

HOPE CITADEL HEALTHCARE

SAFEGUARDING CHILDREN, YOUNG PEOPLE AND ADULTS AT RISK POLICY

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

Statement of Intent

The aim of this policy is to ensure that, throughout the work of Hope Citadel Healthcare, 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 Hope Citadel Healthcare 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. Hope Citadel Healthcare 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.

Hope Citadel Healthcare 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 via the practice intranet and paper copy and reviewed on 07/09/2024.

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 Lead 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.

SECTION 1

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 jigsaw. 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.

Principles of Adult Safeguarding

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

In the safeguarding of all adults, Hope Citadel Healthcare 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

1.3 Legislative Framework

Safeguarding children, young people and adults at risk is a fundamental goal for Hope Citadel Healthcare. This policy has taken into account legislative and government guidance requirements, Oldham’s Safeguarding Children’s Partnership <https://www.olscb.org/> Oldham Safeguarding Adult Board (OSAB) www.osab.org.uk and Greater Manchester Safeguarding Partnership policies and procedures [\[LINK\]](#) . All links to the relevant legislation and guidance can be found in [Appendix 1](#)

1.4 Definitions

Definition of a 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.

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 2018) 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.

Definition of an Adult

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

Safeguarding Adults

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.

Definition 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 2018) and Care Act 2014. Detailed guidance on some of the indicators of abuse can be found within Oldham's Safeguarding Children's Partnership procedures [\[LINK\]](#), Greater Manchester Safeguarding Children Procedures [LINK](#) and within Oldham's Safeguarding Adult Board (OSAB) procedures [\[LINK\]](#)

The Concept of Significant Harm

Some children are in need because they are suffering, or likely to suffer, significant harm. The *Children Act 1989* introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children, and gives local authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer, significant harm.

Significant harm to adults at risk includes ill treatment; the impairment of, or an avoidable deterioration in physical or mental health; and the impairment of physical, intellectual, emotional, social or behavioural development of the vulnerable person.

There are no absolute criteria on which to rely upon when judging what constitutes significant harm. Consideration of the severity of ill-treatment may include the degree and the extent of physical harm, the duration and frequency of abuse and neglect, the extent of premeditation, and the presence or degree of threat, coercion, sadism and bizarre or unusual elements as well as the protective factors in the child, young person or adult at risk's life that may promote their resilience to adverse factors. Each of these elements has been associated with more severe effects on the child, young person or adult at risk and / or relatively greater difficulty in helping them overcome the adverse impact of the maltreatment. Sometimes, a single traumatic event may constitute significant harm (e.g. a violent assault, suffocation or poisoning).

More often, significant harm is a compilation of significant events, both acute and longstanding, which interrupt, change or damage the child or young person's physical and psychological development. Some children, young people or adults at risk live in family and social circumstances where their health and development are neglected. For them, it is the corrosiveness of long-term neglect, emotional, physical, psychological, financial or sexual abuse that causes impairment to the extent of constituting significant harm.

Child Abuse

Abuse and neglect are forms 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 a stranger. 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.

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

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. (*Working Together, 2018*)

Emotional Abuse Including Psychological, Behavioural, Interpersonal & Social Functioning

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 e.g. witnessing domestic abuse. Domestic Abuse can have a significant detrimental effect on the well-being and development of children. The Domestic Abuse Act 2021 states that children should be recognised as victims in their own right and not just as witnesses of domestic abuse.

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. (*Working Together 2018*)

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. (*Working Together 2018*)

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. (*Working Together 2018*)

Adult Abuse

The Care Act 2014 defines the following areas of abuse and neglect; they are not exhaustive but are a guide to behaviour that may lead to a safeguarding enquiry. This includes:

Physical Abuse

The physical mistreatment of one person by another which may or may not result in physical injury, this may include slapping, burning, punching, unreasonable confinement, pinching, force-feeding, misuse of medication, shaking.

Sexual Abuse

Any form of sexual activity that the adult does not want and or have not considered, a sexual relationship instigated by those in a position of trust including: rape, indecent exposure, inappropriate looking or touching, sexual teasing or innuendo, sexual photography,

Financial or Material Abuse

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.

Psychological and/or Emotional Abuse

This abuse may involve the use of intimidation, indifference, hostility, rejection, threats of harm or abandonment, humiliation, verbal abuse such as shouting, swearing or the use of discriminatory and or oppressive language a deprivation of contact, blaming, controlling, coercion, harassment, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks. There may be a restriction of freedom, threat to withdraw care or support, threat of institutional care.

Neglect and Acts of Omission

Behaviour by carers that results in the persistent or severe failure to meet the physical and or psychological needs of an individual in their care. This may include ignoring medical, emotional or physical care needs, failure to provide access to adequate nutrition and heating, wilful failure to intervene or failing to consider the implications of non-intervention in behaviours which are dangerous to them or others, failure to use agreed risk management procedures, inadequate care in residential setting, withholding affection or communication.

Self-Neglect

See Self Neglect section of policy [\[LINK\]](#)

Discriminatory Abuse

This includes forms of harassment; because of race, gender and gender identity, age, disability, sexual orientation, religion or health status and may be the motivating factor in other forms of abuse. It can be personal, a hate crime or institutional

Institutional or Organisational Abuse

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.

Domestic Abuse

See Domestic Abuse section of policy: [\[LINK\]](#)

Modern Slavery

See Human Trafficking and Modern Slavery section of policy: [\[LINK\]](#)

Radicalisation to Terrorism

See Prevent section of policy [\[LINK\]](#)

Mental Capacity Act (MCA) [Appendix 2](#)

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 or refuse treatment. For further guidance please see the GM Primary Care MCA policy and Multi Agency MCA policy in.

1.5 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: [\[insert name and contact details\]](#)

The Company Safeguarding Lead is: **Dr Rachel Belton**

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, such as "The MASH".
- Know and establish links, and when appropriate take advice from named and designated professionals in child and adult safeguarding;
- Has regular meetings with others in the Primary Healthcare Team and personnel from other agencies such as Health Visitors, 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 [Appendix 3](#) for contact details).
- Ensure that the practice team records safeguarding incidents appropriately.

Each practice should appoint a GP Safeguarding Lead.

Safeguarding Supervision

Safeguarding Supervision is vital to support the protection from harm to children, families and vulnerable adults. It is an accountable process which supports assures and develops the knowledge, skills and values of an individual or team. 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. [\[LINK\]](#)

Access to Safeguarding Supervision

Within Hope Citadel Healthcare adhoc 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 and hidden from online visibility. In addition, staff can seek consultation via the GM ICB Oldham locality 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 and hidden from online visibility.

1.6 Notifying the CQC of Allegations of Abuse

The Practice Manager at the Practice is responsible for notifying the CQC without delay about allegations of abuse where the harm is attributable to your Practice:

- Any referral due to suspicion, concern or allegation from any source that a person using the service has been or is being abused, or is abusing another person (of any age), including:
 - a) Details of the possible victim(s), where this is known, including:
 - b) A unique identifier or code for the person.
 - c) The date they were or will be admitted to the service.
 - d) Their age group.
 - e) Their gender.
 - f) Their ethnicity.
 - g) Any disability.
 - h) Any religion or belief.
 - i) Their sexual orientation.
 - j) All relevant dates and circumstances, using unique identifiers and codes where relevant.
 - k) Anything you have already done about the incident.

In a relation to where the alleged or possible victim of abuse is a child or young person under 18 years, the notification must include details of the allegation, including:

- Any relevant dates, witnesses (using unique identifiers or codes) and circumstances.
- The date the allegation was notified to the police, local safeguarding children board and the Local Area Team (where appropriate).
- The type of abuse (using the categories in the Department for Children, Families and Schools document Working Together).
- Anything the registered person has done as a result of the allegation.

Where the Registered Person is unavailable, for any reason, Lisa Nolan will be responsible for reporting the allegation to the CQC.

For further information please CQC Guidance on statutory notifications [\[LINK\]](#)

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.

