



HEALTH SERVICES January 2011

1. General principles for all health services

1.1 The safety and the health of a child are intertwined aspects of their wellbeing. Many 'health' interventions also equip a child to 'stay safe'²⁸

1.2 All organisations commissioning or providing healthcare, whether in the NHS or third sector, independent healthcare sector or social enterprises, should ensure there is board level focus on the needs of children and that safeguarding children is an integral part of their governance systems.

1.3 All healthcare staff involved in working with children should attend training in safeguarding and promoting the welfare of children, and have regular updates as part of continuing professional development. *See Chapter 4 for details of interagency training.*

2. Health organisations

2.1 The Care Quality Commission and registration requirements

2.1.1 The Care Quality Commission (CQC) is the independent regulator of safety and quality for all health services. From April 2010, NHS trusts and NHS foundation trusts need to be registered with the CQC²⁹. The Commission has a range of statutory independent enforcement actions to use where care does not meet the essential levels of safety and quality that users are entitled to expect.

2.1.2 GP practices and high street dental practices will be required to register with the CQC, regardless of whether they provide wholly private or wholly NHS services, or a mix of both and will be subject to a consistent set of quality standards. Registration of primary dental care providers will start from 2011 and primary medical care providers from 2012.

2.1.3 Any enforcement action being considered by the CQC, including possible deregistration, should include, where appropriate, arrangements in partnership with the relevant PCT to re-provide services for children as quickly and safely as possible.

2.2 Monitor

2.2.1 NHS foundation trusts are regulated by Monitor, an independent regulator, which has authority to hold them to account for meeting their responsibilities under the Children Acts. This is unlike NHS trusts, which are overseen by Strategic Health Authorities. However, NHS foundation trusts are assessed by the CQC in the same way as other providers.

2.3 Strategic Health Authorities

2.3.1 SHAs are the regional headquarters of the NHS. Each SHA is responsible for ensuring that patients have access to high-quality services in its area. SHAs oversee the performance of PCTs and NHS trusts and hold PCTs to account, including for safeguarding and promoting the welfare of children. SHAs are themselves directly accountable to the Department of Health and

²⁸ 'Staying safe' is a key outcome of *Every Child Matters*

²⁹ www.cqc.org.uk

safeguarding is considered by the Department of Health as part of their SHA assurance process.

2.3.2 SHAs should consider individual organisations' arrangements for, and contribution to, safeguarding children as an integral part of their governance system. Their performance and management of the healthcare system should be informed by information such as existing national data collections, LSCB audit, progress against action plans and/or child death and Serious Case Review recommendations and regulatory/inspection findings where appropriate. Bespoke local surveys and data gathering should be avoided unless there is a clear business need in order to minimise duplication and burden of reporting.

2.3.3 SHAs membership of LSCBs (see paragraph 3.70) will enable them to oversee the health contribution to safeguarding children at local level. Further advice on how SHAs should engage with LSCBs is set out in Annex D of the *Local Safeguarding Children Boards: A Review of Progress* report³⁰

2.4. Primary Care Trust commissioners

2.4.1 PCTs are responsible for improving the health and wellbeing of their local population, including children and young people. To achieve this, they are under a legal duty to work with the local authority to assess what kind of health services people need.

2.4.2 PCTs can commission services from a range of different organisations and generally hold the providers of these services to account via contracts. PCTs can ask the regulators to step in if the providers are not meeting the expected standards. PCTs should have a collaborative, multi-agency approach to commissioning and should work with local authorities to commission and provide co-ordinated and, wherever possible, integrated services, in particular through Children's Trust co-operation arrangements.

2.4.3 PCTs should identify a senior lead for children and young people³¹ to ensure that their needs are at the forefront of local planning and service delivery. PCTs should also identify a board executive lead for safeguarding children who takes responsibility for governance, systems and organisational focus on safeguarding children. This might be the same person.

2.4.4 Designated professionals should work closely with, and be performance managed and supported in their role by, this board executive lead as part of the board lead's portfolio of responsibilities. If this person is not the board level lead for clinical governance and clinical professional leadership, the designated professional will also need to work closely with this lead person (see paragraphs 2.109–2.123).

2.4.5 There should be a named public health professional who addresses issues related to children in need as well as children in need of protection. The Joint Strategic Needs Assessment should include these needs which in turn should inform the Children and Young People's Plan and the LSCB business plan. When considering commissioning services for the health and wellbeing of children in need in their area, PCTs should ensure this includes those who are temporarily resident in the area, such as children held in secure settings.

