Trust Policy

Child Protection Policy

Issue Date	Review Date	Version
August 2020	April 2023	9

Purpose

To ensure University Hospitals Plymouth NHS Trust (UHPNT) and employees prioritise the safety and welfare of children and their families.
To give direction to staff so that they recognise their responsibilities for safeguarding children and young people and are confident and safe in their actions to protect.

Who should read this document?

All Staff Groups working at University Hospitals Plymouth NHS Trust.

Key Messages

Keeping children safe is everyone's responsibility.
All staff that have contact with children and their families must ensure their safety and protection.

Core accountabilities	
Owner	Alison O'Neill, Head of Safeguarding & Named Nurse Safeguarding Children Sarah Pulley Senior Safeguarding Nurse Advisor
Review	Safeguarding Steering Group
Ratification	Lenny Byrne Chief Nurse (Executive lead for Safeguarding)
Dissemination	Via the intranet, publication and sharing through service lines
Compliance	Safeguarding Committee

Links to other policies and procedures

UHPNT The Safeguarding Adults at risk
UHPNT Training Needs Analysis Document
UHPNT Did not Attend Policy
UHPNT Policy on Whistle Blowing
UHPNT Incident Reporting Policy
UHPNT Risk Assessment Policy and Procedures
UHPNT Safe Recruitment Standard Operating Procedure
UHPNT Supporting Staff policy
UHPNT Performance and Conduct Policy
UHPNT SOP Management of patients with Female Genital Mutilation (FGM)
UPHNT Mental Capacity Act including Deprivations of Liberty
UHPNT Domestic Abuse Policy
UHPNT SOP Bruising for Immobile Babies and Children

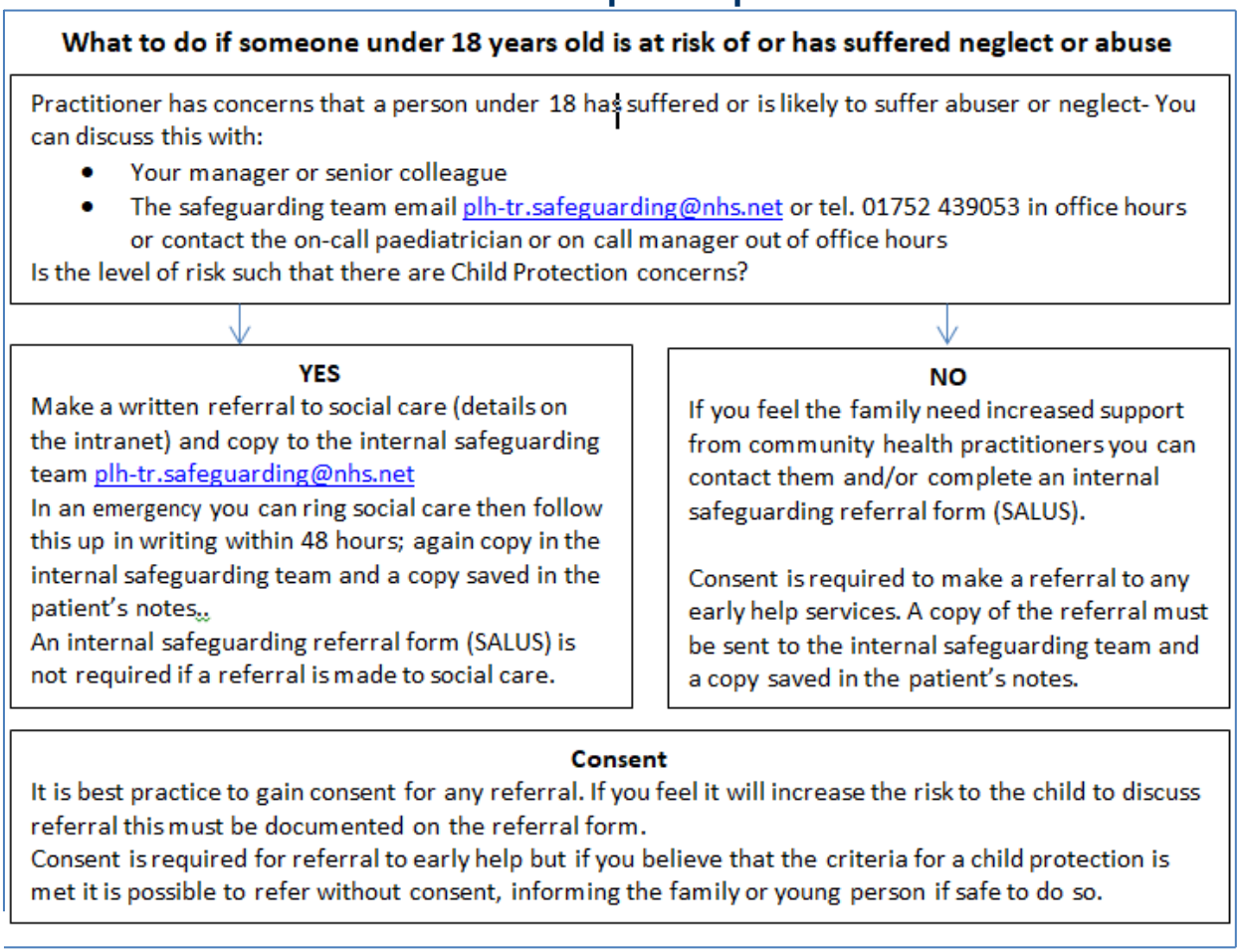
Legislation
The policy should be read in the context of the following list of legislation, guidance documents and reports:
The Children Act 1989 & 2004
Human Rights Act 1998
The Sexual Offences Act 2003
Health and Social Care Act 2012
Safeguarding Children and Young People: Roles and Competences for Healthcare Staff

Intercollegiate Document, Fourth Edition (2019)
Serious Crime Act 2015
Children and Social Work Act 2018
Working Together to Safeguard Children 2018

Version History		
1	April 2009	Trust Child Protection Committee Clinical Governance Steering Group Trust Board
2	July 2009	Training Matrix Appendix A replaced
3	October 2009	Amended and approved by Child Protection Committee
4	February 2012	Amended and approved by Child Protection Committee
5	April 2013	Amended and approved by Child Protection Committee
6	September 2014	Amended and approved by Child Protection Committee
7	May 2016	Amended and approved by Child Protection Committee
8	April 2018	Amended and approved by Safeguarding Steering Group
9	August 2020	Amended and approved by Safeguarding Steering Group

The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on Trust Documents. Larger text, Braille and Audio versions can be made available upon request.



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1 Introduction

It is the responsibility of all staff at University Hospitals Plymouth NHS Trust (UHPNT) to prioritise the welfare and safety of children.

Working together to safeguard children (2018) identifies safeguarding and promoting the welfare of children as “protecting children from maltreatment, preventing impairment of children’s health or development, ensuring children grow up in circumstances consistent with the provision of safe and effective care, taking action to ensure all children have the best outcomes”.

Child protection concerns may be identified by staff who work directly with children as well as staff working with their parents/carers and extended families (NICE 2017).

There is a clear legislative framework for health services to safeguard and promote the welfare of children. In UK law, a person's 18th birthday draws the line between childhood and adulthood (Children Act 1989).

