NHS
University Hospitals of North Midlands
NHS Trust

Safeguarding Children Annual Report 2023-2024

Child Protection Team
June 2024





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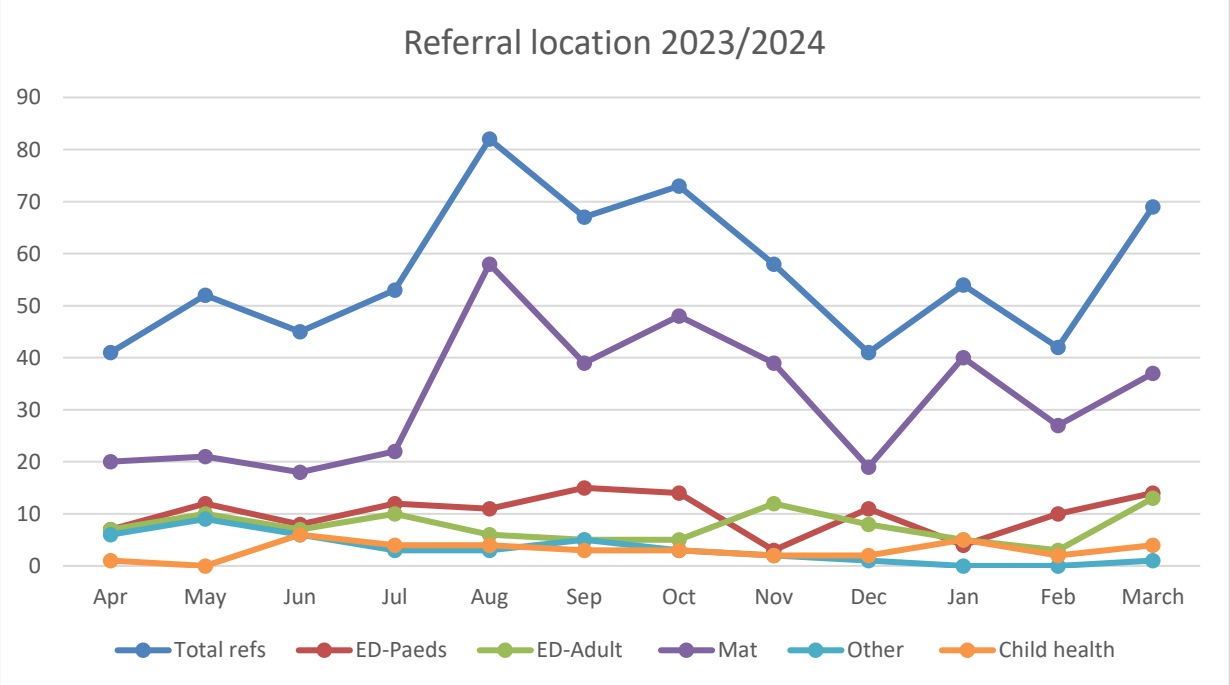
10. **Conclusion** (Pg 32).

An appendix has been devised, which contains additional background information related to the functions of the safeguarding children's team. This has been done to ensure the annual report is more streamlined. This is available via the child protection intranet page on ……

PART 1 CHILD PROTECTION
1. Introduction

The University Hospital of North Midlands NHS Trust (UHNM) comprises of two main sites; the Royal Stoke University Hospital in Stoke-on-Trent and the County Hospital in Stafford. These provide acute hospital services for around 700,000 people in and around Staffordshire. The UHNM sits within the local authority area of Stoke-on-Trent but sees infants, children and young people and families from the Stoke-on-Trent City Council area and Staffordshire County Council area, as well as infants, children and young people from out of the local area.

- Last year (2023) there were 90 455 outpatient attendances involving infants, children and young people under 18 years; of these, 61% and 37% were seen within paediatric specific clinics at the Stoke and County sites respectively.
- There were 14 497 infants, children and young people admissions of which 85% were within the paediatric wards at the Stoke site. 38 young people were admitted at the County site. This shows that a significant number of children are being seen in adult areas. There were 3 944 procedures or treatments provided as a day case.
- 60 681 infants, children and young people attended the Emergency Departments across the Trust, including the Haywood, County site and Leek Moorlands. This is over 10 000 more than 2021.
- In the year 2023/2024, the UHNM made 677 safeguarding referrals (involving 901 infants, children and young people) to social care which is a 36% increase on last year's figure of 498. 193 referrals were made to Staffordshire, and 471 to Stoke-on-Trent. 10 referrals were made of infants, children and young people living out of area.



- The majority, again, were from Midwifery (388, an increase on last year's 185).
- The Emergency Department (ED) also made a significant number of referrals (212, a slight decrease on the previous year's 221). 91 of these referrals were from adult ED (an increased from last year) and 121 from children's ED.
- Only 36 referrals were made by Child Health but many of the infants, children and young people admitted to the children's ward will have already been referred to social care by the Emergency Department.
- 39 referrals were made by staff outside of the three key areas already mentioned which is similar to 40 last year.

Stoke-on-Trent is one of the most deprived areas in the country (13th out of 317 in England). Data from the Joint Strategic Needs Assessment (2024 update) details that 25.7% infants, children and young people under the age of 16 years are living in poverty compared with the England average of 38.3%. Stoke has one of the highest rates in the country for infant mortality (7.3 per 1000 births, which is one of the highest in the country, compared to 3.9 for England).

- On 31st March 2024 there were 710 infants, children and young people on a child in need plan in Stoke and 521 on a child protection plan.
    - There were 1222 people subject to a plan during the year. The breakdown of categories:
        - Emotional abuse – 616 (50.4%)
        - Neglect – 506 (41.4%)
        - Physical abuse – 61 (5.0%)
        - Sexual abuse – 39 (3.2%)
- The number on a child protection plan has remained stable from last year.
- The number of looked after children has increased to 1156 (1109 in April 2023)
- There were 4608 referrals to children's social care locally which is a decrease from last year.

The area covered by Staffordshire County Council includes Staffordshire Moorlands, Newcastle-under-Lyme, and Stafford. Recent data from 2021 shows that the percentage of infants, children and young people living in poverty in the Staffordshire area is 18% (Staffordshire Moorlands) to 26% (East). For the period of April 2023-March 2024:

- On 31st March 2024, there were 5100 (increase from 5030 last year) infants, children and young people on a child in need plan, and 655 (fall from 720 last year) children on a child protection plan.
    - Most infants, children and young people on a child protection plan were under the category of neglect (480). Other causes were for emotional abuse (145), sexual abuse (25) and physical abuse (5).
- The number of infants, children and young people being looked after on 31st March 2024 is 1320 (slight decrease from 1390 last year).

- There were 5600 (fall from 6200 preceding year) referrals to Staffordshire children's social care in 2023/2024.

