University Hospitals of Morecambe Bay
NHS Foundation Trust

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Which Principles of the NHS Constitution Apply? 1-7	**Which Staff Pledges of the NHS Constitution Apply?** 1,2,3,7

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? Yes / No * Please delete as appropriate

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"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 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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BEHAVIOURAL STANDARDS 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 workplace culture that values the contribution of everyone, shows support for staff as well as patients, recognises and celebrates the diversity of our staff, shows respect for everyone and ensures all our actions contribute to safe care and a safe working environment - all of which are principles of our Behavioural Standards Framework.

Behavioural Standards Framework – Expectations 'at a glance'

1. SUMMARY

Working Together 2018[1] states “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[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. It is everyone’s responsibility.

Working Together[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”.

2. PURPOSE

The purpose of this policy is to guide practice and ensure that the Trust fulfils its responsibilities.

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

Lancashire LSCB[2]: http://www.lancashiresafeguarding.org.uk/
Cumbria LSCB[3]: http://www.cumbrialscb.com/professionals/policies.asp

The use of this policy will:

- Be a child-centred approach: for services to be effective they should be based on a clear understanding of the needs and views of children.
- Ensure that all staff are aware of their duties to safeguard children from abuse and neglect.
- Ensure staff are aware of what constitutes child abuse and have recognition of the key indicators.
- Ensure that all professionals share appropriate information in a timely manner and understand the need to discuss concerns about a child with colleagues and social care as appropriate.
- 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 Childrens Services.
- Set out the training requirements for staff.

3. SCOPE

This policy applies to all staff working for UHMBFT and agents of other employers providing healthcare on behalf of the Trust, including:

- All UHMBFT staff
- All staff seconded to UHMBFT
- All students/trainees working on Trust premises
- All volunteers, locum and agency staff working on UHMBFT premises

NB This includes all those who come into contact with children and families in their everyday work even 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 (UHMBFT) 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 reinforced through;

- 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]

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 (e.g. National Service Framework (DHSC 2004)[10], CCG Contractual Standards Safeguarding Children[11], CQC Outcome 7)[12], Every Child Matters (HM Treasury 2003)[13].

4.2 Duties and Responsibilities

Effective safeguarding systems are child centred.

The policy will ensure:

- Clear priorities for safeguarding and promoting the welfare of children are explicitly stated in strategic policy documents.
- A clear commitment by senior management to the importance of safeguarding and promoting children's welfare.

- A clear line of accountability within the organisation for work in safeguarding and promoting the welfare of children.
- 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 against members of staff and volunteers.
- Arrangements to ensure that all staff undertake appropriate training to equip them to carry out their responsibilities effectively, and keep this up to date by refresher training at regular intervals; and that all staff, including temporary staff and volunteers who work with children are made aware of the establishment's arrangements for safeguarding and promoting the welfare of children and their responsibilities for them.

Policies are in place for safeguarding and promoting the welfare of children, including a child protection policy, and procedures that are in accordance with guidance from the local authority and locally agreed inter-agency procedures:

- Arrangements are in place to work effectively with other organisations to safeguard and promote the welfare of children, including arrangements for sharing information.
- A culture of listening to and engaging in dialogue with children – seeking their views in ways appropriate to their age and understanding, and taking account of those both in individual decisions and the establishment or development of services.
- 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).*

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, provide support. This includes understanding risk factors, communicating effectively with children and families, liaising with other agencies, assessing needs and capacity, responding to those needs and contributing to multi-agency assessments and reviews.

4.2.2 Clinical Commissioning Groups (CCGs)

CCGs will be 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 is statutorily 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 (2018)[1]
- Ensuring liaison as appropriate with the Designated Doctor and Designated Nurse appointed by the CCG.
- 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 staff 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 LSCB and Cumbria LSCB sub-committees.

4.2.6 Director of Nursing (In Hospital Services) Clinical Lead for Inclusion and Diversity

Acts as the portfolio holder for Safeguarding and carries out the duties of the Executive Chief Nurse.

4.2.7 Human Resources/Director/Department

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 staff and volunteers.
- Procedures for dealing with allegations of abuse against members of staff and volunteers are in place.

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 staff work within the remit of the policies. It is important that Care Group Managers ensure all their staff are appropriately trained and 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:

- 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 standards and advise the Director of Nursing and Quality and the appropriate Care Group teams on safeguarding concerns.

