

Policy Document

Reference: C23

Managing Risks Associated with Safeguarding Children

Version:	10
Date Ratified:	April 2025 by the Quality & Safety Oversight Group
Date Issued:	April 2025
To Be Reviewed Before:	April 2028
Policy Author:	Named Doctor / Lead Nurse for Safeguarding
Executive Lead:	Chief Nurse

Version Control Schedule

Final Version	Issue Date	Comments
1	November 2008	Ratified
2	June 2011	Ratified
3	September 2013	Ratified
4	October 2015	Updated following integration with County Hospital
5	December 2016	Appendix and Process relating to Female Genital Mutilation and Child Sexual Exploitation Added
6	November 2018	Full review – Only Minor Amendments made
7	February 2020	Minor amendment – Revised FGM data capture pro-forma added
8	December 2021	Full review. No major changes. Update in terminology regarding local safeguarding board arrangements, child safeguarding practice reviews, changes in legislation and guidance. Appendices 3,4,5,6,7,9,10,14 updated to reflect change in processes for making referrals, changes in guidance and legislation, changes in service offered by health visitors, Addition of new appendix 19 regarding safeguarding alerts
8.1	July 2022	Updated to reflect changes with how referrals are made.
8.2	August 2022	Error corrections
9	November 2023	Update to include guidance regarding Prevent and updates regarding CP-IS process. Also included updated guidance on when to contact EDT out of hours. Includes letters to be sent to families not registered to GP.
10	April 2025	<ul style="list-style-type: none"> Updated guidance around managing children not brought to appointments Reference to C76 Child Protection Medical Policy Updated terminology throughout e.g. WT 2023 update, reference to partnerships, junior doctors replaced by resident doctors etc Removal of reference to Steering Group due to change in trust governance structures. Updated roles and responsibilities Updated contact details for social care Updated training needs analysis FII guidance – includes mention of iPortal structured note tool

Statement on Trust Policies

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

Equality Impact Assessment (EIA)

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. The Equality Impact Analysis Form is designed to help consider the needs and assess the impact of each policy. To this end, EIAs will be undertaken for all policies.

Policy Reference, Title & Version Number	C23 Managing Risks Associated with Safeguarding Children V10		
Summary of changes made on this review	<ul style="list-style-type: none"> Updated guidance around managing children not brought to appointments Reference to C76 Child Protection Medical Policy Updated terminology throughout e.g. WT 2023 update, reference to partnerships, junior doctors replaced by resident doctors etc Removal of reference to Steering Group due to change in trust governance structures. Updated roles and responsibilities Updated contact details for social care Updated training needs analysis FII guidance – includes mention of iPortal structured note tool 		
Please list which service users, staff or other groups have been consulted with, in relation to this	Trust Safeguarding Children Working Group General paediatric, community paediatric and neonatal consultant groups		
Were any amendments made as a result? If yes, please specify	Yes – wording change to template letters		
Which Executive Director has been consulted on?	Chief Nurse		
Does this policy have the potential to affect any of the groups listed below differently - please complete the below. Prompts for consideration are provided, but are not an exhaustive list			
Group	Is there a potential to impact on the group? (Yes/No/Unsure)	Please explain and give examples	Actions taken to mitigate negative impact
Age	No		
Gender	No		
Race	No		
Religion & Belief	No		
Sexual orientation	No		
Pregnancy & Maternity	No		

Group	Is there a potential to impact on the group? (Yes/No/Unsure)	Please explain and give examples	Actions taken to mitigate negative impact
Marital status/civil partnership	No		
Gender Reassignment	No		
Human Rights	No		
Carers	No		
Socio/economic	No		
Disability	No		
Are there any adjustments that need to be made to ensure that people with disabilities have the same access to and outcomes from the service or employment activities as those without disabilities?	Yes		
Will this policy require a full impact assessment and action plan?	No		

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1. INTRODUCTION

There is clear statutory guidance in place around arrangements to safeguard children. This is set out in *Working Together to Safeguard Children* (HM Government 2018, updated 2023) and statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004; this is supplemented by standards and guidance published by Royal Colleges and other relevant bodies.

This area has two Local Safeguarding Children Partnerships (LSCPs) - Staffordshire Safeguarding Children Partnership (SSCP) and Stoke-on-Trent Safeguarding Children Partnership (SOTSCP). Each Partnership has developed its own structure of working and lines of accountability, which are underpinned by their Local Safeguarding Children Partnerships' procedures. These should be read in conjunction with this policy and can be found on the respective websites.

Which Safeguarding Children Partnership procedures should be used depends on the home address of the child. The process for making a referral to the appropriate children's social care is at Appendix 2.

Child protection training within the Trust reflects the guidance within the *Intercollegiate Document* 2019, the Local Safeguarding Children Partnerships' training strategies and *Working Together* 2023. Any Trust policies relating to working with children are informed by the same documents.

NICE published a clinical guideline on *When to Suspect Child Maltreatment* (2009). This guidance was updated in October 2017 and provides useful guidance on the circumstances around when to consider and when to suspect child maltreatment. This policy supports the NICE guidance, which can be found at Appendix 1 of this document.

The Health and Social Care Act 2008 (Registration of Regulated Activities) Regulations 2014: Regulation 13 sets out clear standards for the safeguarding of vulnerable children. This is supported by the Care Quality Commission document *Guidance for providers on meeting the regulations – March 2015* which sets out requirements for organisations to minimise the risk of abuse by having effective systems and processes in place, which are subject to both internal and external scrutiny. More information regarding this guidance can be found at Appendix 13 of this document.

All processes associated with the safeguarding of children can be found within the appendices of this policy.

2. STATEMENT

The University Hospitals of North Midlands is committed to ensuring there is an effective framework in place for managing the risks associated with the safeguarding of children, through having robust systems and effective policies and procedures in place which meet national statutory requirements. This includes having clear procedures in place, having adequate specialist support from the Trust child safeguarding professionals and ensuring the delivery of training programmes, which are relevant to specific staff groups.

The child safeguarding professionals consist of the named doctor, named nurses and named midwife supported by the designated professionals.

An overarching statement which is applicable to policy can be found on the Trust Policies Intranet page.

3. SCOPE

This policy applies to all areas across the Trust and sets out clear lines of responsibility and accountability.

Although the child safeguarding professionals have specific responsibilities in relation to the arrangements for safeguarding children, it is clear that all staff who may come into contact with children and their families (patients or visitors) have a duty to comply with this policy in ensuring the safety of children.

4. DEFINITIONS

Safeguarding	Proactively seeking to involve the whole community in keeping children safe and promoting their welfare.
Child Protection	Child protection is a central part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm (<i>Working Together 2023</i>)
Child	Anyone who has not yet reached their 18 th birthday.

5. ROLES AND RESPONSIBILITIES

5.1 Local Arrangements for Managing Risks

All UHNM staff have access to the named professionals for safeguarding children by contacting the Trust child protection office during weekday office hours for advice and support from named professionals or by contacting them direct by telephone. Out of hours, staff are asked to email the named nurses for non-urgent queries. Contact details are available via the child protection page on the Trust Intranet.

The Trust has 24-hour child protection cover every day of the year. There is a first on call rota staffed by resident doctors and SAS doctors in community paediatrics 9am-5pm, Monday to Friday and the acute paediatric resident doctor team cover out of hours. There is a second on call rota staffed by consultants in community paediatrics 9am-5pm, Monday to Friday, excluding bank holidays and the acute consultant paediatrician on call outside of these hours. The community consultants are available for telephone advice during bank holidays and weekends between 10.00am and 11.00am.

5.2 Child Protection Examinations

Child protection medical examinations for suspected physical abuse are conducted within office hours (9 am - 5 pm Monday to Friday). Children will be seen outside of these hours if there is a medical need and following discussion with social care or the police and the acute paediatrician on call.

Radiological imaging in cases of suspected physical abuse is undertaken in line with the Royal College of Radiologists guidance: The radiological investigation of suspected physical abuse in children, September 2017.

There is a separate child protection medical policy (C76) which outlines the standards and processes to be met during child protection medicals.

Medicals for sexual abuse are conducted through the West Midlands Sexual Assault Referral Centre (SARC) Hub. Acute medicals are conducted in Walsall with historic cases being seen at locations around the West Midlands including at the SARC in Cobridge on set days. See child protection pages of intranet for more information.

5.3 UHNM Groups and Committees

The responsibility of these groups and committees complements those arrangements specified within both the Stoke-on-Trent SCP and Staffordshire SCPs' procedures.

5.3.1 Quality Governance Committee

The Quality Governance Committee is responsible for:

- The receipt of updates on compliance with safeguarding responsibilities as and when required, to ensure that safeguarding children remains a high priority on its agenda.

5.3.2 Quality and Safety Oversight Group

The Quality and Safety Oversight Group is responsible for:

- The approval of this policy.
- The receipt of an annual report by means of monitoring implementation of the arrangements set out within this policy and related Safeguarding Children Policy procedures.

- The receipt of the highlight reports of the Trust Safeguarding Children Working Group as a means of receiving assurance that safeguarding arrangements are working effectively.
- The receipt of updates on compliance with safeguarding responsibilities, including audits, as and when required, to ensure that safeguarding children remains a high priority on its agenda.
- Approval of the child protection *training strategy* and *training needs analysis* (in line with the Statutory and Mandatory Training Policy)
- The receipt of national safeguarding children related documents and associated action plans.
- The receipt and approval of risk assessments and action plans developed as part of the Trust's on-going monitoring of compliance with the Care Quality Commission Guidance for providers on meeting the regulations – Care Quality Commission March 2015

5.3.3 UHNM Safeguarding Children Working Group:

In accordance with the *Terms of Reference*, the remit of the Trust Safeguarding Children Working Group is as follows:

Policies and Procedures

- To ensure appropriate policies are reviewed and updated on a regular basis.
- To ensure staff across the Trust are aware of the Policies.
- To review and approve local standard operating procedures and working instructions to ensure these are in line with Trust Policies and latest guidance.

Training

- To ensure the Trust Child Protection Training Strategy is reviewed and updated on a regular basis.
- To review and monitor the child protection training needs analysis (TNA).
- To ensure staff across the Trust are aware of the Training Strategy.
- To monitor the training of staff, against the TNA.

Delivery Plan

- To monitor progress of the delivery plan.
- To review and update the key requirements of the delivery plan where new guidance requires additional performance indicators.

Education and Good Practice

- To act as a forum to share good practice and ensure mechanisms are in place to cascade to staff across the Trust.

Assurance

- To provide assurance to the Quality and Safety Oversight Group
- To review the corporate risk register in relation to safeguarding children and ensure this is updated on a regular basis.
- To receive regular updates on the delivery plan.

Monitoring and Review

- To be appraised of any incident and/or complaint and identify any lessons to be learned.
- To ensure that the Trust is adequately prepared for any external accreditation process in relation to safeguarding children, to include CQC and internal and external audits, child safeguarding practice reviews.
- To ensure shared learning takes place through consideration of incidents, complaints and audits that have Trust wide ramifications.
- To review national legislation and guidance in relation to the child protection and adult safeguarding agendas, to include domestic violence
- To address local implications of such guidance and inform the Group of issues to be reviewed
- To review outcome of local reviews and where necessary, make recommendations to address any gaps identified

- To seek assurance regarding the implementation and monitoring of the strategic approach for child protection and vulnerable adults at the UHNM
- To ensure Trust representation on Safeguarding Children and Adult Boards/Partnerships across Stoke-on-Trent and Staffordshire.

5.4 Individual Roles and Responsibilities

5.4.1 Chief Executive Officer:

The Chief Executive Officer has overall accountability for the safeguarding of children within the Trust.

5.4.2 Chief Nurse:

The Chief Nurse is the nominated executive lead for safeguarding children and is responsible for:

- Ensuring appropriate chairing arrangements of the UHNM Safeguarding Working Group.
- Ensuring the Quality and Safety Oversight Group is provided with an annual report on progress and arrangements.
- Undertaking rigorous self-assessment and the development of action plans as part of the Trust's on-going review of compliance with the *Care Quality Commission Guidance for providers on meeting the regulations – Care Quality Commission March 2015*, supported by the named professionals for safeguarding children

The Chief Nurse is supported by the Deputy Chief Nurse in the operational delivery of the safeguarding agenda.

5.4.3 Chief People Officer:

The Chief People Officer is responsible for:

- Ensuring implementation of the Trust Policy HR09 Policy and Procedure for the Disclosure and Barring Service Check (previously Policy and Procedure for the Disclosure of Criminal Record).
- Ensuring implementation of the Trust Policy HR08 Recruitment and Selection Policy and Procedure.
- Ensuring implementation of HR01 Disciplinary Policy and Procedure, specifically the procedure for managing allegations against people who work with children.

5.4.4 Divisional Operations Directors / Divisional Director of Nursing:

- Ensuring that adequate service level agreements and resources are in place to ensure the effective delivery of services for the safeguarding of children.
- Providing regular assurance via quarterly highlight reports on the uptake of child protection training within their division and, where deficiencies are identified, taking action as appropriate as well as highlighting current risks, items for escalation, good areas of practice and current projects within a safeguarding lens.

5.4.5 Clinical Lead for Community Paediatrics / Clinical Director for Paediatrics:

The clinical lead for community paediatrics and clinical director for paediatrics are responsible for ensuring that an annual appraisal of the named doctor in accordance with the Trust appraisal and personal development policies is undertaken.

