The Shrewsbury and Telford Hospital NHS
NHS Trust

Safeguarding Children and Young People Guidelines and Procedure

(to be read in Conjunction with the 'Safeguarding, Child Protection and Vulnerable Families Maternity Services' Guideline and also the Trust Training Policy)

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V10		November 2023	T Tanner		Annual Review. Addition of bruising in non mobile babies

Contents

The Voice of the Child

As a Trust we have spoken to Children and Young People who have been In Patients and asked them what they think the staff should be doing to keep them safe.

Adults working in our Trust will always try and keep our Children and Young People safe.

With special thanks to Lacey 12, Holly 13, Courtney 17, Will 14, Daisy 14, Eleanor 16 and Sam 11 and also Kerry, Youth Worker for her help with this project

1 Introduction

This Policy is not intended to replace the guidelines of the Local Safeguarding Partnerships, but to be read in conjunction with them. This policy should also be read in conjunction with the West Midlands Regional Procedures.

This document is designed for all staff working within The Shrewsbury and Telford Hospital NHS Trust, to help them to recognise and respond to cases of abuse and neglect of children and young people and are intended to reflect the Safeguarding Guidelines for Telford & Wrekin, Shropshire and Powys Safeguarding Community Partnerships.
The purpose of this policy is to detail the arrangements for safeguarding children and young people

Working Together to Safeguard Children: A Guide to Inter-agency Working to Safeguarding and Promote the Welfare of Children (2018) (Working Together 2018) sets out how professionals should work together in multi-agency team to promote children's welfare and protect them from abuse.

2 Scope

The contents of this policy will apply to all staff working within the Trust. This includes agency staff and all contractors.

3 Purpose

The purpose of this policy is to ensure that all child protection and safeguarding issues identified within the Trust are reported and referred professionally and that effective and appropriate action is taken to always ensure the welfare of all children by all staff.

4 Aims of Policy

To help staff to take all reasonable measures to protect children and young people from abuse and neglect by:

- Early recognition of potential abuse situations so that preventive measures can be taken.
- Early identification of known or suspected abuse of children and young people (there may be firm evidence or merely suspicions and concerns)
- Taking appropriate actions at the right time.
- Co-operation with other relevant agencies to ensure the safety and wellbeing of children and young adults.
- To ensure discharge to a safe environment

5 Principles of Safeguarding Children and Young People

The Children Act 2004, as amended by the Children and Social Work Act 2017, strengthens this already important relationship by placing new duties on key agencies in a local area. Specifically, the police, Integrated Care Board and the local authority are under a duty to make arrangements

to work together, and with other partners locally, to safeguard and promote the welfare of all children in their area.

Everyone who comes into contact with children and families has a role to play

Safeguarding and promoting the welfare of children is defined for the purposes of this guidance as:

- protecting children from maltreatment
- preventing impairment of children's health or development
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care
- taking action to enable all children to have the best outcomes

(Working Together To Safeguard Children HM Govt 2018)

5.1 All services must be provided in a manner that respects dignity, privacy and beliefs of all individuals concerned and does not discriminate based on race, gender, language, sexual orientation or disability.

5.2 When communication with a child is necessary for the purpose of safeguarding and the first language is not English, an interpreter must be used and not a family member.

5.3 The responsibility to refer children considered to be at risk rests with the professional who has the concern and not the Named / Lead Professionals.

5.4 All agencies receiving information in relation to a child protection investigation must treat it as confidential.

5.5 All health professionals working with children, their families and carers have a responsibility to take appropriate action should they believe that a child is at risk or has suffered significant harm. Safeguarding children should not be seen as a separate activity from promoting welfare (Working Together to Safeguard Children, 2018) ***When child protection concerns are identified by staff a referral must be made to social care.***

5.6 All children have the right to be safeguarded from harm and exploitation without regard to:

- Race, religion, preferred language or ethnicity
- Gender or sexuality
- Age
- Health or disability
- Criminal behaviour
- Political or immigration status.

6 Definitions

6.1 Definition of Children

Safeguarding Children is defined in Working Together 2018 as:

- Protecting Children from maltreatment
- Preventing impairment of children's health or development
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care
- Taking action to ensure that children have the best outcome
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For the purpose of this policy, a child is defined as a person who hasn't yet reached their 18th birthday.
(Working Together 2018)

It also includes children and young people who may be 16 years or over and living independently, in further education, a member of the Armed Forces, in hospital, prison or a young offender's institution. This is in accordance with the Children Act 1989.

Here after the word Children applies to Children and Young People.

6.2 Definition of Abuse

Abuse and neglect are forms of maltreatment of a child.

Physical	Hitting; shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. This could also be a fabricated or a deliberately induced illness by the parent /carer.
Emotional	Persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. Conveying to children that they are worthless, unloved or inadequate. Age-inappropriate expectations of a child, overprotection of a child, limitation of exploration and learning. Domestic Abuse, Serious bullying, Exploitation or corruption of children. Racial Abuse.
Sexual	Forcing or enticing a child or young person to take part in sexual activities including prostitution whether or not the child is aware of what is happening. This may involve physical sexual contact e.g., rape, buggery, oral sex. Non-penetrative sexual acts, such as pornography. Watching sexual activities or encouraging children to behave in sexually inappropriate ways.
Neglect	The persistent failure to meet a child's basic physical and or emotional needs. Ignoring medical or physical care needs; failure to provide access to appropriate health, social care or educational services; the withholding of the necessities of life such as medication, adequate nutrition and clothing.

6.3 **Harm**:
Now includes the impairment of a child's' health or development as the result of witnessing harm or ill treatment of another person (Adoption and Children Act 2002)

6.4 **Child In Need:**
A child is defined as being a child in need if:

- They are unlikely to achieve or maintain, or have the opportunity of achieving, or maintaining, a reasonable standard of health or development without the provision for them of services by the local authority.
- Their health or development is likely to be significantly impaired or further impaired without the provision of such services.
- They are disabled. (Children Act 1989, section 17d)

6.5 **Significant Harm:**

Where the question of whether harm suffered by a child is significant, the child's health and development shall be compared with that which could be reasonably expected of a similar child. There are no absolute criteria to judge what constitutes significant harm therefore it is the responsibility of Children's Social Care to make a judgement if the threshold for a section 47 enquiry has been met.

However, staff will make referrals to Children's Social Care if a child.

- Has suffered significant harm – where a child has complex and significant needs that may not be being fully met resulting in a risk to their safety
- Has additional needs and their safety may be at risk.

6.6 **The Concept of Significant Harm:**

6.6.1 Harm is defined as: Ill treatment or impairment of health and development and impairment suffered from seeing or hearing ill-treatment of another

6.6.2 A single traumatic event e.g., severe injury may constitute significant harm, or it may be a compilation of significant events both acute and long-standing.

