Safeguarding Children Policy

Division: Trust-wide

Document No: CG-197

Specific staff groups to whom this policy directly applies	Likely frequency of use	Other staff who may need to be familiar with policy
Staff, volunteers and contractors	Frequently	

Main Author(s):	Claire Foster
Consultation:	Named Safeguarding Professionals Safeguarding Committee
Approval Authority (Committee/ Group/ Lead Clinician):	Safeguarding Committee
Executive Lead (Trust-Wide only):	Steve Hams, Chief Nursing Officer
Date of Approval:	24.03.2023
Next Review Due:	April 2026
Version:	Version 8
KEYWORDS:	Child, Children, Safeguarding, Child Protection
Summary of changes since the previous version	Addition of sections on contemporary safeguarding concerns, removal of some outdated language and update to equality section. No legislative changes or changes to process in the last period.

If you are accessing this policy because you need guidance on managing a children's safeguarding concern, go to Appendix 2 flow chart and accompanying guidance. You can also access quick guides on a range of topics relating to child safeguarding on Link here which support decision making and signposting to wider support services.

For urgent child protection concerns out of office hours contact the Emergency Duty Team on 01454 615 165 to discuss with a social worker.

For children and families who live in the southwest you can find details of their local authority children's services teams via the southwest child protection procedures web page https://swcpp.trixonline.co.uk

If a child is at immediate risk of serious harm call 999 and inform the police.

If you have concerns about a child in office hours Monday to Friday, 0830 – 1630 please call the NBT Integrated Safeguarding Team on 49054 for advice and support.

1. Executive Summary

1.1 Safeguarding children is everyone's responsibility (Working Together to Safeguard Children, 2018). All staff in North Bristol NHS Trust (NBT) have a responsibility to promote the welfare of children and to protect them from harm. This applies to staff working directly with children as well as those working predominantly with adults who have dependent children who may be at risk due to their parent/carer's health or behaviour.

1.2 This policy sets out the safeguarding children's requirements in NBT. This policy should be read in conjunction with legislation, statutory guidance, national NHS policy and locally agreed policies of both NBT and BNSSG local authorities.

1.3 NBT will prioritise and protect the rights of children to live free from harm and abuse, and where concerns are identified follow the appropriate procedures to share that information with the right services and at the earliest opportunity to get support for the family.

Contents

2. Policy Statement

2.1 North Bristol NHS Trust (NBT) is committed to promoting and safeguarding the welfare of children and young people who use services provided by the Trust as directed by Section 11 of the Children Act 2004. At all times the child's welfare will be seen as paramount.

2.2 Where there are concerns about the welfare of a child or young person, whether that child is a direct patient of the Trust or is the relative of a patient in our care, staff within the Trust will take all appropriate actions to address these concerns. Staff will work collaboratively with other agencies involved in safeguarding children and will follow national legislation, national and local policy and guidance.

2.3 The Trust will provide safeguarding children training to all staff to ensure they have an appropriate level of competence in this area of work commensurate to their role. Appendix 5, the training matrix, is based on the national guidance in the intercollegiate document 'Safeguarding Children – Roles and Competencies for Healthcare Staff (RCN, 2019).

2.4 The Children Acts 1989 and 2004, Children and Social Work Act 2017, and Working Together to Safeguard Children (HM Government, 2018) provide the statutory framework for safeguarding children practice and arrangements and NBT will adopt all the definitions, principles, and procedures within these statutory documents. These frameworks are reflected in the standard NHS contracts, Care Quality Commission requirements and in the NHS England Safeguarding Assurance and Accountability Framework (CQC, 2015; NHSE, 2022).

3. Purpose of the Policy

3.1 The purpose of the Safeguarding Children Policy is:

3.1.1 to inform all staff of the statutory requirements of safeguarding children practice.

3.1.2 To direct staff to further guidance available in addition to this policy.

3.1.3 To define safeguarding children practice including definitions of harm and abuse and outline the Trusts roles and responsibilities in contributing to the safeguarding arrangements for children in Bristol, North Somerset, and South Gloucestershire.

4. Scope of the Policy

4.1 This Policy is based on national legislation and policy as well as local guidance and policy and is applicable to all staff employed by the Trust, all volunteers, those working with the Trust under a service level agreement and independent contractors and services hosted by the Trust. All personnel working for or on behalf of NBT are expected to comply with this policy and the Southwest Child Protection Procedures https://swcpp.trixonline.co.uk

5. Definition of Terms

5.1 Child

The Children Acts 1989 and 2004 define a child as anyone who has not yet reached their 18th birthday, therefore in this policy the terms child/children include the unborn, infants, children, and young people.

5.2 Safeguarding

Safeguarding and promoting the welfare of children is defined by statutory guidance Working Together (HM Government, 2018) as:

- Protecting children from maltreatment
- Preventing impairment of children's health and 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
- This broad definition of safeguarding children includes signposting and offering support at the earliest opportunity, often referred to as 'Early Help'.

5.3 Children Act (1989) definitions:

Concerns regarding a child's welfare may, initially, be divided into two categories:

1. A child in need.
2. A child in need of protection from significant harm or potential harm.

It is recognised that the categories are not always clear and may change at any time.

5.4 **Child in Need** (Children Act 1989 Section 17)

5.4.1 He/she is unlikely to achieve or maintain or have the opportunity of achieving or maintaining a reasonable standard of health or development without the provision for him/her of services by the local authority

OR / AND

5.4.2 His/her health or development is likely to be significantly impaired or further impaired without the provision for him/her of such services

OR / AND

5.4.3 He/she is disabled

5.5 **Child Protection** (Children Act 1989 Section 47)

5.5.1 Where a Local Authority is informed that a child who lives or is found in their area:

a) Is the subject of an Emergency Protection Order or is in police protection?

OR

b) Have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, **significant harm**, the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

5.6 Significant Harm (Children Act 1989 Section 31(2))

"Where the question of whether harm suffered by a child is significant depends on the child's health or development, their health or development shall be compared with that which could be reasonably expected of a similar child."

5.7 Child Abuse

Children may be abused or neglected by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community space, most commonly by those known to them. Children can be abused without physical contact e.g., via the internet or social media. They may be abused by an adult or adults, or another child or children. The sustained abuse or neglect of children, physically, emotionally, or sexually can have major long-term effects on all aspects of a child's health, development, and well-being.

5.8 Categories of Abuse

Statutory guidance defines four categories of abuse. These are neglect, physical abuse, sexual abuse and emotional abuse. Further detail on these can be found via the NSPCC website https://www.nspcc.org.uk/keeping-children-safe/

5.8.1 Neglect

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

- Provide adequate food and clothing, shelter (including exclusion from home or abandonment).
- Protect a child from physical and emotional harm or danger
- Ensure adequate supervision, including the use of inadequate caregivers
- Ensure access to appropriate medical care or treatment
- Unresponsiveness to a child's basic emotional needs

5.8.2 Physical Abuse

Physical abuse is a form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms or, or deliberately induces illness in a child. Children who are very young and/or disabled have increased vulnerabilities to abuse due their developmental level preventing them raising concerns or having contact with people outside their home. Any injury to a non-mobile baby or child should be scrutinised carefully and the multiagency guidance for injuries to non-mobile babies and children (https://swcpp.trixonline.co.uk) followed to ensure the appropriate checks are completed. Any staff member assessing injuries to a child should consider whether the described mechanism fits the injury and weigh this against the developmental abilities of the child.

5.8.3 Sexual Abuse

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

5.8.4 Child Sexual Exploitation

A form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (A) in exchange for something the victim needs or wants, and/or (B) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can occur through the use of technology (Department for Education, 2017).