1.1 The Child Protection Department

The child protection department is based at the Child Development Centre at the Royal Stoke University Hospital. The department has child protection specialists with administrative support. The current establishment is as follows:

Name	Position	Brief Overview of Sessions
Dr Ayaz Vantra	Named Doctor	The named doctor provides 4.25 sessions (17 hours) per week for child protection and safeguarding. The named doctor is a member/rotating chair of both the Trust Safeguarding Working Group and the Trust Safeguarding Steering Group.
Ms Gemma Shawis Mrs Charlotte Tongue Ms Dorothy Thomas (seconded from MPFT)	Named Nurses	The named nurse role is a dedicated full-time position. The named nurse sometimes chairs the Trust Safeguarding Children Working Group and a member of the Trust Safeguarding Steering Group. The two named nurses work part time (1.4 WTE) and work as a cohesive team. Dorothy joined the team in March 2024, after being seconded from MPFT to support the named nurses for 12 months.
Mrs Mandy Stenson Michelle Peake	Named midwife Specialist safeguarding midwife	The named midwife for child protection is a dedicated full-time position. The named midwife is a member of the Trust Safeguarding Children Working Group and a member of the Trust Safeguarding Steering Group.
Roxy Buckingham (since August 2023) Jessica Gough (December 2022 – June 2023) Carol Wilson Holly Simmons	Safeguarding Children Administration Team	The safeguarding children administration team provide administrative support for safeguarding including looked after children.

Jasmin Coates		

In addition, the child protection department is supported by:

Mrs Paula Carr	The designated nurse for safeguarding children is employed by Stoke-on-Trent ICB but has an honorary contract with the UHNM. Within the NHS reorganisation the designated nurse covers both Stoke-on-Trent and North Staffordshire ICB, and the RSUH. The designated nurse is a member of the Trust Safeguarding Steering Group.
Dr Janey Merron	The Designated Doctor, employed by the Staffordshire and Stoke on Trent ICB, provides 5 sessions (20 hours) per week in support of strategic leadership for safeguarding children. Dr Merron, a GP in Stoke on Trent, is the Designated Doctor for North Staffs ICB, Stoke-on-Trent ICB, UHNM, Midlands Partnership Foundation Trust (shared with South Staffs designated doctor) and North Staffordshire Combined Healthcare NHS Trust. She provides supervision and support to the named doctors in the provider Trusts and the named GPs. The designated doctor is a member of the UHNM safeguarding steering group.
Mrs Victoria Lewis	The Quality Assurance Manager works within the central Quality, Safety and Compliance Department under the executive lead of the Medical Director and Chief Nurse, providing support around risk management, incident monitoring, assurance and improvement.

As the designated professionals' roles are ICB appointments, the County Hospital is within the remit of the designated professionals for South Staffordshire. The current designated doctor is Dr Hassan Zoaka and the designated nurse is Stephanie Nightingale.

Mrs Ann-Marie Riley is the Chief Nurse and Executive Lead for Safeguarding. The Deputy Chief Nurse, Jane Holmes, has responsibility for safeguarding within her portfolio.

Miss Sarah Curran is the Lead for Vulnerable People, as well as the Operational Lead for Safeguarding for UHNM. She is the UHNM representative on the Stoke-on-Trent and Staffordshire Safeguarding Children Health Forum which feeds into the local authority safeguarding boards/partnership. Sarah also attends the Trust Safeguarding Working Group and chairs the Trust Safeguarding Steering Group.

Ms Laura Collins was seconded from North Staffordshire Combined Healthcare NHS Trust in January 2023, to help support the leadership roles along with Sarah Curran.

Simone Rushton is the lead nurse for safeguarding for the trust.

2. Working in Partnership with the Local Safeguarding Children Board/Partnerships

2.1 Case File/Management Audit

There were two multiagency deep dive/learning case reviews for Stoke-on-Trent in the last 12 months, and none for Staffordshire. These were conducted when it was felt the threshold for a rapid review was not met. The cases and the learning points are summarised below:

1. A school age child was brought for a medical, due to extensive bruising and inflicted injuries being noted. There was close multiagency working once concerns came to light, and the voice of the child was sensitively captured (they only made a disclosure of physical abuse few weeks after the initial medical).

   However, there were missed opportunities to effectively safeguard the child, following the death of his parent, and being returned into the care of the other birth parent. It was unclear during the parenting assessments that were taking place in the preceding 6 months of the abuse coming to the light, whether the voice of the child was being captured. There was a recognition that information sharing between local authorities, when a child moves area needed to be more robust.

   It was concluded that the case did not meet the threshold for a Child Safeguarding Practice Review.

2. A newborn child sustained a head injury whilst being cared for in the hospital setting, sustaining a skull fracture and bleeding to the brain. The mother was a young person who had been supported via school and mental health services.

   The focus of the learning was around concerns raised with lack of information sharing between agencies to help support the young person during her pregnancy. The young person was known to have mental health difficulties, but this was not shared with agencies, and this was not readily shared with the midwifery team by the family. It was reflected that professionals should have exhibited greater professional curiosity and more joined up working to help safeguard the young person.

   Discussions around creating a robust pre-birth pathway for young people who become pregnant are on-going, including the possible need to flag up all expectant mothers under the age of 16, to ensure there are no concerns with sexual exploitation.

2.2 Involvement in/Learning from Child Safeguarding Practice Reviews

The learning and improvement framework, which is used when a child dies or has been seriously harmed, is laid out in Working Together 2023.

The UHNM has been asked to contribute to 9 rapid reviews in the last 12 months. These lead to a significant amount of work as the records of the index infant, child or young person and family members need to be reviewed and a report submitted in advance of the meeting. If the child or family members are known to the UHNM, a representative from the UHNM will attend the meeting.

Of the 9 rapid reviews, one involved 2 siblings who lived in Stoke Local Authority area, 6 were from Staffordshire and 2 involved an out of area child (neither were known to UHNM). 3 of the Staffordshire cases were from South Staffordshire and were not known to the Trust: The themes of the rapid reviews where children were involved with UHNM were:

- Two siblings who were sadly killed by their parent. This case underwent a local CSPR, of which the final report and recommendations are still pending. The review highlighted issues around understanding the impact of parental mental health on parenting, responding to safeguarding concerns out of hours including how information sharing is impacted, 'invisible men'.
- Intrafamilial sexual abuse – Not for CSPR. To note a national CSPR thematic review into child sexual abuse in the family environment has been planned by the national panel. The review highlighted a lack of timely information sharing, particularly with historic concerns, need for professional curiosity, understanding neurodiversity in relation to engaging with families, and trauma informed practice.
- Infant who sadly died after suffering from a non-accidental head injury. The review felt a CSPR was not required given the recency of a thematic review into injuries in non-mobile children. This review flagged concerns with engaging with significant men, information sharing across borders/local authorities, importance of professional curiosity and critical thinking, and the need to commission an information system that is fit for purpose.
- Infant who sadly unexpectedly died. A cause of death has not been determined. It was felt the case met the threshold for local CSPR, but the national panel felt this would not derive further learning. The learning points from review were understanding the triad of risk and impact on parenting, engaging parents at early help stage, having robust processes around missed appointments, being wary of being overly optimistic and self-reporting from parents when this doesn't match information and observations.