The Children’s Act 1989 states:

- Section 47 highlights that health agencies have a statutory responsibility to assist Local Authorities in carrying out enquiries when considering if child is at risk of significant harm. We have a duty to co-operate with reporting and multi-agency enquiry.
- Section 17 places a specific duty on health agencies to co-operate with multiagency plans to provide support for children in need to reach their health and developmental potential. We must co-operate with multi-agency support and planning with the consent of parents.
- Section 11 of The Children Act 2004 reinforces and broadens existing safeguarding legislation; highlighting that health agencies have a legal responsibility to ensure safeguarding children is promoted and is intrinsic to development and delivery of services.

Safeguarding is a wider concept than child protection; to be effective it requires staff to acknowledge their individual responsibility for safeguarding and promoting the welfare of children.

UHPNT must develop a culture where staff are supported to safeguard children and young people; ensuring support for those who care for them

UHPNT will ensure staff have access to:

- appropriate training to comply with recommendations in Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Intercollegiate Document January 2019
- safeguarding supervision, advice and support

All staff working with children and their families should take steps to ensure the child’s wishes and feelings, are taken into consideration in care and service planning (Lansdown 2011). The voice of the child is vital in ensuring children and young people are safeguarded.

2 Purpose

This policy applies to all staff employed by UHPNT. Implementation of this policy will ensure that:

- All staff are aware of their responsibility to ensure children are not at risk of harm.
- All staff have access to Child Protection Training as identified by UHPNT Training Strategy (see appendix 3), and in accord with UHPNT Training Needs Analysis and Induction Process (see UHPNT induction and Training Needs Analysis document).
- All staff will have their training standard met as per Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Intercollegiate Document (2019)
- UHPNT works collaboratively with The South West Peninsula network of Local Safeguarding Children’s Boards/Partnerships to align our agencies responsibility and ensure a collective multiagency approach to safeguarding children.
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3 Definitions

- The Local Safeguarding Children's Board/Partnerships are the key statutory inter-agency, which acts as a focal point for local co-operation to safeguard children. The Trust Plymouth, Cornwall and Devon Safeguarding Partnerships.
- The Designated Nurse and Designated Doctor - Lead on Child Protection within the area covered by the Trust.
- NHS Devon Clinical Commissioning Group (CCG) have oversight for Designated Professionals. Designated Professionals provide advice, supervision and support to the Named Doctor and Nurse at UHPNT.
- Named Doctor and Named Nurse for Safeguarding Children - All NHS Trusts must have an identified Named Doctor and Nurse who take a professional lead within the Trust on Child Protection matters.
- Child - In UK law, a person's 18th birthday draws the line between childhood and adulthood (Children Act 1989 s105).
- Competence to Consent - The right of younger children to provide independent consent is proportionate to their competence; the child's age can be an unreliable predictor of competence to make decisions.
- Like adults, young people (aged 16 or 17) are presumed to have sufficient capacity to decide on their own medical treatment, unless there's significant evidence to suggest otherwise. People aged 16 or over are entitled to consent to their own treatment. This can only be overruled in exceptional circumstances.
- Children under the age of 16 can consent to their own treatment if they're believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment. This is known as being Gillick competent. Gillick competence is the principle used to judge capacity in children to consent to medical treatment. The child's best interests must remain paramount and must be at the heart of decision making.
- Fraser guidelines are used specifically for children requesting contraceptive or sexual health treatment. No child under the age of 13 can be deemed competent to make informed decisions about their sexual activity (Gillick v West Norfolk and Wisbech AHA [1985] UKHL)

4 Duties

Duty of the Trust Board

The Trust board is responsible for:

- Identifying a lead Executive Director with responsibility for Child Protection within the Trust.
- Ensuring that the organisation is complying with statutory and national guidance in relation to child protection.

4.2 Duty of the Safety and Quality Committee

- The Trust Safeguarding Steering Group reports via the quality assurance committee to the Trust Board. The Named Nurse for Child Protection submits a quarterly update report.

4.3 Duty of the Safeguarding Steering Committee

- To provide assurance within the Executive governance arrangements that the Trust is appropriately and adequately safeguarding people who use services from abuse.
- To oversee the arrangements across the Trust to ensure that service users are safeguarded against the risk of abuse through compliance with national regulatory standards
- To monitor adherence to national performance standards and to formulate action plans where standards are not being met.
- To monitor national statutory employment procedures used to screen employees whose work brings them into contact with children.

- To ensure the Trust meets its legal obligations and requirements with respect to the protection of children and adults at risk.
- To oversee the development and implementation of local policies and procedures within the Trust to ensure appropriate arrangements for safeguarding service users
- To provide a formal link to the multi-agency Safeguarding Children's Boards/Partnerships and Safeguarding Adults Boards
- To ensure learning from Serious Case Reviews, Serious Incidents and audit is integrated across services/clinical practice, to improve safeguarding services and outcomes.
- To oversee the training needs analysis and delivery of staff training, ensuring staff have the knowledge and skills to safeguard people and monitor training compliance

4.4 Duty of the Trust Safeguarding Operational Committee

- To support the Named Doctor and Named Nurse in their safeguarding role within UHPNT.
- To enable the Trust to meet and discharge its responsibilities in terms of actions required from local and national guidance.
- To have Service Lines representatives on the committee acting as a communication link with their respective Care Groups.
- To ensure action plans are followed through to meet national performance targets.
- To monitor the provision and uptake of child protection training and supervision.
- To ensure that actions required as a result of Serious Case Reviews and Serious Incidents are implemented, monitored and reviewed within agreed timescales.
- To ensure that actions set out by the Safeguarding Steering group are carried out and information is fed back to the steering group

4.5 Duty of the Chief Nurse

The Chief Nurse is responsible for:

- Acting as the lead Executive with responsibilities for safeguarding.
- Ensuring that the Trust Board is provided with reports on child protection issues and is made aware of child protection activity.
- Ensure all allegations on staff are investigated (South West Child Protection Procedures)

4.6 Duty of the Named Professionals

The Named professionals are responsible for:

- Taking a professional lead within the Trust on child protection matters, including providing advice and support for staff, legal advice, and training.
- Monitoring quality through Audit.
- Promote supervision and support for staff.
- To contribute to Serious Case Reviews, as directed by undertaking internal management case reviews according to agreed standards as laid out in of Working Together to Safeguard Children 2018.
- Presenting an annual report to the Trust Board via the quality improvement board to inform on child protection activity, including changes and progress of practice, training and resource pressures.
- Maintaining a link and contributing to the work of the Local Safeguarding Children Boards/Partnerships through the Designated Professionals and by representing the

interests of the Trust at the constituent Sub Groups of the Boards.

- Liaising with the Named and Designated professionals from other Trusts to enable share good practice and common procedures.
- Investigate and assess any professional differences when dealing with other agencies.

4.8 Duty of the Service Line Director

Clinical Directors are responsible for:

- Managing and implementing the child protection process within their service line including ensuring access for staff to appropriate training.
- Reporting on service line performance in relation to safeguarding children through the Trust's governance process.

