United Lincolnshire Teaching Hospitals NHS Trust

Safeguarding Children and Young People Trust Wide Policy

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Version History Log

Version	Date Published	Details of key changes
V8.0	May 2018	Minor amendments to contact details for HV/SN; minor amendments to Appendix 1a (removal of PLN service);

		removal of FME section. Additional clarity re. DNA/WNB procedure with minor amendments to Pathway at Appendix 3. No significant change to existing procedures.
V9.0	November 2020	Updates to references, external links and process templates; inclusion of recently-introduced multi-Agency processes (e.g. CP-IS; Op Insignia, etc.) and updates to existing multi-Agency processes; amendments to referral process and pathway; updates to all appendices.
V10.0	August 2025	Updates to references, legislative processes, external links, internal pathways and existing multi-Agency processes. Amendments to referral process and pathway; amendments to WNB pathway and all other appendices (logos, links, etc.). Removal of some appendices – replaced with embedded links.

Contents

Equality, Diversity and Inclusion

Corporate Policy Statement

The United Lincolnshire Hospitals NHS Trust is committed to promoting equality and diversity in all its activities to promote inclusive services, processes, practices and culture. This commitment is articulated in our equality objectives for 2022-2025 Our equality objectives - United Lincolnshire Hospitals (ulh.nhs.uk)

This policy reflects the Trust vision, values and behaviours and supports employees in working for the benefit of patient care. It takes account of the provisions outlined in the Equality Act 2010 to ensure no individual receives less favourable treatment on the grounds of age, disability, sex, race, gender reassignment, sexual orientation, religion and belief, marriage/civil partnership and pregnancy/maternity.

Alongside being committed to a proactive delivery of the Equality Act 2010, the Trust proudly seeks to embody the duties of the Public Sector Equality Duty (2011) in all its activity by:

1) Eliminating unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
2) Advancing equality of opportunity between people who share a protected characteristic and those who do not.
3) Fostering good relations between people who share a protected characteristic and those who do not.

We recognise high quality NHS patient care benefits by having a diverse community of staff who value one another and realise the contribution they can make to achieving Outstanding Care, Personally Delivered.

Summary

Policy to support staff in discharging their safeguarding responsibilities in relation to children and young people under the age of 18 years.

1. Introduction

1.1. Legislation and Statutory Guidance make clear the expectation that Safeguarding Children is "everyone's business"; no longer can it be assumed that this is a role for Practitioners working within Children's services. The Children's Act (HMSO 1989 and HMSO 2004) and Working Together to Safeguard Children (HM Government, 2023) clearly define the roles and responsibilities for Health Organisations in Safeguarding and promoting the welfare of children.

1.2. United Lincolnshire Teaching Hospitals Trust (ULTH) is committed to Safeguarding and promoting the welfare of children and young people, both as service users and visitors to Trust premises. ULTH also acknowledge the importance of working with partner Agencies to ensure that children have safe, healthy and happy childhoods, with the necessary support which will help them to prepare for adult life.

1.3. All Health Professionals working directly with children and young people should ensure that Safeguarding and promoting their welfare forms an integral part of all elements of the care they offer. Other Health Professionals who come into contact with children, parents and carers in the course of their work also need to be fully informed about their responsibility to Safeguard and promote the welfare of children and young people. This is important as even though a Health Professional may not be working directly with a child, they may be seeing their parent, carer or other significant adult and have knowledge which is relevant to a child's safety and welfare (SCIE, 2012). The National Institute for Health and Clinical Excellence (NICE 2009) clinical guideline When to Suspect Child Maltreatment is a resource to help Healthcare Practitioners who are not specialists in Child Protection.

1.4. All staff within ULTH, including Locum, Agency, Voluntary and those in contracted services, should receive Safeguarding Children training as part of their essential training requirements, which will aid the identification of potential indicators of abuse and neglect and provide guidance regarding actions to be taken, in line with Organisational, Local and National policy and procedure. All Healthcare staff should attend Safeguarding Children training appropriate to their role, in line with guidance within the intercollegiate document (RCPCH, 2019). Safeguarding Children training requirements are clearly defined within the ULTH Safeguarding Children Training Plan (Safeguarding Children Training Plan.pdf).

2. Purpose

The purpose of this document is to provide all staff, volunteers, students and contractors employed by United Lincolnshire Teaching Hospitals NHS Trust with

guidance regarding their duty to Safeguard children in accordance with The Children's Act (1989 and 2004) and Working Together to Safeguard Children (HM Government, 2023). This policy will define the expected standard of practice as agreed by United Lincolnshire Teaching Hospitals NHS Trust, Lincolnshire Safeguarding Children Partnership and NHS England (2024)

3. Context

This Policy aims to support staff to undertake their safeguarding responsibilities; to comply with Organisational requirements under section 11 of the Children Act and to comply with contractual arrangements.

4. Objectives

4.1. To ensure that all staff, including Agency, Locum, volunteers, students and contracted staff, are aware of their roles and responsibilities in Safeguarding and promoting the welfare of children and young people.

4.2. To provide an awareness of the arrangements in place to safeguard and promote the welfare of children and young people within Lincolnshire.

4.3. To provide a structured approach to the development of local Safeguarding Children procedures and to promote good practice.

4.4. To ensure that a clear standardised approach, where concerns exist regarding the welfare of a child or young person, is in operation within United Lincolnshire Teaching Hospitals NHS Trust; ensuring that lines of accountability are upheld.

5. Scope

5.1. This policy applies to all staff employed; either paid, temporary, voluntary or contracted by United Lincolnshire Teaching Hospitals NHS Trust; including Non-executive Directors and Governors. Student Practitioners should also be supported in accessing this Policy and following the processes within.

5.2. This Policy should be used in conjunction with the resources and additional guidance available on the Safeguarding Children & Young People pages of the Intranet.

6. Compliance

This policy complies with the legislation, standards, guidelines, codes of conduct, and any other relevant document listed in the Referenced Documents' section.

7. Responsibilities

7.1. Trust Responsibilities

7.1.1. The Chief Nurse Board Level responsibility for Safeguarding Children and Chairs the Trust's Safeguarding And Vulnerabilities Group. The Chief Nurse is supported by the Director for Safeguarding and Patient Experience.

7.1.2. The Trust will provide a Named Nurse, Named Midwife and Named Doctor for Safeguarding Children and Young People. These Practitioners will form part of the Safeguarding Team and will carry out their duties in accordance with Statutory Guidance and work in partnership with the Local Safeguarding Children Partnership.

7.1.3. The Named Nurse for Safeguarding Children and Young People will monitor the safeguarding activity that is brought to the Trust's attention via Trust staff, such as referrals to Children's Social Care, reported incidents (IR1), Significant Incidents and Child Safeguarding Practice Reviews (CSPRs). The Named Nurse reports to the Director of Safeguarding and Patient Experience.

7.1.4. All staff who, in the course of their work, are likely to come into contact with children and/or their families will have access to the appropriate level of training as identified within the Safeguarding Children Training Plan and where appropriate, effective methods of clinical and safeguarding supervision. The Supervision Policy can be located here.

7.1.5. All staff will undertake the relevant Disclosure and Barring Service (DBS) checks prior to commencing employment with the organisation, in line with Recommendation 19 of the Safeguarding Vulnerable Groups Act (HMSO, 2006).

7.2. **Managerial Responsibilities**

7.2.1. All new staff members will be made aware of the mandatory Safeguarding training need as part of the induction process.

7.2.2. All new staff members will complete the relevant Module of the Mandatory Training programme within 3 months of commencing employment.

7.2.3. All staff will undertake the relevant mandatory Safeguarding Children training, dictated by the extent to which they work with children and families, as per the Safeguarding Children Training Plan.

7.2.4. Managers should ensure that the relevant DBS checks and references have been received prior to new employees starting employment.

7.2.5. Additional support should be provided to staff working with complex families or where concerns regarding the welfare of children exist. This should be facilitated through individual Line Managers. Safeguarding Children Supervision is available to all Trust staff, as required. The Trust's Safeguarding Children Supervision Policy offers information in relation to the models of support available.

7.2.6. Line Managers will have oversight of all Safeguarding cases identified within their clinical areas. They will support their staff in relation to routine procedures and will also ensure that their staff members have notified the Trust's Safeguarding Children and Young People team of:

- All referrals to Children's Social Care
- All child deaths (up to the age of 18 years) – alongside completion of local Child Death processes.
- IR1s or SIs pertaining to child Safeguarding issues; and
- Any child, whether or not they are in receipt of services from the Trust, or closely connected to a service user, that is subject to a Child Protection/Child in Need plan.
- The Named Nurse for Safeguarding Children and Young People should also be notified of the involvement of any staff member in any Court Case regarding harm to a child.
    - Clinical areas should identify a 'Champion' for Safeguarding who will be given the opportunity to develop an advanced level of knowledge regarding Safeguarding Children issues. The 'Champion' will receive support/guidance from the Safeguarding Professionals as appropriate and should be allocated protected time to disseminate the Newsletters and other information shared with them by the Safeguarding Team and to facilitate their attendance at regular SG Champions' meetings/events, accordingly.
    - Line Managers will ensure that the essential documentation relating to Safeguarding children is completed, by their staff members, in line with this Policy.
- **Responsibilities of Trust Employees**
    - Trust staff will **ALWAYS** act in the best interests of the child and work to safeguard and promote the wellbeing of children and their families.
    - Staff should exercise professional curiosity, asking probing questions, to ensure they are in receipt of all relevant information required to facilitate safe care and a safe discharge for the child/parent/carer. Staff members should also document details (name/relationship) of people accompanying/visiting a child or young person.
    - Trust Staff will ensure that they have a sound working knowledge of the Local Safeguarding Children Partnership Child Protection Procedures and the Trust Policies for Safeguarding Children,

proportionate to their role. The LSCP Policy and Procedures Manual provides guidance to practitioners on handling specific cases.

- It is the responsibility of individual Practitioners/Health Professionals to refer concerns regarding the welfare of a child to the relevant Local Authority Children's Social Care and/or Partner Agencies, as required. Unless unavoidable, this duty should not be delegated to another staff member. Where a referral to Children's Social Care has been made, either for a child in need of protection or in need of additional services, the referrer should assure themselves that an appropriate outcome has been achieved. A copy of the referral form should be sent to the Safeguarding Children Team. If the referrer considers the outcome of their referral to be unsatisfactory, the LSCP's Professional Resolution and Escalation Protocol is to be implemented (see Appendix 2 for ULTH contacts).
- Trust staff will ensure that the relevant documentation is completed in line with Trust policy and professionals Codes of Practice, maintaining contemporaneous, legible and accurate written records. Documentation relating to all discussions, copies of all assessments and/or referrals forms should be filed behind a red Safeguarding divider within the child/young person's records.
- Trust Staff must discuss concerns regarding the welfare of a child with their Line Manager/Matron who can support initially and may then advise contacting a member of the Safeguarding Children and Young People team for specialist advice, support and guidance. Trust Clinical Site Managers (CSMs) and Social Care's Emergency Duty Team (EDT) can be contacted out of office hours. A timely discussion with the relevant Professionals, i.e. Health Visitor, Midwife, Social Worker, Child and Young Person's Nurse (formerly School Nurses) or any other Professional involved with the child, is also required where concerns exist regarding the welfare of a child; whether within normal working hours or out of hours. CYP (School) Nurses/Health Visitors operate a 24hour Single Point of Contact voicemail service to enable messages to be left regarding a child's attendance, if concerns arose during the child's attendance.

