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Clinical Commissioning Group

Protected Learning Time Event

16th June 2022

Safeguarding Children
Level 3

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Agenda

Welcome and Introductions

MASH

Recognition, Response and Information Sharing

Adverse Childhood Experiences

Looked After Children

Advice please

Southwark Team

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Shimona Gayle	Named GP for Safeguarding Children	s.gayle@nhs.net
Michele Sault	Designated Nurse for Safeguarding Children, Looked after Children & Care Leavers	msault@nhs.net
Ros Healy	Consultant Paediatrician and Designated Doctor for Child Protection	
Stacy John-Legere	Consultant Paediatrician and Designated Doctor for Looked After Children	
Megan Morris	Named GP for Safeguarding Adult	meganmorris@nhs.net
Florence Acquah	Designated Nurse for Safeguarding Adults	florence.acquah@nhs.net
Team email/ business support Katarzyna Zawadowska	souccg.southwarksafeguardingteam@nhs.net	

https://selondonccg.nhs.uk/healthcare-professionals/safeguarding/southwark/

Quarterly Safeguarding Forum- Wed 29th June 1-2pm
Modern Day Slavery Level 3 Adult Safeguarding Training
everyone's welcome, link to practice safeguarding lead to forward

Key Principles for Safeguarding Children in General Practice

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- **Do not work with/make decisions/support families alone**
  - **Health Partners**- Practice Team, Health Visitors, School Nurse, Family Nurses, Parental Mental Health Team, CCG team, Acute Trusts, Mental Health Sexual Health, Drug and alcohol services
  - **Safeguarding Partners**- Children Social Care, Family Early Help, Police, Education, Voluntary Services

- The practice team is **uniquely positioned** within the safeguarding network
  - Duty of care to child and parent/carer
  - Longer term cumulative picture,
  - Universal service

- **Recognise, Respond, Risk**

(Child abuse and neglect: NICE 2017)

Safeguarding Children – Protecting Young Southwark

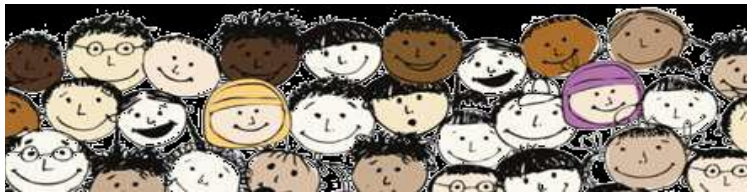
Southwark Council

Metropolitan Police

Community Southwark

Cafcass

Home Start Southwark



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What is Safeguarding?

Safeguarding is

*a. **protecting** children from maltreatment*

*b. **preventing** impairment of children's mental and physical health or development*

*c. ensuring that children are growing up in circumstances consistent with the provision of **safe and effective care***

*d. taking action to enable all children to have the **best outcomes***

Child protection is

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

Working Together to Safeguard Children

A guide to inter-agency working to safeguard and promote the welfare of children

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'**Every** Child Matters'

'Every **Child** Matters'

'Every Child **Matters**'

Is this mandatory?

Safeguarding and Children Protection is a Professional Duty

- Law — Children Act 1989 and 2004
- Statutory Guidance — Working together to safeguarding children
  Information sharing advice for safeguarding practitioners
- Professional Guidance — GMC Protecting children and young people: The responsibilities of all doctors
  RCN Safeguarding children and young people
  Intercollegiate Document: Roles and competencies for health care staff
  Looked after children: Roles and competencies of healthcare staff
  NICE guidance [NG76] Child abuse and neglect
  NICE guidance [CG89] Child maltreatment
- Local Procedures and Policies — London safeguarding children procedures and practice guidance
  Southwark multi-agency threshold guide

Southwark MASH /Assessment & Intervention

Charlotte Allen| Team Manager
MASH, Assessment & Intervention & Out Of Hours

Why ?

The Victoria Climbié Inquiry, 2003- emphasised the need for better communication, better information sharing, joint working.

The Children Act 2004- importance of safeguarding children, working together to promote the wellbeing of the child. (sections 10 and 11 places obligations on partner agencies)

Serious Case Reviews for example: Daniel Pelka- 2013

https://www.lgiu.org.uk/wp-content/uploads/2013/10/Daniel-Pelka-Serious-Case-Review-Coventry-LSCB.pdf

National review into the murders of Arthur Labinjo-Hughes and Star Hobson –

This report asserts that the child protection system must be strengthened, both locally and nationally. That does not mean that the child protection system is 'broken'; indeed there is good evidence that, every day, many thousands of children are protected from harm by conscientious, committed and capable social workers, police officers, health, educational and many other professionals.

MASH Principles

- The Multi-Agency Safeguarding Hub (MASH) model has led to more accurate assessment of risk and need at the ‘front door’ of child protection, when it has been implemented well (Home Office, 2014).
- The MASH aims to promote the safety and welfare of children by providing better access to the information that will help to identify safeguarding risk, underpin a clearer understanding of need and then in turn, lead to effective, timely and proportionate interventions.
- MASH prioritise work, in order of risk, urgency and need.
- The MASH way of working ensures that children and young people have a better chance of receiving the service that is suitable for them, and we spot any potential problems earlier. Accurate case recording also helps us understand family history and past harm.
- The focus of the MASH is to work across partner agencies ensuring families receive early help in order to reduce the need for statutory intervention.

Who is in the MASH?

- Southwark Children's Social Care (1 SM, 4 TM 8 SWs, 1 BSM, 6 MIOs)
- Family Early Help
- Police Public Protection Unit (MASH Police)
- Community Health
- SLAM (Adult Mental Health)
- CAMHS (child adolescent mental health service)
- Solace Women's Aid (Domestic Abuse)
- Youth Justice Service
- Probation
- Housing Department
- CGL (Change Grow Live) Hidden Harm/substance abuse Worker

Current Working arrangements

- MASH and most other Children's Services teams in Southwark continues currently use hybrid working model.
- MASH duty and the Assessment duty teams are office based.
- We have a virtual call centre which enables us to manage calls from home.
- Referrals to MASH from professionals are received via our email inbox which is mash@southwark.gov.uk and police referrals come in via RAD inbox.
- MASH SWs provide consultation to professionals who are concerned for the welfare of children and are not sure whether to make a referral or not.
- The Consultation number is 0207 525 1921 and professional can dial this number and ask to speak to a duty Social Worker for a consultation.

Referral pathway and expectations on professionals making referrals

- All professional referrals received into MASH should be completed on a Southwark MASH referral form.
- Professionals must ensure that referrals sent in to MASH are appropriately filled out with all basic information including family composition, ethnicity and contact telephone numbers.
- Referrals for MASH should identify children in need of statutory help or protection.
- Requests for support eg where children are identified to have unmet needs or parents are in need of support should be sent to Family Early Help for consideration. If received in MASH, we send to FEH directly.

Consent and Information Sharing

- Professionals are expected to discuss their concerns with the parents or guardian of the children to explore parent's perspective, and to obtain consent.
- Referrals made without consent will be returned, unless urgent safeguarding concerns are identified, which override the expectation for a professional to seek consent
- A referral can be made without consent if:
  - you have made all possible efforts to inform the parents, carers or young person over the age of 16 of the referral without success
  - You have informed the parents, carers or young person about the referral, but they don't consent and you feel the child is at risk of significant harm
  - Professionals should indicate the reason why consent has not been obtained in the referral and consider whether child protection threshold to override parental consent is met or contact MASH on 0207 525 1921 for consultation and advice.

Consent and Information Sharing

Why is consent important?

- Families have a right to know what information is shared about them between professional organisations.
- Consent is important in building trust and better working relationships between professionals and parents.

Quote from Crime Prevention Minister Norman Baker 2013

"And I want to send a clear message today – if it's a choice between data protection and child protection, child protection must come first."

(2014).

Information Sharing

Information sharing in the MASH is determined by the1989 and 2004 Children Act. The main legal gateway for cases being placed through the MASH is the 1989 Children Act whereby the MASH is used to determine if the Local Authority has a duty to assess (Section 17) if a child is in need and whether there is a statutory need to undertake a child protection investigation (Section 47). The 2004 Children Act, Section10 and 11 places an obligation on the Local Authority to cooperate with partner such as the police and NHS to promote the welfare of the child.

MASH will often contact health professionals, education settings and other relevant professionals (partner agencies) as well as the referrer for further information before making a decision on whether an assessment should be undertaken or not. MASH work transparently with families and always try to seek consent to gather information from partner agencies.

Open Cases

- Assessment and Intervention Service continues to work with children and families in need of protection during this time with some slight changes to the way they work.
- Most practitioners continue to work from home
- All inquiries on cases that are open and allocated to a Social Worker should be made to our services by dialling **0207 525 1049** and asking to speak to the allocated Social Worker.

‘Threshold’

- **Tier 1:** No additional needs These are children with no additional needs; all their health and developmental needs will be met by universal services. These are children who consistently receive child focused care giving from their parents or carers. The majority of children living in each local authority area require support from universal services alone.

- **Tier 2:** Early help These are children with additional needs, who may be vulnerable and showing early signs of abuse and/or neglect; their needs are not clear, not known or not being met. These children may be subject to adult focused care giving. This is the threshold for a multi-agency early help assessment to begin. These are children who require a lead professional for a co-ordinated approach to the provision of additional services such as family support services, parenting programmes and children’s centres. These will be provided within universal or targeted services provision and do not include services from children’s social care.

- **Tier 3:** Children with complex multiple needs These children require specialist services in order to achieve or maintain a satisfactory level of health or development or to prevent significant impairment of their health and development and/or who are disabled. They may require longer term intervention from specialist services. In some cases these children’s needs may be secondary to the adults needs. This is the threshold for an assessment led by children’s social care under Section 17, Children Act 1989 although the assessments and services required may come from a range of provision outside of children’s social care.

- **Tier 4:** Children in acute need These children are suffering or are likely to suffer significant harm. This is the threshold for child protection. These children are likely to have already experienced adverse effects and to be suffering from poor outcomes. Their needs may not be considered by their parents. This tier also includes Tier 4 health services which are very specialised services in residential, day patient or outpatient settings for children and adolescents with severe and /or complex health problems. This is likely to mean that they may be referred to children’s social care under section 20, 47 or 31 of the Children Act 1989. This would also include those children remanded into custody and statutory youth offending services.

What difference should MASH make *?*

- Accurate assessment of risk and need, as safeguarding decisions are based on collaborative work between agencies.
- It should offer a proportionate and timely response to concerns that have come through to Children's Services (timeframe of 2 hours for RED, 1 working day for Amber and ideally up to 2 working days for Green)
- Least intrusive and interventionist approach.
- Earlier interventions and helps to decide what level of service provision is needed.

What makes a good referral?

- Who is in the family? (siblings in and outside of the home)
- Contact details for the family, demographics such as address , ethnicity, school information.
- Clearly document if you have informed the family of the referral, their views and if have obtained consent.
- Parental consent should never be a barrier to report safeguarding concerns however the rationale must be clear within the referral
- Referrals made in a timely manner (delay could increase risk and impact on response).
- State clearly the nature of the concern.
- Include as relevant much information as possible.
- If there is a mark/bruise to the child , please contact MASH as soon as possible.

Useful links / reading materials (health)

Royal College of Nursing. (2019). *Safeguarding children and young people: roles and competencies for healthcare staff*. Available at: https://www.rcn.org.uk/professional-development/publications/pub-007366#detailTab.

Sidebotham *et al.* (2016). *Pathways to harm, pathways to protection: a triennial review of serious case reviews 2011 to 2014.* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014_-__Pathways_to_harm_and_protection.pdf.

Whittaker, A. (2018). 'How Do Child-Protection Practitioners Make Decisions in Real-Life Situations? Lessons from the Psychology of Decision Making', *The British Journal of Social Work*, 48(7), pp. 1967-1984. Available at: https://doi.org/10.1093/bjsw/bcx145

Wood, A. (2021). *Wood Report: Sector expert review of new multi-agency safeguarding arrangements*. Available at: https://www.gov.uk/government/publications/wood-review-of-multi-agency-safeguarding-arrangements.

Questions

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Referrals and Information Sharing

Recognition-alerting features

Neglect

Lack of basic needs (appropriate clothing, poor standard of hygiene), Unsafe living environment, Malnutrition, Appropriate access to health care. Abandonment

Unborn-maternal substance misuse

Physical Abuse

Bruises, bites, lacerations/ abrasions/scars, burns/scalds, fractures, intracranial injury, spinal Injury, fabricated Induced Illness.

Emotional Abuse

Changes in behaviour or emotional state, unexpected for age/developmental stage, not explained by stressful situation/medical cause/neurodevelopmental disorder

Withdrawn, aggressive, interpersonal behaviour concerns. Substance/alcohol abuse, self-harm, eating disorders

Regularly has responsibilities that interfere with the child's essential normal daily activities.

Sexual Abuse

Sexually transmitted infections, sexualised behaviour, concern about exploitation, (difference in power or mental capacity, relationship with person in position of trust), pregnancy

Under the Sexual Offences Act 2003, any sexual intercourse with a child younger than 13 years is unlawful.