4.9 Duty of the Consultant Paediatrician

The consultant paediatricians are responsible for:

- Maintaining their skills in the recognition of abuse and be familiar with the procedures to be followed if abuse or neglect is suspected.
- Taking a lead and supporting clinical staff in the identification, treatment, and referral of child protection cases.
- Taking the medical lead in multi-agency decision making including strategy discussion.
- Ensuring 24 hour cover for provision of advice to UHPNT employees when child protection concerns arise.
- Providing reports for child protection investigations, civil and criminal proceedings and to appear as a witness to give evidence as required.
- Contributing to multi-agency assessments where abuse or neglect is suspected.

4.10 Duty of Managers

Managers are responsible for:

- Ensuring that all employees who come into contact with children receive child protection training in accord with the Trust Training Strategy, monitored through appraisal.
- Ensuring staff have access to supervision and advice via the safeguarding team, senior management and peer support.
- Ensuring that professional registration is checked before employment and verified annually.
- Ensuring that new staff attend the Trust induction programme and are made aware of national and local child protection procedures and policies.
- Ensuring that all Trust employees who come into contact with children are subject to a formal police check as outlined in UHPNT Trust's Policy for safer recruitment.

4.11 Duty of Staff

Staff are responsible for:

- Being alert to the possibility of child abuse or neglect.
- Exercising their own professional accountability to safeguard children and promote their welfare.
- Complying with this policy.
- Complying with local multi-agency children partnerships Multi-Agency Child Protection Procedures and the South West Child Protection Procedures.

- Referring to social care in writing as required to protect children and sending a copy to the safeguarding team.
- Referring to Social care by phone if urgent and following up within 48 hours in writing and sending a copy to the safeguarding team.
- Complying with any additional Safeguarding guidelines or procedures that have been produced specifically for a department e.g. Emergency Department o Midwives.
- Clearly documenting in a child's medical records where child protection concerns arise including details of discussions held, referrals made and actions arising.
- Ensuring the safeguarding team are aware of concerns promptly using recognised systems.

5 Main Body of Policy

5.1 Background

The abuse or neglect of children has major long term effects on all aspects of a child's health, development, and well-being.

Working together to safeguard children (2018) identifies abuse as maltreatment of a child. Abuse or neglect of a child can occur within a family or institution, by and adult or adults, by another child or children. It can happen online or be facilitated online.

Abuse can be identified in type's as physical, emotional, sexual and neglect. There are also criminal and sexual exploitation.

Serious Case Reviews (SCRs) continue to highlight key themes in cases where children have been significantly harmed. The SCR process has changed when a serious child safeguarding case is identified a rapid review is held within 15 days, following these 3 decisions are made, that no further action is taken, proceed to a local review or refer for a national review.

This list is not exclusive or always an indicator of abuse but risk can increase for children directly with service users and through planning service provision to the risk of:

- Domestic violence
- Mental health
- Substance misuse
- Signs of neglect
- Child Sexual Exploitation (CSE)
- Criminal exploitation (CE)
- Female Genital Mutilation (FGM)
- Online safety
- PREVENT agenda
- Modern slavery
- Child trafficking
- Injuries in non-mobile children
- Young people who deliberately self-harm

5.2 Recognition of Abuse and Neglect

If there are concerns about the safety or welfare of a child staff must always act on these concerns

(See page 2-what to do if someone under 18 year old is at risk or has suffered abuse or neglect).

- Take any immediate emergency action to ensure the child is safe.
- When possible ensure you gain a clear picture of the child or young person's experience, wishes, thoughts and feelings. It is vital that we always listen to the voice of the child when considering protection from abuse.
- Include parents or guardian in discussions unless to do so would place the child or you at risk.
- Do not inform parents or guardian if you feel there are issues regarding sexual abuse or

fabricated illness.

- Seek medical attention for any injuries observed on the child.
- An independent interpreter must be sought if the child/parents are not fluent in English.
- Take into account the racial heritage, language, religion, faith, gender and disability when working with a child and their family
- Where there is a concern regarding a child's ability to communicate effectively e.g. related to learning disability or sensory impairment, specialist advice must be sought to ensure the child's voice is heard.
- Document a clear and comprehensive account of your concerns in the child's records. This should include the child's name, address, age, GP, school, main carer and the person with parental responsibility. This must be factual, unambiguous, contemporaneous, and include documentation of any discussions held with the child. See the NMC Code of Conduct 2015.

Practitioners may receive disclosures of historical abuse. The term 'historical' abuse can lead to complacency in the recognition or identification of the current risk to children. Following disclosure of historic abuse, consideration must be given to whether the alleged perpetrator presents as a current risk to children or vulnerable people. A person may not wish to disclose but the risk to others needs consideration. These cases should be discussed with the safeguarding team to decide whether confidentiality and a person's individual rights or the rights of public protection are paramount.

The professional receiving the disclosure, or the victim, may not be aware of the perpetrators present circumstances and therefore are not able to assess whether they pose a current risk.

Sexual abuse, including child sexual exploitation is a criminal offence and any disclosure or allegation of sexual abuse must be referred to Children's Social Care for an appropriate forensic investigation and police investigation as required (see algorithm page 2). In these cases it is preferable not to inform the parent or person responsible for the young person the referral is being made.

Medical examination in relation to recent sexual abuse/assault should always be discussed urgently with the Sexual Assault Referral Centre (SARC) tel. 0300 3034626. Examination prior to liaison with SARC should only occur if there is clinical need to prevent evidence contamination. Sexualised behaviour which includes abuse to self-coerced by another is sexual abuse.

Advice, guidance and safeguarding supervision can be sought from the safeguarding Children's Team on 01752 4(39053) or from the paediatrician on call or your manager out of hours.

5.3 Completing a Local Multiagency Safeguarding Referral

- Urgent referral may be accepted by the relevant Local Authority via telephone and must be followed up in writing within 48 hours and copied to UHPHT safeguarding team plh-tr.safeguarding@nhs.net.
- Concerns should be discussed with the child (dependent on age and development) and the parents. Consent for referral to children's social care sought from the parents unless to do so would place the child or yourself at increased risk of harm or there are concerns related to sexual abuse or fabricated illness
- Where it is believed that a child may be suffering, or be at risk of suffering significant harm, a referral must be made to the child's local multiagency assessment social care team (Local Authority). If parents do not consent the referral should still be made and the lack of consent documented on the form with the reasons why and they should be informed of referral when it is safe to do so. (Appendix 4 for local referral contacts).
- Consent is not needed under Section 47 of the children's Act if you have reason to believe a child is suffering or likely to suffer significant harm but it is good practice to seek it or inform parents if it is safe to do so.

- If the referral is for Child Protection under section 47 of the Children's Act, a referral must be completed even if consent is refused (DOH 1989).
- When children from other areas of the country presents to UHPNT services and staff recognise child protection concerns; a referral must be sent to the children's social care department where child resides.
- Staff working for UHPNT have a statutory duty to co-operate with any child protection investigation being undertaken under Section 47 of the Children's Act 1989. If you are concerned about information sharing seek advice from your manager or the Safeguarding Team.

