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<th><strong>Author</strong></th>
<th>Deputy Designated Nurse for Safeguarding Children</th>
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<td><strong>Version</strong></td>
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## Version Control

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## Staff or Groups Consulted

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<tr>
<th>Name</th>
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<tr>
<td>Dr Derek Abel</td>
<td>Safeguarding Lead GP</td>
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<td>Joanna Sales</td>
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<td>Eugenia Lee</td>
<td>GP Executive Lead</td>
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<td>Associated Director of Governance &amp; Quality</td>
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<td>Interim Designated Adult Manager</td>
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<td>Carol Berry</td>
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<tr>
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<td>Risk Manager</td>
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<td>Interim Designated Nurse for Looked after Children</td>
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<tr>
<td>Hellen Makamure</td>
<td>Interim Governance Consultant</td>
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<td>GCCG</td>
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1. Introduction ..............................................................................................................6
2. Legal Context ..........................................................................................................6
3. Aims and Objectives ...............................................................................................6
4. Scope .......................................................................................................................7
5. National Context .....................................................................................................7
6. Definitions ...............................................................................................................7
6.1 A child ...................................................................................................................7
6.2 Safeguarding and promoting the welfare of children ...........................................8
6.3 Child protection ....................................................................................................8
6.4 Child in Need ........................................................................................................8
6.5 Significant Harm .................................................................................................8
7. Types of Abuse .......................................................................................................8
8. Actions to take if concerned that a child is being abused .......................................8
9. Roles and Responsibilities ......................................................................................9
10. Greenwich CCG ....................................................................................................9
10.1 GCCG Governing Body: .....................................................................................9
10.2 GCCG Chief Officer: .........................................................................................10
10.3 Integrated Governance Director: .......................................................................10
10.4 Designated Professionals Safeguarding Children ..............................................11
10.5 Designated Doctor: .............................................................................................11
10.6 Lead GP for Safeguarding Children ....................................................................12
10.7 Designated Nurse for Safeguarding Children ....................................................12
10.8 Designated Professionals for Looked After Children ..........................................13
10.9 Designated Doctor for Child Death Review Process .........................................13
10.10 CCG Director of Integrated Commissioning: ....................................................14
10.11 Commissioning Managers ...............................................................................14
10.12 CCG Patient Safety Managers: .........................................................................14
10.13 GCCG Communication Team: .........................................................................15
10.14 All GCCG Staff: ................................................................................................15
11. NHS England (NHSE London Region): .................................................................15
12. Provider Named Professionals: ............................................................................15
13. Governance Arrangements .................................................................................16
13.1 Quality Committee ..............................................................................................16
13.2 Joint Safeguarding Children and Adult Executive Group: ..................................16
13.3 Greenwich Safeguarding Children’s Board (GSCB): ............................................17
13.4 Greenwich Health and Wellbeing Board: ............................................................17
14. Safeguarding Children Training .........................................................................17
1. Introduction

NHS Greenwich Clinical Commissioning Group (GCCG) is strongly committed to safeguarding and promoting the welfare of all children and young people living in the Royal Borough of Greenwich. As with all NHS organisations, Greenwich CCG has a statutory duty to ensure that there are safe and effective arrangements to safeguard children and young people in order to fulfill its legal duties under the Children Act 1989 and section 11 of the Children Act 2004.

GCCG has a statutory responsibility to ensure that the organisations from which it commission services provide a safe system that safeguard children and young people at risk of abuse and neglect. This means safeguarding and promoting the welfare of children must be an integral part of the care offered to all children and their families by all staff working within the Greenwich CCG health economy. This may be care offered to children, young people, families or adults who are parents or carers. This duty applies to commissioners, providers from whom services are commissioned and also our partner agencies. GCCG has a Governance Framework for Safeguarding Children and Adults which shows its relationship to the wider health economy and its partners. GCCG also has a joint Safeguarding children and adult strategy. This policy is compliant with the Care Quality Commission Outcome 7 (Regulation 11) safeguarding service users from abuse. This policy should be read in conjunction with the GCCG Joint Safeguarding Children and Adult Strategy.

2. Legal Context
This policy is underpinned by the following:

The Children Act 1989 which provides a comprehensive framework for the care and protection of all children. The fundamental principle underpinning the Children Act is that the welfare of the child is paramount.

Children Act 2004 (section 11) which sets out duties for a wide range of bodies including Health which is incorporated into the statutory guidance: "Working Together to Safeguard Children" (Department for Education 2015). This guidance sets out how organizations and individuals have a duty to work together to safeguard and promote the welfare of children.

Safeguarding Vulnerable People in the Reformed NHS – Accountability and Assurance Framework (NHS England 2015), this document provides specific guidance to all NHS organizations and clearly sets out the responsibilities of each of agency for safeguarding in the NHS.

3. Aims and Objectives
This policy provides the framework that ensures a robust and safe system is in place to safeguard children and young people. The objectives are as follows:

- For GCCG and its workforce, to be aware of their responsibility to safeguard and promote the welfare of all children whether they work directly with children or not.
- For the workforce to undertake safeguarding children training in accordance with the competence level required by their role.
For GCCG to involve children and young people in the planning of services and incorporate their wishes and feelings in service design and delivery.
To enable the GCCG to work with NHSE, Local Safeguarding Children board, local partners to develop and improve safeguarding practice across the whole health economy.

4. Scope
The policy applies to all staff employed by GCCG, General practitioners as GCCG members, all temporary, voluntary and bank/agency staff. GCCG expects all its commissioned provider services to have their safeguarding children and young people policy.

5. National Context
The Mandate from the Government to the NHS Commissioning Board (NHS CB) is “We expect to see the NHS, working together with schools and children's social services, supporting and safeguarding vulnerable, looked-after and adopted children, through a more joined-up approach to addressing their needs.”

“The role of GCCGs and, indeed, the NHS CB is about more than just managing contracts and employing expert practitioners. It is about working with others to ensure that critical services are in place to respond to children and adults who are at risk or who have been harmed, and it is about delivering improved outcomes and life chances for the most vulnerable. So effective safeguarding arrangements in every local area should be underpinned by two key principles:

- Safeguarding is everyone’s responsibility.
- For services to be effective each professional and organisation should play their full part.

The GCCG should have a child-centred approach to commissioning services for children and for these services to be effective they should be based on a clear understanding of the needs and views of children. Provider services and commissioners should identify welfare needs or safeguarding concerns regarding individual children and where appropriate, provide support. This includes understanding risk factors, communicating effectively with children and families, liaising with other agencies, assessing needs and capacity, responding to those needs and contributing to multi-agency assessments and reviews. There is extensive guidance, national regulations, reports and legislation that govern how services should be commissioned, provided, managed and monitored.

6. Definitions
6.1 A child
This is regarded as 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.
6.2 Safeguarding and promoting the welfare of children
Is defined as:

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

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

6.4 Child in Need
This is defined under section 17 of the Children Act (1989) is a child or young person who is unlikely to achieve or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services; or a child who is disabled.

6.5 Significant Harm
The Children Act 1989 introduced the concept of Significant Harm; it is the threshold that justifies Children Social Services compulsory intervention in family life in the best interests of children. It gives 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.

This definition was clarified in section 120 of the Adoption and Children Act (2002) (implemented on 31 January 2005) so that it may include, “for example, impairment suffered from seeing or hearing the ill treatment of another”.