4.2.10 Medical Staff

As stated in the Laming Recommendations (2003)[14], hospital doctors are expected to adhere to the following:

- All doctors must be aware of the Trust safeguarding policies and procedures.
- All doctors working in Emergency Department and those working with children and young people must be able to recognise abuse and be familiar with local procedures for making enquiries to find out whether a child is subject to a child protection plan.
- When concerns about the deliberate harm of a child have been raised or if staff are worried about a child's welfare, enquiries should be made to find out if the child is subject to a child protection plan.
- For all children with suspected or actual abuse and/or neglect, a full paediatric assessment by a senior paediatrician must be completed and documented using the Child Protection Proforma available in the UHMB Safeguarding intranet site http://uhmb/cs/safeguarding/Pages/default.aspx

- When a doctor has examined a child and concerns about deliberate harm have been raised, no subsequent appraisal of these concerns should be considered complete until each concern has been fully addressed, accounted for and documented.
- The investigation and management of a case of deliberate harm to a child must be approached in the same systematic and rigorous manner as would be appropriate to the investigation of any other potentially fatal disease.
- If abuse is suspected or confirmed, an immediate telephone referral must be made to Children's Social Care. This should be followed up with a written referral within 24 hours.
- When a referral has been made to Children's Social Care about suspected abuse, the child must not be discharged without a full multi-agency discussion or agreement of the social worker in charge of the case. This discussion must be fully documented in the child's notes. The safeguarding team should be informed of all children seen within ED or Paediatric areas where there are child protection concerns. http://uhmb/cs/safeguarding/Process%20and%20Flowcharts/Children's%20Who%20to%20Tell%20v8.pdf
- When a child is admitted to hospital with concerns about deliberate harm, a clear decision must be taken as to which consultant is to be responsible. This must be

clearly documented in the child's notes.

- No child about whom there are child protection concerns should be discharged at any time without the permission of the consultant in charge of the child's care.
- All doctors involved in the care of a child about whom there are concerns about possible deliberate harm must provide Children's Social Care with a written statement of the nature and extent of their concerns. If misunderstandings of medical opinion or diagnosis occur, these must be corrected at the earliest opportunity in writing. It is the responsibility of the doctor to ensure that his or her concerns are properly understood. It is advisable that the report is shown to the Named Doctor for Safeguarding Children before submitting to Children's Social Care.
- When a child is admitted to hospital and deliberate 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).
- When concerns about the deliberate harm of a child have been raised; a record must be kept in the case notes of all discussions about the child, including telephone conversations, ward rounds, any advice from Named Doctor or Nurse.
- During the course of a ward round, when assessing a child where there are concerns about deliberate harm, the doctor conducting the ward round should ensure that all available information is reviewed and taken into account before decisions on the future management of the child's case are taken.
- When differences of medical opinion occur in relation to the diagnosis of possible deliberate harm to a child, a recorded discussion must take place between the persons holding the different views. If after a full discussion the differences are not resolved, this should be escalated upwards and acted upon.
- When the deliberate harm of a child has been raised as an alternative diagnosis to a purely medical one, the diagnosis of deliberate harm must not be rejected without full discussion and, if necessary obtaining a further opinion.
- When deliberate 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 record the child's voice.
- In those cases in which English is not the first language of the child concerned, the use of an interpreter should be considered and commissioned service used. Augmented language tools should be available for children who have no language ability. See page 23.
- Paediatricians should consider contacting GPs or other relevant health personnel to obtain the child's complete medical /social history. The Safeguarding Team should be informed of all children seen within A&E or Paediatric areas where there are child protection concerns.

4.2.11 Named Doctor

The Named Doctor is a named consultant paediatrician who works closely with the named designated doctor(s) for safeguarding and provides clinical advice for UHMBT staff and support for safeguarding and child protection issues.

4.2.12 Named Nurse and Named Midwife

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" staff 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 staff in child protection issues.
- Offering advice on local arrangements within the provider organisation for safeguarding children.
- Providing a key role in promoting, influencing, developing and delivery of relevant training for staff.
- Providing skilled professional input to child safeguarding processes in line with procedures of LSCBs.
- Contribute to reviews undertaken by LSCBs, including Serious Case Reviews (SCR), to be known as Safeguarding Practice Reviews, as appropriate.

Safeguarding Team
Have a key role in promoting good professional practice within UHMBFT and provide elements of the safeguarding children training strategy and safeguarding supervision. The team support the Head of Safeguarding, Named Professionals in providing advice and support regarding all elements of safeguarding children within the Trust and across organisational boundaries.

The safeguarding team ensure that all staff have access to safeguarding children training and supervision appropriate to their role and which enable the organisation to fulfil its statutory responsibilities for training.

4.2.12.1 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 staff they manage attend the mandatory safeguarding training and clinical /safeguarding supervision and review this annually through the Personal Development Review (PDR) process.
- Ensuring that 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 and in their personal development plans.
- Ensuring staff are aware of the supervision policy, including when and how to access supervision.