5.4 Think family

- Think child, think parent, think family (2012)
  https://www.scie.org.uk/publications/ataglance/ataglance09.asp
- This was initially developed in order to find new solutions to improve outcomes for parents with mental health problems and their families.
- This reviewed whether criteria for access to adult mental health and to children's services take into account the individual and combined needs of children, parents and carers
- In recent years there has been a shift in children's and adult guidance now placing greater emphasis on supporting adults in their parenting role.
- Every Child Matters and the updated Working Together guidance provide the framework for children's services to support the child and the family.
- At UHPNT the integrated safeguarding team fully acknowledge endorse a Think Family approach to ensure the safeguarding needs of the whole family are addressed
- When we have adult patients with needs it is essential that we consider the needs of the whole family and safety of children.
- It may be necessary to refer a child of an adult patient due to safeguarding concerns and advice can be gained by contacting the safeguarding team or senior manager at any time.
- The framework for children in Need (see appendix 5) is a good tool to assess what issues or support a child within their wider environment and to frame a referral if needed.
- SCIE's guide says Think child, think parent, think family. It encourages the development of services that:
  - •offer an open door into a system of joined-up support at every point of entry
  - •look at the whole family and co-ordinate care
  - • provide support that is tailored to need
  - • build on family strengths
- It is vital that we recognise the impact of adult mental health and other difficulties have on the safety and welfare of children. The potential impact of parental problems on children over time is substantial and can effect generations
- Practitioners need to:
  - • Take a more holistic approach and involve the whole family in the assessment process, including a carers' assessment for any young carers
  - • Be very clear about what information can be shared and with whom, also seeking parents' and children's permission for information sharing wherever possible
  - • Be better informed about what forms of health problems and associated behaviours could pose a risk of harm to children.
  - • Be aware of their responsibilities for safeguarding children.

5.5 Clinical Responsibilities when a Child Presents, or is Admitted to Hospital with Suspected Abuse or Neglect.

- Any child admitted to hospital where there are concerns about deliberate harm must receive a comprehensive and fully documented physical examination within 24 hours of their admission, except where doing so would compromise the child's care or the child's

physical and emotional well-being.

- When a clinician takes a history they must take into account whether the history of how injury or harm occurred is plausible or appropriate to the child's age and development.

- Practitioners should be aware if this account is consistent and always document this clearly.
- The examining doctor should consider whether taking a history directly from the child is in that child's best interests. If it is possible the voice of the child should be heard and documented.

- When a child has been examined by a doctor, and concerns about deliberate harm have been raised a referral to children's social care must be made and the safeguarding team copied in at plh-tr.safeguarding@nhs.net,

- Each of the concerns should be fully addressed, accounted for and the differential diagnosis documented in the health records.

- Practitioners must ensure that all available information is reviewed and an assessment of risk to the child has taken place. This supports a safe and effective future management plan of the child's care.

- A clear decision must be taken as to which Consultant Paediatrician is to be responsible for the child protection aspects of the child's care and this must be documented in the child's health record.

- The named paediatric consultant is responsible for sharing medical information with the local authority if a strategy meeting needs to be convened (Working Together 2019).

- All Paediatricians and other specialist clinicians leading in the care of a child where there are concerns about deliberate harm must provide Children's Social Care with a written report commenting on the nature and extent of the injuries or harm. This report must be copied to the safeguarding team at plh-tr.safeguarding@nhs.net

- Child protection and safeguarding children is an emotive topic and at times there may be differences of professional opinion. The Plymouth Safeguarding Children Board/Partnership Professionals' Escalation and Resolution Policy should be used in these occasions to ensure that children are safeguarded. (Other neighbouring Safeguarding Children Board/Partnerships also have corresponding escalation policies).

- Safeguarding supervision may be sought from the service paediatrician (via switchboard) or the Named Doctor for Safeguarding Children or UHPNT Safeguarding Team.

- On a child's admission to hospital, enquiries should be made into previous hospital admissions and information about these admissions should be obtained as soon as possible. The paediatric consultant in charge of the case must review this information when making decisions about a child's future care. The child's GP or Public Health Nurse should be contacted for information regarding previous hospital admissions out of area.

- When a child presents to the Emergency Department or Minor Injury Units and there are concerns relating to their injuries that must be seen by a senior practitioner. Consideration must be given to contacting the paediatric service consultant for a review. This must all be clearly documented.
- No child about whom there are child protection concerns should be discharged from hospital without:
    - An identified GP. It is the responsibility of the paediatric consultant under whose care the child is admitted to ensure this
    - A documented plan of future care for that child.

- Permission of either the consultant or a paediatrician above the grade of senior house officer.
- Informing the child's GP of the plan.
- Communication being sent to community health practitioners.

- A record must be kept in the hospital notes of all discussions about the child, including telephone calls, face to face discussions and all decisions made during and after such conversations. A record must be made of who is responsible for carrying out any actions agreed.
- When practitioners are working in circumstances in which case notes are not available to them, a record of all discussions must be entered in the health records contemporaneously and at the earliest opportunity so that it becomes part of the child's permanent health record.
- The UHPNT safeguarding team must be informed of any child admitted or seen for child protection medical
- If a young person (under 18) attends for a mental health reason consideration must be given for their safety and the safety of others prior to discharge. A conversation must be had with the Community Outreach Team (COT from the Child and adolescent mental health service (CAMHS). A SALUS referral must be completed for these attendances (unless a Social Care referral is made and the safeguarding team must be copied in at plh-tr.safeguarding@nhs.net)

5.6 Confidentiality and Information Sharing

Information sharing is crucial in order to safeguard the welfare of children and young people. Information must only be shared with those practitioners who "need to know" and then only the details required to enable professionals to make an informed decision.

Employees must document with whom, when and why information was shared. Disclosure should be justified in each case and guidance should be sought from the safeguarding team, disclosures and UPHNT legal team in cases of uncertainty.

Health records should not be photocopied unless permission has been sought from the disclosures team within UHPNT.

If children, parents or carers request to see their health information they must be signposted to make a freedom of Information (FOI) request from the disclosures team.- this is a subject access request

5.7 Allegations Against Staff or Members of the Public Working with Children

Most adults who work with children act professionally providing a safe and supportive environment which secures the wellbeing of the children in their care (Plymouth Safeguarding Children's Board 2018). However, there will be occasions where a member of staff may have;

- Behaved in a way that has harmed a child, or may have harmed a child.
- Possibly committed a criminal offence against or related to a child.
- Behaved towards a child or children in a way that indicates he or she may pose a future risk of harm to children.

1. All UHPNT staff who have concerns about the behaviour of a colleague or any other adult who works with children must alert the Named Nurse for Children or designated senior manager or their deputy. If an allegation is made against their designated senior manager UHPNT, their senior manager or the Named Nurse for Children should be informed. Make a signed and dated written record of the concerns, observations or the information received and maintain confidentiality.

2. Follow Trust information sharing protocols.

The member of staff should not:

- Attempt to deal with the situation themselves.
- Make assumptions, offer alternative explanations or diminish the seriousness of the behaviour or alleged incidents.
- Keep the information to themselves or promise confidentiality.
- Take any action that might undermine any future investigation or disciplinary procedure, such as interviewing the alleged victim or potential witnesses, or informing the alleged perpetrator or parents or carers.

The same action should be taken if the allegation is about abuse that has taken place in the past or if concerns are about the person's behaviour to her/his own children or outside the work environment.

