

# Policy Document

Reference: C36

## Protection of Adults from Abuse and Neglect who have Care and Support Needs

|                      |                                                           |
|----------------------|-----------------------------------------------------------|
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| Executive Lead:      | Chief Nurse                                               |

### Version Control Schedule

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| 6       | May 2015       | Updated with new flow charts and referral details                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
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| 8       | February 2020  | <ul style="list-style-type: none"> <li>New detailed appendix on prevent – counter terrorism</li> <li>New appendix (3) initial safeguarding decision flow chart</li> <li>Reference to DoLS policy</li> <li>Updated section regarding when allegations are made against a member of staff</li> <li>ACN's to ensure representation at the adult safeguarding working group</li> <li>Section "concerns raised against the Trust – additional actions added (point 9, 10, 11, 12 &amp; 13)</li> <li>Appendix 1 sentence added regarding others that may be at risk.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 9       | June 2021      | Minor amendments: <ul style="list-style-type: none"> <li>Sentence involving letting the Coroner know when a patient has died whilst under a safeguarding enquiry. This has changed in that we let our bereavement services know and they will inform the Coroner.</li> <li>New appendix (12) which advises staff regarding the alert on iportal and what actions to take.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 10      | March 2023     | <ul style="list-style-type: none"> <li>National policies reviewed to reflect current guidance</li> <li>Job titles of UHNM staff amended throughout policy</li> <li>CCG changed to ICB throughout policy</li> <li>Appendix 1; additional information added regarding; discharge considerations, capacity for referrals, mitigation of ongoing risks</li> <li>Appendix 2; updated</li> <li>Appendix 10; Designated trust safeguarding lead details amended, email addresses for UHNM safeguarding teams added</li> <li>Appendix 12; guidance added regarding disclosures received from patients, and safeguarding team contact with the sex offenders management unit</li> <li>New appendix 13 – contact details for support services</li> <li>Appendix 9 – Prevent referrals flow chart amended and new referral form added</li> <li>Job titles amended throughout policy</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 11      | February 2026  | <ul style="list-style-type: none"> <li>Maternity safeguarding team included within responsibilities</li> <li>Education – supervision and bespoke training opportunities included</li> <li>Appendix 4 amended to reflect Stoke local authority new online portal</li> <li>Appendix 1 – Further guidance added regarding police involvement where the adult themselves may be posing a risk of harm to themselves or others</li> <li>Discharge considerations added 1 further consideration regarding discharge communication</li> <li>Information sharing added</li> <li>Appendix 5 – verbal abuse included</li> <li>Appendix 8 Domestic Homicide Reviews removed as included within Domestic abuse policy C37</li> <li>Appendices numbers reviewed from 8 due to this removal</li> <li>Appendix 8 FGM guidance fully reviewed against current Department of Health guidance and proformas updated</li> <li>Appendix 7 removed as NPSA no longer in place</li> <li>Appendix 8 Prevent – training amended to reflect e-learning</li> <li>Appendix 11 sex offenders – sex offenders unit renamed to public protection unit</li> <li>Appendix 13 Safeguarding Adult Reviews guidance added</li> <li>Appendix 14 Adult at risk alert added</li> <li>Appendix 15 Adult Safeguarding concerns against the trust added</li> </ul> |

**Statement on Trust Policies**

The latest version of 'Statement on Trust Policies' applies to this policy and can be accessed [here](#)

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## 1. INTRODUCTION

- 1.1 This guidance has been produced to complement the Staffordshire and Stoke on Trent Safeguarding Adult Safeguarding Enquiry Procedures April 2016.

The University Hospitals of North Midlands NHS Trust works closely with partners to implement and monitor the joint policy to ensure its compliance with the Care Act (Department of Health 2014).

- 1.2 This Policy should be read in conjunction with:

- Trust Policy No RM07 Reporting and Management of Incidents including SIRI and STEIS Reportable Incidents
- Trust Policy No C43 Consent to Treatment (incorporating Mental Capacity Act)
- Trust Policy No CO5 Discharge of Adult Patients
- Trust Policy No RE01 Multidisciplinary Health Records
- Trust Policy No RM02 Handling Complaints and Concerns Trust Policy No HR01 Disciplinary
- Trust Policy No C61 Deprivation of Liberty Safeguards
- Trust Policy No C23 Managing the risks associated with Safeguarding Children
- Trust Policy C33 Use and Reduction of Restrictive Interventions including the use of Clinical Holding Skills (CH-3SM)
- Trust Policy C37 Dealing with Domestic Abuse
- NMC (2018) The Code of Professional standards of practice and behaviour for nurses, midwives and nursing associates
- NMC (2018) Standards of Proficiency for Registered Nurses
- NMC (2019) Standards of Proficiency for Midwives
- NMC (2018) Standards of Proficiency for Nursing Associates
- GMC Code of Conduct
- HCPC (2015) Standards of Proficiency
- Disability and the Equality Act 2010
- Staffordshire and Stoke-on-Trent Safeguarding Adult Safeguarding Partnership Board (SSASPB) Enquiry Procedures (2021)
- SSASPB Escalation Policy
- SSASPB Information Sharing Guidance for Practitioners (2015)

An “Equality Impact Assessment” has been completed and no actual or potential discriminatory impact has been identified relating to this document.

## 2. POLICY STATEMENT

- 2.1 The University Hospitals of North Midlands NHS Trust is a member of Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board which promotes the safety and protection of adults at risk in Staffordshire and Stoke on Trent in line with the Care Act (2014). It sets out definitions of abuse and vulnerability: it outlines our principles and our commitment to a multi-agency approach to the prevention and investigation of abuse.

- 2.2 The University Hospitals of North Midlands is stating its intention to fulfil their obligations as identified in the Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board Terms of Reference. Partnership obligations include:

- Promoting the work of the Partnership including compliance with both the Adult Safeguarding Policy & Procedures and the Mental Capacity Act / Deprivation of Liberty Safeguards.
- Committing representatives to participate in Partnership meetings

- Ensuring that the staff with the appropriate level of seniority, attend the relevant Partnership meetings.
- Actively participating in Partnership meetings
- Ensuring staff attend learning development opportunities
- Providing information that assists in making the governance arrangements for the Partnership effective.

### 3. SCOPE

- 3.1 This policy applies to all staff working within the University Hospital of North Midlands NHS Trust regardless of contract type. It also applies to those who are employed by the contracted agencies of the Trust including; independent contractors, students on placement and volunteers.
- 3.2 The employees of the University Hospitals of North Midlands will work alongside other agencies to ensure compliancy within the Safeguarding of Adults Policy in Stoke-on-Trent and Staffordshire, to ensure adherence by all staff to the flowchart of actions regarding the protection of adults at risk who have care and support needs (Appendix 2). If a member of staff becomes aware of an incident that falls within these guidelines they should report in accordance to trust policy RM07 – An Organisation wide policy for the Management of untoward Incidents including serious untoward incidents by completing a DATIX.

### 4. DEFINITIONS

#### **Adult with care and support needs**

The adult safeguarding duties under the Care Act 2014 apply to an adult aged 18 years or over who:

- has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- is experiencing, or at risk of, abuse or neglect; and as a result of those care & support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

**Abuse** is defined as:

**Abuse** includes physical, sexual, emotional/ psychological, financial/ material, neglect/ acts of omission, discriminatory, organisational abuse, domestic abuse, modern slavery and self-neglect. Abuse may consist of a single act or repeated acts. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it.

**Harm** - Not only ill-treatment (including sexual abuse and forms of ill-treatment that are not physical) but also the impairment of, or an avoidable deterioration in physical or mental health and the impairment of physical, intellectual, emotional, social or behavioural development.

**Ill treatment** Section 44 of the Mental Capacity Act (MCA) 2005 introduced a new offence of ill treatment of a person who lacks capacity by someone who is caring for them or acting as a deputy or attorney for them. That person can be guilty of ill-treatment if they have deliberately ill-treated a person who lacks capacity, or been reckless as to whether they were ill-treating the person or not. It does not matter whether the behaviour was likely to cause, or actually caused, harm or damage to the victim's health.

**MAPPA (multi-agency public protection arrangements);** statutory arrangements for managing sexual and violent offenders.

**MARAC (multi-agency risk assessment conference);** the multi-agency forum of organisations that manage high-risk cases of domestic abuse, stalking and 'honour- based' violence.

**Multi-agency Safeguarding Hub (MASH)-** The MASH is in a building hosted by Staffordshire Police, where a number of statutory agencies have co-located their staff to facilitate information-sharing, shared risk assessment and planning in connection with the abuse of vulnerable people. Partners who are currently based at the MASH include Staffordshire County Council, Stoke-on-Trent City Council, North Staffordshire Combined Healthcare NHS Trust, Staffordshire and Stoke-on-Trent NHS Partnership Trust, South Staffordshire and Shropshire NHS Foundation Trust and the National Probation Service. The MASH serves children as well as adults.

**Potential Source of Risk** - Any individual who is believed to be responsible for, or implicated in, the abuse of an adult. This may include relatives and family members, professional staff, paid care workers, volunteers, other service users, neighbours, friends, associates and people who deliberately exploit vulnerable people and strangers. In these procedures this term will apply equally to people who are believed to have abused an adult irrespective of whether the abuse was done intentionally or unintentionally.

**Safeguarding Enquiry** - The process undertaken in accordance with the duty under section 42 of the Care Act 2014 to establish the facts of the case; ascertain the adult's views and wishes; assess the needs of the adult for protection, support and redress and how they might be met; protect the adult from the abuse and neglect, in accordance with the wishes of the adult; make decisions as to what follow-up action should be taken with regard to the person or organisation responsible for the abuse or neglect; and enable the adult to achieve resolution and recovery. The duty to make enquiry lies with the local authority but it can 'cause enquiry to be made' by other agencies and consideration will be made on a case by case basis as to who the appropriate person would be to undertake the enquiry.

#### **Sister / Charge nurse**

Sister / Charge nurse will apply to the registered practitioner who has 24 hour responsibility for the ward / department.

**Wilful neglect** - An intentional or deliberate omission or failure to carry out an act of care by someone who has care of a person who lacks capacity to care for themselves. Section 44 of the Mental Capacity Act (MCA) makes it a specific criminal offence to wilfully ill-treat or neglect a person who lacks capacity.

## **5. ROLES AND RESPONSIBILITIES**

### **5.1 NHS Provider Trusts**

- **To work in accordance with the Care Act (2014)**
- To work in accordance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009, and the Care Quality Commission (Registration) Regulations 2009
- To ensure the optimum safety of patient/clients and organisational commitment to recognising and responding to vulnerability
- To report all instances of possible abuse in line with these procedures.
- To report significant incidents to CQC as required by regulations.
- To contribute information, specialist skills, knowledge and resources to an enquiry.
- To lead and manage investigations where they work as part of a multi-disciplinary team with social care responsibilities and functions
- To contribute to the assessment of mental capacity or mental health of adults at risk of abuse / neglect and of alleged abusers where they too are at risk
- To attend and contribute to Enquiry Discussions, Enquiry Reviews and Outcomes Conferences
- To produce reports for the above as requested
- To contribute to clinical assessments and provide specialist advice regarding standards of clinical care.
- To ensure that where complaints, disciplinary or serious untoward incident (SUI) Investigations, relate to possible abuse, these investigations take place within the framework of these procedures.

- To implement the DoLS provisions of the Mental Capacity Act 2005 as required of a Managing Authority.
- To make referrals to the Disclosure & Barring Scheme or to professional bodies where necessary

**5.2 The Quality and Safety Oversight Group is responsible for:**

- Providing approval of this policy

**5.3 As Executive Lead for this policy, the Chief Nurse is responsible for:**

- Ensuring that it is reviewed, in accordance with national guidance and within the agreed timescales.
- Ensuring that it is approved by the Quality and Safety Forum.
- Ensuring that it is ratified by the Quality & Safety Oversight Group (QSOG).
- Ensuring that implementation of this policy is monitored and any risks associated with the implementation are included in the Risk Register and managed appropriately.
- Ensuring that all relevant staff are aware of this policy and receive relevant training.
- Ensuring appropriate representation at the Strategic Group of the Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board

**5.4 The Lead for Vulnerable Patients is responsible for:**

- Monitoring the occurrence of reported abuse to adults at risk and reporting this to the Quality Safety Forum ensuring lessons learnt from safeguarding referrals are shared across the organisation.
- Ensuring there is appropriate representation at all the sub groups of the Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board.
- Attending the Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board meetings.

**5.5 The Directors of Nursing (DoN) are responsible for:**

- Attending the Trust Safeguarding Steering Group
- The monitoring of patterns and trends in safeguarding referrals.
- Supporting the Lead for Vulnerable Patients to ensure lessons learnt are shared and practice changed where required.
- Ensuring that their Divisions are 90% compliant with Level 1 & 2 Adult Safeguarding Training.
- Identifying appropriate Senior Nurses to undertake Section 42 Enquiries
- Ensuring representation at the Trust Adult Safeguarding Working Group

**5.6 The Matron is responsible for:**

- Ensuring all the Sisters / Charge Nurses are aware and have an understanding of the policy and SSASPB procedures
- Undertake Section 42 Enquires as instructed by their ACN
- Are involved in Safeguarding meetings as required.
- To produce reports as requested by the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership to contribute towards Serious Case Reviews.
- To support staff in attending level 2 safeguarding training
- Attend Trust Adult Safeguarding Working Group

**5.7 The Lead Nurse for Safeguarding is responsible for:**

- The setting, monitoring and maintenance of robust safeguarding adult arrangements and training programmes.
- Contribute to collaborative interagency working and quality assurance frameworks for safeguarding.
- Provide expert clinical leadership and direction for the safeguarding of adults at risk within UHNM.

- Provide supervision and support to all staff re safeguarding adults, particularly the complexities of statutory requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Advising UHNM on its duties for Safeguarding Adults at Risk as stipulated by government strategy and national, regional and local guidance.
- Attending the Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board sub-group meetings

**5.8 The Adult Safeguarding Nurse and maternity safeguarding team are responsible for:**

- To be accessible to front line staff for advice and guidance with regards to Trust policy and inter-agency adult safeguarding procedures.
- Attend designated partnership groups.
- Manage enquiries of alleged abuse against the Trust ensuring that all allegations are timely captured on the Trust database and shared with the appropriate DoN.
- Facilitate and deliver training in safeguarding adults

**5.9 The Sister / Charge Nurse is responsible for:**

- Ensuring all staff on the ward, particularly those who take charge, are aware of the referral process.
- Ensuring all staff complete the mandatory training relating to the recognition of abuse and the adult at risk.
- To be aware of agency whistle-blowing procedures and use them where appropriate.
- To assist with enquires of alleged abuse.

**5.10 All staff employed by University Hospitals of North Midlands are responsible for:**

- Maintaining the safety of patients and clients in their care
- Providing accurate documentation with regard to the referral of a safeguarding concern.
- Following the flowchart of actions in Appendix 2 in order to prevent abuse to adults at risk within the Trust. The flowchart provides a clear structure within roles/responsibilities and actions to be undertaken by every employer within the statutory multi agency partnership for the population of Stoke on Trent and Staffordshire.
- Following the procedure in cases of suspected adult abuse / neglect in Appendix 1.
- To provide care and treatment that promotes the adult's choice and autonomy as far as this is possible.
- To work in compliance with policies and procedures that promote the safety of the adult at risk (e.g. medication, moving & handling, management of violence & aggression).
- To work in compliance with the principles of the Mental Capacity Act 2005.
- To be aware of how to recognise and report possible abuse / neglect.
- To report all instances of possible, suspected and actual abuse immediately in accordance with these procedures.
- To contribute to and co-operate with adult safeguarding enquiries where necessary or when requested to do so.

## **6. EDUCATION/ TRAINING AND PLAN OF IMPLEMENTATION**

All staff should complete mandatory training which provides signposting to Safeguarding Adults (as outlined in the TNA in appendix B of HR53 Statutory and Mandatory Training Policy). Additional training that is "essential to role" is identified in appendix C of HR53 and also in individual staffs ESR training matrix. Training should be held in the staff personal record, ideally within ESR.

The adult and maternity safeguarding teams provide bespoke training and supervision sessions. These are available upon request to all staff across the trust.

## **7. MONITORING AND REVIEW ARRANGEMENTS**

### **7.1 Monitoring Arrangements**

Regular monitoring will take place to give assurance to the Quality & Safety Oversight Group that there is compliance against the policies and procedures for Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board. This will include:

- Incident reporting
- Annual audit of compliance to policy and procedures
- Bi-annual case file reviews
- Reports will be submitted to the Quality and Safety Oversight Group through the Trust Adult Safeguarding Working Group
- Completion of ICB Dashboard
- Quarterly assurance reports presented to Adult Safeguarding Working Group

### **7.2 Review**

The Chief Nurse is responsible for ensuring that this policy is reviewed 3 years from date of ratification, unless national legislation indicates a requirement to review sooner.