2.4.6 PCT Chief Executives have responsibility for ensuring that the health contribution to safeguarding and promoting the welfare of children is discharged effectively across the whole local health economy through the PCTs' commissioning arrangements. PCTs should ensure that all their staff are alert to the need to safeguard and promote the welfare of children. Each PCT is responsible for identifying a senior paediatrician and senior nurse to undertake the role

³⁰ www.dcsf.gov.uk/everychildmatters/download/?id=3082

³¹ NSF Core Standards 3 – Markers of good practice

of designated professionals for safeguarding children in commissioning services across the health economy (see paragraphs 2.109–2.123).

2.4.7 PCTs should ensure that all providers from whom they commission services – including organisations in the public sector, independent sector, third sector and social enterprises – have comprehensive and effective single and multi-agency policies and procedures to safeguard and promote the welfare of children. These should be in line with, and informed by, LSCB procedures, and easily accessible for staff at all levels within each organisation.

2.4.8 PCTs are expected to ensure that safeguarding and promoting the welfare of children are integral to clinical governance and audit arrangements. Service specifications drawn up by PCT commissioners should include clear service standards for safeguarding and promoting the welfare of children, consistent with LSCB procedures. Section 4A and schedule 11 part 5 of the national contracts provide the means to prescribe the requirements for safeguarding children. By monitoring the service standards of all providers, PCTs will assure themselves that the required safeguarding standards are being met. Where practice-based commissioners undertake commissioning of services, this should be done in partnership with PCTs, who need to ensure their safeguarding duties are fulfilled.

2.4.9 PCTs should ensure 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. PCTs will wish to consider how they support GP practices, for instance by assistance with protected time for, and access to, training in child protection.

2.4.10 PCTs are responsible for planning integrated GP out-of-hours services in their local area, and staff working within these services should know how to access advice from designated and named professionals within the PCT and LSCB. Each GP and member of the Primary Health Care Team should have access to a copy of the LSCB's procedures.

2.4.11 PCTs are encouraged to bring together commissioning expertise on sexual violence services, to form a local Sexual Assault Referral Services (SARS) care pathway for children and young people. All SARS for children and young people, including services provided through Sexual Assault Referral Centres (SARCs), should 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 *Children's NSF*³² and the *You're Welcome quality criteria: Making health services young people friendly*³³. PCTs should ensure that staff know their local services and be clear about the different agencies' roles and responsibilities, so that they are not hesitant about responding appropriately. A *Resource for Developing Sexual Assault Referral Centres*³⁴, jointly published by the Department of Health, Home Office and the Association of Chief Police Officers (ACPO) in October 2009, sets out the minimum elements essential for providing high quality SARCs services for adults and children who are victims of sexual assault.

2.4.12 PCTs must co-operate with the local authority in the establishment and operation of the LSCB and, as partners, must share responsibility for the effective discharge of its functions in safeguarding and promoting the welfare of children. Representation on the Board should be at an appropriate level of seniority. PCTs are also responsible for providing and/or ensuring the availability of appropriate expertise and advice and support to the LSCB, in respect of a range of specialist health functions – for example, primary care, mental health (adult, adolescent and child) and sexual health – and for co-ordinating the health component of Serious Case Reviews

32 www.dh.gov.uk/en/Healthcare/Children/DH_4089111

33 www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4121564.pdf

34 www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_108350.pdf

(see Chapter 8). They should notify the SHA and the CQC of all Serious Case Reviews. The PCT must also ensure that all health organisations, including those in the third sector, independent healthcare sector and social enterprises with whom they have commissioning arrangements, have links with a specific LSCB and are aware of LSCB policies and procedures. This is particularly important where providers' boundaries/ catchment areas (including Ambulance Trusts and NHS Direct services³⁵) are different from those of LSCBs. The PCT should also ensure that health agencies work in partnership in accordance with their agreed LSCB plan, including in secure settings such as Young Offenders Institutions, Secure Children's Homes/Training Centres (where relevant) and Youth Offending Teams in the community.

2.5. General principles for all provider services

2.5.1 These principles apply to all NHS health services and health service providers in both the NHS and independent healthcare settings. The aim is to ensure that all children and young people receive appropriate and timely early intervention and therapeutic interventions.

2.5.2 All health professionals working directly with children and young people should ensure that safeguarding and promoting their welfare forms an integral part of all elements of the care they offer. Other health professionals who come into contact with children, parents and carers in the course of their work also need to be fully informed about their responsibility to safeguard and promote the welfare of children and young people. This is important as even though a health professional may not be working directly with a child, they may be seeing their parent, carer or other significant adult and have knowledge which is relevant to a child's safety and welfare. A National Institute for Health and Clinical Excellence (NICE) clinical guideline, *When to suspect child maltreatment*³⁶, is a resource to help healthcare practitioners who are not specialists in child protection.

