NHS
Stockport
Clinical Commissioning Group

(DR MARSHALL & PARTNERS HEATON NORRIS HEALTH CENTRE)

SAFEGUARDING CHILDREN, YOUNG PEOPLE AND ADULTS AT RISK POLICY

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Safeguarding Children, Young People and Adults at Risk in General Practice

Section 1

1.1 Statement of Intent

The aim of this policy is to ensure that, throughout the work of **Dr Marshall & Partners**, children, young people and adults at risk are protected from abuse and exploitation. This may include direct and indirect contact with children, young people and adults at risk (access to patient's details, communication via email, text message and phone).

We aim to achieve this by ensuring that **Dr Marshall & Partners** complies with national statutory and local guidance for safeguarding and promoting the welfare of children, young people and adults at risk by creating a safe practice. **Dr Marshall & Partners** is committed to providing a practice which safeguards children, young people and adults at risk irrespective of their background and which recognises that a child, young person or adult at risk may be abused regardless of their age, gender, religious beliefs, racial origin or ethnic identity, culture, class, disability or sexual orientation.

Dr Marshall & Partners is committed to implementing this policy and the practice set out for all staff and partners and will provide learning opportunities and make provision for appropriate child and adult protection training to all staff and partners. This policy will be made widely accessible to staff and partners via the practice intranet and paper copy and reviewed on **24th April 2021.**

This policy addresses the responsibilities of all practice employees and those with whom we have arrangements. It is the responsibility of the Practice Manager and GP Safeguarding Leads to brief the staff and partners on their responsibilities under the policy.

For employees, failure to adhere to this safeguarding policy could lead to dismissal or constitute gross misconduct. For others (volunteers, supporters, donors, and partner organisations) their individual relationship with the practice may be terminated.
It is the responsibility of all employees to adhere to this safeguarding policy.

In safeguarding and promoting the welfare of children, young people and adults at risk all employees and partners need to:

- recognise signs of and understand what abuse is.
- be able to respond appropriately to concerns or disclosures of abuse.
- be clear what their role and responsibility is.
- understand what behaviour is acceptable.
- minimise any potential risks to children, young people and adults at risk.
- describe what to do if worried about a child, young person or adult at risk or a pregnant woman or a family.
- ensure practice systems work well to minimise missing vital information or delay in communication.

1.2 Background & Principles

Safeguarding is a shared responsibility. The practice team, however, is not responsible for making a diagnosis of abuse or neglect; rather to share concerns appropriately and refer onto the relevant agency responsible for carrying out an assessment.

Why is safeguarding necessary in General Practice?

- The majority of children, young people and adults at risk are registered with a GP and General Practice remains the first and potentially the only point of contact for most health related issues. This sometimes includes families who are not registered but seek medical attention.
- GPs and their practice teams have a key role not only in providing high-quality services for all children, young people, and adults at risk but also in detecting those families at risk, supporting victims of maltreatment and providing on-going care and assessment while contributing to the multi- agency assessment process and care planning.
- Lack of sensitive responsive care in infancy can seriously impact on the developing infant. Identification of abuse has been likened to putting together a complex multi-dimensional jig-saw. General Practitioners and their teams, who hold knowledge of family circumstances can interpret multiple observations accurately recorded over time and may be the only professionals holding vital pieces necessary to complete the picture
- GP practices have a duty of care for children, young people and adults at risk to whom they provide care and services. This includes ensuring their safety on GP premises and minimising any risk presented by practice staff, including GPs, by having in place safe recruitment practices and procedures for managing allegations.

1.3 Principles of Adult Safeguarding

There are a number of principles underpinning the work we carry out with adults:

In the safeguarding of all adults, **Dr Marshall & Partners** are guided by the principles set out in *The Care Act 2014* and aim to work within the following principles when developing and implementing services for adults.

- **Empowerment**
  We give individuals the right information about how to recognise abuse and what they can do to keep themselves safe. We give them clear and simple information about how to report abuse and crime and what support we can give. We consult them before we take any action. Where someone lacks capacity to make a decision, we always act in his or her best interests.

- **Protection**
  We have effective ways of assessing and managing risk. Our complaints and reporting arrangements for abuse and suspected criminal offences work well. People understand how we work and how to make contact with the right people in our organisation. We take responsibility for dealing with any information we have and ensuring the information is provided to the right people.

- **Prevention**
  We help our community to identify and report signs of abuse and suspected criminal offences. We train staff how to recognise signs and take action to prevent abuse occurring. In all our work, we consider how to make communities safer. Working with abuse demands a high level of skill and can be very stressful. Training and support for workers accused of or investigating potential abuse situations are a high priority

- **Proportionality**
  We discuss with the individual and where appropriate, with partner agencies what to do where there is risk of significant harm **before** we take a decision. Risk is an element of many situations and should be part of any wider assessment.

- **Partnership**
  We are good at sharing information locally. We have multi-agency partnership arrangements in place and staff understand how to use these. We foster a "one" team approach that places the welfare of individuals before the "needs" of the system.

- **Accountability**
  The roles of all people are clear, together with the lines of accountability. Staff understand what is expected of them and others involved. Vulnerable people have the right to expect that staff working with them should have the appropriate level of skill. This is particularly important in relation to extremely sensitive issues, such as suspected or alleged abuse. Staff working with adults at risk will be trained to recognise signs of abuse, and to recognise disclosure. Staff involved in, or leading investigations, will receive specialist training.

1.4 Legislative Framework

Safeguarding children, young people and adults at risk is a fundamental goal for **Dr Marshall & Partner.** This policy has taken into account legislative and government guidance requirements, Stockport's Safeguarding Children Board (SSCB), Stockport Safeguarding Adult Board (SSAB) and Greater Manchester Safeguarding Partnership policies and procedures. All links to the relevant legislation and guidance can be found in Appendix 2.

1.5 Definitions

1.5.1 Child

For the purpose of this policy a child is anyone who has not yet reached their 18th birthday. 'Children' therefore means 'children and young people' throughout.

1.5.2 Safeguarding Children

In Working Together to Safeguard Children, 2018 the Government has defined the terms 'safeguarding and promoting the welfare of children as:

- protecting children from maltreatment;
- preventing impairment of children's health or development;
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care and
- taking action to enable all children to have the best life chances

A child centred and co- ordinated approach to safeguarding (Working Together 2015) states the effective safeguarding arrangements in every local area should be underpinned by two key principles:

- safeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their full part; and
- a child-centred approach: for services to be effective they should be based on a clear understanding of the needs and views of children.

1.5.3 Adult

For the purpose of this policy an adult is anyone who is aged 18 years and over.

Adults at Risk

People's wellbeing is at the heart of the care and support system under the Care Act 2014, and the prevention of abuse and neglect is one of the elements identified as going to make up a person's wellbeing. In the Care Act the term 'adult at risk' replaces

previous terms such as 'vulnerable adult', or 'victim'. The adult at risk describes the person who is the subject of the safeguarding concern.

In the context of the legislation, specific adult safeguarding duties apply to any adult aged 18 years and older who:

- Has care and support needs and
- Is experiencing, or is at risk of, abuse or neglect or
- Is unable to protect themselves because of their care and support needs.

Safeguarding duties apply regardless of whether a person's care and support needs are being met, whether by the local authority or anyone else. They also apply to people who pay for their own care and support services.

It is important to remember that a person's disability or age does not in itself make the adult at risk. The majority of adults who could be considered as 'at risk' will never experience abuse and with the right support in place can safeguard themselves.

Adult safeguarding is the process of protecting adults with care and support needs from abuse or neglect. This may include empowering and enabling people to protect themselves.

1.6 The Care Act (2014)

The Care Act (2014) sets out statutory responsibility for the integration of care and support between health and local authorities which in turn helps adults at risk to develop their resilience and retain their independence and ensures that people understand what their rights and choices are and where they can get help and support if needed.

It highlights the importance of partnership working in safeguarding to develop shared strategies for safeguarding adult at risks. All health, social care professionals and care workers play a key role in safeguarding of adult at risks who are in receipt of health or care services. It is everybody's responsibility to protect adult at risks from abuse, harm and omissions of care.

The Care Act emphasises the importance of 'Making Safeguarding Personal' which aims to develop an outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances. It is about engaging with people about the outcomes they want at the beginning and middle of working with them, and then ascertaining the extent to which those outcomes were realised at the end.

1.7 Categories of Abuse

This section describes what is meant by child and adult abuse it refers to the definitions as stated within Working Together to Safeguard Children (HM Government 2015) and Care Act 2014. Detailed guidance on some of the indicators of abuse can be found within Stockport's Safeguarding Children's Board (SSCB) procedures, Greater Manchester Safeguarding Children Procedures, and within Stockport's Safeguarding Adult Board (SSAB) procedures (all links in appendix 2).

1.7.1 Child Abuse

For children's safeguarding, the definitions of abuse are taken from Government *Working Together to Safeguard Children 2018* (HM Government, 2018).

Abuse is defined as a form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more

rarely, by others (e.g. via the internet). A child may be abused by an adult or adults, or another child or children. An unborn child may suffer harm if his/her mother is subject to domestic abuse, is a tobacco, drug or alcohol abuser or fails to attend for antenatal care.

There are usually said to be four types of child abuse or maltreatment but they often overlap and it is not unusual for a child or young person to have symptoms or signs from several categories (for full descriptions see the NICE guidance, 2014).

1. Physical Abuse
2. Emotional Abuse
3. Sexual Abuse
4. Neglect

1.7.2 Physical abuse

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

Where fabricated or induced illness is suspected, it is important not to share initial concerns with parent/carer or child as this could escalate the abuse. Advice must be sought from the Designated professionals to consider the next steps. Health are central to the risk assessment that is required; a chronology would be compiled and Fabricated Illness strategy meeting requested through Children's Social Care.

1.7.3 Emotional abuse

The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

1.7.4 Sexual abuse

Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

1.7.5 Neglect

The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may

occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of inadequate care-givers); or
- ensure access to appropriate medical care or treatment.
- It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

1.7.6 Female Genital Mutilation (FGM)

Comprises of all procedures involving partial or total removal of the external female genital organs or any other injury to the female genital organs for non-medical reasons.

It is a mandatory reporting duty to report FGM in children who disclose or where it is physically evident that FGM has been performed. The referral is made to the police on 101 or 999 if an urgent referral required.

These Greater Manchester Safeguarding Procedures have been developed and implemented through the co-ordination of the Greater Manchester Safeguarding Partnership working with a company named TRI.x. All Stockport policies are access through the website: safeguardingchildreninstockport.org.uk and searching using the contents page. There are a number of core policies which are key to safeguarding children including pre-birth assessments for the unborn baby and then a number of policies relating to specific circumstance including children with a disability, forced marriage and female genital mutilation. They are updated in line with emerging policy, statutory guidance and local learning therefore policies should not be printed and stored for future reference.

Particular attention is drawn to section 4 of the Greater Manchester Safeguarding children procedure manual www.safeguardingchildreninstockport.org.uk around safeguarding children in specific circumstance including disabled children and Trafficked Children. As trafficked children are largely invisible to professionals and volunteers who could help them, they are at increased risk of significant harm. There is a wealth of supporting guidance and helpful toolkits which also includes information around Modern Slavery; an Act in place since 2015.

1.7.7 Adults at Risk

The Care and Support Statutory Guidance issued under the Care Act 2014 replaces "no secrets" guidance. Safeguarding adults' duties have a legal effect in all organisations including the NHS, Police and Local Authority.

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances. Professionals should work with the adult at risk to establish what being safe means to them.

1.7.8 Physical abuse

Including assault, hitting, slapping, pushing and misuse of medication, restraint or inappropriate physical sanctions.

1.7.9 Domestic violence and abuse

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. Domestic violence and abuse incorporates Female Genital Mutilation, forced Marriage and so called 'Honour Based violence.

1.7.10 Forced Marriage

Is a marriage conducted without the valid informed consent of one or both parties, where some element of duress is a factor.

1.7.11 Honour-based Violence

So called 'Honour' based violence (HBV) is where the person is being punished by their family or their community. They are being punished for actually, or allegedly, undermining what the family or community believes to be the correct code of behaviour. In transgressing this correct code of behaviour, the person shows a lack of conformity, thus bringing shame and dishonour to the family who have failed to control them

1.7.12 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, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.

1.7.13 Psychological abuse

Including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.

1.7.14 Financial or material abuse

Including 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 or misappropriation of property, possessions or benefits.

1.7.15 Modern day slavery and human trafficking

It includes slavery, sex trafficking, forced and bonded labour, organ removal, forced marriage 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. Children and adults can be subject to this abuse.

1.7.16 Discriminatory abuse

Including forms of harassment, slurs or similar treatment;
because of race, gender and gender identity, age, disability, sexual orientation or religion. This incorporates Hate Crime which is any criminal offence which is perceived by the victim or any other person as being motivated by prejudice or hate, based on a person's race, religious belief, sexual orientation (homophobic hate crime), disability or transgender, or a person's perceived race, religious belief, sexual orientation, disability or transgender.

1.7.17 Institutional abuse

Including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's 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.

1.7.18 Neglect and acts of omission

Including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.

1.7.19 Self-neglect

Entails neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. It is also defined as the inability (intentional or unintentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and wellbeing of the individual and sometimes to their community.

1.8 Other issues for consideration

1.8.1 Care quality concerns

Pressure ulcers, falls, medication errors and equipment issues/failures are concerns that providers may need to report concerns which they observe or that they are informed about from either a care quality or safeguarding stance.

In the majority of cases the care quality concerns do not occur because of malicious intent or through repeated episodes, but are usually one off occurrences, which happen because of human factors, such as lack of policy or adherence towards policy, lack of leadership, training, or staff shortages. Tiredness, poor health can also contribute to humanistic failures.

Often care concerns are reported to the Local authority by health care organisations or care agencies for information sharing purposes, these are often reported to notify commissioners that a patient has entered health services because of a fall or that they have an existing pressure ulcer has been observed.

If there are concerns of abuse or neglect has contributed to or caused the care quality concern, then the relevant health professionals in the provider organisations can often advise around the clinical presentation of a patient. For example patients who bruise easy to the touch, may be elderly, frail and on warfarin. Often bruises will occur with no known origin. Bruises in unusual places or sustain in usual places of an non-mobile patient may require further investigation

1.8.2 Non-Access to Health Appointments and Repeat Did Not Attends (adults)

Many Health Care organisations operate a Did Not Attend (DNA) Policy and once a patient breaches this they may be denied access to future appointments.

Careful consideration needs to be given towards those adults who have chronic ill health, a physical disability or lack capacity to make decisions about their health care due to impairment of the mind or brain and who do not attend appointments because of the following reasons (This is not an exhaustive list):

- They are unable to read appointment letters.
- They do not understand the need to attend the appointment and the consequences and risk posed to them if they do not have their health needs addressed.
- They have found it difficult to access premises and equipment due to their disability and have therefore been excluded from screening programmes, etc.

- They are being controlled and put under duress from a carer, family member or paid worker who denies the adult the right to access healthcare because of their own personal beliefs.
- They are removed from screening programmes or removed from re-call registers because of their disability / non-compliance due to cognitive issues.

