# Mastercall Healthcare

# Safeguarding Children's Policy and Procedure

V5

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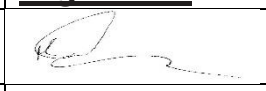
| Dr Michael Rooney |  | Organisational Medical Director | 11/08/2021 |
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## INTRODUCTION

This policy summarises the requirements of all members of staff and sessional workers in relation to the safeguarding of children. It is supported by detailed workflows for child protection and child in need processes out of hours.

**This policy should be read in conjunction with other key Safeguarding documents:**

- Safeguarding Children and Young People: roles and competences for health care staff Intercollegiate Document (2014)
- Safeguarding 2010 Intercollegiate Document
- Safeguarding Children Board Child Protection Policies and Procedures Handbook (available online) at
  http://www.gmsafeguardingchildren.co.uk/
  http://www.tscb.co.uk/procedures/procedures.aspx
  http://www.traffordccg.nhs.uk/safeguarding/safeguarding-children/

  Children in special circumstances
  http://ww.tcsb.co.uk/procedures/children-in-specific-circumstances.aspx
- The Children Act (2004)
- DCSF (2015) Working Together to Safeguard Children: A Guide to Inter-agency Working to Safeguard and Promote the Welfare of Children. London
- Care Quality Commission (2009) Safeguarding Children: a Review of Arrangements in the NHS for Safeguarding Children. London: CQC

### 1.1 SCOPE OF THE POLICY

This policy refers to all employees of and those that work on behalf of Mastercall Healthcare who may come into contact with children during the course of their work.

The Children Act 2004 defines a child as anyone who has not reached their 18th birthday. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital, in prison or in a Young Offenders' Institution **does not change his or her status** or entitlement to services or protection.

### 1.2 What is the meaning of A CHILD IN NEED and CHILD PROTECTION

A child in need is defined under s.17 the Children Act 1989 as a child who is unlikely to reach or maintain a satisfactory level of health or development, or their health or development will be significantly impaired, without the provision of

services, or the child is disabled.

A child who may require a plan to protect him/her is defined under s.47 of the Children Act 1989 as a child who is suffering or is likely to suffer significant harm.

The Children's Social Care department for where the child lives determines whether a child is a child is "in need" or at risk of "significant harm" once they review referrals/information sent over to them.

Mastercall Healthcare is currently using the Child Protection Information Sharing system on Adastra which enables staff to know who is a Looked After Child or a child who is subject to a child protection plan.

### 1.3 Children with additional needs

Staff need to be aware that children with disabilities suffer more abuse than their non-disabled peers. Beliefs that minimise the impact of abuse on disabled children can lead to a failure to report abuse or neglect. When working with children with additional needs, staff need to ensure that children with disabilities are treated with the same degree of professional concern and:

● Be prepared to challenge carers and ensure that abusive and restrictive practices do not go unrecognised.

● The child's impairment should not detract from early multi-agency assessments of need that consider possible underlying causes for concern.

● Always ask when treating a disabled child: "Would I consider that option if the child were not disabled?"

● Recognise the barriers to communication that children with disabilities experience, be aware of different communication methods and where to seek specialist advice.

● Make it everyday practice for children with disabilities to make their wishes and feelings known.

Further information on safeguarding children with additional needs can be found at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/190544/00374-2009DOM-EN.pdf

### 1.4 Looked after children (LAC)

Under the Children Act 1989, a child is looked after by a local authority if he or she is in their care or provided with accommodation for more than 24 hours by the local authority. They fall in to four main groups:

• Children who are accommodated under a voluntary agreement with their parents (section 20).

• Children who are the subjects of a care order (section 31) or interim care order (section 38).

• Children who are the subjects of emergency orders for their protection (sections 44 and 46).

• Children who are compulsorily accommodated – this includes children remanded to the local authority or subject to a criminal justice supervision order with a residence requirement (section 21).

The term ‘in care’ refers only to children who are subject to a care order by the courts under section 31 of the Children Act 1989 - they may live with foster carers, in a Children’s Home, in a residential school, with relatives or with parents under supervision.

Children who are cared for on a voluntary basis are ‘accommodated’ by the local authority under section 20 of the Children Act – they may live in foster care, in a Children’s Home or in a residential school. All these groups are said to be ‘Looked After Children’. They may be looked after by our local authority or may be in the care of another authority but living in the local area.

Those children and young people who are subject to a legal order by which the local authority has gained shared parental responsibility (e.g. Interim care order, full care order , placement order) or who have been voluntarily accommodated by the local authority under section 20 of the Children Act (2002).

They might have been placed in care voluntarily by parents struggling to cope, or children's services may have intervened because a child was at significant risk of harm.

It has been identified nationally that 70% of LAC have emotional or mental health needs which may impact on their presentation within the health setting. This should be a key consideration in all clinical contacts

Children may enter care for all sorts of reasons. But most enter because they have been abused or neglected. These experiences can leave children with complex needs and this can increase their vulnerability to abuse.

Identification of the LAC in the health care setting is key to ensuring that their health needs are addressed whilst paying careful attention to confidentiality; that valid consent is sought and that information is shared appropriately and safely with those who hold parental responsibility and are in a position to ensure actions are undertaken.

### 1.5 Parental responsibility (PR)

It is important when a LAC is known that the following information is recorded by the clinician:

Name of Carer/s
Name and contact details for their allocated Social Worker
Parental Responsibility (in order to clarify any consent issues)

According to Section 3, Children Act 1989:

- PR is 'shared' between parents and the local authority if the child is cared for under an order imposed by the courts, i.e. Section 31 Full Care Order or Section 38 Interim Care Order, or a Section 44 Emergency Protection Order
- Birth parents retain full PR if child is cared for under a Section 20 Voluntary Agreement. Clarification of PR for the child should have been gathered as above. Where there is any doubt the procedure should be deferred and the child's allocated Social Worker contacted for clarification.
- As described above, consent in relation to a child can only be given by the person who holds Parental Responsibility (PR) for the child as set out in the Adoption & Children Act 2002

### 1.6 LAC who Do Not Attend/ Wait

In cases where the child does not attend an appointment this must be followed up and reported to social services if there is failure to contact to ensure the child's health needs are met.

**If a member of staff has information to indicate that any child may be subject to abuse they have a professional duty to follow the reporting procedure outlined.**