4.2.13 Nursing/Midwifery Staff/Allied Professionals

The Laming Recommendations (2003)[14] state that hospital nurses and midwives are expected to adhere to the following: also applicable to Allied Professionals at UHMB

- Nurses should be aware of Safeguarding Children and Child Protection Procedures and Trust Policy.
- Nurses working in ED and those working with children and young people should be able to recognise abuse and be familiar with local procedures for making enquiries to find out whether a child is subject to a child protection plan.
- When a nurse suspects that a child has been the subject of deliberate harm; she/he should speak directly to the paediatrician and reach an agreement of what actions will be taken and by whom. Actions should be clearly documented.
- In the event of a doctor not being in agreement with the nurse's concerns, further advice should be sought from the Named Nurse or the Consultant Paediatrician on call.
- When a child is admitted to hospital and deliberate harm is suspected, the nurse admitting the child must enquire about previous admissions to hospital and, following a positive response, obtain the information about that episode of care.
- When a child is admitted to hospital and deliberate harm is suspected, the nursing notes must take full account of this diagnosis.
- When there are concerns that a child has been subject to deliberate harm, a record must be made in the hospital records of 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. In addition, a clear record must be made of who is responsible for carrying out any actions agreed during such conversations.

Duties of all staff

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 works 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.

4.2.14 Security and Communications Teams

The Trust security teams must ensure that they work closely with the Head 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 becomes aware of any individual in the area who may be a risk the security team must be alerted, together with the areas manager and the Named Nurse or Midwife.

4.2.15 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).*

4.2.16 Duties of All Staff

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.

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 is defined under the Children Act (1989)[15] 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.

4.3.3 Child in Need of Protection (Children Act 1989 Section 47)[15]

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. Duty of care held by NHS as a statutory agency to

respond/report concerns to Social Services. 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 Section 17)[15]
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.
- Those who are disabled.

4.3.5 Children Looked After (CLA) includes 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. A significant number of CLA are subject to care orders due to child protection concerns such as neglect or abuse.

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. The Children Act also places a duty of care on the Local Authority to offer services up to the age of 21 years when the young adult has been a "Child Looked After" often referred to as a child in care.

4.3.6 Parental Responsibility (PR) 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.

- The woman giving birth to the child has automatic parental responsibility.
- Both the child's biological parents 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 courtparent. Other examples are:
    - A Care Order or Interim Care Order. Here, the Local Authority shares PR with the mother and any other people with PR.
    - A Residence Order. This grants the applicant PR for the duration of that Order.
- Being appointed as Guardian to a child automatically gives that person PR shared with any other people with PR.
- Being appointed as a Special Guardian to a child 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.
- Adoption, their adoptive parent(s) automatically get PR and the biological parent(s)

will lose PR.

- 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).

4.3.7 Significant Harm is a concept introduced by the Children Act (1989)[15] 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.

4.3.8 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.

See "How to Recognise Abuse" flowchart in the UHMB Safeguarding intranet site
http://uhmb/cs/safeguarding/Pages/default.aspx

4.3.9 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.

Bruising in non-mobile babies and all non-mobile children.
Babies and children who are observed with injuries / bruises must be considered as possible subjects of non-accidental injury and referred for immediate paediatric assessment, (non-mobile children include very young children or children of any age with motor development delays or physical disabilities that restrict mobility).

4.3.10 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.

4.3.11 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.

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

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- 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 "Recognising Neglect" flowchart in the UHMB Safeguarding intranet site http://uhmb/cs/safeguarding/Pages/default.aspx *and the Cumbria*[16] *and Lancashire Neglect strategy*[17]*.*

4.3.13 Child Sexual Exploitation[15a] is child abuse and children and young people who become involved face huge risks to their physical, emotional and psychological health and well-being. Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive "something" (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, attention, gifts, money), as a result of them performing, or others performing on them, sexual act or activities. Child sexual exploitation grooming can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common involvement in exploitative relationships, being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability" for further information see link below:

https://www.gov.uk/government/publications/tackling-child-sexual-exploitation--2[18]

and
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408843/info_sharing_letterv5.pdf[19]

Department of Education (2017)[20] advice on CSE and the new definition is available at:
https://www.gov.uk/government/publications/child-sexual-exploitation-definition-and-guide-for-practitioners

4.3.14 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. It includes the movement of 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 in 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 must be informed.

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 programme.

http://www.uaschealth.org/

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/or the police must be informed.

Modern Slavery

Modern Slavery Act 2015[21] definition: is the recruitment, movement, harbouring 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.

4.3.15 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)[15]. The Home Office and Department of Health working jointly published guidance 'Safeguarding Children Involved in Prostitution'[1] 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.