## **8. REFERENCES**

Department Of Health (2014) Care Act Home Office London

NHS England (2022) Patient safety incident response framework and supporting guidance

## **PROCEDURE IN CASES OF SUSPECTED ADULT ABUSE / NEGLECT**

The patient must be kept fully informed throughout the entire process. All adults who are at risk have the right to make choices even those that leave them at risk. However, if capacity to make a decision is impaired or where there is clear evidence that a criminal offence has been committed, the right to choices may not be paramount.

### **1.1 Trust Process for suspected and actual adult abuse alerts/referrals**

#### **Immediate danger**

- If the patient is in immediate danger, or physical or sexual abuse is still occurring, the staff discovering the incident should inform the police immediately. When it appears that there may have been a criminal offence, evidence of abuse should be kept safe and free from contamination e.g. all clothing is bagged. The responsibility for initiating action then rests with the Police; **NB a safeguarding concern still needs to be raised with the Local Authority where the abuse is believed to have taken place.**

#### **Police**

- Where it is suspected or known that a criminal offence has occurred and there is no immediate danger, staff should offer the patient support to contact the police.
- If the patient is deemed to have capacity to make this decision and there is no immediate danger, staff should only contact the police with the patient's consent.
- If the patient has been assessed to lack capacity to make the decision of reporting this to the police, then staff must report the concerns to the police within the patients' best interests
- There may also be indication that the adult themselves may pose a significant risk to themselves or others. This may be seen in cases such as self-neglect, or behaviours displayed whilst under the influence of alcohol and substances for example, where their behaviours could pose a significant risk of harm to themselves or others i.e. damage to property, risk behaviours such as arson. A consideration should be made to inform the police of such risks

#### **Inform colleagues, and seek advice**

- Where it is suspected or known that a criminal offence has occurred at UHNM, the scene and any evidence should be preserved.
- After ensuring the person is in no immediate danger and where it is believed that serious abuse has occurred; staff should verbally inform their line manager, the Consultant responsible and Matron. Out of hours, where it is believed serious abuse has occurred, it must be reported to the Site Matron, who will make a decision whether the Trust on call manager should be informed either at that time or at 09:00 hours the next working day, dependent on the nature of the incident. The Site Matron is to support staff in the process of initiation of a referral.
- For all other concerns, staff should verbally inform their line manager and the treating consultant. Incidents occurring out of hours should be discussed with the Site Matron to ensure that the incident has been effectively dealt with and contained. Throughout the process the safety and welfare of the patient is paramount and must be maintained. Throughout the process the safety and welfare of the patient is paramount and must be maintained.
- Within office hours, staff may contact UHNM adult safeguarding team for advice.

#### **Making Safeguarding Personal**

- Staff should speak to the patient to gain their views of what has happened, and to clarify their wishes of what actions they would like to take. This should be facilitated away from the alleged source of risk, if they are present

- Where the patient requires an interpreter, family and friends should not be utilised. Staff should utilise the Translator service or UHNM staff can assist to interpret where available
- Where a patient has been deemed to have capacity to consent to a safeguarding referral, staff should gain the patient's consent and document this within the nursing notes. To note, staff can make a safeguarding referral without the patient's consent, where it is believed that the patient is at significant risk, or there is a risk that the abuse will reoccur.
- Where a patient has been deemed to lack capacity to consent to a safeguarding referral, staff should make the referral within the patient's best interests.
- Staff should keep the patient updated throughout the safeguarding process and signposted to the relevant local authority.

#### **Making an adult safeguarding referral**

- A referral can be initiated by any member of staff; however, it should be discussed with the person in Charge of the ward/ unit/ area. The referral should be made immediately by **telephone or online portal (dependent on the method for the local authority)** or within 24 hours to the Local Authority where the abuse is believed to have taken place. Incidents occurring out of hours should be referred to the local authority Emergency Duty Team (and Police if necessary).
- **Note: If the ambulance notes/ handover indicates that they or others such as the police have already raised a safeguarding concern, this must be checked with the Local Authority Safeguarding Team and if necessary, a further referral is to be made by UHNM.**

#### **Documentation**

- A Datix should be completed immediately following the referral, to record that an adult safeguarding referral has been made. The date, time and name of person who the referral has been made to should be documented in the patient's notes and the Datix reference number. The completion of a Datix will automatically inform the internal corporate Adult Safeguarding team, who will follow up where necessary with ward staff to ensure necessary support is offered to the patient and action has been taken where needed.
- Witness statements should be written by the person receiving information and collected straight away whilst the details of the incident are uppermost in the minds of all the relevant staff. The person in charge should organise this process and keep statements together in readiness should an enquiry be undertaken. When recording any disclosure, record the actual words used by the person. Any physical injuries should be recorded on a Body Map (Appendix 2). Consider the use of clinical photography.

#### **Transfer of patients within UHNM**

- Where a patient is admitted/ transferred to other ward areas, staff are to communicate via handover the safeguarding concerns identified and what action has taken place. The safeguarding section of the patient risk assessment booklet can also be utilised to record adult safeguarding referrals.

#### **Source of risk**

- The initial interview with the source of risk should be conducted by the outside agency – i.e. Social Care Team. UHNM staff should not discuss the concerns identified with the source of risk, as this may pose a risk to the patient and others.
- If the source of risk is visiting the patient whilst they are admitted to UHNM, staff should seek the patients' views and wishes. Where the patient has capacity to make this decision, document the patients' decision. Where the patient lacks capacity, staff may prevent the source of risk from visiting where it is believed that they pose a significant risk of harm to the patient or others. This decision should be made in conjunction with the local authority

safeguarding team (where the safeguarding referral has been made to) and the police (where they have been contacted).

- Staff should consider other methods to mitigate ongoing risk i.e. patient nursed within a cohort bay, increased observations during visiting. This is only to provide examples and is not an exhaustive list. Staff should consult the nurse in charge or matron for further support and advice

### **Think Family**

- Where any concerns of abuse and neglect have been identified for patients, staff must consider others that may be at risk i.e. unborn, children and other adults with care and support needs. Where there are identified others that may be at risk, staff must refer into Children/ Adult safeguarding for those identified.

## **1.2 What to do when abuse is disclosed by an Adult at risk**

| <b>Do</b>                                                                                                                                 | <b>Don't</b>                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| Listen carefully, stay calm and make notes of what they say using their own words.                                                        | Question nor put pressure on the person for more details nor start your own investigation or take photographs. |
| Be aware that medical evidence may be needed.                                                                                             | Act in a way that may prevent the person talking about the abuse in future.                                    |
| Reassure the person that the information will be treated seriously.                                                                       | Promise to keep secrets.                                                                                       |
| Help the person to understand that whatever has happened is not their fault.                                                              | Make any promises that you may not be able to keep (e.g. 'It won't happen again').                             |
| Explain the referral process and that others will need to be made aware.                                                                  | Question the alleged abuser.                                                                                   |
| Explain that the matter will have to be referred or even if they do not consent but that their wishes will be made clear if this happens. | Agree not to refer because the Adult withholds consent.                                                        |
| Make the referral immediately.                                                                                                            | Wait to discuss with colleagues or gather more information.                                                    |

Also refer to Appendix 2 – Flow chart for cases of Suspected Adult Abuse

## **1.3 Discharge considerations when a safeguarding referral has been made**

- Staff should where possible, seek the patient's views and wishes regarding their discharge arrangements.
- In all circumstances when a safeguarding referral has been made by UHNM, or UHNM are aware that other agencies have submitted a referral (i.e. paramedics), staff must ring the local authority of where the referral was made to, to ensure that safe discharge plans are in place. If the safeguarding concern has also been reported to the police, staff must also contact the police to advise of discharge planning and to clarify any actions that the police may require

- Staff should offer the patient referrals onto support services where necessary (see appendix 13)
- Staff should ensure that safeguarding concerns are handed over via the use of verbal handover, discharge letters, nurse-to-nurse records etc. to those involved in the patients' care post discharge.

#### **1.4 When the (alleged) source of risk is a member of staff in addition to 1.1**

- When a patient, member of public or staff alleges that they have witnessed or suspect abuse by a member of staff, a written statement from the person making the allegation must be completed immediately if possible.
- The allegation needs to be passed on to the senior member of staff on duty who will liaise with the Matron/ Director of Nursing/ Head of Nursing, in hours and the site Matron out of hours.
- Matron/ Director of Nursing/ Head of Nursing should discuss the allegation with the Lead for Vulnerable Patients and People Teams (HR) for on-going advice and support. Out of Hours the Site Matron should liaise with the Trust on-call manager for on-going advice.
- Where an allegation of sexual/ physical abuse is made, the Police must be contacted immediately. Whilst a criminal investigation is being undertaken, any internal Trust investigation should not proceed without advice being sought from People Teams or the Police Team investigating. The Police will advise when the Trust is able to interview the alleged source of risk so as not to contaminate their investigation. Advice should be taken from the Police as to whether an internal investigation should proceed. Advice may also be sought from the Trust's legal team
- The Matron (or site team for out of hours) will undertake an initial risk assessment. Action must be taken immediately to remove any threat of harm to the patient or patients. The suspension of the individual/s concerned will be considered in accordance with the Trust's Disciplinary Policy. Where a person is not suspended, consideration must be given to whether that person should continue to practice/work in the clinical environment for the duration of the fact-finding event. Advice should be obtained from People Teams.
- A Datix should be completed.
- An initial fact-finding investigation will need to be undertaken; this would be undertaken by the Matron for the area or Site Matron out of hours. The initial outcome of the investigation must be reported to the Lead for Vulnerable Patients/ Director of Nursing within 12 hours.
- The requirement of a safeguarding referral should be considered and made, if necessary, at this point.
- Should an internal investigation be undertaken, then the member of staff may have an accredited Professional/ Trade Union representative or workplace colleague with them for the interview and must be informed that statements may be used in a disciplinary procedure and that, as a result of the safeguarding referral being made, statements may be required by the Police.
- Where the Fact Finding officer recommends, following discussion with the Lead for Vulnerable Patients/ DoN, that a formal safeguarding referral is not required, a decision will be made, with the agreement of the Fact Finding Officer and People Teams, as to whether any untoward incident has occurred and whether this requires further internal investigation within the disciplinary procedure and/or root cause analysis.

- The Lead for Vulnerable Patients will also contact LADO and DASM as required on a case-by-case basis if the staff member is a Person in Position of Trust.

## **2. Coroner**

If UHNM are aware that one of our patients is subject to an adult safeguarding enquiry or UHNM has identified safeguarding concerns, upon death, a consideration must be made to refer to the Coroner. The ward/ department must contact UHNM Bereavement Officers and inform them of the safeguarding concern. The Bereavement Officer will then consider a referral to the Coroner.

## APPENDIX 2



Staffordshire and Stoke-on-Trent Adult Safeguarding Enquiry procedures V4

Reporting abuse and neglect - General guide to raising concerns

Initial safeguarding decision flow chart

**An adult at risk of abuse or neglect:**

*has needs for care and support (whether or not the Local Authority is meeting any of these needs) and;*

- *is experiencing, or at risk of abuse or neglect; and*
- *as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect significant harm or exploitation*

**Types of abuse:**

Physical  
Sexual  
Financial  
Discriminatory  
Neglect  
Self-neglect  
Emotional abuse  
Organisational abuse  
Domestic abuse  
Modern slavery

Does the person have needs for care and support?

No

Yes

Is the adult experiencing or at risk of abuse or neglect, including self-neglect?

No

Yes

Is the adult unable (due to their care and support needs) to protect themselves from the risk of, or the experience of abuse?

No

Yes

Raise a Safeguarding Concern immediately

If there are other people at risk, including children, please see section 2.13 of these procedures.

Seek alternative support as necessary  
No Safeguarding Concern required

Draft v4 (November 2017) - for publication

## How and when to raise a safeguarding concern

|                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Who can raise a safeguarding concern?</b>   | Anyone – the adult, Carers, paid staff, volunteers, Inspectors, Police Officers, Health and Safety Officers, etc.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Who decides whether to raise a concern?</b> | <p>The person who believes that abuse may be taking place is the best person to raise the concern and they should take the responsibility for doing so.</p> <p>It is not good practice for that person to delegate this to another agency and this will cause difficulties if that agency has a different view on the incident, especially if they do not themselves believe that abuse has occurred.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>How quickly should a concern be raised?</b> | Immediately and always within 24 hours.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Who should be contacted with a concern?</b> | <p>In all cases concerns will be raised with the local authority where the abuse is believed to have taken place:</p> <ul style="list-style-type: none"> <li>• <b>Staffordshire County Council, Social Care and Health</b><br/>Tel: 0345 604 2719 (out of hours, weekend and bank holidays - 0345 604 2886)</li> <li>• <b>Stoke-on-Trent City Council, Adult Social Care</b><br/>Online portal<br/><a href="https://adultsocialcareportal.stoke.gov.uk/web/portal/pages/profsafe#h1">https://adultsocialcareportal.stoke.gov.uk/web/portal/pages/profsafe#h1</a> (anytime)</li> <li>• <b>Out of area - use the free NHS Safeguarding app or search the internet for the local authority's adult safeguarding number</b></li> </ul> <p>Where a crime has taken place or the adult may be in immediate danger contact should be made with Staffordshire Police.</p> <p><b>In emergencies using 999 or if less urgent using 101.</b></p> |
| <b>How is a concern raised?</b>                | <p>By referring to the local authority where the alleged abuse took place.</p> <p>Staff who raise a concern may be asked to provide additional written detail and information. Staff should record who has taken the referral at the local authority, and the date and time of when they made the referral.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>What information should be included when raising the concern?</b></p>  | <p><b>Personal details</b> of the adult (name, date of birth, address, gender, race, faith, culture and current whereabouts).</p> <p>Name, address, contact number of the person raising the concern, and their relationship to the adult.</p> <p><b>Full description of the abuse</b> that is believed to have taken place including where and when it occurred.</p> <p><b>All known details of the potential source of risk</b> (name, address, date of birth, gender, current whereabouts and relationship to the adult).</p> <p><b>Details of any harm caused to the adult.</b> Perception of continuing risks.</p> <p><b>Immediate action</b> taken or required to protect the adult.<br/><b>Details of other people</b> who may be at risk of harm.</p> <p><b>Details of any action already taken</b> (e.g. call to emergency services, crime number, and protection measures.)</p> <p><b>Details of agencies involved</b> with the adult.</p> <p><b>Whether the adult is aware</b> of the concern being raised.</p> <p><b>Whether the adult has agreed</b> to the concern being raised.</p> <p><b>Any known views or wishes of the adult</b> regarding possible outcomes.</p> <p><b>The views of the person raising the concern</b> about what needs to happen next.</p> <p><b>Any information that relates to the mental capacity</b> of the adult in relation to their ability to protect themselves from harm.</p> <p><b>Any known language or communication needs</b> (e.g. need for an interpreter or intermediary).</p> |
| <p><b>What if the adult does not wish for the concern to be raised?</b></p>  | <p>Patient has capacity - Where there is a risk of harm to the wellbeing of the adult or to others, a potential offence or disciplinary issues the concern should be raised but it must be made clear what the adult's view on this is.</p> <p>Patient lacks capacity – Concern should be raised in the person's best interest.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <p><b>What feedback will be given on concerns that have been raised?</b></p> | <p>People raising a concern should be given information regarding the status of the concern they have raised. The extent of this feedback will depend on various things (e.g. the relationship they have with the victim, confidentiality issues and the risk of compromising an investigation).</p> <p>It should normally be possible to advise people whether their concern has led to a section 42 enquiry.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

## **Physical Abuse**

Physical abuse includes assault, hitting, slapping, pushing, kicking, misuse of medication, being locked in a room, inappropriate sanctions or force-feeding, inappropriate methods of restraint and unlawfully depriving a person of their liberty.

### ***Possible indicators:***

- Unexplained or inappropriately explained injuries
- Adults exhibiting untypical self-harm
- Unexplained cuts or scratches to mouth, lips, gums, eyes or external genitalia
- Unexplained bruising to the face, torso, arms, back, buttocks, thighs in various stages of healing. Collections of bruises that form regular patterns which correspond to the shape of an object, or which appear on several areas of the body
- Unexplained burns on unlikely areas of the body (e.g. soles of the feet, palms of the hands, back), immersion burns (from scalding in hot water/liquid), rope burns, burns from an electric appliance
- Unexplained or inappropriately explained fractures at various stages of healing to any part of the body
- Medical problems that go unattended
- Sudden and unexplained urinary and/or faecal incontinence.
- Evidence of over/under-medication
- Adult flinches at physical contact
- Adult appears frightened or subdued in the presence of particular people
- Adult asks not to be hurt
- Adult may repeat what the person causing harm has said (e.g. 'Shut up or I'll hit you')
- Reluctance to undress or uncover parts of the body
- Person wears clothes that cover all parts of their body or specific parts of their body
- An adult without capacity not being allowed to go out of a care home when they as to
- An adult without capacity not being allowed to be discharged at the request of an unpaid carer/family member

## **Domestic Abuse**

In 2013, the Home Office announced changes to the definition of domestic abuse:

- Incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse... by someone who is or has been an intimate partner or family member regardless of gender or sexuality
- Includes: psychological, physical, sexual, financial, emotional abuse; so call 'honour' based violence; Female Genital Mutilation; forced marriage
- Age range extended down to 16.

