Title: **CHILD PROTECTION POLICY**

Ref No: 2075 Version 5
Classification: Policy

Directorate: Organisation Wide

Due for Review: 20-10-2020

Responsible for review: Safeguarding Named Nurses for Safeguarding Children for the ICO

Document Control

Ratified by: Care and Clinical Policies Group
Chief Nurse
Medical Director

Applicability: All staff groups

Contents

This policy applies to all staff, including senior managers and Trust Board members, volunteers, agency staff, students or anyone working on behalf of the organisation.

1 Purpose

- To protect children and young people who receive Torbay and South Devon NHS Foundation Trust's services. This includes the children of adults who use our service

- To provide staff and volunteers with the overarching principles the guide our approach to child protection.

Torbay and South Devon NHS Foundation Trust believes that a child or young person should never experience abuse of any kind. We have a responsibility to promote the welfare of all children and young people and keep them safe. We are committed to practice in a way that protects them.
Safeguarding children information can be found via the intranet-click here:
https://icon.torbayandsouthdevon.nhs.uk/areas/safeguarding-children/Pages/default.aspx

2 Introduction

Torbay and South Devon NHS Foundation Trust recognise that:

- The welfare of the child is paramount as enshrined in the Children Act 1989
- All children regardless of age, disability, gender, racial heritage, religious belief, sexual orientation or identity, have a right to equal protection from all types of harm or abuse.
- Some children are additionally vulnerable because of the impact of previous experiences, their level of dependency, communication needs or other issues.
- Working in partnership with children, young people, parents, carers and other agencies is essential in promoting young people's welfare.

This policy has been drawn up on the basis of law and guidance that seeks to protect children, namely:

- Children Act 1989
- United Convention of the Rights of the Child 1981
- Data Protection Act 1998
- Sexual Offences Act 2003
- Children Act 2004
- Protection of Freedom Act 2012
- Working Together 2015

The overarching principle of the Children Act 1989 states that "The welfare of the child is paramount". Section 27 of the Children Act 1989 places a specific duty on health bodies to co-operate in the interests of children in need ("need" is defined under Section 17 of the Children Act 1989). Section 47 of the Children Act 1989 places a specific duty on health bodies to assist Local Authorities (Social Care) in carrying out enquiries into whether a child is at risk of significant harm.

Section 11 of the Children Act 2004 places a legal duty on all health organisations to ensure that in discharging their functions they have regard to the needs to safeguard and promote the welfare of children. To be effective it requires staff members to acknowledge their individual responsibility for safeguarding and promoting the welfare of children.
It also requires Torbay and South Devon NHS Foundation Trust to support them in this role. This includes ensuring that all staff have access to appropriate training advice, support and supervision in relation to this responsibility. The Trust will ensure that all staff have access to expert advice, support and training in relation to child protection.

3 Roles and Responsibilities

3.1 All staff employed by Torbay and South Devon NHS Foundation Trust will seek to keep children and young people safe by:

- Valuing them and listening to and respecting them
- Adopting child protection practices through procedures and code of conduct for staff and volunteers

- Providing effective management for staff and volunteers through supervision, support and training.
- Recruiting staff and volunteers safely all employees who come into contact with children and young people are subject to a formal Disclosure and Barring Service check.
- Sharing concerns with agencies who need to know and involving parents and children appropriately

3.2 Duties of the Trust Board

The Chief Nurse is the Trust Lead Director with responsibility for Child Protection at Executive Level and the Trust Board will receive annual Child Protection updates.
It is the duty of the identified Lead to ensure that Torbay and South Devon NHS Foundation Trust complies with all Child Protection responsibilities, including the responsibilities set out in '*Working Together to Safeguard Children*, 2013 and Children Act 1989 and 2004

3.3 Duties of the Named Professionals

The Trust will appoint a Named Doctor, Named Midwife and a Named Nurse for Safeguarding Children with responsibility for taking a professional lead within the Trust on Child Protection (including advice and support to staff, legal advice and training).
The Named Professionals will maintain a link with the local Safeguarding Children Boards.
Contact details for named professionals and advice and support - click here:
https://icon.torbayandsouthdevon.nhs.uk/areas/safeguarding-children/Pages/contact.aspx

3.4 Duties of Managers

Managers are responsible for ensuring that all employees receive regular, up-to-date Child Protection Training. This should be monitored through their Annual Personal Development Plan. Staff will have access to advice via the Named Professionals and Safeguarding Children Team and Supervision as appropriate to roles & responsibilities.
Managers will ensure that professional registration is checked before commencement of employment.

3.5 Duties of staff

All staff employed by Torbay and South Devon NHS Foundation Trust should be alert to the possibility of child abuse or neglect. If staff members have concerns about the safety or welfare of a child those concerns must be addressed and consideration made for a referral to Children's Services. Under Section 47 of the *Children Act* (Department of Health, 1989) the Local Authority (Children's Services), has a duty to make enquiries, where it has reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm.

If staff are unsure of the course of action to take they must escalate their concerns to their line manager or contact a member of the Safeguarding Children Team, for advice and guidance.

All staff who come into contact with children will have access to and work to the Child Protection Policy and South West Child Protection Procedures. These can be accessed at:
http://www.proceduresonline.com/swcpp/

New staff to the Trust will be signposted to the Child Protection policy at their Induction Day. All staff will exercise their own professional accountability to safeguard children and promote their welfare.

4.0 Definition of Child Protection Categories and Abuse

There are four types of child abuse. They are defined in the UK Government guidance Working Together to Safeguard Children (2015) as follows:

4.1 Physical abuse

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child or failing to protect a child from that harm.

Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces illness in a child.

Female genital mutilation (FGM)

FGM is a criminal offence – it is child abuse and a form of violence against women and girls, and therefore should be treated as such. Cases should be dealt with as part of existing structures, policies and procedures on child protection and adult safeguarding. There are, however, particular characteristics of FGM that front-line professionals should be aware of to ensure that they can provide appropriate protection and support to those affected

FGM is a procedure where the female genital organs are injured or changed and there is no medical reason for this. It is frequently a very traumatic and violent act for the victim and can cause harm in many ways.

The age at which FGM is carried out varies enormously according to the community. The procedure may be carried out shortly after birth, during childhood or adolescence, just before marriage or during a woman's first pregnancy.

Section 5B of the 2003 Female Genital Mutilation Act introduces a **mandatory reporting duty** which requires regulated health and social care professionals and teachers in England and Wales to report 'known' cases of FGM in under 18s, which they identify in the course of their professional work, to the police.

The duty applies to all regulated professionals (as defined in section 5B(2)(a), (11) and (12) of the 2003 Act) working within health or social care, and teachers. This includes those regulated by the General Medical Council and Nursing and Midwifery Council.

For further information refer to Policy for Female Genital Mutilation

4.2 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 feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

4.3 Sexual Abuse

Sexual abuse involves 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. The activities may involve physical contact including both penetrative and non-penetrative acts such as kissing, touching or fondling the child's genitals or breasts, vaginal or anal intercourse or oral sex.

They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

4.4 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 the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to provide adequate food and clothing; shelter, including

exclusion from home or abandonment; failing to protect a child from physical and emotional harm or danger; failure to ensure adequate supervision including the use of inadequate care-takers; or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

5.0 Recognising Abuse
Also see Appendix 4

Recognising abuse is not always easy despite this however, you have a responsibility and duty, as set out in these child protection procedures, to act in order that the appropriate agencies can investigate and take any necessary action to protect a child.

