SAFEGUARDING CHILDREN AND YOUNG PEOPLE POLICY

POLICY

Reference	*CPG-TW-SG-SgC&YP*		
Approving Body	*Safeguarding Committee*		
Date Approved	*18-Sept-2025*		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
	✓		
Issue Date	*01-October-2025*		
Version	*V7.0*		
Summary of Changes from Previous Version	*Full update of the policy to include updated guidance and legislation, as well as changes to terminology and updates around safeguarding risks to children and young people.*		
Supersedes	*6.2*		
Document Category	*Clinical*		
Consultation Undertaken	*V6.1: Safeguarding Committee members*		
Date of Completion of Equality Impact Assessment	*21/08/2025*		
Date of Environmental Impact Assessment (if applicable)	*N/A*		
Legal and/or Accreditation Implications	NHS organisations have a legal responsibility to safeguard and promote the welfare of children, as outlined in the Children Act 1989 and 2004.		
Target Audience	All clinical and non-clinical substantive, bank and temporary staff who have contractual obligations to the Trust, including all those working in a voluntary capacity within the organisation. Trust wide all ward and departments both clinical and non-clinical at Sherwood Forest Hospitals		
Review Date	*October-2028*		
Sponsor (Position)	*Lisa Nixon - Head of Safeguarding & Head of Service for Mental Health, Learning Disabilities and Violence Reduction*		

Author (Position & Name)	*Liz Cudmore - Named Professional Safeguarding Children and Young People*
Lead Division/ Directorate	*Corporate*
Lead Specialty/ Service/ Department	*Safeguarding*
Position of Person able to provide Further Guidance/Information	*Named Professional Safeguarding Children and Young People* *Specialist Practitioner: Safeguarding Children and Young People* *Wider Safeguarding Team.*

Associated Documents/ Information	Date Associated Documents/ Information was reviewed
If you have associated documents (families of documents for a particular subject matter), it is necessary that they are reviewed in accordance with the review /amendment of this document. Please list them here or write 'Not Applicable'. 1. Female Genital Mutilation (FGM) Recognition, Reporting And Safeguarding Guideline 2. Mandatory And Statutory Training (MAST) Policy 3. Missing Service User – Joint Policy And Procedures 4. Escalating Inter-Agency Safeguarding Children Disagreements Policy 5. Admission and Discharge of Children Where There Are Safeguarding Concerns Policy. 6. Domestic Abuse Policy (Patients) 7. Domestic Abuse Policy – Staff 8. Abduction of a Neonate In Maternity Services Policy 9. Management Of Children And Young People Who Are Not Brought To Or Do Not Attend Appointments (WNB/DNA) Policy 10. Dealing With Safeguarding Allegations Or Concerns About Individuals Undertaking Work With Children, Young People And Vulnerable Adults In The Trust Policy 11. Safeguarding Children Supervision Policy If changes have been made to any of the above documents, please state here and present the amended supporting documents.	Enter the date each document was reviewed here 1. January 2023 2. May 2025 3. July 2023 4. December 2022 5. July 2025 6. June 2023 7. April 2024 8. September 2022 9. March 2025 10. January 2022 11. January 2023

Template control	April 2024

CONTENTS

1.0 INTRODUCTION

All children have an equitable right not to be abused, neglected or exploited and the right to have happy, healthy, safe lives. Sherwood Forest Hospitals NHS Trust, (SFH) is committed to safeguarding and promoting the welfare of all children and young people who have contact with the Trust. This statement also includes the 'unborn child' who, although not legally included within the definition of a child is firmly encompassed within safeguarding practice.

Under the provisions of the Children Act 2004, there is a statutory duty on all agencies to make arrangements to safeguard and promote the welfare of children. The impact that physical, emotional, sexual abuse, neglect and domestic violence can have on a child's development, health and wellbeing should never be underestimated. It is therefore important that all staff who encounter children and their families are aware of potential indicators of abuse or neglect, know what action to take and who to contact about any concerns they have in line with Trust guidance and The Nottinghamshire and Nottingham City Interagency Safeguarding Children Procedures (2025).

2.0 POLICY STATEMENT

The aim of this policy is to effectively safeguard and promote the welfare of children by:

- Providing guidance and support for all Trust staff, irrespective of role or client group with regards to fulfilling their legal duty to safeguard and promote the welfare of children
- Promoting inter-agency working
- Providing clear procedures regarding concerns about the welfare of a child.

This Safeguarding Children policy is supplementary to the Local Safeguarding Children Partnership (LSCP) and should be used in conjunction with the Partnership's procedures, available here: Interagency Safeguarding Children Procedures.

This policy is not a replacement for one-to-one discussion, support or supervision with the practitioners' line manager, divisional leads or with the Trust Named Professional for Safeguarding Children where concerns exist about the welfare of a child. Government legislation and guidance clearly identifies that safeguarding children is 'everybody's responsibility' emphasising the need for all individuals and agencies to work collaboratively to ensure that the welfare of the child remains paramount in line with The Children Act, (1989, 2004).

This clinical policy applies to:

Staff Group (s):

- All staff directly employed by the Trust whether working on Trust premises or in the community. It also applies to all staff working at the Trust employed by other agencies, e.g. Primary Care staff, staff with honorary contracts, locum/agency staff, students and volunteers.

Area(s):

- This policy covers all areas across the Trust irrespective of whether they provide direct care and treatment for children and young people.

Patient Group(s):

- All people under the age of 18 years old (i.e. until the date of their 18th birthday).

Exclusions:

- There are no exclusions to this policy.

The Trust policy is in line with, and supported by the following documents:

2.1 Children Act, (1989, 2004).

The Children Act states that the welfare of the child is paramount and that their emotional, physical, and psychological wellbeing should be always prioritised.

Section 11 of the Children Act 2004 places a statutory duty on organisations to make arrangements to ensure that their functions, including those services contracted out to others, are discharged having regard to the need to safeguard and promote the welfare of children. Arrangements made under section 11 should take account of the Care Quality Commission inspection framework which requires services to be safe, effective, responsive to people's needs, caring and well led.

2.2 Working together to safeguard children 2023: statutory guidance

This statutory guidance sets out key roles for individual organisations and agencies to deliver effective arrangements for help, support, safeguarding, and protection of children and young people. It should be read and followed by leaders, managers and frontline practitioners of all organisations and agencies that have contact with children, which encompasses all individuals, wards and departments within SFH.

2.3 Local Safeguarding Children Partnership Policies and Procedures

These procedures clarify arrangements in the relevant local authority area as to how all agencies, both statutory and voluntary, should work together to safeguard children and promote their welfare. A copy of the procedures can be accessed via the Trust safeguarding intranet site or via the relevant LSCP/B website, SFH is within the remit of the Nottinghamshire Safeguarding Children Partnership (NSCP), and guidance, information, and resources can be found via its website available here: Nottinghamshire Safeguarding Children Partnership.

3. ABBREVIATIONS/DEFINITIONS

SFH	Sherwood Forest Hospitals NHS Foundation Trust
Trust	Sherwood Forest Hospitals NHS Foundation Trust
Staff	All employers of the Trust including those managed by a third party on behalf of the Trust
Designated Professionals:	A Designated Nurse and a Designated Doctor are individuals who have strategic roles and responsibilities for safeguarding children across a health community.
Named Professionals	A Named Doctor, Nurse and/or Midwife who are responsible for Safeguarding Children within their own organisations
CAF	Common Assessment Framework
EHAF	Early Help Assessment Form
LAC or CIC	Looked After Children or Children in Care
FII/PP	Fabricated and Induced Illness/Perplexing Presentations
CSE	Child Sexual Exploitation
CCE	Child Criminal Exploitation
LSCP	Local Safeguarding Children Partnership - a statutory organisation that brings together representatives from agencies and professionals responsible for helping to protect children from abuse and neglect within the Local Authority area. They develop policies and procedures and promote the need to safeguard children as well as monitoring and evaluating what is done. They monitor all child deaths and initiate serious case reviews when required.
NSCP	Nottinghamshire Safeguarding Children Partnership - A statutory organisation that brings together representatives from agencies and professionals responsible for helping to protect children from abuse and neglect within the Local Authority area. They develop policies and procedures and promote the need to safeguard children as well as monitoring and evaluating what is done. They monitor all child deaths and initiate serious case reviews when required.
FFP	Families First Partnership Programme
DoH	Department of Health
WNB/DNA	Was Not Brought / Did Not Attend
CP-IS	Child Protection Information Sharing
PiPOT	Person in Position of Trust
CSA	Child Sexual Abuse
ICPC/RCPC	Initial Child Protection Conference/Review Child Protection Conference

(L) CSPR	(Local) Child Safeguarding Practice Review
DA	Domestic Abuse
FGM	Female Genital Mutilation

3.1 DEFINITION OF A CHILD/YOUNG PERSON

A child is defined as anyone who has not yet reached their 18th birthday. The fact that a child has reached 16 years of age is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate for children and young people does not change his or her status or entitlement to services or protection, (Working Together 2023). “Children” therefore includes “children and young people” under the age of 18 years. Safeguarding and promoting the welfare of children is defined as:

• Protecting children from maltreatment

• Preventing impairment of children’s health or development

• Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care

• Taking action to enable all children to have the best outcomes. (Working Together to Safeguard Children 2023)

3.2 CATEGORIES OF ABUSE

3.2.1 Physical Abuse

Any form of abuse which incurs physical harm to a child, including, but not limited to hitting, shaking, poisoning, drowning or suffocating. Physical harm may also be caused when a parent/carer fabricates the symptoms or deliberately induces illness in a child known as Fabricated or Induced Illness (FII). Female Genital Mutilation (FGM), is also physical abuse, and illegal in the UK, please see the Trust FGM policy: FGM recognition, reporting and safeguarding guideline.

Bruising is the commonest injury encountered when children have been physically abused, however, older children will always sustain bruises during normal childhood activities and play. The likelihood of a baby or young child having bruises is also closely linked to their level of independent mobility, therefore unexplained marks or bruises on a baby that is not independently mobile should be reviewed against the NSCP pathway for non-mobile babies with a bruise or suspicious mark: NSCP Bruising or unexplained marks in non-mobile babies

Sub-conjunctival haemorrhages (bleeding of the conjunctiva of the eye) can occur because of a traumatic or rapid birth. However, where sub-conjunctival haemorrhage is noted on a non-mobile baby and there is no documented record or an explanation because of a birth injury, practitioners should consider the possibility of non-accidental injury and follow appropriate guidance: Subconjunctival Haemorrhage Guidance.pdf or seek further advice from the Trust Safeguarding Team or DNMs.

3.2.2 Emotional Abuse

This is where the child experiences persistent emotional mistreatment where the impact is adverse effects on the child's emotional development and wellbeing. It can include a parent/carer telling the child that they are worthless or unloved, inadequate, or values only insofar as they meet the needs of another person.

It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children and young people. These may include interactions that are beyond the child's capability as well as overprotection and limitation of exploration and learning or preventing the child participating in normal social interaction.

Emotional abuse also occurs when children see or hear the ill treatment of another. It may involve serious bullying (including cyber bullying), causing children and young people to feel frequently frightened or in danger, or the exploitation or corruption of children and young people. Some level of emotional abuse is involved in all types of abuse of a child though it may occur alone.

