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CCG Safeguarding Children, Looked After Children & Child Death Review Team

A co-ordinated approach – safeguarding is everyone’s responsibility.

Everyone who works with Children and Young People (CYP) has a responsibility for keeping them safe. No single practitioner can have a full picture of a child’s needs and circumstances and, if children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action. In order that organisations, agencies and staff collaborate effectively, it is vital that everyone working with children and families, including those who work with parents/carers and commissioners, understands the role they should play and the role of other practitioners. They should be aware of, and comply with, the published arrangements set out by the local safeguarding partners (SET 2018).

CCG Staff - If you have a concern about a child/young person and or their parents, please contact the CCG Safeguarding Children Team for advice, guidance and support.

http://thurrockccg.nhs.uk/safeguarding-children

<table>
<thead>
<tr>
<th>Designation</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Designated Nurse / Named Professional Primary Care</td>
<td>01268 594492 / 07534 918 226</td>
</tr>
<tr>
<td>Designated Doctor Safeguarding and Child Death Reviews</td>
<td>01268594492 / 07940452745</td>
</tr>
<tr>
<td>Designated Nurse Looked After Children (LAC)</td>
<td><a href="mailto:BBCCG.southwestsafeguardingteam@nhs.net">BBCCG.southwestsafeguardingteam@nhs.net</a></td>
</tr>
<tr>
<td>Associate Designated Nurse</td>
<td>01268 594568 / 07814 397827</td>
</tr>
<tr>
<td>Safeguarding Children Specialist Nurse</td>
<td>01268 594482 / 07977 419261</td>
</tr>
<tr>
<td>Safeguarding Team PA</td>
<td>01268 594484</td>
</tr>
<tr>
<td>Generic Safeguarding Children Team’s Generic Email - general enquiries</td>
<td><a href="mailto:BBCCG.southwestsafeguardingteam@nhs.net">BBCCG.southwestsafeguardingteam@nhs.net</a></td>
</tr>
<tr>
<td>Designated Doctor for LAC – post shared across 7 CCG’s</td>
<td>07580 912 018</td>
</tr>
<tr>
<td>CCG Designated Officer for Managing Allegation – Thurrock CCG Chief Nurse</td>
<td>01375 365810</td>
</tr>
</tbody>
</table>

If you need to contact Children Social Care:

<table>
<thead>
<tr>
<th>Basildon &amp; Brentwood – 0345 603 7627 -</th>
<th><a href="https://www.essexeffectivesupport.org.uk/">https://www.essexeffectivesupport.org.uk/</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Thurrock - 01375 652 802 / 652 634-</td>
<td><a href="mailto:thurrockmash@thurrock.gcsx.gov.uk">thurrockmash@thurrock.gcsx.gov.uk</a> /</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.thurrock.gov.uk/childrens-care-professionals/thurrock-mash">www.thurrock.gov.uk/childrens-care-professionals/thurrock-mash</a></td>
</tr>
</tbody>
</table>

If you need to contact the Essex Police:

101 and ask for Child Abuse Investigative Team (CAIT)  
Basildon, Billericay, Laindon, Canvey, Wickford, Rayleigh & Southend Police Ext 384140  
Thurrock, Harlow & Brentwood Police Ext 320200  
Call 999 if you are concerned a child needs immediate protection
1 INTRODUCTION

1.1 Responsibilities for safeguarding are enshrined in legislation. Some duties apply only to children, some apply only to adults, and some apply to both. This policy deals with children.

1.2 The CCG is required to fulfill its legal duties under the Children Act 1989 and section 11 of the Children act 2004. They provide a comprehensive framework for the care and protection of all children.

1.3 The fundamental principle underpinning the Children Act is that the welfare of the child is paramount. In order to achieve positive outcomes for children, all those with responsibility for assessment and provision of services must work together. The policy refers to Safeguarding Children inclusively (Safeguarding Children, Child Protection, Looked After Children and the Child Death Review Process).

1.4 This Safeguarding Children and Young People Policy will be reviewed and updated in accordance with changes in procedures as a minimum, every 2 years or sooner if there are significant local or legislative changes.

2 PURPOSE / POLICY STATEMENT

2.1 The purpose of this policy is to detail how the CCG will discharge and fulfill all its statutory responsibilities for ensuring its organisation and the agencies they commission provide effective services to fulfill their duties to safeguard and promote the welfare of all children and young people they work with.

2.2 The function of this policy is to identify roles and responsibilities of all staff across the organisation so that they are clear about what actions must be taken to safeguard children and Young people. Appendix 1 for Roles and Responsibilities

2.3 To assist with designing and implementing a robust system that supports the CCG to work together to minimise risk, improve outcomes for children, develop and sustain effective partnerships and ensure they are able to access the necessary clinical expertise and advice.

AIM

2.4 This policy requires the CCG 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.

2.5 The workforce should undertake safeguarding children training in accordance with the competence level required by their role.

2.6 The CCG should involve children and young people in the planning of services and incorporate their wishes and feelings in service design and delivery.

2.7 The CCG should work with NHSE, Local Safeguarding Children Boards, and local partners to develop and improve safeguarding practice across the whole health economy.

SCOPE

2.8 The policy applies to all staff employed by NHS Thurrock CCG, General practitioners
who are CCG Board members, all temporary, voluntary and bank/agency staff. Managers must (are to) ensure their staff are aware of the policy and ensure that it is implemented within their work area to ensure all staff know and are aware of what to do if they are concerned that a child has been abused or is at risk of being abused.

**STATUTORY REQUIREMENTS**

2.9 **Section 11 of the Children Act 2004** 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 2018) which sets out how organisations and individuals have a duty to work together to safeguard and promote the welfare of children.

2.10 **Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (NHS England 2015)** provides specific guidance to NHS organisations and it clearly sets out the responsibilities of each of the key players for safeguarding in the NHS. The CCG and NHS England have a statutory responsibility to ensure that the organisations from which they commission services provide a safe system that safeguards children and adults 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 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. The CCG has a Governance Framework for Safeguarding Children which shows its relationship to the wider health economy and its partners.


2.11 Safeguarding Children Roles and Competences for Healthcare Staff - Intercollegiate Document, (RCPCH 2014) and the Looked after Children: Knowledge, skills and competences of health care staff- Intercollegiate Role Framework (RCPCH 2015) 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 this document. This policy is intended to support all staff in safeguarding children who reside either permanently or temporarily, or are visiting the geographical area of Thurrock CCG. The policy sets out the roles and responsibilities of all staff and members with respect to keeping children safe and promoting their welfare.

http://basildonandbrentwoodccg.nhs.uk/  http://thurrockccg.nhs.uk/

2.12 This policy provides the framework that ensures a robust and safe system is in place to safeguard children and is underpinned by Southend Essex and Thurrock (SET) Safeguarding and Child Protection Procedures (2018) and the Working Together (2018) to Safeguarding Children which provide practical guidance to assist all staff working with children or their families. This includes commissioners of services, providers of services and those who work in partnership with the above (e.g. statutory and voluntary services).

2.13 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.
The policy is compliant with the Care Quality Commission Outcome 7 (Regulation 11) Safeguarding service users from abuse.

