South Central Ambulance Service
NHS Foundation Trust

Safeguarding Children Policy

DOCUMENT INFORMATION	
Author:	A Heselton
Ratifying committee/group:	Patient Safety Group
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Contents (this is an automatic table, use the headings throughout the document and then **right** click on the table and select update field, then update entire table

1. Introduction

The welfare of a child is paramount. South Central Ambulance Service NHS Foundation Trust (SCAS) fully recognises its responsibility for protecting and safeguarding the welfare of children. South Central Ambulance Service acknowledges its responsibility to take all reasonable steps to promote safe practice and to protect children from harm, abuse and exploitation.

1.2 Section 11 of the Children Act 2004
http://www.legislation.gov.uk/ukpga/2004/31/contents
places a statutory duty on organisations and individuals to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children. Working Together to Safeguard Children (2018) sets out how organisations and individuals should work together to safeguard and promote the welfare of children and young people in accordance with the Children Act 1989 and the Children Act 2004.

1.3 This policy should be read in conjunction with Local Safeguarding Children Boards Child Protection Procedures. These proceedures can be found on each Local Authority web sites.

2. Scope

This policy details the principles and standards to safeguard children under the age of 18 years who may be in need of additional support or at risk of harm. This policy is relevant to staff working directly or indirectly with children, but also to all South Central Ambulance staff, volunteers and commissioned services. This is in recognition that everyone shares responsibility for safeguarding and promoting the welfare of children and young people irrespective of individual roles. The scope of this document provides staff, commissioned services and volunteers with a clear understanding of their roles and responsibilities for safeguarding children as defined in Working Together to Safeguard Children (2018).

3. Aim

South Central Ambulance Service recognises its responsibility to ensure that effective and safe working systems are in place for staff, commissioned services and volunteers working directly or indirectly with children and their parents or carers. This policy provides details for all South Central Ambulance Service staff, commissioned services and volunteers on the recognition of signs of abuse and specific arrangements for the alerting to, and management, of suspected and confirmed safeguarding issues by:

i. Ensuring that all staff, commissioned services and volunteers understand that safeguarding children is 'everyone's business'.
ii. To ensure that staff, commissioned services and volunteers recognise and know how to respond when children may be at risk of harm.
iii. To embed and maintain the best safeguarding practice across all Directorates and ensure compliance with national and local policies.
iv. To contribute to, learn from the lessons from and implement good practice from local and national child death and serious case or partnership reviews.

The contents of this policy have been developed from and are consistent with relevant law, regulation and statutory and non-statutory Government guidance.

4. Roles and Responsibilities

4.1 Trust Board

South Central Ambulance Service NHS Foundation Trust Board is responsible for setting the strategic context in which South Central Ambulance Service policies are developed and for the formal review and approval of Corporate Policies. South Central Ambulance Service Board must be aware of its duties and responsibilities to safeguard and promote the welfare of children. These are described in Working Together to Safeguard Children (2018) The Board is also required to ensure that:

I. There is representation at both strategic and operational levels on Local Safeguarding Children Boards (LSCBs) across the Trust (where required).
II. Adequate resources are contributed to facilitate the functioning of these LSCB's
III. There are policies in place to safeguard and promote the welfare of children and young people and that staff adhere to Child Protection Procedures.
IV. There is a clear commitment by senior management to the importance of safeguarding and promoting children's welfare through the provision of all services.

4.2 Chief Executive

The Chief Executive has overall responsibility for ensuring that South Central Ambulance Service has appropriate safeguarding processes in place and our contribution to safeguarding and promoting the welfare of children is discharged effectively across South Central Ambulance Service through the organisation's arrangements and ensures that safeguarding children is identified as a key priority area in all strategic planning processes.

4.3 Executive Director

The Executive Director of Patient Safety and Service Transformation is the South Central Ambulance Service Board lead for safeguarding children and is accountable to the Chief Executive. The Executive Director of Patient Safety and Service Transformation has responsibility for ensuring that appropriate safeguarding processes are in place. This responsibility includes working to promote and strengthen the safeguarding framework, including ensuring compliance with all legal, statutory and good practice requirements.

