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NHS
Gloucestershire Health and Care
NHS Foundation Trust

CLINICAL POLICY
Safeguarding Children Policy

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Policy number:	CLP071
Version:	V3.4
Purpose:	This Policy provides guidance and direction for Trust staff on the subject of safeguarding children in line with local lead agency policies and procedures
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Author / Reviewer:	Reviewed by: Kirsty Sedgeman, Named Nurse for Safeguarding Children
Audience:	All trust staff
Dissemination:	The policy will be published on the GHC intranet, and its update will be listed on the Clinical Policy update bulletin.
Impact assessments:	This Policy has been subjected to an Equality Impact Assessment. This concluded that this policy will not create any adverse effect or discrimination on any individual or particular group and will not negatively impact upon the quality of services provided by the Trust.

Version history

Version	Date issued	Reason for change
V1	01/10/2019	Policy development for GHC Trust
V2	18/01/2022	Review by Liz Emmerson, Trust and Partnership changes
V2.1	20/02/2023	New action card added to the Policy
V2.2	11/03/2024	Publication reference: PR00518 NHS E, Local Policy alignment to include sexual safety
V2.3	03/06/2024	Safeguarding Children Supervision Menu added and context around this appendix added on page 9
V3	12/02/2025	Review by Kirsty Sedgeman, Trust and Partnership changes.
V3.1	23/09/2025	New links added and updated.

V3.2	07/11/2025	Contact number for GCC professionals line updated on page 3.
V3.3	07/01/2026	Link added to Missing Children Action Card (CLP071 AC2) ratified at Dec 2025 CPG Meeting
V3.4	28/10/2026	Email addresses and policy links updated following migration

Summary
The Department of Health (December 2023) guidance "Working Together to Safeguard Children", clearly states that everyone who comes into contact with children and families has a role to play in safeguarding children and protecting them from harm.

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SAFEGUARDING CHILDREN POLICY ACTION CARD

CLP071 AC1: Child Safeguarding Concerns: Responding and Reporting

For Use By: All GHC staff	**Liaises With:** Safeguarding Team

Rationale - Safeguarding is everyone's business. If you have reasonable cause to suspect or know of the abuse or neglect of a child or young person.

STEP 1

- Identify and manage any immediate danger to the child or other children including any need to call emergency services, or if you identify a crime: 999/101

STEP 2

- If you have safeguarding concerns for a child, immediate or not, you should consider discussing these concerns with the family and gaining consent to refer.
- If you feel that discussing this will increase the risk to the child, to family members, the public or yourself, you can submit your referral without consent and/or without informing the parent/carer but you must give your clear rational on the MARF.
- Discuss this with your line manager or contact the GHC Safeguarding team by completing a contact form: Safeguarding Advice Line Contact Form (NHS.net) (Monday to Friday, 9am to 4.30pm), or GCC Professionals line 01452 427070 (Monday to Friday, 8.30am to 4pm).
- **For Urgent referrals phone MASH 01452 426565. For an out of hours referral call Emergency Duty Team on 01452 614194.**
- **If the risk of harm is high or imminent you can make a referral without consent.**

STEP 3

- Complete a MARF via GCC online MARF Note – you will need to sign in first.
- Refer to the Gloucestershire Level of Intervention to clarify what level of service is being requested.
- For guidance on completing the MARF, refer to the 5 minute guide on the safeguarding intranet pages Safeguarding - Interact

STEP 4

- Document in the child's notes, following the record keeping guidance for your service. Key things to record include:
  - Who lives in the child's household and/or cares for the child
  - Who has parental responsibility for the child
  - A summary of safeguarding concerns and the impact of these on the child
  - Your actions (advice sought, referrals made, information shared)
  - A SMART plan of the actions you will take to ensure the child's needs are met and they are kept safe.
- Activate any safeguarding alerts on the child's records.
- Communicate with other parties involved **as indicated** (aim to do so with parental consent) in line with the Principles of Information Sharing.
- If the abuse involves a person in a position of trust follow the necessary guidelines Managing Allegations against Professionals who work with Children and Adults (Clinical Policy CLP152) - Interact (ghc.nhs.uk).

STEP 5

- If you have not had a response from a social worker about the MARF within 48 hours then please make contact with children's social care (MASH) 01452 426969 to confirm receipt and its progression.
- Consider the escalation process you disagree with the decision GSCP Escalation Policy

1. Introduction

The aim of this policy is to direct staff on how Gloucestershire Health and Care NHS Foundation Trust (GHC) meets its statutory safeguarding responsibilities, follows guidance and promotes best practice. This policy defines the local arrangements, roles and responsibilities and how as a Trust staff work together with partner agencies to safeguard children.

Section 11 of the Children Act 2004 places a duty on key people and bodies (including NHS Foundation Trusts) to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children. Section 16 of the Children Act 2004 states that 'regard must be given to the new working guidance 'Working Together to Safeguard Children, A Guide to Inter-Agency Working to Safeguard and Promote the Welfare of Children' (2026).

Within this policy, those referred to as children will be considered as anyone who has not yet reached their 18th birthday.

When this policy refers to a child's parents, ensure that you have considered all of the adults in the child's home/homes - parents, carers and other adults living and visiting the home.

2. Purpose

This Policy provides direction for Trust staff on the subject of safeguarding children in line with local lead agency policies and procedures.

3. Scope

This policy applies to all Trust staff, who have a duty to abide by and promote the use of this policy. Chapter 2 of *'Working Together to Safeguard Children'* (HM Government, 2026) sets out the roles and responsibilities of all organisations with regard to safeguarding children.

4. Definitions

Safeguarding:
Safeguarding and promoting the welfare of children is defined for the purpose of statutory guidance under the Children Acts 1989 and 2004 respectively as:

- Protecting children from maltreatment
- Preventing impairment of the child's health or development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care.

To undertake that role so as to enable those children to have optimum life chances and to enter adulthood successfully.

Child in Need (Section 17)
Under Section 17 of the Children Act 1989/04, children in need are those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services. The critical factors to be taken into account in deciding whether a child is in need under the Children Act 1989/04 are what will happen to a child's health and development without services, and the likely effect the services will have on the child's standard of health and development.

Children with a new or an enduring significant disability are by definition 'children in need' under Section 17, as are children who have been in-patients in hospital for more than a period of 3 months.