Professionals need to be mindful of patients who may fit into the above categories and reassess the needs of patients who may not be receiving health care access because of these reasons. A multi-agency approach may be required to gather relevant information and assist in planning to ensure they access future appointments.

1.8.3 Radicalisation to Terrorism

PREVENT

The Prevent duty is the duty in the Counter-Terrorism and Security Act 2015, which is part of the Governments Counter Terrorism Strategy (CONTEST), revised in June 2011. This is a new statutory duty on public bodies to prevent radicalisation in the healthcare sector and for the NHS to support initiatives to reduce the risk of terrorism. Prevent is part of the safeguarding agenda within the health sector. Healthcare professionals must be trained to recognise the signs that someone is at risk of radicalisation and they have a duty to find appropriate support through established arrangements i.e. Channel – a multi-agency programme which provides tailored support to people who have been identified as being at risk of being drawn into terrorism. Prevent operates in the pre criminal space before any criminal activity has taken place.

Radicalisation refers to the process by which people come to support, and in some cases to participate in terrorism.

- Violent Extremism as defined by the Crown Prosecution Service (CPS) as the demonstration of unacceptable behaviour by using any means or medium to express views which:

    - foment, justify or glorify terrorist violence in furtherance of particular beliefs;
    - seek to provoke others to terrorist acts;
    - foment other serious criminal activity or seek to provoke others to serious criminal acts;
    - foster hatred which might lead to inter-community violence in the UK.

See appendix 3 for the prevent flowchart.

1.8.4 Mental Capacity Act (MCA)

The Mental Capacity Act (MCA) (2005) sets out who can, and how to, make decisions relating to care and treatment for those who lack capacity to make such decisions. The MCA covers decisions relating to finance, social care, medical care and treatments, research and everyday living decisions, as well as planning for the future. Within the MCA, the term capacity relates to the person's ability to consent to or refuse care or treatment. The Act provides a two stage test for assessing a person's capacity and this must be used for each individual decision to be made.

The MCA applies to all over the age of 16 years, with a presumption that all young people (16 and 17 years of age) and adults have the ability to give valid consent to accept or refuse treatment. For further guidance please see the GM primary Care MCA Policy NICE (2018) has produced further guidance around Decision-making and mental capacity for health professionals and includes recommendations on:

- supporting decision-making
- advance care planning
- assessing mental capacity to make specific decisions at a particular time
- best interests decision-making

For more information can be found at: https://www.nice.org.uk/guidance/ng108

1.8.5 Supervision

An accountable process which supports assures and develops the knowledge, skills and values of an individual or team.

1.9 Role of GP Safeguarding Lead

This person should be a General Practitioner working within the practice as a permanent employee or a partner. This cannot be the practice manager as they have a separate disciplinary role and it cannot be a non-employed member of the team e.g. a health visitor or district nurse. The roles and responsibilities do not equate to a full time role but where a person is identified to take on this role, these duties should be included in the job description.

The Practice Safeguarding Lead is/are:

Dr K Maguire/ Dr C Gormley- Children & Young People Safeguarding

Dr A Lancashire-Adult Safeguarding

The GP Practice Lead(s) for Safeguarding Children, Young People and Adults will:

- Act as a focus for external contacts on adult and child safeguarding/protection matters;
- Ensure that Practice safeguarding policy and procedures are developed, implemented and regularly monitored and updated
- Support reporting and complaints procedures including safe 'whistle-blowing'
- Ensure that the Practice meets statutory safeguarding responsibilities.
- Ensure safe recruitment procedures are in place, including taking up references and Disclosure and Barring checks where indicated.
- Disseminate adult and child safeguarding/protection information to all practice members;
- Act as a point of contact for practice members to bring any concerns that they have and record it;
- Ensure that practice staff receive adequate support and supervision when dealing with children or adults at risk in need of support or protection;
- Assess information received on safeguarding concerns promptly and carefully, clarifying or obtaining more information about the matter as appropriate;
- Ensure that the practice meets the contractual and clinical governance guidance on safeguarding children, young people and adults at risk including Care Quality Commission quality standards for safeguarding.
- Know and establish links with local child and adult protection agencies
- Know and establish links, and when appropriate take advice from named and designated professionals in child and adult safeguarding;
- Have regular meetings with others in the Primary Healthcare Team and personnel from other agencies such as Health Visitors, School Nurses, Midwives, District Nurses and Social Workers to discuss particular concerns about vulnerable children and families and adults at risk,

- Take a lead role in determining training needs and facilitating meeting these needs of staff , reviewing policy and operating procedures, conducting audit / review of safeguarding in the Practice. (For information on training contact the Safeguarding Team see **appendix 1** for contact details).
- Ensure that the practice team records safeguarding incidents appropriately.

1.9.1 Safeguarding Supervision

Safeguarding Supervision is vital to support the protection from harm to children, families and adults at risk. This is achieved through:

- Ensuring services are delivered competently and effectively to children and families
- Effective, evidence based programmes of care (that are responsive to the individual needs of children and families)
- Improved decision making in Child in Need/Safeguarding/Child Protection work
- Clarity for worker on role and responsibilities
- Ensuring that health and well-being at work issues are addressed
- Effective interagency work based on establishing clear channels of communication and the development of collaborative working within own agency and between other agencies
- Ensuring staff are managed, supported and developed
- Enhanced professional development.
- Learning from practice

The purpose of safeguarding supervision is to enable staff to have the appropriate knowledge, skills and competencies to intervene or act where there are concerns of a safeguarding nature. GMC Guidance for Protecting Children and young people stipulates that if you work with children and young people, you should reflect regularly on your own performance through audit, case discussion, peer review and supervision.https://www.gmc-uk.org/guidance/ethical_guidance/13456.asp

1.9.2 Access to Safeguarding Supervision

Within **Dr Marshall & Partners** ad hoc safeguarding supervision is available for all staff members on a daily basis via the practice safeguarding lead. All supervision discussions and any actions taken as a result should be recorded in the relevant patients' records. In addition staff can seek consultation via Stockport CCG Safeguarding Team. In addition group safeguarding supervision within the remit of practice meetings or multi-disciplinary meetings should also be documented within the relevant patient records.

Section 2

2.1 Disclosure of Information

General Practitioners and their teams are uniquely placed to recognise and act upon concerns for the well-being of children, young people or adults at risk. There are many ways that concerns may come to light, these include:

- a child, young person or adult at risk may tell a member of staff they are being harmed;
- practice staff might be concerned about something a child, young person or adult at risk has said;
- there may be behavioural or physical signs or indicators that suggest a child, young person or adult at risk is being abused,

- problems experienced by a carer, including treatment such as taking medication, may impact on their ability to parent/care ; or the behaviour of the parent /carer may pose a risk to the welfare of the child, young person or adults at risk.

Close observation and careful history taking is important with infants, young children and adults at risk. Midwives, Health Visitors and District Nurses may be an important source of information.

2.2 Management of Disclosure of an Allegation of Abuse

It is vital that all doctors have the confidence to act if they believe that a child, young person or adult at risk may be being abused or neglected. Taking action will be justified, even if it turns out that the child, young person or adult at risk is not at risk of, or suffering, abuse or neglect, as long as the concerns are honestly held and reasonable, and the doctor takes action through appropriate channels. (*GMC: Protecting Children and Young people: The Responsibilities of all Doctors, 2012*)

If a child, young person or adult at risk makes allegations about abuse, whether concerning themselves or a third party, our employees must immediately pass this information on to the lead for child protection/adult safeguarding and follow the child protection/adult safeguarding procedures.

It is important to also remember that it can be more difficult for some children, young people or adults at risk to tell than for others. For example, children, young people or adults at risk who have experienced prejudice and discrimination through racism may well believe that people from other ethnic groups or backgrounds do not really care about them. They may have little reason to trust those they see as authority figures and may wonder whether you will be any different.

A child, young person or adult at risk with a disability, especially a sensory deficit or communication disorder, will have to overcome additional barriers before disclosing abuse. They may well rely on the abuser for their daily care and have no knowledge of alternative sources. They may have come to believe they are of little worth and simply comply with the instructions of adults.

2.3 Responding to a Child, Young Person or Adult At Risk Making an Allegation of Abuse

- Stay calm
- Listen carefully to what is being said
- Reassure the child, young person or adult that they have done the right thing by telling you
- Find an appropriate early opportunity to explain that it is likely the information will need to be shared with others – do not promise to keep secrets
- Do not speak to any alleged perpetrator
- Allow the child, young person or adult at risk to continue at his/her own pace
- Ask questions for clarification only and at all times avoid asking questions that are leading or suggest a particular answer (**T**ell me/ **E**xplain to me/ Can you give me more **D**etail, **TED**)
- Ask the adult at risk what would they like to happen
- Tell them what you will do next and with whom the information will be shared
- Record in writing what has been said using the child, young person or adult at risk's own words as much as possible – note date, time, any names mentioned, to whom the information was given and ensure that paper records are signed and dated and electronic subject to audit trails
- Do not delay in discussing your concerns and if necessary passing this information on.

2.4 Disclosures of Historical Abuse

Allegations of historical child abuse by an adult should be responded to robustly because:

- There is a significant likelihood that a person who abused a child(ren) in the past will have continued and may still be doing so;
- Criminal prosecution remains a possibility if sufficient evidence can be carefully collated

Further information can be found here [link]

2.5 What to Do if Members of the Public Raise Concerns

Members of the public may talk to GPs and their practice staff about the abuse of children, young person or adults at risk known to them. They may specifically allege incidents or knowledge of abuse to a child, young person or adult at risk or may refer to it when discussing other issues. The child, young person or adult at risk may be well known to them. The type and nature of the abuse may be quite specific or it may be described only in very general terms.

It is important that all such allegations or references to abuse are taken seriously and relevant details should be referred to Children's Services/Adult Social for further enquires to be made.

In such circumstances, you should be clear with that person that you **have a duty to report any alleged abuse**, and encourage the person to make a direct referral to the social services themselves: remember, safeguarding is everyone's responsibility.

It is essential that clear notes of any such allegation are kept within the child, young person, adult at risk, parents or carers record if one is available and if possible, clarify details. These may be required at a later date.

If possible take the name and contact details of the person alleging the abuse – it may be necessary for Children's Services/Adult Social Care or the Police to talk to them further.

It is important to note that the identity of the worker referring the concerns will be given to the family except in exceptional circumstances. Members of the public can remain anonymous if they wish.

2.6 Referral Process

2.6.1 WHAT TO DO IF YOU HAVE CONCERNS ABOUT THE WELFARE OF A PATIENT (ADULT, CHILD OR YOUNG PERSON)

Unless it is immediately clear that a child, young person or adult at risk is, or is likely to be, at risk of significant harm, concerns should be discussed with the appropriate health or social care professional, Health Visitor, Midwife, School Nurse or District Nurse who may have additional information about the child, young person or adult at risk or their family. They may be able to provide additional information signpost to support completion of either an early help referral or to MASH or additional services to support the individual and family.

Where you have concerns that a child (including an unborn baby) young person or adult at risk is or may be at risk of suffering significant harm then a referral must be made to the Local Authority Children's Services/Adult Social Care Team in which area the child/ adult at risk resides.

Advice and support for cases regarding children or adults can be sought from the NHS Stockport CCG Safeguarding Team on **0161 426 9905**.

Advice may also be sought directly from Children's Services **0161 217 6028** /Adult Social Care **0161 217 6029**. Between 17.00 and 09.00 the **Emergency Duty Team** can be contacted on **0161 718 2118** for both adults at risk and children.

2.6.2 What to do if immediate action is required

Immediate action may be necessary at any stage in involvement with a child or young person or adult at risk and their parents or carers. In all cases it is vital to take whatever action is needed to safeguard the child, young person or adult at risk.

As a general rule, you should contact Children's Services/ Adult Social Care first unless the issue is more immediate and the child or adult is in need of immediate medical attention or support from the Police

If a child is in immediate danger the Police should be notified as they alone have the power to remove a child to a place of safety without recourse to the courts. Contact should also be made with Children's Services via MASSH using the online child protection referral form which can be found at: https://www.stockport.gov.uk/contacting-the-massh

2.6.3 If a child, young person or adult at risk is in need of immediate medical attention:

- advise the parents/carers of your concern and proposed action wherever possible.
- arrange for the child, young person or adult at risk to be taken to the nearest Emergency Department, notify the Consultant / Registrar on call
- inform Children's Services/ Adult Social Care of your actions and as to the location where the child, young person or adult at risk is to be taken
- Where parents/carers are unable to accompany the child or young person to hospital, parental consent is required before the child can be removed.
- If parental consent is not obtained, make immediate contact with Children's Services via the MASH, where this is not possible; contact the police by dialling 999.

All concerns reported for a child/young person by telephone from professionals should be confirmed in writing by the referrer within 48 hours.

2.6.4 MAKING A REFERRAL TO ADULT SAFEGUARDING SERVICES

'Where a practice member of staff suspects or is made aware of abuse to an adult at risk, the procedure below should be followed:

Are there immediate actions to be taken? Does the adult at risk need medical attention? Has a serious crime been committed? Contact 999 emergency services.

1. **Refer concerns to Adult Social Care.**
   Professionals should discuss concerns with the "adult at risk" and seek agreement to make a referral to Adult Services. For "adults at risk" who may experience cognitive impairment and are unable to consent to a referral to Adult Services this must be completed on behalf of the "Adult at Risk" in their best interests. Your assessment of MCA and Best Interests for the safeguarding concern must be documented in the persons notes. A concern for an "adult at risk" can be reported in verbally by telephone call adult social care on 0161 217 6028

2.6.5 Information to include when reporting a concern:

Stockport Safeguarding Adults Board SMBC Multi Agency Safeguarding Adult policy and procedures)states it is the responsibility of the alerter, either before or immediately after raising the alert to take the following steps when they first become aware of an abusive situation.

Think SPIRE
Safe
Preserve
Inform
Record
Encourage

The following procedures apply to all organisations and their personnel who are engaged in any type of provision to adults at risk regardless of whether this is on a statutory, voluntary, independent or private arrangement.

Step 1 - Safe:
Make sure the person is safe – this may mean calling emergency services if the person is in danger or requires medical treatment.

Step 2 - Preserve:
Any evidence (if applicable) should be preserved e.g. DO NOT disturb or destroy any articles that could be used as evidence, do not wash the person unless this is associated with any first aid treatment that may be necessary. Similarly any clothing, bedding etc. should not be disturbed or washed.

Step 3 - Inform:
Your safeguarding lead or manager, if you have not already done so, or someone more senior if the allegation is against your manager. If there is evidence of a criminal act e.g. a physical assault, theft, neglect or sexual assault the manager should contact the police being careful to record and preserve evidence.

Step 4 - Record:
The adult's views and wishes, any conversations or descriptions in the person's own words, date time and sign the record. If appropriate complete a body map recording any injuries to the individual. It is important to obtain the view of the adult at risk in respect of both their understanding of the situation and the action they would like taken and their desired outcomes. You must be mindful that if the adult at risk does not consent to an alert under this policy, this may be over ridden where there are implications for other adults at risk.