If a medical assessment is required to confirm a possible diagnosis of child abuse, advice should be sought from the Named Doctor or the Consultant Paediatrician on call. Child Protection Medicals on children who are not inpatients will only normally be performed once the Police and Children's Services have had a Strategy discussion. Ideally this discussion will be in conjunction with the Consultant Paediatrician on call, in line with "Working Together to Safeguard Children" guidance – **see Appendix 8**
Linked to CL015 Safeguarding Children Medical Proforma

The following information should help you to be more alert to the signs of possible abuse;

5.1 Recognising Physical Abuse
Injuries should always be interpreted in light of the child's medical and social history, developmental stage and the explanation given. Most accidental bruises are seen over bony parts of the body, e.g. elbows, knees, shins, and are often on the front of the body. Some children, however, will have bruising that is more than likely inflicted rather than accidental.
Important indicators of physical abuse are bruises or injuries that are either unexplained or inconsistent with the explanation given, or visible on the 'soft' parts of the body where accidental injuries are unlikely, e g, cheeks, abdomen, back and buttocks.
A delay in seeking medical treatment when it is obviously necessary is also a cause for concern

The physical signs of abuse may include:
- unexplained bruising, marks or injuries on any part of the body
- multiple bruises- in clusters, often on the upper arm, outside of the thigh
- cigarette burns
- human bite marks
- broken bones
- scalds, with upward splash marks,
- multiple burns with a clearly demarcated edge.

5.2 Recognising Emotional Abuse
Emotional abuse can be difficult to measure, as there are often no outward physical signs. There may be a developmental delay due to a failure to thrive and grow. Even so, children who appear well-cared for may nevertheless be emotionally abused by being taunted, put down or belittled. They may receive little or no love, affection or attention from their parents or carers. Emotional abuse can also take the form of children not being allowed to mix or play with other children.
Behaviours which may be present
- neurotic behaviour e.g. sulking, hair twisting, rocking
- being unable to play
- fear of making mistakes
- sudden speech disorders
- self-harm
- fear of parent being approached regarding their behaviour
- developmental delay in terms of emotional progress

5.3 Recognising Sexual Abuse

Adults who use children to meet their own sexual needs abuse both girls and boys of all ages, including infants and toddlers. Usually, in cases of sexual abuse it is the child's behaviour that may cause you to become concerned, although physical signs can also be present. In all cases, children who tell about sexual abuse do so because they want it to stop. It is important, therefore, that they are listened to and taken seriously.

The physical signs of sexual abuse may include:

- pain or itching in the genital area
- bruising or bleeding near genital area
- sexually transmitted disease
- vaginal discharge or infection
- discomfort when walking or sitting down
- pregnancy

Behaviours which may indicate Sexual Abuse:

- sudden or unexplained changes in behaviour e.g. becoming aggressive or withdrawn
- fear of being left with a specific person or group of people
- having nightmares
- running away from home
- sexual knowledge which is beyond their age, or developmental level
- sexual drawings or language
- bedwetting
- eating problems such as overeating or anorexia
- self-harm or mutilation, sometimes leading to suicide attempts
- saying they have secrets they cannot tell anyone about
- substance or drug abuse
- suddenly having unexplained sources of money
- not allowed to have friends (particularly in adolescence)
- acting in a sexually explicit way towards adults

Disclosure of acute sexual assault/ abuse in the last seven days for children under 17yrs in Torbay and under 15yrs in Plymouth follow Appendix 6

Disclosure of historic sexual abuse / assault or concerns of sexual abuse in a child under 17yrs Torbay follow Appendix 7

5.4 Recognising Neglect

Neglect can be a difficult form of abuse to recognise, yet have some of the most lasting and damaging effects on children.

The physical signs of neglect may include:

- constant hunger, sometimes stealing food from other children
- constantly dirty or 'smelly'
- loss of weight, or being constantly underweight
- inappropriate clothing for the conditions

Behaviour which can also indicate neglect may include:

- complaining of being tired all the time
- not requesting medical assistance and/or failing to attend appointments
- having few friends
- mentioning being left alone or unsupervised

The following guidance will support identification of abuse and understanding of wider child protection issues.

5.5 Child Sexual Exploitation

Child sexual exploitation (CSE) is a form of child abuse, which can happen to boys and girls from any background or community. It can range from seemingly 'consensual' relationships, informal exchanges of sex in order to get affection, accommodation or gifts, through to exploitation by gangs involved in serious, organised crime

Practitioners concerned about a young person can assess risk using the CSE toolkits:-

http://www.torbaysafeguarding.org.uk/workers/missing-cse/

http://www.devonsafeguardingchildren.org/?s=risk&x=0&y=0

Additional information:-

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/278849/Safeguarding_Children_and_Young_People_from_Sexual_Exploitation.pdf

5.6 **Sexual Harmful Behaviour Among Children and Young People**

The NSPCC define harmful sexual behaviour as: " One or more children engaging in sexual discussions or acts that are inappropriate for their age or stage of development. These can range from using sexually explicit words and phrases to full penetrative sex with other children or adults"

A multi-agency approach is required to support the perpetrator and victim effectively and the continuum of intervention can be from Early Help to Youth Offending. Trust staff will be expected to support statutory agencies such as the police and children services to deliver a therapeutic and supportive package of care for the children and families affected.

Further guidance and support can be found through:

NICE Guidance NG55 https://www.nice.org.uk/guidance/NG55

SWCCP

http://www.proceduresonline.com/swcpp/torbay/p_sexually_harm_behav.html?zoom_highlight=sexual+hearmful+behaviour

NSPCC https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/harmful-sexual-behaviour/research-resources/

5.7 Safeguarding Children in Whom Illness is Fabricated or Induced

The fabrication or induction of illness in children by a carer has been referred to by a number of different terms, most commonly Munchausen Syndrome by Proxy (Meadow, 1977), Factitious illness by proxy (Bools 1996; Jones and Bools 1999) or Illness Induction syndrome (Grey et al 1995,)

In this condition carers exhibit behaviours when they wish to convince others their child is ill. This has been considered as rare, however staff are required to notice these behaviours and discuss with their safeguarding supervisors or Named Professionals.

https://www.gov.uk/government/publications/safeguarding-children-in-whom-illness-is-fabricated-or-induced

5.8 Safeguarding Children From Abuse Linked to a Belief in Spirit Possession

The term "belief in spirit possession" is defined as the belief that an evil force has entered a child and is controlling him or her, Sometimes the term "witch" is used and is defined here as the belief that a child is able to use an evil force to harm others.

The abuse has been considered as rare however staff are required to notice these behaviours and discuss with their safeguarding supervisors or Named Professionals.

http://webarchive.nationalarchives.gov.uk/20130401151715/https:/www.education.gov.uk/publications/standard/publicationdetail/page1/DFES-00465-2007

5.9 Safeguarding Children Who May Have Been Trafficked

The trafficking of children is a clandestine activity, which makes it difficult to identify victims and record their numbers. However, data on people suspected of being victims of trafficking is now being collated through the National Referral Mechanism (NRM) which was established in April 2009. Between 1 April 2009 and 31 March 2011, 390 potential child victims of trafficking were referred through the NRM. However the actual numbers is hard to pinpoint since child trafficking is mostly hidden. One estimate is that 50% of all trafficked victims are children. Unicef.org

Children are trafficked for many reasons, including sexual exploitation, domestic servitude, labour, benefit fraud and involvement in criminal activity such as pick-pocketing, theft and working in cannabis farms. There are a number of cases of minors being exploited in the sex industry. Although there is no evidence of other forms of exploitation such as 'organ donation or 'harvesting', all agencies should remain vigilant.

https://www.gov.uk/government/publications/safeguarding-children-who-may-have-been-trafficked-practice-guidance

6.0 Risk Factors Associated with Child Protection

Where concerns exist, staff need to be aware if a child is subject to a child protection plan.

Staff can check the flagging system on IHCS, where children on a child protection plan or are Looked After, will have a flag.

If you are still in doubt contact children services – the information will be provided to you on a call back basis unless you have made it clear the child is at risk of immediate harm.

There are certain risk factors and situations that may place children at particular risk of suffering significant harm. The presence of one or more of these factors does not automatically imply that abuse will result, but may increase the likelihood.

Serious case reviews have shown that children living with a parent or carer with mental illness, substance misuse, or domestic violence are at greater risk of harm. If staff have concerns about

these risk factors, they should speak with their safeguarding supervisor or a member of the safeguarding team.

See Appendix 4 for Safeguarding Prompts

Below are listed some Risk Factors to consider when assessing care of adults and children.