5.4.6 Lead Nurse for Safeguarding and vulnerable patients:

The lead nurse for safeguarding is responsible for:

- Providing line management and clinical leadership to the named nurses for safeguarding children.
- Undertaking annual appraisal of the named nurses in accordance with the Trust appraisal and personal development policies.
- Ensuring that there is continuity and consistency where there is an overlap between adults' and children's safeguarding

- Supporting the Chief Nurse in ensuring that the Trust is compliant with its arrangements for the safeguarding of children.

5.4.7 Designated doctor for safeguarding children:

The designated doctor for safeguarding children is an ICB role, responsible for:

- Providing professional advice on matters relating to safeguarding children for other professionals, the local ICBs and NHS Trusts, local authority children's social care and the Local Safeguarding Children Partnerships (LSCPs).
- Providing advice and support to the named professionals in each provider Trust and the Named GP
- Advising on safeguarding training needs and the delivery of training across the health economy.
- Planning and delivering interagency training through the LSCPs.
- Providing skilled professional involvement in child safeguarding processes, in line with LSCP procedures, and in child safeguarding practice reviews.
- As part of serious case reviews, reviewing and evaluating the practice and learning from all involved health professionals and providers who are involved within the ICB area.

5.4.8 Designated nurse for safeguarding children:

The designated nurse role is an ICB role. The designated nurse is responsible for:

- Supporting the Trust's named professionals in the delivery of services for the safeguarding of children.
- Alongside the designated doctor, provide skilled professional involvement in child safeguarding processes, in line with LSCP procedures, and in child safeguarding practice reviews.
- As part of child safeguarding practice reviews, work with the designated doctor reviewing and evaluating the practice and learning from all involved in health professionals and providers who are involved in the ICB area.

5.4.9 Named doctor, named nurse and named midwife for safeguarding children:

The named professionals for safeguarding children are responsible for:

- The development of an annual report to the Trust Quality and Safety Oversight Group
- The development of a *training strategy*, which complies with national legislation and which is supported by a robust *training needs analysis*.
- Undertaking or participating in audits to assess compliance with statutory requirements, and the development of action plans to address any shortfalls.
- Ensuring that all UHNM staff have access to the Child Protection Office during weekday office hours for advice and support from named professionals either by telephone or email.
- Providing child protection supervision to staff as required (see Appendix 13).
- Ensuring that staff attending child protection conferences are offered support from the named professionals within the conference process.
- Ensuring that they provide advice and support to Trust staff both in the preparation of reports/statements and in attending court if required.
- Supporting all activities necessary to ensure that the Trust meets its responsibilities in safeguarding children, working closely with other named professionals
- Ensuring that the Trust has policies in place to safeguard and promote the welfare of children, and that staff have access to these policies and is accountable within the managerial framework for the Trust.
- Ensuring that new information relevant to the safeguarding and promoting the welfare of children within the Trust is disseminated to staff.
- The delivery of child protection training, in accordance with the *training needs analysis* and *training strategy*.
- Participating in Local Safeguarding Children Partnership activities.

5.4.10 Trust staff who have contact with children and their families:

Trust staff have a responsibility for:

- Ensuring compliance with this policy and the associated Local Safeguarding Children Partnerships' procedures, including making appropriate referrals and acting upon child protection concerns.
- Where required, escalating child protection concerns to the safeguarding children professionals.
- Attending child protection training, relevant to their staff group, as set out in the *training needs analysis* (see APPENDIX 14) and in line with the Intercollegiate Document.
- Accessing child protection supervision

6. EDUCATION/TRAINING AND PLAN OF IMPLEMENTATION

The UHNM Trust named professionals for safeguarding children are responsible for taking a Trust overview of the planning, delivery and evaluation of child protection training. The *training strategy* is developed by the named professionals and incorporates any changes in legislation and policy both from central government and in line with the Local Safeguarding Children Partnerships and their policies and procedures. This *strategy* includes a *training needs analysis* which sets out the training requirements of each specific staff group, to ensure clarity around the level of training required. This can be found at Appendix 14.

The Trust child protection professionals provide at least monthly level 3 training for all staff in regular contact or in intensive but irregular contact with children. This would be the majority of staff working in child health, maternity and children's emergency department. There is a level 2 e-learning package for staff who do not have regular contact with children but have intensive and irregular contact.

The level 2 training package is regularly updated to take account of lessons learned from child safeguarding practice reviews and changes in legislation and guidance.

A basic child protection awareness package is delivered for all newly appointed staff and volunteers and for staff on a three yearly basis who do not require higher level training. This is via e-learning and is pitched at level 1.

Child protection training has also been included in the corporate mandatory and statutory training programme as part of the *training needs analysis*.

All in house safeguarding children training and LSCP training is recorded on ESR

Training compliance is reported to the Trust Safeguarding Children Working Group.

It is divisional responsibility to ensure that staff comply with training.

7. MONITORING AND REVIEW ARRANGEMENTS

7.1 Monitoring Arrangements

Implementation of this policy will be monitored through:

- The work of the Safeguarding Steering Group. The safeguarding performance report and ICB dashboard with key quality indicators are presented at the groups on a quarterly basis.
- The Quality and Safety Oversight Group, receiving minutes of these meetings and an annual report which sets out the delivery of standards set out within this policy and related Safeguarding Children Partnerships' procedures.
- The review of safeguarding children documents and progress against associated action plans.
- The receipt and approval of risk assessments and action plans developed as part of the Trust's on-going monitoring of compliance against the Care Quality Commission's *Guidance for providers on meeting the regulations* – Care Quality Commission March 2015
- Clinical audit as and when required.

7.2 Review

This policy will be reviewed by the named professionals every three years unless there are changes in legislation.

8. REFERENCES

- The Children Act 1989
- The Children Act 2004
- Working Together to Safeguard Children (2018, updated 2023) HM Government
- Local Safeguarding Children Partnership Interagency Procedures for Safeguarding Children and Promoting their Welfare, Stoke-on-Trent and Staffordshire
- C76 Child Protection Medical Policy
- The Victoria Climbié Inquiry 2003 (Laming)
- NICE 2009 updated 2017– When to Suspect Child Maltreatment
- Think Child, Think Parent, Think Family (2009) – Key Recommendations
- Safeguarding Children and Young People: roles and competencies for health care staff, Intercollegiate Document, 2019
- Guidance for providers on meeting the regulations – Care Quality Commission March 2015
- The radiological investigation of suspected physical abuse in children, Royal College of Radiologists, September 2017

Appendix 1: When to Suspect Child Maltreatment ([Quick Reference Guide - NICE Clinical Guideline 89](#))

Listen and Observe

Take into account the whole picture of the child or young person. Sources of information that help to do this include:

- any history that is given
- report of maltreatment, or disclosure from a child or young person or third party
- child's appearance, demeanour or behaviour
- symptom
- physical sign
- result of an investigation
- interaction between the parent or carer and child or young person

Seek an Explanation

Seek an explanation for any injury or presentation from both the parent or carer and the child or young person in an open and non-judgemental manner. An **unsuitable explanation** is one that is:

- implausible, inadequate or inconsistent with the child or young person's presentation, normal activities, medical condition (if one exists), age or developmental stage, or account compared with that given by parent and carers
- between parents or carers
- between accounts over time
- based on cultural practice, because this should not justify hurting a child or young person

Record

Record in the child or young person's clinical record exactly what is observed and heard from whom and when.

CONSIDER child maltreatment

If an alerting feature prompts you to consider child maltreatment:

- look for other alerting features of maltreatment in the child or young person's history, presentation or parent- or carer- child interactions now or in the past

And do one or more of the following:

- Discuss your concerns with a more experienced colleague, a community paediatrician, child and adolescent mental health service colleague, or a named or designated professional for safeguarding children
- Gather collateral information from other agencies and health disciplines
- Ensure review of the child or young person at a date appropriate to the concern, looking out for repeated presentations of this or any other alerting features

At any stage during the process of considering maltreatment the level of concern may change and lead to exclude or suspect maltreatment.

SUSPECT child maltreatment

If an alerting feature or considering child maltreatment prompts you to suspect child maltreatment refer the child or young person to children's social care, following Local Safeguarding Children Board procedures.

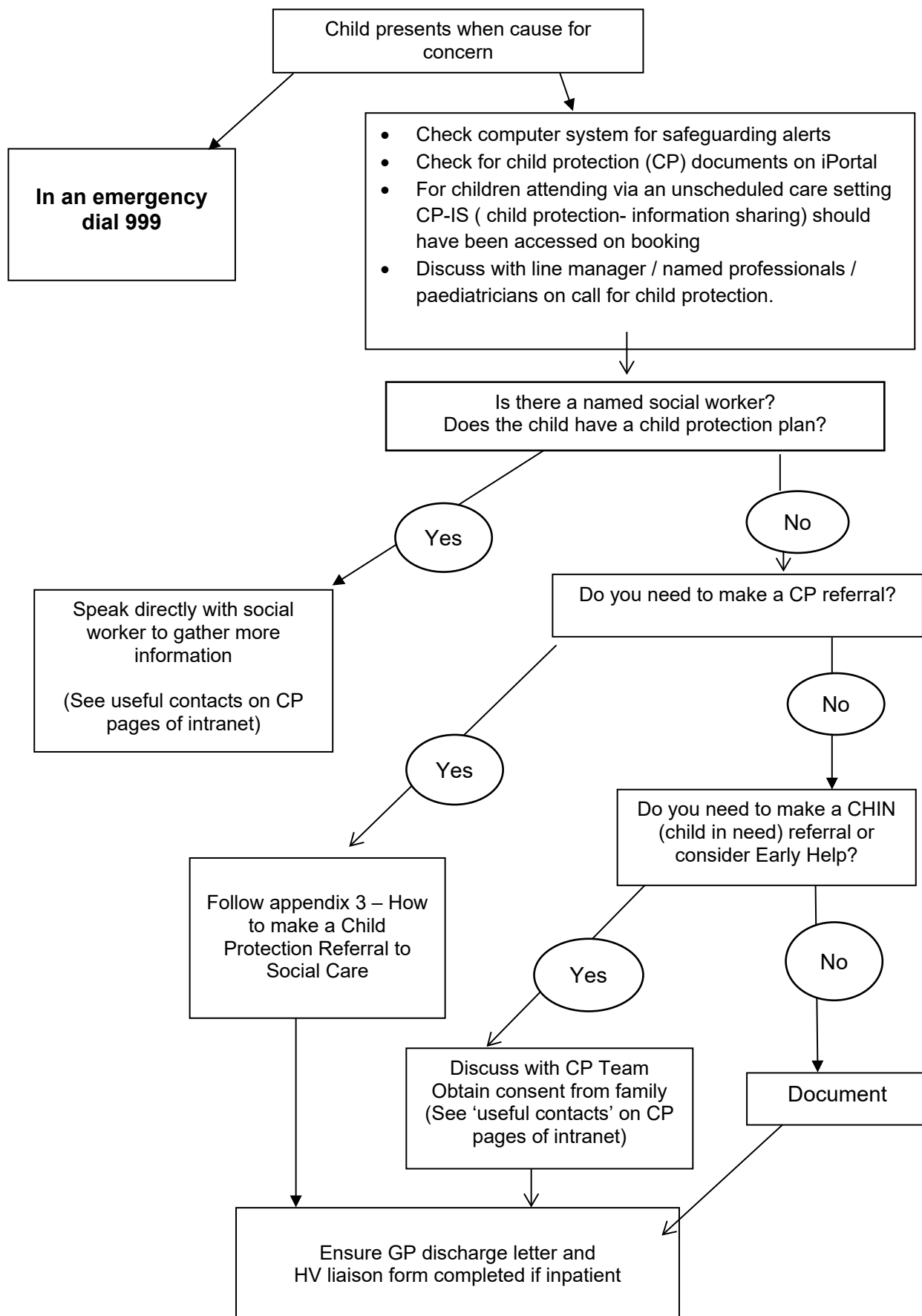
EXCLUDE child maltreatment

Exclude child maltreatment if a suitable explanation is found for the alerting feature. This may be the decision after discussion of the case with a more experienced colleague or gathering collateral information as part of considering child maltreatment.

Record

Record all actions taken and the outcome.

Appendix 2: Process that outlines who staff should contact if they have concerns about a child



Appendix 3: How to make a child protection referral to social care

QUICK GUIDE TO MAKING A CHILD PROTECTION REFERRAL

Do you have a concern that a child may be being abused or neglected? Discuss with senior manager / Matron / CP team 79802 / on call paediatrician

Yes

Do you still have concerns?

No

Is the child subject of a child protection plan?
Is there a safeguarding alert on iPortal?
Unscheduled care centres- check CP-IS.

Yes

Document
in the
child's
notes

Share your concerns
with the allocated
social worker and
document

**In an
emergency
call police -
999**

Document
and make
a referral

Where does the child live?

Stoke-on-Trent

Staffordshire

Elsewhere

Telephone: 01782 235100
Out of Hours: 01782 234234

Telephone: 0300 111 8007
Out of Hours: 0345 604 2886

Telephone: Social Care in
that area (Google is a good way to
find the number)

Follow up your telephone
referral ASAP within 24
hours using documentation
of referral form (DORF) on
intranet by sending to child
protection office

Follow up your telephone
referral ASAP within 24
hours using documentation
of referral form (DORF) on
intranet by sending to child
protection office

Follow up telephone referral
ASAP within 24 hours using
the documentation from that
area, (you will need to
request this from them)
sending to child protection
office

Yes

Have you had any feedback from social
care?

No

Sent to the CP team for
up loading to iPortal

Don't forget to seek
supervision from the CP
team 79802.

