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- Does this document meet the requirements under the Equality Act 2010 in relation to age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation? **Yes**
- Does this document meet our additional commitment as a Trust to extend our public sector duty to carers, veterans, people from a low socioeconomic background, and people with diverse gender identities? **Yes**

Document for Public Display: Yes

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To be completed by Library and Knowledge Services Staff

"Anyone working with children should see and speak to the child; listen to what they say; take their views seriously; and work with them and their families/carers collaboratively when deciding how to support their needs. Special provision should be put in place to support dialogue with children who have communication difficulties, unaccompanied children, refugees and those children who are victims of modern slavery and/or trafficking"[1]

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1. SUMMARY

Working Together to Safeguard Children (2018)[1] state “Nothing is more important than children’s welfare”. “Children who need help and protection deserve high quality and effective support as soon as a need is identified”. “A child centred approach is fundamental to safeguarding and promoting the welfare of every child”.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf

This policy uses the guidelines and definitions from Working Together to Safeguard Children (2018)[1] and clarifies Trust responsibilities for safeguarding children and young people.

Safeguarding children is the action we take to promote the welfare of children and protect them from harm. Children are the centre of all that we do and we ensure that their voice is heard.

Safeguarding is Everyone’s Responsibility.
Working Together to Safeguard Children (2018)[1] goes on to state that “Children are best protected when professionals are clear about what is required of them individually and how they need to work together”.

Children have said that “they need adults to notice when things are troubling them”.

2. PURPOSE

The purpose of this policy is to guide practice and ensure that University Hospitals Morecambe Bay Foundation Trust (UHMBFT) fulfils its responsibilities in safeguarding all children.

This policy should be used as a reference point to inform professional decisions in specific situations and should be read in conjunction with Lancashire Safeguarding Assurance Partnership (CSAP formerly Lancashire LSCB) and Cumbria Safeguarding Children Partnership (CSCP formerly Cumbria LSCB) procedures.
These procedures can be found on:

Lancashire Safeguarding Assurance Partnership[2]:
Home Page - Lancashire Safeguarding Children Board

Cumbria Safeguarding Children Partnership[3]:
Cumbria Safeguarding Children Partnership : Cumbria County Council

The use of this policy will:

- Ensure a child-centred approach: for services to be effective they should be based on a clear understanding of the voice, views and needs of children.
- Ensure that all colleagues are aware of their duties to safeguard children from abuse and neglect.
- Ensure colleagues are aware of what constitutes child abuse and have recognition of

the key indicators.
- Ensure that all colleagues share appropriate information in a timely manner and understand the need to discuss concerns about a child with partner agencies and social care as appropriate.
- Ensure special provision is put in place to support dialogue with children who have communication difficulties, unaccompanied children, refugees and those children who are victims of modern slavery and/or trafficking.
- Provide the procedures and guidance on what to do if a staff member has concerns within UHMBFT, who to contact for advice and support and how to make a referral to the relevant Local Authority Children's Services.
- Detail the training requirements for all colleagues.

3. SCOPE

This policy applies to all colleagues working for UHMBFT and agents of other employers providing healthcare on behalf of the Trust, including:
- All UHMBFT colleagues.
- All colleagues seconded to UHMBFT.
- All students/trainees working on Trust premises.
- All volunteers, apprentices, locum and agency staff working within UHMBFT.

NB This includes all those who come into contact with children and families in their everyday work and those who do not have a specific role in relation to safeguarding children.

4. POLICY

4.1 Policy Statement

University Hospitals of Morecambe Bay NHS Foundation Trust is committed to safeguarding and promoting the welfare of children. Safeguarding children is everyone's business and responsibility.

Whatever your role within UHMBFT, the welfare of children should be your paramount consideration. In cases of suspected abuse, the duty of care that the health professional owes to a child will take precedence over any obligation to the parent or other adult.

The Trust has a responsibility and duty to safeguard all children who access the organisation. This includes the children of adults and carers who use the Trust on a daily basis. This duty is detailed in:
- Section 11 of The Children Act (2004)[4]
- Section 40 of The Children Act (2006)[5]
- Section 175 of the Education Act (2002)[6]
- Section 55 of the Borders, Citizenship and Immigration Act (2009)[7]
- Children and Social Work Act (2017)[8]
- Human Rights Act (1998)[9]
- Working Together to Safeguard Children 2018[1]
- The Children Act (1989)[10]
- The Equality Act (2010)[11]

The above will provide a mechanism that will allow audit to Child Protection compliance with Section 11 of The Children Act (2004)[4], National Standards Framework e.g., National Service framework for children, young people and maternity standards (DHSC 2004,)[12], CQC Contractual Standards Safeguarding Children[13], CQC Outcome 7[14], Every Child Matters (HM Treasury 2003)[15].

4.2 Duties and Responsibilities

Effective safeguarding systems are child centred.

The policy sets out:

- Clear priorities for safeguarding and promoting the welfare of children which are explicitly stated in national strategic policy documents.
- A clear commitment by senior management to the importance of safeguarding and of promoting children's welfare.
- A clear line of accountability within the organisation for work in safeguarding and promoting the welfare of children.
- The importance of ensuring a culture of listening to and engaging in dialogue with children – seeking their views in ways appropriate to their age and understanding, recording the child's voice and taking account of these, both in individual decisions and the establishment or development of services.
- Recruitment and human resources management procedures that take into account the need to safeguard and promote the welfare of children and young people, including arrangements for appropriate checks on new staff and volunteers.
- Procedures for dealing with allegations of abuse involving employees and volunteers.
- Arrangements to ensure that all colleagues undertake appropriate training and supervision to equip them to carry out their responsibilities effectively, and keep this up to date by refresher training at regular intervals.
- All colleagues, including temporary colleagues and volunteers who work with children are made aware of the arrangements for safeguarding and promoting the welfare of children within UHMBFT and the responsibilities expected.
- Policies in place for safeguarding and promoting the welfare of children, including the safeguarding children policy, and procedures that are in accordance with guidance from the local authority and locally agreed inter-agency procedures.
- Arrangements in place to work effectively with other organisations to safeguard and promote the welfare of children, including arrangements for sharing information.
- Appropriate whistle blowing procedures and a culture that enables issues about safeguarding and promoting the welfare of children to be addressed. *The **Freedom to Speak Up** policy can be found on Trust Procedural Document Library (see Section 6 for link).*

Members of the safeguarding team have a key role in promoting good professional practice within UHMBFT and in supporting the Head of Safeguarding and Named Professionals in providing advice and support regarding all elements of safeguarding children both within the Trust and across organisational boundaries. The safeguarding team is available via the safeguarding duty line on 42425.

The safeguarding team ensure that all staff have access to safeguarding children

supervision appropriate to their role and advise on training requirements.
The safeguarding team operate a safeguarding duty line for internal colleagues and external partners.

Furthermore, all staff working directly with children have a duty to ensure that safeguarding and promoting their welfare forms an integral part of all stages of the care they offer.
All staff who come into contact with children, parents and carers in the course of their work also need to be aware of their responsibility to safeguard and promote the welfare of children and young people.

This is important even when staff do not work directly with a child, but may be seeing their parent, carer or significant adult.

Trust staff who work predominantly with adults who have parental responsibilities share a commitment to safeguard and promote the welfare of the child. If there are concerns health professionals will follow instructions for all staff as described in this policy.
Safeguarding - Home (sharepoint.com)

4.2.1 Responsibilities of Healthcare Organisations

Health professionals and organisations have a key role to play in actively promoting the health and well-being of children. Section 11 of the Children Act (2004)[4] places a duty on all Statutory Health Care Bodies to make arrangements to ensure that in discharging their functions, they have regard to the need to safeguard and promote the welfare of children.

Health professionals are in a strong position to identify welfare needs or safeguarding concerns regarding individual children and, where appropriate, to provide support. This includes understanding and identifying risk factors, communicating effectively with children and families, liaising with and referring to other agencies, assessing needs and capacity, responding to those needs and contributing to multi-agency assessments and reviews.

4.2.2 Integrated Care Board

Integrated Care Board (ICB) are the major commissioners of local health services and will be responsible for safeguarding quality assurance through contractual arrangements with all provider organisations.

4.2.3 Trust Board

The Trust Board has statutory responsible for safeguarding and promoting the welfare of children in its care and is committed to meeting these obligations.

4.2.4 Chief Executive

The Chief Executive is ultimately accountable in ensuring that the Trust discharges its duties with respect to safeguarding children and young people.

4.2.5 Executive Chief Nurse

The Executive Chief Nurse is the Trust Lead Director for Children and Young People.

Duties include:

- Ensuring the trust has policies and procedures that reflect the commitment of the Board in all aspects identified in Working Together to Safeguard Children (2018)[1]
  Ensuring liaison as appropriate with the Designated Doctor and Designated Nurse appointed by the ICB.

- Ensuring the appointment of named professionals with a key role in promoting good professional practice and providing advice and expertise for fellow professionals.
- Ensuring that the Trust's training strategy meets the needs of colleagues to be competent and confident at each level in carrying out their responsibilities for safeguarding and promoting the welfare of children.
- Ensuring the establishment and implementation of an appropriate child protection supervision structure that meets the Trust's contractual standards.
- Ensuring appropriate staff attends and represents the Trust on Lancashire Children's Safeguarding Assurance Partnership and Cumbria Safeguarding Children Partnership sub-committees.

4.2.6 Deputy Chief Nurse

The Deputy Chief Nurse acts as the portfolio holder for Safeguarding and carries out the duties of the Executive Chief Nurse.

4.2.7 Workforce

Have a responsibility to ensure:

- Safe recruitment practices that take into account the need to safeguard and promote the welfare of children and young people including arrangements for appropriate checks on new colleagues and volunteers.
- Procedures are in place for dealing with allegations of abuse against members of staff and volunteers.

4.2.8 Clinical Heads of Care Group/Care Group Managers

Have a duty to ensure that the approved strategies, policies and procedures of the Trust for safeguarding and promoting the welfare of children are understood and implemented in their own areas of responsibility. This includes disseminating policies and procedures and ensuring that colleagues work within the remit of the policies. It is important that Care Group Managers ensure all their staff are appropriately trained, receive supervision and are competent in safeguarding.