6.1 Mental Health

The majority of parents who suffer significant mental ill health are able to care for and safeguard their children and/or unborn child but it is essential always to assess the implications for any children involved in the family

Children most at risk of significant harm are those who feature within parental delusions and children who become targets for parental aggression or rejection, or who are neglected as a result of parental mental illness.

6.2 Drug and Alcohol Misuse/ Substance Misuse

As with mental illness in a parent, it is important not to generalise, or make assumptions about the impact on a child of parental drug and alcohol misuse.

However it is important to note the report by the Advisory Council on the Misuse of Drugs (ACMD) *Hidden Harm- responding to the needs of children of problem drug users* estimated that there are between 200,000-300,000 children of problem drug users in England and Wales, i.e. 2-3% of all children under 16 years.

Parental substance misuse can and does cause serious harm to children at every age from conception to adulthood. Parental Misuse of drugs (prescribed and illegal) and/or alcohol is strongly associated with significant harm to children.

6.3 Domestic Abuse

There is a clear link between domestic abuse and child abuse (HM Government 2006). Where there is evidence of domestic violence, the implications for any children in the household must be considered. The negative impact of domestic violence is exacerbated when the violence is combined with alcohol or drug misuse; children witness the violence; children are drawn into the violence or are pressurised into concealing the assault.

6.4 Unborn Babies

Staff working with pregnant women should consider the need for an early referral (no later than 20 weeks of gestation) to Children's Social Care, so that assessments are undertaken and family support services provided as early as possible.
Guidance is found under SWCCP Pre-birth (Safeguarding Unborn Babies) http://www.proceduresonline.com/swcpp/devon/p_prebirth_sg_unborn.html

6.5 Disabled Children

Disabled children have exactly the same human rights to be safe from abuse and neglect, to be protected from harm and achieve the Every Child Matters outcomes as non-disabled children.

Disabled children do however require additional action. This is because they experience greater vulnerability as a result of negative attitudes about disabled children and unequal access to services and resources, and because they may have additional needs relating to physical, sensory, cognitive and/ or communication impairments.

Research indicates that disabled children face an increased risk of abuse or neglect yet they are underrepresented in safeguarding systems. Disabled children can be abused and neglected in ways that other children cannot and the early indicators suggestive of abuse or neglect can be more complicated than with non-disabled children. A summary of the research evidence regarding disabled children and abuse, what is known about prevalence rates and the factors that create disabled children's vulnerability to abuse and neglect is set out in the following document.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/190544/00374-2009DOM-EN.pdf

Trust staff have a duty to ensure they hear the voice of disabled children and recognise their right to communicate. Disabled children will use a variety of communication systems such as Makaton and Rebus, Sign supported English, British Sign Language, Finger spelling and augmented communication systems. Some children will have very limited communication methods with only a sign that indicates yes and no.
Awareness of different methods of communication is essential and how and where to seek specialist advice and assistance. Specialist staff such as Speech and Language therapists and learning disability nurses will have knowledge of these communication methods and working together with partners in school and the local authority will ensure these children's views and wishes are heard.
Further support and guidance can be sought from Named professionals- follow the link:
https://icon.torbayandsouthdevon.nhs.uk/areas/safeguarding-children/Pages/contact.aspx

7.0 Referral to Children Services

See Appendix 3

Where it is believed that a child may be suffering, or be at risk of suffering significant harm, a referral should be made to Children's Social Care (Social Services) via Multi-Agency Safeguarding Hub or MASH (Devon) or (Torbay)
Immediate Child Protection Referrals must be made by telephone and followed up in writing within 48 hours using the relevant Children Social Care Referral Form- click here for details:
Devon:
http://www.devonsafeguardingchildren.org/workers-volunteers/safeguarding-hub-the-mash/

Torbay:
http://torbaysafeguarding.org.uk/workers/hub/

Completed forms are to be sent to the following email addresses or postal addresses:

Devon MASH Enquires:
Email: mashsecure@devon.gcsx.gov.uk
Address:
PO BOX 723,
Exeter,
EX1 9QS,
Tel: 0345 155 1071,
Fax: 01392 448951
Out of Hours
0845 6000 388

Torbay MASH Enquiries
Email: Torbay.Safeguardinghub@torbay.gcsx.gov.uk
Address:
Torbay Children Services
L2 South
TorHill House
C/O Town Hall
Castle Circus
Torquay
TQ1 3DR

Tel: 01803 208100
Out of Hours 01803 524519

Also in Appendix 1 and 2

Where Children's Social Care decides to take no action, the referrer should ask for feedback about that decision and its rationale

7.1 Where there is a disagreement or concern regarding actions taken following a child protection referral then the Team Manager of the Social Care Team should be contacted. In addition the

LSCB (Local safeguarding Children Board) escalation policies can be implemented.

Devon:
http://www.devonsafeguardingchildren.org/documents/2014/07/escalation-policy-may-2014.pdf

Torbay:
http://www.torbaysafeguarding.org.uk/publications/policies/
Where there is a difference of opinion between professionals regarding a risk to a child, the Named Nurse or Named Doctor should be contacted-click here:

http://nww.sdhct.nhs.uk/misc/safeguarding/safeguarding_children/Pages/health_safeguarding_children_team_contacts.aspx

8.0 Consent

Staff must seek agreement from the family for a referral to Children's Social Care unless this may:

- Place a child at increased risk of significant harm
- Place the staff member at risk;
- Lead to the risk of loss of evidential material.

If consent is not given and the bullets above do not apply, the referral will be returned to the referrer to obtain consent and resend within a reasonable timescale depending on this safeguarding concern.

Advice and support is available from the named professionals.
https://icon.torbayandsouthdevon.nhs.uk/areas/safeguarding-children/Pages/contact.aspx

9.0 Record Keeping

Information sharing and recording of information will comply at all times with Torbay and South Devon NHS Foundation Trust and Professional Codes of Conduct relating to confidentiality, Data Protection Act (1998), Health Records Policy (2006), Human Rights Act (1998) and Information Sharing: Practitioners Guide (2006)
Written records must be kept, in accordance with Torbay and South Devon NHS Foundation Trust Record Keeping Policy, documenting any concerns, allegations or disclosures of abuse,

noting dates and incidents. Any discussions with parents, managers, Children's Services or other agencies/professionals must be documented.

9.1 All discussions, decisions and actions must be recorded contemporaneously with a date, name and signature. All recordings should be based on fact or professional opinion, and kept in the service user's records.

9.2 Staff should listen carefully to any child who discloses abuse and record any information obtained from an interview with a child immediately in the Child's Health Record.
If staff are unsure what action to take they should contact their Line Manager, Named Nurse or Safeguarding Children team- click here:
https://icon.torbayandsouthdevon.nhs.uk/areas/safeguarding-children/Pages/contact.aspx

10.0 Information Sharing, Consent and Confidentiality

Information sharing: Guidance for practitioners and managers:
https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice
Information Sharing: Pocket Guide
http://webarchive.nationalarchives.gov.uk/20100202100434/http://www.dcsf.gov.uk/everychildmatters/_download/?id=104

10.1 In July 2007 a joint statement by the Department for Children, Schools and Families (DCSF) and the DH gave additional guidance on the duties of doctors and other health professionals.
'When investigating allegations of child abuse or assessing injuries or symptoms which may arise from child abuse, professionals first duty should be owed to the child They should not be distracted from that duty by a parallel duty to anyone else including the parents or carers' (2007)

10.2 Guidance is similar for Trust Doctors and Consultants. The General Medical Council (GMC) guidance on '*Confidentiality Protecting and Providing Information'* (2004) is clear that information may be released without consent to 3rd parties e.g. Children's Social Care, Police in circumstances where:

- Failure to disclose information may expose the service user or others to risk of death or serious harm;
- You are aware of potential risk occurring from an adult to a child; and
- Children who may be the subject of abuse.