- Trust Staff should ensure that they are fully conversant with all other relevant Safeguarding Policies.
- Trust Staff should consider the needs of service users as parents or carers and work pro-actively to provide additional support to families to ensure their right to family life (Article 8 UN Convention on Human Rights, 1998). The needs of children within the family must be considered and appropriate referrals to Partner Agencies made where necessary. It should be documented on admission whether the patient has children and whether these children have caring responsibilities (SCIE, 2012).
- Trust Staff should ensure that any action taken by other agencies to Safeguard and promote the well-being of children and their families is deemed to be satisfactory. It is the responsibility of Trust Staff to demonstrate a degree of professional curiosity by challenging actions or decisions made, when such actions or decisions are considered to not be in the best interests of the child. Support can be sought from the Safeguarding Professionals, where necessary. The LSCP's Professional Resolution and Escalation Protocol will also support staff to respectfully challenge decision making where necessary (see at Appendix 2 also).
- There are a variety of ways in which staff may be involved in activity to safeguard and promote the wellbeing of children, these are:
    - Being alert and identifying children who are suffering or who are at risk of suffering significant harm, including; Child Exploitation; Human Trafficking/Modern Slavery; Domestic Abuse; Female Genital Mutilation (FGM) and Forced Marriage.
    - Making referrals to Children's Social Care (see Appendix 3) if a child is in need of support or protection from physical, emotional or sexual harm.
    - Identifying and managing concerns relating to arising or long-term neglect in line LSCP Processes; including producing a chronology of concerns to support in evidencing long-term neglect and/or escalation in concerns.
    - Contributing to Section 47 enquiries (Children Act 1989), Child Protection

Conferences, Reviews, TACs (Team Around the Child) and Core Groups

- Providing information for other Agencies and Courts where relevant. Please see the Trust's Guidance for Supporting Staff members appearing in Court as a Witness or Writing Statements for Children's Court/Care Proceedings for further guidance.
- Treating children who are being, or have been abused or neglected
- Supporting parents to ensure their children grow up in circumstances consistent with safe and effective care.
- Advising parents/other Agencies regarding the impact of physical and mental health related problems, learning disabilities, domestic abuse or problematic substance/alcohol use.
- Unborn children – including the initiation of the Pre-Birth Protocol
- Identifying children and young people who may be acting as a 'young carer' and providing support for those who undertake this role. There may be occasions where children and young people are inappropriately functioning within this role and may need action to safeguard them, either via an Early Help Assessment or via a Safeguarding Referral.
- Contributing to multi-agency assessments of children and their families
- Initiating or supporting the completion of the Early Help Assessment
- Liaising with other services for children who have had adverse childhood experiences/traumatic events and are in need of additional trauma informed support or trauma-informed practices so as not to further negatively impact on their emotional wellbeing.
- Participating in parenting assessments
- Continually adopting a Think Family approach and recognising the benefits of considering the needs of the whole family.

Further information relating to the 'Think Family' concept can be found by accessing the link below and scrolling to the bottom of.

- **Responsibilities of the Named Professionals**
    - The Named Professionals will act in accordance with the roles and competencies laid out within Working Together to Safeguard Children 2023: Statutory Guidance (HM Gov., 2023), the Local Safeguarding Children Partnership and Intercollegiate Competencies (RCPCH 2019).
    - The Divisional Safeguarding Leads (with support from the Named Professionals) will be responsible for monitoring the safeguarding children activity within the Trust and will report to the Trust-wide Divisional Safeguarding Operational meetings, providing assurance that any themes or issues have been addressed and learning disseminated.
    - The Named Professionals will provide specialist advice, support and guidance and, where necessary, Safeguarding Training and Safeguarding Children Supervision. **This does not absolve individual practitioners of their Professional accountability and duties.**
    - The Designated Professionals provide support and guidance to Named Professionals and the wider Safeguarding community regarding strategic responsibilities and complex cases.
- **Responsibilities of healthcare staff within Urgent Care and Paediatric settings**
    - Staff working in Urgent Care and Paediatric settings should be able to recognise abuse or neglect and have a thorough knowledge of local procedures for making enquiries to find out whether a child is the subject of a Child Protection/Child in Need Plan, or is a Child in Care/Child Looked After (LAC). Where children and young people are known to have Social Care involvement, liaison should be undertaken with their allocated Social Worker (EDT out of hours) to share information about the attendance.
    - Consideration should also always be given to issues related to, and indicative of, Domestic Abuse, Child Exploitation, Missing persons, Trafficking/Modern Slavery; and those children attending under the influence of drugs and/or

alcohol or due to self-harm and/or suicidal ideation; with the relevant action taken accordingly. Support can be obtained from the Safeguarding Children Intranet site or the Safeguarding Children Team, where required.

- With the increase in national and local incidents of Child Exploitation, it is imperative that staff members have an awareness of how to recognise potential/current victims of this form of abuse. The LSCP has taken a proactive approach to dealing with issues involving the exploitation of children and young people and supportive advice and risk assessment tools/guidance can be found here and advice re. completion of the assessments can also sought from the Safeguarding Children team. Consideration should also be given to the need for onward referrals to Social Care, Police and Drug/Alcohol support services (e.g. Horizon | Lincolnshire). Advice and guidance is also available to support in situations when there is concern that a child/young person may have been trafficked.
- Staff in urgent care settings should also be alert to the need to Safeguard the welfare of children when treating parents or carers of children, and be alert to parents and carers who seek medical care from a number of sources in order to conceal the repeated nature of a child's injuries. Specialist Paediatric advice should be available at all times to ED departments and all units where children receive care, and should be sought where appropriate.
- Repeated attendances to ED should be explored to identify the cause for such attendances. Details of repeated attendances should be relayed to the child's Health Visitor/Children and Young People Nurse (CYPN/School Nurse) if the child is open to the CYPN service. If a child, or children from the same household, presents repeatedly, even with slight injuries, in a way that Doctors, Nurses or other staff find worrying, they should act upon their concerns. Children and families should be actively and appropriately involved in these processes, unless this could result in an increased risk of harm to the child. Children attending due to intoxication (drugs, alcohol, non-psychoactive substances (NPS) should be referred to the relevant Agency for support (e.g. Horizon | Lincolnshire). This action would be required in addition to any relevant

Safeguarding action. Advice can be sought from the Safeguarding Children Team, if required.

- Staff should exercise Professional Curiosity, using probing questions to ensure they are in receipt of all relevant information to facilitate an appropriate diagnosis, provide safe care and support a safe discharge for the child/parent/carer. Staff members should also document details (name/relationship) of people accompanying visiting a child or young person to hospital.
- Staff should be mindful of children attending with injuries (e.g. bruising in babies and children who are not independently mobile) and it should be clearly documented whether staff members are satisfied that the mechanism of injury is appropriate for the circumstances under which the child presents (including stage of development and explanation given by parent/carer). Relevant action should be taken should concerns arise. In terms of developmental stages and milestones achieved, documentation should differentiate between parental reports and achievements witnessed by professionals.
- Use of the Safeguarding 'prompt' stickers is required, as per agreement. Discharge letters (to GP) should clearly and comprehensively identify any safeguarding concerns raised and subsequent action taken.
- If a parent/carer removes a child from the Department against the advice of medical staff, immediate advice should be sought as a Police/Social Care referral notification may be warranted (RCPCH, 2018) (see Appendix 3).

- **Responsibilities of Paediatricians**
  - Paediatricians, wherever they work, will come into contact with child abuse or neglect in the course of their work. All Paediatricians need to maintain their skills in the recognition of abuse, and be familiar with the procedures to be followed if abuse or neglect is suspected. Consultant Paediatricians, in particular, may be involved in difficult diagnostic situations; differentiating those abnormalities which may have been caused by abuse from those that have a medical cause. In their contacts with children and families, they should be sensitive to clues suggesting the need for additional support, enquiries or investigations and initiate a Social

Care Referral, or consider the need for an Early Help Assessment, accordingly.

- Where Paediatricians undertake Child Protection Medical Examinations, they must ensure they are competent to do so and that appropriate consent has been obtained. All documentation to support the medical findings should be completed and filed appropriately.
- Where Paediatricians are required to provide reports for child Protection Investigations, Civil and Criminal proceedings, and to appear as witnesses to give oral evidence, the use of Body Maps and photographic images is encouraged to accurately identify visible injuries. Paediatricians must always act in accordance with guidance from the General Medical Council (GMC) and Royal College of Paediatrics and Child Health (RCPCH).
- Staff should exercise Professional Curiosity, using probing questions to ensure they are in receipt of all relevant information required to facilitate an appropriate diagnosis, safe care and a safe discharge for the child/parent/carer. The names and relationships of all accompanying adults should also be recorded.

8. Definitions

8.1. **Child Protection**: the process of protecting individual children identified as either suffering, or at risk of suffering, significant harm as a result of abuse and neglect (Children Act 1989, 1994 and Working Together to Safeguard Children, 2023).

8.2. **Safeguarding and Promoting the Welfare of Children**: the process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care which is undertaken so as to enable children to have optimum life chances and enter adulthood successfully (Working Together to Safeguard Children, 2023).

8.3. **Significant Harm**: introduced by the Children's Act (1989), there is no absolute criterion for judging what constitutes significant harm. However, consideration of the severity of ill-treatment may include; the degree and the extent of physical harm, the duration and frequency of abuse or neglect, the extent of premeditation and the presence or degree of threat, coercion, sadism and bizarre or unusual elements. It may constitute a single traumatic event, or a compilation of significant events, which interrupt, change or damage the child's physical or psychological development (Working Together to Safeguard Children, 2023).

8.4. **Child Exploitation (CE):** the exploitation of children (under 18 years) can take the form of sexual, criminal or financial abuse and involves exploitative situations, contexts and relationships where young people (or a third person(s)) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them sexual acts or acts connected to criminality (e.g. County Lines – using children and young people in the supply and transportation of drugs). Sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the internet/mobile phones, without immediate payment or gain. In all cases, those exploiting the child/young person have power over them, by virtue of their age, gender, intellect, physical strength and/or economic resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child/young person's limited availability of choice resulting from their social, economic and/or emotional vulnerability.

8.5. **Early Help Assessment (EHA)**: the aim is to identify, at the earliest opportunity, 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. The EHA is:

- A process for undertaking an assessment to help Practitioners gather and understand information about the needs and strengths of the child, based on discussions with the child, their family and other practitioners as appropriate, using a standard form to help Practitioners record, and, where appropriate, share with others the findings from the assessment in terms that are helpful in working with the family to find a response to unmet needs.

8.6. **A Team Around the Child (TAC)** may be initiated when there is concern that a child will not progress towards positive outcomes without additional services and 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 Assessment would help identify the needs, and assist in obtaining services to support the family.*

An Early Help Assessment is not indicated if a child is progressing well, nor has needs that have already been identified that can be met by the service.

If you are worried that a child is suffering, or is at risk of suffering significant harm, you should follow ULTH and/or the Lincolnshire Safeguarding Children Partnership Child Protection Procedures without delay. You should not stop to complete an Early Help Assessment. Contact your Safeguarding & Vulnerabilities Team.

8.7. **The Assessment Framework**: developed by the DOH in Framework for the assessment of children in need and their families (2000) as a multi-Agency 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 (or regular care giver) capacity to meet the needs of the child*
  - *Impact of the wider family and environmental factors on both parenting capacity and the child's development.*
- Staff should refer to this assessment tool when:
  - *Making referrals to Children's Services*
  - *Compiling reports for Child Protection conferences/core groups/multi-agency meetings etc*
  - *Contributing to a TAC (Team Around the Child).*
- Support from the Safeguarding Children and Young People team is available should staff need further guidance regarding the utilisation of this assessment tool.

8.8. Social Care currently utilise the Signs of Safety assessment tool. This tool aims to identify family strengths as well as family need, in order to ensure the safety of children.

8.9. Thresholds for Social Care intervention (e.g. TAC, Child in Need, Child Protection/Significant Harm) are clearly defined within the multi-Agency Thresholds document (Thresholds (8).pdf). This document provides useful information to aid a referral and to assist in escalating concerns should Professionals consider the outcome for the child to be unsatisfactory.

9. Associated Documentation

This section should be used in conjunction with the other Policies, processes and guidance documents hyperlinked throughout.

10. Children and Young People as Service Users

10.1. Children and Young People's services should adopt a child and young person centred culture, putting the child, young people and their families at the heart of actions, whilst operating in suitable environments that are safe and minimise the risks to the young people who utilise Trust services. Children and Young People should be in control of their own health and well-being. It is essential that the voice and opinions of the child are sought and heard in conjunction with the views of their family/carer. Clear documentation should evidence such views and demonstrate whether appropriate consideration was given and relevant action taken in relation

to their views. The Division will be responsible for ensuring that there are appropriate and up to date operational procedures available for all staff.

10.2. It is essential that the voice and opinions of the child are sought and heard in conjunction with the views of their family/carer. Clear documentation should evidence such views and demonstrate whether appropriate consideration was given and relevant action taken in relation to their views. The Division will be responsible for ensuring that there are appropriate and up to date operational procedures available for all staff.

10.3. **Consent**

- Patients aged over 16 years, cared for in Adult clinical areas, would be subject to Children's Safeguarding procedures, should any concerns arise. Staff must also be cognisant of the need to adhere to Mental Capacity Act procedures when assessing capacity to consent to care or treatment.
- Consent for children under 16 years could be provided by a parent/carer with Parental Responsibility for the child/young person. Young people can also consent for their own care and treatment if deemed to be Gillick/Fraser competent. Patients under the age of 18 years also have the right to confidentiality if they are considered competent.
- Further guidance regarding Consent can be found at Appendix 4.

11. Children Connected to Service Users

11.1. All staff who work with service users are obliged to consider the potential effects that parental (or carer/family) illness/behaviour may have on children (SCIE, 2012).