5.8.5 Emotional Abuse

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views,

deliberately silencing them, or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capabilities, as well as overprotection and limitation of exploration and learning, or preventing the child from participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children to frequently feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all forms of maltreatment of a child, although it may also occur alone.

5.9 Extra-Familial Harm

The term extra-familial harm (EFH) is used to describe harms children experience that occur outside the home. It is recognised that there are additional concerns that particularly impact adolescents and these are often referred to as contextual, transitional, or complex safeguarding concerns.

5.9.1 Contextual safeguarding is an approach to understanding and responding to young people's experiences of significant harm beyond their families. It recognises that the contexts where young people spend their time i.e., in their neighbourhoods, schools, peer groups and online can feature violence and abuse. Contextual responses to concerns involve looking at the environments and social groups young people access and addressing reducing risk through interventions that target the context rather than the individual child or family. It recognises that parents and carers may have little influence over these contexts, and this type of harm is very difficult for parents and carers to address due to its nature of occurring away from the home. All children may experience EFH, but those who have experienced abuse or neglect at home, are Children in Care or Care experienced, those who have disabilities or are experiencing mental health or substance misuse problems have an increased level of vulnerability.

5.9.2 Concerns that can particularly affect adolescents include:

- **Serious youth violence** including knife crime
- **Child criminal exploitation**- a form of abuse where children and young people are manipulated and coerced into committing crimes. The victim may have been criminally exploited even if the activity appears consensual. Child criminal exploitation does not always involve physical contact; it can occur through the use of technology.
- **County lines**- a form of criminal exploitation where illegal drugs are transported from one area of the country to another, often across police and local authority boundaries, usually by children or vulnerable people who are coerced into it by gangs or organised criminal networks. The 'county line' is the dedicated mobile phone line or "deal line" used to coordinate the movement of drugs.

- **Cuckooing-** where organised criminal networks take over a local property, normally belonging to a vulnerable person, and use it to operate their criminal activity from. We know that 16- and 17-year-olds living in semi-independent and independent accommodation as Children in Care or Care Experienced Children are particularly vulnerable to this form of exploitation. Children exploited in this way will quite often be exposed to physical, mental and sexual abuse, and in some instances will be trafficked to areas a long way from home as part of the network's drug dealing business.

5.9.3 The research and best practice guidelines for safeguarding children from EFH is rapidly developing and staff who have concerns that link to these areas of safeguarding should seek support from senior staff and the safeguarding team at NBT or the Local Authority for the child. Multiagency actions are often required to help make the child safe. More information on contextual safeguarding approaches is available from the Contextual Safeguarding Network hosted by Durham University www.contextualsafeguarding.org.uk

5.10 Further information on topics related to safeguarding children can be found on the safeguarding pages of the LINK intranet here.

5.11 Transitional Safeguarding

Transitional safeguarding describes the need for "an approach to safeguarding adolescents and young adults fluidly across developmental stages which builds on the best available evidence, learns from both children's and adult safeguarding practice and which prepares young people for their adult lives" (Holmes and Smale, 2018). It focuses on safeguarding young people, from adolescence into adulthood, recognising this period of transition will be experienced differently by young people at different times. Transitional safeguarding of 16 – 25 year olds involves use of both children's and adults safeguarding frameworks and integration of the Mental Capacity Act and its principles.

5.12 Non-recent or Historical Abuse

5.12.1 There may be occasions where an adult will disclose abuse that happened to them during their childhood. Adults with capacity have the right to decide whether they wish to be involved in any investigations or reporting of this information. However, all staff need to consider current risk to children based on the information disclosed. Therefore, this information needs to be treated in the same way as a disclosure of current abuse as the abuser may still represent a risk to children.

5.12.2 Adult patients, carers or relatives can make anonymous reports via the NSPCC if they do not wish to be involved in raising a concern through Children's Services or the police. Where the allegation relates to a perpetrator who is alive, staff should explain to the adult that they need to report the concern, but the adult can choose if they wish to be involved in

any further investigations. All adults can receive support for historical abuse via a range of organisations and should be signposted to the NSPCC website which can be accessed here, the NAPAC Helpline on 0808 801 0331 or, for services related to sexual abuse and assault, the Survivor Pathway which can be accessed here

5.13 Domestic Abuse

When domestic abuse is suspected or known, the health professional must consider the physical or emotional risk to any children in the family. The effect of domestic abuse on children and families is profound. The Domestic Abuse Act (2021) recognises that children experience the negative effects of domestic abuse on their welfare even if they may not have directly witnessed the abuse. Domestic abuse can impact a family's ability to meet their children's needs in an appropriately responsive way, and it models a negative pattern of behaviour for children. Children living in a home where domestic abuse occurs are vulnerable and their safeguarding must always be a consideration. See the Trust Domestic Abuse Policy CG-205 for further information and guidance.

5.14 Unaccompanied Asylum-Seeking Children

5.14.1 An unaccompanied asylum-seeking child is a child who is seeking asylum without the presence of a legal guardian, and who is not being cared for by an adult who has responsibility to do so. Unaccompanied asylum-seeking children can be some of the most vulnerable children in our society. They are alone in an unfamiliar country at the end of what could have been a long, perilous, and traumatic journey. Some asylum-seeking children may have experienced exploitation or persecution in their home country or on their journey to the UK. Regardless of how they arrived in the country, it is essential that they are properly safeguarded as they are vulnerable to harm and are at high risk of going missing due to trafficking or exploitation.

5.14.2 All unaccompanied asylum-seeking children need first and foremost to be seen as children. They need access to education, health, accommodation, and support; unaccompanied children are entitled to the same Local Authority support as Children in Care, and any unaccompanied asylum-seeking child must be immediately referred to the Local Authority Children's services. Information on how to do this can be found on the safeguarding pages of the LINK intranet.

5.14.3 Unaccompanied asylum-seeking children may not be familiar with services and systems in the UK and may be mistrustful of professionals because of their experiences. It is essential that they receive clear and accurate information in a format that they can understand. An interpreter may be required to facilitate this.

5.14.4 Unaccompanied asylum-seeking children aged over 16 should be assumed to have capacity as per the Mental Capacity Act (2019) unless there is a reason to believe they do not. If there is any doubt, then a capacity

assessment should be completed. If capacity is lacking, then they should have access to an Independent Mental Capacity Advocate (IMCA). Language barriers are not an acceptable reason to assume a 16 or 17 year old does not have capacity. Translators and interpreters should be used to facilitate assessments.

6. Southwest Child Protection Procedures

6.1 The information for the child safeguarding and child protection procedures for the Safeguarding Children's Partnerships in the Southwest are located online in one website. Each Partnership has its own site, which provides a 'gateway' to the shared child protection procedures for the region. In addition to the shared procedures, you can also access local policies and threshold guidance for each Local Authority area partnership. These procedures are available via https://swcpp.trixonline.co.uk

6.2 Staff should consult procedures and threshold guidance for the Local Authority where the child lives if they have concerns about the welfare of a child. The threshold guidance can support framing the concerns and the level of intervention required, including if Child Protection procedures are indicated.

7. Roles and Responsibilities

7.1 Everyone shares responsibility for safeguarding and promoting the welfare of children and young people, irrespective of individual roles (Working Together, 2018). This applies to all staff, including those who do not routinely see children but who see patients who may be parents or carers of children. It is important that all staff working with adolescents under the age of 18 remember to consider them as children.

7.2 Responsibilities of the Trust Board

7.2.1 The Trust Board is ultimately accountable for ensuring that children and young people are safeguarded within the trust.

