Contents

The policy is based on local adaptation of the **SAFEGUARDING CHILDREN AND YOUNG PEOPLE A Toolkit for General Practice (2011 revision)** produced by the Royal College of General Practitioners and National Society for the Prevention of Cruelty to Children. The full toolkit and appendices can be found at http://www.rcgp.org.uk/clinical-and-research/clinical-resources/child-and-adolescent-health/safeguarding-children-toolkit.aspx

Debbie Hammersley Designated Nurse for Safeguarding Children NHS Wirral CCG **May 2016**

NSPCC
Cruelty to children must stop. FULL STOP.

RCGP Royal College of General Practitioners

Practices are required to show evidence of a child protection policy and procedure to meet CQC safeguarding standards and as a condition of contracting and commissioning arrangements. Policies and procedures in themselves will not protect young people from harm *per se* but they will ensure that all those who work within the practice know what the practice statement of intent is, what is expected of them and what to do if a concern arises.

Introduction

It is intended that the following 16 pages be printed out and regarded as practice specific guidance. It contains a clinical information action flowchart to guide professionals. It concludes with an undertaking for the practice partners to sign up to.

Statement of Intent

The aim of this policy is to ensure that, throughout the practice, children are protected from abuse and exploitation. This work may include direct and indirect contact with children (access to patient's details, communication via email, text message and phone). We aim to achieve this by ensuring that (insert name of practice) is a child-safe practice.

(Insert name of practice) is committed to a best practice which safeguards children and young people irrespective of their background and which recognises that a child may be abused regardless of their age, gender, religious beliefs, racial origin or ethnic identity, culture, class, disability or sexual orientation.

As a practice, we have a duty of care to protect the children we work with and for. Research has shown that child abuse offenders target organisations that work with children and then seek to abuse their position[1]. This policy seeks to minimise such risks. In addition, this policy aims to protect individuals against false allegations of abuse and the reputation of the practice and professionals. This will be achieved through clearly defined procedures, code of conduct and an open culture of support.

(Insert name of practice) is committed to implementing this policy. The protocols it sets out for all staff and partners, will provide in-house learning opportunities and make provision for appropriate Child Protection training to all Staff and partners. This policy will be made accessible to staff and partners via the practice intranet and paper copy and reviewed on (insert date suggest no later than 2 years from date of ratification).

It addresses the responsibilities of all members of the practice team and those outside the team with whom we work. It is the role of the practice manager and Safeguarding Lead to brief the staff and partners on their responsibilities under the policy. For employees, failure to adhere to the 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.

To achieve a child-safe practice, employees and partners (independent contractors, volunteers and the wider Primary Care Team members) need to be able to:

- describe their role and responsibility
- describe acceptable behaviour
- recognise signs of abuse
- ensure practice systems work well to minimise missing vital information or delay in communication
- describe what to do if worried about a child or a pregnant woman or a family
- respond appropriately to concerns or disclosures of abuse
- minimise any potential risks to children

[1] Grubin, D., (1998) Sex offending against children: Understanding the risk. London: Home Office; Abel,G.G., Becker, J.V., Mittelman, M.S., Cunningham-Rathner, J., Rouleau, J.L. and Murphy, W.D. (1987) 'Self-reported sex crimes of non incarcerated paraphilics', Journal of Interpersonal Violence 2: 3-25 cited in The NSPCC Response to the Home Office consultation on the Belgian proposal framework decision on the recognition and enforcement in the European Union of prohibitions arising from sexual offences committed against children published May 2005: NSPCC accessed on 13/4/11 via www.nspcc.org.uk/Inform/policyandpublicaffairs/Europe/Briefings/BelgianProposal_wdf48520.pdf

Background & Principles

Safeguarding children and young people is a fundamental goal for the (insert name of practice). This policy has
taken into account legislative and government guidance requirements and other internal policies. These include:

Wirral Safeguarding Children Board Information https://www.wirralsafeguarding.co.uk/
Wirral Safeguarding Children Board Procedures:
https://www.wirralsafeguarding.co.uk/In England the relevant legislation and guidance is:
• Adoption and Children Act 2002
• The Children Act 1989
• The Children Act 2004
• The Protection of Children Act 1999
• The Human Rights Act 1998
• The United Nations Convention on the Rights of the Child (ratified by UK Government in 1991 and became statutory in Wales 2011)
• The Data Protection Act 1998 (UK wide)
Serious Crime Act 2015
Criminal Justice and Court Act 2015
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
CQC Regulation 17: Good Governance
CQC Regulation 13: Safeguarding service users from abuse and improper treatment
• Sexual Offences Act 2003
• NICE CG89 Child Maltreatment Guidance 2009 updated 2013
• Working Together to Safeguard Children 2015
• Practice Equal Opportunity Statement
• Practice Disciplinary Policy
• Accidents and Child Development 2009 (www.capt.org.uk)

What is Maltreatment & Neglect?