Acts of Omission Vs Acts of Commission

[NICE CG89] Child maltreatment: when to suspect maltreatment in under 18s

Recognition-Alerting Features

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- Listen and observe
- Seek an explanation
- Record
- Consider, suspect or exclude maltreatment
- Unsuitable explanations

(NICE 2009)

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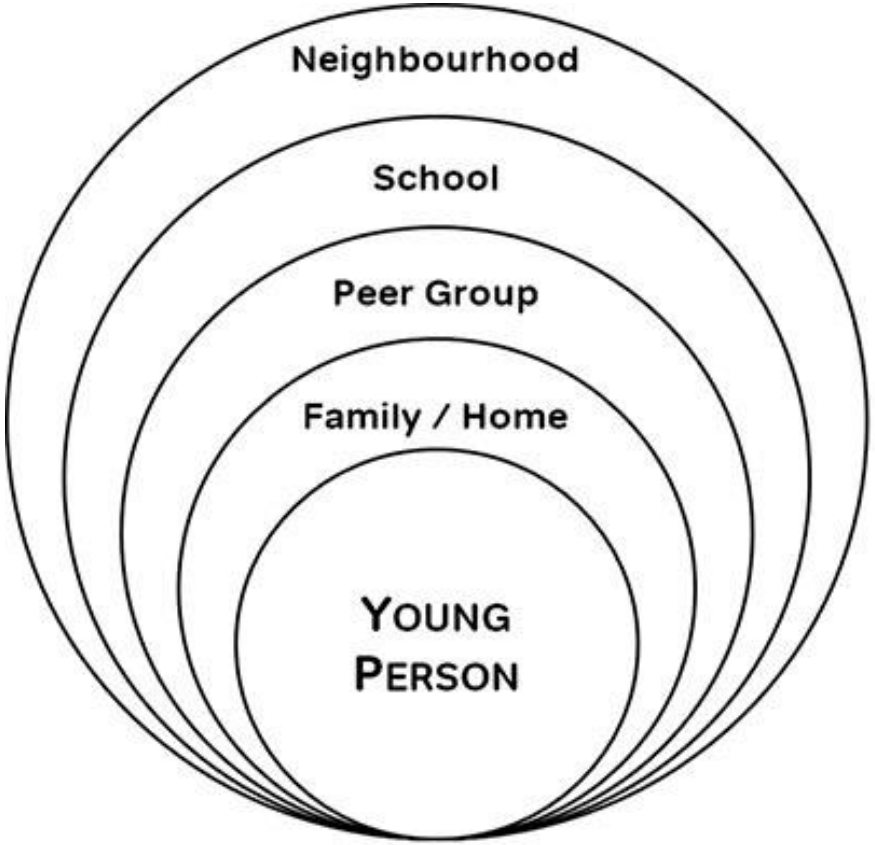
Complex Safeguarding/Extra-familial Harm

Children who experience abuse and neglect carry those experiences with them into adolescence

Complex Safeguarding-range of safeguarding issues related to criminal activity (often organised) involving vulnerable children or adolescents, where there is exploitation and/or a clear or implied safeguarding concern.

This might include (but is not limited to) child criminal exploitation, county lines, modern slavery including trafficking, child sexual exploitation (CSE) and social media assisted harm.

Contextual Safeguarding is an approach that engages with the extra-familial dynamics of risk in adolescence. The primary focus is the need to assess and intervene with extra-familial contexts and relationships in order to safeguard older children and young people.



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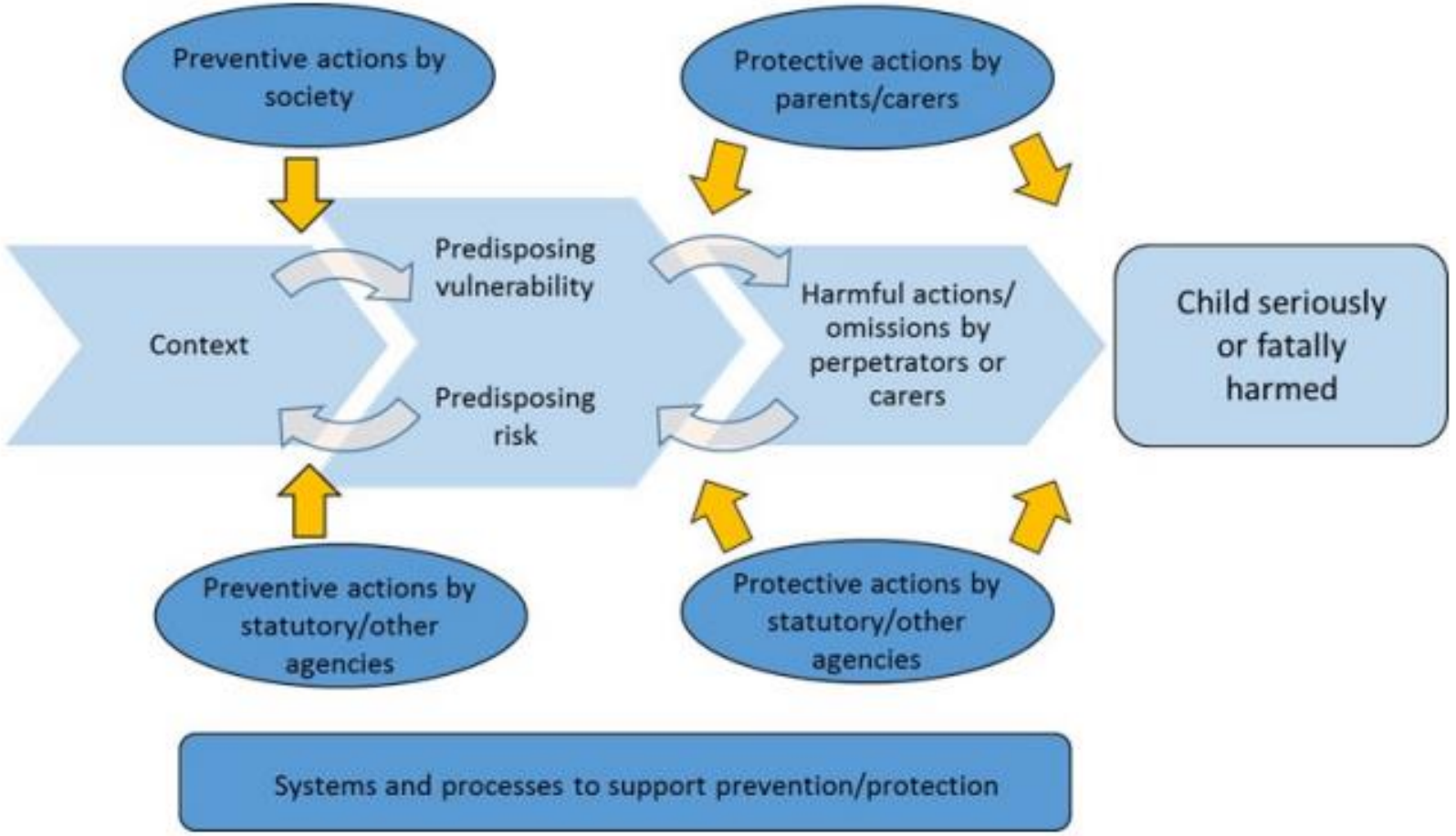
Pathways to Harm, Pathways to Protection



Complexity and challenge: a triennial analysis of SCRs 2014-2017

Pathways to Harm, Pathways to Protection

Predisposing vulnerability, Predisposing risk

Children with disability, chronic physical or mental health problems.

Infancy and adolescence
(in particular with history of childhood neglect)

Parental mental ill health, domestic abuse, alcohol or substance misuse, and parental criminal records, trauma experienced parents, learning difficulties, social isolation.

Complexity and challenge: a triennial analysis of SCRs 2014-2017

Pathways to harm through neglect

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Severe deprivational neglect	where the neglect was the primary cause of death or serious harm; neglect of the child's basic needs leads to impairments in health, growth and development; severe illness or death may result from malnutrition, sepsis, or hypothermia among others.
Medical neglect	failure to respond to a child's medical needs (acute or chronic) and necessary medication; such failure may lead to acute or chronic worsening of a child's health
Accidents	which occur in a context of neglect and an unsafe environment; hazards in the home environment and poor supervision may contribute.
Sudden unexplained death in infancy (SUDI)	within a context of neglectful care and a hazardous home environment; deaths may occur in dangerous co-sleeping contexts, or where other recognised risk factors are prominent and not addressed.
Physical abuse	occurring in a context of chronic, neglectful care; the primary cause of serious harm or death may be a physical assault, but this occurs within a wider context of neglect.
Suicide and self-harm	in adolescents with mental health problems associated with early or continuing physical and emotional neglect.
Vulnerable adolescents harmed through risk-taking behaviours	associated with early or continuing physical and emotional neglect.
Vulnerable adolescents harmed through exploitation	associated with early or continuing physical and emotional neglect.

Triennial Analysis of SCRs: Briefing for health practitioners

Referrals-MASH
Multi-agency Safeguarding Hub

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What are you worried about and what is the impact on the child(ren)?
What type of harm has the child suffered or likely to be suffering and any known history of harm?
If any disclosures have been made include who by and when?
What support has already been offered by your agency and/or other agencies and what were the outcomes in terms of helping the family? If nothing, could this be appropriate?
What is going well for the child(ren)?
What information do you know about the child(ren)'s parent/carer and the wider family? (include relationships, friendships, behaviour, support, stability, safety, language, mental health, substance misuse, domestic abuse etc)
Any other relevant information

Referrals- Family Early Help

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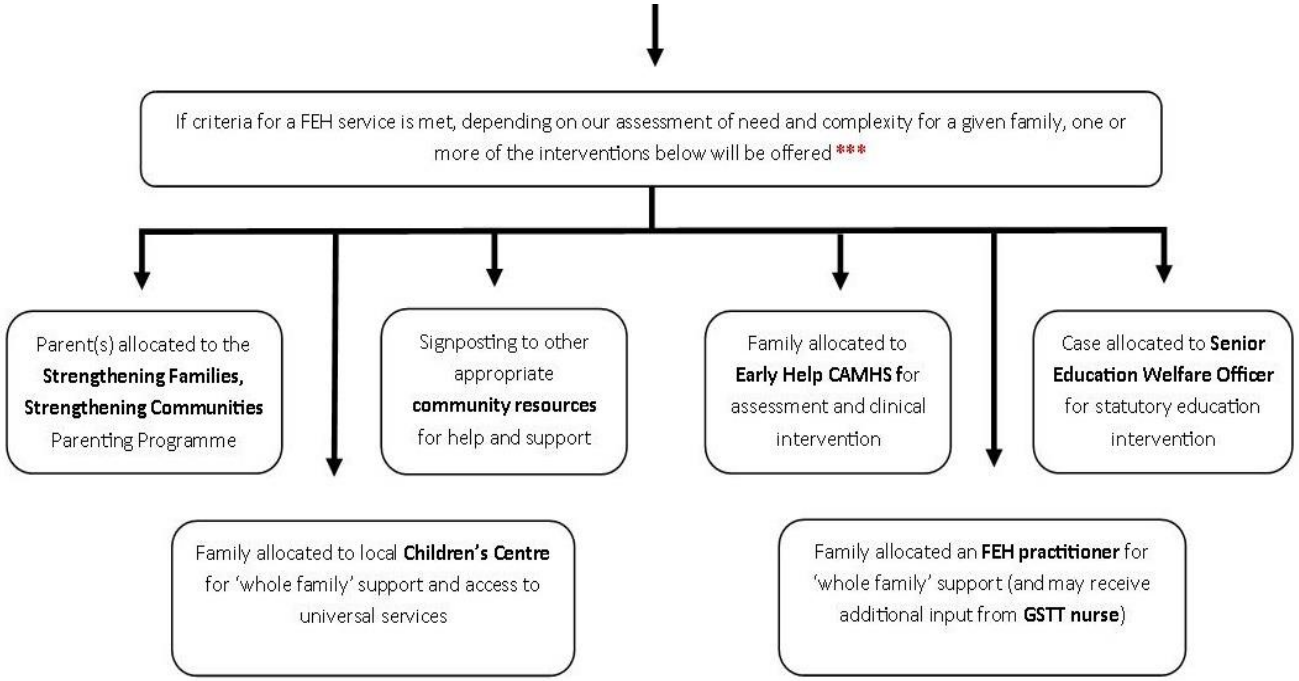
The needs of a child are beyond the level of support that can be provided by universal services



*** *Please note that there may be a short waiting list for allocation*

Southwark Council southwark.gov.uk

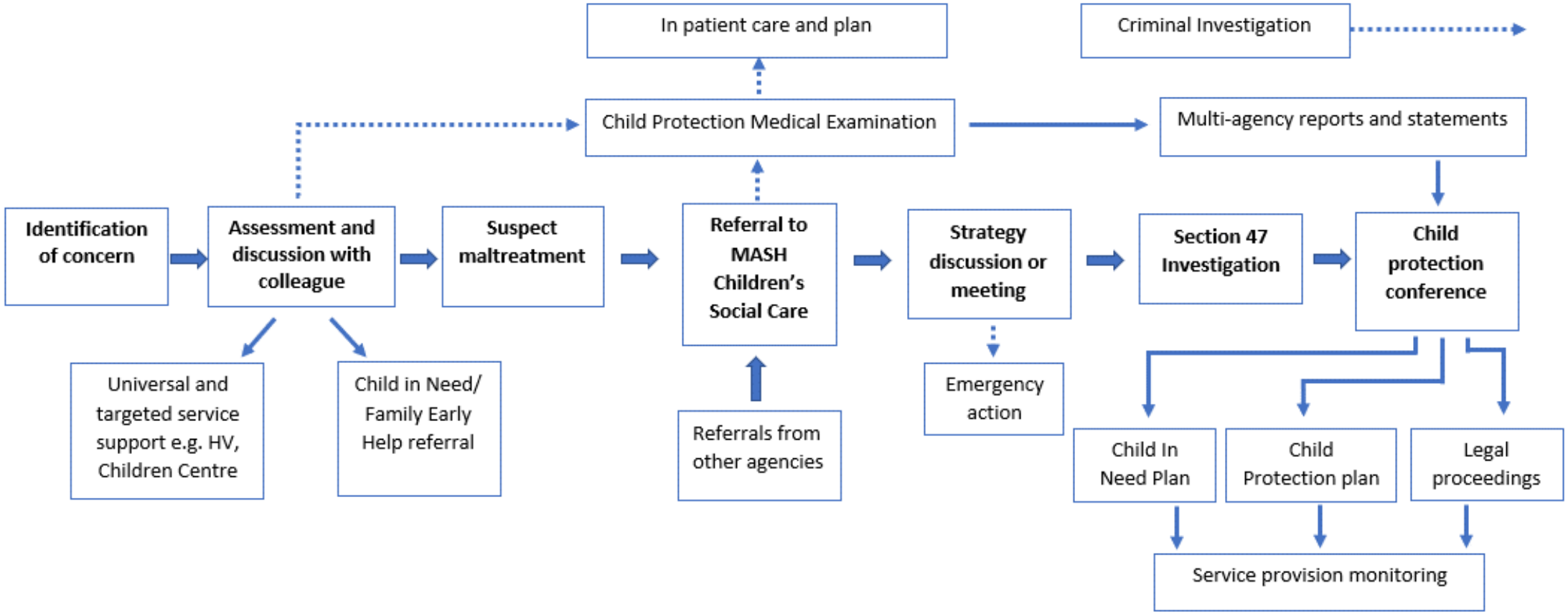
What help have you or others provided to address the child or family needs? And why?
Please send us any assessments you have completed and any Team around the Child or Family meeting?