2.3 Priorities of the Board/Partnerships

The Safeguarding board/partnerships continue to have neglect as one of their priorities going forwards. Neglect continues to feature in both national and local case reviews and child safeguarding practice reviews and is the largest category for children being the subject of a child protection plan across the whole county.

The priorities for Stoke-on-Trent as per their annual report, published February 2023, covering July 2021 to July 2022 are:

- Lead and embed effective partnership arrangements to safeguard children.
- Develop and implement a Quality Assurance and Scrutiny Framework
- Continued focus of child exploitation, neglect (embedded the use of Graded Care Profile 2) and safeguarding young children aged under 2 years.
- Increasing assurance around missing children, serious youth violence and child mental health.

The priorities for Staffordshire, as per their annual report, published January 2023, covering 2022/2023 are:

- A three-year business plan to focus on the following:
    - Neglect – particular focus on under ones and reviewing impact of GCP2 assessments.
    - Child exploitation – full review of MACE process and Risk Factor Matrix Tool.
    - Domestic abuse – refreshed 3-year strategy around domestic abuse and strengthen relationships between boards to ensure a child centred lens and learning across system is translated to practice.
    - Early help – ensure sustained impact of outcomes around whole family approach.
    - Legacy impact of COVID
    - Voice of the child and families running throughout as cross cutting themes.

3. Clinical Audit

The named professionals continue to conduct local audits, usually based on local themes. More recently, we have moved away from doing informal case note reviews, to performing more structure audits, with support via business intelligence, and the audit department, which has been helpful in producing lists of children to audit, as well as helping to analyse and create audit reports, which has been extremely valuable to the child protection team. The audits completed over the last 12 months are summarised below:

3.1 CP-IS (Child Protection Information Sharing) Audit

This is an on-going audit and a standing agenda item on the Trust Safeguarding Children Working Group. There have been marked improvements in compliance with this. The ED has devised an electronic solution to avoid the need for stickers in the ED card which is currently being used in Royal Stoke. Our recent audits showed 100% compliance for both County and Royal Stoke ED, which is a culmination of the hard work being put in by the ED safeguarding children team.

In the future, the plan is for CP-IS to be rolled out across all NHS care settings, including primary care, by March 2024, as per the commitment in the NHS Long Term Plan.

3.2 Audit of safeguarding referrals and Documentation of Referral Forms (DORF) completion

- An audit looking into whether safeguarding concerns were being appropriately referred into social care, and then correctly documented on DORF.
- 30 referrals were audited:
    - Consent was obtained in 2/3 of applicable cases. It was not always documented why consent was not obtained, despite on review of cases, it was felt there were valid reasons to not seek consent e.g. child presenting alone, parent not having capacity.
    - The threshold for safeguarding being met in 100% of cases. 2/3 of cases were telephoned into social care, with the name of the social worker being correctly documented.
    - DORF quality varied – in 2/3 of cases the concerns were correctly recorded, and 57% of DORFs documented the plan from the social worker.
    - The opportunity to safeguard the children had not always been done in a timely manner in some patients.
    - The audit shows that safeguarding of children is being considered, but the process not always followed. In only 1 out of 30 cases, was previously relevant learning attended identified.
- Improvement identified:
    - Staff need to be aware of the UHNM process on when and how to raise safeguarding concerns.
    - To gain appropriate consent on all referrals where possible. If consent is not gained, for it to be clearly documented the reason why.
    - Clear documentation on the discussion with the social care needs to be documented, including decisions/ plans and outcomes.
    - All safeguarding referrals need to be telephoned through to social care. Staff to identify relevant training they have attended when completing DORF.
- Actions taken:
    - The DORF process was re-launched and updated. This was advertised via the monthly newsletters via the intranet and via the safeguarding champions.
    - The named nurses attended ward meetings to flag above learning points.
    - Plan to re-audit later this year (September 2024).

3.3 Audit of children removed from ED before being seen

- 20 cases were audited, to ensure children who were removed from ED before being seen, were not suffering harm, and to ensure safeguarding was being considered.
- Key points:
    - In 19 out of 20 cases audited, the cases involved an out of hours visit to ED.
    - Our audit showed that there was often extremely limited or no information around the reason to why the family left before being seen documented, making any view on safeguarding after the fact poorly informed.

- GPs were informed of the children left before being seen via a discharge letter, but often there was no narrative to why the child attended or the reasons to why the family left before being seen, meaning informed and appropriate action cannot be taken.
- 4 of the children had no casualty cards scanned on to EDMS

- Areas for improvement:
  - Documentation around the reason for the left before being seen and safety netting advice given.
  - Communication on the discharge letter to the GP to be sufficiently detailed to ensure the GP has a full picture of any concerns.
  - For safeguarding screening tools to be completed on every attendance.
  - The names of people with parental responsibility to be documented and the name of who accompanied the child to be clearly documented in the notes.
  - The ED left without being seen process to be made more robust and to take in to account the reason the family left and the views of the nursing team at the time.
- Actions taken:
  - The safeguarding screening tool was reviewed and re-launched in the Emergency Department. The re-launch will be supported by ad-hoc training for staff as required.
  - The current 'left before being seen' process will be reviewed to ensure that it is current, robust, and fit for purpose. Any amendments will be made following consultation with staff working in the Emergency Department.
  - A meeting will be arranged with the Nursing Team / Senior ED team to discuss the findings of the audit and emphasise the importance of clear documentation during the attendance and following the patient's departure from the Emergency Department.
  - The electronic CAS card will be reviewed to ensure that the following data fields are mandatory:
    a) the person with parental responsibility
    b) the person who attended with the child

3.4 JTAI multi agency audits

- As part of preparing for a possible joint targeted area inspection for Stoke-on-Trent, we have been contributing to a rolling 6-week cycle of multi-agency audits, looking 4 families in each cycle. The following themes have recently been audited:
  - Strategy meeting decisions
  - Section 47 enquiries
  - Stepping up and down thresholds
  - Information sharing at the front door.
  - Serious youth violence
  - MARAC arrangements
- The learning points and reflections are fed through to the quality assurance group.

3.5 CPIS on children's ward audit

- Audit currently in progress. Looking into CP-IS checks being done for children presenting to children's wards as well as other acute settings in adult services.
- 28 cases have been audited on children's wards.
- A final audit report is planned for May 2024.

3.6 Audits currently planned:

- Audit looking into frequent attenders to ED, to see if safeguarding was a contributing factor to admissions.
- Audit within maternity services in relation to repeated removals and separation of newborn babies from their mothers.
- Repeat audit into triad of risk presentation in parents/carers – is child safeguarding considered and injuries in non-mobile infants.

