CHUMS

Mental Health & Emotional Wellbeing Service

Safeguarding Children Policy

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CHUMS
Mental Health & Emotional Wellbeing Service
For Children & Young People

Safeguarding Children Policy

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Background

The aim of CHUMS is to offer children an opportunity to explore their thoughts and feelings in a confidential setting, either through 1 to 1 support at home, in school, virtually, at CHUMS premises, or through our group programmes.

Safeguarding is everyone's responsibility.

We commit ourselves to the protection and welfare of all children and adolescents with whom we are in contact.

It is the responsibility of each practitioner to identify the risks of harm through neglect, physical, sexual or emotional abuse of all children contacted through the work of CHUMS and to report any abuse disclosed or suspected to their Team Leader and/or the Safeguarding Lead and to take action where appropriate in line with the Local Safeguarding Children Partnership (LSCP) procedures.

The Service is committed to supporting, resourcing and training all staff and to offering appropriate supervision.

All staff and volunteers will undertake foundation e-learning during the induction process and before working with children and young people. This should be repeated on an annual basis by anyone working directly with children and young people.

All clinical staff will be able to complete a face-to-face safeguarding training course (training recommended by LSCP) in addition to the above where appropriate. It is recommended that all clinical staff attend 4 hours of safeguarding related training annually. The Safeguarding Lead will access enhanced safeguarding training as deemed appropriate by LSCP.

Safer recruitment guidance and practice is embedded throughout our HR processes.

All staff are responsible for keeping up to date with current recommendations for safeguarding children made in the publication "Working Together to Safeguard Children 2023" statutory guidance.

Updates were published December 2023 via link
https://www.gov.uk/government/publications/working-together-to-safeguard-children--2#full-publication-update-history

A member of staff is responsible for all issues relating to Safeguarding Children.

This policy will be reviewed on a tri- annual basis or sooner if important legislation changes.

The Children Act 1989 and the Children Act 2004

In order to safeguard the welfare of children and young people in their charge, voluntary organisations should consider the issues raised by each of the following statements of principle and take any action they see as necessary:

- Adopt a policy statement on Safeguarding the Welfare of Children
- Plan the work of the organisation so as to minimise situations where abuse of children may occur
- Introduce a system whereby children may talk with an independent person
- Apply agreed procedures for protecting children to all paid staff and Volunteers
- Give all paid staff and Volunteers clear roles
- Use supervision as a means of protecting children
- Treat all Volunteers as job applicants for any position involving contact with children
- Gain at least one reference from a person who has experience of the applicant's paid work or volunteer work with children
- Explore all applicants' experience of working or contact with children in an interview before appointing
- Find out if the applicant has any conviction for criminal offences against children
- Make paid and voluntary appointments conditional upon the successful completion of a probationary period
- Issue guidelines and responsibilities on how to deal with the disclosure or discovery of abuse
- Train paid staff and Volunteers, their managers, and policy makers in the prevention of child abuse

Data Protection and Confidentiality (GDPR)

The Data Protection Act (2018) and the General Data Protection Regulation (GDPR) sets the legal framework by which the Trust can process personal information. It applies to information that might identify any living person. The common law duty of confidentiality governs information given in confidence to a health professional (about a person alive or deceased) with the expectation it will be kept confidential. The GDPR is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately.

The General Data Protection Regulations (GPDR), implemented through the Data Protection Act 2018 identifies:

"That it is no longer necessary to seek consent to share information for the purposes of safeguarding and promoting the welfare of a child (i.e. removing the distinction between information sharing for the purposes of assessing need or child protection). It does, of course, continue to be good practice to inform parents/carers that you are sharing information for these purposes and to seek to work cooperatively with them. Agencies should also ensure that parents/carers are aware that information is shared, processed and stored for these purposes."

It is therefore important to be open and honest with the child and their parents/carers where appropriate from the outset about why, what, how and with whom information will, or could be shared, and seek their informed consent, unless it is unsafe or inappropriate to do so.

The information shared should be necessary, proportionate, relevant, accurate, timely and secure. Ensure that the information shared is necessary for the purpose for which you are sharing, it is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.

The child's best interest must be the overriding consideration in making any such decision of sharing information.

Information Sharing

"The duty to share information can be as important as the duty to protect patient confidentiality". (Caldicott 2 principle 7).

Effective sharing of information between professionals and local agencies is essential for safeguarding and promoting the welfare of children and young people. 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. Safeguarding Children Practice Reviews (SCPRs) have shown how poor information sharing has contributed to the deaths or serious injuries of children.

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 professional should assume that someone else will pass on information which they think may be critical to keeping a child safe. If a professional 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's social care.

Where sharing concerns with parents could increase the risks to a child, for example sexual abuse within the family when there is a danger of the parents silencing the

child; you should make the referral without informing the parents and record this in the notes.

Children have a right to be told what is going on. They should not be given promises that cannot be kept. Their views and wishes should be taken into consideration, in accordance with their age and developmental status.

Clients and children should be made aware that confidentiality can never be absolute, as staff have a duty to ensure they are protected from harm.

Information should be shared with the parent or carer and with the child appropriate to their age and understanding. This includes all reports for child protection conferences and some planning meetings, which should always be shared with the family before any meeting.

There will be circumstances in which it will not be in the child's best interests for information to be shared immediately.

Nevertheless, health professionals should not disclose without consent any information obtained in confidence, unless it is necessary to ensure the protection of a child at risk, or is necessary as part of a multi-agency comprehensive assessment to determine the level of risk.

The child's welfare should always be considered whenever a practitioner is communicating via email or post; for example to a GP/referrer, summarising involvement with a patient who is a parent or carer. This may include copying the letter to the relevant Local Authority Children Social Care where there are concerns. 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 social care.

Generally, if children's social care request information as part of a section 47 (child protection) assessment, practitioners have a duty to pass on information with or without client/parental consent. If the requested information is part of a section 17 (child in need) assessment, then information should only be given with service user or parental consent. Therefore, staff should clarify with children social care which section of the Children Act 1989 the assessment is being conducted under, in-order to know the level of client consent required.

Where a child in the family is subject of a child protection plan or where there are safeguarding concerns, services should ensure copies of letters sent to GPs summarising involvement in the case are copied to children's social care.

Data protection and the Caldicott Guardian

For further guidance on information sharing please contact CHUMS Caldicott Guardian. A Caldicott Guardian is a senior person for an organisation which processes health and social care personal data. They make sure that the personal information about those who use the organisation's services is used legally, ethically and appropriately, and that confidentiality is maintained. Caldicott Guardians should be able to provide leadership and informed guidance on complex matters involving confidentiality and information sharing.