4.4 The Head of Safeguarding

The Head of Safeguarding has a responsibility for the development and implementation of systems and processes for safeguarding children and young people working with partner agencies in line with local and national standards and legislation. This includes

overall responsibility for policy development, education content, guidance, advice and safeguarding supervision. The Head of Safeguarding will undertake the role of Named Professional for South Central Ambulance Service NHS Foundation Trust.

4.5 All Staff

All staff working directly or indirectly with children must ensure that safeguarding and promoting the welfare of a child is an integral part of any care they offer. All staff have a responsibility to ensure that they:

I. Know who to contact if they need to discuss concerns about a child's welfare.
II. Are familiar with and adhere to the South Central Ambulance Service NHS Foundation Trust policies and proceedures
III. Work in partnership with other agencies to safeguard and promote the welfare of children when required.
IV. Attend safeguarding training according to their specific role and professional needs.
V. Share information and co-operate with relevant agencies.
VI. Complete safeguarding referrals when appropriate.

Staff should be particularly aware of the impact on a child of an environment where domestic abuse occurs and the potential link with child protection. Staff need to ensure they are aware of the indicators of domestic abuse and when identified take appropriate action including considering the impact on any children. Staff should also be aware of the impact of adult mental health and alcohol and substance misuse on the welfare of children. Staff should be particularly aware of the indicators of child sexual exploitation and seek advice from the safeguarding team should they identify a child who they assess may be at risk. Staff must also be aware of what to do if they are aware that a client has undergone female genital mutilation. Since the Serious Crime Act 2015 came into effect, if female genital mutilation is identified in a child all regulated professionals have a mandatory duty to report to police.

5. Definitions

A child is defined as anyone who has not yet reached their 18th birthday and for the purpose of this document includes the unborn child.

A Looked after child Under the Children Act 1989, a child is legally defined as 'looked after' by a local authority if he or she:

I. Gets accommodation from the local authority for a continuous period of more than 24 hours.
II. Subject to a care order (to put the child into the care of the local authority).
III. Subject to a placement order (to put the child up for adoption).

6. Abbreviations

LSCB Local Safeguarding Childrens Board

7. Main body

7.1 Catogories of Child Abuse

7.1.1 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 the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, 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.

7.1.2 Emotional abuse

Emotional abuse is the persistent emotional ill-treatment 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. It may involve 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 ill-treatment of a child, though it may occur alone.

7.1.3 Physical abuse

Physical abuse 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 feigns the symptoms of, or deliberately causes ill health to a child whom they are looking after. This situation is commonly described using terms such as fabricated illness.

7.1.4 Sexual abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape or buggery) or non-penetrative acts. 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.

7.1.5 Child sexual exploitation (DfE 2009)

Exploitative situations, contexts & relationships where young people receive something as a result of them performing and/or others performing on them, sexual activities. In all cases, those exploiting the child/young person have power over them. Violence, coercion and intimidation are common and are used to control the child. In all cases of suspected child sexual exploitation the police **MUST** be called and the child taken to a place of safety in conjunction with the police. Staff must complete a safeguarding form and be prepared to make police statements immediately following the incident.

7.1.6 Reporting Concerns of Child abuse

The welfare of a child is paramount. In cases of suspected child abuse the duty of care that any health professional owes to a child or young person will take precedence over any obligation to the parent or adult carer. All health professionals must follow South Central Ambulance Service safeguarding referral processes. Advice and support is available from the safeguarding team if any staff member has concerns about the welfare of a child.
A safeguarding referral must be made if any staff member has a concern for welfare for a child South Central Ambulance Service has had contact with. This can be by contacting the local authority children's safeguarding team by phone (this must be followed up by completing a safeguarding form within 48 hours) or by just completing a safeguarding referral.

