### Child Protection Policy

**Issue Date** | **Review Date** | **Version**
---|---|---
April 2018 | April 2020 | Version 8

**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, Named Nurse Safeguarding Children

Josie Griffith Senior Safeguarding Nurse Advisor

**Review**

Safeguarding Steering Group

**Ratification**

Greg Dix Director of Nursing (Executive lead for Safeguarding)

**Dissemination**

Via the intranet, publication and sharing with managers

**Compliance**

Safeguarding Committee

**Links to other policies and procedures**

- UHPNT Safeguarding Adults at risk
- UHPNT Training Needs Analysis Document
- UHPNT DNA 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

**Version History**

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>April 2009</td>
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<td>Amended and approved by Child Protection Committee</td>
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<td>Amended and approved by Child Protection Committee</td>
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<td>Amended and approved by Safeguarding Steering Group</td>
</tr>
</tbody>
</table>
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 on StaffNET. Larger text, Braille and Audio versions can be made available upon request.
What to do if you are worried a child is being abused

Practitioner has concerns about a child or young person’s welfare.
Do you feel there are significant concerns about the welfare of the child/children?

Yes

Written referrals must always be made to the relevant Local Authority.
If Urgent verbally refer to Local Multiagency Safeguarding Hub, following up in writing within 48 hours
- Plymouth 01752 305200
- Cornwall 03001231116
- Devon 03451551071
If you are making a child protection referral it is best practice to discuss with the family to gain informed consent, if it is safe to do so
Always copy the Children’s Safeguarding team into the written referral Ph.tr.safeguarding@nhs.net
A SALUS referral is not required to the safeguarding team if a written referral to social care is made.

No

No further child protection action.
Complete UHPNT SALUS internal Safeguarding Alert
Practitioners must consider whether an Early Help Referral could be made with parents’ consent.

Plymouth: 01752 307160
Cornwall: 01872 322277
Devon: Referral must be in writing available via website https://new.devon.gov.uk/resources/safeguarding-and-early-help

You can discuss with your Manager and/or Senior Colleague. Further advice may be sought from the Children’s Safeguarding Team 01752 439053 in office hours or the on call manager out of hours via switch

Always ensure patient records are completed according to professional guidelines
Please see Appendix 6 for Safeguarding Referral forms
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>Purpose</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>Definitions</td>
<td>6</td>
</tr>
<tr>
<td>4</td>
<td>Duties</td>
<td>6</td>
</tr>
<tr>
<td>5</td>
<td>Main body of policy</td>
<td>9</td>
</tr>
<tr>
<td>5.1</td>
<td>Background</td>
<td>9</td>
</tr>
<tr>
<td>5.2</td>
<td>Recognition of abuse and neglect</td>
<td>10</td>
</tr>
<tr>
<td>5.3</td>
<td>Completing a local multiagency safeguarding referral</td>
<td>11</td>
</tr>
<tr>
<td>5.4</td>
<td>Clinical responsibilities</td>
<td>11</td>
</tr>
<tr>
<td>5.5</td>
<td>Confidentiality and information sharing</td>
<td>13</td>
</tr>
<tr>
<td>5.6</td>
<td>Allegations against staff or members of the public</td>
<td>13</td>
</tr>
<tr>
<td>5.7</td>
<td>Safeguarding Supervision</td>
<td>14</td>
</tr>
<tr>
<td>6</td>
<td>Overall Responsibility for the Document</td>
<td>15</td>
</tr>
<tr>
<td>7</td>
<td>Consultation and Ratification</td>
<td>15</td>
</tr>
<tr>
<td>8</td>
<td>Dissemination and Implementation</td>
<td>15</td>
</tr>
<tr>
<td>9</td>
<td>Monitoring Compliance and Effectiveness</td>
<td>16</td>
</tr>
<tr>
<td>10</td>
<td>References and Associated Documentation</td>
<td>16</td>
</tr>
<tr>
<td>Appendix 1</td>
<td>Dissemination Plan and Review Checklist</td>
<td>18</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>Equality Impact Assessment</td>
<td>19</td>
</tr>
<tr>
<td>Appendix 3</td>
<td>UHPNT Training Strategy</td>
<td>21</td>
</tr>
<tr>
<td>Appendix 4</td>
<td>Safeguarding referral forms</td>
<td>25</td>
</tr>
<tr>
<td>Appendix 5</td>
<td>Framework for assessment</td>
<td>26</td>
</tr>
<tr>
<td>Appendix 6</td>
<td>Identification of supervision</td>
<td>27</td>
</tr>
<tr>
<td>Appendix 7</td>
<td>Safeguarding Supervision Paperwork</td>
<td>28</td>
</tr>
</tbody>
</table>
1 | Introduction