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 may be being abused or neglected. Taking action will be justified, even if it turns out that the child or young person 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*): [\[LINK\]](#)

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. 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.

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 (**Tell me/ Explain to me/ Can you give me more Detail, TED**)
- 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 adults at risk 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.

Disclosures of Non-recent Abuse

Allegations of non-recent 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 [\[LINK\]](#)

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 Care via the MASH 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 MASH 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 and once recorded hidden from online visibility. 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.

2.2 Referral Process

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 GM ICB Oldham locality Safeguarding Team: **Jenny Robertson** 07929861484, **Kristy Atkinson** 07973904305, **Amelia Brummitt** 07773 030157.

Advice may also be sought directly from Children's Services/Adult Social Care via the MASH on **0161 770 7777**. Between 17.00 and 09.00 the **Emergency Duty Team** can be contacted on **0161 770 6936**.

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 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 MASH.

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 on call.
- Inform Children's Services/ Adult Social Care via the MASH on **0161 770 7777** or **0161 770 6936 out of hours** 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.

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.

Refer concerns to Adult Social Care via the MASH.

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. A concern for an "adult at risk" can be reported in verbally by telephone call to MASH or in writing (completion of an electronic referral form/email to MASH) [\[LINK\]](#)

Information to Include When Reporting a Concern:

a. The concern:

- what you understand has occurred
- to whom did it happen – full name, date of birth
- when did it happen - use 24 hour clock
- where did it happen

b. Alleged perpetrator:

- Who are they – name, date of birth, address
- Are they agency staff – if so contact details of the agency – name, telephone, address.

c. Witnesses:

- Who are they – name, DOB, address if known

d. Other people receiving services involving the alleged perpetrator:

- Are other people in the service safe?

e. Is the victim aware of the referral?

- What does the “adult at risk” wish to happen as part of the safeguarding process?
- Has the voice of any child been considered?

f. Do not contaminate evidence.

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.

Making a Referral to Children’s Services

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 [3.4](#) on 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. Contact **Duty and Advice Service** on **0161 770 7777** to have a discussion with a Social Worker regarding the safeguarding concerns and they will be responsible until the point of outcome (signposting, universal services, family support/Early Help, Social work assessment, closure after advice is given).
 2. In preparation for making a call to the duty and advice service you will need to have consent (although consent is not a requirement if that would put the child at greater risk), correct details of the child and the records available if required, factual account of the safeguarding concerns and what the specific family support needs are including the avoidable actual or potential adverse childhood experiences.
 3. Add SNOMED code - Referral to Social Services (procedure) SCTID: 306238000 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.

Action to Be Taken Following a Referral

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.

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 GM ICB Oldham locality Safeguarding Team.

2.3 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.'

There is an Oldham continuum of Need Document [LINK](#)

Early Help services can be accessed by submitting a referral via “worried about a child” [\[MASH Ref\]](#)
Early Help Supporting Tools can be found here [\[LINK\]](#)

2.4 Escalation Process

If you are unhappy regarding the outcome of your referral or decisions made by other agencies please follow Oldham Safeguarding Children Board has published a procedure the ‘OSCB 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 OSCP Escalation policy can be accessed here: [\[LINK\]](#)
The Greater Manchester Guidance can be found here [\[LINK\]](#)

Support with escalation of a case can be obtained from GM ICB Oldham locality Safeguarding Team.

2.5 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 data protection principles [\[LINK\]](#)
- 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.

GMC guidance is available – [\[LINK\]](#)

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

General Principles

Children

Working Together to Safeguard Children 2018 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 Oldham Safeguarding Partnership; **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 (2018): [\[LINK\]](#) 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.

As a general rule in safeguarding children,

- Child Protection (Section 47) consent is not required where a child is considered at risk or is thought to have suffered significant harm, nevertheless consent should be sought unless to do so would increase harm to the child.
- Child in Need (Section 17) referrals are usually made with parent/carer consent but consent is not required in cases where failure to share information could result in the situation deteriorating.
- For Early Help, consent would be required unless failure to provide early help would result in risk or harm to child.

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.

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).

For further information see GM Safeguarding Partnership Procedures [\[LINK\]](#). Information Sharing Flowchart can be found in [Appendix 4](#).

2.6 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).

The contribution of GP's 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.

A process for writing GP case conference reports has been uploaded as a template on EMIS in all Oldham practices.

[Appendix 5](#)

General points for preparing reports for Initial Case Conference is available via the GP Safeguarding Resource pack on Page 14.

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.

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 on all children and family member records including appropriate read codes.

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.

These procedures are regarded as best practice.

2.7 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 Oldham (available in the GP safeguarding resource pack)

- 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 into 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, Code of Practice 2021*

GMC 2013 Guidance *Good Medical Practice* states that '**Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.**'

2.8 GP involvement in Child Safeguarding Practice Reviews (CSPR'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 a CSPR, 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 child, young person or adult at risk and family into a Single Agency Assessment Review (SAAR). The outline format should guide the preparation of SAARs, to help ensure that the relevant questions are addressed and to ensure that information is provided to Oldham Adult Safeguarding Board (OASB) and Oldham Safeguarding Children's Partnership in a consistent format to help prepare an overview report.

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

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 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.

Reporting Form (previously "Form B") for gathering information from agencies or professionals who have information relevant to the case. Reporting forms should be completed by the relevant responsible officer and shared with the relevant CDOP.

Further information can be found in the Child Death Review Statutory and Operational Guidance (England) at: [LINK](#)

2.9 Use of interpreters

Why are interpreting services so important?

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.

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 [\[LINK\]](#)

Under no circumstances must carers, relatives, children or friends be used as interpreters

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; 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 result in an immediate referral to The MASH. The child will then be referred to the on call Safeguarding Paediatrician for further child protection medical assessment as required. [\[LINK\]](#) There is a link to a local protocol [\[LINK\]](#)

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 Services 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.

Bruising in immobile babies and children is rare and must always result in an immediate consultation with Children's Social Care.

3.2 Child Sexual/Criminal Exploitation

Definition of Sexual Exploitation

The Department of Education (2017) defines child sexual exploitation as follows:

'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.'

Child Sexual Exploitation is a form of child sexual abuse and can affect children under the age of 18 of any gender, race or culture. 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. Even though these children are able to legally consent to sexual activity, the law states that consent is only valid where they make a choice and have the freedom and capacity to make that choice.

Please see NHS England CSE Pocket Guide for additional information: [LINK](#)

Definition of Criminal Exploitation

The Home Office (2018) definition of Child Criminal Exploitation as follows:

‘Child Criminal Exploitation involves exploitative situations, contexts and relationships where young people receive ‘something’ (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them completing a task on behalf of another individual or group of individuals; this is often of a criminal nature.

CCE often occurs without the child’s immediate recognition, with the child believing that they are in control of the situation. In all cases, those exploiting the child have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships..’

Children of any age, race, culture and gender can be at risk of criminal exploitation. Children aged between 14-17 years of age are particularly vulnerable, however children as young as 10 have been targeted too.

County lines is a national issue involving the use of mobile phone ‘lines’ by organised crime groups to extend their drug dealing business into new locations. These groups exploit vulnerable persons which involve both children and adults who require safeguarding. Fearless.org has further information and tips on how to spot a child who might be involved.

**A Young Person 16 or 17 – THINK CHILD
Under 13 year NO CONSENT**

Child Exploitation is a complex form of abuse and can be difficult to identify and assess. Quite often victims of this form of abuse can be identified to be presenting with ‘normal’ adolescent behaviour, when in actual fact they are showing signs and indicators of exploitation.