3.2.3 Sexual Abuse

Child Sexual Abuse (CSA) is any form of sexual contact where a child or young person is forced to take part, but does not always involve violence, irrespective of whether the child is aware of what is happening. The assault may include physical contact, including penetration (anal, vaginal, or oral sex), or non-penetrative acts such as masturbation, kissing, rubbing and touching – be that under or over clothing.

CSA can include non-contact activities such as coercing or forcing children/young people to look at or take part in pornography, sexual imagery, watching sexual activities, or grooming children or young people to take part in sexual acts – including on-line grooming. Sexual abuse is not solely perpetrated by adult males, anyone of any gender can commit acts of CSA as can other children and young people. Where the perpetrator is disclosed or suspected to be parent/carer to the child/young person a referral to Children's Social Care should be made *without* informing the parent/carer to reduce risk of there being ramification or harm to the child or young person.

Child Sexual Exploitation is also a form of CSA and consideration of this should be considered when children or young people present at the Trust with self-harm, suicidal ideation or attempt to end their life.

3.2.4 Neglect

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs which would likely result in the serious impairment of the child's health or development. Neglect can occur during pregnancy because of maternal substance or alcohol misuse, or mother to the unborn not being able to protect herself from the experience of Domestic Abuse.

Neglect may involve a parent/carer ***failing*** *to*:

- Provide adequate food, clothing, and shelter (including exclusion from home or abandonment)
- Bring the child for medical treatment or assessment, i.e. not brought for appointments, or delaying presentation to hospital for medical review.
- Protect a child from physical and/or emotional harm or danger.

- Ensure adequate supervision is in place, (including the use of inadequate care givers).
- Failing to respond to a child's basic emotional needs.

3.3 Safeguarding Definitions

3.3.1 Significant Harm

The Children Act, (1989; 2004) provides states that the welfare of the child is paramount. Some children require protection because they are suffering, or likely to suffer, significant harm. This was a concept introduced by The Children Act, (1989; 2004) and Section 47 of The Children Act gives the Local Authority a duty to make enquiries to decide whether they should take action to safeguard the child/ren. It may be a single traumatic event, or a compilation of significant events, which interrupt, change, or damage the child's physical or psychological development.

3.3.2 Child Protection

Child protection is a part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm. All agencies and individuals should aim to pro-actively safeguard and promote the welfare of children, so that the need for action to protect children from harm is reduced.

3.3.3 Child in Need

Children who are defined as being in need under section 17 of the Children Act 1989, are those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired without the provision of services. Children who have significant additional needs/disabilities can also be considered a child in need but may not always have an allocated social worker.

3.3.4 The Assessment Framework

Developed by the DOH in 'The Framework for assessing children in need and their families' (2000) as a multiagency assessment tool to provide a common language to understand what is happening to a child. Assessing the needs of children requires a systematic and purposeful approach.

This involves using the framework to gather and analyse relevant information regarding the three domains:

- Developmental needs of the child
- Parenting capacity (or regular caregiver) to meet the needs of the child
- Impact of the wider family and environmental factors on both parenting opacity and the child's development.

Staff should utilise this assessment tool when:

- Making referrals to Children's Services
- Compiling reports for child protection conferences/core groups/multiagency meetings etc
- Contributing to a EHAF/CAF (Early help Assessment Form/Common Assessment Framework)

3.3.5 Early Help Assessment Form/Common Assessment Framework (EHAF/CAF)

An EHAF/CAF should be completed to identify, children's additional needs that are not being met by the universal services they are receiving and provide timely and co-ordinated support to meet those needs, at the earliest opportunity. Early Help requires parental consent and cannot be completed without this.

An EHAF/CAF is designed to be used if:

- You are concerned about how well a child is progressing
- The needs are unclear, or broader than your service can address
- An early help or common assessment would help identify the needs, and/or get other services to help them
- An EHAF/CAF should be discussed and offered to all families where their baby is born prematurely and has been admitted to the Trust Neonatal Unit (NNU); special consideration for this should be given to those families whose babies remain and inpatient on the NNU for extended periods of time.

The local EHAF/CAF Form is available on the relevant children's partnership website.

If you are worried that a child is suffering, or is at risk of suffering harm, you should follow the LSCP procedures without delay. Do not stop to do an EHAF/CAF.

Contact the Trust Safeguarding Team if you require support or advice around supporting families with EHAF/CAF referrals.

3.3.6 Looked After Child (LAC)/Children in Care (CIC)

The term *Looked After Child (LAC - Children in Care)* has a specific legal meaning based on the Children Act, (1989; 2004). A child who has been in the care of their local authority for more than 24 hours is known as a looked after child or child in care. Or, as set out in Sections 20 and 21 of the Children Act, 1989 is placed in the care of a local authority by virtue of an order made under part IV of the Act.

Section 85 of the Children Act 1989 outlines the notification duties for local authorities when a child is accommodated by a health authority or local education authority for three months or more, or with the intention of being accommodated for that period. While infrequent, infants born very prematurely, or children with long-term/chronic physical or mental health conditions may require the Trust to notify the Local Authority under this section of the Children Act.

Private fostering occurs when a child under 16 (or 18 if disabled) lives with someone who is not their parent or a close relative for 28 days or more. This is a private arrangement between the parent and the carer, and it's important to inform the local authority via a referral to Children's Social Care when this occurs to assess that the child's welfare is adequately provided for.

3.3.7 Female Genital Mutilation (FGM)

Female Genital Mutilation (FGM) is a procedure where the female genital organs are

deliberately cut or injured, but where there is no medical reason for this to be done. This is a form of physical abuse and for girls under 18 the Trust has a statutory duty to report to police as it is also a crime under the Serious Crime Act, 2015. Please refer to the Trust FGM guideline for more information: FGM recognition, reporting and safeguarding guideline.

3.3.8 Contextual Safeguarding

This is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. The relationships young people form outside of their families (whether online or community) can sometimes expose them to violence and/or abuse. These threats can take a variety of different forms and children can be vulnerable to multiple threats, including exploitation by criminal gangs and organised crime groups such as county lines, trafficking, online abuse, sexual exploitation, and the influences of extremism leading to radicalisation.

3.3.9 Missing, Exploited, and Trafficked children

A: Definition of Missing or being absent

To ensure that the appropriate action to promote a child's safety is taken when police receive a concern about a child having gone "missing" the police apply the following categories:

A '**missing'** person is defined as: "Anyone whose whereabouts cannot be established and where the circumstances are out of character, or the context suggests the person may be subject of a crime or at risk of harm to themselves or another"

Those meeting this definition will be actively searched for, with a level of risk and assigned to each case.

An **'absent'** person is defined as a: "Person not at a place where they are expected or required to be."

People categorised as such should not be perceived to be at any apparent risk. Cases classified as 'absent' will be monitored by the police and escalated to the missing person category if risk increases.

For more information refer to the Trust 'Misper' policy: Missing Service User - Joint Policy and Procedures

B: Trafficking

Human trafficking is defined as a process that is a combination of three basic components:

- Movement (including within the UK)
- Control, through harm / threat of harm or fraud
- For the purpose of exploitation (UNHCR 2006)

The Modern Slavery Act (2015) requires public authorities to notify the Home Office when they encounter a potential victim of modern slavery or human trafficking, and for children this is generally done through a referral to the National Referral Mechanism (NRM). Unlike adults, consent is not needed from a child for this referral to be made, when a child/young person discloses or is suspected to be trafficked a referral to Children's Social Care should be made, and police informed via 999/101.

C: Exploitation:

Exploitation is “the action or fact of treating someone unfairly in order to benefit from their work”. (English Dictionary, 2018)

Child Sexual Exploitation (CSE) is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur using technology (Working Together 2023).

Child Criminal Exploitation (CCE) occurs where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18. The victim may have been criminally exploited even if the activity appears consensual.

Child Criminal Exploitation does not always involve physical contact; it can also occur using technology. Criminal exploitation often happens alongside sexual or other forms of exploitation.

Child Criminal exploitation is broader than just county lines and includes for instance children forced to work on cannabis farms, to commit theft, shoplift or pickpocket, or to threaten other young people.

3.3.10 Children at risk of radicalisation (PREVENT)

Radicalisation is defined as the process by which people come to support terrorism and extremism and, in some cases, to then participate in terrorist activity. Extremism is vocal or active opposition to fundamental British values including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs.

Health care professionals may treat children who are vulnerable to radicalisation. The key challenge for the health sector is to ensure that, where there are signs that someone has been or is being drawn into terrorism, the health care workers can interpret those signs correctly, are aware of the support that is available and are confident in referring the child to Children’s Social Care/police/CAMHS for further support (HM Government 2011).

4.0 ROLES AND RESPONSIBILITIES

The Trust has an overarching Think Family Safeguarding Strategy, which recognises that neither children nor adults exist or operate in isolation, therefore promoting co-ordinated thinking and delivery of services to children, adults and families.

Safeguarding is everyone’s responsibility irrespective of roles and looks at how safeguarding is reflected in the Trusts Key Priorities. The Trust has transparent and accountable governance arrangements and organisational structures to ensure effective delivery of safeguarding arrangements. Those working within the Trust are empowered to be confident in their practice through training at the appropriate level and have access to quality management and safeguarding supervision.

Working Together to Safeguard Children (2023) requires that each Trust has identified professionals within the organisation to provide leadership in respect of safeguarding children.

4.1 The Trust Board

Identifies a lead member with responsibility for safeguarding children within the Trust. The lead member will be responsible for ensuring regular feedback on safeguarding children is provided for the Trust Board.

4.2 The Executive Lead for Safeguarding

Holds board level responsibility for safeguarding, providing a strategic leadership for safeguarding across the organisation.

4.3 Head of Safeguarding

Provides support to the executive lead in exercising their functions in providing strategic leadership for safeguarding across the organisation. Other responsibilities include:

- Ensuring that there is a clear line of accountability and governance within the Trust and the provision of services designed to promote and safeguard the welfare of children.
- Collaborating with the People Directorate Department in order to ensure recruitment and human resources management procedures, including contractual arrangements, take account of the need to safeguard and promote the welfare of children and young people.
- Ensuring that there are procedures for dealing with the allegations of abuse against members of staff and volunteers
- Leading the organisation to understand and embed learning from serious case reviews
- Represent the organisation at the Local Safeguarding Children Partnership (LSCP).
- Working collaboratively with partner organisations to grow business and ensure that
- the health economy is an equal partner in all safeguarding delivery.

4.4 The Named Professionals

The Trust has a Named Professional and Named Doctor for Safeguarding Children, who form part of the Safeguarding Team. They carry out their duties in accordance with statutory guidance and work in partnership with the Local Safeguarding Children Partnership/Board and are responsible for:

- Promoting and developing good safeguarding practice throughout the Trust
- Providing expert advice and support on safeguarding issues for the Trust and Trust employees.
- Provide safeguarding supervision as and when required.
- Providing arbitration when professional or agency opinions differ as to whether a child is at risk (if this involves a Named Professional the Designated Professionals will become involved)
- Conducting the Trust's serious case reviews following a child death or serious/life threatening injury to a child through abuse or neglect
- Ensuring recommendations from serious case reviews (both internal and external) are implemented and subsequent learning is disseminated
- Support the organisation in its clinical governance role by ensuring that audits on safeguarding are undertaken and that safeguarding issues are part of the clinical governance systems.