2.5.3 All health professionals who work with children, young people and families should be able to:

- understand risk factors and recognise children and young people in need of support and/or safeguarding;
- recognise the needs of parents who may need extra help in bringing up their children, and know where to refer for help and use the CAF to access support as appropriate for them;
- recognise the risks of abuse or neglect to an unborn child;
- communicate effectively with children and young people and stay focused on the child's safety and welfare;
- liaise closely with other agencies, including other health professionals, and share information as appropriate;
- assess the needs of children and the capacity of parents/carers to meet their children's needs, including the needs of children who display sexually harmful behaviours;
- plan and respond to the needs of children and their families, particularly those who are vulnerable;
- contribute to child protection conferences, family group conferences and strategy discussions;
- contribute to planning and commissioning support for children who are suffering, or likely to suffer, significant harm, for example, children living in households with domestic violence or parental substance misuse;
- help ensure that children who have been abused or neglected and parents under stress have access to services to support them;
- be alert to the strong links between adult domestic violence and substance misuse and child

35 NHS Direct is a national service staffed by nurses and health advisors providing 24 hour health advice and information through a national telephone number (0845 46 47), the NHS Choices website (www.nhs.uk) and a digital TV service

36 www.nice.org.uk/nicemedia/pdf/CG89FullGuideline.pdf

abuse and recognise when a child is in need of help, services or at potential risk of suffering significant harm;

- where appropriate, play an active part, through the child protection plan, in keeping the child safe;
- as part of generally safeguarding children and young people, provide ongoing promotional and preventative support, through proactive work with children, families and expectant parents; and
- contribute to child death and Serious Case Reviews and implementation of the lessons learned (see Chapters 7 and 8).

2.5.4 The above should all be undertaken with reference to the core processes set out in this document (summarised in *What to do if you're worried a child is being abused*), *Responding to domestic abuse: A handbook for health professionals*³⁷, *Improving safety, Reducing Harm: Children, young people and domestic violence; a practical toolkit for front line practitioners*³⁸ and LSCB procedures. It is essential that all health professionals and their teams have access to advice and support from named and designated child safeguarding professionals, clinical supervision and undertake regular safeguarding training and updating (see paragraphs 2.109–2.123).

2.5.5 All health professionals working with children will commonly complete CAFs, which should be the responsibility of all concerned with child welfare. This includes GPs, health visitors, school nurses and other community health professionals and should not be dependent on grade or position, but rather on competence and degree of involvement with, and knowledge of, the child or young person.

2.5.6 The cross-government guidance *Information Sharing: Guidance for practitioners and managers* and associated training materials provides advice on when and how practitioners can share information legally and professionally (see paragraphs 2.12–2.14).

2.6. NHS trusts, NHS foundation trusts and PCT provider services

2.6.1 NHS trusts, NHS foundation trusts and PCT provider services are responsible for providing health services in hospital and community settings. They must co-operate with the local authority in the establishment and operation of the LSCB and, as statutory partners, share responsibility for the effective discharge of its functions in safeguarding and promoting the welfare of children. They should have a board executive lead for safeguarding children who takes responsibility for governance, systems and organisational focus on safeguarding children and works closely with the named health professionals.

2.6.2 Representation on the LSCB should be at an appropriate level of seniority. A wide range of their staff will come into contact with children and parents in the course of their normal duties. All these staff should be trained in how to safeguard and promote the welfare of children, be alert to potential indicators of abuse or neglect in children, and know how to act on their concerns in line with LSCB procedures.

2.6.3 All NHS trusts, NHS foundation trusts and PCT provider services should identify a named doctor and a named nurse – and a named midwife where they provide maternity services – for child protection (see paragraph 2.109).

2.6.4 Staff working in urgent care settings should be able to recognise abuse or neglect and have a thorough knowledge of local procedures for making enquiries to find out whether a child is the subject of a child protection plan. Staff in urgent care settings should also be alert to the

37 www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4126619.pdf

38 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108697

need to safeguard the welfare of children when treating parents or carers of children, and be alert to parents and carers who seek medical care from a number of sources in order to conceal the repeated nature of a child's injuries. Specialist paediatric advice should be available at all times to A&E departments and all units where children receive care. If a child – or children from the same household – presents repeatedly, even with slight injuries, in a way that doctors, nurses or other staff find worrying, they should act upon their concerns in accordance with Chapter 5 of this guidance (the key processes are summarised in *What to do if you're worried a child is being abused*). Children and families should be actively and appropriately involved in these processes, unless this could result in an increased risk of harm to the child.