## 2 BACKGROUND

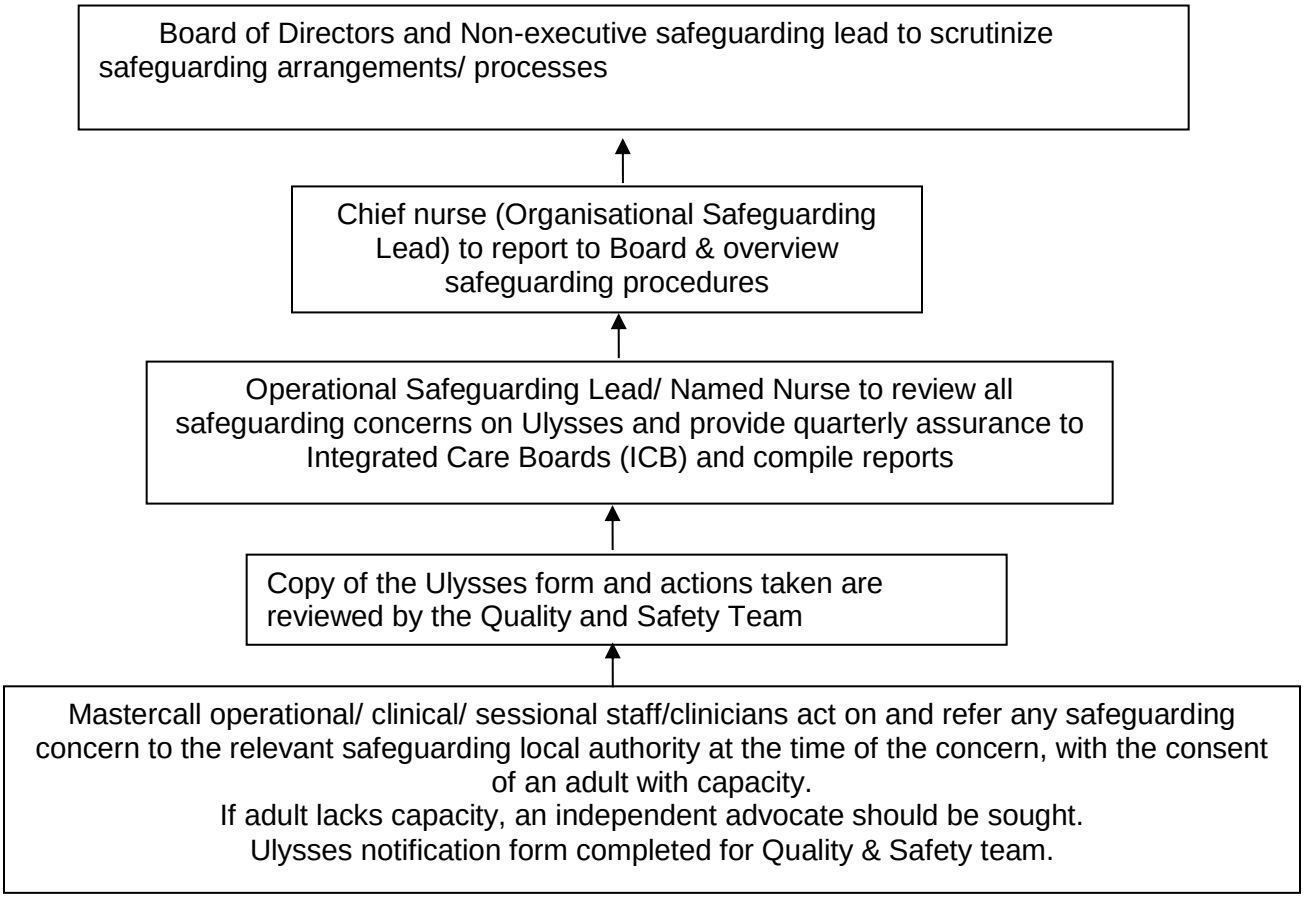
In providing a health care service, Mastercall Healthcare is committed to ensuring that all patients, of all ages, receive the best possible care and treatment within the resources available, that all statutory and legal requirements are met, and that the welfare of a child is paramount.

Section 11 of the Children Act 2004 places a duty on key people and bodies to make arrangements to have regard to the need to safeguard and promote the welfare of children.

All staff should have access to appropriate safeguarding training and should be able to recognise abuse, to respond, and refer to appropriate services without delay.

Local Safeguarding Partnerships reinforce the message that all professionals need to be aware of their safeguarding responsibilities.

## 3. Mastercall Lines of Reporting and Responsibility




All Staff should follow the above framework for referring / reporting any causes for concern relating to children. Also, any concerns should be reported that relate to parents of children where drugs, violence, alcohol or mental ill health may affect the children, directly or indirectly. Concerns requiring an immediate action should follow the emergency action algorithm **(see appendix 2).**

The Director and Board level Lead for Safeguarding is the Chief Nurse, who presents an annual report on Safeguarding Children to the Board of Directors. The Director level lead takes overall responsibility for the organisational Safeguarding strategy and all matters relating to the Safeguarding of Children for Mastercall Healthcare. The Board lead provides information and assurance to the ICB that standards outlined on the Safeguarding audit are met. Where any audit standard is not met, the Board lead is responsible for ensuring that action plans are in place to address any gaps.

The nominated operational lead for Safeguarding Children is the Safeguarding Lead for Adults as well. This person deputises for the Director Level/ Chief Nurse lead when necessary and ensures that the Safeguarding Children policy is implemented by all Heads of Department/ Service leads. This person produces an annual report based upon the organisational strategy to present to the Chief nurse and Board of Directors (Safeguarding Lead). The operational lead liaises with the Designated Nurses for Safeguarding within the ICBs and also with any other appropriate individuals with regard to the sharing of information where a Safeguarding report has been raised.

The quality and safety team receive reports of cause for concern via the on-line Ulysses reporting system, and ensure that these are referred to the named nurse or doctor. These are reviewed by the safeguarding lead, named nurse or named Doctor, once they have been received through the ULYSSES reporting system. Any appropriate further action or follow up is then arranged. Should the on-line system be “down”, and only then, the Ulysses report should be completed on paper and forwarded to Quality & Safety for processing.

Recording safeguarding referrals provides an audit trail and if the referrer provides an email address they will automatically receive an acknowledgement from Ulysses and will receive feedback where appropriate.

## 4. Types of Abuse

Within this policy, the term abuse refers to:

‘An act or omission by another person that causes significant harm to the physical, emotional or social well-being of a child.’

**Types of abuse:**

Physical Abuse
Emotional Abuse
Sexual Abuse
Neglect

Additionally, the following are also forms of abuse that a child may be at risk of which are related to the above main categories of abuse:

- Fabricated or Induced Illness
- Domestic Abuse
- Female Genital Mutilation
- Child Sexual Exploitation
- Forced Marriage
- Honour Based Violence
- Child Trafficking
- Online abuse

### 4.1 Physical Abuse

Physical abuse isn't accidental - children who are physically abused suffer violence such as being hit, kicked, poisoned, burned, slapped or having objects thrown at them, suffocating, drowning or otherwise causing physical harm to a child. Shaking or hitting babies can cause non-accidental head injuries (NAHI).

A number of factors may give rise to suspicion about the cause of an injury, the most obvious being a statement by the child and/or another person that the injury has been caused deliberately or not accidentally.

The following guidance is intended to help all professionals who come into contact with children. It should not be used as a comprehensive guide, nor does the presence of one or more factors prove that a child has been abused, but it may however, indicate that further enquiries should be made. The following factors should be taken into account when assessing risks to a child.
This is not an exhaustive list.

Professionals should be alert to situations where a child is injured and:

- The explanation provided by the parent or carer is apparently incompatible with the physical injury;
- There are conflicting or different explanations provided;
- There is no explanation provided or a lack of awareness of how the injury occurred;
- There is a reluctance on the part of the parent or carer to provide information about the current or previous injuries;
- There is a reluctance to agree to medical assessment;
- There is a delay or failure to seek appropriate medical attention for an injury;
- There are frequent minor injuries or presentations of the child at Accident and Emergency Departments;
- The parent or carer is impatient, angry or aggressive towards the child;
- The parent or carer is under the influence of alcohol or another substance;
- A child reacting in a way that is inappropriate to his/her age or development;
- The parent indicates difficulties in coping with the child;
- There is evidence of domestic abuse or parental mental ill health

#### 4.1.1 Bruising

Children frequently have accidental bruising, but it is often possible to differentiate between accidental and inflicted bruises. It may be necessary to do blood tests to exclude a clotting disorder.
The following must be considered as non-accidental unless there is evidence or an

adequate explanation provided:

- Any bruising to a pre-crawling or pre-walking baby;
- Bruising in or around the mouth, particularly in small babies, for example 3 to 4 small round or oval bruises on one side of the face and one on the other, which may indicate force feeding;
- Two simultaneous bruised eyes, without bruising to the forehead, (rarely accidental, though a single bruised eye can be accidental or abusive);
- Repeated or multiple bruising on the head or on sites unlikely to be injured accidentally, for example the back, mouth, cheek, ear, stomach, chest, under the arm, neck, genital and rectal areas;
- Variation in colour possibly indicating injuries caused at different times - it is now recognised in research that it is difficult to age bruises apart from the fact that they may start to go yellow at the edges after 48 hours;
- The outline of an object used e.g. belt marks, hand prints or a hair brush;
- Linear bruising at any site, particularly on the buttocks, back or face;
- Bruising or tears around, or behind, the earlobe/s indicating injury by pulling or twisting;
- Bruising around the face;
- Bite marks;
- Grasp marks to the upper arms, forearms, leg or chest of a small child;
- Petechial haemorrhages (pinpoint blood spots under the skin). These are commonly associated with slapping, smothering/suffocation, strangling and squeezing.

### 4.1.2 Burns and Scalds

It can be difficult to distinguish between accidental and non-accidental burns and scalds, and will always require experienced medical opinion. Any burn with a clear outline may be suspicious e.g.:

- Circular burns from cigarettes (but may be friction burns if along the bony protuberance of the spine, or impetigo, in which case they will quickly heal with treatment);
- Linear burns from hot metal rods or electrical fire elements;
- Burns of uniform depth over a large area;
- Scalds that have a line indicating immersion or poured liquid (a child getting into hot water of its own accord will struggle to get out and cause splash marks);
- Old scars indicating previous burns/scalds which did not have appropriate treatment or adequate explanation.
- Scalds to the buttocks of a small child, particularly in the absence of burns to the feet, are indicative of dipping into a hot liquid or bath.