Chase up and
document within the
child's notes

Appendix 4: When to contact EDT out of hours?

Child Safeguarding STOKE and STAFFORDSHIRE **When to use the Emergency Duty Team (EDT)**

EDT is designed to deal with emergency situations only, where there is a serious risk or cause for concern that cannot wait until the next working day.

Examples of when to contact EDT include the following situations:

- Suspicions that a child is at **immediate** risk of being harmed as a result of abuse or neglect – consider if police to be called also (999)
- Children involved where there is significant domestic violence / substance misuse / mental ill health of a parent or carer
- Significant concerns have been raised regarding child but there is immediate risk to siblings at home
- Child absconds, is abducted or goes missing.
- Significant concerns have been raised and the child is not being admitted
- Or any other situation that needs an immediate response

Stoke-on-Trent emergency duty team is available:

- Monday to Friday 5pm to 8.30am
 - Saturday and Sunday
 - All bank holidays
- 01782 234234**

Staffordshire emergency duty team is available:

- Monday to Thursday 5pm to 8.30am
 - Friday 16:30pm through to Monday 08:30am
 - All bank holidays
- 0345 604 2886**

When not to contact EDT, but wait until the next working day to contact social care:

- When the child is being admitted
- If the child has a named social worker
- When the child is being discharged and there is no immediate risk to the child or other children.

You must-

- Ensure the ward or the nurse in charge (NIC) for the day shift has a clear verbal and written handover including concerns and need for the ward / NIC to refer the next working day ASAP.
- Departmental process must be followed for any child who is discharged who needs a referral and DORF.

If a child has a named social worker, where possible the named social worker should be contacted and informed of the admission / concerns in hours the next working day. This must be done by the admitting ward team. (check alerts on the electronic patient records for information as to whether a child is on a child protection plan or a looked after child (LAC) social worker details can be found on these alerts).

If the child has a social worker and you do not have concerns about the ED attendance, the social worker does not need to be contacted.

CP-IS MUST BE COMPLETED FOR ALL PATIENTS

Remember, a child is anyone up until their 18th birthday and don't forget that an unborn can be on a child protection plan!

Appendix 5: Process for identification of children / young people who are at risk from domestic abuse, and for recognising / acting on concerns

Working Together to Safeguard Children (2023) states; *Professionals should, in particular, be alert to the potential need for early help for a child who is in a family circumstance presenting challenges for the child, such as substance abuse, adult mental health, **domestic abuse**;*

The Domestic Abuse Act 2021 states that domestic abuse is when the behaviour of one person (A) towards another (B), when both are aged 16 or over and are personally connected to each other, and the behaviour is abusive.

Behaviour is abusive if it consists of any of the following:

- Physical or sexual abuse
- Violent or threatening behaviour
- Controlling or coercive behaviour
- Economic abuse
- Psychological, emotional or other abuse

Personally connected is when the parties (A and B) are, or have been, intimate partners or are related to each other.

Children can be victims of domestic abuse where a child (anyone up to the age of 18 years) sees or hears, or experiences the effects of the abusive behaviour of a person A towards another B, and they are related to either A or B

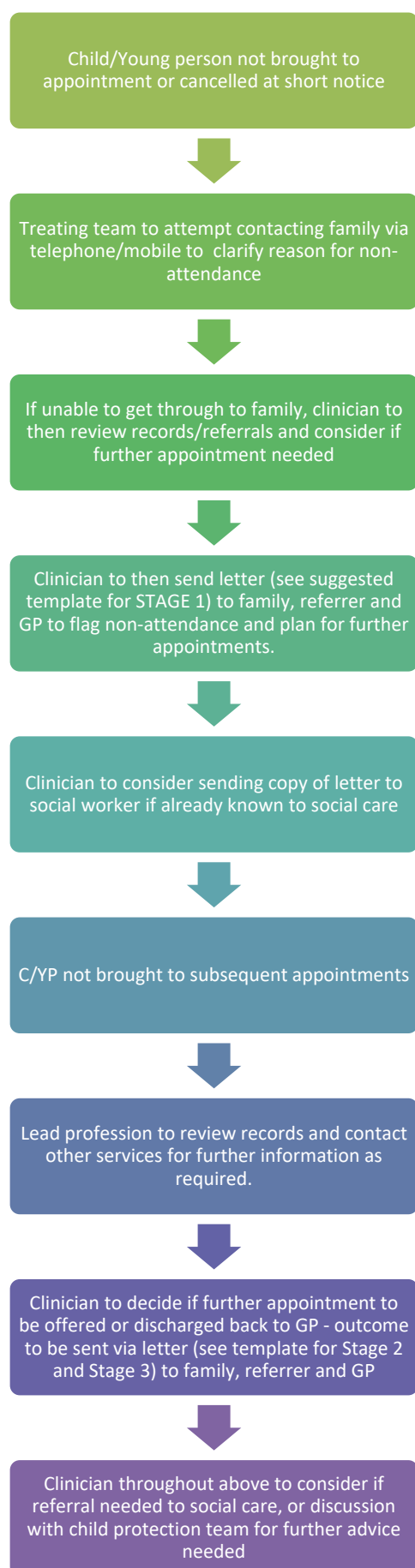
More guidance regarding domestic abuse is available via the Safeguarding Children Partnerships' policies and procedures

ACTION:

If you have concerns that a child or young person is at risk from domestic abuse, please follow the referral process set out in Appendix 3.

Appendix 6: Children & young persons who are not brought to hospital appointments (WNB)

For the unborn and non-attendance at antenatal appointments see APPENDIX 16



General principles:

There have been several child safeguarding practice reviews where medical neglect has been a key theme and the 'was not brought' policy was included in the learning recommendations. It is important that practitioners recognise the significant harm that medical neglect can have on children and that we follow up to date guidance and procedures to identify concerns early to mitigate risk.

Staff are advised to check address and contact details are correct – we would suggest including the contact numbers you have tried in the clinic letter and ask families to inform your service if contact details are incorrect. You can also check via Graphnet SCR (GP records) if address and contact details are correct.

Consider safeguarding for children who are not brought to appointments across other specialties – we would suggest reviewing the last 12 months' worth of outpatient appointments and count the number of missed appointments. This information would be useful to include in the letter to the GP and family.

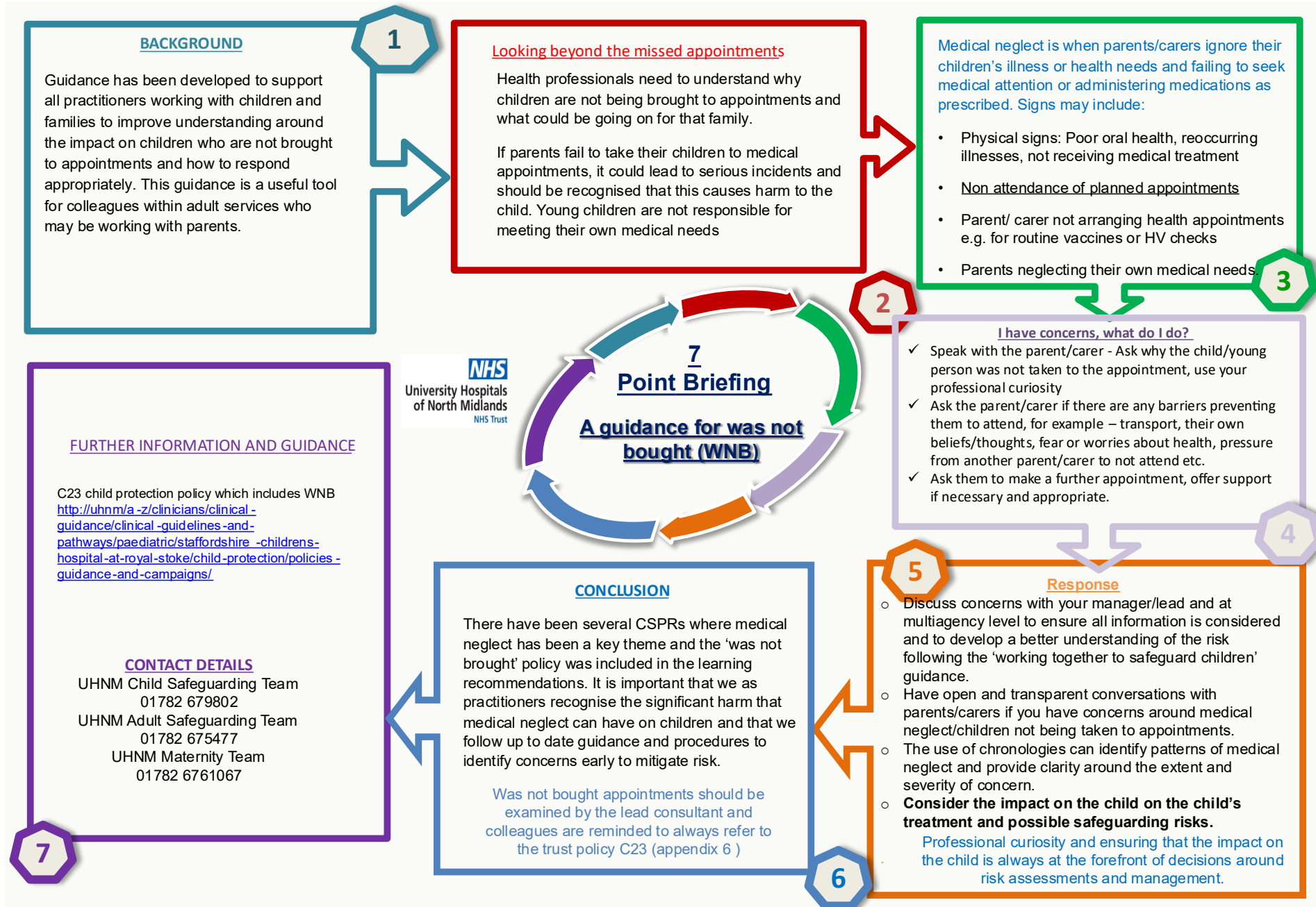
Consider safeguarding for children who have multiple WNB/cancelled appointments.

Safeguarding should be considered at all stages and acted on as appropriate

If it's felt the child not being brought to appointments is having an impact on their health, this needs a consideration around referring to social care e.g. Child with poorly controlled diabetes/asthma that has required frequent admissions in past and not being brought to appointments meaning their long term control is not being optimised.

We would suggest considering following a similar process if children are not brought for elective investigations e.g. scans, blood tests. Clinicians will need to decide in terms of whether the child not being brought for a particular investigation raises risk of health complications e.g. not being brought for an appointment for an ultrasound scan to find a cause for an unexplained lump, we may then not be able to rule out a cancer if not brought.

If you have any child protection concerns about the child or young person, contact your named doctor / named nurse for safeguarding children for advice



STAGE 1 TEMPLATE LETTER FOR CHILD NOT BROUGHT TO APPOINTMENT

Child Development Centre
Royal Stoke University Hospital
Hilton Road
Stoke on Trent
ST4 6QG
Tel: 01782 679829

Our Ref: AV/ABC123

Date Dictd: 19/07/2024
Date Typed: 19/07/2024

Email:

Department of Paediatrics

Parents of John Smith

John SMITH
10 St. Elsewhere, Stafford
ST10 1BC

D.O.B. 01/01/2024
Hospital No. ABC123
NHS No. 123 456 7890

Unfortunately, John was not brought for his planned appointment with **community paediatrics** today.

I attempted to contact you on the phone number we have on our system, which was **0123 456789**, but was not successful in getting through to you.

I checked on the GP records and confirmed this was the correct number and address we have on file. If either are incorrect, I would be grateful if you could get in touch with the admin team via the number above to help update the records.

I have decided to **offer you one further appointment today, but if this is not attended, we will have no choice but to discharge you from our service OR I have made the decision to discharge you from our service today.**

Yours sincerely

Electronically checked and authorised by

Dr ABCDE, consultant paediatrician

Copy to:
GP, Health visitor (if relevant), Social worker (if known)

STAGE 2 TEMPLATE LETTER FOR CHILD NOT BROUGHT TO APPOINTMENT

Our Ref: AV/ABC123

Date Dictd: 19/09/2024
Date Typed: 19/09/2024

Parents of John Smith

John SMITH
10 St. Elsewhere, Stafford
ST10 1BC

D.O.B. 01/01/2024
Hospital No. ABC123
NHS No. 123 456 7890

Unfortunately, John was again not brought for his planned appointment with **community paediatrics** today. He was also not brought for his previous appointment on 19th July 2024.

I attempted to contact you on the phone number we have on our system, which was **0123 456789**, but was not successful in getting through to you.

I checked on the GP records and confirmed this was the correct number and address we have on file. If either are incorrect, I would be grateful if you could get in touch with the admin team via the number above to help update the records.

I have reviewed John's clinical records and noticed he has missed **8** other appointments with other specialities also.

It is important that John is brought for his appointments to help ensure his health concerns are being appropriately managed.

If you miss appointments often, health professionals need to think about your child's safety, as this has come up in serious case investigations where children have been harmed or neglected. If you're having trouble making it to appointments, it's a good idea to talk to your GP. They can help you find support, like getting help from Early Help services.