I. The referral must be made by the individual who identifies the concerns.
II. The assessment of risk is integral to protecting children and staff will be expected to contribute to these processes by including this in any safeguarding referral made.
III. Every effort must be made to share these referrals with the family and where appropriate with the child or young person.

The reasons for referral should normally be discussed with the child (age appropriate) and their parents and their consent sought for the referral unless:

I. It is considered that such a discussion would place the child (or other children) at increased risk of harm.
II. It is considered that such a discussion would place the member of staff at risk of harm.
III. It is considered that such a discussion would jeopardise a criminal investigation.

Any reason for not seeking consent must be clearly documented within the safeguarding referral.

Guidence documents on how to make a safeguarding referral for ePR, CCC web based referrals and on paper are available on the safeguarding intranet page

7.1.7 Concealed Pregnancy

Staff must always make a safeguarding referral if they come across a concealed pregnancy and ensure that the mother is safe. Please be aware that any pregnancy that is concealed will be for a reason, so take extreme care when discussing this issue with the patient as the person the pregnancy is being concealed from could be a close family member and present at the time.

7.1.8 Female genital mutilation (FGM)

Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths. However, more than 18% of all FGM is performed by health care providers, and the trend towards medicalisation is increasing. Any child or young person that has been identified as having been subjected to FGM must be

reported to the police immediately via the Clinical Call Centre. This is a legislatlve requirement.

Female Genital Mutilation (FGM) mandatory reporting duty is a legal duty provided for in the FGM Act 2003 (as amended by the Serious Crime Act 2015). The legislation requires regulated health and social care professionals and teachers in England and Wales to make a report to the police where, in the course of their professional duties, they either:

i. Are informed by a girl under 18 that an act of FGM has been carried out on her; or
ii. Observe physical signs which appear to show that an act of FGM has been carried out on a girl under 18 and they have no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth.

For the purposes of the duty, the relevant age is the girl's age at the time of the disclosure/identification of FGM (i.e. it does not apply where a woman aged 18 or over discloses she had FGM when she was under 18).

7.1.9 Allegations against staff

All staff, commissioned services and volunteers working with children should understand that the nature of their work and their responsibilities related to it, place them in a position of trust. South Central Ambulance Service will not accept inappropriate behaviour towards children, staff or volunteers and will ensure that any concerns or allegations of impropriety are dealt with quickly, fairly and sensitively.

All children and young people have a right to be treated with respect and dignity even in those circumstances where they display difficult or challenging behaviour.

Please refer to the Trusts allegations policy for further information.

7.1.10 Record keeping

Record keeping must comply with individual Professional Codes of Conduct. All concerns and incidents should be recorded in a clear and factual way as soon as possible after the event but on the same day as the concerns where identified.

7.1.11 Safer Recruitment

Safer recruitment is covered under the Human Resources Recruitment policy

7.1.12 Looked after children

When a South Central Ambulance Service staff come across a looked after child we must make a safeguarding referral even if there are no safeguarding concerns identified. This is to inform the responsible local authority of the contact South Central Ambulance Service has had with the child. The foster carer is fully aware that this process is going to happen as they also have a

duty to notify the responsible local authority of our contact with the looked after child.

7.1.13 Injuries/ brusing on a non-mobile babies

Bruising in babies who are not rolling or crawling is unusual. National and local serious case reviews have identified the need for heightened concern about any bruising in a baby who is not independently mobile. It is important that any suspected bruising is fully assessed even if the parents feel they are able to give a reason for it. The Baby **MUST** be transported and seen at the nearest emergency department with paediactric facilities and **NOT** discharged for home care.

See Bruising Protocol at the end of the main policy. Staff are to follow this protocol when dealing with any injuries on a non-mobile baby

7.1.14 Training requirements

Staff should refer to the South Central Ambulance Service training needs analysist document (TNA) to identify what level of training is needed.

All staff and volunteers must attend face to face child protection training relevant to their role as soon as possible after commencing employment. Further child protection training must then be accessed at a level relevant to an individual's role.