Many people think that domestic abuse is about intimate partners, but it is clear that other family members are included and that much safeguarding work that occurs at home is, in fact, concerned with domestic abuse. This confirms that domestic abuse approaches and legislation can be considered safeguarding responses in appropriate cases.

Family members are defined as: mother, father, son, daughter, brother, sister and Grandparents, whether directly related, in-laws or stepfamily.

**Forced marriage** is a term used to describe a marriage in which one or both of the parties are married without their consent or against their will. A forced marriage differs from an arranged marriage, in which both parties' consent to the assistance of their parents or a third party in identifying a spouse.

In a situation where there is concern that an adult with care and support needs is being forced into a marriage they do not or cannot consent to, there will be an overlap between action taken under the forced marriage provisions and the adult safeguarding process. In this case action will be co-ordinated with the police and other relevant organisations. The police must always be contacted in such cases as urgent action may need to be taken.

The Anti-social Behaviour, Crime and Policing Act 2014 mean it is now a criminal offence to force someone to marry. In addition, the Forced Marriage (Civil Protection) Act 2007 may be used to obtain a Forced Marriage Protection Order as a civil remedy.

**Honour-based violence** is a crime and referring to the police must always be considered. It has, or may have, been committed when families feel that dishonour has been brought to them. Women are predominantly (but not exclusively) the victims, and the violence is often committed with a degree of collusion from family members and/or the community. Many of these victims will contact the police or other organisations. However, many others are so isolated and controlled that they are unable to seek help.

Adult safeguarding concerns that may indicate honour-based violence include domestic violence, concerns about forced marriage, enforced house arrest and missing person's reports. If an adult safeguarding concern is raised and there is a suspicion that the adult is victim of honour-based violence, referring to the police must always be considered as they have the necessary expertise to manage the risk.

**Female genital mutilation (FGM)** involves procedures that intentionally alter or injure female genital organs for non-medical reasons. The procedure has no health benefits for girls and women. The Female Genital Mutilation Act (FGMA) was introduced in 2003 and came into effect in March 2004. The Act makes it illegal to practise FGM in the UK or to take girls who are British nationals, or permanent residents of the UK, abroad for FGM whether or not it is lawful in another country. It also makes it illegal to aid, abet, counsel or procure the carrying out of FGM abroad.

### **Sexual Abuse**

Sexual abuse including, rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts to which the adult has not consented or was pressured into consenting.

It includes penetration of any sort, incest and situations where the person causing harm touches the abused person's body (e.g. breasts, buttocks, genital area), exposes his or her genitals (possibly encouraging the abused person to touch them) or coerces the abused person into participating in or looking at pornographic videos or photographs. Denial of a sexual life to consenting adults is also considered abusive practice.

Any sexual relationship that develops between adults where one is in a position of trust, power or authority in relation to the other (e.g. day centre worker/social worker/residential worker/health worker etc.) may also constitute sexual abuse (see section on position of trust).

### ***Possible indicators:***

- Adults have urinary tract infections, vaginal infections or sexually transmitted diseases that are not otherwise explained
- Adult appears unusually subdued, withdrawn or has poor concentration
- Adult exhibits significant changes in sexual behaviour or outlook
- Adult experiences pain, itching or bleeding in the genital/anal areas
- Adults underclothing is torn, stained or bloody
- A woman who lacks the mental capacity to consent to sexual intercourse becomes pregnant
- Sexual exploitation.

The sexual exploitation of adults with care and support needs involves exploitive situations, contexts and relationships where adults with care and support needs (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of performing sexual activities and/or others performing sexual activities on them.

Sexual exploitation can occur using technology without the person's immediate recognition. This can include being persuaded to post sexual images or videos on the internet or a mobile phone with no immediate payment or gain, or being sent such an image by the person alleged to be causing harm. In all cases those exploiting the adults have power over them by virtue of their age, gender, intellect, physical strength, and/or economic or other resources.

### **Psychological Abuse**

Psychological abuse includes 'emotional abuse' and takes the form of threats of harm, or abandonment, deprivation of contact, humiliation, rejection, blaming, controlling, intimidation, coercion, indifference, harassment, verbal abuse (including shouting or swearing), cyber bullying, isolation or withdrawal from services or support networks.

Psychological abuse is the denial of a person's human and civil rights including choice and opinion, privacy and dignity and being able to follow one's own spiritual and cultural beliefs or sexual orientation.

Verbal abuse is a form of emotional or psychological abuse that involves the use of words to cause harm, control, or manipulate another person. It can occur in any type of relationship—personal, professional, or social—and often includes patterns of behaviour intended to demean, belittle, or intimidate.

Common forms of verbal abuse include:

- Insults or name-calling (e.g., calling someone stupid or worthless)
- Yelling or screaming in a threatening or demeaning way
- Criticism that is harsh, constant, or unjustified
- Blaming the victim for things they didn't do or for the abuser's own actions
- Gaslighting, where the abuser manipulates the victim into doubting their own memory or perception
- Threats of harm, punishment, or abandonment
- Sarcasm or mockery used to belittle or humiliate

Verbal abuse can be subtle or overt, and over time, it can severely impact a person's self-esteem, mental health, and sense of safety. It includes preventing the adult from using services that would otherwise support them and enhance their lives. It also includes the intentional and/or unintentional withholding of information (e.g. information not being available in different formats/languages etc.).

### ***Possible indicators***

- Untypical ambivalence, deference, passivity, resignation
- Adult appears anxious or withdrawn, especially in the presence of the alleged abuser
- Adult exhibits low self-esteem
- Untypical changes in behaviour (e.g. continence problems, sleep disturbance)
- Adult is not allowed visitors/phone calls
- Adult is locked in a room/in their home
- Adult is denied access to aids or equipment (e.g. glasses, dentures, hearing aid, crutches, etc.)
- Adult's access to personal hygiene and toilet is restricted
- Adult's movement is restricted by use of furniture or other equipment
- Bullying via social networking internet sites and persistent texting

### **Financial, Material or Economical Abuse**

This includes theft, fraud, internet scamming coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse of misappropriation of property, possessions or benefits.

### ***Possible indicators***

- Lack of heating, clothing or food

- Inability to pay bills/unexplained shortage of money
- Lack of money, especially after benefit day
- Inadequately explained withdrawals from accounts
- Unexplained loss/misplacement of financial documents
- The recent addition of authorisation signatories on an adult's accounts or cards
- Disparity between assets/income and living conditions
- Power of attorney obtained when the adult lacks the capacity to make this decision
- Recent changes of deeds/title of house or will
- Recent acquaintances expressing sudden or disproportionate interest in the adult and their money
- Service user not in control of their direct payment or individualised budget
- Mis-selling/selling by door-to-door traders/cold calling
- Illegal moneylending

### **Modern Slavery**

Modern Slavery encompasses slavery, human trafficking, forced and compulsory labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.

A large number of active organised crime groups are involved in modern slavery. But it is also committed by individual opportunistic perpetrators.

There are many different characteristics that distinguish slavery from other human rights violations, however, only one needs to be present for slavery to exist.

#### ***Someone is in slavery if they are:***

- forced to work – through mental or physical threat
- owned or controlled by an 'employer', usually through mental or physical abuse or the threat of abuse
- dehumanised, treated as a commodity or bought and sold as 'property'
- physically constrained or has restrictions placed on his/her freedom of movement.

Contemporary slavery takes various forms and affects people of all ages, gender and races.

**Human trafficking** involves an act of recruiting, transporting, transferring, harbouring or receiving a person through a use of force, coercion or other means, for the purpose of exploiting them.

If an identified victim of human trafficking is also an adult with care and support needs, the response will be co-ordinated under the adult safeguarding process. The police are the lead agency in managing responses to adults who are the victims of human trafficking.

There is a national framework to assist in the formal identification and help to co-ordinate the referral of victims to appropriate services, known as the National Referral Mechanism.

#### ***Possible indicators:***

Signs of various types of slavery and exploitation are often hidden, making it hard to recognise potential victims. Victims can be any age, gender or ethnicity or nationality. Whilst by no means exhaustive, this is a list of some common signs:

- Adult is not in possession of their legal documents (passport, identification and bank account details) and they are being held by someone else
- The adult has old or serious untreated injuries, and they are vague, reluctant or inconsistent in explaining how the injury occurred
- The adult looks malnourished, unkempt or appears withdrawn
- They have few personal possessions and often wear the same clothes
- What clothes they do wear may not be suitable for their work
- The adult is withdrawn or appears frightened, unable to answer questions directed at them or speak for themselves and/or an accompanying third party speaks for them. If they do speak, they are inconsistent in the information they provide, including basic facts such as the address where they live

- They appear under the control/influence of others, rarely interact or appear unfamiliar with their neighbourhood or where they work. Many victims will not be able to speak English
- Fear of authorities
- The adult perceives themselves to be in debt to someone else or in a situation of dependence.

### ***Environmental indicators***

- Outside the property there are bars covering the windows of the property or they are permanently covered on the inside. Curtains are always drawn. Windows have reflective film or coatings applied to them. The entrance to the property has CCTV cameras installed. The letterbox is sealed to prevent use. There are signs the electricity may have been tacked on from neighbouring properties or directly from the power lines
- Inside the property – access to the back rooms of the property is restricted or doors are locked. The property is overcrowded and in poor repair.

### **Discriminatory Abuse**

This includes discrimination on the grounds of race, faith or religion, age, disability, gender, sexual orientation and political views, along with racist, homophobic or ageist comments or jokes, or comments and jokes based on a person's disability or any other form of harassment, slur or similar treatment. Hate crime can be viewed as a form of discriminatory abuse, although will often involve other types of abuse as well. It also includes not responding to dietary needs and not providing spiritual support. Excluding a person from activities on the basis they are 'not liked' is also discriminatory abuse.

### ***Possible indicators***

Indicators for discriminatory abuse may not always be obvious and may also be linked to acts of physical abuse and assault, sexual abuse and assault, financial abuse, neglect, psychological abuse and harassment, so all the indicators listed above may apply to discriminatory abuse.

- An adult may reject their own cultural background and/or racial origin or other personal beliefs, sexual practices or lifestyle choices.
- An adult making complaints about the service not meeting their needs.

### **Organisational Abuse**

Including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, or where care is provided within their own home. This may range from one off incidents to ongoing ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

Organisational abuse is the mistreatment, abuse or neglect of an adult by a regime or individuals in a setting or service where the adult's lives or that they use. Such abuse violates the person's dignity and represents a lack of respect for their human rights.

Organisational abuse occurs when the routines, systems and regimes of an institution result in poor or inadequate standards of care and poor practice which affect the whole setting and deny, restrict or curtail the dignity, privacy, choice, independence or fulfilment of adults with care and support needs.

Organisational abuse can occur in any setting providing health or social care. A number of inquiries into care in residential settings have highlighted that organisational abuse is most likely to occur when staff:

- receive little support from management
- are inadequately trained
- are poorly supervised and poorly supported in their work
- receive inadequate guidance

or where there is:

- Unnecessary or inappropriate rules and regulations
- Lack of stimulation or the development of individual interests
- Inappropriate staff behaviour, such as the development of factions, misuse of drugs or alcohol, failure to respond to leadership

- Restriction of external contacts or opportunities to socialise.

### **Neglect and Acts of Omission**

These include ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, social care or educational services, and the withholding of the necessities of life such as medication, adequate nutrition and heating. Neglect also includes a failure to intervene in situations that are dangerous to the person concerned or to others, particularly when the person lacks the mental capacity to assess risk for themselves.

Neglect and poor professional practice may take the form of isolated incidents or pervasive ill-treatment and gross misconduct. Neglect of this type may happen within an adult's own home or in an institution. Repeated instances of poor care may be an indication of more serious problems. Neglect can be intentional or unintentional.

### ***Possible Indicators***

- Adults has inadequate heating and/or lighting
- Adult's physical condition/appearance is poor (e.g. ulcers, pressure sores, soiled or wet clothing)
- Adult is malnourished, has sudden or continuous weight loss and/or is dehydrated
- Adult cannot access appropriate medication or medical care
- Adult is not afforded appropriate privacy or dignity
- Adult and/or carer has inconsistent or reluctant contact with health and social services
- Callers/visitors are refused access to the person
- Person is exposed to unacceptable risk.

### **Self-neglect**

Self-neglect covers a wide range of behaviour, neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. Self-neglect is also defined as the inability (intentional or non-intentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and well-being of the individual and sometimes to their community.

### ***Indicators of self-neglect may be:***

- living in very unclean, sometimes verminous, circumstances
- poor self-care leading to a decline in personal hygiene
- poor nutrition
- poor healing/sores
- poorly maintained clothing
- long toenails
- isolation
- failure to take medication
- hoarding large numbers of pets
- neglecting household maintenance
- portraying eccentric behaviour/lifestyles
- alcohol and substance misuse

NOTE: Poor environments and personal hygiene may be a matter of personal or lifestyle choice or other issues such as insufficient income.

### **Location of Abuse**

Abuse can take place anywhere. For example:

- the person's own home, whether living alone, with relatives or others
- day or residential centres
- supported housing
- work settings

- educational establishments
- care homes
- clinics/hospitals
- prisons
- other places in the community.

### **Who Might Abuse?**

Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the adult with care and support needs. A wide range of people may harm adults. These include:

- a spouse/partner
- an adult with care and support needs
- other family members
- neighbours
- friends
- local residents
- people who deliberately exploit adults they perceive as vulnerable to abuse
- paid staff or professionals
- volunteers and strangers.

A lot of attention can be paid to targeted fraud or internet scams perpetrated by complete strangers, however, it is far more likely that the person responsible for abuse is known to the adult and is in a position of trust and power.

### **Mental Capacity**

The presumption in the Mental Capacity Act 2005 is that adults have the mental capacity to make informed choices about their own safety and how they live their lives. Issues of mental capacity and the ability to give informed consent are central to decisions and actions in adult safeguarding. All interventions need to take into account the ability of adults to make informed choices about the way they want to live and the risks they want to take. This includes their ability:

- to understand the implications of their situation and to take action themselves to prevent abuse
- to participate to the fullest extent possible in decision-making about interventions.

The MCA 2005 provides a statutory framework to empower and protect people who may lack capacity to make decisions for themselves and establishes a framework for making decisions on their behalf. This applies whether the decisions are life-changing events or everyday matters. All decisions taken in the adult safeguarding process must comply with the Act.

The Mental Capacity Act (MCA) states that if a person lacks mental capacity to make a particular decision, then whoever is making that decision or taking any action on that person's behalf must do this in the person's best interests.

The person who has to make the decision is known as the 'decision-maker', and depending on the decision to be made this may be a carer responsible for the day-to-day care (including both care staff, relatives or friends), or a professional such as a doctor, nurse or social workers where decisions about treatment, care arrangements or accommodation have to be made.

## APPENDIX 6

### BODY MAP1 (Female)

Name of adult: .....

Date of birth.....

Name of person completing body map: .....

Date/time of completion: .....

Date of incident/injury.....

Contact details of completing person: .....