Consent

Young people aged 15 and under may have capacity to consent to treatment. However, consent will likely need to be sought from an adult with parent responsibility. For further information please refer to CHUMS Consent to Treatment Policy. In most cases decisions can be taken by one individual with parental responsibility. Should another adult with parent responsibility object, they could seek a Prohibitive Steps Order. Cases of this nature should be discussed with a clinical supervisor and assessed on a case-by-case basis to consider some of the following:

- best interests of the child
- clinical relevance and timing of support

Young people aged 16 or 17 are presumed in UK law, like adults, to have the capacity to consent to medical treatment. However, unlike adults, their refusal of treatment can, in some circumstances be overridden by a parent, someone with parental responsibility or a court. This is because we have an overriding duty to act in the best interests of a child. This would include circumstances where refusal would likely lead to death, severe permanent injury or irreversible mental or physical harm. If there are reasons to believe a child aged 16 or over lacks capacity, an assessment of capacity to consent should be conducted and recorded in their notes. Please note -The Mental Capacity Act 2005 generally applies to people 16 and above, however there are some exemptions which apply to people age 18 and above.

Children under the age of 16 can consent to their own treatment if they have sufficient understanding and intelligence to fully understand what is involved in a proposed treatment. This includes its purpose, nature, likely effects, risks, and chances of success and the availability of other options. This is known as being Gillick competent. There is no presumption of Gillick competence. However, as with adults, this consent is only valid if given voluntarily and not under undue influence or pressure by anyone else. Additionally, a child may have the capacity or Gillick competence to consent to

some treatments but not others as assessment is decision specific and time specific. The understanding required for different interventions will vary and can fluctuate. Therefore, each individual decision requires assessment of Gillick competence.

If a child is assessed as not being Gillick competent or as lacking mental capacity to consent to particular treatment/intervention, then the consent of a person with parental responsibility, or in some circumstances the courts, is needed in order to proceed with the treatment. This could be:

- the child's mother or father (however not every father will have a parental responsibility)
- the child's legally appointed guardian
- a person with a child arrangement order with the live with component
- a local authority designated to care for the child
- a local authority or person with an emergency protection order for the child

Where a health professional accepts the consent of a Gillick competent child it cannot be overruled by the person with parental responsibility. However, where the same child refuses consent then they may obtain it from another person with parental responsibility who can consent to treatment on the child's behalf.

For more guidance on seeking consent for medical examination in children and young people see the General Medical Council's 0-18 years: Ethical Guidance for all Doctors.

Additionally, in cases where a child lacks mental capacity or is assessed as not being Gillick competent to consent to particular treatment/intervention and parents decline to provide such consent, practitioners should immediately seek advice from their clinical supervisor.

Furthermore, the advice should be sought in cases where the child is looked after by the Local Authority, as in some cases the local authority will not be in position to give consent to the treatment/intervention, especially if the care plan would amount to the deprivation of child’s liberty.

Categories of Abuse

Compulsory intervention into family life can only be justified where a child is deemed to be at risk of/or experiencing significant harm. Below this threshold support can be given to the family through an Early Help Assessment (EHA). The EH team can be contacted via the local social care teams. An EHA requires consent from the family to proceed.

For further information, refer to: Pan Bedfordshire Child Protection Procedures via https://bedfordscb.proceduresonline.com/contents.html

Physical abuse

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

Emotional abuse

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

Sexual abuse

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

Neglect

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

- Provide adequate food, clothing and shelter (including exclusion from home or abandonment)
- Protect a child from physical and emotional harm or danger

- Ensure adequate supervision (including the use of inadequate 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.

Fabricated or Induced Illness

Fabricated or Induced Illness (FII) Fabricated or induced illness is a condition whereby a child has suffered, or is likely to suffer, significant harm through the deliberate action of their parent and which is attributed by the parent to another cause. There are three main ways of the parent fabricating (making up or lying about) or inducing illness in a child:

- Fabrication of signs and symptoms, including fabrication of past medical history
- Fabrication of signs and symptoms and falsification of hospital charts, records, letters and documents and specimens of bodily fluid
- Induction of illness by a variety of means

The above three methods are not mutually exclusive. Existing diagnosed illness in a child does not exclude the possibility of induced illness. The very presence of an illness can act as a stimulus to the abnormal behaviour and also provide the parent with opportunities for inducing symptoms. Fabrication of illness may not necessarily result in a child experiencing physical harm, but there may be concerns about the child suffering emotional harm. They may suffer emotional harm as a result of an abnormal relationship with their parent and/or disturbed family relationships. Where fabricated or induced illness is suspected the parents/carers MUST NOT be informed as this could jeopardise the child/young person's safety and compromise any Section 47 (Children's act 1989/2004) enquiries. If any concerns relate to a member of staff, please contact the Safeguarding Children Team for advice.

Bruising in non-mobile babies

Current guidance Most safeguarding partnerships and NHS trusts have protocols for the assessment and management of bruising in non-mobile infants/children. These are typically based on the National Institute for Health and Care Excellence (NICE) clinical guideline 89 – when to suspect child maltreatment (National Institute for Health and Care Excellence, 2009) 2. This was originally published in July 2009 and last updated in October 2017. It contains evidence-informed guidance on when to suspect/consider child maltreatment. It is guidance intended for all health practitioners.

Specifically, in relation to bruises, the NICE guidance recommends that health professionals: 'Suspect child maltreatment if there is bruising or petechiae (tiny red or

purple spots) that are not caused by a medical condition (for example, a causative coagulation disorder) and if the explanation for the bruising is unsuitable… [including] bruising in a child who is not independently mobile.' In such situations a healthcare professional 'should refer the child… to children's social care, following local multi-agency arrangements'.

We recommend that in all cases of bruising in children who are not independently mobile there is: – a review by a health professional who has the appropriate expertise to assess the nature and presentation of the bruise, any associated injuries, and to appraise the circumstances of the presentation including the developmental stage of the child, whether there is any evidence of a medical condition that could have caused or contributed to the bruising, or a plausible explanation for the bruising; – a multi-agency discussion to consider any other information on the child and family and any known risks, and to jointly decide whether any further assessment, investigation or action is needed to support the family or protect the child. This multi-agency discussion should always include the health professional who reviewed the child.

