Policy Document

Reference: C36

University Hospitals of North Midlands NHS Trust

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

Version:	**10**
Date Ratified:	**July 2023 by Quality & Safety Oversight Group**
Date of Next Review:	**July 2026**
Policy Author:	**Lead Nurse for Safeguarding**
Executive Lead:	**Chief Nurse**

Version Control Schedule

Version	Issue Date	Comments
1	Jan 2004	
2	Sep 2006	
3	Nov 2008	
4	Nov 2010	
5	September 2013	Policy reviewed and approved by Compliance Steering Group, Quality and Safety Forum and Executive Committee.
6	May 2015	Updated with new flow charts and referral details
7	December 2016	
8	February 2020	• New detailed appendix on prevent – counter terrorism • New appendix (3) initial safeguarding decision flow chart • Reference to DoLS policy • Updated section regarding when allegations are made against a member of staff • ACN's to ensure representation at the adult safeguarding working group • Section "concerns raised against the Trust – additional actions added (point 9, 10, 11, 12 & 13) • Appendix 1 sentence added regarding others that may be at risk.
9	June 2021	Minor amendments: • Sentence involving letting the Coroner know when a patient has died whilst under a safeguarding enquiry. This has changed in that we let our bereavement services know and they will inform the Coroner. • New appendix (12) which advices staff regarding the alert on iportal and what actions to take.
10	July 2023	• National policies reviewed to reflect current guidance • Job titles of UHNM staff amended throughout policy • CCG changed to ICB throughout policy • Appendix 1; additional information added regarding; discharge considerations, capacity for referrals, mitigation of ongoing risks • Appendix 2; updated • Appendix 10; Designated trust safeguarding lead details amended, email addresses for UHNM safeguarding teams added • Appendix 12; guidance added regarding disclosures received from patients, and safeguarding team contact with the sex offenders management unit • New appendix 13 – contact details for support services • Appendix 9 – Prevent referrals flow chart amended and new referral form added • Job titles amended throughout policy

Statement on Trust Policies

The latest version of 'Statement on Trust Policies' applies to this policy and can be accessed here

CONTENTS **Page**

1. INTRODUCTION

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

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

1.2 This Policy should be read in conjunction with:

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

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

2. POLICY STATEMENT

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

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

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

- Committing representatives to participate in Partnership meetings

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

3. SCOPE

3.1 This policy applies to all staff working within the University Hospital of North Midlands NHS Trust regardless of contract type. It also applies to those who are employed by the contracted agencies of the Trust including; independent contractors, students on placement and volunteers.

3.2 The employees of the University Hospitals of North Midlands will work alongside other agencies to ensure compliancy within the Safeguarding of Adults Policy in Stoke-on-Trent and Staffordshire, to ensure adherence by all staff to the flowchart of actions regarding the protection of adults at risk who have care and support needs (Appendix 2). If a member of staff becomes aware of an incident that falls within these guidelines they should report in accordance to trust policy RM07 – An Organisation wide policy for the Management of untoward Incidents including serious untoward incidents by completing a DATIX.

4. DEFINITIONS

Adult with care and support needs
The adult safeguarding duties under the Care Act 2014 apply to an adult aged 18 years or over who:
- has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- is experiencing, or at risk of, abuse or neglect; and as a result of those care & support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

Abuse is defined as:

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

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

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

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

MARAC (multi-agency risk assessment conference); the multi-agency forum of organisations that

manage high-risk cases of domestic abuse, stalking and 'honour- based' violence.

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

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

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

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

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

5. ROLES AND RESPONSIBILITIES

5.1 NHS Provider Trusts

- **To work in accordance with the Care Act (2014)**

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

- To ensure that where complaints, disciplinary or serious untoward incident (SUI) Investigations, relate to possible abuse, these investigations take place within the framework of these procedures.
- To implement the DoLS provisions of the Mental Capacity Act 2005 as required of a Managing Authority.
- To make referrals to the Disclosure & Barring Scheme or to professional bodies where necessary

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

- Providing approval of this policy

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

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

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

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

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

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

5.6 **The Matron is responsible for:**

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

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

- The setting, monitoring and maintenance of robust safeguarding adult arrangements and training programmes.
- Contribute to collaborative interagency working and quality assurance frameworks for safeguarding.

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

5.8 **The Adult Safeguarding Nurse is responsible for:**

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

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

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

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

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

6. EDUCATION/ TRAINING AND PLAN OF IMPLEMENTATION

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

Training should be held in the staff personal record, ideally within ESR.

7. MONITORING AND REVIEW ARRANGEMENTS

7.1 Monitoring Arrangements

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

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

7.2 Review

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

8. REFERENCES

Department Of Health (2014) Care Act Home Office London

Department of Health (2010) Clinical Governance and Adult Safeguarding - An Integrated Process

NHS England (2015) Serious Incident Framework Supporting learning to prevent recurrence

APPENDIX 1

PROCEDURE IN CASES OF SUSPECTED ADULT ABUSE / NEGLECT

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

Where suspected abuse has occurred, consideration must be given to others that may be at risk such as children or the unborn, and other adults who have care and support needs. Please refer to Policy 23 Child Protection.

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

Immediate danger

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

Police

- Where it is suspected or known that a criminal offence has occurred and there is no immediate danger, staff should offer the patient support to contact the police.
- If the patient is deemed to have capacity to make this decision and there is no immediate danger, staff should only contact the police with the patient's consent.
- If the patient has been assessed to lack capacity to make the decision of reporting this to the police, then staff must report the concerns to the police within the patients' best interests

Inform colleagues, and seek advice

- After ensuring the person is in no immediate danger and where it is believed that serious abuse has occurred; staff should verbally inform their line manager, the Consultant responsible and Matron. Out of hours, where it is believed serious abuse has occurred, it must be reported to the Site Matron, who will make a decision whether the Trust on call manager should be informed either at that time or at 09:00 hours the next working day, dependent on the nature of the incident. The Site Matron is to support staff in the process of initiation of a referral.

- For all other concerns, staff should verbally inform their line manager and the treating consultant. Incidents occurring out of hours should be discussed with the Site Matron to ensure that the incident has been effectively dealt with and contained. Throughout the process the safety and welfare of the patient is paramount and must be maintained. Throughout the process the safety and welfare of the patient is paramount and must be maintained.

- Within office hours, staff may contact UHNM adult safeguarding team for advice.

Making Safeguarding Personal

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

- Where the patient requires an interpreter, family and friends should not be utilised. Staff should utilise the Translator service or UHNM staff can assist to interpret where available

- Where a patient has been deemed to have capacity to consent to a safeguarding referral, staff should gain the patient's consent and document this within the nursing notes. To note, staff can make a safeguarding referral without the patient's consent, where it is believed that the patient is at significant risk, or there is a risk that the abuse will reoccur.

- Where a patient has been deemed to lack capacity to consent to a safeguarding referral, staff should make the referral within the patient's best interests.

- Staff should keep the patient updated throughout the safeguarding process

Making an adult safeguarding referral

- A referral can be initiated by any member of staff; however, it should be discussed with the person in Charge of the ward/ unit/ area. The referral should be made immediately by **telephone** or within 24 hours to the Local Authority where the abuse is believed to have taken place. Incidents occurring out of hours should be referred to the Social Care & Health Emergency Duty Team (and Police if necessary). **Note**: Royal Stoke only – if abuse occurs within the Royal Stoke University Hospital then the Hospital Social Care Team can be contacted within working hours. Out of hours contact the Stoke on Trent Local Authority Safeguarding Team.