The Body Map is to be used by practitioners to record the location, size and number of injuries which may have been caused as a result of abuse or inappropriate care (as a precursor to medical/police photography). Please draw on the body map, in black ink, using the following key to indicate the different types of injury (alphabetic code), and provide brief details for each injury, e.g. measurements of wound, colour of bruise, etc. using arrows:

A - Pressure ulcers

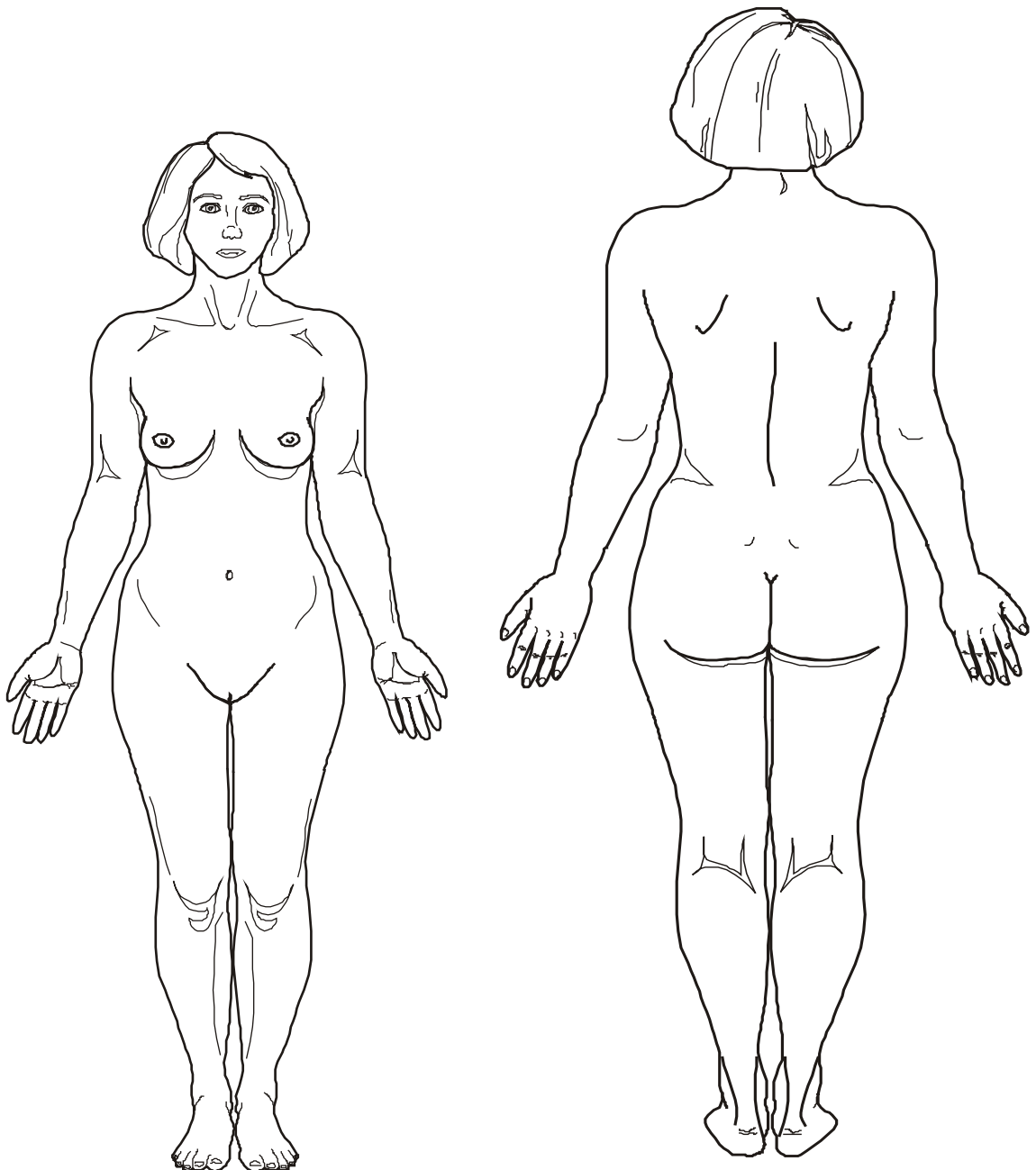
D - Excoriation, red areas (not broken down)

B - Bruising

E - Scalds, burns

C - Cuts, wounds

F - other (specify)



## BODY MAP2 (Male)

Name of adult: .....

Date of birth: .....

Name of person completing body map: ..... Date/time of completion: .....

Contact details of completing person: .....

The Body Map is to be used by practitioners to record the location, size and number of injuries which may have been caused as a result of abuse or inappropriate care (as a precursor to medical/police photography).

Please draw on the body map, in black ink, using the following key to indicate the different types of injury (alphabetic code), and provide brief details for each injury, e.g. measurements of wound, colour of bruise, etc. using arrows:

A - pressure ulcers

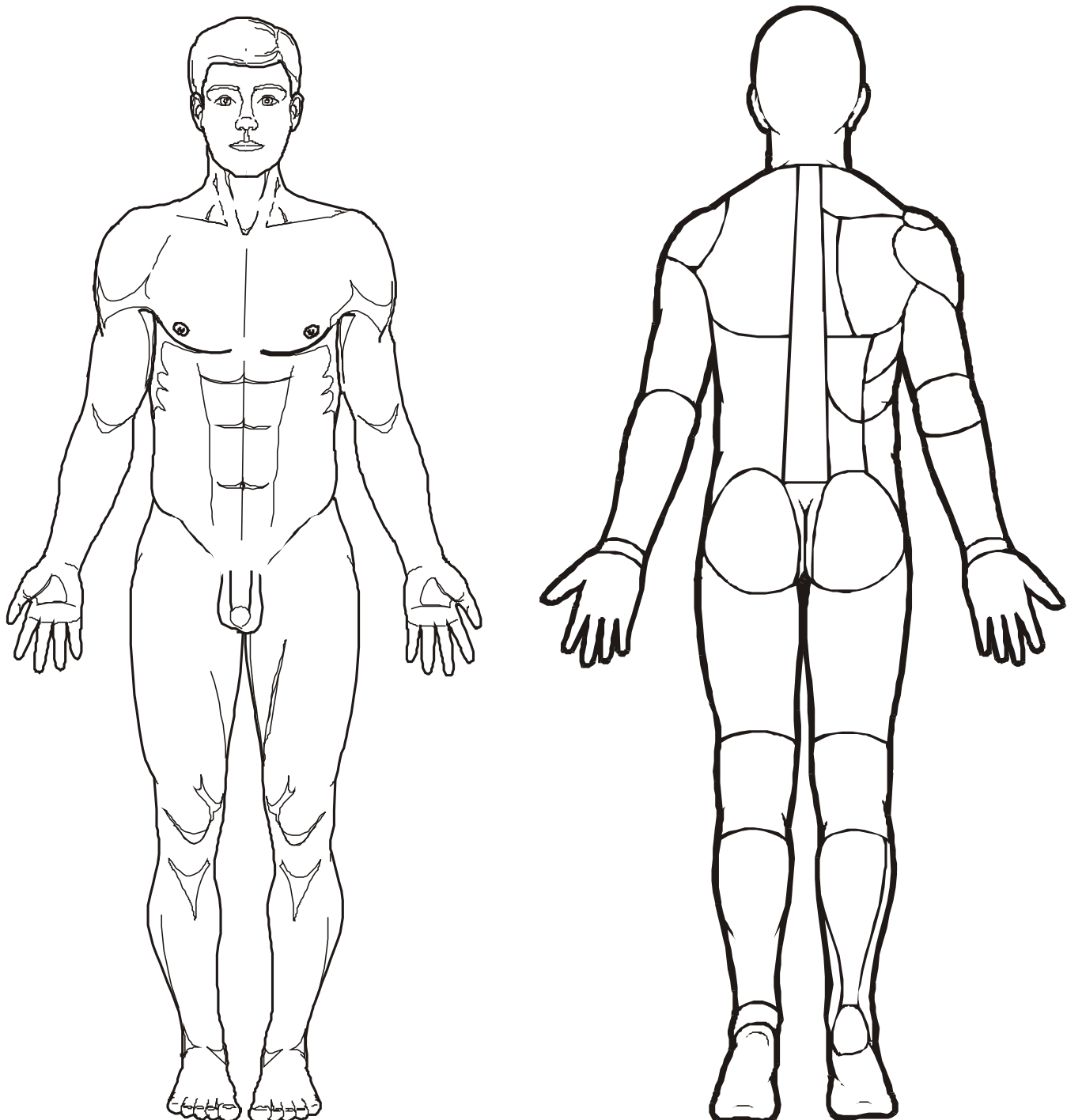
B - bruising

C - cuts, wounds

D - excoriation, red areas (not broken down)

E - scalds, burns

F - other (specify)



## Prevent Guidance

### 1.0 Summary

- 2.1 The Trust operates a zero tolerance to those who abuse or neglect vulnerable people; this includes staff and the public. All suspected cases of abuse or radicalisation of patients whilst under the care of the Trust will be thoroughly investigated within the Trust and with partner agencies as per the Prevent Duty. The Trust's Disciplinary Procedure will be followed in any suspected cases and the appropriate action will be taken.
- 2.2 The objectives of this guidance are to provide clear direction on reporting any safeguarding concerns or allegations of abuse or exploitation in relation to radicalisation and to set out the levels of responsibility to ensure that:
- Staff members are aware of the policy
  - Children and adults are not subjected to any form of radicalisation whilst under the care of the University Hospitals of North Midlands (UHNM)
  - Staff members receive the appropriate levels of Prevent training
  - Staff members consider the potential for radicalisation and feel supported in identifying suspected signs of radicalisation
  - Any concerns regarding radicalisation are reported and thoroughly investigated
  - Appropriate action is taken
  - The Trust complies with relevant legislation and partnership policies

#### What this means for staff?

This guidance sets out the aims, objectives and scope for the provision and development of prevention of the radicalisation of vulnerable patients within UHNM. The policy is relevant to all clinical, managerial and support staff and volunteers. The guidance refers to vulnerable adults, children and young people who are under the care of staff employed by UHNM.

### 3.0 Introduction

- 3.1 In 2017, we saw a significant shift in the terrorist threat to the UK, with five attacks in London and Manchester that led to the deaths of 36 innocent people and injured many more. The recent attacks across Europe and the UK have demonstrated the speed diversity and accessibility of methods, by which individuals who are vulnerable to these radicalising messages can prepare and commit attacks
- 3.2 This has had a profound effect on the threat to the UK. Although Islamist terrorism is the foremost terrorist threat to the UK, extreme right-wing terrorism is an increasing threat. In December 2016, National Action was the first extreme right-wing group to be proscribed, under the Terrorism Act 2000. The Government took further action in September 2017, proscribing Scottish Dawn and National Socialist Anti-Capitalist Action (131) as aliases of National Action.
- 3.3 CONTEST (2023): is the Government's national counter terrorism strategy. It aims to reduce the risk to the United Kingdom and its interests overseas from international terrorism, so that people can go about their lives freely and with confidence.

CONTEST has four main work streams:

- Pursue: to stop terrorist attacks
- Protect: to strengthen our protection against terrorist attack
- Prepare: where an attack cannot be stopped, to mitigate its impact
- Prevent: to stop people becoming terrorists or supporting terrorism

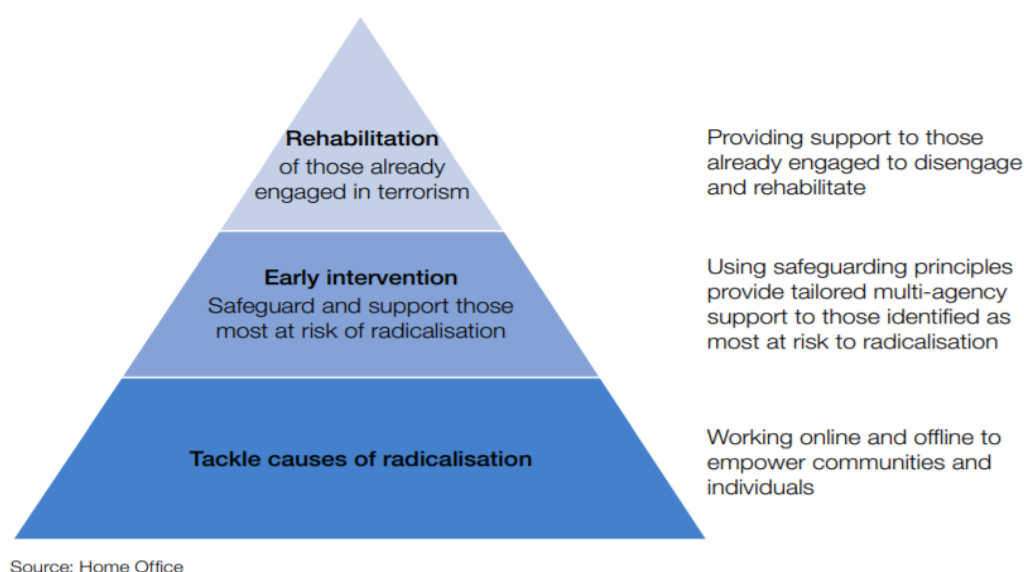
- 3.4 The Prevent Strategy was first published in June 2011 and is part of the United Kingdom's counter-terrorism strategy overall counter-terrorism strategy. The Counter Terrorism and Security Act 2015: Section 26 places a legal duty on certain bodies including the NHS to have 'due regard to the need to prevent people from being drawn into terrorism

These forms of terrorism include but are not limited to:

- Al-Qa'ida/ISIS influenced groups
- The Extreme Far Right
- Left Wing Extremists
- Irish dissident republican groups
- Environmental extremists
- Animal Rights extremists

A list of proscribed terrorist groups or organisations can be found on the Home Office's website <https://www.gov.uk/government/publications/proscribed-terror-groups-or-organisations--2/proscribed-terrorist-groups-or-organisations-accessible-version#list-of-proscribed-international-terrorist-groups>

- 3.5 CONTEST 3.0 was published in June 2018 to reflect the findings from a review of all aspects of counter-terrorism and to future-proof the strategy in its response to heightened threats. It has defined three core aims of the Prevent strategy to reduce the threat to the UK from terrorism by: -
- Safeguarding and support those at most risk of radicalisation through early intervention, identifying them and offering support.
  - Enabling those who have already engaged in terrorism to disengage and rehabilitate.
  - Tackling the causes of radicalisation and respond to the ideological challenge of terrorism.



- 3.6 Health's primary role will continue to be under the safeguarding element of these approaches and is no different from the duty of care to safeguard vulnerable individuals from other forms of exploitation, including protecting people from gang activity, drug abuse, and physical and sexual abuse. All healthcare staff have a duty to safeguard the vulnerable and raise concerns if they suspect that someone may be at risk of harm.

#### 4.0 Scope:

- 4.1 Preventing someone from becoming a terrorist or supporting terrorism is no different from safeguarding vulnerable individuals from other forms of exploitation. Therefore, this guidance sits alongside the UHNM's Safeguarding Adults Policy and Safeguarding Children's Policy.

- 4.2 This guidance applies to all staff employed by UHNM either directly or indirectly, including volunteers, sub-contractors, and agency workers across all service lines, both clinical and non-clinical and any other person or organisation that uses UHNM premises for any purpose.

## 5.0 Duties within the organisation in delivering the *Prevent* Strategy

- 5.1 Radicalisation is a process and not an event, and there is no single route or pathway to radicalisation. Evidence indicates that those targeted by radicalisers may sometimes have doubts or call into question about what they are doing and there may therefore be opportunities to intervene and safeguard them or others from harm. It is because of this doubt that frontline health and social care workers need to have mechanisms and interventions in place to support a person being exploited and to help safeguard them from being drawn into criminal activity and terrorism.
- 5.2 Thus, UHNM has a duty to ensure safe environments where extremists are unable to operate or exploit others. It is essential, therefore, that all staff know how they can recognise and support vulnerable people (patients, service users, carers or members of staff) who they feel may be at risk of being radicalised or drawn into terrorism. *Prevent* is a legal duty for all NHS Trusts and Foundation Trusts and is a contractual requirement for any service provider who is subject to the Standard NHS Contract. It is also part of the everyday safeguarding routine for NHS staff and those providing NHS services.

## 5.3 Specific duties include

- 5.3.1 The Chief Executive: - is responsible for ensuring that the Trust has policies in place and complies with its legal and regulatory obligations. The Chief Executive will provide the means necessary to ensure that staff develop and promote good practice in *Prevent*. As such, the Chief Executive has delegated a number of responsibilities to the following managers and key workers within the Trust: -
- 5.3.2 Chief Nurse: As the executive *Prevent* Lead, the Executive Director of Nursing will ensure that quarterly *Prevent* returns are submitted to the Clinical Commissioning Group/London Regional *Prevent* Co-ordinator, in line with NHS England guidance. This data relates to the Safeguarding clause of the NHS Standard Contract [clause SC32] and progress being made by the organisation to implement the *Prevent* Duty requirements. This includes data relating to numbers of referrals and staff attending Basic *Prevent* Awareness and Level 3 *Prevent* Training.
- 5.3.3 Lead for Vulnerable Patients / Prevent Lead
- They are also responsible for trust wide implementation and compliance with the *Prevent* policy.
  - Making arrangements for a suitable number of training places and events to be delivered to allow all relevant staff identified in the training needs analysis to access the *Prevent* training programme.
  - Ensuring that a Training Plan is in place for *Prevent* Training at Level 1- 3.
  - Providing training reports to the Trust Board as required
  - Ensure that quarterly *Prevent* returns are submitted to the Clinical Commissioning Group
- 5.3.4 Matrons/ Departmental Managers
- Matrons have been identified as key figures in supporting the safeguarding vulnerable adults agenda, including *Prevent*, within their areas, working with the Senior Nurse for Safeguarding, ensuring clinical staff know what action to take should a *Prevent* concern be disclosed.

Managers are responsible for ensuring policies are implemented, communicated to their staff and that staff adhere to the guidance detail: -

- They are responsible for ensuring staff attend relevant training.

- Supporting staff with the processes to escalate a concern
- Liaising with Human Resources Department if the concern raised is about a member of staff

#### 5.3.5 Lead Nurse for Safeguarding

The Lead Nurse for Safeguarding will assist the Lead for Vulnerable Patients in implementing, monitoring and reporting on the progress of implementation, uses and outcomes related to this policy.