Step 5 - Encourage:
Reassure the adult at risk that they have done the right thing and that you are taking their concerns seriously. Advise them that you will be informing your GP safeguarding lead immediately.

Where the alleged abuse has occurred in a care setting the first responsibility to act must lie with the employing organisation as the provider of the service. The focus should be on prompting the wellbeing of the adult at risk once the allegation or suspicion has been raised with the line manager with responsibility for the organisation, s/he must decide without delay the most appropriate course of action.

2.6.6 Information adult social care and/or police will need from you when making a safeguarding alert

- Personal details of adult at risk (name, address, date of birth, NHS number, ethnicity, current whereabouts, language spoken).
- Who you are and why you are involved.
- What happened, when and where?
- Details of alleged abuser(s) (name, address, date of birth) and relationship to adult(s) at risk.
- Are there any other people at risk including any children?
- Details of any other agencies involved.
- Is the adult at risk aware of the referral and have they consented?

2.6.7 Action to be taken following a referral

The adult contact centre should ask if you would like to be contacted for the outcome of you referral. If you are not informed of the outcome within five working days, the referrer should contact the contact centre. Record all concerns, discussions about the adult and all decisions made, as well as the reasons for those decisions in the adult's record. Records should be accurate, legible, timed, dated and signed.

2.6.8 The Six Stages of the Multi Agency Investigation Process

1. Alert Process (initial through to formal alert)
2. Referral (decision to progress under the SMBC Multi Agency Safeguarding Adult policy and procedures)
3. Strategy discussion or meeting
4. Investigation (Section 42 Enquiry under the Care Act 2014)
5. Case Conference and Protection Plan
6. Review & Case Closure

2.6.9 Making Safeguarding Personal

The Care Act (2014) clearly defines safeguarding adults and their right to live in safety, free from abuse and neglect. Making Safeguarding Personal (MSP) aims to make safeguarding person-centred and outcomes focussed, and moves away from process driven approaches to safeguarding.

MSP is a shift in culture and practice in response to what we now know about what makes safeguarding more or less effective from the perspective of the person being safeguarded. It is about having conversations with people about how we might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them. MSP aims to shift from a process supported by conversations to a series of conversations supported by a process.

When considering an adult safeguarding referral, key focus should be on the following:

- What does the person wish to achieve?
- What would be their desired outcome?
- If the person lacks capacity – discuss and agree with an appropriate advocate/ representative.

It is acknowledged that adults may have unrealistic or contradictory outcomes that cannot be achieved and have preferred outcomes which change over time and Local Authority processes are being designed to capture this information.

2.6.10 What to do if the person does not fit the definition of an Adult at Risk

It is recognised that not all circumstances involving adults will fall within the definition that invokes this policy and procedure (i.e. Adult at risk has known care and support needs). Some adults however, may still be at risk from harm and/or abuse from others

because of other factors such as lifestyle choices, homelessness, exploitation, drug and alcohol misuse etc. The decision to carry out a safeguarding enquiry does not depend on the person's eligibility, but should be taken wherever there is reasonable cause to think that the person is experiencing, or is at risk of, abuse or neglect and because of their care needs are not able to protect themselves from the abuse or neglect. Where this is the case, a the Local Authority must carry out (or request others to carry out) whatever enquiries it thinks are necessary in order to decide whether any further action is necessary As such we have a duty to consider anyone being abused and their desired outcomes regarding the abuse, ensuring that an appropriate outcome is achieved. This may result in a needs assessment and subsequent provision of services under section 18 or 19 of the Care Act or the provision of preventative services under section 20 or information and advice under section 4 of the Care Act, such as a referral to Multi Agency Adult At Risk System (MAARS) via the contact centre or Targeted Prevention Alliance (TPA) https://stockporttpa.co.uk/.

Who may be suitable for referral to MAARS?

- threat of homelessness
- anti-social behaviour issues
- complex needs
- victimisation (including domestic violence)
- at risk of harm to themselves and others
- substance misuse issues
- offender/ or at risk of offending
- problems with independent living
- low level mental health
- physical health problems
- learning disability
- lack of resilience to cope, or lack of problem-solving

For more information including escalation please follow the SMBC Multi Agency Safeguarding Adult policy and procedures

MAKING A REFERRAL TO CHILDEN'S SERVICES

2.6.11 Referral

Professionals should discuss any concerns with the family and seek agreement to make a referral to Children's Services. If, having taken full account of the parent's wishes it is still considered that there is a need for referral the following action must be taken:

- the reason for proceeding without parental agreement must be recorded in the child's record;
- the parents withholding of permission must form part of the verbal and written referral to children's social care;
- The parents should be contacted to inform them, that after considering their wishes, a referral has been made.

(See Section **2.5** for further guidance on information sharing).

In cases where such a discussion and agreement seeking will place a child at increased risk of significant harm a referral to Children's Services should not be delayed and should be made without parental consent.

This includes:

- Suspected sexual abuse

- Suspected fabricated or induced illness (see section FII prior to making referral)
- Increased risk to the child
- Risk to workers own personal safety
- Female genital mutilation
- Forced marriage (under 18's)

1. Complete Children's Services referral form You will be asked to complete the following information:

i) Details of person being referred
ii) Family details
iii) Family member/ carer details
iv) Contact/referrer details (ensure you include an email address)
v) Presenting issues

2. You will then receive an email from The MASSH confirming the submission of your completed referral form.

3. To save a copy of the referral you need to print/screen shot prior to submission and then add to all the records of all family members i.e. parents and all children.

4. Add Read code 8HHB – "Referral to Social Services" to all records.

Please note: A child protection referral from a professional cannot be treated as anonymous, so the parent will ultimately become aware of the identity of the referrer.

2.6.12 Action to be taken following a referral

Children's Services should acknowledge referrals within one working day of receipt of the written referral. If this does not occur within three working days, the referrer should contact the MASSH. Record all concerns, discussions about the child and all decisions made, as well as the reasons for those decisions in the child's record. Records should be accurate, legible, timed, dated and signed (electronically where appropriate).

2.6.13 Enquiry Process

Practice staff (particularly health professionals) may be asked to contribute information to Social Care's enquiry and will be expected to provide a written report in order to support this process. It is possible that attendance at a case conference or court proceedings may be required in order to share the information. In these situations it may be advisable for a member of staff to be accompanied by a manager and seek support from the NHS Stockport CCG Safeguarding Team.

2.7 Early Help

'Early Help is intervening early and as soon as possible to tackle problems emerging for children, young people and their families or with a population most at risk of developing problems. Effective intervention may occur at any point in a child or young person's life.'

2.8 Escalation Process

If you are unhappy regarding the outcome of your referral or decisions made by other agencies please follow Stockport Safeguarding Children Board has published a procedure the 'SSCB Escalation Policy' which addresses how a professional can do this with regards to:

- the response of agencies to child concern referrals or,
- the completion of tasks identified in Child Protection Plans.

The Greater Manchester Guidance can be found here [Link].

Support with escalation of a case can be obtained from NHS Stockport Safeguarding Children Team.

2.9 Information Sharing

The practice will follow this policy on sharing information in child protection/adult safeguarding cases which is as follows:

- Everyone responsible for using data must follow the GDPR Principles.
- In England and Wales, the Children's Acts of 1989 and 2004 give GPs a statutory duty to co-operate with other agencies (*Children Act* 1989 section 27, 2004 section 11) if there are concerns about a child's safety or welfare. Health authorities (PCOs) (section 47.9) have a duty to assist local authorities (Social/Childcare Services) with enquiries.
- The Children, Schools and Families Act 2010 section 8 amends The Children Act 2004 providing further statutory requirements for information sharing when the LSCB requires such information to allow it to carry out its functions.
- Articles 2 and 3 of the Human Rights Act 1998 place an obligation on public authorities to protect people's rights to life and their freedom from torture, inhumane and degrading treatment. Meeting these obligations may necessitate lawful information sharing.

The new revised guidance – Confidentiality: good practice in handling patient information came into effect 25th April 2017 [link].

This means that the default position is that the practice will share relevant and proportionate information with Social Care and not doing so maybe legally indefensible.

2.9.1 General Principles

2.9.2 Children

Working Together to Safeguard Children 2015 outlines effective sharing of information between professionals and local agencies is essential for effective identification, assessment and service provision.

Early sharing of information is the key to providing effective early help where there are emerging problems. At the other end of the continuum, sharing information can be essential to put in place effective child protection services. Serious Case Reviews (SCRs) have shown how poor information sharing has contributed to the deaths or serious injuries of children.

Fears about sharing information cannot be allowed to stand in the way of the need to promote the welfare and protect the safety of children. To ensure effective safeguarding arrangements:

- all organisations should have arrangements in place which set out clearly the processes and the principles for sharing information between each other, with other professionals and with the LSCB; **and**

- no professional should assume that someone else will pass on information which they think may be critical to keeping a child safe. If a professional has concerns about a child's welfare and believes they are suffering or likely to suffer harm, then they should share the information with local authority children's social care.

Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers (2015) (link) supports frontline practitioners, working in child or adult services, who have to make decisions about sharing personal information on a case by case basis. The advice includes the seven golden rules for sharing information effectively and can be used to supplement local guidance and encourage good practice in information sharing.

2.9.3 Adults

You can share information relating to abuse, without consent from the person:

- If the person lacks capacity to make the decision (Mental Capacity Act 2005)
- For the prevention and detection of crime (Crime and Disorder Act 1998)
- To prevent serious harm/distress or threat to life (Data Protection Act 1998)
- If there is risk to others / children
- If the person is under duress, coercion or undue influence (Care Act 2014)
- If staff are implicated
- Domestic Abuse which meets the MARAC threshold
- If there is a court order/other legal authority in place instructing you to do so
- Where the alleged abuser has care and support needs and may be at risk.

2.9.4 General Medical Council (GMC) Guidance

The General Medical Council (GMC) offers guidance on Confidentiality and Information Sharing which is regularly reviewed. This can be accessed via the link – [link]. The GMC advises that the first duty of doctors is to make the care of their patients their first concern:

- when treating children and young people, doctors must also consider parents and others close to them, but the patient must be the doctor's first concern
- when treating adults who care for, or pose risks to, children and young people, the adult patient must be the doctor's first concern, but doctors must also consider and act in the best interests of children and young people (GMC 2012).

For further information see GM Safeguarding Partnership Procedures [link].

Information Sharing Flowchart can be found in Appendix 5.

2.10 Child Protection Case Conferences

The contribution of GPs to safeguarding children is invaluable and priority should be given to attendance at initial case conferences and sending a report. Consider liaising with your local health visitor and school nurses about your attendance. Even if attendance is not possible or judged necessary, the provision of the report, even to say that the child has not been seen, is essential. (GMC Protecting Children and Young People 2012).

The contribution of GPs to safeguarding children is invaluable and priority should be given to attendance wherever possible.

GPs invited to a Child Protection Conference should provide details of their involvement with the child and family, and their assessment of the capacity of the parents to meet the needs of their child within their family and environmental context. This information must be submitted in a written, legible and signed report.

Best practice would suggest that the report is shared with the family prior to conference.

Case Conference Outline Plans & Minutes Storage

Case conference minutes frequently raise concerns - much of it about third parties. See also the Good Practice Guidance to GP electronic records: (Link).

When a GP attends a case conference it is imperative the minutes are checked to ensure accurate documentation of the discussion

Conference minutes should **not** be stored separately from the medical records because:

- they are unlikely to be accessed unless part of the record
- they are unlikely to be sent on to the new GP should the child register elsewhere
- they may possibly become mislaid and lead to a potentially serious breach in patient confidentiality.

Minutes of case conferences and outline plans should be stored and Read coded onto all childrens' records, whilst adult family members records should include appropriate read codes to identify that a conference has taken place along with the outcome.

Whilst GPs may have concerns about third party information contained in case conference minutes, part of the solution is to remove this information if copies of medical records are released for any reason, rather than not permitting its entry into the medical record in the first place. Case conference minutes are the property of Children's Social Care so cannot be released without the consent of the author.

These procedures are regarded as best practice.

2.11 Recording information

- Concerns and information about vulnerable children and adults at risk should be recorded in the clinical notes and where appropriate the notes of siblings and significant adults. These should be recorded using agreed Read codes for Stockport (Please refer to the documentation flowcharts pack & use the EmisWeb safeguarding templates to facilitate this).
- Concerns and information from other agencies such as social care, education or the police or from other members of the Primary Care Team, including Health Visitors, District Nurses and Midwives, should be recorded in the notes.
- Conversations with and referrals to outside agencies should be recorded under an appropriate Read code within the patient record
- Case Conference notes may be scanned in to electronic patient records. This will usually involve the summary/actions, appropriately annotated by the child's usual doctor or Practice Safeguarding Lead
- Records, storage and disposal must follow national guidance for example, *Records Management, NHS Code of Practice* 2009.

2.12 GP involvement in Statutory Reviews (Serious Case Reviews (SCR's), Safeguarding Adult Reviews (SAR's) or Domestic Homicide Review (DHR))

Once it is known that a case is being considered for review, each organisation should secure its records relating to the case to guard against loss or interference.

Once it is decided that an SCR, SAR or DHR will be undertaken, individual organisations, having secured their case records promptly, should begin quickly to draw up a chronology of their involvement with the adult at risk and family. This will be requested in the form of an Agency contact form. The CCG safeguarding team will contact the practice to access the records of a individual Management Review (IMR) is required for a SSAB commissioned **Statutory Review**.

The Designated Nurses /Named GP will support practices through this process.

2.12.1 Child Death Reviews

Each death of a child is a tragedy and enquiries should keep an appropriate balance between forensic and medical requirements and supporting the family at a difficult time. Professionals supporting parents and family members should assure them that the objective of the child death review process is not to apportion blame, but to learn lessons. The purpose of the child death review is to help prevent further such child deaths

Following a child death GP practices will be requested to complete a Form B via the CDOP (child death overview panel notification)

Following Sudden Deaths the SUDC Paediatrician will initiate an immediate information sharing and planning discussion between the lead agencies (i.e. health, police and local authority children's social care) to decide what should happen next and who will do it.

Further information can be found in Chapter 5 of Working Together to Safeguard Children [link]

2.13 Use of interpreters

Why are interpreting services so important?

2.13.1 Children Act 1989 states 'the welfare of the child is paramount'

The high profile Serious Case Review (SCR) undertaken by Coventry LSCB in relation to the tragic death of Daniel Pelka in September 2013 found that there were significant safeguarding lessons to be learned in relation to agencies failing to use interpreting services and subsequently missing opportunities to identify and explore safeguarding and wellbeing concerns and take steps to protect and safeguard.

The Serious Case Review recommended that agencies should consistently utilise interpreter services with families who do not have English as a first language and that interpreters must be used to interview children alone or to enable them to understand their wishes and feelings, when they are the subject of safeguarding concerns.

Working Together to Safeguard Children states that family members or friends should not be used as interpreters, since the majority of domestic and child abuse is perpetrated by family members or adults known to the child.