4.2.9 Head of Safeguarding and Professional Lead

The Head of Safeguarding has a strategic lead for safeguarding across the Trust with a responsibility to:

- Ensure the Trust meets its corporate and operational responsibilities for safeguarding through strategic planning and development.
- Provide consultation, managerial, professional and visible leadership.
- Be responsible and accountable for the delivery of a high quality, patient centred service across the safeguarding agenda that meets the needs of patients and clients.
- Lead and develop the Trust safeguarding team ensuring robust safeguarding arrangements are in place.
- Implement strategies, policy, procedure, guidance and action plans to meet national, statutory and local requirements.
- There will be a focus on robust risk management systems to ensure safe, efficient, effective and timely management of the safeguarding agenda.
- Ensure Trust staff are aware of their responsibilities across the safeguarding agenda and receive appropriate training, supervision and support in carrying out these responsibilities.
- Be accountable for safeguarding practice standards and to escalate concerns of safeguarding practice to the Deputy Chief Nurse, Quality team and the relevant care

groups.

4.2.10 Medical Staff

The Laming Recommendations (2003)[16], GMC Protecting Children and Young People Guidance (2018)[17] and locally agreed partnership processes all clearly detail the expectations that hospital doctors adhere to the following:

- All doctors must be aware of the Trust safeguarding policies and procedures.
- All doctors working with children and young people, and those working with adults with parental responsibility must be able to recognise safeguarding concerns and be familiar with local procedures.
- All doctors must take immediate action on the concerns they have about the safety or welfare of a child or young person.
- When you care for an adult with parental responsibility, you must consider whether your patient's presentation and condition impact on their parenting capacity.
- When colleagues are concerned about suspected or actual harm and/or neglect of a child or young person, an immediate referral must be made to Children's Social Care and Police.
- A child protection medical by a senior paediatrician may be requested after a strategy discussion by Police and Children's Social Care and is completed and documented using the Child Protection Proforma available in the UHMBFT Safeguarding intranet site https://nhscanl.sharepoint.com/sites/Safeguarding
- The investigation and management of a case of harm to a child or young person must be approached in the same systematic and rigorous manner as would be appropriate to any other medical investigation.
- The safeguarding team should be informed of all children and young people seen within ED, Paediatric or adult areas where there are concerns about harm. Safeguarding Children and Young People - Who Do I Tell?
- When a child is admitted to hospital and harm is suspected, the doctor admitting the child must enquire about previous admissions to hospital and obtain the information about these admissions from within the Trust (or another hospital if applicable). The summary tab on Lorenzo records previous admissions.
- When concerns about the harm to a child have been raised; a record must be kept in the electronic patient record of all discussions about the child, including telephone conversations, email exchanges, ward rounds, any advice from Named Doctor or Nurse and safeguarding team.
- When differences of medical opinion occur in relation to the diagnosis of possible harm to a child, documentation on Lorenzo must reflect these differing views. If differences are not resolved, this should be escalated.
- When harm to a child has been raised as an alternative diagnosis to a purely medical one, the diagnosis of harm must not be rejected without full multi-agency discussion and, if necessary, obtaining a further opinion.
- When harm of a child is identified as a possibility; the examining doctor should consider whether taking the history directly from the child is in the best interests of that child. If it is, the history may be taken from the child even when consent from the person with parental responsibility has not been sought. The examining doctor should document the child's voice clearly.
- In those cases, in which English is not the first language of the child concerned, the use of a Trust approved interpreter must be utilised. Augmented language tools should be available for children who have no language ability.

Safeguarding advice and support are available Monday to Friday, 9am – 5pm, telephone: 01524 512425, Ext: 42425, email: safeguarduarding@mbht.nhs.uk

4.2.11 Named Doctor

The Named Doctor is a Consultant Paediatrician who works closely with the named designated doctor(s) for safeguarding and provides clinical advice for UHMBFT colleagues and support for safeguarding and child protection processes.

4.2.12 Named Nurse and Named Midwife

The Named Nurse and Named Midwife take the lead for ensuring that the strategic vision of the Trust with respect to safeguarding of children and young people is implemented.
NB "Named" colleagues must have specific expertise in children's health and development and in treating children who have been abused or neglected.
Their work includes:

- Providing supervision and support to other colleagues in child protection issues.
- Offering advice on local arrangements within the provider organisation for safeguarding children.
- Providing a key role in promoting and influencing relevant training for staff.
- Providing skilled professional input to child safeguarding processes in line with procedures of children's safeguarding partnerships.
- Contributing to reviews undertaken by safeguarding children partnerships including Child safeguarding practice reviews (CSPRs) previously known as Serious Case Reviews (SCR).
- Representing the Trust in children's safeguarding partnership meetings e.g. child death overview panels (CDOPs).

4.2.13 Line Managers

Senior Managers throughout the trust have a duty to ensure that the approved strategies, policies and procedures of the trust for safeguarding and promoting the welfare of children in their care are understood and implemented in their own areas of responsibility.

Line Managers will have varying degrees of responsibility for services that directly or indirectly provide care for children.

Line managers also have responsibility for:

- Ensuring all colleagues, they manage, attend the mandatory safeguarding training and clinical /safeguarding supervision and review this annually through the Personal Development Review (PDR) process and TMS.
- Ensuring staff are aware of the supervision policy, including when and how to access supervision and that both supervisors and supervisees have sufficient time to attend and participate in child protection supervision.
- Ensuring that the duty to safeguard and promote the welfare of children is reflected in individual job descriptions.
- Ensuring that staff have appropriate access to training.
- Releasing staff for safeguarding meetings and arrange cover to facilitate attendance.
- Ensuring that the training needs of their staff are identified at induction, developmental reviews, appraisals and in their personal development plans.

4.2.14 Nursing/Midwifery Staff/Allied Professionals

Hospital nurses and midwives are expected to adhere to the requirements which are also

applicable to Allied Professionals at UHMBFT, Laming Recommendations (2003)[16]:

- Nurses, midwives and AHPs should be aware of Safeguarding Children policy and Child Protection Procedures and Trust Policy.
- Nurses, midwives and AHPs have a duty to recognise the signs and symptoms of harm and to act on any concerns.
- Nurses working in ED and those working with children and young people and with adults with parental responsibility should be able to recognise abuse and be familiar with local procedures for making enquiries to the local authority.
- When a nurse/midwife/ANP suspects that a child has been subjected to harm; she/he should speak directly to the local authority and/or Police and notify the safeguarding team (in office hours) and clinical site manager (out of hours).
- In the event of a doctor not being in agreement with the nurse's concerns, further advice should be sought from the Safeguarding Duty line or the Named Nurse or the Consultant Paediatrician on call.
- When a child is admitted to hospital and harm is suspected, the nurse admitting the child must use the summary tab on Lorenzo to look at previous admissions to hospital.
- All face-to-face discussions including nursing 'handover' and telephone conversations relating to the care of the child and of all decisions made during such conversations including those with external agencies must be documented contemporaneously in the safeguarding tab. In addition, a clear record must be made of who is responsible for carrying out any actions that have been agreed during such conversations.

4.2.15 Security and Communications Teams

The Trust security teams must ensure that they work closely with the Head of Safeguarding, Named Nurse and Named Midwife for Safeguarding Children. Any concerns regarding individuals who may pose a risk to children and may be denied access must be communicated fully.

There must be a secure door to the Maternity and any Paediatric areas. Staff must be advised not to let people into the areas without being clear about who they are and why they are accessing the area. This includes any individual wearing Trust ID, which must be checked.

If staff become aware of any individual in the area who may be a risk the security team must be alerted, together with the area's manager and the Named Nurse or Midwife.

Link to Baby and Child Abduction Policy: Baby and Child Abduction Policy.docx

4.2.16 Guest Visitors/Celebrities

When guest visitors including celebrities and representatives of charitable organisations visit the Trust premises, they must be accompanied at all times by a member of Trust staff. In maternity and paediatric areas this must be a member of staff from the area who has undergone enhanced Disclosure and Barring Service (DBS) checks.

Guest visitors must be made aware that they should not approach babies, children or young people randomly. Such visits must be arranged through the Trusts communications department.

See Section 6 for link to '**VIP and Celebrity Visits'** procedure on Trust Procedural Document Library.

This department will liaise with the Named Nurse or Named Midwife who will ensure all risks are assessed prior to approval for the visit. The security team and departmental managers must also be informed and agree to the visit.

Consent must also be gained from the parents and children prior to the visit. Photographs must not be taken without written consent of the child's parent and full agreement of the Trusts communication department.

Also refer to the '**Operational Policy for Children**' under **Service Provision** on Trust Procedural Document Library (see Section 6 for link).

4.3 Definitions

4.3.1 Safeguarding and Promoting the Welfare of Children

This means:

- Protecting children from maltreatment.
- Preventing impairment of children's health or development.
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care.
- Undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successfully.

4.3.2 Child

A child is defined under the Children Act (1989)[10] as any person who has not yet reached their 18th birthday. The term 'child' or 'children' is used throughout this policy to mean children and young people under the age of 18 years.
The fact that a child is over 16 years of age, is living independently, is in Further Education, is a member of the armed forces, is in hospital, in prison or a young offenders institute does not change their status or their entitlement to services or protection under the Children Act.

4.3.3 Child in Need of Protection (Children Act 1989[10], Section 47)

A child may be in need of protection because they are suffering or likely to suffer significant harm. Significant harm is the threshold that justifies compulsory intervention in family life in the best interests of children. As a statutory agency, the NHS has a duty of care to respond/report concerns. The Local Authority has a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering or likely to suffer, significant harm.

4.3.4 Children in Need (Children Act 1989[10], Section 17)

A child in need is:

- A child whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development.
- A child whose health or development will be significantly impaired without the provision of services.
- A child who is disabled.

4.3.5 Children Looked After (CLA)

Children described as 'Children Looked After' include children in foster or residential homes and those who still reside with their parents but are subject to a Care Order. This is a legal arrangement in the UK for local Children's Services to look after the child. It also includes children who are temporarily looked after for respite on an emergency or planned basis.