6.6.3 Children and young people may be vulnerable to the risk of significant harm by virtue of their own risk taking or dangerous behaviour. Examples of this may be seen when children are.

- Beyond parental control
- Engaging in self harm or
- Extreme risk-taking behaviour

6.6.4 Significant harm represents the threshold that justifies compulsory intervention in family life in the best interest of the children and gives the Local Authority a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer significant harm.

6.6.5 If a staff member suspects that a child is at risk or has suffered significant harm including self harm, this must be referred immediately to Children's social work services.

6.7 **Domestic Abuse**:

Significant harm resulting from domestic abuse may manifest itself in a variety of ways, including physical violence, emotional abuse, sexual violence and abuse, financial control and abuse and the imposition of social isolation or movement deprivation. Working Together 2018 states “Normally one serious incident or several lesser incidents of domestic abuse where there is a child in the household would indicate that Children’s Social care should carry out an initial assessment of the child and family, including consulting existing records”

When any professional becomes aware of domestic abuse within a family, they should make a risk assessment as to the impact on any unborn baby or children in the household. Agreement to refer should be sought but it is not necessary if the professional is concerned about the child.

The Domestic Abuse Act 2021 has changed the definitions of Domestic Abuse and has included children as victims.

Behaviour of a person (A) towards another person (B) is domestic abuse if:

> A and B are each aged 16 or over and are personally connected to each other and the behaviour is abusive

A’s behaviour may be behaviour “towards” B even though it consists of conduct directed at another person (for example B’s child)

Children are victims of domestic abuse if they:

see or hear, or experience the effect of the abuse and are related (as a parent or relative) to A or B

People are personally connected if:

a. They are or have been married to each other
b. They are or have been civil partners of each other
c. They have agreed to marry one another (whether or not the agreement has been terminated)
d. They have entered into a civil partnership agreement (whether or not the agreement has been terminated)
e. They are or have been in an intimate personal relationship with each other
f. They each have, or there has been a time when they each have had a parental relationship in relation to the same child (parental relationship is if the person is a parent of the child or has parental responsibility for them)
g. They are relatives

Domestic Abusive behaviour includes:
a) Physical or sexual abuse
b) Violent or threatening behaviour
c) Controlling or coercive behaviour
d) Economic abuse (any behaviour that has a substantial adverse effect on person B’s ability to acquire, use or maintain money or other property or obtain goods or services)

e) Psychological, emotional, or other abuse.

Read the Trust Domestic Abuse Policy and the Trust Domestic Abuse and Sexual Violence Policy for Staff

6.8 **Human Trafficking / Modern Slavery**: The United Kingdom (UK) is a destination country for men, women, and children primarily from Africa, Asia, and Eastern Europe who are subjected to human trafficking for the purposes of sexual slavery and forced labour, including domestic servitude. If any member of staff is concerned that a child or young person has been trafficked or is the victim of modern slavery, either from outside the country or within the UK, they must seek advice from the relevant Children's Social Care.

6.9 **Child Sexual Exploitation / Criminal Exploitation:** Exploitation of young people is an increasingly and concerning issue.

Child sexual exploitation affects more people than many of us realise and it's important that people understand this type of abuse can happen to any child anywhere.

Young people may not realise that what is happening to them is exploitation, or they may not feel able to seek help if they are being pressured into activities they are uncomfortable with.

Parents and carers may have lots of questions and concerns about how to protect their children. Businesses may have concerns about their responsibilities to help protect children from child sexual exploitation.

Child Sexual Exploitation is a form of sexual abuse. It occurs where an individual or group take advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 years into sexual activity a, in exchange for something the victim needs or wants, and or b, the financial advantage or increased status of the perpetrator.

The victim may have been sexually exploited even if the sexual activity appears consensual. It does not always involve physical contact, it can be through the use of technology.

Definitions of County Lines and Child Criminal Exploitation-referenced in Serious Violence Strategy published by the Home Office

The Serious Violence Strategy (2018) defines county lines and criminal exploitation as follows: 'county lines' is a term used by police and partner agencies to refer to drug Page 5 of 14 networks (both gangs and organised crime groups) who use children and young people and vulnerable adults to carry out illegal activity on their behalf.
Gangs dealing drugs is not a new issue but the extent to which criminal exploitation (often organised) of children and vulnerable adults, as well as the increasing use of violence, has become an inherent part of it through county lines makes it especially damaging. In order to support different agencies and sectors working together it is important we have common definitions of the issues we are tackling.
The UK Government definition of county lines is set out below together with our definition of child criminal exploitation, which is increasingly used to describe this type of exploitation where children are involved:

County lines is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas [within the UK], using dedicated mobile

phone lines or other form of “deal line”. They are likely to exploit children and vulnerable adults to move [and store] the drugs and money and they will often use coercion, intimidation, violence (including sexual violence) and weapons.

Child Criminal Exploitation occurs where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18 into any criminal activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial or other advantage of the perpetrator or facilitator and/or (c) through violence or the threat of violence. The victim may have been criminally exploited even if the activity appears consensual. Child criminal exploitation does not always involve physical contact; it can also occur through the use of technology.

Missing Children

Children who go missing may be at increased risk of exploitation Governmental guidance describes a young runaway or a missing child as ‘children and young people up to the age of 18 who have run away from their home or care placement, have been forced to leave, or whose whereabouts is unknown’. The College of Policing definition is ‘Anyone whose whereabouts cannot be established will be considered missing until located and their wellbeing or otherwise confirmed. Categories of risk will be ‘no apparent risk, low, medium, or high’.

See exploitation pages for the referral paperwork for Shropshire, Telford & Wrekin and Powys

SaTH Intranet - Child Exploitation

Also further training available for staff

6.10 **Female Genital Mutilation:**

FGM covers all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. It is also sometimes referred to as female genital cutting or female circumcision.
It has been estimated that over 20,000 girls under the age of 15 are at risk of FGM in the UK each year, and that 66,000 women in the UK are living with the consequences of it. However, the true extent is unknown, due to the "hidden" nature of the crime.
The girls may be taken to their countries of origin so that FGM can be carried out during the Summer holidays, allowing them time to "heal" before they return to school. There are also worries that some girls may have FGM performed in the UK.

Forms of mutilation

FGM is usually carried out on young girls between infancy and the age of 15, most commonly before puberty starts.