4. Child Protection Training

4.1 Updates to the current child protection training offer at UHNM

A training away day was held in September 2023, to plan and review the current training offer across UHNM. At the time, the offer was as follows:

Level	e-Learning	Face-to-face
1 – All staff working in health care settings	30 minute eLearning (usually done at induction)	N/A
2 – All non-clinical and clinical staff who have any contact (however small) with CYP or adults who may pose a risk to children	1 hour e-Learning to be renewed every 3 years. Target audience – whole trust APART from those working in key areas (maternity, child health, ED)	3 hour study day to be renewed every 3 hours. Target audience – staff working in key areas
3 – Clinical staff who could potentially contribute to assessing or providing support to children and families **3+ - Clinical staff undertaking specialist safeguarding roles, including those who assess looked after children**	Vie e-LFH or additional ESR modules	UHNM level 3 study day delivered by external trainers (3 times a year) – full day to be renewed every 3 years OR Attend level 3 equivalent study day with safeguarding boards

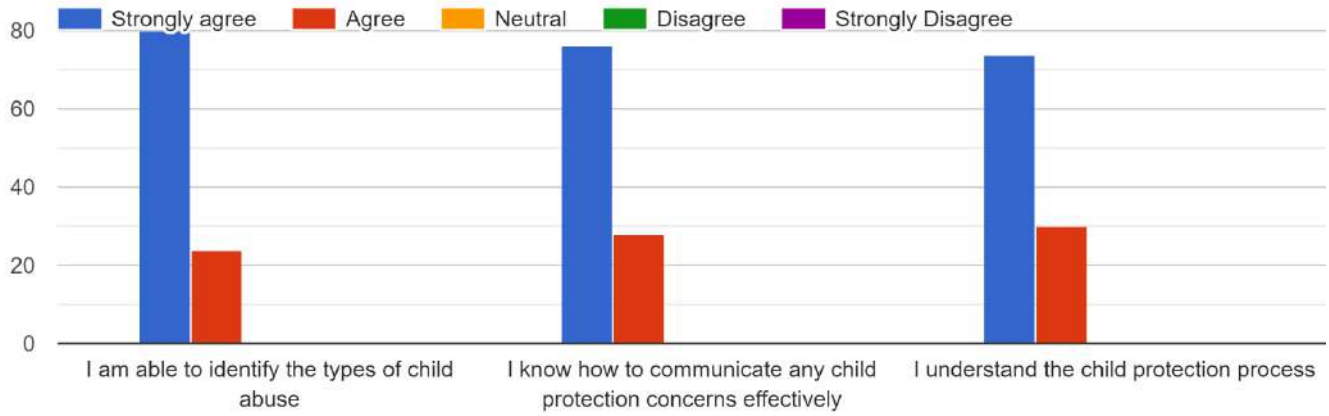
It was felt, there was a need to simplify and streamline the current training offering, with the overall aim to upskill the workforce, particularly those working in key areas, by increasing the number of staff with level 3 training. The current system allowed those to complete a single e-LFH module to sign off for L1, L2 and L3 on their ESR matrix, and this was felt to not provide the essential breadth of knowledge. Those working in key areas were previously expected to attend both level 2 and level 3 training every 3 years.

The current level 2 training package was updated, to include more interactive case scenarios, with the development of online questionnaires/feedback forms, to enable better quality feedback to be obtained, as well as immediate production of certificates once the quiz at the end of the session was completed. The current face to face session is now fully CSTF compliant for the level 3 curriculum.

The current offer is as follows:

Level	e-Learning	Face-to-face
1 – All staff working in health care settings	30 minute eLearning (usually done at induction)	N/A
2 – All non-clinical and clinical staff who have any contact (however small) with CYP or adults who may pose a risk to children	1 hour e-Learning to be renewed every 3 years. Target audience – whole trust APART from those working in key areas (maternity, child health, ED)	N/A – no more face to face sessions for L2.
3 – Clinical staff who could potentially contribute to assessing or providing support to children and families **3+ - Clinical staff undertaking specialist safeguarding roles, including those who assess looked after children** **NOTE – those requiring level 3 training, need to evidence between 8 and 16 hours (dependant on role) of learning over a 3 year period.**	e-LFH or additional ESR modules can be used to evidence additional hours for L3 compliance, but will no longer sign you off on ESR for being compliant with Level 3.	4 hour session to be renewed every 3 hours. Target audience – mainly those working in key areas, but there may be some according to the training needs analysis that will need L3 training also. A 3 year rolling cycle of sessions to target compliance in key areas: • Year 1 – ED (done 2023) • Year 2 - Child Health (2024) • Year 3 -A specialist whole day level 3 course, where external speakers will be invited (likely for 2025 and will be held every quarter). • Maternity will continue to train throughout. Four times a year, a day will be advertised for those not working in key areas who require L3 can enrol.

The current course was rolled out in February 2024, and we have trained around a 100 staff so far across multiple areas. The feedback has been overwhelmingly positive, and audiences have left sessions feeling more confident in knowing how to raise concerns:



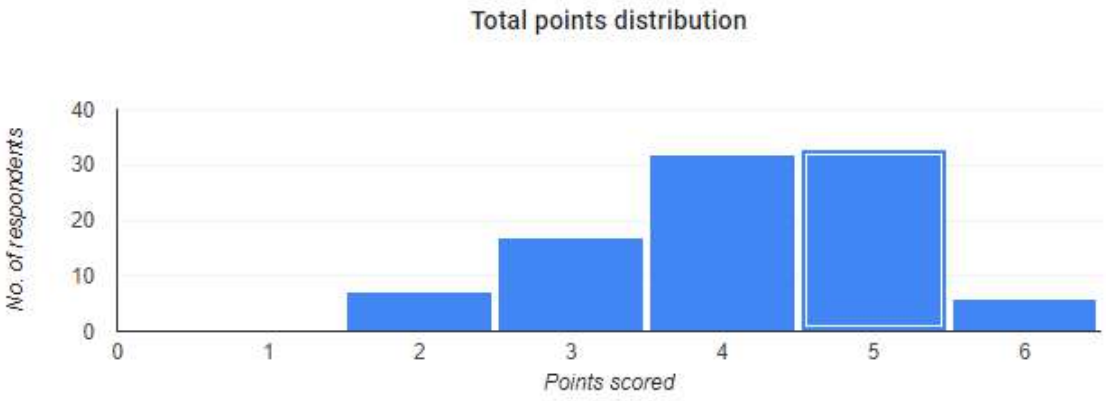
Some of the comments we have received via the feedback form:

- The course was very useful and address all their objectives thoroughly and addressed doubts with clarity.
- I have more understanding of each category. I have wider knowledge of MDT and work. It's made me think about the family not just the individual.
- …I have learned so much today especially regarding documentation and what happens once you've completed a DORF.
- Very enlightening. Highlighted some of the real-life issues relating to addressing concerns, consent, referrals, and safeguarding discussions/meetings.
- Gave me confidence in myself to challenge others if I have safeguarding concerns, no improvements.
- I feel like it could have been an all-day course due to how much is involved when it comes to safeguarding. It was very informative and learning information in which I would never of been exposed to potentially.
- Everything was really good; I think the course could of been longer as there was so much to discuss.
- The course was well prepared and was a safe space to ask any questions and learning how to manage safeguarding concerns.
- It was heavy on the slides! But was so informative. The videos were so heartbreaking, but I feel it hits home more knowing these are actual cases.
- This has been much better doing a F2F course than on the intranet. Helps me to process better.
- Great training and better that online as allows for discussion and shared learning.