The following points are also worth remembering:

- A responsible adult checks the temperature of the bath before the child gets in;
- A child is unlikely to sit down voluntarily in a hot bath and cannot

accidentally scald its bottom without also scalding his or her feet;
- A child getting into too hot water of his or her own accord will struggle to get out and there will be splash marks.

**4.2 Female Genital Mutilation (FGM)**

FGM involves procedures that include the partial or total removal of the external female genital organs for non-medicinal reasons. The practice is extremely painful and has serious health consequences, both at the time when the mutilation is carried out, and in later life.

The age at which girls undergo FGM varies. The procedure may be carried out when the girl is new-born, during childhood or adolescence, just before marriage or during the first pregnancy. However, the majority of cases of FGM are thought to take place between the ages of five and eight and therefore girls within that age bracket are at a higher risk.

FGM is illegal in the UK. It is an offence for UK nationals, or permanent UK residents, to carry out FGM abroad or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the procedure is legal.

**There is a legal duty on professionals to report known cases of FGM in under 18-year-olds, to the police. Failure to do so will result in disciplinary measures.**

**4.3 Emotional Abuse**

Emotional abuse is the persistent emotional ill treatment of a child such as to cause severe and persistent effects on the child's emotional development, and may involve:

- Conveying to a child that s/he is worthless, unloved, inadequate, or valued only insofar as s/he meets the needs of another person
- Imposing developmentally inappropriate expectations e.g. interactions beyond the child's developmental capability, overprotection, limitation of exploration and learning, preventing the child from participation in normal social interaction
- Causing a child to feel frightened or in danger e.g. witnessing domestic violence, seeing or hearing the ill treatment of another
- Exploitation or corruption of a child

Staff need to be aware that emotional abuse can also take the form of online abuse. Online abuse is any type of abuse that happens on the web, whether through social networks, playing online games or using mobile phones. Children can be at risk of online abuse from people they know, as well as from strangers.

Emotional abuse may be difficult to recognise, as the signs are usually behavioural rather than physical. The manifestations of emotional abuse might also indicate the presence of other kinds of abuse.

The indicators of emotional abuse are often also associated with other forms of abuse.
The following may be indicators of emotional abuse:

- Developmental delay;
- Abnormal attachment between a child and parent/carer e.g. anxious, indiscriminate or no attachment;
- Indiscriminate attachment or failure to attach;
- Aggressive behaviour towards others;
- A child scapegoated within the family;
- A child's frozen watchfulness, particularly in pre-school children;
- A child's low self-esteem and lack of confidence;
- A child appearing withdrawn or seen as a 'loner' with difficulty relating to others.

**Some level of emotional abuse is involved in most types of ill treatment of children, though emotional abuse may occur alone.**

### 4.4 Fabricated or Induced Illness

Fabricated or induced illness (FII) is a rare form of child abuse. It occurs when a parent or carer, usually the child's biological mother, exaggerates or deliberately causes symptoms of illness in the child. Fabricated illness is a form of physical and emotional abuse to a child.

There are three main ways of fabricating or inducing illness in a child:

- Fabrication of signs and symptoms; this may include fabrication of past medical history;
- Falsification of hospital charts, records, letters, documents, or specimens of bodily fluids;
- Induction of illness by a variety of means.

Concerns about possible fabricated or induced illness may arise when:

- Reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering;
- Physical examination and results of medical investigations do not explain reported symptoms and signs;
- There is an inexplicably poor response to prescribed medication and other treatment;
- New symptoms are reported on resolution of previous ones;
- Reported symptoms and found signs are not seen in the presence of the professionals;
- Over time the child repeatedly presents with a range of symptoms;
- The child's normal activities are being curtailed beyond that which might be expected for any medical disorder from which the child is known to suffer.

## 4.5 Domestic abuse

The cross-government definition of domestic violence and abuse is [1]
'any incident or pattern of incidents of controlling, coercive, threatening behaviours, violence or abuse between those who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- Psychological
- Physical
- Sexual
- Financial
- Emotional.'

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. The definition of domestic violence and abuse has now been extended to include young people aged 16 and 17.

Witnessing domestic abuse within a home is really distressing and frightening for a child, and causes serious harm including delayed or abnormal developmental in young children. Children living in a home where domestic abuse is happening are at risk of other types of abuse too. Children can experience domestic abuse or violence in lots of different ways. They might:

- see the abuse
- hear the abuse from another room
- see a parent's injuries or distress afterwards
- be hurt by being nearby or trying to stop the abuse

Prolonged and/or regular exposure to domestic violence/abuse is likely to have a serious impact on a child's health, development and emotional well-being, despite the best efforts of the adult victim to protect the child. It will often be appropriate for such children to be regarded as children in need, and in some cases as children suffering or likely to suffer significant harm.

The amendment made in the Adoption and Children Act 2002 to the Children Act 1989 clarifies the meaning of "harm" and makes it clear that "harm" includes impairment suffered from seeing or hearing the ill treatment of another.

[1] HM Government (March 2015) *Domestic Violence and abuse; new definition.* Accessed at :https://www.gov.uk/guidance/domestic-violence-and-abuse.

Domestic violence/abuse can have an impact on the safety and welfare of children in a number of ways, including:

- Children receiving blows or sustaining injuries during episodes of domestic violence;
- Children being emotionally harmed by witnessing the physical and emotional suffering of parents;
- Children's brain development being damaged by the impact of high levels of cortisol, caused by the stress of witnessing violence – especially during the first 1001 critical days of life, or during adolescence.
- The safety of an unborn child being threatened, where a pregnant woman is assaulted;
- The experience of violence/abuse having a negative impact on the ability of the adult victim to look after the children.

The impact of domestic violence/abuse on children is exacerbated when:

- The abuse is combined with substance misuse;
- Children witness the violence/abuse;
- Children are drawn into the violence/abuse;
- Children are pressurised into concealing the violence/abuse.

Even so, children's exposure to parental conflict, with or without exposure to violence, can lead to serious anxiety, stress and distress among children, with resulting negative outcomes.

### 4.6 Children educated in non-registered establishments

Whilst many children and young people receive good quality education in alternative provision or at home, some do not, and are largely invisible to services. The children who are most likely to fall into this category are children not attending school nor on a school roll, including children who have been excluded either on a permanent or an informal basis and for whom no suitable alternative provision is arranged, and also includes some children who may not be known to their local authority (LA) or any agencies, as there is no requirement for parents to register children as being educated at home. Research has shown that children and young people with additional needs were excluded, absent or missing from school much more frequently than other pupils nationally. These children can be hard to parent, and their parents do not then benefit from the respite that school provides – sometimes stretching their coping abilities to breaking point.

Children do not have a voice about whether they wish to be educated at home. These children do not have access to the same support and safeguards as other children. This includes teachers, school nurses, school counsellors and other support services that the school may offer. This could leave vulnerable children

educated at home more exposed to risks in their community. The police have also expressed strong concerns about this cohort of children. Their concern is that these children are beyond the reach of the Government's 'Prevent' strategy and therefore potentially more vulnerable to radicalisation. Some of these children may also experience risks within their family, such as abuse and neglect or exploitation.

It is therefore important that we ask callers which school the child in question is attending, to identify those that may be vulnerable, and then entering a safeguarding concern on Ulysses. This enables us to then share any concerns about children missing education with children's social care teams, and keep them safe.

### 4.7 Neglect

Neglect involves 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 and development. Children can sometimes be neglected due to parental mental or physical health issues or substance misuse.

Neglect may occur during pregnancy as a result of maternal substance misuse. Once the child is born, neglect may involve failure to:

- Provide adequate food, clothing or shelter (including exclusion from home or abandonment)
- Protect from physical and emotional harm or danger
- Meet or respond to basic emotional needs
- Ensure adequate supervision including the use of adequate care-takers
- Ensure adequate supervision in relation to risks posed by dogs
- Ensure access to appropriate medical care or treatment
- Ensure that her/his educational needs are met
- Ensure her / his opportunities for intellectual stimulation are met.