There are four main types of FGM:
Type 1 – Clitoridectomy – removing part or all of the clitoris.
Type 2 – Excision – removing part or all of the clitoris and the inner labia (lips that surround the vagina), with or without removal of the labia majora (larger outer lips).
Type 3 – Infibulation – narrowing of the vaginal opening by creating a seal, formed by cutting and repositioning the labia.
Type 4—Pricking or Piercing the genitals
Other harmful procedures to the female genitals, which include pricking, piercing, cutting, scraping and burning the area.
Whilst types 1-3 may be observed in Obstetrics and Gynaecology areas, it is Type 4 which may become apparent to others areas of the hospital. E.g., patients having to remove metal piercings before radiological / surgical procedures.

The FGM-IS alert can be seen on the Summary Care Record of all females under 18 living in England and will be an indication of whether they are at risk of FGM

6.11 **Radicalisation:**

There is no single way of identifying an individual who is likely to be susceptible to a terrorist ideology. As with managing other safeguarding risks, staff should be alert to changes in children's behaviour which could indicate that they may need help or protection. Children at risk of radicalisation may display different signs or seek to hide their views. Please read Trust Prevent Strategy. If you consider a child is being radicalised, take advice from the Trust Safeguarding Children Team / or make a referral to Children's Social Care.

6.12 **Think Family**:

Some situations are known to cause additional stress within families, including social exclusion, racism and racial harassment, mental illness of a parent or carer and drug and alcohol misuse. Sources of stress within families may have a negative impact on a child's health, development and well-being, either directly or because they affect the capacity of the parents to respond to their child's needs. This is particularly the case when there is no other significant adult who can respond to the child's needs. All staff working with adult patients need to be aware of circumstances where the parent's ability to parent their children, including keeping them safe, may be compromised. They should share their concerns with the Named Nurse or Midwife. Discussions and action taken should be recorded in the records. If any safeguarding concerns are raised, then these should be discussed directly with Children's Social Care.

6.13 **Parental Responsibility:**

Parental responsibility (PR) is defined as 'In England & Wales, if the parents of a child are married to each other at the time of the birth, or if they have jointly adopted a child, then they both have parental responsibility. Parents do not lose parental responsibility if they divorce, and this applies to both the resident and the non-resident parent'

If the parents are not married this is not the case. Current law says that a mother always has parental responsibility for her child. A father has this responsibility only if he is married to the mother when the child is born, or has acquired legal responsibility though:

- Jointly registering the birth of the child with the mother (from 1.12.2003)
- By a PR agreement with the mother
- By a PR order made by the court.

Living with the mother does not give a Father PR and if the parents are not married, PR does not pass to the birth father if the mother dies.

All parents (including adoptive parents) have a legal duty to financially support their child, whether they have PR or not.

PR can only be lost:

- When children are adopted.
- A person acquiring PR through a court order that is later revoked by the court.
- Local authority taking a care order and the local authority later revoking the care order.
- Where the court appoints a guardian.

Any letter asking a parent to attend clinic with a child must say that a person who has PR must accompany the child to clinic. This is important for aspects of consent to treatment etc.

Guide to parental consent - January 2(

6.14 **Looked After Children:**

A Looked After Child, is one who is being 'Looked After' by the Local Authority, often heard as Child in Care or Child Looked After. They must have been in the care of the Local Authority for more than 24 hours

Children & Young People could be in the care system for any number of reasons, their own safety because of safeguarding concerns at home, to keep them safe because family are unable to, a parent is in hospital and there is no one else to look after them. They could also be unaccompanied asylum seekers

They could be:

- living with foster parents
- living in a residential children's home or
- living in residential settings with educational provision or secure units

Looked After Children could be subject to the following Orders:

- Children Accommodated under section 20, Children Act (1989)
- Children receiving respite care from the local authority Section 20 Children Act (1989)
- Children subject to an Emergency Protection Order under Section 44 of the Children Act (1989)
- Children subject to court orders Section 31 and 38 Children Act (1989)

The Trust uses the Child Protection Information Sharing System to check all children who attend the Emergency Department and Child Assessment Unit for the Child Care Alert that denotes they are a Looked After Child. This alert will also give the details of the Local Authority responsible for the child.

- All children under 18 who are admitted via ED are checked against this system.
- Looked After Children from England are alerted on this system as a Child Care Alert, and when that alert is opened, the date the child became a LAC is there together with the LA responsible and phone numbers. The LA are also notified that the alert has been opened and therefore know the child is in SaTH somewhere

Private Fostering / Kinship Care is slightly different from a Looked After Child

Family and friends care (or kinship care) is an arrangement where a child who cannot be cared for by their parent(s) goes to live with a relative, friend or other connected person.

The Intercollegiate Document for Looked After Children: Roles and Competencies of Health care Staff 2020 gives guidance on the training requirements for staff. These requirements form part of the Safeguarding Children Training already in place in the Trust and are met in every level of training.

7 Responsibilities

7.1 Chief Executive Officer:

The Chief Executive Officer (CEO) is responsible for ensuring that the health needs of all children and young people are at the front of local planning and that high quality health services that meet identified quality standards are provided. The CEO will ensure that monitoring takes place of safeguarding activity to fulfil the requirements under Working Together 2018 and Care Quality Commission standards.

7.2 Executive Director Lead for Safeguarding:

The Executive Director Lead for Safeguarding takes leadership responsibility at Board level for the organisation's safeguarding arrangements

7.3 Designated Nurse and Doctor (based with the Integrated Care Board):

The term Designated Doctor or Nurse denotes professionals with specific roles and responsibilities for safeguarding children, including the provision of professional and strategic advice and guidance to organisational Boards across the health economy. This may include Named / Lead Safeguarding Health Professionals. Local Authority Children's Services Departments, the Integrated Care Board and the Local Safeguarding Partnership

7.4 Named Doctor:

Their role is to support other professionals in the Trust to recognise the needs of children.

- To promote good practice within the Trust.
- To safeguard children within the Organisation.
- To provide advice and expertise to staff.
- To liaise with colleagues in Powys when necessary
- To co-ordinate child protection training for medical staff
- To provide child protection supervision for medical staff
- To participate in internal management and serious case reviews.

7.5 Named Nurse and Midwife / Lead Nurse

Have a key role in promoting professional practice within the Trust, providing advice and expertise for other professionals and ensuring that safeguarding training is in place. They should work closely with the Executive Lead, Designated Professionals and the Safeguarding Partnership

7.6 Specialist Nurse for Safeguarding Children

The Specialist Nurse will support the Lead Nurse to provide safeguarding and child protection advice, support and training for all staff within the Trust

7.7 Heads of Department / Ward Managers

These individuals will have overall responsibility to ensure that all staff within their areas are aware of the policy and the correct procedure to follow when child abuse is suspected. To ensure that all staff have access to relevant training and child protection meetings. To liaise with the named professionals in regard to incidents concerning child protection practice.