7.2.2 The Chief Nursing Officer is the designated executive with responsibility for safeguarding children and young people and is also the designated allegations officer with the Chief Medical Officer as the nominated deputy allegations officer

7.3 Responsibilities of the Trust Safeguarding Committee

7.3.1 The committee will meet at least quarterly to review and monitor the children's safeguarding activity across NBT.

7.3.2 The committee will ensure oversight and review of action plans agreed from Child Safeguarding Practice Reviews, Rapid Reviews and Domestic Homicide Reviews. This includes upward reporting to Quality Committee and Trust Board of any specific learning and actions for NBT from a statutory review process.

7.3.3 The committee will monitor safeguarding training compliance across the Trust through Divisional reports.

7.3.4 The committee will support driving positive change in safeguarding children practice through senior leadership participation and dissemination of good practice.

7.3.5 The committee will ensure compliance for children and young people with Care Quality Commission Regulation13 'Safeguarding service users from abuse and improper treatment' and the NHS England Safeguarding Accountability and Assurance Framework (2022).

7.3.6 The committee will ensure that changes in current legislation and recommended practice are identified and disseminated to all divisions within the Trust.

7.4 Responsibilities of the Integrated Safeguarding Operational Group

7.4.1 The Integrated Safeguarding Operational Group (ISOG) contributes to identifying risks around safeguarding children within the Trust and communicating these via the Trust Safeguarding Committee to the Trust Board.

7.4.2 Through representatives from each Division, the ISOG supports operational safeguarding development and improvement through shared learning from Divisional reporting on safeguarding activity and incidents.

7.4.3 When there are changes in current legislation and recommended practice the ISOG will participate in disseminating these through all Divisions within the Trust.

7.4.4 The ISOG will support implementation of new learning and contribute to action plans following recommendations by local Child Safeguarding Practice Reviews.

7.5 Responsibilities of the Named Professionals (doctor/nurse/midwife)

7.5.1 The statutory guidance stipulates that all providers of NHS funded health services should identify a dedicated Named Doctor and Named Nurse and a Named Midwife, if the organisation provides maternity services, for safeguarding children. Named professionals have a key role in promoting good professional practice within their organisation, providing advice and expertise for fellow practitioners, and ensuring safeguarding training is in place. They should work closely with their organisation's safeguarding executive lead, named professionals for adult safeguarding, and Designated health professionals for the health economy and other statutory safeguarding partners (Working Together, 2018).

7.5.2 The roles and responsibilities of the Named professionals are defined in the intercollegiate document (2019) and include taking a lead within the Trust on safeguarding children matters, and to advise and support the Trust Board in matters relating to safeguarding children.

7.5.3 They will ensure access to safeguarding children supervision and/or peer support for those staff involved in cases at Child Protection level.

7.5.4 They will identify the training needs of the organisation and signpost staff to appropriate mandatory training for their role.

7.5.5 They will initiate and participate in audit and the monitoring of standards.

7.5.6 They will provide advice to staff on child protection legal matters and signpost to and work with the Trust solicitors when court reports are required.

7.5.6 They will oversee the completion of the Trust's internal safeguarding children reviews and contribute towards partnership Child Safeguarding Practice Reviews unless substantially personally involved in the case.

7.5.7 They will liaise with the relevant Designated Professionals on safeguarding children matters.

7.6 Responsibilities of healthcare professionals

7.6.1 All healthcare professionals have a duty to safeguard children. Staff working directly with children must ensure that safeguarding forms an integral part of all stages of care offered.

7.6.2 All professionals also need to be aware of their responsibility to safeguard and promote the welfare of any child or young person when they are not working directly with a child but may be seeing their parent, carer, or significant adult. It is essential that whenever they become concerned that a child is at risk or has experienced significant harm the information is shared with the relevant Children's Services for the local authority where the child lives. To ensure those staff members receive appropriate support, their line manager and the safeguarding team should be made aware of the concern and any actions taken.

7.6.3 Where there is uncertainty around the threshold of harm, concerns must be discussed with a senior member of clinical staff and/or one of NBT's integrated safeguarding team practitioners. If out of hours and immediate advice is required, the on-call community pediatrician for child protection, or the emergency duty team can be contacted (Appendix 1). All staff must document decisions made to either share or not share information relating to risk of harm with a clear rationale, and ongoing plans need to be recorded.

7.6.4 Health practitioners must ensure that they are familiar with how to access the child protection procedures (https://swcpp.trixonline.co.uk) and know who to call for advice. Contact details for the NBT integrated safeguarding team are on the safeguarding pages of the LINK intranet .

7.6.5 Staff may be required to participate in formal procedures for Child Protection under Section 47 of the Children Act 1989. This can include attending strategy discussions, Initial Child Protection Conferences, Review Child Protection Conferences, and core groups. For staff who may only do this occasionally extensive support through these processes is available from the integrated safeguarding team. For staff who regularly participate in CP activity training and supervision is available to develop and support practice and safeguarding competencies for participating in Section 47 activities. For all staff the focus of these processes is the lived experience of the child and reducing risk of harm.

7.7 Responsibilities of all other staff

7.7.1 All staff working for the Trust (including contractors and agency staff) have a duty to safeguard children. No single employee can have a full picture of a child's needs and circumstances. If children and families are to receive the right help at the right time then everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action.

8. Equality Issues

8.1 All safeguarding advice and guidance will be provided in a way that ensures the safety of children and respects the individuality of each child, ensuring there is no discrimination in respect of age, gender, race, religion, disability, or sexual orientation.

8.2 Due regard must be given to issues of race, religion, culture, sexual orientation, language, gender and disability in all child safeguarding work, however respect for difference should not be confused with acceptance of any form of abuse or neglect. The focus must remain on the child and their day-to-day experiences.

8.3 Adultification and unconscious bias in safeguarding: All staff should be aware that recent research indicates that children from black and minority ethnic backgrounds are more likely to experience Adultification and unconscious bias and can have their rights to protection ignored by professionals as notions of innocence and vulnerability are displaced by notions of responsibility and culpability (Davis, 2022). Adultification bias is a form of racism and discrimination that can impact professional's responses to safeguarding children and prevents us from understanding the lived experience of the child by viewing them as 'streetwise' or more grown up than other children (NSPCC, 2022). Unconscious bias occurs when practitioners have preconceived ideas or prejudices about others due to stereotypes. This might result in people making harmful generalisations about specific communities, or generalising all minorities as having similar traits, practices and beliefs. This in turn is likely to result

in children and families not receiving the appropriate level of support and protection. Unconscious bias might also lead practitioners to interpret behaviour differently depending on the ethnicity of the person displaying it. For instance, if a child from a Black, Asian and minoritized ethnic communities shows fear around a family member, this may be interpreted as a cultural expression of respect rather than an indicator of abuse (NSPCC, 2022).

9. Supporting Children at the Earliest Opportunity

9.1 Staff working in the Trust who work with or come in to contact with children/young people and the people that care for them need to be aware of and alert to signs that early help may be required within a family or for a child or young person. Providing early help is more effective in promoting the welfare of children than responding later to a more serious level of harm.

9.2 Early help means offering signposting or providing support as soon as a problem emerges. This may be at any point in a child's life from the unborn through to adolescence. Early help can include Trust staff signposting patients to local organisations who can offer support with a range of needs. Effective early help relies on local organisations working together to identify needs, communicate with families about support available and sharing information. The Trust will work with local authorities, organisations and agencies to develop joined up early help approaches based on a clear understanding of local needs. This requires all practitioners, including those in acute trust services and those providing services to adults with caring responsibilities for children, to understand their role in identifying emerging problems and to share information with other practitioners to support early identification and assessment. All Local Authorities publish threshold guidance to assist staff in assessing the level of support required. These can be found on the safeguarding partnership website via https://swcpp.trixonline.co.uk for areas in the Southwest.