4.3.16 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.

4.3.17 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[22] 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).

4.3.18 Self-harm
Deliberate self-harm has emerged as a major public health issue. Self-harm refers to any damaging activity that individuals deliberately inflict upon themselves, including cutting, "overdosing" (self-poisoning), hitting, burning or scalding, pulling hair, picking or scratching skin, self-asphyxiation, ingesting toxic substances and fracturing bones. Prevalence figures are bound to understate the true extent of self-harming because it is often kept secret as young people are reluctant to admit to it.

People who deliberately harm themselves should always be taken seriously since this presentation indicates that individuals may have acute or chronic psychiatric disorders or significant psychosocial problems. This applies to young people who are under 16 years old.

Deliberate self-harm may be a key indicator of the existence of a range of serious problems which includes all types of child abuse. Deliberate self-harm may be the route by which child abuse or severe failures of child care come to light. It is important to recognise that

self-harm is not usually triggered by one isolated event but rather a set of circumstances that leave young people overwhelmed and unable to manage their feelings: it is not the core problem but a sign and symptom of underlying emotional difficulties, used as a way of coping.

https://www.nspcc.org.uk/preventing-abuse/keeping-children-safe/self-harm/

Risk factors which may trigger self-harming:

- Being bullied at school.
- Not getting on with parents.
- Stress and worry.
- Parental divorce.
- Bereavement.
- Unwanted pregnancy.
- Experience of abuse in earlier childhood.
- Severe and prolonged sexual abuse is known to lead to a higher incidence of self-harm.
- Difficulties associated with sexuality.
- Problems to do with race, culture or religion.
- Low self-esteem.
- Feeling rejected.

It is clear that treating the physical injuries caused by self-harm in a sensitive and non-judgemental manner is an important first step in encouraging children to engage with support services.

If a child requires assessment under the Mental Health Act 1983[23] this will be made in conjunction with the paediatric consultant and CAMHS team and a referral made to a child psychiatrist.

Please note if following assessment the child is to be detained under the Mental Health Act 1983[23] then a bed needs to be identified at a specialist unit and arrangements made to transfer child immediately.

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 by 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[23]

4.3.19 Female Genital Mutilation (FGM) 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[24] 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[25] which is available on https://www.gov.uk/government/collections/female-genital-mutilation-fgm-guidance-for-healthcare-staff All suspected cases of FGM must be discussed with Safeguarding team.

Female Genital Mutilation - Information Sharing (FGM-IS)

The Female Genital Mutilation - Information Sharing (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 (FGM).

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 UHMB will be able to view FGM-IS.

4.3.20 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, producing symptoms and then presenting the child for medical care, disclaiming knowledge of the cause of the problem. Usually this is with the purpose of obtaining an emotional or psychological benefit.

R*efer to "FII' in the UHMB Safeguarding intranet site process and flowcharts*
http://uhmb/cs/safeguarding/Pages/default.aspx

4.3.21 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).

4.3.22 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).

4.3.23 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. 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).

4.3.24 Forced Marriage is a marriage conducted without the full consent of both parties and where duress is a factor. The Governments Forced Marriage Unit[26] produce guidelines and these are available at https://www.gov.uk/guidance/forced-marriage

4.3.25 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.

4.3.26 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)[15] 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.

4.3.27 Children in Hospital The National Service framework for Children, Young People and Maternity Services (2004)[8] 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)[15] 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.

Children Not Brought for Appointments
When children and young people are not brought to appointments, this can raise safeguarding or child protection concerns. Therefore, within UHMB, children and young people non-attendances is not treated the same as adults, and this procedure has been developed to reflect this. 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

all children and young people receive healthcare. Unfortunately, not all parents have the capacity 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 and submit a Patient Safety Incident (PSI).

http://uhmb/cs/safeguarding/Process%20and%20Flowcharts/DNA%20policy.pdf

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 UHMB, such as emergency departments, PCAS, antenatal clinic. 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

4.3.28 Safe Environment
No child about who there is a safeguarding concern should 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 the child is discharged into a safe place.

Children will be cared for in age appropriate environments. 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.

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.

4.3.29 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 "Accessing Telephone and Face-to-Face Interpretation Services" on Trust Procedural Document Library (see Section 6 for link).

4.3.30 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.

4.3.31 Child Deaths
A 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 learned 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 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 Local Safeguarding Children Board[2 and 3] 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 Safeguarding intranet http://uhmb/cs/safeguarding/Pages/default.aspx.*

4.3.32 Child Death Overview Panel (CDOP)
The Child Death Overview Panel (CDOP) is a multi-agency group responsible for reviewing all child deaths. The Panel is a sub group of the Local Safeguarding Children Boards. The deaths of all live-born children 0-17 (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 child or young person will be asked to contribute to the review of the child's death. CDOP forms to be completed will be sent to the safeguarding team who will then forwarded to the appropriate practitioner, more likely to be a paediatrician, who will complete and forward back to the CDOP Coordinator with copy sent to safeguarding team.