7.8 All staff

Children can be identified anywhere within the Trust. Every member of staff needs to be aware of children and alerted to policies and procedures related to this specific group. All staff who work with children in any capacity in any area should have an enhanced DBS check completed before commencing work.

All staff should ensure that the Safeguarding Checklist has been completed. On Children's ward these are part of the admission booklet, for any of the Designated Adult wards caring for 16/ 17-year-olds. The over 16 years checklist is on the Safeguarding pages on the Intranet. Staff should ensure that the relevant Standard Operating Procedure has been followed

Staff have a duty to report any allegations or suspicions of abuse or potential abuse of a child or young person to their line Manager or more senior manager. Failure to do so may lead to disciplinary action. This is important for the protection of the person reporting the abuse and also for the safety and protection of other potential victims. This duty comes from:

- Contract of employment.
- Children Act 1989 2004
- Professional Codes of Practice (e.g., GMC, NMC)

Trust staff who work predominately or completely with adults who have parental responsibilities have the same commitment to safeguard children.

When making a referral to another agency, staff should seek the agreement of the parent / carer. However, if personal safety or the safety of the child is compromised by doing so, a referral can be made without the consent of the parent/ carer.

Telephone calls to social care must be followed up in writing within 48 hours.

7.9 What you should do if you have a concern about a child

Alerting is the necessary first step in the process of keeping children safe.

Staff are asked to document their concerns and report them to the appropriate authorities.

If staff are not sure about the need to make a referral to safeguarding, please contact the Trust Named Professionals, Named Doctor, Named Nurse or Named Midwife.

Any member of staff can refer to safeguarding.

Children, who are known to Safeguarding, will be alerted on SEMA, as 'Child at Risk, Child with Child Protection Plan', 'Vulnerable Child' (which could be that the child or young person is known the CSE / CE Panel or there are concerns about possible FII) Staff can check SEMA.

All children who attend ED and Children's Assessment Unit will be checked against the National Spine for any Child Care Alerts. This does not apply to children from Powys, as it is an English only system.

If there are child abuse concerns regarding a child from Powys, then the Child Protection Register needs to be checked for the areas the child lives in by ringing Powys Social Care.

- If the child or young person is in immediate danger, urgent action must be taken to ensure their safety by contacting the Social Care dept for where the child lives.
- Arrange immediate medical attention if required.
- Keep detailed records of what has been said.
- Listen carefully to the child and make no comments other than to offer support.
- Do not ask the child any leading questions.
- Immediately report the allegation/incident to the line manager.
- Provide adequate information on the nature of the abuse so that this can be promptly and appropriately investigated.

The referrer should:

- Contact Children's Social Care for Shropshire, Telford & Wrekin or Powys and share their concerns. All phone numbers are on the Safeguarding Children pages
- Follow up in writing by using the relevant referral form – all available under the Regional Guidelines on the Safeguarding Pages
- A copy of the referral should be kept in the notes behind the purple safeguarding divider
- If the line manager is implicated, the member of staff must raise the concern with a more senior manager e.g., Head of Nursing, or an Executive Director.

Staff should also refer to the Threshold Document for the Safeguarding Partnership where the child lives. This document is a guide for all practitioners that work with or involved with children, young families and their families. The aim of the Threshold Document is to assist staff in identifying what level of need the child has and what type of resources or services can be offered.

These documents are on the Safeguarding Children pages on the Intranet

Where staff are referring to Shropshire Children's Services they must send the MARF to the safeguarding children's team within the Trust and not directly to Social Care. Shropshire referrals are triaged each week,

Information Sharing:
Information appropriately shared on a need-to-know basis will be compliant with the Data Protection Act 1998.

Information should always be shared with the parent/carer unless your personal safety or the safety of the child is compromised

Staff have a duty under the Children Act 2004 to share information if they believe a child is at Risk of or is suffering significant harm.

8.9 **Trust Doctors:**
Following the Laming recommendations, (2003) hospital doctors need to adhere to the following:

- Doctors should be aware of the SaTH Safeguarding Children Guidelines and the Local Safeguarding Children Partnership policies.

- Doctors working in ED and those who work with children and young people should be able to recognise abuse and be familiar with local procedures for making enquiries to find out whether a child is on a child protection plan (pan Shropshire children are alerted on SEMA)

- For all children with suspected or actual abuse and / or neglect a full paediatric assessment by a paediatric consultant must be completed and documented in line with the Child Protection Medical Assessment Guideline.

- Doctors in ED should be completely satisfied that any child under the age of 18 months, who presents with a fracture, has not been subject to a Non-Accidental Injury. If there are any doubts the child should be referred to Paediatrics for a full assessment, likewise any child under 18 months for whom this is not the first fracture. Likewise any Non Mobile baby with a bruise / mark with no explanation should be discussed with Paediatrics prior to discharge from the ED

- When a doctor has examined a child and concerns of deliberate harm have been raised, no subsequent appraisal of these concerns should be considered complete until each concern has been fully addressed, accounted for and documented.

- If abuse is suspected or confirmed, an immediate phone referral must be made. This should be followed up in writing within 48 hours.

- The Lead Nurse for Safeguarding must be informed of all children seen within A/E or Paediatric areas where there are child protection concerns.

- No child about whom there are child protection concerns should be discharged at any time without the permission of the Consultant in charge of the child's care.

- When a child is admitted to hospital and deliberate harm is suspected, the doctor admitting the child must ask about previous admissions to hospital including ED attendances.

- When concerns about harm to a child have been raised, records must be kept of all telephone calls, conversations, ward rounds, and any advice from the Named Doctor / Nurse.

- When differences of medical opinion occur in relation to the diagnosis of possible abuse, a recorded discussion must take place between the relevant parties. If after a full discussion the differences are not resolved, this should be escalated upwards to the Named Dr and acted upon.

- When the deliberate harm of a child is identified as a possible diagnosis, the examining doctor should consider whether taking the history directly from a child is in the best interests of that child. If it is, the history can be taken from the child with consent from the parent with parental responsibility; this should be recorded by the Doctor.

- Hospital doctors should be alert to the potential that carers may seek medical care from a few sources in order to conceal the repeated nature of the child's injuries (Safeguarding Children in whom illness is fabricated or induced DOH 2002)

- In the event of nursing staff having concerns which are not shared by the doctors, nursing staff will be expected to report their concerns to the Named Nurse and refer to social care as required.

- No (in-patient) child for whom there are child protection/ safeguarding concerns should be discharged without a pre discharge planning meeting taking place. This should be a multiagency meeting.