The Children's Act also places a duty of care on the Local Authority to offer services up to the age of 25 years when the young adult has been a "Child Looked After" often referred to as a care leaver.

Safeguarding Arrangements for Children Looked After and Care Leavers.docx

4.3.6 Parental Responsibility (PR)

Parental responsibility is defined in the Children Act (2004)[4] as being the rights, duties, powers, responsibilities and authority which by law a parent has in relation to a child and its property. The term attempts to focus on the parents' duties rather than rights over their child. In health care it includes consent to medical treatment.

Guidance on parental responsibility:

- The woman giving birth to the child has automatic parental responsibility.
- Both the child's biological parents have parental responsibility if married to each other at the time of birth. They both keep parental responsibility if they later divorce.
- Fathers not married to the child's mother do not automatically have parental responsibility. They may acquire this by jointly registering the birth with the child's mother, by parental responsibility agreement with the mother or by obtaining a parental responsibility agreement via a court parent.

Other examples where PR can be granted are:

- Care Order where the local authority shares joint parental responsibility with others who hold PR.
- Interim Care Order. The Local Authority shares PR with the mother and any other people with PR for a temporary period of time.
- Through a Residence Order. This grants the applicant PR for the duration of that Order.
- Being appointed as Guardian to a child which automatically gives that person PR shared with any other people with PR.
- Being appointed as a Special Guardian to a child which automatically gives that person PR. The biological parent(s) will keep their PR, but they will not have equal PR to the Special Guardian who can override decisions made by the parent if there is an issue they disagree on.
- Through adoption as the adoptive parent(s) automatically get PR and the biological parent(s) will lose PR.
- Being appointed as Testamentary Guardians (i.e., a person who is appointed to care for a child after the death of a parent or the death of a special guardian who has parental responsibility).

People aged 16 or over are entitled to consent to their own treatment. This can only be overruled in exceptional circumstances.

Like adults, young people (aged 16 or 17) are presumed to have sufficient capacity to decide on their own medical treatment, unless there's significant evidence to suggest

otherwise.

Children under the age of 16 can consent to their own treatment if they are believed to have enough intelligence, competence and understanding to fully appreciate what is involved in their treatment. This is known as being Gillick competent. Otherwise, someone with parental responsibility can consent for them.

It is best practice to gain both the child's consent (age dependent) and that of the person with parental responsibility.

Children and young people Consent to treatment[38]

Mental Capacity Act and Deprivation of liberty
It is a key principle of the Mental Capacity Act 2005[48], which applies to people aged 16 and over, that a person must be given all practicable support to make a decision.

Where a young person is confined (continuous supervision and control and not free to leave), and practitioners are seeking consent from the young person, it is important that they remain objective in their support to avoid any 'coercion'. This is particularly important where practitioners believe the confinement is in the interests of the young person. A crucial consideration is whether the young person has a choice about what kind of arrangements are to be put in place. If the young person cannot understand, retain, use and weigh the information about their confinement and communicate their decision to agree to it, then they cannot give consent to it, and will therefore be deprived of their liberty for which it will be necessary to seek an authorisation. This will be so even if the young person appears to be compliant, acquiescent, or even actively to be content with the arrangements. Compliance, therefore, does not constitute consent. If the young person can understand, retain, use and weigh the information about their confinement, and communicate a decision to agree to it, but does not give that consent, then no one can seek to override that refusal. The young person must therefore be seen as deprived of their liberty.[50]

Mental Health Act plan on a page (1).pdf

4.3.7 Significant Harm
Significant harm is a concept introduced by the Children Act (1989)[10] as the threshold which justifies compulsory intervention in family life in the best interests of the children. There are no absolute criteria to define significant harm; it may be a single traumatic event or more commonly a compilation of significant events. Consideration should be given to the severity of ill treatment, duration and frequency of abuse or neglect, extent of premeditation, and the presence of threat, coercion, sadism, and bizarre or unusual elements.

4.4 Definitions of Abuse and Neglect

Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting, by those known to them or, more rarely, by a stranger. They may be abused by an adult or adults, or by another child or children.

4.4.1 Physical Abuse

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

4.4.2 Bruising/ Non-mobile Babies and all Non-mobile Children[49]

Babies and children who are observed with injuries / bruises / unexplained marks must be considered as possible subjects of non-accidental injury. An immediate referral to Children's Social Care and Police should be initiated and an urgent strategy discussion requested, which will lead to the baby/child being seen by the hot week Consultant Paediatrician" for assessment. The hot week Consultant and safeguarding team should be informed that a referral has been made. Non-mobile children include very young children or children of any age with motor development delays or physical disabilities that restrict mobility.

4.4.3 Emotional Abuse

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

4.4.4 Sexual Abuse

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

NB in the case of suspected sexual abuse the police will arrange a medical examination this **must** only be carried out by a designated expert. In some areas across the country multi-agency teams have been established with a specific remit to recognise and support young people who are victims of Sexual abuse.

In Lancashire there is the SAFE (Sexual Assault Forensic Examination) Centre and In Cumbria there is The Bridgeway Sexual Assault Referral Centre (SARC) which both

provide forensic examinations, advice and comprehensive support services for women, men and children of all ages who make a complaint of rape or sexual assault.

4.4.5 Neglect

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs[49], likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of inadequate care-givers);
- ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

Also refer to Lancashire Safeguarding Assurance Partnership[2] and Cumbria Safeguarding Children Partnership[3].

4.4.6 Child Sexual Exploitation (CSE)

Child Sexual Exploitation (CSE) is a form of child sexual abuse. CSE occurs where an individual or group takes advantage of a power imbalance to coerce, manipulate or deceive a child under the age of 18 years into sexual activity. This may be in exchange for something the child needs or wants, and/or for the financial advantage or other benefit of the perpetrator.

It is important to note that a child may have been sexually exploited even if the sexual activity appears consensual and indeed a child who is being sexually exploited may not recognise this fact. Child sexual exploitation includes direct and non-direct contact by a perpetrator/s. A child may have been sexually exploited by someone who they have never met in real life. For example, online child sexual exploitation includes the use of technology to groom children online, life streaming of child sexual abuse or the sharing of explicit images.

NSPCC Child Sexual Exploitation[18]

HM Government (2015) Tacking child sexual exploitation[19]

DoH(2015) Information sharing letter[20]

4.4.7 Child Criminal Exploitation (CCE)

Child Criminal Exploitation is a form of child abuse where an individual or group takes advantage of a power imbalance to coerce, control, manipulate or deceive a child under the age of 18 into any criminal activity. This may be in exchange for something the child needs or wants, and/or for the financial or other benefit of the perpetrator/s.
Violence, or the threat of violence to the child or someone close to the child may be used to incite the child into criminal activity.

As with CSE, Child Criminal Exploitation can involve direct and non-direct contact with a perpetrator and online methods are utilised to criminally exploit children.

County Lines is one form of Criminal Exploitation. County lines refers to the transportation of illegal drugs from one area to another. It is often children or vulnerable people who are coerced into this criminal activity. The 'lines' are the mobile phones used to take orders of the drugs and to control the children who are being coerced into delivering the drugs to areas which are often outside their home county.

NSPCC, Child Criminal Exploitation[21] Criminal exploitation and gangs | NSPCC

4.4.8 Extra-familial Harm

This term reflects the fact that children may be vulnerable to abuse that occurs outside of the family home. Child Exploitation is an example of extra-familial harm and can be broadly defined into two categories; Child Sexual Exploitation and Child Criminal Exploitation. It should be noted that there is often overlap between these two categories and children may be at risk of, or experiencing both sexual and criminal exploitation at any given time. Contextual safeguarding is an approach to safeguarding which examines how professionals and parents can best understand these risks outside of the home in order to protect children from harm.

4.4.9 Child Trafficking

The UK is a destination country for trafficked children and young people. Trafficking in people includes the exploitation of children through force, coercion, threat and the use of deception and human rights abuses. Exploitation occurs through prostitution and other types of sexual exploitation, forced employment and domestic servitude. It includes the movement of children and young people across borders and also the movement and exploitation within borders.

Some children enter as unaccompanied asylum seekers, or students or visitors. Children are also brought into the country by adults who state they are their dependents, or are met at the airport by an adult who claims to be a relative. If it is suspected that a child is the victim of trafficking Children's Social Care and/or the Police and the safeguarding team must be informed.

4.4.10 Asylum Seekers

Unaccompanied asylum-seeking children are placed within the United Kingdom through the National Transfer Scheme (unaccompanied). Unaccompanied females under 18 years and males under 16 years are placed in foster care, males 16 to 18 years are placed in supported living.

Asylum seeking families are supported through the resettlement programmes. UASC Health[22]

4.4.11 Missing Children

A 'missing' person is defined as: "Anyone whose whereabouts cannot be established and where the circumstances are out of character or the context suggests the person may be subject of a crime or at risk of harm to themselves or another".

An 'absent' person is defined as a: "Person not at a place where they are expected or required to be".

If it is suspected that a child is missing or absent, Children's Social Care and the police

must be informed.

4.4.12 Modern Slavery

Modern slavery is defined in the Modern Slavery Act (2015)[23] (Home Office statement 2020 to 2021) as: 'the recruitment, movement, harboring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. Individuals may be trafficked into, out of, or within, the UK, and they may be trafficked for a number of reasons including sexual exploitation, forced labour, domestic servitude and organ harvesting.'

If this is suspected Children's Social Care and/or the police must be informed.

4.4.13 Children Involved in Prostitution

Children involved in prostitution and other forms of commercial sexual exploitation should be treated as victims of abuse and their needs carefully assessed. They are likely to be in need of children's services and protection under the Children Act 1989[10]. The Home Office and Department of Health, working jointly, published the guidance 'Safeguarding Children Involved in Prostitution' (2020)[24], which promotes an approach whereby agencies should work together to:

- Recognise the problem.
- Treat the child primarily as a victim of abuse.
- Safeguard the children involved and promote their welfare.
- Prevent abuse and provide children with opportunity and strategies to exit from prostitution.
- Investigate and prosecute those who coerce, exploit and abuse children.