Microsoft Word - PAN BEDS PATHWAY PROTOCOL IMMOBILE BABIES CHILDREN Final Updated 24.3.22 (proceduresonline.com)

Female Genital Mutilation (FGM)

Female genital mutilation (FGM) is a collective term for procedures, which include the removal of part or all of the external female genitalia for cultural or other non-therapeutic reasons. The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life. The procedure is typically performed on girls aged between 4 and 13, but in some cases it is performed on new-born infants or on young women before marriage or pregnancy. FGM is practised in at least 29 countries across Africa, parts of the Middle East and South East Asia. FGM is usually carried out on young girls between infancy and the age of 15, most commonly before puberty starts. It is estimated that 60,000 girls under 15 are at risk of FGM in the UK, and 137,000 women and girls in the UK have already been subjected to it. Child protection procedures should be followed when there are concerns that a girl is at risk of, or is already the victim of, FGM. It comprises all procedures that involve partial or total removal of the external genitalia or other injury to the female genital organs for cultural or non-therapeutic reasons. The practice is medically unnecessary and is linked to a number of forms of physical and psychological distress. There are also mandatory reporting procedures in place for health professionals in relation to FGM.

The duty to report applies in specific situations: Either

- A health professional is informed by a girl under 18 that an act of FGM has been carried out on her

Or

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

All clinicians should refer to and familiarise themselves with the publication "Mandatory Reporting of Female Genital Mutilation – procedural information HM Gov. Jan 2020. https://www.gov.uk/government/publications/mandatory-reporting-of-female-genital-mutilation-procedural-information.

For further information, refer to: FGM pathway – domestic abuse Pan Bedfordshire Child Protection Procedure May 2021 Section 3.6.4
https://bedfordscb.proceduresonline.com/contents.html

Breast Ironing

Breast Ironing (also known as breast flattening), is the process during which young pubescent girls' breasts are ironed, massaged, flattened and/or pounded down over a period of time (sometimes years) in order for the breasts to disappear or delay the development of the breasts entirely.

Breast ironing usually starts with the first signs of puberty, which can be as young as nine years old and is usually carried out by female relatives.

Warning signs that a girl could be at risk of breast ironing or breast flattening:

- A girl is embarrassed about her body
- A girl is born to a woman who has undergone breast flattening
- A girl has an older sibling or cousin who has undergone breast flattening
- If there are references to breast flattening in conversation, for example a girl may tell other children about it
- A girl may request help from an adult if she is aware or suspects that she is at immediate risk
- A girl from an affected community is withdrawn from Relationship and Sex Education (RSE) and/or Personal, Social, Health and Economic Education as her parents wish to keep her uninformed about her rights
- One or both parents or elder family members consider breast flattening integral to their cultural identity

- The family indicate that there are strong levels of influence held by elders who are involved in bringing up female children and support breast flattening
- A girl/family has limited level of integration within UK community

Warning signs that a girl is undergoing breast ironing or flattening:

- A girl may disclose to a professional
- Some girls may ask for help, perhaps talk about pain or discomfort in their chest area, but may not be explicit about the problem due to embarrassment or fear
- A girl may display reluctance to undergo medical examination

There is likely to be an impact on the child's social and psychological well-being. Although there is no specific law within the UK around breast flattening or breast ironing, it is a form of physical abuse and if professionals are concerned a child may be at risk of, or suffering significant harm, they must refer to their local safeguarding procedure. For more information on breast ironing / breast flattening, visit National FGM Centre website by clicking here

Child Criminal Exploitation and County Line

As set out in the Serious Violence Strategy (2018) published by the Home Office, where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18 into any criminal activity

(a) in exchange for something the victim needs or wants, and/or

(b) for the financial or other advantage of the perpetrator or facilitator and/or

(c) through violence or the threat of violence. The victim may have been criminally exploited even if the activity appears consensual.

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

County Lines is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of 'deal line'. They are likely to exploit children and vulnerable adults to move and store the drugs and money, and they will often use coercion, intimidation, violence (including sexual violence) and weapons. Potentially a child involved with a gang or with serious violence could be both a victim and a perpetrator. This requires professionals to assess and support his/her welfare and well-being needs at the same time as assessing and responding in a criminal justice capacity. Professionals should always take what the child tells them seriously. If a professional is concerned that a child is at risk of harm as a victim or a perpetrator of serious youth violence, gang-related or not, the

professional should wherever possible, consult with their line manager or the Safeguarding Children Team and make an immediate referral to Children's Social Care.

For further information, refer to: Pan Bedfordshire Child Protection Procedures May 2023, Section 3.8.5
https://bedfordscb.proceduresonline.com/contents.html
In addition, access information via VERU https://bedsveru.org/veru-village/frontline/

Extremism & The Prevent Duty

Extremism is defined in the Counter Extremism Strategy 2015 as the vocal or active opposition to our fundamental values, including the rule of law, individual liberty and the mutual respect and tolerance of different faiths and beliefs. Extremism goes beyond terrorism and includes people who target the vulnerable – including the young by seeking to sow division between communities on the basis of race, faith or denomination; justify discrimination towards women and girls; persuade others that minorities are inferior; or argue against the primacy of democracy and the rule of law in our society.

Children and young people can be radicalised in different ways:

- They can be groomed either online or in person by people seeking to draw them into extremist activity. Older children or young people might be radicalised over the internet or through the influence of their peer network – in this instance their parents might not know about this or feel powerless to stop their child's radicalisation
- They can be groomed by family members who hold harmful, extreme beliefs, including parents/carers and siblings who live with the child and/or person(s) who live outside the family home but have an influence over the child's life
- They can be exposed to violent, anti-social, extremist imagery, rhetoric and writings which can lead to the development of a distorted world view in which extremist ideology seems reasonable. In this way they are not being individually targeted but are the victims of propaganda which seeks to radicalise.

A common feature of radicalisation is that the child or young person does not recognise the exploitative nature of what is happening and does not see themselves as a victim of grooming or exploitation. The harm children and young people can experience ranges from a child adopting or complying with extreme views which limits their social interaction and full engagement with their education, to young children being taken to war zones and older children being groomed for involvement in violence.

PREVENT focuses on working with vulnerable individuals who may be at risk of being exploited by radicalisers and subsequently drawn into terrorism related

activity. What is important, if you are concerned that a vulnerable individual is being exploited in this way, you can raise these concerns in accordance with the CHUMS policies and procedures. Contracts of employment and professional codes of conduct require all healthcare staff to exercise a duty of care to patients and, where necessary, take action for safeguarding and crime prevention. If you have a concern, discuss it with the Safeguarding team and they will advise you regarding your local referral pathway.