4.3.33 Lancashire Common Assessment Framework (CAF)[27], Early Help Lancashire Assessment and Cumbria Early Help Assessment[28]

The *CAF* is an assessment tool for use across all children's services in England. It is designed to support early identification of children with additional needs and facilitate appropriate support services. CAF can be used for babies (including unborn infants) children and young people. CAF assists professionals to assess the child's needs then work alongside other practitioners and agencies to meet those needs. It covers all aspects that affect a child's development including health, education and social development. A CAF may be initiated by any professional involved with a child. In Lancashire, full guidance for the use of CAF, information and access CAF forms is available by following the link http://www.lancashirechildrenstrust.org.uk/resources/?siteid=6274&pageid=45056

In Lancashire if you are working with an unborn child, young person, family, or adult with parental responsibility, who would benefit from early help and support then you are required to refer to WELLBEING, PREVENTION AND EARLY HELP SERVICE Lancashire – now Children and Family Wellbeing Service.

Wellbeing, Prevention and Early Help Commissioned Services April 2017[29]
http://www.lancashirechildrenstrust.org.uk/resources/?siteid=6274&pageid=44492

In Cumbria, if you are working with a child in need that you feel would benefit from early help, you are required to register the child with the Cumbria Safeguarding Hub by following the link http://www.cumbrialscb.com/professionals/earlyhelp/default.asp

Making a Referral to Children's Social Care
UHMB will share information which will potentially lead to an Inquiry under Section 47 of the Children Act[15] 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 discussed with consent. In Safeguarding, when making a Section 47 referral it is best practice to gain consent, which could include the consent from a young person if age appropriate.

https://www.nhs.uk/conditions/consent-to-treatment/children/[30]

When a member of staff has a cause for concern that a child is suffering or at risk of suffering significant harm through child abuse the following procedure must be implemented.

Professionals should discuss any concerns with the family and seek agreement to make a referral to Children's Social Care. There are circumstances when seeking agreement/consent about the concerns would place a child at increased risk of further harm and would not be advisable.

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.

Referrals should be made to the Local Authority Children's Social Care for the area where the child is living or is found. 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 Duty Officer.

http://uhmb/cs/safeguarding/Pages/Safeguarding-Children-CSC-Referral.aspx

If staff have safeguarding concerns that a child is at risk of, or is suffering significant harm and the parents/carers do not agree to a referral, staff must still refer.

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.

4.3.34 "Who To Tell" Guidance/ Patient Safety Incidents

The "Who To 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).* This forms part of Safeguarding Level 1 and 2 training which staff should familiarise themselves with.

Multi-Agency Safeguarding Hub (MASH)

The MASH concept is the co-locating of safeguarding agencies and their data into a secure assessment, research and decision making unit that is inclusive of all notifications relating to safeguarding child and adult welfare in a Local Authority area. The co-location of agencies builds trust and confidence and speeds up the process of information sharing and decision-making. The added value of MASH is that it provides for a fuller, more informative intelligence product with a risk assessment supported by a clearly recorded rational for operational use at the earliest stage. Referrals generated by UHMB are risk assessed through the MASH process.

Safeguarding Huddle

The concept of safety huddles are an established part of provision of high quality clinical care within UHMB 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 UHMB NHS FT engages with.

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

4.4 Local Safeguarding Children Boards (LSCB)

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

The LSCB has a range of roles and statutory functions including developing local safeguarding policy and procedures and scrutinising local arrangements.

The objectives of LSCBs 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 Board 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.

LSCBs also monitor and evaluate the effectiveness of training.

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

Whilst the frameworks are the same for referrals, the processes are slightly different and information on the referral pathway is found in the Safeguarding intranet site: http://uhmb/cs/safeguarding/Pages/default.aspx.

4.4.1 Improving Child Protection and Safeguarding Practice (formally 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 (the 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 commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken.

The Safeguarding Team at UHMB FT also report the incident to the relevant Local Safeguarding Children's Board,(LSCB) at the same time as notifying the panel.

UHMBFT should carry out a rapid review of the case and complete this within 15 working days of becoming aware of the incident. Once complete, the safeguarding partners should send a copy to the Panel.

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

https://www.gov.uk/guidance/report-a-serious-child-safeguarding-incident

4.5 Confidentiality, Information Sharing and Record Keeping

Working Together (2018)[1] 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"[33] 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(2018)[34], the Human Rights Act (1998)[9] and the Common Law Duty of confidentiality[35] and Caldicott principles[36].