7. Types of Abuse
There are four main categories of child abuse namely:

- Physical Abuse
- Emotional Abuse
- Sexual Abuse
- Neglect (see appendix 1 for details)

8. Actions to take if concerned that a child is being abused.
Most GCCG staffs are unlikely to encounter children during the course of their normal working activities but those groups of staff who work directly with families are in a unique position to identify any abuse or neglect, or changes in behaviour which may indicate a child may be abused or neglected. Therefore GCCG staff should be:

- Alert to the signs of abuse and neglect in any setting;
- Question the behaviour of children and parents/carers if unusual.
- Take what they are told at face value.
- Contact designated professionals if they need help or advice and should know how
to refer to MASH if concerned.

- Contact the Police, NSPCC, and Children Social Care if they suspect that a child is in immediate danger.

All GCCG staff should be guided by the following principles:

- Children have a right to be safe and should be protected from all forms of abuse and neglect;
- Safeguarding children is everyone’s responsibility;
- It is better to help children as early as possible, before issues escalate and become more damaging; and children and families are best supported and protected when there is a coordinated response from all relevant agencies.
- Staff should not let other considerations, like the fear of damaging relationships with adults; get in the way of protecting children from abuse and neglect.

9. **Roles and Responsibilities**

Safeguarding Children and Young people is everyone’s responsibility; therefore it is important that all GCCG staff are clear about their roles and responsibilities with regard to safeguarding children and young people and their families.

10. **Greenwich CCG**

GCCG is a statutory partner of the Greenwich Safeguarding Children’s Board. The GCCG need to ensure its NHS commissioned providers meets their safeguarding responsibilities through its commissioning arrangements with them.

10.1 **GCCG Governing Body:**

The Governing Body ensures that there are robust safeguarding systems in place to effectively safeguard children and young people in the local health economy and these systems are monitored. The Governing Body is also responsible for:
• Ensuring that the GCGG and all commissioned provider services are meeting their statutory duties in relation to safeguarding children, young people and their families.

• Ensuring that safeguarding children and promoting the welfare of children experiencing or at risk of abuse and neglect is implemented effectively across the local health economy, both through commissioning arrangements and through the responsibilities of commissioned provider services’ boards and committees.

• Receiving an annual safeguarding children report and should be updated through reports to the Quality Committee.

10.2 **GCCG Chief Officer:**
The Chief Officer has overall responsibility for ensuring that the GCGG has appropriate strategies, structures, policies and procedures in place to ensure that children experiencing or at risk of abuse and neglect are safeguarded and that the commissioned provider services comply with relevant national legislation and discharge their duties effectively. The Chief Officer is also responsible for:

• Ensuring the GCGG and its commissioned providers work in partnership with the Royal Borough of Greenwich for promoting the development of initiatives to improve the prevention, identification, response and welfare of children experiencing or at risk of abuse and neglect across the whole local health economy.

• Seeking assurance from Safeguarding children designated professionals that the systems and practices are effective in recognising and preventing abuse and neglect.

• For signing the GCGG’ strategic plan and annual safeguarding children report.

10.3 **Integrated Governance Director:**
The Integrated Governance Director is the GCGG Executive Lead for Safeguarding children and provides appropriate representation alongside the Designated Nurse at the Greenwich Safeguarding Children Board to ensure their professional expertise is effectively linked into the local safeguarding arrangements. The Integrated Governance Director will work in partnership with the NHS England Director of Nursing in complying with the accountability and assurance framework. The Integrated Governance Director is responsible for:

• Ensuring that the needs of all children and young people are at the forefront of local planning and ensuring that the health services commissioned meet identified quality and safety standards.

• Ensuring that all commissioned services give assurance on their processes and systems for children’s safeguarding and that it is a standing agenda item at all Quality meetings.

• Working with NHSE to ensure that processes for safeguarding children are supported in primary care member practices and specialist services, also advice and support are in place to ensure safe services.
10.4  Designated Professionals Safeguarding Children
The Designated Doctor and Designated Safeguarding Nurse will take a strategic, lead on all aspects of the health service contribution to safeguarding children across the CCG area serve as appropriate, represent the GCG on the GSCB and sub-committees, providing expert advice on safeguarding issues. They will provide safeguarding advice and support on individual cases to statutory and voluntary agencies, including the Police and Children’s Social Care.

10.5  Designated Doctor:
The Designated Doctor will be responsible for the following:

- Ensuring primary care teams have easy access to pediatricians trained in examining, identifying and assessing children who may be experiencing abuse or neglect, and that local arrangements include having all the necessary equipment and staff expertise for undertaking forensic medical examinations. These arrangements should avoid repeated examinations.

- Supporting the Commissioning Team to bring together commissioning expertise on sexual violence services, to form a local Sexual Assault Referral Services (Haven) care pathway for children and young people. All SARS for children and young people, including services provide through

- Ensuring Sexual Assault Referral Centers (SARCs), services to Greenwich Children comply with the standards for paediatric forensic medical services’ Service Specification for the Clinical Evaluation of Children and Young People who may have been sexually abused (RCPCH, 2009), the National Service Framework for Children and the You’re Welcome quality criteria: Making health services young people friendly

- Advising other agencies, particular social care and the police, on health matters relevant to safeguarding children, to include policy as well as individual complex cases

- Liaising with health education providers to ensure appropriate child protection content is contained within pre-registration/undergraduate/postgraduate health professional training programmes

- Advising on practice guidance and policies for all those working within health and ensure that they are appropriately audited

- Ensuring that expert health advice on child protection is available to other agencies

- Ensuring that expert health advice on child protection is available on policy and procedures and day to day management of children and families to all specialties of health including, but not limited to, GPs, A&E, orthopedics, obstetrics, gynecology, child and adult psychiatry

- Attending the Local Safeguarding Children Board Partnership meetings and be an active member of any workgroup including serious case review workgroups.

- Providing safeguarding supervision to the Named GP for safeguarding children.
10.6 Lead GP for Safeguarding Children
The Lead GP for Safeguarding Children will be responsible for the following:

- Working with GP practices and staff to have robust systems/practices in place to ensure they can fulfill their role in safeguarding and promoting the welfare of children.
- Providing support to GP practices, protected time and access to Safeguarding training.
- Planning integrated GP out-of-hours services in their local area. Staff working within these services should know how to access advice from Designated and Named professionals within the GCCG and GSCB.
- Ensuring GPs and members of the Primary Health Care Team have access to a copy of the London Safeguarding Procedures.
- Attending the Local Safeguarding Children Board Partnership meetings and be an active member of any workgroup, including serious case review workgroups.
- Providing Safeguarding training to GPs in the local health economy.

10.7 Designated Nurse for Safeguarding Children
The Designated Nurse for Safeguarding Children is responsible for the following:

- Acting as a resource with expert knowledge of local support and services available for children and families to facilitate good communication and consistency of service provision.
- Ensuring staff know their local services, and be clear about the different agencies’ roles and responsibilities, so that they are not hesitant about responding appropriately.
- Delivering child safeguarding training with Named GP to all local GPs.
- Ensuring that provider organisations have training programmes and supervision is in place so that the level of safeguarding children supervision is commensurate with the degree and nature of contact that staff have with children and young people.
- Engaging in dialogue with the organisation's Named Nurse where provider organisations are subject to recommendations made by the Care Quality Commission.
- Ensuring that provider organisations have acted on recommendations from internal management reviews, serious case reviews and national inquiries.
- Informed of allegations against staff referral made to the Local Authority Designated Officer (LADO) by GCCG.
- Ensuring staff have easy access to safeguarding information during working hours and being a source of advice, expertise and good practice on child protection matters.
- Ensuring staff inductions include advice and instruction on the individual professional’s responsibilities in relation to promoting children’s welfare and safeguarding them from harm.
• Ensuring relevant staff receive regular supervision, sufficient to support staff to recognize children in need of support and/or safeguarding, which is appropriate to their responsibilities within the organisation.