For further information, please refer to:
Pan Bedfordshire Child Protection Procedures (VERU, PREVENT) Section 3.8.3
https://bedfordscb.proceduresonline.com/files/sg_radical_prevent.pdf

Abuse linked to Spiritual, Cultural and Religious Beliefs

Where parents, families and the child themselves believe that an evil force has entered a child and is controlling them, the child is likely to suffer significant harm. The belief includes the child being able to use the evil force to harm others. This evil is also known as black magic, kindoki, ndoki, the evil eye, djinns, voodoo, and obeah. Children are called witches or sorcerers. Parents can be initiated into and/or supported in the belief that their child is possessed by an evil spirit by a privately contacted spiritualist/indigenous healer, or by a local community faith leader. The task of exorcism or deliverance is often undertaken by a faith leader, or by the parents or other family members. A child may suffer emotional abuse if they are labelled and treated as being possessed with an evil spirit. In addition, significant harm to a child may occur when an attempt is made to “exorcise“ or “deliver“ the evil spirit from the child. Staff need to remember that while recognising that child rearing practices are highly diverse, and that all differences are to be valued and understood, it is also important that any judgements about the care and protection of children are based on objective assessment of facts. Sensitivity to parental behaviours, culture, religion, or ideology, whilst being important in the provision of care, must not mean that children from any background receive a lower level of care or protection.

For further information, refer to: https://www.beds.police.uk/advice/advice-and-information/caa/child-abuse/faith-based-abuse/

Forced Marriage

A forced marriage is one where either or both parties do not (or in cases of people with learning disabilities, cannot) consent to the marriage and pressure or abuse is used against them. Forced marriage, as distinct from a consensual 'arranged' one, is a marriage conducted without the full consent of both parties and where duress is a factor. Duress cannot be justified on religious or cultural grounds. It is recognised in the UK as a form of violence against women and men, domestic/child abuse and a serious abuse of human rights.

In 2004, the UK Government's definition of domestic abuse was extended to include acts perpetrated by extended family members as well as intimate partners. The pressure that is put on people to marry against their will may be physical (including threats, actual physical violence and sexual violence) or emotional and psychological (for example, when someone is made to feel that they are bringing shame on their family). Financial abuse (taking away a person's wages or not giving them any money) may also be a factor. If a person does not consent or lacks capacity to consent to marriage, that marriage must be viewed as a forced marriage whatever the reason for it taking place. Capacity to consent can be assessed and tested but is time-and-decision specific. Professionals should respond in a similar way to forced marriage as with domestic violence and honour based violence (i.e. in facilitating disclosure, developing individual safety plans, ensuring the child's safety by according them confidentiality in relation to the rest of the family, completing individual risk assessments, etc.)

For further information, refer to: Pan Bedfordshire Child Protection Procedure Section 3.6.1 May 2023 https://bedfordscb.proceduresonline.com/contents.html

E-Safety Children exposed to abuse through digital media

E- Safety: Children Exposed to Abuse through Digital Media Online / Information and communication technology (ICT) - based forms of child physical, sexual and emotional abuse can include bullying via mobile telephones or online (internet) with verbal and visual messages.

Children can experience a wide range of upsetting things online. The most common upsetting experience was 'trolling' (defined as 'unkind comments or rumours circulated online'). However, 'a significant minority had received sexual messages, been encouraged to self-harm, or subjected to language which was violent or aggressive' (NSPCC, 2017).

The Trust has a responsibility to:

- Understand e-safety issues
- Know how to help children stay safe on line
- Have procedures in place to support those working with children in knowing how to respond when concerns arise. Staff must have an understanding of the risks, dangers and potential harm, and be aware of the mechanisms which are in place to mitigate any risks and potential dangers; staff are required to recognise, challenge and respond to e-safety concerns. All CHUMS staff should conduct themselves in a professional manner, adhering to their professional codes of conduct and Trust policies at all times. This includes consideration in the personal use of social media and information technology.

For further information, refer to: Pan Bedfordshire Child Protection Procedures Nov 2023 Section 3.9.3 https://bedfordscb.proceduresonline.com/contents.html

Looked After Children/Young People or Children in Care

In England and Wales the term "looked after" is defined in law under the Children Act 1989. Looked after children fall into the groups below:

- Children who are accommodated under voluntary agreement with their parents (Children Act Section 20)
- Children who are subject to a care order (Children Act Section 31) or an interim care order (Children Act Section 38)
- Children who are subject to emergency care orders for their protection (Children Act Section 44 and Section 46)
- Children who are compulsorily accommodated; this includes children remanded to the local authority or subject to a criminal justice supervision order with a residence requirement (Children Act Section 21). The term also applies to children who are: Unaccompanied asylum seekers or those trafficked from abroad
- Children in family and friends placements
- Children where the agency has the authority to place the child for adoption. It does not apply to children who have been adopted or who are on a special guardianship order.

Looked after children are also often referred to as children in care, a term which many children and young people prefer (NSPCC, May 2023). This term will be used hence forth in this document.

Children in care have the same health needs as other children and young people, but their backgrounds and past experiences, and sometimes their experiences while they are "in care", make them especially vulnerable. In particular, many have to cope with sadness, distress and trauma which may affect their mental health and cause them to be more vulnerable. This may mean that they are more likely to engage in behaviours that can be detrimental to their health or expose them to risk.

Identifying and supporting Children in Care

CHUMS staff are responsible for collating information relating to the living circumstances of children and young people as part of an holistic assessment, particularly whether they are a Child in Care or have other related safeguarding needs. This information may be present in documentation from other services, from contact with the young person and/or their guardian/carer. We proactively seek and identify professionals involved as early as possible to ensure a robust care plan (e.g. Social Worker, Children in Care Nurses, Designated Teacher for Children in Care). For children in care the responsibility of care will remain with the allocated social worker.

Consequently, care plans must be developed under the supervision and advisement of the social worker, within the service remit and skills of the practitioner.

CHUMS has a statutory role in ensuring that arrangements are in place to meet the health needs of children in care. The team is responsible for assessing and ensuring that the health needs of all children in care with CHUMS referrals are shared with appropriate professionals to provide ongoing support (e.g including Social Worker in discharge care plans as best practice).

CHUMS has developed additional mandatory training relating to working with Children in Care including current best practice which highlights (NICE guidelines 2021):

- the importance of sharing information between services
- hearing young people's and carer's voices in all aspects of their care
- understanding their potential vulnerabilities and critical moments
- promoting positive relationships
- being aware of specific issues, e.g health needs or language barriers.

CHUMS has close links with local authority and specialised child in care teams to fulfil our statutory responsibilities. There is a pan Bedfordshire Children in Care local authority team. The team is supported by the ELFT Named Professionals for Safeguarding Children in Bedford.