I have decided to **offer you one further appointment today, but if this is not attended, we will have no choice but to discharge you from our service OR I have made the decision to discharge you from our service today.**

Yours sincerely

Electronically checked and authorised by

Dr ABCDE, consultant paediatrician

Copy to:
GP, Health visitor (if relevant), Social worker (if known)

STAGE 3 TEMPLATE LETTER FOR CHILD NOT BROUGHT TO APPOINTMENT

Our Ref: AV/ABC123

Date Dictd: 19/11/2024

Date Typed: 19/11/2024

Parents of John Smith

John SMITH
10 St. Elsewhere, Stafford
ST10 1BC

D.O.B. 01/01/2024
Hospital No. ABC123
NHS No. 123 456 7890

Unfortunately, John was not brought for his 3rd planned appointment in a row with **community paediatrics** today.

I attempted to contact you on the phone number we have on our system, which was **0123 456789**, but was not successful in getting through to you.

I checked on the GP records and confirmed this was the correct number and address we have on file. If either are incorrect, I would be grateful if you could get in touch with the admin team via the number above to help update the records.

I have reviewed John's clinical records and noticed he has missed **10** other appointments with other specialities also.

I have decided to **offer you one further appointment today, but if this is not attended, we will have no choice but to discharge you from our service OR I have made the decision to discharge you from our service today.**

Recent reviews in children who have suffered harm or abuse have shown that when children miss their appointments, it can be a sign of possible medical neglect or other types of harm. As a health organisation, we have a duty to keep your child safe. That's why if a child keeps missing appointments, it can raise concerns.

We have sent a copy of this letter to your child's doctor. We suggest that your GP talks to you about why you are missing appointments to see if you need help to make sure you can attend. The GP will also think about whether your child needs to be referred to children's social care.

OR Following safeguarding guidelines, we have told children's social care about our concerns. They may contact you to talk about this more.

Yours sincerely

Electronically checked and authorised by

Dr ABCDE, consultant paediatrician

Copy to:
GP, Health visitor (if relevant), Social worker (if known)

Appendix 7: Process for ensuring that local families with children who are not registered with a GP are offered registration

When a child presents at the UHNM and has been identified as not being registered with a GP, the parent/carer should be directed to the NHS website <https://www.nhs.uk/nhs-services/gps/how-to-register-with-a-gp-surgery/>

ACTION:

In addition to the above, if you have concerns about a child or young person who is not registered with a GP, please follow the referral process set out in APPENDIX 3.



Stafford Education & Enterprise Park
Weston Road
Stafford
ST18 0BF
Telephone: 0300 123 1461

Dear Sir/Madam

You have brought a child to A&E/the walk-in centre today who is not registered with a general practitioner (GP). Whilst you can bring children to A&E/the walk-in centre if you have a concern for their health and wellbeing, we would strongly advise that you register the child with a GP. A&E/The walk-in centre notifies your GP of the child's attendance so this is recorded on their health record.

Registering the child with a GP is considered to be in the child's best interests as it ensures they have routine health checks, are called for routine immunisations and have easy access to health services should these be required.

If your child is not registered with a GP this may trigger safeguarding concerns and lead to a referral to children's social care, as it is our duty and priority to ensure that the child's best interests and welfare are upheld at all times.

Whilst we appreciate there are many reasons a child may not be registered with a GP, we want to make you aware of the importance and reasons for doing so.

If you need help in finding a GP you can visit the following website:

<https://www.nhs.uk/nhs-services/gps/>

This details how to find a GP and how to go about registering with a GP.

Yours sincerely

UHNM

North Staffordshire & Stoke-on-Trent Child Safeguarding Team

Chair: David Pearson

Chief Executive Officer: Peter Axon

Appendix 8: Process for ensuring children or young people (for whom there have been concerns about their safety and welfare) are not discharged until their welfare is safeguarded

Trust Policy No. C21 Policy for the Discharge of Children

The Trust Policy for the Discharge of Children (C21) stipulates that a child about whom there are concerns of deliberate harm should not be discharged home until it is safe to do so. It is the responsibility of the admitting consultant to ensure that discharge does not take place where concerns have been identified, until a referral to children's social care has been made and a discharge plan is in place.

The named professionals are available for support and advice around discharge planning which should also include children's social care and the police if appropriate. A formal discharge planning meeting may be needed with all relevant parties.

Lord Laming, following the Inquiry in 2003 into the death of Victoria Climbié, made the following recommendations:

Laming Recommendation 72: No child about whom there are concerns about deliberate harm should be discharged from hospital back into the community without an identified GP.

Laming Recommendation 70: No child about whom there are child protection concerns should be discharged from hospital without the permission of either the consultant in charge of the child's care or a paediatrician above the grade of senior house officer.

ACTION:

If you have concerns that a child or young person is at risk, please follow the referral process set out in APPENDIX 3.

Appendix 9: Process for handling suspected fabricated or induced illness and perplexing presentations (FII/PP)

Please refer to NICE guidance (see link in APPENDIX 1) for more information along with the LSCP policy and procedures.

Perplexing Presentations /Fabricated or Induced Illness in Children RCPCH Guidance (2021) is also useful particularly where the child is not in immediate risk of serious harm. Local process and this guidance is available via the Child Protection Intranet site.

ACTION:

If you have concerns that a child or young person is at risk of fabricated or induced illness, and there are immediate and serious risks to the child's health and or life, please follow the referral process set out in APPENDIX 3.

Early discussion with the named professionals is recommended in cases of suspected FII/PP.

Do not discuss the referral with the parents or carers until agreement has been reached with other professionals, including police and social care as to what information should be shared with the parents and when, as this may place the child at increased risk of harm.

For perplexing presentations where the child is not at immediate risk of serious harm a safeguarding referral may not be needed at this point and the RCPCH guidance should be followed.

There is an iPortal structured note which can be used to alert other UHNM professionals that there are evolving FII/PP concerns – this is available via the Structured Note section of iPortal and is titled 'PERPLEXING PRESENTATIONS / MEDICALLY UNEXPLAINED SYMPTOMS PLAN'.

Appendix 10: Process for resolving cases where health professionals have a difference of opinion

Laming Recommendation 67: When differences of opinion occur in relation to the diagnosis of possible deliberate harm to a child, a recorded discussion must take place between the persons holding the different views.

When the deliberate harm to a child has been raised as an alternative diagnosis to a purely medical one, the diagnosis of deliberate harm must not be rejected without full discussion and, if necessary, obtaining a further opinion (from the named doctor or nurse for child protection or the child protection paediatrician on call).

Laming Recommendation 77: All doctors involved in the care of a child about who there are concerns about possible deliberate harm should provide social services with a written statement of the nature and extent of their concerns. If misunderstandings of medical diagnosis occur, these must be corrected at the earliest opportunity in writing. It is the responsibility of the doctor (or healthcare professional) to ensure that his or her concerns are properly understood.

Laming Recommendation 81: Actions agreed in relation to the care of a child about whom there are concerns about deliberate harm are recorded, carried through and checked for completion.

Laming Recommendation 83: The investigation and management of a case of a possible deliberate harm to a child must be approached in the same systematic and rigorous manner as would be appropriate to the investigation and management of any other potentially fatal disease.

ACTION:

If you are in a situation where health professional colleagues have a different opinion from your own, the named professionals for safeguarding children should be contacted via the child protection office 679802, to discuss the case. Out of hours the acute paediatrician on call may be contacted if a delay could put the child at increased risk of harm.

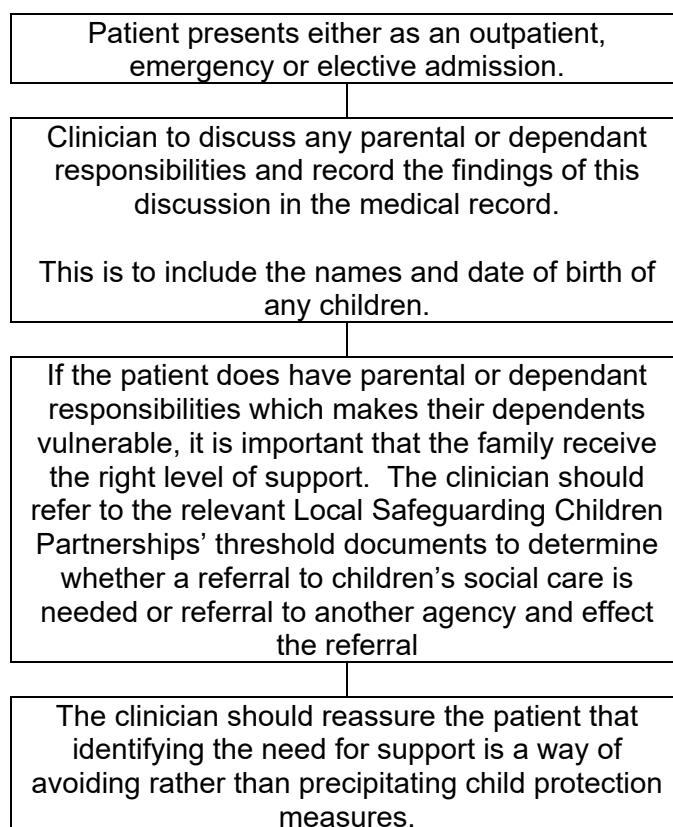
Where necessary, the referral process set out in APPENDIX 3 should be followed.

Where there are interagency disagreements the escalation policy for the Local Safeguarding Children Partnerships must be used. This can be found on the Local Safeguarding Children Partnerships' websites

Appendix 11: Process for ensuring that all patients are routinely asked about dependants such as children, or about any care responsibilities

This is particularly important in services such as those dealing with acute admissions or treatment, for example some mental health conditions or where those seeking help for substance misuse may have dependent children or younger siblings needing care. These children may be vulnerable because of the admission of the carer and it is important that appropriate assessment and communication between agencies occurs.

In recent years, there has been a shift in policy, which is now placing greater emphasis on supporting adults in their parenting role. *Working Together 2023* provides the framework for children's services to support the child and the family.



ACTION:

If you have concerns that the child is at risk of significant harm as a result of parental factors, a safeguarding referral should be made. Please follow the referral process set out in APPENDIX 3 of this policy.

Appendix 12: Child protection supervision for UHNM staff

Working to ensure children are protected from harm requires sound professional judgements to be made. It is demanding work and can be distressing and stressful.

Section 11 of the Children Act 2004 says that as an organisation there should be in place arrangements that reflect the importance of safeguarding and promoting the welfare of children; this includes appropriate supervision and support for staff. (*Working Together* 2023).

Effective professional supervision can play a critical role in ensuring a clear focus on a child's welfare. Supervision should support professionals to reflect critically on the impact of their decisions on the child and their family.

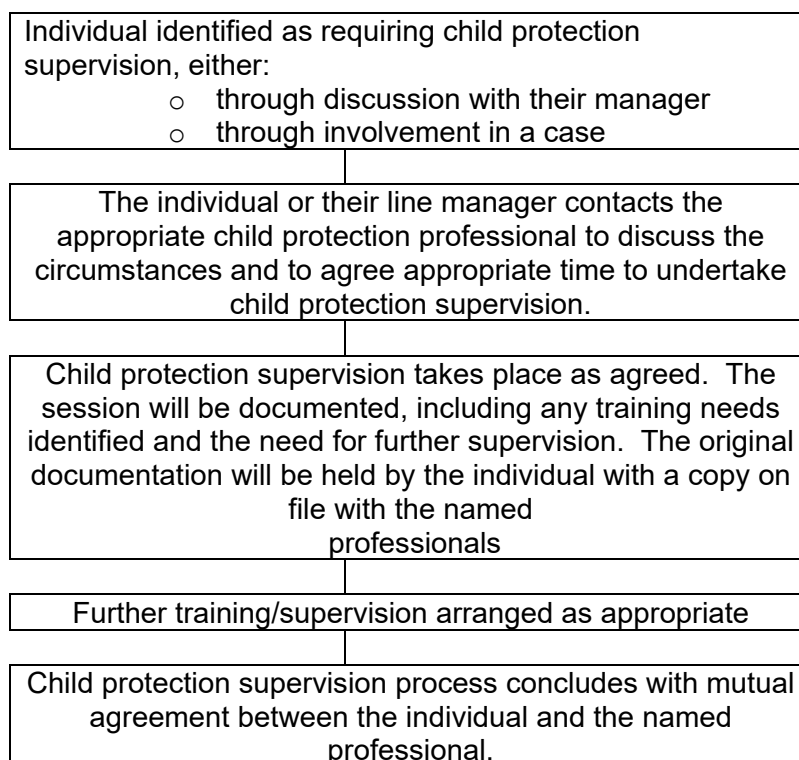
It is considered good practice within the UHNM for all clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns to undertake child protection supervision.

The named doctor, named nurses and named midwife offer child protection supervision. This is available to all staff. When the child protection department receive a copy of the DORF from a member of staff, following a referral, an e-mail is sent to the member of staff inviting them to contact the child protection department or their named professional for child protection supervision.

For professionals who are involved in day-to-day work with children and families child protection supervision is important to:

- ensure that practice is consistent with local safeguarding procedures
- support them in delivering their role and responsibilities
- help to identify any training and development needs.

The Trust named professionals can provide child protection supervision. To access child protection supervision, the following process should be followed:



FORM A: UHNM CHILD PROTECTION SUPERVISION

Name of Supervisee:

Name of Supervisor:

It is considered good Trust practice for all clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns to undertake child protection supervision.

- To enable the member of clinical staff to perform to the standards specified by their own professional body, Staffordshire and Stoke-on-Trent Safeguarding Children Boards' policies and procedures and UHNM policies and procedures.
- To ensure that the member of clinical staff is clear about his/her roles and responsibilities.
- To clarify roles and responsibilities within inter-agency working.
- To promote professional development; identify gaps in knowledge and skills requiring child protection training.
- To ensure accountability for the work undertaken by clinical staff.
- To be a source of support for clinical staff.
- To provide the opportunity to address issues relating to clinical staff care.