11.2. The following points may impact negatively upon the Parent's/Carer's ability to meet the needs of children for whom they provide care or with whom they have significant contact:

- Problematic and chaotic substance/alcohol misuse
- Non-attendance and disengagement
- Complex physical and Mental Health needs; including poor compliance, unstable Mental Health, symptomology, effects of prescribed medication, etc.
- Adverse childhood experiences
- Learning Disability
- Aggression/violence (including Domestic Abuse)
- Self-neglect/poor motivation
- Dangerous persons/Adults who may pose a risk to children
- Chaotic family environments/family dynamics

- Parents/Carers who are receiving end of life care or present in a critical condition and are unlikely to survive.

11.3. Consideration must be given to the need for information sharing/referral to other Agencies (including Social Care) if the needs of the adult/parent/sibling are perceived to be having a negative impact upon the child or young person or if there are concerns about the appropriateness of a 'young carer' role.

11.4. If the Parent/Carer/Young Person's first language it not English, other Children and young people within the family should not be used as interpreters. For further information regarding access to Interpretation Services, consult the Trust's Translation and Interpretation Policy.

12. Young Carers

Routine questioning as to whether Service Users, including children and young people have parent or carer responsibilities, should become common practice. Consideration should be given to whether the individual needs of the adult service user places a child at risk of significant harm or whether the expectations placed upon young carers are appropriate.

12.1. Where it is identified that a child or young person may be at risk of significant harm, or is being inappropriately supported as a young carer, a referral to Local Authority Children's Social Care may be required.

12.2. Where it is identified that a child or young person is undertaking caring responsibilities, but not deemed to be at risk of significant harm, a discussion with the young carer and their family should occur regarding any support that is required and a referral to a Young Carers service offered. Liaison with/referral to the CYP (School) Nurse should also be undertaken and an Early Help Assessment should be completed to facilitate the initiation of a TAC (Team around the Child).

12.3. Children and young people who identify themselves as young carers should remain involved in the care of their parent/relative and communication maintained, as appropriate. Children or young people who are caring for an adult/parent/sibling are likely to require emotional support as well as practical help.

13. Pregnant Women and Expectant Partners

13.1. Trust Services that provide direct specialised care for pregnant women and young people will ensure that safeguarding children is an integral part of operational procedures.

13.2. Trust staff should consider the needs of pregnant service users, expectant partners or other service users who are in close contact with a pregnant woman.

13.3. The holistic needs of pregnant women and their unborn children should be considered at the earliest opportunity, irrespective of whether there are obvious concerns regarding the welfare of an existing or unborn child.

Liaison with relevant Agencies already involved with the pregnant woman or young person should also be undertaken, where required.

13.4. A multi-agency Pre-Birth Protocol is available to facilitate early recognition of the needs of the unborn and, hence, appropriate early intervention.

13.5. The Pre-Birth Protocol should be initiated whenever antenatal concerns arise (or were evident in a previous pregnancy). Relevant factors (this list should not be considered exhaustive) may include:

- Concerns regarding the parent/carers ability to provide adequate levels of self-care and care for a child/unborn child – e.g. failure to access medical advice and services, neglect, Learning Disability
- Disclosure of Domestic Abuse, Sexual Abuse or Sexual Exploitation
- Sibling previously removed from care of parent/carer/partner
- Sibling subject to Child Protection Plan/Child in Need Plan/Team Around the Child
- A parent/carer known to have committed an offence against a child/known to pose a risk to children
- Previous unexplained death of a child whilst in the care of parent/carer
- Parental mental ill health/substance misuse may significantly impact on the safety, health and development of the baby.
- Concerns regarding the baby being at risk of significant harm - e.g. fabricated or induced illness, violence and aggression
- Late bookings or concealed/denied pregnancy
- Teenage pregnancy; young parent or Child Looked After (LAC)/Care Leaver.

13.6. Consideration must also be given to any risks posed by a mentally ill, substance misusing, or domestically abusive partner to a new baby and/or the mother and the impact that the birth may have on their well-being and family dynamics. The Pre-Birth Protocol should be initiated accordingly (see Paragraph 12.4). A number of Maternity Guidelines relating to Safeguarding issues are available.

14. Domestic Abuse, Female Genital Mutilation, Honour-Based Violence and Forced Marriage

Domestic Abuse

14.1. Domestic Abuse definition (HM Government, 2021): The Act defines domestic abuse as abusive behaviour by a person towards another person who is personally connected to them, such as a spouse, partner, relative or parent. It also lists the types of abusive behaviour, such as physical, sexual, controlling or economic abuse. The definition of

Domestic Abuse includes so-called “Honour”-based violence; Forced Marriage and FGM.

14.2. The Domestic Abuse Act, 2021 reinforces the serious impact on children and young people’s emotional wellbeing and development of prolonged and/or regular exposure to domestic abuse, despite the best efforts of the victim parent to protect the child. As such, the Act ensures that children/young people are seen as victims of domestic abuse in their own right.

14.3. Following any disclosure of domestic abuse from a parent/carer of a child/young person, or from the young person themselves (if in an abusive relationship), Trust clinical staff should refer to the Trust’s Policy and Procedure for the Prevention and Management of Domestic Abuse.

14.4. Any cases (regardless of risk assessment outcome) involving Honour-based Violence (HBV), Female Genital Mutilation or Forced Marriage in children under the age of 18 years should immediately be escalated to the Named Safeguarding Professionals.

14.5. Where there is evidence/concern regarding domestic abuse, the use of Professional Curiosity is essential in assessing the current risk to such children. Parents/carers may underestimate the impact of Domestic Abuse on their children/vulnerable dependents, believing them to the unaware of the situation. It is important to ascertain whether the parent/carer has an understanding of the impact the Domestic Abuse could have on their children and whether they are implementing any protective factors.

14.6. Practitioners who are aware of a child living within a domestically abusive household have a responsibility to make a children’s safeguarding referral to the Local Authority Children’s Social Care team, as such children would be deemed at risk of emotional harm and, potentially at risk of physical harm. Vulnerable adults living in similar circumstances should be referred to Adults Social Care following liaison with the Trust’s Safeguarding Adults team.

14.7. Further advice, resources and guidance can be sought from the Domestic Abuse pages within the Safeguarding Hub on the intranet, via the Safeguarding Children and Young People team, or via the Professionals’ area of the Lincolnshire Domestic Abuse Specialist Support Services (LDASS).

Female Genital Mutilation (FGM)

14.8. FGM comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. It has no health benefits and harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue and hence interferes with the natural function of girls’ and women’s bodies. The practice causes severe pain and has several immediate and long-term consequences, including difficulties in childbirth also causing danger to the child. FGM is illegal in the UK.

14.9. The Trust is required to provide monthly figures to the Home Office, relating to the identification of any patients who have undergone FGM (either historical or recent cases). As a result, staff are required to report any cases of FGM (including genital piercings) to the Safeguarding Team, and to also consider whether there is a need for a Social Care Safeguarding Referral to be made (the Safeguarding Team can assist/advise, as necessary).

14.10. Since October 2015, there has also been a mandatory requirement for staff to report, to the Police, any case of FGM identified in a girl/young person under the age of 18 years. As a result, if a female patient (under the age of 18 years) discloses that she has been subject to FGM, or shows signs which appear to suggest FGM has been undertaken, the Police should be contacted (via their non-emergency advice line – 101). Further guidance can be found on the Domestic Abuse/FGM pages of the Intranet. The SG Team should also be informed and standard Safeguarding Processes initiated.

15. Missing / Mobile Families

15.1. There may be occasions where a child/children or family (including unborn babies) have disappeared from a known address and there may be concerns of significant harm for the children in respect of unmet need, vulnerability or abuse. When there are reasons to believe that a family is missing, health staff are expected to take all reasonable and practical steps to locate the family. This may involve contacting or talking to neighbours, friends, family members or other Health Professionals and investigate IT systems available in health, in accordance with NHS England Safeguarding/Organisational Alerts processes.

15.2. On all occasions the Named Nurse/Midwife for ULTH must be consulted and advice will be provided regarding the circulation of alerts within their locality areas.

15.3. In cases where it is believed that the family has moved out of the area or overseas, liaison should be undertaken in line with LSCP's Transient Families Guidance.

15.4. If a child/family, who was known to be missing, attends one of our hospitals, contact should be made with the professionals detailed within the Alert to inform them of the child/family's current whereabouts. Incoming Missing Alerts are received and circulated by the Named Nurse for Safeguarding Children and Young People, to the relevant departments and an Alert placed on CareFlow, if previously known to ULTH.

16. Privately Fostered Children

16.1. Privately Fostered children and young people are those up to the age of 16 (or disabled children up to the age of 18) who are looked after full time for more than 27 days by someone who is not their parent, grandparent,

aunt, uncle, sister or brother, and who has not been given Parental Responsibility by the Court.

16.2. If Professionals become aware of a child/adult involved in a Private Fostering arrangement, notification to Children's Social Care should be made, to enable the relevant Social Care assessments to be undertaken.

17. Section 85 Children Act Notifications

17.1. When a child or young person has been in hospital for a period of three consecutive months, or is expected to be in hospital for such a period, the Trust ('accommodating authority') is obliged to inform the Local Authority Children's Services ('responsible authority') of this fact under Section 85 of Children Act (1989). This is to enable the responsible authority to:

- Take such steps as are reasonably practicable to enable them to determine whether the child's welfare is adequately safeguarded and promoted whilst he is accommodated by the accommodating authority **and**
- Consider the extent to which (if at all) they should exercise any of their functions under the Children Act with respect to the child.

17.2. Please see the Trust's Section 85 Children Act Notification Policy for further guidance.

18. Fabricated and Induced Illness (FII) or Perplexing Presentation

18.1. Fabrication or induction of illness in children is considered to fall under the category of Physical Abuse. Where concerns exist, it requires Professionals (across Health, Social Care, Education and the Police, etc.) to work together to ensure careful management of the case in question.

18.2. National Guidance to support the management of Fabricated or Induced Illness (FII) in children is available to assist Professionals in appropriately dealing with suspected cases (RCPCH, 2021), whilst the LSCP Guidance provides information regarding our locally agreed processes.

18.3. If FII/PP is suspected, please contact the Trust's Safeguarding Team. We would also advise that you commence a Chronology of significant events. In line with local guidance, please DO NOT inform the parents/carers of your concerns until further advice has been sought.

19. Making a Referral to Children's Social Care

19.1. The Trust wide Referral Protocol (see Appendix 3) outlines the line of accountability for Safeguarding issues and makes clear identified personnel to whom they can report concerns and who are appropriately skilled to advise on concerns should staff members be worried about a child's welfare.

19.2. Where staff members are unable to contact the Trust's Safeguarding Children and Young People team, or the inquiry is outside working hours,

advice can be sought internally via the on-call Clinical Site Managers (as per Escalation Procedure – see Appendix 2). In addition, an SBAR communication sheet (Appendix 5) can be used to communicate information to the Safeguarding Team or request non-urgent advice) – this can also be filed in the child/young person's record (behind the red Safeguarding divider) to evidence liaison and assist in summarising concerns. The Safeguarding Team will then respond, in line with need. **Completion of the SBAR form does not constitute a Social Care referral.**

19.3. To make a safeguarding referral for a child or young person (under the age of 18 years) - Trust staff should telephone their referral through to Social Care (Daytime - **01522 782111**; Out of Hours - **01522 782333**) and follow the referral up in writing by completing the online referral form within 24 hours.

19.4. A PDF copy of your referral form will be returned to you – this can then be filed in the child/young person's records behind a red Safeguarding divider and a copy should also be sent to the Safeguarding Team. It is important that any other Professional/Agency (i.e. Health Visitor/School Nurse/CCN) involved in the child's care is informed, in a timely manner, of any Referral made to Children's Services. An Alert should also be placed on the Child's CareFlow record (as per Section 25).

19.5. In the event that a difference of opinion occurs between Local Authority Children's Social Care (or any other Agency) and the referrer, staff should consult the LSCP Professional Resolution and Escalation protocol. Tips relating to the effective use of this document is available here. It is important to remember that escalation should occur at all levels; all professionals and their Managers/Matrons have a role to play in attaining resolution at a local level.

20. Completing an Early Help Assessment (EHA) / Team around the Child Referral (TAC)

20.1. Staff should consider completing an Early Help Assessment (EHA) if concerns exist regarding the development of a child or young person. Issues may involve health, welfare, behaviour, progress in learning or any other aspect of their well-being. The Early Help Assessment can assist in identifying what additional support/Agency involvement is required; whilst the Team Around the Child (TAC) process initiates and co-ordinates that support. If there is an unmet need identified which cannot be met by another Agency, an Early Help Worker (EHW) could be requested from Social Care. An EHW is not automatically allocated upon completion of the EHA.

20.2. An Early Help Assessment (EHA) should not be competed if a child or young person is deemed to be at risk of significant harm or in need of protection. If immediate or significant harm is indicated, a Social Care referral should be completed (as per Section 18).