What are you still worried about? Please indicate the individual needs of the child(ren) and what needs to change for the child(ren) and why? What has prompted this referral now?

What information do you know about the parent/carer and the wider family support network? (include relationships, friendships, behaviour, support, stability, safety, language, mental health, substance misuse, domestic abuse etc)
Are there any risk issues we need to be aware of?

Signposting and wider referrals- children centres, IAPTS, CGL, SLAM referral, local offer

Information Sharing



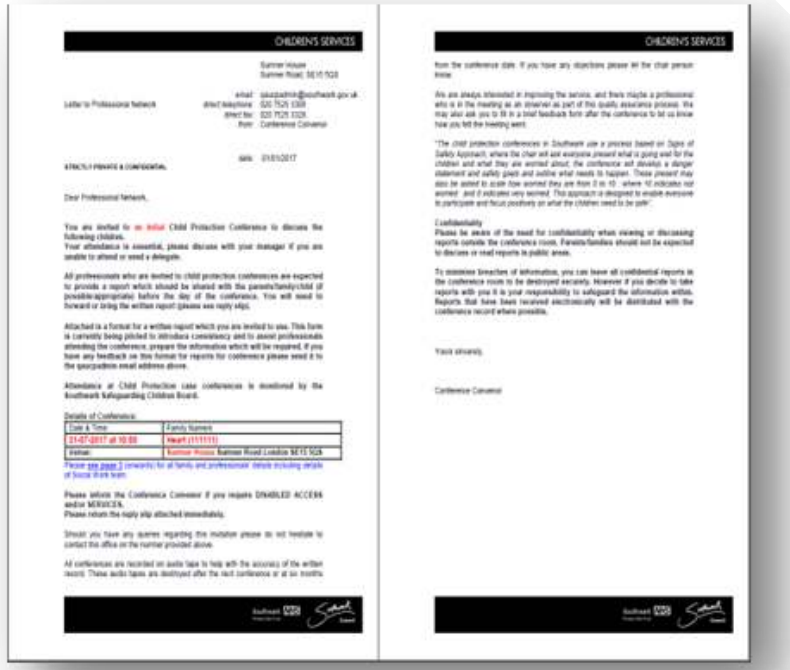
What should I include?

Every request for information should contain brief details on concern

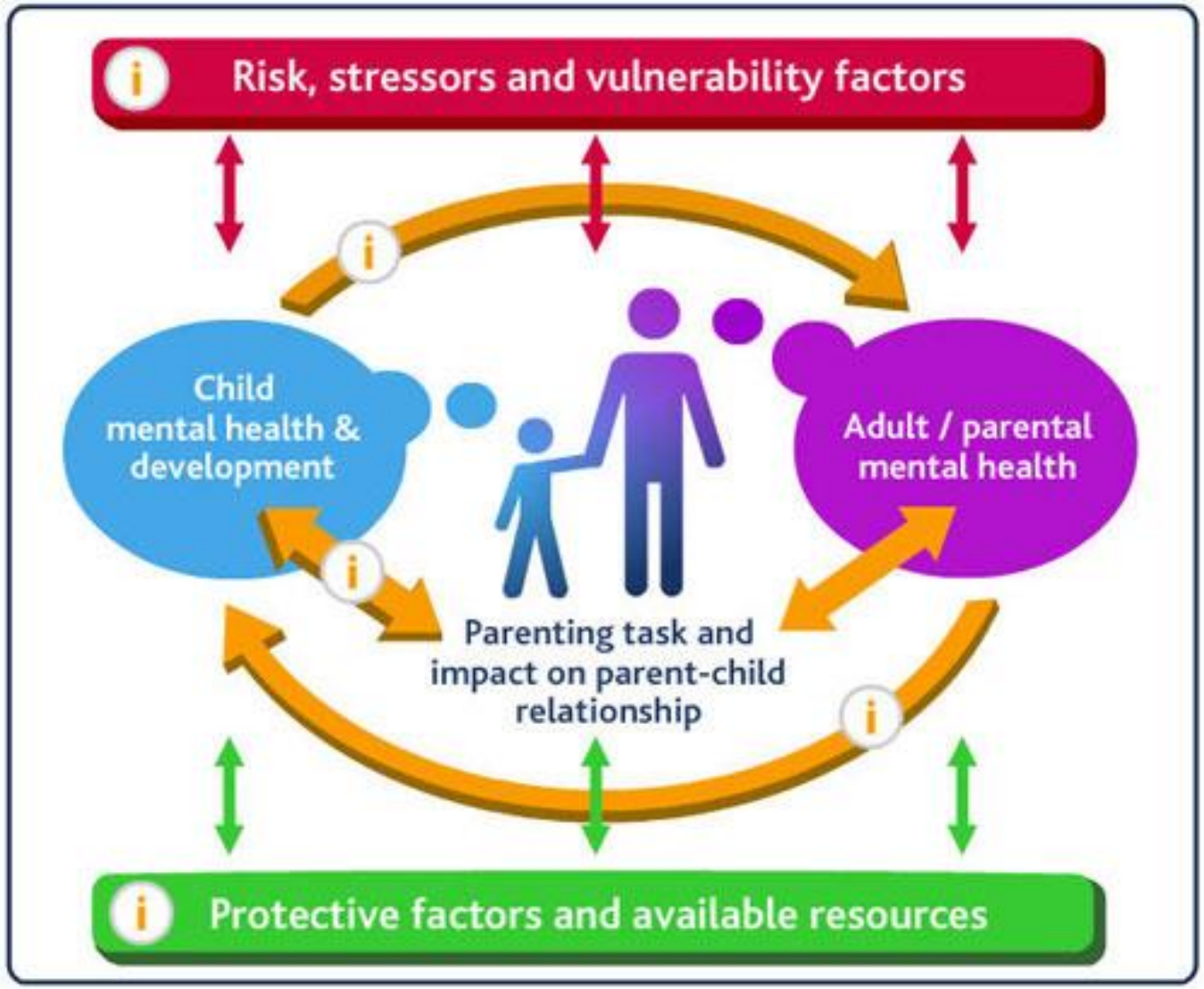
Context beyond medical summary

Strengths ‘what’s going well’ and area of potential concern

- Child’s health and development,
- ‘Was not brought’, A&E/Hospital appointments,
- Impact of medical conditions,
- Identified wider needs
- Factors impacting parenting capacity
- Known protective/supportive factors
- Avoid medical jargon



‘Think Family’



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Adverse Childhood Experiences (ACEs)

Adverse Childhood Experiences (ACEs) - YouTube

Adverse Childhood Experiences (ACEs)

- Widely accepted as:

(Di Lemma *et al*., 2019)

Health inequality and beyond

Must reads/ Must watch

Asmussen, K., Fischer, F., Drayton, E. and McBride, T. (2020)
Adverse childhood experiences: What we know, what we don't know and what should happen next.
Available at: https://www.eif.org.uk/report/adverse-childhood-experiences-what-we-know-what-we-dont-know-and-what-should-happen-next

ACE Aware Wales - Public Health Wales (nhs.wales)

TED talk
Dr Nadine Burke Harris
How childhood trauma
affects health across a lifetime

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General Practice is a key constituent of health care provision in the UK,
in terms of safeguarding children holds equal duty of **care to both the child and parent or carer**.

The concept of Adverse Childhood Experiences (ACEs) and long-term effects on physical and mental health and health-affecting behaviours is widely researched. General Practice, with its lifespan view of both short-term and longer term illness, is a key agency is progressing work on ACEs.

Three supra-themes emerged from analysis,
namely **voice of the child, professional focus and community and environmental factors**.
There was a striking concentration of papers within professional focus, which in itself includes routine enquiry, training and parenting programmes.

There is evidence that **elements of ACEs** form part of safeguarding practices in General Practice, but not yet of its incorporation as an overall concept.

Category of Childhood exposure	
	While you were growing up, before the age of 18 years
Childhood abuse:	
Psychological abuse	*Did a parent or other adult in the household…* Often or very often swear at, insult, or put you down? Often or very often act in a way that made you afraid that you would be physically hurt?
Physical Abuse	*Did a parent or other adult in the household…* Often or very often punch, grab, shove, or slap you? Often or very often hit you so hard that you had marks or were injured?
Sexual abuse	*Did an adult or person at least 5 years older ever…* Touch or fondle you in a sexual way? Have you touch their body in a sexual way? Attempt oral, anal, or vaginal intercourse with you? Actually have oral, anal, or vaginal intercourse with you?
Household dysfunction:	
Substance abuse	Live with anyone who was a problem drinker or alcoholic? Live with anyone who used street drugs?
Mental illness	Was a household member depressed or mentally ill? Did a household member attempt suicide?
Mother treated violently	*Was your mother (or stepmother)* Sometimes, often, or very often pushed, grabbed, slapped, or had something thrown as her? Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Ever repeatedly hit over at least a few minutes? Ever threatened with, or hurt by, a knife or gun?
Criminal behaviour in household	Did a household member go to prison?

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The ACEs Study (Felitti *et al*., 1998)

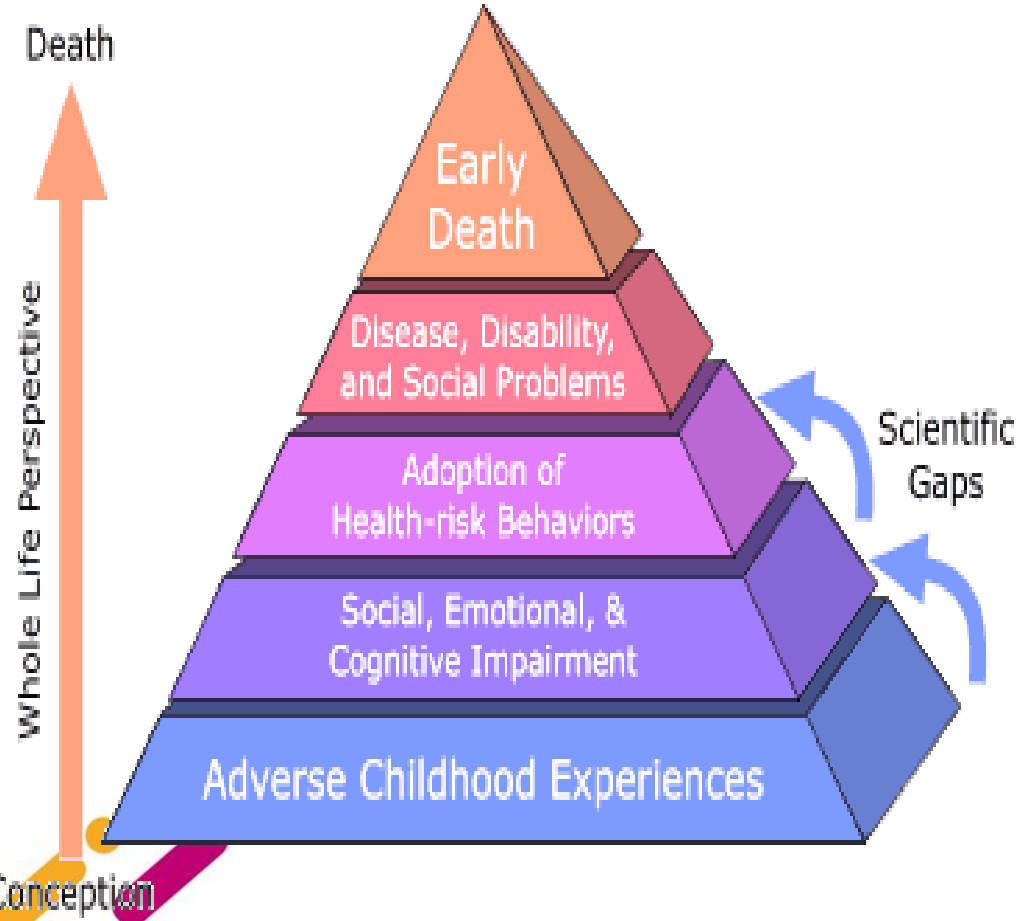
Large scale, population level, questionnaire based study (n= 9508 adult health care plan members completing a standard medical evaluation)

The team sought to examine the long-term relationship and cumulative effect of multiple categories of childhood experiences of abuse on outcomes in adulthood, including risk factors for incidence of disease, quality of life and mortality

Every respondent given score of 0-7 as a measure of their individual childhood exposure

The categories of ACEs are commonly expanded to include physical and emotional neglect, poverty and parental separation, added from later studies (Felitti *et al.,* 2010; Bellis *et al.*, 2013, Crouch *et al.*, 2019).

Statistically significant graded relationship



Normative research within the UK suggests half of all individuals are exposed to at least one ACE in childhood and 9% experience four or more ACEs (Bellis *et al.*, 2014).

A statistically significant graded relationship identified between ACEs and a large number of health related outcome including smoking, depression, ischaemic heart disease and chronic lung disease.