• Ensuring arrangements are in place for child protection supervision for all staff involved in providing services to children and families and vulnerable adults who are parents and/or who may pose a risk to children.

• Coordinating the health component of serious case reviews and ensuring that the Chief Officer for the GCCG signs it off before submission.

• Attending the Local Safeguarding Children Board, GSCB Partnership meetings and be an active member of any workgroup, including serious case review workgroups.

10.8 Designated Professionals for Looked After Children
GCCG is responsible for ensuring that all Looked-after Children have their health needs assessed. This is achieved through a hosting arrangement with Oxleas NHS Foundation Trust. The Designated professionals for Looked after Children are responsible:

• Providing strategic leadership and clinical advice to the GCCG and Local Authority regarding how to improve the health of looked after children.

• Assisting GCCG in fulfilling its responsibilities as commissioner of services to improve the health outcomes for looked after children.

• Ensuring all looked after children get their health assessments and develop health plans, and advise on their implementation;

• Ensuring that Looked after Children are able to access universal services as well as targeted and specialist health services where necessary.

• Providing training for other health professionals and other agencies about looked after children’s health issues.

• Supporting provider services to gather and analyse the views of looked after children with regard to health and wellbeing, linking it to strategic and clinical advice and also service development.

• Engaging with and contributing to local, regional, national forums and networks as appropriate to the roles and responsibilities.

10.9 Designated Doctor for Child Death Review Process
Child Death review process is a statutory function set out in Regulations 6 of the Local Safeguarding Children Board Regulation (2006), made under section 14(2) of the Children Act (2004). The purpose of the child death review is to help prevent further such child deaths; it is not to allocate blame but to learn lessons. There two panels involved in the process: Child Death overview panel and the Rapid Response Panel.

GCCB is responsible for collating and analysing information about each death with a view to identifying any case giving rise to the need for a review:

• Responsible for any matters of concern affecting the safety and welfare of children in the area of the authority;

• Responsible for any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area;
• Putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

GCCG is responsible for:

• Securing the expertise of, consultant paediatrician and this is achieved through a hosting arrangement with a provider service.
• Providing advice on commissioning paediatric services, attending the Child Overview panel (CDOP) alongside the Designated Nurse and leading the Rapid Response process (RR).
• Disseminating learning and training on CDR processes.

10.10 CCG Director of Integrated Commissioning:
The Director of Integrated Commissioning is responsible:

• Ensuring the CCG’s procurement processes, service specifications, and invitations to tender guidance and service contracts have clear safeguarding children requirements considered in all prospective and new contracts.
• Ensuring that existing contracts have safeguarding children explicitly stated and that all commissioned provider services and contractors are fully aware and adhere to the agreed GCCG and multi-agency policies and procedures.

10.11 Commissioning Managers
Commissioning managers within the GCCG will ensure that service specifications of all health providers from whom services are commissioned include clear service standards for safeguarding and promoting the welfare of children, consistent with s1 1 of the Children Act (2004), London Child Protection Procedures (2011) and statutory guidance within Working Together to Safeguard Children (2015)

Services/service level agreements should take account of:

• Safeguarding responsibilities
• Equality and diversity
• The right to family life
• The principles of information sharing in accordance with statutory and other sharing information guidance
• All services commissioned or provided are delivered, are child centered and respect the individuality of each child.

These standards will then be robustly managed through GCCG’s contract monitoring processes. The Commissioning Managers will ensure that all new pathways, commissioning cases and QIPP schemes are impact assessed by the GCCGs Equality Impact assessment to ensure all consideration is given to children’s safeguarding requirements.

10.12 CCG Patient Safety Managers:
The GCCG Patient Safety Manager is responsible for the day-to-day management and oversight of all commissioned provider services serious incident (SI). The Patient Safety
Manager will work with and support the Designated Nurse for Safeguarding Children who will lead on coordinating/monitoring safeguarding serious incident (SI).

10.13 GCCG Communication Team:
GCCG communication team is responsible for managing incident that attracts media interest such as serious case review or domestic homicide review. GCCG Communication team has responsibility for:

- Identifying a clear communication plan for working with relevant colleagues both internally and externally to support effective management of safeguarding children concerns.
- For working with all the relevant parties to prepare media statements.
- Ensuring that patients and staff and other affected parties are informed before media statements are released.
- Confirming proposed handling arrangements with NHSE, where considered necessary develop communications/media handling strategies with other organizations and liaise with relevant stakeholders as appropriate
- Designing and implementing strategies for on-going and longer-term management of communications.

10.14 All GCCG Staff:
- Should be able to identify children at risk of abuse or neglect or a “child in need” and know how to act upon concerns, their depth of knowledge being commensurate with their roles and responsibilities.
- They must be aware of the vulnerabilities of certain groups of children such as those who are disabled, ‘looked after’ or privately fostered.
- Where there are child protection concerns GCCG Staff should discuss their concerns with the Designated Safeguarding Professionals as required and must know how to access support.

11. NHS England (NHSE London Region):
NHSE is responsibility for assuring the Department of Health that all NHS organizations in London are complying with government legislation as it relates to safeguarding Children and Young people and for commissioning independent investigations/inquiries in safeguarding Children cases which meet national agreed criteria.

12. Provider Named Professionals:
- Provider Named Nurses and Doctors should provide professional and clinical leadership on safeguarding children services within their own organizations and they need to ensure that a coordinated and integrated safeguarding service is provided.
- Ensure that services in their provider organizations are delivered in accordance with their Safeguarding Children Policy and that there are safe systems and processes in place for their staff.
- Promote good professional practice and provide specialist advice and support to health professionals within their organisation on any issue relating to safeguarding children.
• Ensure child protection supervision and training is provided for all staff as appropriate to their roles and responsibilities within their organizations. They have a key role in ensuring a safeguarding training strategy is in place and is delivered within their organization.

• Support provider organizations in their clinical governance role, by ensuring that safeguarding audits are undertaken, that safeguarding policies and procedures are in place.

• Support the GSCB local learning and improvement framework to learn from experience and improve services as a result. They should conduct internal management reviews as part of Serious Case Reviews when conducive to the chosen methodology and work closely with the Designated Professionals in implementing any recommendations made.

• Work closely with the Designated Professionals and to seek advice support and clinical supervision from them about complex cases.

Provider Executive Director should have overall accountability and responsibility for children safeguarding. All Provider Services including independent contractors should have their own safeguarding children guidance for their staff to follow in order that they can meet the above stated requirements.

13. Governance Arrangements
GCCG has a clearly defined safeguarding accountability and governance arrangements in place which ensures the GCCG is able to fulfill all its statutory requirements including the proactive and effective management of risk.

13.1 NHS GCCG Governing Body
• GCCG governing body has overall responsibility and accountability for ensuring that all quality and safeguarding duties are discharged effectively.

• The Governing Body will receive assurance that all responsibilities are discharged and that systems / processes are in place to monitor quality issues including safeguarding in an on-going way.

• Ensures arrangements are in place to deal with and learn from serious incidents and never events and has established appropriate systems for safeguarding from a committee of the Board, the Quality committee.

The governance reporting arrangement is mapped out in the Appendix 3.