Some of the signs and indicators that a child may be at risk of exploitation are as follows:

- Missing from home, education, located a distance from home
- Found with large quantities of drugs/ weapons
- Unexplained amounts of money, mobile phones, expensive items
- Unexplained injuries, unkempt
- Change in behaviour
- Expressions around invincibility / Fear of reprisal
- Increased interest in making money
- Reports being taken to parties, people’s houses, unknown areas
- Using of drugs or alcohol
- Parental concerns
- Repeated STI’s and/or pregnancy, sexual assault
- Associating with children at risk of exploitation / adults of concern
- Multiple referrals for incidents in the same location
- Alienated from family/community
- Placement breakdown
- Offending behaviour
- Victim of bullying
- Deteriorating mental health/self harm

There are certain vulnerabilities that can increase the risk of child exploitation such as:

- Children Looked After
- Physical, emotional, sexual abuse, neglect
- Learning disability / difficulties
- Questioning sexuality
- Bereavement of a significant person
- Lack of protective factors
- Parenting concerns – Mental Health, substance use, domestic abuse
- Living in poverty/Homelessness
- Social isolation
- Missing from home/education
- Associating with gangs
- Drug/alcohol use
- Peers who are victims of exploitation

It is important to note that any child can be a victim of child exploitation. This is extrafamilial abuse that occurs outside of the family home in most instances. The risk factors and vulnerabilities listed above are not exhaustive and identified concerns should be highlighted and explored.

Children at risk of exploitation are vulnerable to physical and emotional abuse and neglect, which can result in a child suffering significant harm. Child exploitation is never the victim's fault, even if there is some form of exchange: all children and young people under the age of 18 have a right to be safe and should be protected from harm.

The Complex Safeguarding Hub is a specialist multi agency team that supports children at risk of exploitation. There is a health representative within the team which provides a link between health partners in Oldham. This is to ensure that all relevant information is available in relation to children and young people at risk of exploitation. Ensuring there is health input into multi agency decision making.

GPs will be notified when a child or young person is open to Complex Safeguarding, where they are known to be at risk of sexual/criminal exploitation. It is essential that a Child Exploitation flag is placed on the child's health record, stating that the child is at risk of exploitation. As a result of this all professionals who access the record will be immediately aware that the child is at risk. The Complex Safeguarding Hub should be notified of any contact with the child, including feedback following GP appointments.

To support the work of the Complex Safeguarding Hub and to ensure that all appropriate safeguards are in place, relevant health information will be requested from the GP records. This will be current and historic information about children at risk of exploitation and, in some cases, in relation to wider family members. The information is often required immediately due to significant concerns about the safety of a child.

Children at risk of exploitation are often hard to reach and difficult to engage, often with a number of unmet health needs. Due to this we recommend that health professionals who have contact with a child known to be at risk of exploitation, prioritise same day appointments where possible, ensuring that all health needs are addressed during each contact. This is because they may not access another health service for a significant period of time thereafter.

Where concerns are identified that a child may be at risk of exploitation, the wishes and feelings of the child should be obtained when deciding how to proceed with concerns. However, due to the grooming and coercion children at risk of exploitation experience, they are unlikely to disclose that they are being sexually exploited. They often identify the perpetrator of this abuse as the person they are loyal to and can trust. Due to this, professionals need to have the knowledge, skills and professional curiosity to make an assessment of the child, analysing the risk, ensuring that the signs and symptoms are interpreted correctly and the appropriate support is given.

Where there are concerns that a child disengage from the support they are being offered when they access a service as a result of reporting concerns, this should be discussed and specialist safeguarding support should be accessed, to agree a way forward. Any decision made 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.

As in all cases, concerns that a child may be at risk of exploitation should be discussed with the practice safeguarding lead, the Specialist Nurse for Child Sexual/Criminal Exploitation in the Complex Safeguarding Hub or from Oldham locality GM ICB Safeguarding Team. Advice should be sought, and a decision made as to whether there should be a referral to Children's Social Care and the Complex Safeguarding Hub.

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 [\[LINK\]](#)

Contact Details:

MASH	0161 770 7777
Oldham Complex Safeguarding Hub	0161 856 9088
Specialist Nurse for Child Sexual & Criminal Exploitation : Jane Moores	07811 755 680 jane.moores1@nhs.net
GM ICB Oldham locality Safeguarding Team	OLDCCG.safeguardingoldham@nhs.net

3.3 Looked After Children* & Care Leavers

The term looked After children (LAC,) Children Looked After (CLA) and children in Care (CIC) are all used to refer to children who are in placed in the care system. Young people in Oldham wished to be referred to “Children Looked After”

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 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*).

Do not remove from the list any Looked After Child from the Practice List unless it is confirmed that they have registered elsewhere.

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 consultations should be forwarded to the Oldham Lac Health Team at the below generic email address: oldhamlac@nca.nhs.uk.

Children Looked After should be identified using the SNOMED codes.

Care Leavers:

The legal definition of a Care Leaver is a young person who was in the care of the Local Authority for a period of 13 weeks or more spanning their 16th birthday. A Care Order can last until the child is aged 18. When Cared for Children reach the age of 16, they begin preparing to leave the care system as young adults

Leaving Care Services are statutory services that are commissioned by the Local Authority to provide support and guidance to improve the life chances of young people living in and leaving care aged 16 to 25. During this crucial period of transition from ‘care’ to independence, services aim to prevent or reduce the long-term negative impact of a traumatic transition, providing support with:

- finding a suitable place to live
- securing and sustaining constructive education, training or employment
- establishing and maintaining supportive relationships

A care leaver SNOMED code is available for practices SCTID: 770347003. This can be used if a young person has agreed for the code to be used on their records, it should be removed once the young person reaches their 25th birthday. It will highlight those young people who are no longer in care but are likely to have increased vulnerabilities. Greater Manchester ICB supports care leavers with prescription costs and young people can be directed to the Greater Manchester Combined Authority Care Leaver App - Bee Connected Care leaver App.

A GP resource is available to support primary care to care from Children Looked After and Care Leavers:



GM GP Resource
Pack updated 2023.c

Unaccompanied Asylum Seeking Children

Unaccompanied asylum seeking children 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 Oldham 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/Nurse for Safeguarding Children (see [Appendix 3](#) for contact details) or where relevant, with the consultant providing care for the child. Any referrals where concerns are substantiated or still persist, then the child must be referred to Children's Services by a consultant paediatrician 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

Definition

The Domestic Abuse Act 2021 was passed in Law in April 2021. The Act created a new cross government statutory definition of Domestic Abuse:

Domestic Abuse is now defined as:

Behaviour of a person towards another person is "domestic abuse" if the persons are aged 16 or over and are personally connected to each other. Behaviour is abusive if it consists of any of the following:

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

Issues related to so called "Honour" Based Abuse, Forced Marriage and Female Genital Mutilation, Stalking and Harassment also fit under the umbrella of domestic abuse and victims are not confined to specific genders or ethnic groups.

It does not matter whether the behaviour consists of a single incident or a course of conduct. Domestic Abuse is often driven by the desire of one person to have power and control over another person. This is what is termed as Intimate Terrorism - domestic abuse that includes control and coercion with the victim living in fear of the perpetrator. However, research also shows that there can be differences in the driver and causes and desired objectives of the perpetrator of domestic abuse. Situational Couple Violence is where there is no dynamic of power, control and fear but there is conflict and arguments which may lead to emotional and physical violence and involves both partners. Violent Resistance is reactive violence where the victim can become the perpetrator. It is not the same as self-defence. In all 3 types there is a risk of escalation and serious physical and psychological impacts. The focus of support should be on identification and management of risks.

Stalking is also a type of domestic abuse which involves a pattern of repeated and persistent unwanted behaviour that is intrusive and engenders fear, it is when one person becomes fixated or obsessed with another and the attention is unwanted. Threats may not be made but victims may still feel scared. Importantly threats are not required for the criminal offence of stalking to be prosecuted. Stalking within an abusive relationship is very common and a high percentage of victims of domestic homicide had been stalked. Stalking is a crime and any concern related to stalking should be taken seriously. The victim should be advised to report stalking to the Police.

So called Honour based abuse is a crime or incident which may have been committed to protect or defend the honour of the family or community. These are crimes which are committed in the name of Honour but in which there is no justification. This may include forced marriage, and domestic violence and abuse or female genital mutilation. Children, young people and adults can suffer these types of abuse.