2.6.5 In most circumstances, the relevant child's GP should be notified of visits by children to all urgent care settings. Children and young people or, where they lack competency, their parents, should be informed about this information sharing; where they object, and clinicians agree that it would not be in their best interests for information to be shared with their GP (for example, where a young person is seeking contraceptives) then a disclosure should not take place.

2.6.6 Where the child or young person is not registered with a GP, the appropriate contact in the PCT is to be notified for arranging registration. Consent should be sought from the child, young person or their family, as appropriate, for relevant information to be disclosed to the PCT, health visitor, school nurse or other health professional. It is important to strike an appropriate balance between protecting the confidentiality of individuals and allowing appropriate information sharing between professionals; any decision to share information without seeking consent or to override a refusal to provide consent should therefore only take place when it is in the public interest to do so. Where there is a clear risk either of a child suffering significant harm, or serious harm to an adult, the public interest test will almost certainly be satisfied. There will be other cases where practitioners will be justified in sharing some confidential information in order to make decisions on sharing further information or taking action. In these cases the information shared should be proportionate. All decisions to share or not share information about a child or young person should be fully documented, and information sharing should be explained to the child, young person or family, as appropriate, unless this could increase the risk of harm to the child.

2.6.7 In addition to the accountability arrangements for NHS foundation trusts set out in paragraph 2.46, NHS foundation trusts are accountable to the PCTs that commission services from them and to their local populations through a board of governors. National standards and the legal framework for the NHS apply to NHS foundation trusts just as they do to other parts of the NHS.

2.7 Ambulance Trusts and NHS Direct sites

2.7.1. The staff working in these health services will have access (by phone or in person) to family homes and be involved with individuals in a time of crisis. They may therefore be in a position to identify initial concerns regarding a child's welfare and be able to alert children's social care, the GP or other appropriate health professional in line with locally agreed procedures. Ambulance trusts and NHS Direct sites should have a named professional for safeguarding children (see paragraph 2.109 for more detail). All staff should be aware of local procedures in line with LSCB policies and be appropriately trained.

2.8 Independent sector, third sector and social enterprises

2.8.1 Independent sector, third sector and social enterprise providers contracted to provide NHS services should comply with the requirements in this document with respect to safeguarding and promoting the welfare of children, including the requirement to notify the local authority of children who are, or are likely to be, accommodated for at least three months (see paragraph 11.30)³⁹. This will be included in their contract with the commissioning PCT, and PCTs should

³⁹ Section 85, Children Act 1989

ensure that they apply the same standards and requirements as for NHS providers.

2.8.2 All providers of healthcare, whether operating in the NHS or independently are subject to registration requirements set out under the Health and Social Care Act 2008 and administered by the CQC. Independent, third sector and social enterprise providers should enable access for staff to regular safeguarding training and supervision as appropriate, and should have proportionate coverage of named professionals (see paragraphs 2.109–2.123), and access to designated professionals for complex issues or where concerns may have to be escalated and involve social services. Clinical networks⁴⁰ can provide a further opportunity for sharing highly specialised resources across teams and geographical areas and PCTs should facilitate these where appropriate.

2.9. GP practices

2.9.1 The family doctor or general practitioner (GP) is the first point of contact with the health service for most people. Most people are registered with a GP practice and have an ongoing relationship with that practice. In addition to maintaining their own professional skills in safeguarding and promoting the welfare of children, GPs have an important role to play as employers in ensuring staff whom they employ are trained in safeguarding and promoting the welfare of children (see Chapter 4).

3. Roles of different health services

3.1 Universal services

3.1.1 Universal child and family health services are provided by a range of professionals and their teams working within general practice or other provider organisations. There are many common responsibilities although specific arrangements may be different within community health services to those within general practice. While GPs and other health practitioners have responsibilities to all their patients, children may be particularly vulnerable and their welfare is paramount.

3.1.2 The Healthy Child Programme⁴¹, 0-5 years and 5-19 years, provides a framework to ensure the promotion of the health and wellbeing of children and young people. It is delivered by multi-agency support services involved with children and young people.

3.1.3 As part of the Programme, regular health reviews are undertaken which provide the opportunity to identify risk factors that make children more likely to experience poorer outcomes later in life, including family and environmental factors. This enables professionals to put together a package of support or referral to specialist services to address the issues raised. All professionals need to be alert to concerns and the requirements to safeguard children. More support should be targeted to children and families who are vulnerable or those with complex needs.