20.3. Trust staff should follow the Early Help Assessment/TAC procedure to initiate the Early Help/TAC process.

20.4. Trust staff should retain a copy of the Early Help Assessment Form in the patient's records, filed behind the red Safeguarding divider and should also share a copy with the Safeguarding Children and Young People team.

21. Discharge Arrangements

21.1. Discharge plans must consider the impact on children and young people within the household, family and wider community, in particular any specific needs and/or support required by the family. Discharge plans must evidence discussions held with the family, Trust Professionals and Professionals from other relevant Agencies and must clearly denote action planned/required post-discharge.

21.2. A Discharge Planning Meeting (DPM) should be held routinely when dealing with children and/or families with whom Safeguarding concerns exist/have been identified. Discharge Planning Meetings should routinely invite a representative from Local Authority Children's Social Care where they are (or will be) involved in supporting the family. It is also good practice to invite the Community Midwife (if still involved with the care of the mother/child), Health Visitor (for children aged under 5) or CYP/School Nurse (for school aged children open to their service). Consideration should also be given as to whether the child's School may also need to be informed about the discharge arrangements of a child.

21.3. Children or young people for whom there have been concerns about safety or welfare must not be discharged until the Consultant Paediatrician, under whose care they are admitted, is assured that there is an agreed plan in place which will safeguard the children's welfare. Consideration should be given as to whether the discharge should be delayed pending a Multi-Agency discussion/convening of a Discharge Planning Meeting (or resolution of an existing escalation) to ensure provision of appropriate support is in place and a safe discharge facilitated.

21.4. Discharge letters (eDDs) should be copied, with the client's knowledge, to the relevant Professionals involved with the family (including GP and SW). Letters should be addressed and mailed directly to the relevant professionals (and not given to parents/carers to relay) thereby ensuring all relevant information regarding the child's admission, treatment and current medication requirements is delivered in an accurate and timely manner. Any Safeguarding concerns known, or arising, should be clearly documented within the discharge letter(s), along with information relating to any action undertaken (i.e. referral made to Social Care; DPM held, etc.).

21.5. Please see the LSCP's Discharge Planning from Physical Healthcare Hospitals Guidance for additional support. The Safeguarding Children Team will also support, as required.

22. Transferring a Patient, Discharging Clinic, No Access Visits, Repeat Appointment Cancellation or Was Not Brought (WNB)

22.1. Following an episode when a child/young person was not brought to their appointment; appointments are repeatedly cancelled or No Access Visits (NAV) have been identified, the responsibility for any assessment of the situation rests with the Practitioner to whom the child has been referred in conjunction with the referrer (Laming 2003). Trust Staff must consider the impact on a child (born or unborn) or young person, if either they themselves or a parent/carer or close relative does not engage with services, and whether there is any intervention required in order to secure the child's welfare.

- Check addresses and other details for accuracy (GP/Health Visitor/School Nurse may be contacted to cross-reference contact details).
- Offer a further appointment.
- Ensure parents/carers are informed about the health and social consequence(s) of further non-attendance/failure to bring the child/young person and with whom information will be shared should the child not attend/be presented for a future appointment.
- Liaise with the referrer, if the patient has not been brought to their initial appointment with your service.
- Repeated WNB episodes or repeated cancellations for children/young people known to have other Health Agency and/or Social Care involvement should result in a multi-Agency discussion/meeting within to agree the best course of action.
- Team Around the Child (TAC) (through an identified Lead Professional) may be helpful; particularly if there are concerns re. Financial viability of the family to attend.
- A referral to Social Care should be made where it is recognised that WNB and/or repeated cancellations is detrimental to the child/young person, or if already known to Social Care (EM SG Children Network, 2008) as this would constitute medical neglect and potential place the child/young person at risk of significant harm.
- 'Automatic' discharge of the Child/Young Person should not occur unless the Practitioner is assured that WNB processes have been followed or that the child/young person will not be adversely impacted by the lack of treatment/review/care.

A flowchart, to assist with the reporting of WNB can be found at Appendix 6.

22.2. Prior to the transfer of a case to another Health Clinician/service, Trust staff must ensure that the relevant documentation is completed and the pre-discharge demographic information is accurate. Any

identified/potential risks or concerns should be clearly documented and communicated to the child/young person's new worker(s). Providing a chronology of events and a verbal handover is also considered good practice.

22.3. If a decision is made to discharge/transfer the child from ULTH care, other involved professionals (e.g. Social Care/School/CAMHS, etc.) should be informed in writing, with the client's knowledge, highlighting any concerns and ensuring they are clear that your service is no longer involved with the family. In the case of children who are subject to Child Protection/Child in Need plans or Local Authority intervention, discussions with the allocated Social Worker must occur prior to discharge/transfer.

22.4. Prior to transfer/discharge staff members are required to consider any additional support needs the child, young person or family may have and determine what might be available to assist them.

22.5. In situations where ULTH staff members are involved in Safeguarding cases, which are being stepped-down/closed to Social Care intervention, and the closure of a case is deemed, by ULTH staff, to be inappropriate and to not be in the best interests of the child, the use of respectful Professional challenge and appropriate escalation is essential.

23. Safer Recruitment & Allegations against Staff

23.1. All new appointments to United Lincolnshire Teaching Hospitals NHS Trust, including those services contracted by ULTH, will be undertaken in line with Safer Recruitment Practices and guidance provided by the Disclosure and Barring Service (NHSE, 2015).

23.2. Trust staff must adhere to the Policy for Managing Allegations of Abuse Made against Persons who Work with Children and Young People (ULTH 2019), which is also applicable when disclosures are made about staff members about their personal lives, when there is potential for this to impact on their own children and young people – or children and young people who are service users.

23.3. Discussion with the Senior HR Manager, Senior Clinical Manager, Line Manager and Named Nurse Safeguarding Children should follow any allegation made against a staff member who works with children.

23.4. Consideration should be given as to whether the staff member should be suspended or redeployed, pending an investigation, in order to safeguard a child. HR Manager(s), in conjunction with the Named Nurse for Safeguarding Children and Young People should consider holding an internal strategy discussion to assist in determining whether a referral to a Professional Regulatory Body, the LADO (Local Authority Designated Officer) or the Disclosure and Barring Service is required.

23.5. If there is Police involvement, discussions with the Police regarding any potential internal investigation and/or any intended action, should occur prior to investigation/action taking place. The Named Nurse for Safeguarding will initiate discussions with the Police/LADO as appropriate.

23.6. Guidance is available to assist staff in protecting children and vulnerable adults in the presence of Celebrities, Volunteer Fundraisers and other External Visitors.

24. Risk Assessment

24.1. Trust staff should have open and honest discussions with patients regarding any concerns that they may have arising from their physical/mental illness or problematic substance/alcohol misuse. Specific consideration should be given to level of insight shown by the patient regarding the actual or potential impact that their illness/difficulties may have upon their child(ren). Referrals to other Agencies should be discussed with parents and carers prior to the referral being made, unless to do so would increase the risk of harm to children or another adult. If discussion with parents/carers is likely to increase the risk of harm to a child or young person, the practitioner should contact Local Authority Children's Social Care or Trust Safeguarding Children Team for advice.

24.2. The following leaflet provides families/carers with information about the Trust's Safeguarding processes. This leaflet should be printed and handed to all parents/carers when safeguarding concerns arise, to inform them of what action may be required.

24.3. When completing a risk assessment, it is essential that Trust staff consider the following points:

- Actual/potential risk posed by the patient as a consequence of physical or mental ill health, domestic abuse, unstable family dynamics, etc..
- Complicating factors which have the potential to result in physical/emotional harm
- Diagnosis and symptomology
- Age and developmental stage of the child (including unborn baby), children aged under 5 and especially infants are particularly vulnerable.
- Impact of situation on child's emotional well being
- Neglect (unresponsiveness to both physical and emotional needs)
- Contact with children in the family and wider community, either presently or in the future.
- Strengths and weaknesses of the family including access to formal or informal support networks
- Any risk of injury, aggression or dangerous behaviour (including criminality or domestic abuse).

25. Information Sharing

25.1. Trust staff are expected to adhere to organisational and Legislative Policy regarding the sharing of information and in line with professional codes of conduct. Staff are encouraged to utilise Information Sharing Guidance (HM Gov., 2024) to ensure best practice.

25.2. Trust staff members are expected to work in partnership with other Agencies involved with the child, young person or families, adopting a multi-agency approach. Timely liaison should occur, with any Professionals involved with the family, when children attend a ULTH hospital. A child's Health Visitor or CYP (School) Nurse (if open to their service) should be contacted to advise of admission and/or discharge when Safeguarding concerns are known/arise.

25.3. We all know that decisions to share information, with whom and when, can have a profound impact on a child's life. These decisions enable action to disrupt and deter offenders early on, to protect children from risk and support them to recover from the harm they may have suffered. These decisions can even mean the difference between life and death (HM Gov., 2023).

25.4. There can be no justification for failing to share information that will allow action to be taken to protect children. We know that skilled frontline staff can be hesitant and uncertain as to when and how they should be sharing information with other Agencies (HM Gov., 2023).

25.5. All children and young people who attend ULTH services for the purpose of a Child Protection Medical should be entered onto CareFlow and the attendance recorded. A copy of the Medical Report should be sent electronically to the Named Nurse for Safeguarding Children and Young People.

25.6. In the event that a child, young person or family are NOT registered with a General Practitioner, signposting and in certain circumstances, assistance in registering with a local GP should occur.

26. Safeguarding Alerts

26.1. In the event that a child/young person attends a ULTH hospital with existing or arising Safeguarding concerns, contact should be made with the Safeguarding CYP team who will add an alert to CareFlow. A red 'Safeguarding' divider should also be inserted into the child's medical records, with relevant supplementary documentation filed behind, for ease of identification/access.

26.2. Each clinical area should ensure there is a member of staff available to access CareFlow and review any existing Safeguarding alerts (including the supplementary notes) when required.

26.3. Safeguarding Children Alerts should be added whenever a referral is made to Social Care, or if a child attends and it is known that the child is subject to a Child Protection/Child In Need Plan. Please contact the

Safeguarding CYP Team should there be a requirement to add an alert to the child's record.

26.4. Additional Safeguarding Children Alerts are available to highlight other specific issues, i.e. Missing child/adult; at risk of Child Exploitation (CE); Looked After Child (LAC); or if identified as being subject to a Child Protection/LAC/Unborn Baby plan via CP-IS (Child Protection information Sharing system). See Appendix 7 for the CP-IS flowchart in use within ULTH's non-scheduled care settings.

26.5. If a child attends and an Alert is noted (upon registering the attendance on CareFlow), the relevant Clinician(s) caring for the child should be informed immediately and further enquiries made in relation to the reason for the Alert, as per the Alerts Pathway and in accordance with the 'free text' section within the alert. If a child is known to be subject to Social Care involvement, appropriate decision-making and multi-Agency liaison/information-sharing should occur. The Safeguarding Children and Young People team should be informed patients attending whom have a Child Exploitation Alert. Consideration should also be given to completion of a Child Exploitation Screening Tool and other CE-related processes (see also Section 8).

26.6. If an Alert has been placed on a child's record and you have established (via liaison with Social Care) that the Social Care involvement had ended, inform the Trust's Safeguarding Children and Young People Team, who can ascertain whether it is appropriate for the Alert to be removed.

26.7. If a MARAC Alert is noted on a child's record, this indicates that the child/child's family have been discussed at MARAC and that the child is not necessarily subject to Social Care involvement. Should you have any concerns regarding the nature of the child's/parent's attendance, advice should be sought from the Trust's Safeguarding Children and Young People team.

27. Implementation

Implementation of this policy will be through the Director for Safeguarding and Patient Experience; Medical Director; HR team, Clinical Directors, Divisional Lead Nurses/Clinical Leads; and Clinical and Professional Leads.

28. Training

28.1. In order to meet its obligations, the Trust has made training of all staff in Safeguarding Children mandatory, as part of the Core Learning programme.

28.2. Safeguarding Children training is part of Core Learning/Mandatory/Statutory training and is reported to the Quality Governance Committee via the Safeguarding and Vulnerabilities Oversight Group.