- **Note: If the ambulance notes/ handover indicate that they or others such as the police have already raised a safeguarding concern, this must be checked with the Local Authority Safeguarding Team and if necessary, a further referral is to be made by UHNM.**

Documentation

- A Datix should be completed immediately following the referral, to record that an adult safeguarding referral has been made. The date, time and name of person who the referral has been made to should be documented in the patient's notes and within the Datix. The completion of a Datix will automatically inform the internal Adult Safeguarding team, who will follow up where necessary with ward staff to ensure necessary support is offered to the patient and action has been taken where needed.

- Witness statements should be written by the person receiving information and collected straight away whilst the details of the incident are uppermost in the minds of all the relevant staff. The person in charge should organise this process and keep statements together in readiness should an enquiry be undertaken. When recording any disclosure, record the actual words used by the person. Any physical injuries should be recorded on a Body Map (Appendix 2). Consider the use of clinical photography.

Transfer of patients within UHNM

- Where a patient is admitted/ transferred to other ward areas, staff are to communicate via handover the safeguarding concerns identified and what action has taken place

Source of risk

- The initial interview with the source of risk should be conducted by the outside agency – i.e. Social Care Team.

- If the source of risk is visiting the patient whilst they are admitted to UHNM, staff should seek the patients' views and wishes. Where the patient has capacity to make this decision, document the patients' decision. Where the patient lacks capacity, staff may prevent the source of risk from visiting where it is believed that they pose a significant risk of harm to the patient or others. This decision should be made in conjunction with the local authority safeguarding team (where the safeguarding referral has been made to) and the police (where they have been contacted).

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

Think Family

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

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

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

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

1.3 Discharge considerations when a safeguarding referral has been made

- Staff should where possible, seek the patient's views and wishes regarding their discharge arrangements.

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

- Staff should offer the patient referrals onto support services where necessary (see appendix 13)

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

- When a patient, member of public or staff makes an allegation that they have witnessed or suspect abuse by a member of staff, a written statement from the person making the allegation must be completed immediately if possible.

- The allegation needs to be passed on to the senior member of staff on duty who will liaise with the Matron/ Director of Nursing/ Head of Nursing, in hours and the site Matron out of hours.

- Matron/ Director of Nursing/ Head of Nursing should discuss the allegation with the Lead for Vulnerable Patients for on-going advice and support. Human Resources will be contacted by the Lead for Vulnerable Patients/ Director of Nursing as appropriate. Out of Hours the Site Matron should liaise with the Trust on-call manager for on-going advice. An initial fact finding investigation will need to be undertaken; this would be undertaken by the Matron for the area or Site Matron out of hours. The initial outcome of the investigation must be reported to the Lead for Vulnerable Patients/ Director of Nursing within 12 hours.

- The Matron (or site team for out of hours) will undertake an initial risk assessment. Action must be taken immediately to remove any threat of harm to the patient or patients. The suspension of the individual/s concerned will be considered in accordance with the Trust's Disciplinary Policy. Where a person is not suspended, consideration must be given to whether that person should continue to practice/work in the clinical environment for the duration of the fact finding event. Advice may be obtained from Human Resources.

- The requirement of a safeguarding referral should be considered and made if necessary at this point. A Datix should be completed.

- Where an allegation of sexual/ physical abuse is made, the Police must be contacted immediately. Whilst a criminal investigation is being undertaken, any internal Trust investigation should not proceed without advice being sought from Human Resources or the Police Team investigating. The Police will advise when the Trust is able to interview the alleged source of risk so as not to contaminate their investigation.

- Legal advice should be taken from the Police as to whether an internal investigation should proceed.

- Should an internal investigation be undertaken, then the member of staff may have an accredited Professional/ Trade Union representative or workplace colleague with them for the interview and must be informed that statements may be used in a disciplinary procedure and that, as a result of the safeguarding referral being made, statements may be required by the Police.

- Where the Fact Finding officer recommends, following discussion with the Lead for Vulnerable Patients/ DoN, that a formal safeguarding referral is not required, a decision will be made, with the agreement of the Fact Finding Officer and Human Resources, as to whether any untoward incident has occurred and whether this requires further internal investigation within the disciplinary procedure and/or root cause analysis. The Lead for Vulnerable Patients will also contact LADO as required on a case by case basis.

1.5 Adult Safeguarding Concerns against the Trust

Adult Safeguarding concerns against the Trust are often around quality of care, for example pressure ulcers or lack of nutrition however can cover any category of abuse or neglect. The concern is not usually against one member of staff, but a ward or department. The Trust will be asked to undertake a Section 42 Enquiry as follows;

1. UHNM can be instructed by the Local Authority (LA) to undertake a Safeguarding Enquiry. UHNM safeguarding team must ensure that a causing letter is received from the local authority of which details specific terms of reference. UHNM adult safeguarding team will then review the concern and add any further terms of reference to be considered as part of the enquiry

2. UHNM Safeguarding Team will Email the DoN to appoint an independent Senior Nurse/ Doctor to undertake the Enquiry (Investigating Officer - IO). The Divisional Governance Manager is to be copied into the email for reporting i.e. complete Datix

3. IO to undertake the Enquiry and produce a report which demonstrates findings and any recommendations, and proposed actions to address these. IO is to forward the completed report to UHNM Safeguarding Team to review

4. UHNM Safeguarding Team to forward the completed report to the DoN for approval

5. Once approved, UHNM Safeguarding Team will forward the completed report to the Local Authority

6. Should the Local Authority wish to undertake an Enquiry Review Meeting/ Outcome Meeting then the IO will be invited to attend with a member of the Safeguarding Team to present their findings

7. When the outcome of the enquiry is determined and fed back to Safeguarding Team by the Local Authority i.e. proven, unproven, partially proven or insufficient evidence, the outcome will be fed back to the DoN by the Safeguarding Team.

8. DoN to share within the division and request that an action plan is completed in response to any recommendations made by the local authority in addition to those identified by the IO.

9. DoN to nominate a representative to feedback to the Adult Safeguarding Working Group for wider learning at UHNM.

10. The division will be invited back to the Adult Safeguarding Working Group to update against actions.

11. Actions will be added to the corporate Safeguarding action tracker.

2. Coroner

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

APPENDIX 2

- Ensure the patient is not in immediate danger and the patient is supported.
- Note: If the patient is in immediate danger, or physical or sexual abuse is still occurring i.e. Physical / Sexual abuse then contact the Police immediately. Ensure any evidence e.g. clothing is kept safe and free from contamination. On-going responsibility and actions in these circumstances will rest with the Police.

- The alerter should inform their line manager and the treating consultant verbally regarding their concerns.
- Within hours, staff may contact UHNM safeguarding team for advice

- Speak to the patient to gain their views and wishes

- The alerter should telephone their concern through to the Local Authority where the abuse is believed to have taken place:Note: A referral should be completed immediately and within 24 hours.
- Staffordshire County Council - 0345 604 2719 (out of hours, weekend and bank holidays - 0345 604 2886)
- Stoke on Trent Council - 0800 561 0015 (24hours)
- Out of area - use the free NHS Safeguarding app or search the internet for the local authority's adult safeguarding number

- The alerter should complete a Datix to record that they have made a safeguarding referral, and record within the patients' notes

- Witness statements should be written and collected straight away whilst the incident is clear and uppermost in all relevant staff(s) minds. When any patient disclosure is recorded this should be recorded detailing the actual words used. Any physical injuries should be recorded on a body map. Consider use of clinical photography.

- Think family - staff should consider others that may be at risk i.e. unborn, children, other adults with care and support needs.

- Discuss the safeguarding concerns and action taken within handover when the patient is transferred to oter ward areas
- Inform the local authority safeguarding team once discharge planning commences

APPENDIX 3

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

Reporting abuse and neglect - General guide to raising concerns

Initial safeguarding decision flow chart

An adult at risk of abuse or neglect:

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

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

Types of abuse:

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

Draft v4 (November 2017) - for publicatio

Does the person have needs for care and support?