- Defining and with the safeguarding team and NSCP, delivering Safeguarding Children training.
- Producing quarterly and annual Safeguarding Children and Young People Reports for presentation to the Trust Safeguarding Steering Group, Patient Safety and Quality Group and Quality Committee.

4.5 Divisional Heads and all Managers:

- Ensure that all staff are made aware of their roles and responsibilities in relation to this policy.
- Ensure that all staff have read the policy and are aware of what actions they need to take.
- Identify any additional training and support needs required by their staff to enable them to perform their duties as defined in this policy.
- Monitor periodically staff awareness of their roles in relation to this policy.
- Follow other appropriate Trust procedures, simultaneously where necessary e.g. disciplinary procedures, complaints and incident reporting.
- Ensure appropriate Divisional representation at the Trust's Safeguarding Steering Group.

4.6 All Trust staff:

- Undertake Safeguarding Children training as required by the Trust's Mandatory and Statutory Training Policy (MAST): MAST Policy
- For staff who work in specialist maternity, neonatal, or paediatric areas who require Level 3 role specific additional knowledge, skills and competencies, the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff, (2019) stipulates a minimum of 12-16 hours refresher training, (following initial training of eight-16 hours), over a three-year period. The Trust provides a minimum of eight hours training via the Mandatory Training programme, it is the staff member's responsibility to ensure that they are compliant with any additional hours required.
- As appropriate to their role know how to access NSCP Safeguarding Children Procedures and local/national practice guidance via the Safeguarding Children intranet site and understand how, when and where to seek additional support and advice
- Respond immediately to any allegations against staff from any source as per the trust's 'Policy for dealing with safeguarding allegations or concerns about individuals undertaking work at the Trust'
- It is the responsibility of Trust staff (relevant to their role) to challenge actions/decisions made by other staff members/professionals/agencies if they are felt to be unsatisfactory. Support will be provided by their manager and Safeguarding Team where required. See the Trusts internal interagency escalation policy
- Staff must ensure that the relevant documentation is completed in line with Trust policy and Codes of Practice, maintaining up to date and accurate written records.

Appendix Six provides an overview of the training compliance required dependent on role.

5.0 APPROVAL

Approval is via the Trust Safeguarding Committee.

6.0 DOCUMENT REQUIREMENTS

6.1 Making a referral to Children's Social Care

The Human Rights Act 1998 incorporated the European Convention on Human Rights (ECHR) into UK law, ensuring that children's rights are protected under UK law. This means children can access UK courts to claim their rights, and if denied, can appeal to the European Court of Human Rights. The Act protects children's rights to life, freedom from torture and slavery, and their right to a fair trial, among other rights. A child's right to a safe and happy childhood is enshrined within UK legislation via The Children Act, 1989 and their welfare is paramount.

Safeguarding the welfare of the child should be considered at every contact and when concerns are raised that the child may be suffering, or likely to suffer, significant harm a referral must be raised with Children's Social Care. Consent from parents/carers with Parental Responsibility (PR), should be sought, except when:

- There are concerns that the parent/carer is perpetrating sexual abuse
- There are concerns that the parent/carer is perpetrating FII
- Discussing a referral with the parent/carers is believed to put the child at risk of further or increased harm
- Discussing a referral with the parent/carers may put the health professional at risk of significant harm.

Where consent is sought but not given this does not prevent a referral being made as safeguarding referrals for children can be made without consent, but the discussion and any subsequent actions should be documented appropriately as part of the referral and in the patient's record. If the child is of an appropriate age, and competent to do so, consent can and should be sought from the child/young person themselves; but lack of consent from them should not prevent a referral to be made when there are safeguarding concerns.

Practitioners working with adults must identify and record on admission if:

- Medical presentation of the adult will impact on children for whom the adult has caring responsibilities, even when children do not permanently live with the adult, e.g. co-parenting arrangements.
- If there are children, ensure that there are safe and appropriate childcare arrangements in place.
- Whether there are any agencies currently involved with the children, e.g. Children's Social Care.

Where there are concerns around an adult patient's ability to provide care for child/ren, (including unborn babies) due to their medical presentation and prognosis or safeguarding concerns this must be recorded in the patient's records, a referral made to Children's Social Care and/or advice sought from the Safeguarding Team or Duty Nurse Manager if out of hours.

Referrals to Children's Social Care must be made to the local authority where the child/ren is normally resident.

Further information and guidance on making a referral to Children's Social Care can be found in Appendix One – ''How to Make a Referral to Children's Social Care'' or via the Nottinghamshire Safeguarding Children's Partnership core safeguarding procedures: Referrals.

6.1.2 What to do if you Suspect a Child is at Risk

If you are concerned that a child is experiencing abuse or neglect, there are several avenues where support can be provided:

- Via the Trust Safeguarding Team on extension 3357 or email on sfh-tr.safeguardingchildren@nhs.net. The team's core hours are Monday – Friday except Bank Holidays.
- Discuss with Line Manager/Senior Colleague/or if out of hours with the Duty Nurse Manager
- Check the multiagency practice guidance including Children's Social Care referral thresholds, which can be found via the Nottinghamshire Safeguarding Children's Partnership website along with all the local policies and procedures: Pathway to provision | Nottinghamshire County Council, or Interagency Safeguarding Children Procedures
- The Safeguarding Intranet site has resources and signposting available: Safeguarding
- NHS England has a webpage dedicated to providing safeguarding information and resources: Safeguarding - NHS Safeguarding

6.2 Outcome of Referral to Children's Social Care

As per 'Working Together to Safeguard Children', (2023): ''Within one working day of a referral being received, local authority children's social care should acknowledge receipt to the referrer and a social work qualified practice supervisor or manager should decide next steps and the type of response required.'' This will include where there is no further action for the local authority.

When the Trust generic Safeguarding Children email address is used, the Trust Safeguarding Team will receive a copy of the referral which is logged to maintain an auditable trail of referrals made by Trust colleagues. If Social Care send an outcome, the Trust Safeguarding Team will share with the referrer, if there are concerns around the outcome, the referrer should make contact with the Trust Safeguarding Team to discuss further and for consideration of escalation if required, see Section 6.2.3.

6.2.1 Strategy Discussions

Where there is reasonable cause to suspect a child is suffering or likely to suffer significant harm, a strategy discussion will be held to determine the child's welfare and plan rapid action where required. A local authority Social Worker, health practitioner, and police representative should, as a minimum, be involved in the strategy discussion – other agencies may also be invited including, education, Early Help, or any other practitioners supporting the child/ren.

All attendees should be sufficiently senior to make decisions on behalf of their organisation and be skilled and experienced to prepare for and engage with the strategy discussion and be able to critically assess and challenge their own and others' input.

The discussion should be used to:

- share, seek and analyse available information
- agree the conduct and timing of any criminal investigation
- consider whether enquiries under Section 47, (where the local authority gathers information about the child and family to determine the child's needs and level of risk of harm) of the Children Act 1989 should be undertaken.

During the strategy discussion, participating health practitioners should:

- advise about the appropriateness or otherwise of medical assessments and explain the benefits that arise from assessing previously unmanaged health matters that may be further evidence of neglect or maltreatment.
- provide and co-ordinate any specific information from relevant practitioners regarding family health, maternity health, school health mental health, domestic abuse and violence, and substance misuse to assist strategy and decision making.
- secure additional expert advice and support from named and/or designated professionals for more complex cases if needed.
- undertake appropriate examinations or observations, and further investigations or tests, including in some cases decisions around carrying out a Child Protection Medical Examination to determine how the child's health or development may be impaired.

Following a strategy discussion taking place it is imperative that the discussion, actions, and the outcome of the discussion is documented in the patient's record. The Local Authority will send minutes of the meeting, and these must also be included in the patient's record, (and, if available, in the records of any siblings to the child, and/or in maternal records if the child at risk is an unborn).

6.2.2 Child Protection Conferences.

Following Section 47 enquiries and assessment of the child and family, the Local Authority may decide to convene an Initial Child Protection Conference (ICPC). The ICPC brings together family members, including the child/ren where appropriate, with the supporters, advocates, and practitioners most involved with the child and family, to make decisions about the child's future safety, health and development. If concerns relate to an unborn child, consideration should be given as to whether to hold a child protection conference prior to the child's birth. It is the responsibility of the conference to make recommendations on how organisations and agencies work together to safeguard the child/ren in future.

All involved practitioners should work together to safeguard children from future harm, and take timely, effective action according to the agreed Child Protection Plan.

Information by all agencies about their involvement with the family should be submitted in a written report for the conference following the agreed template (see Local Resources - Agency Report to Initial/Review Conferences). The report should be available to the conference Chair 24 hours in advance of the conference and 5 working days for a review conference. All agencies should have a conference report proforma. The report should be discussed with the child, if appropriate, and their family at least 48 hours prior to the conference (to the extent that it is believed to be in their interests).

6.2.3 Resolving Professional Disagreement/Escalation

Professional challenge is a positive activity and a sign of good practice and effective multi-agency working. Being professionally challenged should not be seen as a criticism of the person's professional capabilities.

Disagreements can arise around issues such as thresholds for intervention, outcomes of assessments, service provision, or information sharing/communication in relation to practice or actions which are believed will not effectively ensure the safety or wellbeing of a child or young person. It is important to avoid professional disputes that put children at risk or obscure the focus of the child. Difficulties should be resolved within and between organisations quickly and openly.

Throughout any dispute between individuals or organisations practitioners must remain child focused.

If a referrer is not informed of the outcome of their referral, they should contact Children's Social Care and request this information. If the referrer is unhappy with the outcome from Children's Social Care, they should contact the Trust Safeguarding team who will review the case and may escalate when needed.

Further information can be found within the Trust Escalating Inter-Agency Safeguarding Children Disagreements Policy, (Trust Escalation Policy).

6.2.4 Admission or Discharge of a child and/or parent /carer when there are Safeguarding child/adult concerns.

It is generally not appropriate to admit children who do not require medical care to a ward as a place of safety. Any consideration for such admissions should be discussed with the paediatric consultant before admission and would be exceptional.

Before any decision is made around discharging a child and/or a parent/carer from hospital where there are safeguarding concerns a discharge planning meeting may be required which should include all relevant agencies. At this meeting a clear safe plan for discharge must be agreed. If a safe discharge plan cannot be agreed upon then staff should discuss this with the safeguarding team who will support in decision making around next steps and any necessary escalation required. Discharge should not occur until a clear safe discharge plan is agreed.

More details and further information can be found in the Admission and Discharge where there are Safeguarding Concerns Policy, (Admission and Discharge for CYP where there are Safeguarding Concerns).

6.2.5 Confidentiality and Information Sharing

The decision to share or not to share information about a child/young person should always be based on professional judgement, supported by the cross-governmental guidance Information *Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers* (HM Government, 2015).

Information sharing must be done in a way that is compliant with the General Data Protection Regulation, the Human Rights Act and the common law duty of confidentiality. However, a concern for

confidentiality must never be used as a justification for withholding information when it comes to safeguarding a child/young person. The welfare of the child must always be of paramount consideration.