*The General Data Protection Regulation (GDPR)[34] 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.

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)[34] 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).

4.5.1 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.
In cases of FII it may be detrimental to discuss initial suspicions with the parents or carers. Advice can be sought from Named safeguarding professionals when unsure.

4.5.2 Adoption Records

When a child is formally adopted, a new NHS number is given to the child. If UHMB is aware of the adoption and 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, filed and previous NHS number or hospital number cross referenced.

4.5.3 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.

4.5.4 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[37]
  http://cumbrialscb.proceduresonline.com/chapters/p_conflict_res.html

- Lancashire Resolving Professional Disagreements guidance[38]
  http://panlancashirescb.proceduresonline.com/chapters/p_resolving_prof_disagree.html

4.5.5 Risk Assessment

Risk factors can include health concerns, environmental issues, financial / housing / employment difficulties, domestic violence, non-compliance with health advice, difficulties in engagement, unrealistic expectations of a child, general lifestyle concerns, specific stresses within the family, alcohol/drug addiction and/or mental health issues. A good guide to risk assessment would be to objectively decide exactly why you have concerns about this child at this time, compared to the other children on your caseload about whom you have no concerns.

http://www.cumbrialscb.com/[3]

http://www.lancashiresafeguarding.org.uk/[2]

4.5.6 Attendance at Strategy /Discussion/ Multidisciplinary Meeting

A strategy discussions 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 following the child admission and may take place on Trust premises and short notice. Attendance is required by those caring for the individual or leading on the case supported by Safeguarding team. All strategy discussions and meetings must be recorded in the case notes, either in paper form or 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.

Refer to Strategy Meeting documentation template on the UHMB Safeguarding Intranet site http://uhmb/cs/safeguarding/Pages/default.aspx.

4.5.7 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 7 working days for non-urgent cases. Best practice would dictate 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 filed in the child's hospital notes or uploaded electronically onto Lorenzo. In addition signed originals forwarded to Social Worker and Police if involved.

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.

Guidance Notes for completing a Medical Report following a Child Protection Medical

1. Reports should begin with your qualifications and experience.
2. Reports should be double-spaced and in a minimum font size 12.
3. Remember that most of the people reading your report will not be medically qualified. Avoid the use of medical terminology or ensure terms are defined/explained.
4. Remember, your duty as a medical expert is to the Court, not to either party, nor even to the child. The Court relies on the objectivity; professional competence and integrity of expert witnesses. Try to avoid being manipulated into a partisan position by lawyers

or others; express only opinions you genuinely hold and which are not biased in favour of one party.

5. State clearly what is fact and what is opinion.
6. Be balanced and accurate. Do not exaggerate. Stick to the facts you know and be clear about the source of your knowledge. You should keep to your own area of expertise and make it clear if a question falls outside your knowledge/competence. Be willing to admit if you do not know the answer to a question and be prepared to admit uncertainty.
7. Do not just quote aspects of literature or parts of an article that would advance the cause of the party that called you. Give both (or several) points of view. If you quote from any literature ensure you have a full copy which can be provided should the Court request it.
8. Do not mislead by omission: consider all material facts in reaching your conclusions. Do not omit consideration of material facts which could detract from your concluded opinion.
9. Include positives and negatives in your report. Avoid selective extraction of negative information.
10. Avoid making generalisation or sweeping recommendations which are outside a medical expert's remit and would more properly come from another expert, such as a social worker or psychologist.
11. Point our any limitations in your report, such as certain information not being available at the time you make the report. If need be, you can provide an addendum report at a later date.

Medical Reports should contain the following:

History

Place of examination
Time and date
Who requested the examination
Reason for referral
Persons present (include chaperone)
"I saw AB on Ward x at 3pm on 02.02.02 at the request of … with ... Present"
Current concerns / complaints / allegations
- In child's / parent's own words
- If information from other – whom e.g. – "social worker told me …"
Previous medical history
General systems inquiry
Relevant family history
Social history
Developmental milestones / School progress
Behaviour

Examination

General – quiet & withdrawn / uncontrollable: cleanliness, signs of neglect; cooperation / behaviour with ano-genital examination
Growth including height and weight and centiles
List injuries / bruises – size, site, shape, colour, depth. Attach diagram with numbered injuries and explanations by the side of each of the lesions.
General examination

Tanner Staging
Ano-genital examination
Developmental findings
Investigations
Photographs if recommended and whether taken or not by police photographer)
Colposcope used / not

Interpretation
Interpretation of all clinical findings, both positive and negative. For example:

i) the group of bruises (no's 6, 7, 8) on shins would be in keeping with normal day to day activity/accidental trauma.
ii) the bruises 1 and 2 on the front of the right upper arm together with bruise 3 on the back of the right arm could be indicative of a firm grip.