13.2 Quality Committee
The Quality Committee is directly accountable to the GCCG Governing Body:

• Provides assurance that the governance systems, processes and behaviours by which the GCCG leads, directs and controls functions in place to achieve its organisational objectives. It is also responsible for:

• Oversees processes and compliance issues concerning both safeguarding children and adult and informs the GCCG Governing Body of any gaps in assurance or serious incidents in a timely manner.

13.3 Joint Safeguarding Children and Adult Executive Group:
This group has delegated responsibility and is directly accountable to the Quality Committee for ensuring that the GCCG discharges its statutory responsibilities in
relation to safeguarding and promoting the welfare of children and adults experiencing or at risk of abuse and neglect. This group is responsible for:

- Ensuring National safeguarding children directives are incorporated into GCCG’s processes including commissioning processes.
- Providing clinical leadership, expert advice to inform service delivery and development and provides assurance to GCCG.
- Seeking assurance that effective processes are in place for safeguarding children, young people and adult experiencing or at risk of abuse and Neglect.

13.4 Greenwich Safeguarding Children's Board (GSCB):
GSCB is the statutory body responsible for safeguarding children. The functions undertaken by the GSCB reflect the requirements of the Children Act 2004, and the Board has an Independent Chair with membership from Local Authority, Health commissioning and providers, police and probation service, legal advisor, voluntary sector, fire service, ambulance service and a Lay Member. The Director of Governance who is the GCCG executive lead for safeguarding children is a full member of the Greenwich Safeguarding Children Board. GSCB is responsible for:

- Improving outcomes for children by coordinating the work of local agencies to safeguard and promote the welfare of children and ensuring the effectiveness of that work.
- Providing strategic multi-agency leadership to obtain assurance from its partners that local safeguarding arrangements are effective and they protect and promote the welfare of children and young people living in Greenwich.
- Providing and/or ensuring the availability of appropriate expertise and advice and support to GSCB in respect of a range of specialist health functions, e.g. primary care, mental health (adult, adolescent and child) and sexual health and for co-ordinating the health component of serious case reviews.

13.5 Greenwich Health and Wellbeing Board:
The Greenwich Health and wellbeing boards has overall strategic responsibility for assessing local health and wellbeing needs in the Joint Strategic Needs Assessment (JSNA) and agreeing Joint Health and Wellbeing Strategies for RBG. They play a vital role in identifying and ensuring that the needs of children at risk of abuse or neglect are identified and addressed. The JSNA will support the commissioning of services so that effective coordinated help can be provided to those at risk and their families. The exact relationship between the GSCB and Greenwich health and wellbeing boards is for local determination.

14. Safeguarding Children Training
‘Safeguarding Children Roles and Competences for Healthcare Staff - Intercollegiate Document, (RCPCH 2014), sets out the levels of competence expected of all staff working within the health service. All staff must ensure that they possess the required knowledge, skills and competences as set out in that document.

Safeguarding Children Training is a mandatory requirement for all staff employed by GCCG – Appendix 5. Safeguarding competences are the set of abilities that enable staff to effectively safeguard, protect and promote the welfare of children.
and young people. They are a combination of skills, knowledge, attitudes and values that are required for safe and effective practice. Different staff groups require different levels of competence depending on their role and degree of contact with children, young people and families, the nature of their work, and their level of responsibility. The Intercollegiate Document identifies six levels of competence, and gives examples of groups that fall within each of these. The levels are as follows:

- Level 1: Non-clinical staff working in health care settings.
- Level 2: Minimum level required for clinical staff that have some degree of contact with children and young people and/or parents/carers.
- Level 3: Clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.
- Level 4: Named professionals
- Level 5: Designated professionals
- Level 6: Experts

15. Support and Supervision
The National Service Framework core standard 5 (NSF Standard 5-14, p170) recommends that ‘agencies provide direct supervision to staff working with children where there are concerns about harm, self-harm or neglect of a child. Supervision should be recorded using the appropriate form at the time of supervision and this will be signed by both the supervisor and the supervisee.

- Designated Doctor should provide supervision to the Named GP who will be supported to provide case by case supervision to local Greenwich GPs.
- Designated Nurse for Greenwich will provide safeguarding children supervision to Named Nurses in the community and the local hospital
- Designated Professionals will receive support from the Board lead for safeguarding and formal supervision should be paid for by the GCGG. This should be every quarter as a minimum.
- Designated Nurse should have peer-to-peer supervision to ensure continued development in their practice in line with agreed best practice.
- Designated Nurse is required to attend supervision meetings regularly with a lack of attendance raised as a professional concern in the annual appraisal and review process. These supervision meetings are to be formally recorded and preferably professionally facilitated.

The GCGG will also ensure that protected time is available to enable staff to receive safeguarding children supervision when required and it will be provided in addition to and separately from clinical supervision and management supervision within the GCGG.

16. Managing of allegation against Staff.
GCCG has procedure for dealing with allegation against staff or volunteers which is in line with GSCB policies. An allegation may relate to a person who works with children who has behaved in a way that has harmed a child, or may harm a child. The staff may have committed a criminal offence against or related to a child or behaved toward a child in a way that indicates they may pose a risk of harm to children.
- An allegation against GCCG staff that work with children should be reported immediately to the Integrated Governance Director and the Designated Nurse for safeguarding children who will inform the local authority Designated officer (LADO) within one working day.
- The allegation should not be dealt with in isolation. Any action taken to address the corresponding welfare concerns in relation to the child or children involved should be taken without delay or in a coordinated manner.
- The staff should be informed of the processes, including timescales, investigation and what support and advice is available to the individual.

17. Legal Advice
In complex situations it may be necessary to seek legal advice and guidance on specific safeguarding issues and access to legal advice/solicitors for GCCG is managed by the Director of Integrated Governance. Access to legal advice is via a Legal Services Framework Agreement. The Director of Integrated Governance can be contacted directly for further information and advice.

18. Serious case review / Alternative Reviews
NHS Greenwich Clinical Commissioning Group is responsible for coordinating the health component of serious case reviews (SCRs) following current national and local guidance via the Designated Child Protection Professionals.
- All SCRs will be notified to the Director of Integrated Governance, the Chief Officer as executive lead for safeguarding children and the Chair of NHS Greenwich Clinical Commissioning Group.
- The Director of Integrated Governance and the designated professionals will oversee Internal Management Reviews (IMRs) and/or Health Overview Reports for SCR’s completed for the Clinical Commissioning Group.
- GCCG will ensure that NHS England (London) and the Care Quality Commission (CQC) are notified of all SCRs.
- The Chief Officer will sign off the reports.
- The Quality Committee will monitor the implementation of any actions arising from an IMR or SCR and will provide reports to the CCG Governing Body.
- IMRs completed by Health Providers should be signed off by the respective NHS Trust Executive Lead for Safeguarding Children, not the Clinical Commissioning Group.
- The Communications, Safeguarding professionals and Governance team will agree any responses to media if appropriate.

19. Serious Incident Reporting and Multi-agency Safeguarding Procedures
GCCG aims to ensure that there are effective interface between safeguarding Children procedures and serious incident procedures. The coordination of investigations requires a mutual understanding of organisations’ statutory and legal responsibilities, effective communication, cooperation, transparency and learning across the multi-agency safeguarding Children partnership.

Serious incidents requiring investigation was defined in the NHS England Serious Incident Framework (March 2015) as an incident that occurred during NHS funded healthcare (including in the community), which resulted in one or more of the following:
• unexpected or avoidable death or severe harm of one or more patients, staff or members of the public;
• a never event - all never events are defined as serious incidents although not all never events necessarily result in severe harm or death;
• a scenario that prevents, or threatens to prevent, an organisation’s ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population;
• allegations, or incidents, of physical abuse and sexual assault or abuse; and/or
• loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation.