If a child has clearly been injured and/or there is clear evidence of child protection concerns please follow Child Protection procedures as a priority ("What to do if you are worried about a child being abused" https://www.gov.uk/government/publications/what-to-do-if-youre-worried-a-child-is-being-abused--2) and inform the designated senior manager.

The designated senior manager having received information must inform the Local Authority Designated Officer (LADO) who will provide advice and guidance and ensure a multiagency risk assessment plan is held if needed. (South West Child Protection Procedures 2018).

Staff who report suspicions or allegations of abuse should receive support and acknowledgement. They should be offered feedback on the progression of the concerned however this would be within the bounds of confidentiality.

5.8Safeguarding supervision

Supervision is a reflective process and a distinction should be drawn between this and debrief. Supervision must give the supervisee opportunity to reflect and improve future practice. Use of a reflective model (for e.g. KOLB. see Appendix 6) is essential to ensure the process is thorough and to maximise benefit. The supervisee and supervisor should have understand reflective process.

Safeguarding supervision is an important requirement of all professionals engaged in clinical activities. It is an essential element within the governance framework; supervision plays a significant role in ensuring the continuous improvement in the delivery of high quality care to patients/service users.

University Hospitals Plymouth NHS Trust (UHPNT) attaches the greatest importance to the provision of adequate support and guidance to its employees, thereby enabling them to develop their skills and experience to an appropriate level and practice safely.

Supervision is offered to all clinical staff involved in the safeguarding children system (see appendix 6 for details of the process

UHPNT will provide staff with case loading responsibility regular supervision from an appointed safeguarding supervisor. Staff in areas where there are high risk for safeguarding cases can access supervision individually as needed in addition to regularly accessing group supervision.

UHPNT acknowledges the importance of ensuring employees who work with children; young people and their families develop their skills in reflective practice enhancing the process of learning from experience. This is vital in order to meet the differing needs of patients/service users and UHPNT employees, and supports both services, professional and clinical development.

The planning and delivery of supervision for staff employed to deliver clinical care must be undertaken within existing resources, and in time protected for this purpose .

Over the last decade a number of major national and local children death enquiries have highlighted the need for a robust child protection supervision process. Child protection supervision must have a clear place and rationale in the objectives and culture of the hospital (Laming 2009).

The provision of supervision should be regarded as support to good practice and not as a substitute for individual professional accountability.

Purpose of child protection supervision is to:

- Provide support, guidance and education to practitioners in safeguarding unborn babies and children. It does not replace any existing clinical supervision.
- Help to ensure that practice is soundly based and consistent with the Local Safeguarding Children's Board and organisational standards.
- Provide advice and expertise, and when required, endorsement of judgements, made by workers, in the child protection process.

Working Together to Safeguard Children, (2018)

It is the practitioners' responsibility to access supervision, advice, support or guidance when they recognise potential safeguarding issues.

All Practitioners must document the plan from any supervision sought via telephone or face to face in the child's health records. For examples of paperwork used in supervision see Appendix 7

6 Overall Responsibility for the Document

The Named Nurse and Named Doctor for Safeguarding Children are responsible for the development of this policy and for ensuring that draft copies were widely circulated to individual stakeholders for comment before seeking approval from the relevant committees.

7 Consultation and Ratification

Safeguarding Committee

Safeguarding Steering Group

8 Dissemination and Implementation

Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process via the intranet and management structures.

Document control arrangements will be in accordance with The Development and Management of Formal Documents.

The document owner will be responsible for agreeing the training requirements associated with the newly ratified document with the named nurse and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

9 Monitoring Compliance and Effectiveness

9.1 Process for Monitoring Compliance

The Chief Executive is ultimately responsible for ensuring compliance with the Child Protection Policy.

Monitoring of the compliance of this policy will be carried out under direction of the Executive Lead for Safeguarding within the UHPNT Safeguarding Steering Committee.

- Regular clinical audits identified in the annual audit plan are undertaken to ensure compliance with local and national guidance.
- The Safeguarding Steering Committee is informed of outcomes of clinical audits and

Serious Case Reviews and is made aware of new national policies and guidance by the named and designated professionals.

Action plans are formulated where standards are not being met.

- Action plans are reviewed regularly by the Safeguarding Steering Committee and signed off once completed.
- Registers are kept of all staff attending Child Protection Training.
- This data will be included on the electronic staff record.
- Matrons / Lead Nurses / Service Line managers are accountable for ensuring their staff have received the appropriate level of training according to the Intercollegiate document 2019

Annual Service Line reporting to the Clinical Governance Committee will include provision of evidence of the uptake of Child Protection Training within each directorate.

- The Child Protection Committee will monitor the supervision arrangements for all staff working in Child Protection.

10 References and Associated Documentation

1. Brandon, M, Bailey, Sorensen, P, Belderson, P, Dodsworth, J,(2016) **Pathways to protection, pathways to harm: A Triennial Analysis of serious case reviews 2011- 2014**. Department of Education
2. Caldicott, F, (2013) **The Information Governance Review**. Crown: London
3. General Medical Council (2004) **Confidentiality: Protecting and providing information**. Online resource
4. Health Care Professionals Council (2017) **Confidentiality- guidance for registrants**. Online resource
5. HM Government (2015) **Information sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers**. Online resource
6. HM Government (2015) **Working Together to Safeguard Children.** TSO: London
7. Home Office (2013) **Information for Local Areas on the change to the Definition of Domestic Violence and Abuse.** Crown: UK
8. Lambing, L (2009) **The protection of Children in England: A progress report**. Crown: London
9. Lansdown, G (2011) **Every Childs right to be Heard: A resource guide on the UN Committee on the rights of the child.** Save the Children: UK
10. Mental Capacity Act (2005) London HMSO
11. National Institute for Clinical Excellence (2017) **Child abuse and neglect** Online resource
12. NSPCC (2018) **Domestic Abuse Signs Indicators and Effects** Online resource
13. Nursing and Midwifery Council (2004) **Code of professional conduct**. Online resource
14. Stanley, N, (2011) **Children Experiencing domestic violence: A research review**. Totnes, Devon: Research in practice
15. The Children Act 1989 London HMSO
16. The Children Act 2004 London HMSO

Abbreviations:

- CP- Child Protection
- CSE-Child Sexual Exploitation
- DOH-Department of Health
- FGM- Female Genital Mutilation
- FOI-Freedom of Information
- GMC-General Medical Council
- HCPC-Health Care Professional Council
- LAC-Looked after Child
- NICE-National Institute for Clinical Excellence
- SCBs-Safeguarding Children's Boards
- SCR-Serious Case Review

- UHPNT-University Hospitals Plymouth NHS Trust

Dissemination Plan and Review Checklist — Appendix 1

Dissemination Plan	
Document Title	Child Protection Policy
Date Finalised	August 2020
Previous Documents	
Action to retrieve old copies	Electronic version on Trust Documents Network Share Folder

Dissemination Plan

Recipient(s)	When	How	Responsibility
All Trust staff	August 2020	Information Governance StaffNet Page	Alison O'Neill
All DMs	August 2020	Email	Alison O'Neill