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- ACEs appear to have gained particular traction in the past few years (Petruccelli *et al.,* 2019)
- Taken 'centre stage' White *et al.* (2019)
- Gaining momentum internationally and within in the UK (Edwards *et al.*, 2019)

- A number of routes including:
  - Troubled Families Programme (Crossley, 2018),
  - Government inquiry (Parliament. House of Commons, 2018)
  - Early years initiative within family nurse partnership work (Early Intervention Foundation, 2019)

- Internationally too there is a growing body of research into the biological impact of childhood adversity and its accompanying toxic stress (Purewal Boparai *et al.,* 2018)

- The impact of ACEs presents to primary care (Wen *et al.,* 2017)
- Health-care systems have been evaluated as having the best health outcomes when based in primary health care (Marmot *et al*., 2008)

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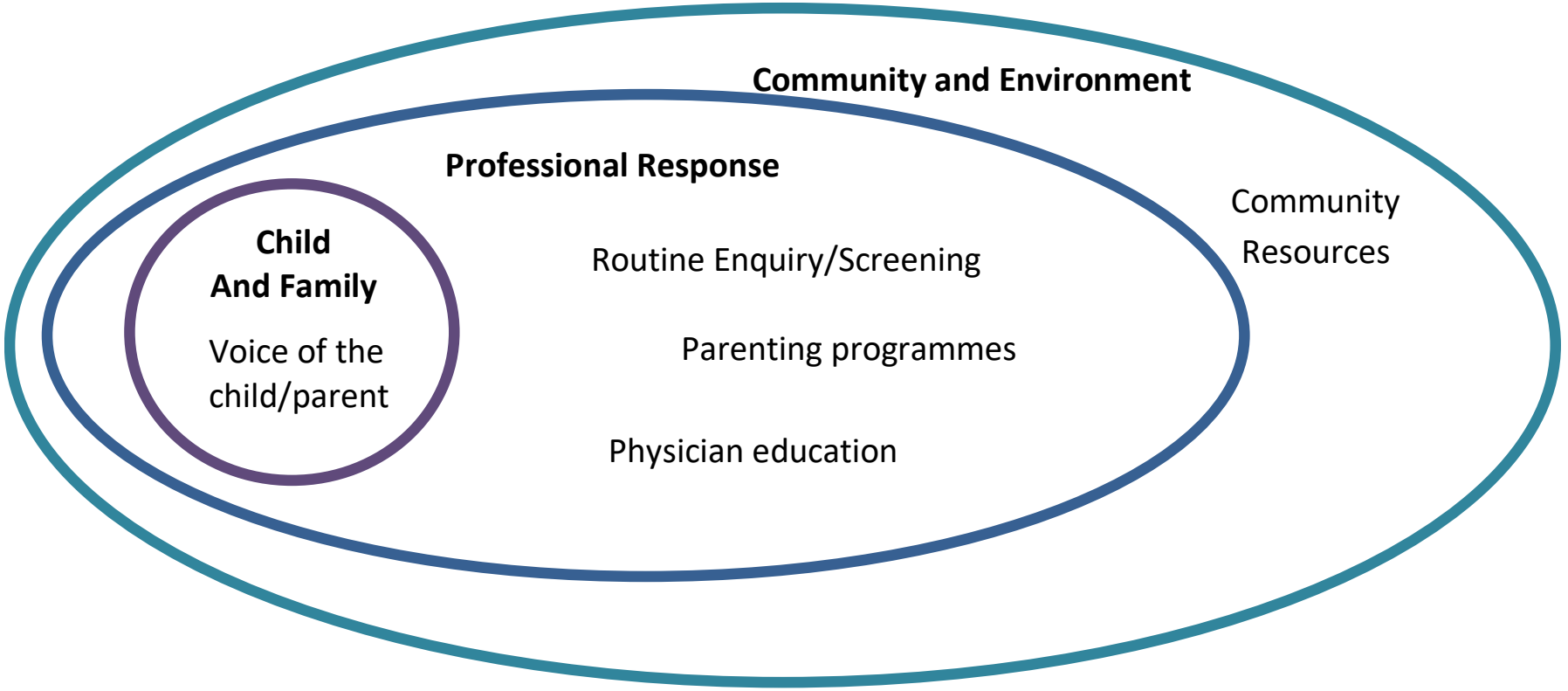
Literature Review Themes



Critique

- Literature mostly **adult in focus** (Petruccelli *et al.*, 2019), retrospective data,
  - Generic conclusions to 'address in childhood'
- '**Lustre of science**' (White *et al,.* 2019)
  - Now part of common safeguarding language
- **Over attention to the negative** (Leitch 2017)
  - Not matched with efforts to understand protective factors
- Are we approaching point of saturation for literature related to adult outcomes?
- Majority of studies use retrospective cross-sectional studies of adults
  - ACEs retrospective survey data from adults are reported to both overestimate (e.g. cases of mental illness) and underestimate (e.g. recollection abuse at young age) the prevalence of ACEs
  - **Limitations** in extrapolation across the generations
  - **New risks** such as those related to internet use and recognition of trauma in asylum seekers
- Pinto *et al.* (2012), provide a singular publication of original research calling into question the dependability of retrospective data
  - significant 'under-reporting', with episodes of abuse not framed or recognised as such for the individual, and at other times unreported.

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Definition of ACEs

- ACEs is associated with a range of different emphases and interpretations.
  - children experiencing harm, adults living with consequential poor health conditions and agendas set by policymakers
- Variations in the questionnaire
  - Discrimination due to race, sexuality, pressures of urban/rural settings, poverty, neighbourhood violence, WHO ACE-IQ tool includes child marriage and exposure to war
- Common language?
- Absolute need to differentiate between an adult with impact of their historic ACEs and a present child with current or experience of ACEs

Routine Enquiry/Screening

- National Institute for Health and Care Excellence (2018) *Child Abuse and Neglect* advises clinicians to **consider where 'routine questions' should occur**
- **Ethics** of screening
  - where the benefits of screening are not established and there is a lack of evidenced based interventions (Finkelhor, 2018)
  - need to establish validity and reliability of screening (Barnes *et al.*, 2020)
- Routine enquiry of domestic violence, FGM and mental health in the perinatal period
  - pathways include **provision of local services** with IDVAs, perinatal mental health teams, guidance for GPs on clinical management and thresholds for social care referrals
  - routine schedules of appointments during the perinatal period
- As foundations for screening, ACEs are described as 'insufficient' (Kelly-Irving *et al.*, 2019).

Resilience

- an individual's capacity to adapt to adversity
- Complex, multi-faceted and accumulative
- promoting resilience in children involves decreasing exposure to adversity
- Individual characteristics, trusted relationships (Landers et al., 2020)
- Wider community and environmental factors 'social capital' (Kotch et al., 2014)
- Onus on the individual to bounce back (Davidson et al., 2019)

Category of Positive Experiences	Examples of Key Positive Childhood Experience
Being in nurturing, supportive relationships	Having: • Secure attachments. • Warm, responsive, sustained relationships. • A physically and mentally healthy parent. • A parent who can provide supportive care given their unique physical characteristics and circumstances. • Trusting relationships with peers and other adults
Living, developing, playing, and learning in safe, stable, protective, and equitable environments	Having: • A safe and stable home. • Adequate nutrition and sufficient sleep. • High-quality learning opportunities. • Opportunities for play and physical activity. • Access to high-quality medical and dental care
Having opportunities for constructive social engagement and to develop a sense of connectedness	Experiencing: • Involvement in social institutions and environments. • Fun and joy in activities and with others. • Success and accomplishment. • Awareness of one's cultural customs and traditions. • A sense of belonging and personal value.
Learning social and emotional competencies	Learning: • Behavioural, emotional, and cognitive self-regulation. • Executive function skills. • Positive character traits. • Self-awareness and social cognition

Sege *et al.*, 2017

Trauma Informed Practice

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- Trauma Response Vs Challenging Behaviour

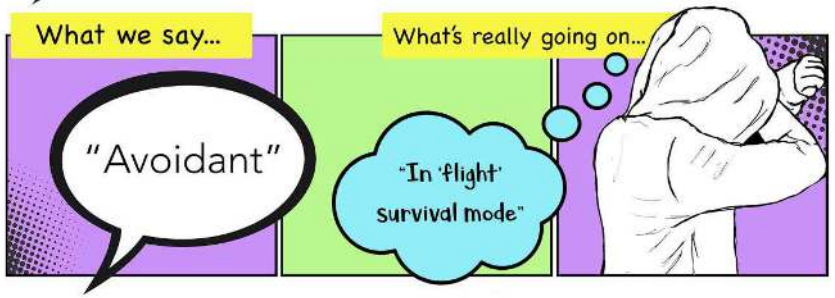
- Traumatised children and young people can have reduced capacity to respond to new stressors
    - Negative behaviour coping strategy that was adaptive in trauma-genic environment BUT NOW self-destructive or harmful, hyperarousal or hypo-arousal states

- Limited frame for reference e.g. regulation of emotions, assessing for safety, experience of safe healthy relationships

- A 'trauma-informed' approach recognises the impact of traumatic experiences on daily life, capacity for growth healing and resilience
- Recognise signs and symptoms of trauma
- Acknowledge the impact that traumatic experiences can have
- Intentionally seeking to avoid re-traumatising other
- Incorporating understanding of trauma and resilience into practice and organisation policy
- **'What has happened to you?' rather than 'What's wrong with you?'**
- Psychoeducation- Validating feelings, window of tolerance and grounding techniques
- As professionals we may have our own experience of historic of trauma

6 Principles of
Trauma-informed practices

A brief introduction to trauma informed practice, Dr Kristine Hicke



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YOUNGMiNDS

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Addressing childhood adversity and trauma

WHAT IS ADVERSITY?

Adverse Childhood Experiences (ACEs) are highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence

It can be a single event, or prolonged threats to, and breaches of, the young person's safety, security, trust or bodily integrity. These experiences directly affect the young person and their environment, and require significant social, emotional, neurobiological, psychological or behavioural adaptation.

Adaptations are children and young people's attempts to:

- Survive in their immediate environment
- Find ways of mitigating or tolerating the adversity by using available resources
- Establish a sense of safety or control
- Make sense of the experiences they have had

WHAT KINDS OF EXPERIENCES ARE ADVERSE?

Forms of ACEs include:

Maltreatment
i.e. abuse or neglect

Violence & coercion
i.e. domestic abuse, gang membership, being a victim of crime

Adjustment
i.e. migration, asylum or ending relationships

Prejudice
i.e. LGBT+ prejudice, sexism, racism or disablism

Household or family adversity
i.e. substances misuse, intergenerational trauma destitution, or deprivation

Inhuman treatment
i.e. torture, forced imprisonment or institutionalisation, or genital mutilation

Adult responsibilities
i.e. being a young carer or involvement in child labour

Bereavement & survivorship
i.e.traumatic deaths, surviving an illness or natural accident

HOW COMMON ARE ACES?

WHAT PROTECTS YOUNG PEOPLE FROM ACES?

Not all young people who face childhood adversity or trauma go on to develop a mental health problem.

There are personal, structural and environmental factors that can protect against adverse outcomes, as shown in the protection wheel opposite.

WHAT CAN WE DO ABOUT IT?

Commissioners can address childhood adversity and trauma by:

1. Making childhood adversity and trauma a local commissioning priority
2. Creating a common identification and enquiry framework for identifying need
3. Investing in adversity and trauma-informed models of care

Adversity and trauma-informed models of commissioning and care are always:

Prepared
ensures addressing ACEs is a strategic priority, analyses the available data and anticipates need in local commissioning and service pathways.

Aware
understands childhood adversity and trauma, has a common framework for identification and routine enquiry, and responds appropriately to the cultural and personal characterises of the young person and their communities.

"When you notice, or I tell you that I need help, you should already know what the next step is"

"Recognise all of my needs"

"Don't label me with the experiences I've had"

"Understand my behaviour"

www.youngminds.org.uk/professional/resources/addressing-trauma-and-adversity/

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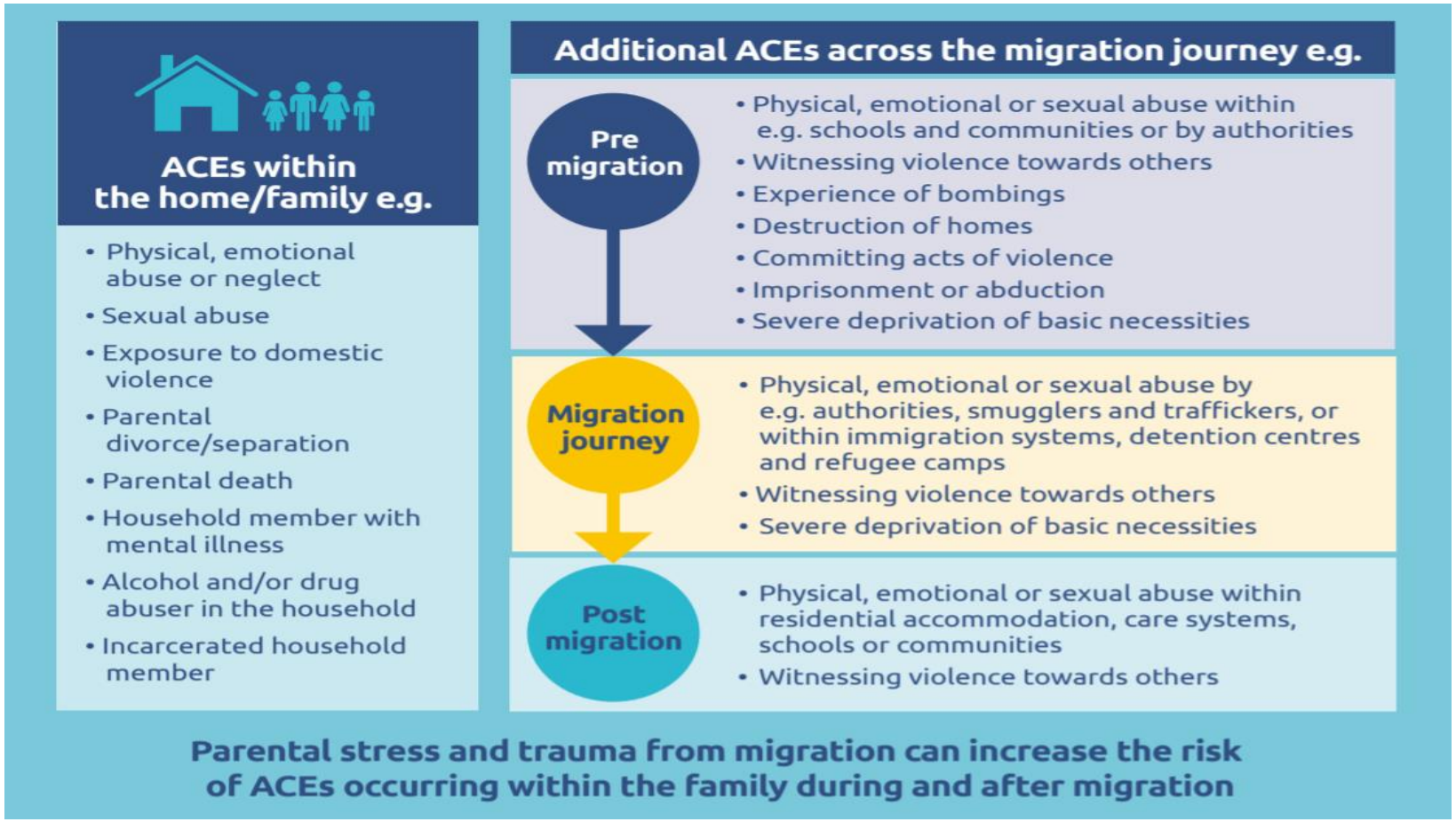
ACEs in child refugee and asylum seeking populations



Ref: Wood S, Ford K, Hardcastle K, Hopkins J, Hughes K and Bellis MA (2020). Adverse Childhood Experiences in child refugee and asylum seeking populations. Cardiff: Public Health Wales NHS Trust

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The potential for ACEs occurs across the migration journey

Pre migration

ACEs within the home/family e.g. abuse, neglect, domestic violence, household dysfunction

ACEs within other settings

- Physical, emotional or sexual abuse within schools and communities or by authorities / military
- Witnessing violence towards others
- Experience of bombings
- Destruction of homes
- Committing acts of violence
- Imprisonment or abduction
- Severe deprivation of basic necessities

Parental stress and trauma from migration and its causes can increase the risk of ACEs occurring within the family during and after migration

Migration journey

ACEs within the home/family, including separation from parents or wider family

ACEs within other settings

- Physical, emotional, sexual abuse by e.g. authorities, smugglers and traffickers, or within immigration systems, detention centres or refugee camps
- Witnessing violence towards others
- Severe deprivation of basic necessities

Post migration

ACEs within the home/family

ACEs within other settings

- Physical, emotional or sexual abuse within residential accommodation, care systems, schools (e.g. bullying) or communities.
- Witnessing violence towards others

Certain factors increase the risk of negative impacts...