As a supervisee I agree to:

- Prepare for the sessions, for example, by having an agenda or preparing notes or transcripts.
- Take responsibility for making effective use of the time, including punctuality, and the outcomes and any actions I may take as a result of child protection supervision.
- Be willing to learn, to develop my child protection skills and be open to receiving support and challenge.

As a child protection supervisor I agree to:

- Keep all information you reveal in the clinical supervision sessions confidential, with the following exceptions:
 - If you should disclose any unsafe, unethical or illegal practice and you are unwilling to go through the appropriate procedures to address the issues identified
 - You repeatedly fail to attend for the appointed sessions.
 - You disclose a child protection incident that has not been reported

In the event of an exception arising, I will attempt to support you to deal appropriately with the issue. If I remain concerned, I will inform your line manager and the safeguarding children lead for the Trust, only after informing you that I am going to do so.

- Offer you advice, support and supportive challenge to enable you to reflect in depth on issues affecting your child protection practice.

FORM B - Child Protection Supervision for UHNM Staff

SPECIFIC CASE SUPERVISION

DATE			TELEPHONE/FACE TO FACE
NAME OF SUPERVISEE / GROUP SUPERVISEE TITLE			
NAME OF SUPERVISOR TITLE			
AREA/DEPARTMENT			
Subject of a Child in Need Plan		Subject of a Child Protection Plan	

NATURE OF CONCERN/QUERY		Tick as appropriate	
Neglect		Physical	
Emotional		Unexplained injury	
Alcohol abuse		Substance misuse	
Schedule / Offender		Vulnerable family	
Learning disability child/carer		Other (<i>Please state</i>)	
INDIVIDUAL CASE LOAD SUPERVISION		GROUP SUPERVISION	

KEY THEMES

ACTION PLAN

CHILD'S VOICE

Review date

Supervisor signature

Print name

Supervisee signature

Print name

Dear

Subject: DORF

Thank you

We have received the documentation of your referral to Children's Social Care Services.

If you receive an outcome letter / email from social care please send it to the child protection team UHNMChildProtectionTeam@uhnm.nhs.uk for us to upload onto the child's records.

If you did not call social care please do so, your referral will not be processed unless it has been called through.

The child protection team will endeavour to inform you of any outcomes that are received.

Please phone ext. 79802 (Child Protection Office UHNM) if you are not satisfied with the outcome of your referral, or if you have any queries.

Please ensure that the e discharge makes it clear that a referral has been made and that the liaison health visitor is aware

It is recommended that any professional who is directly working with a child protection case, seeks support from the Child Protection Team.

Child protection supervision is important to:

- ensure that practice is consistent with local safeguarding procedures
- provide support in delivering your role and responsibilities
- help to identify any training and development.

You are invited to contact the named professionals on 79802 to arrange this at a mutually convenient time.

For midwives or maternity staff please contact Mandy Stenson on 71067 or e-mail mandy.stenson@uhnm.nhs.uk

Yours sincerely

Named professionals

Appendix 13: Care Quality Commission Safeguarding and Registration Requirements

NB: Please note that this regulation relates to the safeguarding of children and adults

Regulation 13: Safeguarding service users from abuse and improper treatment from the Care Quality Commission's ***Guidance for providers on meeting the regulations of quality and safety***, published February 2015 sets out what providers should do to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13

It states that providers should minimise the risk of abuse occurring by adherence to a series of regulations outlined below:

13.—(1) Service users must be protected from abuse and improper treatment in accordance with this regulation.

(2) Systems and processes must be established and operated effectively to prevent abuse of service users.

(3) Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

(4) Care or treatment for service users must not be provided in a way that—

- (a) Includes discrimination against a service user on grounds of any protected characteristic (as defined in section 4 of the Equality Act 2010) of the service user,
- (b) includes acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint,
- (c) is degrading for the service user, or
- (d) significantly disregards the needs of the service user for care or treatment.

(5) A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority.

(6) For the purposes of this regulation— “abuse” means—

- (a) any behaviour towards a service user that is an offence under the Sexual Offences Act 2003(a),
- (b) ill-treatment (whether of a physical or psychological nature) of a service user,
- (c) theft, misuse or misappropriation of money or property belonging to a service user, or
- (d) neglect of a service user.

(7) For the purposes of this regulation, a person controls or restrains a service user if that person—

- (a) uses, or threatens to use, force to secure the doing of an act which the service user resists, or
- (b) restricts the service user's liberty of movement, whether or not the service user resists, including by use of physical, mechanical or chemical means.

The intention of this regulation is to safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment. Improper treatment includes discrimination or unlawful restraint, which includes inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005.

To meet the requirements of this regulation, providers must have a zero tolerance approach to abuse, unlawful discrimination and restraint. This includes:

- Neglect.
- Subjecting people to degrading treatment.
- Unnecessary or disproportionate restraint.
- Deprivation of liberty.

Providers must have robust procedures and processes to prevent people using the service from being abused by staff or other people they may have contact with when using the service, including visitors. Abuse and improper treatment includes care or treatment that is degrading for people and care or treatment that significantly disregards their needs or that involves inappropriate recourse to restraint.

For these purposes, 'restraint' includes the use or threat of force, and physical, chemical or mechanical methods of restricting liberty to overcome a person's resistance to the treatment in question.

Where any form of abuse is suspected, occurs, is discovered, or reported by a third party, the provider must take appropriate action without delay. The action they must take includes investigation and/or referral to the appropriate body. This applies whether the third party reporting an occurrence is internal or external to the provider.

CQC can prosecute for a breach of some parts of this regulation (13(1) to 13(4)) if a failure to meet those parts results in avoidable harm to a person using the service or if a person using the service is exposed to significant risk of harm. We do not have to serve a Warning Notice before prosecution. Additionally, CQC may also take any other regulatory action.

The CQC must refuse registration if providers cannot satisfy them that they can and will continue to comply with this regulation.

The guidance is available to read in full at www.cqc.org.uk

Appendix 14: Child Protection Training Needs Analysis

Detailed TNA available via intranet - <http://uhnm/a-z/clinicians/clinical-guidance/clinical-guidelines-and-pathways/paediatric/staffordshire-childrens-hospital-at-royal-stoke/child-protection/training/>

Training requirements for staff

Staff Group	Type of Training			
	Level 1 ("Stat and Mand training)	Level 2	UHNM Level 3 (CSTF level 3 equivalent)	Level 3 + with additional responsibilities
Hours as per intercollegiate document every 3 years	At corporate induction + Minimum of 2 hours refresher every 3 year cycle which can include adult safeguarding and vulnerable patients training e.g. mental health.	4 hours every 3 year cycle	8 hours every 3 year cycle	8-16 hours every 3 years according to job role (please consult the RCN/RCPCH intercollegiate document for guidance)
Consultant and Career Grade working in a Paediatric Speciality e.g. child health, paediatric surgeons, orthopaedics and paediatric anaesthetists	✓	✓	✓	✓
Consultant working within ECC	✓	✓	✓	✓
Doctor in Training in a Paediatric Speciality e.g. child health, paediatric surgeons and paediatric anaesthetists	✓	✓	✓	✓
Ward Based Midwives (band 6 and above)	✓	✓	✓	✓
Community Midwives	✓	✓	✓	✓
Nurses (band 6 and above) working within a Paediatric Speciality and ECC	✓	✓	✓	✓
Nurses (up to band 5) working within a Paediatric Speciality and ECC	✓	✓	✓	✓
Ward Based Midwives (band 5 and below)	✓	✓	✓	
Allied Health Professionals (i.e. therapy staff, therapeutic radiographers / physicists / dieticians / audiologists / orthoptists) working with children.	✓	✓	✓	
Therapy Staff working within a Paediatric Speciality	✓	✓	✓	

University Hospitals of North Midlands NHS Trust
C23 Managing the Risks Associated with Safeguarding Children

Pharmacists (working with children)	✓	✓	✓	
Diagnostic radiographers	✓	✓	✓	
Play Specialists	✓	✓	✓	
Consultant and Career Grade NOT working with children	✓	✓		
Consultant and Career Grade who have contact with children however small or adults who could be parents or carers	✓	✓		
Doctor in Training NOT working with children	✓	✓		
Doctor in Training who have contact with children however small or adults who could be parents or carers	✓	✓		
Theatre Staff	✓	✓		
Nursing staff not working with children.	✓	✓		
Nursing staff working with children outside a Paediatric Speciality or ECC (not routinely seeing children – e.g plastics)	✓	✓		
Nursing Assistants not working with children (e.g. Elderly Care)	✓	✓		
Nursing Assistants working with children outside a Paediatric Speciality (i.e. ENT)	✓	✓		
Nursing Assistants working within a Paediatric Speciality and ECC	✓	✓		
Allied Health Professionals (i.e. therapy staff, therapeutic radiographers / physicists / dieticians / audiologists / orthoptists) not working with children.	✓	✓		
Pharmacists (not working with children)	✓	✓		
Maternity support workers	✓	✓		
Nursery Nurses (Maternity Wards/Neonatal Unit)	✓	✓		
Non clinical support staff (e.g. Sodexo - Porters, Estates, Laundry, Domestic, Catering)	✓			

Management Staff not working within a clinical environment	✓			
Administrative and Clerical Staff (including ICT)	✓			

How to book onto training:

An Introduction to Child Protection (**Level 1**):

Follow the statutory and mandatory training guide to complete via e-learning on ESR

Level 2 training:

Access via ESR **e-Learning package**. Competence title in your Compliance Matrix is: NHS | CSTF | Safeguarding Children (Version 2) Level 2 -3 years

Level 3 Training (face to face only):

Book via ESR: **Search for** 205 Level 3 Child Protection [CSTF Level 3]

Level 3 Working Together and Specific (Level 3) Training:

This training is provided externally by both Staffordshire Safeguarding Children Partnership and Stoke-on-Trent Safeguarding Children Partnership. Staff may attend courses provided by either SCBP. A separate application must be completed.

There are also Level 2 and Level 3 e-Learning for Health courses available for further learning, but this will no longer automatically sign off the above competencies. They can be used as evidence in your training passport to evidence the hours required.

Contact Details for Further Advice:

If you would like to discuss your training needs, please contact the child protection team, who will be able to provide advice.

Contact No: 79802

- The child protection intranet page (please see clinical guidance section) also contains details of the training available.
- Detailed Training Needs Analysis documents is available via intranet - <http://uhnm/a-z/clinicians/clinical-guidance/clinical-guidelines-and-pathways/paediatric/staffordshire-childrens-hospital-at-royal-stoke/child-protection/training/>

For training at levels 3 or above, the SCP each have details on their websites.

Appendix 15: ASQUAM Achieving Sustainable Quality in Maternity Services Guidelines

There are a number of guidelines particularly relating to the unborn child. These can be accessed via the UHNM intranet Obs and Gynae pages.

<http://uhnm/a-z/clinicians/clinical-guidance/clinical-guidelines-and-pathways/obs-and-gynae/>

Examples include:

ASQUAM Guideline for the Management of Women at Risk of Domestic Abuse in Pregnancy
Also see APPENDIX 4

ASQUAM Concealed Pregnancy Guideline

ASQUAM Guideline for the Management of Missed Appointments

Female Genital Mutilation (FGM) Guideline – (Maternity Specific)

Appendix 16: Female Genital Mutilation (FGM)

Female Genital Mutilation is child abuse and is illegal.

Under mandatory reporting legislation, FGM in an under 18 year old must be reported. See the flowchart (below). Complete the blue FGM proforma, below

If there are concerns that a girl is at risk of FGM, a referral to children's social care must be made. Follow the process laid out in APPENDIX 3.

Following a strategy discussion with social care/police, if it's felt a child requires examination to confirm presence of FGM, then this should be discussed with the on-call child protection team (via 79802), who will then discuss with the Paediatric Gynaecology team to arrange an appointment for this to happen.