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 [with a fifth recognised in Scotland] but they often overlap and it is not unusual for a child or young person to have symptoms or signs from several categories (for full descriptions see the NICE guidance[11]).
http://publications.nice.org.uk/when-to-suspect-child-maltreatment-cg89

1. Physical Abuse
2. Emotional Abuse (this includes children living in households with domestic abuse)
3. Sexual Abuse (this includes Child Sexual Exploitation)
4. Neglect
5. Non-organic Failure to Thrive [Scotland only]

General Indicators

The risk of child maltreatment is recognised as being increased and should be suspected or considered when there is:
• parental or carer drug or alcohol abuse
• parental or carer mental health disorders or disability of the mind
• intra-familial violence or history of violent offending
• previous child maltreatment in members of the family
• known maltreatment of animals by the parent or carer
• vulnerable and unsupported parents or carers
• pre-existing disability in the child, chronic or long term illness

NICE CG89 uses a further aid to prioritising concerns: **suspecting, considering** and **excluding** maltreatment. These are the definitions used:

- **suspect** means a serious level of concern about the possibility of child maltreatment but not proof of it.
- **conside**r means that maltreatment is one possible explanation for the alerting feature and so is included in the differential diagnosis;
- **exclude** maltreatment if a suitable explanation is found for the alerting feature, which might be after discussion with colleagues.

Physical Abuse

Definition

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child, including by fabricating the symptoms of, or deliberately inducing, illness in a child.

(Working Together 2015)

Alerting features to suspect include:

- abrasions
- bites (human)
- bruises
- burns or scalds
- cold injuries
- cuts
- eye injuries
- fractures
- hypothermia
- intra-abdominal injuries
- intracranial injuries
- intrathoracic injuries
- lacerations
- ligature marks
- oral injuries
- petechiae
- retinal haemorrhage
- scars
- spinal injuries
- strangulation
- subdural haemorrhage
- teeth marks

Or consider
- Child with hypothermia and legs inappropriately covered in hot weather [concealing injury]
- For fabricated illness discrepancy in the clinical picture with one or more of the following:
- Reported signs or symptoms only in the presence of the carer, multiple second opinions being sought, inexplicably poor response to medication or excessive use of aids, biologically unlikely history of events even if the child has a current or past physical or psychological condition.

Emotional Abuse, Behavioural, Interpersonal & Social Function

(**Full definition from WT 2015)**
Emotional abuse is 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 children 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 the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber-bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

(Working Together 2015)

Alerting features to suspect include:

• persistent harmful parent or carer – child interactions
• hiding or scavenging for food without medical explanation
• precocious or coercive sexualised behaviour

Or consider:

- physical/mental/emotional developmental delay
- low self-esteem
- changes in behaviour or emotional state without
- explanation
- self-harming/mutilation
- extremes of emotion, aggression or passivity
- secondary enuresis or encopresis
- drug/solvent abuse
- running away
- responsibilities which interfere with normal daily
- activities (such as school)
- school refusal

Sexual Abuse

Definition

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 sexual images or grooming a child in preparation for abuse (including via the internet). Women can also commit acts of sexual abuse, as can other children.