In all cases of domestic abuse, stalking, honour-based abuse and female genital mutilation safeguarding advice should be sought. It is important to not discuss these concerns with the victims family members or friends and specialist advice should always be obtained in the case of an emergency if you think someone is at immediate risk contact the police (Tel 999 or 101).

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.

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 creates 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 [\[LINK\]](#)

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.

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.

Non-Fatal Strangulation

Non-fatal strangulation was made a specific offence as part of the Domestic Abuse Act. The practice typically involves a perpetrator strangling or intentionally affecting their victim's ability to breathe in an attempt to control or intimidate them. Strangulation can be defined as obstruction of blood vessels and/or airways by external pressure to the neck resulting in decreased oxygen supply to the brain. Non-fatal strangulation is where such strangulation has not directly caused the death of the victim.

Guidance can be accessed on the links below:

[Non-fatal strangulation in physical and sexual assault-Dr-C-White-Jan-2023.pdf](#)

ifas.org.uk please look at page 3 halfway down right hand column it says when to refer to A+E/ENT immediately.

[IFAS 01 - Patient Information v2.indd](#) is a leaflet for victims with patient information on. See here for other languages [Information Leaflet for Victims \(Other Languages\) - Institute for Addressing Strangulation \(ifas.org.uk\)](#)

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.

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/healthcare professionals in the practice receive a disclosure of domestic abuse A Domestic Abuse, Stalking and Harassment risk assessment: [DASH/RIC](#) can be completed to identify the level of risk a victim is faced with

If a victim is identified as high risk a referral should be made to MARAC and safeguarding agencies.

If the risk is not assessed as high then consent 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: [\[LINK\]](#)

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 [\[LINK\]](#)

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.

[Appendix 6](#)

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: [DASH/RIC](#)

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

MARAC referral form is available [here](#) and is uploaded to the Oldham sharepoint page. Instruction on completing this are embedded below.



How to Upload a
MARAC referral.doc

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, 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). Ensure consultations are locked from online visibility. Safe Lives have produced some additional guidance for GPs [\[LINK\]](#)

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. Patients can be directed to: [\[LINK\]](#)

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.

Have you:

- Checked immediate safety of victim and any children
- Completed DASH risk assessment if unclear case is low risk.
- Referred to MARAC if case is high risk
- Made appropriate referrals to Children's Services/ Adult Social Care
- Ensure the victim has contact details for IDVA service 0161 770 5557/8 /National Domestic Violence Helpline (0808 2000 247)
- Documented actions on patient records, added appropriate read code and protected from online visibility.

3.6 Forced Marriage & Honour Based Violence

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.

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. [\[LINK\]](#)

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.

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 the MASH [\[LINK\]](#)

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 updated 2023); [\[LINK\]](#)
- Forced Marriage resource pack (HM Government updated 2023): [\[LINK\]](#)

3.7 Female Genital Mutilation (FGM)

Definition of FGM

The World Health Organisation (WHO) states that female genital mutilation (FGM):
“is a traditional harmful practice that involves the partial or total removal of external female genitalia or other injury to female genital organs for non-medical reasons”.

FGM is also known as Female Circumcision (FC) and Female Genital Cutting (FGC) or initiation. The reason for these alternative definitions 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

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 resource pack, updated 2023 can be found here [LINK]

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.

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.

The Greater Manchester FGM Pathway can be found here [LINK]
Referral to Children’s Services can be made here [LINK]

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]

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

FGM Enhanced Dataset GP Approach can be found here [LINK]

Have you:

- Made appropriate safeguarding referrals
- Mandatory reported to police via 101 if criteria met
- Documented in notes of victim and any children who may be at risk and added appropriate read codes
- Liaised with other Health Professionals involved i.e. Health Visitor, School Health Advisor, Midwife
- Added data to HSCIC FGM Clinical Audit Platform

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 – see section 2.2

For further information see GM Safeguarding Procedures [LINK]

There have been recent cases in relation to young girls who are binding their chests. They are young girls who are wishing to identify as male or non-binary. This is not inflicted by others as in the above scenarios however young people need support to understand how to safely make these choices.

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.

Response to Self-Neglect and Hoarding

Types of self-neglect:

- Lack of self-care to an extent that it threatens personal health and safety
- Neglecting to care for one's personal hygiene, health or surroundings
- Inability to avoid self-harm
- Failure to seek help or access services to meet health and social care needs
- Inability or unwillingness to manage one's personal affairs

Indicators of self-neglect:

- Very poor personal hygiene
- Unkempt appearance
- Lack of essential food, clothing or shelter
- Malnutrition and/ or dehydration
- Living in squalid or unsanitary conditions
- Neglecting household maintenance

Hoarding

- Collecting a large number of animals in inappropriate conditions
- Non-compliance with health or care services
- Inability or unwillingness to take medication or treat illness or injury

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.

When there are concerns with self-neglect for a patient, a think family approach needs to be utilised for example, are there any children in the household and the impact of this upon them

needs to be considered. There may be an impact upon the patients parenting capacity due to their own needs.

For further advice on Self Neglect, contact ICB Oldham locality Designated Professional Safeguarding Adult's on 07973904305 or contact MASH on 0161 770 7777.

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.

GM ICB Oldham locality 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'.

See Appendix 7 for reporting flowchart for raising concerns that an individual is being radicalised into extremist activities.

To discuss any concerns and referrals in respect of Radicalisation contact the Safeguarding Team within GM ICB Oldham locality:

07929861484 jennifer.robertson13@nhs.net
07973904305 Kristy.atkinson@nhs.net
07773030157 amelia.brummitt@nhs.net

Channel Panel

The 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. See here for further information and referral.

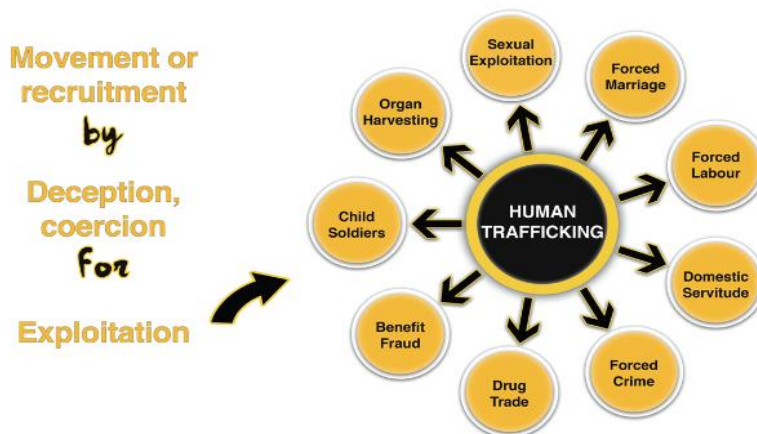
Protecting children and young people from radicalisation and extremism requires careful assessment and working collaboratively across agencies. Professionals who are concerned about a child or young person should follow their safeguarding arrangements and refer to the designated safeguarding lead. Local 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

3.11 Human Trafficking & Modern Slavery

What is Human Trafficking?

Trafficking is the movement of people by means such as force, fraud or deception with the aim of exploiting them.

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.



Trafficking of adults is:

The act: recruitment, transportation, transfer, harbouring or receipt of persons;

The means: threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person;

The purpose: exploitation. Trafficking persons is a criminal offence. The fact that the adult consents to the intended exploitation is irrelevant where any of the means (above) have been used.

Trafficking of children:

Requires only the “act” and “purpose” above. The “means” does not have to be shown.

Greater Manchester Safeguarding Children from Trafficking and Modern Slavery Procedure [\[LINK\]](#)

See Appendix 8 for advice for healthcare staff.

A Modern Slavery Toolkit has been adapted providing an overview of Modern Slavery and a detailed pathway and guidance for everyone across Oldham to use and is available [here](#).
A supporting 7 minute briefing is available [here](#).

Cuckooing

'Cuckooing' is a form of exploitation and the term used when an individual or a criminal gang target the home of a vulnerable person so they can use the property for criminal purposes such as drug-dealing, hiding weapons and other criminal activities. Criminals often befriend a vulnerable person in order to exploit them and use their property. The term takes its name from cuckoos who take over the nests of other birds.