10.3 The Paediatric Liaison Service ensures the timely sharing of relevant information about children and young people who have had contact with professionals in the acute hospital setting.
Information is shared by the Paediatric Liaison Nurse to all agencies who are involved with the care of the child within the family. This can include Health Visitors, School Nurse, GP's, Social

Workers, Family Support Workers, Looked After Child teams and CAMHS. The information is shared with the consent of parents / guardians / young people.
Further information regarding the service can be found on the ICONetwork page
https://icon.torbayandsouthdevon.nhs.uk/areas/safeguarding-children/Pages/paed-liaison.aspx

11.0 Training and Supervision

11.1 Practitioners will know how to contact their Named Safeguarding Professionals within the Trust for advice and support on Child Protection issues. This will be achieved through a robust Induction Programme and on-going training, provided by the Trust.

11.2 Torbay and South Devon NHS Foundation Trust will ensure that Child Protection Training Programmes are reviewed and updated in line with current legislation to provide practitioners with skills appropriate to their needs.

11.3 All Torbay and South Devon NHS Foundation Trust staff will access Child Protection Training as set out in the Training Protocol.

11.4 Annual appraisals must include reference to Child Protection Training needs relevant to their roles and responsibilities.

11.5 Managers should ensure that professional development plans incorporate the Child Protection development needs of their staff.

11.6 Managers must ensure that staff are released from service duties to attend single and multi-agency Child Protection Training and update sessions, and monitor and record attendance of their staff group.

11.7 Staff will have access to Child Protection Supervision as appropriate to their role.

12.0 Managing Allegations Against Staff

12.1 Where allegations have been made against a staff member who work with children, the Trust has a responsibility to make a clear distinction between an allegation, a concern about the quality of care or a complaint.

An allegation may relate to a person who works with children who 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

(Working Together to Safeguard Children 2015)

Where these criteria have been met the Trust has a responsibility to inform the Local Authority Designated Officer LADO. **Appendix 4**

The LADO has overall responsibility for the management of allegations of abuse against adults who work with children.

A “staff member” is a person whose work brings them into contact with children in their setting. It therefore applies to all adults whether paid or working in a voluntary capacity (including agency workers) on or off the premises.

12.2 The rights of the child and member of staff must be considered however the child’s interest must be paramount as set out in the Children Act 1989.

12.3 All staff have a responsibility to report staff if they believe a member of staff is harming or using unacceptable behaviour towards a child. Information may come to light about behaviour outside the workplace which could indicate a breach of acceptable professional conduct. In investigating

12.4 Allegations, actions should be conducted in a way that recognises the vulnerability of staff and seeks to protect as far as possible from mistaken or false allegations.

12.5 The LADO will provide advice, guidance and help to determine whether a concern or allegation sits within the scope of safeguarding procedures.

12.6 For advice and guidance please contact your named nurse or line manager and refer to managing allegations against those working with children flow chart **Appendix 5** and Trust policies named *Disciplinary Policy* and also *Management Guidance for Disciplinary* for further guidance.

13.0 Monitoring and Auditing

Child Protection Audits will continue to be undertaken as identified by the Operational Safeguarding Committee. The results of these will be included in the annual report to the Board.

14.0 References

Bools C N, Neale B A and Meadow S R (1993) Follow up of victims of fabricated illness (Munchausen Syndrome by Proxy). Archives of Disease in Childhood. **69**: 625-630.

Children Act 2004 (2004) London, The Stationery Office

Cm 2860 (2003) Every Child Matters. London: The Stationary Office www.everychildmatters.gov.uk

Child Sexual Exploitation
http://www.devonsafeguardingchildren.org/children-young-people/sexual-exploitation/

HMSO (1998) Data Protection Act 1998

Department for Education & Skills (2008) Analysing child deaths and serious injury through abuse and neglect: what can we learn? London: DfES
www.dcsf.gov.uk

Department for Education & Skills (2008) Information Sharing: Guidance for practitioners and managers. London: DfES www.dcsf.gov.uk

Department of Health (1995) Child Protection: Messages from Research. London: HMSO

Department of Health (2006) Responding to Domestic Abuse – A Handbook for Health Professionals London: DOH

Department of Health, Department for Education and Employment and Home Office (2000) Framework for the Assessment of Children in Need and their Families. London: The Stationery Office

DOH (2006) Health Records Policy

Department of Health, Department for Education and Employment and Home Office (2007) Statement on the duties of Doctors and other Health Professionals in investigations of Child Abuse. London: The Stationery Office

Department of Health (2006) Standards for Better Health London HMSO

GMC guidance on 'Confidentiality Protecting and Providing Information (2004)

Gray J, Bentovim A and Milla P (1995) The treatment of children and their families where induced illness has been identified. In: Horwath J and Lawson B (eds) (1995) Trust Betrayed? Munchausen Syndrome by Proxy – inter-agency child protection and partnership with families. National Children's Bureau, London.

Hidden Harm – Responding to the needs of children of problem drug users.
Advisory Council on the Misuse of Drugs (ACMD)

HM Government (2007) Statutory guidance on making arrangements to safeguard and promote the welfare of Children under Section 11 of the Children Act 2004. London: DfES

Information Sharing Advice for Safeguarding Professionals
https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice

Nursing and Midwifery Council (2006) Advice on Record Keeping. London: NMC
South West Child Protection Procedures
http://www.proceduresonline.com/swcpp/devon/
http://www.proceduresonline.com/swcpp/torbay/index.html

Torbay and Devon Safeguarding Children Board
http://www.devonsafeguardingchildren.org/

http://www.unicef.org/protection/files/ipuglobaltrafficking.pdf

What to do if you're worried a child is being abused HM Government 2006
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/190604/DFES-04320-2006-ChildAbuse.pdf

WHO (1998) Human Rights Act 1998

Working Together to Safeguarding Children – A guide to interagency working to safeguard and promote the welfare of children DH 2015
http://www.workingtogetheronline.co.uk/index.html

15.0 Equality and Diversity

15.1 This document complies with the South Devon Healthcare Foundation Trust and Torbay and Southern Devon Health and Care NHS Trust Equality and Diversity statements.

16.0 Further Information

16.1 Links to policies.

Links or overlaps with other policies:

Female Genital Mutilation 1646
Disengagement in Relation to Children 1906
Domestic Abuse Guideline for Routine Enquiry 1339
Domestic Violence and Abuse to Staff Policy 1857
Domestic Abuse SOP for Management of Police Notifications 1985
Procedure for Following up children's A&E Department attendances & hospital discharges into the Torbay area 1942
Child Protection prompts for all staff (includes NICE guidelines) 0931

17. Appendices
18. Document Control Information
19. Mental Capacity Act and Infection Control Statement
20. Quality Impact Assessment (QIA)
21. Rapid Equality Impact Assessment

Appendix 1

Devon Children Referral Form

When Should I use This Form?
This form should be used to refer cases into the Devon Multi Agency Safeguarding Hub where there are children resident in the household or have regular contact that might put them at risk of significant harm.