Working Together 2015

Alerting features to suspect include:

• ano-genital symptom in a girl or boy that is associated with behavioural change
• sexually transmitted infection
• hepatitis B or C in under 13
• pregnancy in under 13s

Or consider:
• persistent unexplained ano-genital symptoms
• sexually transmitted infection in 13-15yr old
• ano-genital warts (see CG89)
• marked power differential in relationship
• behaviour changes
• sudden changes
• inappropriate sexual display
• secrecy, distrust of familiar adult, anxiety left alone with particular person
• self-harm/mutilation/attempted suicide
• unexplained or concealed pregnancy

Neglect

Definition

Neglect is 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. It involves 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 2015)

Alerting features to suspect include:

- abandonment
- repeatedly not responding to child or young person
- repeated injuries suggesting inadequate supervision
- persistently smelly or dirty
- failure to seek medical help appropriately

Or consider:

- poor personal hygiene, poor state of clothing
- frequent severe infestations (scabies, head lice)
- faltering growth (due to poor feeding)
- untreated tooth decay
- repeated animal bites, insect bites or sunburn
- treatment for medical problems not being given consistently
- poor attendance for immunisations
- low self-esteem
- lack of social relationships; children left repeatedly without adequate supervision
- parents failing to engage with healthcare, attend appointments [practice or wider health professional] and/or use A&E/Out-of-Hours services frequently.

Patterns of Maltreatment

The sections above have been significantly altered to reflect the increasing emphasis on the importance of observation of patterns of possible maltreatment including the interaction between the parent or carer and the child or young person, as well as physical signs which are inconsistent with their developmental stage (not always the same as the age in months or years) or the explanation given. The practice receptionist may be alerted by abuse on the phone or observing altercations in the waiting room.
Providing inappropriate supervision (or none) leading to accidental injury or burns can also be forms of maltreatment.

Injury Patterns:

As well there are a number of injury patterns that cause immediate concern in terms of child protection including:

- multiple bruising, with unusual bruises of different ages
- bruising in non-mobile baby particularly facial bruising
- baby rolls over at six months
- baby attempts to crawl at eight months

The alert practitioner observes these when the child is brought with an incidental respiratory infection, nappy rash or apparently minor illness, although distinguishing cigarette burns from impetigo can be difficult!

Accidents and Child Development 2009 (Child Accident Prevention trust) see
www.education.gov.uk/search/results?q=accidents+and+Child+Development
www.nspcc.org.uk/inform/trainingandconsultancy/learningresources/coreinfo/coreinfo_wda54369.html

Female Genital Mutilation

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 remember that some females may be traumatised from their experience and have already resolved never allow their daughters to undergo this procedure.

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.

It is mandatory for health professionals to record the presence of FGM in a patient's healthcare record whenever it is identified through the delivery of NHS healthcare.

The patient's health record should always be updated with whatever discussions or actions have been taken. If the patient has had FGM, referral to a specialist FGM clinic should always be considered. In addition to any referral to social services and/or police, and this being recorded in the medical record appropriately.

GPs, and Practice Nurses: A question about FGM could be asked when a routine new patient history is being taken from girls and women. Information on FGM could be included in a welcome pack which is given to new patients. In addition those that attend for health checks or travel vaccinations from affected communities could be asked about FGM and advised about its health impacts.

GP's and Practice Nurses should be vigilant to any health issues such as resistance to partake in cervical smear testing. When a female attends the practice presenting with symptoms related to urology/gynaecology/sexual health problems the FGM trigger question must be asked and the https://www.wirralsafeguarding.co.uk/procedures/new-procedures/ pathway in the multi-agency practice guidance must be followed

In accordance with the new mandatory reporting requirements; The GP/Nurse should document in the patients record if a female patient has:

Undergone FGM;

What type of FGM;

If there is a family history of FGM;

If any FGM-related procedure has been carried out on a women - (including de-infibulation).

Further clarification questions should be asked to determine if there are any safeguarding issues. The risk assessment will help to determine the most appropriate referral pathway. They should be offered/referred for additional support. Document any advice or leaflets provided. Professionals should consult with their child protection adviser and with the CADT/MASH about making a referral to them.

In all cases of FGM identified (whether there are safeguarding issues identified or not), the information should be submitted via the Datix incident reporting system this will enable the practice to receive support if required, it will also enable the anonymised data to be uploaded to the HSCIC dataset (New legal duty 2015)
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Practice Arrangements

Practice Lead

The Practice Safeguarding Lead is (insert name & contact details)

His/her Deputy is (insert name & contact details)

This is a necessary function complementing the individual's daily duties. The responsibilities are detailed below.