Child Protection (Section 47)
Some children are in need of protection because they have suffered or are likely to suffer significant harm. Section 47 of the Children Act 1989/04 gives the local authority Children's Social Care the duty to make enquiries to decide whether they should act to safeguard or promote the welfare of a child who is suffering or is likely to suffer significant harm. It identifies significant harm as the threshold that justifies compulsory intervention in family life in the best interest of the child. A person may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm.

It is essential that all Trust staff are able to recognise any concerns or risks relating to safeguarding children and to take the appropriate action in response to this concern or risk.

Abuse and Neglect: are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting, or those known to them or, more rarely, by a stranger. They may be abused by an adult or adults, or another child or children.

Types of Abuse:

(1) Physical abuse - may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

(2) Sexual abuse - involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape, vaginal, anal or oral sex) or non – penetrative acts. They may involve non-contact activities, such as involving children in looking at, or in the production of, sexual online images, watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

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

- provide adequate food, clothing and shelter (including exclusion from home or abandonment
- protect a child from physical and emotional harm or danger
- ensure adequate supervision (including the use of inadequate caregivers)
- ensure access to appropriate medical care or treatment.

The Quality of Care E-Tool (formally known as the Neglect Toolkit) is available to help evidence neglect and inform professional decision making when neglect is suspected. A Quality of Care E-Tool should be completed, alongside a MARF when referring to the Local Authority due to concerns of neglect. The e-tool can be found at:

Quality of Care E-Tool

(4) Emotional abuse - is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effect on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying, causing children to be frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Perplexing Presentations and Fabricated and Induced Illness – (Fictitious Illness):
GSCP Guidance Fabricated or Induced illness/Perplexing Presentations
Concerns may be raised when it is considered that the health or development of a child is likely to be significantly or further impaired by a parent or caregiver who has fabricated or induced illness by the:

(1) fabrication of signs and symptoms - this may include fabrication of past medical history
(2) fabrication of signs and symptoms and falsification of hospital charts and records, and specimens of bodily fluids - this may also include falsification of letters and document
(3) induction of illness by a variety of means.

These are not mutually exclusive.

Alerting features that should prompt you to **consider** perplexing presentations, fabricated or induced illness:

- A child's history, physical or psychological presentation, or findings of assessments, examinations or investigations, leads to a discrepancy with a recognised clinical picture,
- even if the child has a past or concurrent physical or psychological condition.
- Alerting factors that should prompt you to suspect fabricated or induced illness:
- A child's history, physical or psychological presentation, or findings of assessments, examinations or investigations leads to a discrepancy with a recognised clinical picture plus one or more of the following, even if the child has a past or concurrent physical or psychological condition;
- reported symptoms and signs are only observed by, or appear in the presence of, the parent or carer
- an inexplicably poor response to prescribed medication or other treatment
- new symptoms are reported as soon as previous symptoms stop
- biologically unlikely history of events
- despite a definitive clinical opinion being reached, multiple opinions from both primary and secondary care are sought and disputed by the parent or carer and the child continues to be presented for investigation and treatment with a range of signs and symptom child's normal daily activities (for example, school attendance) are limited, or they are using aids to daily living (for example, wheelchairs) more than expected from any medical condition that the child has.

Parental Mental Health and Safeguarding:

The majority of parents who suffer mental ill-health are able to care for and safeguard their children and/or unborn child. Some parents, however, will be unable to meet the needs and ensure the safety of their children and at the most extreme, parental mental ill-health has been identified as a clear factor in a significant number of child deaths. The welfare of the child must be paramount.

Where professionals suspect a child and/or unborn child has suffered or is at risk of suffering significant harm as a result of commission or omission on the part of the parent/carer, the referral process must be followed.

A referral to Children's Social Care **must** always be made where there is evidence of any of the following high-risk indicators: -

- psychotic beliefs particularly if focussed on or involving the child e.g. command led hallucinations suggesting harm to the child.
- persistent negative views expressed about a child, including rejection
- ongoing emotional unavailability, unresponsiveness and neglect, including lack of praise and encouragement, lack of comfort and love and lack of age-appropriate stimulation
- inability to recognise a child's needs and to maintain appropriate parent-child boundaries
- ongoing use of a child to meet a parent's own need
- suicide plans which include the child
- distorted, confusing or misleading communications with a child including involvement of the child in the parent's symptoms or abnormal thinking. For example, delusions targeting the child, incorporation into a parent's obsessional cleaning/contamination rituals, or a child kept at home due to excessive parental anxiety or agoraphobia
- ongoing hostility, irritability and criticism of the child or young person, inconsistent and/or inappropriate expectations of child
- serious neglect of the child.

The following are other negative indicators which, if present, increase the risk of abuse: combination of depression, substance misuse and personality disorders at various points in time are the most frequently reported psychiatric conditions affecting parents who abuse their children.

- mental illness combined with a background of domestic abuse
- both parents have a mental disorder or a lone parent with limited support has a mental disorder
- poor compliance with treatment
- lack of insight into the disorder and its likely impact on the child
- self-harming behaviour and suicide attempts
- parental learning difficulties and mental illness.

It is also important to consider the nature of the illness:

- **Pattern:** frequency of episodes, length of episodes. In general, an illness that has longer and more frequent episodes will have a greater impact than illnesses of short duration
- **Severity:** the impact of an illness will not be directly related to its severity, e.g. a parent with a short severe illness may be hospitalised and substitute care provided for the child with little impact on parenting.
- **Chronicity:** a less severe illness that is chronic may lead to substandard care or neglect of the child, if long term medication or the illness itself lead to cognitive and/or personality

changes
- **Specificity:** what are the symptoms of the illness and their likely impact?

The following are positive indicators/protectors which may reduce the risk of significant harm:

- older age of the child at the onset of their parent's illness (less exposure to difficulties and a greater range of potential coping resources)
- the more sociable child who is able to form positive relationships
- a more able child
- a parent who has discrete episodes of mental illness with a good return of parenting skills and abilities between episodes
- alternative support from adults with whom the child has positive, trusting relationship
- success outside of the home e.g. at school or in sport.

Professionals can improve children's chances of avoiding significant harm by strengthening these protectors.