3 DEFINITIONS

<table>
<thead>
<tr>
<th>Thurrock CCG</th>
<th>is defined as a NHS Clinical Commissioning Group (the CCG) responsible for commissioning health services for the population of their catchment area.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioning</td>
<td>Is the process of arranging continuously improving services which delivery the best quality outcomes for patients.</td>
</tr>
<tr>
<td>A child</td>
<td>is 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 under the Children Act 1989. Children therefore, mean children and young people throughout this policy.</td>
</tr>
</tbody>
</table>
| 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 and  
  ▪ Take action to enable all children to have the best outcomes. |
| Abuse        | is a form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by other (e.g. via the internet). They may be abused by an adult or adults, or another child or children. |
| Child protection | 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. |
| Child In Need | is defined under Section 17 of the Children Act 1989 as a child 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. |
| Significant Harm | The Children Act 1989 introduced the concept of significant harm, it is any physical, sexual or emotional abuse, neglect, accident or injury that is sufficiently serious to adversely affect progress and enjoyment of life. Significant harm is the threshold that justifies 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 31st January 2005) so that it may include, ‘for example, impairment suffered from seeing or hearing the ill treatment of another; (Domestic Abuse / Violence).

| Looked After Children (LAC) | This term to children currently being looked after and/or accommodated by local authorities/health and social care trusts, including unaccompanied asylum seeking children and those children where the agency has authority to place the child for adoption. A child or young person is ‘Looked After’ under the Children Act 2002, if he/she accommodated by the local authority. |

### CATEGORIES OF ABUSE

3.1 As outlined in the Working Together to Safeguard Children 2015 and 2018


3.2 There are four (4) categories of Abuse. There are:

| Physical Abuse | Is a form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child. Harm can also occur due to practices linked to faith and culture, e.g. Female Genital Mutilation (FGM). |
| Emotional Abuse | The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child’s emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or ‘making fun’ of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child’s developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone. |
| Neglect | The persistent failure to meet a child’s basic physical and/or psychological needs, likely to result in the serious impairment of the child’s health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. |
Once a child is born, neglect may involve a parent or carer failing to:
- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of inadequate care-givers); or
- ensure access to appropriate medical care or treatment.
- It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs.

**Child Sexual Abuse (CSA)**

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.

All cases of children under the age of 13 years believed to be engaged in penetrative sexual relationships or activity must be referred to local authority children’s social care and the police. This is Statutory Rape - Sexual Offence Act 2003.


### 4 ROLES AND RESPONSIBILITIES

#### 4.1 Governance Arrangements

**4.1.1** The CCG has a clearly defined safeguarding accountability and governance arrangements in place which ensures the CCG is able to fulfil all its statutory requirements including the proactive and effective management of risk.

**4.1.2** The CCG: is a statutory partner of the Thurrock Safeguarding Children’s Board. The CCG need to ensure its NHS commissioned providers meets their responsibilities through its commissioning arrangements with them.

#### 4.2 CCG Board

**4.2.1** The CCG Board has the ultimate responsibility and accountability for ensuring that all quality and safeguarding duties are discharged effectively. The Board will receive assurance that all responsibilities are discharged; that systems and process are in place to monitor quality issues including safety in an on-going way, that
arrangements are in place to proactively identify early warnings of a failing service, arrangements are in place to deal with and learn from serious untoward incidents and never events and has established appropriate systems for safeguarding from a committee of the Board, the Patient Safety and Quality Committee.

4.2.2 The CCG Board is responsible for ensuring 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. They are also responsible for ensuring that all commissioned provider services are meeting their statutory duties in relation to safeguarding Children, Young people and their families.

4.2.3 The Board will receive an annual safeguarding children report and will be updated through reports to the Quality and Patient Safety Committee.

4.3 Quality and Patient Safety Committee (QPSC)

4.3.1 The Quality and Patient Safety Committee is directly accountable to the CCG Governing Body and provides assurance that the governance systems, processes and behaviours by which the CCG leads, directs and controls functions in order to achieve its organisational objectives, and the way in which they relate to patients and carers, the wider community and partner organisations are integrated and effective. The Quality Committee oversees processes and compliance issues concerning safeguarding children and informs the CCG Governing Body of any escalation or sensitive issue in a timely manner.

4.4 The Thurrock Safeguarding Children Board (TLSCB)

4.4.1 The TSCB is the statutory body responsible for safeguarding children. The functions undertaken by the LSCB reflect the requirements of the Children Act 2004, and are based upon the objectives set out in Chapter 3 of ‘Working Together to Safeguard Children (2015)’. The Board has an Independent Chair and membership from Local Authority, Health commissioning and providers, police and probation service, legal advisor, voluntary sector, fire service, ambulance service and a Lay Member.

4.4.2 The Chief Nurse who is the CCG Executive Lead for safeguarding children is a full member of the LSCB or its equivalent. The aim of the TSCB is to improve 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. The CCG works with Local Authority Council, Police, Probation, Education Services, Health Services and the Voluntary Sector. The Safeguarding Team also works closely with the TSCB.

4.4.3 TSCB provides 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 the area. The CCG is responsible for providing and/or ensuring the availability of appropriate expertise and advice and support to TSCB 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.

4.5 The Health and Wellbeing Board (H&WBB)

4.5.1 The 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. They play a vital role in identifying and ensuring that the needs of adults 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 TSCB and H&WBB is for local determination.

4.6  **CCG Accountable Officer**

4.6.1 The CCG Accountable Officer has overall accountability for ensuring that the CCG 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. They are also responsible for ensuring the contribution by health services to safeguarding and in partnership with the Local Safeguarding Children Board (LSCB) 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. They need to be aware of and able to respond to national developments and ask searching questions of the CCG to obtain assurance that the systems and practices are effective in recognising and preventing abuse and neglect.

4.7  **The Chief Nurse**

4.7.1 The CCG Chief Nurse is the Executive Lead for Safeguarding and will ensure that the CCG works closely with partner organisations and provides appropriate representation alongside the Designated Professionals Nurse at the relevant Local Safeguarding Children Board and its subcommittees.

4.7.2 The Chief Nurse will work in partnership with the NHS England Director of Nursing in complying with the new accountability and assurance framework and will work closely with other regulators through the various Groups to ensure sharing and learning of key information relating to all aspects of patient safety and quality, including safeguarding.

4.7.3 The Chief Nurse 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.

4.7.4 The Chief Nurse will ensure 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.

4.7.5 In collaboration with the NHS England; the Chief Nurse will 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.

4.7.6 The Chief Nurse will ensure, through reporting to the Patient Safety and Quality Committee, that monitoring takes place of safeguarding activity to fulfil the requirements of Section 11 of the Children Act (2004), Working Together to Safeguard Children (DFE 2015), Standard 5 of the National Service Framework for Children Young People and Maternity Services (DH 2004), the Care Quality Commission Regulations (2010) and the recommendations from serious case reviews to the Board of the CCG.

4.7.7 The Chief Nurse will ensure that the expertise of the Designated Professionals for Safeguarding and LAC are used to contribute to the design and planning of services.