(Insert name of practice) recognises that it is the role of the practice to be aware of maltreatment and share concerns but not to investigate or to decide whether or not a child has been abused

The Practice Lead(s) for Safeguarding Children & Young People:

- implements (insert name of practice) child protection policy
- ensures that the practice meets contractual guidance
- ensures safe recruitment procedures
- engages the Primary Healthcare Team to establish "You're Welcome" policies (see RCGP Child Health Strategy)

www.rcgp.org.uk/pdf/CIRC_RCGP_Child_Health_Strategy_2010_2015_FINAL.pdf)

- supports reporting and complaints procedures
- advises practice members about any concerns that they have
- ensures that practice members receive adequate support when dealing with child protection
- leads on analysis of relevant significant events
- determines training needs and ensures they are met
- makes recommendations for change or improvements in practice procedural policy
- acts as a focus for external contacts including the named GP
- has regular meetings with others in the Primary Healthcare Team to discuss particular concerns

Staff Employment & Training

Inter Collegiate Guidance (ICG) for Safeguarding Competencies
The RCGP is one of over twenty colleges and professional groups to collaborate in producing joint training guidelines for staff updated in March 2014. The emphasis is on flexibility and relevant learning commensurate with responsibilities. The concept of "levels" (of learning requirements) is preserved, with **level 1** being basic induction for all practice staff, **level 2/3 (core)** for practice nurses and **level 3 (specialist)** for GPs.
The RCGP recommends GPs give evidence of a significant event in safeguarding and of learning being integrated into practice for appraisal.

Training Resources

RCGP e-GP at www.rcgp.org.uk – free to RCGP members (apply for password)
Excellent general resources, such as the consultation with the child, under Section 8 Children and Young People; also Safeguarding Children and Young People – 4 modules – Initial "All staff" one and Level 2 (Recognition, Response and Record)

Safeguarding e-Academy
Awareness of Child Abuse and Neglect module
£30 per person
www.safeguardingchildrenea.co.uk/

Spotting the Sick Child
www.spottingthesickchild.com/

NSPCC produce a range of materials and educational tools for professionals, including the Educare – Health package, which has been extremely successful in many professional fields.(Charge made).

In collaboration with Cardiff University, NSPCC has developed a series called CORE – INFO, including:

- head & spinal Injuries
- fractures in children
- bruises on children
- oral injuries and bites on children
- thermal injuries on children

www.nspcc.org.uk/inform/trainingandconsultancy/learningresources/coreinfo/coreinfo_wda54369.html

RCGP encourages publication of material on safeguarding children, including:

- Polnay: Child Protection in Primary Care [Radcliffe Medical Press, 2001][ISBN 1 85775 224 4]
- Bannon & Carter: Protecting Children from Abuse and Neglect in Primary Care [Oxford University Press 2003]
- [ISBN 0 19 263276 0]
- responses to the Laming Reports
- RCGPChildHealthStrategy2010-2015www.rcgp.org.uk/pdf/CIRC_RCGP_Child_Health_Strategy_2010_2015_FINAL.pdf (accessed 16/4/11)

Wirral LSCB provides training and further information can be accessed from their website

https://www.wirralsafeguarding.co.uk/

Single agency training by the Named GP for Safeguarding Children can be accessed by telephoning 0151 651 0011 Ext 1017

Minimum Criteria for all Staff

The minimum safety criteria for safe recruitment of all staff that work on the (insert name of practice) are:
• have been interviewed face to face
• have 2 references that have been followed up
• have CRB check [enhanced for clinical staff]

Staff Training

Those working with children and young people and/or parents 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.

All members of staff will undergo training in line with ***Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff. Intercollegiate Document [RCPCH lead] March 2014**

- All new members of Staff need in-house training or other basic awareness training, organised by the practice
- or local PCO, under local arrangements
- Non-clinical staff Level 1*
- Clinical staff who only occasionally have contact with children [practice nurses and others] Level 2*
- Clinical staff who have regular contact with children [Nurse practitioners & GPs] Level 3 core & Level 3 specialist respectively bearing in mind that level 3 includes training relevant to the inter-agency nature of their work
- Practices need an annual training session of which:
    - all clinical and non-clinical staff are expected to attend
    - update training is available
    - significant events in safeguarding can be reviewed
    - practice safeguarding policy can be reviewed
- All staff undergoing training will be expected to keep a learning log for their appraisals and or personal development for CQC
- The practice will discuss and record at least one clinical incident involving safeguarding children

Mentoring/Supervision

Practices should have given thought to how to support staff and doctors working in this complex area of clinical practice, especially those in training or within the first five years of practice.