Effective information sharing is an essential element of Safeguarding Children. The Children Acts 1989 and 2004 state we have a duty to co-operate with other agencies to safeguard and promote the welfare of children. Sharing information to protect children is in the public interest.

Written Trust guidance on information sharing will be available to staff and will comply with statutory legislation/guidance, multiagency information sharing agreements and trust information governance policies.

6.2.6 Checking whether a child is known to Children's Social Care

Documentation within paediatric areas of the Trust will ask if the child is currently open to social care, and if so, asks for the name of the social worker and the reason for their involvement. Staff within these areas must inform the social worker of the child's attendance/admission and discharge from the hospital, (where a Discharge Planning Meeting has been confirmed as not required).

Providing a brief overview of the reasons for the admission and any concerns they may have as a result. If there are immediate concerns this contact needs to occur as soon as possible and the child must **not** be discharged until this liaison with social care has taken place and discharged agreed.

To clarify whether a child is known to Children's Social Care on a Child in Need or Child Protection Plan or has been previously open to Children's Social Care then a Safeguarding Children Information Management Team (SCIMT) check can be undertaken. Consent is required to carry out this check. A SCIMT check should not replace a safeguarding referral when safeguarding concerns are identified. If the name of the allocated social worker is known, then any new concerns, updates to patient's condition, or changes that may impact the welfare of the child should be shared with them via the Duty Social Worker or Emergency Duty Team if their contact details are not known.

See Appendix Two: 'Making a Safeguarding Children Information Management Team, (SCIMT) Check.

6.2.7 CP-IS (Child Protection Information Sharing)

The CP- IS service help health and social workers share information securely to better protect children and young people who are open to Children's Social Care because they are a Child in Care/Looked after Child or subject to a Child Protection Plan.

If that child attends an NHS unscheduled care setting, such as an emergency department or a minor injury unit:

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

When the mother of an unborn child is known to social care and subject to an unborn child protection plan, this information is shared securely with the NHS and processed in the same way, (Child Protection - Information Sharing (CP-IS) service - NHS England Digital).

6.3 Children not Registered with a GP

If a child attends/is admitted and they are not registered with a GP, professional curiosity should be used to explore this with the parent/carer and ensure the reason given is clearly documented. Although the Trust should always advise parents/carers to register the child/ren with a GP, this is not a legal requirement in the UK and parents/carers may choose to forgo this, especially if they have alternative arrangements such as private healthcare.

Some children become invisible to services, this may be families who choose to home educate, young people who are not in education, employment or training (NEET), and not registered with a GP. While this does not automatically indicate safeguarding concerns, professional curiosity should be exercised to ensure that the child/ren are not experiencing neglect or abuse which is hidden from view.

When children have been harmed deliberately, they should not be discharged without discussion with Children's Social Care about recommending the child/ren are registered with an identified GP. This responsibility rests with the Consultant under whose care the child has been admitted and should be discussed as an action as part of the Discharge Planning Meeting.

When the child is not an inpatient of the Trust and Children's Social Care have been involved, the discharge discussions should recommend that child/ren are registered with a GP. However, this should not be a barrier to discharge.

6.4 Children with Special Educational Needs and Disabilities (SEND).

Children with special educational needs and disabilities (SEND) are at increased risk compared to children who do not have SEND to be abused or neglected. Sometimes this is because of high care needs where they are dependent on adults for practical assistance in daily living, including personal care, which may increase their risk of experiencing abuse. Additionally, they may have difficulties expressing their concerns or understanding that what is being done to them is abusive. Parents/carers of children with SEND may experience additional stresses and challenges which may heighten the potential for abuse and neglect.

When caring for children and young people with SEND, it is important to consider the voice of the child, and as for very young children, if they are non-verbal be aware of red flags such as bruising, unexplained marks or injuries, or signs they are frightened around their carer/s.

If there are safeguarding concerns ensure that a referral is raised, and that the vulnerabilities associated with their diagnosis are included as part of the risk assessment.

6.5 Children at risk from Domestic Abuse

Domestic abuse is physical, psychological, sexual, financial, or emotional abuse; including coercive control, and occurs within a previous or current intimate relationship or between family members and applies to anyone over the age of 16. Children under the age of 16 may be experiencing Domestic Abuse from a romantic partner, but this should trigger a Children's Social Care referral, as would abuse perpetrated by family members.

The Domestic Abuse Act, (2021) acknowledges children (anyone prior to their 18th birthday) as victims of Domestic Abuse, not just 'witnesses', and they will be automatically treated as victims irrespective of whether they were present at the time of the abusive incident/s. Children can also be injured accidentally/non-accidentally during an incident of domestic abuse/physical assault and this should form

part of professional curiosity if a child presents and has unexplained marks or injuries, or an explanation inconsistent with the marks/injuries.

If routine enquiry is undertaken and a positive response is disclosed, any risk to children should be assessed and where needed a referral made to Children's Social Care. This would include children living in the household, or children who visit regularly, e.g. 'blended' families or grandchildren. If the patient is pregnant, a referral should be made to Children's Social Care.

In the event the children are not resident in the patient's home, then names and dates of birth of the children should be taken where possible, and refusal to provide them may escalate the concerns around risk. If it is not feasible to take the names and dates of birth of the children, then all demographic details for the patient and the alleged perpetrator must be given to allow Children's Social Care to carry out the relevant checks.

Discussions about the referral should **never** be held in the presence of the alleged perpetrator, nor should they be given **any** information about the referral as this may put the patient and/or children at increased risk of harm. Additional information about supporting patients or colleagues who are experiencing domestic abuse can be found in the Domestic Abuse Policy (Patients) or Domestic Abuse policy (staff).

6.6 Female Genital Mutilation, (FGM)

FGM is any procedure that involves partial or total removal of the external female genitalia with no medical basis. The practice has no health benefits for girls and women and can cause significant health problems. The practice of FGM is recognised internationally as a violation of the Human Rights of girls and women.

FGM is mostly carried out on young girls between infancy and age 15 and more than 230 million girls and women have been subjected to the practice globally, with more than four million estimated to be at risk of FGM annually, (World Health Organisation, 2025: Female genital mutilation)

FGM is illegal in the UK and is an offence in the Serious Crime Act, (2015) and as such there is a mandatory reporting duty where all regulated healthcare professionals **must** report FGM in a girl under 18, either through disclosure by the victim or her relative, or if visually confirmed.

If the FGM is historic, then the report to the police can be made via 101 and a referral to Children's Social Care should be made. If it is believed the child is at imminent risk of FGM or has just had FGM performed on her, then this should trigger reporting to the police immediately on 999. An immediate and urgent referral to Children's Social Care **must** also be made via telephone with written follow up. Do not discharge the child from the Trust until a safe place of discharge is confirmed via police and Children's Social Care. Refer to the Admission and Discharge of Children where there are Safeguarding Concerns Policy if needed.

If the parents/relatives/carers attempt to remove the girl from Trust premises, police and Children's Social Care must be notified immediately, and steps followed for missing, abandoned, or abducted children as outlined here:

Further information can be found in the Trust FGM Guideline, FGM: Recognition, Reporting and Safeguarding.

6.7 Missing Children/Families, Abandoned or Abducted Children.

6.7.1 Missing Families Process

There is a national system used by Children's Social Care for disseminating information about children, including unborn babies, who go missing from Social Care caseloads as this always triggers serious concerns for their welfare and safety.

The Trust receives alerts via the local Integrated Care Board (ICB) Safeguarding Team and will be disseminated in relevant areas across the Trust, e.g. ED and/or Maternity.

When a missing alert is received, the Safeguarding Team will add an alert on to the relevant Electronic Patient Record , e.g. CareFlow, NerveCentre or SystmOne. Please see Appendix Three for for details relating to the alert process.

6.7.2 Abandoned or estranged babies/children

In law, child abandonment is defined as the act of leaving a child alone and having no intention of returning to ensure their health, safety, and wellbeing.

Fortunately, child abandonment is rare, but when it does occur it may be for a variety of reasons. For some it may be the stress and responsibility of being a carer, especially if the child has SEND, there are complicated circumstances in their lives or relationships, or acute mental health crisis.

In an acute hospital setting, people are often at their most vulnerable, or complex family dynamics may reach crisis point which triggers them to abandon their child/ren.

Sadly, there may be acute medical crisis which leaves child/ren without a parent/carer temporarily or permanently. Consideration should be given of the caring responsibilities of adults who die or are in critical condition in a ward area. Where there is reason to believe children may be impacted by an adult's medical presentation, a referral to Children's Social Care should be made.

Appendix Four provides guidance on what to do if a baby/child is abandoned within any area of the hospital.

6.7.3 Abducted babies/children

Infant and child abductions are rare, however, the trauma and publicity surrounding such events highlight the importance of ensuring that the Trust has an easy to follow and comprehensive response plan to:

- Ensure that staff are aware of how to raise the alarm quickly as time is critical.
- Ensure that staff are fully aware of their roles and responsibilities.
- Ensure that staff are deployed effectively to conduct a search of the area.
- Ensure effective communication and co-operation between Trust staff, the police and security services.
- Ensure effective communication with other agencies including Social Care.

If a member of staff becomes aware of the unexplained absence of a baby or child, they should follow the guidance as set out in the Trust
https://sfhnet.nnotts.nhs.uk/content/showcontent.aspx?contentid=71152

6.8 Underage Sexual Activity

Sexual relationships and activity are a normal part of life. Although the legal age of consent for sexual activity is 16 years old, many young people below this age will develop and show an interest in sex and sexual relationships.

There must be balanced risk assessments to ensure that young people are able to access safe, confidential health services while promoting and safeguarding their welfare. If at any stage, concerns are raised relating to sexual exploitation or abuse, advice should be sought from the Safeguarding Team, and a referral to Children's Social Care should be made.

Assessment of risk is essential when considering underage sexual activity. It is important to explore with the young person the nature of the relationship, especially the age/maturity of their sexual partner.

This assessment should include, but is not limited to:

- Whether the young person can understand and give informed consent to the sexual activity they are involved in.
- Children under the age of 13 **cannot** give consent.
- The nature of the relationship between those involved, with emphasis on the ages of those involved and any issues relating to power imbalance.
- Whether aggression, controlling or coercive behaviours, or bribery (including use of alcohol or substances) was involved.
- Whether the young persons' behaviours, e.g. substance use, places them at risk and prevents them giving informed consent
- Any attempt at secrecy beyond what would be considered usual in a teenage relationship
- If the young person denies, minimises, or does not understand the concerns for their welfare
- Whether methods to silence, secure secrecy, and/or compliance by the sexual partner are consistent with grooming behaviours
- Any other indicators of safeguarding concerns identified during assessment.

6.8.1 Gillick Competence/Fraser Guidelines

Medical professionals need to consider Gillick competency if a young person under the age of 16 wishes to receive treatment without their parents' or carers' consent or, in some cases, knowledge.