#### 5.3.6 All Staff

All Trust staff, including volunteers have a responsibility to familiarise themselves with this guidance and to adhere to its process.

Any concerns must be reported and to the relevant line manager. Staff members have a responsibility to respond sensitively to a Prevent concern, act in a professional manner and take appropriate action

### 6.0 Training

6.1 All staff at UHNM will undertake Basic Prevent Awareness Training (BPAT) level 1 & 2. This training is mandatory and is covered within the Adult Safeguarding Level 1 training. E-learning training can be accessed via ESR, and staff must undertake a 3 yearly update.

6.2 Qualified Nurses, Midwives, Allied Health Professionals and Medical staff are required to undertake an enhanced level of training (WRAP level 3, 4 & 5). This training can be accessed via E-learning by logging on to the following external site:

<https://www.elearning.prevent.homeoffice.gov.uk/mentalhealth>

**Note: if you undertake the above E-learning package please print off the certificate and forward via E-mail to [Adult.SafeguardingTeam@uhnm.nhs.uk](mailto:Adult.SafeguardingTeam@uhnm.nhs.uk) in order that your training can be uploaded to ESR.**

### 7.0 Health Engagement with the Prevent strategy 2011

7.1 The *Prevent* Strategy 2011 addresses all forms of terrorism and non-violent extremism which can create an atmosphere conducive to terrorism and can popularise views which terrorists then exploit. *Prevent* deals with all kinds of terrorist threats to the United Kingdom. The most significant of these threats is currently from organisations in Syria and Iraq and Al Qa'ida/ISIS associated groups. Terrorist associated with the extreme right wing also poses a continued and increasing threat to safety and security. The aim of *Prevent* is to stop people from becoming terrorists (often referred to as being radicalised) or supporting terrorism. It operates in the pre-criminal space before any criminal activity has taken place.

7.2 The three revised key objectives of the *Prevent* Strategy are to:

- I. Safeguard and support those at most risk of radicalisation through early intervention, identifying them and offering support.
- II. Enable those who have already engaged in terrorism to disengage and rehabilitate.
- III. Tackle the causes of radicalisation and respond to the ideological challenge of terrorism.

Health organisations are expected to be involved in delivering objective 1 only and health staff are well placed to recognise individuals, whether service users, patients, or colleagues, who may be vulnerable and more susceptible to radicalisation by violent extremists or terrorists. All staff have a safeguarding duty and are expected to act as they would when they identify any other safeguarding concern.

## **8.0 Process of Exploitation**

- 8.1 Radicalisation is a process and not an event. Government and academic research has consistently indicated that there is no single socio-demographic profile of a terrorist in the UK and no single pathway, or 'conveyor belt', leading to involvement in terrorism. Terrorists come from a broad range of backgrounds and appear to become involved in different ways and for differing reasons.
- 8.2 While there is no one single reason to cause someone to become involved in terrorism, several factors can converge to create the conditions under which there is a cognitive opening where radicalisation can occur. There are also certain engagement factors sometimes referred to as "psychological hooks" related to personal circumstances which may make some individuals more susceptible to being drawn into terrorism
- 8.3 However, the increasing body of evidence indicates that factors relating to personal experiences of vulnerable individuals affect the way in which they relate to their personal environment and may make them susceptible to exploitation or supporting terrorist activities (see APPENDIX 1-VULNERABILITY FACTORS). Vulnerable individuals who may be susceptible to radicalisation can be patients, carers and/or staff and everyone's pathway is different.
- 8.4 Radicalisers often use a persuasive rationale or narrative to promote their extremist ideology and are usually charismatic individuals who can attract people to their cause which is based on an interpretation or distortion of history, politics and/or religion.
- 8.5 The key challenge for the health sector is to ensure that, where there are signs that someone is vulnerable to being drawn into terrorism, health and social care workers are aware of the support that is available and are confident in referring the person for further support when a concern is identified.

## **9.0 Internet**

- 9.1 Islamist and Extreme Right-Wing radicalisers exploit the internet to promote their narratives, influencing extremists within our own communities to disrupt our way of life through acts of violence. They groom the vulnerable and the young to join their movement, inspiring people within our own communities to harm others
- 9.2 Vulnerable individuals may be exploited in many ways by radicalisers and this could be through often through leaflets, direct face to face contact, or increasingly through the internet, social networking or other media.
- 9.3 The power of the internet in the radicalisation process cannot therefore be underestimated and radicalisers are making ever more sophisticated use of social media to spread their extremist messages and ideologies.
- 9.4 The internet provides a platform for extremists to promote their cause and encourage debate through websites, internet forums and social networking. It is a swift and effective mechanism for disseminating propaganda material and mobilising support but is not always easy or possible to monitor or regulate.
- 9.5 UHNM staff should be aware of anyone making frequent visits to websites showing images such as armed conflict around the world and providing speeches and access to material from those involved in the radicalising process.
- 9.6 A dedicated website to report suspected terrorism or suspicions that some may be involved in terrorism is available at:  
<https://www.gov.uk/report-terrorism>

## 10.0 Raising *Prevent* Concerns on People that that receive services through UHNM

10.1 During daily work, healthcare workers may face situations that give them cause for concern about the potential safety of a patient, their family, staff or others around them. Early intervention can redirect a vulnerable individual away from carrying out an act of terrorism. By working closely with partners, such as local authorities, social services, the police and others, healthcare organisations can improve their effectiveness in how they protect vulnerable individuals from causing harm to themselves or the wider community. The health sector will need to ensure that the crucial relationship of trust and confidence between patient and clinician is balanced with the clinician's professional duty of care and their responsibility to protect wider public safety.

10.2 In the event that a member of UHNM staff has concerns that a colleague, patient, service user or carer may be at risk of being drawn into terrorism, has begun to express radical extremist views or may be vulnerable to grooming or exploitation by others, the primary point of contact will be their ward or department manager (see para 13.0 Escalating Concerns in relation to Employees). The UHNM *Prevent* Lead will support such enquires with assistance where required from the appropriate Local Authority Prevent Team Lead.

10.3 If there is an immediate threat to life, staff must call the police via 999. Report to the site team and your manager. Complete the Prevent record of referral following and submit to [Adult.SafeguardingTeam@uhnm.nhs.uk](mailto:Adult.SafeguardingTeam@uhnm.nhs.uk)  
If there is no immediate threat - all concerns should initially be discussed with the care team supporting the person prior to referral. If agreed that escalation is appropriate, this should be done by completing the Prevent record of referral, sending to [Adult.SafeguardingTeam@uhnm.nhs.uk](mailto:Adult.SafeguardingTeam@uhnm.nhs.uk)  
Within office hours (Monday – Friday) Line Manager to discuss with the PREVENT Lead on extension 71589 at the earliest opportunity. Out of office hours – send the completed referral form and send to [Adult.SafeguardingTeam@uhnm.nhs.uk](mailto:Adult.SafeguardingTeam@uhnm.nhs.uk)

10.4 If it is determined that an adult safeguarding referral needs to be made, it will be done in accordance with Policy C36.

10.5 Staff can also seek general advice from their manager and any On-Call Manager.

10.6 All referrals for children (age under 18 years) to the PREVENT lead (as per 10.3) must also be referred to the local children's social care service as a child protection referral – see Policy C23

10.7 Staff can also seek general advice from the Safeguarding Team or Trust Prevent Lead.

10.8 The Home Office have introduced new Prevent awareness training which introduces users to the NOTICE-CHECK-SHARE procedure for evaluating and sharing concerns. The package shares best practice on how to articulate concerns about an individual, and ensure that they are robust and considered.  
<https://www.elearning.prevent.homeoffice.gov.uk/preventreferrals>.

## 11.0 Escalating Concerns in relation to Employees

11.1 Although there are relatively few instances of staff radicalising others or being drawn into extremist activity, it is still a risk that UHNM needs to be aware of and have processes within which to manage any concerns e.g. disciplinary action.

11.2 Where any employee expresses views, brings material into UHNM, uses or directs patients to extremist websites or acts in other ways to promote terrorism, UHNM will look to use non-safeguarding processes to address the concerns.

11.3 Where a staff member has a concern about a colleague, this should be raised with their Line Manager. The Prevent record of referral is to be completed and sent to [Adult.SafeguardingTeam@uhnm.nhs.uk](mailto:Adult.SafeguardingTeam@uhnm.nhs.uk) The Line Manager will discuss the concerns with the *Prevent*

Lead and Human Resources Department in the first instance. If deemed necessary, the *Prevent* Lead will support the completion of/complete the relevant Raising a *Prevent* Concern Referral Form/ Safeguarding referral form on behalf of the staff member.

- 11.4 The *Prevent* Lead will liaise with colleagues in the Local Safeguarding Team to assess and manage any related safeguarding risks and, where appropriate, the Local Authority Prevent Lead. The Human Resources Advisor will lead on advising the Line Manager in relation to the disciplinary process; should this be appropriate.

If you feel that a call needs a more urgent Prevent response (e.g. if there is a significant concern – particularly it is out of hours) there are some useful telephone numbers you can call. Remember: - you should always trust your instincts.

The 101 number is designed encourage people to make contact with the police at an early stage to prevent or detect crime. In terms of Prevent, the earlier authorities can be involved the greater the chance we can intervene with partners and stop someone from being radicalised.

#### Confidential Anti-Terrorist Hotline

If you are suspicious that someone is being radicalised or that the call is terrorism related you can call the confidential Anti-Terrorist Hotline on 0800 789 321

In an emergency where you feel that there is an immediate terrorist threat please call 999

## **12 Requests for Information about an Individual raised by another organisation:**

- 12.1 Generally requests for patient information should be made in writing, justifying the grounds for disclosure and submitted to the Data Controller of the data system from which the information is sought. The seriousness of the potential crime and the risk of harm to the individual or the public may outweigh the need to maintain patient confidentiality. The amount of information shared should be appropriate and responsive to the concern raised (see para(s) 16.3/16.6)
- 12.2 In situations where disclosures to (or information sharing with) the police may become routine, it is considered as good practice to have a purpose specific information protocol which is agreed between the organisation and the police, so that all staff involved know what to do.
- 12.3 Note that the Crime and Disorder Act 1998 (see Appendix 3 Information Sharing) does not in itself constitute a statutory requirement for NHS organisations to disclose patient information to other agencies. This should be determined on a case by case basis with an informed *Prevent* Lead for each organisation
- 12.4 If the *Prevent* Lead is asked to share information for the purposes of preventing an individual from being drawn into terrorism, the following question should be considered:
- By sharing the information, is the intention to safeguard the individual from criminal exploitation, grooming (being drawn into terrorism) or self-harm?
  - In sharing information, is a serious crime being prevented or detected
  - Is the information that has been requested appropriate to the risk of the serious crime of exploitation to the individual who may be drawn into supporting terrorism?
  - In being drawn into terrorism does this individual pose harm to themselves or the wider public?
  - Can the public interest justification be clearly stated?  
(If in doubt, seek advice from your organisation's Caldicott guardian)
  - The GMC *Confidentiality: good practice in handling patient information guidance updated May 2018* also provides a framework to help you decide when you can share information and helps you to think about why you are sharing the information. This may be for the direct care or protection of the patient, to protect others or for another reason. It also has a handy flowchart which you can use to help you decide whether to share the information Toolkit.

## **APPENDIX 1 - VULNERABILITY FACTORS**

### **Use of extremist rational (often referred to as 'narrative')**

Radicalisers usually attract people to their cause through a persuasive rationale contained within a storyline or narrative that has the potential to influence views. Inspiring new recruits, embedding the beliefs of those with established extreme view and/or persuading others of the legitimacy of their cause is the primary objective of those who seek to radicalise vulnerable individuals.

### **What factors might make someone vulnerable?**

In terms of personal vulnerability, the following factors may make individuals susceptible to exploitation. None of these are conclusive in themselves and therefore should not be considered in isolation but should be contextualised and considered in conjunction with the circumstances of the case and any other signs of radicalisation. Remember Prevent does not require you to do anything in addition to your normal duties. What is important is that if you have a concern that you raise these in line with the University Hospitals of North Midlands policies and procedures

### **Use of extremist rational (often referred to as 'narrative')**

Radicalisers usually attract people to their cause through a persuasive rationale contained within a storyline or narrative that has the potential to influence views. Inspiring new recruits, embedding the beliefs of those with established extreme views and/or persuading others of the legitimacy of their cause is the primary objective of those who seek to radicalise vulnerable individuals.

### **Identity Crisis:**

Adolescents/vulnerable adults who are exploring issues of identity can feel both distant from their parents/family, cultural and religious heritage and uncomfortable with their place in society around them. Radicalisers can exploit this by providing a sense of purpose or feelings of belonging. Where this occurs, it can often manifest itself in a change in a person's behaviour, their circle of friends and the way in which they interact with others and spend their time.

### **Criminality:**

In some cases, a vulnerable individual may have been involved in a group that engages in criminal activity or, on occasion, a group that has links to organised crime and be further drawn to engagement in terrorist-related activity

### **Personal Grievances:**

The following are examples of grievances which may play an important in the early indoctrination of vulnerable individuals into the acceptance of a radical view and extremist ideology:

- A misconception and/or rejection of UK foreign policy
- A distrust of Western media reporting
- Perceptions that UK government policy is discriminatory (e.g. counter-terrorism legislation)
- Ideology and politics
- Provocation and anger (grievance)
- Need for protection
- A distrust of Western media reporting
- Seeking excitement and action
- Fascination with violence, weapons and uniforms
- Youth rebellion
- Seeking family and father substitutes
- Seeking friends and community
- Seeking status and identity

### **Personal Crisis:**

This may, for example, include significant tensions within the family that produce a sense of isolation of the vulnerable individual from the traditional certainties of family life.

### **Personal Circumstances:**

The experience of migration, local tensions or events affecting families in countries of origin may contribute to alienation from UK values and a decision to cause harm to symbols of the community or state.

### Unemployment or under-employment:

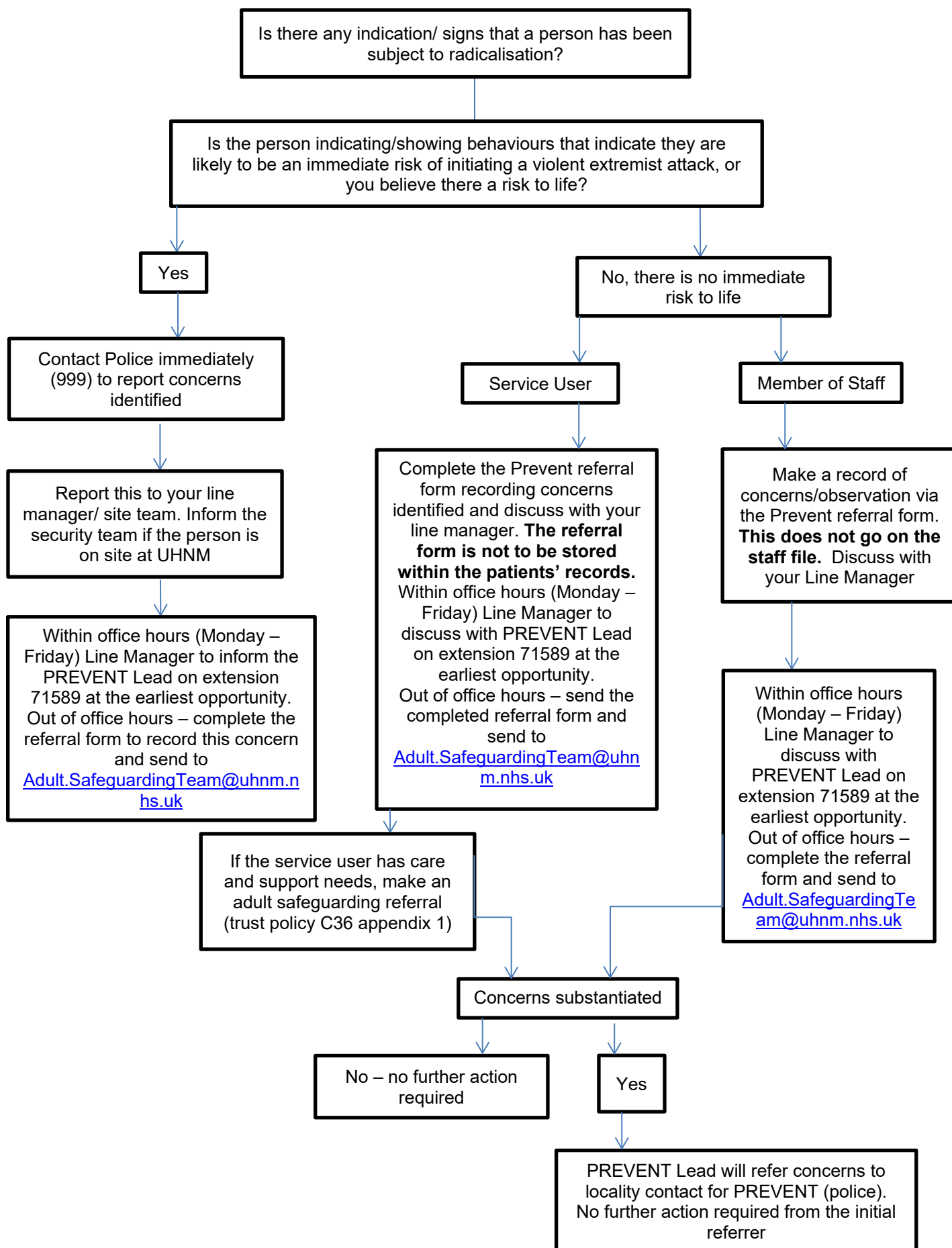
Individuals may perceive their aspirations for career and lifestyle to be undermined by limited achievements or employment prospects. This can translate to a generalised rejection of civic life and adoption of violence as a symbolic act.