Mentoring systems are beginning to emerge in general practice often run by associate directors in postgraduate medical education, such schemes provide opportunity for safe supported reflection on practice and allow professionals to analyse problems and reflect on improvements which could be made. Similar opportunities may also be available through the GP appraisal process. Safeguarding issues should form a standard part of this process.

Supervision, which has been an established part of Nursing Practice for many years, provides an opportunity both for supervisors and staff to share concerns about work. Supervision is important to promoting good standards of practice, based on and consistent with LSCB procedures.

(you will need to insert practice requirements here)

Whistle Blowing

(Insert name of practice) recognises the importance of building a culture that allows all Practice Staff to feel comfortable about sharing information, in confidence and with a lead person, regarding concerns they have about a colleague's behaviour. This will also include behaviour that is not linked to child abuse but that has pushed the boundaries beyond acceptable limits. Open honest working cultures where people feel they can challenge unacceptable colleague behaviour and be supported in doing so, help keep everyone safe.

Where a complaint or allegation has been made against a member of staff, the managing allegations against staff policy must be followed and the early involvement of the Local Authority Designated Officer **(LADO)** may be necessary (section 11 Children Act 2004). https://www.wirralsafeguarding.co.uk/

Complaints Procedure

(Insert name of practice) has a clear procedure that deals with complaints from all patients (including children and young people), employee, accompanying adult or parent. Please refer to (insert link or attach practice document)

General Guidelines for Staff Behaviour

These guidelines are here to protect children and staff alike. The list below is by no means exhaustive and all staff should remember to conduct themselves in a manner appropriate to their position.

Wherever possible, you should be guided by the following advice. If it is necessary to carry out practices contrary to it, you should only do so after discussion with and the approval of, your manager/general practitioner.

- You must challenge unacceptable behaviour
- Provide an example of good conduct you wish others to follow
- Respect a young person's right to personal privacy and encourage children, young people and adults to feel comfortable to point out attitudes or behaviours they do not like
- Involve children and young people in decision-making as appropriate
- Be aware that someone else might misinterpret your actions
- Don't engage in or tolerate any bullying of a child, either by adults or other children
- Never promise to keep a secret about any sensitive information that may be disclosed to you but follow the practice guidance on confidentiality and sharing information
- Never offer a lift to a young person in your own car
- Never exchange personal details such as your home address, personal phone number or any social networking details with a young person
- Don't engage in or allow any sexually provocative games involving or observed by children, whether based on talking or touching
- Never show favouritism or reject any individuals

Internet, Mobile Phone Information Governance

See Practice information Governance Policy

Practice Systems & Early Help

Good practice recommendations include:

- New child registrations – check names of parents or carers, school, social care involvement
- Scan (and appropriately code) reports from other agencies into the child's notes
- Follow-up repeated attendances at Accident and Emergency
- Follow-up repeated missed appointments
- See also "recording information"

Management of Disclosure of an Allegation of Abuse

If a child 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 and follow the child protection procedures below.

It is important to also remember that it can be more difficult for some children to tell than for others (see earlier section on barriers). Children 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.

Children 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 Making an Allegation of Abuse

- Stay calm
- Listen carefully to what is being said
- Reassure the child 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
- Allow the child 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 them what you will do next and with whom the information will be shared
- Record in writing what has been said using the child's own words as much as possible – note date, time, any names mentioned, to whom the information was given and ensure that paper records are signed and dated and electronic subject to audit trails
- Do not delay in discussing your concerns and if necessary passing this information on

Referral

Best practice is to inform parents/carers of your concerns and next steps unless to do so may put the child or yourself at risk

When external authorities need to be contacted, the relevant details are below. As a general rule, you should contact the child Social Care Services first unless the issue is more immediate and the child is indeed of immediate medical attention or support from the Police.