Parental Substance Misuse and Safeguarding Children:
Substance misuse by parents may not, by itself, necessarily lead to concerns about parenting, child abuse and neglect. However, children are more at risk of harm and neglect if parents misuse drugs or alcohol. The category of neglect now includes the impact on the unborn child as a result of maternal substance abuse. Please see the GSCP website for further guidance. Gloucestershire Safeguarding Children Partnership | Gloucestershire Safeguarding Children's Partnership

Impact on Children:

- Serious effect on unborn child due to poor nutrition and lifestyle
- Lack of basic care and poor school attendance
- Child taking on caring role of siblings or parents
- Exposure to criminal or other inappropriate behaviour.

Impact on Parent/s:

- Can affect - parent's caring skills
- perception and judgement
- attention to basic physical needs
- control of emotion
- attachment to child.

The risk is greater where the substance misuse is chaotic and out of control and where both parents are misusing.

Parent's needs may be prioritised above their children's needs and there may be less money available.

There is a risk of physical harm if drugs and paraphernalia or alcohol are not kept safely out of a child's reach.

Children may also be at risk from adults who are visiting the house when parents are not in a position to protect them.

Safeguarding Children Risk Assessment Substance Misuse:

To be completed if the service user is a parent; has regular contact with children or lives in a household where there are children (i.e. the partner of someone who has children).

Parental Domestic Abuse: (See below for Teenager Intimate Violence)

There is a cross-government definition of domestic violence and abuse. Below is a summary of how domestic abuse is defined within this definition:

Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- Psychological /Emotional
- Physical
- Sexual
- Economic/financial.

The full cross-government definition of domestic abuse can be located here.

There is a strong link between domestic violence and child protection. The Domestic Abuse Act 2021 explicitly recognises the children as 'victims' of domestic abuse if they see, hear or otherwise experience the effects of domestic abuse.

Prolonged and/or regular exposure to domestic abuse can have a serious impact on a child's development and emotional wellbeing:

- Physical assaults to pregnant women cause risk to both the foetus and mother
- Older children may suffer physical blows during episodes of violence
- Children may be greatly distressed by witnessing physical and emotional abuse
- There may be a negative impact on their ability to look after children by adults suffering physical and psychological abuse.
- Children may be drawn into the violence or emotional abuse or may be pressurised into concealing the abuse
- Children's exposure to parental conflict, even where violence is not present, can lead to serious anxiety and distress.
- The risks increase when violence is combined with drink or drug misuse.

Where professionals are aware of domestic abuse, and there are children living in the house, a referral should be made to Children's Social Care.

Please refer to the Trusts Domestic Abuse Policy for further guidance.

Recognised Risk Factors:

- **History**
  Previous domestic assault is the simplest, most robust risk marker of subsequent domestic assault.

- **Escalation**

Minor violence is a predictor of escalation to major violence.

- **Separation**
  Victims are at greatest risk of homicide at the point of separation or after leaving a violent partner.

The Role of Health Professionals:

Evidence shows that men and women find it difficult to raise the subject of domestic abuse themselves and that direct questions get more positive results than vague queries. Health professionals should be prepared to take a proactive approach.

- Never ask about domestic abuse when someone else is present. Find a way of seeing the victim alone.
- Ensure privacy and no interruptions. Consider that they might want to talk to someone else i.e. different gender, race.
- Be patient and understand that they may also have time pressures
- Aim to have a supportive conversation and avoid pushing the person into revealing domestic abuse
- Never accept culture as an excuse for domestic abuse
- Might children be involved? Consider the link between domestic abuse and child abuse.

If a man or woman discloses Domestic Abuse:

- Focus on safety and that of children, if there are any;
- Give information and refer to relevant agencies;
- Make it easy for the victim to talk about the experience;
- Support and reassure;
- Be non-judgemental and
- Look after yourself.

Jointly complete the 'DASH' (Domestic Abuse, Stalking and Harassment) form to assist with assessment of risk. This can be found on the GSCP website and on the Safeguarding Pages of the Trust Intranet Safeguarding.

Further information and training refer to the Domestic Abuse Policy

Gloucestershire Domestic Abuse Support Services (GDASS) 01452 726570
support@gdass.org.uk

This service is for agencies and individuals (men and women) seeking support with domestic abuse in Gloucestershire

- Cases will be risk assessed, and all very high-risk cases will be referred into the Multi Agency Risk Assessment Conference (MARAC)
- Individuals will be supported through a Safety Plan.

Freephone 24-hour National Domestic Violence Helpline: 0808 2000 247

Teenage Intimate Violence:
Domestic abuse is not limited to adults. Intimate teenage abusive relationships are reported to be increasing. The terms "domestic abuse" and "intimate relationships" can lead to

preconceptions on how teenage victims and perpetrators are identified and the response they receive. Many teenagers who experience intimate relationship abuse do not regularly share the same "domestic" setting as adults because they usually live with their parents or carers, reside in care settings or live independently in supported accommodation.

Teenagers may not be willing to disclose to their parents, carers or professionals that they are in a sexual relationship which may limit their support network and may result in missed opportunities to identify and respond to abuse.

In 2024 the World Health Organisation (WHO) stated that nearly 24% of adolescent females will have experienced physical and/or sexual intimate partner violence by time they turn 20 years of age with almost 1 in 6 (16%) experiencing violence in the last year. Their study focussed on existing data of the prevalence of intimate relationship violence experienced by 15 to 19 years old girls and can be found here.

Although the lowest rates of 10% were reported in central Europe, specific UK data reports a higher prevalence of up to 40% of teenagers being in an abusive dating relationship.

Research from the University of Bristol and the NSPCC shows that 25% of girls aged 13-17, and 17% of boys, have experienced physical violence such as pushing, slapping, hitting or being physically restrained in a relationship.

Furthermore, 72% of girls and 51% of boys had experienced emotional abuse. Overwhelmingly, young people keep these incidents within their peer group, talking to friends rather than to parents, carers or to other adults Abuse in Teenage Relationships - Reducing the Risk.

Health care professionals who regularly come into contact with teenage people need to be aware of the indicators of domestic abuse, but should also consider other potential "red flags" including:

- The monitoring of their social media accounts by their partner
- Being pressured into sexual behaviour or to send nudes or sexual images
- Being bullied or experiencing sexual bullying either online, in private or in front of others in or outside of school.
- Feeling reluctant to go to school or college.
- Being prevented from working or attending school or college.
- Persistent changes to their mood and/or behaviour.