Oldham Safeguarding Adults Board have adapted guidance on Cuckooing and is available [here](#).
A supporting 7 minute briefing is available [here](#).

3.12 Safe Sleep Guidance

Bury Oldham and Rochdale 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

The safest place for a baby to sleep is on their back in a cot, crib or Moses basket and in the same room with their parents or carers for the first six months.

Sleeping with a baby on a sofa puts the baby at greatest risk.

Infants should never share a bed with anyone who is a smoker, has consumed alcohol or has taken drugs (legal or illegal).

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 [\[LINK\]](#)

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 ICON



Abusive Head Trauma (AHT), also known as Shaken Baby Syndrome, is a devastating form of child abuse. Catastrophic injuries which result often present in a constellation including intracranial injuries, retinal haemorrhage and certain long bone fractures and spinal fractures which can lead to brain damage, blindness, learning difficulties and death.

Based on the study of AHT prevention programmes in the USA and Canada learning and experience and research into effective intervention, a multi-agency co-ordinated programme, known as ICON, has been developed comprising a series of 'touch points'. Each 'touch point' is brief but reinforces the simple evidence based 4 point message which makes up the ICON acronym:



*Version 5 updated 19/02/2018

Babies Cry, You Can Cope!

I	C		N
<p>Infant crying is normal and it will stop! Babies start to cry more frequently from around 2 weeks of age. The crying may get more frequent and last longer. After about 8 weeks of age babies start to cry less each week.</p>	<p>Comfort methods can sometimes soothe the baby and the crying will stop. Think about are they:</p> <ul style="list-style-type: none"> • hungry • tired • in need of a nappy change <p>Try simple calming techniques such as singing to the baby or going for a walk.</p>	<p>It's  to walk away if you have checked the baby is safe and the crying is getting to you. After a few minutes when you are feeling calm, go back and check on the baby.</p>	<p>Never, ever shake or hurt a baby. It can cause lasting brain damage or death. If you are worried that your baby is unwell contact your GP or call NHS 111.</p>

Speak to someone if you need support such as your family, friends, Midwife, Health Visitor or GP.

© Hampshire Clinical Commissioning Groups Safeguarding Children Services

Crying babies facts

Parents may, at some point, struggle to cope with their baby's crying. Evidence shows that in some extreme cases, crying can lead parents to feel like they may actually harm their child: This is an emotional response of both anger and frustration.

It is important to offer an alternative response to help control these extreme emotions. Crying is a normal part of child development which can have a significant negative impact on the emotional health of parents. All babies will cry a lot from the ages of 2 weeks to 3-4 months,

but this can vary from baby to baby. Crying seems to peak in the late afternoon and early evening but this can vary.

No one is really sure why babies cry so much in this period research is on-going. An immature nervous system may make babies more irritable and crying is their only means of expression. Crying is sometimes misdiagnosed as colic.

ICON is an evidenced-based delivery method discussing crying at the 6-8 week development check and asking how this is making parents feel is a touch point for the programme. Give the ICON advice and signpost for support.

There are useful resources at: [LINK](#)

3.14 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 town.

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 Oldham Council online form: [LINK](#)

**Have you asked which school a child attends at registration?
Is there a process in place to ensure the child remains in education or has entered education if not at school age at time of registration?**

3.15 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](#)

Cyber Bullying:

Cyberbullying is bullying with the use of digital technologies. It can take place on social media, messaging platforms, gaming platforms and mobile phones. It is repeated behaviour, aimed at scaring, angering or shaming those who are targeted. Examples include:

- spreading lies about or posting embarrassing photos or videos of someone on social media
- sending hurtful, abusive or threatening messages, images or videos via messaging platforms
- impersonating someone and sending mean messages to others on their behalf or through fake accounts.

Face-to-face bullying and cyberbullying can often happen alongside each other. But cyberbullying leaves a digital footprint – a record that can prove useful and provide evidence to help stop the abuse.

Safeguarding issues where technology is involved: Children and young people's relationship to technology is increasingly embedded across all walks of life and as such we cannot address their wellbeing and safety effectively without considering a potential risk that this can bring. Technology by its nature is constantly evolving and bringing both new opportunities and new risks for all but particularly for our children and young people. We can no longer adequately consider the safeguarding or wellbeing of our children and young people without considering their relationship to technology.

3.16 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 [\[LINK\]](#)

3.17 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 Salford Children's Services. 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.

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 other than parents, uncles/ aunts, 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.

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.

What is not private fostering?

- Looked After Children.
- Children living in arrangements under the care of Educational Authorities.
- Children cared for by parents, uncles/ aunts, 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 Oldham 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.

Oldham Council private fostering procedure can be accessed [LINK](#) It is a statutory requirement on Oldham 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

3.18 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 as 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.

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. For further information see Greater Manchester Safeguarding Procedures [\[LINK\]](#)

3.19 Children with Special Educational Needs and Disabilities (SEND)

A child or young person could be considered to have special educational needs or a disability if he or she has significant problems with communication, understanding, vision, hearing or physical functioning, social and emotional mental health concerns.

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 lead to a child with SEN or disability 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.

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.

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

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.

Once a death has been reported an independent reviewer will be allocated to conduct the review. Further information can be sought from the Safeguarding Team if required.

See [Appendix 10](#)

SECTION 4

4.1 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 GM ICB Oldham locality and GM Safeguarding partnership procedure for Managing Allegations of Abuse Made Against Adults Who Work with Children and Young People accessed at: [\[LINK\]](#)

Working Together to Safeguard Children, 2018, 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:

[Insert name] 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.

[insert name] 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.

[Insert name] will be the **Nominated Senior Officer** who will

- ensure that the practice deals with allegations in accordance with the GM ICB Oldham locality and Oldham 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 (LADO) [\[LINK\]](#)

All substantiated cases should be reported to the Designated Nurse for Safeguarding Children and CLA, GM ICB Oldham locality in addition to other regulatory bodies.

Adults at Risk

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. If an adult has suffered harm a referral should be made to the agency PIPOT (Person in a Position of Trust) lead to lead on the concern. If the agency do not have a PIPOT lead they should discuss this with the safeguarding lead within in the agency. Advice can be sought through MASH if required. The agency is responsible for coordinating the response to concerns made against a person in a position of trust who has or may harm an adult. For further information please see the Oldham Safeguarding Adults Board [OSAB-Guidance-and-Procedure-for-Adults-Allegation-Management.pdf](#)

The organisation must also follow internal disciplinary procedures which may include possible suspension without prejudice.

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 11](#)

4.2 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. [Appendix 9](#)