Summary and Opinion (NB. Children's Social Care **ONLY** receive this page)
"I saw AB a 5 year old boy, on ward X at 3pm on 02.02.02 at the request of … in the presence of ……"
Summarise history and examination (you do not need to include the full details)
E.g. "The bruising on the inner arms was consistent with fingertip bruises such as a forceful grip".

Opinion – as clear as possible
Include if consultant a colleague/senior (E.g. Case reviewed by ……...Consultant Paediatrician) Include:-
Opinion as to whether this may be abuse
Any recommendations
Any follow up arrangements
Taken from CP Companion (2013) Royal College of Paediatrics and Child Health[39]

Examples of when Child Protection medical is required

- If a medical report is likely to be needed for a case conference or legal proceedings:
- Allegation of injury caused by parent, stepparent or intimate partner or family member who is an adult
  - Injury caused when child has been restrained
  - During argument
- Child injured while being reprimanded or punished
- Allegation of a child being injured by an older sibling when there is an element of control (much older sibling)
- Allegation of injury caused by a teacher, care worker, person who was is a position of responsibility for the child
- Suspicious injury
- When the history of an injury and the explanation for it change over time
- When different mechanisms are reported or an unlikely mechanism given
- When there has been a delay in presentation without a reasonable explanation
- When there is suspicion of a child suffering neglect
- Baby with any unexplained bruises/marks

Template of proforma can be found in the UHMB Safeguarding intranet
http://uhmb/cs/safeguarding/Pages/default.aspx.

4.5.8 Attendances at Case Conferences

The contribution of UHMB 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 UHMB 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 UHMB 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[2]

http://www.cumbrialscb.com/professionals/childprotectionconferences.asp[3]

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)[40]. If individual practitioners are unable to attend, staff must inform the Safeguarding team.

4.5.9 Police Interviews, Access to Patient Records and Care Proceedings

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

The police do not have the right to access patient records, although they can obtain a right to information by virtue of an appropriate court order. UHMBT may permit access to information with the consent of the person with parental responsibility.

If it is not possible or unsafe to obtain consent, or to do so would hinder police enquiries or place the child, family or staff at risk the Trust may permit access in order to prevent serious harm, detect a crime or apprehend or prosecute an offender providing the investigation would be prejudiced without the information. If the Trust decides to release information a record of the specific reason for this must be kept, to defend any later allegation of breach of confidentiality. Where disclosure is necessary it should be limited to the minimum necessary. UHMBT should maintain control over the original records at all

times unless there is a court order, or if they are seized by the police on the basis of a reasonable belief that they may otherwise be tampered with.
To access photocopies of records the police must complete the appropriate paperwork in conjunction with the medical records department. There are few circumstances when this would be necessary out of hours.

When a child suffers serious harm or death there may be a requirement for a Root Cause Analysis, internal management review or serious case review. There is a requirement for the patient records to be secured and photocopied. This is the responsibility of the named nurse/midwife for safeguarding. Notes must be obtained by this person. Under no circumstances should notes be sent to any other named nurse outside UHMB.

4.5.10 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 UHMB Safeguarding team email address is safeguarding@mbht.nhs.uk Staff 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. Staff 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 on the UHMB Safeguarding Intranet site http://uhmb/cs/safeguarding/Pages/default.aspx.

4.6 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 2014[41].

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 Strategy.*

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 (http://uhmb/cs/safeguarding/Pages/default.aspx) *for training requirements for each staff group.*

4.7 Supervision

"Supervision is the cornerstone of good practice and should be seen to operate effectively at all levels of the organisation" – Lord Laming 2003[14]

Working Together (2015)[1] 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).

4.7.1 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 ; cited in Royal College of Nursing, 2003; Chilvers & Ramsey, 2009) Cinical Supervision is not within the scope of this policy.

4.7.2 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.

4.8 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 (2007)[42] 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).

4.8.1 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)[43] 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 UHMBT 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 Policy [CPFT]" on the Trust Procedural Document Library (see Section 6 for link).