These are further articulated in the <https://www.gov.uk/government/publications/channel-vulnerability-assessment>

## APPENDIX 2: DEFINITIONS

|                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Terrorism</b>            | Actions of individuals or groups who seek to bring about social or political change through actions intended to cause serious harm, loss of life or raise attention through fear and/or damage to property to cause loss of life, disruption or raise attention by fear and/or damage to property                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Radicalisation</b>       | The process of grooming an individual to support, encourage or condone violence to advance terrorist ideology                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Extremism</b>            | Vocal or active opposition to fundamental values including democracy, the rule of the law, individual liberty, and mutual respect and tolerance of different beliefs and faiths. We also include in the definition of extremism calls for the death of members of our armed forces, whether in this country or overseas.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>CONTEST Strategy 3.0</b> | Sits under the Home Office and is a national strategy or long-term plan of action designed to reduce the risk of terrorism, by stopping people becoming terrorists, preventing terrorist attacks, strengthening the UK's resilience to terrorism and facilitating emergency preparedness procedures in the event of attack                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prevent Strategy</b>     | Safeguarding and support those at most risk of radicalisation through early intervention, identifying them and offering support.<br>Enabling those who have already engaged in terrorism to disengage and rehabilitate.<br>Tackling the causes of radicalisation and respond to the ideological challenge of terrorism.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Vulnerability</b>        | In the context of <i>Prevent</i> is a person who is susceptible to extremists' messages and is at risk of being drawn into terrorism or supporting terrorism at a point in time.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Channel</b>              | Multi-agency approach to protect people at risk from radicalisation.<br>Channel uses existing collaboration between local authorities, statutory partners (such as education and health sectors, social services, children's and youth services and offender management services, the police and the local community) to: <ul style="list-style-type: none"> <li>• identify individuals at risk of being drawn into terrorism;</li> <li>• assess the nature and extent of that risk; and</li> <li>• develop the most appropriate support plan for the individual concerned.</li> </ul> Channel is about safeguarding children and adults from being drawn into committing terrorist-related activity. It is about early intervention to protect and divert away from the risk they face before illegality occurs |

## **PREVENT – REPORTING FLOWCHART FOR RAISING CONCERNS**



## **Prevent Referral Form**

### **1. Referrer's details**

|                |                          |
|----------------|--------------------------|
| Date:          | Your Name:               |
| Clinical area: | Your work email address: |

### **2. Details of person the concern is relating to**

|                                                      |                                              |
|------------------------------------------------------|----------------------------------------------|
| Patient/ staff members name:                         | Their clinical area of work if staff member: |
| Hospital Number if the concern relates to a patient: |                                              |

### **3. Details of concern**

|                                                                                                                                                                                                             |                 |  |    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|--|----|
| <b>Details of concern</b><br>Please provide a summary of concerns identified                                                                                                                                |                 |  |    |
| <b>Did the concerns warrant an immediate call to the police?</b><br>Police should only be contacted if the person is indicating/ showing behaviours that pose an immediate risk to life (as per flow chart) | Yes             |  | No |
|                                                                                                                                                                                                             | Date of call    |  |    |
|                                                                                                                                                                                                             | Time of call    |  |    |
|                                                                                                                                                                                                             | Outcome of call |  |    |
| <b>Have you reported your concerns to others? I.e. HR, your line manager?</b><br>If so please provide names of those you have reported to here                                                              |                 |  |    |
| <b>Immediate action taken</b><br>Please provide here a summary of any immediate action taken i.e. HR and managers notified for staff, for patients higher observations and escalation to security           |                 |  |    |

**Once completed, please submit via email to [Adult.SafeguardingTeam@uhnm.nhs.uk](mailto:Adult.SafeguardingTeam@uhnm.nhs.uk) and the internal safeguarding team will process your referral. You will receive a reply on the next working day and you will be updated as to the outcome of your referral**

## **Guidance for the Reporting of Female Genital Mutilation (FGM)**

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## 1.0 Purpose

Any staff member within the Trust has the potential to influence a woman not to subject their daughter to FGM by emphasising the risks to their health and potential lifelong complications.

This guidance provides information on identifying when a girl (under the age of 18) or women may be at risk of being subjected to FGM and responding appropriately to protect and support them in addition to the correct recording procedures.

## 2.0 Background

Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons (WHO, 2025).

Communities that practice FGM, describe a variety of social and religious reasons for the practice. The practice of FGM has no health benefits, and can result in severe bleeding, problems urinating, and later in life; cysts, menstrual difficulties, infections, and complications during childbirth.

WHO estimates over 200 million girls and women have been subjected to FGM in the 30 countries in Africa, the Middle East and Asia where FGM is concentrated. In the UK, it is estimated that:

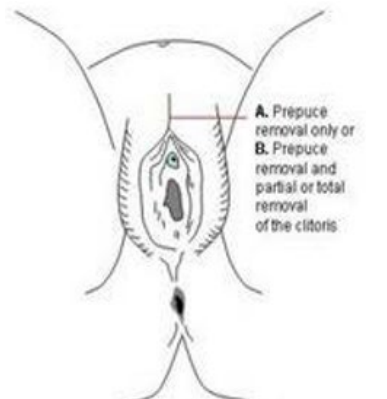
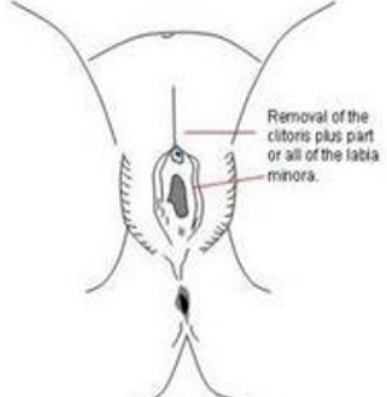
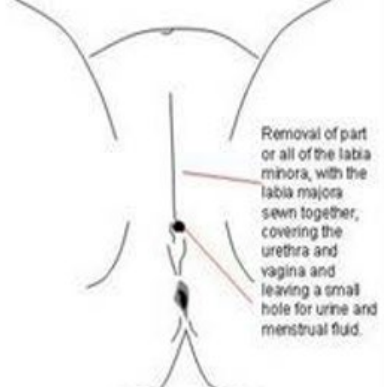
- Around 137,000 women have undergone FGM
- Around 60,000 girls under the age of 15 years old are at risk

FGM is illegal for females under the age of 18, and must be reported to the police if detected. It is an extremely harmful procedure and has been recognised as a form of child abuse and gender violence against women (DH, 2015).

## 3.0 Types of FGM

Recognition of the different types of FGM is important, and where possible recorded accurately within the notes. The World Health Organisation (2025) classifies FGM as -

| Picture                                                                             | Type          | Description |
|-------------------------------------------------------------------------------------|---------------|-------------|
|  | Usual anatomy |             |

|                                                                                                                                                                                                                                                                     |               |                                                                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>FGM guidance page 4</p>  <p>A. Prepuce removal only or<br/>B. Prepuce removal and partial or total removal of the clitoris</p>                                                  | <p>Type 1</p> | <p>This is the partial or total removal of the clitoral glans (the external and visible part of the clitoris, which is a sensitive part of the female genitals), and/or the prepuce/clitoral hood (the fold of skin surrounding the clitoral glans).</p>                                                          |
|  <p>Removal of the clitoris plus part or all of the labia minora.</p>                                                                                                             | <p>Type 2</p> | <p>This is the partial or total removal of the clitoral glans and the labia minora (the inner folds of the vulva), with or without removal of the labia majora (the outer folds of skin of the vulva).</p>                                                                                                        |
|  <p>Removal of part or all of the labia minora, with the labia majora sewn together, covering the urethra and vagina and leaving a small hole for urine and menstrual fluid.</p> | <p>Type 3</p> | <p>Also known as infibulation, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoral prepuce/clitoral hood and glans.</p> |
|                                                                                                                                                                                  | <p>Type 4</p> | <p>This includes all other harmful procedures to the female genitalia for non-medical purposes, e.g., pricking, piercing, incising, scraping and cauterizing the genital area.</p>                                                                                                                                |

#### 4.0 Policy for the Reporting of Female Genital Mutilation

If a health care professional during the course of their professional practice comes across the physical findings of FGM in a female they should follow the **FGM flowchart** (FGM guidance appendix 1).

FGM is a crime and if you have reason to believe a vulnerable person i.e. child or adult is in immediate and serious risk of harm, or that a crime has been committed call the Police on 999.

##### Children and young adults (those aged below 18years old) –

If the female is under the age of 18 discloses FGM, staff discover FGM, or there is a risk of FGM –

- then staff must inform the police immediately via 101
- complete FGM guidance appendix 4 child/ young adult proforma

FGM guidance page 5

- seek guidance from the Trust Safeguarding team
- Any suspicion of intended or actual FGM for a child aged under 18 years must be referred to Children's Social Care (as per trust policy C23). Social Care will conduct a Section 47 enquiry and may formulate a Child Protection Plan for any female children at risk
- When it has been identified that a young girl or woman has had FGM undertaken, information must be included within any clinical notes or discharge summary information sent to the patient's GP. This will be in addition to any other clinical findings as part of the provision of care.

### **Adults –**

There is no requirement for automatic referral of adult women with FGM to adult social services or the police. Healthcare professionals must be aware that any disclosure may be the first time that a woman has ever discussed her FGM with anyone. Referral to the police must not be introduced as an automatic response when identifying adult women with FGM, and each case must continue to be individually assessed. The wishes of the woman must be respected at all times (Department of Health, 2016).

In all cases it is also important to consider whether the individual or her family are known to social services, and whether there are any existing safeguarding arrangements in place (HM Government Multi-Agency Statutory Guidance on Female Genital Mutilation 2016).

If the female is 18 years or older discloses FGM, staff discover FGM, or there is a risk of FGM -

- complete either FGM guidance appendix 2 for women who are pregnant or recently given birth, or FGM guidance appendix 3 for non-pregnant adult women
- gather information regarding any female children within the family to identify anyone that might be at risk of this. If others at risk, complete relevant referrals for those identified as per this guidance

### **Adults with care and support needs –**

- As above (adults guidance).
- A safeguarding referral should be made to the local authority – as per Trust Adult safeguarding Policy.
- Seek support from the trust Adult or Maternity Safeguarding Team

When it has been identified that a young girl or woman has had FGM undertaken, information must be included within any clinical notes or discharge summary information sent to the patient's GP. This will be in addition to any other clinical findings as part of the provision of care.

The trust's Safeguarding teams must be made aware of any cases identified of FGM.

Adults – extension 75477 [Adult.SafeguardingTeam@uhnm.nhs.uk](mailto:Adult.SafeguardingTeam@uhnm.nhs.uk)

Children – extension 79802 [ChildProtectionNamedNurses@uhnm.nhs.uk](mailto:ChildProtectionNamedNurses@uhnm.nhs.uk)

Maternity – extension 71067/ 72102 Mandy.Stenson@uhnm.nhs.uk or [Michelle.Peake@uhnm.nhs.uk](mailto:Michelle.Peake@uhnm.nhs.uk)

### **Recording –**

All information and actions should be recorded within the patients' records.

Health professionals must be familiar with the requirements of the Health and Social Care Information Centre (HSCIC) FGM Enhanced Dataset and explain its purpose to the woman. The requirement for her personal data to be submitted without anonymisation to the HSCIC, in order to prevent duplication of

data, should be explained. However, she should also be told that all personal data are anonymised at the point of statistical analysis and publication (RCOG, Green-top Guideline, 2015).

All FGM patients should be offered a referral to the *FGM clinic* (run by Dr Fidelma O'Mahony – Gynaecology) and their details recorded on the relevant data collection form.

The FGM data collection forms will be uploaded by the relevant data team to the Department of Health.

## 5.0 The Law

In 1985 the Prohibition of Female Circumcision Act was passed within UK law stating it is an offence for any person:

- 1) To excise, infibulate or otherwise mutilate the whole or any part of the labia majora or clitoris of another person, or
- 2) To aid or abet, counsel or procure the performance of another person of any of those acts on that other person's body.

In 2003 the law was updated (Female Genital Mutilation Act 2003) making it illegal to send children abroad for the purpose of FGM. If found guilty of an offence under this act a person may be imprisoned for up to 14 years.

In 2015, section 74 of the Serious Crime Act (2015) was added to section 5B of the FGM Act 2003 mandating that all health and social care professionals in addition to teachers within England and Wales are required by law to report any 'known' cases of FGM in any under 18-year-old which they discover to the police. This duty came into effect on the 31st of October 2015.

## 6.0 Female Genital Mutilation in the UK

WHO estimates over 200 million girls and women have been subjected to FGM in the 30 countries in Africa, the Middle East and Asia where FGM is concentrated. In the UK, it is estimated that:

- Around 137,000 women have undergone FGM
- Around 60,000 girls under the age of 15 years old are at risk

It is an offence for anyone (regardless of their nationality and residence status) to perform FGM in the UK or to assist a girl to perform FGM on herself in the UK.

## 7.0 The Way Forward

**Attitudes** - It must be appreciated that these women did not choose mutilation. All staff should be aware of the practice and types of female genital mutilation and the adverse effects on women's sexual and reproductive health. Staff should be sensitive to the traditions of the communities where mutilation is practised.

**Hospital Services:** where FGM is confirmed by observation or disclosure then referral for on-going psychological support should be offered.

Identification of any female children/grandchildren/nieces/siblings should be done and safeguarding initiated. Liaison with Professionals involved with these children is also required e.g. Health Visitor/GP/School Nurse. Referral to Children's Social Care may be necessary

## 8.0 Support Services

The NSPCC has launched a free 24-hour helpline which will provide advice and support to protect UK children from female genital mutilation (FGM).

The Female Genital Mutilation helpline, 0800 028 3550 or email [fgm.help@NPSpcc.org.uk](mailto:fgm.help@NPSpcc.org.uk) is a free 24/7 service staffed by trained counsellors offering advice and support to anyone worried about female genital mutilation (FGM). The free 24-hour helpline on 0800 028 3550 and at [FGMhelp@nspcc.org.uk](mailto:FGMhelp@nspcc.org.uk) is for anyone concerned that a child's welfare is at risk because of female genital mutilation and are seeking advice, information or support. Though callers' details can remain anonymous, any information that could protect a child from abuse will be passed to the police or social services

## 9.0 Training and Resources

All new Trust staff shall have safeguarding training during induction. See the Trust's Mandatory Training Policy.

FGM E-learning package available via eLfH <https://www.e-lfh.org.uk/programmes/female-genital-mutilation/>

## 10.0 Audit and Monitoring

Audit of compliance with this guideline will be undertaken as per the Trust's safeguarding policies arrangements (C23 and C36)

Key findings and learning points will be disseminated to relevant staff.

The contact details for the FGM leads are detailed below:

**Emergency Medicine** - Dr Richard Fawcett, Emergency Department, RSUH, Ext: 74757

**Obstetrics & Gynaecology** – Dr F O'Mahony ext 72376 or Dr Usman ext 72378

**Paediatric Gynaecology** – Dr F O'Mahony ext 72376 or Dr Kadian ext 72378

If none of the above are available and it is an emergency contact the on-call consultant for obstetrics or gynaecology (adults) or paediatric consultant on call for children.