4.4.14 Complex (Organised or Multiple) Abuse

This is defined as abuse involving one or more abusers and a number of children. It may occur as part of a network of abuse across a family or community, or within institutions. The designated and named professionals within the Trust should be aware of these cases and will offer support to individual healthcare practitioners who may be involved.

4.4.15 Domestic Abuse

Domestic abuse is a complex issue. It is a serious crime that can occur across all sections of society, in all social classes and cultures and is not age specific. Although in the majority of cases it is perpetrated by men against women, men can also be victims and it can also occur in same sex relationships.

The Home Office[25] definition is, 'Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality'. This definition includes issues of Honour Based Violence, Forced Marriage and Female Genital Mutilation.

It is known that prolonged or repeated exposure to domestic abuse can have a serious impact on the wellbeing and safety of children, even if children are not in the same room witnessing the abuse.

Refer to "**Domestic Abuse**" policy on Trust Procedural Document Library (see Section 6 for link) and the Domestic Abuse policy for staff.

4.5 Mental Health

Mental health in children and young people has emerged as a major public health issue. Mental health presentations can include low mood and depression, anxiety, eating disorders and self-harm. Child and Adolescent Mental Health Services (CAMHS) (sharepoint.com)

Local CAMHS and mental health services provide this support to children accessing UHMBFT services. All children and young people who access UHMBFT with mental health presentations must be referred to local mental health services prior to discharge.

If a child requires assessment under the Mental Health Act (1983)[26] this will be made in conjunction with the paediatric Consultant and CAMHS team and a referral made to a child psychiatrist.

If following assessment, the child is to be detained under the Mental Health Act (1983)[26] then a bed needs to be identified at a specialist unit and arrangements made to transfer child as soon as possible. This bed will be sourced by the mental health team via the bed hub.

Please refer to "Section 5(2): **Completion, Receipt and Scrutiny of Mental Health Act Section Papers**" on Trust Procedural Document Library (see Section 6 for link).

Support for the care of the young person should be sought from specialist teams whilst remaining on the Children's Ward until the young person is transferred to a specialist unit. Also refer to Mental Health Act (1983)[26].

4.6 Female Genital Mutilation (FGM)

Female Genital Mutilation is a collective term for procedures which include the removal of part or all of the external female genitalia for cultural or other non-therapeutic reasons. FGM is a form of child abuse.

FGM has been a criminal offence in the UK since 1985. In 2003, the Female Genital Mutilation Act[27] made it an offence for UK nationals or permanent UK residents to carry out FGM abroad or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where it is legal.

Further information about the Act can be found in Home Office circular 10/2004.[28] All suspected cases of FGM must be discussed with Safeguarding team.

Female Genital Mutilation - Information Sharing (FGM-IS)
The Female Genital Mutilation - Information Sharing[29] (FGM-IS) is a national IT system that supports the early intervention and ongoing safeguarding of girls, under the age of 18, who have a family history of Female Genital Mutilation.

The FGM-IS is part of the NHS Spine and healthcare professionals can view, add and remove the FGM indicator. It is accessed via the Summary Care Record Application

(SCRa). Access is controlled via NHS smartcards and the appropriate permissions, so only authorised healthcare professional can access the FGM information.

The FGM-IS contains an indicator that the girl has a family history of FGM and the date that the FGM indicator was added to the system. As this is a national system it allows authorised healthcare professionals to view information about girls with a family history of FGM, regardless of location.

This allows for relevant and timely information sharing and provides an opportunity to provide the appropriate support to the girl and her family.

The safeguarding team will be responsible for adding and/or removing FGM indicators but all necessary healthcare staff within UHMBFT will be able to view FGM-IS.

4.7 Perplexing Presentation (PP) / Fabricated and Induced Illness (FII)

Fabricated and Induced Illness (FII) was previously known as Munchausen Syndrome by Proxy. FII occurs when a caregiver misrepresents the child as ill either by fabricating, or much more rarely, inducing symptoms and then presenting the child for medical care, disclaiming knowledge of the cause of the problem.

It is now recognised that a more common presentation of true FII is that of “Perplexing Presentations” (PP), which primarily involves verbal accounts and descriptions by carer that are not aimed at deliberate deception; or the carer may simply exaggerate genuine symptoms and signs.

In March 2021 the Royal College of Paediatrics and Child Health (RCPCH) published new guidance for procedures to follow when Perplexing Presentation or Fabricated and Induced Illness is known or suspected (Perplexing presentations/Fabricated or induced illness in Children, 2021) and this guidance has been adapted for use across Lancashire and South Cumbria.

This guidance can be accessed below and should be used within UHMBT when managing cases of Perplexing Presentation or Fabricated Induced Illness.

CSAP Publication Template (proceduresonline.com)

A plan on a page can be found in Appendix 1.

4.8 Bullying

Bullying may be defined as deliberately hurtful behaviour, usually repeated over a period of time, where it is difficult for those bullied to defend themselves. The damage inflicted by bullying can frequently be underestimated. It can cause considerable distress to children, to the extent that it affects their health and development or, at the extreme, causes them significant harm (including self-harm).

4.9 Cyber Issues and E-Safety

As technology develops, the internet and its range of content, services and accessibility increases. At the same time the risks to children from all areas increases. There are issues relating to grooming online, accessing unsuitable information, pornography and online bullying. Staff should be vigilant to any disclosure or suspicion of these issues and make referrals to children's services in the usual way.

Further information can be accessed from '**Acceptable Use Policy for Information Communication & Technology (ICT) Systems and Equipment', 'Use of Internet' guideline, and 'Guest Wi-fi – user guide'** found via Trust Procedural Document Library (see Section 6 for link).

4.10 Radicalisation of Violent Extremism

The Government's strategy for addressing these concerns is known as PREVENT which forms part of CONTEST, the government's counter terrorism strategy, the government's counter-terrorism strategy. Radicalisation of those deemed to be vulnerable which may include young people is therefore considered a form of abuse; signalling concerns that an individual may have been subject to exploitation, coercion and intimidation.

Refer to **"PREVENT"** policy on Trust Procedural Document Library (see Section 6 for link).

4.11 Forced Marriage

Forced marriage is a marriage conducted without the full consent of both parties and where duress is a factor. The Governments Forced Marriage Unit[31] produce guidelines and these are accessed here: https://www.gov.uk/guidance/forced-marriage

4.12 Children Living Away from Home

Children living away from home are particularly vulnerable. Issues such as sexual abuse, physical and emotional abuse and neglect, peer abuse, bullying and substance misuse are also a threat in institutional settings. Concern for the child living away from home has to be put into the context of attention to the overall developmental needs of such children and the best possible outcomes for them.

4.13 Private Fostering

A private fostering arrangement is essentially one that is made without the involvement of the local authority for the care of a child under the age of 16, or 18 if the child is disabled, by someone other than a parent or relative for a period of 28 days or more.
Under the Children Act (1989)[10] private foster carers are required to notify the local authority of their intention to private foster, have a child privately fostered, or when a child is privately fostered in an emergency.

Health care professionals should notify the local authority of any private fostering arrangements which come to their attention, where they are not satisfied that the local authority has or will be notified of the arrangement.

4.14 Children in Hospital

The National Service framework for Children, Young People and Maternity Services (2004)[12] sets out standards for hospital services:

- When children are in hospital this should not in itself jeopardise the health of the child or young person.
- The Local Authority where the hospital is located is responsible for the welfare of children in its hospitals.

Additionally, the Children Act (1989)[10] requires hospitals to notify the local authority for the area where the child is ordinarily resident when a child has been or will be accommodated in hospital for 3 months or more.

4.15 Children not Brought for Appointments

When children and young people are not brought to appointments, it can raise safeguarding or child protection concerns. It is important to bear in mind that children do not fail to attend appointments but that their parents or carers may not bring them to an appointment. This can occur for various reasons; however, parents and carers have a responsibility to ensure that all children and young people receive healthcare, not all parents have the capacity or ability to facilitate this.

A missed health appointment for a child or young person on its own may be of no concern or it may be very significant. Each non-attendance should be reviewed on an individual basis and the need for further action decided after assessing the risk. This would include failure to wait to be seen in the Outpatient or Emergency Department.

Each practitioner is accountable for the decisions they make and the consequences of those decisions. If there are safeguarding concerns, staff should discuss with their line manager or a member of the safeguarding team via the duty line and submit a Patient Safety Incident (PSI). Was Not Brought and Did Not Attend Guidance for Children, Young People, and Adults with Care and Support Needs.docx

4.16 Transition from Child to Adult Services

The Children and Families Act (2014)[32] and The Care Act (2014)[33] together create a new comprehensive legislative framework for transition, when a child turns 18 (MCA applies when a person is 16). The duties in both Acts are primarily for the local authority, but there is also a need for UHMBFT to work together to ensure that the safeguarding adult at risk policy works in conjunction with the children and young people policies.

Where it is anticipated that on reaching 18 the young person is likely to require adult safeguarding, arrangements should be discussed as part of transition support planning and protection.

The aim of an effective transition is to empower young people to own and understand their health and understand any changes in their care, as well as, instilling confidence to seek advice when required.

Transition should be inclusive, with an integrated family approach, that delivers support for the young person and their family. Good planning that puts the young person at the centre, will prepare them and their family for the move to adult services.
The UHMBFT is committed to ensuring the smooth transition of children and young people who are transferring from child into adult services.

4.17 Child Protection – Information Sharing (CP-IS)

The Child Protection - Information Sharing (CP-IS) is designed to help health and social care professionals to share information and better protect society's most vulnerable children.

The CP-IS links health and social IT systems together so information about children on child protection plans or being a Child Looked After (CLA)-that is a child with a full or interim care order or voluntary care agreements. Pregnant women whose unborn child has a pre-birth protection plan in place can be shared securely between social workers and staff working in UHMBFT, such as emergency departments, Urgent Treatment Centre, antenatal clinic and children's wards.

Individual teams will develop a Standing Operational Procedure pertinent to their work place that supports staff accessing CP-IS.

The safeguarding team will act as single point of contact for all inquiries from children social care in relation to CP-IS.
https://digital.nhs.uk/about-nhs-digital/nursing-and-nhs-digital/the-child-protection-information-sharing-project-cp-is#summary

4.18 Safe Environment

Children with an immediate safeguarding concern should not be discharged from hospital without the permission of the Consultant and with the awareness of local authority. Clear arrangements should have **been** made which take into account the need to ensure that the child is discharged into a safe place.