Service Name	Contacts	Area and referrals
Bedfordshire Local Authority Children in Care Team	Telephone: 0300 555 0606 E-mail: ccs.beds.childrens.lac@nhs.net Website: https://www.cambscommunityservices.nhs.uk/Bedfordshire/services/CIC	Pan Bedfordshire Service Referrals from Children's Social care
North Bedfordshire CAMHS	Telephone: 01234 893301 E-mail for referrals: elft.spoebedfordshire@nhs.net Website: https://www.elft.nhs.uk/services/north-bedfordshire-camhs?ID=201	Referrals to be made on the website or CHUMS practitioners can complete a step-up for specialist support
South Bedfordshire CAMHS	Telephone: 01582 708140 E-mail for referrals: elft.luton-southcamhs-spoe@nhs.net Website: https://www.elft.nhs.uk/services/c	Referrals to be made on the website or CHUMS practitioners can complete a step-up for specialist support

	amhs-south-bedfordshire-and-luton	
ELFT Named Professional for Safeguarding Children in Bedfordshire	Elft.safeguardingchildrenteam@nhs.net	EWS staff currently attend quarterly safeguarding supervision and can liaise as needed

Responding to Potential Abuse and Neglect of Children in Care

Identification of Children in Care and contact information for adults/professionals with parental rights at the point of referral/assessment

Concern relating to a disclosure or evidence of potential:
- risk of from others (abuse/neglect)
- risk to self (self-harm/absconding)
- risk to others (violence/aggression)

Is the child or young person at risk of significant harm?

If you are not sure you can:

Review the Pan Bedfordshire Threshold document:

https://bedfordscb.proceduresonline.com/index.html

- seek guidance via the CHUMS escalation hierarchy and/or speak with the CHUMS safeguarding lead/Caldicott Guardian

- contact the appropriate integrated front door team for a "What if" call/advice and guidance

Yes

Ensure immediate safety of the child/young person, whilst you act e.g.

Keep them in a safe place whilst the danger is assessed/removed

This might include:

- Calling 999
- Liaising with the other relevant professionals to ensure immediate safety
- Removing dangerous objects
- Checking parental rights

Urgently share information:

1. Share information with the CYP's social worker
2. Share information with the adult responsible for caring for the CYP as long as this doesn't increase risk e.g.:
    a. Foster carer
    b. Residential home staff
3. Share with other designated staff as needed e.g. designated teacher for CIC, CAMHS LAC team, CAMHS Crisis
4. For concerns of gang activity, exploitation sexual and criminal, county lines, drug dealing, home invasion/cuckooing a Multi-agency information sharing form should also be sent: https://bedfordscb.proceduresonline.com/files/ma_form_revised_guidelines.pdf

No

With the CYP collaboratively consider sharing information with the social worker/adult with parental rights

(see appendix F in Safeguarding policy)

Follow CHUMS procedures for information sharing (appendix F) and local safeguarding referrals e.g.: follow-up within 72 hours

Designated Team

• Allocated social worker	
• Bedfordshire Local Authority Children in Care Team	0300 555 0606
• ELFT designated safeguarding children team	elft.safeguardingchildrenteam@nhs.net
• Designated Teacher for Looked After Children	Located in school
• CAMHS Children in Care and Crisis Teams	

Transition Planning for Children in Care

All children seen by CHUMS should experience a robust and collaborative transition of care to a responsible party, when this is required e.g. discharge, transition to adult services. This can be more complicated when the child is in care as there may be multiple stakeholders or transition of responsibility. Staff should therefore ensure that they are aware of the individuals with legal responsibility and liaise with them regarding the CYP care plan accordingly. When planning any transition every effort should be made to put the service user and their family/carers at the centre of this process. Particular consideration should be given to the service user's developmental needs around this time. The principles of personalisation, inclusion, participation and co-production are outlined in law (Care Act, 2014 & Children and Families Act, 2014) and should be adhered to during any transition.

Children to adult service transition

There is a duty on Health and Social Care to conduct transition assessments for children, children's carers and young carers where there is a likely need for care and support after the child in question turns 18 (Care Act, 2014). The guidance states that in order to fully meet these duties, local authorities should consider how they can identify young people and carers who are not receiving children's services but are nevertheless likely to have care and support needs as adults. CHUMS staff must therefore engage with this process and the relevant parties to share information appropriately to allow holistic and timely care planning. Practitioners working with young people requiring care and support needs should consider how to establish mechanisms and identify young people as early as possible in order to plan for or prevent the development of care and support needs and thereby fulfil their duty relating to 'significant benefit' and the timing of assessments.

Staff Ratios

The following are the minimum recommended staffing ratios for workshop or group programmes/events:

Children under 7 years

Two adults for up to eight children and one additional adult for every eight children.

Children over 7 years

Two adults for up to eight children and one additional adult for every twelve children.

Where children with additional needs are being supported, the ratio should increase dependent upon the needs of each individual child.

Good Practice Guidelines for the Prevention of Child Abuse

Children and Young People

As far as is possible, a worker should not be left alone with a child where their activity cannot be seen. This may mean leaving doors open, or two groups working in the same room.

In a therapeutic situation, where privacy and confidentiality are important, ensure that another adult knows that the session is taking place, where and with whom. At all times another adult should be in the building and the child should know that they are there and are contactable by the practitioner and young person. This is equally relevant for on-line and virtual working.

All children and young people should be treated with respect and dignity. Language, tone of voice, body position and body language should all be considered, as should discipline and maintaining control by establishing appropriate boundaries.

Do not let children involve you in excessive attention seeking that is of an overtly sexual or physical nature.

Confidentiality must be maintained at all times, except in the instance of suspected abuse or neglect.

Protecting Children on-line (following Covid-19)

Please refer to the link below from Unicef:

https://www.unicef.ca/sites/default/files/2020-04/PROTECTING_CHILDREN_ONLINE.pdf

Colleagues

If another member of staff is acting in a manner that might be misconstrued, be prepared to speak to them, your Team Leader or the Safeguarding Lead about your concerns.

As a service, we strive for an atmosphere of mutual support and care of each other, enabling us to be comfortable enough to discuss inappropriate attitudes and behaviour.

These measures should protect staff from false accusations.

Supervision

Supervision is mandatory for all, staff/volunteers should be committed to meeting at regular intervals to review, evaluate and plan the work.

Staff will be given time to reflect on the relationship they have with children/young people and the feelings that may arise as a result of this relationship. An entry should be recorded following each intervention on the dedicated database. The notes should not contain any judgements or personal thoughts but be a record of what was covered in the session. A personal journal may be kept for reflection. Any paper notes should be kept in a safe, locked place and returned to the office after sessions have finished.