## 11.0 Equality and Diversity

The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

**FGM Guidance Appendix 1:** FGM Mandatory reporting duty flowchart

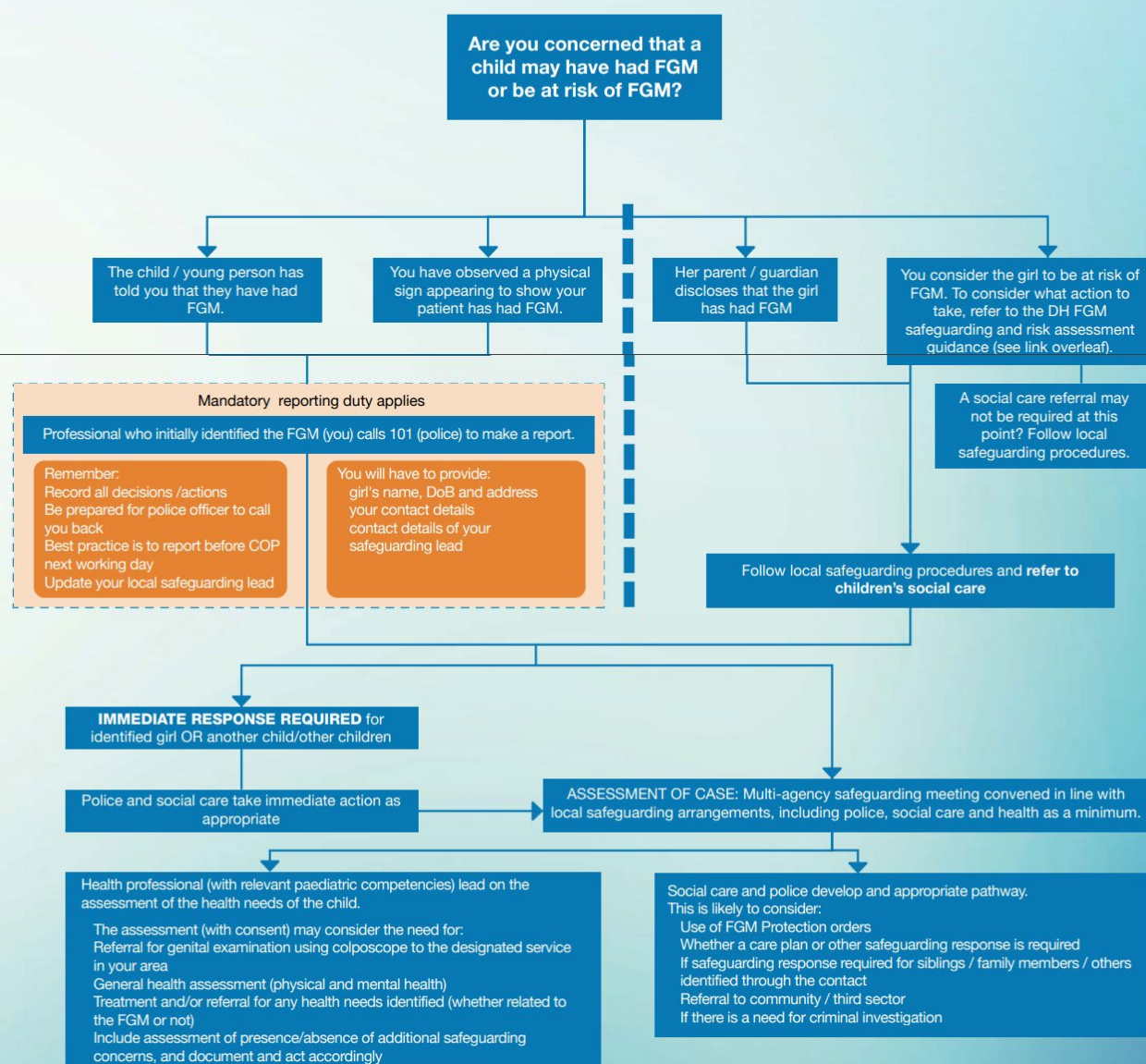


Department  
of Health



# Female Genital Mutilation (FGM)

## Mandatory reporting duty



If a girl appears to have been recently cut or you believe she is at imminent risk, act immediately – this may include phoning 999.

**REMEMBER:** Mandatory reporting is only one part of safeguarding against FGM and other abuse. **Always ask your local safeguarding lead if in doubt.**

## Female Genital Mutilation (FGM) is child abuse and illegal.

Regulated health and social care professionals and teachers are required now to report cases of FGM in girls under 18s which they identify in the course of their professional work to the police.

### How can I prepare?

FGM mandatory reporting duty and FGM safeguarding best practice guidance is available from: [www.gov.uk/dh/fgm](http://www.gov.uk/dh/fgm)

FGM eLearning:  
[www.e-lfh.org.uk/programmes/female-genital-mutilation](http://www.e-lfh.org.uk/programmes/female-genital-mutilation)

Videos: [www.nhs.uk/fgmguidelines](http://www.nhs.uk/fgmguidelines)

FGM Multi Agency Practice Guidelines: [www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation](http://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation)

- [www.workingtogetheronline.co.uk](http://www.workingtogetheronline.co.uk)

Search for guidance from Royal Colleges and regulators

### Remember:

This is a personal duty; the professional who identifies FGM / receives the disclosure must make the report. If a woman is over 18 when she discloses / you identify FGM, the duty does not apply and you should follow local safeguarding processes.

Do not undertake a genital examination unless this is already part of your role.

Complying with the duty does not breach data protection rules or other confidentiality requirements.

Non regulated healthcare staff should report through existing safeguarding procedures.

This duty is about reporting a crime. NHS organisations continue to be responsible for collecting and recording data on FGM.

## FAQs

### A girl is using another term which I think is FGM. Do I need to report?

Yes. Whether she uses the term 'FGM' or any other term or description, e.g. 'sunna' or 'cut', the duty applies.

### Does the duty apply to professionals in private education/healthcare?

Yes, if working as a regulated professional, the duty will apply.

### Should you only report if you are certain that FGM has been carried out?

When you see something which appears to show in your opinion that a girl has FGM, you should make the report. A formal diagnosis will be sought as part of the subsequent multi-agency response.

### I have identified a case but the patient is over 18, what should I do?

The duty does not apply in this case. You should signpost the woman to services offering support and advice. You may also need to carry out a safeguarding risk assessment considering children who may be at risk or have had FGM.

### Some FGM is very difficult to notice. What if I did not notice signs when I was caring for a patient who is later identified as having had FGM?

If an allegation of failure to report is made, all relevant circumstances will be taken into account by the regulators, including your experience and what could reasonably have been expected.

### I am treating a girl under 18 with a genital piercing / tattoo / non-medically indicated genital surgery. What should I do?

You should make a report.

### How quickly should I make a report?

The safety of the girl or others at risk of harm is the priority. You should report ASAP with the same urgency as for all other safeguarding cases. If you believe reporting would lead to risk of serious harm to the child or anyone else, contact your designated safeguarding lead for advice; you may need longer to take action, in exceptional circumstances.

### Should I tell the girl / family about the report?

Yes, wherever possible you should explain why the report is being made and what it means. If you believe reporting would lead to risk of serious harm to the child or anyone else, do not discuss it but instead contact your local designated safeguarding lead for advice.

### Following a risk assessment for a girl I've identified as being at risk of FGM, it isn't appropriate to refer to social care at this point. What should I do?

You should share information about the potential risk and your actions with your colleagues across health (GP, school nurse and health visitor as a minimum) and discuss next steps with your local safeguarding lead.

## FGM guidance APPENDIX 2 -

### Part One (a): PREGNANT WOMEN (OR HAS RECENTLY GIVEN BIRTH)

Date: \_\_\_\_\_ Completed by: \_\_\_\_\_  
Assessment: Initial/On-going

This is to help you make a decision as to whether the unborn child (or other female children in the family) are at risk of FGM or whether the woman herself is at risk of further harm in relation to her FGM.

| Indicator                                                                                                                                                      | Yes                      | No                       | Details |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|---------|
| <b>CONSIDER RISK</b>                                                                                                                                           |                          |                          |         |
| Woman comes from a community known to practice FGM                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Woman has undergone FGM herself                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Husband/partner comes from a community known to practice FGM                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |         |
| A female family elder is involved/will be involved in care of children/unborn child or is influential in the family                                            | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Woman/family has limited integration in UK community                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Woman and/or husband/partner have limited/no understanding of harm of FGM or UK law                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Woman's nieces, siblings and/or in-laws have undergone FGM                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Woman has failed to attend follow-up appointment with an FGM clinic/FGM related appointment                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Woman's husband/partner/other family member are very dominant in the family and have not been present during consultations with the woman                      | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Woman is reluctant to undergo genital examination                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |         |
| <b>SIGNIFICANT OR IMMEDIATE RISK</b>                                                                                                                           |                          |                          |         |
| Woman already has daughters who have undergone FGM                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Woman or woman's partner/family requesting reinfibulation following childbirth                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be considered if she is found to have FGM              | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Woman says that FGM is integral to cultural or religious identity                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Family are already known to social care services – if known, and you have identified FGM within a family, you must share this information with social services | <input type="checkbox"/> | <input type="checkbox"/> |         |

#### ACTION

**Ask more questions** – if one indicator leads to a potential area of concern, continue the discussion in this area.

**Consider risk** – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

**Significant or Immediate risk** – if you identify one or more serious or immediate risks, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services/CAIT team/ Police/MASH, in accordance with your local safeguarding procedures.

**If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.**

#### In all cases:-

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

**Please remember: any child under 18 who has undergone FGM must be referred to police under the Mandatory Reporting duty using the 101 non-emergency number.**

**Please send completed form to [Mandy.Stenson@uhnm.nhs.uk](mailto:Mandy.Stenson@uhnm.nhs.uk) and [Michelle.Peake@uhnm.nhs.uk](mailto:Michelle.Peake@uhnm.nhs.uk)**

### FGM guidance Appendix 3

## Part One (b): NON-PREGNANT ADULT WOMAN (over 18)

Date: \_\_\_\_\_ Completed by: \_\_\_\_\_  
Assessment: Initial/On-going

This is to help decide whether any female children are at risk of FGM, whether there are other children in the family for whom a risk assessment may be required or whether the woman herself is at risk of further harm in relation to her FGM.

| Indicator                                                                                                                                                 | Yes                      | No                       | Details |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|---------|
| <b>CONSIDER RISK</b>                                                                                                                                      |                          |                          |         |
| Woman already has daughters who have undergone FGM – who are over 18 years of age                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Husband/partner comes from a community known to practice FGM                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |         |
| A female family elder (maternal or paternal) is influential in family or is involved in care of children                                                  | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Woman and family have limited integration in UK community                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Woman's husband/partner/other family member may be very dominant in the family and have not been present during consultations with the woman              | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Woman/family have limited/no understanding of harm of FGM or UK law                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Woman's nieces (by sibling or in-laws) have undergone FGM                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Woman has failed to attend follow-up appointment with an FGM clinic/FGM related appointment                                                               | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Family are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services | <input type="checkbox"/> | <input type="checkbox"/> |         |

|                                                                                                                                                  |                          |                          |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--|
| <b>SIGNIFICANT OR IMMEDIATE RISK</b>                                                                                                             |                          |                          |  |
| <b>Woman/family believe FGM is integral to cultural or religious identity</b>                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Woman already has daughters who have undergone FGM                                                                                               | <input type="checkbox"/> | <input type="checkbox"/> |  |
| Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be triggered if she is found to have FGM | <input type="checkbox"/> | <input type="checkbox"/> |  |

**Please remember: any child under 18 who has undergone FGM must be referred to police under the Mandatory Reporting duty using the 101 non-emergency number.**

### ACTION

**Ask more questions** – if one indicator leads to a potential area of concern, continue the discussion in this area.

**Consider risk** – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

**Significant or Immediate risk** – if you identify one or more serious or immediate risk, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services/CAIT team/ Police/MASH, in accordance with your local safeguarding procedures.

**If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.**

**In all cases:-**

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

**Please send completed form to [Adult.SafeguardingTeam@uhnm.nhs.uk](mailto:Adult.SafeguardingTeam@uhnm.nhs.uk)**

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## FGM guidance APPENDIX 4

### Part 2: CHILD/YOUNG ADULT (under 18 years old)

This is to help when considering whether a child is AT RISK of FGM, or whether there are other children in the family for whom a risk assessment may be required

Date: \_\_\_\_\_ Completed by: \_\_\_\_\_  
Assessment: Initial/On-going

| Indicator                                                                                                                                                                                        | Yes                      | No                       | Details |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|---------|
| <b>CONSIDER RISK</b>                                                                                                                                                                             |                          |                          |         |
| Child's mother has undergone FGM                                                                                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Other female family members have had FGM                                                                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Father comes from a community known to practice FGM                                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |         |
| A female family elder is very influential within the family and is/will be involved in the care of the girl                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Mother/family have limited contact with people outside of her family                                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Parents have poor access to information about FGM and do not know about the harmful effects of FGM or UK law                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Parents say that they or a relative will be taking the girl abroad for a prolonged period – this may not only be to a country with high prevalence, but this would more likely lead to a concern | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Girl has spoken about a long holiday to her country of origin/another country where the practice is prevalent                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Girl has attended a travel clinic or equivalent for vaccinations/anti-malarials                                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |         |
| FGM is referred to in conversation by the child, family or close friends of the child (see Appendix Three for traditional and local terms) – the context of the discussion will be important     | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Sections missing from the Red book. Consider if the child has received immunisations, do they attend clinics etc.                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Girl withdrawn from PHSE lessons or from learning about FGM – School Nurse should have conversation with child                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Girls presents symptoms that could be related to FGM – continue with questions in part 3                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Family not engaging with professionals (health, school, or other)                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Any other safeguarding alert already associated with the family                                                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |         |

#### ACTION

**Ask more questions** – if one indicator leads to a potential area of concern, continue the discussion in this area.

**Consider risk** – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

**Significant or Immediate risk** – if you identify one or more serious or immediate risk, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services /CAIT team/ Police /MASH, in accordance with your local safeguarding procedures.

**If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.**

#### In all cases:-

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

**Continued....**

FGM guidance page 13

| Indicator                                                                                                                                                                                            | Yes                      | No                       | Details |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|---------|
| <b>SIGNIFICANT OR IMMEDIATE RISK</b>                                                                                                                                                                 |                          |                          |         |
| A child or sibling asks for help                                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |         |
| A parent or family member expresses concern that FGM may be carried out on the child                                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Girl has confided in another that she is to have a 'special procedure' or to attend a 'special occasion'. Girl has talked about going away 'to become a woman' or 'to become like my mum and sister' | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Girl has a sister or other female child relative who has already undergone FGM                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |         |
| Family/child are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services                                      | <input type="checkbox"/> | <input type="checkbox"/> |         |

**Please remember: any child under 18 who has undergone FGM must be referred to police under the Mandatory Reporting duty using the 101 non-emergency number.**

#### ACTION

**Ask more questions** – if one indicator leads to a potential area of concern, continue the discussion in this area.

**Consider risk** – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

**Significant or Immediate risk** – if you identify one or more serious or immediate risk, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services /CAIT team/ Police /MASH, in accordance with your local safeguarding procedures.

**If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.**

#### In all cases:-

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

**Please send completed form to [ChildProtectionNamedNurses@uhnm.nhs.uk](mailto:ChildProtectionNamedNurses@uhnm.nhs.uk)**

## FGM Guidance Appendix 5 Traditional and local terms for FGM

| Country      | Term used for FGM                                               | Language | Meaning                                                                                                                                               |
|--------------|-----------------------------------------------------------------|----------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| EGYPT        | Thara                                                           | Arabic   | Deriving from the Arabic word 'tahir' meaning to clean/purify                                                                                         |
|              | Khitan                                                          | Arabic   | Circumcision – used for both FGM and male circumcision                                                                                                |
|              | Khifad                                                          | Arabic   | Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)                                                            |
| ETHIOPIA     | Megrez                                                          | Amharic  | Circumcision/cutting                                                                                                                                  |
|              | Absum                                                           | Harrari  | Name giving ritual                                                                                                                                    |
| ERITREA      | Mekhnishab                                                      | Tigreña  | Circumcision/cutting                                                                                                                                  |
| KENYA        | Kutairi                                                         | Swahili  | Circumcision – used for both FGM and male circumcision                                                                                                |
|              | Kutairi was ichana                                              | Swahili  | Circumcision of girls                                                                                                                                 |
| NIGERIA      | Ibi/Ugwu                                                        | Igbo     | The act of cutting – used for both FGM and male circumcision                                                                                          |
|              | Sunna                                                           | Mandingo | Religious tradition/obligation – for Muslims                                                                                                          |
| SIERRA LEONE | Sunna                                                           | Soussou  | Religious tradition – obligation for Muslims                                                                                                          |
|              | Bondo                                                           | Temeneé  | Integral part of an initiation rite into adulthood – for non Muslims                                                                                  |
|              | Bonde/Sonde                                                     | Mendee   | Integral part of an initiation rite into adulthood – for non Muslims                                                                                  |
|              | Bondo                                                           | Mandingo | Integral part of an initiation rite into adulthood – for non Muslims                                                                                  |
|              | Bondo                                                           | Lima     | Integral part of an initiation rite into adulthood – for non Muslims                                                                                  |
| SUDAN        | Khifad                                                          | Arabic   | deriving from the Arabic word 'Khalad' meaning to lower (rarely used in everyday language)                                                            |
| GAMBIA       | Kuyango Mandinka<br>Niaka Mandinka<br>Musolula Karoola Mandinka |          | Meaning the 'affair' but also the name for a shed built for initiates.<br>Cut/weed clean<br><br>Meaning 'the womens side'/'that which concerns women' |
| SOMALIA      | Gudiniin                                                        | Somali   | Circumcision used for both FGM and male circumcision                                                                                                  |
|              | Halalays                                                        | Somali   | Deriving from the Arabic word 'halal' i.e. 'sanctioned' – implies purity. Used by Northern & Arabic speaking Somalis.                                 |
|              | Qodiin                                                          | Somali   | Stitching/tightening/sewing refers to infibulations                                                                                                   |

## **FGM Guidance APPENDIX 6 References:**

Department of Health (2015). Female genital mutilation (FGM): resources for healthcare staff

Available at: <https://www.gov.uk/government/collections/female-genital-mutilation-fgm-guidance-for-healthcare-staff>

Foundation for Women's Health, Research and Development (FORWARD) ET AL (2007) a Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales. Available at:

<https://www.forwarduk.org.uk/wp-content/uploads/2019/06/Forward-2007-FGM-Prevalence-study.pdf>

Lockhat H. (2004) Female Genital Mutilation: Treating the Tears. London: Middlesex University Press.