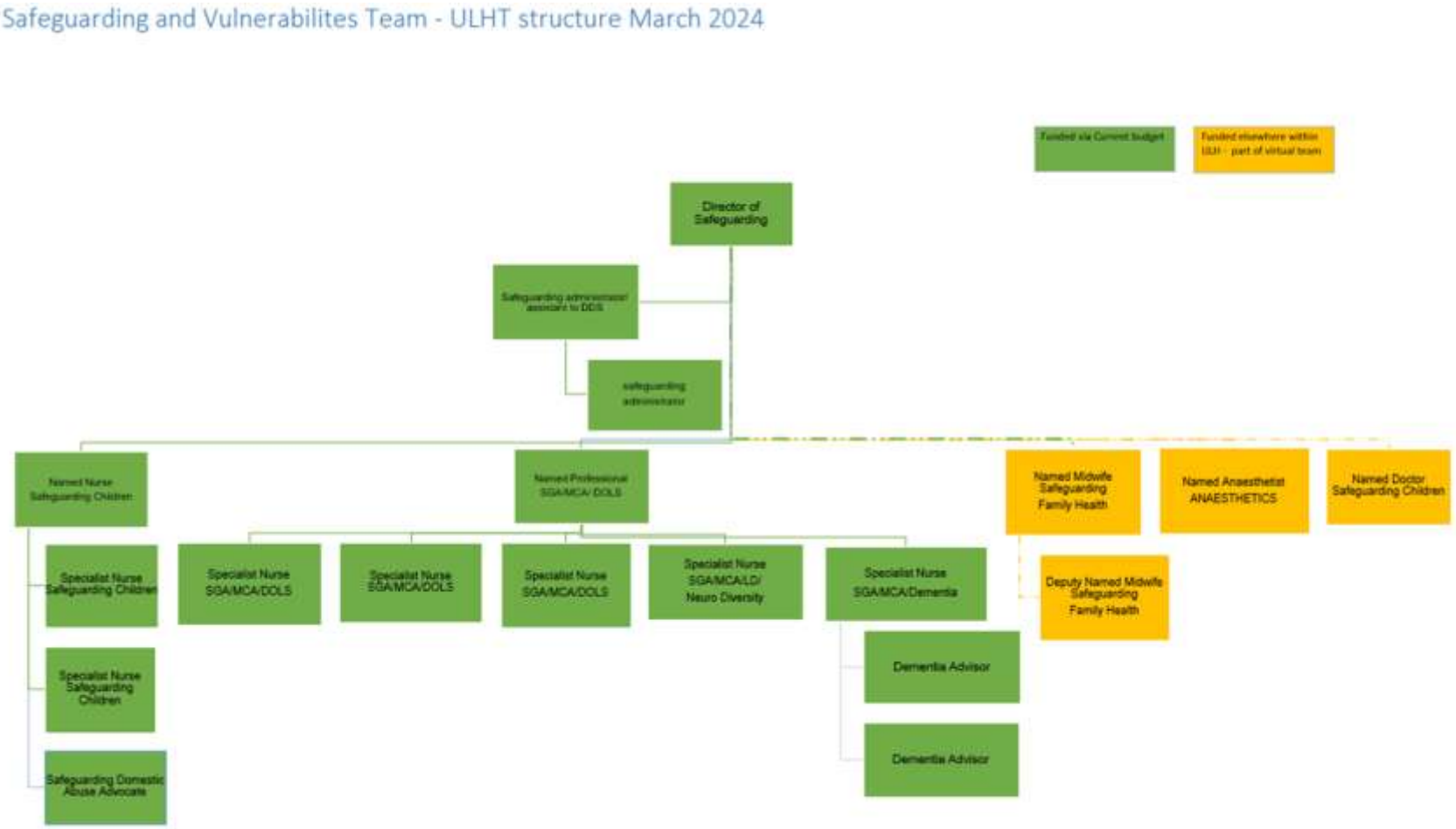
29. Target Audience

This policy applies to all staff employed or contracted by United Lincolnshire Teaching Hospitals NHS Trust, including volunteers and students.

Monitoring Compliance

Minimum requirement to be monitored –monitoring against standards set out in policy	**Process for monitoring** **e.g. audit**	**Responsible individuals/ group/ committee**	**Frequency of monitoring/ audit/ reporting**	**Responsible individuals/ group/ committee for review of results and determining actions required**
Compliance with whole Policy	Quarterly notes audits. Ad-hoc attendance reviews. Supervision. Training. Governance Committees.	SG CYP team will monitor compliance via Audits. Governance oversight via Divisional SG Operational meetings and SVOG.	Quarterly Audits (internally) and via ad-hoc case reviews/external audits/research-gathering – as required.	Named Nurse for Safeguarding CYP. Director for Safeguarding and Patient Experience.

Appendix 1 – Organisational Structure for Safeguarding



Appendix 2 – Safeguarding Children Escalation Procedure

Lincolnshire Safeguarding Children Partnership (LSCP) and Working Together to Safeguard Children (2023) expect collaborative inter-agency working to share information appropriately and develop effective plans to safeguard children. Every professional is responsible for ensuring completion of actions as agreed, and constructive challenge amongst colleagues within and across agencies is encouraged. Use in conjunction with the LSCP Professional Resolution and Escalation Protocol

Conflict

Are there differences of opinion regarding judgement, leading to inter-Agency/inter Professional disagreement?

For example:

- Lack of communication between agencies/ professionals
- Disagreement about actions taken/ to be taken
- Agency conflict about how a child's needs can be met
- Conflict regarding the need for a Child Protection Plan versus team around the child

Resolution

Step 1 – Discuss differences of opinions or judgement between parties

(Direct discussion – Professional to Professional)

To achieve a shared understanding and agree a resolution; in line with an established plan, or develop a new/amended plan.

Step 2 – If the problem is not resolved (Direct discussion – Manager to Manager)

Discuss with Line Manager who will agree to support a resolution process with the Professional(s) concerned and their own Line Manager.

Step 3 – If the problem is still not resolved (Direct discussion – SLO to SLO)

Contact ULTH's Named Nurse for Safeguarding Children and Young People, Elaine Todd on **01522 573831** or email elaine.todd4@nhs.net. Alternatively, contact ULTH's Director of Safeguarding and Patient Experience, Craig Ferris via craig.ferris@nhs.net who will advise on resolving the conflict.

Out of normal working hours contact the Clinical Site Manager who can facilitate escalation with the out-of-hours Manager for the relevant Agency.

Remember - it is your responsibility to be persistent and follow-up situations where you believe a child is at risk or their needs are not being met. At every stage of the discussion, actions should be followed up in writing between the Agencies and documented accordingly in the ULTH records.

Children and young people should not be discharged from services until the responsible Clinician is assured that their safety needs have been addressed.

Appendix 3 – Children / Young People Safeguarding Referral Pathway

Emergency Action

Immediate risk of Significant Harm – contact Police 999

Further guidance is available on the Safeguarding section of the Trust's Intranet site Safeguarding Children & Young People or within the LSCP's Policy and Procedure Manual Welcome to the Lincolnshire SCP Policy and Procedures Manual

Practitioner has concerns about the welfare of an unborn child/child/young person up to 18 years of age. Discuss concerns with family (unless alerting them will endanger the child further, place an adult at risk of serious harm, prevent the detection of serious crime, or lead to an unjustified delay in making enquiries) **and discuss with your manager**. Concerns regarding suspected fabricated or induced illness/sexual abuse **should not be discussed** with parents/carers prior to multi-Agency discussion.

Document concerns and whether information-sharing with family has occurred, detailing reasons for decision.

Discuss concerns with Manager/Colleague/ Champion. Out of hours - contact CSM for support.

Concerns not validated by Manager/Colleague/ Safeguarding Champion but

No longer has concerns Record all conversations and decisions for action taken in child/family records.

No further child protection action required; though may need to act to ensure support Services are provided. Record conversations in into patient records and file behind a red divider.

Undertake a **Child Protection Enquiry**

CPRUAdmin@lincolnshire.gov.uk or EDT (01522 782333) out of hours to check for current Social Care involvement/Social Worker details.

Child has a Social Worker – Discuss your concerns with the Social Worker/EDT, confirming a plan of action and document discussions held.

Child does not have a Social Worker and Practitioner is still concerned.

Discuss concerns with any professionals involved with the child's care and then the Trust's SG CYP Team – or - make a Social Care referral (if urgent and to avoid delay).

Key Contacts:

- **Children's Social Care** – 01522 782111 (or 782333 OOH)
- **SG Children Team** - ext. 573831 (or CSM OOH)
- **SG Midwifery Team** – ulth.safeguardingmidwives@nhs.net
- **HV/School Nursing Teams** – 01522 843000
- **CAMHS** – 0303 1234000
- **Children's Community Nursing Teams** – 01476 464457 (GDH); 01522 573784 (LCH) and 01205 445702 (PHB)

Make a Telephone Referral to Children's Social Care

01522 782111 (daytime)

01522 782333 (out of hours)

Explain how concerns impact on child (i.e. risk to child). Follow-up your verbal referral with an electronic referral within 24 hours using the online **Safeguarding Referral Form** via the following link:

Make a safeguarding referral

Inform your Manager of the referral. A copy of your online referral will be sent to you via email (PDF). **Please forward a copy of the PDF to the Trust's Safeguarding Children Team** – ULTH.SafeguardingCYP@nhs.net - or to the Safeguarding Midwives (ULTH.SafeguardingMidwives@nhs.net) if concerns relate to an unborn baby.

Within approximately 48 hours of submitting your referral, you will receive an outcome letter from Social Care, detailing their intended action.

Share details of the referral with key Professionals involved with the family, e.g. Health Visitor/School Nurse; Midwife; Mental Health or Substance Misuse worker, as relevant.

If you are dissatisfied with the Referral outcome, it is your professional responsibility to challenge the outcome with Social Care. Please refer to the contact number of the Outcome letter – and then to the LSCP Professional Resolution and Escalation Protocol. The SG Children and Young People Or Midwifery Teams can support further, as needed.

The Safeguarding Children Team/Safeguarding Midwives would be happy to support at any stage of this process.

Appendix 3.1 – (One Page Version) – Children / Young People Safeguarding Referral Pathway

Emergency Action

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Practitioner has concerns about the welfare of an unborn child/child/young person up to 18 years of age. Discuss concerns with family (**unless** alerting them will endanger the child further, place an adult at risk of serious harm, prevent the detection of serious crime, or lead to an unjustified delay in making enquiries) and discuss with your manager. Concerns regarding suspected fabricated or induced illness/sexual abuse should not be discussed with parents/carers prior to multi-Agency discussion.

Discuss concerns with Manager/Colleague/ Champion. **Out of hours -** contact CSM for support.

Concerns not validated by Manager/Colleague/ Safeguarding Champion but Practitioner still concerned

No longer has concerns
Record all conversations and decisions for action taken in child/family records

Undertake a **Child Protection Enquiry**

CPRUAdmin@lincolnshire.gov.uk or EDT (01522 782333) out of hours to check for current Social Care involvement/Social Worker details.

Child has a Social Worker – Discuss your concerns with the Social Worker/EDT, confirming a plan of action and document discussions held.

No further child protection action required; though may need to act to ensure support Services are provided. Record conversations in into patient records and file behind a red divider

Child does not have a Social Worker and Practitioner is still concerned

Discuss concerns with any professionals involved with the child's care and then the Trust's SG CYP Team – or - make a Social Care referral (if urgent and to avoid delay).

KEY CONTACTS

Children's Social Care – 01522 782111 (or 782333 OOH)

SG Children Team - ext. 573831 (or CSM OOH)

SG Midwifery Team – ulth.safeguardingmidwives@nhs.net

HV/School Nursing Teams – 01522 843000

CAMHS – 0303 1234000

Children's Community Nursing Teams – 01476 464457 (GDH); 01522 573784 (LCH) and 01205 445702 (PHB)

Make a Telephone Referral to Children's Social Care

01522 782111 (daytime)

01522 782333 (out of hours)

Explain how concerns impact on child (i.e. risk to child). Follow-up your verbal referral with an electronic referral within 24 hours using the online **Safeguarding Referral Form** via the following link:

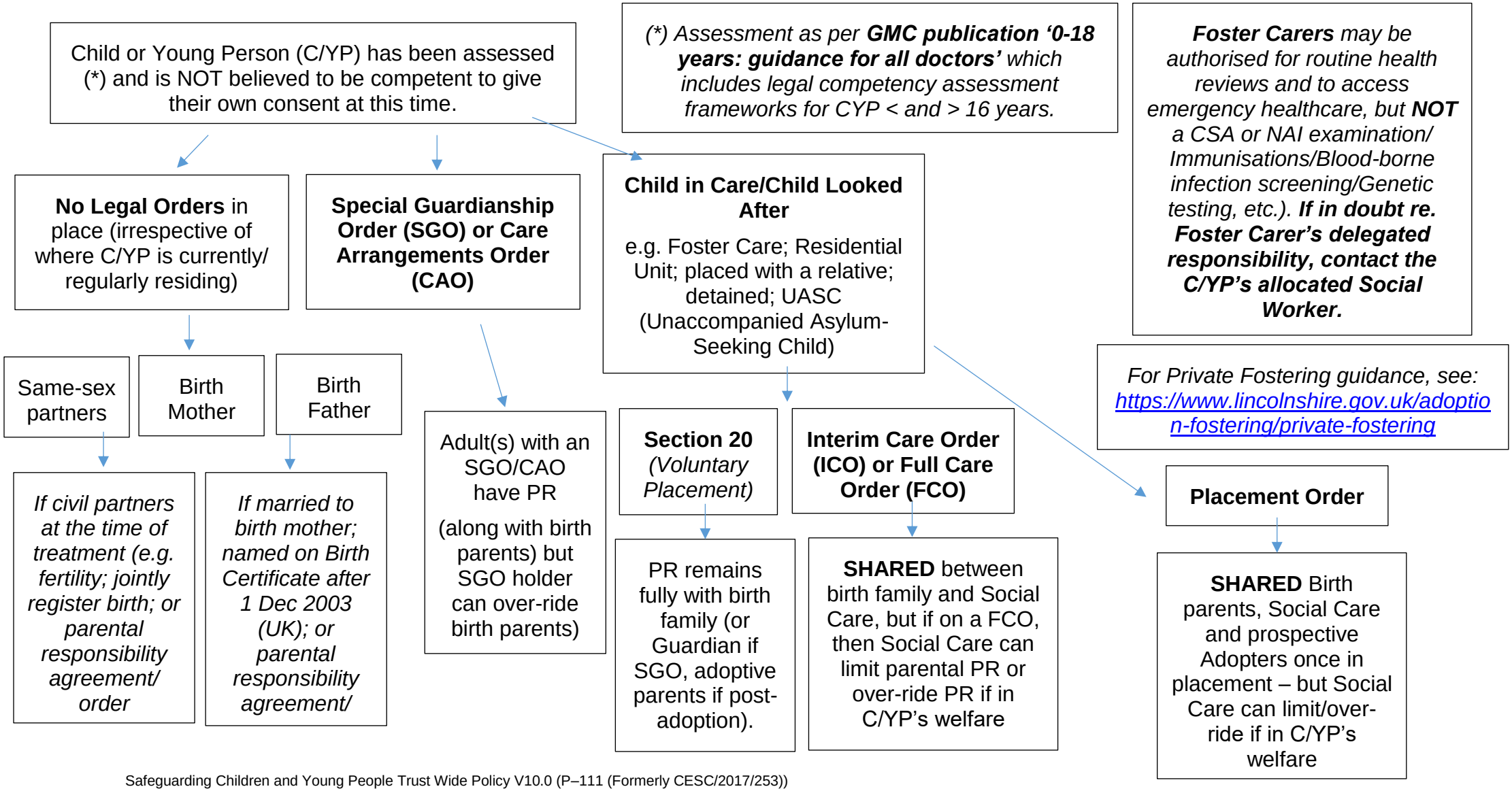
Make a safeguarding referral

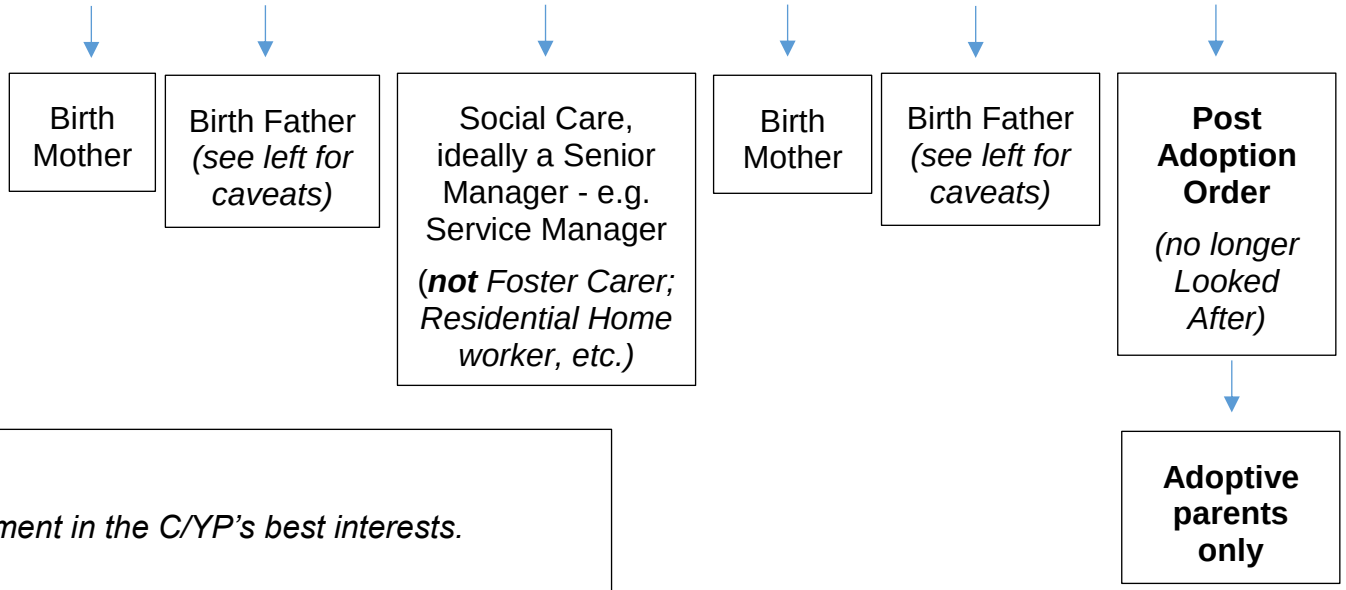
Inform your Manager of the referral. A copy of your online referral will be sent to you via email (PDF). **Please forward a copy of the PDF to the Trust's Safeguarding Children Team** – ULTH.SafeguardingCYP@nhs.net - or to the Safeguarding Midwives (ULTH.SafeguardingMidwives@nhs.net) if concerns relate to an unborn baby.

If you are dissatisfied with the Referral outcome, it is your professional responsibility to challenge the outcome with Social Care. Please refer to the contact number of the Outcome letter – and then to the LSCP Professional Resolution and Escalation Protocol. The SG Children and Young People Or Midwifery Teams can support further, as needed.

Appendix 4 – Parental Responsibilities Flowchart

If in doubt or Parental Responsibility (PR) is unclear, ask to see copies of the Birth Certificate or any Legal consent documents/Court Orders, and take advice from Legal Services/MDU/Social Care, as required.





Emergency Situations *(including out of hours)*

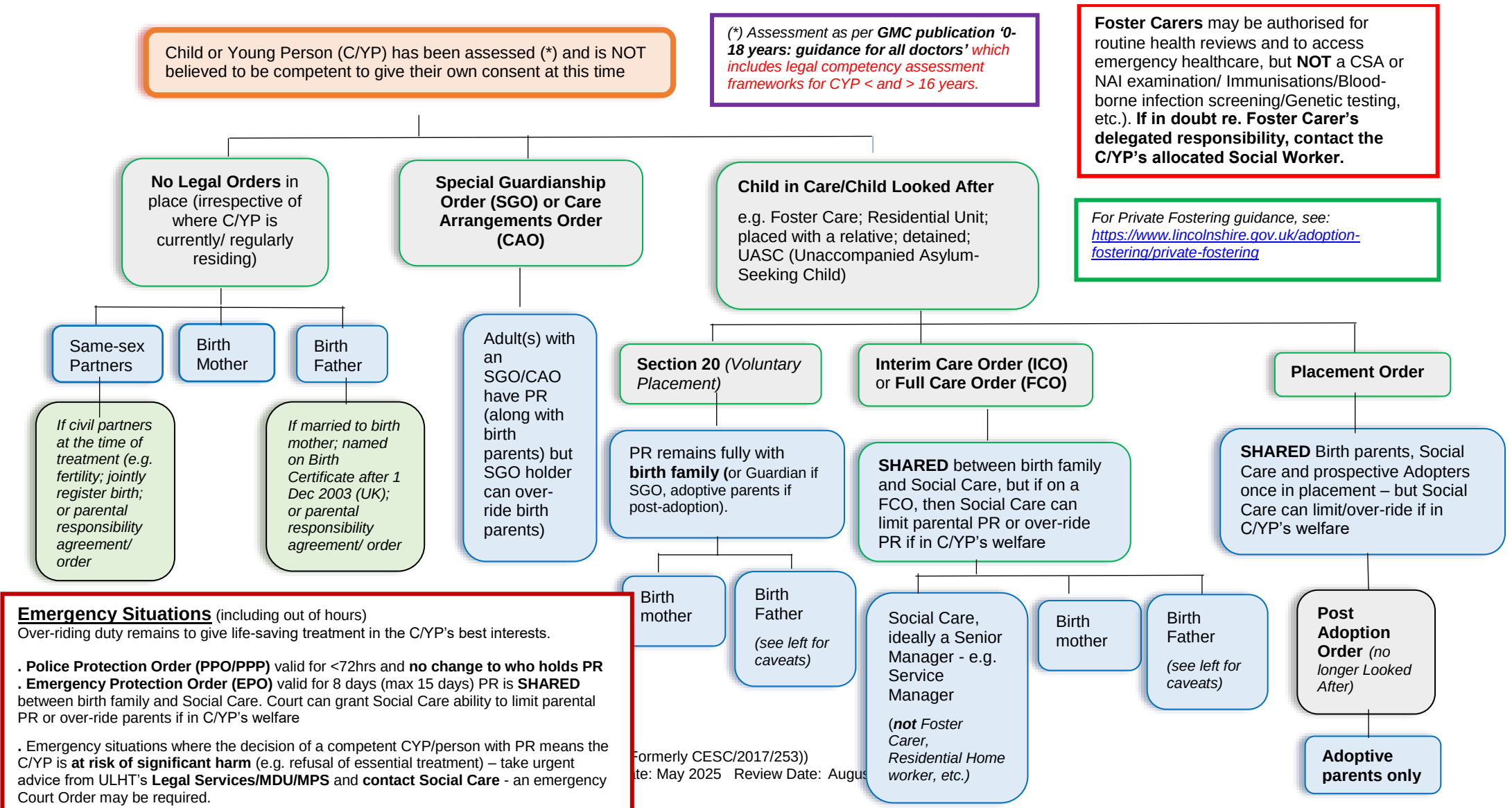
Over-riding duty remains to give life-saving treatment in the C/YP's best interests.

- ***Police Protection Order (PPO/PPP)*** *valid for <72hrs and* ***no change to who holds PR***
- ***Emergency Protection Order (EPO)*** *valid for 8 days (max 15 days) PR is* ***SHARED*** *between birth family and Social Care. Court can grant Social Care ability to limit parental PR or over-ride parents if in C/YP's welfare*
- *Emergency situations where the decision of a competent CYP/person with PR means the C/YP is* ***at risk of significant harm*** *(e.g. refusal of essential treatment) – take urgent advice from ULHT's* ***Legal Services/MDU/MPS*** *and* ***contact Social Care*** *- an emergency Court Order may be required.*

Appendix 4.1. (One Page Version) – Parental Responsibilities Flowchart

Who has Parental Responsibility (PR)?

If in doubt or Parental Responsibility (PR) is unclear, ask to see copies of the Birth Certificate or any Legal consent documents/Court Orders, and take advice from Legal Services/MDU/Social Care, as required.



Emergency Situations (including out of hours)
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. Emergency situations where the decision of a competent CYP/person with PR means the C/YP is **at risk of significant harm** (e.g. refusal of essential treatment) – take urgent advice from ULHT's **Legal Services/MDU/MPS** and **contact Social Care** - an emergency Court Order may be required.

Appendix 5 – Safeguarding Advice SBAR

SAFEGUARDING SBAR COMMUNICATION TOOL

Please complete and email to the Safeguarding Children Team ulth.safeguardingcyp@nhs.net (keeping a copy in the child's records behind a red SG divider)

S **Situation**	**Who are you and where do you work?** **What is the child/young person's name, date of birth/NHS number? (**Mother's name/DoB if query relates to an unborn)**?** **What is it that you want the Team to know?** (*Child/YP was brought to department because….* or *concerns arising about…., etc.)* **What investigations have already taken place or are planned?**	**Please type your response here:**
B **Background**	**Is there an Alert on Care Flow and/or have you checked for CP-IS information?** (CP-IS information is for unscheduled/Maternity care settings only) **How does the child/YP and the accompanying adults present?** **Who is the child/YP accompanied by?** (names and relationship) **and do they have PR?** **The child/YP's Parents/Carers are…** (names and DoB)	**Please type your response here:**

	The child/YP's siblings are… (names and DoB) **Other people in the household are…** (names and DoB if known) **Have you (or a colleague) undertaken a child protection enquiry to establish any current/recent Social Care involvement?** (this can be actioned by emailing CPRUAdmin@lincolnshire.gov.uk) **Does the Child/YP/family have current involvement from any other support services?** (e.g. Mental Health/Early Help/Respite, etc.)	
A **Assessment**	**Additional details identified following examination/assessment –** e.g. the cause of complaint; the mechanism of the injury and how the history given fits the presentation**.** **Parenting capacity:** explanation given to parents, parents' reaction, parents' comprehension of situation. **Family and environmental factors: safety of home environment, security of environment, issues regarding others sharing home environment.** **My concern is: Child is/may be at risk or likely to be at risk of significant harm, Child is in need, Parent(s) require support, advice, help. . ., etc.**	**Please type your response here:**

R **Recommendation**	**What liaison have you already undertaken?** (e.g. Health Visitor/School/Midwife/Social Care – *document in the records their names and contact numbers*) **What action have you already undertaken** (*e.g. referral to Social Care or liaison with child's Social Worker; Child Exploitation Screening Tool; DASH assessment, etc*.) **and what was the outcome of that action?** **Is your Manager aware of the concerns and what have they advised?** **What support do you need from the Safeguarding Team?** (e.g. advice call or this is shared for information only – no action is requested).	**Please type your response here:**

Appendix 6 – Was Not Brought Policy

Procedure for a Child Who Was Not Brought Appointments (Including Repeated Cancellations by Parent/Carer)

If existing Safeguarding concerns are known, or could arise due to non-attendance, the Clinician should give consideration as to whether automatic discharge (after the second WNB episode) is appropriate and/or in the child's best interests.