9.2.1 All staff should be alert to the potential need for early help for a child who:

- is disabled and has specific additional needs
- Has special educational needs
- Is a young carer
- Is showing signs of being criminally exploited
- Frequently missing/going missing from care or from home
- Is at risk of modern slavery, trafficking, or exploitation
- Is in a family circumstance presenting challenges for the child, such as drug and alcohol misuse, adult mental health issues or domestic abuse
- Is at risk of being radicalised
- Is misusing drugs or alcohol themselves

- Has returned home to their family from a care placement
- Is a privately fostered child
- (Working Together, 2018, page 14)

9.2.2 Information on how to make a referral for early help can be found on the safeguarding children pages of the LINK intranet here.

10. Escalation and Resolution of Professional Difference

10.1 Where there is a disagreement between professionals in different agencies on the outcome of a referral for support to children's services then the Local Authority Resolution of Professional Differences policy for each Local Authority can be found via the Southwest Child Protection Procedures webpage (https://swcpp.trixonline.co.uk). Practitioners must use the policy that relates to the Local Authority where the child lives, and not the Local Authority that their service is based in. The policy steps must be followed to resolve professional differences and to ensure the right help is offered to the family. Trust staff who wish to challenge the outcome of a referral to children's social care must contact the NBT safeguarding team to notify them and to receive support during the escalation process. Each Local Authority policy contains the guidance for each step of the process.

10.2 See appendix 2 for flow chart of process for raising concerns about a child or family.

11. Request for Reports and Legal Statements

11.1 **Staff must never make a statement over the phone or by email and must always inform their manager and Trust solicitors when asked for information for court or criminal proceedings**.

11.2 Requests for statements are primarily received from Local Authority Children's Services and relate to civil proceedings regarding arrangements for the care and protection of children, usually a Care Order. However, health professionals may also be required to give statements to the police in criminal proceedings related to abuse and serious harm of children.

11.3 **Staff must ensure they inform their line manager immediately** if they receive a request for any statement, report, or request for health information from records held by the trust for a court or criminal proceeding.

11.4 **The staff member and their manager should inform the legal team of the request before commencing the report so the request can be verified.** The production of a legal statement in response to a request from a Local Authority or the police can take a considerable amount of time. Managers need to ensure they give staff sufficient protected time to complete these reports. The Local

Authority solicitor who is requesting the statement can be contacted if clarification regarding time scales is required. For criminal investigations the police will make arrangements with the individual practitioner to meet and complete the statement. It is advisable to have line management support during this process and afterwards.

11.5 Additional advice and support with drafting a care proceedings statement or report can be obtained from the Named Safeguarding Children Professionals and Trust solicitors. Any request for statements from an individual family member's solicitor (often related to custody disputes and/or contact arrangements) must be alerted to the line manager and Trust solicitors. The Trust solicitor will advise if a response can be made on a case-by-case basis.

11.6 Staff may need additional wellbeing support following a court proceeding and this can be accessed through a range of services at NBT including through safeguarding supervision which is provided through the integrated safeguarding team.

12. Information Sharing and Safeguarding

12.1 People using the services of the trust may normally be assured that their details and information known to professionals about them is kept confidential in line with current legislation and regulatory body guidance. However, in the case of concerns about child abuse the welfare of the child is paramount (The Children Act, 1989; Human Rights Act, 1998; United Nations Convention on the Rights of a Child, 1991). Information that is relevant to the child's wellbeing will be shared with other professionals within health or other agencies as is necessary to safeguard a child's welfare. The Data Protection Act has never been a barrier to sharing information to safeguard children (Data Protection Act, 2018; General Data Protection Regulation, 2018).

12.2 The General Data Protection Regulation (GDPR) and the Data Protection Act 2018 introduce new elements to the data protection regime, superseding the Data Protection Act 1998. Practitioners must have due regard to the relevant data protection principles which allow them to share personal information. The GDPR and Data Protection Act 2018 do not prevent, or limit, the sharing of information for the purposes of keeping children and young people safe. Please refer to the trust information governance policy IMT-88 and please seek advice from managers, the Information Governance team, or the Integrated Safeguarding team if in any doubt as to the requirements for information sharing for child safeguarding. There is also government guidance available in the document Information Sharing: advice for practitioners providing safeguarding services (2018).

12.3 In general, the law does not prevent individual sharing of information with other practitioners if:

- Those likely to be affected give their consent.
- The public interest in safeguarding the child welfare overrides the need to keep the information confidential.
- Disclosure is required under a court order or other legal obligation.

13. Child Protection Information System (CPIS)

13.1 As part of sharing information to safeguard children, notifications of a child's attendance at ED or MIU due to illness or injury are routinely sent to the GP and Health Visitor or School Health Nurse. If a child who is on a Child Protection plan or is a Child in Care attends the ED or MIU then the allocated social worker is also notified of the attendance via telephone call, email or using a Local Authority referral form. A record of this information sharing should be documented in the health records (RCPCH, 2018).

13.2 The Trust is also linked to the national Child Protection Information System. When a child is known to Children's Services, either as a Child in Care or as a child on a Child Protection plan, basic information about that plan is shared securely with the NHS via the summary care record. If that child attends an NHS unscheduled care setting such as an emergency department or minor injuries unit then:

- The health team is alerted that they are on a plan and has access to the contact details for the social care team
- The social care team is automatically notified that the child has attended
- Both parties can see details of the child's previous 25 visits to unscheduled care settings in England

13.2.1 This means that health and social care staff have a more complete picture of a child's interactions with health and social care services. This enables them to provide better care and earlier interventions for children who have been identified as vulnerable and at risk of harm (NHS Digital 2022).

13.3 This system strengthens notification of events but does not replace the need to share good quality information with the allocated social worker regarding the presentation and any worries or protective factors that may have been identified.

14. Supervision and Training

14.1 Child protection supervision will be provided for all staff holding a child protection caseload. Advice and support are available as the need arises (ad-hoc safeguarding supervision) from the integrated safeguarding team. The safeguarding senior leadership team will ensure that specialist practitioners and named professionals have adequate training to provide safeguarding supervision.

Safeguarding supervision is not a substitute for management supervision and 1:1's or clinical supervision. A synopsis of the supervision offer is in Appendix 4 aligned to the Intercollegiate Document (2019) roles.

14.2 All professionals who work regularly with children and families are expected to engage in reflective practice and case discussion regarding safeguarding children. This can be achieved through group supervision or by including a standing agenda item at an identified clinical meeting for a team/department/service.

14.3 Reflective practice and peer review provides an opportunity to review cases, identify learning points, and provides staff with professional and emotional support. More detailed guidance on safeguarding supervision is available on the safeguarding pages of the LINK intranet.

14.4 Training in safeguarding children is a statutory requirement (HM Gov., 2018) for all staff and volunteers in the Trust. However, the national approach is that the level of training required is reflected in the role and responsibilities staff hold and that staff who work directly with children receive an enhanced level of training that enables them to recognise and manage risks related to safeguarding children. The Trust uses the Intercollegiate Document (RCN, 2019) to guide which staff receive which level of training. A synopsis of this can be found in matrix form in Appendix 5. The safeguarding team will update the matrix in line with any national updates for training.