Designated professionals for safeguarding children will lead on safeguarding incident involving GCCG staff while Safeguarding serious incidents within primary care will be the responsibility of NHSE.

20. Risk Management
The Integrated Risk Management Framework sets out the GCCG’s overarching approach to managing risk in the organisation. It describes in sequence processes to enable continual improvement in decision-making when a safeguarding risk is identified:

• Discuss with the designated professionals and Director of Integrated Governance and a risk assessment form completed.
• Identified risk should be discussed at the Joint Safeguarding Children & Adult Executive Group and placed on the Risk register as appropriate.
• Joint Safeguarding Children & Adult Executive Group is responsible for approving; reviewing, monitoring and closing all identified safeguarding children risks.
• Designated Professional should provide regular update on the management until it is closed.

21. Duty of Candour
There is a legal “duty of candour” on all commissioned provider services. This involves acknowledging mistakes or other incidents in writing and face to face where desired have outcomes have not been achieved. Also apologies offered where appropriate, and advise on any action taken as a result. GCCG expects it commissioned provider services to have an open and transparent approach to its safeguarding practices and to work in partnership with commissioners to ensure the best outcomes are achieved for children and young people in the borough.

22. Disclosure and Barring Service.
This system provides checks on people entering the workforce, and maintains lists of individuals who are barred from undertaking regulated activity. GCCG will check all potential employees with the disclosure and baring service to help make safer recruitment decision.

All staff working with children and families will be checked at an enhanced level. Any exceptions to this will be flagged to the recruiting manager and GCCG board lead for safeguarding. NHS recognises that a disciplinary investigation and potentially a hearing may result in the commissioned provider service taking informal or formal measure.
which may include dismissal and possibly referral to the DBS. There are three levels of a DBS check. Each contains different information and the eligibility for each check is set out in law. They are:

- **Standard check**
- **Enhanced check**
- **Enhanced with barred list check.**

### 23. Information Sharing

Information sharing is an intrinsic part of every health practitioners’ job when working with children and young people. The decisions about how much information to share, with whom and when, can have a profound impact on individuals’ lives. It could ensure that a child receives the right services at the right time and prevent a need from becoming more acute and difficult to meet. At the other end of the spectrum it could be the difference between life and death. Poor or non-existent information sharing is a factor repeatedly flagged up as an issue in Serious Case Reviews carried out following the death of, or serious injury to, a child. Fears about sharing information cannot be allowed to stand in the way of the need to safeguard and promote the welfare of children at risk of abuse or neglect. No practitioner should assume that someone else will pass on information which may be critical to keeping a child safe.

GCCG expects all its commissioned provider services to have arrangements and mechanisms in place which set out clearly the processes and the principles for sharing information with other professionals, GCCG and the GSCB: this could be via an Information Sharing Agreement to formalise the arrangements.

**Key principles in information sharing:**

- Openly and honestly explain what, how and why information will be shared
- Always consider child’s safety and welfare – this must be the overriding consideration
- Seek consent always unless there is sufficient need to override.
- Seek advice when in doubt.
- Ensure that information is accurate, necessary, shared with appropriate people and stored safely
- Record the reasons for the decision – to share or not share information (HM Government Information Sharing (2015)).

### 24. Record Keeping

Good record keeping is a vital component of professional practice. Whenever a complaint or allegation of abuse is made, GCCG expects its staff and all commissioned provider services to:

- Keep clear and accurate records.
- Have procedures for managing a complaint or allegation and to record all actions taken;
- Keep records in such a way that the information can easily be collated for local use and national data collections;
• Identify arrangements, consistent with principles and rules of fairness, confidentiality and data protection for making records available to those children affected by, and subject to, an enquiry.

• Make information available to the GSCB or CCG on request.

GCCG expects managers of commissioned provider services to regularly review it processes when a concern is raised, review past incidents, concerns, risks and identity patterns. This information needs to be made available to RBG, the GCCG and the CQC when requested so necessary action can be taken. GCCG expects its commissioned provider services to give staff clear direction as to what information should be recorded and in what format.

25. Confidentiality
GCCG expects its commissioned provider services to have agreement relating to confidentiality and setting out principles governing the sharing of information. GCCG expects any agreement to be consistent with the principles set out in the Caldecott Review ensuring that:

• information will only be shared on a ‘need to know’ basis when it is in the interests of the child

• confidentiality must not be confused with secrecy;

• Informed consent should be obtained but, if this is not possible and the child is at risk this should override confidentiality.

26. Consent
Sharing information for safeguarding purposes would normally require the consent of a Gillick competent child or their parent. However if this agreement cannot be obtained for a child in need of protection the relevant information should be shared with appropriate services as the need to safeguard the child would be considered to be in the wider public interest. GCCG staff should document reasons for decision made.

27. Whistle Blowing
GCCG has a Whistle Blowing policy which enables concerns to be raised at an early stage and in the right way without fear of reprisals or concern for safety. A culture of open practice underpins effective safeguarding within an organisation. This may be in relation to an individual’s conduct and practice, illegal activity or a widespread or systemic failure in the provision or management of services to children and adults which places them at risk.

28. Resolving Professional Conflict
When a GCCG employee is not satisfied with the outcome of a child protection or safeguarding referral then they can use the Greenwich Safeguarding Children Board Resolving professional Conflict Policy. Discuss concerns with professional involved, line manager, then the Designated Nurse or doctor who will escalate it to the services manager and then to GSCB if still unable to resolve.
29. Safeguarding Contract Monitoring Arrangements
The NHS Standard Contract requires all provider services to comply with commissioner’s policy for safeguarding. GCCG expects all its commissioned provider services to demonstrate strong commitment to safeguarding children within all the services they provide and to comply with the commissioner’s policy, safeguarding children metrics, standards and training documents. GCCG expects all commissioned provider services to demonstrate evidence that it is:

- Addressing safeguarding concerns,
- Meeting expected standards,
- Training its staff in accordance with its training strategy and policy
- Includes the metrics, standards and concerns being discussed at the provider services’ safeguarding committee prior to submission to the GCCG.
- Participating in the development of any local multi-agency safeguarding quality audit.

Compliance monitoring is based on the identified safeguarding children key performance indicators identified within the contract and demonstrated via the GCCG’s safeguarding dashboard. All provider services are expected to present the GCCG’s safeguarding dashboard to their respective safeguarding committee. The completed dashboard plus the minutes from their respective safeguarding committee will then be submitted to GCCG. This will be discussed at the GCCG’s Joint Children and Adult Safeguarding Executive Group meeting. GCCG expects the commissioned provider services’ boards to seek assurances that directly employed staff have access to training and advice on safeguarding. Training is a continuing responsibility and should be provided as a rolling programme. Whilst training may be undertaken on a joint basis and the GSCB has an overview of standards and content, it is the responsibility of each commissioned provider services to train its own staff.

Designated professionals must be consulted and able to influence decision at all points in the commissioning cycle to ensure all services commissioned meet the statutory requirement to safeguard and promote the welfare of children.