(BLUE) FGM REPORTING PRO-FORMA Females under 18 years of age

1. Healthcare Practitioner Details (person completing the form)			
Name:			
Contact Number:			
Role:			
Place of Work (Site):			
Date Form Completed (care contact date):			
2. Patient's Details			
Forename:		Surname:	
DOB:		Age:	
NHS Number:		Unit Number:	
Address:		Postcode:	
3. Country & Region of Patient. **Please see appendix for frequent areas. If not available please write place name			
Country of Birth Code **:		Country of Origin Code **:	
Region of Origin:		County where FGM Performed Code **:	
Is patient currently pregnant?:		☐ Yes	☐ No
If Delivery Event. Were any daughters born this attendance?	☐ Yes	☐ No	☐ Unknown
Country of Birth / Origin of baby's Father **:			
Number of Daughters under 18:	Numerical value 0-20 ☐ _____	☐ Unknown / Not Specified ☐ Not stated	
4. FGM Details			
How FGM Identified:	☐ Self-Report = 1 ☐ On examination = 2	☐ Other clinician = 3 ☐ Other = X	
Age Range when FGM Performed:	☐ Under 1 = 01 ☐ 1 and under 5 = 02 ☐ 5 and under 10 = 03	☐ 10 and under 15 = 04 ☐ 15 and under 18 = 05 ☐ 18 and over = 06	
FGM Type Identified Please tick appropriate number:	☐ Type 1 = Clitoridectomy ☐ Type 2 = Excision ☐ Type 3 = Infibulation	☐ Type 4 = Other ☐ Unknown	
FGM Type 4 Other additional classification:	☐ Pricking = 41 ☐ Piercing = 42 ☐ Scraping = 43	☐ Incising = 44 ☐ Cauterisation 45	
FGM Family History Indicator:	☐ Yes = Y ☐ No = N	☐ Unknown ☐ Not stated	
Advised On The Health Implications Of FGM:	☐ Yes = Y ☐ No = N	☐ Unknown = 9	
Advised on the Illegalities of FGM:	☐ Yes = Y ☐ No = N	☐ Unknown = 9	
Deinfibulation undertaken	☐ Yes	☐ No	
5. Details of Trust's Designated Safeguarding Lead			
Sarah Curran: sarah.curran@uhnm.nhs.uk		Tel: 01782 675474	
UHNM, Royal Stoke University Hospital, Springfield Building, Ground Floor, Newcastle Road, Stoke-on-Trent ST4 6QG			

6. Mandatory safeguarding referral to Police

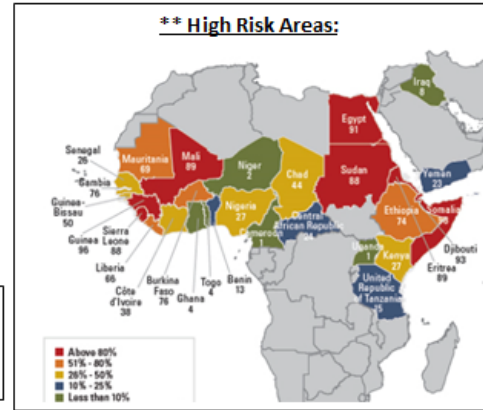
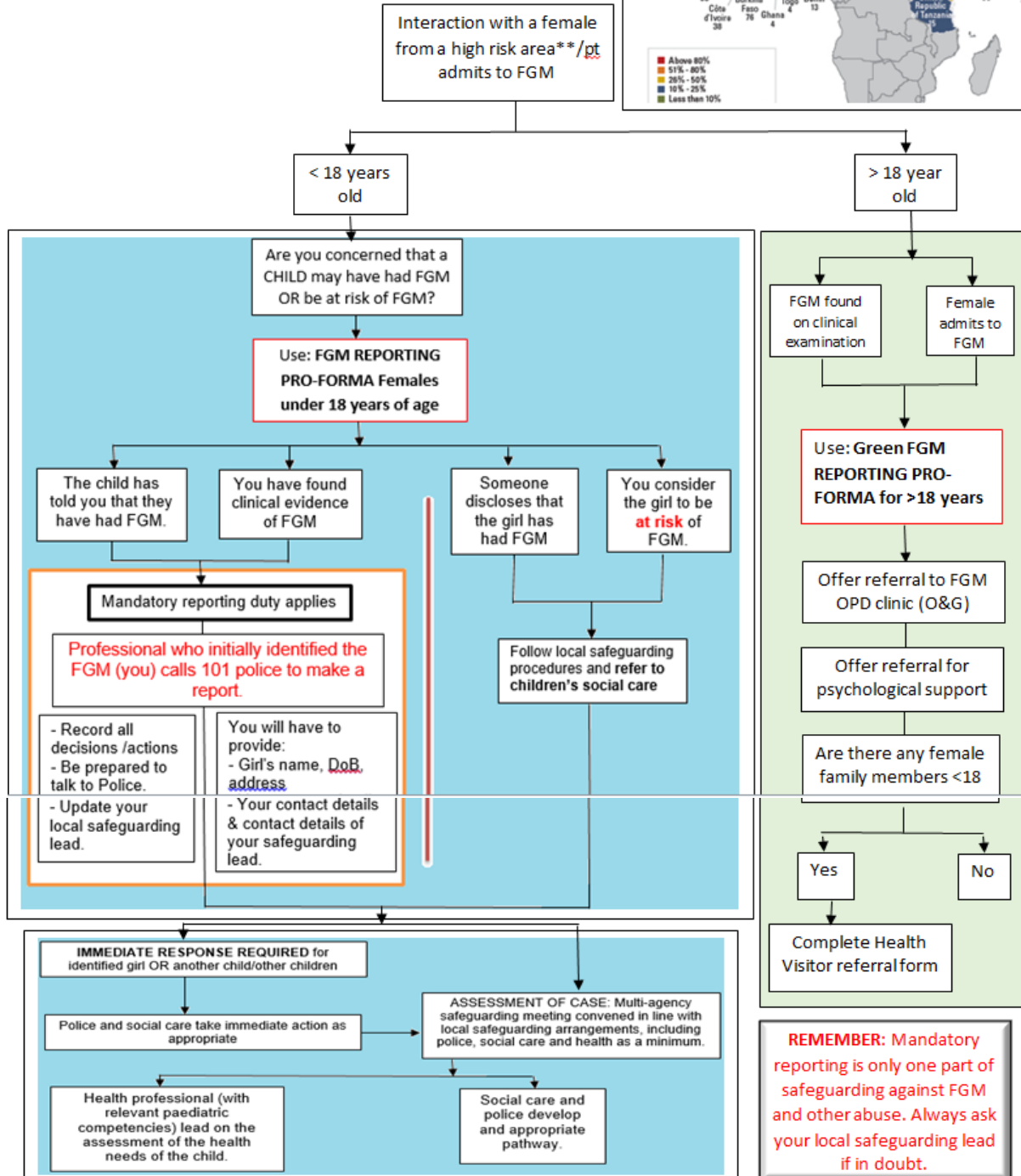
Police Reference Number:		
Date& Time of Referral:	Date:	Time:
Child Protection Contacted	☐ Yes	☐ No
Discussed with Family/child	☐ Yes	☐ No

Additional Information to assist with appropriate completion

Country FGM Performed detail. To be used in Section 3			
'ARE' - Arab Emirates	'ERI' - Eritrea	'LBY' - Libya	'SDN' - Khartoon
'ZAF' - Africa - South	'ETH' - Ethiop	'MYS' - Malaysia	'UKR' - Ukraine
'CAF' - Africa - Central	'GBR' - UK	'NGA' - Nigeria	'ZMB' - Zambia
'COG' - Congo	'GMB' - Gambia	'SAU' - Saudi	If NOT listed please enter as text Region: Enter as text
'CIV' - Côte d'Ivoire	'GIN' - Guinea	'SAU' - Arabia	
'CIV' - Ivory Coast	'IRQ' - Iraq	'SOM' - Somalia	
'EGY' - Egypt	'IRQ' - Kurdistan	'SDN' - Sudan	

University Hospitals of North Midlands **NHS**
NHS Trust

FEMALE GENITAL MUTILATION (FGM) FLOWCHART



Appendix 17: Child Sexual Exploitation - Child Sexual Exploitation

DEF: Child Sexual Exploitation (CSE) is when an individual takes sexual advantage of a child or young person (anyone under 18) for his or her benefit.

CSE occurs throughout the UK affecting boys as well as girls from any social, ethnic or financial background. It robs them of their childhood and has serious long-term effects on every aspect of their lives and may be life-threatening.

Have you considered Child Sexual Exploitation?

See <http://uhnm/a-z/clinicians/clinical-guidance/clinical-guidelines-and-pathways/paediatric/staffordshire-childrens-hospital-at-royal-stoke/child-protection/child-exploitation/>

In all cases trust in your professional instinct and remember to be professionally curious. Consider talking to the patient alone

Consider Possible Indicators of CSE

- Self-harm/attempted suicide
- Repeated symptoms of UTI
- Pelvic inflammatory disease
- Repeated pregnancies / miscarriages / terminations
- Repeated or prolonged alcohol abuse
- Drug / substance misuse
- Unexplained injuries
- Lack of personal hygiene / care
- Repeated / frequent attendances / admissions

Concerns – complete the Risk Factor Matrix (RFM) on child protection pages of the Intranet

Medium / High risk
Refer to Catch 22 AND

Follow Trust guidance as per box below

Low risk refer to
Catch 22 (details
on RFM)

No concerns

No action
required

Making a child protection referral – see child protection pages of intranet - <http://uhnm/a-z/clinicians/clinical-guidance/clinical-guidelines-and-pathways/paediatric/staffordshire-childrens-hospital-at-royal-stoke/child-protection/child-exploitation/>

- Ring appropriate children's social care services
- Complete the DORF (Documentation of Referral Form)
- Send form to Trust Child Protection Team
- UHNM Child Protection Team are available for advice on 01782 679802

Appendix 18: SOP Child Protection Information Sharing System

Standard Operating Procedure (SOP)

Child Protection Information Sharing System

(C23)

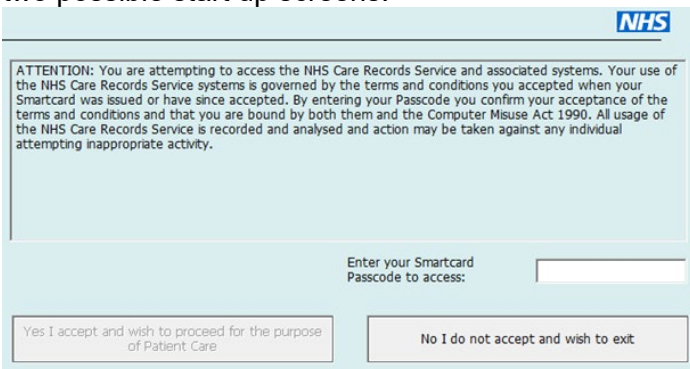
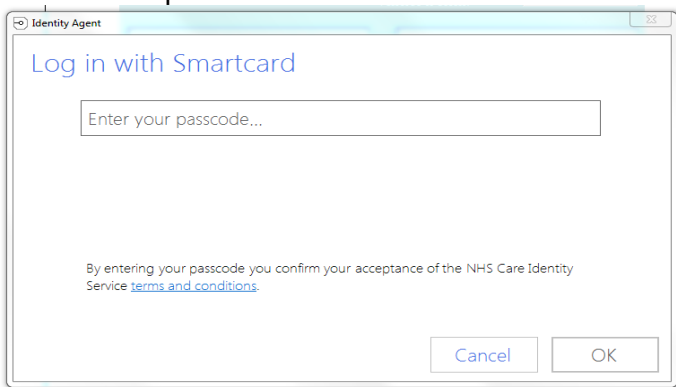
April 2025 V5

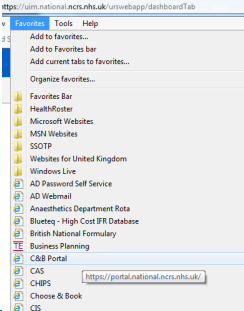
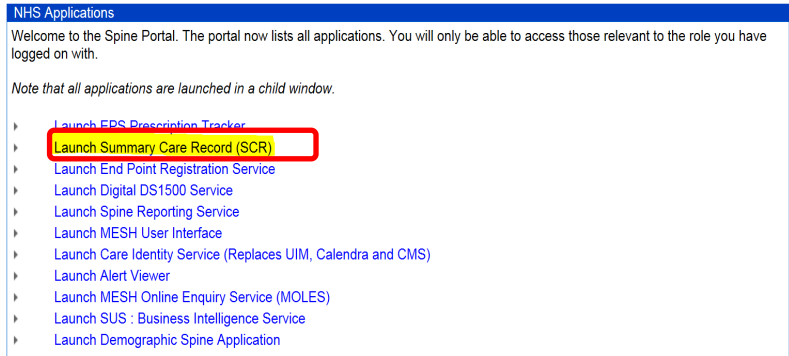
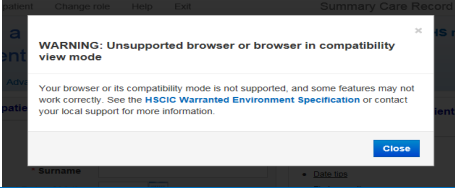
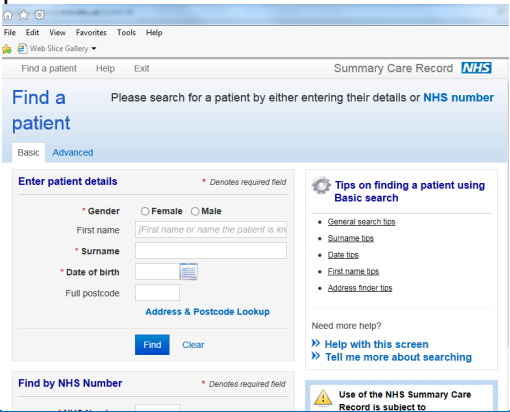


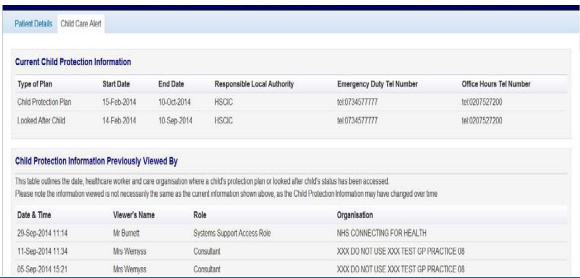
University Hospitals
of North Midlands
NHS Trust

The purpose of this SOP is to enable practitioners to identify if a child / unborn is subject to a Child Protection Plan via the Child Protection Information Sharing system (CP-IS). It does not replace, but works alongside the Trust's current Safeguarding processes by improving communication between agencies when a child / unborn is known to Children's Social Care. Access to the system will allow the health team to be alerted that they are subject to a plan and have access to the contact details for the Social Care Team. The Social Care Team is automatically notified that the child /unborn has attended and both parties can see details of the child / unborn previous 25 visits to unscheduled care settings in England.

This SOP links to Trust Policy C23 and C36.