Appendix 1 : Guidance & Legislation

Document	Hyperlink
Data Protection Act 1998 (UK wide)	https://www.gov.uk/data-protection/the-data-protection-act
Working Together to Safeguard Children (2018) – HM Government	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf
Children and Social Work Act 2017	http://www.legislation.gov.uk/ukpga/2017/16/pdfs/ukpga_20170016_en.pdf?view=interweave
Domestic Abuse Act 2021	Domestic Abuse Act 2021 (legislation.gov.uk)
Safeguarding Adults: a guide for health care staff	NHS England » Safeguarding Adults: a guide for health care staff
Human Rights Act 1988	Human Rights Act 1998 (legislation.gov.uk)
Children Act 1989	http://www.legislation.gov.uk/ukpga/1989/41/contents
Adoption & Children Act 2002	Adoption and Children Act 2002 (legislation.gov.uk)
Children Act 2004	Children Act 2004 (legislation.gov.uk)
The United Nations Convention on the Rights of the Child (ratified by UK Government in 1991 and became statutory in Wales 2011)	https://downloads.unicef.org.uk/wp-content/uploads/2010/05/UNCRC_united_nations_convention_on_the_rights_of_the_child.pdf?ga=2.88277851.1307204172.1495717558-1399211569.1495717536
Care Act 2014	Care Act 2014 (legislation.gov.uk)
Serious Crime Act 2015	https://www.gov.uk/government/collections/serious-crime-bill
Sexual Offences Act 2003	Sexual Offences Act 2003 (legislation.gov.uk)
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
Greater Manchester Safeguarding Partnership	http://www.gmsafeguardingchildren.co.uk/
Promoting the Health and Wellbeing 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	http://www.rcgp.org.uk/clinical-and-research/toolkits/the-rcgp-nsppcc-safeguarding-children-toolkit-for-general-practice.aspx
Safeguarding Children Toolkit for General Practice, 2014.	Child safeguarding toolkit: Introduction (rcgp.org.uk)
Protecting children and young people. The responsibilities of all doctors (2012) – GMC	Protecting children and young people: The responsibilities of all doctors - ethical guidance summary - GMC (gmc-uk.org)
Children and young people ethics tool kit (2023) – BMA	Children and young people ethics toolkit (bma.org.uk)
RCN Safeguarding Children and Young People – Every Nurse’s Responsibility (2021)	Safeguarding Children and Young People – Every Nurse’s Responsibility Royal College of Nursing (rcn.org.uk)
Confidentiality and disclosure of health information tool kit – BMA	Confidentiality and health records toolkit (bma.org.uk)
Adult safeguarding toolkit (2020)	Adult safeguarding toolkit (bma.org.uk)
Safeguarding children and young people: roles and competences for health care staff	Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Royal College of Nursing (rcn.org.uk)

Document	Hyperlink
INTERCOLLEGIATE DOCUMENT (2019)	
Looked After Children: Roles and Competencies of Healthcare Staff (2020)	Looked After Children: Roles and Competencies of Healthcare Staff Royal College of Nursing (rcn.org.uk)
Prevent Duty Guidance	Prevent duty guidance - GOV.UK (www.gov.uk)
Prevent duty toolkit for local authorities and partner agencies	Prevent duty toolkit for local authorities and partner agencies - GOV.UK (www.gov.uk)
Channel Duty & Subsequent Guidance	Channel Duty Guidance: Protecting people vulnerable to being drawn into terrorism (publishing.service.gov.uk)
The Caldicott Principles	The Caldicott Principles - GOV.UK (www.gov.uk)
Safeguarding Vulnerable Groups Act 2006	Safeguarding Vulnerable Groups Act 2006 (legislation.gov.uk)
Mental Health Act, 1983 and code of practice	http://www.legislation.gov.uk/ukpga/1983/20/contents
Mental Capacity Act, 2005	Mental Capacity Act 2005 (legislation.gov.uk)
MCA Code of Practice	Mental Capacity Act Code of Practice - GOV.UK (www.gov.uk)
Deprivation of Liberty Safeguards (DoLS) at a glance	Deprivation of Liberty Safeguards (DoLS) at a glance SCIE
Health and Social Care Act 2008/2012	Health and Social Care Act 2012 (legislation.gov.uk)
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/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf
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
GDPR	http://safelives.org.uk/sites/default/files/resources/Legal Grounds for Sharing Information Guidance.pdf
Freedom to Speak up in Primary Care (2016)	whistleblowing-guidance.pdf (england.nhs.uk)
Multi-agency statutory guidance on female genital mutilation	Multi-agency statutory guidance on female genital mutilation - GOV.UK (www.gov.uk)
Modern Slavery Act, 2015	Modern Slavery Act 2015 (legislation.gov.uk)

Appendix 2



OSAB-Multi-Agency
-Mental-Capacity-Ac

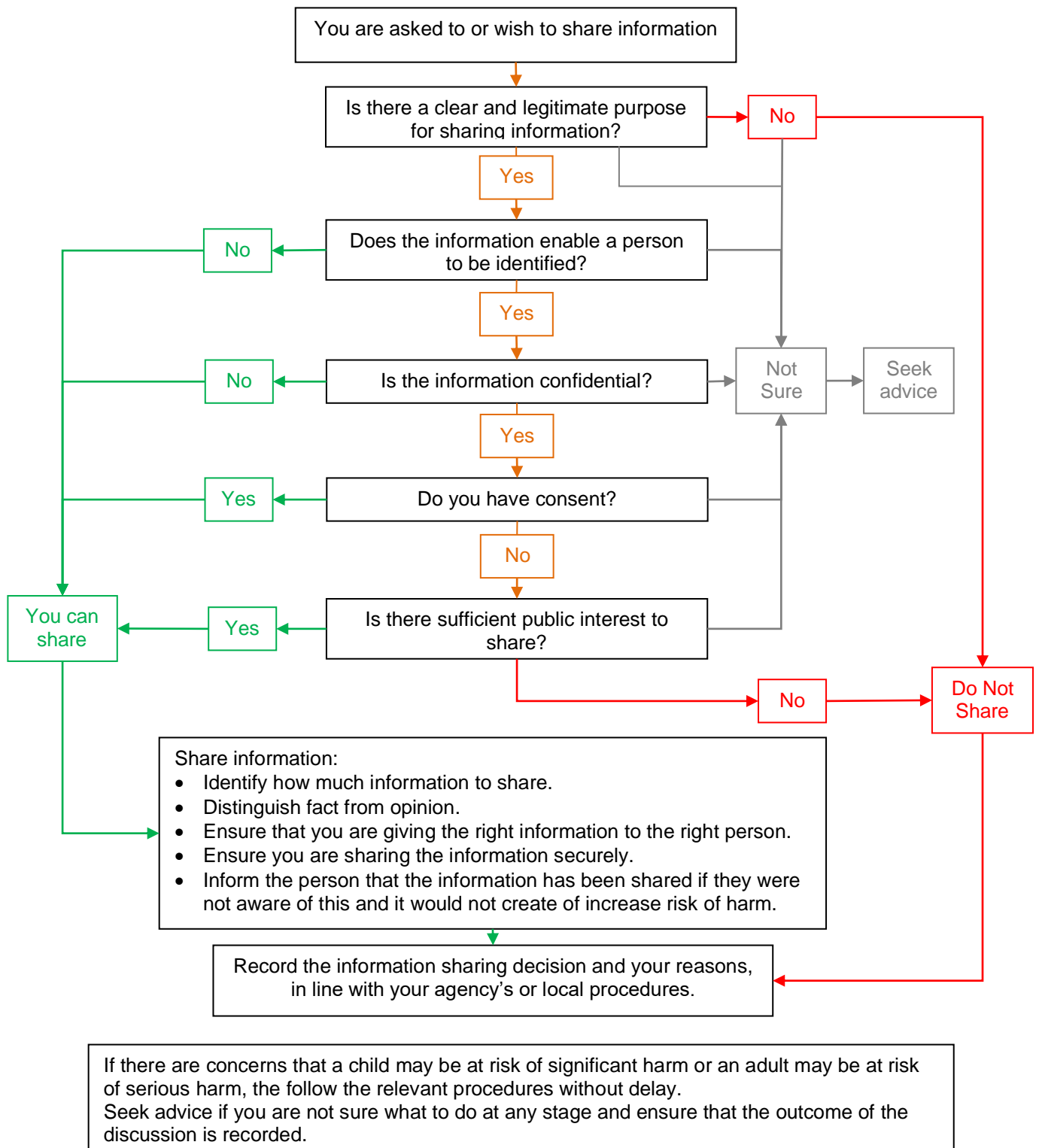
Appendix 3 – GM ICB- Oldham locality Safeguarding Team Contact Details