Healthy relationships | NSPCC

The following link will direct you to the Gloucestershire Safeguarding Children Partnership's home page where you can read a local Serious Case Review concerning a 16-year-old female who died as a result of being a victim of intimate teenage violence in 2014. scr-0114-lucy-final-010616-66831.pdf.

5. Duties

At Trust level the ultimate responsibility for safeguarding children arrangements lies with the Chief Executive Officer of the Trust.

General Roles, Responsibilities and Accountability

Gloucestershire Health and Care NHS Foundation Trust (GHC) aims to take all reasonable steps to ensure the safety and independence of its patients and service users to make their own decisions about their care and treatment.

In addition, **GHC** will ensure that:

- All employees have access to current, evidence-based policy documents.
- Appropriate training and updates are provided to support staff in their roles.
- Staff have access to equipment that meets safety standards and maintenance requirements.

Managers and Heads of Service will ensure that:

- All staff are aware of and have access to relevant policy documents.
- All staff are supported to access training and development as appropriate to individual employee needs.
- All staff participate in the appraisal process, including the review of competencies.

Employees (including bank, agency, and locum staff) must ensure that they:

- Practice within their level of competency and within the scope of their professional bodies where appropriate.
- Familiarise themselves with and adhere to relevant GHC policies and procedures.
- Identify any areas for skill update or training required.
- Participate in the appraisal process.
- Ensure that all care and consent complies with the Mental Capacity Act (2005) – see section on MCA Compliance below.

6. Mental Capacity Act (MCA) Compliance

Where parts of this document relate to decisions about providing any form of care, treatment or accommodation, staff using the document must do the following: -

- Establish if the person is able to consent to the care, treatment or accommodation that is proposed. (Consider the 5 principles of the Mental Capacity Act 2005 as outlined in section 1 of the Act. In particular principles 1, 2 and 3) Mental Capacity Act 2005 (legislation.gov.uk).
- Where there are concerns that the person may not have mental capacity to make the specific decision, complete and record a formal mental capacity assessment on the GHC Trust approved MCA forms. These are available as templates on clinical record systems and on the GHC intranet.
- Where it has been evidenced that a person lacks the mental capacity to make the specific decision, complete and record a formal best interest decision making process using the best interest checklist as outlined in section 4 of the Mental Capacity Act 2005 Mental Capacity Act 2005 (legislation.gov.uk). Evidence of Best Interests decision making must be provided on the GHC Trust approved forms. These are available as templates on clinical record systems and on the GHC intranet.
- Where a person is admitted to hospital for the treatment of a physical health condition and is assessed as being unable to consent to admission, care or treatment, an application for an Urgent DOLS Authorisation must be submitted to the Local Authority. This applies in all cases where the person lacks capacity, regardless of their compliance with or objection to their admission. Establish if there is an attorney under a relevant and registered Lasting Power of Attorney (LPA) or a deputy appointed by the Court of Protection to make specific

decisions on behalf of the person (N.B. they will be the decision maker where a relevant best interest decision is required. The validity of an LPA or a court order can be checked with the Office of the Public Guardian) Office of the Public Guardian - GOV.UK (www.gov.uk).

- If a person lacks mental capacity, it is important to establish if there is a valid and applicable Advance Decision before medical treatment is given. The Advance Decision is legally binding if it complies with the MCA, is valid and applies to the specific situation. If these principles are met it takes precedence over decisions made in the person's best interests by other people. To be legally binding the person must have been over 18 when the Advance Decision was signed and had capacity to make, understand and communicate the decision. It must specifically state which medical treatments, and in which circumstances the person refuses and only these must be considered. If a patient is detained under the Mental Health Act 1983 treatment can be given for a psychiatric disorder.
- Where the decision relates to a child under the age of 16, the MCA does not apply. In these cases, the competence of the child must be considered under Gillick competence. If the child is deemed not to have the competence to make the decision, then those who hold parental responsibility will make the decision, assuming it falls within the Zone of Parental control. Where the decision relates to treatment which is life sustaining, or which will prevent significant long-term damage to a child under 18 their refusal to consent can be overridden even if they have capacity or competence to consent.

7. Policy Detail

The statutory guidance set out in 'Working Together to Safeguard Children' (December 2023) is a document that will be complied with 'unless exceptional circumstances arise'.
The two key principles outlined are:

- that safeguarding is everyone's responsibility
- a child-centred approach is stressed as essential for effective safeguarding.

Clear local arrangements for collaboration between professionals and agencies to improve multi agency working and to ensure effective safeguarding systems are child centred should be in place. "Failings in safeguarding systems are too often the result of losing sight of the needs and views of the children within them or placing the interests of adults ahead of the needs of children" (December 2023).

It is essential that all staff understand what they need to do, and what they can expect of one another, to safeguard children. Within this 'Safeguarding Children Policy', information is drawn from Gloucestershire Safeguarding Children Partnership (GSCP) and associated policies and procedures. This in turn is based on the South West Child Protection Procedures and the 'Working Together to Safeguard Children – A guide to inter-agency working to safeguard and promote the welfare of children (December 2023).

Safeguarding Children Lead Director Responsibilities:

The Trust has an identified lead Executive Director for safeguarding children at board level. This is the Trust's Director of Nursing, Therapies and Quality who will:

- keep the board fully informed of their accountability to the Gloucestershire Safeguarding Children's Partnership (GSCP)
- responsible for the appointment of the Trust named professionals
- support and ensure the named professionals fulfil their responsibilities
- ensure an annual safeguarding children report is presented to the Trust Board and that other

executive and non-executive directors are briefed appropriately
- ensure that safeguarding children is an integral aspect of the Trust's governance arrangements; that there is organisational compliance with clinical standards and requirements for child protection; that these issues are always considered when monitoring or planning new services
- ensure that the Trust works effectively with other relevant organisations to identify, assess and manage children in need of protection
- have explicit working links with the named professionals in the Trust and ensure that the named professionals are appropriately line managed
- ensure clinical records, both electronic and hard copy, meet the required standards
- ensure that staff in all areas respond positively and sensitively to the needs of individual children; environments in which children and young people are cared for are safe and appropriate.