No.	Description of Procedural Steps
1	Nominated professional to triage and assess patient / Mother as per local procedure in the Emergency Care Portal (Children's Emergency Department CED & Children's Assessment Unit CAU) or Maternity Assessment Unit MAU
2	Nominated CP-IS checker to check status of child or Mother if baby unborn on CP-IS system for all attending children to CED & CAU & Mothers to MAU who are out of area, known to Social Care Team, presenting history does not match injury or illness or any other suspicious circumstances. Any children/unborn of adult patients where concerns may be raised around their ability to care.
3	<p>To check CP-IS, place smartcard into the smartcard reader slot on the computer. You will see one of two possible start up screens.</p>  <p>Enter your smart card passcode For the first option select the box on the left "Yes I accept ..."</p> 
4	<p>Select the required role from the list Please note: you may have more than one role on your list.</p>  <p>UNIVERSITY HOSPITALS OF NORTH MI... RJE Clinical Practitioner Access Role</p>

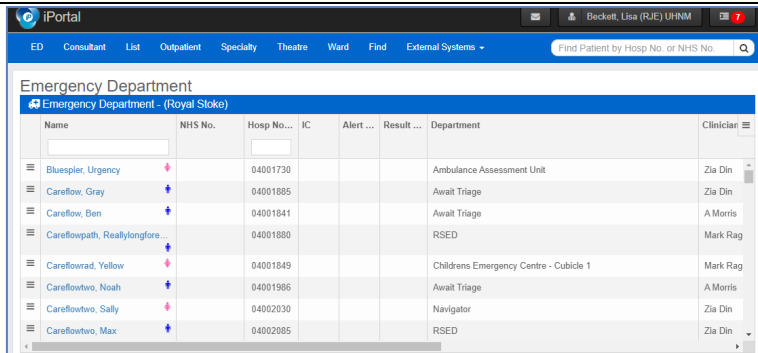
No.	Description of Procedural Steps
5	<p>Open Internet → Explorer → Click on Favourites → click on C&B portal</p> 
6	<p>Click on Launch Summary Care Record (SCR)</p> 
7	<p>Warning page – click on CLOSE icon</p> 
8	<p>You will now see the following page. To find the child's or Mothers details, type in patient's NHS number or date of birth and surname and press FIND</p> 
9	<p>You may be presented with a list of children or Mothers, verify the correct child or Mother by clicking on the name.</p>
10	<p>If there is a Child Care Alert this will be indicated via the Child Care Alert tab.</p> 

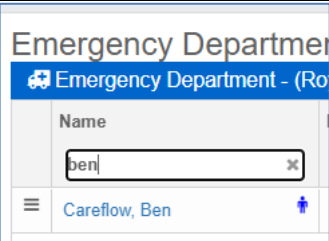
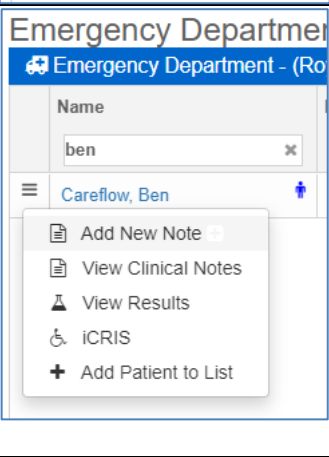
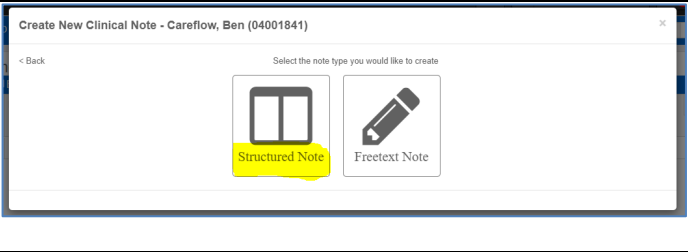
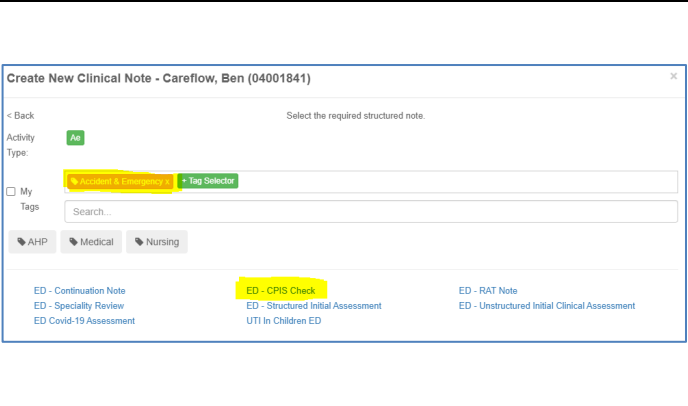
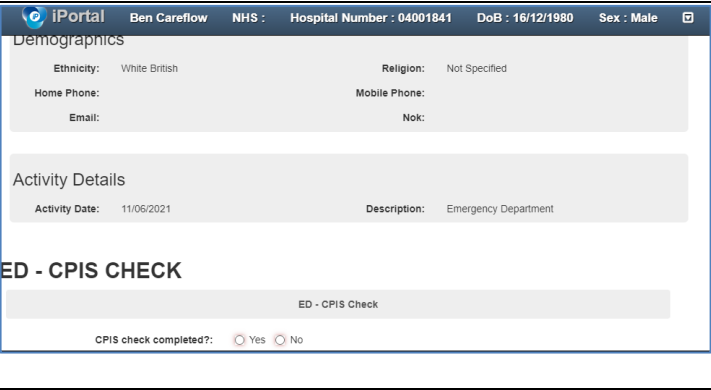
No.	Description of Procedural Steps
11	<p>Click on the Child Care Alert tab if there is one, to view details. If there is no tab then there are no social care details held</p> 
12	<p>If there is a child care alert then transcribe information onto the white CP-IS sticker. Place the completed CP-IS sticker in the child's health record alongside the admission clerking details.</p> <p>For the unborn baby document on K2 within admission text that CP-IS has been reviewed and details if there is a child care alert</p> <p>If there is no alert on the CP-IS system then indicate "No" on line one on the white CP-IS sticker and in K2 records</p> <div data-bbox="204 801 957 1646" style="border: 1px solid black; padding: 10px;"> <p style="text-align: center;"><u>Child Protection Information Sharing</u></p> <p>System Checked: Yes No</p> <p>Known to social care: Yes No</p> <p>Responsible local authority _____</p> <p>Emergency telephone numbers _____</p> <p>Office hours numbers _____</p> <p>Type of plan _____</p> <p>Start Date _____ End Date _____</p> <p>Date _____ Time _____</p> <p>Name _____</p> <p>Signature _____</p> <p>Designation _____</p> </div>
13	<p>Prior to transfer out of an Emergency Care Portal (unscheduled attendance) ensure receiving area is aware of the CP-IS alert and that the sticker has been placed in the child's health care record.</p> <p>Prior to transfer out of MAU the midwife caring for the Mother uses SBAR to receiving professionals on transfer of on-going care to reduce multiple accessing of CP-IS and document on K2</p>
14	<p>If there is no CP-IS sticker in the notes follow steps 2 to 13 above.</p>
15	<p>If there is no CP-IS Child Care Alert and there are concerns for the child refer to Policy No. (C23) Trust Policy for Managing Risks Associated with Safeguarding Children.</p>
16	<p>Continue to follow Trust Child Protection process in raising concerns</p>

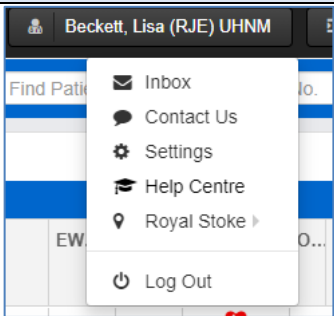
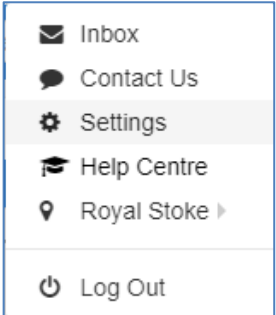
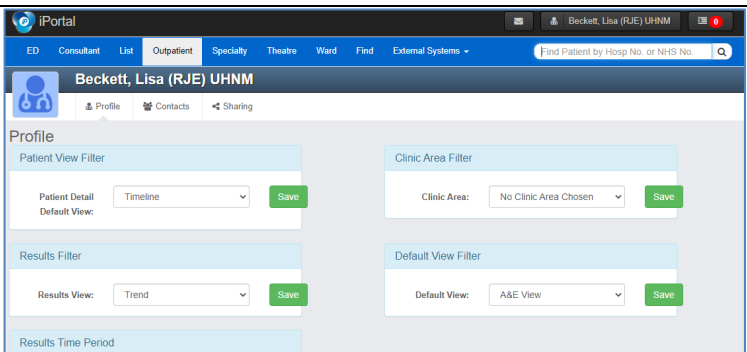
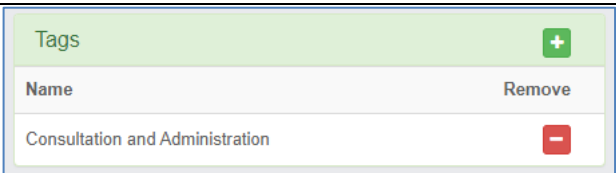
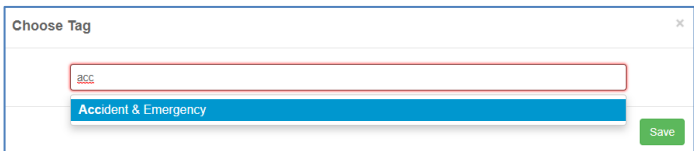
Standard Operating Procedure

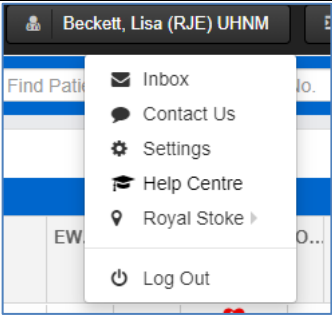
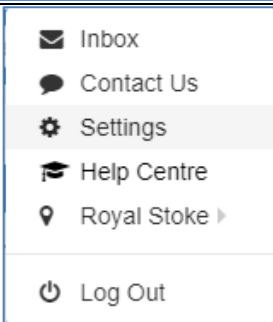
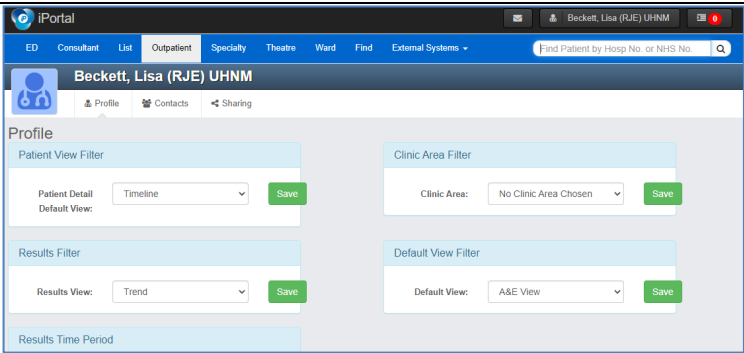
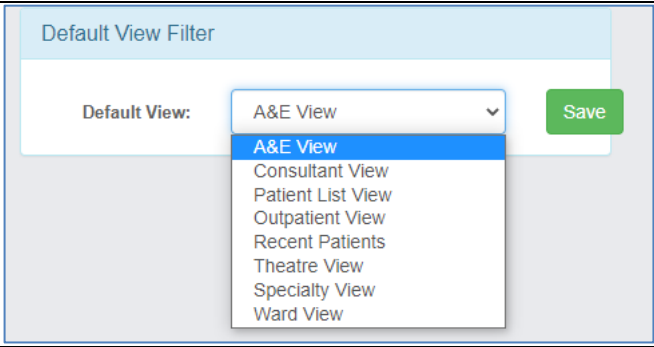
ED – CPIS Check - Structured Note - iPortal

Purpose:	Steps to add the ED-CPIS check structured note in iPortal to record the CPIS check has been completed. SOP includes advice regarding setting up user settings in iPortal to streamline the process.
Scope:	1-8 Adding a structured note against a child's ED attendance to record the CPIS check confirmation 9-13 Configuring your iPortal settings to the Accident & Emergency tag. 14-17 Configuring the ED view as your iPortal home page
SOP Reference Number:	
Policy SOP Relates To:	
Date of Issue:	April 2025
Date of Review (Align to Policy Review Date):	
Version Control:	2

Instruction		Photograph / Diagram
Adding a structured note against a child's ED attendance to record the CPIS check confirmation. Patient must first be attended into the Emergency Department and check the NHS spine record.		
1.	Launch iPortal from the desktop	
2.	Select ED from the Menu at the top of the screen	

3.	<p>Search for the patient from the filter in the Name column</p> <p>Check you have the right patient using the Hospital Number column</p>	
4.	<p>Select the menu icon to the left hand side of the patient's name, a menu will display.</p> <p>Choose Add New Note</p>	
5.	<p>The Create New Clinical Note screen will open.</p> <p>Select the Structured Note box</p>	
6.	<p>A list of structured notes will display.</p> <p>Choose the ED-CPIS Check note.</p> <p>Please be aware that the Accident & Emergency tag will need to be selected.</p> <p>You configure your settings to Accident & Emergency, this will mean you won't need to set the tag each time you add the note.</p>	
7.	<p>The ED-CPIS Check will display</p> <p>Complete the form by answering the first question, CPIS check completed?</p>	
8.	<p>When the form as been completed, select Complete from the bottom right hand portion of the screen.</p>	

Configuring your iPortal settings to the Accident & Emergency tag.		
9.	<p>Select your name in the top right hand portion of the screen</p> <p>The drop down list menu will display</p>	
10.	<p>Select Settings</p>	
11.	<p>Your personal settings page will open</p>	
12.	<p>From the Tags section, click on the green plus button</p>	
13.	<p>Type in accident, Accident & Emergency will display, select it and choose Save</p>	
Configuring the ED view as your iPortal home page		

14.	<p>Select your name in the top right hand portion of the screen</p> <p>The drop down list menu will display</p>	
15.	<p>Select Settings</p>	
16.	<p>Your personal settings page will open</p>	
17.	<p>Navigate to the Default View Filter From the drop down list, select A&E View.</p> <p>Choose Save.</p> <p>Each time you open iPortal, your home page will be set to the ED view.</p>	

Appendix 19: Safeguarding Alerts

Information sharing is essential for effective safeguarding and promoting the welfare of children and young people. It is a key factor identified in many CSPRs, where poor information sharing has resulted in missed opportunities to take action that keeps children and young people safe. (HM government, Information Sharing 2023)

Practitioners should be proactive in sharing information as early as possible to help identify, assess and respond to risks or concerns about the safety and welfare of children, whether this is when problems are first emerging, or where a child is already known to local authority children's social care (e.g. they are being supported as a child in need or have a child protection plan). Practitioners should be alert to sharing important information about any adults with whom that child has contact, which may impact the child's safety or welfare. (HM Government, Working together to safeguard children 2023)

The following electronic alerts are used within UHNM for safeguarding children and young people.