The Fraser guidelines are a set of criteria within Gillick Competence used in the UK to determine if a child under 16 has the maturity and understanding to make their own decisions about contraception and sexual health, without parental consent. They can be used by a range of healthcare professionals working with children under 16, including doctors and nurse practitioners. Following a legal ruling in 2006, Fraser Guidelines can also be applied to advice and treatment for sexually transmitted infections (STIs) and the termination of pregnancy.

Practitioners using the Fraser guidelines should be satisfied of the following:

- the young person cannot be persuaded to inform their parents or carers that they are seeking this advice or treatment (or to allow the practitioner to inform their parents or carers).

- the young person understands the advice being given.
- the young person's physical or mental health or both are likely to suffer unless they receive the advice or treatment.
- it is in the young person's best interests to receive the advice, treatment or both without their parents' or carers' consent.
- the young person is very likely to continue having sex with or without contraceptive treatment.

Remember that consent is not valid if a young person is being pressured or influenced by anyone else, including someone within their peer group, family member, or someone with influence over a child, e.g. faith leader.

When using Fraser Guidance, the health practitioner must consider child protection concerns and consider that underage sexual activity is a potential indicator of child sexual abuse, and children who have been groomed and exploited may not realise they are being abused. Sexual activity with anyone under the age of their 13th birthday should always trigger a referral to Children's Social Care and consideration of reporting to police. Where children present repeatedly with STIs, seeking contraception, or termination of pregnancy health professionals should practice professional curiosity and explore with the young person whether they are victims of child sexual abuse or exploitation and refer to appropriate agencies where required.

The NSPCC has general guidance around Gillick Competency and Fraser Guidelines, Gillick competence and Fraser guidelines | NSPCC Learning. The Trust Legal Team can also be contacted for advice and support.

If the child or young person is not deemed to be Gillick Competent, Fraser Guidelines cannot be applied, and Trust colleagues should seek further advice and support from the Trust Safeguarding Team, Legal Team, and/or Children's Social Care.

6.9 Children at Risk of Exploitation (CRE)

6.9.1 Child Sexual Exploitation (CSE)

CSE is a specific form of child sexual abuse and may require a different approach to take account of its complex nature. CSE occurs when an individual or group takes advantage of an imbalance of power to coerce, deceive or manipulate a child into sexual activity. This can include gifts of drugs, money, alcohol, material goods, or of 'love' and affection.

CSE may not always include physical contact, as it can be initiated over social media, the Internet, or text message; but it may also be a combination of all of these.

Adolescents can be secretive and engage in risk taking behaviours with a reduced sense of danger and increased impulsivity. Children and young people who have experienced abuse or neglect, are looked after children, or live in chaotic or dysfunctional households, or are not in education, employment or training (NEET) are especially vulnerable to exploitation. However, it

can happen to any child or young person and health professionals should be mindful of some of the indicators, which include:

- presenting to hospital with adults or peers that are not known to the child

- multiple phones or access to funds unusual for a child or young person
- presenting in mental health crisis, including self-harm, suicidal ideation, or suicide attempt
- presenting with an STI or pregnant, and no clear identity provided for their sexual partner
- displaying inappropriate sexualised behaviours
- presenting to the Trust from an area that is not within normal catchment, and limited explanation as to how they got here
- not knowing where they are, or having unexplained physical injuries
- repeat presentations for STIs, pregnancy and/or terminations.
- It is an offence for a person to have a sexual relationship with a 16- or 17-year-old if they hold a position of trust or authority
- Those aged 16 and 17 years may be viewed by health professionals and others as being of 'the age of consent' in terms of the Sexual Offences Act (2003), but this age group are particularly vulnerable to CSE being missed precisely because of the legalities of sexual consent in this age group
- Sexual activity without consent is sexual assault and/or rape irrespective of age
- Consent cannot be given when under pressure or duress, or when under the influence of drugs or alcohol.

When young people are known to be sexually active, e.g. when accessing sexual health services, the ‘spotting the signs’ proforma should always be completed and professional curiosity exercised around the risk factors for grooming and exploitation.

Other patterns of sexual exploitation identified in the National Audit on Group Based Child Sexual Exploitation and Abuse, (2025) carried out by Baroness Casey included sexual exploitation of girls within street gangs where the motive is sexual gratification of gang members, but also to lure girls into working for them. Child sexual exploitation has also emerged as a key feature in children who are victims of modern slavery (a term that includes any form of human trafficking, slavery, servitude or forced labour).

Themes emerged from the audit that are relevant from a Trust perspective, and that is especially around recognising the children as victims, and avoiding the ‘adultification’ of teenage girls, and where possible clearly documenting the description or identity of perpetrator/s of CSE.

Where there are concerns around CSE an assessment of risk should be made using the Multiagency CSE Risk Assessment Tool , this can then be attached to the referral to children’s social care when applicable.

6.9.2 Child Criminal Exploitation (CCE)

Child Criminal Exploitation (CCE) takes a variety of forms but is ultimately the grooming of children into criminal activity. It can include ‘County Lines’, where children are exploited to move drugs from one area of the country to another on the basis that children will often be ‘under the radar’. But may also include children being forced to work in cannabis factories, moving across the country, ‘’plugging’’ where children are forced to insert drugs into their vagina or anus, forced to commit financial fraud, shoplift/pickpocket, commit burglaries, or take part in assault or violent crime.

Victims of CCE can also be victims of CSE, and it is important that children are viewed as victims rather than criminals, even when they are known or suspected to have taken part in criminal activities.

Indicators that the Trust will need to be considering include:

- Sustaining injuries because of perpetrating or being a victim of knife or violent assault
- Sustaining injuries in a Road Traffic Collision, especially involving mopeds, motorbikes, or 'e-scooters'.
- Injuries or medical presentations associated with having drugs inserted into the anus or vagina
- Being under the influence of drugs, or found to be in possession of drugs, including the inhalation of aerosols/solvents.
- Disclose that their safety, or the safety of their friends and/or family is threatened
- Disclosing that they are subject to threats, blackmail, and violence
- Indicators that a child is being exploited or influenced by extremism
- Any other indicator that the child is being criminally exploited.

A full risk assessment is available via the Nottinghamshire Safeguarding Children's Partnership and can be shared with Children's Social Care and/or police as part of any onward referral: Child Criminal Exploitation

6.10 Children at risk of radicalisation (PREVENT)

6.10.1 PREVENT – The Government's Counter Terrorism Strategy

The government's counter terrorism strategy called CONTEST aims to reduce the risk to the United Kingdom and its interests overseas from international terrorism so that people can go about their lives freely and with confidence. These forms of terrorism include Far Right extremists, Al-Qa'ida influenced groups, environmental and animal rights extremists.

CONTEST has four workstreams:

- Pursue (to stop terrorist attacks)
- Protect (to strengthen our protection against terrorist attack)
- Prepare (where an attack cannot be stopped to mitigate its impact)
- **Prevent (to stop people becoming terrorists or supporting terrorist activities)**

Staff may meet and treat children or young people who are vulnerable to radicalisation and/or express views and ideas that are indicators of extremism. Staff may also meet or treat adults who have care of children and young people and who express views and ideas that are indicators of extremism. The Counter-Terrorism and Security Act, (2015) places a duty on specified authorities in England, Wales, and Scotland to have due regard to prevent people from being drawn into terrorism.

Channel Panels arrange support for individuals who have been assessed as vulnerable to terrorism. When support is being provided to an individual on the Channel programme due regard should be given to align assessments under the Children Act to promote and safeguard the wellbeing of the child/ren.

It is not employee's duty to investigate PREVENT concerns, but it is a Trust wide duty across all employees to report concerns around extremism or radicalisation about patients, patients' families or carers, or colleagues as per the Trust's PREVENT flowchart, (Appendix X) to the Trust's nominated

PREVENT lead. Each issue will be taken seriously and handled appropriately in line with the Trust's safeguarding responsibilities.

6.11 Concerns about Fabricated Induced Illness (FII)/Perplexing Presentations

While there is no single, nationally agreed, definition of FII/PP the term describes FII as behaviours by a parent/carer that may include, but are not limited to:

- Deliberately inducing symptoms or signs of illness, including exaggerating or making false claims about medical history.
- Interfering with treatment or neglecting to administer treatment.
- Obtaining specialist treatment or equipment that is not required.
- Alleging unfounded psychological illness.

FII can occur when a child has a confirmed diagnosis of illness or disability and the two may coexist but the health seeking behaviour or presentation is outside that expected for the condition or disability.

Perplexing Presentations or 'medically unexplained symptoms' describes a child presented for medical attention with unusual or perplexing symptoms which are not attributable to or adequately explained by any confirmed diagnosis and yet may not involve deliberate fabrication or deception.

The Royal College of Paediatrics and Child Health (RCPCH) recognises that within this challenging field of work, there is evidence that paediatricians and other health professionals play a role in inadvertently contributing to harm to the child. Health care professionals must practise evidence-based medicine, whilst retaining professional curiosity and setting appropriate boundaries in their practice. Indicators of family dysfunction should not be underestimated and the voice and lived experience of the child/ren should remain the paramount concern. What is already known about the child and family by the wider professional network when assessing the needs of children should also be considered. The challenge is to correctly identify any illness present whilst at the same time not performing unwarranted investigations or interventions driven by exaggerated reporting of symptoms, (RCPCH, 2021: Perplexing Presentations (PP)/Fabricated or Induced Illness (FII) in children – guidance - RCPCH Child Protection Portal).

Initial concerns about FII/PP should be discussed with the Named Professionals for Safeguarding Children prior to making a referral, unless this would create delay that may put a child or young person at risk of significant harm.

6.12 Children and Young People who are not brought to appointments - 'Was Not Brought (WNB).

"Was not brought" (WNB) is a term used in healthcare, particularly when referring to children, to indicate that a scheduled appointment was missed because the child was not brought by a parent or carer. It replaces the term "did not attend" (DNA) because it more accurately reflects the fact that children often rely on others to get to appointments.

There may be a number of reasons a child or young person is not brought to an appointment, these can include incorrect address/contact details, that the problem has resolved or been treated elsewhere, the parent/carer has simply forgotten the appointment, or the appointment conflicts with other health appointments or external factors such as a child's GCSE exam timetable. Many parents will telephone to cancel or rearrange an appointment, however failure to bring the child without notice should trigger

professional curiosity and further exploration of the circumstances with the family. Persistent failure to present the child for health appointments despite contact being made with parents/carers to confirm appointments may be an indicator of neglect and consideration of a referral to Children's Social Care should be included in the risk assessment and actions.

When a child is not brought it is crucial to:

- Record the incident and the reason for non-attendance.
- Consider the potential risks and safeguarding concerns.
- Discuss the situation with colleagues and other relevant agencies.
- Contact the individual or their parent/carer to understand the reasons for non-attendance and offer support.
- Consider making a safeguarding referral if there are concerns about the child's safety or well-being.

Further information can be found in the Trust's WNB/DNA policy: Management of Children and Young People who are not brought or do not attend appointments.