30. Archiving of Documents
Documents must be retained in accordance with the requirements of Records Management: NHS Code of Practice DH (2006) and the CCGs Records Management Policy.
31. Review/ Monitoring

<table>
<thead>
<tr>
<th>Measurable Policy Objective</th>
<th>Monitoring/Audit</th>
<th>Frequency of monitoring</th>
<th>Responsibility for performing the monitoring</th>
<th>Responsible Committee or Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding policy will be reviewed / updated in accordance to changes in legislation or guidance.</td>
<td>Policy review</td>
<td>2 yearly</td>
<td>Designated Nurse</td>
<td>Governing Body</td>
</tr>
<tr>
<td>GCCG staff training compliance report</td>
<td>Training</td>
<td>Six monthly</td>
<td>Designated Nurse</td>
<td>Quality Committee</td>
</tr>
<tr>
<td>Report Safeguarding alerts to RGB</td>
<td>Safeguarding alerts</td>
<td>Quarterly</td>
<td>Designated Nurse</td>
<td>Quality Committee</td>
</tr>
<tr>
<td>NHSE Assurance framework audit</td>
<td>Assurance</td>
<td>Annually</td>
<td>Designated Nurse</td>
<td>Governing Body</td>
</tr>
</tbody>
</table>

32. Audit
To ensure that the safeguarding arrangements are satisfactory, a safeguarding audit will be undertaken by the Safeguarding Children Team as part of the annual safeguarding audit programme. The results of the audit will be submitted to the Quality Committee through the Joint Safeguarding adult and Children Executive group.

Further audits, either internally or by Greenwich Safeguarding Children Board may be undertaken in relation to specific circumstances to ensure compliance with for example, Serious Case Reviews recommendations and section11 statutory requirements.
33. References

Children Act 1989 London: HMSO

Children Act 2004 London: HMSO

Children (Leaving Care) Act (2000)
www.opsi.gob.uk/acts/acts2000/00035-a.htm

Care Leavers (England) Regulations 2010


Equality Act 2010

Human Rights Act 1998 London: HMSO,

Safeguarding Children Roles and Competences for Healthcare Staff - Intercollegiate Document, (RCPCH 2014)


Sexual Offences Act 2003. London: HMSO,

www.everychildmatters.gov.uk/socialcare/safeguarding/privatefostering
Guidance


Department of Education (2009) Statutory guidance on children who run away and go missing from home or care. www.education.gov.uk/childrenandyoungpeople/safeguarding/a0066653/youn_g-runaways


HM Government 2015 Information Sharing – Advice for practitioners providing safeguarding services. DfE publications.


HM Government (2014) Multiagency Practice Guideline- Female Genital Mutilation (Home office publication) www.gov.uk
<table>
<thead>
<tr>
<th><strong>Appendix 1: Child Abuse Information</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical abuse</strong></td>
</tr>
<tr>
<td>This may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. A parent or carer may be fabricating the symptoms of illness in a child or deliberately inducing illness in a child which may also cause physical harm.</td>
</tr>
<tr>
<td><strong>Emotional abuse</strong></td>
</tr>
<tr>
<td>This is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child’s emotional development. Emotional abuse may involve conveying to children 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. Emotional abuse 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.</td>
</tr>
<tr>
<td><strong>Sexual abuse</strong></td>
</tr>
<tr>
<td>This involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. It may not necessarily involve a high level of violence. The sexual 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. Sexual abuse 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). Adult males do not solely perpetrate sexual abuse; women can also commit acts of sexual abuse, as can other children.</td>
</tr>
<tr>
<td><strong>Child sexual exploitation</strong></td>
</tr>
<tr>
<td>This is a form of sexual abuse where children / young people are sexually exploited for various reasons such as money, power or status. It can involve violent, humiliating and degrading sexual assaults. In some cases, young people are persuaded or forced into exchanging sexual activity for money, drugs, gifts, affection or status. Consent cannot be given, even where a child may...</td>
</tr>
</tbody>
</table>
believe they are voluntarily engaging in sexual activity with the person who is exploiting them. Child sexual exploitation doesn't always involve physical contact and can happen online. A significant number of children who are victims of sexual exploitation go missing from home, care and education at some point. If concerned that a child or young person is or may be sexually exploited, refer immediately to MASH team and also contact the Safeguarding Lead for CSE on 0208 921 4435 for consultation /complete Part 1 of the CSE MAP referral form and email it to CSEMAP@royalgreenwich.gov.uk at least one week before the meeting. The referrer will need to attend the meeting to present the case to the panel.

### Neglect:
This 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.) Neglect may involve failing to protect a child from physical and emotional harm or danger, not ensuring adequate supervision (including the use of inadequate care-givers) or not ensuring access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs.

### Forced Marriage
Forced’ marriage is defined as that marriage which is conducted without the valid consent of at least one of the parties and where duress is a factor, it is different from a consensual ‘arranged’ marriage. Duress cannot be justified on religious or cultural grounds, and forced marriage is an abuse of human rights. Forced marriages of children must be regarded as a child protection issue. You would not contact the parents in this situation and you should make a direct referral to the Police Child Abuse Investigation Team who will liaise with social care. For further advice contact the Forced Marriage Unit on 020 7008 0230 or 020 7008 0151 www.fco.gov.uk

### Honour Based Crime
Honour Crimes- involves violence, including murder, committed by people who want to defend the reputation of their family or community. Honour killing is the murder of a person accused of bringing shame upon his or her family. Where young or vulnerable adults are suspected or at risk of suffering from this a referral to social services must be made. When an interpreter is required, it is imperative that family members are not used; the use of an independent interpreter is required.

### Female Genital
This comprises of all procedures involving the partial or total removal of the external female genitalia or other injury to the...
Mutilation: Female genital organs for non-medical reasons. FGM is child abuse and a form of violence against girls and women. Greenwich has a very diverse population. There are a significant number of girls who come from communities where Female Genital Mutilation has been traditionally practiced. It is illegal in the UK and carries a custodial sentence. It is now mandatory for any NHS healthcare professionals to record within a patient’s clinical record and report cases of FGM in the under 18 to the police. It is also mandatory for all acute hospitals, mental health services and GP to collate and submit data about the number of patients identified with FGM to the Department of Health.

Health professionals encountering a girl or woman who has undergone FGM should be alert to the risk of FGM in relation to her:

- Younger siblings;
- Daughters or daughters she may have in the future;
- Extended family members.

There is no requirement to ask every woman whether they have had FGM. Professionals are reminded to be aware of the risk factors, including country of origin (see multi-agency guidelines for list of countries), and to use their professional judgement to decide when to ask the patient if they have had FGM. It remains best practice to share information between healthcare professionals to support the on-going provision of care and efforts to safeguard women and girls against FGM. For example, after a woman has given birth, it is best practice to include information about her FGM status in the discharge summary record sent to the GP and Health Visitor, and to include that there is a family history of FGM within the Personal Child Health Record (PCHR).

Fabricated Induced Illness: Concerns may occur when the health and development of a child is significantly impaired by the actions of the parent or carer who has fabricated or induced an illness in a child. Working Together to Safeguard Children 2013, and the NICE guidance on ‘When to Suspect Maltreatment’, give detailed descriptions on what to look for in these cases, but three main indicators of fabricating or inducing illness are:

- Fabrication of past medical history
- Falsification of medical charts, documents or letters
- Induction of illness by a variety of means

This is not an exclusive list. Where a member of staff suspect a
| **Private Fostering Arrangements** | Private fostering occurs when a child under 16 (or 18 if disabled) is cared for by an adult who is not a relative for more than 28 days, by private arrangements between the parent and the carer. This is different from children in the care of a local authority.

Should any member of the CCG become aware of a child who is privately fostered they must inform the Designated Nurse for Safeguarding Children and Children Social care, to ensure the child and family receives the appropriate care and support. |
|---|---|
| **Children not brought to their health appointments** | When parents or children frequently miss health appointments then the professionals must review their case and see if there are any issues of neglect or abuse. The NICE guidance on ‘When to Suspect Child Maltreatment’ (2009), states that neglect should be considered if:

A parent fails to administer essential prescribed treatment for their child.