### 4.7.1 Dog bites:

1 in 4 families in the UK own a dog, all of which have the potential to injure a child.

All children are potentially vulnerable to attack(s) from dog(s);

- Young and very small children are likely to be at greatest risk;
- A young child may be unaware and unprepared for the potential dangers they could face;
- A young child is less able to protect themselves, and more likely to be of a size that leaves especially vulnerable parts of their body exposed to any 'assault';
- If it is a large dog in a small home;
- If the dog left alone with the child;

If you consider a dog is a serious risk to a child you should contact the police immediately. In addition, following an actual injury, a referral should be considered if any of the following criteria apply:-

- The child injured is under two years of age;
- The child is under five years of age and injuries have required medical treatment;
- The child is over five years and under 16 and has been injured more than once by the same dog;
- The child is between five years and 18 years and the injuries are significant;
- The child/young person is under 16 years of age, injuries have required medical treatment and initial information suggests the dog responsible could be prohibited and/or dangerous;
- A prohibited and/or dangerous dog is reported and/or treated, and is believed to be living with and/or frequently associated with children under five years.

Prohibited breeds are: Pit Bull Terrier, Japanese Tosa, Dogo Argentino and Fila Braziliero.

Neglect is the most common reason child safeguarding action needs to be taken.

### 4.8 Sexual abuse

Sexual abuse involves forcing or enticing a child to take part in sexual activities, including prostitution, whether or not s/he is aware of what is happening.

Activities may involve physical contact, including penetrative and non-penetrative acts. ‘Penetrative acts’ include ‘rape’ (forced penetration of vagina, anus or mouth with a penis) and ‘assault by penetration’ (sexual penetration of vagina or anus of a child with a part of the body or an object).
Sexual activities may also include non-contact activities, e.g. involving a child in looking at /production of abusive images, watching sexual activities or encouraging her/him to behave in sexually inappropriate ways. It may include use of photos, pictures, cartoons, literature or be via various media forms.

### 4.9 Child Sexual Exploitation

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 such as gifts, money or affection as a reward for performing sexual activities, or others performing sexual activities on them., 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.

Children or young people may be tricked into believing they're in a loving, consensual relationship. They might be invited to parties and given drugs and alcohol. They may also be groomed and exploited online.

When sexual exploitation happens online, young people may be persuaded, or forced to:

- send or post sexually explicit images of themselves
- take part in sexual activities via a webcam or smartphone
- have sexual conversations by text or online.

Abusers may threaten to send images, video or copies of conversations to the young person's friends and family unless they take part in other sexual activity. Images or videos may continue to be shared long after the sexual abuse has stopped.

Child sexual exploitation is a hidden crime. Young people often trust their abuser and don't understand that they're being abused. They may depend on their abuser or be too scared to tell anyone what's happening.

Children involved in any form of sexual exploitation should be treated primarily as the victims of abuse and the appropriate procedures followed, even in situations where the young person appears to be making choices of their own, and even where the young person is over the age of consent.

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

### 4.10 Working with Sexually active children

Children less than sixteen years of age cannot lawfully consent to sexual intercourse, although in practice may be involved in sexual contact to which, as individuals, they have agreed. Young people who are sexually active and below the age of 18 years should be assessed for risk of sexual exploitation using the Bichard's risk assessment. A copy of the proforma can be downloaded at: http://www.safeguardingchildreninstockport.org.uk/practitioners/policies-and-procedures/ NHS Bichard assessment tool.

**See appendix 3** for flow chart for professionals working with sexually active under 18s

A child **aged below 13** is considered in law **incapable of providing consent and intercourse will always be considered as rape.** If you aware that a child under 13 years is sexually active **you must make a referral to children's social care immediately or if you are concerned the child is in imminent danger you should ring 999.**

Once completed, the proforma should be submitted to the Safeguarding lead via the Quality and Safety team.

The primary concern of anyone working with sexually active young people under the age of eighteen years must be to safeguard and promote the welfare of the young person. The purpose of the Bichard guideline is to provide clear operational guidance for all practitioners where the processes of assessment and decision making are required.

The assessment provides;

- Actions to be taken in order to ensure sexually active young people are safeguarded
- A means of ensuring the obligation in relation to recommendation 12 of Michael Bichard's report is met (Bichard Inquiry, 2004)

### 4.11 Forced Marriage

A forced marriage is:

> "A marriage conducted without the valid consent of one or both parties, where duress is a factor".

Forced marriages are a form of domestic abuse and are dealt with as such by the police.

Forced marriages are where one or both persons involved get forced into a marriage that they do not want to enter and do not consent to the marriage. Forced marriage is not the same as arranged marriage. In an arranged marriage, people always have a choice about whether they get married or not. Because forced marriage is illegal, it can happen in secret and can also be planned by parents, family or religious leaders. It may involve physical abuse, sexual abuse or emotional abuse. It is felt that males may still be reluctant to report to the police that they have been forced into a marriage.

### 4.12 Honour Based Violence

Honour Based Violence (HBV) is a crime or incident committed to protect or defend the honour of a family and/or community.

HBV does not cover one specific crime; it generally occurs in domestic settings and can involve a range of offending behaviours which are used against individuals, families or other social groups to control and protect perceived cultural / religious beliefs and honour.

HBV may include murder, fear of or actual forced marriage, controlling sexual activity, domestic violence and abuse (including psychological, physical, sexual, financial or emotional), child abuse, rape, kidnapping, false imprisonment, assault, harassment and forced abortion. This list is not exhaustive.

These crimes cut across all cultures, nationalities, faith groups and communities. They transcend national and international boundaries; they are violations of human rights and there is no 'honour' in the commission of them. Offences of Honour Based Violence are prosecuted under the specific offence committed e.g. common assault, grievous bodily harm, harassment, kidnap, rape and murder.

Isolation is one of the biggest problems facing those trapped in, or under threat of violence. Many children or young people who face violence will not even discuss their worries with their friends for fear their families may find out.

If a child tells a member of staff about Honour Based Violence or Forced Marriage in respect of themselves or another family member, the staff member should:

- See the child alone in a safe and private place to obtain their wishes, views and feelings and explain confidentiality fully, including the need to share
- NOT make contact with the family or community leaders, and should not under any circumstances, tell the family or their social network about what the child has said, attempt mediation or use members of the community to interpret on behalf of the child;

### 4.13 Child Trafficking

Child trafficking and modern slavery are child abuse. Children are recruited, moved or transported and then exploited, forced to work or sold. Many children are trafficked into the UK from abroad, but children can also be trafficked from one part of the UK to another.

Trafficked children may be used for:

- Sexual exploitation;
- Domestic servitude;
- Sweatshop, restaurant and other catering work;

- Credit card fraud;
- Begging or pick pocketing or other forms of petty criminal activity;
- Agricultural labour, including tending plants in illegal cannabis farms;
- Benefit fraud;
- Drug mules, drug dealing or decoys for adult drug traffickers;
- Illegal inter-country adoption

Trafficked children experience multiple forms of abuse and neglect. Physical, sexual and emotional violence are often used to control victims of trafficking. Children are also likely to be physically and emotionally neglected.

Guidance on these and other issues relating to children can be found at:
www.safeguardingchildreninstockport.org.uk
http://www.gmsafeguardingchildren.co.uk
http://www.tscb.co.uk/procedures/procedures
http://www.traffordccg.nhs.uk/safeguarding

**County Lines**

County Lines County lines (Home Office, 2018) is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of 'deal line'. They are likely to exploit children and vulnerable adults to move and store the drugs and money and they will often use coercion, intimidation, violence (including sexual violence) and weapons. County lines activity and the associated violence, drug dealing and exploitation has a devastating impact on young people, vulnerable adults and local communities.

**4.14 Safeguarding disabled Children (physical and learning)**

Disabled children are recognised as the most vulnerable group in respect of safeguarding their wellbeing. They may have physical, sensory and learning disabilities and difficulties. Severely disabled children often rely on parents and carers to meet most or all of their needs. They may have limited mobility and may find it hard to make their feelings and wishes known because of communication or language difficulties. Children with complex needs may receive services in a range of settings from a number of care providers leaving them vulnerable to ill or cruel treatment, to neglect and abuse. If they have been harmed or ill-treated they may find it difficult to know how they can express their own concerns about their welfare and they may not even know that the care they are receiving is not safe or appropriate.