Macfarlane, A. J. & Dorkenoo, E. (2014). Female Genital Mutilation in England and Wales: Updated statistical estimates of the numbers of affected women living in England and Wales and girls at risk Interim report on provisional estimates. London: City University London.

Royal College of Obstetricians and Gynaecologists (2015). Green-top Guideline No. 53 Female Genital Mutilation and its management. Accessed from;

<https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-53-fgm.pdf>

World Health Organization (2025). Female Genital Mutilation. Geneva , Switzerland : World Health Organization.

## **Resources:**

<https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/female-genital-mutilation-fgm/>

Call to End Violence against Women & girls: Action Plan 2014.

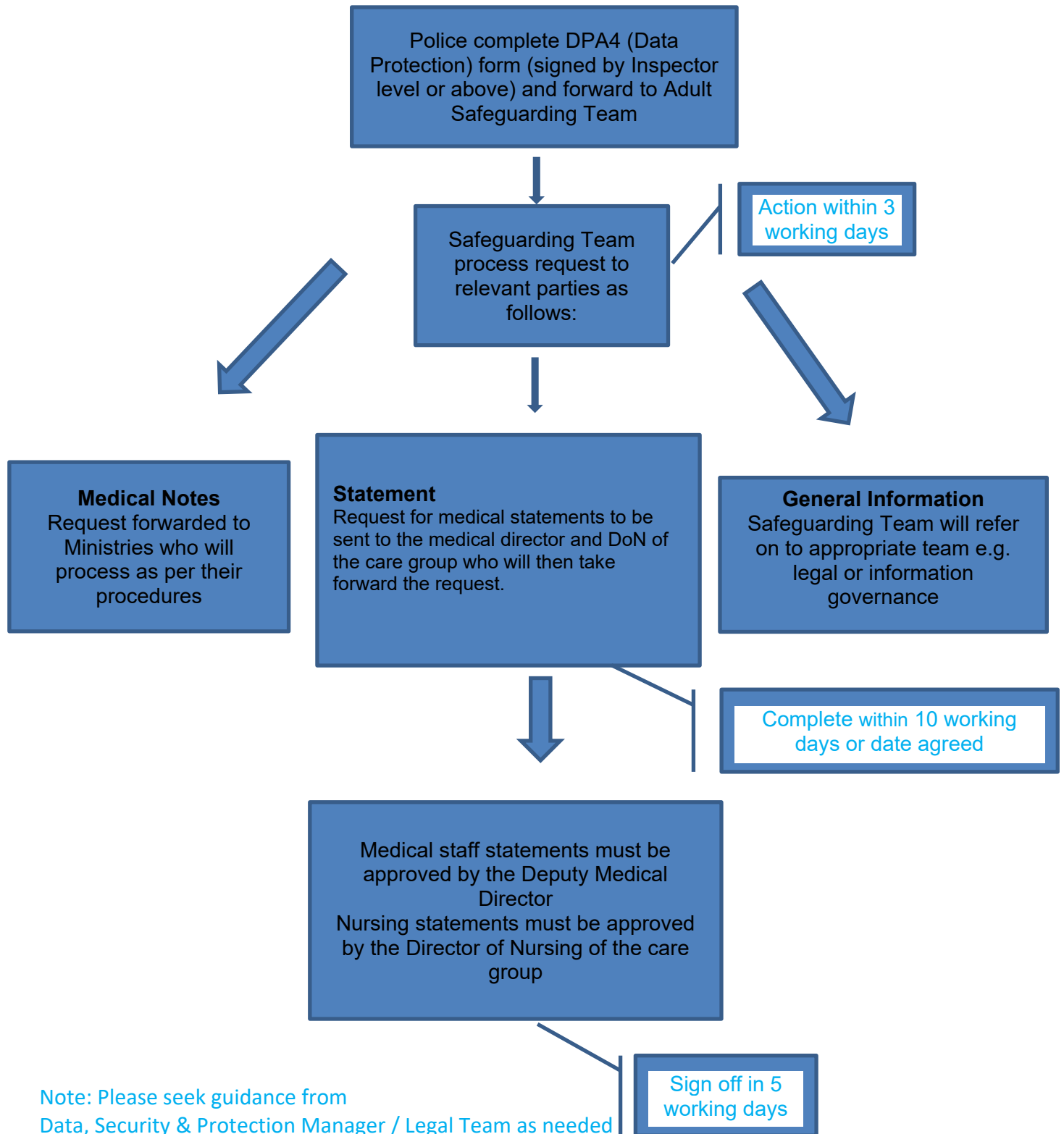
Female Genital Mutilation Risk and Safeguarding; Guidance for professionals: DOH March 2015

Mandatory Reporting of Female Genital Mutilation – procedural information: Home Office 2015

Leaflets: [https://assets.publishing.service.gov.uk/media/5a7583b9ed915d6faf2b395c/FGM\\_leaflet.pdf](https://assets.publishing.service.gov.uk/media/5a7583b9ed915d6faf2b395c/FGM_leaflet.pdf)

Home Office online training package: [www.fgmelearning.co.uk](http://www.fgmelearning.co.uk)

Information Requests from the Police



## APPENDIX 10

### Sex Offenders Alerts

In the United Kingdom, the **Violent and Sex Offender Register (ViSOR)** is a database of records of those required to register with the police under the Sexual Offences Act 2003 (the 2003 Act), those jailed for more than 12 months for violent offences, and those thought to be at risk of offending.

The sex offender management unit inform the adult safeguarding team at UHNM if they are aware that someone on the register is due to attend our hospital. At this point an alert “sex offender” is added by the safeguarding team to Medway / iportal. The comments section within the alert will provide one of the following statements:

- Person is a risk to children
- Person is a risk to females
- Person is a risk to males
- Person is a risk to others – (this alert indicates that risk is posed to those of any gender)

The alert may indicate for staff to contact the Public Protection Unit to inform them if the patient attends or is admitted to UHNM. Staff must do so as soon as possible via the number provided on the alert

When a patient attends or is admitted to UHNM and has an alert of this nature, staff must ensure that patients and staff are protected whilst maintaining confidentiality. The Nurse in charge of the ward / department must alert their Matron and consideration should be given the following:

- If the person is a risk to children and you are an adult area, do you have any 16/17 year old patients on your ward?
- Do you have any young apprentices in your area?
- Do you need to think about what gender of staff care for this patient?
- Does your patient need to be nursed in a side room if clinically appropriate?
- Does your patient need to be nursed in a cohort bay if clinically appropriate?
- Think about who in the team needs to be aware of the alert – this should be on a “need to know” basis
- Do you need to ensure that there is no lone working with the patient?
- Think about visitors to the ward / department and ensuring their safety
- Plan for if the patient needs to leave the ward for a test – who will escort etc.

The UHNM adult safeguarding team can be contacted for advice in hours if required – extension 75477

If a patient discloses information that may indicate that they are on the Sex Offenders Register and alert is currently not on iPortal, staff should contact the internal safeguarding team via extension 75477. The safeguarding team will where required, contact the public protection unit to clarify if the patient is known to them and what risks the patient may pose. The safeguarding team will then add the alert onto Careflow/ iPortal.

## Appendix 11

### Support services

| Agency                                      | Contact details                                                                                                           |                                                                 |                                                                             |
|---------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------------|
| Stoke on Trent Adult Social Care            | 0800 561 0015                                                                                                             |                                                                 |                                                                             |
| Staffordshire Adult Social Care             | 0300 111 8010                                                                                                             |                                                                 |                                                                             |
| Integrated Discharge Hub (Royal Stoke Base) | Internal extension 75555                                                                                                  | Social assessments, complex discharges                          |                                                                             |
| Discharge Hub (County Hospital Base)        | Internal extension 2830                                                                                                   | Social assessments, complex discharges                          |                                                                             |
| Housing Solutions (Stoke on Trent)          | 01782 233696                                                                                                              | Accommodation                                                   |                                                                             |
| Brighter futures rough sleepers team        | Stoke on Trent and Newcastle - 0800 970 2304<br>All other areas - 0300 500 0914                                           | Accommodation, claiming benefits, assistance to access services |                                                                             |
| Newcastle Housing Advice                    | 01782 717717 (Mon-Fri)<br>01782 615599 (emergency out of hours)                                                           | Accommodation                                                   |                                                                             |
| Staffordshire police                        | 999<br>101<br><a href="https://www.staffordshire.police.uk/">https://www.staffordshire.police.uk/</a>                     |                                                                 |                                                                             |
| Staffordshire Fire and Rescue               | Email referral form to <a href="mailto:contactcentre@staffordshirefire.gov.uk">contactcentre@staffordshirefire.gov.uk</a> | Fire safety assessment, Hoarding                                | Referral form can be found on the Trust's safeguarding adults intranet page |
| Grangewood Park                             | 0330 223 0099 (24hours)                                                                                                   | SARC - Sexual Assault Referral Centre                           |                                                                             |
| New Era                                     | 0300 303 3778                                                                                                             | Local Domestic Abuse Support Service                            | Refer to policy C37 for further guidance                                    |
| National Domestic Abuse Helpline            | 0808 2000 247                                                                                                             | National Domestic Abuse Support Service                         | Refer to policy C37 for further guidance                                    |
| Karma Nirvana                               | 0800 5999 247 (24hours)                                                                                                   | National Honour Based Abuse Support Service                     |                                                                             |

## Appendix 12

### Safeguarding Adults Reviews (SAR)

A safeguarding adult review (SAR) is a multi-agency process that considers whether or not serious harm experienced by an adult, or group of adults at risk of abuse or neglect, could have been predicted or prevented. The process identifies learning that enables the partnership to improve services and prevent abuse and neglect in the future.

Safeguarding Adults Partnership Boards are responsible for receiving and managing the SAR process.

The Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board (SSASPB) SAR process is only relevant to an adult with care and support needs in the area if:

- a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult

**and** either of the following conditions are met:

- b1) The adult has died, **and** the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died)

**or**

- b2) The adult is still alive, **and** the SAB knows or suspects that the adult has experienced serious abuse or neglect.

### SAR referral

UHNM can make a SAR referral if the above criteria is met. All queries and SAR referrals must be made to the UHNM Adult Safeguarding team – extension 75477 or email [Adult.SafeguardingTeam@uhnm.nhs.uk](mailto:Adult.SafeguardingTeam@uhnm.nhs.uk). The team will review the information and submit the referral on behalf of the trust to the relevant Safeguarding Adults Board if required.

### SAR engagement

As a member of the SSASPB, the UHNM Adult Safeguarding team will work with the Safeguarding Adults Partnership, in the involvement of SARs, by responding to information requests, the production of reports and chronologies where applicable, and the implementation of action plans.

SARs, action plans and good practice identified will be discussed within the trusts Adult Safeguarding working group. Due to the sensitive nature of SARs, it is often that cases will not be presented internally until the SAR report has been published by the SSASPB.

### Published SARs

Once published, SARs will be available on the relevant Adult Safeguarding Partnership Boards internet page.

## APPENDIX 13

### Adult at risk alert

An adult at risk alert may be added to patients' records at UHNM when –

- An adult has care and support needs
- There are identified safeguarding concerns
- Actions may be needed upon admission or discharge from UHNM

The purpose of this alert will be to alert UHNM staff to safeguarding concerns specific to the individual patient, and to highlight any necessary actions upon attendance to and discharge from UHNM. UHNM staff will be aware of concerns that place the adult at significant risk of harm and/ or abuse. Actions then can be taken by UHNM staff to safeguard the patient and other, mitigating risks whilst admitted to UHNM and upon discharge.

Alerts will be placed onto adults' records by the UHNM corporate adult safeguarding team only. The local authority or other external agency (i.e. the police) will inform the adult safeguarding team at UHNM of concerns and subsequent actions to be taken when the patient attends or is discharged from UHNM. Due to the limited text available within the alert, the adult safeguarding team will then add a new note onto the patients iPortal record, including the full information of the disclosure, actions required and contact details of the social worker where necessary. An alert will then be created to indicate that the adult is at risk and will direct staff to view the specific iPortal note.

The alert will appear with the following text –

*Safeguarding concerns identified. Please see iPortal entry dated [insert date], titled [insert title].  
If support or advice is required, contact the UHNM Safeguarding team via exten. 75477 or  
Adult.SafeguardingTeam@uhnm.nhs.uk  
See policy C36 for full guidance*

Should a patient with an adult at risk alert attend or be admitted to UHNM, then the following should be taken into consideration:

- Does the alert indicate any actions to be completed i.e. contact the allocated social worker?
- Are there any indicators that the current attendance/ admission is related to the safeguarding concerns?
- Has a disclosure been made by the patient or other professionals during this attendance/ admission?
- Are there concerns that the patient has been subjected to abuse or neglect? – the patient may have denied this, but their presentation gives you cause for concern

If safeguarding concerns are suspected or disclosed, then appendix 1 procedure should be followed.

Staff should record their actions in response to the alert and any concerns noted within the patients' records.

## APPENDIX 14

### Adult Safeguarding Concerns against the Trust

Where it is alleged that an adult with care and support needs has experienced abuse or neglect whilst under the care of UHNM, the Trust will be asked to undertake a Section 42 Enquiry as follows:

1. UHNM can be instructed by the Local Authority (LA) to undertake a Safeguarding Enquiry under section 42 of the Care Act. The UHNM corporate safeguarding team must ensure that a causing letter is received from the local authority of which details specific terms of reference. The corporate safeguarding team will then review the concern and add any further terms of reference to be considered as part of the enquiry
2. The corporate UHNM Safeguarding Team will endeavor to complete enquiries where capacity allows. Where support is required from the care ward/ department or it is felt that the ward/ department are best placed to answer the enquiry, the corporate safeguarding team will Email the DoN to appoint an independent Senior Nurse/ Doctor to undertake the Enquiry (Investigating Officer - IO).
3. IO to undertake the Enquiry and produce a report which demonstrates findings and any recommendations, and proposed actions to address these. IO is to forward the completed report to UHNM Safeguarding Team to review
4. The Lead Nurse for Safeguarding will review the report for approval
5. Once the Lead Nurse for Safeguarding has been approved, the UHNM Safeguarding Team to forward the completed report to the DoN for approval
6. Once approved, UHNM Safeguarding Team will forward the completed report to the Local Authority
7. Should the Local Authority wish to undertake an Enquiry Review Meeting/ Outcome Meeting then the IO will be invited to attend with a member of the Safeguarding Team to present their findings
8. When the outcome of the enquiry is determined and fed back to Safeguarding Team by the Local Authority i.e. proven, unproven, partially proven or inconclusive, the outcome will be fed back to the DoN by the Safeguarding Team via the Adult Safeguarding working group.
9. UHNM Safeguarding team to share within the division and request that an action plan is completed in response to any recommendations made by the local authority in addition to those identified by the IO.
10. DoN to nominate a representative to feedback to the Adult Safeguarding Working Group for wider learning at UHNM. Or the Safeguarding team will feedback on behalf of the care group
11. The division will be invited back to the Adult Safeguarding Working Group to update against actions. Or the Safeguarding team will feedback on behalf of the care group
12. Actions will be added to the corporate Safeguarding database.

### Information sharing to inform the decision of an enquiry

The adult safeguarding team may be contacted regarding concerns raised against the trust, where the local authority is fact-finding to inform the decision whether to progress to a section 42 enquiry. The adult safeguarding team will comply with requests as per the care act, only sharing relevant and proportionate information to the enquiries.

### **Discharge concerns**

The adult safeguarding team may receive discharge concerns against the trust, which have closed to the local authority safeguarding team and have not progressed or do not meet the threshold for further investigation under Safeguarding procedures.

Upon receipt of a discharge concern, the adult safeguarding team will complete a Datix against the area/ ward of the concern, and record on the central safeguarding database. The investigation and monitoring of the Datix and any actions, will then be the responsibility of the identified area. The adult safeguarding team will monitor the number of discharge concerns, the areas identified, and any themes quarterly via the quarterly adult safeguarding assurance report. The report will be distributed to divisions via the adult safeguarding working group.