• A parent fails to attend essential appointments or follow-ups that are necessary for their child's health and well being

• A parent persistently fails to obtain NHS treatment for their child’s dental caries (tooth decay). If a child has missed a health appointment then staff should:

• Check the appointment was given to the correct person/address

• Are there any known safeguarding concerns including neglect or patterns of missed appointments in the child or other family members’ records?

• Offer another appointment

• Talk to a line manager and Designated Nurse for Safeguarding Children.

• Consider a referral to social care. GCGG expect all service providers to have a policy that address these issues. Each GP should develop practice guidance and procedures to manage children who miss appointment. |
| **Prevent** | The Prevent Strategy was reinforced by the Prevent and Channel statutory duties set out in the Counter-Terrorism and Security Act (2015). This strategy sets out how the UK Government aims to stop people becoming terrorists or
supporting terrorism. Channel is a supportive multi-agency process, designed to safeguard those individuals who may be vulnerable to being drawn into any form of terrorism.

Channel works by identifying individuals who may be at risk, assessing the nature and extent of the risk, and where necessary, providing an appropriate support package tailored to their needs. A multi-agency panel, chaired by the local authority, decides on the most appropriate action to support an individual after considering their circumstances. Prevent aims to deliver early intervention to protect and divert people away from the risk they may face at an early opportunity. Partners already work with individuals vulnerable to being drawn into criminal activity such as drugs, knife or gang crime. In a similar way the process of radicalisation allows us to intervene to prevent individuals being drawn into terrorist related activity.

NHS GCCG expects its commissioned provider services to report on PREVENT activities in accordance with the NHS England Prevent quarterly returns and discussed at their respective safeguarding committee.
Legal Framework

The Equality Act (2010) outlaws direct and indirect discrimination, including less favorable treatment, harassment and victimisation of people based upon their protected characteristics. The Act applies to all individuals, providers of services and employers.

This Safeguarding Children Policy supports the legislation and guidance in:

- Health and social care Act 2012
- Safeguarding children and young people: roles and competencies for health care staff. Intercollegiate document (2014)
- Protecting children and young people: the responsibility of all doctors D GMC (2012)
- Every Child Matters (DCSF 2003)
- Public Law Outline (2008)
- The Victoria Climbié Inquiry (SH 2003)
- The Sexual Offences Act 2003
- Female Genital Mutilation Act 2003
- Human Rights Act 1998
- When to suspect child maltreatment: Quick reference guide, NICE clinical guideline 89 (July 2009)
- The Adoption and children act 2002.

This is not an exhaustive list of all safeguarding legislation, policies and procedures but directs staff to the key publications they may wish to reference in their work.
Appendix 2 Managing allegations against staff/ volunteers

**ALLEGATIONS/CONCERNS AGAINST STAFF AND VOLUNTEERS CHILD PROTECTION PROCESS**

- Allegations/concerns identified in organisation to be reported to Designated Senior Manager
- Allegation/concern made direct to police or social care

**Local Authority Designated Officer (LADO)** to be informed if alleged behaviour:
- harmed a child, or may have
- is a possible criminal offence
- towards child/ren indicates unsuitable to work with children

**Consultation between LADO and Designated Senior Manager**

- No further action, but refer to:
  - social care as ‘child in need’
  - police if allegation deliberately invented

**Allegation is demonstrably false**

**Allegation is a possible disciplinary matter**

- Child suffering or at risk of suffering significant harm
  - LADO refers to social care for strategy discussion
- No significant harm but allegation might constitute a criminal offence
  - LADO refers to police for initial evaluation

**Social care and/or police Investigation**

**No social care or police investigation**

- Share Information
- Decide action
- Consider suspension

**After completion (earlier if agreed with social care and police)**

**Consider:**
- No further action
- Professional advice
- Disciplinary process
Appendix 3 Escalation Concerns raised by Provider Named Professionals

1. Named Doctor/Nurse clarifies provider has followed internal escalation process, (Appendix 1)

2. Discussion with Designated Nurse/Doctor
   Escalation agreed, action plan jointly drawn up including issues and risks
   *if not for escalation support organisation to review at stage 2/3 again

3. Written issues, risks and actions taken to resolve presented to Children Social Care services manager & Inform GCCG Director Integrated Governance.
   Consider
   - Joint meeting to discuss
   - Joint action plan with outcomes
   - Date for reviewing joint progress
   *Timescales set should meet the safety of the children being discussed

NON-RESOLUTION

- Designated raises to Director Children Services & GSCB Independent Chair cc into correspondence

RESOLUTION

- Consider multi-agency locality learning outcomes i.e. MA Audit

Escalation must be evidenced via audit trail i.e. emails, referral letters.
*to be read in conjunction with London Child Protection Procedures 2011*

Prepare summary of background chronology & own interpretation of risk

Decide with Named professional who would attend a meeting

Feedback to Provider (if not in attendance) & GCCG Safeguarding Exec Lead

Inform GCCG Chief Officer and Executive Lead

5 working days
Appendix 4 Multiagency safeguarding hub process

MASH Consultation Service  020 8 921 2267

A telephone Consultation Service for professionals provided by Children’s Social Care Multi Agency Safeguarding Hub (MASH) Team

Consultation Service aims to:

- Offer quick access to Children’s Safeguarding and Social Care advice.
- Provide advice on Children’s Safeguarding and Social Care thresholds
- Improve information sharing about universal and target services providing early help in the borough.
- Allow professionals the opportunity to talk through situations that are raising concern to help determine what an appropriate response might be, without the need for formal referral.

How the Consultation Service works:

- Consultation will be offered by the MASH Duty Manager for all professionals seeking advice about a child or children who they are concerned about.
- Anonymity of the child or children will be maintained unless both the professional involved and/or the MASH Duty Manager have good reason to believe that there is a valid safeguarding reason to disclose further details.
- Written records of the consultation will not be kept by Children’s Service unless a formal process is required, and the contacting professional is expected to follow the record keeping and information guidelines for their own agency.
- Professionals and their agencies are not obliged to follow the advice offered.
- This is not a short cut or referral route into Children’s Services. If a referral is required, the usual Inter-Agency Referral Form will be completed by the contacting professional following the discussion

To download MASH form:  
http://www.greenwichsafeguardingchildren.org.uk/safeguardingchildrenboard/info/200131/the_safeguarding_children_board/70/report_child_abuse-contact_details
Appendix 5 NHS GCCG’s Safeguarding Governance Relationships
Appendix 6 CCG Safeguarding structure

Safeguarding Structure

- Registered Nurse: Governing Body
- CCG Chief Officer
- Governing Body Member Safeguarding Lead
- GP Lead adult safeguarding
- Director of Integrated Governance
- Business Support Officer
- Designated Nurse: Safeguarding Children
- Lead Nurse: Adult safeguarding & care homes assurance
- Named GP: Safeguarding children
- *Designated Nurse: Looked After Children
- *Designated Doctor: Safeguarding Children
- *Designated Doctor: Looked After Children
- *Designated Doctor: Child Death

*The Designated roles are hosted by providers on behalf of Greenwich CCG
## Appendix 6  Safeguarding Training Levels