14.5 Staff working directly with children and their families will be prioritised for safeguarding children training at level 3. Professionals need to consult with their manager, the safeguarding training matrix (Appendix 5) and the staff development team as to what would be most appropriate for their role and/or discuss their training and development needs for child safeguarding with a member of the safeguarding team.

15. Recruitment of Staff

15.1 It is known that people who pose a risk to children are attracted to organisations which provide services for children and young people. The Trust is committed to ensuring that all staff recruitment is maintained within employment law and NHS employment check standards in a setting that is committed to safeguarding and promoting the welfare of children and young people. This policy also applies to bank workers, contractors, work trials, interns, volunteers, charity fundraisers and celebrities. This ensures that Disclosure and Barring Scheme (DBS) checks are carried out on all staff, including volunteers, whose work will bring them in to contact with children/young people and adult patients prior to them having unsupervised access to children/young people and adult patients. References will also be sought for all new staff and followed up as necessary. Additional information and links can be found in the NBT recruitment and selection policy and accompanying user guide.

16. People Who Pose a Risk to Children

16.1 There may be occasions when an adult will disclose that they have previously abused a child or young person or is currently doing so. This information will need to be shared with the police and Children's Services for them to determine if the person remains a risk to children. Staff should be aware that abuse can be committed by children and this type of disclosure will need the referral to be explicit that both the perpetrator and victim are under 18 years old.

16.2 If it is known that a patient or visitor is a person who presents a risk or possible risk of harm to children, whilst maintaining confidentiality, staff will support other visitors to ensure that any children with them are always supervised by those responsible for them when visiting the area where a patient is cared for. It must be noted that it is the parent/carer's responsibility to ensure that the child/ young person is supervised whilst on Trust property, and Trust staff will support the parent/carer in this process.

16.3 If it is known that a patient admitted to a ward area may present a risk of harm towards children, senior staff on the ward must review their patient and staff cohort for any 16- or 17- year-olds and ensure that they are protected. Staff who are 16- and 17-year-olds must not be allocated to work with patients where this concern has been identified.

16.4 If the patient is currently in prison for proven or alleged offences against children, the Trust staff will work with the prison staff to ensure that the patient is not able to have any unsupervised contact with children whilst receiving care at the Trust.

16.5 If it is known that a visitor may pose a risk to children advice must be sought from a Named Children's Safeguarding Professional. A risk assessment in conjunction with Children's Services must be carried out; this will include a written visiting agreement. Risk assessments must be based on all the information available including that held by other agencies including Children's Services and the police.

16.6 This above applies to maternity services where a partner/father is known to pose a risk to children. Advice should be sought from the matron of the area, senior maternity management, or the Named Midwife for safeguarding. A risk assessment including a written visiting agreement must be completed collaboratively with other agencies.

16.7 If at any time you have concerns about the safety of a child or young person, please ensure the child is safe and consult with your line manager and/or the integrated safeguarding team about what other action must be taken.

17. Allegations of Child Abuse Made Against Members of Staff

17.1 The Children Act 1989 clearly states the principle which underpins the management of an allegation of child abuse against a member of staff, that is, the welfare of the child is the paramount consideration.

17.2 Your line manager must be informed immediately if a report is received, or it comes to your attention that a member of staff 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 they may pose a risk of harm to children.

17.3 In addition, these principles apply:

17.3.1 If there are concerns about the person's behaviour towards their own children or children unrelated to their employment or voluntary work, and there has been a recommendation from a strategy discussion that consideration must be given to the risk posed to children they work with.

17.3.2 When an allegation is made about abuse that took place some time ago and the accused person may still be working with or having contact with children.

17.4 Dealing with an allegation that a professional, staff member, or volunteer has abused a child is difficult but must be taken seriously and dealt with carefully and fairly. It is not for the recipient of information to make a judgement regarding its validity. If you are informed of a concern by a member of staff it should be reported to the Divisional Senior Leadership team and the CNO or their deputy informed.

17.5 Every Local Authority has an identified Local Authority Designated Officer (LADO) who has responsibility for:

- Managing and overseeing individual allegations from across the children's workforce.
- Providing advice and guidance to employers.
- Liaising with children's services, police, and other relevant agencies.
- Monitoring progress of all cases to ensure they are dealt with in accordance with recommended timescales.
- Coordinating and collating reports to provide information to the local safeguarding partnership.

17.6 Every organisation that provides services for children, or works with children, needs to ensure that child protection procedures are followed. These can be found at the Southwest Child Protection Procedures website here.

17.7 **Allegations procedures** see flowchart in Appendix 3 and the NBT Disciplinary Policy PEO-06 for the combined HR and safeguarding response to allegations against staff.

18. 'Was Not Brought' (WNB) – Children Who Do Not Attend

18.1 All services are encouraged to use the phrase 'Was Not Brought' (WNB) rather than 'Did Not Attend' (DNA) to support reframing the focus on the needs of the child. This is especially so if the child is of an age or has disabilities that mean they could not reasonably be expected to get themselves to an appointment without their parent/carers help.

18.2 If a child is not brought to an appointment, then the referrer and the GP must be informed. The referrer and/or GP, along with the clinician who offered the appointment, must assess the impact on the child's health of the child not being brought to the appointment. This includes sharing if there are any known safeguarding concerns. Another appointment should be offered and the contact details for the child/family checked to ensure the appointment is received.

18.3 Children who are subject to a Child Protection plan or who are Children in Care have an alert on their patient record. This allows staff to identify those children who will have social worker involvement and staff should consider if the missed health appointment should be shared with the social worker. Where staff are unsure if information relating to missed health appointments should be shared, they should discuss the case with the integrated safeguarding team.

18.4 All staff need to be aware that young children and children with complex health needs or disabilities are more dependent on parents/carers to have their needs met and to enable them to access healthcare. Staff should be mindful that older adolescent children may still require significant support to manage their health needs and appointments, particularly if they have had adverse experiences in childhood.

19. Mental Capacity and Liberty Protection Safeguards

19.1 The Mental Capacity Act (MCA) (amended 2019) provides a framework to safeguard and empower people over 16 years of age who are unable to make all or some decisions for themselves. As per the MCA, all 16- and 17-year-olds should be assumed to have capacity unless proved otherwise. If capacity is lacking, then the MCA applies and must be followed. The Act includes a range of powers and services which are designed to protect vulnerable people who lack capacity and to ensure that their best interests are paramount.

19.2 Whilst the MCA applies from 16 years old the Deprivation of Liberty Safeguards only apply from the age of 18. Currently, if a 16- or 17-year-old needs to be deprived of their liberty an application must be made to the Court of Protection to authorise the deprivation of liberty. Please liaise with the trust legal team and safeguarding team if this situation arises.

20. Monitoring Effectiveness

20.1 The below table details the monitoring procedures in order that NBT can be assured that compliance with a policy is being met. It identifies both the processes for monitoring compliance and the actions to be taken where deficiencies and non-compliance are identified. This table must be completed in all policies

What will be monitored	**Monitoring/ Audit method**	**Monitoring responsibility *(individual/group/ committee)***	**Frequency of monitoring**	**Reporting arrangements *(committee/group the monitoring results are presented to)***	**How will actions be taken to ensure improvements and learning where the monitoring has identified deficiencies**
Training compliance	Attendance rates at safeguarding children training Level1, 2 and 3 as per Training Matrix (Appendix 5)	Learning and Research Dept. Divisional Leads	At least quarterly	ICB Quality Contract, Safeguarding Committee, Annual Report	Divisional recovery plans will be developed when training compliance falls below 85%
Allegations management	Safeguarding Team to keep database of referrals and outcomes.	Named Nurse	At least quarterly	ICB Quality Contract, Safeguarding Committee	Individual cases to be reviewed by the Named Nurse and issues highlighted to the Safeguarding committee.