6.13 Allegations made against a Person in a Position of Trust/Managing Allegations against a Professional.

Despite all efforts to recruit safely there will be occasions when allegations of abuse against children/young people are raised. All employees of the Trust, whether employed substantively, by an agency, volunteering, or contracted to work in the Trust are considered to be a person in position of trust and as such held to a standard where the child or young person's welfare is paramount. The law gives protection for children and it is not lawful for a person in a position of trust (for example teachers or care workers) to engage in sexual activity with anyone under the age of 18 who is in the care of their organisation

Allegations may relate to an individual's behaviour at work, at home, or in a coaching or volunteer capacity or other setting. All allegations against people who work with children must be taken seriously. All allegations against adults working or volunteering with children must be referred to the Local Authority Designated Officer (LADO). The LADO will then provide advice and guidance to employers and volunteer organisations, liaise with police and Social Care, and monitor the progress of cases to ensure that they are dealt with as quickly as possible, and follow a thorough and fair process.

If you are aware of a person who works/volunteers with children and 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 in a way that indicates the individual is unsuitable to work with children,

Then it is imperative that you inform your line manager who should then escalate to the Trust Safeguarding Team or DNMs out of hours.

Do not complete a Datix incident report. All allegations against professionals are managed in confidence by the Trust senior leadership team to ensure that the process is in line with the Trust 'Just Culture/Being Fair Tool'.

For more information and guidance, refer to the Trust Managing Allegations Policy: Dealing with safeguarding allegations or concerns about individuals undertaking work with children, young people and vulnerable adults

6.14 Allegations of historic abuse.

The term 'historical abuse' is used to refer to disclosure s of abuse that happened in the past. These can be made by children or adults, but normally when the victim is no longer in circumstances where they consider themselves at risk from the perpetrator/s.

Allegations of child abuse, especially sexual abuse, can be made by children and adults many years after the abuse has occurred. This can be for a myriad of reasons and often causes complexity if the alleged perpetrator is no longer linked to the original address, setting, or employment role. It is important to try to establish as a matter of urgency whether the perpetrator is still working with, has regular contact with, or is caring for, children and young people. where it is likely that this is the case, a referral to Children's Social Care may be necessary. To complete this, the victim/professional must endeavour to determine the current residential area for the perpetrator/children and as much demographic detail as possible and the details of the allegations of historic abuse shared.

There may be some reticence around this from the alleged victim, and it may be possible to ensure that their details remain confidential, but the welfare of the current child/ren is paramount and therefore information should be shared appropriately. If the disclosure warrants it and location of perpetrator, or details of children that they have contact with, are not identifiable, police may be contacted for further investigation. Please seek advice and support from the Trust Safeguarding Team if required.

Support should be offered to the person making the disclosure, including signposting to services that can provide onward care/counselling, if the disclosure constitutes a crime the alleged victim can be supported to make a referral to police. If the victim does not feel they wish to report to police, but there is an assessment that the alleged perpetrator may pose a risk to the wider public then it may be necessary for the Trust to contact police to share information appropriately as required. Please seek further advice and support from the Trust Safeguarding Team if required.

6.14.1 Adverse Childhood Experiences (ACEs)

ACEs are highly stressful, potentially traumatic, events or situations that occur during childhood or adolescence.

ACEs can impact physical health, as well as psychological wellbeing, social and financial stability, education and relationships. Examples of ACEs include abuse, neglect, domestic abuse, household dysfunction such as parent/carer alcohol or substance misuse; or events that many children will cope with including parental relationship breakdown or bereavement. While experiencing ACEs does not guarantee problems in later life, the prevalence of some conditions such as low mental wellbeing does rise significantly with the number of ACEs that individuals experience.

Survivors of adverse childhood experiences can often be reluctant to disclose voluntarily, due in part to feelings of shame, guilt and anxiety about their experiences and the act or consequences of disclosure. However, survivors have suggested that these issues can either be exacerbated or alleviated by the responses of the person listening to their disclosure, (NHS Safeguarding, 2025).

Disclosures should always be taken seriously and considered within a whole family approach with the welfare of children being paramount.

Further information can be found via the NHS Safeguarding website: Adverse childhood experiences and the lasting impact - NHS Safeguarding

6.15 Safeguarding Children and Young People Supervision

Safeguarding children supervision is offered via the Trust Safeguarding Team in accordance with the Trust Safeguarding Supervision Policy: Safeguarding Children Supervision Policy.

Safeguarding supervision dates/venues are available via the Trust Safeguarding Intranet site.

6.16 Child Deaths

The Child Death Review Specialist Nurse/Midwife and Named Professionals for Safeguarding Children must be informed of all child deaths within the Trust: Child Death notification flowchart .

If the death is not expected, i.e. not anticipated as a significant possibility 24 hours prior to the death, the Joint Nottingham City/Nottinghamshire Safeguarding Children Partnership multiagency rapid response procedures are initiated: Child Death Review Procedures

6.17 Child Safeguarding Practice Reviews (CSPRs)/Rapid Reviews

When a child has come to significant harm or has died due to the experience of abuse or neglect, a Child Safeguarding Practice Review (CSPR) may be triggered at either local or national level to identify improvements to safeguard and promote the welfare of children. Reviews should seek to prevent, or reduce, the risk of recurrence of similar incidents and are therefore not conducted to hold individuals or organisations to account as there are other processes for this purpose.

If any of the three statutory partners as per 'Working Together to Safeguard Children', (2023): police, health, social care, assess a case as meeting threshold for a Serious Incident Notification (SIN) they will notify the local safeguarding partnership and a discussion will take place on whether the criteria is met or not. A SIN must be submitted within five days of awareness of the incident.

When a decision is reached that threshold is met, the partnership will arrange for a Rapid Review to be undertaken. The aim of this review is to enable all relevant agencies to gather the initial facts about the case, establish whether immediate action is required to safeguard children, consider any potential improvements required, and decide what next steps may be required. It is the responsibility of the Trust Safeguarding Team to complete this.

- The Named Professional for Safeguarding Children will receive the request via secure email from the ICB Designated Nurse for Safeguarding, (or Associate) and alert the Associate Director for Safeguarding and Vulnerabilities that a Rapid Review request has been made for information and in case of any escalation to the Executive Team is required.
- All Rapid Review requests are reported via the Trust Safeguarding Team Quarterly Reports/Annual Report.
- The Named Professional for Safeguarding Children may delegate completion of the Rapid Review to the Specialist Practitioner for Safeguarding.

- The Safeguarding Team will request and secure any paper records required for the Rapid Review/IMR.
- Timeframe for completion and return of the Rapid Review to the partnership is within six days of request as the full report must be completed and returned to the National Child Safeguarding Review Panel within 15 days with recommendation of whether the Rapid Review will meet threshold for a Local or National Child Safeguarding Practice Review.

Local Child Safeguarding Practice Reviews are initiated by the Safeguarding Children's Partnership for the area in which the child is/was resident. When deciding whether to undertake a CSPR the Safeguarding Partners will have due regard for:

- Improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified;
- Recurrent themes in the safeguarding and promotion of the welfare of children;
- Concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children;
- Is one which the Child Safeguarding Practice Review Panel have considered and concluded a local review may be more appropriate.
- Where the safeguarding partners have cause for concern about the actions of a single agency;
- Where there has been no agency involvement and this gives the safeguarding partners cause for concern;
- Where more than one local authority, police area or Integrated Care Board is involved, including in cases where families have moved around;
- Where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings.

If the Panel decides to undertake a national review, they will discuss with the safeguarding partners the potential scope and methodology of the review and how they will engage with them and those involved in the case.

More detailed information on the process for Rapid Reviews/CSPRs can be found via the Nottinghamshire Safeguarding Children's Partnership procedures: Child Safeguarding Practice Reviews

Where threshold is met for completion of a CSPR, individual organisations undertake Individual Management Reviews (IMRs). The author of the IMR will be a Named Professional or an appropriately trained member of the Trust Safeguarding Team. Arrangements will be made for the author of the IMR to have sufficient time for completion. In some cases, the IMR author may need to follow up with members of staff to discuss their involvement with the patient/s or their families/carers. As the CSPR is a statutory document, Trust Divisions must ensure that wherever possible and upon request staff members are made available to the author at a time/format mutually convenient. This may take the form of a face-to-face or Microsoft Teams (or equivalent) meeting, or maybe via telephone or email. Support should be offered to the member of staff from line management as well as the Safeguarding Team due to the nature and content of these reviews.

The IMR process will be undertaken and written in accordance with NSCP/OFSTED prescribed terms of reference, format, and timescales.

The Trust Board will be made aware of the content and recommendations arising from the IMR.

Recommendations and actions will be completed within the prescribed timescales, and it is an expectation that relevant Trust Divisions will support these as required.

All learning outcomes will be disseminated Trust wide appropriately and in a timely fashion. Learning Bulletins are available via the Trust Safeguarding Intranet as well as the Nottinghamshire Safeguarding Children Partnership website: Learning and improvement framework. Learning from national reviews can also be found via the NSPCC: NSPCC library catalogue

6.18 Dissemination of Safeguarding Children Information

Safeguarding children information/resources/learning briefings are all available via the Trust Safeguarding intranet site: Safeguarding. As new information is shared, the Trust Safeguarding Team will share Trust wide via Divisional meetings, Safeguarding Committee members/meetings, email, '7 Minute Briefings', The Children and Young Person Committee, and the Trust Bulletin.

Contact information for the Trust Safeguarding Team is made available via the Safeguarding intranet site, training, supervision, and on email signatures.

The Trust's expectations of staff, parents, and child/young people's behaviours will be made explicit and displayed in relevant areas. Children and young people will have information displayed on confidentiality, the limits to confidentiality, and any organisations they can contact for help and support.

6.19 Safeguarding Documentation

Accurate, contemporaneous documentation is critical when managing children and young people when there are safeguarding concerns. Currently the main hospital record remains the paper records, it is therefore imperative that safeguarding documentation is behind a red divider, and if available, completed on yellow A4 paper to ensure it is visible. Where children have more than one set of records, safeguarding documentation must be transferred to the most recent set of records.

Documentation should be clearly dated and time of incident recorded. All actions taken should be recorded, timed, and dated. Any current safeguarding concerns, and where relevant outstanding actions, should be clearly handed over to the receiving healthcare professional/team, including where patients are being transferred to a different Trust or discharged to community teams.

When completing safeguarding documentation, it is essential that staff clearly identify themselves as well as signing the completed records. This is to ensure that in the event there is a Rapid/Child Safeguarding Practice Review, requirement for legal statement, or attendance in court, members of staff can be easily identified and supported.

All ED records, copies of referrals, relevant documentation – e.g. Child Protection Conference Reports or minutes, and any other relevant safeguarding information must also be filed behind the red divider.

Safeguarding documentation is audited annually by the Safeguarding Team with reporting via the Safeguarding Committee and Annual Report.

For further information or advice, please see Appendix Three, or contact the Safeguarding Team.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored **(WHAT – element of compliance or effectiveness within the document will be monitored)**	**Responsible Individual** **(WHO – is going to monitor this element)**	**Process for Monitoring e.g. Audit** **(HOW – will this element be monitored (method used))**	**Frequency of Monitoring** **(WHEN – will this element be monitored (frequency/ how often))**	**Responsible Individual or Committee/Group for Review of Results** **(WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)**
Safeguarding Documentation Audit	Named Professional Safeguarding Children	Audit	Annual	Safeguarding Committee
Training Compliance	Named Professional Safeguarding Children	Compliance Data from Training and Education Department.	Quarterly	Safeguarding Committee
Safeguarding Activity and Audit Programme	Named Professional Safeguarding Children	Audit Programme and Quarterly Reports	Quarterly	Safeguarding Committee
Number of Safeguarding Children Referrals made by Trust staff	Named Professional Safeguarding Children	Collated by the Safeguarding Team and reported on through Quarterly Reporting	Quarterly	Safeguarding Committee
Compliance with NSCP Marker of Good Practice Section 11 self-assessment tool	Named Professional Safeguarding Children	Monitored via Safeguarding Children workplan and RAG rating compliance system on tool	Completed and submitted externally every two years.	Safeguarding Committee and NSCP.