<p>Jenny Robertson Designated Nurse Safeguarding Children Civic Centre West Street Oldham OL1 1UT</p> <p>Mobile: 07929861484</p> <p>Email: jennifer.robertson13@nhs.net</p>	<p>Kristy Atkinson Designated Professional for Safeguarding Adults</p> <p>Civic Centre West Street Oldham OL1 1UT</p> <p>Mobile: 07973904305</p> <p>Email: Kristy.atkinson@nhs.net</p>
<p>Amelia Brummitt Designated Nurse Looked After Children Civic Centre West Street Oldham OL1 1UT</p> <p>Mobile: 0777303157</p> <p>Email: amelia.brummitt@nhs.net</p>	<p>Dr Adam Shipp Designated Dr for Safeguarding Children Consultant Community Paediatrician Salford Royal NHS Trust Featherstall Road South Oldham OL 9 7AY</p> <p>Telephone:</p> <p>Email: adam.shipp1@nhs.net</p>
<p>Janey Moores CSE Specialist Nurse Oldham Police Station 5Barn Street Oldham OL11LP</p> <p>Mobile: 07811 755 680</p> <p>Email: jane.moores1@nhs.net</p>	<p>Dr Shelley Grumbridge</p> <p>Email: shelley.grumbridge@nhs.net</p> <p>Mobile: 07970730248</p>
<p>Dawn Mills Specialist Safeguarding Nurse for Children (MASH) Civic Centre West Street Oldham OL1 1UT</p> <p>Mobile 07970 841854</p> <p>Email dawn.mills15@nhs.net</p>	<p>Monica Chapman Safeguarding Administrator Civic Centre West Street Oldham OL1 1UT</p> <p>Telephone: Mobile 07811 720865</p> <p>Email: monica.chapman1@nhs.net</p>

<p>Making a referral</p> <p>If you suspect a person is at immediate risk of harm call 999 and speak to the Police.</p> <p>You can contact the MASH from 8:40am – 5:00pm on Monday – Friday.</p> <p>Telephone: 0161 770 7777 Email: adult.mash@oldham.gov.uk (adults) Email: child.mash@oldham.gov.uk (children) Fax: 0161 770 1576</p>	<p>Ask for a social care assessment - to refer yourself or someone you know for a Care Act assessment for care and support, or to report a safeguarding concern for a vulnerable adult.</p> <p>Make a professional referral (adults) https://www.oldham.gov.uk/forms/form/270/en/make_a_professional_referral</p>
<p>LADO contact details</p>	<p>Colette.morris@oldham.gov.uk Tel: 0161 770 8870 Mob: 07583 101863</p> <p>Samia.Sagunder1@oldham.gov.uk Tel: 0161 770 0008 Mob: 07974 619094</p> <p>We have a referral form to assist you making your referral LADO referral form</p> <p>If you have a general LADO enquiry and would like to discuss it, please contact our Allegations Management Co-Ordinator Catherine.Leach@oldham.gov.uk or by phone - 0161 770 8081.</p>

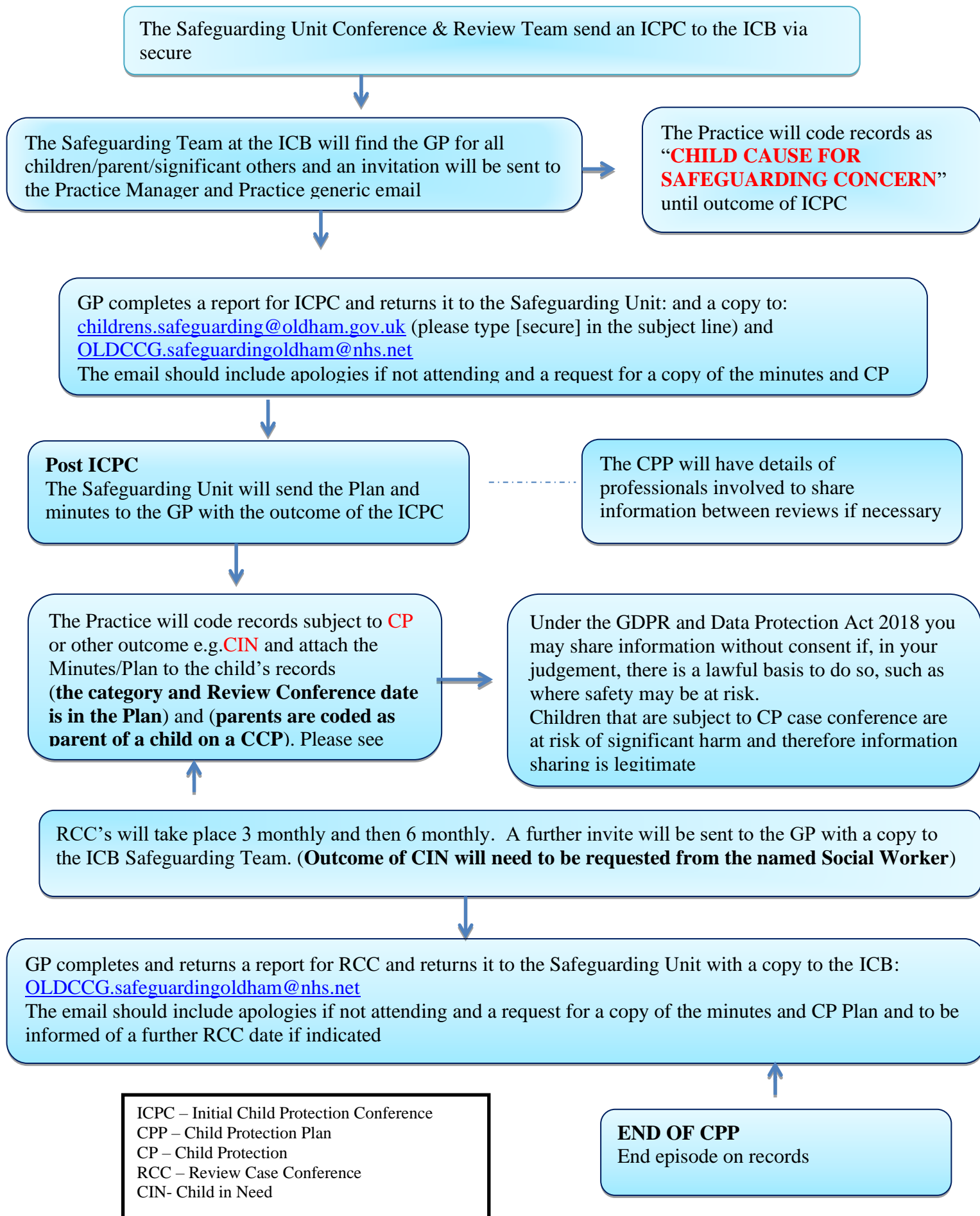
Appendix 4 – Information Sharing Guidance And Seven Golden Rules

FLOWCHART FOR KEY QUESTIONS FOR INFORMATION SHARING



Seven golden rules for information sharing can be found overleaf

Appendix 5 - Case Conference Process



GP INFORMATION FOR MARAC

GP notified by the Safeguarding Team that the patient is to be discussed at MARAC (victim/alleged perpetrator/children)

GP to share relevant information via the Safeguarding Team as per proforma

Information shared to include details about mental health, substance misuse, clinical history and any disclosures about domestic abuse **NB: the information shared only needs to be relevant to domestic abuse. A full medical history is not required**

Return form to

OLDCCG.safeguardingoldham@nhs.net

Following MARAC Action Plan to be forwarded to the GP via the Safeguarding Team

GP to review outcome and act on any recommendations

Information regarding MARAC to be stored confidentially on patient records and not accessible to third parties

Flag domestic abuse 13Hm (EMIS CODE) subject to Multi-Agency Risk Assessment Conference on relevant records