- Pre-existing vulnerability
- Experiencing multiple ACEs
- Poor parental mental health
- Parental financial difficulties
- Low level of social support
- Longer asylum seeking duration
- Perceived discrimination
- More relocations in asylum system
- Low host country language skills

ACEs can impact negatively on health and behaviour

- Mental health problems such as PTSD, depression and anxiety
- Physical health problems, including injury and infection
- Affects academic achievement
- Behavioural problems

Other factors protect against them (i.e. promote resilience)

- Positive early attachments to carers
- Good family functioning
- Good parental mental health
- Healthy family communication
- Ability to think positively
- Having a long-term vision
- Belief that life has meaning and value
- Faith and religious involvement
- Extended family network
- Peer friendships
- Willingness to engage in education
- Attending school
- Good community resources

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Looked after Children and Care Leavers

Surrey Heartlands
HEALTH AND CARE PARTNERSHIP

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Looked after Children Health Needs

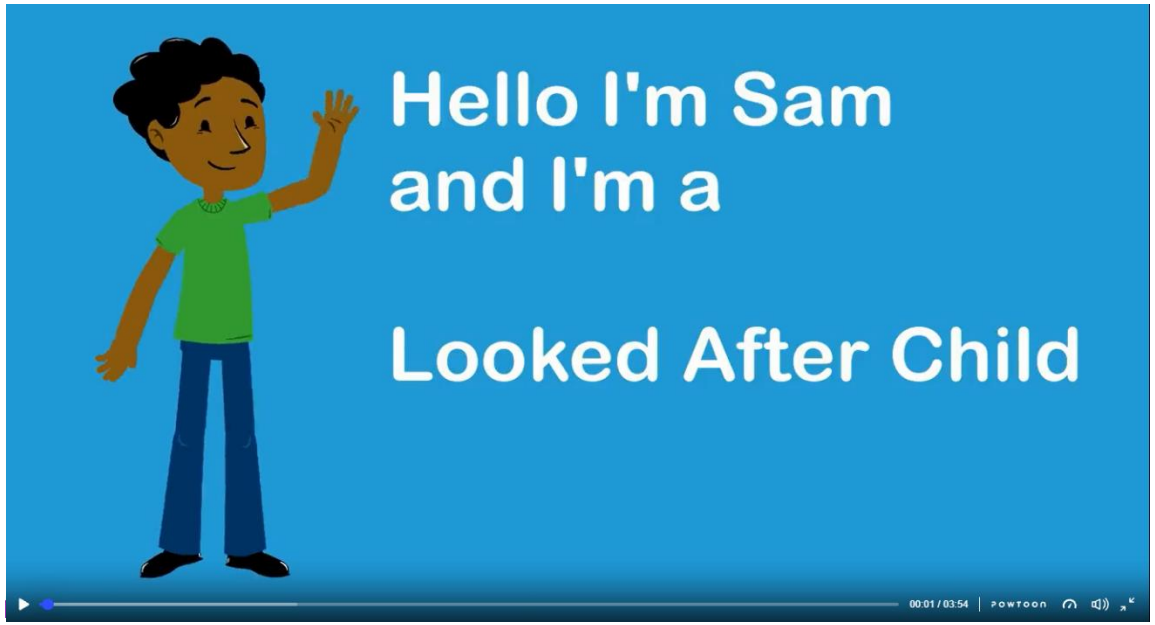
How Primary Care health professionals can help Looked after Children stay healthy and safe

Drs Sharon Kefford and Tamsin Robinson

Learning outcomes

- Role of Primary Care
  - *'you are my doctor; you need to know about children like me'*
- Children in care are individuals and Every Child Matters
  - *'treat me like you would like your own child to be treated'*
- Safeguarding
  - Looked after Children are still vulnerable
  - Think safeguarding; gangs, missing, child sexual exploitation, substance misuse
- Making a difference / Advocacy
  - Supporting the physical and mental health needs of Looked after Children helps individuals to reach their full potential and stay healthy and safe into adulthood. We have the ability to make a difference.

Looked after Children Primary Care Powtoon



- https://www.powtoon.com/c/eXUqshyeiFJ/1/m

What is a Looked after Child?

Under the Children Act 1989, a child is legally defined as 'looked after' by a local authority if he or she:

- **gets accommodation from the local authority for a continuous period of more than 24 hours**
- **is subject to a care order (to put the child into the care of the local authority)**
- **is subject to a placement order (to put the child up for adoption)**

- Under 18 years old
- Terms: Looked after Child/ Child in Care/ Children Looked After

Local Authority becomes the Corporate Parent. All professionals around the child have corporate parenting responsibilities.

Why and how do children become Looked after?

- Abuse and neglect
- Abandonment/ poverty/ parental illness or imprisonment
- Unaccompanied Asylum Seeking Child (UASC)
- Custody, on remand awaiting sentencing

- Section 20
- Section 31 (Care Order)
- Section 38 (Interim Care Order)

- Parental Responsibility

Where do they live?

- Foster Carer
- Residential children's home or other residential settings like schools or secure unit
- Semi-independent housing
- Parents (under the supervision of the Local Authority)
- Grandparents/ family member
- Future parents (waiting for adoption)

- In borough vs Out of Borough

Inequalities and vulnerabilities

- Children come into care with poorer physical and mental health than their peers
- More likely to bed-wet, have coordination difficulties and problems with their sight, speech and language

- Looked after children are likely to struggle with their behaviour and emotional needs.
- Looked after children are amongst the most vulnerable groups in society
- Looked after children are more likely to have a disability than their peers

Supporting the physical and mental health needs of Looked after Children helps individuals to reach their full potential and write their own future.

How can primary care staff support Looked after Children?

- Identification/ Registration
- Health Assessments
- Communication
- Safeguarding
- Transition

Identification

- They tell you….
- Child Protection Plan outcome
- Receive a placement notification
- Receive a statutory health assessment/ Health Action Plan

- CP-IS (Child Protection Information Sharing)

Registration

- Always register first and ask for paper-work to follow
- Record: responsible Local Authority/ Social Worker
- Delegated Authority

- Code notes: Looked after Child
- Add to Practice's Vulnerable Child list

"WE WANT THRIVING,NOT SURVIVING"
Caring for better health.
Care Leaver's Association 2017

Statutory Health Assessments

- Initial Health Assessment (within 20 working days of coming into care)
- Review Health Assessment every 6 months for child <5 years old
- Review Health Assessment every 12 months for child 5 –17 years old

- Leaving Care Summary - transition

- **Look at the Health Action Plan!**

Form RHA-C CONFIDENTIAL coramBAAF ADOPTION & FOSTERING ACADEMY

Name NHS/CHI number DoB

HEALTH RECOMMENDATIONS FOR CHILD CARE PLAN

Include all details needed to create and implement the health care plan and the dates of the last dental check-up and doctors'/hospital appointments. The expectation is that those completing the actions from the health care plan should notify the LAC health team.

Date of health assessment (date/s child seen)	
Date of next health assessment:	

Health issues	Action required	By when	Person responsible

Communication

- ***'I'm not a LAC, I'm a kid'***

- Streetwise/ Mini adult
- ‘Ask me what I call my carer’
- Don't label children… avoid professional speak
- Trauma informed care
- Accompanying adult
- Continuation of care

- **Code Looked after Child in electronic health record**
- **Ensure Universal Services are aware**
- **Include Looked after Child status in Referrals**

- **Low threshold for liaising with Social Worker**

Safeguarding

- **Safeguarding Children is everybody's responsibility**

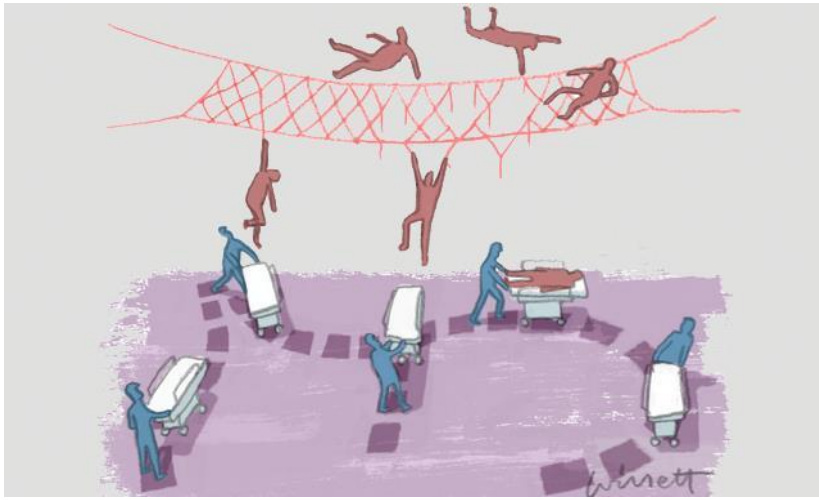
- ‘Looked After…so I don’t need to think about..’
- ‘Social Worker will know about…’
- ‘Street wise… can look after herself’

- Add to your Vulnerable child list
- Gangs
- Child Sexual Exploitation
- Substance misuse
- Missing
- Pregnancy

Transition

- Becoming Looked After
- Between homes
- Moving boroughs
- Leaving care
- Becoming a Care Leaver

- Transition of health services.



"We want thriving,not surviving"
Caring for better health.
Care Leaver's Association 2017

A Looked after Child

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I AM A LOOKED AFTER CHILD

AS MY GP YOU NEED TO KNOW ABOUT PATIENTS LIKE ME….

Adobe Acrobat Document

What is a looked after child?

A child is legally defined as 'Looked After' by a Local Authority if he or she:

- is accommodated by the local authority for a continuous period of more than 24 hours
- is subject to a Care Order (to put the child into the care of the local authority)
- is subject to a Placement Order (child placed for adoption)

A Looked After Child might be living with foster parents, at home with their parents under the supervision of the Local Authority, in a residential children's home or other residential settings like schools or secure unit.

A Looked After Child might have been placed in care voluntarily by parents, or more commonly, the Local Authority may have intervened because a child was at significant risk of harm.

The terms Looked After Child(ren) (or LAC) or Child Looked After (CLA) are used interchangeably, and mean the same thing.

Looked after children are, by legal definition, under 18 years of age.

The Looked after children population within a local authority, are a mix between those who originate from that borough and those who are under the care of other Local Authorities, and live in the borough.

EVERY LOOKED AFTER CHILD IS AN INDIVIDUAL WITH THEIR UNIQUE OWN STORY.

I AM A LOOKED AFTER CHILD

AS MY GP YOU NEED TO KNOW ABOUT CHILDREN LIKE ME

Statutory Health Assessments

Statutory health assessments are an opportunity to assess a child's physical and mental health status, review the health care plan and provide health promotion advice, information and counselling.

Older children need advice on lifestyle choices, drugs, alcohol, and sexual health and should be offered Chlamydia screening.

Looked after children are amongst the most vulnerable groups in society. It is well recognised that children often come into care with poorer physical and mental health than their peers, and that in longer term outcomes are also worse for them.

Looked after children when considered as a group, are likely to struggle with their behaviour and emotional needs. They also are more likely than others their age to bed-wet, have co-ordination difficulties and problems with their sight, speech and language.

Supporting health needs and recognising looked after children as individuals helps to overcome disadvantage, improves life chances and assists children to reach their full potential.

In the year after leaving care, young people are almost twice as likely to have problems with drugs or alcohol and also to report mental health problems during this time.

On a national level Looked After children do less well than their peers in educational terms. Early identification of health issues that affect learning ensures appropriate support is in place for children and young people.

Across England and Wales most children become looked after as a result of abuse and neglect. Although they have many of the same health issues as their peers, the extent of these is often greater because of their past experiences. For example, almost half of children in care have a diagnosable mental health disorder (including conduct disorder) and two-thirds have special education needs. Looked after children are more also likely to have a disability than their peers.

https://www.youtube.com/watch?v=l9FEPNB1_2w

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Could I have some advice please?

Case vignettes

I think this child may have bruising?