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

All those who come in to contact with children and their families have a duty to ensure the safety and protection of children. This applies to those who have a specific role caring for children and those who occasionally come into contact with children in their work and wider community (Working Together to Safeguard Children 2015).

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). To a limited extent, 16 and 17 year-olds can also take medical decisions independently of their parents according to the Mental Capacity Act 2005 but safeguarding children must always be the priority in practitioner’s decision making.

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 multi-agency 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 Management must develop and lead a culture within the organisation where staff feel supported in safeguarding children.

UHPNT will ensure staff have access to:

- appropriate training
- advice and support
- safeguarding supervision

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 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), and in accord with UHPNT Training Needs Analysis and Induction Process (see UHPNT induction and Training Needs Analysis document).
UHPNT works collaboratively with The South West Peninsula network of Safeguarding Children’s Boards (SCB) to align our agencies responsibility and ensure a collective multiagency approach to safeguarding children.

3 Definitions

- The Safeguarding Children’s Board (SCB) is currently a key statutory inter-agency, which acts as a focal point for local co-operation to safeguard children. The Trust works in partnership with the Plymouth SCB and contributes to partnership working with the Cornwall and Devon SCB’s.
- Designated Nurse and Designated Doctor - Lead on Child Protection matters within the area covered by the Trust. The CCG have oversight for Designated Professionals. Designated Professionals provide advice, supervision and support to the Named Doctor and Nurse.
- Named Doctor and Named Nurse - 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). To a more limited extent, 16 and 17 year-olds can also take medical decisions independently of their parents.
- 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.

Gillick competence is the principle used to judge capacity in children to consent to medical treatment. Fraser guidelines are used specifically for children requesting contraceptive or sexual health treatment. If a child under the age of 16 is not Gillick competent they lack the capacity to consent and this can be given on their behalf by someone with parental responsibility. The child’s best interests must remain paramount and their best interests must be at the heart of decision making. No child under the age of 13 can be deemed competent to make informed decisions about their sexual activity.

4 Duties

4.1 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 issues.

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 Group

- 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 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 and Safeguarding Adults Boards.

To ensure learning from Serious Case Reviews, Serious incidents and clinical audit is integrated across services/clinical practice, to improve safeguarding and protection of service users.

To oversee the training needs analysis and delivery of staff training, ensuring staff have appropriate knowledge and skills to safeguard people and monitor training compliance.

4.4 Duty of the Trust Safeguarding Committee (formally the Child Protection Committee)

- To support the Named Doctor and Named Nurse in their child protection 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 monitor adherence to national performance standards and to formulate action plans where standards are not being met.
- To ensure action plans are followed through to enable national performance targets to be achieved.
- To monitor the provision and uptake of child protection training and supervision by UHPNT staff.
- To monitor national statutory employment procedures used to screen employees whose work brings them into contact with children.
- 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 Director of Nursing

The Director of Nursing is responsible for:

- Acting as the lead Director with executive responsibilities for child protection.
- 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 the Plymouth, Cornwall or Devon SCB by undertaking internal management case reviews according to agreed standards as laid out in Chapter 4 of Working Together to Safeguard Children.
- Presenting an annual report to the Trust Board on child protection activity within the Trust, including training undertaken and consequent resource pressures.
- Maintaining a link and contributing to the work of the Local Safeguarding Children Boards 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 across the South West Peninsula to enable sharing of 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 oral 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 requirements, monitored through their annual appraisal.
- Ensuring staff have access to supervision and advice via the safeguarding team, 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.