3.1.4 If concerns arise during an assessment that may require support from another agency it will be important for the professionals involved to work in partnership and share relevant information as required, in accordance with the Government's information sharing guidance.

3.1.5 All professionals delivering universal services have key roles to play both in the identification of children who may have been abused or neglected and those who are likely to be; and in subsequent intervention and protection from harm. Surgery consultations, home visits, treatment room sessions, child health clinic attendance, drop-in centres and information from staff such as health visitors, midwives, children's centre staff, school health team staff and

40 A Guide to Promote a Shared Understanding of the Benefits of Managed Local Networks (Department of Health, 2005)

41 www.dh.gov.uk/en/Healthcare/Children/Maternity/index.htm

practice nurses may all help to build up a picture of the child's situation and can alert the appropriate professional if there is a concern.

3.1.6 All professionals delivering primary care should know when it is appropriate to refer a child or young person to children's social care for help as a 'child in need', and know how to act on concerns that a child may be suffering, or likely to suffer, significant harm through abuse or neglect.

3.1.7 GPs, their staff and community health practitioners such as health visitors and school nurses are also well placed to recognise when a parent or other adult has problems that may affect their capacity as a parent or carer, or that may mean they pose a risk of harm to a child. When GPs and other health professionals have concerns that an adult's illness or behaviour may be causing, or putting a child at risk of, suffering significant harm, they should follow the procedures set out in Chapter 5 of this guidance (summarised in *What to do if you're worried a child is being abused*).

3.1.8 GPs, practice staff, and other community health practitioners have an important role in all stages of the child protection process and should have a clear means of identifying in records those children (together with their parents and siblings) who are the subject of a child protection plan. This will enable them to be recognised by the partners of the practice and any other doctor, nurse or health visitor who may be involved in the care of those children. There should be good communication between GPs, health visitors, school nurses (and the wider School Health Team), practice nurses and midwives in respect of all children and their families about whom there are concerns.

3.1.9 GPs and other community health practitioners, such as health visitors and school nurses, have key roles in appropriate information sharing with children's social care when enquiries are being made about a child. They will also contribute to assessments and be involved in a child protection plan, as appropriate. GPs, community health practitioners, other primary care professionals and practice staff should make available to child protection conferences relevant information about a child and family, whether or not they are able to attend.

General practitioners

3.1.10 All GPs have a duty to maintain their skills in the recognition of abuse and neglect, and to be familiar with the procedures to be followed if abuse or neglect is suspected. GPs should take part in training about safeguarding and promoting the welfare of children, and have regular updates as part of their post-graduate educational programme⁴².

Health visitors

3.1.11 The specialist skills of the health visitor are crucially important in protecting children. Health visitors contribute to all stages of the child protection process, including Serious Case Reviews. They support the work of the LSCB through the delivery of multi-agency training programmes and membership of working and task sub-groups.

3.1.12 Health visitors are trained to recognise risk factors, triggers of concern and signs of abuse and neglect. Through their preventative work, they are frequently the first to recognise children who are being or are likely to be abused or neglected and therefore when safeguarding procedures need to be initiated. Knowledge of the family and their circumstances, as well as the child, probably gathered during home visits, enables the health visitor to recognise signs and symptoms of a worsening environment, lack of progress to improve the child's circumstances, or actual harm being suffered by the child.

42 Good Medical Practice (GMC).

www.gmc-uk.org/GMC_Good_Medical_Practise_1209.pdf_30373048.pdf

3.1.13 Health visitors must have time to maintain effective contact with the child and family, to establish and develop a successful working relationship so they can place, health visitors need ongoing contact with families so that they continue to receive preventative health interventions both during the crisis, and in the future.

3.1.14 Health visitors should liaise with other professionals and agencies so that a full picture of risk factors and progress is obtained. A recurring theme in Serious Case Reviews has been inadequate sharing of information about vulnerable children. Health visitors should use professional judgement about what, and when, information is shared with others such as children's social care services, police and children's centres.

3.1.15 Health visitors should also consider the competence of those in their team, guiding them and ensuring they understand their own roles, responsibilities and relevant policies and procedures, as well as the legislative framework for safeguarding and promoting the welfare of children. Health visitors must have access to regular proactive child protection supervision to ensure good practice (see Chapter 4).

*School nurses*⁴³

3.1.16 School nurses have a crucial role to play in safeguarding. They have regular contact with children aged 5-19 who spend a significant proportion of their time in school and are commonly the lead professional for CAFs. School nurses are educated in child health and development and have a prominent role in delivering the Healthy Child Programme. They have opportunities for periodic, anticipatory health assessments of this group of children as part of universal services. They lead public health actions, implement health education programmes and deliver enhanced services according to assessment of individual or group needs. They may be the first to identify the needs of specific children and instigate preventative interventions, and/or safeguarding procedures.