Mastercall follow the Greater Manchester guidance for children with disabilities and complex health needs:

https://greatermanchesterscb.proceduresonline.com/chapters/p_ch_with_disabilities.html

### 4.15 Mental Capacity Act/Deprivation of Liberty

The Mental Capacity Act (2005) provides a legal framework to empower people to make decisions for themselves, or professional care providers who have to make decisions on behalf of individuals who lack the mental capacity to make specific decisions at a specific time and should offer the least restrictive option. The Act applies to individuals who are 16 and over.

Whether a young person has mental capacity to make a particular decision or not, has to be considered on an individual basis in the light of the circumstances at the time. It is not something to consider once, which then applies across all decision making. The Act confirms that individuals should be presumed to have capacity unless it can be shown that they lack capacity to make a decision for themselves at the time the decision needs to be made.

No young person can be protected by the Mental Capacity Act from making an unwise decision.

The Act also states that people must be given all appropriate help and support to enable them to make their own decisions or to maximise their participation in any decision-making process.

The fundamental philosophy of the Act is to ensure that any decision made, or action taken, on behalf of someone who lacks the capacity to make decision or act for themselves is made in their Best Interests.

The Mental Capacity Act / Deprivation of Liberty Safeguards (MCA DOLS) provide protection for 16 and 17 year olds who are accommodated in hospitals or care homes in circumstances that amount to a deprivation of their liberty and who lack the capacity to consent to the care or treatment they need. For young people in other settings the Local Authority must apply to the Court of Protection, who can authorize a deprivation of liberty.

The Mental Capacity Act 2005 creates a new role: The Independent Mental Capacity Advocate (IMCA). Information re referring individual for an IMCA can be found at http://www.advocacyexperience.com/

Advice around MCA/DOLS and 16 and 17 year olds can be obtained from the local authority where the young person resides.

### 4.16 PREVENT

The Prevent Strategy is a cross-Government policy that forms one of the four strands of CONTEST: the United Kingdom's Strategy for Counter Terrorism. It includes the anti-radicalisation of vulnerable adults and children.

CONTEST as a counter-terrorism strategy is organised around four work streams, each comprising a number of key objectives:

- **PURSUE:** To stop terrorist attacks;
- **PREVENT:** To stop people becoming terrorists or supporting terrorism;
- **PROTECT:** To strengthen our protection against a terrorist attack; and
- **PREPARE:** To mitigate the impact of a terrorist attack.

The PREVENT lead is the operational safeguarding lead. All staff should complete the e-learning module for PREVENT and confirm completion of this by submitting the printed certificate to the HR department.

Click here to view the Prevent eLearning:

https://www.elearning.prevent.homeoffice.gov.uk

The e-learning includes information on how Channel links to the government's counter-terrorism strategy (CONTEST) through the Prevent strategy. It also provides guidance on how to identify people who may be vulnerable to radicalisation and how to refer them into the Channel programme. There are case studies to help users understand the process of identifying and referring vulnerable individuals, in addition to providing them with support, and is a good way of providing staff with a fundamental understanding of Channel. It also provides guidance on how to identify people who may be vulnerable to radicalisation and how to refer them into the Channel programme. There are case studies to help users understand the process of identifying and referring vulnerable individuals, in addition to providing them with support, and is a good way of providing staff with a fundamental understanding of Channel.

**What do we mean by the term terrorism?**

Although there is no generally agreed definition of terrorism internationally, in the United Kingdom the Terrorism Act 2000 defines terrorism as:

"The use or threat of action designed to influence the government or an international governmental organisation or to intimidate the public, or a section of the public; made for the purposes of advancing a political, religious, racial or ideological cause; and it involves or causes:

serious violence against a person;

serious damage to a property;

a threat to a person's life;

a serious risk to the health and safety of the public;

or serious interference with or disruption to an electronic system."

**What do we mean by the term radicalisation?**

Radicalisation refers to the process by which a person comes to support terrorism, and forms of extremism leading to terrorism.

The process of radicalisation is different for every individual and can take place over an extended period or within a very short time frame. There is no obvious profile of anyone likely to become involved in extremism or a single indicator of when a person might move to adopt violence in support of extremist ideas.

**What do we mean by the term prevention?**

Prevention means reducing or eliminating the risk of individuals or groups becoming involved in terrorism. Prevent involves the identification and referral of those susceptible to violent extremism into appropriate interventions. These interventions are aimed to stop the vulnerable being radicalised.

Extremists will always target the vulnerable in a bid to spread their firmly held, but flawed, ideologies, but we must tackle them at source and prevent people being brainwashed into terrorism.

**Channel Panel**

This is a multiagency panel chaired by the Local Authority to support individuals who have been identified as being groomed into terrorism. The role of the 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
- 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.

If anyone has any concerns about an individual being potentially radicalised they should phone 101 using the term ‘Channel’ or ring the anti-terrorism hotline on 0800 789 321. In an emergency 999 should be used.

**Further help**

HM Government multi agency guidelines can be found at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97857/FGM.pdf

**4.17 Modern slavery**

Modern slavery encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their

disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment. Although a large number of active organised crime groups are involved in modern slavery, it must be remembered that individual opportunistic perpetrators can also commit such acts.

The damage to the individual, by being used as a commodity for the profit of others, can be difficult to comprehend and thus we all have a role in preventing vulnerable people from being exploited and providing enhanced support as part of an overall response.

Modern slavery can take many forms but the most common involve sexual exploitation, forced labour and domestic servitude.

The Modern Slavery Act 2015 ensures that the National Crime Agency, the police and other law enforcement agencies have the powers they need to pursue, disrupt and bring to justice those engaged in human trafficking and slavery, servitude and forced or compulsory labour. It also introduces measures to enhance the protection of victims of slavery and trafficking.

Section 52 requires that where a specified public authority to which the Section applies, has reasonable grounds to believe that a person may be a victim of slavery or human trafficking, it must notify the Home Office.

**Mastercall's statement on modern slavery and human trafficking:**

Mastercall recognises we have an obligation to prevent slavery and human trafficking and will do all in its power to prevent slavery and human trafficking within our Organisation.

Modern slavery can take many forms including the trafficking of people, forced labour, servitude and slavery. Mastercall takes our responsibility extremely seriously. Our recruitment processes ensure our recruitment team and human resources department are alert to the signs of exploitation, in order that we may take the necessary action promptly and effectively should it be identified. Sectors affected include, but are not limited to, operational staff and clinical staff and GPs.

This statement focuses specifically on Mastercall' s compliance with the Modern Slavery Act 2015 (the Act) and highlights the steps we take to ensure there is no slavery or human trafficking occurring within the organisation or any suppliers.

In regards to Mastercall staff, if it is suspected that a patient or member of staff could be a victim of slavery then staff should call 101 and report it to the Police.

### 4.18 Homelessness

The health and wellbeing of people who experience homelessness is poorer than that of the general population. The longer a person experiences homelessness, particularly from young adulthood, the more likely their health and wellbeing will be at risk. Co-morbidity (two or more diseases or disorders occurring in the same person) among the longer-term homeless population is not uncommon. The average age of death of a single homeless person is 30 years lower than the general population at 47 years, and even lower for homeless women, at just 43 years.

The legal definition of homelessness is that a household has no home in the UK or anywhere else in the world, available and reasonable to occupy. Homelessness does not just refer to people who are sleeping rough. The following housing circumstances are examples of homelessness:

- rooflessness (without a shelter of any kind, sleeping rough)
- houselessness (with a place to sleep but temporary, in institutions or a shelter)
- living in insecure housing (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence)
- living in inadequate housing (in caravans on illegal campsites, in unfit housing, in extreme overcrowding).

For most people who are at risk of, or experiencing, homelessness there isn't a single intervention that can tackle this on its own, at population or at an individual level. Healthcare professionals play an important role, working alongside other professionals to minimise the impact on health from homelessness among people who are already experiencing it.

Action to prevent and respond to homeless across the life course is essential, these can include reducing the risk of homelessness to children and young people to strengthen their life chances

- enabling working age adults to enjoy social, economic and cultural participation in society
- breaking the cycle of homelessness or unstable housing by addressing parental mental health problems, and/or drug and alcohol use, and/or experience of the criminal justice system.