Management Responsibilities:

Line managers will ensure that all staff
- have access to and know how to seek specialist safeguarding children advice
- have a DBS check, to the appropriate level, as part of the recruitment process; this includes bank staff, agency staff, students and volunteers
- have undertaken child protection training at the right level for their role, and they have updates at the appropriate time interval
- have access to the GSCP Child Protection Procedures www.gloucestershire.gov.uk/gscp
- there is a regular audit of child protection practice, to include audit of child protection record keeping
- are supported to participate in individual management reviews; Rapid Reviews; Local Child Safeguarding Practice Reviews (LCSPR) or Domestic Homicide Reviews as appropriate.

Named Professional Responsibilities:

'*Working Together to Safeguard Children' (HM Government, 2026),* states that each NHS Trust must identify a named nurse and a named doctor for safeguarding children. Named professionals have a key role in promoting good professional practice within the Trust, and provide advice and expertise for fellow professionals and will:

- support the Trust in its clinical governance role, by ensuring that audits on safeguarding are undertaken and that safeguarding issues are part of the trust's clinical governance system
- support the Head of Safeguarding to provide a quarterly report to the Trust Governance Assurance Group
- take responsibility for completing the Trust's Summary of Involvement Reports for Rapid Reviews, and Internal Management Reviews (IMRs)/Critical Analysis Reports for LCSPR's, and other learning models except where there has been GHC involvement in the case
- have a key role in ensuring a safeguarding training strategy is in place and working with the designated professionals and other named professionals to develop and deliver in-house safeguarding children training within the Trust
- support and advise other professionals on the management of more complex cases of child abuse
- participate in GSCP activities and sub-committee membership in agreement with and shared with other named and designated professionals
- promote good practice and effective communication within and between NHS Trusts and all agencies on matters relating to the protection of children, working closely with the

designated and other named professionals
- ensure that safeguarding is an integral part of the Trust's risk management strategy
- ensure that GSCP Child Protection policies and procedures are accessible to and understood by GHC staff
- attend relevant local, regional and national forums and maintain up-to-date skills and competencies.

Individual Responsibilities of Staff:

- All staff should actively safeguard and promote the welfare of children
- Concerns that children are at risk of or are suffering from child abuse or neglect should always be shared with a senior member of staff. Reasons for the concern and actions taken must be documented in the health and social care notes/clinical records. Please refer to agency guidance. Health Records and Clinical Record Keeping Policy (CLP005) - Interact (ghc.nhs.uk)
- Band 5 staff and below should discuss with a senior member of staff prior to making a children's safeguarding referral for support
- The practitioner who has the safeguarding concern should complete the MARF – with support as required – so that first-hand information is always shared
- Help and advice can be sought from the GHC Safeguarding team - Safeguarding Advice Line Contact Form (NHS.net), the Named Nurse or Doctor for Safeguarding Children, Safeguarding Children Service with the Local Authorities the Gloucestershire Multi Agency Safeguarding Hub (MASH), or the Emergency Duty Team (out of hours).
- It is essential that when staff receive an allegation of abuse they do not seek to investigate, gather evidence from the child, or take steps to corroborate these allegations. Doing so may impact upon future criminal investigations and cause unnecessary trauma for the child and/or family. Factual accounts of the allegations should be recorded in clinical records and used to complete onward referrals to Children's Social Care and/or the Police.
- If a child may be at risk of significant harm a referral must be made to the Gloucestershire Multi Agency Safeguarding Hub (MASH) of the Local Authority. A referral phone call may be made in the first instance to:

  - **Children's front door (may be referred to as MASH or children's social care front door)** - 01452 426565

  - Out of hours contact the **Children's Social Care Emergency Duty Team** (Mon-Fri 5pm-8am and weekends) - 01452 614194

  - **Or in an emergency:** Police Control Room 101/999

  This must be immediately followed up in writing by completing a Multi-Agency Request Form (MARF) via the GCC on-line referral. Gloucestershire on-line MARF
- The reasons for the referral will normally be discussed with the parents and the child if age appropriate and consent discussed/gained, unless such a discussion would place the child (or other children) or an adult (including staff) or at increased risk. If sexual abuse or fabricated illness is suspected, the family should not be informed at this point.
- It is the responsibility of the person who identifies the concern to make the referral into Children's Social Care, however all staff should discuss the referral with their line manager and receive the right amount of support to do so.

- Staff should be mindful that 'health' is not an 'investigating agency' (unlike the Police and Children's Social Care) but does have a 'duty to inform' where there are issues concerning the welfare of children and young people. Please refer to the 'Levels of Intervention Guidance' for guidance on risk identification, evidence of need, and threshold. It can be found at: Gloucestershire Levels of Intervention
- If staff disagree with the action from the referral, then the Escalation Policy should be implemented. This is found on the GSCP website and on the GHC Trust intranet. This GSCP Escalation Policy should be employed at any time, between any agency if there is a disagreement with a plan of action relating to the protection of a child or young person. Please see below links for further guidance. GSCP Escalation Policy
- All staff have a duty to follow the policy and procedures laid down by the Gloucestershire Safeguarding Children Partnership.

Think Family

GHC practitioners have a responsibility to take a 'Think Family' approach in the context of safeguarding children and adults. A Think Family approach refers to the steps taken by child and adult practitioners to identify wider family needs which extend beyond the individual they are supporting.

Whatever your role and whether you are working primarily with children or adults, you should be thinking about the needs of the family members and any significant others – including any risks that they may pose. Safeguarding is everyone's responsibility.

Adverse Childhood Experiences (ACES):

Adverse Childhood Experiences are highly stressful and potentially traumatic events that occur before a child's 18th birthday. These can be single events, or prolonged experiences of stress.

Adverse childhood experiences can have an impact upon a person's future mental and physical health and can affect a child's and/or parents' attachment. There is a large body of evidence which shows that the adversity we experience as children can affect us into adulthood.

Within a general population anyone can be susceptible to ACEs regardless of ethnicity, sex and socioeconomic status, although the number of ACEs experience tends to increase with lower socioeconomic status.