Children will be cared for in age-appropriate environments where they and their families can be confident that best practice is being followed at all times and that the safety of everyone is of paramount importance. Chaperone Procedure.docx

All maternity, neonatal and children wards will have robust security systems with access only by authorised personnel. Each area will have a local security policy for visiting arrangements.

Colleagues will acknowledge the UHMBFT safeguarding children's arrangements for young people aged up to 18 years placed or seen in adult areas.

When discussing child protection issues with parents/carers or children, the sensitive nature of the discussions must be considered and interviews undertaken in a private environment.

The child and infant abduction policy is designed to ensure that the safety and welfare of any baby, child or young person is maintained at all times and in the event of an incident arising which results in a known or suspected missing person, that appropriate steps are taken to resolve the situation. Baby and Child Abduction Policy.docx

4.19 Use of an Interpreter

Where English is not the first language of the child concerned, and communication is necessary for the purpose of safeguarding and promoting the child's welfare, the use of an interpreter who is not a family member must be considered. If the use of an interpreter is dispensed with, the reason for doing so must be recorded. It is appropriate to consider local language dialects in particular respect of asylum seekers.

Refer to **"Interpretation Services Procedure"** on Trust Procedural Document Library (see Section 6 for link).

4.20 Child Abuse – linked to belief in "possession" or "witchcraft" or in other ways related to spiritual or religious belief

The belief in "possession" and "witchcraft" is widespread. It is not confined to particular countries, culture or religions nor is it confined to new immigrant communities in this country. Such abuse generally occurs when a carer views a child as being "different", attributes this difference to the child being "possessed", or involved in "witchcraft" and attempts to exorcise the child.

Health professionals should be aware of indicators and to be able to identify children at risk of this type of abuse and intervene to prevent it. They should apply basic safeguarding processes including information sharing, being child focused at all times and keeping an open mind when talking to parents and carers.

4.21 Child Deaths

The death of a child is obviously one of the most tragic events that a family or practitioner will have to experience. It is essential that all deaths are rigorously reviewed so that lessons can be learnt for future practice. Not all deaths will be as a result of child abuse but there are often common features which will ultimately influence future practice.

- **Expected death of a child is** where a child's death is not regarded as unexpected and there should be a case discussion with those involved in providing care.
- **Unexpected death of a child** will trigger the need for an investigation under the safeguarding children's partnerships procedures.

For staff guidance on what to do when there is an unexpected death of a child, see

Sudden Unexpected Death in Infancy & Childhood (SUDIC) process in the Trust Procedural Document Library.
Sudden Unexpected Death in Infancy and Childhood (SUDIC) Process - Ward staff.pdf

Child Death Review: statutory and operational guidance (England)[34] Child death review: statutory and operational guidance (England) - GOV.UK (www.gov.uk)

Cumbria Safeguarding Children Partnership Child Deaths[35]
Child Deaths : Cumbria County Council (cumbriasafeguardingchildren.co.uk)

Lancashire Child Death Overview Panel[36]
Child Death Overview Panel - Lancashire Safeguarding Children Board

Children's Safeguarding Assurance Partnership Contents (proceduresonline.com)

4.22 Child Death Overview Panel (CDOP)

Child Death Overview Panels (CDOP) are multi-agency groups responsible for reviewing all child deaths nationally. The local panels are sub groups of the safeguarding children's partnerships.

The deaths of all live-born children up to the age of 18 years (excluding infants live-born following planned, legal terminations of pregnancy), are reviewed by the Child Death Overview Panel in line with statutory guidance.

All practitioners involved in the care of the deceased child or young person will be asked to contribute to the review of the child's death. A joint agency response and subsequent child death review meeting will be facilitated by either the safeguarding team or Lancashire SUDI nurse.

Occupational health can offer support to those colleagues involved in child deaths.
https://nhscanl.sharepoint.com/sites/OccupationalHealthWellbeingService/Services Offered/Forms/AllItems.aspx?id=%2Fsites%2FOccupationalHealthWellbeingService%2FServices Offered%2FTrauma Risk Management %28TRiM%29%2Epdf&parent=%2Fsites%2FOccupationalHealthWellbeingService%2FServices Offered

4.23 Early Help and Intervention

In line with Lancashire Family Safeguarding model, the early help assessment is a key tool in the early identification of children and young people and families who may experience problems or who are vulnerable to poor outcomes and underpins the work of Early Help. The process identifies unmet needs and works with the family to highlight strengths and protective factors. The voice of the child, young person and family is encouraged throughout the process.

If you identify a child and their family/carers who would benefit from early intervention from local support services, you can request this, with their consent, from the single point of access referral. Early Help (sharepoint.com)

In Cumbria, in line with the Signs of Safety model, if you are working with a child in need that you feel would benefit from early help, you are required to consider a referral for early help.

Cumbria County Council. Early Help Assessment[37] Early Help : Cumbria County Council (cumbriasafeguardingchildren.co.uk)

Safeguarding - Home (sharepoint.com)

4.24 Referrals to Children's Social Care

UHMBFT will share information which will potentially lead to an Inquiry under Section 47 of the Children Act 2006[5] and would be made in cases where there is reasonable cause to suspect that a child is suffering or likely to suffer, significant harm.

Personal information about children and families is subject to a legal duty of confidentiality and should normally only be shared with consent. In Safeguarding, when making a referral to CSC it is best practice to gain consent, which could include the consent from a young person if age appropriate. However, if consent is not gained and concerns remain, then a referral must still be completed.

Children and young people Consent to treatment[38]

There are circumstances when seeking agreement/consent about the concerns may place a child at increased risk of further harm and would not be advisable.

Some examples include:

- Suspected sexual abuse.
- Suspected fabricated or induced illness.
- Increased risk to the child.
- Risk to worker's own personal safety.
- Female genital mutilation.
- Forced marriage (under 18's).
- Honour Based Abuse.
- Human Trafficking.
- Radicalisation.

Where a decision is taken not to seek parental permission before making a referral to Children's Social Care the decision must be recorded in the records and include reasons for that decision, and confirmed in the written referral.

In all cases where a parent suggests relinquishing their child for adoption or giving their child into care of unrelated 'others' (private fostering) this should automatically trigger a referral to Children's Social Care for a core assessment in order to explore the motivation behind the plan and ensure the child is adequately safeguarded.

All unaccompanied asylum-seeking children should be referred to Children's Social Care.

4.24.1 How to refer to Children's Social Care

Referrals should be made to the Local Authority Children's Social Care for the area where the child is living, (sometimes out of our area) or is found. Children's Social Care is 24-hour service seven days a week. They are available for advice at any time if this is required.

For Lancashire CSC a single point of access form is completed and for Cumbria CSC Strata via Lorenzo link is used.

Making a Referral to Children's Social Care (sharepoint.com)

Other local authorities can be found via the internet search facility.

Where it is known that Children's Social Care are already actively involved with the child, concerns should be referred directly to the child's social worker or their team manager or, in the absence of both, the Emergency Duty Officer.

4.25 "Who do I tell" Guidance / Patient Safety Incidents

The "Who do I Tell" is a practical tool to aid staff when considering and making a referral to safeguard or protect children and young people, or sharing of information with partner agencies. The latest version can be found on the Trust Procedural Document Library (see Section 6 for link).

4.26 Safeguarding Huddle

The concept of safety huddles is an established part of provision of high-quality clinical care within UHMBFT NHS FT. The Trust is committed to continuous learning and service improvement and acknowledges that systematic review of safeguarding incidents reported by frontline teams is crucial in delivering public protection within the Morecambe Bay heath footprint. This also facilitates and provides assurance of quality public protection.

This operating procedure focuses on ensuring that the mechanisms for reviewing safeguarding incidents are effective in protecting patients from harm and promotes partnership working with other statutory and voluntary agencies that UHMBFT NHS FT engages with. As well as the safeguarding daily huddle, high risk incidents are discussed at the daily triage of incidents meeting.

Refer to **"Safeguarding Safety Huddle Teleconference"** SOP on the Trust Procedural Document Library (see Section 6 for link).

4.27 Local Safeguarding Children's Partnerships formerly known as Local Safeguarding Children Boards (LSCB)

Working Together to Safeguard Children (2018)[1] state that "organisations and agencies should have in place arrangements that reflect the importance of safeguarding and promoting the welfare of children."

The Lancashire Safeguarding Assurance Partnership[2] and The Cumbria Safeguarding

Children Partnership[3] have a range of roles and statutory functions including developing local safeguarding policy and procedures and scrutinising local arrangements.

The objectives of the safeguarding children's partnerships are set out in Section 14 of the Children Act (2004)[4] and are:

- To co-ordinate what is done by each person or body represented on the partnership for the purpose of safeguarding and promoting the welfare of children, and;
- To ensure the effectiveness of what is done by each such person or body for these purposes.

Safeguarding children's partnerships also monitor and evaluate the effectiveness of training.

NHS Trusts have representatives on these partnerships and for UHMBFT there are two partnerships, Lancashire Safeguarding Assurance Partnership[2] and Cumbria Safeguarding Children Partnership[3].

4.28 Child Safeguarding Practice Reviews (formerly known as Serious Case Reviews)

Where a local authority in England knows, or suspects, that a child has been abused, neglected, or the child dies, (including suspected suicide) or is seriously harmed in the local authority's area, while normally resident in the local authority's area, the child dies or is seriously harmed outside England, the local authority must notify the Child Safeguarding Practice Review Panel within 5 working days of becoming aware that the incident has occurred.

Locally, safeguarding partners must make arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area. They must oversee the review of those cases, where they consider it appropriate for a review to be undertaken.

Individual practitioners may be required to participate and share learning at practice reviews and will be supported by the safeguarding team.

GOV.UK Report a serious child safeguarding incident[39]

4.29 Confidentiality, Information Sharing and Record Keeping

Working Together[1] (2018) states "Effective sharing of information between professionals and local agencies is essential for effective identification, assessment and service provision and to keep children safe".