No → Seek alternative support as necessary *No Safeguarding Concern required*

Yes

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

No → Seek alternative support as necessary *No Safeguarding Concern required*

Yes

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

No → Seek alternative support as necessary *No Safeguarding Concern required*

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

Yes

Raise a Safeguarding Concern immediately

APPENDIX 4

How and when to raise a safeguarding concern

Who can raise a safeguarding concern?	Anyone – the adult, Carers, paid staff, volunteers, Inspectors, Police Officers, Health and Safety Officers, etc.
Who decides whether to raise a concern?	The person who believes that abuse may be taking place is the best person to raise the concern and they should take the responsibility for doing so. It is not good practice for that person to delegate this to another agency and this will cause difficulties if that agency has a different view on the incident, especially if they do not themselves believe that abuse has occurred.
How quickly should a concern be raised?	Immediately and always within 24 hours.
Who should be contacted with a concern?	In all cases concerns will be raised with the local authority where the abuse is believed to have taken place: • **Staffordshire County Council, Social Care and Health Tel: 0345 604 2719 (out of hours, weekend and bank holidays - 0345 604 2886)** • **Stoke-on-Trent City Council, Adult Social Care Tel: 0800 5610015 (anytime)** • **Out of area - use the free NHS Safeguarding app or search the internet for the local authority's adult safeguarding number** Where a crime has taken place or the adult may be in immediate danger contact should be made with Staffordshire Police. **In emergencies using 999 or if less urgent using 101.**
How is a concern raised?	By telephone to the above numbers. Staff who raise a concern may be asked to provide additional written detail and information. Staff should record who has taken the referral at the local authority, and the date and time of when they made the referral .

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

APPENDIX 5

Physical Abuse

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

Possible indicators:

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

Domestic Abuse

Domestic abuse includes psychological, physical, sexual, financial, emotional abuse, and ‘honour’ based violence.

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

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

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

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

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

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

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

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

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

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

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

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

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

Possible indicators:
- Adults has urinary tract infections, vaginal infections or sexually transmitted diseases that are not otherwise explained;
- Adult appears unusually subdued, withdrawn or has poor concentration;
- Adult exhibits significant changes in sexual behaviour or outlook;
- Adult experiences pain, itching or bleeding in the genital/anal areas;
- Adults underclothing is torn, stained or bloody;

- A woman who lacks the mental capacity to consent to sexual intercourse becomes pregnant;
- Sexual exploitation.

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

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

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

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

It includes preventing the adult from using services that would otherwise support them and enhance their lives. It also includes the intentional and/or unintentional withholding of information (e.g. information not being available in different formats/languages etc.).

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

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

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

- Mis-selling/selling by door-to-door traders/cold calling;
- Illegal money-lending

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

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

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

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

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

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

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

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

Possible indicators:
Signs of various types of slavery and exploitation are often hidden, making it hard to recognise potential victims. Victims can be any age, gender or ethnicity or nationality. Whilst by no means exhaustive, this is a list of some common signs:
- Adult is not in possession of their legal documents (passport, identification and bank account details) and they are being held by someone else;
- The adult has old or serious untreated injuries and they are vague, reluctant or inconsistent in explaining how the injury occurred
- The adult looks malnourished, unkempt or appears withdrawn
- They have few personal possessions and often wear the same clothes
- What clothes they do wear may not be suitable for their work
- The adult is withdrawn or appears frightened, unable to answer questions directed at them or speak for themselves and/or an accompanying third party speaks for them. If they do speak, they are inconsistent in the information they provide, including basic facts such as the address where they live
- They appear under the control/influence of others, rarely interact or appear unfamiliar with their neighbourhood or where they work. Many victims will not be able to speak English
- Fear of authorities
- The adult perceives themselves to be in debt to someone else or in a situation of dependence.

Environmental indicators
- Outside the property there are bars covering the windows of the property or they are permanently covered on the inside. Curtains are always drawn. Windows have reflective film or coatings applied to them. The entrance to the property has CCTV cameras installed. The letterbox is sealed to

prevent use. There are signs the electricity may have been tacked on from neighbouring properties or directly from the power lines?
- Inside the property – access to the back rooms of the property is restricted or doors are locked. The property is overcrowded and in poor repair.

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

Possible indicators
Indicators for discriminatory abuse may not always be obvious and may also be linked to acts of physical abuse and assault, sexual abuse and assault, financial abuse, neglect, psychological abuse and harassment, so all the indicators listed above may apply to discriminatory abuse.
- An adult may reject their own cultural background and/or racial origin or other personal beliefs, sexual practices or lifestyle choices.
- An adult making complaints about the service not meeting their needs.

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

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

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

Organisational abuse can occur in any setting providing health or social care. A number of inquiries into care in residential settings have highlighted that organisational abuse is most likely to occur when staff:
- receive little support from management;
- are inadequately trained;
- are poorly supervised and poorly supported in their work;
- receive inadequate guidance;

or where there is:
- Unnecessary or inappropriate rules and regulations;
- Lack of stimulation or the development of individual interests;
- Inappropriate staff behaviour, such as the development of factions, misuse of drugs or alcohol, failure to respond to leadership;
- Restriction of external contacts or opportunities to socialise.

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

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

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

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

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

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

Location of Abuse
Abuse can take place anywhere. For example:
- the person's own home, whether living alone, with relatives or others;
- day or residential centres;
- supported housing;
- work settings;
- educational establishments;
- care homes;
- clinics/hospitals;
- prisons;
- other places in the community.

Who Might Abuse?
Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the adult with care and support needs. A wide range of people may harm adults. These include:
- a spouse/partner;
- an adult with care and support needs;

- other family members;
- neighbours;
- friends;
- local residents;
- people who deliberately exploit adults they perceive as vulnerable to abuse;
- paid staff or professionals; and
- volunteers and strangers.

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

Mental Capacity

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

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

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

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

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

APPENDIX 6

BODY MAP1 (Female)

Name of adult: ……. Date of birth……..