(a) Insert your local arrangements here

Wirral Safeguarding Children Board Procedures: https://www.wirralsafeguarding.co.uk

Children's Services		
Wirral Children's Social Care Services	During Office Hours Tel: 0151 606 2008 cadtsocialcare@wirral.gcsx.gov.uk	Out of Hours Tel: 0151 677 6557 Fax: 0151 677 5372
Police	Non-Urgent 101	Urgent 999
Merseyside Police	Tel: 0151 777 2683 (office hours)	Tel: 0151 709 6010 (24 hours)
NSPCC	National Helpline – for adults who have concerns about a child	0808 800 5000
Local Authority Designated officer for Wirral Susan Cottrell	For allegations about staff	Tel: 0151 666 4580 Fax: 0151 666 4582
Practice safeguarding lead	Insert Name	

SAFEGUARDING CHILDREN REFERRAL TO
WIRRAL CHILDREN'S SERVICES
ACTIONS FOR ALL HEALTH STAFF INCLUDING GPs AND OUT OF HOURS

TIMESCALES

Staff must take **immediate and appropriate** action to protect the child when

- A member of staff observes signs of abuse
- Information is received from any source of suspected alleged abuse
- A member of staff is concerned about the welfare and safety of a child/children

Immediately

Be **open and honest with parents and carers**, particularly if you have concerns about a child's welfare and intend to share this with other professional colleagues, unless the professional assessment of the situation indicates that it is not in the child's best interest to inform parents i.e. immediate safety or risk issues to any children/or affecting a possible criminal investigation or risks to staff safety

NB: If suspected sexual abuse **Do Not** examine

May need to **consult for advice and support** with

1. Designated or named professionals
2. Consultant Paediatrician on call
3. Children's Services

Check if child has protection plan

Same day

Make a telephone referral to:
Wirral Central Advice and Duty Team (CADT) Tel: 0151 606 2008
Out of Hours contact:
The Emergency Duty Team (EDT) Tel: 0151 677 6557

Without delay

Follow up with written confirmation of referral using Multi-agency referral form

https://www.wirralsafeguarding.co.uk/

email cadtsocialcare@wirral.gcsx.gov.uk and Retain copy for records

As soon as possible and within 48 hrs

- **Send copy of referral to GP**
- **Inform Health Visitor or School Nurse**

Record information on child's records (including Significant Events form if available)

Same day

Children's Services Department should **inform referrer** in writing of their decision. This can include:

No further action
Referral to other services
Undertake S47 enquiry

If you have not received feedback within 3 working days or you are **dissatisfied** with the decision of the Children's Services you should immediately contact the Team Manager and/or Named/Designated professionals. All information is to be recorded in the child's records.

What To Do *if you have concerns about a child*

Safeguarding Children
Flowchart For Referral in Wirral

PRACTITIONER HAS CONCERNS ABOUT CHILD'S WELFARE

Practitioner discusses with manager and/or other senior colleagues as they think appropriate

Still has concerns

No longer has concerns

Practitioner refers to social services, following up in writing within 48 hours

No further child protection action, although may need to act to ensure services provided

Feedback to referrer on next course of action

Social worker and manager acknowledge receipt of referral and decide on next course of action within one working day

No further social services involvement at this stage, although other action may be necessary, e.g. onward referral

Initial assessment required

Contact social care in 72 hours if no feedback is received

NB: If Concerns about child's Immediate safety contact police

Social Services, Central Advice & Duty Team (CADT) (office hours)
Tel: 0151 606 2008
cadtsocialcare@wirral.gcsx.gov.uk

Social Services Emergency Duty Team (EDT) (after 5pm)

Tel:0151 677 6557

Merseyside Police

Non Urgent 101

Urgent 999

For advice prior to referral
(9-5 Monday - Friday)

Named GP for Safeguarding Children
Dr Santiago Puig
Tel: 07810756779

Designated Doctor for Safeguarding Children Dr Amanda Bennett
0151 514 2501

Designated Nurse for Safeguarding Children
Debbie Hammersley:
Tel: 0151 651 0011 ext: 1621

After 5pm contact:
Consultant Paediatrician On Call
0151 678 5111

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 designated and named health professionals.

Child Protection Conferences

The contribution of GPs to safeguarding children is invaluable and priority should be given to attendance and sending a report wherever possible. Contributing to the child protection process is a statutory requirement for GPs as CQC registered providers.

NB: In Wirral there is a Multiagency Case Conference report template, on which all agencies are expected to submit a written report.

Case Conf report template Wirral.doc

General Points for Preparing Reports for Conference

The Assessment Framework Tool[26] recommends a triangle model of assessment.