Sharing information in cases of concern about children's welfare will enable professionals to consider jointly how to proceed in the best interests of the child and to protect children generally. Often, it is only when information from a number of sources has been shared and is then put together that it becomes clear that a child is at risk or suffering harm.

Practitioners often feel confused by different legislation relating to confidentiality and

information sharing. The non-statutory guidance Information Sharing[20] provides further advice to improve practice by giving clear guidance on when and how to share information legally and professionally.

All practitioners have a duty to be aware of their responsibilities from the General Data Protection Regulations (GDPR), (2018)[40], the Human Rights Act (1998)[9] and the Common Law Duty of Confidentiality and Caldicott Principles.

*The General Data Protection Regulation (GDPR) is a Europe-wide law that came into force on 25 May 2018. It is part of a wider package of reform of data protection in the UK that replaces the Data Protection Act (1998). It applies to those responsible for controlling and processing personal data, including general practices and health organisations.

4.30 What are the Key Changes?

While the key principles of the original legislation remained unchanged, the new regulation strengthens the rights of individuals ('data subjects') to request access to their personal data and tightens up data security and accountability. It will not be enough for NHS and other public bodies to comply - compliance must be 'actively demonstrated'. There are new legal requirements to report data breaches that pose a risk to subjects' rights, normally within 72 hours, and potentially higher financial penalties for breaches and non-compliance. Patients should be able to access their records free of charge in most cases.

All staff and practitioners must protect all confidential information concerning patients and clients obtained in the course of their professional practice and abide by their professional codes of conduct. Disclosures should only be made with consent, where required by order of the Court, where justification of disclosure is in the wider public interest or where there is an issue of child protection and sharing information is in the best interests of the child. "Wider public interest" means the interests of an individual or groups of individuals or of society as a whole, and would, for example, cover matters such as serious crime, child abuse, drug trafficking or other activities, which place others at risk.

Sharing of information is vital for early intervention to ensure that children with additional needs get the services they require. It is also essential to protect children from suffering harm from abuse and neglect. It is essential that all practitioners understand when, how and why they should share information.

The Data Protection Act (2018)[41] is the UKs implementation of the general data protection regulation (GDDR).

- Remember that the GDPR is not a barrier to sharing information, but provides a framework to ensure that personal information about living persons is shared appropriately.
- Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
- Seek advice, if you are in any doubt, without disclosing the identity of the person where possible.
- Share with consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share

information without consent if, in your judgement, that lack of consent can be overridden in the public interest. You will need to base your judgement on the facts of the case.

- Consider safety and wellbeing. Base your information sharing decisions on considerations of the safety and wellbeing of the person and others who may be affected by their actions.
- Necessary, proportionate, relevant, accurate, timely and secure. Ensure that then information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion and is shared securely.
- Keep a record of your decision and the reasons for it, whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

Good record keeping is essential and must reflect the voice of the child or young person. Records must be clear and comprehensive and meet all local and professional record keeping standards. All entries must be legible, dated, timed and signed in both electronic and paper records.

All discussions with other agencies and with the child and family must be documented. The names of responsible professionals must be clearly recorded. All records which relate to safeguarding must be included on Lorenzo and or in the paper records.

Refer to the **"Information Governance Policy and Framework"** on the Trust Procedural Document Library (see Section 6 for link).

4.31 Consent and Confidentiality

When deciding whether there is a need to share information there must be consideration as to whether the information is confidential, and if it is, whether there is a public interest sufficient to justify sharing. Confidential information can be shared if the person to whom it relates gives consent. However, where sharing of confidential information is not authorised, you may lawfully share it if this can be justified in the public interest. Seeking consent should be the first option if appropriate.

The child's best interests must be the overriding consideration in making any such decision on sharing information. The key factor on deciding whether or not to share confidential information without consent is proportionality, i.e. is the information you wish to, or are asked to share, a balanced response to the need to safeguard a child? In making the decision you must weigh up what might happen if the information is shared against what might happen if it is not, and make a decision based on a reasonable judgement.

4.32 Adoption Records

When a child is formally adopted, a new NHS number is given to the child. If UHMBFT is aware of the adoption and the Trust has the previous record (electronic or paper) for this child, the previous records need to be summarised by midwifery or lead paediatrician and filed in the new record. Once summary has been completed, all previous records need to be sealed, and previous NHS number or hospital number cross referenced.

4.33 Pre-Adoption – Obstetrics and Midwifery Information

When a child is placed for adoption, Children's Social Care will request completion of pre-adoption obstetrics and midwifery care documents. These requests will come via the Safeguarding team electronically and forms will be forwarded to Community Midwife for completion and an electronic copy is kept by the Safeguarding Team.

4.34 Differences of Opinion between Professionals

Safeguarding is everyone's business so if any member of staff still feels there is a safeguarding concern after discussing with a senior colleague who does not feel the same way, the member of staff is still entitled to make a referral and should be supported to do so.

Referral is not solely a senior management decision or responsibility. Clinical and safeguarding advice is accessible at all times via the duty paediatrician. All practitioners working with children and families should be familiar with and follow the Trust's procedures and protocols for promoting and safeguarding the welfare of children and know who to contact to express concerns about a child's welfare.

Both Cumbria and Lancashire have procedures.

- Cumbria Conflict Resolution Policy[42]
- Lancashire Resolving Professional Disagreements guidance[43]

4.35 Attendance at Strategy/ Discussion/ Multidisciplinary Meeting

A strategy discussion or meeting takes place when there is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm and will often take place before or following the child's admission. They may take place on Trust premises, by Microsoft teams and can be at short notice. Attendance is required by those caring for the individual or leading on the case supported by Safeguarding team. It is best practice that a multiagency strategy meeting takes place before any examination of a child suspected to have been caused harm. All strategy discussions and meetings must be recorded electronically using the safeguarding tab or in clinical notes. In some cases, it may be necessary to have a follow-up meeting to establish how the investigation is progressing, for example in the case of suspected fabricated and induced illness.

4.36 Medical Reports following Medical Examinations for Suspected Abuse

Following a medical examination, the doctor should provide a written report of their findings for the agency requesting the examination. The report should normally be provided to relevant agencies within 10 working days for non-urgent cases. Best practice would suggest that this is shared with the Named Doctor prior to distribution. If urgent, by mutual arrangement between doctor and partner agency, report to be completed on the

same day. Copies should be made for the child's family doctor, Named Nurse and Named Doctor and a copy uploaded electronically onto Lorenzo. In addition, signed originals are forwarded to Social Worker and Police.

A doctor wishing to attend the initial child protection conference should state this wish in the report so that their availability is taken into consideration in arranging the meeting.

Template of proforma can be found in the UHMBFT Safeguarding intranet
https://nhscanl.sharepoint.com/sites/Safeguarding
BLANK REPORT.docx (sharepoint.com)

4.37 Attendances at Case Conferences

The contribution of UHMBFT to safeguarding children is invaluable and priority should be given to attendance wherever possible. All children, young people and adults with parental responsibilities attendances at UHMBFT are shared with health partners therefore actual attendance at case conferences would be minimal as information would be shared by these partner agencies.

A written report will be made available at specific request of independent reviewing officer.

The author of any case conference report is required to attend and, in some circumstances, it may be required that a Paediatric Consultant also needs to attend, with support from safeguarding team.

The report should provide details of the UHMBFT involvement with the child and family, and their assessment of the capacity of the parents to meet the needs of their child within their family and environmental context.

http://panlancashirescb.proceduresonline.com/chapters/p_initial_cp_conf.html
http://www.cumbrialscb.com/professionals/childprotectionconferences.asp

The report must make it clear the distinction between fact, observation, allegation and opinion. When information is provided from another source, this should be made clear. It is good practice that the report is shared with the family prior to conference.

Attendances at case conferences/core group meetings must be documented in the Childs health record to be completed by the practitioner on return to base on the day of the meeting or the next working day (NMC Code of Conduct, 2015)[44]. If individual practitioners are unable to attend, staff must inform the Safeguarding team.

4.38 Police Interviews, Access to Patient Records and Care Proceedings

Police interviews with UHMBFT staff witnesses for child protection investigations should be arranged to take place in normal working hours on UHMBFT premises. Staff must not give statements/interviews without the prior knowledge of the Safeguarding Team. In the absence of UHMBFT Safeguarding Team, a manager should be present at all police interviews of UHMBFT staff.

The police do not have the right to access patient records, although they can obtain a right to information by virtue of a DP1 application to medical records department. However, if it would hinder police enquiries or place the child, family or staff at risk the Trust may permit access to records. If the Trust decides to release information, the specific reason for this must be documented on Lorenzo, to defend any later allegation of breach of confidentiality.

4.39 Care Proceedings

Occasionally staff will be requested to produce a report or copy of records, or both in connection with care proceedings. When a child is subject to care proceedings, the judge overseeing the proceedings will produce a Court Order detailing what is required of the practitioners. These requests should be made via the safeguarding office by email from the local authority legal team.

The UHMBFT Safeguarding team email address is safeguarding@mbht.nhs.uk

Colleagues will be requested to produce a report supported by their line manager or a member of the safeguarding team. Reports will then be sent via the safeguarding team. Very rarely you may be requested to attend court in connection with care proceedings. Colleagues may then be asked to attend by the judge or you may receive a court summons.

You will be supported in attendance to court by the Trust, either by your line manager, the Trust legal team or the safeguarding team.

Report template can be found here: Template for court report.docx (sharepoint.com)

4.40 Safeguarding Training

Safeguarding competences are the set of abilities that enable staff to effectively safeguard, protect and promote the welfare of children and young people. They are a combination of skills, knowledge, attitudes and values that are required for safe and effective practice. These are governed by the Safeguarding Intercollegiate Document (2019)[45].

Different staff groups require different levels of competence depending on their role and degree of contact with children, young people and families, the nature of their work, and their level of responsibility.

Please read in conjunction with the Safeguarding Training Matrix.

Safeguarding training is mandatory and is an individual responsibility to ensure that they remain updated. This is monitored through annual appraisals and the Trust TMS (Training Management System).

Refer to Safeguarding Intranet Training Matrix (sharepoint.com) for training requirements for each staff group.