Schools report:

Children affected by homelessness often felt an overwhelming sense of displacement, having lost a place that felt like home. This led to a number of practical, emotional and behavioural challenges.

Practical challenges included keeping track of possessions and uniform, limited access to bathroom or laundry facilities and no quiet place to do homework.

Homelessness could also cause severe emotional trauma leading to emotional stress, anxiety and problematic behaviours. Whereas younger children often became withdrawn, older children could also become angry or aggressive at times.

These issues were compounded when a child was forced to move outside the area, increasing the length of journey to and from school: exacerbating tiredness, lateness, anxiety, and undermining children's ability to maintain relationships with peers and teachers.

Negative impacts were particularly influential at critical points in a child's educational journey – e.g. when a child was nearing exams, making it difficult for them to catch up irrespective of capability and potential.

Impacts could also be more pronounced in areas of mixed levels of affluence and deprivation, as children experiencing homelessness 'stood out' more to peers and teachers, leading to feelings of alienation and self-consciousness.

Teachers and education professionals also described how working with children experiencing homelessness led them to feel emotionally and physically exhausted, frustrated and, at times, despondent.

http://england.shelter.org.uk/__data/assets/pdf_file/0011/1474652/2017_12_20_Homelessness_and_School_Children.pdf

All of these factors impact negatively on a child's development and may cause significant harm.

The Homelessness Reduction Act 2017 (the Act) introduces new duties for local housing authorities to help prevent the homelessness of all families and single people, regardless of priority need. Local housing authorities must offer individuals who are homeless, or threatened with homelessness, a greater package of advice and support. The Act should mean more people get the help they need earlier, to prevent them from becoming homeless in the first place.

The Act introduces a new duty on specified public services to refer service users they consider may be homeless, or threatened with homelessness, to a local housing authority. The referring service must have the person's consent. The service user will need to decide which local housing authority they are being referred to, mirroring the way people choose which local housing authority to seek help from when approaching directly for housing assistance.

The Act defines an individual as "threatened with homelessness" if they are likely to become homeless within 56 days. However, the Department of Health & Social Care

encourages health services to refer individuals that may be at risk of homelessness, as early as possible to maximise the opportunities to prevent homelessness.

The basic legal requirement for a referral is the inclusion of the individual's:

- contact details,
- consent, and
- the agreed reason for the referral (i.e. that they are homeless or threatened with homelessness).

## 5 Our responsibility

Mastercall Healthcare will ensure that;

- The welfare of the child remains paramount.
- All children whatever their age, culture, disability, gender, language, racial origin, religious beliefs and/ or sexual identity have the right to be protected from harm.
- All suspicions and allegations of abuse must be taken seriously and responded to swiftly and appropriately, making a referral to the Children's Services department in the appropriate local authority.
- All staff (paid/ unpaid) working in the organisation have a responsibility to report concerns to the organisational Safeguarding Lead using the reporting tab within the **Ulysses system**. Should the Ulysses system be off-line, a Cause for Concern report may be completed and submitted to the Quality and Safety team using the Safeguarding box in main reception at Mastercall.
- The Caldicott Principles should be adhered to in relation to the sharing of information and confidentiality.

## 6. Information sharing

Robust information-sharing is at the heart of safe and effective safeguarding practice. Information sharing is covered by legislation, principally the General Data Protection Act 2018 (GDPR) and the Data Protection Act 2018. The GDPR and the Data Protection Act 2018 introduce new elements to the data protection regime, superseding the Data Protection Act 1998. Practitioners must have due regard to the relevant data protection principles which allow them to share personal information. The GDPR and Data Protection Act 2018 place greater significance on organisations being transparent and accountable in relation to their use of data.

All organisations handling personal data need to have comprehensive and proportionate arrangements for collecting, storing, and sharing information. The GDPR and Data Protection Act 2018 do not prevent, or limit, the sharing of information for the purposes of keeping children, young people and adults safe.

Professionals should refer to specific advice from their professional body regarding information sharing, for instance, the General Medical Council's (GMC's) Ethical Guidance for Child Protection or section 5 of the NMC Code 2015. There is a requirement for professionals to contribute, participate and share information for the purpose of statutory reviews.

Such guidelines are further supported by the Caldicott Principles, updated in 2017. Principle Seven states that the duty to share information can be as important as the duty to protect patient confidentially. It is crucial to understand that sharing information, when there is a need to share it, and a lawful basis for doing so, and maintaining its security and confidentiality, are compatible activities.

### 6.1 Information sharing specific to safeguarding children

Information must be shared to protect children, or to prevent or detect a crime. In addition, there are some specific statutory provisions that will require information sharing, for example relating to the operation of local safeguarding children's partnerships and relating to the statutory vetting and barring process for staff.

A child may be safeguarded and protected under the Children Act 1989 until their 18th birthday. However, medical consent, mental capacity, and consent to sexual activity, are lawful from the age of 16. A Gillick Competency Assessment may be used to determine a child's capacity to consent to medical treatment or intervention before the age of 16. The Assessment was designed to test whether a young person prior to their 16th birthday, had sufficient capacity, without parental intervention, to make decisions regarding their own medical treatment. The Fraser Guidelines were developed specifically in relation to consent for contraceptive or sexual health advice and treatment. Child protection procedures should always be instigated however when child exploitation is suspected, even if the child or young person is deemed competent.

### 6.2 Child protection - information sharing (CP- IS)

The Child Protection Information Sharing (CP-IS) programme is linking the IT systems used across health and social care to securely share basic information via a child's NHS number for children and unborn children who are subject to Child Protection Plans or Children in Care. It is endorsed by the Care Quality Commission (CQC) and is included in the key lines of enquiry during CQC inspections. It is also included in the 2019 NHS Standard Contract for providers of NHS unscheduled care. This programme moved into its second phase in 2019 and includes NHS scheduled care settings.

## 7 What should you do if a young person reports abuse or is at risk of any of the aforementioned concerns?

- React calmly
- Reassure the child that they were right to tell and that they are not to

blame, and take what the child says seriously

- Be careful not to be deemed as putting words into the child's mouth, the easiest way of doing this is by only asking open questions – i.e. "T.E.D" questions "tell me" "explain" "describe".
- Do not promise confidentiality
- Inform the child/ young person what you will do next
- Make a full and written record of what has been said as soon as possible and don't delay in making a referral to Children's Services.
- Complete a Cause for Concern/Safeguarding report in the Ulysses system or on a paper form if Ulysses is off line **(see appendix 1).**

### 7.1 Referrals

Where there is any concern relating to a child protection issue, the case must be referred to Children's Social Care as below. Referral should be made to the local Children's Social Care department, stating where the child is normally resident. Have all the relevant information at hand- details of the young person and any written concerns.

**Referrals to Children's Social Care**

Stockport 0161 217 6028 In hours
Stockport 0161 718 2118 Out of hours

Trafford 0161 912 5125 In hours
Trafford 0161 912 2020 Out of Hours

Children Social Care can also be contacted for advice.

The written report should include:

- **The child's known details including name, date of birth, address and contact numbers. The call number should also be logged.**
- **Whether or not the person making the report is expressing their own concerns or those of someone else.**
- **The nature of the allegation, including dates, times, specific factors and any other relevant information.**
- **Make a clear distinction between what is fact, opinion or hearsay.**
- **A description of any visible bruising or other injuries, also any indirect signs, such as behavioral changes.**
- **Details of witnesses to the incidents.**
- **The child's account if it can be given, of what has happened and how any bruising or others injuries occurred.**
- **Accounts from others, including colleagues and parents.**

The aim of the local authority Safeguarding Children team is to promote the welfare and safety of children while ensuring that they provide the family/carers with the support and tools to care for a child. Mastercall Healthcare will meet with named contacts on the Stockport and Trafford Safeguarding Children's Teams, Dental Access Centre and Walk in Centre on a regular basis to ensure that good working relationships are maintained and cases referred are discussed and fed back.

### 7.2 Emergency action – see appendix 2

During the out-of-hours period when a clinician is on duty, any safeguarding concerns should be immediately identified to a clinician. The child should then be seen and assessed by the clinician.