- No child is to be discharged without a Named GP. If the child does not have a GP, the family must be asked to register with one as soon as possible

8.10 **Trust Nurses:**

- Nurses should be aware of the SaTH Safeguarding Children Guideline and the Local Safeguarding Children Partnership policies and the regional policies, all are available on the Safeguarding Pages on the Intranet

- Nurses working in ED and those who work with children and young people should be able to recognise abuse and be familiar with local procedures for making enquiries to find out whether a child is on a child protection plan (pan Shropshire children are alerted on SEMA)

- All children under 18 years will have the Summary Care Record checked on attendance at ED by the reception staff, this information, whether there is a Child Care Alert or not will be recorded on the front page of the ED notes

- In the event of doctors having concerns which are not shared by the nursing staff, further advice must be sought from the named professionals.

- When a child is admitted to hospital and deliberate harm is suspected, the nurse admitting the child must ask about previous admissions to hospital including ED attendances. The number of previous ED attendances is recorded on the front sheet of the ED notes automatically

- Where there are concerns that a child has been subject to deliberate harm, a record must be made in the hospital notes of all face-to-face discussions including nursing 'handover' and telephone calls relating to the child, and of all decisions made during such calls. In addition, a record should be made of who is responsible for carrying out any actions agreed.

- A current GP, school, names and relationships of all adults present with the child should be recorded.

9.0 When a child dies under the age of 18 years

Please refer to the West Mercia Police / Powys guidelines on the intranet if the death is suspicious or unexpected or the Guidelines on What to Do if A Child Under 18 Dies, if it is expected.
There are Child Death Processes that must be followed including the completion of the eCDOP form

9.1 Discharges from Hospital of a child where Non-Accidental Injury / Neglect are suspected.

No child is to be discharged from hospital until it has been approved by both Social Care and the Paediatrician involved with the child. The senior Paediatric Doctor (Tier 2 or above) on duty at the time of the child's discharge should document that the social worker is happy for discharge.

Any discharge planning or strategy meeting that takes place should involve staff from the hospital, social care and the child's primary health team (G.P, Health Visitor / School Nurse)

Any arrangements for discharge should be recorded.

If the child is to be accommodated, the Social Care team will inform the ward manager and Consultant of the Foster carer's name and address and if required the name of a different social worker.

Where possible the foster carer should visit the hospital prior to discharge, and they must show ID when collecting the child.

The discharge summary must provide details of any follow up and a copy sent to the allocated Social Worker as well as the GP / Health Visitor / School Nurse.

9.2 Discharge from Hospital against medical advice

For a parent to wish to discharge their child against medical advice there must have been a communication failure between the parent and medical staff. Either the child is well enough to go home, or there is significant risk attached to the discharge. All staff should approach this as a communication problem.

Their wish to do so is likely to first come to the notice of the nursing staff who should discuss the reasons for the parent's request and try to explore where the communication breakdown has

happened and, if appropriate, try to dissuade the parents, explaining the possible detrimental effect this could have on the child. The nurse must document this in the nursing notes.

If the nurse is unable to dissuade the parents, the medical staff should be informed. The Doctor should then review the child and again try to resolve the issue, involving the on-call Tier 2 doctor if necessary. If all attempts to dissuade the parent are unsuccessful and discharge is thought to be potentially harmful for the child, the Responsible Consultant must be informed who will then make further decisions about management. The same process should be used for children wishing to discharge themselves.

If removing the child from hospital places them at significant risk of harm, or the child is the subject of a Protection Order, the safeguarding children process as set out in this policy must be initiated. The parent should be informed of the risk that removal from hospital poses.

If the parent does take the child despite being advised of any safeguarding concerns, if the child is at significant risk of harm by not seeing a Dr or is subject to a Child Protection Plan, consideration should be made to contacting the police to immediately to return the child to hospital and a phone call to children's services should also be made.

Staff, however, must not place themselves in any danger by trying to obstruct the parent.

There may be a few occasions when it is appropriate to ask parents to sign the 'Discharge against Medical Advice' form. This form is an addition to, not a substitute for, a comprehensive record in the child's notes. Parents must be advised to contact their GP if the child continues to need care. If the parent refuses to sign and wishes to self-discharge this should be recorded in the notes.

In all cases the child's GP, Health Visitor / School Nurse, and any other relevant professionals such as Social Worker must also be informed within 24 hours that the child has left / been removed from the ward.

If the parent wants to discharge their child due to a complaint or concern about care, every effort must be made to address the issues.

In all events a DATIX must also be completed, and inform the Safeguarding Children Team

10 Children who are not brought to appointments

The National Service Framework for Children 2004 states that children and young people failing to attend clinic appointments…" may trigger concern, given that they are reliant on their parent or carer to take them to the appointment. Failure to attend may be an indicator of families' vulnerability, potentially placing the child's welfare in jeopardy".

- In 2006, the pilot study "A confidential enquiry into Maternal and Child Death: Why Children Die", stated there were several cases which were reviewed where failure to follow up a child who did not attend appointments was associated with their later death.

In light of the current covid-19 pandemic there may be many reasons for non-attendance e.g. child self-isolating after a contact at school, child unwell with fever or cough or difficulties with transport. Neglect should still be considered however the previous guidance is now as follows.

Therefore:
All children who "Were Not Brought" (WNB) or those parents that we were "Unable to contact" (UTC) should have their notes reviewed by a consultant or deputy and any decision made based on the priority of the referral.

- Consideration should be given to the accuracy of the demographic details as a cause of non-attendance and trying to contact the parents at the time of the appointment might be useful.
- The GP should be informed of the non-attendance/non-contact even if a second appointment is being offered e.g., “this boy was due to be seen in clinic today but did not attend. I telephoned the parents with the up-to-date contact no ….. but unfortunately was unable to carry out either a telephone or face to face appointment today. I have therefore done the following: - “

10.1 Children who miss First NEW Appointments – Face to Face
All NEW appointment should be Face to Face.

All Children who “Were Not Brought” should have their notes/referral letter reviewed to decide on the clinical urgency and divided into 3 groups:

1) For urgent cases (risk of harm) - try and contact the parents and either do a telephone consultation and rearrange the appointment, documenting the reason for the WNB.
2) For cases that need to be seen in secondary care: -

- A letter should be written to the general practitioner advising them of the WNB and the plan.
- Will usually be offered a second appointment.
- If appropriate the consultant may change it to a telephone consultation and arrange any investigations prior to the reappointment.
- Should the second appointment also be missed a letter must be sent to the G.P, copied to the parents, informing them of two WNB’s and suggesting that they re-refer if the problem persists.