Members of the Safeguarding team and other selected staff will be required to undertake multi agency safeguarding training. These staff groups will be identified in the Trusts TNA.

All internal safeguarding training will be delivered by the Head of Safeguarding, the safeguarding team or identified staff from the Education department. Those staff must have completed a train the trainer course delivered by either the Head of Safeguarding or a member of the safeguarding team.

Safeguarding training compliance for all staff with be monitored by the safeguarding team and regular updates will be provided at the safeguarding group meetings for all areas of the Trust. It is the responsibility of the line management for all trust staff to ensure that their staff remain compliant in all forms of safeguarding training. This includes volunteer and commissioned staff also.

Training compliance for safeguarding will be reported to the board by the Assistant Director for Education.

8. Equality and Diversity

9. Monitoring

The Care Quality Commission Standards require all NHS Providers to give assurance that they are protecting children by following national guidance both internally and in their working with other organisations.

The safeguarding and promotion of the welfare of children is an integral part of clinical governance and audit arrangements. Compliance with the reporting arrangements as detailed above are audited reported via the Safeguarding Group.

Standard / process / issue	Monitoring and audit			
	Method	By	Committee	Frequency
Through the monitoring of safeguarding referrals	An audit of safeguarding referrals	The Safeguarding team and a multi disiplanary team.	Safeguarding Group	Annually
Through CCG contract monitoring	Quertely contract returns	Head of Safeguarding	CQRM and quality shedules CCG returns	Quartley

10. Consultation and Review

Stakeholder or Group Title	Consultation Period (From-to)	Comments received (Yes/No)
All staff groups	26/9/18 to 17/10/18	No

11. Implementation (including raising awareness)

This policy will be sent out for 21 days consultation and will be referred to during traiing. A copy of this policy will be available in all areas of the Trust and on the intranet.

12. References

The Children Act (1989) HM Government.

The Children Act (2004) HM Government.

HM Government (2015) Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children (2018).

Improving Safety, Reducing harm. Children, young people and domestic violence. A practical toolkit for frontline practitioners. www.orderline.dh.gov.uk

HM Government (2015) Information sharing: advice for practitioners providing safeguarding services to children, young people, parents and carers.

Human Rights Act (1998) .

National Institute for Health and Clinical Excellence (2009): When to suspect child maltreatment.

Royal College of Paediatrics and Child Health (2014): Safeguarding Children and Young People: Roles and Competences for Health Care Staff (Intercollegiate Document) RCPCH.

13. Associated documentation

Safeguarding adults policy
Allegations policy
Chaporone policy
Recruitment policy
Domestic abuse policy
Whistleblowing policy
Consent policy
Data protection policy
Information goverance policy
Code of Conduct in Respect of Confidentially Policy
Discipline and Conduct Policy
Adverse Incident policy

Bruising protocol for non-mobile babies

1 Introduction

1.1 Bruising in babies who are not rolling or crawling is unusual. National and local serious case reviews have identified the need for heightened concern about any

bruising in a baby who is not independently mobile. It is important that any suspected bruising is fully assessed even if the parents feel they are able to give a reason for it.

2 Aim of protocol

2.1 This protocol must be followed in all situations where an actual or suspected bruise is noted in an infant who is not independently mobile.

2.2 The term not independently mobile applies to those infants who are not yet rolling or crawling.

3 Action to be taken on identifying actual or suspected bruising

3.1 If the infant appears seriously ill or injured:
a) Seek emergency treatment at an emergency department (ED).
b) Notify Children's Services of your concerns by either contacting them directly or via a safeguarding referral. If you call children services staff **must** follow this up by submitting a safeguarding referral

3.2 In all other cases:
a) Record what is seen, using a body map or line drawing on the patient clinical record.
b) A full history must be taken, recording any explanation or comments by the parents/carers word for word.
c) Complete a detailed safeguarding referral to Children's Services.
d) All non-mobile babies with identified bruising MUST be transported to the nearest ED with paediatric facilities for further investigations.