4.9 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**
Appendix 1	Equality and Diversity Impact Assessment Tool

6 OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	**Title and web links from the document library**
Corp/Pol/112	Freedom to Speak Up – Raising Concerns http://uhmb/cs/tpdl/Documents/CORP-POL-112.docx
Corp/Proc/053	VIP and Celebrity Visits http://uhmb/cs/tpdl/Documents/CORP-PROC-053.docx
Obs/Gynae/Pol/004	Operational Policy for Children UHMB http://uhmb/cs/tpdl/Documents/OBS-GYNAE-POL-004.docx
Corp/Proc/046	Domestic Abuse http://uhmb/cs/tpdl/Documents/CORP-PROC-046.docx
Corp/Pol/096	Section 5(2): Completion, Receipt and Scrutiny of Mental Health Act Section Papers http://uhmb/cs/tpdl/Documents/CORP-POL-096.docx
Corp/Pol/116	Acceptable use policy for information communication and technology (ICT) systems and equipment UHMB http://uhmb/cs/tpdl/Documents/CORP-POL-116.docx
Corp/Guid/008	Use of the internet http://uhmb/cs/tpdl/Documents/CORP-GUID-008.docx
Corp/SOP/041	Guest Wi-fi – user guide http://uhmb/cs/tpdl/Documents/CORP-SOP-041.docx
Corp/Strat/103	PREVENT Strategy http://uhmb/cs/tpdl/Documents/CORP-STRAT-103.docx
Corp/Guid/001	Accessing Telephone and Face-to-Face Interpretation Services http://uhmb/cs/tpdl/Documents/CORP-GUID-001.docx
Corp/Pol/021 (Attachment)	Safeguarding Children and Young People – Who To Tell http://uhmb/cs/tpdl/Attachments/CORP-POL-021/
Sguard/SOP/001	Safeguarding Safety Huddle Teleconference http://uhmb/cs/tpdl/Documents/SGUARD-SOP-001.docx
Corp/Pol/014	Information Governance Policy and Framework http://uhmb/cs/tpdl/Documents/CORP-POL-014.docx
Corp/Pol/084	Safeguarding Supervision http://uhmb/cs/tpdl/Documents/CORP-POL-084.docx
Corp/Proc/015	Managing Allegations against Staff and Volunteers http://uhmb/cs/tpdl/Documents/CORP-PROC-015.docx

7 SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS

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8. DEFINITIONS / GLOSSARY OF TERMS

Abbreviation or Term	Definition

9 CONSULTATION WITH STAFF AND PATIENTS

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

Name	Job Title	Date Consulted
Mark Lippett	Head of Safeguarding & Professional Lead	October 2018
Liz Thompson	Interim Deputy Head of Safeguarding	October 2018
Jane Heath	Named Midwife Safeguarding Children	October 2018
Sharon Hilton	Named Nurse Safeguarding Children	October 2018
Gillian Graham	Named Nurse Safeguarding Adults	October 2018
Jackie Maguire	Clinical Nurse Specialist Safeguarding	October 2018
Cathy Wright	Clinical Nurse Specialist Safeguarding	October 2018
Carla Clarke	Clinical Midwife Specialist Safeguarding	October 2018
Sharon Taylor	Clinical Nurse Specialist Safeguarding	October 2018
Care Group	Children & Young People	October 2018
Care Group	Midwifery	October 2018
Care Group	Medicine	October 2018
Care Group	Surgery	October 2018

9 CONSULTATION WITH STAFF AND PATIENTS Enter the names and job titles of staff and stakeholders that have contributed to the document		
Name	**Job Title**	**Date Consulted**
Care Group	Core Clinical	October 2018
Care Group	Workforce	October 2018
Care Group	Estates & Facilicites	October 2018
Care Group	Community Care Group	October 2018

10 DISTRIBUTION PLAN	
Dissemination lead:	Named Nurse and Interim 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 UHMB Weekly News – New documents uploaded to the Document Library
Dissemination A copy of the policy will be available to staff on the Intranet through the Library service	

11 TRAINING Is training required to be given due to the introduction of this procedural document? **Yes**		
Action by	**Action required**	**Implementation Date**
	UHMB safeguarding training follows that of the guidance in intercolliegiate 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 Toghther 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	01/10/2018

12 AMENDMENT HISTORY				
Version No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**
			08/09/2018)	
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 Clinical Commissioning Groups (CCGs) Ayslum 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

Appendix 1: Equality & Diversity Impact Assessment Tool

University Hospitals of Morecambe Bay NHS Foundation Trust

Equality Impact Assessment Form

Department/Function	Safeguarding			
Lead Assessor	Liz Thompson			
What is being assessed?	Safeguarding Children Policy			
Date of assessment				
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	☐	Staff Side Colleagues	☐
	Service Users	☐	Staff Inclusion Network/s	☒
	Personal Fair Diverse Champions	☐	Other (Inc. external orgs)	☒
	Please give details:			

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 and 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. caring, human rights)	Neutral	

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	

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 for Policies and Procedures once approved by Policy Group. For all other assessments, please return an electronic copy to EIA.forms@mbht.nhs.uk once completed.