There has been evidence of increased knowledge when we measured understanding via a pre and post course quiz, demonstrating the training has been impactful.

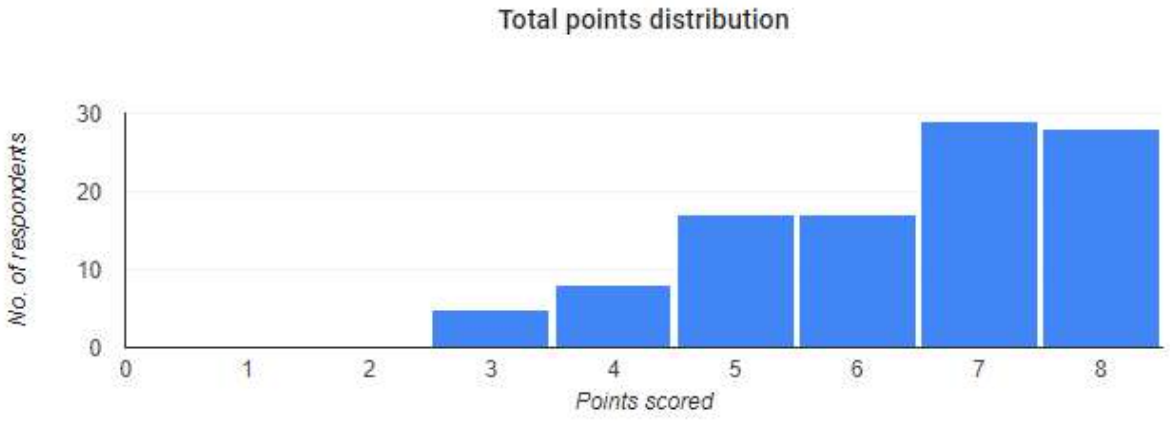
Pre score quiz scores (score out of 6)

Average	Median	Range
4.15/6 points	4/6 points	2-6 points



Post course quiz (score out of 8)

Average	Median	Range
6.36/8 points	7/8 points	3-8 points



4.2 Training compliance figures for L1, L2 and L3 training.

The child protection team continue to work closely with the Academy to ensure that all the training episodes are captured on ESR. We have as a result had an increase in the number of staff that require level 3 training identified, and as a result we expected this to result in a drop off in the compliance rates for Level 3 training.

Summary of UHNM training figures over the last 3 years:

Level	2021-2022	2022-2023	2023-2024
Level 1 (% compliance)	92%	91%	93%
Level 2 (E-Learning)		2632	2713
Level 2 (Face to Face)		77	246
% compliance	88% (Key areas 88%)	84% (Key areas 81%)	87% (key areas 83%
Level 3 (E-Learning)	518	1153	717
Level 3 (Face to face)		85	158
% compliance	79%	75%	67%

In 2023, the child protection conducted 14 additional level 2 training sessions with ED, to help address compliance rates. 228 members of staff were trained in ED via these additional over the last year. As mentioned above, the plan is to hold a similar number of sessions in ED every 3rd year. These sessions were held in addition to trust wide sessions, as well as sessions held for new trainee doctors.

As part of their own personal development, the safeguarding professionals are expected to attend appropriate training so that they can maintain their expertise. The named professionals have attended several level 3+ courses over the last year:

- The named doctor is a member of the local child protection special interest group and attends the meetings where good practice and learning is shared. They have attended CPD relating to child sexual exploitation, supporting GCP2 assessments for cases of suspected neglect, child abuse linked to faith and beliefs, safeguarding in education Autumn Conference for Stoke-on-Trent social care and imaging in cases of suspected physical abuse course.

- Named nurses have attended training on topics including level 3 child protection days, the champions day, forced marriage training, mental health training, psychological first aid training, Critical Incident Stress Management course, safer internet, predators of sexual abuse course and leadership/ teamworking training (Insights Model). They have continued to deliver training for

SSCB (level 2 working together training) as well as running and facilitating level 2 and 3 training within UHNM. One of the named nurses attended a training course focussing on providing psychological first aid, which will help to provide further supervision and peer review support within the organisation.

- The specialist safeguarding midwife has attended training covering perinatal mental health, sexual abuse, statement writing, substance misuse, domestic abuse, and adult safeguarding. The named midwife has attended training covering statement writing, preventing children entering care, Enable and Insight (leadership) training, domestic abuse, and adult safeguarding training.

- Level 4 training - level 4 training is to be undertaken by the Named Professionals. The named doctor attended the level 4 training via the RCPCH in July 2023. The named doctor is planning on attending a Leadership in Safeguarding course in the next year.

5. Medical Examinations

The Trust has a rota for child protection medicals where physical abuse is suspected. Community paediatric consultants provide cover between the hours of 9am to 5pm for weekdays and provide telephone advice for consultant colleagues for an hour 10.00 am until 11.00am at weekends and on Bank Holidays. The first on call is either a paediatric doctor in training or SAS doctor, usually one working within community paediatrics. Infants, children, and young people who require admission for medical treatment because of abuse, presenting out of hours, will be seen by the acute paediatric team and picked up by the on call for child protection during office hours the next working day.