Devon MASH Form and contact details
https://new.devon.gov.uk/educationandfamilies/child-protection/making-a-mash-enquiry

Devon MASH Enquiries:
Email: mashsecure@devon.gcsx.gov.uk
Address:
PO BOX 723,
Exeter,
Ex1 9QS,
Tel: 0345 155 1071,
Fax: 01392 448951.
Out of Hours 0845 6000 388

For further information on **MASH** regarding how we use and process this information, please visit: http://www.devonsafeguardingchildren.org/workers-volunteers/concerned-about-a-child/

Appendix 2

TORBAY MASH Referral FORM –SHEF (Safeguarding Hub Enquiry Form)

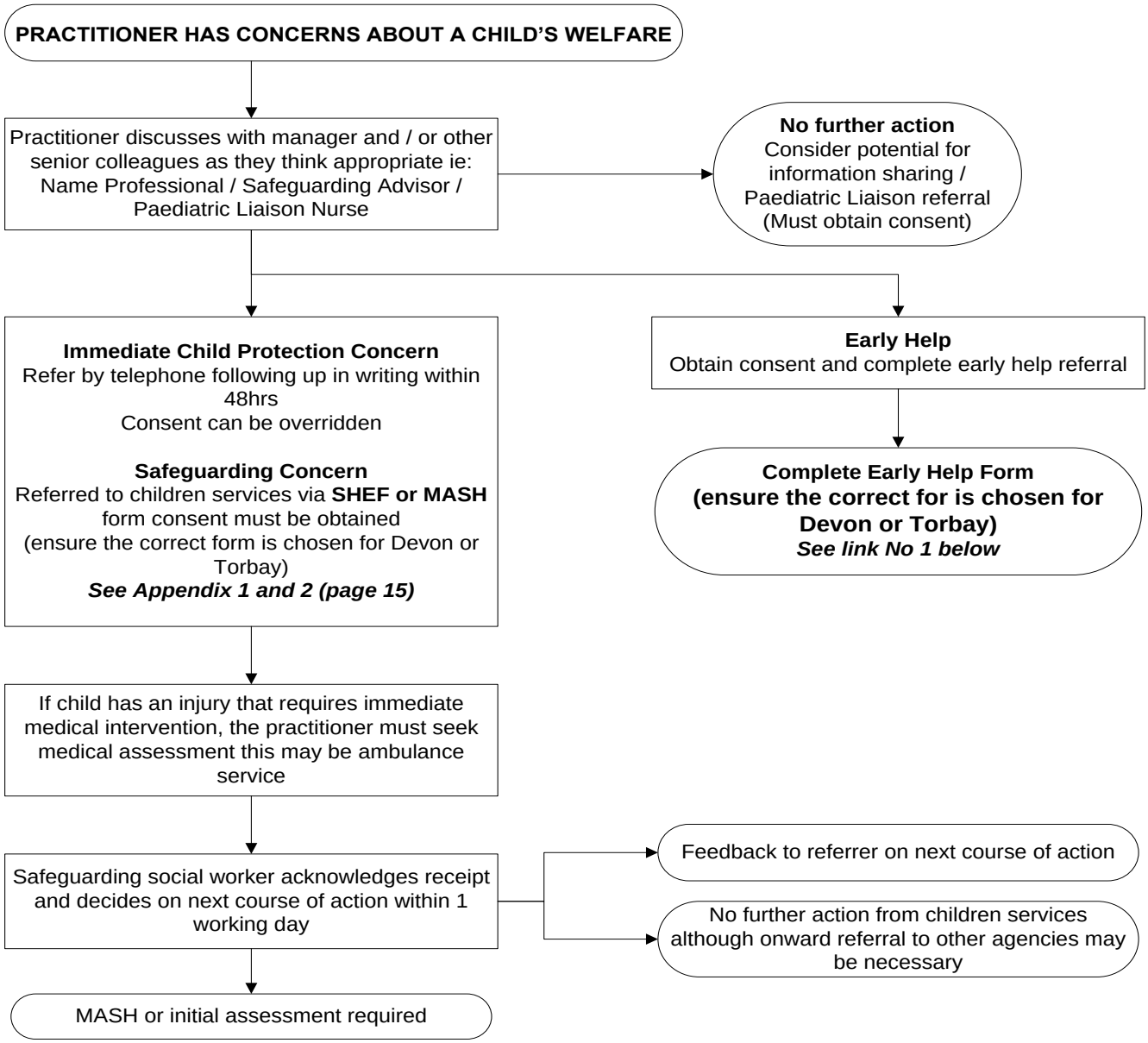
When Should I use This Form?
This form should be used to refer cases into the Torbay Multi Agency Safeguarding Hub (MASH) where there are children resident in the household or have regular contact that might put them at risk of significant harm.

http://torbaysafeguarding.org.uk/workers/hub/

Torbay MASH Enquiries:
Email: Torbay.Safeguardinghub@torbay.gcsx.gov.uk
Address:
Torbay Children Services
L2 South
TorHill House
C/O Town Hall
Castle Circus
Torquay
TQ1 3DR
Tel: 01803 208100
Out of Hours 01803 524519

Appendix 3

SAFEGUARDING CHILDREN ACTION FLOWCHART



Record all actions and discussions in line with record keeping policy

TORBAY SAFEGUARDING HUB Tel: 01803 208100
OUT OF HOURS Tel: 01803 524519
See link No 2 below

DEVON MASH Tel: 0844 8803563
OUT Of HOURS 0845 6000 388
See link No 3 below

Linked to:

1. http://www.torbay.gov.uk/children-and-families/services-and-support/early-help/
2. torbay.safeguardinghub@torbay.gcsx.gov.uk
3. mashsecure@devon.gcsx.gov.uk