The Care Act statutory guidance, 2014 outlines local authority's requirements to ensure that information is in an accessible format for those to whom it is provided. This will include the requirement for appropriate independent advocacy for those with substantial difficulties in engaging with assessment processes.

From 31 July 2016, all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard [link].

Section 3

3.1 Bruising in Immobile Babies and Children

A non-mobile infant is defined as a child who is not yet crawling, bottom shuffling, pulling to stand, cruising or walking independently and includes all children under the age of six

months. Children of an older age with a disability may also not have independence of mobility.

Any bruising, or a mark that might be bruising, in a child of any age who is not independently mobile, that is brought to the attention of any professional (including GPs) should be taken as a matter for inquiry and concern.

Unexplained bruising (or bruising without an acceptable explanation) in a child not independently mobile must always raise suspicion of maltreatment and should ALWAYS result in an immediate referral to the MASSH. The child will then be referred to the on call Safeguarding Paediatrician for further child protection medical assessment as required. (Link to GM Procedure)

If there is uncertainty as to the mechanism of injury, then the medical and social history should be considered and, where this gives rise to concern, a referral to Children's Social Care should be made.

It is recognised that a small percentage of bruising in non-independently mobile children will have an innocent explanation. Occasionally spontaneous bruising may occur as a result of a medical condition. Nevertheless because of the difficulty in excluding non-accidental injury, practitioners should seek advice from a consultant paediatrician via Children's Social Care in all cases. **Child Protection concerns should not delay the referral of a seriously ill child to acute paediatric services. If a child is in need of urgent medical care they should not delay sending them to hospital and the practitioner should inform social care so they can commence Section 47 Enquiries**. (See Section 2.2 – referral processes).

It is the responsibility of Children's Social Care Services in conjunction with the local acute paediatric department to decide whether the circumstances of the case and the explanation for the injury are consistent with an innocent cause or not. Children should **NOT** be referred to GPs for a decision as to whether any 'bruising' is accidental or otherwise.

3.2 Child Sexual Exploitation

3.2.1 Definition of Sexual Exploitation

The National Working Group has developed the following definition:

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

Any child or young person may be at risk of sexual exploitation, regardless of their family background or other circumstances.

There are strong links between children involved in sexual exploitation and other behaviours such as running away from home or care, bullying, self-harm, teenage pregnancy, truancy and substance misuse. In addition, some children are particularly vulnerable, for example, children with special needs, those in residential or foster care, those leaving care, migrant children, unaccompanied asylum seeking children, forced marriage and those involved in gangs.

The fact that a young person is 16 or 17 years old should not be taken as a sign they are no longer at risk of sexual exploitation.

Sexual exploitation is a form of child sexual abuse and can result in a child suffering significant harm. Sexually exploited children will also be vulnerable to physical and emotional abuse and neglect.

As in all cases, concerns that a child may be at risk of sexual exploitation should be discussed with the practice safeguarding lead or advice sought from NHS Stockport CCG Safeguarding Team and a decision made as to whether there should be a referral to Children's Social Care.

The wishes and feelings of the child or young person should be obtained when deciding how to proceed but practitioners should be aware that perpetrators may have groomed the child's responses and that the child may be denying what is happening.

Where there is concern engagement of a child or young person may be lost by reporting their concern to Children's Social Care, this should be discussed with Children's Social Care to agree a way forward. Any decision not to share information or refer a child should be recorded with a full explanation of the rationale behind that decision and the prevailing circumstances at that time. This will assist in future if there is a review of the case and the decision-making processes.

There may be concerns about siblings suffering significant harm within the household which then meet the child protection threshold and requires a response under child protection procedures. If this is the case then please refer to Greater Manchester Safeguarding Partnership procedures (link) and follow the referral pathway outlined in section **2.2** of this policy.

Please see NHS England CSE Pocket Guide for additional information [link].

3.3 Looked After Children

Primary care teams have a vital role in identifying the individual health care needs of looked-after children. They often have prior knowledge of the child, of the birth parents and of carers, helping them to take a child-centred approach to health care decisions. They may also have continuing responsibility for the child when he or she returns home. From 1 April 2015, all patients (including children) should have a named accountable GP at the practice with which they are registered, who is responsible for the coordination of services provided under the GP contract. GP practices should:

- ensure timely access to a GP or other appropriate health professional when a looked-after child requires a consultation
- provide summaries of the health history of a child who is looked after, including information on immunisations and covering their family history where relevant and appropriate, and ensure that this information is passed promptly to health professionals undertaking health assessments
- maintain a record of the health assessment and contribute to any necessary action within the health plan
- make sure the GP-held clinical record for a looked-after child is maintained and updated and that health records are transferred quickly if the child registers with a new GP practice, such as when he or she moves into another CCG area, leaves care or is adopted.

Treating a patient as a temporary resident should be avoided, as the medical record is not available to the treating medical practitioner. If it cannot be avoided, the treating practitioner will normally wish to talk to the child's named GP to avoid treating the patient

"blind". Temporary registration is for those who intend to be in an area for more than 24 hours but less than three months, and where there is any doubt over the potential length of stay the GP practice should opt for full registration (*Statutory Guidance on Promoting the Health and Well-being of Looked After Children 2015)*

When a child or young person becomes "looked after" an initial health assessment is undertaken. Information will be requested from the GP to contribute to this assessment. Information regarding health history and recent consultations should be forwarded to the Stockport LAC Health Team via email to: snt-tr.stockportlac@nhs.net

Looked after children should be identified using the Read code 13IB1 "Looked after Child".

Unaccompanied Asylum Seeking Children

Unaccompanied asylum seeking children from Calais are arriving in the UK under an ongoing Home Office programme. Clinicians are available to see the children on arrival and are able to address any immediate needs. The children are then being placed into the care of their families under Child in Need or of local authorities across the UK as Looked After Children under section 20 of the Children's Act.

Upon arrival in Stockport the child's keyworker will support them to register at a local GP practice. Practices should be mindful they are unlikely to have appropriate identification or an accompanying family member however should be registered at the Practice due to their vulnerability.

A full assessment of the child's health needs should be undertaken upon registration.

3.4 Safeguarding Children in Whom Illness Is Fabricated Or Induced (FII)

Where a GP has concerns regarding possible FII they must discuss their concerns with the Designated Doctor for Safeguarding Children (see Appendix 1 for contact details) or where relevant, with the consultant providing care for the child. Where concerns are substantiated or still persist, then the child must be referred to Children's Social Care as outlined in section 2.2.

Under no circumstances must the referral be discussed with the parent/carer until a multi-agency action plan has been agreed.

Detailed guidance on FII can be accessed at (Link).

A record of all discussions must be made, regardless of what action is taken, and should include an explanation as to the reasons for the decision, who is responsible for carrying out any actions agreed during the discussion and who was spoken to.

Where the child is not under the care of a paediatrician, the child's GP should make a referral to a paediatrician, preferably one with expertise in the specialism which seems most appropriate to the reported signs and symptoms.

3.5 Domestic Violence and Abuse

3.5.1 Definition

Domestic abuse is defined by the Home Office (2013) as:

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

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

*Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."**

**This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group."*

Domestic violence and abuse is a complex issue and can occur within any relationship i.e. same sex, heterosexual and familial. Domestic violence and abuse is perpetrated by men and women, and within any community.

The Serious Crime Act 2015 created a new offence of controlling or coercive behaviour in intimate or familial relationships. Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time in order for one individual to exert power, control or coercion over another (See link).

3.5.2 Young People

Young people in the 16-24 age group are most at risk of being victims of domestic abuse. Whilst they are under the age of 18 years these young people (in some cases teenage mothers) should receive support and safeguarding in line with the Children Acts 1989 & 2004.

3.5.3 Research by Against Violence and Abuse (AVA) and Families, Drugs and Alcohol (ADFam) with parents who had experienced Adolescent to Parent Violence and Abuse (APVA) clearly showed that GPs were a common first port-of-call for parents looking for help, and a Parent line Plus survey (2010) found that 57% of parents sought help from their GP. However, the research also identified four factors which can inhibit disclosure: shame, guilt, fear and the lack of a sufficiently trusting relationship with the service. (Link).

3.5.4 Adults at risk

There have been instances whereby an Adult at Risk of abuse and/or neglect can become the perpetrators of domestic abuse and this can often be hidden or go unrecognised by family members/ professionals. Even where the abuse appears to be linked to a person's condition or state - dementia or mental illness – it does not mean that the abuse should be tolerated by the victim or ignored/colluded with by professionals. It is crucial to identify and manage the risks posed to the victim and to any others exposed to the abuse.

If the victim is the perpetrator's primary carer, options to consider may include reassurance that the perpetrator's care needs can be met in an alternative way and that any transitions can be well-managed. The perpetrator may need information about care and support services and may also require a safeguarding response in line with multi-agency procedures.

3.5.5 Role of the GP

According to HM Ending Violence Against Women and Girls Strategy 2016-2020 (Link) women who have experienced abuse use health care services more than women who have not experienced abuse. They identify health care workers as the professionals they would be most likely to speak to about their experience. GPs, amongst other health service staff are all well placed to identify abuse. They have the opportunity to intervene early and direct victims to the most appropriate statutory and non-statutory services.

If GP/health care professionals in the practice receive a disclosure of domestic abuse, a Domestic Abuse, Stalking and Harassment DASH) risk assessment can be completed to identify the level of risk a victim is faced with. Up to date forms can be found at the following link and incudes forms with or without guidance and in different languages http://www.safelives.org.uk/practice-support/resources-identifying-risk-victims.

If a victim is identified as high risk, either on the DASH checklist or by professional judgment then a referral should be made to MARAC and safeguarding agencies.

This referral can be done without express consent, but if the risk if not assessed as high then consent to refer for support is required.

It must be ensured the victim is safe to return home prior to them leaving the practice.

The link below give advice on support available for victims- they should be made aware there is help and support is available to them. See Appendix 6 for a list of local and national DVA support contacts.

The impact of domestic abuse on children should be considered in assessment and child safeguarding procedures must be followed.

See also NICE Guidance – Domestic Violence and Abuse (Link).

3.5.6 Multi Agency Risk Assessment Conference (MARAC)

MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local agencies.

After sharing all relevant information they have about a victim and the family, the representatives discuss options for increasing the safety of the victim and turn these into a co-ordinated action plan. The primary focus of the MARAC is to safeguard the adult victim. The MARAC will also make links with other forums to safeguard children and manage the behaviour of the perpetrator.

3.5.7 Risk Assessment and Referral

All cases referred to MARAC must be risk assessed using the **DASH** (Domestic Abuse, Stalking and Harassment) risk assessment. The DASH risk assessment is a 24 point assessment used to establish the level of risk from the victims perspective.
http://safelives.org.uk/practice support/resources-identifying-risk-victims

The current criteria for referral to MARAC are:

- Potential escalation - recent incidents (3 police callouts in 12 months or abuse appears to be escalating)
- Visible high risk -14 ticks on the DASH risk assessment
- Professional judgment

All GP MARAC referrals must be sent in via email to the CCG safeguarding team on: STOCCG.Safeguarding@nhs.net .

Patients discussed at MARAC and any children in the household should have their records flagged with the Read codes 14XD “History of domestic abuse” AND 13Hm “Subject to Multi-Agency Risk Assessment Conference”.

3.5.8 Recording in domestic abuse

Records play an important role in responding to domestic abuse.

Records can be used in:

- Criminal proceedings if a perpetrator faces charges;
- Obtaining an injunction or court order against a perpetrator;
- Immigration and deportation cases;
- Housing provision; and
- Civil procedures in family courts to assess the risks associated with granting an abusive parent contact with children

Always keep a detailed record of what you have discussed – even if your suspicions of domestic abuse haven’t led to disclosure. They might in the future. Keep records as detailed as possible and use client’s own words (with quotation marks) rather than your own. Make clear to a victim that you have a duty to keep a record of disclosure and injuries as a duty of care. Document injuries in as much detail as possible, detailing if an injury and the victim’s explanation for it are consistent. If possible, use drawings or body maps to show injuries. Domestic abuse should never be recorded in hand held records such as maternity notes. Where computerised records are used, ensure that nothing about domestic abuse is visible on the opening screen (which could be seen by a perpetrator or a member of staff who doesn’t need to see the information). Adding a major alert on EMIS saying “HARK+” can alert practitioners opening the record to a history of domestic abuse.

Safe Lives have produced some additional guidance for GPs (Link).

3.5.9 Responding to Domestic Abuse

- Those experiencing abuse may find it difficult to raise the subject of domestic abuse themselves or may not recognise that they are experiencing domestic abuse. Health professionals should therefore be prepared to take a pro-active approach. It is important that those subjected to abuse are given regular opportunities to disclose their violence and abuse and lack of disclosure on previous occasions should not preclude raising the issue again, since research shows that repeated questioning increases the likelihood that an individual will tell the practitioner about the violence and abuse.
- Health professionals should know how to “ask the question” and be able to understand the dangers faced.

3.5.10 Asking the question - Ensure it is safe to ask

If unable to speak to the patient/client alone the practitioner should make additional attempts to assess privately. This may be to interview the patient/client in another private area:

- Consider the environment.
- Ensure privacy – make sure you cannot be overheard.
- Is it conducive to ask?
- Is it safe to ask?

- Document actions on patient records and add appropriate read code(s)

Never ask in the presence of another family member, friend, or child who can verbalise:

- Create the opportunity to ask the question.
- Use an appropriate professional interpreter. Never use friends of the family as an interpreter as they may report back to the abuser what has been discussed. Be mindful of the fact that interpreters may be part of the adult's local community. This is particularly relevant if there are concerns that a patient may be experiencing so-called "honour"-based violence. Using an interpreter from the patient's community may put them at significant risk.

3.5.11 Ask

Frame the topic first then ask a direct question.

Examples:

- Framing: *"As violence in the home is so common we now ask contacts about it routinely"*
- Direct Question: *"Are you in a relationship with someone who hurts or threatens you?"*
- *Did someone cause these injuries to you?"*

3.5.12 Validate

Validate what's happening to the individual and send important messages to the contact:

"You are not alone"
"You are not to blame for what is happening to you"
"You do not deserve to be treated in this way."

3.5.13 Assess (Use DASH Risk Identification Checklist)

Assess contacts safety:

- "Is your partner here with you?"
- "Where are the children/any adults at risk?"
- "Do you have any immediate concerns?"
  "Do you have a place of safety?"

3.5.14 Action

- Be aware of your local domestic abuse agency, how to contact local independent domestic violence advisor (IDVA), offer support numbers and suggest referral - see appendix 6.
- Action any local safeguarding procedures for children and adults at risk Remember the One Chance Rule. That is that practitioners may only have once chance to speak to a potential victim and thus may only have one chance to save a life.

3.5.15 Document

- Consider safety and confidentiality when recording information in patient notes. If any information is recorded that you would not want disclosing inadvertently, add a Read code that flags the entry to be redacted before releasing the records. We suggest using 9LL "Record contains third party information". You must also toggle this consultation to not be visible on the online records viewer.
- Be aware of appropriate read-codes to use on EMIS Web.
- Medical records can be used by survivors in future criminal justice proceedings and may be called on to be used in MARAC.