If a child is at immediate risk of harm dial 999. **It is not the organisations responsibility to decide whether abuse has taken place or not, however it our responsibility to pass on information to the appropriate authority immediately.**

In the case of suspected or reported sexual assault, the Police should be called immediately and the reference number recorded.

In the case of suspected Non-accidental injury, the child should be referred to the pediatrician at Stockport NHS Foundation Trust (Stockport patients) or South Manchester University Hospitals NHS FT (Trafford patients) via children's social care in the relevant local authority. Refer to the flow chart on page 9 for all telephone numbers. All concerns should be copied to the Safeguarding lead.

### 7.3 Allegations against professionals

The vast majority of adults who work with children act professionally. However, some individuals will actively seek employment or voluntary work with young people in order to harm them.

All concerns regarding staff practice should be reported to the organisational Medical Director, Chief Nurse or the safeguarding lead. Mastercall falls within Greater Manchester and as such is subject to the requirements of the Greater Manchester Safeguarding Partnership (GMSP). GMSP requires Mastercall to comply with their policy when managing allegations against professionals. This policy can be found at:
http://greatermanchesterscb.proceduresonline.com/chapters/p_man_allegations.html

Working Together to Safeguard Children stipulates that information must be shared with the Local Authority Designated Officer (LADO) where it is considered that a member of health staff poses a risk to children or might have committed a criminal offence against one or more children.

Any allegations involving an external professional e.g. a teacher, carer, a counsellor who works with children need to be shared with the Children's Services and/or the Police.

## 8 Human Resources

Mastercall Healthcare operates a safe recruitment policy in line with national Safeguarding requirements. Please refer to the policy on Safe Recruitment.

## 9 Training and Education

All employees, including directors and non-executive directors, must attend mandatory training in Safeguarding Children in line with national guidance as outlined within the Mastercall Safeguarding strategy.

The HR team will maintain a register of staff with the dates of last mandatory training dates and will produce a quarterly report in this regard to the operational Safeguarding Lead. Any gaps in training and education will be addressed by developing and implementing a robust action plan. Training of staff will be monitored on a quarterly basis and reported annually in the Board report. Staff who fail to complete mandatory training updates may be subject to disciplinary action.

Any staff that feel that they would benefit around safeguarding training around any particular matter are encouraged to communicate this to the Safeguarding Lead.

## Further references


- Working Together to Safeguard Children- A Guide to Inter-agency Working to Safeguard and Promote the Welfare of Children (DCSF 2006)
- Safer Working Practice for Adults who work with Children and Young People (DCSF 2007)
- Safeguarding Children and Young people: roles and competences for health care staff
- Intercollegiate document September 2010
- The Children Act (2004)
- DCSF (2010). Working Together to Safeguard Children: A Guide to Inter-agency Working to Safeguard and Promote the Welfare of Children. London:
- Care Quality Commission (2009). Safeguarding Children: a Review of

Arrangements in the NHS for Safeguarding Children. London: CQC.

- Department of Health (2009) No secrets: Guidance on developing and implementing multi- agency policies and procedures to protect vulnerable adults from abuse. DH. London.

**Useful web links:**

**www.gmsafeguardingchildren.co.uk**

**www.safeguardingchildreninstockport/practitioners/policies2**

**www.safeguardingchildreninstockport.org.uk/handbook.html**

**www.cyps.org.uk/safeguarding.procedures**

**As a professional you have a responsibility to safeguard children from harm.**

**Appendix 1**

# MASTERCALL HEALTHCARE
# SAFEGUARDING CONCERN

| | | |
|---|---|---|
| **PLEASE TICK APPROPRIATE BOX**<br><br>**CHILD** ☐ **OR** **ADULT** ☐ | | |
| **Full Name of person you are concerned about:** | | |
| **Call Number:** | **Date of concern:** | |
| **Ethnicity of person you are concerned about:** | **DOB:** | **Gender of person you are concerned about:** |
| **First Language of person you are concerned about:**<br><br>**Is an interpreter required?**<br>**No**<br>**Yes** **(if yes, please state language required)** | | |
| **Address for person you are concerned about:** | **Contact Number:** | |
| **Are there any known health and safety risks within the home?**<br>**No**<br>**Yes**<br>**(if yes, please detail)** | | |
| **Has the adult or child you are concerned about got any special needs?**<br>**No**<br>**Yes**<br>**(if yes, please detail)** | | |

| | |
|---|---|
| **Next of kin information:**<br>**Forename:**<br>**Surname:**<br><br>**Relationship to individual you are concerned about:** | **Address for next of kin:** |
| **Are there any other key contact people for the child or adult you are concerned about?**<br>**(e.g. carer, foster carer)**<br>**No**<br>**Yes**<br>**(if yes, please detail)** | |
| **Service Location:** | **GP Surgery:** |
| **CCGs Affected (Please tick all that apply):**<br><br>**Bury** **NHS England** **Trafford**<br>**HMR** **Stockport**<br>**Manchester** **North West Ambulance Service** | |
| **If concern relates to a professional organisation, please give details:** | |
| **CONCERN DETAILS** **Date:**<br><br>**Categories of concern applicable:**<br>**Physical abuse**<br>**Emotional abuse**<br>**Neglect**<br>**Sexual abuse**<br>**Female Genital Mutilation**<br>**Fabricated Illness**<br>**Exploitation (including Child Sexual Exploitation, financial abuse)**<br>**Forced Marriage**<br>**Domestic Violence**<br>**Honour Based Violence** | |

| |
|---|
| **Human Trafficking**<br>**Mental Capacity**<br>**Deprivation of Liberty**<br>**Discriminatory abuse**<br>**Organisational abuse**<br>**Self-neglect**<br>**Homelessness**<br>**Family support needed** |
| **Summary of what are you concerned about why?** |
| **Your role:** |
| **Is there an alleged perpertrator of abuse?**<br>**No**<br>**Yes (please detail)** |
| **What action did you take at the time of your concern?**<br><br>**Police 999 call (please write reference number)**<br><br>**Police 101 call (please write reference number)**<br><br>**Referral to Trafford Children's Social Care (name of person spoken to)**<br><br>**Referral to Trafford Adult's Social Care (name of person spoken to)**<br><br>**Referral to Trafford Out of Hours Social Care (name of person spoken to)**<br><br>**Referral to Stockport Children's Social Care (name of person spoken to)**<br><br>**Referral to Stockport Adult's Social Care (name of person spoken to)** |