ACEs are prevalent across the population and recent studies have shown:

- Nearly half of people in England experience at least one ACE, with around 9% experiencing four or more ACEs (Blackburn and Darwen Study)
- Six ACEs can **reduce your life expectancy by 20 years**
- For every 100 adults in England, **48 have suffered at least one ACE** during their childhood and nine suffered four or more.

How childhood trauma affects health across a lifetime | Nadine Burke Harris | TED

The ten adverse childhood experiences are:

- Physical abuse
- Sexual abuse
- Emotional abuse

- Neglect
- Exposure to domestic abuse
- Living with someone who abuses alcohol
- Living with someone who abuses drugs
- Living with someone who has gone to prison
- Living with someone with serious mental illness
- Losing a parent through divorce, death or abandonment.

Adverse Childhood Experiences (ACEs) - YouTube

Training on Adverse Childhood Experiences can be found on Care to Learn.

Young Carers:

There may be situations where children are providing care for their parents or taking on responsibilities greater than normally expected for their age. Whilst this is not abusive, it may have negative effects on them both in practical terms and emotionally.

Young carers are individuals who provide regular and/or ongoing care for a family member they reside with who has an illness, disability, mental ill-health or abuses substances. Their caring roles can differ greatly and can involve household chores, monitoring or the giving of medication, personal care, practical support and/or emotional support.

Healthcare professionals need to recognise and learn to identify young carers so that appropriate support can be offered in a timely manner. This starts with identifying them through maintaining an open mind with family circumstances and asking who else is present in the household.

If you think a child you know is taking on responsibilities like this and could have a caring role – then please contact '*Gloucestershire Young Carers'* to make a referral.

To refer a young carer please gain consent from the family, then either use:

- Website online referral form http://www.glosyoungcarers.org.uk/,
- Email on mail@glosyoungcarers.org.uk
- Call on 01452 733060.

The key information required are details of the referrer, the date of birth of the young person, who they are caring for and contact details for the family.

If you are concerned that a child is providing an inappropriate level of care to a parent, or members of their family (which may be the case when a Service User becomes unwell), a referral to Children's Social Care may be appropriate.

Children and Mental Health:

Mental health is as important to a child's safety and wellbeing as their physical health. It can impact on all aspects of their life, including their physical wellbeing, relationships and educational attainment. Mental health can also change over time, to varying degrees of seriousness, and for different reasons.

Negative experiences such as abuse, and neglect can adversely impact a child's mental health.

Mental health issues can also sometimes lead to safeguarding and child protection issues, for example if a child's mental health begins to put them or other people at risk of harm.

Children who have experienced abuse may be reluctant to talk about how they are feeling, particularly if they haven't yet told anyone about the abuse. They may feel that something is wrong with them or that things may get worse if they talk about it.

Identifying and responding to mental health concerns may be one way of helping children who are experiencing abuse to get the support and protection that they need.

Self-Harm and Suicide:

Children who self-harm are vulnerable individuals who have a number of needs. The organisation has a duty to ensure that appropriate and reasonable safeguards exist where possible to protect children who are at risk from self-harm, and to ensure appropriate management of their case.

Please refer to GHC Management of Self Harm in Young People attending Minor Injuries and Illness Unit (MIIU) CLP035 Self Harm in Young People attending MIIU (Management of) Policy CLP035 - Interact

Child Criminal Exploitation (CCE) and Child Sexual Exploitation (CSE):

Child Criminal Exploitation occurs where organised crime groups or individuals exploit an imbalance of power between themselves and a child, to manipulate the child into carrying out illegal activities on their behalf. This type of exploitation commonly occurs within County Lines and Modern-Day Slavery, both of which interlink with a wide range of recognised vulnerabilities including child sexual exploitation (CSE), human trafficking, debt bondage, Children in Care and school exclusion.

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

What to do if you suspect a child is being Criminally or Sexually exploited

- If in immediate danger – contact the Police – 999
- Discuss with your manager and include consideration to:
    a) a child under 13 is not legally capable of consenting to sex
    b) sexual activity with a child under 16 is an offence
    c) it is an offence to have a sexual relationship with a 16 or 17-year-old if in a 'position of trust' to that child.

If concerns remain:

1. Commence safeguarding procedures and refer to Local Authority Children's Social Care at the Multi Agency Safeguarding Hub (MASH). Details as above.

2. Complete a CSE Screening Tool, which can be accessed via the link below, and refer to the Multi Agency Protocol for Safeguarding Children who are at risk of abuse through Criminal and Sexual Exploitation for advice and guidance. CSE Screening Tool. CSE Screening Tool Guidance
3. If advice/referral is required out of hours contact the Emergency Duty Team (EDT). Details as above.

Safeguarding Children Supervision:

All Trust staff will have access to child protection support and children's safeguarding supervision through the Named Doctor, Named Nurse and safeguarding team.

The Safeguarding Children's Supervision Menu provides the practitioner with a choice of sessions they would like to attend in regards to which they feel is the most relevant to their role, experience and knowledge base. See Appendix 1 - Safeguarding Children's Supervision Menu.

Safeguarding discussions should also be incorporated into operational and professional supervision for all staff. Please refer to agency Supervision Policy for further information.

All staff working directly with children should attend any three supervision sessions per year as described on the Safeguarding Supervision Menu. Sessions are available to book onto via the Trust's Training booking system, Care to Learn.

Statutory Safeguarding Responsibilities

Allegations Management:

If a member of staff is concerned that another member of staff or volunteer has:

- behaved in a way that has harmed, or may have harmed, a child
- possibly committed a criminal offence against children, or related to a child, or
- behaved towards a child or children in a way that indicates s/he may pose a risk to children. (Working Together 2023)
- Behaved or may have behaved in a way that indicates they may not be suitable to work with children.

They must consult with their Manager/HR and refer their concerns to the Head of Nursing who is the Allegations Manager for the Trust who must be included in any decisions made and actions taken. Any allegations made against a member of staff must be reported to the Local Authority Designated Officer (LADO) by the Deputy Director of Nursing and Quality, the Head of Safeguarding or the Named Nurse Safeguarding Children and the Trust will cooperate fully with any subsequent investigation or recommendations made. Staff can be confident that allegations will be dealt with fairly and in line with the GSCP, Local Authority, and national guidance.