- Document actions on patient records and added appropriate read code.

3.5.16 Following a Disclosure of Domestic Abuse

It must be remembered that the time that a person discloses abuse is extremely important as research had identified that a victim is likely to have suffered abuse as many as 35 times before they seek help and that on average a woman has to approach 11 agencies before she receives the help she needs. This figure rises to 17 times in the cases of black and ethnic minority women.

Victims of domestic abuse are most at risk of increased, life threatening or fatal abuse when they start to disclose abuse or try to leave an abusive relationship. It is of paramount importance those disclosing abuse are safe and that the delicacy of the situation is understood.

Staff should be aware of their own limitations and competence. Practitioners should be fully aware of their own safety, both in working in situations where clients are known to be violent, but also regarding the emotional impact of the issue.

It is not a health workers role to encourage the victim to leave their partner or to take any other particular course of action. This could lead to problems including increased danger for them and their children.

When a disclosure has been made, the role of the health worker in responding to domestic abuse should be:

3.5.17 Receive

Adopt a believing approach; acknowledge the courage needed to make a disclosure.

3.5.18 Respect

Explain the boundaries and responsibilities of confidentiality, informing the person what needs to happen next, reassure that disclosure is a positive step, enabling support to be offered.

3.5.19 React

Prioritise safety and plan to reduce risk with an assessment focussing on the victim's safety and that of any dependent children or adults at risk:

3.5.20 Offer and complete and Domestic Abuse Risk Assessment Form

Encourage them to report the abuse to the police. Offer the domestic abuse support numbers.

3.5.21 Respond

Consider referral to Safeguarding Adults, Safeguarding Children, Social Care, GM Police, MARAC and ongoing support.

3.5.22 Record

Fully document the contact, clearly documenting any visible injuries, any referrals, decisions and plans made. Never record in client held records.

All support offered should be fully documented. If the person declines any of the support offered including the DASH RIC, police or support numbers please ensure this is fully documented

3.5.23 Domestic Violence Disclosure Scheme

DVDS (also known as 'Clare's Law') commenced in England and Wales on 8 March 2014. The DVDS gives members of the public a formal mechanism to make enquires

about an individual who they are in a relationship with, or who is in a relationship with someone they know, where there is a concern that the individual may be violent towards their partner. (See Link)

3.5.24 Domestic Violence Protection Order

Domestic Violence Protection Orders (DVPOs) were implemented across England and Wales from 8 March 2014. A DVPO allows a perpetrator to be banned with immediate effect from returning to a residence and from having contact with the victim for up to 28 days, allowing the victim time to consider their options and get the support they need.

3.6 Forced Marriage & Honour Based Violence

3.6.1 Definitions

Forced marriage is primarily, but not exclusively, an issue of violence against females. Most cases involve young women and girls aged between 13 and 30, although there is evidence to suggest that as many as 15 per cent of victims are male. One or both spouses do not consent to marriage and some element of duress including physical and emotional pressure and abuse is involved

Forced marriage is a human rights issue. It can constitute both child abuse and sexual abuse. The United Nations considers it a form of trafficking, sexual slavery, and exploitation. Some, however, still see it as a private, personal, domestic, family, religious, or cultural issue.

A clear distinction must be made between a **forced** marriage and an **arranged** marriage.

3.6.2 The Forced Marriage Unit

The Forced Marriage Unit (FMU) is the Government's central unit dealing with forced marriage casework, policy and projects. The FMU provides confidential information and assistance to potential victims and concerned professionals. It works with partners both in the UK and overseas to ensure that all appropriate action is taken to prevent a forced marriage taking place.

The FMU also provides advice and information to individuals who have already been forced to marry. All caseworkers in the FMU have wide experience of the cultural, social and emotional issues surrounding forced marriage. (Link)

3.6.3 Legal Position

The Forced Marriage (Civil Protection) Act 2007 was implemented on 25 November 2008, enabling a court to make a Forced Marriage Protection Order to protect someone who is facing being forced into a marriage or who is in a forced marriage.

3.6.4 Intervention

All attempts to intervene with families involved in the practice of forced marriages must be approached in a culturally sensitive and non-punitive manner with appropriate professionals who can communicate effectively with the family concerned.

Reports of forced marriage, including reports from victims who fear they may be forced to marry, must be taken seriously. For young people under the age of 18 years, it will be appropriate to deal with the situation as a child protection issue and a referral should be made to social care

Very careful consideration must be given to who will be given what information, which must be on a 'need to know' basis only. This applies to professionals as well

as members of the family or the community. Any disclosure, which could lead to the child/young person being traced, could put her or him at considerable risk of harm from family or others.

For further information on management of allegations of forced marriage see GM Safeguarding Procedures (Link).
Further information can be found:

- The Right to Choose - Multi Agency Statutory Guidance for Dealing with Forced Marriage (HM Government 2008); (Link).
- Multi-Agency Practice Guidelines - Handling Cases of Forced Marriage (Forced Marriage Unit 2009) (Link).
- Forced Marriage and Learning Disabilities: Multi Agency Practice Guidelines (Forced Marriage Unit 2011) (Link).
- The new revised guidance – Confidentiality: good practice in handling patient information came into effect 25th April 2017 [link].

3.7 Female Genital Mutilation (FGM)

3.7.1 Definition of FGM

The World Health Organisation (WHO) states that female genital mutilation (FGM):
"Comprises of all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons".
WHO Fact sheet No. 241 (February 2014)

FGM is also known as Female Circumcision (FC) and Female Genital Cutting (FGC) or initiation. The reason for these alternative names is that it is better received in the communities that practice it, who do not see themselves as engaging in mutilation.

FGM is included within the revised (2013) government definition of Domestic Violence and Abuse.

FGM is a deeply rooted practice, widely carried out mainly among specific ethnic populations in Africa and parts of the Middle East and Asia. It serves as a complex form of social control of women's sexual and reproductive rights. There are substantial populations of people in Greater Manchester from countries where FGM is endemic.

3.7.2 Health Impact

FGM has no health benefits, and it harms girls and women in many ways, both physically and psychologically. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls' and women's bodies.

Further information on the impact of FGM can be found in GM Safeguarding Procedures [link].

HM Female Genital Mutilation Statutory Guidance, published 1st April 2016 can be found here [link].

3.7.3 Responsibility of GP Practices

Health professionals in GP surgeries, sexual health clinics, Women's Health, A&E and maternity services are the most likely to encounter a girl or woman who has been subjected to FGM. All girls and women who have undergone FGM should be given information about the legal and health implications of practicing FGM.

Health Professionals should deal with FGM in a sensitive and professional manner, and not exhibit signs of shock when treating patients affected by FGM. They should ensure that the mental health needs of a patient are taken into account.

GPs and Practice Nurses should be vigilant to any health issues such as resistance to partake in cervical smear testing, recurrent urinary tract infections or vaginal infections that may indicate FGM has been carried out. Those that do attend for health checks or travel vaccinations from affected communities could be asked about FGM and advised about its health impacts and informed that it is illegal within the UK.

3.7.4 Referral Process

There are three circumstances relating to FGM which require identification and intervention:

- Where someone is at risk of FGM;
- Where someone has undergone FGM;
- Where a prospective mother has undergone FGM.

Professionals and volunteers in most agencies have little or no experience of dealing with female genital mutilation. Encountering FGM for the first time can cause people to feel shocked, upset, helpless and unsure of how to respond appropriately to ensure that a child, and/or a mother/any female adult, is protected from harm or further harm.
Refer to children's social care via the MASH

The Greater Manchester FGM Pathway can be found here [link]

3.7.5 Mandatory Reporting

From 31st October 2015 the Government introduced Mandatory Reporting Duty.

The duty applies to regulated health and social care professionals and teachers in England and Wales and requires these professionals to make a report to the police if, in the course of their professional duties, they:

- are informed by a girl under 18 that an act of FGM has been carried out on her; or
- observe physical signs which appear to show that an act of FGM has been carried out on a girl under 18 and have no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth.

Mandatory Reporting Guidance can be found here [link].

3.7.6 HSCIC Clinical Audit Platform

Data regarding identified cases of FGM is being collected in order to determine appropriate commissioning of services dependent on prevalence. It is therefore imperative that practices are registered on the Clinical Audit Platform and input data when cases are identified.

Guidance of how to register on the platform can be found here [link].

The log in page to access & add cases to the FGM Enhanced Dataset can be found here.

3.8 Breast Ironing

Breast Ironing also known as 'Breast Flattening' affects 3.8 million women around the world and is the process whereby young pubescent girls breasts are ironed, massaged and/or pounded down through the use of hard or heated objects in order for the breasts

to disappear or delay the development of the breasts entirely. Those who derive from richer families may opt to use an elastic belt to press the breasts so as to prevent them from growing.

The mutilation is a traditional practice from Cameroon, however has been reported in other countries. It is believed that by carrying out this act, young girls will be protected from harassment, rape, abduction and early forced marriage and therefore be kept in education. The practice is commonly performed by family members, 58% of the time by the mother. In many cases the abuser thinks they are doing something good for their daughter

Breast Ironing has been identified as one of the five under-reported crimes relating to gender-based violence. Much like Female Genital Mutilation (FGM), Breast Ironing is a harmful cultural practice and is child abuse. Professionals working with children and young people must be able to identify the signs and symptoms of girls who are at risk of or have undergone breast ironing.

Breast ironing is painful and violates a young girl's physical integrity. It exposes girls to numerous health problems such as cancer, abscesses, itching, and discharge of milk, infection, dissymmetry of the breasts, cysts, breast infections, severe fever, tissue damage and even the complete disappearance of one or both breasts.

Whilst there is no specific law around breast ironing in the UK it is viewed as a form of physical abuse and if professionals believe a child is suffering significant harm safeguarding procedures must be followed

For further information see GM Safeguarding Procedures [link].

3.9 Self Neglect (Adults)

There is no single operational definition of self-neglect however, the Care Act makes clear it comes within the statutory definition of abuse or neglect, if the individual concerned has care and support needs and is unable to protect him or herself. The Department of Health (2016), defines it as, *'… a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding'.*

There are various reasons why people self-neglect. Some people have insight into their behaviour, while others do not; some may be experiencing an underlying condition, such as dementia or an infection.

3.9.1 Response to Self-Neglect and Hoarding.

The Environmental Health Service has a range of powers to intervene where a property is in a condition that is detrimental to health, or where the premise is materially affecting neighbouring premises. However given the complex and diverse nature of self-neglect and hoarding and the impact on health, responses by a range of organisations are likely to be more effective than a single agency response.

For further advice on Self Neglect please see the SSAB Multi Agency Self Neglect Strategy which includes practitioners guidance.

3.10 PREVENT

The healthcare sector is a key partner in delivering the HM Government's Prevent strategy and promotes a non-enforcement approach to support the health sector in preventing people becoming radicalised. Healthcare staff are well placed to recognise individuals, whether patients or staff, who may be vulnerable and therefore more

susceptible to radicalisation by violent extremists or terrorists. It is fundamental to our 'duty of care' and falls within our safeguarding responsibilities.

NHS Stockport CCG is committed to safeguarding and supporting vulnerable children and adults, including staff, who may be at risk of being radicalised by violent extremists. Appropriate systems are in place for staff to raise concerns if they are aware of this form of exploitation taking place and to promote and operate a safe environment where violent extremists are unable to operate:

- **Radicalisation** refers to the process by which people come to support, and in some cases to participate in terrorism

- **Violent Extremism** – is defined by the Crown Prosecution Service (CPS) as: the demonstration of unacceptable behaviour by using any means or medium to express views which:

  - foment, justify or glorify terrorist violence in furtherance of particular beliefs;
  - seek to provoke others to terrorist acts;
  - foment other serious criminal activity or seek to provoke others to serious criminal acts;
  - foster hatred which might lead to inter-community violence in the UK.

And more recently by the Home Office in 2015 as:

'Extremism is the vocal or active opposition to our fundamental values, including democracy, the rule of law, individual liberty and the mutual respect and tolerance of different faiths and beliefs. We also regard calls for the death of members of our armed forces as extremist'.

Appendix 3 provides a procedural flowchart for Prevent referrals within the Stockport CCG area.

3.10 Channel Panel

The Channel panel is a multi-agency panel chaired by the Local Authority to support individuals who have been identified as being groomed into terrorism. The role of the multi-agency panel is to develop an appropriate support package to safeguard those at risk of being drawn into terrorism based on an assessment of their vulnerability of being at risk of radicalisation. The purpose of the panel is to:

- Assess the nature and extent of that risk; and
- Develop the most appropriate support plan for the individuals concerned.

The panel is responsible for managing the safeguarding risk which is in line with other multi-agency panels where risk is managed, such as the Multi-Agency Public Protection Arrangements (MAPPA). Local safeguarding structures have a role to play for those eligible for adult safeguarding.

Protecting children and young people from radicalisation and extremism requires careful assessment and working collaboratively across agencies. Professionals who are concerned about a child or young person should follow their safeguarding arrangements and refer to the designated safeguarding lead. Local referral procedures must always be followed and the response and level of appropriate support will be determined via a multi-agency assessment meeting. If professionals are concerned about a child, young person or their family they must treat it the same as any other safeguarding concern

Further information regarding safeguarding children and young people vulnerable to violent extremism can be found here [Link].

3.11 Modern Slavery & Human Trafficking

Modern slavery is a serious crime. It encompasses slavery, servitude, and forced or compulsory labour and human trafficking. Modern slavery victims can often face more than one type of abuse and slavery, for example if they are sold to another trafficker and then forced into another form of exploitation. (Salvation Army 2018).

Human trafficking has 3 elements:

a) **The Act**: (WHAT is done) e.g. Recruitment, transfer, transportation, harbouring or receipt of persons.
b) **The Means**: (HOW it is done) e.g. threat or use of force, coercion, abduction, fraud, deception, abuse of power or position of vulnerability, giving or receiving of payments or benefits used to control a person.
c) **The Purpose**: (WHY it is done) e.g. to exploit a person through prostitution, other forms of sexual exploitation, forced labour or services, slavery, servitude or removal of organs from a person.

For children there may only be two components required – **ACT and PURPOSE**. Any child transported for exploitative reasons is considered to be a trafficking victim - whether or not they have been deceived, because it is not considered possible for children to give informed consent.

A person may be trafficked from another country but could also be trafficked without crossing any national borders, e.g. only within the UK.

A person may be trafficked between a number of countries in the EEA (European Economic Area) or globally, prior to being trafficked into/within the UK. The adult or child may have entered the UK illegally or legally (i.e. with immigration documents). The intention to exploit the person underpins the entire process.

The Modern Slavery Act 2015 consolidates current offences of trafficking and slavery and details the different forms of exploitation that a victim of trafficking may be forced into.

The exploitation can take place in a number of ways including:

- Sexual Exploitation
- Labour Exploitation
- Criminal Exploitation
- Domestic Servitude
- Organ Harvesting

The Modern Slavery Act 2015 consolidates current offences of trafficking and slavery and details the different forms of exploitation that a victim of trafficking may be forced into.