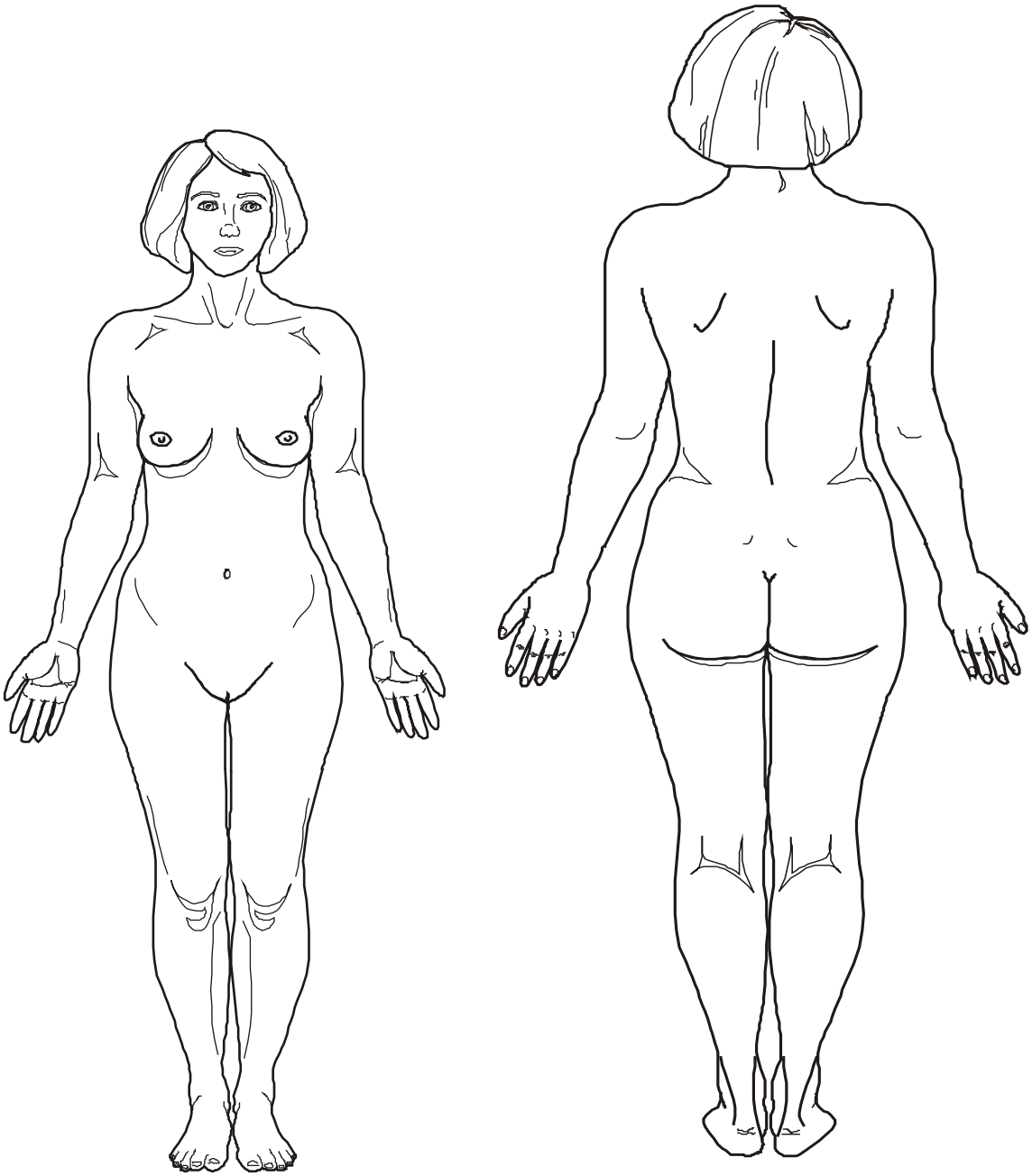
Name of person completing body map: ……

Date/time of completion: …… Date of incident/injury……..

Contact details of completing person: ……...

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

A - Pressure ulcers
B - Bruising
C - Cuts, wounds F - other (specify)
D - Excoriation, red areas (not broken down)
E - Scalds, burns



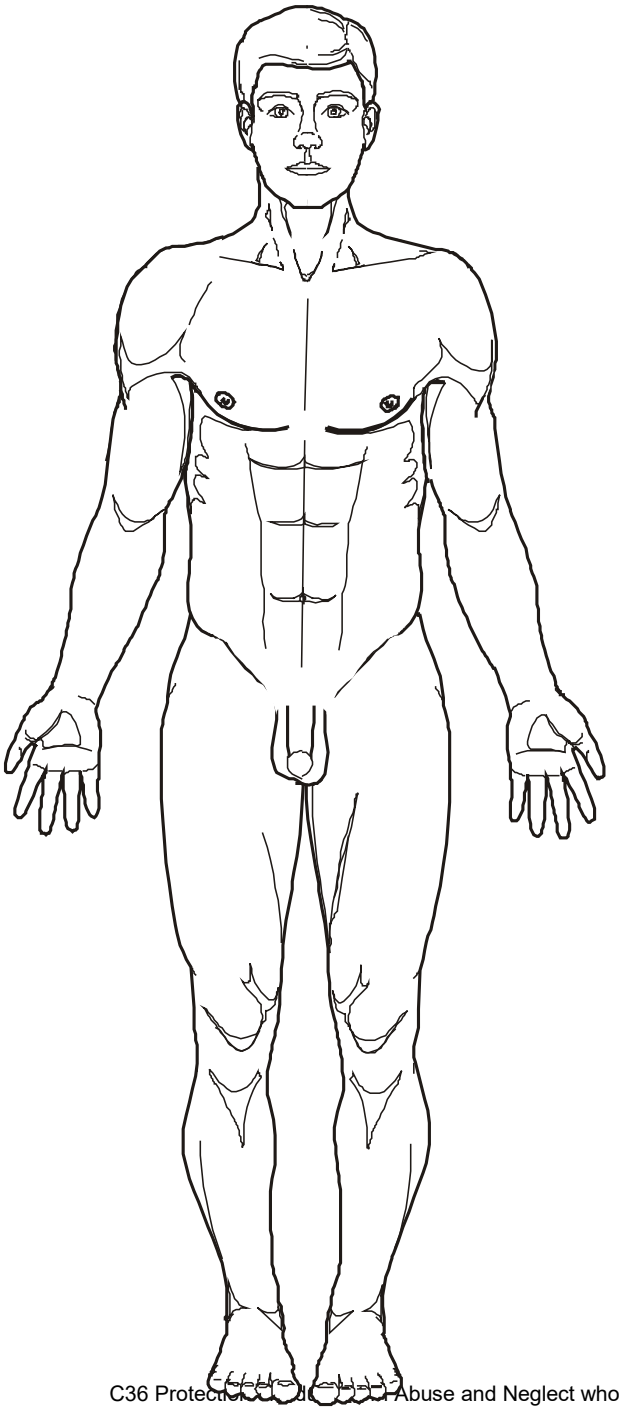
BODY MAP2 (Male)

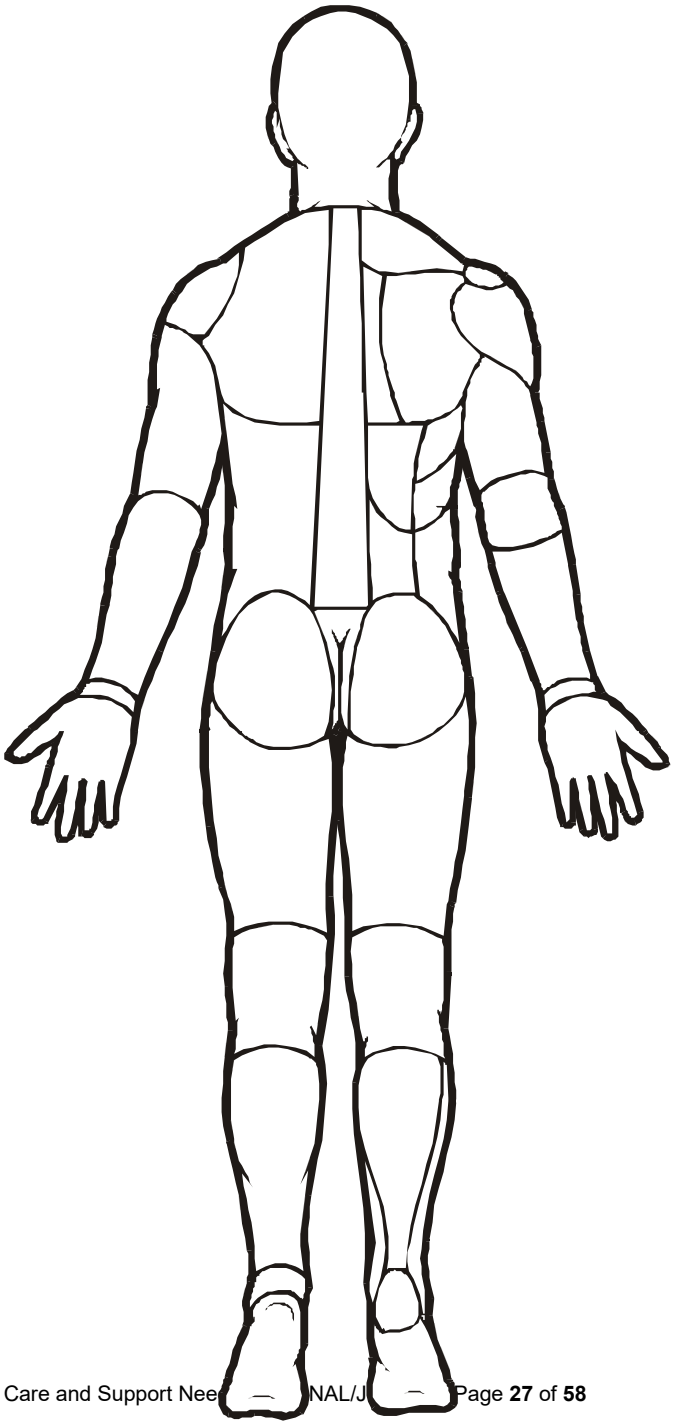
Name of adult: ……. Date of birth: ……..……

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

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

A - pressure ulcers
B - bruising
C - cuts, wounds
D - excoriation, red areas (not broken down)
E - scalds, burns
F - other (specify)





APPENDIX 7

Clinical Governance and Adult Safeguarding- An Integrated Process Terms and Definitions

Event: The term 'event' is used here to signify any incident or occurrence that has the potential to cause harm and/or has caused harm to a person or persons. This might happen as a consequence of an intervention, relating to a piece of equipment and/or as a consequence of the working environment.