8.0 TRAINING AND IMPLEMENTATION

Staff will undertake Safeguarding Children Training in accordance with the Trust's Mandatory Training Policy.

9.0 IMPACT ASSESSMENTS

Delete/ amend as applicable:

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix Seven
- This document is not subject to an Environmental Impact Assessment

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance)

- Children Act, (1989): Children Act 1989
- Domestic Abuse Act, (2021): Domestic Abuse Act 2021
- Nottinghamshire/Nottingham City Joint Safeguarding Children's Partnership Safeguarding Procedures, Welcome to the Interagency Safeguarding Children Procedures
- Working Together to Safeguard Children, (2023), Working together to safeguard children 2023: statutory guidance
- Nottinghamshire Safeguarding Children's Partnership website, Nottinghamshire Safeguarding Children Partnership
- Nottinghamshire Safeguarding Children's Partnership 'Bruising in Non-Mobile Babies Pathway', Bruising in Babies Pathway
- Nottinghamshire Safeguarding Children's Partnership 'Assessment of Subconjunctival Haemorrhage (SCH) in Infants, Subconjunctival Haemorrhage Guidance.pdf
- Nottinghamshire County Council – Pathway to Provision, Pathway to Provision
- NHS England, NHS Safeguarding Guide, NHS Safeguarding
- NHS England – NHS Digital, Child Protection – Information Sharing (CP-IS) Service, Child Protection - Information Sharing (CP-IS) service - NHS England Digital
- World Health Organization - Female Genital Mutilation, Female genital mutilation
- NSPCC Gillick Competency and Fraser Guidelines, Gillick competence and Fraser guidelines | NSPCC Learning
- National Audit on Group-Based Child Sexual Exploitation and Abuse, child sexual exploitation and abuse
- Multi Agency Serious Youth Violence and Child Criminal Exploitation Risk Assessment Tool, Child Criminal Exploitation
- Counter-Terrorism and Security Act, (2015): Counter-Terrorism and Security Act 2015

- Royal College of Paediatrics and Child Health: Perplexing Presentations (PP)/Fabricated or Induced Illness (FII) in children – guidance, Perplexing Presentations (PP)/Fabricated or Induced Illness (FII) RCPCH Child Protection Portal

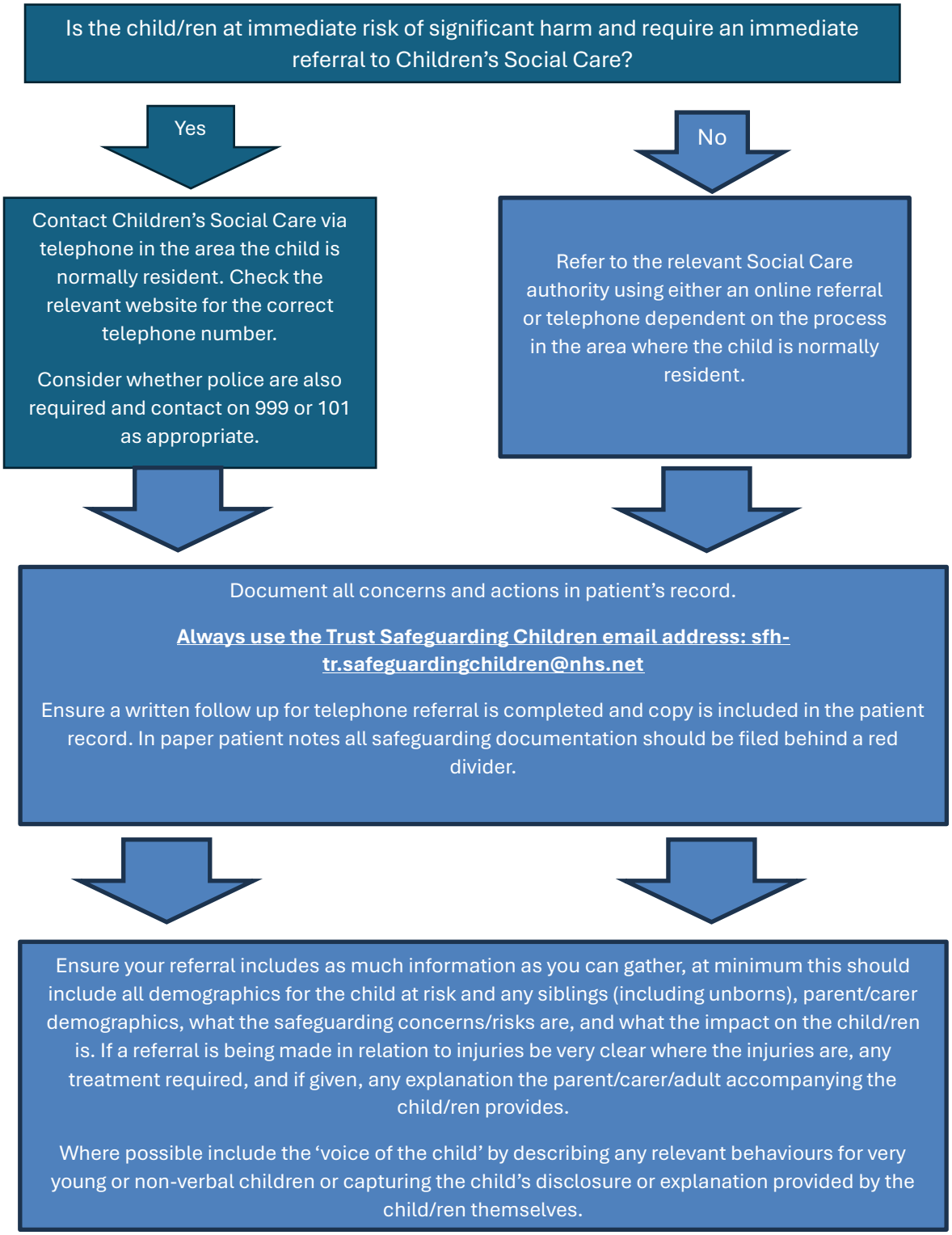
11.0 KEYWORDS

- Child Assessment Framework, CAF
- Early Help Assessment Framework, EHAF
- Children in Care/Looked After Children, (CIC/LAC)
- Fabricated and Induced Illness/Perplexing Presentations, (FII/PP)
- Child Criminal Exploitation, (CCE)
- Child Sexual Exploitation, (CSE)
- Department of Health
- Was Not Brought/Did Not Attend, (WNB/DNA)
- Child Protection Information Sharing (CP-IS)
- Female Genital Mutilation, (FGM)
- PREVENT, radicalisation, extremism, terrorism
- Think Family
- Special Educational Needs and Disabilities (SEND)
- Domestic Abuse (DA)
- Missing, Abandoned, Abducted
- Underage Sexual Activity
- Gillick Competence, Fraser Guidelines
- Child protection
- Referral
- Escalation, professional disagreement

12.0 APPENDICES

- Refer to list in contents table

Appendix One: Process for making a children's safeguarding referral



Appendix Two: Undertaking a Safeguarding children information management team (SCIMT) check

Safeguarding Children Information Management Teams (SCIMT) are responsible for holding information on children who are judged to be at continuing risk of significant harm and are subject to an active Child Protection Plan.

When to make a SCIMT check

If after initial assessment and discussion with the parents/carers concerns remain that a child or young person may be known to Childrens Social Care a SCIMT check can be undertaken.

A SCIMT check should also be considered if a child:

- Presents for treatment and lives out of area (and is not on holiday) – however the check will need to be made in the area the child is normally resident as the local social care team will not have access to this information. Use the internet to find out contact details for the relevant team.
- Is not registered with a GP
- Parents/carers remove the child from Emergency Department/Minor Injuries Unit & Urgent Care Centre/ward without the child being seen – however, a SCIMT check should not be made in lieu of a referral.

NB: Unless the enquiry is made clearly stating the relevant exemption under the Data Protection Act, consent from the subject (child or parent/carer) of the enquiry is required.

SCIMT Process

The SCIMT are a business support team and therefore are not able to disclose full information on any person. Information that can be provided on any check where consent has been provided is limited to:

- whether the person is known to Children's Social Care
- the name and contact details of the current social worker
- dates of when involvement started
- if any child in the household is currently subject of a child protection plan or has been previously, including dates and category of the plan.

If further information is required, the enquiry will be forwarded on to the relevant social care team to respond directly to the request.

SCIMT telephone numbers are available on the SFH Safeguarding Intranet and the Nottinghamshire County Council/MASH website.

Appendix Three – Safeguarding Documentation Process

All safeguarding children information is filed within the child's medical record, for an unborn child within the mother's record until baby is born and then a set of records should be made for the baby and all copies of the safeguarding information are then filed in baby's records.

This includes hospital alerts and reports or minutes of meetings etc. from Children's Social Care.

For the ongoing safety of the child, it is important that safeguarding information is easily identified and accessible. To ensure this the following process is followed:

1. **Red Safeguarding Divider**: Insert the red "safeguarding divider" behind the red boarded alert divider in the patient medical records. Tick the "Safeguarding Children" box (the divider is multi-purpose and is also used for "Adults and Risk" and "Multi-Agency Public Protection Risk Assessments")

2. **Chronology Sheet**: Place a Safeguarding Children "chronology sheet" directly behind the red safeguarding divider. Document the date of each admission where safeguarding concerns are identified (this provides a reference guide for finding safeguarding information within the main body of the record). NB: File copies of written referrals to social care, child protection reports, case conference/strategy minutes etc. behind the red safeguarding divider and chronology sheet. (If your ward/department is currently using yellow safeguarding front/continuation sheets these should also be filed here.)

For midwives:

Although Maternity Services use BadgerNet, the wider Trust does **not** have access and therefore relevant safeguarding information **must** also be completed and included in the patient's main hospital records.

Midwifery Social and Domestic alerts are placed behind the obstetric referral letter for the current pregnancy and are filed in chronological order. As soon as the baby is born, a set of records **must** be created, and a copy of the safeguarding information *must* also be filed in a set of baby notes when baby is born.

On BadgerNet, all safeguarding information should be completed on the Social Tab and any conference reports, meeting minutes, pre-birth plans, or other relevant documents should be uploaded for teams to access. For guidance on using BadgerNet please contact your line manager, NHIS, or the Named Midwife for Safeguarding.

Adult patients who are parent/carers may have health issues that impact on their children/unborn child e.g. substance use, mental health problems, domestic violence. Where there are any concerns about safeguarding children these should always be addressed. Safeguarding children information should be documented and filed in their medical record as outlined above.