See the NHS Stockport Modern Slavery Guidance
Greater Manchester Safeguarding Children from Trafficking and Modern Slavery Procedure [link]

Leaflet on Guidance for Healthcare staff.p

3.12 Safe Sleep Guidance

Tameside, Stockport and Trafford Safeguarding Children Boards and the Tripartite Child Death Overview Panel (CDOP) support the NICE, UNICEF and the Lullaby Trust guidance on safe sleeping. It is recommended that parents should always be advised that the safest place for their infant to sleep for the first six months is in a separate cot or Moses basket in the same room as their parents (including day time sleeps).

All parents and carers should be informed of the association between co-sleeping (sleeping on a bed, sofa or chair with an infant) and SIDS.

It is recognised that the factors which influence the sleeping arrangements of infants and children are a combination of parental values, socio-economic factors and cultural diversity.

- Universal/Key Messages
- Always advise that babies are placed on their back to sleep and to sleep in a separate cot or Moses basket in the same room as parent/carer for the first 6 months
- Advise re baby being not exposed to smoke during pregnancy and after birth
- Use a firm, flat, waterproof mattress in good condition
- Advise re not sleeping a sofa or in an armchair with baby
- Advise re not sleeping in the same bed if parent/carer smokes, drinks or taking drugs (legal or illegal) or are extremely tired, if baby was born prematurely or was of low birth-weight
- Avoid letting baby get too hot
- Baby's face or head to be uncovered while sleeping
- The incidence of SIDS is higher in the following groups: parents in low socio-economic groups, parents who abuse alcohol or drugs, parents who smoke, young mothers with more than one child, premature infants, those with low birth weight and boys.

Staff should be able to give appropriate information and advice to parents to enable them to make an informed choice about safe sleeping arrangements for their babies and infants and take into account the following:

- Doctors and practice staff should be familiar with the safe sleeping messages and practice guidance and encourage parent(s)/carer(s) of new babies and young children to be aware of sleep safe publicity materials (posters, leaflets).
  See https://www.lullabytrust.org.uk/
- Doctors and practice staff who have consultations with pregnant women, their partners and parents of new or very young babies should use the opportunity to ask about sleeping arrangements for their baby and promote safe sleeping messages, highlighting the associated factors with SIDS.
- Doctors or other health professionals who undertake the 6-8 week baby health review should ask about sleeping arrangements for the baby and promote safe sleeping messages, highlighting associated factors with SIDS.
- Where there are indications of higher vulnerability (e.g. **parental smoking, social or housing issues, young parents, prematurely, possible alcohol or drug use**) the Doctor or health professional should review with the parent(s)/carer(s) the Safe Sleeping Assessment completed by the Midwife or Health Visitor and recorded in

the Red Book. The need for additional support or intervention to promote safe sleeping practices should be considered. If the Doctor has concerns or identifies the need for further support this should be referred to the family's Health Visitor.

3.13 Children Missing From Education

There are many reasons why children and young people fall out of the education system and are at risk of 'going missing'. These range from failing to start in a new school or formally arranging home schooling to simply not re-registering at a new school when they move into the city.

To help identify children and young people currently missing from education, the council works closely with health employees, school employees and housing officers. This multi-agency working comes under the Education and Inspections Act 2006.

Children Missing From Education: Statutory Guidance for Local Authorities [link]

If you have any information about a child you think may be missing from school and not receiving a suitable education please complete the Stockport Council online form link.

3.14 Bullying

A definition of bullying is as follows:

"Behaviour by an individual or group usually repeated over time, that intentionally hurts another individual or group physically or emotionally".

Bullying is therefore:

- Repetitive and persistent. Bullying is usually experienced as part of a continuous pattern and it can be extremely threatening and intimidating even when very subtle. Nevertheless, sometimes a single incident can have precisely the same impact as persistent behaviour over time;
- Intentionally harmful. The act of bullying intends harm to another individual although occasionally the distress it causes is not consciously intended by all of those who are present;
- Involves an imbalance of power. Bullying leaves someone feeling helpless to prevent it or put a stop to it. In some cases an imbalance of power may mean that bullying crosses the threshold into abuse. This would require implementation of safeguarding procedures.

Bullying can take place anywhere in the community and can affect both adults and children.

For further guidance see Greater Manchester Safeguarding Procedure [link].

3.15 Concealed Pregnancy

A concealed pregnancy is when a woman knows she is pregnant but does not tell any health professional; **or** when she tells another professional but conceals the fact that she is not accessing antenatal care; **or** when a pregnant woman tells another person or persons and they conceal the fact from all health agencies.

If a health professional suspects or identifies a concealed or denied pregnancy and there are significant concerns for the welfare of the unborn baby, they must refer to Children's Social Care and inform all the health professionals, including the General Practitioner, involved in the care of the woman.

All health professionals should give consideration to the need to make or initiate a referral for a mental health assessment at any stage of concern regarding a suspected (or proven) concealed or denied pregnancy.

Health professionals who provide help and support to promote children's or women's health and development should be aware of the risk indicators and how to act on their concerns if they believe a woman may be concealing or denying a pregnancy.

Further information can be found in Greater Manchester Safeguarding Procedure [Link]

3.16 Private Fostering

Be aware of private fostering/children cared for by the wider family or friends. All practitioners have a shared responsibility to be aware, identify and notify private fostering arrangements to Stockport MASSH. Private fostering is connected with legal requirements in the Children Act 1989. It is a safeguarding matter with deep implications for the welfare of children.

3.17 What is private fostering?

Private fostering occurs when children up to the age of 16 (18 if the child has a disability) are being looked after by anyone other than parents, uncles/aunties, grandparents or siblings for a period of 28 days or longer. This period can be interrupted occasionally and still remains private fostering. The Children Act 2004 further established a duty to notify these arrangements even before its commencement, if a planned placement is evident.

3.18 Private fostering may also include:

- Children sent from abroad to stay with another family, usually to improve their educational opportunities;
- Asylum-seeking and refugee children;
- Teenagers who, having broken ties with their parents, are staying in short-term arrangements with friends or other non-relatives;
- Language students living with host families.

3.19 What is not private fostering?

- Looked After Children.
- Children living in arrangements under the care of Educational Authorities.
- Children cared for by parents, uncles/ aunties, grandparents or siblings.
- Children who spend less than 3 days a week in the placement.
- Children who are cared for by distant relatives or friends at the parents' home.

The duties of Stockport Council are to:

- Identify privately fostered children.
- Undertake a placement assessment towards suitability.
- Monitor and support the placement to increase its stability and improve outcomes for privately fostered children.
- Mediate between parents and carers
- Ensure the welfare of the child.
- Assist carers to provide and sustain appropriate standards of care.

Stockport Council private fostering procedure can be accessed at: (Link). It is a statutory requirement on Stockport Council to appoint an officer to monitor the way a local authority discharges its duties in private fostering.

In all cases of private fostering, the council needs to be notified. This is so they can ensure the child is safe and provides support to people who are privately fostered

3.20 Abuse Linked to Spiritual and Religious Beliefs

The belief in "possession or "witchcraft" is widespread. It is not confined to particular countries, cultures or religions, nor is it confined to new immigrant communities in this country.

The definition which is commonly accepted across faith-based organisations, non-governmental organisations and the public sector is the term 'possession by evil spirits' or 'witchcraft'.

Such abuse generally occurs when a carer views a child as being "different", attributes this difference to the child being "possessed" or involved in "witchcraft" and attempts to exorcise him or her.

A child could be viewed as "different" for a variety of reasons such as, disobedience; independence; bed-wetting; nightmares; illness; or disability. There is often a weak bond of attachment between the carer and the child and constitutes emotional abuse.

The attempt to "exorcise" may involve severe beating, burning, starvation, cutting or stabbing and isolation, and usually occurs in the household where the child lives although it can often occur in church or faith group settings.

A number of faith groups have beliefs which affect how they use health services and specifically treatment and immunisations for children. A number of churches and faith groups believe in the power of prayers and faith in God and as a result may refuse medical interventions and treatments including assistance at child births, health checks and immunisations. Where a practitioner becomes aware of a belief held by the parents, where it may impact on the health and development of the child, the practitioner should consult with other professionals to assess the potential risks of significant harm to the child.

For further information see Greater Manchester Safeguarding Procedures [link].

Practitioners should be alert to the indicators and should be able to identify and refer children at risk of this type of abuse to prevent it as soon as possible – see section 2.2 for referral procedures.

3.21 Children with Disabilities

A child could be considered to have disabilities if he or she has significant problems with communication, comprehension, vision, hearing or physical functioning. The Equality Act 2010 defines a person with a disability as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities. The definition of disability encompasses a broader range of impairments than might be commonly assumed, including children on the autistic spectrum, those with Tourette's syndrome and those with communication difficulties.

Many factors can make a child with disabilities more vulnerable to abuse than a non-disabled child of the same age. Safeguarding children with disabilities demands a greater awareness of their vulnerability, individuality and particular needs.

Children with disabilities may be especially vulnerable to abuse for a number of reasons. Some children with disabilities may:

- Have fewer outside contacts than other children;
- Receive intimate care possible from a number of carers, which may increase the risk of exposure to abusive behaviour and make it more difficult to set and maintain physical boundaries;
- Have an impaired capacity to recognise, resist or avoid abuse;
- Have communication difficulties that may make it difficult to tell others what is happening;
- Be inhibited about complaining for fear of losing services;
- Be less able to defend themselves and advocate for themselves;
- Be more vulnerable than other children to abuse by their peers

It should be remembered that children with disabilities are children first and foremost, and have the same rights to protection as any other child. People caring for and working with children with disabilities need to be alert to the signs and symptoms of abuse.

3.22 Management in General Practice:

- Health services often play a key role in working with families where there are disabilities and interpreting how the condition may impact on the day to day life of both the child and family members
- GP practices often have the whole family registered: each family member needs to be assessed in their own right and will have very different needs
- Consider the impact on other, non-disabled siblings who may be undertaking some degree of caring responsibility
- Families where there are children with a disability will need extra, and earlier, help and support from a range of practitioners
- Be alert to the risk of abuse and neglect: allow yourself to think the unthinkable.

3.23 People with Learning Disabilities:

- People with learning disabilities often have poorer physical and mental health than other people, but this is preventable.
- Adults and young people aged 14 years or above with learning disabilities, who are known to their local authority social services, and who are registered with a GP should be invited to come for an Annual Health Check.

It is also a good opportunity to discuss transitional arrangements which will take place when a child becomes an adult.

Greater Manchester Safeguarding Procedures [link],
0 to 25 SEND code of practice: a guide for health professionals [Link] and
DfE Special educational needs and disability: managing the September 2014 changes to the system [link] provide further information

3.24 LeDeR (Learning Disability Mortality Reviews):

The recommendations of the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD) reported that some people with learning disabilities were dying sooner than they should. Some of the reasons for this were related to the standard of health and social care that they received.

One of the key recommendations of CIPOLD was for professionals to look in more detail into the deaths of people with learning disabilities, in order to identify common issues or

problems that might have led to these deaths. Once these issues are identified, improvements to health or social care could be made.

The LeDeR Programme supports local areas in England to review the deaths of people with learning disabilities aged 4 years and over. An initial review of the death will then take place. If necessary, a more in-depth review will be carried out involving people from health, social services and other agencies.

A confidential telephone number and website enables professionals and families to notify the LeDeR team of the death of someone with learning disabilities. If the Practice is informed a person with a learning disability has died, the practice should inform the central site to initiate a review. This can be done by accessing the following link.

Section 4

4.1 Safe Recruitment

Section 11 of the Children Act 2004 places a duty on NHS organisations to have safe recruitment practices for individuals whom the organisation will permit to work regularly with children, including policies on when to obtain a criminal record check.

The aim of creating a safe environment is to minimise risks to children, young people and adults at risk from abuse in practice. We sometimes need to be mindful that there may be people who work, or seek to work, in organisations who pose a risk to children, young people and adults at risk. The following is intended to further support practices in creating a safer environment by setting out key safeguarding arrangements that help to protect patients as well as protecting individuals against false allegations of abuse and the reputation of the practice and professionals. Safer recruitment practice should be applied at all stages of the recruitment process.

Dr Marshall & Partners will also comply with GM Safe Recruitment guidance – [link].

Pre-employment checks

- Advertisements
- Job Description and Person Specification
- Application Process
- Short Listing
- Interviews
- References- at least two and where possible verified by telephone
- Verification of applicants identity
- Verification of medical fitness
- Ensure applicant has permission to work in UK
- Verification of professional qualifications
- DBS Check including check of barred lists if in regulated activity

Post-Employment Checks

- Appointment
- Induction
- Training including raising awareness of safeguarding policy and name of GP Safeguarding Lead, whistleblowing and disciplinary procedures
- Probation period
- Effective supervision and appraisal

4.1.1 The Disclosure & Barring Service (DBS)

The Coalition Government has introduced the Protection of Freedoms Act 2012. This has resulted in the merger of the Independent Safeguarding Authority (ISA) with the Criminal Records Bureau (CRB); creating the Disclosure and Barring Service (DBS).
This amalgamated Service is responsible for vetting individuals who apply to work in specified posts, and helps prevent unsuitable individuals from working or volunteering with vulnerable groups. It also takes responsibility for creating barred lists of individuals identified to be a risk to people due to their past behaviour.

The DBS uses data gathered by itself and other appropriate sources, which include relevant criminal convictions, cautions and police intelligence.

All staff working in positions exempt from the Rehabilitation of Offenders Act 1974 (Exceptions Order) 1975 or who perform a Regulated Activity must undertake DBS checks.

An optional online Update Service is operated by the Disclosure and Barring Service (DBS), designed to reduce the number of DBS checks requested.

It is an offence for an employer knowingly to offer work in a regulated position, or to procure work in a regulated position for an individual who is disqualified from working with children, or fail to remove such an individual from such work.

CQC state no member of staff should undertake the role of a chaperone unless they have undergone a DBS check. CQC guidance on DBS checks can be found here [link]

When considering eligibility a check must be carried out to see if the role being offered is listed within the Exceptions Order to the Rehabilitation of Offenders Act (ROA). This includes the majority of positions were it has been determined that the 'employer' has a **legal** right to ask the prospective 'employee' to reveal details of any conviction history. The list can be found at:
https://www.gov.uk/government/collections/dbs-eligibility-guidance

To be eligible for an 'Enhanced' level DBS check, the position must be included in both the ROA Exceptions Order and in Police Act Regulations.

If the position is not listed eligibility can still exist if it is considered the post holder will be engaged in 'Regulated Activity'.

The New eligibility tool will assist in determining if an employee is eligible for a DBS check

4.2 Managing Allegations Against Staff

Children and Young People

Children can be subjected to abuse by those who work with them in any and every setting. All allegations of abuse or maltreatment of children by an employee, agency worker, independent contractor or volunteer will be taken seriously and treated in accordance with NHS Stockport CCG and GM Safeguarding partnership procedure for *Managing Allegations of Abuse Made Against Adults Who Work with Children and Young People* accessed at: Link. The Local Authority Designated Officer in Stockport is Gill Moore, in Children's Social Care. She is contactable on: 0161 474 5657.