Child WNB to first appointment or OPA is cancelled

- Clinic staff to liaise with the family to confirm their contact details/reason for non-attendance or cancellation. If unable to contact, check address/contact details alongside the NHS Spine to ensure correct contact details are held on Care Flow. If incorrect details held, send a new appointment to correct address.
- Letter to be sent to GP/Referrer and Parents, informing of non-attendance and detailing risks and/or possible Health and Social consequences of non-attendance/cancellation, along with intention to offer a further appointment.
- Further appointment to be provided.
- **If you are aware that a Child/Young Person has Social Care involvement, the allocated Social Worker is to be informed of non- attendance / cancellation at the first non-attendance.**

Child WNB or 2nd OPA is cancelled

Follow initial checking steps, as above, plus:

- If it is not known whether there is Social Care involvement, an CP enquiry can be undertaken by contacting CPRUAdmin@lincolnshire.gov.uk (you will need to provide the child' details/address and details of their parent – along with a summary of your concern).
- If known to be subject to Social Care involvement, Social Worker to be informed of second non-attendance/cancellation and new appointment to be sent.
- If not known to Social Care, and after liaising with the family to establish reason for child not being brought, Clinician should consider whether a Social Care referral is warranted (the Trust's Safeguarding Team are available to advise/support, as required). Rationale for decision-making should be documented.

Automatic discharge back to care of GP/Referrer should **only** be considered, at this stage, if there are no known Safeguarding concerns or if the non-attendance is not deemed to constitute a significant risk to the child**.**

Possible Outcome 1

No known/potential concerns.

Discharge.

Possible Outcome 2

Concerns arising. Referral to Social Care to be undertaken and further appointment to be sent.

Possible Outcome 3

Child Attends. No further action.

NEW REFERRALS. If the patient is newly referred and either:

- the referrer has not made you aware of any previous Social Care involvement – or
- you are not in a position to determine any potential health implications arising from the CYP not being brought - the initial checks in this process (i.e. contact with parents/checking contact details and CP enquiry) will still need to be undertaken.

However, you may not be in a position to make a decision regarding referral. In such cases, a discussion will need to take place with the referrer, suggesting that they undertake a referral, if they are concerned re. neglect or significant harm.

Appendix 6.1. (One Page Version) – Was Not Brought Policy

PROCEDURE FOR A CHILD WHO WAS NOT BROUGHT APPOINTMENTS (including REPEATED CANCELLATIONS BY PARENT/CARER)

If existing Safeguarding concerns are known, or could arise due to non-attendance, the Clinician should give consideration as to whether automatic discharge (after the second WNB episode) is appropriate and/or in the child's best interests.

Child WNB to first appointment or OPA is cancelled

- **Clinic staff to liaise with the family to confirm their contact details/reason for non-attendance or cancellation. If unable to contact, check address/contact details alongside the NHS Spine to ensure correct contact details are held on CareFlow. If incorrect details held, send a new appointment to correct address.**
- **Letter to be sent to GP/Referrer and Parents, informing of non-attendance and detailing risks and/or possible Health and Social consequences of non-attendance/cancellation, along with intention to offer a further appointment.**
- **Further appointment to be provided.**
- **If you are aware that a Child/Young Person has Social Care involvement, the allocated Social Worker is to be informed of non-attendance/cancellation at the first non-attendance.**

Child WNB or 2nd OPA is cancelled

Child Attends – No further action

Follow initial checking steps, as above, plus:

- **If it is not known whether there is Social Care involvement, an CP enquiry can be undertaken by contacting CPRUAdmin@lincolnshire.gov.uk (you will need to provide the child' details/address and details of their parent – along with a summary of your concern).**
- **If known to be subject to Social Care involvement, Social Worker to be informed of second non-attendance/cancellation and new appointment to be sent.**
- **If not known to Social Care, and after liaising with the family to establish reason for child not being brought, Clinician should consider whether a Social Care referral is warranted (the Trust's Safeguarding Team are available to advise/support, as required). Rationale for decision-making should be documented.**

Automatic discharge back to care of GP/Referrer should only be considered, at this stage, if there are no known Safeguarding concerns or if the non-attendance is not deemed to constitute a significant risk to the child.

Possible Outcome 1

No known/potential concerns.

Discharge

Possible Outcome 2

Concerns arising. Referral to Social Care to be undertaken and further appointment to be sent.

Possible Outcome 3

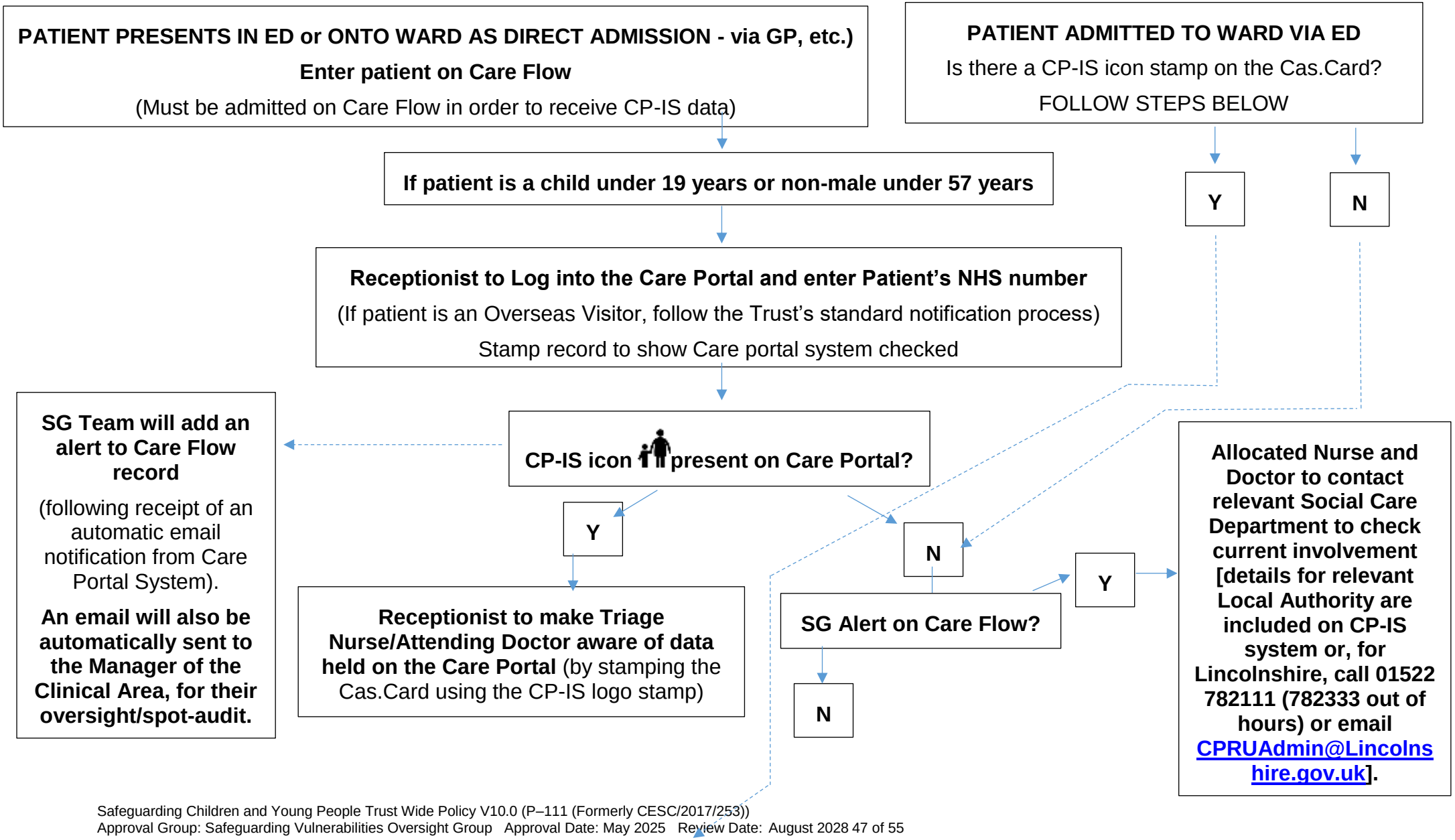
Child Attends. No further action.

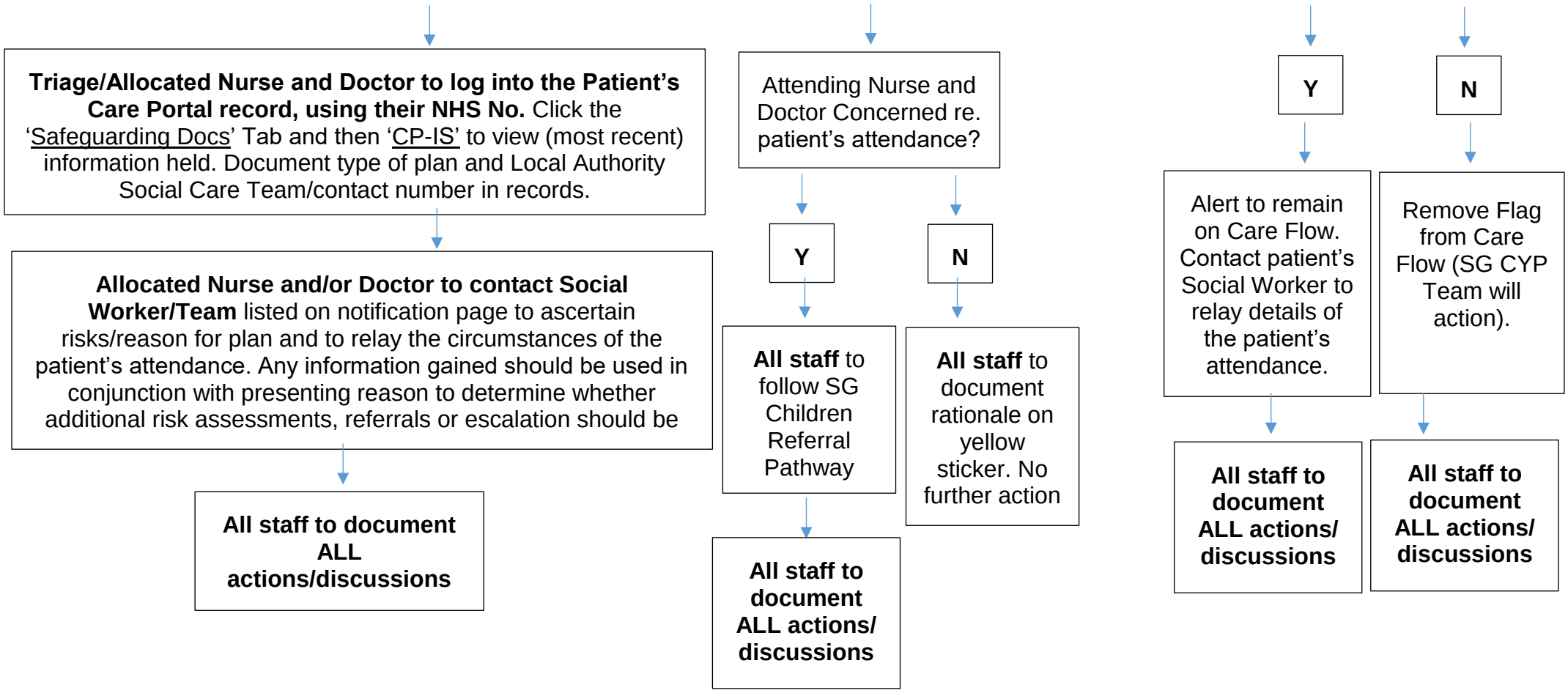
NEW REFERRALS. If the patient is newly referred and either:

- **the referrer has not made you aware of any previous Social Care involvement – or**
- **you are not in a position to determine any potential health implications arising from the CYP not being brought - the initial checks in this process (i.e. contact with parents/checking contact details and CP enquiry) will still need to be undertaken.**

However, you may not be in a position to make a decision regarding referral. In such cases, a discussion will need to take place with the referrer, suggesting that they undertake a referral, if they are concerned re. neglect or significant harm.