- **Child in Care**
- **Child Protection**
- **Child Protection – Maternity**
- **Child Safeguarding**

These alerts can be found on CareFlow and iPortal. As well as the alerts, child protection conference information is held on iPortal.

What these alerts mean.

Child in Care

This alert means that the child is a looked after child/ child in care. The child in care (looked after child) alert will state the name and telephone contact number of social worker. *This alert is to support staff with knowing who to contact if there are any concerns, or for example consent for medical treatment is required.* This alert remains on the child's records until the child protection department is notified of any change. This alert will also make the child's address details confidential. *If you require information on a confidential address, please contact the child protection department on ext-79802*

Child Protection

This alert means that the child is on a child protection plan. The **Child Protection** alert will state: 'Subject of a child protection plan' and will provide details of the social workers name and contact details – *we ask that for any concern or admissions that the named social worker is contacted directly. If out of hours, we ask that social care out of hours are contacted and that a DORF is completed for information sharing purposes.*

The start date for these alerts is the date of the child protection conference decision (This is when the decision is made for the child to be made the subject of a child protection plan). The alerts are end dated 7 months from this date. This is because a child protection review conference normally takes place every 6 months until the child is either stepped down from child protection or the child becomes a child in care. At which point, a child in care alert will replace this alert.

Child Protection – Maternity

This alert is when an unborn child is on a child protection plan. The Child Protection - Maternity alert is placed onto the mother's electronic hospital records. The alert will state: 'Contact SW (social worker's name and contact details) on admission or EDT if out of hours. See maternity alert for concerns.'

For unborn alerts which are for information purposes only, the alert is placed onto the mother's electronic hospital records. The alert will state: 'Alert for information only'

The start date for this alert is the date on which a maternity unborn alert was received from maternity into the child protection team. The end date is 6 months after the estimated delivery date (EDD).

For unborn alerts, once the baby is born the alert is placed on the baby's electronic medical record, the alert will state 'Unborn Child Protection concerns raised during the maternity period please speak to the named professionals: Named Midwife-71067 or Named Nurses Child Protection – 79802 for information, Follow the normal hospital process for any new CP concerns.' *The purpose of this alert is to inform staff that there have been concerns raised in the maternity period. These alerts are to support decision making. If staff have any current concerns, they must follow normal safeguarding procedures.*

The start date of this alert is the child's date of birth and the alert is end dated 12 months later.

Child Safeguarding

The child safeguarding alert is used for any other safeguarding concerns that require an alert, for example:

- If a strategy meeting has been held, and concerns have been raised regarding FII (fabricated induced illness) - The lead professional or the named nurses for child protection add an alert. Details of what the alert will include, for example, 'for all attendances at hospital please inform Dr ***, see iPortal note created on date- XX/XX/XXXX – The end date for these alerts, Will differ depending on the concerns. – *The purpose of this alert is to inform staff of concerns so informed decisions can be made.*
- If a child has been stepped down from a CP plan and are now the subject of a child in need plan / Early Help / no further action. These alerts will state: 'Has been the subject of a Child Protection plan in the past 12 months. Please see iPortal for child protection paperwork uploaded on xx/xx/xx.' If there is a current social worker their name and number will also be place on this alert. – *The purpose of this alert is to inform staff of previous concerns so informed decisions can be made by staff.* These alerts are end dated 12 months after the date of the decision to step down.
- To flag up if the child or a sibling has been subject to a rapid review, local/child safeguarding practice review in the past. This alert will remain until the child turns 18 years of age. The purpose is to ensure children are being appropriately safeguarded, and to flag up admissions to hospital, whilst ensuring any new concerns are appropriately shared with the appropriate social care team. The alerts will be monitored by the named nurses.
- To flag if a child has been discussed at a multiagency exploitation or domestic abuse panel (MACE/MARAC)

What you need to do-

- check for an alert on CareFlow or iPortal for any/all attendances or admissions.
- follow the guidance on the alert.
- document your actions within the medical note / iPortal.
- speak to the CP team if you have any concerns 79802

APPENDIX 20

PREVENT GUIDANCE

1.0 Summary

- 1.1 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 and the Pan London guidance for Adults at Risk/Working Together to Safeguard Children Guidance 2018. The Trust's Disciplinary Procedure will be followed in any suspected cases and the appropriate action will be taken.
- 1.2 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 vulnerable 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

2.0 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: 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. The CONTEST strategy (CONTEST 3.0) was updated in 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.

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

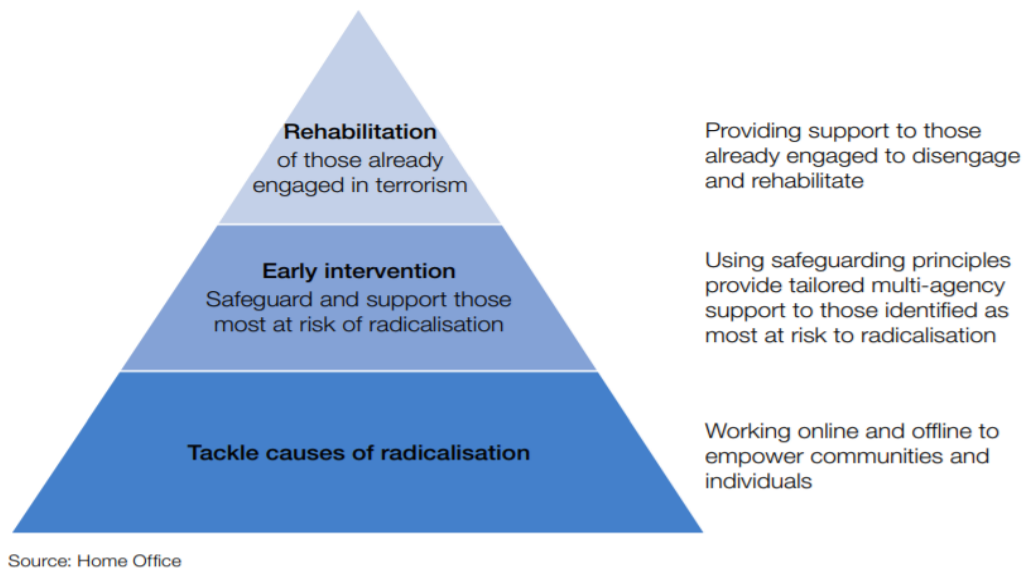
3.4 The Prevent Strategy was first published in June 2011 and is part of the United Kingdom's overall counter-terrorism strategy.. The Counter Terrorism and Security Act 2015: Section 26 places a legal duty on certain bodies including the NHS to have 'due regard to the need to prevent people from being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

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 are 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 additional duties include (please also refer to section 5.4 in main C23 guidance)

- 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
 - Will ensure any *prevent* referrals are forwarded onto the named professionals for child protection.
- 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 Named professionals for safeguarding children

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

5.3.7 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. Face to face or 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 face to face via E-learning or staff can undertake 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 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 too 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 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 discussing with the PREVENT Lead (ext. 71589) who will complete the relevant "*Raising Prevent Concern Form*."
- 10.4 If it is determined that an adult or child safeguarding referral needs to be made, it will be done in accordance with Policy C36 or C23.
- 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 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 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

12.0 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 - 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')

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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:

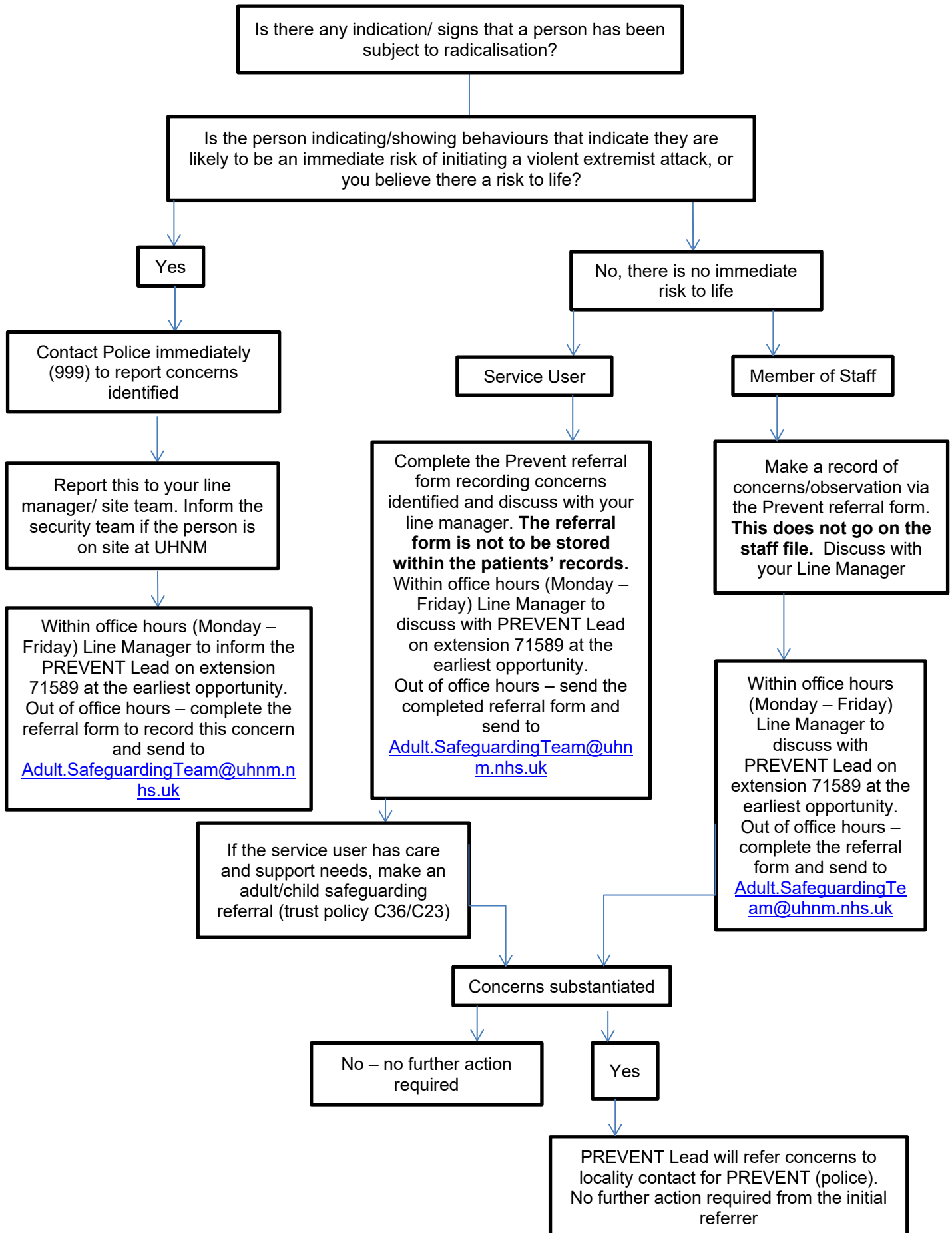
Individuals may perceive their aspirations for career and lifestyle to be undermined by limited achievements or employment prospects. This can translate to a generalised rejection of civic life and adoption of violence as a symbolic act.

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

APPENDIX: DEFINITIONS

Terrorism	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
Radicalisation	The process of grooming an individual to support, encourage or condone violence to advance terrorist ideology
Extremism	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.
CONTEST Strategy 3.0	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
Prevent Strategy	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.
Vulnerability	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.
Channel	Multi-agency approach to protect people at risk from radicalisation. 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"> • identify individuals at risk of being drawn into terrorism; • assess the nature and extent of that risk; and • develop the most appropriate support plan for the individual concerned. 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

Details of concern Please provide a summary of concerns identified			
Did the concerns warrant an immediate call to the police? 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		
Have you reported your concerns to others? I.e. HR, your line manager? If so please provide names of those you have reported to here			
Immediate action taken 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@uhnms.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