Review Checklist		
Title	Is the title clear and unambiguous?	y
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	y
	Does the style & format comply?	y
Rationale	Are reasons for development of the document stated?	y
Development Process	Is the method described in brief?	y
	Are people involved in the development identified?	y
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	y
	Is there evidence of consultation with stakeholders and users?	y
Content	Is the objective of the document clear?	y
	Is the target population clear and unambiguous?	y
	Are the intended outcomes described?	y
	Are the statements clear and unambiguous?	y
Evidence Base	Is the type of evidence to support the document identified explicitly?	y
	Are key references cited and in full?	y
	Are supporting documents referenced?	y
Approval	Does the document identify which committee/group will review it?	y
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A
	Does the document identify which Executive Director will ratify it?	y
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	y
	Does the plan include the necessary training/support to ensure compliance?	y
Document Control	Does the document identify where it will be held?	y
	Have archiving arrangements for superseded documents been addressed?	y
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	y
	Is there a plan to review or audit compliance with the document?	y
Review Date	Is the review date identified?	y
	Is the frequency of review identified? If so is it acceptable?	y
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	y

Equalities and Human Rights Impact Assessment | Appendix 2

Core Information	
Date	01/08/2020
Title	Child Protection Policy
What are the aims, objectives & projected outcomes?	This policy sets out guidance for all employees of UHPNT of what action should be taken to protect children. The policy applies to all children up to their 18th birthday that may access any service provided by UHPNT. The policy applies to all who use UHPNT services who have contact with children

Scope of the assessment
This is the initial EIA conducted for the Child Protection Policy All protected characteristics have been considered when designing the policy. The policy will be adapted if necessary to address any future gaps or needs on equality and human rights issue.

Collecting data	
Race	There is no evidence to suggest that there is a disproportionate impact on race regarding this policy. Reasons for this category having an impact are: - Language - Understanding of NHS (UK health system) - Transient population (for some) Cultural issues that may arise are identified at an early stage of treatment regarding end of life and are fully documented in the mother and child's care plan.
Religion	All patients referred to or attending any service are treated regardless of their characteristics. All patients are seen in order of specific clinical criteria. Based on this there would be a neutral impact on religion or belief and non-belief.
Disability	There is no evidence to suggest that there is a disproportionate impact on disability. It should have a positive impact on people with disabilities providing a better understanding of the community support processes.
Sex	All patients referred or attending the service are treated regardless of their characteristics. All patients are seen in order of specific clinical criteria.
Gender Identity	There is no evidence to suggest a negative impact on this group.
Sexual Orientation	There is no evidence to suggest a negative impact.
Age	The policy is specifically targeted at children and young people under the age of 18, and any adults who come into contact with children.
Socio-Economic	The policy for the protection of children is inclusive of all children regardless of their socio-economic status
Human Rights	No adverse impact on human rights has been identified. We will continue to monitor this.
What are the overall trends/patterns in the above data?	None, this will be monitored by current quality assurance methods and processes.
Specific issues and data gaps that may need to be addressed through consultation or further research	None

Involving and consulting stakeholders	
Internal involvement and consultation	There has been engagement internally around the Protection of Children and this includes: • Child protection Committee • Safeguarding Steering Group • Staff Engagement
External involvement and consultation	Consultations with the following NHS Plymouth 0-19 service NHS Cornwall 0-19 service NHS Devon 0-19 service
Impact Assessment	
Overall assessment and analysis of the evidence	This work programme should have a positive impact on all the characteristics outlined above. The policy does not have the potential to cause unlawful discrimination by excluding certain groups

Action Plan

Action	Owner	Risks	Completion Date	Progress update

Safeguarding Children

Training for Health Care Staff

University Hospitals Plymouth NHS Trust

2020

All healthcare organisations have a duty under the Children Act, 2004 (S 10 & 11) to make arrangements to safeguard and promote the welfare of children and young people. Chief Executives need to ensure that all staff have training commensurate with their specific duties relating to children, young people and their families.

Independent inquiries into child deaths as a result of abuse or neglect have revealed that many staff are inadequately trained in child protection and that this has been afforded low priority.

The intercollegiate document; Safeguarding children and young people; Roles and Competencies for Health Care Staff (2019) provides a generic framework with which professional group training programmes can be developed to meet the needs of specific staff groups.

Five levels of knowledge, skills and competencies have been specified to help identify and plan training and education across the range of healthcare employees. This falls broadly in line with the guidance on training and development of staff included within 'Working Together to Safeguard Children 2018'.

Scope

This document outlines the safeguarding competencies required for staff and the training requirements and opportunities available for different staff groups.

Levels of training and competencies

There are five levels of training. Levels 4 and 5 will not be considered as they only apply to a small number of named and designated professionals. There are in addition specific requirements for Trust Executives.

The level of training required by staff is dependent on their roles and responsibilities. This is in accordance with the guidance from the intercollegiate document (3). The competencies required at each level and within specific staff groups are provided in detail in the above document.

Level of Training	Who for?	Requirements	Current UHPNT provision
Level 1	All staff working in a healthcare setting. Basic safeguarding / child protection training across all organisations working with children and young people.	A mandatory induction programme (at least 30 minutes). Over a 3 year period, staff should receive refresher training equivalent to a minimum of 2 hours. Receipt of written briefings of any changes in legislation and practice provided by named professionals at least annually	Child protection awareness /signposting as part of corporate induction programme and statutory update training for all UHPNT staff. Regular update via Trust publicity pathways 3 yearly update mandatory
Level 2	All non-clinical and clinical staff who have any contact with children, young people and /or parents / carers.	In house training to include scenario based discussion and personal reflective practice. New staff, not having previously obtained level 2 competencies, should access training within 6months (minimum 2 hours). Over a 3 year period professionals at level 2 should receive refresher training equivalent to a minimum of 3 – 4 hours.	Method 1 3 hour programme delivered by Trained Safeguarding team Method 2 In-house training to specific staff groups by request. The programme is adapted to particular needs. Method 3 Half day training for F1 doctors once a year as part of education programme. Formal training should be supplemented by personal reflective practise. Method 4 On-line training 3 hours 3 yearly update is mandatory
Level 3 Core	All clinical staff working with children, young people or their parents who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are	Those individuals moving in to a permanent senior level post who have not obtained relevant knowledge, skills and competence required at level 3 are expected within 6 months of appointment to complete the equivalent of 8 hours of educational learning related to safeguarding	Attendance at CPF (Child protection foundation) one or two day multiagency training course run by SCB. On-going attendance of one of multiagency training courses run by Plymouth LSCB in accordance with roles and responsibilities Reflective practice. This may include; •Attendance at strategy meeting or case conference to include a reflective summary on the process, outcome