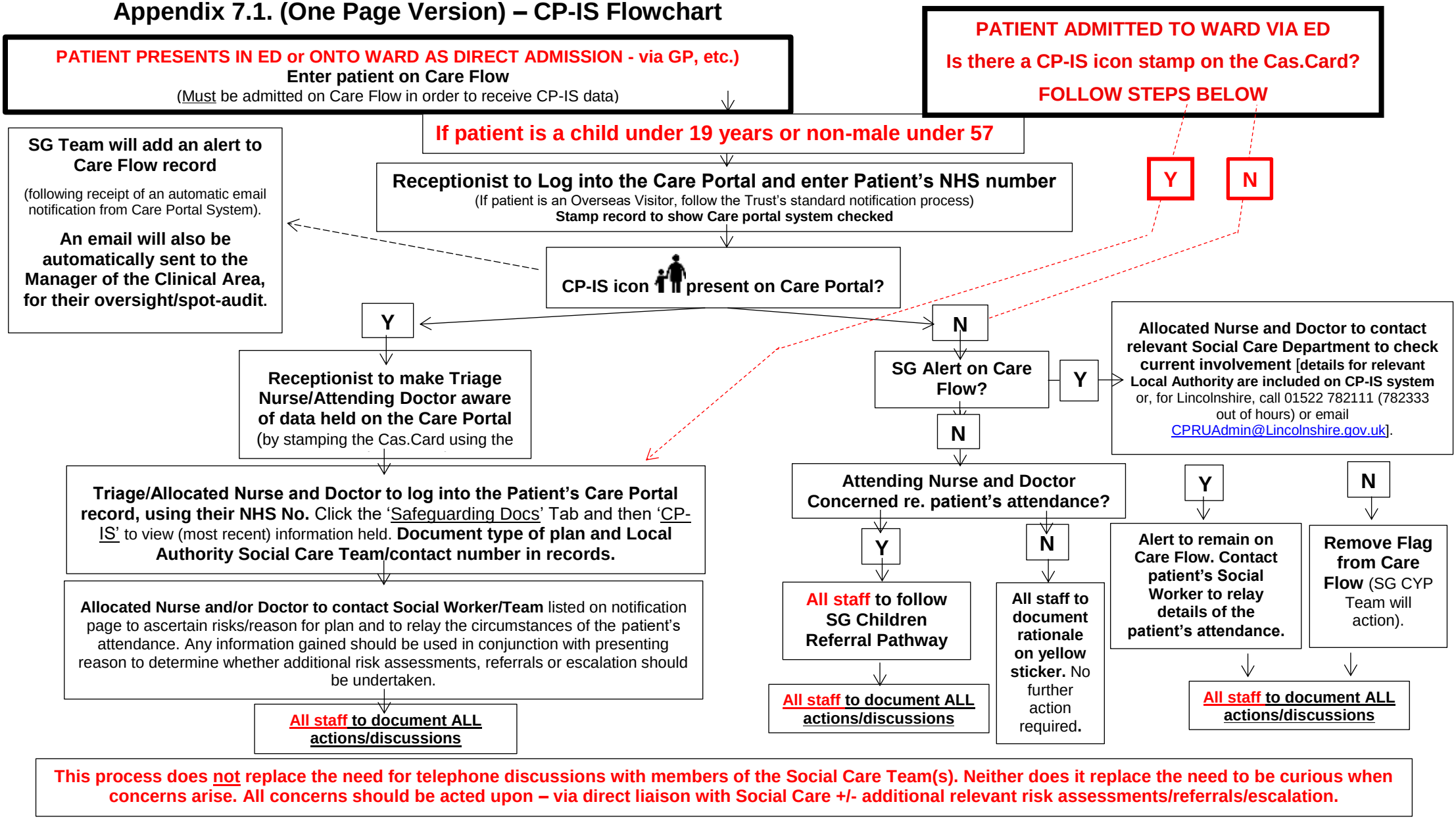
Appendix 7 – CP-IS Flowchart





This process does <u>not</u> replace the need for telephone discussions with members of the Social Care Team(s). Neither does it replace the need to be curious when concerns arise. All concerns should be acted upon – via direct liaison with Social Care +/- additional relevant risk assessments/referrals/escalation.

Appendix 7.1. (One Page Version) – CP-IS Flowchart



Equality and Health Inequality Impact Assessment Tool

This tool has been developed by the Equality, Diversity and Inclusion Leads for use in the NHS Provider organisations in Lincolnshire. The tool is designed to ensure due regard is demonstrated to the Equality Act 2010, the Public Sector Equality Duty and potential health inequalities are also identified and addressed (as outlined in the Health and Social Care Act). Please complete all sections below. Instructions are in ***italics***. Support can be found at http://ulhintranet/equality-and-diversity.

A. Service or Workforce Activity Details	
1. Description of activity	Policy
2. Type of change	Adjust existing
3. Form completed by	Elaine Todd, Group Named Nurse for Safeguarding Children and Young People
4. Date decision discussed & proposed	13th May 2025
5. Who is this likely to affect?	Service users x Staff x Wider Community x If you have ticked one or more of the above, please detail in section B1, in what manner you believe they will be affected.
B. Equality Impact Assessment	
Complete the following to show equality impact assessment considerations of the decision making to ensure equity of access and to eliminate harm or discrimination for any of the protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation. Further, please consider other population groups which are at risk of health inequality and can include, but not be limited to, people who are; living in poverty / deprivation, geographically isolated (e.g. rural), carers, agricultural workers, armed forces, migrants, homeless, asylum seekers/refugees, surviving abuse, in stigmatised occupations (e.g. sex workers), use substances etc. Please ensure you consider the connections (intersectionality) between the protected characteristics and population groups at risk of health inequality (e.g. it is recognised that older men from a BAME background, with one or more comorbidities and living in deprivation are more at risk of a poorer outcome if they contract CV-19).	
1. How does this activity / decision impact on protected or vulnerable groups? (e.g. their ability to access services / employment and understand any changes?) Please ensure you capture expected positive and negative impacts.	Staff – for staff with a disability, this Guidance can be made available in alternative formats, if required. Patients – staff receive training to manage patients with a physical or learning disability. LD Nurses are accessible to ward staff and patients, as requires and an LD toolkit is available to ensure patient's needs are known and met, with appropriate reasonable adjustments implemented. Children with a need for CAMHS service involvement can access the service regardless of their admitting ward. The Act is clear that staff must not discriminate on these grounds and the decision making must be person-centred. The Act is clear that staff must not discriminate on these grounds and the decision making must be person-centred. Translation services are available to support all patients, as required. The Act is clear that staff must not discriminate on these grounds and the decision making must be person-centred. Guidance applies to any child/young person under the age of 18 years (as per definitions in the Children's Act). This Guidance is specifically aimed to support all staff involved with the care of those patients aged under 18years. The Act is clear that staff must not discriminate on these grounds and the decision making must be person-centred.

	The Act is clear that staff must not discriminate on these grounds and the decision making must be person-centred. The Act is clear that staff must not discriminate on these grounds and the decision making must be person-centred. The Chaplaincy service is available to provide support, as required. The Act is clear that staff must not discriminate on these grounds and the decision making must be person-centred. The Act is clear that staff must not discriminate on these grounds and the decision making must be person-centred. Not applicable in this instance as the majority of patients to whom this Guidance applies will be under 16 years.
2. What data has been/ do you need to consider as part of this assessment? What is this showing/ telling you?	Nil additional
C. Risks and Mitigations	
1. What actions can be taken to reduce / mitigate any negative impacts? (If none, please state.)	Neutral impact
2. What data / information do you have to monitor the impact of the decision?	In-house data re. SG activity.
D. Decision/Accountable Persons	
1. Agreement to proceed proposed?	Yes
2. Any further actions required?	Not Applicable
3. Name & job title accountable decision makers	Elaine Todd, Group Named Nurse for Safeguarding Children and Young People. Craig Ferris, Director of Safeguarding and Patient Experience.
4. Date of decision	13th May 2025
5. Date for review	August 2028

Purpose of the Equality and Health Inequality Assessment tool

- The NHS in Lincolnshire has a legal duties under the Equality Act 2010, Public Sector Equality Duty 2011 and the Health and Social Care Act 2012 to demonstrate due regard in all decision making, for example, when making changes to services or workforce practices, to ensure access to services and workforce opportunities are equitable and to avoid harm and eliminate discrimination for each of the protected characteristics and other groups at risk of inequality.

- Within the guidance toolkit there are also some examples of decisions this tool has been used on in other organisations and the impacts they have identified.

Checklist

- Is the purpose of the policy change/decision clearly set out? □
- Have those affected by the policy/decision been involved? □
- Have potential positive and negative impacts been identified? □
- Are there plans to alleviate any negative impact? □
- Are there plans to monitor the actual impact of the proposal? □

This form is based on a template produced by Cambridge University Hospitals NHS Trust and used with their kind permission. FINAL Trust Leadership Team approved for use 01.04.2021

Referenced Documents and Metadata

References

- The Children's Act (HMSO 1989/2004)
- Working Together to Safeguard Children (HM Government, 2023)
- Safeguarding Assurance and Accountability Framework, NHS England (2019)
- NSF for Children, Young People and Maternity Services (DFES 2004)
- DNA/NAV Information Sheet, East Midlands Safeguarding Children Network (2008)
- Framework for Assessment for Children in Need and Their Families (DoH 2000)
- Laming Report into the death of Victoria Climbié (TSO 2003)
- Facing the Future: Standards for Children in Emergency Care Settings, RCPCH (2018)
- UN Convention for the Rights of the Child (1989) [Ratified UK 1991]
- Human Rights Act (HM Gov. 1998)
- Domestic Abuse Act (HM Gov. 2021)
- Safeguarding Children, Young People and Adults at Risk in the NHS (NHS England, 2024)
- The Right to Choose: Multi-Agency Statutory Guidance for dealing with Female Genital Mutilation, (HM Government, Ma2014)
- Think Child, Think Parent, Think Family (SCIE, 2012)
- Safeguarding Vulnerable Groups Act (HMSO 2006)
- Safeguarding Children and Young People: Roles and Competences for Health Care Staff - Intercollegiate Document (RCPCH, 2019)
- Information sharing: Advice for practitioners providing safeguarding services for children, young people, parents and carers (HM Government 2024)
- Every Child Matters (ECM) green paper, HMSO (2003)
- Management of Allegations of Abuse made against a person who works with Children ULTH (2019)
- NICE guidance CG89 – When to Suspect Child Maltreatment (NICE 2009)
- Mental Capacity Act (HM Government – 2005)
- Lincolnshire Safeguarding Children Partnership Policies and Procedures Manual - Welcome to the Lincolnshire SCP Policy and Procedures Manual
- Female Genital Mutilation: Multi-Agency Practice Guidelines (HM Government, 2015)
- Safeguarding Alerts – NHS England https://www.england.nhs.uk/long-read/safeguarding/#organisational-alerts-warnings

- Perplexing Presentations (PP)/Fabricated or Induced Illness (FII) in children – guidance (RCPCH, 2021).
- Management of External Agency Visits, Inspections and Accreditations (including VIP Visits) Policy (ULTH, 2022)
- Safeguarding Children Supervision Policy (ULTH, 2025)

Other Documents

The Trust is aware of its duties under The Children's Act (HMSO 2004) Section 11; its duties to cooperate to improve the well-being of children (section 10); including the sharing of information (section 12).

The Trust operates to the principles and guidance laid down in the documents listed in Source Documents. As this is not an exhaustive list the Trust operates to the principles and guidance contained in all documents relevant to and relating to children and young people.

Metadata (Maximum of 255 Characters including Spaces)

- Children
- Domestic Abuse
- Female Genital Mutilation
- FGM
- Forced Marriage
- Safeguarding
- Section 85
- Young People

Signature Sheet

Names of people consulted about this policy:

Name	Job title	Department
Craig Ferris	Director for Safeguarding and Patient Experience	Corporate
Members of the Divisional SG Operational Meeting and members of the Group Safeguarding and Vulnerabilities oversight Group	Divisional meetings – Chaired by Divisional SG representatives.	Members of the Divisional SG Operational Meeting and members of the Group Safeguarding and Vulnerabilities oversight Group

Author(s) confirm that they have collected all the signatures, as listed above, email Corporate Governance at ulth.corporate.policies@nhs.net	**YES**

Names of committees which have approved the policy	Approved on
Safeguarding and Vulnerabilities Oversight Group	13/05/2025