3) Routine cases that should be dealt with in primary care: -

- If the initial referral states a problem that is likely to be short lived, or seems driven by parental anxiety, a second appointment may not be sent, but a letter should be sent to the GP and parents informing them of this, and saying we assume the problem has now resolved, and asking for a re-referral if needed.

For ALL cases - If the GP mentions Social Worker or Health Visitor concerns in the letter then a second appointment is offered and contact with those professionals MUST be done.

10.1 **Follow-ups which are missed**

Follow-ups which are missed – face to face

- Could be offered a telephone consultation during the clinic session
- Will normally be offered a second face to face appointment. If that is also missed, the consultant will write to the GP and family discharging them unless:

- They’ve had multiple WNB’s in the past, when maybe one WNB will warrant such a letter.
- If the consultant knows the family well, may offer a third appointment or contact the family via phone / letter
- If child is at risk, the consultant should try to contact the family expressing concerns before contacting Social Care.
- If the child has a chronic illness and is therefore likely to be well known, input from the Specialist nurse may be helpful, or ask GP to make contact via the repeat prescription mechanism.

Unable to contact (UTC) during the clinical session

Attend Anywhere Appointments

- If possible, resend the attend anywhere link in the clinic session
- Could be offered a telephone consultation during the clinic session.
- See below if UTC following a telephone call

Telephone appointments

If you are UTC a parent during a telephone consultation, then:

- A message could be left on the parent's answerphone advising of them the appointment and a time to phone back during the clinical session. It is expected that trying twice during the clinic session is routine practice.
- If is not possible during the clinical session then the consultant/practitioner should: - **Review the notes** to decide on the clinical priority and to consider if the parent's behaviour to possibly be neglectful, action should be taken.

Options

A) Clinical Priority - Routine

- Routine follow-up with non-concerning features that you feel a general practitioner could manage. Refer to GP for clinical review.

B) Clinical Priority – Does require a hospital appointment

Child does require a further appointment clinically.

- Offer a second appointment and decide on time frame you feel the child should be seen.
- If the child needs to be seen within the next 12 weeks, then write to the general practitioner and copy in the parents explaining the outcome of today's appointment. E.g., "this boy was due to be reviewed in an attend anywhere/telephone consultation today, but we were unable to contact them on the following telephone number…...on 2 occasions during the clinic session but unfortunately, we were unable to complete the consultation today. I have copied this letter to the parents asking them to telephone my secretary on the above number to rebook a follow up appointment"

C) Concerns about possible Neglect

As discussed during the current covid-19 pandemic there may be many reasons for non-attendance, being unable to contact parents and if following an attempt to telephone during the clinical session you have concerns that there are, or may be clinical concerns about neglect, e.g. previous or multiple WNBs.

Contact the parents to rearrange the appointment.

- Discuss with the Named Doctor or Lead Nurse for Safeguarding Children & Young People
- Refer to Trust Safeguarding Policy and if required refer to Social Care if child thought to be at risk of significant harm.

11 Suspicion or Allegations of Abuse by Staff towards Children

All allegations of abuse of children by those who work with children must be taken seriously. Allegations against any person who works with children, whether in a paid or unpaid capacity, can cover a wide range of circumstances.

This procedure should be applied when there is such an allegation or concern that a person who works with children, has:

- 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 risk of harm to children.
- Behaved or may have behaved in a way that indicates they may not be suitable to work with children.

Any concerns should be considered within the context of the four categories of abuse (i.e., physical, sexual and emotional abuse and neglect). These will include concerns relating to inappropriate relationships between members of staff and children or young people, for example:

- Having a sexual relationship with a child under 18 if in a position of trust in respect of that child, even if consensual
- 'Grooming', i.e., meeting a child under 16 with intent to commit a relevant offence
- Other 'grooming' behaviour giving rise to concerns of a broader child protection nature (e.g., inappropriate text / e-mail messages or images, gifts, socialising etc).
- Possession of indecent photographs / pseudo-photographs of children.

If concerns arise about the person's behaviour in relation to their own children, the Police and/or Children's Social Care must consider informing the employer / organisation to assess whether there may be implications for children with whom the person has contact at work / in the organisation, in which case this procedure will apply.

Allegations of historical abuse should be responded to in the same way as contemporary concerns. In such cases, it is important to find out whether the person against whom the allegation is made is still working with children and if so, to inform the person's current employer or voluntary organisation or refer their family for assessment.

The line manager of the member of staff concerned should inform the Safeguarding Lead in People's Services who then considers the alleged behaviour and contacts the Local Authority Designated Officer (LADO). The LADO will decide who to report the allegation to, either the Police or Children's Social Care

For further information see Trust Policy on "Managing Allegations made against Staff"

It is the responsibility of the all staff to report allegations or suspicions of abuse or potential abuse of a child or young person to Children's Social Care.
This is not only important for the protection of the child but for the safety of other potential other victims.

12 Whistle blowing

Staff are entitled to disclose information or concerns of malpractice or abuse within the context of the "Whistle Blowing" policy.

13 Confidentiality

Staff may be anxious about sharing information with other agencies. The protection of confidential information is an important part of the NMC Code of Professional Conduct 2015.

However, there are exceptions where there is an overwhelming responsibility to intervene:

- Members of staff who suspect abuse is being carried out by another member of staff have a duty to discuss the matter immediately with their line manager or person in charge of the clinical area.

- If a member of staff suspects that abuse is taking place by a parent, carer or other person known to the child.

In both of the above situations the parent's right to refuse referral to other agencies is **overridden** by the risk to other children. All incidences of suspected or actual abuse involving members of staff must be reported to the appropriate agency for further investigation

Information should be shared between agencies on the basis of: -

- The need to know
- Informing parents from the beginning on the boundaries of confidentiality.
- Overriding duty to share information with Social Services Departments and the Police during investigations

14 Guidance on Sexual Offences Act 2003

Young people up to the age of 18: In cases where a practitioner has concerns that a young person (up to the age of 18 years) is being sexually abused (including allegations of rape) or is at risk of sexual abuse a referral must be made to children's social care and the Police.

Young People Under the age of 13: Under the Sexual Offences Act 2003, children under the age of 13 years are considered of insufficient age to give consent to sexual activity. For this reason all cases of children under the age of 13 years of age, where there is an allegation of penetrative sex or other intimate sexual activity must be referred to Social Care and a strategy discussion will be held.

Young People 13-15 years of age: Young people are not deemed able to give consent if the sexual activity is with an adult in a position of trust or a family member as defined by the Sexual Offences Act 2003.

Young People aged 15-17 years:
The Children Act 1989 and the Sexual Offences Act 2003 still applies in the above circumstances.

15 Consent

A young person aged 16 or above has an explicit right to provide consent to surgical, medical or dental treatment and unless grounds for doubting her/his mental health, no further consent is required.