What will be monitored	Monitoring/ Audit method	Monitoring responsibility *(individual/group/ committee)*	Frequency of monitoring	Reporting arrangements *(committee/group the monitoring results are presented to)*	How will actions be taken to ensure improvements and learning where the monitoring has identified deficiencies
Compliance with S11 audit, Children Act 2004	Audit completed as per agreed process and format with BNSSG ICB and partners	Named Nurse, Named Doctor, Named Midwife and Divisional Leads as required or indicated by Audit.	As cycle agreed with BNSSG ICB. Last completed in full Nov 2022.	Safeguarding Committee, BNSSG ICB. Safeguarding Children Partnerships	Action Plan to be developed to rectify any recommendations identified.

What will be monitored	Monitoring/ Audit method	Monitoring responsibility *(individual/group/ committee)*	Frequency of monitoring	Reporting arrangements *(committee/group the monitoring results are presented to)*	How will actions be taken to ensure improvements and learning where the monitoring has identified deficiencies
Information Sharing – Unscheduled Care to Primary Care. Referrals to Children's Social Care	Reporting as agreed in quality contract to BNSSG ICB of the referrals made to the Local Authority for Safeguarding Children. Multi-agency audit of the information sharing between NBT and Primary Care	Named Nurse, Doctor, ED Matron.	Quarterly report of referrals for children in Medicine Division Safeguarding Committee report.	ICB Quality Contract, Safeguarding Committee.	Multi-agency audit is led by ICB. Action plan developed for recommendations from each audit.

21. Associated Policies / Documents

21.1 Legislative Framework relevant to the policy

- The Children Act 1989 and 2004
- HM Government (2018) Working Together to Safeguard Children. A guide to inter-agency working to safeguarding and promote the welfare of children (statutory guidance)
- The Human Rights Act 1998
- The Children and Families Act 2014
- The Children and Social Work Act 2017
- The Mental Capacity (Amendment) Act 2019
- The Serious Crime Act 2015
- The General Data Protection Regulation 2018
- The Data Protection Act 2018
- The Domestic Abuse Act 2021

21.2 Guidance relevant to the policy

- HM Government (2018) Information sharing: advice for practitioners providing safeguarding services.
- HM Government (2015) What to do if you are worried a child is being abused. Advice for practitioners.
- Domestic Abuse: Statutory Guidance https://www.gov.uk/government/publications/domestic-abuse-act-2021
- Department for Education (2017) Child sexual exploitation. Definition and guide for practitioners.
- Department for Education (2017) Care of unaccompanied migrant children and child victims of modern slavery.
- HM Government (2016 [updated 2020]) Multiagency statutory guidance on Female Genital Mutilation. https://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation
- Royal College of Paediatrics and Child Health (2021) Perplexing presentations (PP)/fabricated or induced illness (FII) in children-guidance.
- Royal College of Paediatrics and Child Health (2019) Safeguarding children and young people: roles and competencies for health care staff. Intercollegiate Document.

- National Institute for Health and Clinical Excellence (2009) Child maltreatment: When to suspect maltreatment in under 18s. https://www.nice.org.uk/guidance/cg89 (checked and updated online March 2019)
- BNSSG Safeguarding Children Partnerships (2018) Multi-agency guidance for injuries in non-mobile babies.

21.3 **North Bristol Trust related policies**

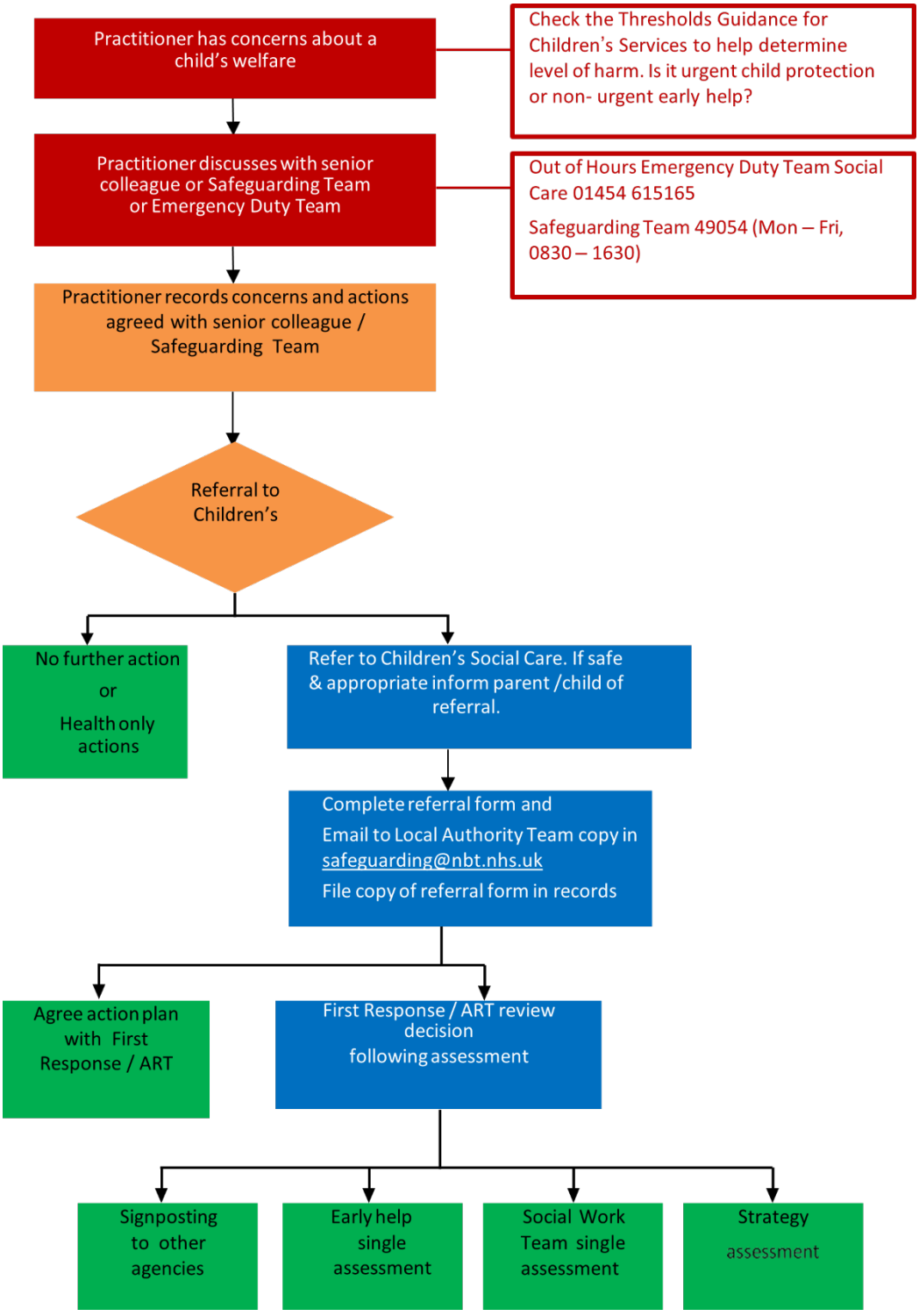
- Domestic Abuse Policy CG-66
- Management of infants and children presenting with a parent patient to inpatient wards CG-64
- Recruitment and Selection Policy and User Guide
- Disciplinary Policy and User Guide
- Freedom to Speak Up: Raising Concerns Policy (Whistleblowing)

Appendix 1 Safeguarding Children Professionals Contact Details

Redacted content

For all other areas in the Southwest, see the Southwest Child Protection Procedures page: https://swcpp.trixonline.co.uk

Appendix 2 Raising A concern About A Child or Family



What You Need To Do – Urgent Child Protection Threshold

1. Staff should consult and use the Thresholds guidance published by the Local Authority for where the child lives to help them decide the level of concern and to articulate the impact on the child in their referral.