Please refer to the GHC Managing Allegations against Professionals who work with Children and Adults Clinical Policy CLP152 for further guidance.

For more information on the role of the LADO and the Allegations Management Process can be found here:

The allegations management process and role of the LADO.

The Disclosure and Barring Service (DBS):

The core purpose is to prevent unsuitable people from working or volunteering with children and vulnerable adults. Employers retain their responsibilities for ensuring safe recruitment and employment practices.

The Safeguarding Vulnerable Groups Act 2006 sets out the scope of the scheme for England, Wales and Northern Ireland.

A regulated activity (work that a barred person must not do) in relation to children is:

(i) Unsupervised activities: teach, train, instruct, care for or supervise children, or provide advice/guidance on well-being, or drive a vehicle only for children
(ii) Work for a limited range of establishments (specified place) with opportunity for contact e.g. schools, children's home, childcare premises. Not work by supervised volunteers.

Work under (i) or (ii) is regulated activity only if done regularly (see Department of Education Regulated Activity in Relation to Children: Scope).

Further information can be found at:

www.gov.uk/government/organisations/disclosure-and-barring-service

Multi-Agency Working:

The Trust must demonstrate that it works effectively with its partner agencies.

Information Sharing:

The Trust must ensure that there are robust mechanisms in place for sharing information with partner agencies in order that:

- information on vulnerable children is passed efficiently between agencies and
- each child receives a service that meets their needs.

Health professionals have a key role to play in actively promoting the health and well-being of children. There is a growing recognition of the importance of the mental health of parents and how they might impact on children. Lessons learned nationally from Serious Case Reviews and Child Safeguarding Practice Reviews highlight the importance of interagency working in the field of safeguarding. Close collaboration and liaison between services involved with a family is essential. This may require the sharing of information to safeguard and promote the welfare of children or protect a child from significant harm.

If you are unsure about if you can or should share information with a partner agency or are uncertain about what information to share with whom, discuss with line management or the Trust's Safeguarding Team. If uncertainty remains contact GHC's Caldicott Guardian Email: ghc.caldicott.guardian@nhs.net

Remember that the Data Protection Act is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately.

Information Sharing: Guidance for practitioners and managers. (HM Gov, 2008)

Confidentiality:

If a child is confiding in you, they may ask you not to tell anyone what they've said. But if you're concerned about someone's safety and welfare you must share this information with relevant professionals.

You should never promise to keep what a child tells you a secret. Explain from the outset that you might have to talk to someone else who can help.

Collaboration:

The Trust promotes a culture of multi-agency collaboration, and any issues or disputes will be dealt with promptly and at the appropriate level in order to demonstrate effective conflict resolution. See the GSCP website and the Trust intranet for the Escalation Policy (Management of Professional Disputes).

Child Death Reviews:

Working Together to Safeguard Children (2023) requires that child death review partners to make arrangements to review all deaths of children normally resident in the local area. The Named Doctor and Named Nurse for Safeguarding Children are partners on this panel. National Guidance is provided within 'Working Together' (Chapter 6) GHC's Child Death Review Process is available on the Trust Intranet.

Rapid Reviews and Local Child Safeguarding Practice Reviews (LCSPRs):

The duty on local authorities to notify incidents to the Child Safeguarding Practice Review Panel 16C(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017) states;

Where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Review Panel if-

(a) The child dies or is seriously harmed in the local authority's area, or
(b) While normally resident in the local authority's area, the child dies or is seriously harmed.

A Rapid Review of the incident must be arranged.

The purpose of the Practice Review (PR) is:

- To establish whether there are lessons to be learned about the way in which local professionals and organisations work together to safeguard and promote the welfare of children
- To identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and
- As a consequence, to improve inter-agency working and better safeguard and promote the welfare of children *(Working Together to Safeguard Children (2023).*

Following the Rapid Review, a Local Child Safeguarding Practice Review may be recommended and undertaken by all agencies involved in the case. Each agency produces an Internal Management Review (IMR) or Critical Analysis Report which examines their agencies involvement with the child and any relevant adults. All reports are then collated to produce an Overview Report with recommendations.

Executive Summaries of all SCRs and LCSPR's undertaken in Gloucestershire can be found at:

Local child safeguarding practice reviews | Gloucestershire Safeguarding Children's Partnership

8. Process For Monitoring Compliance

Are the systems or processes in this document monitored in line with national, regional, trust or local requirements?	YES

Monitoring Requirements and Methodology	Frequency	Further Actions
The Trust Children's Safeguarding Team will undertake annual auditing of compliance with this and other safeguarding related policies.	Annually	Results of audit reported to the Safeguarding Group for monitoring.
Incident Reporting: The Trust uses the Serious Incident Requiring Investigation (SIRI) Reporting Process to ensure that any incidents relating to safeguarding issues within the Trust are fully investigated and the lessons learned are cascaded to practitioners. See CLP071 SOP1 Action to be taken upon Notification of Children's SG Practice Reviews	On-going	Risks highlighted from incidents occurring are discussed and monitored through Quality Assurance Group and Safeguarding Group meetings.
Commissioning Services Standards for Safeguarding Children: All employees of a service commissioned by the NHS and Local Authority have a statutory responsibility to safeguard and promote the welfare of children under section 11 of the Children Act 2004. This is monitored through the completion Section 11 audit.	Annually	The work is reported to the Safeguarding Group meeting to ensure that the effectiveness of safeguarding work is monitored. Specific areas of concern regarding safeguarding practices can be shared as above, and with the GSCP via Strategic Health Group.
Annual Safeguarding Report	Annually	Reported to Safeguarding Group meeting with assurances, concerns and recommendations.

9. Incident and Near Miss Reporting and Regulation 20 Duty Of Candour Requirements

To support monitoring and learning from harm, staff should utilise the Trust's incident reporting system, Datix. For further guidance, staff and managers should reference the Incident Reporting Policy. For moderate and severe harm, or deaths, related to patient safety incidents, Regulation 20 Duty of Candour must be considered and guidance for staff can be found in the Duty of Candour Policy and Intranet resources. Professional Duty of Candour and the overarching principle of 'being open' should apply to all incidents.