Working Together to Safeguard Children, 2015, Chapter 2 outlines agencies responsibilities in line with section 11 of the Children Act 2004 to ensure there are clear policies in place for whistleblowing and to manage allegations against staff.

The procedure must be followed when there are concerns that any person who works with children, either in a paid or unpaid capacity i.e. any employee, independent contractor, or volunteer, where the adult is in a position of trust in relation to the child and family, has:

- behaved in a way that has harmed a child, or may have harmed a child
- possibly committed a criminal offence against or related to a child
- behaved towards a child or children in a way that indicates s/he may pose a risk of harm to children

These behaviours should be considered within the context of the four categories of abuse i.e. physical, sexual and emotional abuse and neglect and includes concerns relating to inappropriate relationships between members of staff and children or young people.

It is essential that any allegation of abuse made against a professional who works with children and young people or other member of staff or volunteer in any setting is dealt with fairly, quickly, and consistently, in a way that provides effective protection for the child or children and at the same time supports the person who is the subject of the allegation.

Compliance with the above procedures allows for consideration of the adult's behaviour at the earliest opportunity when a concern or allegation arises. Compliance also helps to ensure that allegations of abuse are dealt with expeditiously and in a manner that is consistent with a thorough and fair process.

In complying with this procedure the practice will identify a Designated Senior Manager, a Nominated Senior Officer and a deputy whose roles are identified below:

- **Mrs Margaret Wallis** will be the **Designated Senior Manager** who has *overall* responsibility for:
- ensuring procedures are properly applied and implemented.
- providing advice, information and guidance for staff within the practice.
- being the designated senior manager within the practice to whom all allegations or concerns are reported.

Dr K Maguire will be appointed as their deputy to whom reports should be made in the absence of the designated Senior Manager or where that person is the subject of the allegation or concern.

Mrs Margaret Wallis will be the Nominated Senior Officer who will

- ensure that the practice deals with allegations in accordance with the NHS Stockport CCG and Stockport Safeguarding Children Board procedure for Managing allegations against workers and volunteers who have contact with children above named procedure;
- resolving any inter-agency issues;
- Liaise with the Local Authority Designated officer (0161474 5657).

All substantiated cases should be reported to the Designated Nurse for Safeguarding Children and LAC, NHS Stockport CCG in addition to other regulatory bodies.

4.2.1 Adults at Risk

Whilst managing allegations of abuse against staff with respect to adults does not require employers to pay due regard to Local Authority Designated Officers, the same

considerations needs to be given to investigation of the allegation and protection of adults at risk of harm and protection of the staff member. Primary care practitioners are expected to have in place policy and procedures to address allegations of abuse made against staff about adults at risk of harm. This needs to include policies on safe recruitment, whistleblowing and DBS checking.

4.2.2 Referral to DBS

If an organisation removes an individual (paid worker or unpaid volunteer) from work such as looking after children (or would have, had the person not left first) because the person poses a risk of harm to children, the organisation must make a referral to the Disclosure and Barring Service. It is an offence to fail to make a referral without good reason.

For additional useful links on Disclosure on Barring Service please see Appendix 4.

4.2.3 Whistle Blowing

Dr Marshall & Partners recognises the importance of building a culture that allows all Practice Staff to feel comfortable about sharing information, in confidence and with a lead person, regarding concerns they have about a colleague's behaviour. This will also include behaviour that is not linked to abuse but that has pushed the boundaries beyond acceptable limits.

Problems raised in primary care can include:

- Poor clinical practice or other malpractice which may harm patients;
- Failure to safeguard patients;
- Maladministration of medications;
- Untrained or poorly trained staff;
- Lack of policies creating a risk of harm.

Open and honest working cultures where people feel they can challenge unacceptable colleague behaviour and be supported in doing so, help keep everyone safe. Where allegations have been made against staff, the standard disciplinary procedure and the early involvement of the Local Authority Designated Officer (LADO) may be necessary (section 11 Children Act 2004).

Freedom to Speak up in Primary Care – Guidance to Primary Care Providers on Supporting Whistleblowing in the NHS provides further information (Link).

All NHS primary care providers should work to ensure:

- It is safe to speak up
- Staff have the confidence to speak up
- Concerns are investigated
- Speaking up makes a difference
- Concerns are well received.

Complaints procedure

Dr Marshall & Parners has a clear well publicised procedure that is capable of dealing with complaints from all patients (including children, young people and adults at risk), employees, accompanying adult or parent. Consideration should always be given to whether a complaint meets the criteria for managing allegations procedures.

4.3 Staff Training

Those working with children, young people and adults at risk and/or parents/carers should take part in clinical governance including holding regular case discussions, training, education and learning opportunities should be flexible with a multi-disciplinary component. They include e-learning but also personal reflection and scenario based discussion, drawing on case studies and lessons from research, critical event analysis, analysis of feedback, complaints and included in appraisal.

In line with both the Safeguarding children and young people: roles and competences for health care staff Intercollegiate document (2014) and the Safeguarding adults :roles and competences for health care staff Intercollegiate document (2018).

All new members of staff will undergo safeguarding children and adults training as follows:

- All Non-Clinical Staff must be at a minimum Level 1;
- GP practice managers and Healthcare Assistants (HCAs) must be at a minimum Level 2;
- General Practitioners (GPs), Practice Nurses and Advanced Practitioners should be a minimum Level 3 .

The Practice will also ensure that:

Those new to Level 3 must receive a further 8 hours of safeguarding children training and 8 hours of safeguarding adults training within a year of appointment.
GPs, Practice Nurses and Advanced Practitioners should undertake:

- ➢ A further 4-6 hours training each year, over a three-year period (up to 12-16 hours over three years) to refresh and build upon the learning relevant to safeguarding children,
- ➢ A further 2-3 hours training each year (up to 8 hours over three years) relevant to safeguarding adults.
- ➢ This can include the mandatory Level 3 training in PREVENT which can be accessed here.

- Practice staff should be encouraged to attend relevant safeguarding sessions at Stockport CCG masterclasses
- GP safeguarding leads should endeavour to attend the adults and childrens GP safeguarding leads briefings & to cascade the information from these within the practice teams
- All Staff members will undergo children and adult safeguarding training at 3 yearly intervals. Please refer to Stockport CCG Safeguarding Training Strategy found on the CCG Hub.
- All staff members undergoing training will be expected to keep a learning log for their appraisals and or personal development
- The Practice will discuss and record at least one clinical incident involving safeguarding children.

4.4 General Guidelines for Staff Behaviour

Use of internet, mobile phones and electronic equipment
You must always act responsibly with regard to internet, electronic and telecommunications equipment (including use of mobile phones), using them in a professional, lawful and ethical manner.

4.4.1 E-Safety

Digital technology has become an important part of everyday life and offers exciting opportunities. However the increasing number of cases where workplace practice has highlighted inappropriate use of technology, grooming behaviour and an inability to challenge colleagues has demonstrated the need for clear practice guidance for workers and organisations around safer working practice.

4.4.2 Inappropriate types of sites

Accessing or downloading data from inappropriate websites (e.g. pornographic websites or emails, racist, sexist or gambling websites or emails, sites promoting violence and illegal software) at any time is forbidden and may lead to disciplinary proceedings.

See Greater Manchester Safeguarding Procedures for E-Safety guidance for staff [link].

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Appendix 1

NHS STOCKPORT CCG SAFEGUARDING TEAM
CONTACT DETAILS

CCG Safeguarding Leads:	
Head of Safeguarding/Designated Nurse for Safeguarding Children Julie Parker	0161 426 9905 Julie.parker1@nhs.net
Designated Nurse Safeguarding Adults/MCA Lead Sarah Martin	0161 426 9905 Sarah.martin50@nhs.net
Designated Nurse Looked After Children Sue Gaskell	0161 426 9905 Sue.gaskell@nhs.net
Designated Doctor (Contact via switchboard and ask to bleep) Jane Connell	0161 483 1010 Jane.connell2@nhs.net
Named GP for Safeguarding James Higgins	0161 426 9905 James.higgins2@nhs.net
Safeguarding Team Co-ordinator Sue Jeeves	0161 426 9905 Sue.Jeeves@nhs.net
Safeguarding Team group Email **Email:**STOCCG.Safeguarding@nhs.net	

Appendix 2: Guidance and Legislation

Document	Hyperlink
Stockport Safeguarding Children Board have adopted the Greater Manchester Safeguarding Children Procedures Manual	http://greatermanchesterscb.proceduresonline.com/
Stockport Safeguarding Adults Board Multi Agency Safeguarding Adults policy and Procedures	https://www.stockport.gov.uk/policy-and-procedures
Data Protection Act 1998 (UK wide)	https://www.gov.uk/data-protection/the-data-protection-act
Working Together to Safeguard Children (2010) – HM Government	
Working Together to Safeguard Children (2013) – HM Government	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf
Working Together to Safeguard Children (2015) – HM Government	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf
Working Together to Safeguard Children (2018) HM Government (2018)	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf
Children and Social Work Act 2017	http://www.legislation.gov.uk/ukpga/2017/16/pdfs/ukpga_20170016_en.pdf?view=interweave
NICE guideline 89: When to suspect child maltreatment (updated March 2014) – National Institute for Health and Care Excellence	https://www.nice.org.uk/guidance/cg89
Safeguarding adults: the role of health service practitioners (2011) – Department of Health	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215714/dh_125233.pdf
National Framework of Standards for Good Practice and Outcomes in Adult Protection work (2005) – Leaders in Social Care	http://lx.iriss.org.uk/sites/default/files/resources/Safeguarding%20Adults%20Framework2-1.pdf
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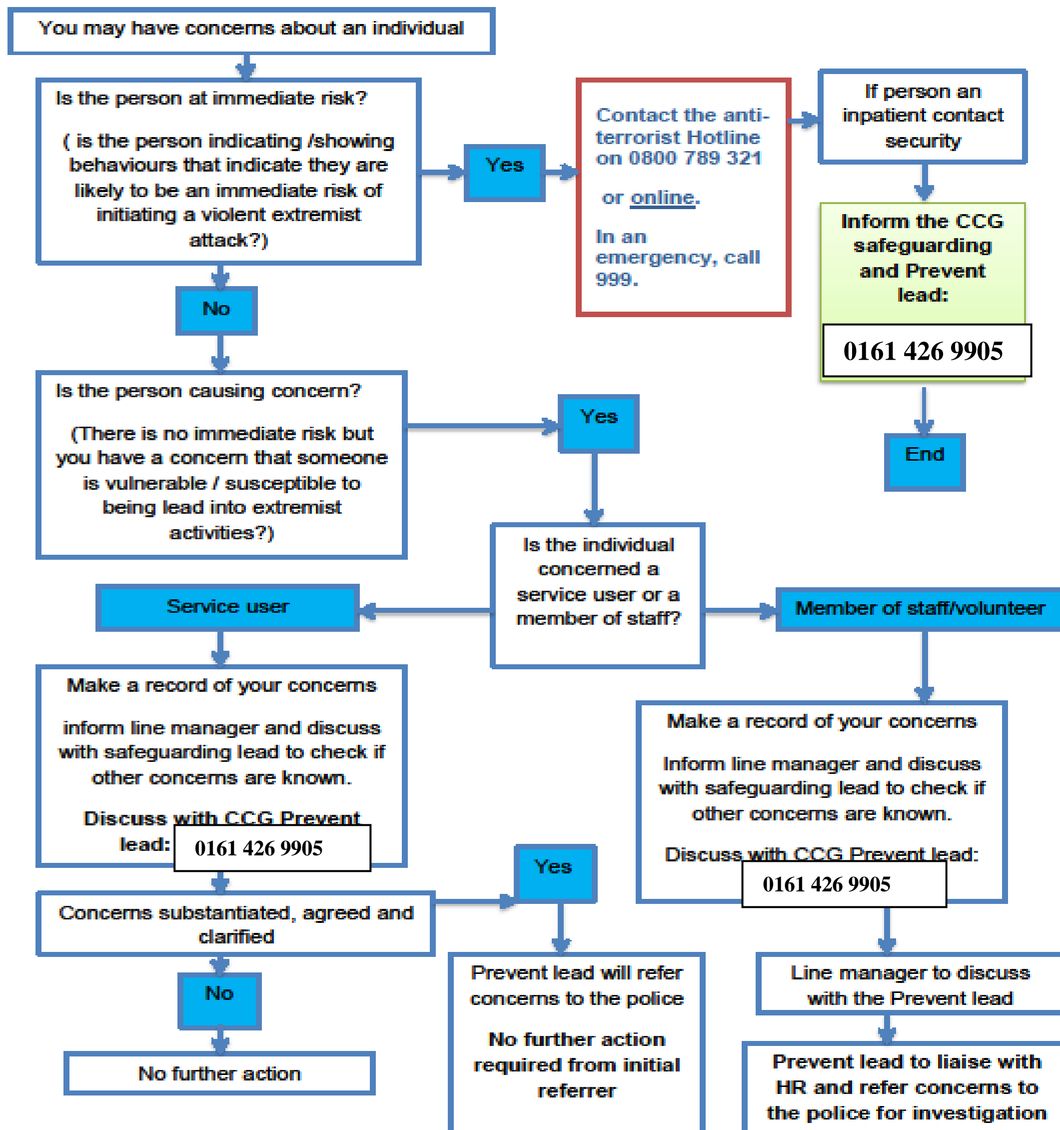
Children Act 1989	http://www.legislation.gov.uk/ukpga/1989/41/contents
Adoption & Children Act 2002	http://www.legislation.gov.uk/ukpga/2002/38/pdfs/ukpga_20020038_en.pdf
Children Act 2004	http://www.legislation.gov.uk/ukpga/2004/31/pdfs/ukpga_20040031_en.pdf
The United Nations Convention on the Rights of the Child (ratified by UK Government in 1991 and became statutory in Wales 2011	https://www.unicef.org.uk/what-we-do/un-convention-child-rights/
Care Act 2014	http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf
Serious Crime Act 2015	https://www.gov.uk/government/collections/serious-crime-bill