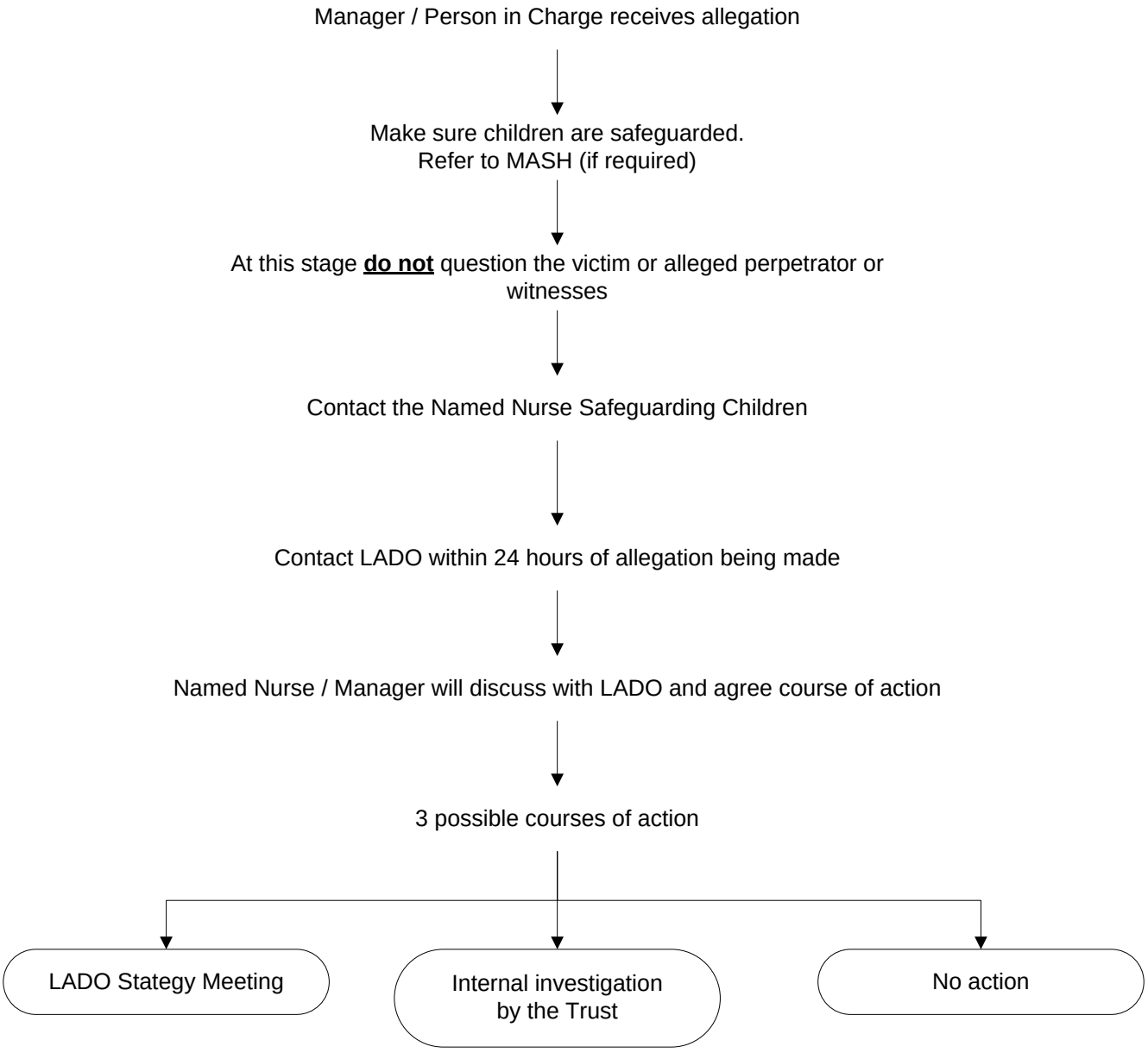
Appendix 4

SAFEGUARDING PROMPTS

Common indicators of physical abuse	**Common indicators of emotional abuse**
• Multiple bruising of different ages (consider age and development of child) • Bruising to the face (other than forehead) or neck • Bruising in a pattern • Bite marks, especially adult size • Burns and scalds, especially with a clear outline or unusual position • Fractures especially of a child under 2 years • Loss of consciousness, apnoeic attacks or fits when other causes eliminated • Poisoning • Burns or bruising to soft, non-protruding parts of the body • Torn frenulum &/or other oral injuries • Multiple attendances with injuries • Bruising in non-mobile children **Sentinal injuries** - The presence of a number of minor injuries to an infant / child at same or different times , may be an indication that they are at risk of significant harm	• Withholding of approval or affection by the parent/carer • Discipline that is severe and inappropriate or non-existent with few or no boundaries • Exploitation by parents/carers to meet their needs • Impaired ability for play and enjoyment • Lack of curiosity and natural exploration, air of detachment • Persistent head banging or rocking in a younger child • Delayed social and language skills • Low self-esteem, feeling of worthlessness • Eating disturbance, poor growth • Family history of domestic violence, mental illness of carer or substance misuse • Behavioural difficulties including aggression • Self harm, attempted suicide • Inappropriate responses to painful situations • Frozen watchfulness • Pseudo mature or explicit sexual behaviour • Only happy at school or when kept away
Common indicators of neglect	**Common indicators of sexual abuse**
• Failure to thrive • Disturbed appearance • Poor skin care, hygiene, hair loss • Inadequate clothing • Lack of appropriate supervision • Developmental delay, impaired language and social skills, dejected presentation • Persistent failure to seek or follow medical advice • Poor or non-school attendance • Dirty, smelly and always hungry • Abandonment • Unhygienic home conditions • Poor relationships with peers, but attention seeking from adults	• Genital or anal lacerations, bleeding or trauma • Sexually transmitted diseases • Pregnancy • Overt sexualised behaviour, compulsive masturbation, acting out and aggressive behavior • Withdrawn, depression, self-harm, running away, truancy, substance misuse • Change in normal behaviour or sexual awareness and knowledge beyond years • Refusing to stay with or be looked after by certain persons • Secondary enuresis/encopresis, vaginal discharge and recurrent UTI are common and may occasionally be indicators of abuse
Accidental or non-accidental injury? Does the explanation seem likely? Does the explanation fit the age and development of the child? Does the explanation match the injury? Is the explanation consistent? Are the injuries recurrent? Has there been a delay in seeking medical advice? What does the child say? What is the child or carer communicating in other ways?	

Appendix 5

Managing allegations against those working with children



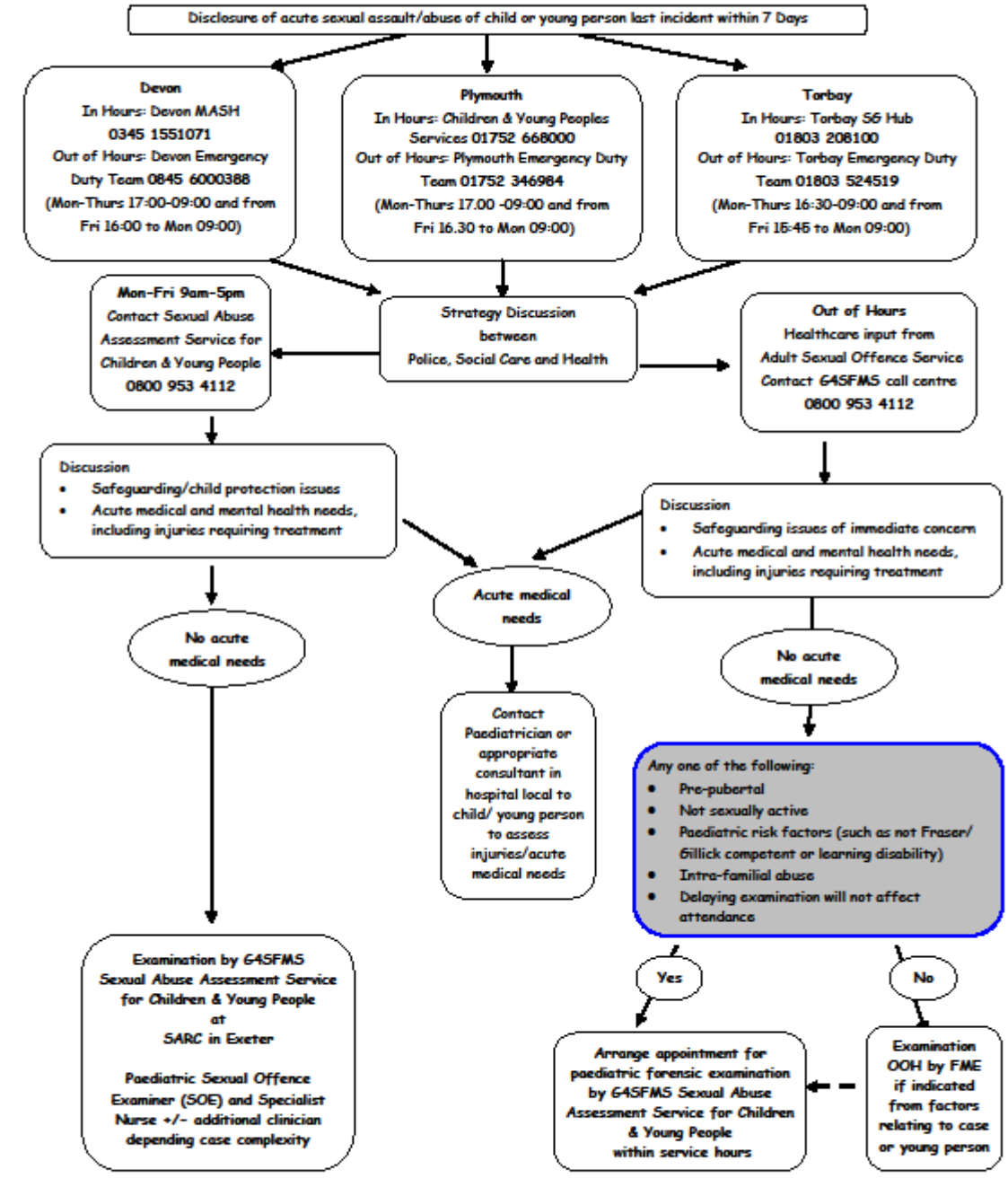
Appendix 6

Care Pathway for Acute Sexual Abuse Assessment Service for Children and Young People