SI: Serious Incident requiring investigation is defined as an incident that occurred in relation to NHS funded services and care resulting in; unexpected or avoidable death, permanent harm, a scenario that prevents a provider organisations ability to continue to deliver health care services, a person suffering from abuse, never events and adverse media coverage. (Please refer to the NPSA National Framework for full definition): http://www.npsa.nhs.uk/nrls/reporting/patient-safety-direct/

Complaint: In general use, a complaint is an expression of dissatisfaction. All complaints should always be considered in relation to safeguarding particularly when the complaint involves poor care, poor care culture, neglect or omissions.

Patient Related Incident: A patient incident is an incident that has occurred in an environment where health care is provided. It may be as a result of prescribed or unprescribed care, administration of procedures and interventions. For example 'trips' and 'falls', a medication error, shortage of staff, incorrect procedure, an episode of aggression, unsafe storage of equipment etc.

PET: 'Patient Experience Teams' are being developed in some organisations to help to implement a set of behaviours in the NHS that will improve the emotional experience for patients.

PALs: often diffuse potential complaints and are able to work with teams to identify concerns from the patient/public perspective. Some of the concerns may require a formal report.

Whistle blowing: Whistle blowing policies and procedures are in place to enable staff to raise serious concerns that cannot or have not been addressed through normal line management routes. The issues raised through whistle blowing could be of a clinical nature or about the culture of care.

Significant Event: A significant event is a term used by GP's to describe a positive or negative incident that has occurred in primary care and is similar to a patient incident report.

Safeguarding Team: The safeguarding team varies from organisation to organisation. It could be a team of dedicated posts across health and social care, or a virtual team of people with safeguarding interest and expertise that form part of a local partnership with the safeguarding board at the local authority. Each local authority area has multiagency policies and procedures in place for safeguarding.

NPSA: National Patient Safety Agency is the national reporting and learning service, which provides support, advice and guidance to NHS organisations to promote national learning from serious incidents.

IO: An investigating officer is an appropriate person across health and social care that has the skills and experience to undertake a comprehensive investigation of the incident using the appropriate tools e.g. Root cause analysis, *No secrets* policies and procedures.

APPENDIX 8

1. Domestic Homicide Reviews

Where there has been a domestic homicide the UHNM (NHS) Trust will be approached to see if either the perpetrator, victim or others were known to any of their services. If any persons were known to the Trust then the Lead Nurse for Safeguarding / Adult Safeguarding Nurse will be invited to attend a Panel meeting with colleagues from other agencies to see if a DHR is required. If a DHR is instigated then a detailed chronology and Individual Management Review (IMR) will be undertaken by an appointed member of UHNM staff.

The basis for the domestic homicide review (DHR) process is to ensure agencies are responding appropriately to victims of domestic violence by offering and/or putting in place suitable support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

The review will also assess whether agencies have sufficient procedures and protocols in place, which were understood and followed by their staff and where there may be a need to improve these procedures.

A DHR should be carried out to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide, and improve service responses for all domestic violence victims and their children, through improved intra and inter-agency working.

Domestic homicide reviews are not inquiries into how the victim died or into who is to blame. That is a matter for Coroners and criminal courts to determine. DHRs are also not a part of any disciplinary enquiry or process. Where information emerges in the course of a DHR suggesting that disciplinary action should be taken, the agency concerned will follow its own internal disciplinary procedures separately to the DHR process.

APPENDIX 9

Prevent Guidance

1.0 Summary

2.1 The Trust operates a zero tolerance to those who abuse or neglect vulnerable people; this includes staff and the public. All suspected cases of abuse or radicalisation of patients whilst under the care of the Trust will be thoroughly investigated within the Trust and with partner agencies as per the Prevent Duty 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.

2.2 The objectives of this guidance are to provide clear direction on reporting any safeguarding concerns or allegations of abuse or exploitation in relation to radicalisation and to set out the levels of responsibility to ensure that:

- Staff members are aware of the policy
- Children and 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

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

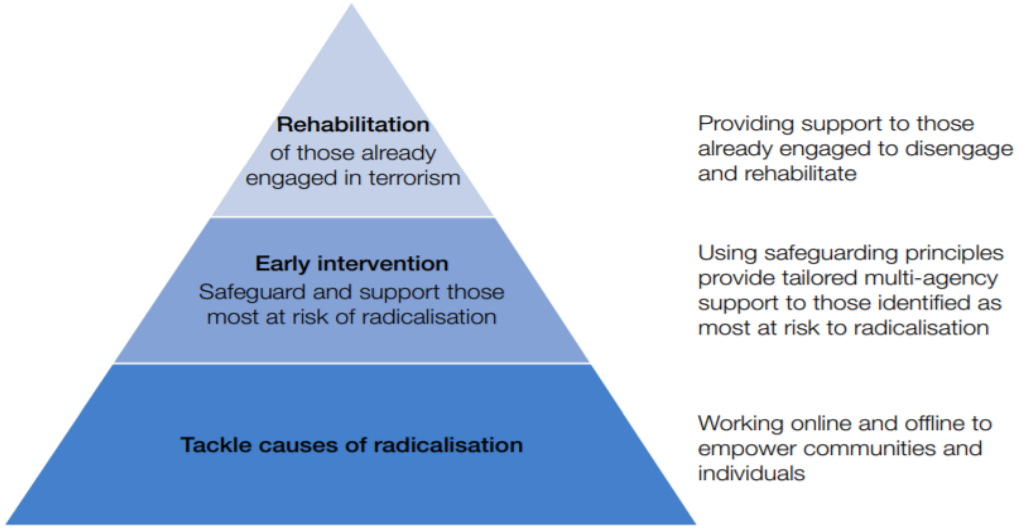
3.4 The Prevent Strategy was first published in June 2011 and is part of the United Kingdom's counter-terrorism strategy overall counter-terrorism strategy. The Counter Terrorism and Security Act 2015: Section 26 places a legal duty on certain bodies including the NHS to have 'due regard to the need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

These forms of terrorism include but are not limited to:

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

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.



Source: Home Office

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 duties include

5.3.1 The Chief Executive: - is responsible for ensuring that the Trust has policies in place and complies with its legal and regulatory obligations. The Chief Executive will provide the means necessary to ensure that staff develop and promote good practice in Prevent. As such, the Chief Executive has delegated a number of responsibilities to the following managers and key workers within the Trust: -

5.3.2 Chief Nurse: As the executive Prevent Lead, the Executive Director of Nursing will ensure that quarterly Prevent returns are submitted to the Clinical Commissioning Group/London Regional Prevent Co-ordinator, in line with NHS England guidance. This data relates to the Safeguarding clause of the NHS Standard Contract [clause SC32} and progress being made by the organisation to implement the Prevent Duty requirements. This includes data relating to numbers of referrals and staff attending Basic Prevent Awareness and Level 3 Prevent Training.