4.7.9 The Chief Nurse will ensure that the Joint Strategic Needs Assessment includes the needs which contribute to informing the strategic work of the Health and Wellbeing
board, the Children and Young People’s Plan and the Local Safeguarding Children Board business plan.

4.7.10 The QPSC are responsible for signing off the CCG’s Strategic Plan and Annual Safeguarding Children Report.

4.7.11 The Chief Nurse is responsible for ensuring the CCG’s procurement processes, service specifications, invitations to tender guidance and service contracts have clear safeguarding children requirements considered in all prospective and new contracts. They ensure that existing contracts have safeguarding children explicitly stated and that all commissioned provider services and contractors are fully aware and adhere to the agreed CCG and multi-agency procedures.

4.7.12 To fulfil all the responsibilities the Chief Nurse has support from the Designated Children Safeguarding and Looked After Children Professionals.

4.8 Designated Professionals Safeguarding Children and Looked After Children (LAC)

4.8.1 The Designated Professionals (Safeguarding Children, LAC and Child Death Review Team) will take a strategic, professional lead on all aspects of the health service contribution to safeguarding children across the CCG area as appropriate, sit on the LSCB Board and sub-committees providing expert advice on safeguarding issues. They will provide safeguarding training, supervision. They will also provide advice and support on individual cases to statutory and voluntary agencies, including the Police and Children’s Social Care.

4.8.2 The Designated Nurses for Safeguarding Children is responsible for the following:

- Act as a resource with expert knowledge on safeguarding children and young people.
- 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 which is appropriate to their function within the Governing Body and that supervision and training are on-going.
- Ensuring that provider organisations have training programmes and supervision 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.
- Where provider organisations are subject to recommendations made by the Care Quality Commission, engaging in dialogue with that organisation’s Named Nurse.
- Ensuring that provider organisations have acted on recommendations from internal management reviews, serious case reviews and national inquiries.
- Supporting the Chief Nurse in their role as Senior Officers for managing allegations against staff and information sharing with the Local Authority Designated Officer (LADO) of any concerns.
- Ensuring staff have easy access during working hours and being a source of advice, expertise and good practice on safeguarding and child protection matters
- Ensuring relevant staff receive regular supervision, sufficient to support staff to recognise children in need of support and/or safeguarding, which is appropriate to their responsibilities within the organisation.
- Ensuring arrangements are in place for safeguarding supervision of all staff involved in providing services to children and families 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 Nurse for the CCG signs it off before submission.
- To attend the Local Safeguarding Children Board meetings and be an active member of subgroups.

4.9 **Designated Professionals - Looked After Children**

4.9.1 The CCG is responsible for ensuring that all Looked-after Children have their health needs assessed. This is achieved through a hosting arrangement with Mid Essex CCG. Designated Doctors and Nurse for Looked After Children should engage with and contribute to local, regional, national forums and networks as appropriate to the roles and responsibilities. The Designated Doctor and Designated Nurse for Looked After Children should provide strategic and clinical advice and leadership to the CCG and Local Authority regarding how to improve the health of looked after children; They should assist the CCG 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; They should ensure that Looked after Children are able to access universal services as well as targeted and specialist health services where necessary. Provide training for other health professionals and other agencies about looked after children’s health issues. Support, gather and analyse the views of looked after children with regard to health and wellbeing, linking this to strategic and clinical advice and service development. This is done by asking every child and young person during their individual health assessment and by ensuring a yearly user survey is carried out.

4.10 **Designated Doctor for Safeguarding Children**

4.10.1 The Designated Doctor will be responsible for the following:
- Support the Commissioning Team to bring together commissioning expertise on safeguarding medical matters.
- 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, orthopaedics, obstetrics, gynaecology, child and adult psychiatry.
- To attend the Local Safeguarding Children Board Partnership meetings and be an active member of any workgroup including serious case review workgroups.
- Reviewing and contributing to the medical aspects on Serious Case Reviews and Audits.
- 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.
- Facilitating and Reviewing safeguarding educational forums and training for medical professionals.
Advising on practice guidance and policies for all those working within health and ensure that they are appropriately audited.

4.11 **Lead GP/Named Professional for Safeguarding Children**

4.11.1 The Lead and Named Professionals for Safeguarding Children will be responsible for the following:

- Ensuring GP practices and staff have robust systems and practices in place to ensure they can fulfil their role in safeguarding and promoting the welfare of children.
- Providing support to GP practices, for instance by assistance with protected time for, and access to training in safeguarding and LAC.
- Ensuring GPs and members of the Primary Health Care Team have access to a copy of the SET Procedures 2015.
- Ensures that Practice safeguarding policy and procedures are developed, implemented and regularly monitored and updated.
- Encourage regular meetings with others in the Primary Healthcare Team and personnel from other agencies such as health visitors, school nurses, community children's nurses and social workers to discuss particular concerns about vulnerable children and families.
- Ensures that the Practice meets statutory responsibilities.
- Ensuring that GP Practice Safeguarding Leads have access to Safeguarding Educational Forums, where local, regional, national guidance and learning from SCR are discussed and disseminated, including group reflection and peer support.
- Ensures that the Practice meets their national and local regulatory requirements relating to Safeguarding Children.
- Ensures that the Practice meets regulatory inspection requirements.
- Ensures safe recruitment procedures are included in the Section 11 audits.
- Engages the Primary Healthcare Team to establish effective Child Health provision including Safeguarding Policies (see also RCGP Safeguarding Toolkit).
- Advises Practice members if they have concerns.
- Lead and facilitate in the local GP Practice Safeguarding Leads Educational Forums.
- Ensures that Practice members receive adequate assistance when dealing with child protection.

4.12 **Commissioning Managers**

4.12.1 Commissioning Managers within the CCG 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 Section 11 of the Children Act (2004), Statutory Guidance within Working Together to Safeguard Children (DFE 2015) and SET Procedures (2015).

4.12.2 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 centred and respect the individuality of each child.

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

4.13 CCG Patient Safety & Quality Managers
4.13.1 Is responsible for the day to day responsibility for the management and oversight of all commissioned provider services Serious Incident (SI). Where there is Safeguarding SI raised, the Designated Safeguarding Team will work with and or support the Patient Safety Manager on this process.
4.13.2 Please refer to the CCG’s SI Policy
   http://thurrockccg.nhs.uk/policies-and-procedures

4.14 CCG Communication Team
4.14.1 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. They will work with all the relevant parties to prepare media statements. They will ensure that patients and staff and other affected parties are informed before media statements are released. They will also confirm proposed handling arrangements with NHSE, where considered necessary develop communications/media handling strategies with other organisations and liaise with relevant stakeholders as appropriate.
4.14.2 The Communication Team will design and implement a strategy for on-going and longer-term management of communications. They will upload and update the CCG intranet and website.