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>For whom</th>
<th>Frequency &amp; duration</th>
<th>Training, education and learning opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Non-clinical staff working in healthcare settings eg receptionists, administrative, domestics, maintenance staff, volunteers across health care settings</td>
<td>Over a three-year period, staff at level 1 should receive refresher training equivalent to a minimum of 2 hours.</td>
<td>Online <a href="http://www.skillsforhealth.org.uk/e-learning">http://www.skillsforhealth.org.uk/e-learning</a></td>
</tr>
<tr>
<td>Level 2</td>
<td>Minimum level required for non-clinical &amp; clinical staff who have some degree of contact with children and young people and/or parents/carerers eg administrators for looked after children and safeguarding teams, health care students practice nurses</td>
<td>Need to complete level 1 first Over a three-year period, professionals at level 2 should receive refresher training equivalent to a minimum of 3-4 hours</td>
<td>Multi-disciplinary and scenario-based discussion drawing on case studies and lessons from research and audit. Organisations should consider encompassing safeguarding learning within regular, multiagency or vulnerable family meetings, clinical updating, clinical audit, reviews of critical incidents and significant unexpected events and peer discussions.</td>
</tr>
<tr>
<td>Level 3</td>
<td>Clinical staff working with children, young people and/or their parents/carerers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding /child protection concerns eg GP’s specialist nurses for safeguarding, sexual health staff</td>
<td>Initial: Within a year of appointment minimum of 8 hours of education and learning related to safeguarding/child protection Those requiring specialist-level competences should complete a minimum of 16 hours Refresher: Over a three-year period, professionals should receive equivalent to a minimum of 6 hours (minimum of 2 hours per annum)</td>
<td>Multi-disciplinary and inter-agency, and delivered internally and externally. It should include personal reflection and scenario-based discussion, drawing on case studies, serious case reviews, lessons from research and audit, as well as communicating with children about what is happening. Consider encompassing safeguarding/child protection learning within regular multi-professional and/or multi-agency staff meetings, vulnerable child and family meetings, clinical updating, clinical audit, reviews of critical incidents and significant unexpected events, and peer discussions</td>
</tr>
</tbody>
</table>
| Level 4 | Named professionals  
E.g. named doctors, named nurses | Named professionals should attend a **minimum** of 24 hour of education, training and learning over a three-year period | This should include non-clinical knowledge acquisition such as management, appraisal, and supervision training  
• Named professionals should participate regularly in support groups or peer support networks for specialist professionals at a local and National level, according to professional guidelines  
• Named professionals should complete a management programme with a focus on leadership and change management within three years of taking up their post  
• Named Professionals responsible for training of doctors are expected to have appropriate education for this role. |
|---|---|---|---|
| Level 5 | Designated Professionals,  
Designated Nurse, Designated Doctors, including lead paediatricians and Consultants. | Attend a minimum of 24 hours of training, Education and learning over three years | This should include non-clinical knowledge acquisition such as management, appraisal, supervision training. Designated professionals should participate at local, regional and national level according to professionals guideline (attendance recorded) An executive level management programme with focus on leadership and change management should be completed within three years of taking up post. Training at level 5 will be required at 1-4 and negate the need to undertake refresher training at level 1-4 in addition to level 5 |
Appendix 7 Equality & Equity Impact Assessment & EDS2 Checklist

This is a checklist to ensure relevant equality and equity aspects of proposals have been addressed either in the main body of the document or in a separate equality & equity impact assessment (EEIA)/equality analysis. It is not a substitute for an EEIA which is required unless it can be shown that a proposal has no capacity to influence equality. The checklist is to enable the policy lead and the relevant committee to see whether an EEIA is required and to give assurance that the proposals will be legal, fair and equitable.

The word proposal is a generic term for any policy, procedure or strategy that requires assessment.

<table>
<thead>
<tr>
<th>Challenge questions</th>
<th>Yes/No</th>
<th>What positive or negative impact do you assess there may be?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the proposal affect one group more or less favorably than another on the basis of:</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>• Race</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>• Pregnancy and Maternity</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>• Sex</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>• Gender and Gender Re-Assignment</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>• Marriage or Civil Partnership</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>• Religion or belief</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>• Sexual orientation (including lesbian, gay bisexual and transgender people)</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>• Age</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>• Disability (including learning disabilities, physical disability, sensory impairment and mental health problems)</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>2. Will the proposal have an impact on lifestyle? (e.g. diet and nutrition, exercise, physical activity, substance use, risk taking behavior, education and learning)</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>3. Will the proposal have an impact on social environment? (e.g. social status, employment (whether paid or not), social/family support, stress, income)</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>4. Will the proposal have an impact on physical environment? (e.g. living conditions, working conditions, pollution or climate change, accidental injury, public safety, transmission of infectious disease)</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>5. Will the proposal affect access to or experience of services? (e.g. Health Care, Transport, Social Services, Housing Services, Education)</td>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>
By using evidence and insight to assess and grade our equality performance, NHS Greenwich can generate much of the information we will require to demonstrate compliance with the PSED. The checklist is to enable the policy lead and the relevant committee to see if a particular policy or project will provide the relevant evidence to assist NHS Greenwich CCG meet the set out EDS goals to achieve better outcomes for patients and staff. Please assess your policy, project or service against the following:

<table>
<thead>
<tr>
<th>The goals and outcomes of EDS2</th>
<th>Description of outcome</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Better health outcomes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>Services are commissioned, procured, designed and delivered to meet the health needs of local communities</td>
<td>NO</td>
</tr>
<tr>
<td>1.2</td>
<td>Individual people’s health needs are assessed and met in appropriate and effective ways</td>
<td>Yes</td>
</tr>
<tr>
<td>1.3</td>
<td>Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed</td>
<td>NO</td>
</tr>
<tr>
<td>1.4</td>
<td>When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse</td>
<td>NO</td>
</tr>
<tr>
<td>1.5</td>
<td>Screening, vaccination and other health promotion services reach and benefit all local communities</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Improved patient access and experience</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds</td>
<td>NO</td>
</tr>
<tr>
<td>2.2</td>
<td>People are informed and supported to be as involved as they wish to be in decisions about their care</td>
<td>NO</td>
</tr>
<tr>
<td>2.3</td>
<td>People report positive experiences of the NHS</td>
<td>NO</td>
</tr>
<tr>
<td>2.4</td>
<td>People’s complaints about services are handled respectfully and efficiently</td>
<td>NO</td>
</tr>
<tr>
<td><strong>A representative and supported workforce</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1</td>
<td>Fair NHS recruitment and selection processes lead to a more representative workforce at all levels</td>
<td>NO</td>
</tr>
<tr>
<td>3.2</td>
<td>The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations</td>
<td>NO</td>
</tr>
<tr>
<td>3.3</td>
<td>Training and development opportunities are taken up and positively evaluated by all staff</td>
<td>NO</td>
</tr>
<tr>
<td>3.4</td>
<td>When at work, staff are free from abuse, harassment, bullying and violence from any source</td>
<td>NO</td>
</tr>
<tr>
<td>3.5</td>
<td>Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives</td>
<td>NO</td>
</tr>
<tr>
<td>3.6</td>
<td>Staff report positive experiences of their membership of the workforce</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Inclusive leadership</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1</td>
<td>Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations</td>
<td>NO</td>
</tr>
<tr>
<td>4.2</td>
<td>Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed</td>
<td>NO</td>
</tr>
<tr>
<td>4.3</td>
<td>Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination</td>
<td>NO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy Author</th>
<th>Signature:</th>
<th>Date: 24/8/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equalities Lead</td>
<td>Signature:</td>
<td>Date: 24/8/15</td>
</tr>
</tbody>
</table>