- 5pm Thursday evening in practice
- 10 week old baby brought by mother for upper respiratory infection symptoms
- Born by SVD, uneventful pregnancy, no social concerns notes on post-natal discharge summary
- Brought on time for 6 week check and had first primary immunisations 2 weeks ago
- Newly registered family
- Mother on household link

During examination you see a ‘mark’ just in front of the ear

What are the next steps in assessment? | What else do you need to know? | What actions do you take?

Key Principles

A bruise must **never be interpreted in isolation** and must always be assessed in the context of medical and social history, developmental stage, explanation given, full clinical examination and relevant investigations [1]

Children less than two years of age are at an increased risk of severe physical abuse [2]

Pre-mobile bruising is also a widely reported 'sentinel' injury in babies and younger and its recognition is vital in prevention of more severe abuse [1]

Presentations in older children can also represent 'sentinel' injuries.

Abusive bruises are often located away from bony prominences and are found predominantly over soft tissue areas. Sites include ears, neck, cheeks, buttocks, back, chest, abdomen, arms, hands and posterior thigh. However, **no site is pathognomonic,** and a careful history must be taken in all cases [2]

Listen and observe, seek explanation, record explanations by parents and carers [3]

You cannot age a bruise

Seek second option/ discuss with colleague

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Characteristics and features of bruising that may suggest physical child abuse

Bruising in children who are not independently mobile

Bruises that are seen away from bony prominences

Bruises to the face, abdomen, arms, buttocks, ears, neck, and hands

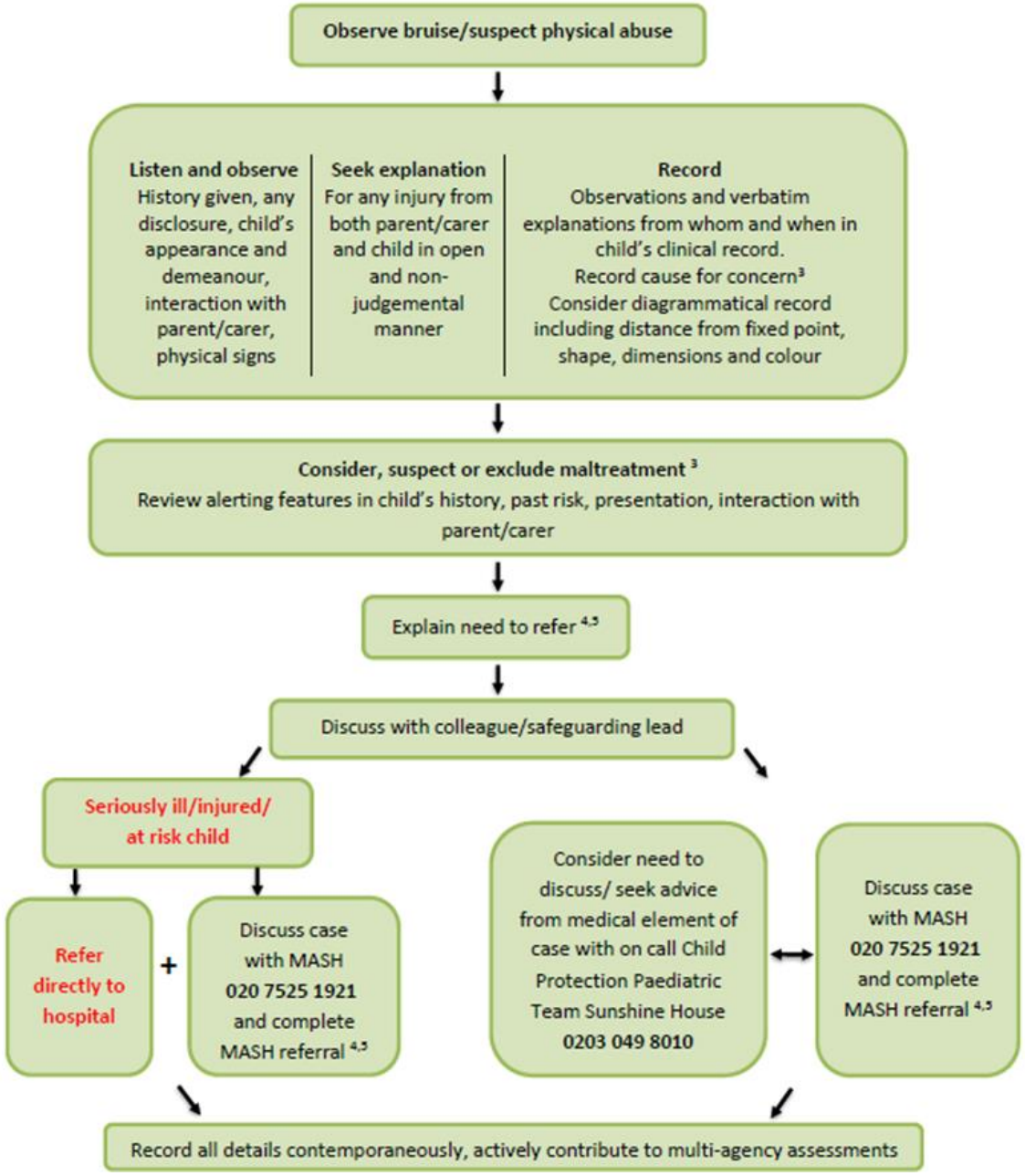
Multiple bruises in clusters

Multiple bruises of uniform shape

Bruises that carry the imprint of implement used or a ligature, this includes single or multiple linear bruising due to being struck with a rod-like instrument, banding where the hand has been tied or an imprint of the implement such as an electrical cord or studded belt

Bruises that are accompanied by petechiae, in the absence of underlying bleeding disorders [1]

A significant injury where there is no explanation
An explanation that does not fit with the pattern of injury seen
An explanation that does not fit with the motor-developmental stage of the child
Injuries in infants who are not independently mobile.
An explanation that varies when described by the same or different parents/carers
Multiple explanations that are proposed but do not explain the injury seen
An inappropriate time delay in seeking appropriate medical assessment or treatment
Inappropriate parent or carer response (e.g. unconcerned or aggressive)
A history of inappropriate child response (e.g. didn't cry, felt no pain)
Presence of multiple injuries
Child or family known to children's social care or subject to Child Protection Plan
Previous history of unusual injury/illness (e.g. unexplained apnoea)
Repeated attendance with injuries that may be due to neglect or abuse [2]



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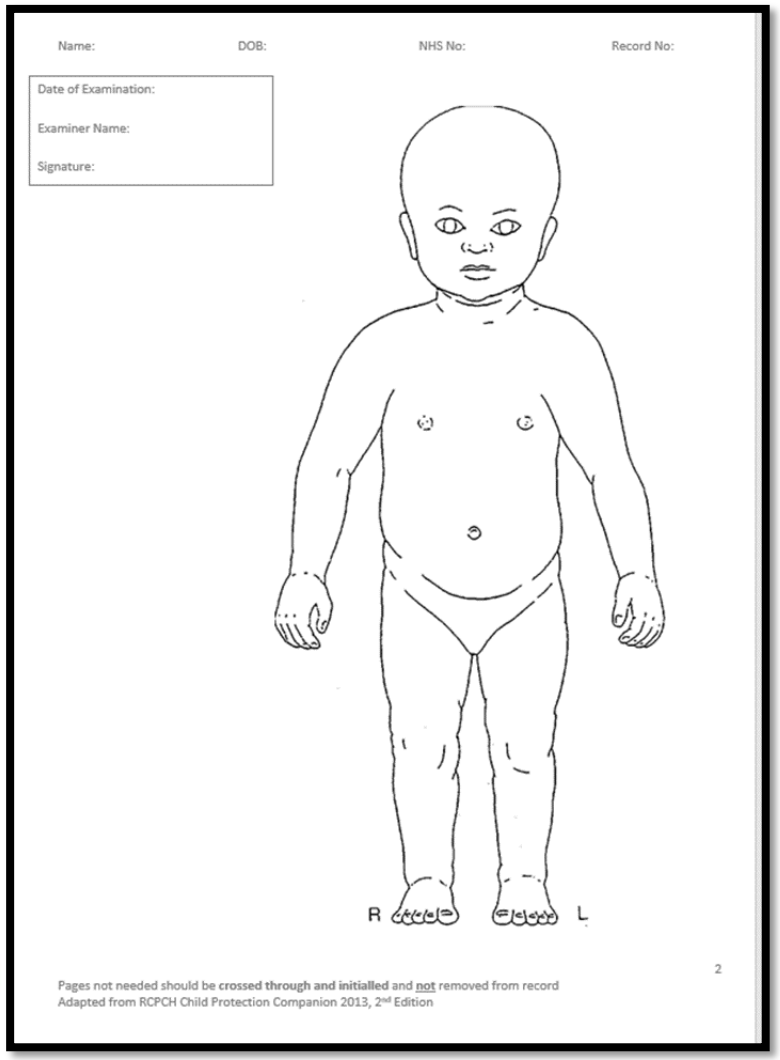
6. Chapter 3. Not making a referral after bruising to non-mobile babies, (2016) *Learning into practice: improving the quality and use of Serious Case Reviews, Practice issues from Serious Case Reviews/* Available at: https://www.scie.org.uk/safeguarding/children/case-reviews/learning-from-case-reviews/03.asp

Consider diagrammatic record


Name: DOB: NHS No: Record No:

Date of Examination:

Examiner Name:

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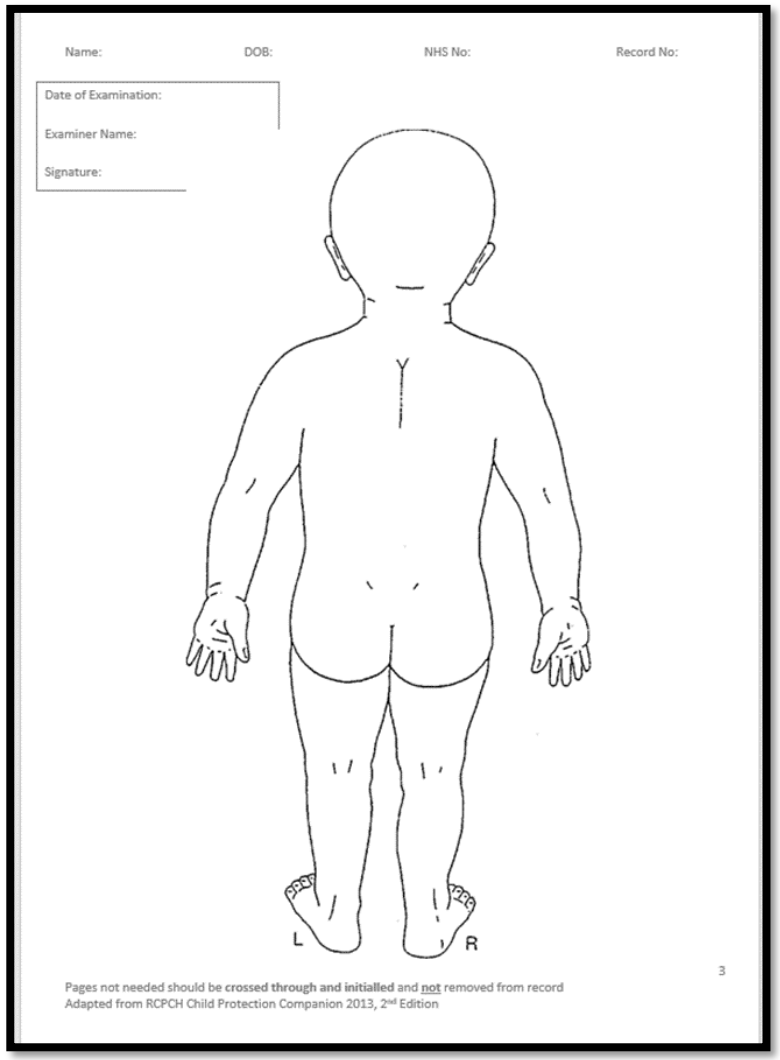
Pages not needed should be **crossed through and initialled** and **not** removed from record
Adapted from RCPCH Child Protection Companion 2013, 2nd Edition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NHS
South East London
Clinical Commissioning Group

Not making a referral after observation of bruising in non-mobile babies- what's the issue?[6]

Social Care Institute for Excellence (SCIE) undertook analysis of Serious Case Reviews which identified incidences of observation of bruising which did not result in referrals, a number of reasons were highlighted

- Lack of understanding local procedures
- Lack of professional curiosity, respectful scepticism on explanations
- Influence of relationship with family

Differentials and Potential Mimics [2]

Bleeding disorders that may present with bruising: **Defects in primary haemostasis** (the formation of platelet plugs at the site of injury) result in bruises, petechiae and bleeding from mucosal membranes. Disorders include: Von Willebrand disease, Idiopathic Thrombocytopenic Purpura, inherited disorders of platelet function (e.g. storage pool disorder, Glanzmann's thrombasthenia) **Defects in secondary haemostasis** (coagulation factor deficiencies) results in bruising and bleeding in deep tissues such as muscle, joints and	**Other conditions** that mimic or present with bruises or bruising • Birthmarks (Mongolian blue spots, haemangioma, congenital melanocytic naevi) • Vascular disorders • Infection related (e.g. meningococcal septicaemia) • Drug related (e.g. aspirin, nonsteroidal anti-inflammatory drugs (NSAIDs) • Erythema Nodosum