A child of any age who has sufficient understanding to make informed decisions can provide lawful consent to all or part of a medical assessment and emergency treatment. (Gillick competency)

16 Documentation

A full, accurate timed and dated history of events, contacts, decision-making process and actions is essential.

Care must be taken to preserve evidence e.g., photographs of bruising.

A member of staff should complete an incident report form if appropriate for example suspected or alleged abuse.

Safeguarding Information form to be completed and sent to the Safeguarding Children Team

17 Safeguarding Supervision

Safeguarding supervision is different to Clinical Supervision. Safeguarding Supervision is available to all staff,

Safeguarding Supervision Guidance is on the Safeguarding Pages on the Intranet

Support will be available to staff from their immediate line manager, Named professionals for child protection. The Guidelines for Supporting Staff involved in Traumatic / Stressful Incidents, Complaints, or Claims provide further guidance on supporting staff. Ongoing concerns can be highlighted within the appraisal process and through the identified training mechanisms.

Safeguarding children supervision is a formal process of professional support and learning, which aims to ensure that clinical practice, safeguards children and promotes their welfare. This is achieved by facilitating reflective discussion, assessment, planning and review, thereby supporting the development of good quality, innovative practice provided by safe, knowledgeable and accountable practitioners. This process is different from, and in addition to, the discussion and seeking of advice regarding specific concerns or situations, which happens during the course of everyday practice.

The specific objectives of safeguarding supervision are as follows:

- To enable and empower practitioners to develop knowledge and competence
- To provide a safe and structured environment for practitioners to reflect on, plan, review and account for their safeguarding children work
- To ensure that local and national policies and procedures are followed
- To provide support and recognition of the stress and uncertainties which safeguarding work may cause

18 Training

To protect children and young people from harm, all healthcare staff must have the competencies to recognise child maltreatment and to take effective action as appropriate to their role. Safeguarding Children and Young People: Roles and Responsibilities for Healthcare staff (2019) provide some guidance on the minimum requirements for health care staff.

The trust is committed to ensuring that all staff receives awareness raising and that different levels staff will have appropriate knowledge for their role.

The details of staff training expectation are contained in the trust risk management training needs analysis. Appendix 1

The policy will be highlighted in the Trust induction training of all staff, individual clinical area induction sessions and within mandatory training sessions.

Safeguarding competencies are a set of abilities that enable staff to effectively safeguard, protect and promote the welfare of children and young people. They are a combination of skills, knowledge, attitudes and values that are required for safe and effective practice.

Safeguarding Children and Young People: Roles and Responsibilities for Healthcare staff (2019) provides a framework for the competencies needed by healthcare staff and identifies five levels of competence. The levels are as follows:

- Level 1: All staff including non-clinical managers and staff working in health care settings
- Level 2: Minimum level required for non-clinical and clinical staff who have some degree of contact with children and young people and/or parents/carers
- Level 3: Clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns - this now includes Designated Adult Areas who will be caring for 16/17 year old young people who will receive Level 3 Core – 6-8 hours / 3 yearly
- Level 4: Named professionals

Training will be provided by the Trust's Lead Nurse / Midwife for Safeguarding Children as well as the multi agency training teams from the local safeguarding children partnerships.

If a member of staff is unsure which level of safeguarding children training they require, they should contact their Line Manager or a member of the Safeguarding Team for advice.

18.1 Training Needs Analysis – Refer to Appendix 1

19. Section 11 Audit

Working Together 2018 is clear that organisations should work together to take a co –ordinated approach to ensure effective safeguarding arrangements.

Section 11 of the Children Act (2004) places duties on a range of organisations and individuals to ensure their functions and any services they contract out to others, are discharged having regard for the need to safeguard and promote the welfare of children

In line with the Section 11, the Trust should have:

- A clear line of accountability for the commissioning and or provision of services designed to safeguard and promote the welfare of children
- A senior Board level lead to take leadership responsibility for the organisations safeguarding arrangements
- A culture of listening to children and taking account of their wishes and feelings
- Clear whistleblowing procedures, which reflects Sir Robert Francis's Freedom to Speak
- Arrangements which sets out Information Sharing
- A lead for Safeguarding Children
- Safer Recruitment practices for all staff who work with children and their families
- Appropriate Supervision and support for staff, including training
- Clear Policies and Procedures for dealing with allegations against people who work with children

The Section 11 is requested annually by the Partnership and completed by the Lead Nurse.

SaTH implement internal safeguarding audits and have a reporting cycle for safeguarding audits. e.g Child Safeguarding Practice Review recommendations to improve organisational practice, i.e. record keeping annual safeguarding audit of records to ensure good practice.

20 Equality Impact Assessment (EQIA)

This document has been subject to an Equality Impact Assessment and is shown to have a positive impact on children.

21 Publication and Distribution

Please note that the Intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as 'uncontrolled' and as such, may not necessarily contain the latest updates and amendments. When superseded by another version, it will be archived for evidence in the electronic document library.

Copies of this document should not be printed unless absolutely necessary as this could pose a risk of out of date copies in circulation within the Trust.

22 Monitoring of Policy

Care Quality Commission

All NHS Trusts are required to register with the CQC for the services they provide. As part of this registration the Trust must declare its position with regard to compliance with the Health and Social Care Act (Regulated Activities) Regulations 2008 and the CQC(Registration) Regulations (2009) Safeguarding is covered by Regulation 11 and Outcome 7

Section 11 Audit - The Lead Nurse will complete annually on request of the Safeguarding Partnerships

23 Review Process

The policy will be reviewed annually from the date of issue. However, it may be reviewed within this period if there are monitoring or audit reports that suggest a policy review is required earlier. Similarly, if there are relevant new external standards or evidence, policy review will be undertaken earlier. Any amendments made will be in collaboration with the users of the policy.

In order this policy retains up to date, any of the appendices to this document can be amended during the lifetime of the document, without having to review the entire the document.

24 References and Associated Trust Documents

- HM Government (2018) Working Together to Safeguard Children: A guide to inter-agency Working to Safeguard and Promote the Welfare of Children
- NMC (2023) Code of Professional Conduct
- Intercollegiate Document for Looked After Children: Roles and Competencies of Health care Staff 2020
- Care Quality Commission (Registration) Regulations 2009
- Children Act 1989
- Children Act 2004
- Health and Social Care Act (Regulated Activities) Regulations 2008
- Domestic Abuse Act 2021
- Safeguarding and Protecting Children and Young People: roles and competencies for health care staff; Intercollegiate document (2020)

Associated Trust Documents

- Managing Allegations Against Staff Who Work With Children Policy
- Guidelines for supporting staff involved in traumatic / stressful incidents, complaints or claims
- Supervision Guideline
- Domestic Abuse Policy and Domestic Abuse and Sexual Violence Policy for staff (2023)
- Freedom to Speak Up: Raising Concerns (Whistleblowing) (2019)
- Child Protection Medical Guideline (2022)

26 Appendices

Appendix 1 Safeguarding Training Needs Analysis

The purpose of this document is to provide a clear statement of the expectations that The Shrewsbury and Telford Hospital NHS Trust (SaTH) has in relation to the provision of Safeguarding Training.