**Referral to Stockport Out of Hours Social Care (name of person spoken to)**

**Referral to a support service (Name of service and person spoken to)**

**Referral to Housing Department (Name of service and person spoken to)**

**Is there any outstanding action required?**

**No**

**Yes (please detail)**

**Is the patient aware that you will are sharing this information**

**Yes**

**No (please state why this has not been discussed)**

| **Was the patient admitted to hospital? YES/NO** | **Details:** |
|---|---|

**Is the client aware referral was made:**
**Yes**
**No**
**If not, why not**

**Details of the person reporting:**

**Name:**

**Role:**

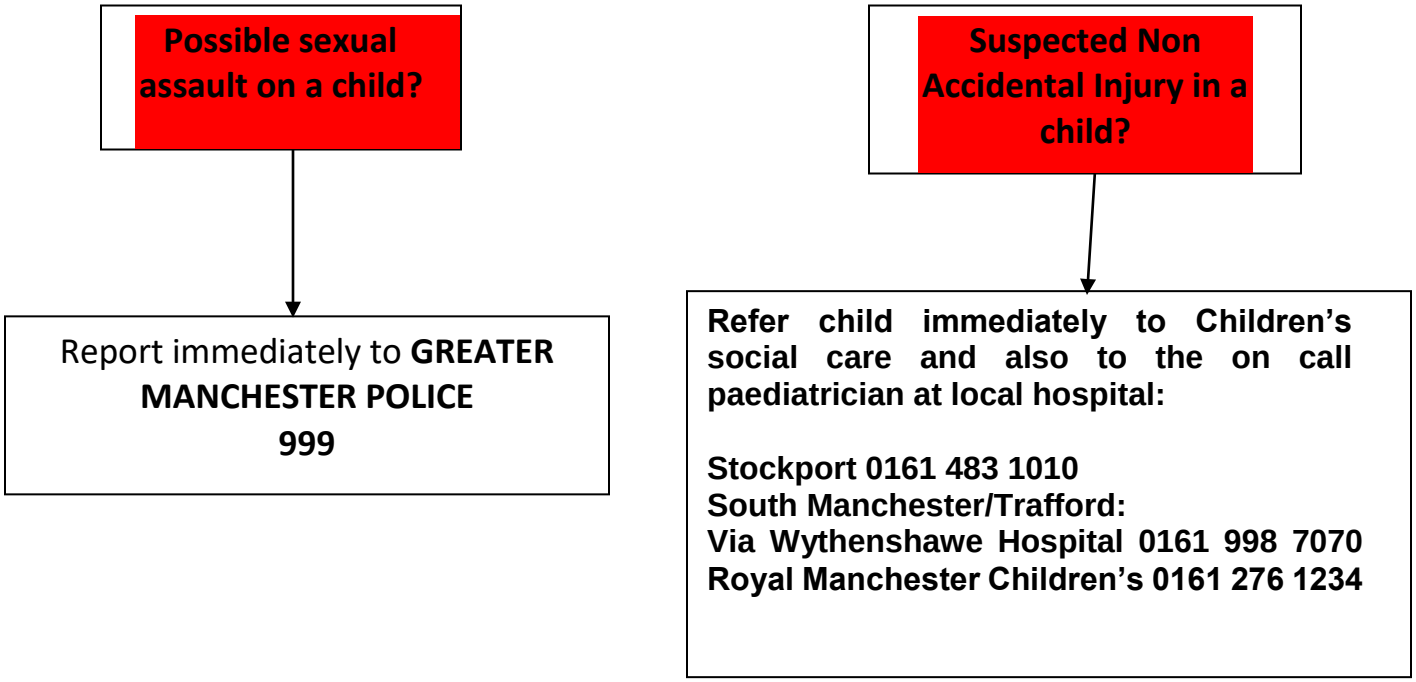
**Email:**

**Date:**

**PLEASE SEND THE COMPLETED FORM TO**
QANDS.MASTERCALL@NHS.NET **OR PUT COMPLETED FORM IN THE QUALITY AND SAFETY TRAY**

**Appendix 2:**

## EMERGENCY ACTION ALGORITHM
## Who to contact in case of Safeguarding Concerns in the Out of Hours setting

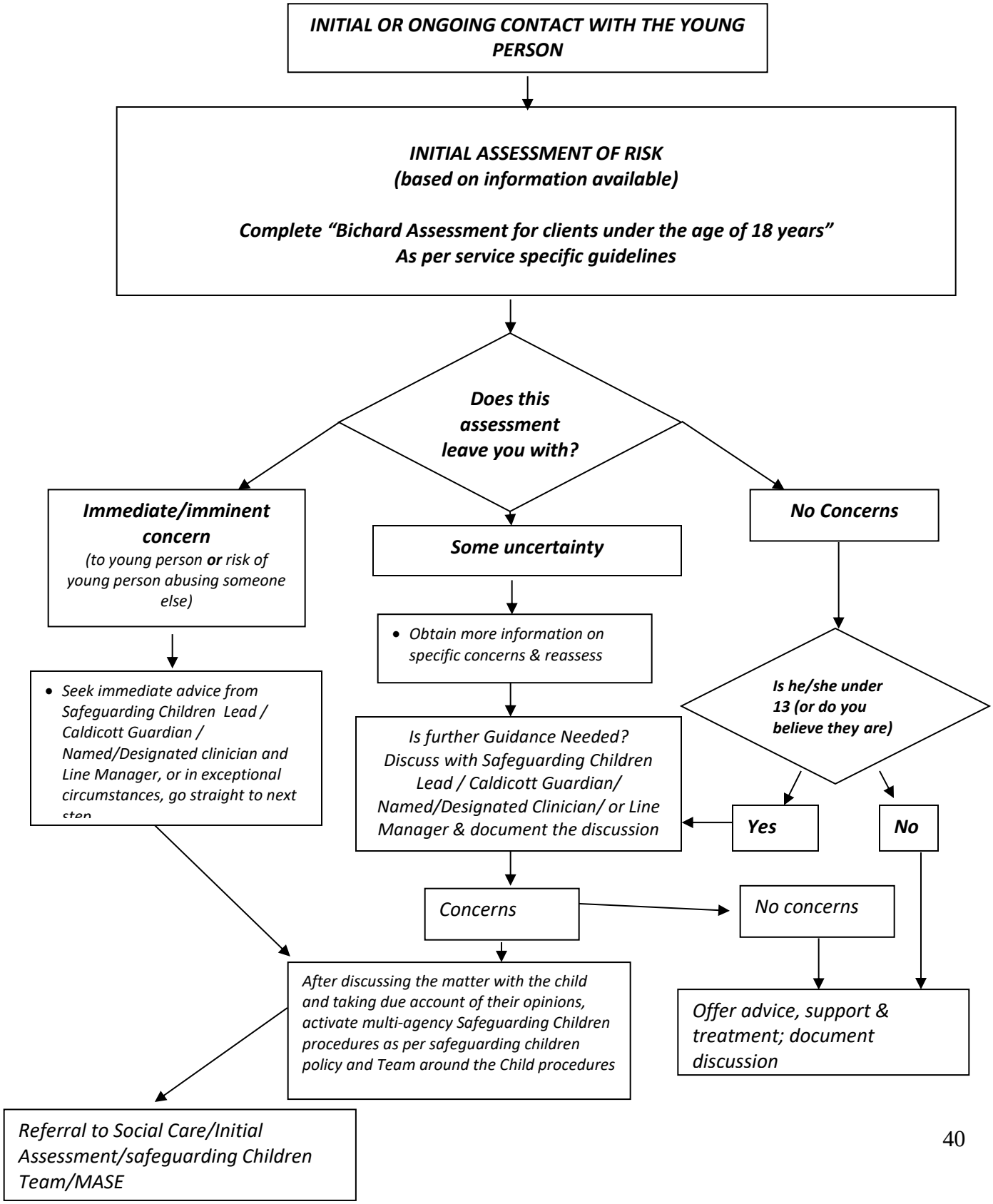



**All other safeguarding concerns regarding children please contact the teams below**

| CCG Area | Telephone Number | Out of Hours |
|---|---|---|
| Stockport | 0161 217 6028 | 0161 718 2118 |
| Trafford | 0161 912 5125 | 0161 912 2020 |
| HMR | 0844 264 0867 | 0845 226 5570 |
| BURY | 0161 253 5151 | 0161 253 6606 |

**Appendix 3:**

## *FLOW CHART FOR PROFESSIONALS WORKING WITH SEXUALLY ACTIVE UNDER 18'S*



## ASSURANCE STATEMENTS

**Assurance**

The Children Safeguarding Policy has been uploaded to the Mastercall intranet Documents folder for all staff to access.
A word copy is saved in Departmental drive under 'Policies and Procedures'.

**Purpose of policy**

To ensure that staff comply with the laws and legislations around Data Protection and NHS code of Practice

**Which CQC Standards**
Outcome 13 - Safeguarding service users from abuse and improper treatment

**How it impacts on patient care**

Confidential and sensitive data needs to be securely stored and shared to enable that records are kept safe and that the patients trust us to keep their data.

**EQUALITY IMPACT ASSESSMENT TOOL**

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

| | | Yes / No | Comments |
|---|---|---|---|
| **1.** | **Does the policy / guidance affect one group less or more favourably than another on the basis of:** | | |
| | • Race | No | |
| | • Ethnic origins (including gypsies and travellers) | No | |
| | • Nationality | No | |
| | • Gender | No | |
| | • Culture | No | |
| | • Religion or belief | No | |
| | • Sexual orientation including lesbian, gay and bisexual people | No | |
| | • Age | No | |
| **2.** | **Is there any evidence that some groups are affected differently?** | No | |
| **3.** | **If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?** | N/A | |
| **4.** | **Is the impact of the policy / guidance likely to be negative?** | No | |
| **5.** | **If so can the impact be avoided?** | Not known | |
| **6.** | **What alternatives are there to achieving the policy / guidance without the impact?** | Not known | |
| **7.** | **Can we reduce the impact by taking different action?** | No | |

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Policy Author, together with any suggestions as to the action required to avoid / reduce this impact.
For advice in respect of answering the above questions, please contact the Policy Author.