• Ensuring that all Trust employees who come into contact with children during the course of their work are subject to a formal police check as outlined in UHPNT Trust’s Policy and Procedure 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.


• Referring to social care in writing as required to protect children.

• Complying with any additional Safeguarding guidelines or procedures that have been produced specifically for a department e.g. Emergency Department, or staff groups e.g. 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 (SALUS).

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. Abuse of children is categorised as – Physical, Emotional and Sexual abuse and Neglect (Working Together 2015).

Any abuse has to be seen in context, to assess the extent of harm to a child and access effective intervention. Often it is the interaction between a number of factors which increase the likelihood of abuse and potential level of significant harm.

There is a clear link between domestic abuse, mental health, substance misuse and child abuse. Research continually shows a synergy effect on the significant risk to the health, development and safety of children when these themes are part of a child’s parenting and/or environment (Brandon et al 2016).

The cross-government definition of domestic violence and abuse (HMGOV 2018) is any incident or pattern of incidents of controlling, coercive, 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. The abuse can encompass, but is not limited to:

• psychological
• physical
• sexual
• financial
• emotional

Domestic abuse definition now includes controlling and coercive behaviour.
Serious Case Reviews (SCRs) continue to highlight key themes in cases where children have been significantly harmed.

This list is not exclusive or always an indicator of abuse but consideration should be given when working 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)
- Female Genital Mutilation (FGM)
- Online safety
- PREVENT agenda
- Modern slavery
- Child trafficking
- Injuries in non-mobile children
- Young people who deliberately self-harm

Appendix 6 identifies possible cases where safeguarding supervision may be sought by practitioners

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 (page 3 ‘What to do if you are worried about a child being abused’).

- Take any immediate emergency action to ensure the child is safe.
- Include parents in discussions unless to do so would place the child or you at risk.
- 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.

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.

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. Professionals must consider that the perpetrator may present a risk to children and should share the information with a statutory agency.
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 3).

Medical examination in relation to sexual abuse should always be undertaken by Sexual Assault Referral Centre (SARC).

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

- Concerns should be discussed with the child (dependent on age and development) and the parents and 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.

- 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. If parents do not consent they should be informed of referral when it is safe to do so. (Appendix 4 for local referral forms).

- Urgent referral may be accepted by the relevant Local Authority via telephone but must be followed up in writing within 48 hours and copied to UHPHT safeguarding team.

- 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.

- When children from another country presents to UHPNT services and staff recognise child protection concerns; a referral must be sent to Plymouth Safeguarding Children Hub on 01752 305200.

- 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 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 full 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.

• When a child has been examined by a doctor, and concerns about deliberate harm have been raised, 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 2015).

• 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.

• The investigation and management of a case of possible deliberate harm to a child must be approached in the same systematic and rigorous manner as would be appropriate to the investigation and management of any other potentially fatal disease.

• Child protection and safeguarding children is an emotive topic and at times there may be differences of professional opinion. The Multiagency escalation policy should be used in these occasions (LSCB website) to ensure that children are safeguarded.

• Safeguarding supervision may be sought from the Named Doctor for Safeguarding Children or the 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 should be contacted for information regarding previous hospital admissions out of area.

• No child about whom there are child protection concerns should be discharged from hospital to the community without an identified GP. It is the responsibility of the paediatric consultant under whose care the child is admitted to ensure this.

• No child about whom there are child protection concerns should be discharged from hospital without:
  • 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 either by telephone or safe email.
  • 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 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 via SALUS.

5.5 Confidentiality and Information Sharing
Personal information about children and families held by health professionals is normally subject to a duty of confidence and would not be disclosed without consent (HM Government 2015). However, practitioners are able to share information to protect a child at risk of significant harm under the jurisdiction of the 1989 Children’s Act.

Practitioners must apply the Caldicott principles when sharing information without consent and document in the records reasoning of why consent has been over ridden (Caldicott 2013).