4.15 All CCG Staff
4.15.1 Safeguarding Children and Young people is the responsibility of all staff employed by the CCG; therefore it is important that all CCG staff are clear about their roles and responsibilities with regard to safeguarding children and young people and their families.
4.15.2 All staff must always be alert to the possibility of significant harm to a child resulting from abuse or neglect, or to a child who is ‘in need’. All staff should be able to recognise the indicators and know how to act upon concerns, their depth of knowledge being commensurate with their roles and responsibilities.
4.15.3 All staff must be aware of the vulnerabilities of certain groups of children such as those who are disabled, ‘looked after’ or privately fostered.
4.15.4 All staff must be aware of the increased vulnerabilities of certain groups of adults who
may find parenting difficult, for example, those experiencing domestic abuse, unmanaged mental health problems, uncontrolled substance or alcohol misuse, severe learning disabilities or those with unmet support needs.

4.15.5 All staff working primarily with adults who are parents or carers of children and young people should always consider the effects on parenting capacity and subsequent implications for children of the adult's illness or behaviour.

4.15.6 All staff must recognise that sharing information is vital for early intervention to ensure that children are protected from abuse and neglect and that the safeguarding of children is paramount and can override any duty of confidentiality.

4.15.7 All staff regardless of band or position must follow the SET Procedures (2015) where there are safeguarding / child protection concerns.

4.15.8 Staff should be aware that when they have safeguarding / child protection concerns they can discuss them with a Designated/Named Safeguarding Professional, as required and must know how to access this support. However these discussions must never delay any emergency action that needs to be taken to protect a child.

4.15.9 All staff should co-operate with managers to implement this policy to enable the CCG to discharge its legal obligations. All staff should act in a timely manner on any concern or suspicion that a child is being or is at risk of being abused, neglected or exploited and ensure that the concern is reported, documented and investigated.

4.15.10 All staff should adhere to this Safeguarding Children policy.

4.15.11 All staff should uphold the rights of the child to be able to communicate, be heard and safeguarded from harm and exploitation whatever their:

- Ethnicity
- Religion/belief
- Spoken Language
- Gender
- Sexual Identity
- Age
- Health
- Ability
- Location or placement
- Criminal behaviour
- Political or immigration status

4.16 **NHS England (East of England Region - Essex)**

4.16.1 Has responsibility for assuring the Department of Health that all NHS organisations in Essex 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.

4.17 **Provider Named Professionals**

4.17.1 Provider Named Nurses and Doctors should provide professional and clinical leadership on safeguarding children services within their own organisations and they need to ensure that a coordinated and integrated safeguarding service is provided.

4.17.2 Named Nurses and Doctors ensure that services in their provider organisations are
delivered in accordance with their Safeguarding Children Policy and that there are safe systems and processes in place for their staff.

4.17.3 Provider Named Professionals should have specific expertise in children and young people’s health and development, child maltreatment and local arrangements for safeguarding and promoting the welfare of children.

4.17.4 Provider Named Nurses and Doctors in collaboration with the Designated Professionals are responsible for promoting good professional practice and providing specialist advice and support to health professionals within their organisation on any issue relating to safeguarding children.

4.17.5 Provider Named Doctors and Nurses will ensure safeguarding supervision and training is provided for all staff as appropriate to their roles and responsibilities within their organisations. They have a key role in ensuring a safeguarding training strategy is in place and is delivered within their organisation.

4.17.6 Provider Named Doctors and Nurses will support provider organisations in their clinical governance role, by ensuring that safeguarding audits are undertaken, that safeguarding policies and procedures are in place.

4.17.7 Provider Named Doctors and Nurse will support the LSCB local learning and improvement framework to learn from experience and improve services as a result. They will 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.

4.17.8 Provider Named Professionals have a responsibility to work closely with the Designated Professionals and to seek advice support and safeguarding supervision from them about complex cases.

4.17.9 Each Health Provider Organisation will have an Executive Director or equivalent with accountability and responsibility for children’s and young people’s safeguarding.

5 POLICY DETAIL

HIDDEN HARM

5.1 The inclusion of hidden harms within the Police & Crime Plan reflects a broadening of existing focus on domestic abuse. Hidden Harm is a term which captures a number of harms which are generally under-reported and therefore hidden from the public, police and partners. These include, but are not limited to; hate crime, abuse, ‘honour’ based abuse, modern-day slavery, fraud, and child sexual and criminal exploitation, female genital mutilation and forced marriage.

5.2 SAFEGUARDING CHILDREN AFFECTED BY GANG ACTIVITY/SERIOUS YOUTH VIOLENCE

5.2.1 A child who is affected by gang activity or serious youth violence may have suffered, or may be likely to suffer, significant harm through physical, sexual and emotional abuse and neglect.

- Definition of a gang (serious youth violence)

5.2.2 Groups of children often gather together in public places to socialise, and peer association is an essential feature of most children’s transition to adulthood. Groups
of children can be disorderly and/or anti-social without engaging in criminal activity.

5.2.3 Defining a gang is difficult, however it can be broadly described as a relatively durable, predominantly street-based group of children who see themselves (and are seen by others) as a discernible group for whom crime and violence is integral to the group’s identity.

5.2.4 Children may be involved in more than one ‘gang’, with some cross-border movement, and may not stay in a ‘gang’ for significant periods of time. Children rarely use the term ‘gang’, instead they use terms such as ‘family’, ‘breddrin’, ‘crews’, ‘cuz’ (cousins), ‘my boys’ or simply ‘the people I grew up with’.

5.2.5 Definitions may need to be highly specific to particular areas or neighbourhoods if they are to be useful. Furthermore, professionals should not seek to apply this or any other definition of a gang too rigorously; if a child or others think s/he is involved with or affected by ‘a gang’, then a professional should act accordingly. SET 2018 P.483. Please contact team on Page 3 for advice and guidance/contact police/criminal exploitation.

5.3 COUNTY LINES GUIDANCE

5.3.1 The Home Office has published a new version of the county lines guidance relating to the criminal exploitation of children and vulnerable adults, for professionals across the UK who work with children. The new version includes a definition of child criminal exploitation, which is common in county lines, noting: it occurs 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; it does not always involve physical contact and can also occur through the use of technology; and it is broader than just county lines, including children forced to work on cannabis farms or to commit theft.


5.4 CHILD SEXUAL EXPLOITATION (CSE)

SET Procedures uses the HM Government 2017 definition of child sexual exploitation.

5.4.1 Chapter 24.1.2 ‘Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.

The CCG CSE Champion is Jacquie Baguley – see Page 3 for her details.

Please see SET (2018) Part B, Chapter 24, Safeguarding Children from Sexual Exploitation on what to do if you have a concern.

5.5 FEMALE GENITAL MUTILATION (FGM)
5.5.1 Female Genital Mutilation (FGM) comprises of all procedures involving the partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. FGM is child abuse and a form of violence against girls and women. The CCG 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 (FGM Act 2003) and carries a 13 year sentence. [https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/472691/FGM_guidance.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/472691/FGM_guidance.pdf)

5.5.2 It is now a mandatory requirement on all professionals to report FGM in under 18s. This came into effect on Saturday 31st October 2015. Should you have any concerns about FGM, or a child discloses FGM to you, Children’s Social Care (CSC) and or Police should be informed and the information recorded. For guidance and support –


DOMESTIC ABUSE (DA)

5.6 SAFEGUARDING CHILDREN AFFECTED BY DOMESTIC ABUSE AND VIOLENCE

5.6.1 There is a strong link between domestic abuse and all types of significant harm to children and young people. Witnessing domestic violence is a form of emotional abuse to a child/young person which may result in long lasting implications for their future wellbeing.