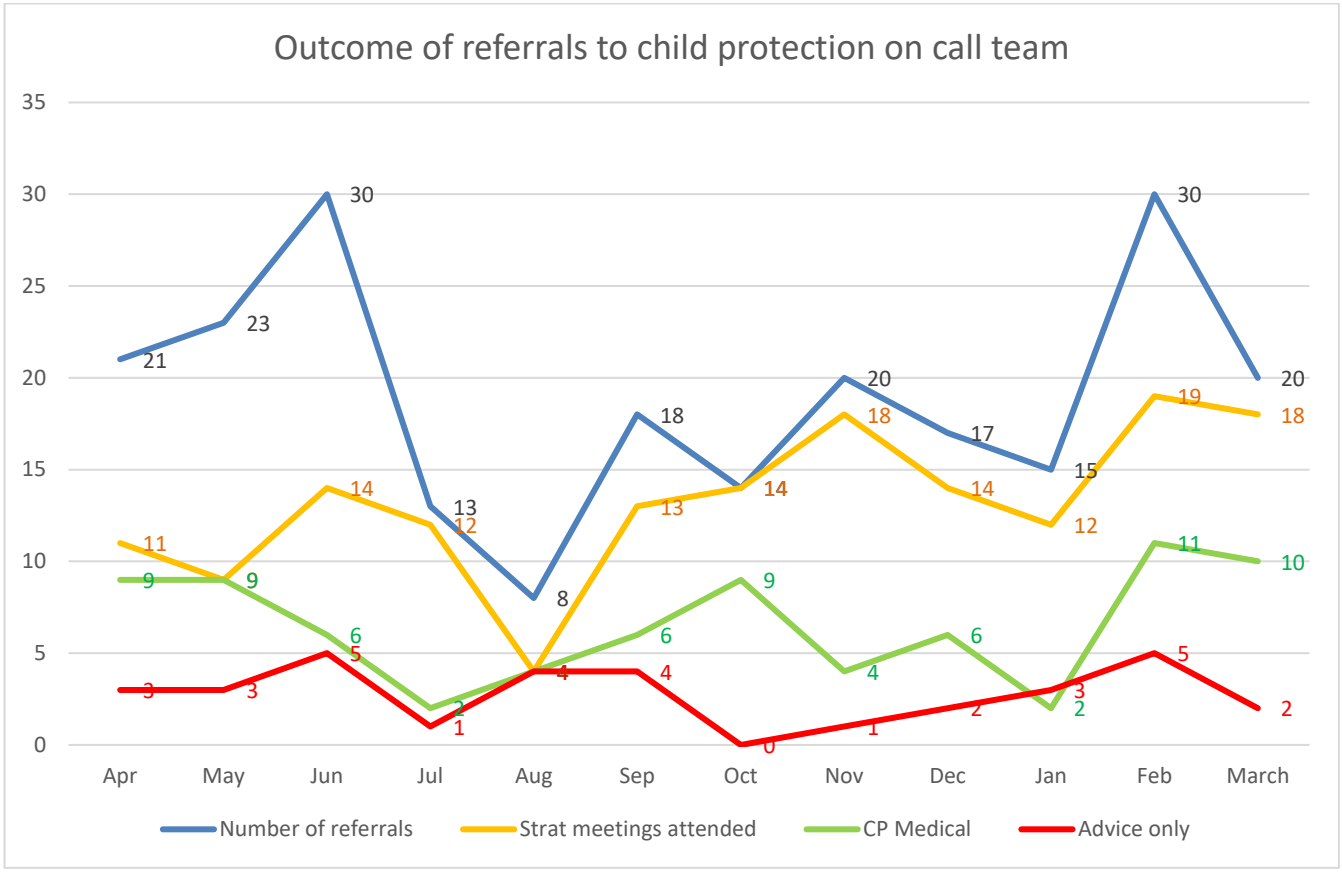
Sexual abuse examinations are carried out external to the UHNM at various Sexual Assault Referral Centres run by Mountain Healthcare.

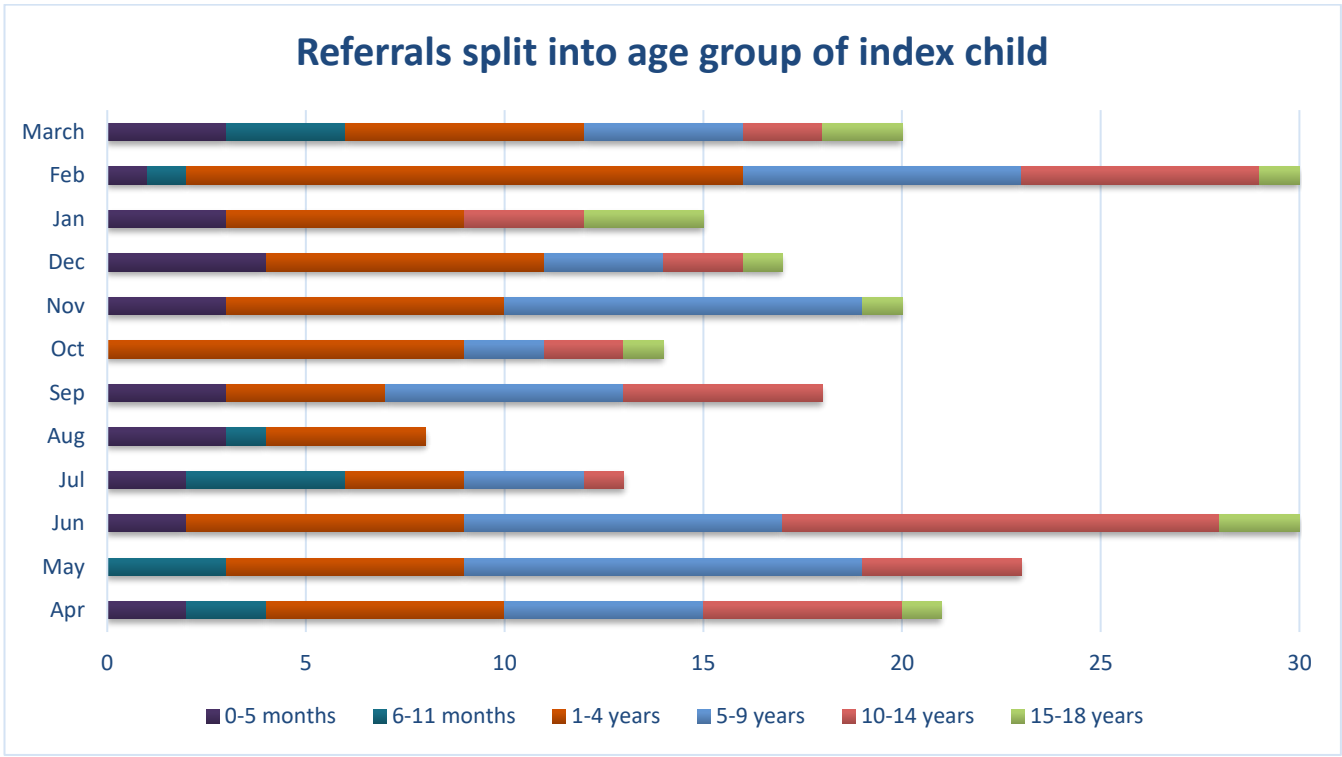
All examinations are discussed during a peer review meeting, which is held every month. A term of reference for peer review meetings was agreed in November 2023, and will be reviewed every 4 years to ensure it matches the RCPCH guidelines.

5.1 Numbers and Types of Medical Examinations

78 child protection medicals were done over the last 12 months.