3.1.17 In their care and treatment of vulnerable children, school nurses may work with parents or carers, referring to, and liaising with specialists and can be instrumental in securing extra resources or support for families to increase their capacity for appropriate parenting.

3.1.18 The position of school nurses at the heart of caring about health and wellbeing within the school environment, alongside the personal care they offer, enables them to establish trusting relationships with children so they are the frequent recipient of confidences, which can lead to earlier intervention.

3.2. Maternity services

3.2.1 The Healthy Child Programme starts in pregnancy. Midwives are the primary health professionals likely to be working with and supporting women and their families throughout pregnancy. However, other health professionals – including maternity support workers, health visitors and, where applicable, specialist key workers – may also be directly engaged in providing support. The close relationship they foster with their clients provides an opportunity to observe attitudes towards the developing baby and identify potential problems during pregnancy, birth and the child's early care.

3.2.2 It is estimated that a third of domestic violence starts or escalates during pregnancy (see paragraphs 11.79–11.92). All health professionals working with pregnant women should understand that vulnerable women are more likely to delay seeking care, to fail to attend antenatal clinics regularly and to deny and minimise abuse. It is important to provide a supportive and enabling environment, where the issue of abuse is raised with every pregnant woman, with the provision of information about specialist agencies, thus enabling disclosure

⁴³ Nurses working in schools are often called 'school health advisers' or 'health advisers'

should a woman so choose (Maternity Section Children's NSF, 2004). The Department of Health issued revised guidance, *Responding to Domestic Violence: a Handbook for Health Professionals*⁴⁴, in 2006.

3.3 Child and Adolescent Mental Health Services (CAMHS)

3.3.1 Standard 9 of the NSF is devoted to the 'Mental Health and Psychological Wellbeing of Children and Young People'. The importance of effective partnership working is emphasised, and this is especially applicable to children and young people who have mental health problems as a result of abuse and/or neglect. Some forms of emotional distress may, however, fall short of being an identifiable mental health issue. It is also important that the more general need to promote emotional wellbeing among children and young people is not neglected as an essential component of safeguarding.

3.2.2 In the course of their work, child and adolescent mental health professionals will therefore want to identify as part of assessment and care planning whether child abuse or neglect, or domestic violence, are factors in a child's mental health problems, and ensure that this is addressed appropriately in their treatment and care. If they think a child is currently affected, they should follow local child protection procedures. Consultation, supervision and training resources should be available and accessible in each service (see Chapter 4).

3.3.3 Child and adolescent mental health professionals have a role in the initial assessment process in circumstances where their specific skills and knowledge are helpful. In addition, assessment and treatment services may need to be provided to young people with mental health problems or with other emotional difficulties who offend. The assessment of children with significant learning difficulties, a disability or sensory and communication difficulties may require the expertise of a specialist learning disability service or CAMHS.

3.3.4 CAMHS also have a role in the provision of a range of psychiatric and psychological assessment and treatment services for children and families. Services that may be provided, in liaison with local authority children's social care services, include the provision of reports for court, and direct work with children, parents and families. Services may be provided either within general or specialist multi-disciplinary teams, depending on the severity and complexity of the problem. In addition, consultation and training may be offered to services in the community – including, for example, social care schools, primary healthcare professionals and nurseries.

3.4 Adult Mental Health Services

3.4.1 Adult mental health services – including those providing general adult and community, forensic, psychotherapy, alcohol and substance misuse and learning disability services – have a responsibility in safeguarding children when they become aware of, or identify, a child suffering or likely to suffer significant harm. This may be as a result of a service's direct work with those who may be mentally ill, a parent, a parent-to-be, or a non-related abuser, or in response to a request for the assessment of an adult perceived to represent a potential or actual risk to a child or young person. Adult mental health staff need to be especially aware of the risk of neglect, emotional abuse and domestic abuse to children. Staff should be able to consider the needs of any child in the family of their patient or client and to refer to other services or support for the family as necessary and appropriate, in line with local child protection procedures. Consultation, supervision and training resources should be available and accessible in each service.

3.4.2 In order to safeguard children of patients, mental health practitioners should routinely record details of patients' responsibilities in relation to children, and consider the support needs of patients who are parents and of their children, in all aspects of their work, using the Care Programme Approach. Mental health practitioners should refer to Royal College of Psychiatrists

44 www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_4126161

policy documents, including *Patients as Parents*⁴⁵ and *Child Abuse and Neglect: the Role of Mental Health Services*⁴⁶ and SCIE Guide 30⁴⁷.