5.6.2 5.6.1 All the outcomes for children can be adversely affected for a child living with domestic abuse - the impact is usually on every aspect of a child's life. The impact of domestic abuse on an individual child will vary according to the child's resilience and the strengths and weaknesses of their particular circumstances.

5.6.3 The three central imperatives of any intervention for children living with domestic abuse are:

- To protect the child/children;
- To support the carer (non-abusive partner) to protect themselves and their child/children; and
- To hold the abusive partner accountable for their violence and provide them with opportunities to change.

5.6.4 When a professional becomes aware of domestic violence/abuse within a family, the professional must seek advice. Professional guidance can also be accessed from: [http://www.escb.co.uk/media/1670/set-procedures-oct-2018-updated.pdf](http://www.escb.co.uk/media/1670/set-procedures-oct-2018-updated.pdf)

5.7 FORCED MARRIAGE AND HONOUR BASED ABUSE/VIOLENCE

5.7.1 Children and young people can be subjected to domestic abuse perpetrated in order to force them into marriage or to ‘punish’ him/her for ‘bringing dishonour on the family’.

5.7.2 A ‘forced’ marriage (as distinct from a consensual ‘arranged’ marriage) is defined as
one that is conducted without the valid consent of at least one of the parties and where duress is a factor. Duress cannot be justified on religious or cultural grounds, and forced marriage is an abuse of human rights.

5.7.3 Forced marriages of children must be regarded as a child protection issue. You would not contact the parents in this situation and you would make a referral direct to the Police Child Abuse Investigation Team (CAIT) who will liaise with social care.

5.7.4 Whilst honour based violence can culminate in the death of the victim, this is not always the case. The child or young person may be subjected over a long period to a variety of different abusive and controlling behaviours ranging in severity. The abuse is often carried out by several members of a family including mothers, and female relatives/community members and may, therefore, increase the child’s sense of powerlessness and be harder for professionals to identify and respond to.

5.7.5 Procedures for responding to forced marriage and honour-based violence are available as Forced marriage of a child and honour based violence. These sections are included in sections 40.1 and 40.2 of the SET Procedures.


5.7.6 You can also contact the Forced Marriage Unit on 020 7008 0230 or 020 7008 0151 www.fco.gov.uk

MODERN SLAVERY AND HUMAN TRAFFICKING

5.8 Modern Slavery

5.8.1 Modern Slavery is the term used within the UK and is defined within the Modern Slavery Act 2015. The Act categorises offences of Slavery, Servitude and Forced or Compulsory Labour and Human Trafficking which comes from the Palermo Protocol.

5.8.2 These crimes include holding a person in a position of slavery, servitude forced or compulsory labour, or facilitating their travel with the intention of exploiting them soon after. Although human trafficking often involves an international cross-border element, it is also possible to be a victim of modern slavery within your own country.

5.8.3 It is possible to be a victim even if consent has been given to be moved.

5.8.4 Children cannot give consent to being exploited therefore the element of coercion or deception does not need to be present to prove an offence. The impact of trafficking on children: Trafficked and exploited children are not only deprived of their rights to health and freedom from exploitation and abuse - they are usually also deprived of their right to an education and the life opportunities this brings.

5.9 TYPES OF HUMAN TRAFFICKING

5.9.1 There are several broad categories of exploitation linked to human trafficking, including:

- Sexual exploitation
- Forced labour
- Domestic servitude
- Organ harvesting
- Child related crimes such as child sexual exploitation, criminal exploitation and county lines, forced begging, illegal drug cultivation, organised theft, related benefit frauds etc
- Forced marriage and illegal adoption (if other constituent elements are present)

5.9.2 In the first instance the point of contact for all modern slavery crimes should be the local police force.

5.9.3 If you have information about modern slavery crimes – those who are committing such crimes or where victims are at risk that requires an immediate response dial 999 / 101.

5.9.4 If you hold information that could lead to the identification, discovery and recovery of victims in the UK, you can contact the Modern Slavery Helpline 08000 121 700.

http://www.nationalcrimeagency.gov.uk/crime-threats/human-trafficking or SET 2018 p.455

5.10 FAITH BASED ABUSE (SPIRIT POSSESSION OR WITCHCRAFT)

5.10.1 Is where parents, families and the child themselves believe that an evil force has entered a child and is controlling them. 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.

5.10.2 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.

5.10.3 A child may suffer physical and 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.

5.10.4 Further information is available from the SET Procedures 2018
https://www.thurrocklscb.org.uk/lscb/sitemap

5.11 RADICALISATION AS A FORM OF ABUSE – PREVENT STRATEGY

5.11.1 Radicalisation is defined as causing someone to become an advocate of radical political or social reform by supporting terrorism and violent extremism. Radicalisation of children and young people may include encouraging them to undertake violent activities on the grounds of religious belief. This may include attacks on others including suicide attacks.

5.11.2 Children may be exposed to messages about terrorism through a family member or friend, a religious school or group, or through social media and the internet. This creates a risk of a child or young person being drawn into criminal activity and exposure to significant harm. There is a cross-Government Strategy to stop people becoming terrorists, known as „PREVENT”.

5.11.3 One of “PREVENT”s foremost objectives are to support individuals who might be vulnerable to recruitment or who have already been recruited by violent extremists and guidance is available for healthcare workers.

5.11.4 The CCG has a PREVENT Policy to support staff in identifying potential staff, children, young people and adults at risk from violent extremism.
Other significant areas of safeguarding children

5.12  MISSING CHILDREN

5.12.1 Refers to any child /young person whose whereabouts cannot be established and where the circumstances are out of character or the context suggests the young person may be the subject of a crime or at risk of harm to themselves or another. The Local Safeguarding Children Board has guidance on how to manage cases where children go missing.

See ESCB website for more details - http://www.escb.co.uk/
See TLSCB website for more details - http://www.thurrocklscb.org.uk/


5.12.2 Please also contact the Police and Children Social Care if you are concerned or aware of a missing child or young person.

5.13  FABRICATED OR INDUCED ILLNESS – LINKED TO PHYSICAL AND EMOTIONAL ABUSE AND NEGLECT

5.13.1 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.

5.13.2 Working Together to Safeguard Children and the NICE guidance on ‘When to Suspect Maltreatment’, section 5.7, and SET 2018 gives detailed descriptions on what to look for in 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

5.13.3 This is not an exclusive list. Where a member of staff suspects a case of fabricated or induced illness they should recognise this as a safeguarding concern and seek support and make appropriate referrals. **You should not raise your concerns with the parents.**

5.13.4 Please see the FII Policy and Pathway accessible from the CCG’s Intranet under Policies


http://thurrockccg.nhs.uk/policies-and-procedures

5.14 **PERPLEXING PRESENTATIONS (PP)/AVOIDABLE IMPAIRMENT**

5.14.1 There is currently no official/national definition for PP. Most Medical Professionals have classified this as anxiety-related, misconstrued, exaggerated, fabricated or induced illness (FII), medically unexplained symptoms or perplexing Paediatric Presentations, or medical child abuse. On investigation some cases that are initially referred as suspected FII are established as perplexing presentations.