Year	Number of Medicals
2023-24	78
2022-23	79
2021-22	91





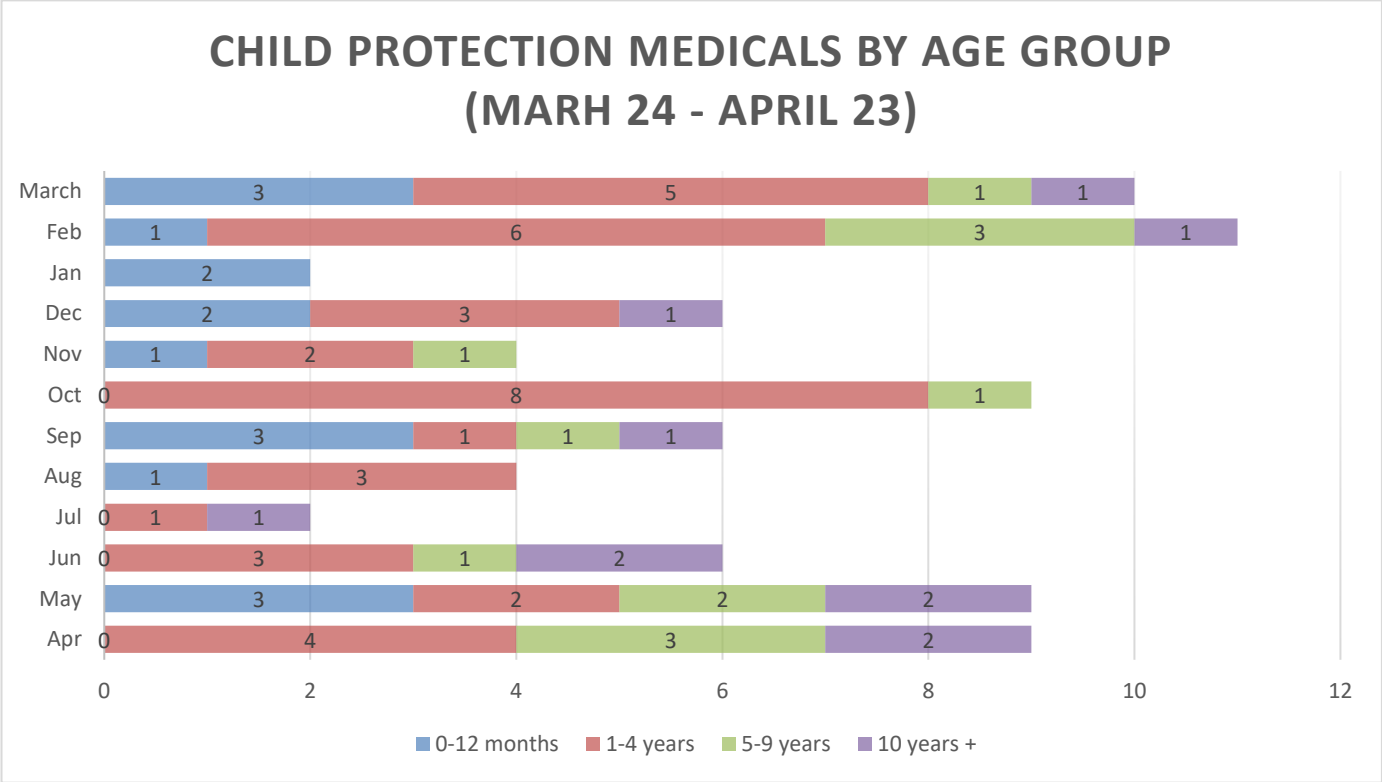
There were in total 229 referrals to the child protection service (up from 197 total contacts in 2022-23):

- 78 resulted in child protection medicals – the majority were for concerns with physical abuse.
    - As seen above the workload varies, as we often note a fall in referrals during the school holidays i.e. 21 referrals in July and August combined, compared to 30 referrals in February alone.

- 33 were advice only
- 158 required attendance at a strategy meeting (this is an increase from 83 strategy meetings attended last year)

The community paediatricians undertaking child protection medicals are pleased to be more involved in strategy discussions and advice calls in general where the need for a medical can be discussed.

5.2 Summary of Medical Examinations Undertaken



As in previous years there is no pattern to proportion of medicals presenting in any given month. As last year around 70% of medicals were conducted on children under the age of 5 years which is commonly what we see. Interestingly, 14% of medicals were on children over the age of 10 years, which is a rise from 6% last year, which illustrates the vulnerability of the older child too.

All child protection medicals are followed up by a report, which is sent to social care, GP, police and health visitors, once authorised by the consultant in charge of the case.

6. Child Protection Conferences

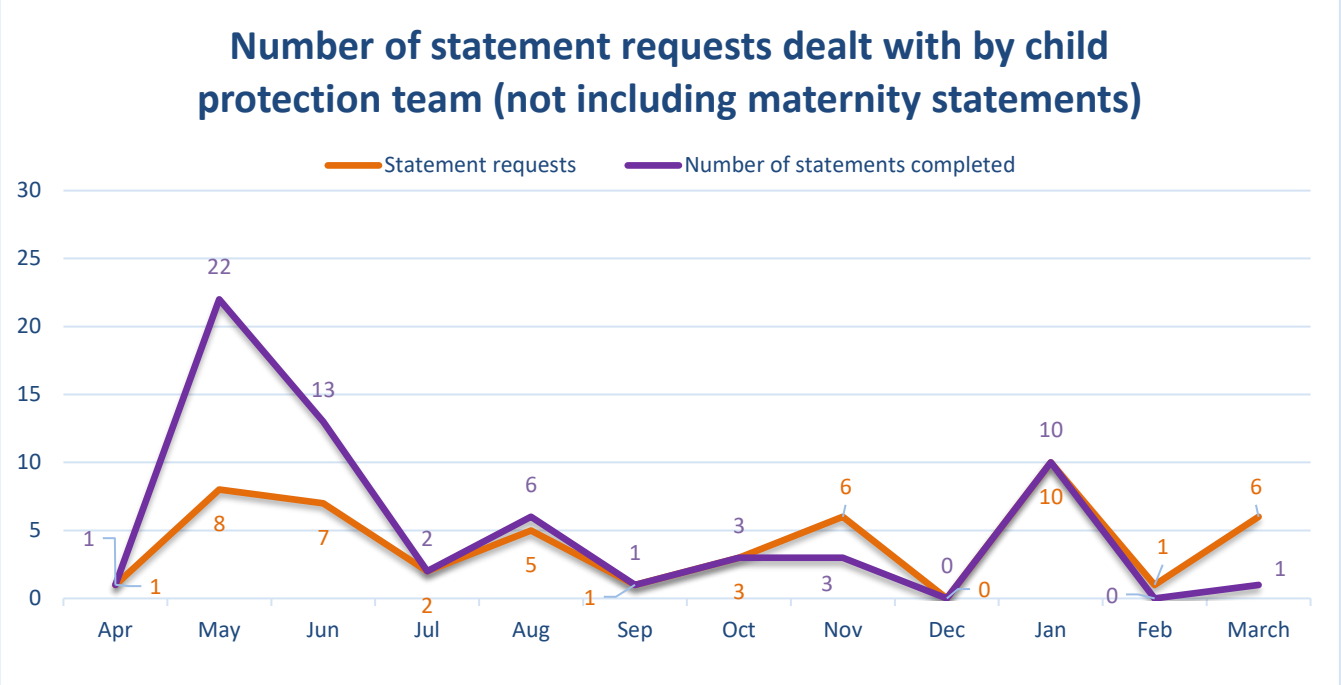
During 2023-2024, the department has received 1566 notifications for either initial or review conferences, which is a decrease on last year's 1867.