	safeguarding / child protection concerns.	/ child protection. Over a 3 year period professionals should receive refresher training equivalent to a minimum of 6 hours Training should be multi-disciplinary and interagency. It should include personal reflection and scenario based discussion drawing on case studies, serious case review, lessons from research and audit as well as communicating with children about what is happening.	and own role (2 hours equivalent) •Participation in a multiagency case review to include reflective summary of core learning outcomes (2 hours equivalent) •Participation in peer review of a child protection case in which there was multiagency involvement to include personal reflective summary (2 hours equivalent) •Attendance at local case review following the death of a child about whom there were child protection concerns to include a reflective summary. (2 hours equivalent)
Level 3 Specialist	Additional specialist competencies are required as appropriate to role for staff who may take a professional lead and responsibility for managing a child where there are safeguarding concerns.	Those requiring a specialist level of competencies should complete a minimum of 16 hours within a year of appointment Over a three year period professionals should receive a minimum of 12 – 16 hours. Training should be multi-disciplinary and interagency. It should include personal reflection and scenario based discussion drawing on case studies, serious case review, lessons from research and audit as well as communicating with children about what is happening.	Attendance at CPA (child protection advance), 2 day multiagency training course run by SCB As for level 3 core Reflective practice may also include; •Conducting root cause analysis relating to serious concerns about the management of child protection case in which there was multiagency involvement (6 hours equivalent) •Completion of a chronology relating to child(ren) in whom there are complex child protection concerns to include an analysis of each episode of care (6hours equivalent) •“Holding a conversation” with a serious review team relating to a case with personal involvement to include reflective summary (2 hours equivalent). •Forming part of a review group for a serious case review or local case review to include personal reflective summary (6 hours equivalent) •Running training sessions relating to safeguarding to a multidisciplinary and multiagency audience (2 hours equivalent).
Level 3	Each member of staff should take personal responsibility for maintaining a training log/passport An example of a template training log/passport is included at the end of this matrix.		

	Child protection supervisors and the named professionals for safeguarding will provide oversight of reflective practice and notify the training department of satisfactory completion of training. UHPNT applications for the multiagency SCB courses are administered from the safeguarding children office and the training department is notified of attendance.

University Hospitals Plymouth NHS Trust

Safeguarding Training Passport

Staff must be proficient and work within their competence to deal with Child Protection/Safeguarding issues .This passbook is for staff that require Safeguarding Children Level 3 competencies as defined in the: " **Safeguarding Children & Young People: roles and competences for health care staff – Intercollegiate Document 2019**" or/and **Safeguarding Adult Level 3 competencies as defined in the Adult Safeguarding Roles and Competencies for Health Care Staff Intercollegiate Document 2018**
(indicate as appropriate)

Safeguarding Adult Level 3	
Safeguarding Children Level 3	
Safeguarding Adult Level 3 & Safeguarding Children Level 3	

Outcome measures for Level 3 Training

1. To gain knowledge and understanding of child abuse/adult abuse issues
2. To have an understanding of the roles and responsibilities of agencies
3. To gain an understanding of child protection/adult protection procedures
4. To become aware of, and be alert to signs of abuse
5. To maintain a focus on the child/adult at risk and safeguarding while recognising the varying complexities in different families and the needs of parents/carers
6. To be confident in making effective referrals
7. To understand responsibilities to and be confident in sharing information within and between agencies.
8. To engage in supervision for the safeguarding of children/adults

Summary of training requirements

A minimum of 2 hours per year/6-12hours over 3 years for all staff who's role means they require level 3 training for both adults and children. This passport can be used for both or either depending on your requirements Training experience should include a combination of the following:

a. Face-to-face training, e.g. Safeguarding Children Board-(in house Safeguarding adults training) courses/seminars/updates
b. Recognised e-learning courses

c. External meetings, courses, conferences – (a variety of course topics will count towards Child Protection training e.g. domestic violence, drug and alcohol abuse
d. Experiential learning – documented supervision, peer review, departmental meetings, audit and attendance at case conferences - (Reflective learning record must be completed). If unsure, please contact the safeguarding team for advice 01752439053.

Personal details:

Name	

Current role / Job Title	

Date of completion of evidence for compliance

Date	Nature of training	Start Time	Finish Time	Reflection Completed Yes/No	Managers signature

Safeguarding Referrals | Appendix 4

1.

Referrals to Social care

All referrals to Children's Social Care must be done in writing and all referrals to social care must be copied to the safeguarding team plh-tr.safeguarding@nhs.net

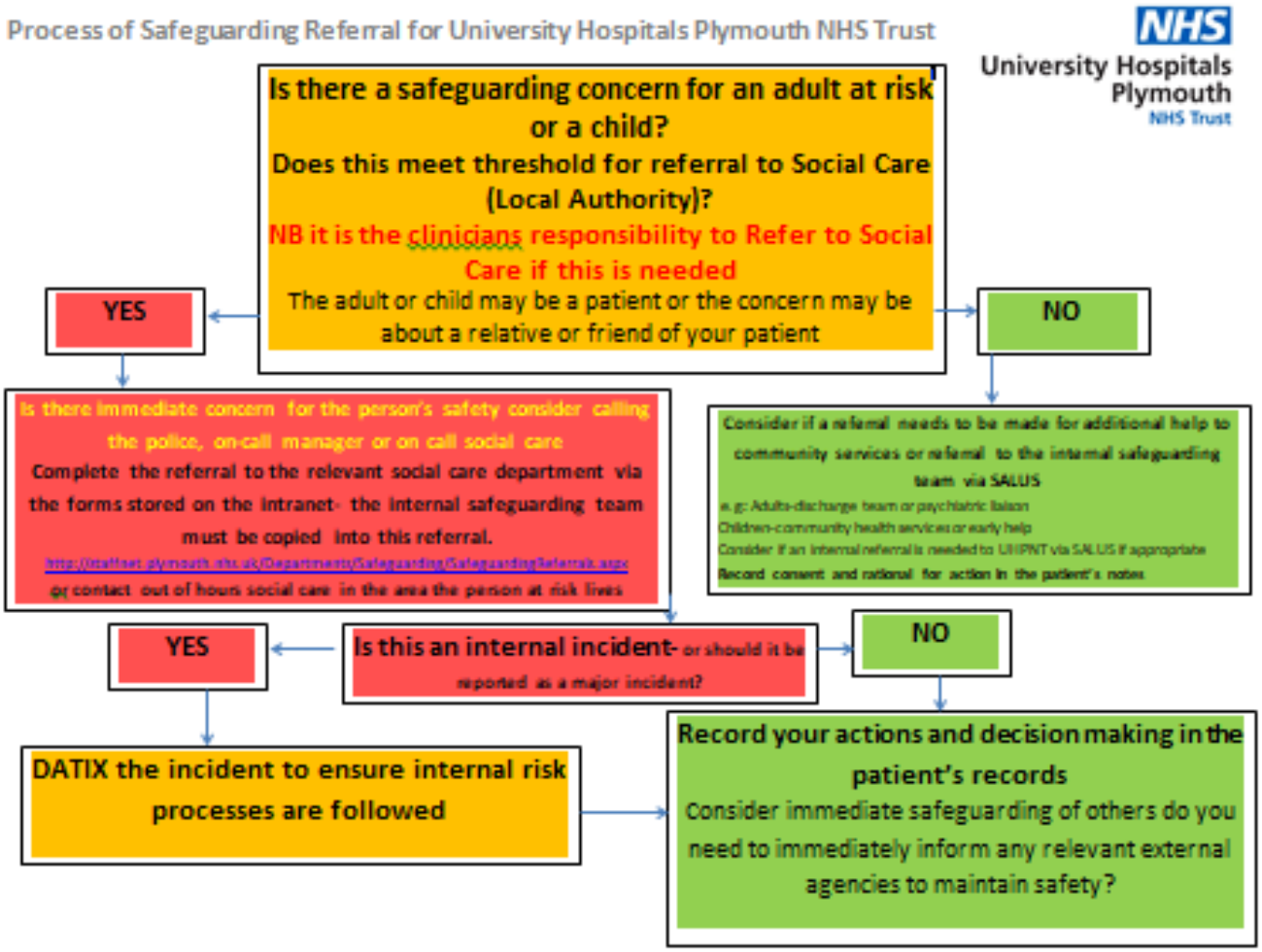
Up to date referral forms for our main areas can be found on the intranet
http://staffnet.plymouth.nhs.uk/Departments/Safeguarding/SafeguardingReferrals.aspx

It may be necessary to make an urgent verbal referral especially out of hours and this must be followed up within 48 hours but as soon as possible in writing and copied to the internal safeguarding team.