3.4.3 Close collaboration and liaison between adult mental health services and children's social care services are essential in the interests of children. It is similarly important that adult mental health liaise with other health providers, such as health visitors and general practitioners. This may require sharing information to safeguard and promote the welfare of children or to protect a child from significant harm. The expertise of substance misuse services and learning disability services may also be required. The assessment of parents with significant learning difficulties, a disability, or sensory and communication difficulties, may require the expertise of a specialist psychiatrist or clinical psychologist from a learning disability service or adult mental health service.

3.4.4 From April 2010, under section 131A of the Mental Health Act 1983, there is a duty on hospital managers to ensure that if a child or young person under the age of 18 is admitted to hospital for mental health treatment, the environment in the hospital is suitable having regard to their age. Managers of adult services must consult with a person who can provide appropriate advice on CAMHS who would need to be involved in decisions about accommodation, care and facilities for education in hospital.

3.5 Visiting of psychiatric patients by children

3.5.1 All inpatient mental health services must have policies and procedures relating to children visiting inpatients, as set out in the *Guidance on the Visiting of Psychiatric Patients by Children* to NHS trusts⁴⁸. Additional guidance has been provided for high-security hospitals. Mental health practitioners must consider the needs of children whose parent or relative is an inpatient – whether formal or informal – in a mental health unit, and make appropriate arrangements for them to visit if this is in the child's best interests.

3.6 Alcohol and drug services

3.6.1 A range of services are provided, in particular by health and voluntary organisations, to respond to the needs of adults (who may have parental or caring responsibilities) and children who misuse drugs and alcohol. These services are linked to the relevant agencies at local level through Drug Action Teams, which comprise, as a minimum, health, social care, education and police representatives. It is important that arrangements are in place to enable children's social care services and substance misuse (including alcohol) services referrals to be made in relevant cases. Where children may be suffering significant harm because of their own substance misuse, or where parental substance misuse may be causing such harm, referrals need to be made by Drug Action Teams or alcohol services, in accordance with LSCB procedures. Where children are not suffering significant harm, referral arrangements also need to be in place to enable children's broader needs to be assessed and responded to. Further information can be found in the DCSF/DH Joint Guidance on *Development of Local Protocols between Drug and Alcohol Treatment Services and Local Safeguarding and Family Services*⁴⁹.

4. Health professionals

4.1 Designated and named professionals

4.1.1 The terms 'designated professionals' and 'named professionals' denote professionals with specific roles and responsibilities for safeguarding children. As commissioners, all PCTs should have a designated doctor and nurse to take a strategic, professional lead on all aspects of the

45 www.rcpsych.ac.uk/files/pdfversion/cr105.pdf

46 www.rcpsych.ac.uk/files/pdfversion/cr120.pdf

47 Think child, think parent, think family: a guide to parental mental health and child welfare, 2009 SCIE Guide 30. www.scie.org.uk/publications/guides/guide30/index.asp

48 www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4012658.pdf

health service contribution to safeguarding children across the PCT area, which includes all providers. PCTs should ensure establishment levels of designated and named professionals are proportionate to the local resident populations and to the complexity of provider arrangements. For large PCTs, NHS trusts and foundation trusts which may have a number of sites, a team approach can enhance the ability to provide 24-hour advice and provide mutual support for those carrying out the designated and named professional role. If this approach is taken, it is important to ensure that the leadership and accountability arrangements are clear.

4.1.2 Designated and named professional roles should always be explicitly defined in job descriptions, and sufficient time, funding, supervision and support should be allowed to fulfil their child safeguarding responsibilities effectively. Further information can be found in the intercollegiate document *Safeguarding Children and Young People: Roles and Competencies for Health Care Staff*⁵⁰.

Designated professionals

4.1.3 Designated professionals are a vital source of professional advice on safeguarding children matters to the PCT, health professionals, particularly named safeguarding health professionals, local authority children's services departments and the LSCB. Appointment as a designated professional may be a full-time role employed as part of the PCT commissioning arm or the person may be employed by a provider organisation with certain time dedicated to the designated role. If the person is not employed by the PCT commissioning arm a clear service level agreement should be in place.