NHS Trusts are responsible for ensuring their staff are competent in carrying out the statutory responsibility for safeguarding children. This includes being able to recognise when a child may require safeguarding and knowing what to do in response to concerns about a child.

This strategy is written in conjunction with Safeguarding and Protecting Children and Young People: roles and competencies for health care staff; Intercollegiate document (2019) Intercollegiate Document for Looked After Children: Roles and Competencies of Health care Staff 2020 and HM Government Working Together to Safeguard Children (2018) and is based on the requirements stated in the Review of Safeguarding Children Services (2009) Care Quality Commission Document.

Target Group	Key Outcomes	Level	Methods of delivery / achieving key outcomes	Updates/ refresher	Staff Groups
All SaTH staff, clinical and non clinical	Understand what is meant by ‘ safeguarding children’, adults at risk and Prevent Recognise the statutory duty of SaTH to safeguard and promote welfare of children, young people and adults Demonstrate a ‘ basic awareness’ of the key indicators of child / adult maltreatment Be able to recognise signs of abuse as this relates to their role Demonstrates appropriate information sharing Gain knowledge of local policies and procedures Know who to contact if there are concerns about the welfare of a child , young person or an adult Know what to do or who to contact if they feel that their concerns are not taken seriously Awareness of risks associated with the internet and online social networking Plan own future learning an development needs To be able to demonstrate an awareness and understanding of looked after children, young people and care leavers.	Induction / Level 1	Corporate induction e-Learning Self directed learning Supervision External Programmes Local Safeguarding Children Partnerships Junior Doctors will complete the West Midlands Deanery Induction and also have safeguarding training as part of their FY1 & FY2 Education Course	45 minutes 1 Minute Briefs Trust Safeguarding Quarterly Newsletters	All SaTH staff including volunteers

Target Group	Key Outcomes	Level	Methods of delivery / achieving key outcomes	Updates/ refresher	Staff Groups
All clinical staff at SaTH	Be familiar with national guidance and local procedures and appreciate own role and responsibilities and those of others in safeguarding and promoting the welfare of children. Demonstrate an awareness of the safeguarding roles of parents and carers and recognise factors that can impact on parenting capacity such as drug / alcohol abuse and mental health problems. Demonstrate appropriate referral for assessment for family support to reduce risks of child maltreatment Understand statutory requirements governing consent, confidentiality and information sharing Awareness of normal child development and importance of adopting a child centred approach to practice. Plan own future learning and development needs. Uses professional and/or clinical knowledge, understanding who constitutes a looked after child, young person and care leaver so as to identify any healthcare issues that may relate to previous maltreatment or life experience. Awareness that certain factors may be associated with child maltreatment, such as	Universal Level 2 as per ICG	Class room Training 1 hour Child Protection, 1 Hour Domestic Abuse Awareness and 1 hour Awareness of Adults at Risk Be spoke training e-Learning Core Skills for Health level 2 module(a,b,c) Child Protection conference attendance Self directed learning Supervision Child Protection Workbook level 2 Domestic Abuse workbook level 2 External Programmes Local Safeguarding Children Partnership training	1 Minute briefs Bespoke training to include service specific updates	Radiology Dental Pharmacists Ophthalmology Surgeons Anaesthetists All clinical staff working in adult areas

	child disability and preterm birth, special educational needs and disability, and living with parental mental health problems, other long-term chronic conditions, drug and alcohol abuse, and domestic abuse. Awareness of the increased needs and vulnerability of looked after children, care leavers and youth offenders and their increased risk of further maltreatment such as child sexual exploitation, criminal exploitation/county lines/gangs/radicalisation and children who go missing. Awareness of confidentiality, and consent issues including parental responsibility and court orders related to looked after children and young people. Understand the role of the Looked After health team, how to contact them and know that children should be recorded as a Looked After Child with social worker details recorded.				

Target Group	Key Outcomes	Level	Methods of delivery / achieving key outcomes	Updates/ refresher	Staff Groups
Practitioners who predominately work with children, young people and adults who are parents/ carers	Increased awareness of legislation, interagency policy, national guidance and children's rights in the safeguarding protection context, including the role of LSP Be able to communicate effectively and develop working relationships with other practitioners and professionals, children and families to safeguard and promote the welfare of children Make an effective contribution through the use of relevant assessment frameworks, report writing and interagency referrals, including improving confidence in both verbal and written communication to multi disciplinary case planning, reviews and strategy meetings. Understand the assessment of risk and significant harm, considering family's history, function, religious and cultural background. The impact of parenting issues such as domestic abuse, substance misuse, learning difficulties and the ability to parent effectively. Develop skills and confidence in communicating with children and valuing their participation in decisions that affect them. Know who to share information with, when and how to record information related to assessment, planning, intervention and review. Have the confidence to challenge if they	Targeted / Level 3	Class room Training 4 hours. Includes, Basic Awareness, Domestic Abuse, FGM, Learning from CSPR and Supervision Child Exploitation and theme training Be spoke training e-Learning Core Skills for Health Child Protection conference attendance Self directed learning Supervision External Programmes Local Safeguarding Children Partnership training Paediatric, ED and Maternity staff will complete 4 hours per year to achieve 12 hours at least over a 3 year period. Other staff such as Leads and the staff on designated adults wards will require 6-8 hours in a	1 Minute briefs Annual training Bespoke training to include service specific updates e.g A/E and O&G depts.. Courses will vary according to need	Paediatricians Neonatologist Paediatric / Neonatal nurses Nursery Nurses Midwives ED staff Paediatric leads for: Orthopaedics Radiology Surgeons Anaesthetists Theatre Managers of women and children centre. All Registered

	disagree with decisions or fell that their concerns have not been acknowledged. Plan own future learning and development needs. Know about court reports for Care, Placement and Adoption Orders (and equivalent Orders).		3 year period, this can therefore be done on SSU3 yearly with newsletters.		Nurses and Drs working on Designated Adult Wards
Named Professionals for the Trust	In addition to level 3	Level 4	24 hours over 3 years to include: Supervision, Leadership and Appraisal training	Courses will vary according to need	All Named Professionals in the Trust
Trust Board		Level 1			