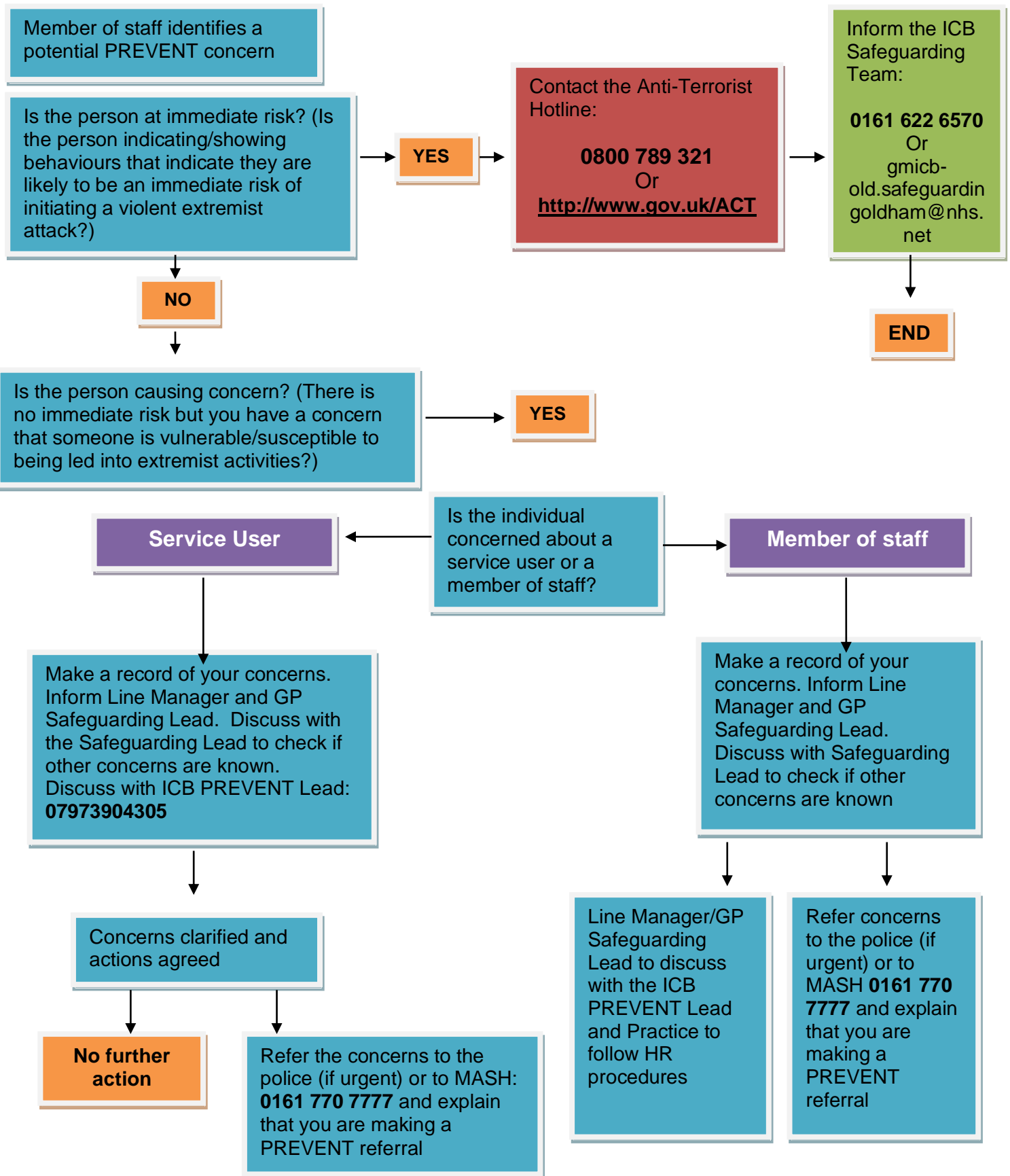
Consider domestic abuse when patient next presents at surgery. Try to see patient alone, if patient is not alone **DO NOT** discuss domestic abuse or MARAC as this may increase risks to patient

If you become aware of further incidents of domestic abuse within a 12 month period contact MASH and refer as a repeat victim

Code to be removed 12 months after the last meeting

Please note that perpetrators are not informed when a victim is referred to the MARAC, so it is unlikely that they will be aware of this information. The risks associated with sharing this information with the perpetrator may increase risks to the victim so this information **must not** be shared with the perpetrator.

Appendix 7- Reporting Flowchart raising concerns that an individual is being radicalised into extremist activities



Appendix 8 Guidance for Healthcare Staff



Trafficking Guidance
for Healthcare Staff.]

Appendix 9 –Staff Safeguarding Training Needs Primary Care



Primary care
SAFEGUARDING TR/



Learning Disabilities Mortality Review
(LeDeR) Programme



Notifying the LeDeR Programme of a death

The Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England.

The LeDeR Programme aims to guide improvements in the quality of health and social care services for people with learning disabilities across England. It will do so by supporting local reviews of deaths of people with learning disabilities aged 4 years and above across England.

Notification of a death

Families, friends, professionals and other key people can notify us of the death of someone with learning disabilities. This can be done via our website (<https://www.bris.ac.uk/sps/leder/notification-system/>) or a confidential telephone number **(0300 777 4774)**.

People who notify a death either online or by telephone will be asked a series of questions which will provide the LeDeR team with the information required for the review. This includes details about:

- The person who has died.
- The person reporting the death.
- A person who knew the person who died well.
- Any known health conditions or problems.
- Whether they were registered with a GP.
- Where they died and whether the cause of death was known.

What happens following a notification of a death?

An initial review of the death will then take place. As part of the review, the local reviewer would speak to family members, friends, professionals and anyone else involved in supporting the person who has died to find out more about their life and the circumstances leading to their death. If indicated, a more in-depth, multiagency review will be conducted.

For more information contact the LeDeR team on leder-team@bristol.ac.uk or phone 0117 331 0686 or visit www.bristol.ac.uk/sps/leder/

Appendix 11- Equality Outcome Analysis

1	Directorate	General Practice	
2	Team	Safeguarding	
3	Date	21/08/2023	
4	Lead Officer	Jenny Robertson, Kristy Atkinson, Amelia Brummitt	
5	Job Title	Designated Nurses/ Professional for Safeguarding Children, Safeguarding Adults and Looked After Children GM ICB- Oldham	
6	Document/ service	Safeguarding/ General Practice	
7	<input type="checkbox"/> New	<input checked="" type="checkbox"/> Existing	
8	People involved in the assessment		
9	Aims and objectives	To provide a model policy to support general practices with safeguarding responsibilities	
10	Who are the main stakeholders and how are they affected by this piece of work?	General Practitioners and General Practice Staff who will be supported by the policy in safeguarding practices	
11	Population Groups Affected:		
	Equality Strand	Research and data on the population groups affected What data is available and what does it show? E.g. local population data, service user monitoring data, relevant consultations, complaints, patient experience etc. Are there any gaps in the information? Think in terms of ACCESS, EXPERIENCE & OUTCOMES (see appendix 3 for examples of assessment considerations)	Based on the evidence is there Differential impact? * Yes /No/ Unknown no
	Racial & Ethnic Groups, (including Gypsies, Travellers, Asylum seekers Refugees, Migrants etc)	Access Experience Outcomes	no
	Religion & Belief	Access	no
			* Is the difference Justified? Yes/ No Please explain

	Experience		
	Outcomes		
Disabilities (physical, sensory impairments, learning difficulties & mental illnesses).	Access	no	
	Experience		
	Outcomes		
Age (Young & older)	Access	no	
	Experience		
	Outcomes		
Sexual Orientation (Lesbian, Gay, Bisexual)	Access	no	
	Experience		
	Outcomes		
Gender (Male & Female)	Access	no	
	Experience		
	Outcomes		
Transgender	Access	no	
	Experience		
	Outcomes		

	Carers	Access Experience Outcomes	no	
	Socio Economic Deprivation	Access Experience Outcomes	no	
	Pregnancy & Maternity (for employment only)	Access Experience Outcomes	no	
	Marriage & Civil partnership (for employment only)	Access Experience Outcomes	no	

12 Are further actions required to address the issues highlighted in this assessment?
e.g. changes to document, removal of barriers etc
 Yes No
(If Yes, please record these on the impact assessment Action plan below)

13 How is the effect of the document/strategy on different equality target groups going to be monitored? Through NHS Oldham Safeguarding Team, audit and review

14 Date assessment completed 19/12/2019 reviewed 21/08/2023 (no changes)

Equality Impact Assessment Action Plan

15	Action Plan				
Issue identified and equalities group or communities affected	Action to be taken	Expected outcome	Responsibility	Completion date	
16	Review Date : Usually 12 months but no longer than 3 years		31/10/2025		