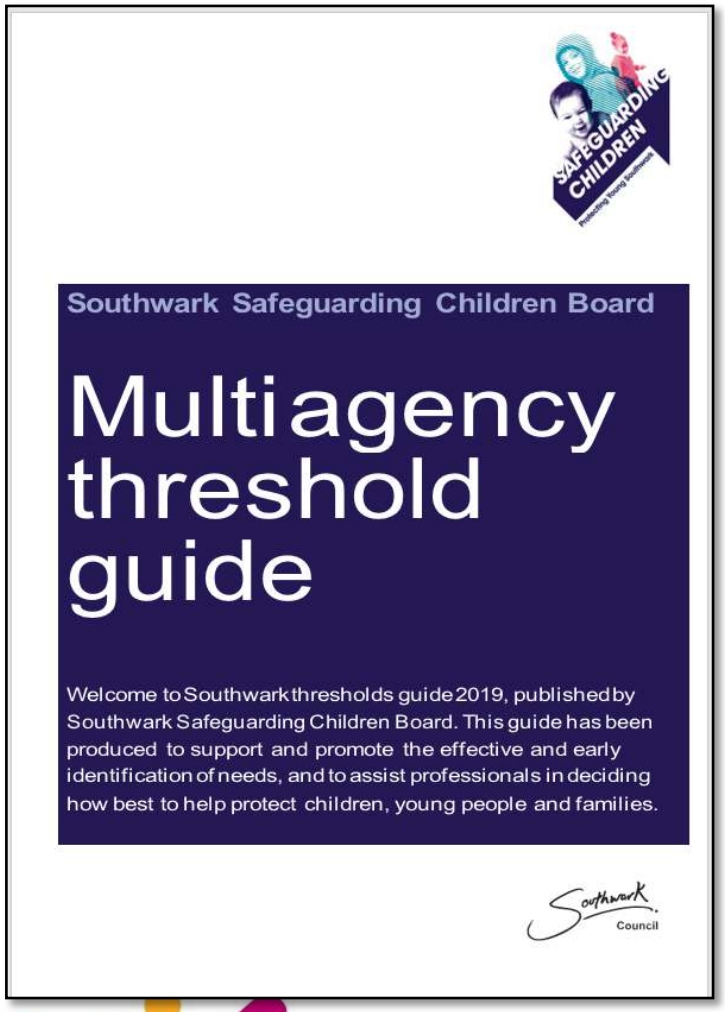
One differential is physical child abuse

ICON Babies Cry, You Can Cope!

www.iconcope.org safe sleeping information- for professionals and parents
I – Infant crying is normal C –Comforting methods can help
O – It's OK to walk away N – Never, ever shake a baby

Thresholds and referrals

South East London Clinical Commissioning Group



DEVELOPMENT OF THE BABY, CHILD OR YOUNG PERSON

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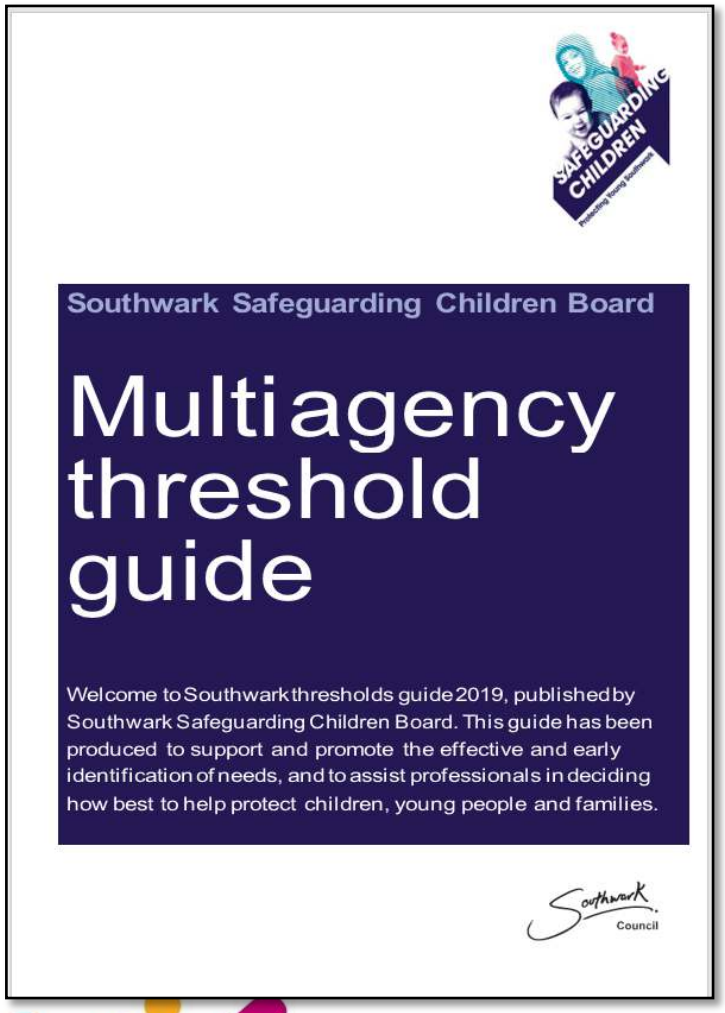
http://www.londoncp.co.uk/

Thresholds and referrals

NHS South East London Clinical Commissioning Group



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DEVELOPMENT OF THE BABY, CHILD OR YOUNG PERSON			
The child has occasional bruising on their shins etc. which is consistent with normal childish play and activities.	The child exhibits occasional injuries which are accidental and explained by parents voluntarily.	The child shows signs of physical abuse, for example bruising, scalds, burns and scratches, which are accounted for but are more frequent than would be expected for a child of a similar age.	The child shows signs of physical abuse, for example bruising, scalds, burns and scratches, which are not accounted for. The child makes disclosure and implicates parents or older family members.

PARENTAL FACTORS			
The parent/carer uses reasonable physical chastisement that is within legal limits – that is they do not leave the child with visible bruising, grazes, scratches, minor swellings or cuts.	The parent/carer physically chastises their child within legal limits but there is concern that this is having a negative impact on the child's emotional wellbeing (for example, the child appears fearful of the parent).	The parent/carer physically chastises their child leaving the child with visible bruising, grazes, scratches, minor swellings or cuts –this may result from a loss of control. The parent is willing to access professional	The parent/ carer significantly physically harms the child.

http://www.londoncp.co.uk/

Advice please- Case 2

- 12 year old boy, Year 7, brought in by his mother
- ‘I’m just not sure what to do, he’s not himself?’
- Worrying and anxious, recent started having vivid dreams about death of mother,
- Struggling more and more, and now missing school at least 1/week in the last month

- What are the next steps in assessment? | What else do you need to know? | What actions do you take?

- Mother was reviewed last week,
  - History of generalised anxiety
  - 2 year old sibling referred to Community Paediatrics with speech and communication delay
  - Request letter of support for housing

Advice please- Case 2

Multi-layered 'think–family' approach

- **12 year old boy**

www.thenestsouthwark.org.uk/
Free & confidential mental wellbeing advice and support for young people 11 – 25 in Southwark

www.kooth.com/
Free, safe, anonymous online therapeutic support for young people

www.thinkuknow.co.uk/ is a resource for children of all ages and parents/carers to learn more about how they can be protected online.
www.ceop.police.uk/Safety-Centre

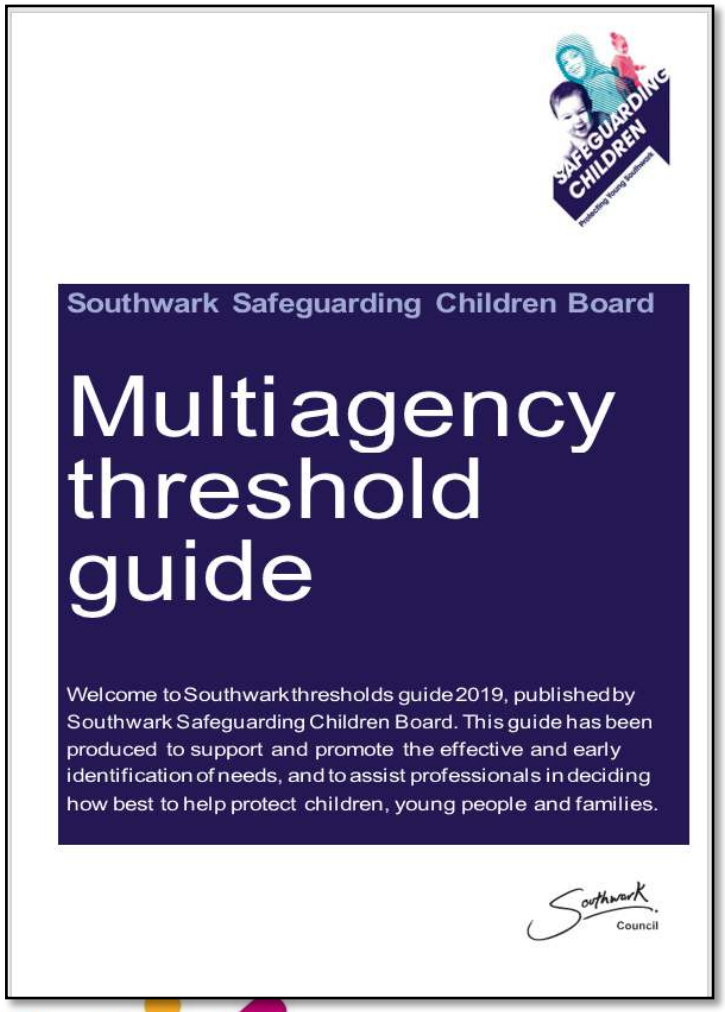
www.imago.community/Children-and-Young-People/Southwark-Young-Carers
Young Carers are anyone aged 8-18 who are taking on caring responsibilities for a family member with a long-term illness, disability, mental health or substance misuse issue. This can include caring for a disabled sibling.

- **Mother**
  - PMHT Parental_Mental_Health_Team_Southwark@slam.nhs.uk

  an early intervention nurse led service working with parents suffering from mental distress such as low mood or anxiety and have young children under the age of 5.
- **Family Early Help**

Thresholds and referrals

South East London Clinical Commissioning Group



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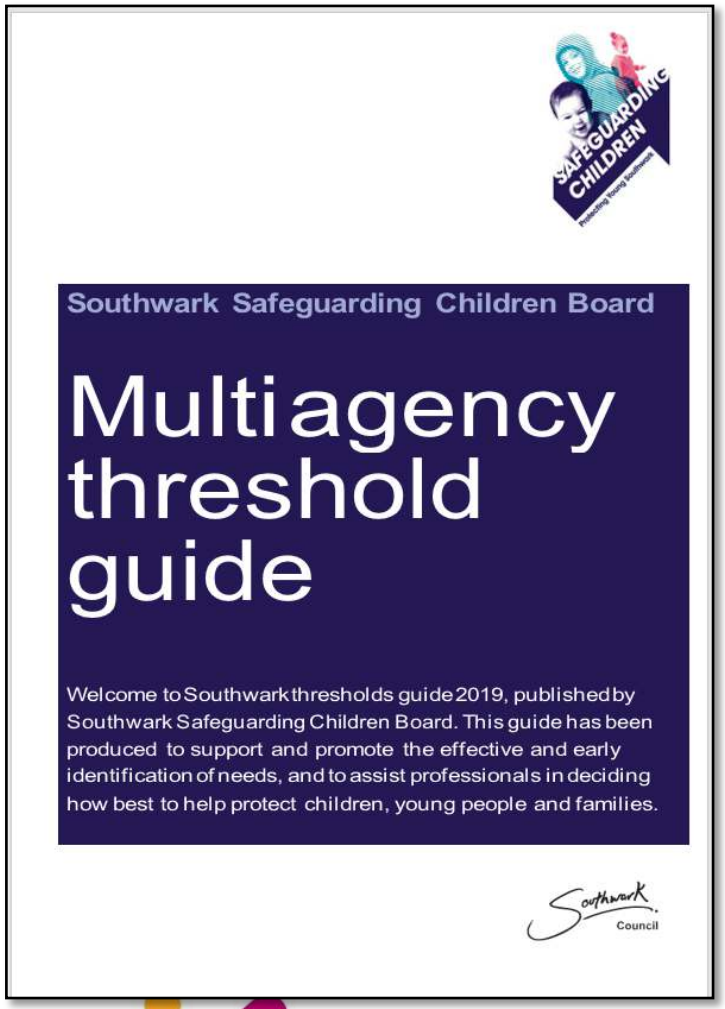
Thresholds and referrals

NHS
South East London
Clinical Commissioning Group



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DEVELOPMENT OF THE BABY, CHILD OR YOUNG PERSON			
The child is healthy and does not have a physical or mental health condition or disability.	The child has a mild physical or mental health condition or disability which affects their everyday functioning but can be managed in mainstream school. Child may be on school action or action plus/SEN statement. Child in hospital.	The child has a physical or mental health condition or disability which significantly affects their everyday functioning and access to education. Child may have SEN statement.	The child has a complex physical or mental health condition or disability which is having an adverse impact on their physical, emotional or mental health and access to education.

PARENTAL FACTORS			
The parent/carer's mental health does not impact the child adversely.	Adult mental health impacts on the care of the child. The carer presents with mental health issues which has sporadic or low-level impact on the child however there are protective factors in place.	Adult mental health impacts on the care of the child. The carer presents with mental health issues which has sporadic or low-level impact on the child and there is an absence of supportive networks and extended family to prevent harm.	Adult mental health is significantly impacting on the care of the child. Any carer for the child presents as acutely mentally unwell and /or attempts significant self harm and/or the child is the subject of parental delusions.

http://www.londoncp.co.uk/

Advice please- Case 3

- 60 year old female patient
  - ‘I’m worried about my grand-daughter’
  - 14 year, stays with grandmother often, mother currently drug-user - recently disengagement from CGL
  - Subject to child protection plan aged 10-11yrs
  - Staying out later and later, did not come home one night, concerned about influence of new ‘older’ friends
  - Mentioned a new boyfriend once, but won’t speak again
  - Found new expensive clothes and grandmother not sure where she got the money
  - Changes in mood

- What are the next steps in assessment? | What else do you need to know? | What actions do you take?

Child Sexual Exploitation

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.