It is the responsibility of all staff dealing with safeguarding children information to ensure this process is followed.

NB: There should only be one safeguarding divider in use. When volume 2 of a patient record is started all safeguarding information should be transferred into this volume.

If you require further advice please contact: Safeguarding Team – extension: 3357 or email: sfh-tr.safeguardingchildren@nhs.net
Social & Domestic Alerts and Chronology sheets are available to download from the Safeguarding Intranet site in "Documentation" folder

Appendix Four - Missing Child/Families/Unborn Child Alerts Process

The Safeguarding Team are notified of a "missing child/family/pregnant woman" via the local Missing family process.

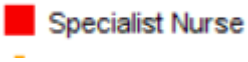
The Safeguarding Team place a Safeguarding children alert (Purple Dot – see below) on the patient SystmOne record and a RAPA alert is generated.

Safeguarding Alert

A 'missing child/family/pregnant woman' presents at KMH ED or **Newark UCC**

The SystmOne alert (will display on the ED whiteboard – when staff hover over the alert it advises staff they must retrieve the patient record on systmOne.

Once ED/UCC staff have retrieved the record, they will click on the specialist nurse tab (see below) on the left hand side of the record.



This will contain the information regarding the missing alert – advising of the professionals to contact e.g., police and social worker (contact details will be available).

ED /UCC staff are to contact the named professionals and advise of the missing person/family attendance, police and social care will then advise on next steps.

The child/family/pregnant woman/ are not to be made aware of the above actions [these individuals are deliberately avoiding Children's Social Care and may flee again if alerted and put their child[ren]/unborn child at further risk]

The Trust children safeguarding team should also be contacted. In hours they will support and advise. (it is important that the team are informed out of hours by leaving a message on the secure answerphone so that follow up can be undertaken the next working day.

A Missing Child/family/pregnant women presents elsewhere in the Trust

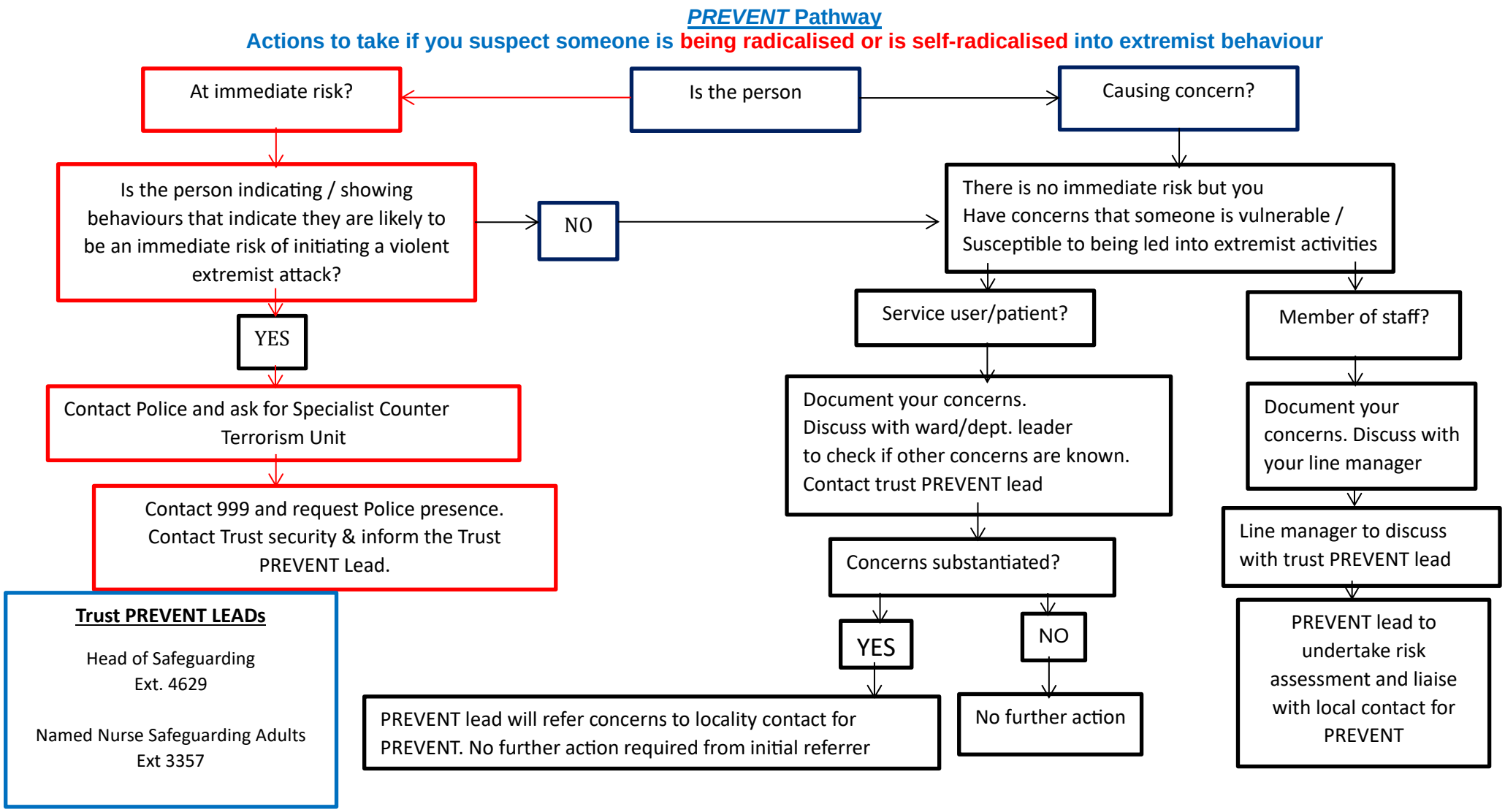
The RAPA alert is triggered – this alert will automatically trigger a notification to the safeguarding team who in hours will liaise with the relevant department where the missing person/child/family have presented to advise on next steps and will liaise directly with the relevant professionals.

The child/family/pregnant woman/ are not to be made aware of the above actions [these individuals are deliberately avoiding Children's Social Care and may flee again if alerted and put their child[ren]/unborn child at further risk]

"Missing Child Alerts" must be:

Removed from systems on the specified expiry date (usually 3 months after receipt of the alert) or when notification is given that the child or pregnant woman has been found. This will be undertaken by the Safeguarding team.

Appendix Five – *PREVENT* Flowchart



Appendix Six – Safeguarding Training

Safeguarding Children and Young People Level 3 Training Pathway

Level 3 Competency

Includes all clinical staff working with children, young people and/or their parents/carers and those who could potentially contribute to assessing, planning, intervening and evaluating the needs of children & young people or parenting capacity where there are safeguarding/child protection concerns

New Staff to SFHT

Follow the New starter pathway

Existing Staff Needing to Maintain Level 3 Competency

Think Family Safeguarding (level 2) E-Learning Package undertaken prior to commencement (HR send this our automatically for new starters to complete)

Safeguarding Think Family Induction session (Level 3) this is a 2 hour face to face (E-Learning for Medical staff) session included in the Trust wide induction programme.

Booked via HR on commencement to the Trust

NSCB: (Multi-agency) Working Together to Safeguard Children – Level 3

Book via the NSCB website

https://nscp.nottinghamshire.gov.uk/training/wtsclevel3-20july2022/

Level 3 Refresher Training

Competency gained through the Trust mandatory training programme – yearly.

This includes:

1 Hour Face to Face Think Family Safeguarding session

MCA E-Learning

PREVENT update – E-Learning

Other Level 3 Safeguarding Children Training Available

External Training - Other Safeguarding children level 3 training is available through the Nottinghamshire Safeguarding Children Partnership (NSCP). https://nscp.nottinghamshire.gov.uk/training/

This is free training for NHS staff with E-Learning and Face to Face sessions available.

You will need to register on the site to access training using SFH's unique code – this is available by contacting the Safeguarding team on ext 3357.

In House Seminars

Themed in-house seminars will be advertised as topics arise

Appendix Seven - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Equality Impact Assessment (EIA) Form (Please complete all sections)

EIA Form Stage One:

Name EIA Assessor: Liz Cudmore	**Date of EIA completion: 01/10/2025**
Department: Safeguarding	**Division:**
Name of service/policy/procedure being reviewed or created: Safeguarding Children and Young People Policy	
Name of person responsible for service/policy/procedure: Liz Cudmore	
Brief summary of policy, procedure or service being assessed: All children have an equitable right not to be abused, neglected or exploited and the right to have happy, healthy, safe lives. Sherwood Forest Hospitals NHS Trust, (SFH) is committed to safeguarding and promoting the welfare of all children and young people who have contact with the Trust. This statement also includes the 'unborn child' who, although not legally included within the definition of a child is firmly encompassed within safeguarding practice.	
Please state who this policy will affect: Patients or Service Users, Carers or families, Commissioned Services, Communities in placed based settings, Staff, Stakeholder organisations. **(Please delete as appropriate)**	

Protected Characteristic	**Considering data and supporting information, could protected characteristic groups' face negative impact, barriers, or discrimination? For example, are there any known health inequality or access issues to consider? (Yes or No)**	**Please describe what is contained within the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening.**

		Please also provide a brief summary of what data or supporting information was considered to measure/decipher any impact.
Race and Ethnicity	No	This policy replaces the previous Safeguarding Children and Young People Policy. A person-centred approach is promoted for safeguarding and this policy ensures that the child or vulnerable adult's emotional and physical wellbeing is prioritised. Quarterly EDI data is submitted to NHSEI through the data collections framework.
Sex	No	
Age	No	
Religion and Belief	No	
Disability	No	
Sexuality	No	
Pregnancy and Maternity	No	
Gender Reassignment	No	

Marriage and Civil Partnership	No	
Socio-Economic Factors (i.e. living in a poorer neighbour hood	No	

/ social deprivation)		

If you have answered 'yes' to any of the above, please complete Stage 2 of the EIA on Page 3 and 4.

What consultation with protected characteristic groups including patient groups have you carried out?

This policy acknowledges the needs of patients that require care from an acute perspective. To ensure that it is complaint with all legislation it has been shared with senior medical/nursing and safeguarding colleagues for consultation and feedback to ensure that it effectively meets the needs of all staff and patients.

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

Nil

On the basis of the information/evidence/consideration so far, do you believe that the policy / practice / service / other will have a positive or negative adverse impact on equality? (delete as appropriate)

Positive						
High						

If you identified positive impact, please outline the details here:

No negative impacts identified, and this policy promotes good practise around all equality aspects. Only positive impacts identified. No requirement for stage 2 EIA

Protected Characteristic	**Please explain, using examples of evidence and data, what the impact of the Policy, Procedure or Service/Clinical Guideline will be on the protected characteristic group.**	**Please outline any further actions to be taken to address and mitigate or remove any in barriers that have been identified.**
Race and Ethnicity		
Gender		
Age		
Religion		
Disability		
Sexuality		
Pregnancy and Maternity		
Gender Reassignment		
Marriage and Civil Partnership		

EIA Form Stage Two:		
living in a poorer neighbourhood / social deprivation)		

Signature: 

I can confirm I have read the Trust's Guidance document on Equality Impact Assessments prior to completing this form

Date: 01/10/2025