2. Services for children living in the southwest can be found via https://swcpp.trixonline.co.uk Staff trained at Levels 1 and 2 Children's safeguarding and those without experience in making safeguarding referrals can anticipate significant support from Trust safeguarding professionals to complete these.

3. The member of staff who has identified the concern must inform their line manager / more senior colleague at the earliest opportunity (and definitely by the end of their working day). Out of office hours discuss concerns with the on-call matron or clinical site manager. For urgent external out of hours advice the Local Authority Emergency Duty Team for Children's Services is available on 01454 615165. The EDT telephone number is also on the Child Safeguarding pages of the LINK intranet. During discussion it may be suggested that the practitioner should seek further advice and discuss the case (without sharing personal information) with a duty children's social worker.

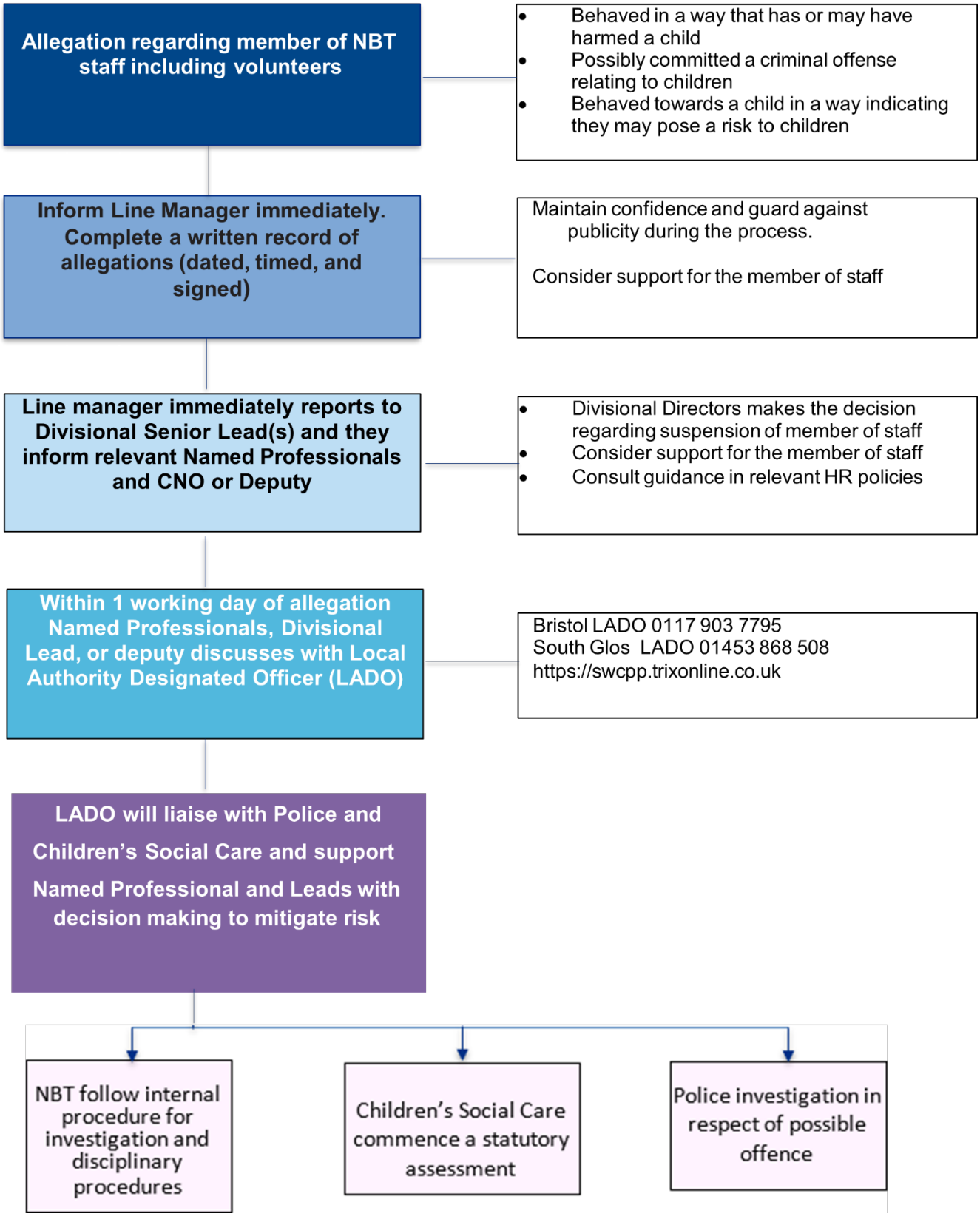
4. At Child Protection threshold you do not need consent from the parent/carer to share the concerns with Children's Social Care, however it is best practice to inform them that a referral will be made and why you are concerned. Inform whoever has shared the concerning information with you that the information cannot be kept confidential and will be passed to appropriate agencies on a need-to-know basis. This discussion should be had with the parent or carer unless this would put the child or professional at greater risk, would potentially contaminate evidence or contacting the parent or carer would cause an unacceptable delay making the referral. 16- and 17-year-olds can usually consent in this process for themselves. In cases of suspected Fabricated or Induced Illness or suspected Sexual Abuse advice must be sought from the Trust Safeguarding Team, Children's Social Care, or the police prior to informing a parent or carer. If unsure, please consult one of the Trust Named Professionals for Safeguarding Children and/or a member of the Safeguarding Team or out of office hours the Emergency Duty Team for Social Care on 01454 615165.

5. Referral forms for the Bristol, North Somerset and South Gloucestershire Children's Social Care teams are posted on the Child Safeguarding pages of the LINK intranet. Alternatively, they can be accessed for an individual Local Authority via the Southwest Child Protection Procedures website at https://swcpp.trixonline.co.uk. Any referral made to a local authority for a child by staff in the Trust must be sent securely by email and copied to the integrated safeguarding team for quality assurance and monitoring using the team email address safeguarding@nbt.nhs.uk. Urgent referrals can be made by telephone to the Local Authority and followed up with a written referral within 48 hours, Local Authorities may ask for this sooner if police action is anticipated.

6. Complete the referral with as much information as possible relating to the concerns identified stating clearly the impact on the child. Professionals must maintain accurate, dated, legible, contemporaneous and signed records in line with the Trusts record keeping policy and professional body requirements, e.g. British Medical Association (BMA) and Nursing and Midwifery Council (NMC).

7. An action plan must be agreed between the staff member or their manager and a child protection professional / senior colleague / Children's Social Care within 24 hours. The name of the person for each action and the timescale for completion of the action point will be clearly documented. Staff working shifts should clearly document who will be following up the concern when it is handed over to the next shift. It is good practice to share this information with any social care professionals who have been contacted to reduce delay and improve information sharing.

Appendix 3 Allegations Management Flowchart



Appendix 4 NBT Safeguarding Children Supervision Matrix

Following guidance in Safeguarding Children and Young people: roles and competences for health care staff. Intercollegiate document (2019).