5.14.2 Nationally, we are awaiting new guidances on this presentation. In the meantime, if you have any concerns, please contact the Designated Doctor and/or the safeguarding team on Page 2.

5.15 **CHILDREN WHO HAVE NOT BEEN BROUGHT FOR THEIR HEALTH APPOINTMENTS**

5.15.1 5.15 When parents or children frequently miss health appointments then the professional 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), page 76 states, consider neglect 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 member’s records
- Offer another appointment
- Talk to a line manager / Safeguarding Leads
- Consider a referral to social care.

5.15.2 The CCG expect all service providers to have a policy that addresses these issues.

5.15.3 Each GP Practice should develop practice guidance and procedures to manage children who miss appointments.


**POLICY MONITORING, REVIEWS AND AUDITS**

5.16 To ensure that the safeguarding arrangements are satisfactory, a safeguarding audit should 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 Patient Safety and Quality Committee.

5.17 Further audits, either internally or by the CCG may be undertaken in relation to specific circumstances to ensure compliance with for example, Serious Case Reviews recommendations and section11 statutory requirements.

**SAFEGUARDING CONTRACT MONITORING ARRANGEMENTS**

Version 2.0 March 2019
5.18 The NHS Standard Contract requires all provider services to comply with commissioner’s policy for safeguarding. The CCG 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. The CCG 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
- This includes the metrics, standards and concerns being discussed at the provider services’ safeguarding committee prior to submission to the CCG.
- Participating in the development of any local multi-agency safeguarding quality indicators.

5.19 Compliance monitoring is based on the identified safeguarding children key performance indicators identified within the contract and demonstrated via the CCG’s safeguarding dashboard. All provider services are expected to present the CCG’s safeguarding dashboard to their respective safeguarding committee. The completed dashboard plus the minutes from their respective safeguarding committee will then be submitted to the Clinical Quality Review Group Meetings chaired by the Chief Nurses. The completed safeguarding children provider dashboard will be discussed at the Safeguarding Clinical Network (SCN) meetings where applicable and shared with the LSCB’s as required. In a context of personalisation, the CCG expects the commissioned provider services’ boards to seek assurances that directly employed staff (e.g. Personal Assistants) 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 LSCB has an overview of standards and content, it is the responsibility of each commissioned provider services to train its own staff.

LEGAL ADVICE

5.20 In complex situations it may be necessary to seek legal advice and guidance on specific safeguarding issues and access to legal advice/solicitors for the CCG is managed by the Chief Nurse. Access to legal advice is via a Legal Services Framework. The Chief Nurse can be contacted directly for further information, guidance and advice.

SERIOUS CASE REVIEWS (SCR), SERIOUS INCIDENT, MULTI AGENCY SAFEGUARDING PROCEDURES AND AUDITS

5.21 The CCG will ensure that NHS England (Essex) and the Care Quality Commission (CQC) are notified of all SCRs, and with the involvement of the Communications and Governance team, will agree any responses to media interest.

5.22 All SCRs will be notified to the Accountable Officer, the Chief Nurse as executive lead for safeguarding children and the Chair of Board. The Chief Nurse and the Designated professionals will oversee Internal Management Reviews (IMRs) and/or Health Overview Reports for SCR’s completed for the CCG. The Chief Nurse will sign off the reports. The Patient Safety and 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 for Health Providers (Primary Care) should be signed off by NHSE Essex Area Team. Alternatively this could be signed off by the CCG on behalf of NHSE.

5.23 The CCG 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.

5.24 The purpose of the safeguarding investigation is to establish whether abuse or neglect has occurred in order to inform the protection planning process. As the focus of the investigations is different, the findings of one investigation do not in itself determine the conclusions of the other. The safeguarding and incident/serious incident processes must both assess the information obtained during the investigation and satisfy themselves that its decisions are appropriate. A number of events that are reported as a serious incident are often safeguarding issues too (for example, neglect or poor child care in a health setting). Whilst such incidents should always be reported as serious incidents they are also a safeguarding issue and an alert must also be raised in line with multi agency procedures. Integrating the processes allows:

- Responses in line with requirements of LSCB multi-agency safeguarding children procedures, compliance with NHS England guidance 2015;
- Enables effective communication and support to service users involved;
- Enables a transparent, coordinated and comprehensive investigation;
- Brings together learning for continuous improvement;
- voids duplication of effort from multiple investigations

http://thurrockccg.nhs.uk/policies-and-procedures

DUTY OF CANDOUR

5.25 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 outcomes have not been achieved. Also apologies offered where appropriate, and advise on any action taken as a result. The CCG expects its commissioned provider services to be open and transparent around its safeguarding practices and to work in partnership with commissioners to ensure the best outcomes are achieved for children and young people in their catchment area.

5.26 For further information, please access https://ico.org.uk/for-the-public/personal-information/

INFORMATION SHARING, CONFIDENTIALITY AND CONSENT – WORKING TOGETHER 2018

5.27 Practitioners should be proactive in sharing information as early as possible to help identify, assess and respond to risks or concerns about the safety and welfare of children, whether this is when problems are first emerging, or where a child is already
known to local authority children’s social care (e.g. they are being supported as a child in need, have a child protection plan, or LAC). Practitioners should be alert to sharing important information about any adults with whom that child has contact, which may impact the child’s safety or welfare.

5.28 Information sharing is also essential for the identification of patterns of behaviour when a child has gone missing, when multiple children appear associated to the same context or locations of risk, or in relation to children in the secure estate where there may be multiple local authorities involved in a child’s care. It will be for local safeguarding partners to consider how they will build positive relationships with other local areas to ensure that relevant information is shared in a timely and proportionate way.

5.29 Fears about sharing information must not be allowed to stand in the way of the need to promote the welfare, and protect the safety, of children, which must always be the paramount concern. To ensure effective safeguarding arrangements:

5.30 All organisations and agencies should have arrangements in place that set out clearly the processes and the principles for sharing information. The arrangement should cover how information will be shared within their own organisation/agency; and with others who may be involved in a child’s life.

- all practitioners should not assume that someone else will pass on information that they think may be critical to keeping a child safe. If a practitioner has concerns about a child’s welfare and considers that they may be a child in need or that the child has suffered or is likely to suffer significant harm, then they should share the information with local authority children’s social care and/or the police. All practitioners should be particularly alert to the importance of sharing information when a child moves from one local authority into another, due to the risk that knowledge pertinent to keeping a child safe could be lost
- all practitioners should aim to gain consent to share information, but should be mindful of situations where to do so would place a child at increased risk of harm. Information may be shared without consent if a practitioner has reason to believe that there is good reason to do so, and that the sharing of information will enhance the safeguarding of a child in a timely manner. When decisions are made to share or withhold information, practitioners should record who has been given the information and why
- Practitioners must have due regard to the relevant data protection principles which allow them to share personal information, as provided for in the Data Protection Act 2018 and the General Data Protection Regulation (GDPR). To share information effectively:
  - all practitioners should be confident of the processing conditions under the Data Protection Act 2018 and the GDPR which allow them to store and share information for safeguarding purposes, including information which is sensitive and personal, and should be treated as ‘special category personal data’
  - where practitioners need to share special category personal data, they should be aware that the Data Protection Act 2018 contains ‘safeguarding of children and individuals at risk’ as a processing condition that allows practitioners to share information. This includes allowing practitioners to share information without consent, if it is not possible to gain consent, it cannot be reasonably expected that a practitioner gains consent, or if to gain consent would place a child at risk.