Procedures if Child Abuse is Disclosed or Discovered

Code of conduct for all staff and Volunteers

Always remember that while you are caring for other people's children you are in a position of trust and your responsibilities to them and the organisation must be uppermost in your mind at all times.

DO NOT:

- Use any kind of physical punishment or chastisement such as smacking or hitting
- Smoke in front of any child
- Use non-prescribed drugs or be under the influence of alcohol
- Behave in a way that frightens or demeans any child
- Use any racist, sexist, discriminatory or offensive language
- Invite a child to your home or arrange to see them outside the set activity times
- Engage in any sexual activity (this would include using sexualised language) with a child you meet through your duties or start a personal relationship with them, this would be an abuse of trust
- Engage in rough or physical games, including horseplay
- Let allegations a child makes go unchallenged, unrecorded or not acted upon
- Rely upon good nature to protect you or believe "it could never happen to me"
- Give children presents or personal items *

*Exceptions to this could be a custom such as: buying children a small birthday token or leaving present, help to a family in need - such as equipment to enable them to participate in an activity. Both types of gift should come from the organisation and from a professional capacity and be agreed with the named person for safeguarding children and the child's parent/carer. Similarly do not accept gifts yourself other than small tokens for appropriate celebrations, which you should mention to the activity leader.

DO:

- Exercise caution about being alone with a child. In situations where this is unavoidable, ensure another worker or volunteer knows what you are doing and where you are
- Ensure that any physical contact is open and initiated by the child's needs, e.g. for a hug when upset or help with toileting. Always prompt children to carry out personal care themselves and if they cannot manage ask if they would like help
- Talk explicitly to children about their right to be kept safe from harm
- Listen to children and take every opportunity to raise their self-esteem
- Work as a team with your co-workers. Agree with them what behaviour you expect from children and be consistent in enforcing it
- Remember if you have to speak to a child about their behaviour you are challenging 'what they did', not 'who they are'
- Make sure you have read the Safeguarding Children Procedure and Policy and that you feel confident that you know how to recognise when a child may be suffering harm, how to handle any disclosure and how to report any concerns
- Seek advice and support from your colleagues and your designated lead for safeguarding children
- Be clear with anyone disclosing any matter that could concern the safety and wellbeing of a child that you cannot guarantee to keep this information to yourself
- Seek opportunities for training
- Where possible encourage parents to take responsibility for their own children
- Make sure you are up to speed with your organisation's confidentiality policy and the LSCP Information Sharing Protocol

Signs of abuse

The following MAY indicate abuse, but conclusions should not be made – there could be other explanations.

- Physical – unexplained or sudden injuries and lack of medical attention
- Emotional – reverting to younger behaviour, nervousness, sudden under-achievement, attention seeking, running away, stealing or lying
- Sexual – preoccupation with sexual matters, evident from words, play, drawings, etc. Being sexually provocative with adults. Disturbed sleep, nightmares, bed wetting, secretive relationships with adults or children, tummy pains with no apparent cause
- Neglect – looking ill-cared for or unhappy. Being withdrawn or aggressive. Having lingering injuries or health problems

If abuse is disclosed, discovered or suspected write down what you have been told using the 'Safeguarding Recording Incidents/Concerns' form attached to this policy (Appendix A).

Do not delay

Do not act alone

Do not start to investigate

Consult with your Team Lead or the Safeguarding Lead as soon as possible
If the child is in immediate danger, call the police and children's social care or Multi Agency Safeguarding Hub (MASH) in the area in which the child lives.

What to do if a child tells you about abuse (a summary for reference only)

- Look directly at the child
- Keep calm
- Accept what the child says
- Be aware that the child may have been threatened
- Tell the child that they are not to blame
- Do not press for information
- Reassure the child that they are right to tell and that you believe them
- Let them know what you are going to do next, who you are going to tell and why and roughly what will happen. Do not promise confidentiality
- Finish on a positive note
- As soon as possible afterwards, make notes of exactly what the child said and the date and time
- Consider your own feelings and seek support if needed
- Refer immediately to your Team Leader or the Safeguarding Lead for further action to be taken

Helpful things you may say:

- I believe you
- Thank you for telling me
- It's not your fault
- I will help you

Do not say:

Why didn't you tell anyone before?

I can't believe it

Are you sure this is true?

Why? How? When? Who? Where?

Never make false promises

Never make statements such as 'I am shocked, don't tell anyone else.'

Usual process of professional involvement

The child or young person (as appropriate to their understanding) and usually the parent or guardian should be informed that you plan to make a referral (unless telling them will put the child at additional risk or could impact on any criminal proceedings). If the child is at risk of significant harm you can refer without consent even if the family disagree with your decision. It is always best to discuss this with your safeguarding lead. A referral outcome should be received within 48 hrs. If not, this needs to be followed up after 3 days. If the referral is not accepted, consider if this decision should be challenged through escalation procedures. Please see the "Sharing Information – When and How Flowchart" for further information on consent and sharing information when safeguarding.

If a referral is accepted, following initial investigation a strategy meeting will be established involving Children's Social Care, Police Public Protection Team and other appropriate professionals which may include the referrer.

The investigation may include:

- An informal talk with the child
- A formal police and/or Children's Social Care video-recorded interview
- Medical examination
- Preliminary family assessment. There may be a decision to hold a child protection conference and information should be shared at this meeting. Alternatively, a decision may be made that the threshold has not been met and a child in need or early help team around the family meeting may be held instead.

Safeguarding Children and Young People with Suicidal Ideation

CHUMS supports children and young people who may be suffering with low mood. Clinical risk within most CHUMS services remains with the G.P. It is however, imperative that a clinical risk assessment is undertaken for all CYP and where it is felt there is a medium to high level of risk, with no or few protective factors, the clinician should ensure there is a safety plan in place. This may include, but is not

exclusive to, informing the G.P. of the current risk. In cases where there is immediate risk the clinician should contact the CAMHS crisis team. Where there is a raised level of risk but no immediate risk the clinician should ensure that the child/young person and their parent/carer know what to do should the level of risk escalate. Each clinician is responsible for talking to their clinical supervisor and/or the relevant safeguarding lead where the risk appears to be high or significantly escalating. In some circumstances the safeguarding lead may suggest a safeguarding form is completed. The safeguarding lead is then responsible for ensuring this is followed up appropriately. However, it is imperative that the clinical risk assessment form is continuously updated also within the PCMIS client database, along with chronological notes. The PCMIS alert function should be used where there is any increased level of risk. This will also alert the supervisor to the level of risk.