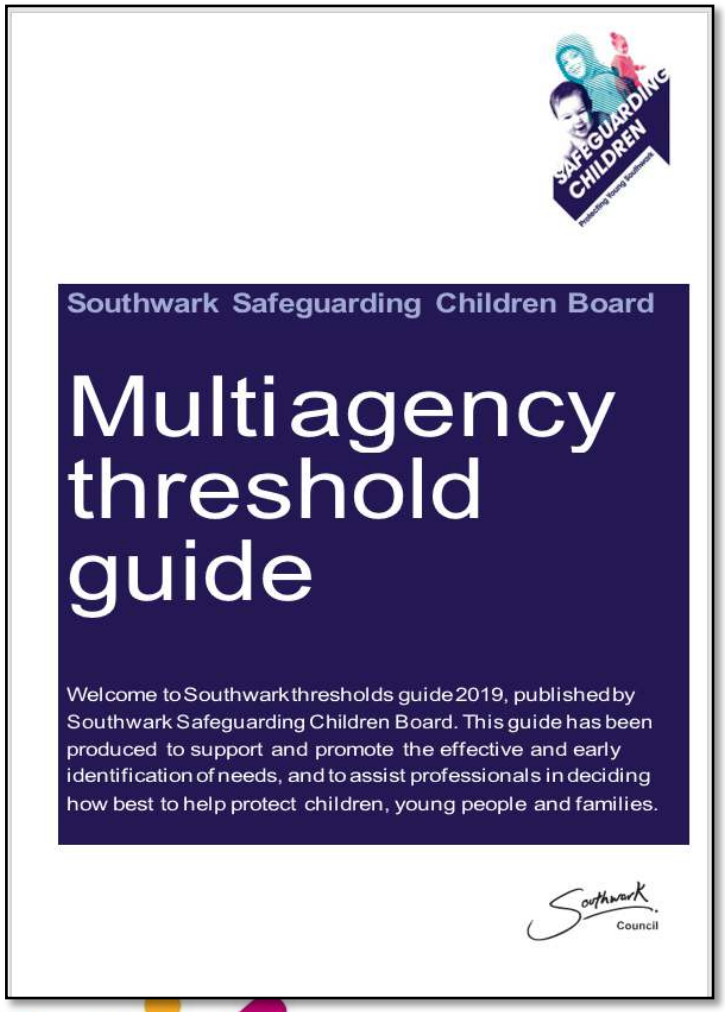
The victim may have been sexually exploited even if the sexual activity appears consensual.

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

Child sexual exploitation: definition and guide for practitioners - GOV.UK (www.gov.uk)

Thresholds and referrals

South East London Clinical Commissioning Group



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Thresholds and referrals

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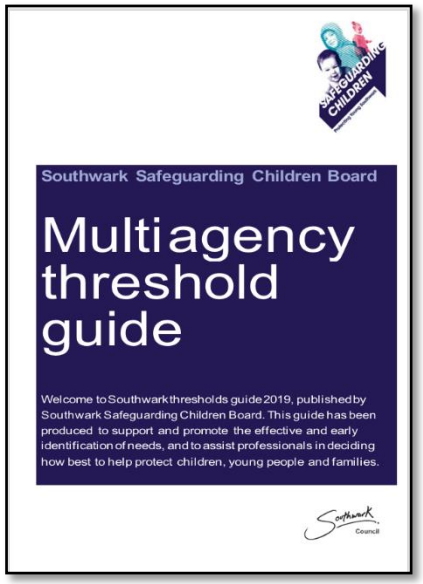


DEVELOPMENT OF THE BABY, CHILD OR YOUNG PERSON			
The child engages in age appropriate use of internet, gaming and social media.	The child is at risk of becoming involved in negative internet use, lacks control and is unsupervised in gaming and social media applications.	The child is engaged in or victim of negative and harmful behaviours associated with internet and social media use, e.g. bullying, trolling, transmission of inappropriate images. Or is obsessively involved in gaming which interferes with social functioning.	The child is showing signs of being secretive, deceptive and is actively concealing internet and social media activities, e.g. at risk of being groomed for child sexual exploitation or is showing signs of addiction (gaming, pornography).
The child does not run away from home.	The child has run away from home on one or two occasions or not returned at the normal time.	The child persistently runs away and/or goes missing.	The child persistently runs away and/or goes missing and does not recognise that he/she is putting him/herself at risk.

London safeguarding children Partnership

The child's emotional wellbeing			
The child engages in age appropriate activities and displays age appropriate behaviours.	The child is at risk of becoming involved in negative behaviour/ activities - for example anti-social behaviour [ASB] or substance misuse.	The child is becoming involved in negative behaviour/ activities, for example, non-school attendance and as a result may be excluded short term from school. This increases their risk of being involved in ASB, crime, substance misuse and puts them at risk of grooming and exploitative relationships with peers or adults.	The child frequently exhibits negative behaviour or activities that place self or others at imminent risk including chronic non-school attendance. Child may be permanently excluded or not in education which puts them at high risk of CSE.

Advice please- Case 3
Extra-familial Harm and Child Sexual Exploitation

NHS South East London Clinical Commissioning Group

Factors Which Increase Risk

- Living in a chaotic or dysfunctional household
- History of abuse
- Living in residential care, hostel, B&B or being homeless
- Gang association either through relatives, peers, intimate relationships or neighbourhood
- Lacking friends from the same age group
- Not attending school or are friends with young people who are sexually exploited
- Not engaging in education/training or employment
- Unsure about their sexual orientation or unable to disclose sexual orientation to their families
- Learning disabilities
- Young carer
- Recent bereavement or loss
- Missing

Pace Parents against child exploitation

Parents Against Child Exploitation (Pace) UK (paceuk.info)

Contextual Safeguarding Network

Homepage (csnetwork.org.uk)

METROPOLITAN POLICE

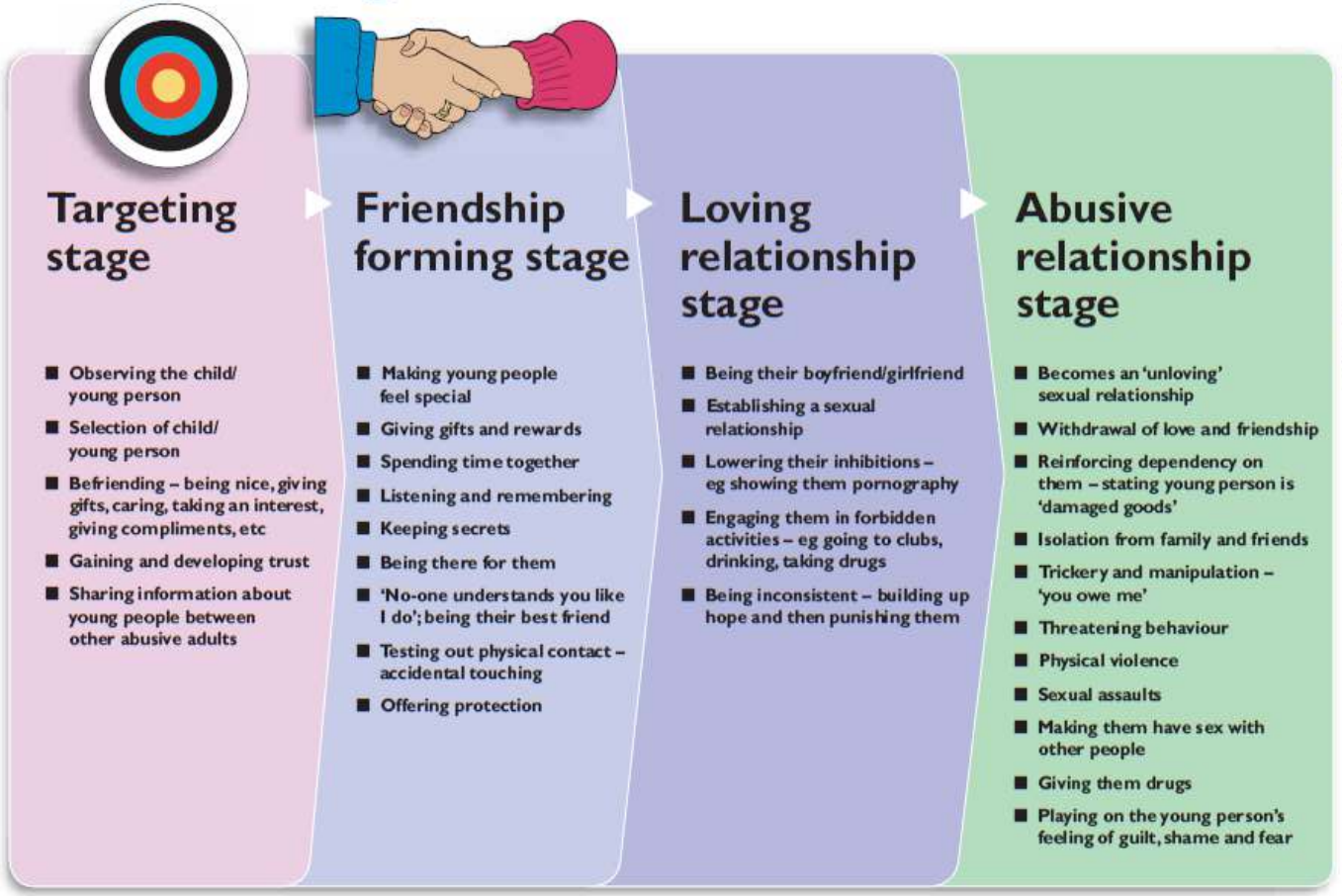
Operation Makesafe: protecting children | Metropolitan Police

London safeguarding children Partnership

Sexual Exploitation (londonsafeguardingchildrenprocedures.co.uk)

NHS
South East London
Clinical Commissioning Group

The grooming line



S exual health and behaviour concerns

A bsent from school or repeatedly running away

F amilial abuse and/or problems at home

E motional and physical condition

G angs, older age groups and involvement in crime

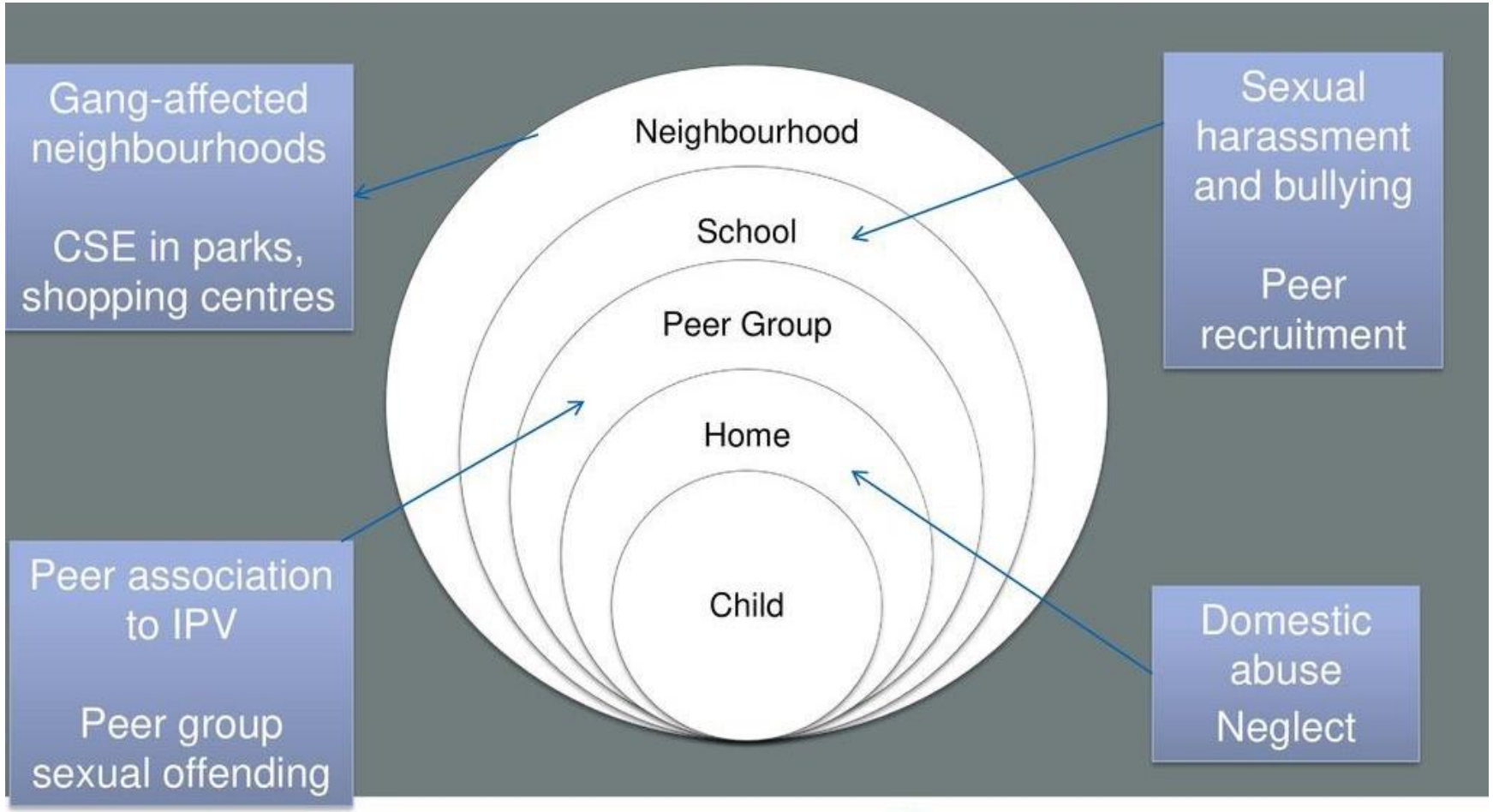
U se of technology and sexual bullying

A lcohol and drug misuse

R eceipt of unexplained gifts or money

D istrust of authority figures

Contextual Nature of Exploitation and Abuse



Thank you

NHS
South East London
Clinical Commissioning Group

Shimona Gayle	Named GP for Safeguarding Children	s.gayle@nhs.net
Michele Sault	Designated Nurse for Safeguarding Children, Looked after Children & Care Leavers	msault@nhs.net
Ros Healy	Consultant Paediatrician and Designated Doctor for Child Protection	
Stacy John-Legere	Consultant Paediatrician and Designated Doctor for Looked After Children	
Megan Morris	Named GP for Safeguarding Adult	meganmorris@nhs.net
Florence Acquah	Designated Nurse for Safeguarding Adults	florence.acquah@nhs.net
Team email/ business support Katarzyna Zawadowska	souccg.southwarksafeguardingteam@nhs.net	

https://selondonccg.nhs.uk/healthcare-professionals/safeguarding/southwark/

Quarterly Safeguarding Forum- Wed 29th June 1-2pm
Modern Day Slavery Level 3 Adult Safeguarding Training
everyone's welcome, link to practice safeguarding lead to forward