Staff Groups		Supervision
All non-clinical staff working in health care settings: Includes Board Level Executives and non-executives, receptionists, admin staff, domestics.	Level 1	Ad-hoc discussion with safeguarding team on case-by-case basis.
All non-clinical and clinical staff who have any contact with children, young people and / or parents/carers. Staff groups: Includes administrators for safeguarding teams, health care students, clinical laboratory staff, phlebotomists, pharmacists, dentists, dental care practitioners, audiologists, opticians, adult physicians, adult physicians, surgeons, anaesthetists, radiologists, nurses working in adult acute/community services, allied health care practitioners and all other adult orientated secondary care, health care professionals, including technicians	Level 2	Ad-hoc discussion with safeguarding team on case-by-case basis. Reflective Practice / Peer review sessions to be offered regularly. Critical Incident Reviews. Standing agenda item at Clinical/ Departmental meetings.
All 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 Staff groups: This includes forensic physicians, urgent and unscheduled care staff, mental health staff (adult and CAMHS), child psychologists, child psychotherapists, adult learning disability staff, learning disability nurses, health professionals working in substance misuse services, youth offending team staff, paediatric allied health professionals, sexual health staff, school nurses, health visitors, all children's nurses, midwives, child psychologists, obstetricians, all paediatricians, paediatric radiologists, paediatric surgeons, children's/paediatric anaesthetists, paediatric intensivists, paediatric dentists .	Level 3 core	Ad-hoc discussion with safeguarding team on case-by-case basis. Reflective Practice / Peer review sessions to be available a minimum of every 3 months. Critical Incident Reviews Standing agenda item at Clinical/ Departmental meetings. Group Supervision or Multi-disciplinary team meetings with support from member of Safeguarding team or specialist psychologist (eg Renal, Neurosciences). Included in case discussion in Clinical Supervision.

Staff Groups		Supervision
Additional specialist competences Staff groups: paediatricians, paediatric intensivists, Forensic Physicians, child and adolescent psychiatrists, child psychologists, child psychotherapists, children's nurses, school nurses, child and adolescent mental health nurses, children's learning disability nurses, midwives and health visitors and specialist nurses for safeguarding children (Child Protection Supervisors) and Specialist Nurses for looked after children	Level 3 specialist	As above as per level 1, 2, and 3 (core): 1:1 for complex cases with Named or Designated Professionals. Specialist Midwives 1:1 supervision quarterly. Community Midwives group supervision quarterly.
Specialist roles - Named professionals Staff groups: This includes Named Doctors, Named Nurses, Named Midwives (in organisations delivering maternity services)	Level 4	Multi-agency Case Review. Critical Incident Reviews. Reflective Practice / Peer Review. Multiagency debriefs for Safeguarding Children Practice Reviews 1:1 Supervision with Designated Professional's

Appendix 5 NBT Safeguarding Children Training Matrix

Following guidance in Safeguarding Children and Young people: roles and competences for health care staff. Intercollegiate document. (2019)

Who	What	When	*Updating
All staff including non-clinical managers working in health care settings. Staff groups include: Board Level Executives and non-executives, receptionists, administration and facilities and maintenance staff and volunteers.	Level 1	At induction, 2 hours combined children and adults safeguarding session via e-learning within 4 weeks of starting role. 3 yearly update thereafter.	Staff at level 1 should receive refresher training equivalent to a **minimum** of 2 hours over 3 years via mandatory updating sessions or E-learning.
All clinical and non-clinical staff who, within their role, have contact (however small) with children, young people and / or parents/carers or adults who may pose a risk to children. Staff groups include: Administrators for Looked After Children and safeguarding teams, health care students, clinical laboratory staff, phlebotomists, pharmacists, dentists, dental care practitioners, audiologists, opticians, adult physicians, adult physicians, surgeons, anesthetists, radiologists, nurses working in adult acute/community services, allied health care practitioners and all other adult orientated secondary care health care professionals, including technicians **All security staff**	Level 2	At induction complete the level 2 Safeguarding Children e-learning session. 3 yearly update thereafter.	Staff at level 2 can access the e-learning for health level 2 program to complete their update.

Who	What	When	*Updating
Additional specialist competences for: Midwives and health visitors and specialist nurses for safeguarding children (Child Protection Supervisors) paediatricians, paediatric intensivists, Forensic Physicians, child and adolescent psychiatrists, child psychologists, child psychotherapists, children's nurses, school nurses, child and adolescent mental health nurses, children's learning disability nurses, and Specialist Nurses for looked after children.	Level 3 specialist	Within 4 months of starting role full day level 3 training. Within12 months of appointment participation in group or 1:1 supervision with child safeguarding specialist quarterly to include a review of child safeguarding cases held by practitioner.	Over a three-year period, professionals must receive refresher training, learning and education equivalent to a minimum of 12-16 hrs. Can be achieved via. • Safeguarding supervision • Reviews of significant events and Child Safeguarding Practice Reviews • Peer review • Documented personal reflection • Trust level 3 updates • Attending conferences or specialist training that includes safeguarding children • Multi-agency training Safeguarding children discussions as part of regular multi professional or multiagency meetings
Named professionals Staff groups include: Named doctors, named nurses, named midwives.	Level 4	Named professionals must complete a management program with a focus on leadership and change management within three years of taking up their post	Named professionals must attend a minimum of 24 hours of education, training and learning over a three-year period. This must include non-clinical knowledge acquisition such as management, appraisal, and supervision training. Named professionals must participate regularly in support groups or peer support networks for specialist professionals at a local and National level, according to professional guidelines (attendance must be recorded).

References

- Care Quality Commission (2015) Statement on CQC's roles and responsibilities for safeguarding children and adults. Available at: https://www.cqc.org.uk/sites/default/files/20150710_CQC_New_Safeguarding_Statement.pdf
- Children Act 1989
- Children Act 2004
- Children and Social Work Act 2017
- Data Protection Act 2018 and Regulations
- Davis, J. (2022) Adultification bias in child protection and safeguarding. Available at: Adultification bias in child protection & safeguarding - Russell Webster
- Domestic Abuse Act 2021 (Domestic Abuse: Statutory Guidance https://www.gov.uk/government/publications/domestic-abuse-act-2021)
- HM Gov. (2018) Working Together to Safeguard Children. Statutory guidance on inter-agency working to safeguarding and promote the welfare of children. Available at: https://www.gov.uk/government/publications/working-together-to-safeguard-children--2
- Holmes, D and Smale, E (2018) Transitional Safeguarding: Adolescence to Adulthood. Dartington: Research in Practice
- Mental Capacity Act (Amended) 2019
- NHS Digital 2022 Child Protection – Information Sharing service Available at: https://digital.nhs.uk/services/child-protection-information-sharing-service
- NHSE (2022) Safeguarding Accountability and Assurance Framework. Safeguarding children, young people and adults at risk in the NHS. Available at: https://www.england.nhs.uk/wp-content/uploads/2015/07/B0818_Safeguarding-children-young-people-and-adults-at-risk-in-the-NHS-Safeguarding-accountability-and-assuran.pdf
- National Institute for Health and Clinical Excellence (2009) CG 89 Child Maltreatment: When to suspect maltreatment in under 18s (updated online October 2017). Available at: https://www.nice.org.uk/guidance/cg89
- NSPCC (2022) Safeguarding children from Black, Asian and minoritized ethnic communities. Available at: https://learning.nspcc.org.uk/safeguarding-child-protection/children-from-black-asian-minoritised-ethnic-communities#skip-to-content
- RCN (2019) Safeguarding children and young people: Roles and competencies for healthcare staff. Available at: https://www.rcn.org.uk/professional-development/publications/pub-007366
- RCPCH (2018) Facing the Future: Standards for children in emergency care settings. Available at: https://www.rcpch.ac.uk/resources/facing-future-standards-children-young-people-emergency-care-settings