5.3.3 Lead for Vulnerable Patients / Prevent Lead

- They are also responsible for trust wide implementation and compliance with the Prevent policy.
- Making arrangements for a suitable number of training places and events to be delivered to allow all relevant staff identified in the training needs analysis to access the Prevent training programme.
- Ensuring that a Training Plan is in place for Prevent Training at Level 1- 3.
- Providing training reports to the Trust Board as required
- Ensure that quarterly Prevent returns are submitted to the Clinical Commissioning Group

5.3.4 Matrons/ Departmental Managers

Matrons have been identified as key figures in supporting the safeguarding vulnerable adults agenda, including Prevent, within their areas, working with the Senior Nurse for Safeguarding, ensuring clinical staff know what action to take should a Prevent concern be disclosed.

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

- They are responsible for ensuring staff attend relevant training.

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

5.3.5 Lead Nurse for Safeguarding

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

5.3.6 All Staff

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

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

6.0 Training

6.1 All staff at UHNM will undertake Basic Prevent Awareness Training (BPAT) level 1 & 2. This training is mandatory and is covered within the Adult Safeguarding Level 1training. 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 or staff can undertake E-learning via the Home Office Virtual Training Platform 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 re-direct 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 safeguarding referral needs to be made, it will be done in accordance with Policy C36.

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

10.6 All referrals for children (age under 18 years) to the PREVENT lead 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 1 - VULNERABILITY FACTORS

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

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

What factors might make someone vulnerable?

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

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

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

Identity Crisis:

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

Criminality:

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

Personal Grievances:

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

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

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

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

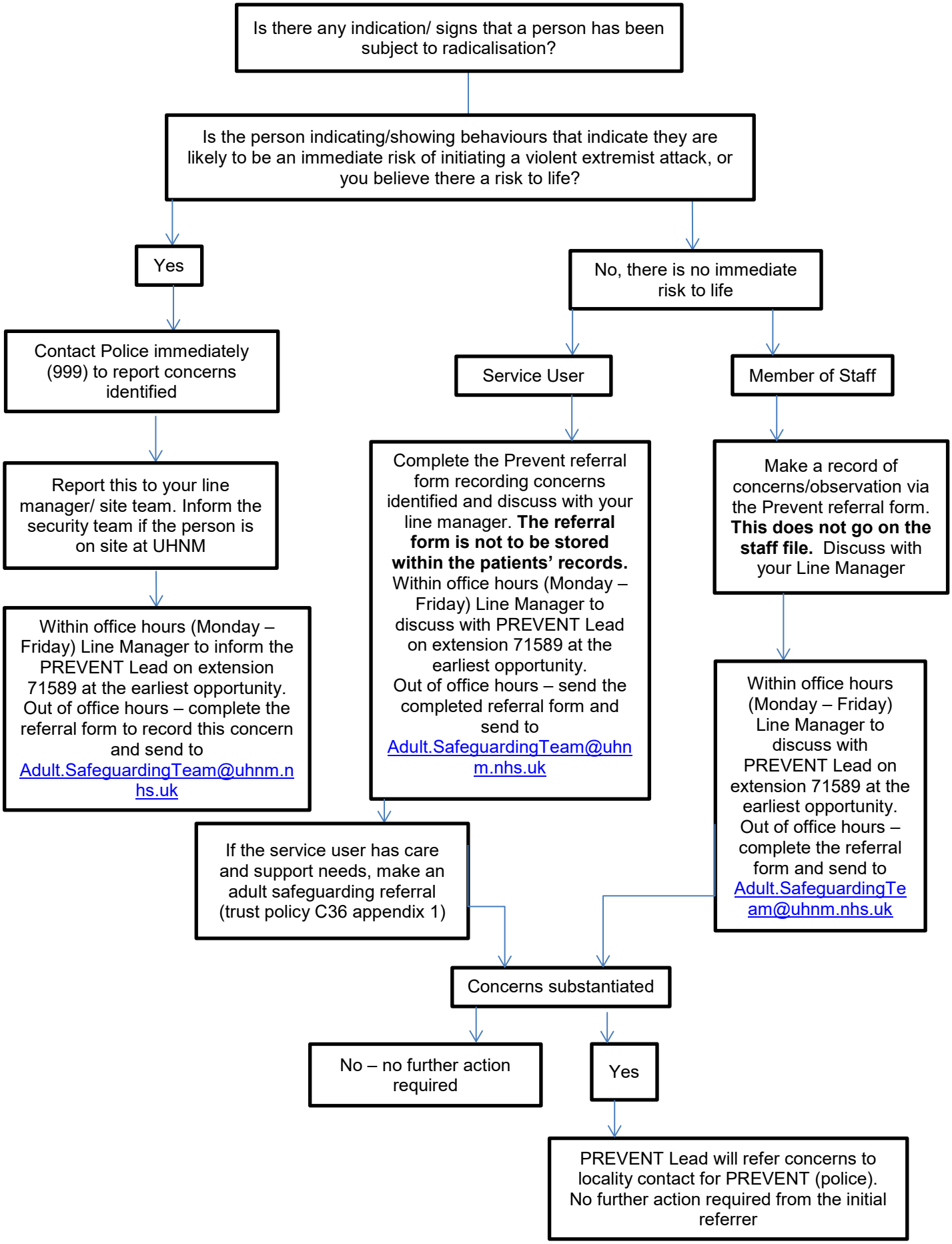
Unemployment or under-employment:
Individuals may perceive their aspirations for career and lifestyle to be undermined by limited achievements or employment prospects. This can translate to a generalised rejection of civic life and adoption of violence as a symbolic act.

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

APPENDIX 2: DEFINITIONS

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, weather in this country or overseas.
CONTEST 3.0 Strategy	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 *Prevent* 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: • 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@uhnm.nhs.uk and the internal safeguarding team will process your referral. You will receive a reply on the next working day and you will be updated as to the outcome of your referral

APPENDIX 10

Guidance for the Reporting of Genital Mutilation (FGM / Female Circumcision)

Table of Contents

1.0 Purpose

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

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

2.0 Background

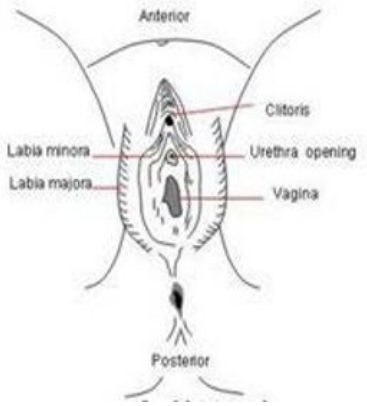
Female Genital Mutilation (FGM), which is also known as female genital cutting, involves any procedure that includes the removal of any part of the female genital organs for cultural or any other non-therapeutic reasons (WHO, 1996).