The department received 1017 decisions and recommendations, and minutes of conferences.

7. Preparation for Court Reports

In the last year there were 93 statement requests of which 31 were for maternity (25 maternity statements in the previous year). This is an increase on the previous year (82). For context few years ago, the team were dealing with around 25-30 statements per year.

Court order and statement requests for children and young people are currently managed by the child protection team, and this leads to a significant workload.



In 2023/2024, the child protection team dealt with 50 court order requests, resulting in 62 separate statements. Most of these statements were supervised or checked by the child protection team, including formatting and correcting, as well as requesting deadline extensions, and sending statements back securely to the requesting legal team. It is estimated, each individual statement results in between 2-3 hours of work for the child protection team.

To illustrate this workload, the named doctor alone received and sent 755 emails regarding the 62 statements above over the last 12 months.

Discussions are being held within the trust with the aim to remove this piece of work from the team, to free them up to deliver more face-to-face activities such as liaison and supervision.

44 babies were removed from mother and taken into care from maternity. This is a decrease from last year (57).

8. Other Child Protection Department Activity

8.1 Newsletters and other information

Recent newsletters have covered topics such as ICON, gambling, road safety, referring into social care and county lines.

8.2 Information Sharing

In quarter 4, the trust met 95% compliance for checking the CP-IS system, for all children presenting to ED. This is being internally monitored via the ED safeguarding subgroup.

8.3 National and Maternity Alerts

During 2023-2024, there were 923 attendance alerts were triggered for maternity (increase from 851 in previous year), and 1444 for attendances via emergency portals (decrease from 1890 the previous year). These are alerts for children who have information held on the national NHS spine, on their CP-IS records either because they are looked after, subject to an unborn alert or subject to a child protection plan. Any visits to emergency portals trigger an email to the named social worker and the child protection team, to inform of the admission, providing an opportunity to ensure no new safeguarding concerns have been picked up.

A meeting was held with the ICB and Senior Local Authority representatives and interim measures immediately put into place to ensure that national alerts were received by UHNM. A review of the alerts for the previous 6 months was undertaken and relevant alerts were forwarded to the Named Midwife who actioned these appropriately. A further meeting is planned to review the process with the named nurse and midwife with the administration team.

In the year 2023-2024 Q4, there were 139 national alerts received.

8.4 Freedom of information requests

There has been one FOI request in the last 12 months regarding mandatory reporting of FGM, which was responded to.

9. Future Developments

Work is on-going to embed the process which ensures that the historic information regarding a child having had an unborn alert on the mother's records is transferred to their own records so that staff are aware of the previous safeguarding concerns.

Not all children admitted to the UHNM are placed on children's wards. Work is on-going to ensure that children on adult wards receive appropriate care and consideration as children. A live dashboard is now in place to accurately flag young people on adult wards, which is regularly reviewed, to ensure any safeguarding concerns are correctly addressed.

The named nurse and lead for vulnerable people filmed a video for the #DitchTheBlade campaign, for Staffordshire Police. Tackling knife crime remains one of our key priorities under the multi-agency serious violence strategy, and the video was filmed to educate young people around some of the consequences related to knife crime.

The chaperoning Policy is currently being reviewed, and consideration is being given to developing a training package for staff.

There is work being done that current mandatory information sharing processes related to FGM notifications are robust. We have recently contributed to the national consultation on reducing the amount of data required for the national dataset.

The named nurse, using the professional nurse advocate qualification, is planning on setting up a formal restorative supervision process for nurses involved with safeguarding cases, with an aim to hold monthly session across child health and neonates.

One of the named nurses will be relaunching ICON across child health. The current SOP is awaiting approval via governance, with a plan for posters and training to advertise the relaunch. The ICON programme helps to prevent abusive head trauma, by providing advice and support to new parents, with respect to dealing with an excessively crying baby.

The process around dealing with court statement and report requests is currently being reviewed. Historically, this area of work has sat with the child protection team, despite most requests not being related to child protection/safeguarding. Recently, this has taken up a lot of resource within the child protection team, impacting on their ability to deliver the usual work required from the named professionals. Meetings with the legal service and local authorities are planned, to hopefully devise a solution, whilst ensuring this key area of work is being adequately supported.

We are also aiming to run another local training day around court statements at UHNM, facilitated by our own legal department.

The named doctor has developed a guideline around child protection medicals that will hopefully continue to ensure practices remain consistent within the team, whilst also ensuring recent updates regarding blood investigations in suspected physical abuse cases are reflected within local guidance. This is awaiting approval from QSOG. Leaflets around this process have been updated, including creation of an easy read leaflet format also.

Over the last few months, we have commenced the 'CP Star of the Month' award, to champion individuals and teams who are championing child protection within the area. Over the last year the child protection/LAC admin team, Sheila Bowers (ED nursing education lead) and Dr Brijesh Patel (ED consultant) have all been nominated.

Maternity services have been involved with the LA and the Light Box Project and the project will be rolled out July 2024 once the LA restructuring has commenced. The aim of the boxes and the project is to reduce the trauma for birth parents when having children removed from their care at birth and hopefully reducing the number of reoccurring pregnancies. The boxes are also aimed at improving practice around separation at birth; ensuring when it necessary for this to be done, practice is built on compassion to ensure the least possible trauma for parents and babies.

A new Lead for Perinatal Mental Health has been appointed. An expansion of maternity safeguarding team to include full time Band 6 midwife is being planned. Continued safeguarding supervision for maternity staff via Safeguarding Surgeries and attendance at team meeting is taking place with peer review of cases to commence.

A domestic abuse study session has been implemented in Maternity and further dates for specific Non-fatal Strangulation training delivered by New Era has been arranged. Development of individualised parent education sessions for woman where learning disabilities are identified continues.

There is on-going development of the working relationship with NICU to ensure up to date communication with risks and planning is shared. There are on-going discussions with the Department of Justice regarding working relationships with Drake Hall Prison in relation to changes in their service and pregnant service users when on remand.

10. Conclusion

Child protection remains a challenging arena to work in and an ever-changing landscape. The child protection team are passionate about what they do and strive to deliver the best service to the Trust and their safeguarding partners, keeping the child at the centre of all they do.