Forensic and Medical Services (UK) Ltd

NHS England

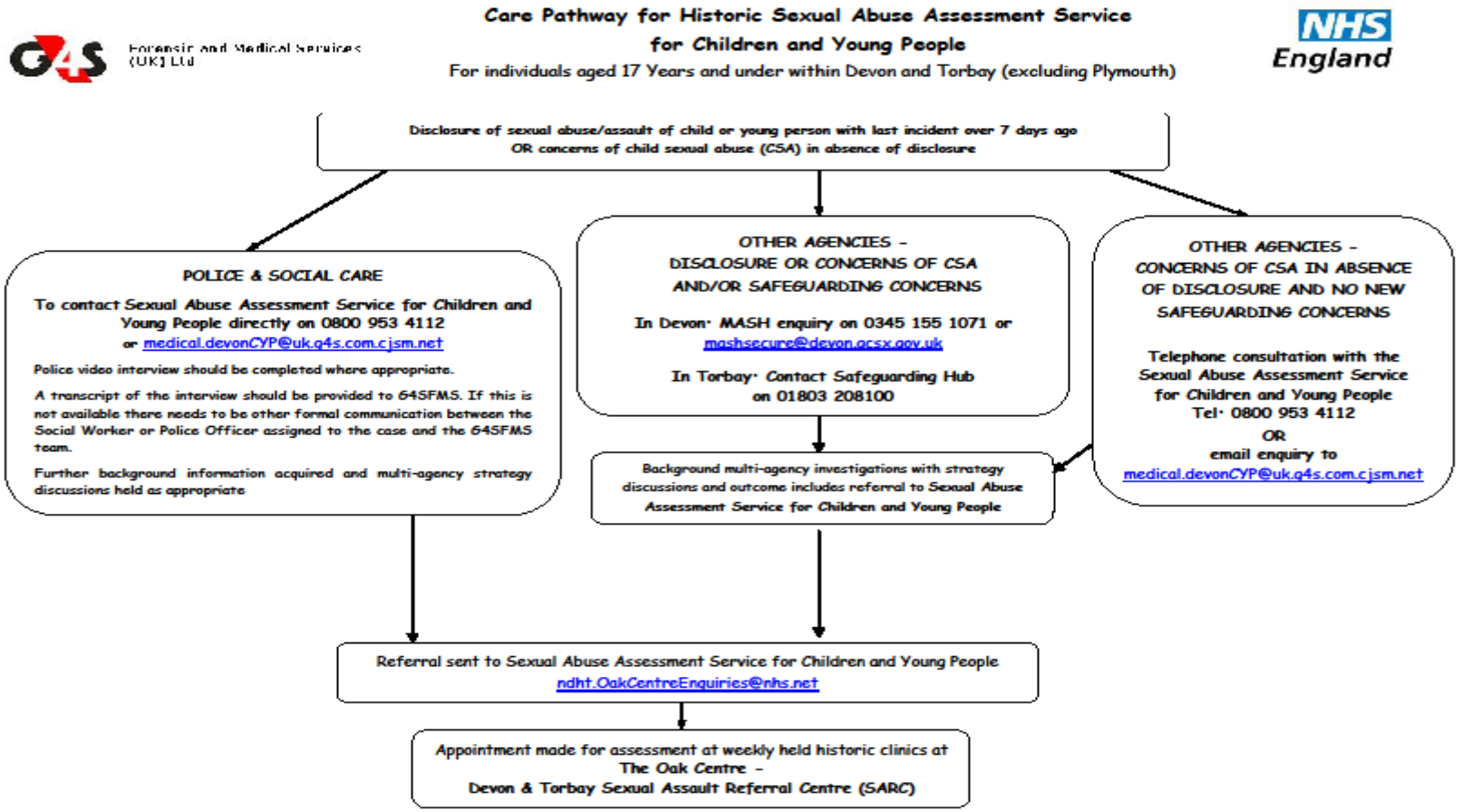
For individuals **aged 17 Years and under within Devon and Torbay AND aged 15 and under from Plymouth**



Represents scenario where additional information is acquired by the SOLO/SOE after call has been allocated, i.e. paediatric risk factors previously thought to be absent have now been identified. This may deem it more appropriate for the individual to be seen within paediatric service and therefore the pathway allows for referral back .

2016_ v9

Appendix 7



2016_V6

Linked to: medical.devonCYP@uk.g4s.com.cjsm.net
mashsecure@devon.gcsx.gov.uk
ndht.OakCentreEnquiries@nhs.net

Appendix 8

CHILD PROTECTION MEDICAL EXAMINATIONS

- This guideline describes the usual processes of performing medical examinations for child protection purposes other than for suspected sexual abuse.
- Child Sexual Abuse Medicals are not carried out by TSDFT staff. Ask police or social worker to follow multi agency flowchart and contact G4S Forensic and Medical Services (UK) Limited – (see Appendix 6 & 7 Child Protection Policy). Occasionally it is appropriate for a consultant paediatrician to provide an opinion for example a child brought with an acute genital injury said to have occurred accidentally. He/she can discuss this with Children and Young People's Services (CYPS) if necessary.
- Staff below the level of consultant should not accept referrals without discussing with a consultant

'IN HOURS' Monday to Friday 09:00 to 17:00

- Most referrals are made by CYPS following referrals from health (GPs, health visitors, midwives etc), education, police and other agencies
- Information will be collated in the Multi-Agency Safeguarding Hub (MASH) and a strategy discussion held. (MASH may occasionally request the COW/PAC or one of the Named Doctors for Safeguarding Children be involved in the strategy discussion)
- Further information will usually be obtained by CYPS/Police which may include interviewing parent/s, the child and other professionals
- If a decision is made that a CP medical examination is required CYPS will telephone the Consultant of the Week (COW) on 07825 144452 (if no response the Paediatric Acute Consultant (PAC) on 07584 272641) to discuss this request:
    - Why – what will the medical add to understanding what has happened and safeguarding the child?
    - When – consider best interests of child and service implications, is a same day medical required, would it be preferable to arrange an appointment the next day?
    - Who – ensure the person who is going to do the medical is free of other commitments wherever possible. If the medical is performed by Middle Grade – Child Protection Supervision must be sought as soon as possible (ideally while child is still present) and the report approved by a Consultant before sending.
    - Where – the Child Protection Co-Ordinator (ext 55801) can assist in arranging this
- The consultant telephones the Child Protection Coordinator to inform them that a CP medical request has been accepted. The CP Coordinator will confirm time, place and examiner and liaise with CYPS, including confirming details of who will accompany child. Hospital notes will be obtained and prepared including check WINDIP, Infoflex, standard proforma etc.
- A parent must attend if at all possible to give consent and to allow a detailed history to be taken. This should not preclude the child or young person being seen on their own.
- The examiner will provide verbal feedback to CYPS once medical completed before the child leaves the hospital and will inform the parent/guardian of broad conclusions.
- A final plan and outcome will be documented in the hospital notes.

- The report must be dictated and handed to the Child Protection Coordinator for typing as priority on an Infoflex CP medical proforma. The report should reach CYPS within 48 hours.

OUT OF HOURS

- Most concerns are raised acutely by out of hours health services (ED, MIUs, out of hours GP etc).
    - Some referrals are then made to CYPS - Emergency Duty Service (EDS) by the health provider. CYPS EDS also receive referrals from police and other agencies.
    - Some referrals are directed to the on-call paediatric team – see below. Staff below the level of consultant should not accept referrals without discussing with a consultant.
- If the referral is made to CYPS information will be collated by the EDS and a strategy discussion may be held. Further information may then be obtained by CYPS/Police which may include interviewing parent/s, the child and other professionals
- If a decision is made that a CP medical examination is required CYPS will telephone the Paediatric Acute Consultant (PAC) on 07584 272641 to discuss this request:
    - Why – what will the medical add to understanding what has happened and safeguarding the child
    - When – consider best interests of child and service implications, is a same day medical required, would it be preferable to arrange an appointment the next day?
    - Who – ensure the person who is going to do the medical is free of other commitments wherever possible. If the medical is performed by Middle Grade – Child Protection Supervision must be sought as soon as possible (ideally while child is still present) and the report approved by a Consultant before sending.
    - Where – ward or Emergency Department
- The consultant is then responsible for the administration process, assistance from a ward clerk or nursing staff can be sought:
    - Confirm time, place and examiner with CYPS, including confirming details of who will accompany child.
    - Hospital notes obtained and prepared including check WINDIP, Infoflex etc. The standard CP medical proforma is available on intranet - Safeguarding Children/Medical Reporting. The patient name, DOB and hospital number needs to be entered on top of page 2 (automatically pulled through rest of document).
    - Inform the Child Protection Coordinator (ext 55801 or email: sdhct.cpp@nhs.net) that a CP medical has been performed.
- The examiner will provide verbal feedback to CYPS once medical completed before the child leaves the hospital and will inform the parent/guardian of broad conclusions.
- A final plan and outcome will be documented in the hospital notes.
- The report must be dictated and handed to the Child Protection Coordinator for typing as priority on an Infoflex CP medical proforma. The report should reach CYPS within 48 hours.