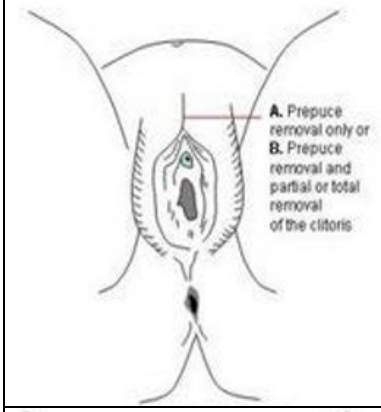
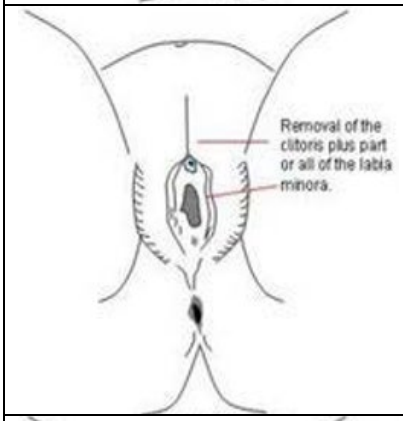
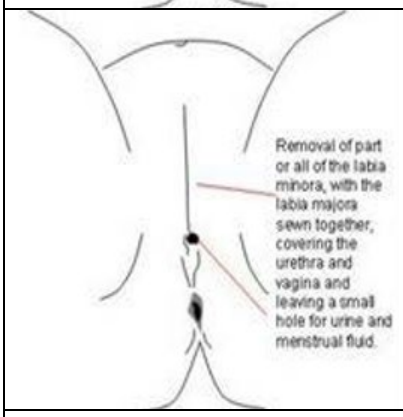
There are many reasons why this custom is still seen as acceptable by those that agree with its practice. It has a positive meaning by enhancing marriageability, improving hygiene and ensuring virginity. They believe that the clitoris removal reduces women's promiscuity, which reduces the risk of pre- or extramarital sex and family dishonour (Lockhat, 2004). FGM has become more prevalent within the UK due to an increase in immigration of women from countries where FGM is practiced.

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

3.0 Types of FGM

Recognition of the different types of mutilation is important, and where possible recorded accurately within the notes.

Picture	Type	Description
	Normal	

	Type 1 Clitoridectomy	Partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
	Type 2 Excision	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).
	Type 3 Infibulation	Narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.
	Type 4 Unclassified	All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

4.0 Policy for the Reporting of Female Genital Mutilation

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

If the female is under the age of 18, then they must inform the police immediately, fill in the **BLUE FGM proforma** (appendix 3), inform the Named Nurse for Child Safeguarding and refer the child to social services and health care professional (with relevant paediatric experience with FGM).

If discovered in a female who is 18 years or older then they should fill in the **GREEN FGM proforma** (appendix 2), and gather information regarding any female children within the family to identify anyone that might be at risk of this.

Health professionals must be familiar with the requirements of the Health and Social Care Information Centre (HSCIC) FGM Enhanced Dataset and explain its purpose to the woman. The requirement for her personal data to be submitted without anonymisation to the HSCIC, in order to prevent duplication of data, should be explained. However, she should also be told that all personal data are anonymised at the point of statistical analysis and publication (RCOG, Green-top Guideline, 2015).

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

The FGM data collection forms will be sent on the last day of the month to the specified data analyst who will upload data to the Department of Health.

5.0 The Law

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

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

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

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

6.0 Female Genital Mutilation in the UK

It is estimated that approximately 2 million females worldwide undergo a type of FGM each year, with the majority of them being unaware that they are even at risk (FORWARD 2007). There is an estimated 137,000 females in England and Wales who have undergone a type of FGM, including 10,000 girls under the age of 15 years of age (Macfarlane A and Dorkenoo E, 2014).

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

7.0 The Way Forward

Attitudes - It must be appreciated that these women did not choose mutilation. All staff should be aware of the practice and types of female genital mutilation and the adverse effects on women's sexual

and reproductive health. Staff should be sensitive to the traditions of the communities where mutilation is practised.

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

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

8.0 Safeguarding Children and Adult Issues

Professional Leads Named Midwife/Lead Nurse Safeguarding Adults /Named Nurse Safeguarding Children must be informed of any cases of suspected FGM.

For a Child aged under 18, any disclosure of FGM or confirmation during examination in a child should be treated as child abuse and reported to the police using 101. Any suspicion of intended or actual FGM for a child aged under 18 years must be referred to Children's Social Care. Social Care will conduct a Section 47 enquiry and may formulate a Child Protection Plan for any female children at risk.

For any suspicion of an Adult 18+ of intended or actual FGM, the alleged victim should be managed by a person with specialist knowledge and understanding wherever possible with regards to their welfare, risk assessment and monitoring. If you are concerned that a person 18+ who has care and support needs is at risk of FGM then an adult safeguarding referral should be made (Policy C36).

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

Staff must ensure that all Safeguarding paperwork relating to the patient is kept under lock and key, with very limited access. All records should comply with the organisational policies on managing records of domestic incidents/safeguarding.

9.0 Support Services

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

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

10.0 Training and Resources

All new Trust staff shall have safeguarding training during induction. That training should make reference to this policy.

Emergency Department staff shall have enhanced training in the detection and operational management of suspected Female Genital Mutilation, via Safeguarding Children Level 3.

See appendices B and C of the Trust's Statutory & Mandatory Training policy (HR53).
FGM E-learning package available via ESR.

11.0 Audit and Monitoring

Audit of compliance with this guideline will be undertaken on an annual audit basis in accordance with the Clinical Audit Strategy and Policy. The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies.

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

The contact details for the FGM leads are detailed below:

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

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

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

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

12.0 Equality and Diversity

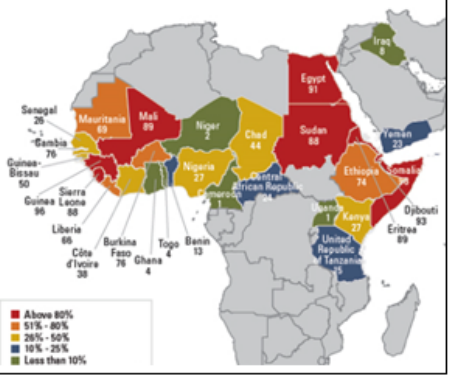
The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

Appendix 1:

University Hospitals of North Midlands NHS
NHS Trust

FEMALE GENITAL MUTILATION (FGM) FLOWCHART

**** High Risk Areas:**



Interaction with a female from a high risk area**/pt admits to FGM

< 18 years old

Are you concerned that a CHILD may have had FGM OR be at risk of FGM?

Use: **FGM REPORTING PRO-FORMA Females under 18 years of age**

The child has told you that they have had FGM.

You have found clinical evidence of FGM

Someone discloses that the girl has had FGM

You consider the girl to be **at risk** of FGM.

Mandatory reporting duty applies

Professional who initially identified the FGM (you) calls 101 police to make a report.

- Record all decisions /actions
- Be prepared to talk to Police.
- Update your local safeguarding lead.

You will have to provide:
- Girl's name, DoB, address
- Your contact details & contact details of your safeguarding lead.

Follow local safeguarding procedures and **refer to children's social care**

IMMEDIATE RESPONSE REQUIRED for identified girl OR another child/other children

Police and social care take immediate action as appropriate

ASSESSMENT OF CASE: Multi-agency safeguarding meeting convened in line with local safeguarding arrangements, including police, social care and health as a minimum.

Health professional (with relevant paediatric competencies) lead on the assessment of the health needs of the child.

Social care and police develop and appropriate pathway.