4.1.4 Designated professionals:

- provide advice to ensure the range of services commissioned by the PCT take account of the need to safeguard and promote the welfare of children;
- provide advice on the monitoring of the safeguarding aspects of PCT contracts;
- provide advice, support and clinical supervision to the named professionals in each provider organisation;
- provide skilled advice to the LSCB on health issues;
- play an important role in promoting, influencing and developing relevant training, on both a single and inter-agency basis, to ensure the training needs of health staff are addressed;
- provide skilled professional involvement in child safeguarding processes in line with LSCB procedures; and
- review and evaluate the practice and learning from all involved health professionals and providers commissioned by the PCT, as part of Serious Case Reviews (see paragraph 8.30).

Named professionals

4.1.5 All NHS trusts, NHS foundation trusts, and public, third sector, independent sector, social enterprises and PCTs providing services for children should identify a named doctor and a named nurse – and a named midwife if the organisation provides maternity services – for safeguarding. In the case of NHS Direct, Ambulance trusts and independent providers, this should be a named professional. The focus for the named professional's role is safeguarding children within their own organisation and they should work closely with the board safeguarding children lead to ensure all services are aware of their responsibilities (see paragraphs 2.61–2.65).

4.1.6 Named professionals have a key role in promoting good professional practice within their organisation, and provide advice and expertise for fellow professionals. They should have specific expertise in children's health and development, child maltreatment and local arrangements for safeguarding and promoting the welfare of children.

4.1.7 Named professionals should support the organisation in its clinical governance role, by ensuring that audits on safeguarding are undertaken and that safeguarding issues are part of the Trust's clinical governance system. They also have a key role in ensuring a safeguarding training strategy is in place and is delivered within their organisation.

4.1.8 Named professionals are usually responsible for conducting the organisation's internal management reviews, except when they have had personal involvement in the case when it will be more appropriate for the designated professional to conduct the review. Named professionals should be of sufficient standing and seniority in the organisation to ensure that the resulting action plan is followed up.

4.2 Paediatricians

4.2.1 Paediatricians, wherever they work, will come into contact with child abuse or neglect in the course of their work. All paediatricians need to maintain their skills in the recognition of abuse, and be familiar with the procedures to be followed if abuse and neglect is suspected. Consultant paediatricians, in particular, may be involved in difficult diagnostic situations, differentiating those where abnormalities may have been caused by abuse from those that have a medical cause. In their contacts with children and families, they should be sensitive to clues suggesting the need for additional support or enquiries.

4.2.2 Where paediatricians undertake forensic medical examination, they must ensure they are competent to do so, or work together with a colleague, such as a forensic medical examiner, who has the necessary complementary skills⁵¹.

4.2.3 Paediatricians are sometimes required to provide reports for child protection investigations, civil and criminal proceedings, and to appear as witnesses to give oral evidence. They must always act in accordance with guidance from the General Medical Council (GMC)⁵² and professional bodies, ensuring their evidence is accurate. The Academy of Royal Colleges also issued guidance for those undertaking expert witness work in 2005⁵³.

4.3 Dental practitioners and dental care professionals (DCPs)

4.3.1 Dental practitioners and dental care professionals (dental therapists, dental hygienists, dental nurses, etc.) may see vulnerable children, both within healthcare settings and when undertaking domiciliary visits. They are likely to identify injuries to the head, neck, face, mouth and teeth, as well as potentially identifying other child welfare concerns. From April 2011, primary dental practitioners will be required to register with the CQC and comply with the regulations for safeguarding.

4.3.2 The dental team, irrespective of the healthcare setting in which they work, should therefore be included within the child protection systems and training within the local trust. *Child protection and the Dental Team – an introduction to safeguarding children in dental practice* is available⁵⁴ as guidance for all dental practice staff. Dentists should have access to a copy of the LSCB's procedures.

4.3.3 The dental team should have the knowledge and skills to identify concerns regarding a child's welfare. They should know how to refer to children's social care and who to contact for further advice, including the local named and designated professionals.

51 The core and case-dependent skills required are outlined in detail in *Guidance on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse* (2004), produced by the Royal College of Paediatrics and Child Health and the Association of Forensic Physicians. See: www.rcpch.ac.uk/doc.aspx?id_Resource=1750

52 Acting as an expert witness. See: www.gmc-uk.org/guidance/ethical_guidance/expert_witness_guidance.asp. This guidance also lists other sources of information and advice.

53 *Medical Expert Witness: Guidance from the Academy of Medical Royal Colleges* (2005) www.aomrc.org.uk

54 www.cpd.org.uk/

4.4 Other health professionals

4.4.1 All other health professionals, including those not specifically covered in the preceding sections, and staff who provide help and support to promote children's health and development should have knowledge of the LSCB procedures and how to contact named professionals for advice and support. They should receive the training and supervision they need to recognise and act on child welfare concerns and to respond to the needs of children.