Transport

All vehicles used for transporting children must be registered, taxed and properly maintained. Vehicles must have a minimum of third party insurance and the insurance company should be made aware of the use of the car for this purpose. The number of passengers must not exceed the number of seats for which the vehicle is registered. It is the responsibility of the Safeguarding Lead to audit this on a regular basis.

When transporting children, the driver should normally have more than one child in the vehicle. If there is only one child, then they should be seated in the rear of the vehicle.

The driver must ensure that all children are using appropriate safety devices as required, including age and height appropriate booster seats etc. (for further information see appendix A). When collecting a child, the driver must be able to prove his/her identity via a CHUMS I.D. badge. As with Volunteers in other areas of the service all drivers must undergo enhanced DBS checks.

CHUMS Safeguarding Children Contacts

Bedfordshire & Luton

Safeguarding Lead – Debbie Robson
Main Office: 01525 863924
Email: debbie.robson@chums.uk.com

In event of absence – Antoinette Deavin
antoinette.deavin@chums.uk.com

Kent & Medway
Safeguarding Lead – Debbie Robson
Main Office: 01525 863924
Email: debbie.robson@chums.uk.com

In the event of absence – Oonagh Fowler
oonagh.fowler@chums.uk.com

Hertfordshire
Safeguarding Lead – Debbie Robson
Main Office: 01525 863924
Email: debbie.robson@chums.uk.com

In the event of absence – Polly Baddeley
polly.baddeley@chums.uk.com

Local Safeguarding Children's Social Care Contacts - Bedfordshire

Bedford Borough Council
Integrated Front Door
Tel: 01234 718700 (8.50-5.20 Mon-Thurs, 8.50-4.30 Fri)
Referral is via on-line form
Out of hours emergency duty team Tel: 0300 300 8123

Central Bedfordshire Council
Access and Referral Hub/MASH
Tel: 0300 300 8585
Referral is via on-line form
Out of hours emergency duty team Tel: 0300 300 8123
cs.accessandreferral@centralbedfordshire.gov.uk

Luton Council
MASH/Rapid Intervention & Assessment
Tel: 01582-547653
Referral is via on-line form
Email: mash@luton.gov.uk

Local Authority Designated Officer (LADO)
The LADO/Designated Officer should be contacted if you have concerns or receive a complaint or allegation that a worker/volunteer has:

- behaved in a way that has harmed a child, or may have harmed a child possibly committed a criminal offence against or related to a child
- behaved towards a child or children in a way that indicates he or she may pose a risk of harm to children

or

- behaved or may have behaved in a way that indicates they may not be suitable to work with children

Please see contact detail below.

Bedford – 01234 276 693 lado@bedford.gov.uk
Central Bedfordshire – 0300 300 8142 lado@centralbedfordshire.gov.uk
Luton – 01582 548 069 lado@luton.gov.uk

Other Useful Contacts:

Timothy Bull
ELFT Associate Director for Safeguarding Children
Tel: 07908 427759
Email: timothy.bull@nhs.net

Karen Patchett
Named Professional for Safeguarding Children in Bedford, East London NHS Foundation Trust
Mob: 07436 027740
Email: karen.patchett@nhs.net or mailto: elft.safeguardingchildrenteam@nhs.net

Mandy Park
ELFT Named Professional for Safeguarding Children (Luton and South Beds)
Tel: 07940 001247
Email: mandy.park@elft.nhs.uk or elft.safeguardingchildrenteam@nhs.net

Kent Safeguarding Children's Multi Agency Partnership
Room 2.71, Sessions House
County Road
Maidstone
ME14 1XQ
Tel: 03000 421126

Email: kscmp@kent.gov.uk
www.kscmp.org.uk

Out of Hours - Kent
Tel: 03000 419191

Medway Safeguarding Children's Partnership (MSCP)
Gun Wharf
Dock Road
Chatham
Kent
ME4 4TR
Tel: 01634 336329
Email: mscp@medway.gov.uk
www.medwayscp.org.uk/mscb/

Children's Social Service Care (First Response Service)
Gun Wharf
Dock Road
Chatham
Kent ME4 4TR
Tel: 01634 334466

Out of Hours
Tel: 03000 419191

Local Authority Designated Officer
Tel: 01634 331065

Designated Nurse for Safeguarding Children (Medway & North Kent)
Tel: 01634 335043

Hertfordshire Safeguarding Children Partnership

Hertfordshire Safeguarding Children Partnership | Hertfordshire County Council

Report concerns about a child or request support | Hertfordshire County Council

Essex Safeguarding Children Board

Concerns about the welfare of a child (escb.co.uk)

Appendix A

Transport Information

Children aged 3 and above, until they reach EITHER their 12th birthday OR 135cm in height:

In the Front Seat - The child MUST use the correct child restraint. It is illegal to carry a child in a rear-facing child seat in the front, which is protected by an active frontal airbag.

In the Rear Seat - The child MUST use the correct restraint, where seat belts are fitted.

There are three exceptions where there is not a child seat available. In each case the child MUST use the adult belt instead. They are:

1) In a licensed taxi or private hire vehicle
2) If the child is travelling a short distance for reason of unexpected necessity
3) If there are two occupied child restraints in the rear which prevent the fitment of a third

In addition, a child aged 3 and over may travel unrestrained in the rear seat of a vehicle if seat belts are not available.

It is the driver's legal responsibility to ensure that the child is correctly restrained.

Children over 1.35 metres in height, or who are 12 or 13 years old:

- In the Front Seat - The adult seat belt MUST be worn if available
- In the Rear Seat - The adult seat belt MUST be worn if available
- It is the driver's legal responsibility to ensure that the child is correctly restrained

Passengers over 14 years old:

- When travelling in the front or rear seat, an adult seat belt MUST be worn if available
- It is the responsibility of the individual passenger to ensure that they are wearing the seat belt

Appendix B

Safeguarding Form for Recording Incidents/Concerns (for Safeguarding Lead)

The importance of recording all stages of the safeguarding process cannot be overemphasised. Evidence from reports and reviews into deaths of children indicates the vital importance of good record keeping. This form is designed as an aide memoir to help ensure appropriate procedures are followed after a safeguarding concern. Please ensure that you distinguish between a fact, an allegation and an opinion within the report.

Please forward to the relevant safeguarding lead who is responsible for recording the information on the CHUMS Incident Tracker.

Name of child		Date of birth	

Brief description of concerns (including child's view)

By Whom………………………………………………………….

Date……………………………………….