> 18 year old

FGM found on clinical examination

Female admits to FGM

Use: **Green FGM REPORTING PRO-FORMA for >18 years**

Offer referral to FGM OPD clinic (O&G)

Offer referral for psychological support

Are there any female family members <18

Yes

No

Complete Health Visitor referral form

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

Appendix 2 - (Green) FGM REPORTING PRO-FORMA Females 18 years & over

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 (Reversal surgery):	☐ Yes = Y ☐ No = N		
5. Details of Trust's Designated Safeguarding Lead			
Sarah Curran Lead for Vulnerable Patients Sarah.curran@uhnm.nhs.uk		Tel: 01782 671589	
UHNM, Royal Stoke University Hospital, Springfield Building, Ground Floor, Newcastle Road, Stoke-on-Trent ST4 6QG			

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	
'CIV' - Côte d'Ivoire	'GIN' - Guinea	'SAU' - Arabia	**If NOT listed please enter as text**
'CIV' - Ivory Coast	'IRQ' - Iraq	'SOM' - Somalia	**Region: Enter as text**
'EGY' - Egypt	'IRQ' - Kurdistan	'SDN' - Sudan	

Return completed proforma to Adult Safeguarding Team, Department of Nursing, Floor 2, Springfield Building, Royal Stoke Hospital
Or via email - Adult.SafeguardingTeam@uhnm.nhs.uk

Appendix 3

(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 Lead for Vulnerable Patients Sarah.curran@uhnm.nhs.uk		Tel: 01782 671589	
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	
'CIV' - Côte d'Ivoire	'GIN' - Guinea	'SAU' - Arabia	**If NOT listed please enter as text**
'CIV' - Ivory Coast	'IRQ' - Iraq	'SOM' - Somalia	**Region: Enter as text**
'EGY' - Egypt	'IRQ' - Kurdistan	'SDN' - Sudan	

Return completed proforma to Child Safeguarding Team & FGM Department Lead (as per Trust SOP)
ChildProtectionNamedNurses@uhnm.nhs.uk

Appendix 4

Traditional and local terms for FGM

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

Appendix 5

References:

Department of Health (2015). Female Genital Mutilation Risk and Safeguarding Guidance for professionals. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418564/2903800_DH_FGM_Accessible_v0.1.pdf

Foundation for Women's Health, Research and Development (FORWARD) ET AL (2007) a Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales. Available at: http:/www.forwarduk.org.uk/key-issues/fgm/research

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

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

Royal College of Obstetricians and Gynaecologists (2015). Green-top Guideline No. 53 Female Genital Mutilation and its management. Accessed from; https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-53-fgm.pdf

World Health Organization (1996). Female Genital Mutilation. Geneva , Switzerland : World Health Organization.

Resources:

http://www.nspcc.org.uk/Inform/resourcesforprofessionals/minorityethnic/female-genital mutilation_wda96841.html

http://www.nspcc.org.uk/help-and-advice/enquiries/frequently-asked questions_wda83770.html#fgm

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

www.who.int/reproductivehealth/publications/fgm/en/index.html

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

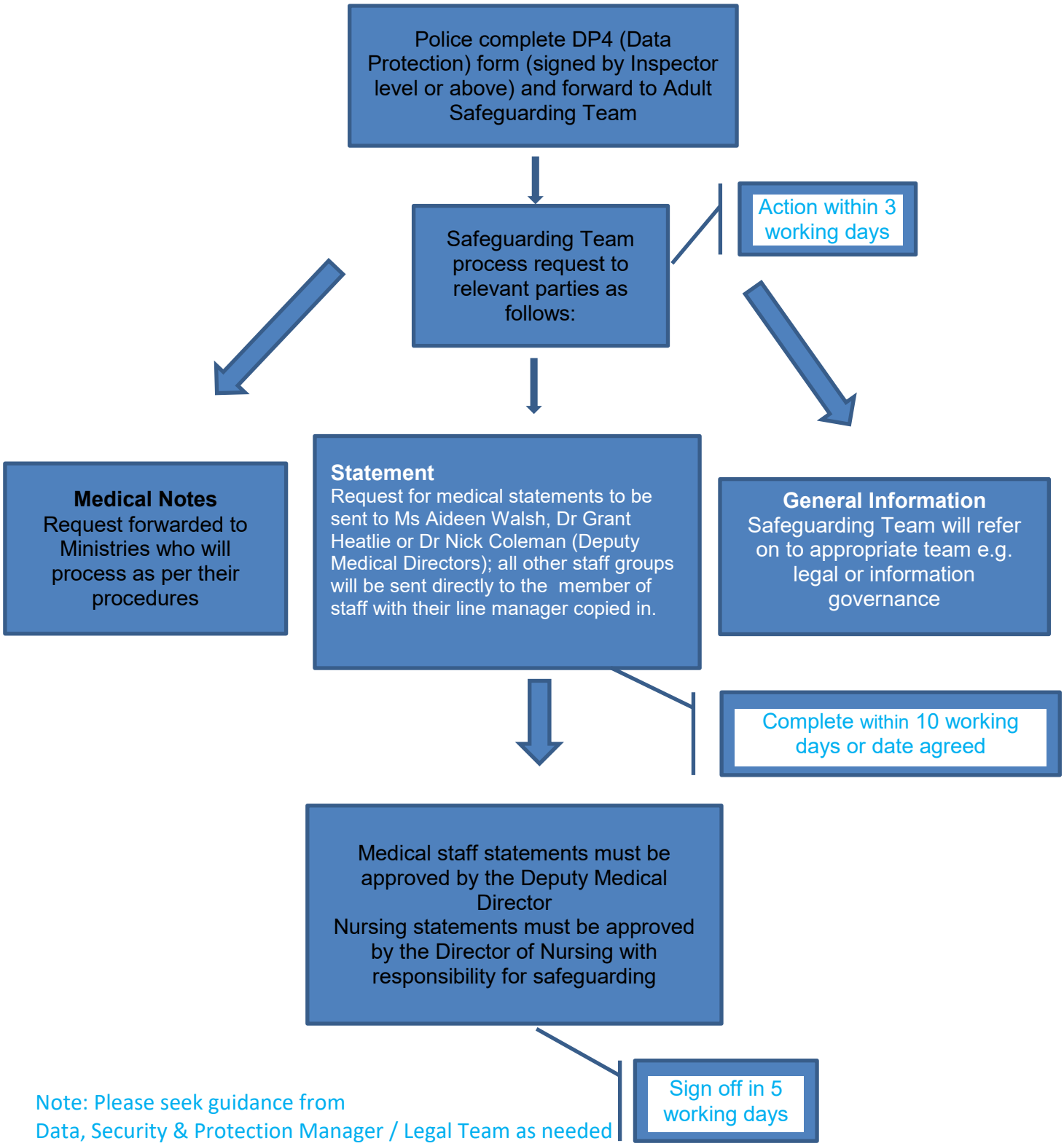
Mandatory Reporting of Female Genital Mutilation – procedural information: Home Office 201

Leaflets: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/472694/FGM_leaflet.pdf

Home Office online training package: www.fgmelearning.co.uk

APPENDIX 11

Information Requests from the Police



Note: Please seek guidance from
Data, Security & Protection Manager / Legal Team as needed

APPENDIX 12

Sex Offenders

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

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

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

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

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

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

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

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

Appendix 13

Support services

Agency	Contact details		
Stoke on Trent Adult Social Care	0800 561 0015		
Staffordshire Adult Social Care	0300 111 8010		
MPFT - Track and Triage (Royal Stoke Base)	Internal extension 75555	Social assessments, complex discharges	
MPFT - Track and Triage (County Hospital Base)	Internal extension 2830	Social assessments, complex discharges	
Housing Solutions (Stoke on Trent)	01782 233696	Accommodation	
Brighter futures rough sleepers team	Stoke on Trent and Newcastle - 0800 970 2304 All other areas - 0300 500 0914	Accommodation, claiming benefits, assistance to access services	
Newcastle Housing Advice	01782 717717 (Mon-Fri) 01782 615599 (emergency out of hours)	Accommodation	
Staffordshire police	999 101 https://www.staffordshire.police.uk/		
Staffordshire Fire and Rescue	Email referral form to contactcentre@staffordshirefire.gov.uk	Fire safety assessment, Hoarding	Referral form can be found on the Trust's safeguarding adults intranet page
Grangewood Park	0800 970 0372 (24hours)	SARC - Sexual Assault Referral Centre	
New Era	0300 303 3778	Local Domestic Abuse Support Service	Refer to policy C37 for further guidance
National Domestic Abuse Helpline	0808 2000 247	National Domestic Abuse Support Service	Refer to policy C37 for further guidance
Karma Nirvana	0800 5999 247 (24hours)	National Honour Based Abuse Support Service	