4.41 Supervision

“Supervision is the cornerstone of good practice and should be seen to operate effectively at all levels of the organisation” – Lord Laming, (2003)[16]

Working Together to Safeguard Children (2018)[1] page 32, states “effective professional supervision can play a critical role in ensuring a clear focus on a child’s welfare. Supervision should support professionals to reflect critically on the impact of their decisions on the child and their family”.

See **“Safeguarding Supervision”** Policy on Trust Procedural Document Library (see Section 6 for link).

4.41.1 Clinical Supervision

“Clinical Supervision is a term used to describe a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and to enhance consumer protection and the safety of care in complex clinical situations” Clinical supervision in nursing and midwifery, (Department of Health,1993,[51] Chilvers & Ramsey, 2009).[52] Clinical Supervision is not within the scope of this policy.

4.41.2 Safeguarding Supervision

Safeguarding supervision is more focused in its approach and is concerned with issues to support staff members to ensure that they are competent to safeguard and promote the welfare of children.

Supervision for practitioners is an essential component for maintaining safe and effective practice. Organisations should ensure that a robust supervision model is available to all frontline staff and first line managers. Within UHMBFT safeguarding supervision is provided by the named nurse/midwife, safeguarding team and specially trained Safeguarding Children Supervisors. Supervision involves elements of reflection and case management and is available to all Trust staff either on a one-to-one basis or in a group setting. Safeguarding Supervision.docx

4.42 Allegations against Healthcare Staff

It is important that all adults working with children understand that the nature of their work and their responsibilities related to it, place them in a position of Trust.

Guidance for Safer Working Practice for Adults who work with Children and Young People (2019)[46] provides clear advice on appropriate and safe behaviours for all adults working with children in paid or unpaid capacities in all settings and contexts.

When information has been received about a staff member’s actions or behaviour regarding a child, it is important that a decision is made about whether the information should be treated as an allegation or a complaint.

If this decision is not obvious then it should be made by the Line Manager in consultation with the Human Resources (HR) Manager and the Head of Safeguarding and Professional Lead, Named Nurse Safeguarding Children, Named Midwife or Named Nurse for Adults.

There may be three strands of an investigation:

- A police investigation of a possible criminal offence.
- Enquiries and assessment by Social Services about whether a child is in need of protection or services.
- An employer's investigation which could lead to disciplinary action.

As these cases tend to be complex, it is not unusual for all three strands to be involved in one case and good information sharing can ensure appropriate safety and decision making.

As soon as an allegation is made this should be reported to the Executive Director of Nursing who will ensure an appropriate investigation and will liaise with HR regarding potential suspension from work.

Procedures need to be applied with common sense and judgement. Some allegations will be so serious that they require immediate referral to children's social care and the police for investigation. It is important to ensure that even less serious allegations are followed up and are examined objectively by someone independent of the organisation concerned.

The allegation must also be reported to the Local Authority Designated Officer (LADO) within 1 working day.

It must be noted that allegations may not be in connection with the individuals work and may be in relation to their home or other circumstances. This does not remove the obligations described above and it is incumbent upon the Trust as an employer to ensure that their staff are fit and proper persons to carry out their paid responsibilities.

Please refer to **'Managing Allegations Against Staff'** policy on Trust Procedural Document Library (see Section 6 for link).

4.43 Individuals who Pose a Risk to Children

Any person identified as posing a risk to children should have had an assessment completed about the risks they pose; this information may or may not be known to health professionals.

If a member of staff becomes aware that an individual may pose a risk to children and is having contact with children, a referral should be made via safeguarding asking that an up-to-date risk assessment is completed. You must include details about any child who you are aware the person is having contact with.

The Multi Agency Public Protection Arrangements (MAPPA)[47] Multi Agency Risk Evaluation (MARE) enables agencies to work together within a statutory framework to manage the risk of harm to the public. Its focus is on specified sexual and violent offenders in and returning to the community.

MAPPA/MARE hold regular meetings to share information, assess and manage risk, and UHMBFT is represented by Local Security Management Specialist (LSMS) who will share relevant information within the Trust.

Refer to **"Multi-Agency Public Protection Arrangements / Multi-Agency Risk Evaluation (MAPPA/MARE) Pathway**

4.44 Dissemination and Implementation

It is expected that the policy will be fully operational by the dates identified. Each Care Group is responsible for ensuring full implementation of the policy and for monitoring its use within the organisation; this includes ensuring that staff are trained according to the training requirements of the policy.

5. ATTACHMENTS		
Number	**Title**	**Separate attachment**
1	Management of Perplexing Presentation and Fabricated Induced Illness - Plan on a Page	N
2	Values and Behaviours Framework	N
3	Equality & Diversity Impact Assessment Tool	N

6. OTHER RELEVANT / ASSOCIATED DOCUMENTS The latest version of the documents listed below can all be found via: Trust Procedural Document Library intranet homepage.	
Unique Identifier	**Title and web links from the document library**
Corp/Pol/112	Freedom to Speak Up.docx
Corp/Proc/053	VIP and Celebrity Visits.docx
Obs/Gynae/Pol/004	Operational Policy for Children.docx
Corp/Proc/046	Domestic Abuse - Guidance and Procedures for Asking about and Responding to Domestic Abuse.docx
Corp/Pol/096	Section 5(2) - Completion, Receipt and Scrutiny of Mental Health Act Section Papers.docx
Corp/Pol/116	Acceptable Use Policy for Information Communication and Technology (ICT) Systems and Equipment.docx
Corp/Plan/026	PREVENT Strategy Implementation Plan.docx
Corp/Proc/081	Interpretation Service and Document Translation Procedure.docx
Corp/SOP/077	Safeguarding Operational Arrangements at UHMBT.docx
Corp/Pol/014	Information Governance Policy and Framework.docx
Corp/Proc/015	Managing Allegations Against Staff and Volunteers.docx
Cumbria MAPPA/MARE Pathway Document	Multi-Agency Public Protection Arrangements - Multi-Agency Risk Evaluation (MAPPA-MARE) Pathway [CPFT].pdf

7. SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS	
If 'Yes', full references are shown below:	
No.	**References**
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8. DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	**Definition**
CSE - Child Sexual Exploitation	Child Sexual Exploitation (CSE) is a form of child sexual abuse. CSE occurs where an individual or group takes advantage of a power imbalance to coerce, manipulate or deceive a child under the age of 18 years into sexual activity. DfE (2017) Child sexual exploitation: definition and guide for practitioners. Available from: https://www.gov.uk/government/publications/child-sexual-exploitation-definition-and-guide-for-practitioners (accessed 15/02/22)
CCE – Child Criminal Exploitation	Child Criminal Exploitation is a form of child abuse where an individual or group takes advantage of a power imbalance to coerce, control, manipulate or deceive a child under the age of 18 into any criminal activity.
FII - Fabricated Induced Illness	FII is a clinical situation in which a child is, or is very likely to be, harmed due to parent(s) behaviour and action, carried out in order to convince doctors that the child's state of physical and/or mental health and neurodevelopment is impaired (or more impaired than is actually the case). FII results in physical and emotional abuse and neglect, as a result of parental actions, behaviours or beliefs and from doctors' responses to these. The parent does not necessarily intend to deceive, and their motivations may not be initially evident
PP - Perplexing Presentation	The term Perplexing Presentations (PP) has been introduced to describe the commonly encountered situation when there are alerting signs of possible FII (not yet amounting to likely or actual significant harm16), when the actual state of the child's physical, mental health and neurodevelopment is not yet clear, but there is no perceived risk of immediate serious harm to the child's physical health or life. The essence of alerting signs is the presence of discrepancies between reports, presentations of the child and independent observations of the child, implausible descriptions and unexplained findings or parental behaviour. https://childprotection.rcpch.ac.uk/resources/perplexing-presentations-and-fii/
CLA – Child Looked After	Children described as 'Children Looked After' include children in foster or residential homes and those who still reside with their parents but are subject to a Care Order. This is a legal arrangement in the UK for local Children's Services to look after the child. It also includes children who are temporarily looked after for respite on an emergency or planned basis.
PR – Parental Responsibility	Parental responsibility is defined in the Children Act (2004)4 as being the rights, duties, powers, responsibilities and authority which by law a parent has in relation to a child and its property. The term attempts to focus on the parents' duties rather than rights over their child. In health care it includes consent to medical treatment.
FGM – Female Genital Mutilation	Female Genital Mutilation is a collective term for procedures which include the removal of part or all of the external female genitalia for cultural or other non-therapeutic reasons. FGM is a form of child abuse.
CDOP – Child Death Overview Panel	Child Death Overview Panels (CDOP) are multi-agency groups responsible for reviewing all child deaths nationally. The local panels are sub groups of the safeguarding children's partnerships.

8. DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	**Definition**
SUDIC – Sudden Unexpected Death in Infancy and Childhood	When a child dies, families desperately need to know what happened. To understand why an infant died, it is vital agencies work together, share information and keep families included at every stage. These guidelines were published in November 2016 by a multi-agency working group convened by the Royal College of Pathologists (RCPath) and Royal college of Paediatrics and child Health RCPCH.