10. Training

The Trust is committed to the adoption of the Gloucestershire Safeguarding Children Partnership Child Protection Training Strategies; *NHS England, Working Together to Safeguard Children (HMG December 2023)* and Section 11 of *The Children Act (DOH 2004).*

All GHC staff have a key role to play in Safeguarding children and will undertake training developed by NHS England eLearning for healthcare (HEE elfh).

The programme consists of the following levels and the sessions meets the statutory and mandatory training requirements and learning outcomes in the UK Core Skills Training framework (UK CSTF).

The level of training will depend on role and is specified in individual training profiles. Line managers have responsibility for ensuring staff are trained to the necessary level and are up to date with mandatory training.

Safeguarding Children Level 1 – Introduction to Safeguarding Children
This training is for all staff including non-clinical managers and staff working in all areas across the Trust.

This eLearning will need to be completed within three months of starting to work in the Trust and will be repeated every three years.

Safeguarding Children Level 2 – Recognition, Response and Record
For non-clinical staff who have some degree of contact with children and/or their parents/carers.
For all clinical staff working within the Trust, irrespective of grade, should complete this level 2 Mandatory Training.

Service managers should consider administrative and other staff undertaking these sessions if they have significant contact with service users and their families, either in person, on the telephone or virtually.

The agreed list of staff who have been identified on the Trust Training Matrix will undertake a refresher session every three years. This will negate the need to repeat the Safeguarding Children– Level 1.

This national eLearning programme will include a presentation about the local safeguarding child processes and arrangements and will include the Think Family approach.

Safeguarding Children Level 3 - Multi Agency Child Protection Training (Specialist)
It is essential for clinical staff working with children, and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child and parenting capacity where there are safeguarding/child protection concerns.

All qualified staff working with children should complete the multiagency Safeguarding Child Protection Inter-agency (CPIA Level 3) provided by the GSCP, details can be found on Care to Learn.

A refresher session should be undertaken every 3 years. This will negate the need to repeat the Safeguarding Children – Level 2.

Level 4 Specialist Strategic Safeguarding Children.
This is mandatory for Named Doctor for Safeguarding Children, Named Nurse for Safeguarding Children and Head of Safeguarding and repeated every 3 years.

Level 5 Designated professionals.
This applies to designated doctors and nurses, consultant/lead nurses for Safeguarding (Strategic).

11. References

Children Act 1989. London: HMSO

Children Act 2004. London: HMSO

Department for Education and Skills (2004) Statutory Guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004

Department for Education and Skills (2004) Every Child Matters – Change for Children

Department for Education and Skills (2006b) The Children Act 1989 Report 2004 and 2005.

Department for Children, Schools and Families (2008) Safeguarding children in whom illness is fabricated or induced. Supplementary guidance to Working Together to Safeguard Children

Domestic Abuse Act 2021

HM Government 2008

HM Government (July 2018) Working Together to Safeguard Children.

Human Rights Act (1998) London: HMSO

National Health Service Executive (1999) Safety, Privacy and Dignity in Mental Health Units.

Royal College of Nursing. (4th ed. January 2019) Safeguarding children and young people: roles and competencies for health care staff.

12. Associated Documents

- GHC Freedom to Speak Up Policy
- GHC Sexual Safety Policy (CLP154)
- NHS England Sexual Safety Charter for reference (NHS England » Sexual safety in healthcare – organisational charter).
- GHC Lone Working Policy (HS&S-06)
- GHC Sexual Assault Referral Centre (SARC) Operational Policy
- Relationships and Professional Boundaries Action Card
- Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (MHA 2007)
- GHC PREVENT Policy (CLP211)
- GHC Child Death Review Process Guideline (CLG075)
- GHC Managing Allegations against Professionals who work with Children and Adults Policy (CLP152)
- GHC Children and Young People Visiting Mental Health (Psychiatric) Units Policy (CLP212)
- GHC Health Records and Clinical Record Keeping Policy (CLP005)
- GHC Young People Receiving Care and Treatment in Adult MH Inpatient Services (CLP262)
- GHC Domestic Abuse Policy (CLP102)
- Guidance for Health Visiting Teams to Recognise and Support Families with Parental, Perinatal, Infant, and Preschool Mental Health Needs.
- Commissioning Services Standards for Safeguarding Children
- Resolution of Professional disagreements in work relating to the safety of children
- GSCP Escalation Policy

- GHC Overarching Supervision Policy: Clinical and Non-Clinical Supervision (CLP116)
- GHC Safeguarding Adults Policy (CLP101)
- GSCP multi-agency guidance for injuries in non-mobile infants and injuries of concern in non-mobile older children
- NHS England Safeguarding Guide (Safeguarding - NHS Safeguarding)
- NHS England Training Guide (Safeguarding Children and Young People - elearning for healthcare)
- GHC Management of Self Harm in Young People attending Minor Injuries and Illness Unit (MIIU) CLP035

CLP071 SOP1: Action to be taken upon Notification of Children's Safeguarding Practice Reviews SOP

CLP071 AC2: Missing Children Action Card

Appendix 1 – Safeguarding Children Supervision Menu

Safeguarding Children Supervision Menu

Please think about safeguarding children and your role and attend the session that you feel will best meet your needs.

Care to Learn compliance will be updated for every Safeguarding Supervision session that you attend.

Reflective Safeguarding Group Supervision for Case Holders – book via Care2 Learn (max x8 participants). For everyone with Safeguarding cases/concerns/experiences/issues including a short-term package of care

Safeguarding Group Supervision for Non-case Holders – book via Care2Learn (max x12 participants). For those who do not hold cases/those who require updates/general information/want to discuss general safeguarding concerns/experiences/issues.

Safeguarding Children Group Supervision for Public Health Nurses (incl. Health Visitors, School Nurses, Community Nursery Nurses, Sexual health) (x8 practitioners) **–** book via Care to Learn

Bespoke/121 Safeguarding Supervision - in respect of an identified case – request via Safeguarding Advice Line

Case Supervision - specific to an identified case (for GHC practitioners only, working on same case) - request via Safeguarding Advice Line.

Reflective Safeguarding Supervision for Team Leaders/Managers – available monthly - book via Care2Learn

Safeguarding team available to attend forums/team meetings for safeguarding updates as requested via Advice line.

Adult Safeguarding supervision can also be arranged via the Safeguarding contact form
Safeguarding Advice Line Contact Form (NHS.net)