Guidance from NMC (Nursing and Midwifery Council 2017) HCPC (Health Care Professions Council 2017) and GMC (General Medical Council 2012) on confidentiality is clear that information may and should be disclosed to third parties to assist in the prevention and detection of abuse.

This relates to both children who may be the subject of abuse and adults who may pose a risk to children.

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. The Safeguarding Children’s team can provide supervision and advice to staff around safeguarding and child protection issues.

5.6 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.

All UHPNT staff who have concerns about the behaviour of a colleague or any other adult who works with children must alert the designated senior manager or their deputy. If an allegation is made against their designated senior manager UHPNT, their senior manager or the safeguarding team should be informed.

If anyone has concerns that a colleague or manager may have behaved inappropriately or has received information that may constitute an allegation the member of staff should:

1. Report it to the designated senior manager as soon as possible.
2. Make a signed and dated written record of the concerns, observations or the information received.
3. Maintain confidentiality and guard against publicity while an allegation is being considered.

TRW.SAF.POL.346.8 Child Protection Policy
4. 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 behavior 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” See Pg. 3) 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).

All UNPNT employees have a professional obligation to protect children and escalate concerns at all times within the working and non-working environments. Support or supervision can be requested via your line manager or the safeguarding children’s team 01752 439053

5.7 Safeguarding 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 (Gibbs 1998, see Appendix 7) is essential to ensure the process is thorough and to maximise benefit. The supervisee and supervisor should have knowledge and contract into the 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.


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. (See Appendix 6)

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, currently the ‘Vital Signs’ electronic newsletter.

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 Child Protection Committee.

- Regular clinical audits identified in the annual audit plan are undertaken to ensure compliance with local and national guidance.
- The Child Protection 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 Child Protection Committee and signed off once completed.
- Registers are kept of all staff attending Child Protection Training.
- It is planned that 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 2014.

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


5. HM Government (2015) *Information sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers*. Online resource


12. NSPCC (2018) *Domestic Abuse Signs Indicators and Effects* Online resource


15. The Children Act 1989 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

### Dissemination Plan

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Child Protection Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Finalised</td>
<td>April 2018</td>
</tr>
</tbody>
</table>

### Previous Documents

**Action to retrieve old copies**

Electronic version on Trust Documents Network Share Folder

### Dissemination Plan

<table>
<thead>
<tr>
<th>Recipient(s)</th>
<th>When</th>
<th>How</th>
<th>Responsibility</th>
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<tbody>
<tr>
<td>All Trust staff</td>
<td>April 2018</td>
<td>Vital Signs</td>
<td>Alison O’Neill</td>
</tr>
<tr>
<td>All DMs</td>
<td>April 2018</td>
<td>Email</td>
<td>Alison O’Neill</td>
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### Review Checklist

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

<table>
<thead>
<tr>
<th>Date</th>
<th>11.04.18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Child Protection Policy</td>
</tr>
</tbody>
</table>

### 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 adults 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

<table>
<thead>
<tr>
<th>Internal involvement and consultation</th>
<th>There has been engagement internally around the Protection of Children and this includes:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Child protection Committee</td>
</tr>
<tr>
<td></td>
<td>- Safeguarding Steering Group</td>
</tr>
<tr>
<td></td>
<td>- Staff Engagement</td>
</tr>
<tr>
<td>External involvement and consultation</td>
<td>Consultations with the following</td>
</tr>
<tr>
<td></td>
<td>NHS Plymouth 0-19 service</td>
</tr>
<tr>
<td></td>
<td>NHS Cornwall 0-19 service</td>
</tr>
<tr>
<td></td>
<td>NHS Devon 0-19 service</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Action</th>
<th>Owner</th>
<th>Risks</th>
<th>Completion Date</th>
<th>Progress update</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>
Safeguarding Children
Training for Health Care Staff
University Hospitals Plymouth NHS Trust
2018

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 (2014) 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 2015’.