Document	Hyperlink
Sexual Offences Act 2003	http://www.legislation.gov.uk/ukpga/2003/42/pdfs/ukpga_20030042_en.pdf
NICE CG89 Child Maltreatment Guidance 2009-11	https://www.nice.org.uk/Guidance/CG89
DH Statement of Government Policy on Adult Safeguarding 2013	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/197402/Statement_of_Gov_Policy.pdf
CQC - Safeguarding children: A review of arrangements in the NHS for safeguarding children 2009	http://www.cqc.org.uk/sites/default/files/documents/safeguarding_children_review.pdf
Greater Manchester Safeguarding Partnership	http://www.gmsafeguardingchildren.co.uk/
Promoting the Health and Well being of Looked After Children 2015	https://www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-looked-after-children--2
Safeguarding Children and Young People: The RCGP/NSPCC Safeguarding Children Toolkit for General Practice, 2014	http://www.rcgp.org.uk/clinical-and-research/toolkits/the-rcgp-nspcc-safeguarding-children-toolkit-for-general-practice.aspx
Protecting children and young people. The responsibilities of all doctors (2012) – GMC	http://www.gmc-uk.org/static/documents/content/Protecting_children_and_young_people_-_English_1015.pdf
Children and young people tool kit: 1st edition (2010) – BMA	http://bma.org.uk/-/media/files/pdfs/practical%20advice%20at%20work/ethics/children%20and%20young%20people%20toolkit/childrenyoungpeopletoolkit_full.pdf
RCN guidance for nursing staff: Safeguarding children and young people – every nurse's responsibility – Royal College of Nursing	GP Safeguarding Policy - saved links\004542.pdf
Confidentiality and disclosure of health information tool kit – BMA	http://bma.org.uk/-/media/files/pdfs/practical%20advice%20at%20work/ethics/confidentialitytoolkit_full.pdf
CQC registration - what you need to know: Guidance for GPs, BMA(2012)	http://bma.org.uk/practical-support-at-work/gp-practices/cqc-registration
Safeguarding Vulnerable Adults: a toolkit for general practice – BMA (2011)	http://www.google.co.uk/url?q=http://bma.org.uk/-/media/files/pdfs/practical%2520advice%2520at%2520work/ethics/safeguardingvulnerableadults.pdf&sa=U&ei=cmyxU66XNa2M7AbG74CQBQ&ved=0CBQQFjAA&usg=AFQjCNFiOgxHWvU0umVlWQN4N8eNKXnukA
Safeguarding children and young people: roles and competences for health care staff	http://www.rcn.org.uk/__data/assets/pdf_file/0008/474587/Safeguarding_Children_-_Roles_and_Competences_for_Healthcare_Staff_02_0....pdf

Document	Hyperlink
INTERCOLLEGIATE DOCUMENT (2014)	
RCN Adult Safeguarding: Roles and Competencies for Health Care Staff INTERCOLLEGIATE DOCUMENT (2018)	https://www.rcn.org.uk/professional-development/publications/pub-007069
Looked after children: Knowledge, skills and competences of health care staff INTERCOLLEGIATE ROLE FRAMEWORK March 2015	https://www.rcpch.ac.uk/sites/default/files/Looked_after_children_Knowledge__skills_and_competence_of_healthcare_staff.pdf
Prevent Duty & Subsequent Guidance	http://www.legislation.gov.uk/ukdsi/2015/9780111133309/pdfs/ukdsiod_9780111133309_en.pdf
Prevent Guidance Toolkit (2011)	https://www.gov.uk/government/publications/building-partnerships-staying-safe-guidance-for-healthcare-organisations
Channel Duty & Subsequent Guidance	https://www.gov.uk/government/publications/channel-guidance
Caldicott Guidance	
Safeguarding Vulnerable Groups Act 2006	http://www.legislation.gov.uk/ukpga/2006/47/pdfs/ukpga_20060047_en.pdf
Mental Health Act, 1983 and code of practice	http://www.legislation.gov.uk/ukpga/1983/20/contents
Mental Capacity Act, 2005	http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf
MCA Statutory Code of Practice, 2008	https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
DoLS Statutory Code of Practice, 2009	http://www.cqc.org.uk/sites/default/files/Deprivation%20of%20liberty%20safeguards%20code%20of%20practice.pdf
Mental Health Act 2007 (DoLs)	http://www.legislation.gov.uk/ukpga/1983/20/pdfs/ukpga_19830020_en.pdf
NHS & Community Care Act 1990	http://www.legislation.gov.uk/ukpga/1990/19/pdfs/ukpga_19900019_en.pdf
Health and Social Care Act 2008/ 2012	http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf
Carers Recognition & Services Act, 1995	http://www.legislation.gov.uk/ukpga/1995/12/pdfs/ukpga_19950012_en.pdf
Common Law Duty	https://www.health-ni.gov.uk/articles/common-law-duty-confidentiality
Equality Act 2010	https://www.gov.uk/guidance/equality-act-2010-guidance
Care and Support Statutory Guidance (Chapter 14 – Safeguarding)	https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance
Children Missing from Education (2016)	https://www.gov.uk/government/publications/children-missing-education
Information Sharing for Safeguarding Practitioners (2015)	https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice
Freedom to Speak up in Primary Care (2016)	https://www.england.nhs.uk/publication/freedom-to-speak-up-in-primary-care-november-2016/
Department of Health Female Genital Mutilation Resource Pack (2016)	https://www.gov.uk/government/publications/female-genital-mutilation-resource-pack
Modern Slavery Act, 2015	http://www.legislation.gov.uk/ukpga/2015/30/pdfs/ukpga_20150030_en.pdf

Appendix 3: PREVENT flowchart



Appendix 4

Disclosure and Barring Service Useful Links

Disclosure:

New eligibility tool
DBS workforce guides
DBS Update Service: employer guide
DBS update service: applicant guide
DBS check: eligible positions guidance
Completing the DBS application form: e-guide
Criminal records checks for overseas applicants
Use the DBS website to answer your query
Filtering rules for criminal record check certificates

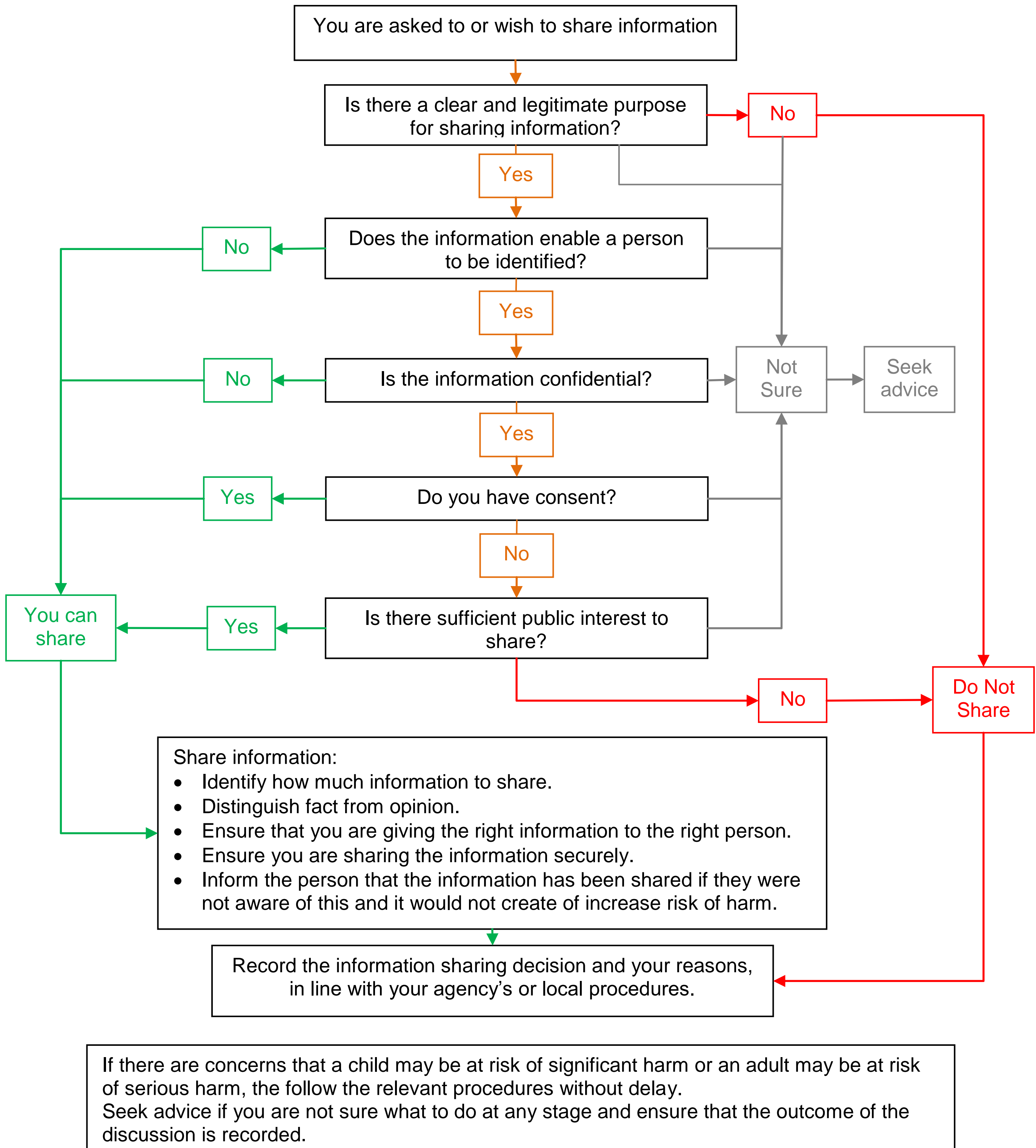
Barring:

Regulated activity with children
Regulated activity with adults
Supervision of activity with children
Referral duty and power for local authorities and regulatory bodies
DBS referrals: form and guidance
DBS barring referrals flowchart

DBS referrals: frequently asked questions guide

Appendix 5

FLOWCHART FOR KEY QUESTIONS FOR INFORMATION SHARING



Seven golden rules for information sharing can be found overleaf

Appendix 6

List of Useful local DVA Contacts

POLICE, COURTS AND PROBATION SERVICE
GREATER MANCHESTER POLICE, Tel: 999 in an emergency, 101 for non-emergency, GMP Public Protection Unit Tel:0161 856 9684 - www.gmp.police.uk

STOCKPORT PROBATION (Manages and rehabilitates offenders released from custody) Tel: 03000 477500 or 0161 429 0010 - www.cgm-probation.org.uk

CHESHIRE & GREATER MANCHESTER CRC (supervise offenders assessed as posing either a low or medium risk of committing a serious crime). Tel: 01442 296 011

STOCKPORT COUNTY COURT AND FAMILY COURT (including magistrates) Tel: 0161 477 2020 The Courthouse, Edward Street, Stockport, SK1 3DQ

MANCHESTER AND SALFORD MAGISTRATES COURT (for remand cases) Crown Square, Manchester M60 1PR Tel: 0161 830 4200

MANCHESTER CIVIL JUSTICE CENTRE Tel: 0161 240 5000

STOCKPORT SOCIAL SERVICES

DESIGNATED OFFICER/LOCAL AREA DESIGNATED OFFICER (allegations and concerns about any person who works with children and young people in Stockport) Tel: 0161 474 5657

SMBC ADULT SAFEGUARDING TEAM MANAGER (to discuss allegations and concerns about any person who works with adults at risk with care and support needs in Stockport) Tel: 0161 474 3936

MASSH (MULTI-AGENCY SAFEGUARDING & SUPPORT HUB) (Advice and reporting concerns about children) Tel:0161 217 6028

ADULT SOCIAL SERVICES (Advice and reporting concerns about adults) Tel: 0161 217 6029 Out of hours service for children and adults: Tel:0161 718 2118 - https://www.stockport.gov.uk

VICTIM SERVICES
GREATER MANCHESTER VICTIMS' SERVICES (Website providing useful information and practical advice for victims and survivors of crime, and their families). www.gmvictims.org.uk

STOCKPORT VICTIM SUPPORT (Help for victims who have been victim of or affected by a crime) Tel: 0161 474 4682 or 0161 200 1950, 24 hour helpline 0808 16 89 111 - www.victimsupport.org.uk

STOCKPORT SAMARITANS (A safe place to talk, don't have to be suicidal) Tel: 0161 432 1221 - www.samaritans.org

CITIZENS ADVICE STOCKPORT – (Impartial, confidential, and independent advice and information on Benefits, Money, Family, Housing and Employment). 0300 3309 075 - www.castockport.org.uk

SPECIALIST DVA SERVICES
STOCKPORT WITHOUT ABUSE (A charity offering a range of services for families affected by DVA) Tel: 0161 477 4294 - www.stockportwithoutabuse.org.uk

THE POSITIVE RELATIONSHIPS TEAM WITHIN STOCKPORT TPA (works with Stockport residents who wish to create more healthy relationships, this includes men and women who have or are experiencing domestic abuse). Tel: 0161 474 1042.

NATIONAL WOMEN'S AID DVA HELPLINE (24/7 DVA helpline) Tel: 0808 2000, 247 Greater Manchester DVA Helpline: 0161 636 7525

INDEPENDENT CHOICES (For women who are experiencing or have experienced DVA,

LGBT specialists and language services) Tel: 0161 636 7525 - www.domesticabusehelpline.co.uk

STOCKPORT WOMEN'S CENTRE (Services for women in need of support with DVA) Tel:0161 355 4455 - www.thewomenscentre.uk.net

MEN'S ADVICE LINE (A service for men experiencing DVA)Tel: 0808 801 0327 - www.mensadviceline.org.uk

MANKIND (for male victims of DVA) Tel: 01823 334244 - www.mankind.org.uk

KARMA NIRVANA (Supporting victims of honour-based abuse and forced marriage) Tel: 0800 5999 247 - www.karmanirvana.org.uk

BEHAVIOUR CHANGE
RESPECT (A confidential and anonymous helpline for anyone concerned about their violence and/or abuse towards a partner or ex-partner). Tel: 0808 802 4040 - www.respectphoneline.org.uk

BRIDGING TO CHANGE (changing DVA behaviour).Tel: 0161 872 1100 - www.talklistenchange.org.uk

START (support with healthier lifestyle changes) Tel: 0161 474 3141 - www.healthystockport.co.uk

OTHER SUPPORT
STOCKPORT AND DISTRICT COMMUNITY MENTAL HEALTH TEAM (MIND) (Offering friendly, accessible support and information to people in mental distress and working with others to promote well-being in the local community). Tel: 0161 480 7393 - www.stockportmind.org.uk

THE PREVENTION ALLIANCE (TPA) (wide range of information, advice and links, plus a team of Keyworkers and Community Connectors for those wishing to make changes in any area of their life). Tel: 0161 474 1042 - www.stockporttpa.co.uk

MANCHESTER RAPE CRISIS (Confidential support service for women and girls who have been raped or sexually abused) Tel: 0161 273 4500 - www.manchesterrapecrisis.co.uk

ST MARY'S SEXUAL ASSAULT REFERRAL CENTRE (If you have been raped or sexually assaulted, help to recover from physical and emotional effects - current and historic)
Tel: 0161 276 6515 - www.stmaryscentre.org.uk

COMMUNITY DRUG AND ALCOHOL SERVICES (Help for anyone suffering from a drug or alcohol problem) Tel: 0161 716 4000 - www.stockportdrugsandalcohol.org

BOAZ TRUST (accommodation and support for destitute asylum seekers and refugees) Tel: 0161 202 1056 - www.boaztrust.org.uk

THE GUARDIAN PROJECT (Safeguarding and supporting girls affected by FGM. Tel: 07449 651 677

HOUSING
STOCKPORT HOMES (Manage the housing stock owned by Stockport Council) Tel: 0161 217 6016 www.stockporthomes.org . For homeless emergency outside our opening hours, please call 0161 474 2818

SECURITY AND SAFETY
GREATER MANCHESTER FIRE AND RESCUE SERVICE (Offer safety checks for any potential fire risks,smoke alarms, escape plans, advice on home security and health and wellbeing). Tel: 0800 555815

CRIME PREVENTION PAGES
Advice and information on preventing and reducing crime - www.gmp.police.uk