Action Taken

Description of action taken (including who referred to, names, times, telephone numbers, etc.)

By Whom………………………………………………………………….
Date……………………………………….

If a referral has not been made, please give reasons as to why not	Signed	Date

Further Notes

Has this report been shared with the parents/guardian? Yes/No

Child's relationship with peers and with adults. (Include child's social skills).
CHUMS relationship with family and child.
Child's presentation (physical appearance, hygiene, diet if known, etc.).

Attendance and punctuality.			
Other comments.			
Signed:		Dated:	

Chronology of Events/Concerns

(to be kept in child's file)

Concern/event	Action/result

Signature…………………………………………………………………..

Date……………………………………….

Concern/event	Action/result

Signature…………………………………………………………………..

Date……………………………………….

Concern/event	Action/result

Signature………………………………………………………………..

Date……………………………………….

Chronology of Events/Concerns

Concern/event	Action/result

Signature………………………………………………………………..

Date……………………………………….

Concern/event	Action/result

Signature……………………………………………………………………..

Date……………………………………….

Concern/event	Action/result

Signature……………………………………………………………………..

Date………………………………………

Appendix C

CHUMS SAFEGUARDING CHILDREN FLOWCHART (Kent & Medway)

Are you concerned for a child's welfare?

↓

Discuss with Safeguarding Lead (or manager)

← **Still have concerns?** | **No longer have concerns** →

Still have concerns? ↓

Contact Children's Social Care (CSC) for the area in which the child lives:	
Kent Safeguarding Children's Multi Agency Partnership Room 2.71, Sessions House County Road Maidstone ME14 1XQ Tel: 03000 421126	Email: kscmp@kent.gov.uk www.kscmp.org.uk Out of Hours - Kent Tel: 03000 419191
Medway Safeguarding Children's Partnership (MSCP) Gun Wharf Dock Road Chatham Kent ME4 4TR Tel: 01634 336329	Email: mscp@medway.gov.uk www.medwayscp.org.uk/mscb/

↓

If it is decided that a formal referral should be made, complete a joint safeguarding referral form outlining the specific concerns/risks and send to appropriate team. **Emails must be sent to a secure email address.**	A CHUMS Safeguarding form should also be completed and given to the Safeguarding Lead. A chronology of events should be scanned and added to CYP notes. CHUMS practitioners also need to complete the "has safeguarding information dropdown" in the "Other demographics" section of the client record on PCMIS. This will create a flag on the record and allow staff to search for safeguarding flags.

Follow up with social care team if you have not had feedback within 48 hours of sending the referral. →

Record all actions and discussions:Who you discussed concerns with. Date and time of discussion: Rationale for decision and any follow up action

Appendix D

CHUMS SAFEGUARDING CHILDREN FLOWCHART
(Bedfordshire)

Are you concerned for a child's welfare?

↓

Discuss with Safeguarding Lead (or manager)

← **Still have concerns?** | → **No longer have concerns**

Still have concerns? ↓

Contact Children's Social Care (CSC) for the area in which the child lives:	
Bedford Borough Council Integrated Front Door	01234 718700 Out of hours emergency duty team : Tel: 0300 300 8123. Referral is via on-line form
Central Bedfordshire Council Access and Referral Hub/MASH	0300 300 8585 Out of hours emergency duty team : Tel: 0300 300 8123 Referral is via on-line form cs.accessandreferral@centralbedfordshire.gov.uk
Luton Council MASH/Rapid Intervention & Assessment	01582 547653 Referral is via on-line form Email: mash@luton.gov.uk

↓

If it is decided that a formal referral should be made, complete a referral form outlining the specific concerns/risks and send to appropriate CSC.

Emails must be sent to a secure email address.

A CHUMS Safeguarding form should also be completed and given to the Safeguarding Lead. A chronology of events should be scanned and added to CYP notes. CHUMS practitioners also need to complete the "has safeguarding information dropdown" in the "Other demographics" section of the client record on PCMIS. This will create a flag on the record and allow staff to search for safeguarding flags.

Follow up with CSC if you have not had feedback within 48 hours of sending the referral.

→

Record all actions and discussions:

- Who you discussed concerns with
- Date and time of discussion
- Rationale for decision
- Any follow up action

Appendix E

CHUMS SAFEGUARDING CHILDREN FLOWCHART (Hertfordshire & Essex)

Are you concerned for a child's welfare?

↓

Discuss with Safeguarding Lead (or manager)

← **Still have concerns?**

→ **No longer have concerns** → Record all actions and discussions (see below)

Still have concerns? ↓

Contact Children's Social Care (CSC) for the area in which the child lives:	
Hertfordshire Safeguarding Children Partnership Team Room 152 County Hall Hertford SG13 3DQ	0300 123 4043
Essex Safeguarding Children Board Room C228, County Hall Chelmsford CM1 1QH	0345 603 7627

↓

If it is decided that a formal referral should be made, complete a referral form outlining the specific concerns/risks and send to appropriate CSC. **Emails must be sent to a secure email address.**	A CHUMS Safeguarding form should also be completed and given to the Safeguarding Lead. A chronology of events should be scanned and added to CYP notes. CHUMS practitioners also need to complete the "has safeguarding information dropdown" in the "Other demographics" section of the client record on PCMIS. This will create a flag on the record and allow staff to search for safeguarding flags.

Follow up with CSC if you have not had feedback within 48 hours of sending the referral.

→

Record all actions and discussions:

- Who you discussed concerns with
- Date and time of discussion
- Rationale for decision
- Any follow up action

Flowchart of when and how to share information

You are asked to share information

Is there a clear and legitimate purpose for sharing information?

No

Yes

Yes

Do you have consent to share?[1]

No

No

Does the information enable an individual to be identified?

Yes

Not sure

Seek advice

Yes

Have you identified a lawful reason to share information without consent?

No

Do not share

You can share

Share information:

- Identify how much information to share.
- Distinguish fact from opinion.
- Ensure that you are giving the right information to the right individual.
- Ensure where possible, you are sharing the information securely.
- Inform the individual that the information has been shared if they were not aware of this as long as this would not create or increase risk of harm.

Record the information sharing decision and your reasons in line with your organisation or local procedures

If there are concerns that a child is in need, suffering or likely to suffer harm, then follow the relevant procedures without delay. Seek advice if unsure what to do at any stage and ensure that the outcome of the discussion is recorded.

Governance Committee Authorisation

Signature*	
Name Print	Dee Hogman
Position/Role:	Head of Quality
Date:	January 2024
Date of review:	January 2027

*Authorised signatory must be the chair (or deputising chair) of Governance Committee