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.
<table>
<thead>
<tr>
<th>Level of Training</th>
<th>Who for?</th>
<th>Requirements</th>
<th>Current UHPNT provision</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1</strong></td>
<td>All staff working in a healthcare setting. Basic safeguarding / child protection training across all organisations working with children and young people.</td>
<td>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</td>
<td>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</td>
</tr>
<tr>
<td><strong>Level 2</strong></td>
<td>All non-clinical and clinical staff who have any contact with children, young people and /or parents / carers.</td>
<td>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 6 months (minimum 2 hours). Over a 3 year period professionals at level 2 should receive refresher training equivalent to a minimum of 3 – 4 hours.</td>
<td>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</td>
</tr>
<tr>
<td><strong>Level 3 Core</strong></td>
<td>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</td>
<td>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</td>
<td>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</td>
</tr>
<tr>
<td>Safeguarding / Child Protection Concerns</td>
<td>/ Child Protection.</td>
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<tr>
<td>----------------------------------------</td>
<td>--------------------</td>
<td></td>
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<tr>
<td>Over a 3 year period professionals should receive refresher training equivalent to a minimum of 6 hours.</td>
<td></td>
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</tr>
<tr>
<td>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.</td>
<td></td>
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<tr>
<td>and own role (2 hours equivalent)</td>
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<tr>
<td>• Participation in a multiagency case review to include reflective summary of core learning outcomes (2 hours equivalent)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• Participation in peer review of a child protection case in which there was multiagency involvement to include personal reflective summary (2 hours equivalent)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• 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)</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Level 3 Specialist**

<table>
<thead>
<tr>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>Attendance at CPA (child protection advance), 2 day multiagency training course run by SCB</td>
</tr>
<tr>
<td>As for level 3 core</td>
</tr>
<tr>
<td>Reflective practice may also include;</td>
</tr>
<tr>
<td>• Conducting root cause analysis relating to serious concerns about the management of child protection case in which there was multiagency involvement (6 hours equivalent)</td>
</tr>
<tr>
<td>• 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 (6 hours equivalent)</td>
</tr>
<tr>
<td>• “Holding a conversation” with a serious review team relating to a case with personal involvement to include reflective summary (2 hours equivalent).</td>
</tr>
<tr>
<td>• Forming part of a review group for a serious case review or local case review to include personal reflective summary (6 hours equivalent)</td>
</tr>
<tr>
<td>• Running training sessions relating to safeguarding to a multidisciplinary and multiagency audience (2 hours equivalent).</td>
</tr>
</tbody>
</table>

**Level 3**

| Each member of staff should take personal responsibility for maintaining a training log. An example of a template training log 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. |
Safeguarding Referral Forms

1. **Referrals to Social care**

All referrals to social care must be copied to the safeguarding team ph-tr.safeguarding@nhs.net

All information re referral to the Local Authority is on the Safeguarding page of the intranet including on-line referral forms.

- **Plymouth** are often happy for a verbal referral but this must be followed up within 48 hours in writing so that they have written confirmation and we have evidence.
  
  *Out of hours contact: 01752 346984*

- **Cornwall** need a written referral using the correct template (see below). Urgent referrals must be followed up in writing within 48 hours using the same template. Cornwall have requested non-urgent telephone calls are not made as they have a sleeping on-call service. Non-urgent referrals must be made in writing using the recognised Cornwall referral form (See below).
  
  *Out of hours contact: 01208 251300*

- **Devon** may accept verbal referrals via telephone however must have a written referral using the correct template within 48 hours (see below).
  
  *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.**

- PDF: 1 - Installing SALUS.pdf
- PDF: 2 - Sending alert.pdf
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 requiring Supervision

Identification of Cases to be brought to Safeguarding Supervision

Practitioners should seek support within the supervisory process when:

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 2014).
For practitioners with caseload holding responsibilities accessing supervision please see attached

Safeguarding Supervision Paperwork

For practitioners accessing group supervision sessions please see attached

Safeguarding Supervision Paperwork

For practitioners delivering telephone supervision please see attached

Safeguarding Supervision Paperwork

Safeguarding Supervision Monitoring Form (for supervisor’s records)

Safeguarding Supervision Monitoring Form

Gibbs reflective cycle

GIBBS reflective cycle.docx