CONCERNS OCCURING REGARDING A CHILD ALREADY IN HOSPITAL OR REFERRED BY A HEALTH PRACTITIONER DIRECTLY TO A CONSULTANT PAEDIATRICIAN

- It would be impossible to detail every possible variation from the above standard procedures but there are occasions when a paediatrician may be involved with providing services to a child who may have suffered abuse prior to CYPS being informed. This may involve a child referred from primary care or under the care of the Emergency Department or another

speciality. It is the responsibility of professionals who believe that a child has been or is likely to be harmed to make a referral to CYPS or the Police with consent of someone with parental responsibility. However in some circumstances it may be appropriate for a different course of action to be taken. For example:

Health professional has concerns that abuse may be part of a differential that includes other medical conditions e.g. multiple bruising - ?Non-accidental injury or haematological disorder	Paediatrician undertakes standard medical assessment. If there is concern over abuse after that assessment Paediatrician refers to CYPS.
Health professional has reason to believe that the child is at risk of harm if not sent directly to hospital e.g. seriously unwell or injured	Paediatrician accepts referral and advises other professional to make referral to CYPS. Other professional documents reasons if referral is made without consent.
There is reason to believe that the professional, the child or other individual may be at risk of harm if concerns are raised regarding abuse in the current location	

If concerns arise during care of child in hospital, e.g. a fracture is seen on a chest xray taken for medical reasons or bruises seen during an examination it may be difficult to be clear where standard assessment merges into a child protection medical process. It is good practice when it is clear that a thorough documented assessment for child protection purposes is required that staff consider the need to discuss with a consultant paediatrician and complete a CP medical assessment on standard proforma with the express knowledge and consent of a person with parental responsibility.

18. Document Control Information

This is a controlled document and should not be altered in any way without the express permission of the author or their representative.

Please note this document is only valid from the date approved below, and checks should be made that it is the most up to date version available.

If printed, this document is only valid for the day of printing.

Ref No:	2075		
Document title:	Child Protection Policy		
Purpose of document:	To protect children and young people who receive Torbay and South Devon NHS Foundation Trust's services. This includes the children of adults who use our services. To provide staff and volunteers with the overarching principles the guide our approach to child protection.		
Date of issue:	20 October 2017	**Next review date:**	20 October 2020
Version:	5	**Last review date:**	18 October 2017
Author:	Named Nurses for Safeguarding Children for the ICO		
Directorate:	Organisation Wide		
Equality Impact:	The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief		
Committee(s) approving the document:	Care and Clinical Policies Group Chief Nurse Medical Director		
Date approved:	13 October 2016		
Links or overlaps with other policies:	All TSDFT Trust Strategies, policies and procedure documents: 1646 Female Genital Mutilation 1906 – Disengagement in Relation to Children 1339 – Domestic Abuse Guideline for Routine Enquiry 1857 – Domestic Violence and Abuse to Staff Policy 1985 – Domestic Abuse SOP for Management of Police Notifications 1942 – Procedure for following up Children's A&E Department attendances and hospital discharges into the Torbay area. 0931 – Child Protection Prompts for all Staff		

	Please select	
	Yes	*No*
Have you considered using Equality Impact Assessment?	☐	☐
Does this document have implications regarding the Care Act? *If yes please state:*	☐	☐
Does this document have training implications? *If yes please state:*	☐	☐
Does this document have financial implications? *If yes please state:*	☐	☐
Is this document a direct replacement for another? *If yes please state which documents are being replaced:*	☐	☐

Document Amendment History

Date	Version no.	Amendment summary	Ratified by:
21 October 2016	1	New	Care and Clinical Policies Group Chief Nurse Medical Director
24 November 2016	2	Links amended in Points 7, Appendix 2 and Appendix 3	Named Nurse Safeguarding Children
30 December 2016	3	Appendix 8 reworded. (Flowchart removed). No change to current practice	Consultant Paediatrician Named Nurses for Safeguarding Children
9 June 2017	4	Minor amendments to hyperlinks and flowchart in Appendix 3	Named Nurse for Safeguarding Children
20 October 2017	5	Point 5.6 Sexual Harmful Behaviour Among Children and Young People added	Named Nurse for Safeguarding Children
19 February 2018	5	Review date extended from 2 years to 3 years	

19.

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

"The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves". (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

20.

Quality Impact Assessment (QIA)

	Please select			
Who may be affected by this document?	Patient / Service Users	☒	Visitors / Relatives	☒
	General Public	☒	Voluntary / Community Groups	☒
	Trade Unions	☐	GPs	☒
	NHS Organisations	☒	Police	☒
	Councils	☒	Carers	☒
	Staff	☒	Other Statutory Agencies	☒
	Others *(please state):*			

Does this document require a service redesign, or substantial amendments to an existing process?	☐
If you answer yes to this question, please complete a full Quality Impact Assessment.	

Are there concerns that the document could adversely impact on people and aspects of the Trust under one of the nine strands of diversity?	Age	☐	Disability	☐
	Gender re-assignment	☐	Marriage and Civil Partnership	☐
	Pregnancy and maternity	☐	Race, including nationality and ethnicity	☐
	Religion or Belief	☐	Sex	☐
	Sexual orientation	☐		
If you answer yes to any of these strands, please complete a full Quality Impact Assessment.				
If applicable, what action has been taken to mitigate any concerns?				

Who have you consulted with in the creation of this document? *Note - It may not be sufficient to just speak to other health & social care professionals.*	Patients / Service Users	☐	Visitors / Relatives	☐
	General Public	☐	Voluntary / Community Groups	☐
	Trade Unions	☐	GPs	☒
	NHS Organisations	☒	Police	☒
	Councils	☒	Carers	☐
	Staff	☒	Other Statutory Agencies	☐
	Details *(please state):*			

Rapid Equality Impact Assessment *(for use when writing policies and procedures)*

Policy Title (and number)	2075 Child Protection Policy	**Version and Date**	1 October 2016
Policy Author	Named Nurse Safeguarding Children - Acute		

An equality impact assessment (EIA) is a process designed to ensure that a policy, project or scheme does not discriminate or disadvantage people. EIAs also improve and promote equality. Consider the nature and extent of the impact, not the number of people affected.

EQUALITY ANALYSIS: How well do people from protected groups fare in relation to the general population?
PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below

Is it likely that the policy/procedure could treat people from protected groups less favorably than the general population? (see below)

Age	Yes ☐ No☒	Disability	Yes ☐ No☒	Sexual Orientation	Yes ☐ No☒
Race	Yes ☐ No☒	Gender	Yes ☐ No☒	Religion/Belief (non)	Yes ☐ No☒
Gender Reassignment	Yes ☐ No☒	Pregnancy/ Maternity	Yes ☐ No☒	Marriage/ Civil Partnership	Yes ☐ No☒

Is it likely that the policy/procedure could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)	Yes ☐ No☒

Please provide details for each protected group where you have indicated 'Yes'.

VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion

Is inclusive language[5] used throughout?	Yes ☒ No☐
Are the services outlined in the policy/procedure fully accessible[6]?	Yes ☒ No☐
Does the policy/procedure encourage individualised and person-centered care?	Yes ☒ No☐
Could there be an adverse impact on an individual's independence or autonomy[7]?	Yes ☐ No☒

If 'Yes', how will you mitigate this risk to ensure fair and equal access?

EXTERNAL FACTORS

Is the policy/procedure a result of national legislation which cannot be modified in any way?	Yes ☒ No☐

What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)

Statutory obligation as an agency

Who was consulted when drafting this policy/procedure? What were the recommendations/suggestions?

Named Professionals / Designated Professionals – recommendations encompassed in the policy

ACTION PLAN: Please list all actions identified to address any impacts

Action	Person responsible	Completion date

AUTHORISATION:
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them

Name of person completing the form	Named Nurse for Safeguarding Children - Acute	**Signature**	
Validated by (line manager)	Named Nurse for Safeguarding Children	**Signature**	