4 Specific considerations

a) Birth injury: Both normal birth and instrumental delivery may lead to bruising and to bleeding into the white of the eye. However, staff should be alert to the possibility of physical abuse even within a hospital setting and follow this protocol if they believe the injury was not due to the delivery.
b) Birthmarks: These may not be present at birth, and appear during the early weeks or months of life. Mongolian blue spots can look like bruising. These are rare in children of white European background, but very common in children of African, Middle Eastern, Mediterranean or Asian background.

These do **NOT** need to be referred under this protocol where a clinician believes a mark is likely to be a birthmark. These cases do not need to be transported to hospital but requires further advice to be certain, the clinician must seek advice from a GP who should see the child the same day. If there is still uncertainty a safeguarding referral should be made to Children's Services Staff must document all findings on all clinical paperwork.
c) Self-inflicted injury is very rare for non-mobile infants to injure themselves.

Suggestions that a bruise has been caused by the infant hitting themselves with a toy, or hitting the bars of a cot, should not be accepted without detailed assessment by a paediatrician and social worker. In these cases the baby must be taken to the nearest ED with paediatric facilities for further assessment and a safeguarding referral must be completed.

d) Injury from other children: It is unusual but not unknown for siblings to injure a baby. In these circumstances, the infant must still be taken to the nearest ED with paediatric facilities for further assessment and a safeguarding referral completed. Staff must include a detailed history of the circumstances of the injury, and consideration of the parents' ability to supervise their children.

5 Rationale and evidence base

5.1 Bruising is the commonest presenting feature of physical abuse in children. Systematic review[1] of the literature relating to bruises in children shows that:

a) Bruising is strongly related to mobility (about one in five children who are starting to walk by holding on to the furniture have bruises)

b) Bruising in infants who are not independently mobile is unusual (2.2% of babies who are not yet rolling)[2].The message from this research is that infants who have yet to acquire independent mobility (rolling or crawling) should not have bruises without a clear explanation.

5.2 The National Institute for Clinical Excellence (NICE) guideline[3] 'When to suspect child maltreatment'[3], aimed at health professionals, categorises features that should lead staff to 'consider abuse' as part of a differential diagnosis, or 'suspect abuse' such that there is a serious level of concern. In relation to bruising, health professionals are advised to 'suspect abuse' and refer to Children's Services in the following situations:

a) If a child or young person has bruising in the shape of a hand, ligature, stick, teeth mark, grip or implement.

b) If there is bruising or petechiae (tiny red or purple spots) that are not caused by a medical condition (for example, a bleeding disorder) and if the explanation for the bruising is unsuitable. Examples include:

- Bruising in a child who is not independently mobile
- Multiple bruises or bruises in clusters
- Bruises of a similar shape and size
- Bruises on any non-bony part of the body or face including the eyes, ears and buttocks
- Bruises on the neck that look like attempted strangulation
- Bruises on the ankles and wrists that look like ligature marks

5.3 The NICE guideline[3] also advises clinicians to 'suspect abuse' when features of injury such as bites, lacerations, abrasions, scars and thermal injuries are seen on a child who is not independently mobile and there is an unsuitable explanation.

5.4 Numerous serious case reviews have identified situations where children have died because practitioners did not appreciate the significance of what appeared to be minor bruising in a non-mobile infant.

5.5 National analysis of reports published as 'New learning from serious case reviews' (Department for Education 2012)[4] reiterates the need for 'heightened concern about any bruising in any pre mobile baby….any bruising is likely to come from external sources. The younger the baby the more serious should be the concerns about how and why even very tiny bruises on any part of the child are caused'.