9. CONSULTATION WITH STAFF AND PATIENTS

Enter the names and job titles of staff and stakeholders that have contributed to the document

Name/Meeting	Job Title	Date Consulted
Sarah Whitaker	Clinical Nurse Specialist Safeguarding	November 2021
Kath Gardner	Clinical Nurse Specialist Safeguarding	November 2021
Mark Lippett	Head of Safeguarding & Professional Lead	January 2022
Liz Thompson	Deputy Head of Safeguarding	January 2022
Jane Heath	Named Midwife Safeguarding Children	January 2022
Sharon Hilton	Named Nurse Safeguarding Children	January 2022
Maureen Huddleston	Named Nurse Children Looked After	January 2022
Sarah Wright	Named Nurse Safeguarding Adults	January 2022
Amy Davies	Clinical Nurse Specialist Safeguarding	January 2022
Carla Clarke	Clinical Midwife Specialist Safeguarding	January 2022
Sharon Taylor	Clinical Nurse Specialist Safeguarding	January 2022
Care Group	Children & Young People	January 2022
Care Group	Midwifery	January 2022
Care Group	Medicine	January 2022
Care Group	Surgery	January 2022
Care Group	Core Clinical	January 2022
Care Group	Workforce	January 2022
Care Group	Estates & Facilities	January 2022
Care Group	Community Care Group	January 2022

10. DISTRIBUTION & COMMUNICATION PLAN	
Dissemination lead:	Named Nurse Named Nurse Safeguarding Children
Previous document already being used?	Yes
If yes, in what format and where?	Electronic version on Trust Procedural Document Library
Proposed action to retrieve out-of-date copies of the document:	• Replace document on the Trust Intranet – Policy Library. • Email key staff to remove or update any printed copies.
To be disseminated to:	
Document Library	
Proposed actions to communicate the document contents to staff:	Include in the UHMBFT Weekly News – New documents uploaded to the Document Library

11. TRAINING

Is training required to be given due to the introduction of this procedural document? **Yes**

If 'Yes', training is shown below:

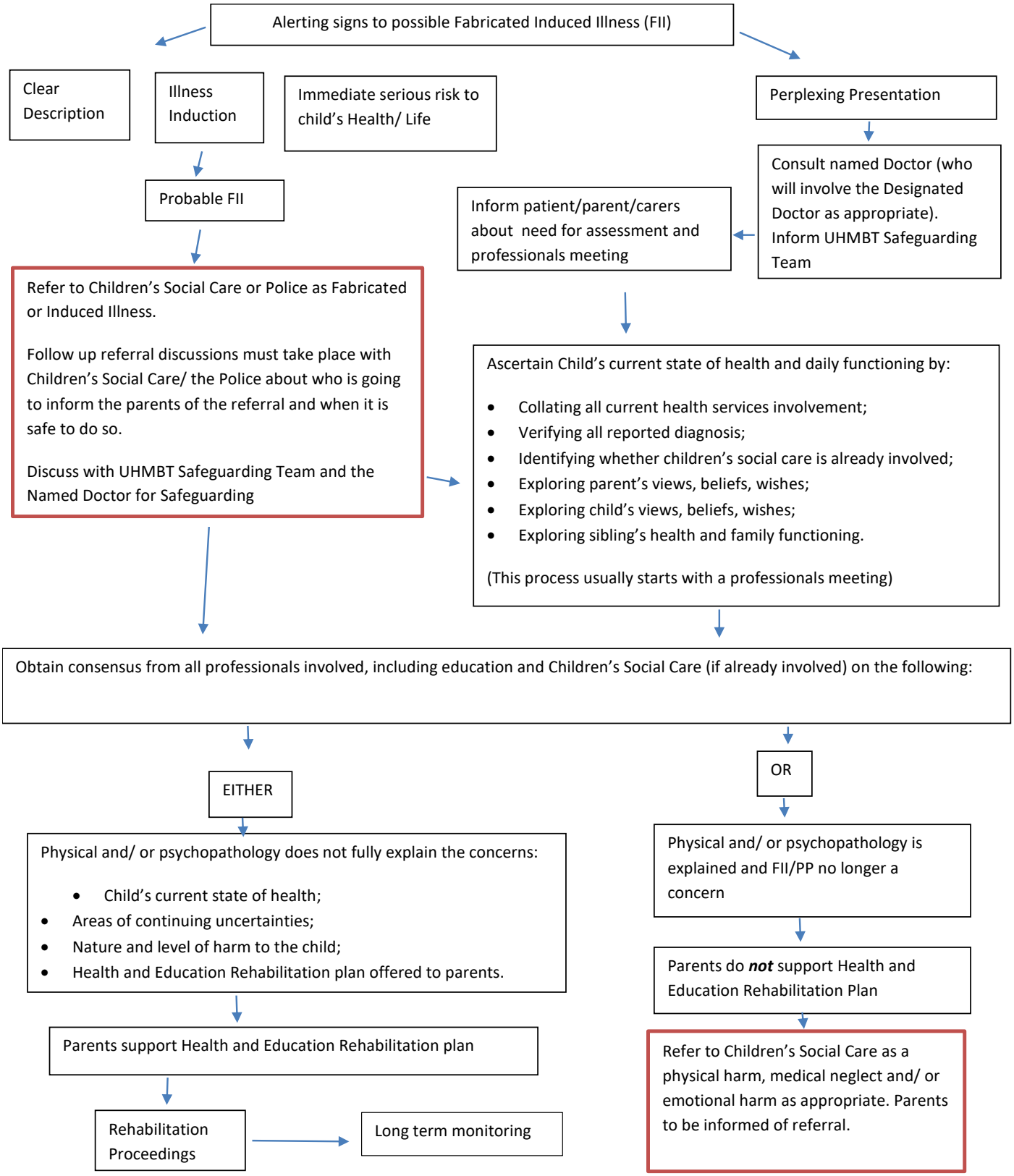
Action by	Action required	To be completed (date)
	UHMBFT safeguarding training follows that of the guidance in intercollegiate Document 2014 at the: https://www.rcpch.ac.uk/sites/default/files/Safeguarding_Children_-_Roles_and_Competences_for_Healthcare_Staff._Third_Edition_March_2014.pdf and has been updated following the publication of Working Together 2018.	Ongoing

12. AMENDMENT HISTORY

Version No.	Date of Issue	Page/Selection Changed	Description of Change	Review Date
			Revision due to changes in national and local safeguarding procedures	01/02/2018
18.1	04/10/2017	Page 4	BSF page added	01/06/2018
18.2	12/07/2018		Review date extended (form 08/09/2018)	01/10/2018
18.3	05/09/2018 02/10/2018	Section 4.5 Section 7 Section 4.2.2 Section 4.3.14 Section 4.8.1 Section 4.3.34	Reference to Data Protection Act updated Integrated Care Board (ICB) Asylum Seekers Individuals Who Pose a Risk to Children Clinical Supervision Removed 'Who to Tell' Guidance/ Patient Safety Incidents	01/10/2018
19	12/11/2018	Section 4.4.1 Section 4.4.2	Updated: Serious Case Reviews (SCR). Removed: Individual Management Reviews	01/08/2021
19.1	21/08/2019	Section 4.3.27	Changed PCAS to UTC	01/08/2021
20	22/03/2022	Summary	Added child's voice.	01/08/2024
		4.1	Policy statement, S40 Children's Act removed. Added the Children Act, Equality Act, Working together, Child and Social Work Act and Human Rights Act.	

12. AMENDMENT HISTORY				
Version No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**
		4.2	Added child's voice.	
		4.2.9	Refreshed to reflect current responsibilities	
		4.2.10	Added up to date guidance from GMC and refined advice.	
		4.2.12	Added child death processes to reflect current practice	
		4.2.13	Highlighted use of the Safeguarding Tab.	
		4.2.14	Added use of safeguarding tab for documentation	
		4.3.2	Further clarity added to the definition of a child.	
		4.4.6	Added to reflect changes in national definitions	
		4.5	Sub title changed to reflect generic mental health content	
		4.7	Amended to reflect most up to date terminology following RCPCH guidance	
		4.16	New sub heading to cross reference with adult policy	
		4.18	Cross referenced to Child Abduction Policy.	
		4.22	Cross referenced to occupational health support available	
		4.23 and 4.24	Changed to reflect new model of working in LCC.	
		4.27 and 4.28	Title changes to reflect external changes.	
		4.34	Links changed to reflect external processes	
		4.35	Teams added to reflect new ways of working	
		4.36	More concise guidance	
		4.5.5	Removed as no longer relevant.	
20.1	16/03/2023	Throughout	Clinical Commissioning Group (CCG) replaced by Integrated Care Board (ICB)	01/08/2024
20.2	17/04/2023	4.7	Perplexing Presentation and Fabricated Induced Illness local guidance embedded and Appendix 1 added	01/08/2024

Appendix 1: Management of Perplexing Presentation and Fabricated Induced Illness - Plan on a Page



Appendix 2: Values and Behaviours Framework

To help create a great place to work and a great place to be cared for, it is essential that our Trust policies, procedures and processes support our values and behaviours. This document, when used effectively, can help promote a positive workplace culture. By following our own policies and with our **ambitious** drive we can cultivate an **open, honest and transparent culture** that is truly **respectful and inclusive** and where we are **compassionate** towards each other.

Appendix 3: Equality & Diversity Impact Assessment Tool

University Hospitals of Morecambe Bay NHS Foundation Trust

Equality Impact Assessment Form

Department/Function	Safeguarding	
Lead Assessor	Mark Lippett Head for Safeguarding & Professional Lead	
What is being assessed?	Safeguarding Children Policy	
Date of assessment	22:03:2022	
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Network for Inclusive Healthcare?	NO
	Staff Side Colleague?	NO
	Service Users?	NO
	Staff Inclusion Network(s)?	YES
	Personal Fair Diverse Champions?	NO
	Other (including external organisations): Circulated through agenda as part of the Safeguarding Operational Performance Group as an updated policy including MBCCG	

1) **What is the impact on the following equality groups?**

Positive:	**Negative:**	**Neutral:**
➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups	➢ Unlawful discrimination / harassment / victimisation ➢ Failure to address explicit needs of Equality target groups	➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged

Equality Groups	**Impact** (Positive / Negative / Neutral)	**Comments** ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?
Race (All ethnic groups)	Neutral	
Disability (Including physical and mental impairments)	Neutral	
Sex	Neutral	
Gender reassignment	Neutral	
Religion or Belief	Neutral	
Sexual orientation	Neutral	
Age	Neutral	
Marriage and Civil Partnership	Neutral	
Pregnancy and maternity	Neutral	
Other (e.g. carers, veterans, people from a low socioeconomic background,	Neutral	

people with diverse gender identities, human rights)		

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	The policy promotes the rights of children and young people and acknowledges national and local changes in relation to equality and diversity. It positively promotes the equality and diversity and children's rights of particular groups such as Children with disabilities and those who may be Children Looked After

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**

- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
- This should be reviewed annually.

Action Plan Summary

Action	**Lead**	**Timescale**

This form will be automatically submitted for review once approved/noted by Trust Procedural Document Group.
For all other assessments, please return an electronic copy to EIA.forms@mbht.nhs.uk once completed.