- **Plymouth Out of hours contact: 01752 346984**
- **Cornwall Out of hours contact: 01208 251300**
- **Devon Out of Hours: 01392 384050**

2. **Referrals to the children's safeguarding team including midwifery safeguarding**.
Please refer any safeguarding out of hours concerns to UHPNT safeguarding team using SALUS. See attached for referral process. **This is an internal referral system and not to replace a children's social care referral.**

Flow chart 2020.docx



Framework for Assessment | Appendix 5

The Framework for the Assessment of Children in Need and their Families provides a systematic basis for collecting and analysing information to support professional judgements about how to help children and families in the best interests of the child. Practitioners should use the framework to gain an understanding of the following domains:

- A child's developmental needs;
- The capacity of parents or caregivers to respond appropriately to those needs, including their capacity to keep the child safe from harm;
- The impact of wider family and environmental factors on the parents and child.

This is conceptualised in the Assessment Triangle shown below.

Plymouth Safeguarding Children Board currently references this assessment of children's needs throughout their multiagency guidance.

Identification of Cases to be brought to Safeguarding Supervision

Examples of when practitioners should seek support within the supervisory process include:

Cases where:

- A referral to children's social care has been made
- Children are subject to Child Protection (CP) Plans
- Children are subject to Child In Need (CIN) plans
- Staff are working directly with a Looked After Child (LAC)
- Staff have been asked to contribute to an Early Help Assessment
- The practitioner has attended / been invited to a strategy meeting
- Professionals have concerns regarding interagency working
- Professionals feel that they would benefit from support to aid reflection in practice

- When working with families suffering from Domestic Abuse/ Domestic Violence (DA/ DV)
- When working with families where Substance Misuse is an issue
- When working with families where Mental Health problems are an issue

Supervision can be used to discuss issues such as:

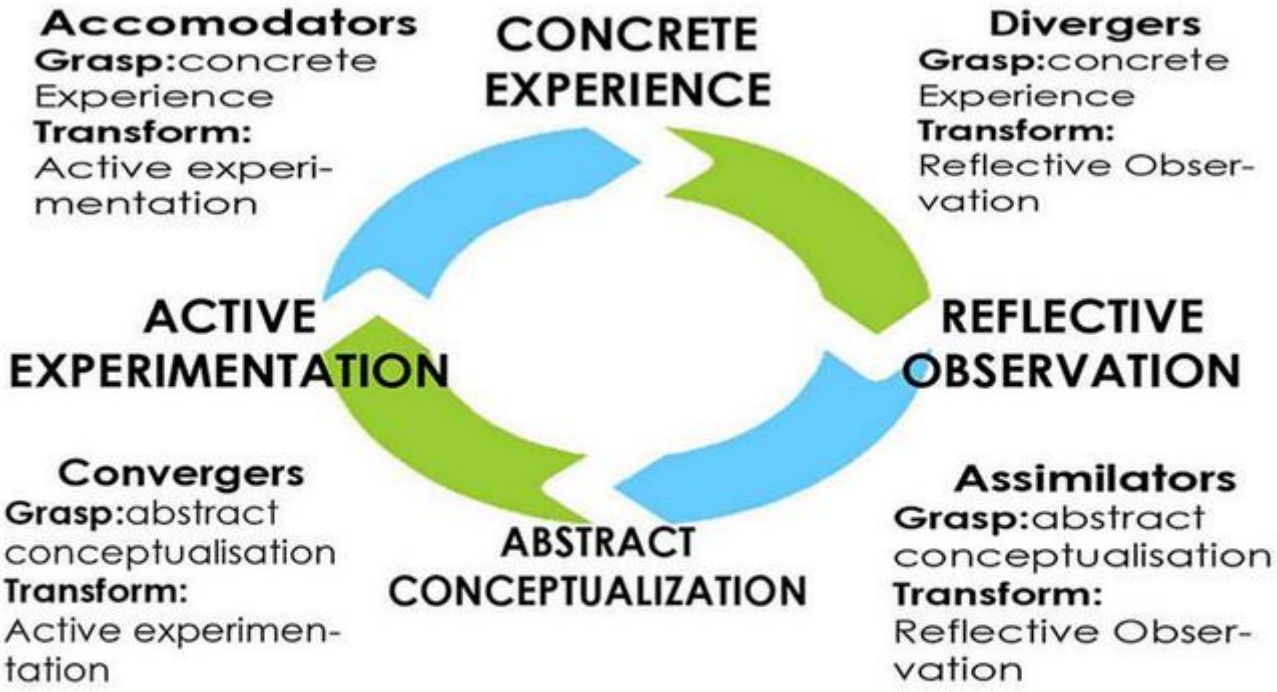
- The safety of an unborn child
- Staff have identified an adult at risk who has dependent children
- There are young parents / young parents expecting a child
- Parents themselves have been subject to professional intervention as a child
- A pre-mobile child has sustained any bruise or injury
- There has been a previous sudden infant death in the family
- The family are homeless or have just moved to the area and not known to community health services
- A child presents to UHPNT services alone
- The practitioner feels uncertain, is anxious or may be changing their behaviour to avoid conflict.
- The practitioner is afraid to share concerns with a family or feel relieved when they do not have to see a family or leave a visit.
- To discuss management of a case when multi-agency working is key to management.
- When escalation is being considered when working with multi-agency partners

Safeguarding Supervision can be accessed via telephone or face to face in the safeguarding office on L12 Derriford Hospital during office hours.

The safeguarding team hold safeguarding supervision sessions in local areas where practitioners have been assigned as requiring safeguarding specialist training (Intercollegiate document 2019).

Kolb reflective cycle

Kolb's theory has a holistic perspective which includes experience, perception, cognition and behavior. The learning cycle basically involves four stages, namely: concrete learning, reflective observation, abstract conceptualization and active experimentation. Effective learning can be seen when the learner progresses through the cycle.



KOLB'S LEARNING CYCLE

Safeguarding Supervision paperwork | Appendix 7

For practitioners with caseload holding responsibilities accessing supervision please see attached

Safeguarding Supervision Paperwor

For practitioners accessing group supervision sessions please see attached

Safeguarding Group Supervision Paperwor

For practitioners delivering telephone supervision please see attached

Safeguarding Supervision Paperwor