8 References

1) Core Info Cardiff Child Protection Systematic Reviews
2) Kemp AM, Dunstan F, Nuttall D et al. Patterns of bruising in preschool children – a longitudinal study. *Arch Dis Child* 2015; 100: 426-431
3) When to Suspect Child Maltreatment, NICE Clinical Guideline 89, July 2009
4) New learning from serious case reviews, July 2012

9 Additional Reading

- Working Together to Safeguard Children, HM Government, March 2015
- Hampshire 4lscb Procedures, online at: http://4lscb.proceduresonline.com
- Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, Def. May 2016
- Bruising in young babies – Information for parents and carers, NHS WHCCG Sept 2016

This Bruising protocol is for face to face assessments only. The Clinical Call Centre process for non-mobile babies follows pathways which will always come out with a disposition of a face to face consultation for any trauma related injuries no matter how minor for all under one year olds. This will be in the form of a GP appointment in or out of hours, the baby to be seen at the nearest ED or an ambulance response. If an ambulance response is required then the attending clinician will be required to follow this bruising protocol.

14. Appendix 1: Review Table

Version	Reason for change	Overview of change
V1.0		

15. Appendix 2: Responsibility Matrix – Policies, Procedures and Strategies

Policy Group	Lead Director / Officer	Working Group	Committee	Board Ratification
Strategies	As appropriate	As appropriate	As appropriate	Required
Standing Orders & Standing Financial Instructions	Chief Executive + Director of Finance	Not applicable	Audit Committee	Required
Corporate Policies	Chief Executive +Director of Patient Care	As appropriate	Quality and Safety Committee	Required/ Committee decision
Health and Safety Policies and Procedures	Director of Patient Care	Strategic Health, Safety and Risk Group	Quality and Safety Committee	Health and Safety Policy – Required H&S Appendices – Committee decision
Control of Infection Policy and Procedures	Director of Patient Care	Clinical Review Group	Quality and Safety Committee	Required
Personnel Policies and Procedures	HR Director	Staff Consultation Group	Quality and Safety Committee	Required for new policies. Committee decision for revisions
Financial Policies and Procedures.	Director of Finance	Not applicable	Audit Committee	Required for new Policies. Committee decision for procedural changes.
Operational Policies and Procedures	Director Operations	As appropriate or through Team Meeting	Quality and Safety Committee	Committee decision
Information and IT Policies and Procedures	Director of IT	Information Governance Steering Group	Quality and Safety Committee	Committee decision

Emergency Operational Centre Policies and Procedures	Director Operations	As appropriate	Quality and Safety Committee	Committee decision
Clinical Policies and Procedures	Director of Clinical Services	Clinical Review Group	Quality and Safety Committee	Committee decision

16. Appendix 3: Equality Impact Assessment Form Section One – Screening

Name of Function, Policy or Strategy: Safeguarding Childrens policy

Officer completing assessment: A Heselton Head of Safeguarding

1. What is the main purpose of the strategy, function or policy?
Policy to outline safeguarding children procedures
2. List the main activities of the function or policy? (for strategies list the main policy areas)
To give guidance to staff when dealing with vulnerable children
3. Who will be the main beneficiaries of the strategy/function/policy?
Vulnerable children
1. Use the table overleaf to indicate the following:- a. Where do you think that the strategy/function/policy could have an adverse impact on any equality group, i.e. it could disadvantage them? b. Where do you think that there could be a positive impact on any of the groups or contribute to promoting equality, equal opportunities or improving relations within equality target groups?

		Positive Impact – it could benefit	Negative Impact – it could disadvantage	Reasons
GENDER	Women	Yes		
	Men	Yes		
RACE	Asian or Asian British People	Yes		
	Black or Black British People	Yes		
	Chinese people and other people	Yes		
	People of Mixed Race	Yes		
	White people (including Irish people)	Yes		
	Disabled People	Yes		
	Lesbians, gay men and bisexuals	Yes		
	Trans people	Yes		
AGE	Older People (60+)	Yes		
	Younger People (17 to 25) and children	Yes		
	Faith Groups	Yes		

	Equal Opportunities and/or improved relations	Yes		

Notes:

Faith groups cover a wide range of groupings, the most common of which are Muslims, Buddhists, Jews, Christians, Sikhs and Hindus. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and to the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

