Safeguarding Children Partnership

<https://solihulllscp.co.uk/>

Solihull Local Safeguarding Children Partnership and Threshold Guidance information

<https://solihulllscp.co.uk/practitioner-volunteers/threshold-guidance-22.php>

Solihull Safeguarding Children Interagency Referral Form

[Safeguarding children and young people | solihull.gov.uk](#)

Specific to Information Sharing

Information Sharing: advice for practitioners providing safeguarding services (2018)

[Information sharing: advice for practitioners \(publishing.service.gov.uk\)](#)

Confidentiality NHS Code of Practice 2003

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/200146/Confidentiality_-_NHS_Code_of_Practice.pdf

Working Together to Safeguard Children. A guide to interagency working to safeguard and promote the welfare of children (2018)

[Working Together to Safeguard Children 2018 \(publishing.service.gov.uk\)](#)

Specific to Professional Challenge & Dispute Resolution

Birmingham Escalation and Resolution Policy

http://www.lscpbirmingham.org.uk/images/BSCP/Professionals/Procedures/Resolution_and_Escalation_Protocol_FINAL_1.pdf

Solihull Escalation and Resolution Policy

[Birmingham Safeguarding Children Partnership Resolution And Escalation Protocol \(birminghamandsolihullccg.nhs.uk\)](#)

Specific for Identifying the Need for Early Help

[The Victoria Climbié Inquiry \(Laming 2003\)](#)

[The Protection of Children in England: A Progress Report \(Laming 2009\)](#)