5.31 Practitioners must have due regard to the relevant data protection principles which
allow them to share personal information, as provided for in the Data Protection Act
2018 and the General Data Protection Regulation (GDPR). To share information
effectively: this is bullet point 1 above

5.32 All practitioners should be confident of the processing conditions under the Data
Protection Act 2018 and the GDPR which allow them to store and share information
for safeguarding purposes, including information which is sensitive and personal, and
should be treated as ‘special category personal data’ this is in bullet point 2 above

5.33 Where practitioners need to share special category personal data, they should be
aware that the Data Protection Act 2018 contains ‘safeguarding of children and
individuals at risk’ as a processing condition that allows practitioners to share
information. This includes allowing practitioners to share information without consent,
if it is not possible to gain consent, it cannot be reasonably expected that a
practitioner gains consent, or if to gain consent would place a child at risk. This is
bullet point 3 above

5.34 For further support, please contact safeguarding team Page 2 / Information
Governance Team (CCG)

**REFERRAL**

5.35 To make a referral of a safeguarding / child protection concern, telephone the
Children’s Social Care and completes a referral form within two working days.

5.36 If the child is known to have an allocated social worker, the referral should be made
to them, or in their absence to the social worker’s manager or a duty children’s social
worker. In all other circumstances referrals should be made to the duty officer.

5.37 The referrer should keep formal contemporaneous records of all discussions with the
child/ parent/ managers etc; decisions taken; information shared and with whom;
copies of referrals. Times of events should be recorded.

5.38 The Children’s Social Care department must acknowledge your referral in writing
within one working day. If this acknowledgment is not received within three working
days the referrer should contact the social care department again and follow this up.

**RESOLVING CASES WHERE PROFESSIONALS HAVE DIFFERENT
OPINIONS**

5.39 When a CCG employee is not happy with the outcome of a child protection or
safeguarding referral then they can use the CCG Safeguarding Children Team for
advise and also refer to the SET 2018 procedures. The CCG has a flow chart for this
escalation of concerns (Appendix2)

5.40 Discuss concerns with professional involved, line manager, then the designated
Nurse or doctor who will escalate it to the services manager and then to LSCB if still
unable to resolve. Please ensure the Escalation Notification is completed (Appendix
3)

5.41 Also see SET Procedures 2018

**RECORD KEEPING**

5.42 Good record keeping is a vital component of professional practice. Whenever a
complaint or allegation of abuse is made, the CCG expects its commissioned
provider services to:

- keep clear and accurate records and to have procedures for incorporating, on receipt of a complaint or allegation, all relevant records into a file to record all action 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 adults affected by, and subject to, an enquiry. If the alleged abuser is using care and support themselves, then information about their involvement in an adult safeguarding enquiry, including the outcome, should be included in their case record. If it is assessed that the individual continues to pose a threat to other people then this should be included in any information that is passed on to service providers or other people who need to know;
- Make information available to the LSCB or CCG on request.

5.42.2 For further information on retention of records, please access CCG Intranet site.

5.42.3 When abuse or neglect is raised, the CCG expects managers of commissioned provider services to review it processes where appropriate, past incidents, concerns, risks and identity patterns. This information needs to be made available to the LSCB, the CCG and the CQC so necessary action can be taken. The CCG expects its commissioned provider services to give staff clear direction as to what information should be recorded and in what format.

5.43 **Archiving Of Documents**

5.43.1 Documents must be retained in accordance with the requirements of Records Management: NHS Code of Practice (DH 2006) and the CCGs Records Management Policy.

**PRIVATE FOSTERING ARRANGEMENTS**

5.44 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.

5.45 Should any member of the CCG become aware of a child who is privately fostered they must inform Children Social Care, to ensure the child and family receives the appropriate care and support.

**LOOKED AFTER CHILDREN**

5.46 **What is a Looked After Child?**

5.46.1 This term applies to children currently being looked after and/or accommodated by Local Authorities/Health and Social Care Trusts, including unaccompanied asylum seeking children and those children where the agency has authority to place the child for adoption. A child or young person is “Looked After” under the Children Act, 1989 if he/she is accommodated by the local authority:
- Under a voluntary agreement with parental consent or own consent if aged 16 or 17 (S20)
- Under the Legal Aid, Sentencing and Punishment of Offenders Act (LASPOA 2012) any young person under 18 years remanded to custody becomes ‘Looked after’ under Section 20, if not already on a care order.
- Subject to a care order imposed by the courts (Care order S31 or Interim Care Order S38/ child suffering or likely to suffer significant harm)
- Subject to an Emergency Protection Order (S44). Section 47 investigations are undertaken.
- Is remanded to local authority care (S21/compulsory accommodation)
- Subject to a Secure Order (S25) and placed in secure accommodation. Home Office approval is required for children under 12 years of age.

Any young person who has been in care at any time during their childhood is considered to be vulnerable and at greater need until at least their 21st birthday (24 if in education or disabled)

5.46.2 The term Looked after Child does not apply to those who have been adopted and those in a private fostering arrangement.

5.46.3 Most children who are in care live safely but a small number do experience harm. There are a number of risk factors related to being in care which can make children more vulnerable to abuse and neglect.

5.46.4 NSPCC Website - https://www.nspcc.org.uk/

HUMAN RESOURCES

5.47 Whistle Blowing

5.47.1 The CCG Whistle Blowing policy enables concerns about malpractice to be raised at an early stage and in the right way without fear of reprisals or concern for safety.

5.47.2 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.

5.47.3 Refer to CCG Whistle Blowing policy.

5.48 Managing Allegations Against Staff

5.48.1 The CCG has procedures for dealing with allegation against staff or volunteers which is in line with SET 2018 and NHSE 2015 policies. It should set out the processes, including timescales, investigation and what support and advice is available to the individual against whom an allegation have been made. 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.

5.48.2 Possibly committed a criminal offence against or related to a child or behaved towards a child in a way that indicates they may pose a risk of harm to children. An allegation against people who work with children should be reported immediately to the Chief Nurse and the Designated Nurse for Safeguarding children for guidance, advice and support within one working day or that made directly to the police.
Local Authority Designated Officer (LADO) should be informed of the allegation and this 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.

5.48.3 Please also refer to SET Procedures 2018 and under CCG / HR Policies.

5.49 SAFER RECRUITMENT: DISCLOSURE AND BARRING SERVICE

5.49.1 This system provides checks on people entering the workforce, and maintains lists of individuals who are barred from undertaking regulated activity. The CCG will check all potential employee with the disclosure and baring service to help make safer recruitment decision.