5. If you have indicated that there is a negative impact, is that impact:		
		No
Legal (it is not discriminatory under anti-discriminatory law)		
Intended		
	High	**Low**
Level of Impact		

If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

6(a). Could you minimise or remove any negative impact that is of low significance? Explain how below:
6(b). Could you improve the strategy, function or policy positive impact? Explain how below:

7. If there is no evidence that the strategy, function or policy promotes equality, equal opportunities or improves relations – could it be adopted so it does? How
Please sign and date this form, keep one copy and send one copy to the Trust's Equality Lead.
Signed: 
Name: A Heselton
Date: 27th August 2018

17. Appendix 4: Equality Impact Assessment Form Section Two – Full Assessment

Name of Function, Policy or Strategy:……

……..

Officer completing assessment:……..

Telephone.....

Part A

Looking back at section one of the EQIA, in what areas are there concerns that the strategy, policy or project could have a negative impact?

Gender

Race

Disability

Sexuality/Transgender

Age

Faith

2. Summarise the likely negative impacts:-

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3. Using the table below, give a summary of what previous or planned consultation on this topic, policy, function or strategy has or will take place with groups or individuals from the equality target groups and what has this consultation noted about the likely negative impact?

Equality Target Groups	Summary of consultation planned or taken place
Gender	
Race	
Disability	
Sexuality/Transexuality	
Older People	
Younger People	
Faith	

4. What consultation has taken place or is planned with Trust staff including staff that have or will have direct experience of implementing the strategy, policy or function?

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5. Check that any research, reports, studies concerning the equality target groups and the likley impact have been used to plan the project and guide or indicate what research you intend to carry out:-

Equality Target Groups	Title/type of/details of reserach/report
Gender	
Race	
Disability	
Sexuality/Transexuality	
Older People	
Younger People	
Faith	

6. If there are gaps in your previous or planned consultation and research, are there any experts/relevant groups that can be contacted to get further views or evidence on the issues?

☐ Yes (Please list them and explain how you will obtain their views)

.....

.....

☐ No

6

Part B

Complete this section when consultation and research has be carried out

7a. As a result of this assessment and available evidence collected, including consultation, state whether there will be a need to be any changes made/planned to the policy, strategy or function.

7b. As a result of this assessment and available evidence is it important that the Trust commission specific research on this issue or carry out monitoring/data collection?

(You may want to add this information directly on to the action plan at the end of this assessment form)

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.....

8. Will the changes planned ensure that negative impact is:

Legal? ☐

(not discriminatory, under anti-discriminatory legislation)

Intended? ☐

Low impact? ☐

9a. Have you set up a monitoring/evaluation/review process to check the successful implementation of the strategy, function or policy?

Yes ☐ No ☐

9b. How will this monitoring/evaluation further assess the impact on the equality target groups/ensure that the strategy/policy/function is non-discriminatory?

Details:

.....

.....

.....

.....

Please complete the action plan overleaf, sign the EQIA, retain a copy and send a copy of the full EQIA and Action Plan to the Trust's Equality Lead.

Signed:.....

18. Appendix 5: Ratification Checklist

Section 1: To be completed by Author prior to submission for ratification

Policy Title	Safeguarding Children policy
Author's Name and Job Title	A Heselton Head of Safeguarding
Review Deadline	September 2018
Consultation From – To (dates)	
Comments Received? (Y/N)	
All Comments Incorporated? (Y/N)	
If No, please list comments not included along with reasons	
Equality Impact Assessment completed (date)	27th August 2018
Name of Accountable Group	Patient Safety Group
Date of Submission for Ratification	6th of September 2018

Section 2: To be completed by Accountable Group

Template Policy Used (Y/N)	
All Sections Completed (Y/N)	

Monitoring Section Completed (Y/N)	
Date of Ratification	
Date Policy is Active	
Date Next Review Due	
Signature of Accountable Group Chair (or Deputy)	
Name of Accountable Group Chair (or Deputy)	