5.49.2 The CCG expect its provider services to make referral to the DBS on all staff who work with children and young people.

5.49.3 Please refer to CCG Corporate / HR Policies

6 MONITORING COMPLIANCE – SUPPORT AND SUPERVISION

6.1 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 will be recorded using the appropriate form http://basildonandbrentwoodccg.nhs.uk / http://thurrockccg.nhs.uk at the time of supervision and this will be signed by both the supervisor and the supervisee. The Designated Doctor provides supervision for the Named Doctors who will be supported to provide group supervision to the link safeguarding GP Practice Leads in each Practice.

6.2 The Designated and Associate Professionals for the CCG provide Safeguarding Children and LAC Supervision for the Provider Named Nurses. The Designated Professionals will receive support from the Board lead for safeguarding and formal supervision should be paid for by the CCG. This should be every quarter as a minimum. Please refer to the separate Supervision Policy for requirements.

6.3 In addition Designated Professionals should have peer-to-peer supervision to ensure continued development in their practice in line with agreed best practice. Designated professionals are 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 CCG 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 CCG.

7 STAFF TRAINING

7.1 Safeguarding Children Training is a mandatory requirement for all staff employed by the CCG. The competences specifically needed by healthcare workers to promote children’s safety within the healthcare system are described in Safeguarding Children and Young People: Roles and Competences for Health Care Staff (Intercollegiate Document 2014 – https://www.rcpch.ac.uk/sites/default/files/Safeguarding_Children -
7.2 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 who 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

7.3 These can also be accessed via the CCG Intranet - http://basildonandbrentwoodccg.nhs.uk/  http://thurrockccg.nhs.uk/

8 ARRANGEMENTS FOR REVIEW

8.1 This policy will be reviewed no less frequently than every two years. An earlier review will be carried out in the event of any relevant changes in legislation, national or local policy/guidance.

8.2 If only minor changes are required, the sponsoring Committee has authority to make these changes without referral to the CCG Board. If more significant or substantial changes are required, the policy will need to be ratified by the relevant committee before final approval by the CCG Board.

9 ASSOCIATED DOCUMENTATION

- Safeguarding Adults Policy

10 REFERENCES

- Looked After Children: Roles and Competences for Health Care Staff Intercollegiate Document (2015) Royal College of Paediatrics and Child Health
- Promoting the Health of Looked After Children (2015) Department of Health & Department of Education
- Records Management Policy CCG Intranet Sites
- Safeguarding Children Roles and Competences for Health Care Staff Intercollegiate Document (2014) Royal College of Paediatrics and Child Health
- Southend Essex and Thurrock (SET) 2018

11 LIST OF STAKEHOLDERS CONSULTED

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Date circulated</th>
<th>Were Comments incorporated into Policy?</th>
<th>Comments incorporated ? Y/N</th>
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<tr>
<td>Lisa Allen</td>
<td>Accountable Officer</td>
<td>10.1.19</td>
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<td>N</td>
</tr>
<tr>
<td>Mandy Ansell</td>
<td>Accountable Officer</td>
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</tr>
<tr>
<td>Jane Foster-Taylor</td>
<td>Chief Nurse</td>
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<tr>
<td>Matt Rangue</td>
<td>Chief Nurse</td>
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<td>Stephen Mayo</td>
<td>Deputy Chief Nurse</td>
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<td>Yes - 5.2.19</td>
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<tr>
<td>Dr Puva</td>
<td>Designated Doctor</td>
<td>28.12.18</td>
<td>Yes - 2.1.19</td>
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<tr>
<td>Jacquie Baguley</td>
<td>Associate Designated Nurse SGC</td>
<td>28.12.18</td>
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<td>Clarissa Wye</td>
<td>Specialist Nurse Advisor</td>
<td>28.12.18</td>
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<tr>
<td>Paula Gregory</td>
<td>Designated Nurse LAC</td>
<td>28.12.18</td>
<td>Yes - 7.1.19</td>
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</table>
12 RESULTS OF EQUALITY IMPACT ASSESSMENT

12.1 The EIA has identified no equality issues with this policy.

12.2 The EIA has been included as Appendix A

12.3 Equal Opportunities

12.3.1 This policy reflects the organisation’s determination to ensure that all parts of our community have equality of access to services and that everyone receives a high standard of service as a service user, a carer or employee. This policy anticipates and encompasses the CCG’s commitment to prevent discrimination on any illegal or inappropriate basis and recognise and respond to the needs of individuals based on good communication and best practice.

12.3.2 We recognise that some groups of the population are more at risk of discrimination or less able to access to services than others and that services can often unintentionally put barriers in place that can limit or prevent access. The organisation is continually working to prevent this from happening.

12.3.3 The CCG is committed to carrying out a systematic review of all its existing and proposed policies to determine whether there are any equality implications.

13 CHANGE HISTORY:

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<th>Date</th>
<th>Version</th>
<th>Author</th>
<th>Description</th>
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<td>1.0</td>
<td>Yvonne Anarfi – Designated Nurse / Named Professional for Primary Care</td>
<td>April 2016</td>
<td>June 2018</td>
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<td>2.0</td>
<td>Yvonne Anarfi – Designated Nurse / Named Professional for Primary Care</td>
<td>Jan 2019</td>
<td>February 2022</td>
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<td>Appendix 1</td>
<td>CCG Workforce and Organisation’s Roles and Responsibilities in Safeguarding Children</td>
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<td>Appendix 2</td>
<td>Escalation Pathway</td>
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<td>Escalation Pathways 2015 v2FINAL.docx</td>
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<td>Escalation Notification Form</td>
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</table>
## Equality Impact Assessment

To be completed and attached to any policy/procedural document when submitted to the appropriate committee for consideration and approval.

<table>
<thead>
<tr>
<th></th>
<th>Does the policy/guidance affect one group less or more favourably than another on the basis of:</th>
<th>Yes/No</th>
<th>Comments</th>
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<tbody>
<tr>
<td>1</td>
<td>Race</td>
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<td></td>
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<tr>
<td></td>
<td>Ethnic origins (including gypsies and travellers)</td>
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</tr>
<tr>
<td></td>
<td>Nationality</td>
<td>No</td>
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<tr>
<td></td>
<td>Gender</td>
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<td></td>
<td>Culture</td>
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<tr>
<td></td>
<td>Religion or belief</td>
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<td></td>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Age</td>
<td>No</td>
<td></td>
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<tr>
<td></td>
<td>Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
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<td>2</td>
<td>Is there any evidence that some groups are affected differently?</td>
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<td></td>
</tr>
<tr>
<td>3</td>
<td>If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</td>
<td>N/A</td>
<td></td>
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<tr>
<td>4</td>
<td>Is the impact of the policy/guidance likely to be negative?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>If so can the impact be avoided?</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>What alternatives are there to achieving the policy/guidance without the impact?</td>
<td>N/A</td>
<td></td>
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<tr>
<td>7</td>
<td>Can we reduce the impact by taking different action?</td>
<td>N/A</td>
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