- Child's developmental needs
- Parenting capacity
- Family & environmental factors

Consider:

- missed appointments with GP, practice nurse and midwife
- failed immunisations
- missed hospital appointments
- education: discuss with school nurse or health visitor
- parental mental health or substance abuse
- ability of the carer to parent [disability, physical or intellectual]
- evidence of domestic violence
- cruelty to animals in the family
- are both parents registered with your practice?
- who has parental responsibility?
- sharing the report with the child if old enough and the parents where appropriate

Recording Information

This section will need to be modified to your own practice systems and LSCB guidance.

- Concerns and information about vulnerable children should be recorded in the child's notes and where
- appropriate the notes of siblings and significant adults. These should be recorded using agreed Read codes
- The GMC document 'Protecting children and young people: guidance for
- doctors',(2011) advises doctors to record minor concerns, as well as their decisions and information given to
- parents/carers. 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 and midwives, should be recorded in the notes
- under a read code
- Email should only be used when secure, [e.g. nhs.net to nhs.net] and the email and any response(s) should
- be copied into the record
- Conversations with and referrals to outside agencies should be recorded under an appropriate Read code
- Case Conference notes may be scanned in to electronic patient records as described below. This will usually
- involve the summary/actions, appropriately annotated by the child's usual doctor or Practice Safeguarding
- Lead
- Records, storage and disposal must follow national guidance for example, Records Management, NHS Code
- of Practice
- If information is about a member of staff this will be recorded securely in the staff personnel file and in line
- with your own jurisdiction guidance[2]

[2] Framework for the Assessment of Children in Need and their Families DH, DFEE 2000

Consideration should be given to recording the following information in the child record.

- Record of abuse in the child or any other child in the household
- Record of whether the child or any other child in the household is or has been subject to a child protection plan
- Observed and alleged harmful parent – child interactions
- Basic family details (e.g. adults in the family, other siblings etc., including individuals who may not live at the address but who have regular contact with the child e.g. father, grandparents etc.)
- Details of any housing problems
- Details of significant illness or problems in the family, such as parental substance misuse or mental illness
- History of domestic abuse in the household
- House fires
- Ante-natal concern
- Multiple new registrations
- Multiple consultations especially emergencies

Information can be sought and entered from:

- the new patient health checks on all children, including enquiry about family, social and household
- circumstances – (a Climbié Inquiry recommendation[27])
- any contact with a potential carer – 'seeing the child behind the adult' – so that a patient with a substance misuse problem for example is asked about any responsibility they may have for a child, and that child's record amended accordingly, with a relevant code (Appendix 8) so that such families' progress can be reviewed.
- opportunistic consultations
    - Antenatal booking
    - Postnatal visit
    - 6 week check
- Practice Team meetings, where regular discussion of all practice children subject to child protection plans, or any other children in whom there may be concerns, should highlight safeguarding issues in children and their families
- correspondence from outside agencies, such as A&E/OOH reports and other primary and secondary care providers[28]

Case Conference Summaries & Minutes

Case conference minutes frequently raise concerns - much of it about third parties.

See also the Good Practice Guidance to GP electronic records: (accessed 16/4/11)
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125310

27 The Victoria Climbie Inquiry – report of an inquiry by Lord Laming Jan 2003, Recommendation 86
28 Care Quality Commission 2009: Review of the involvement and action taken by health bodies in relation to the case of Baby P
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Until further guidance, they should be processed and stored in the following way:

	Read code significant details	Scan in summary	Scan in full minutes[4]
Child (subject of conference)	Yes	Yes	Yes
Adults & other household members named in report	Yes	Yes	No

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.

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, but may vary between UK jurisdictions. You are advised to consult local PCO policies for further details.

Sharing Information

The practice will follow the policy on sharing information in child protection cases which is as follows.

- 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 agencies (section 47.9) have a duty to assist local authorities (Social/Childcare Services) with enquiries; named Doctors for child protection can be powerful advocates for this function.
- 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 adding Section 14b see www.legislation.gov.uk/ukpga/2010/978010542103/section/8.

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

The '**Seven Golden Rules'** of information sharing are set out in the government guidance, Information sharing Advice for practitioners providing safeguarding services to children, young people, parents and carers March 2015. This guidance is applicable to all professionals charged with the responsibility of sharing information, including in child protection scenarios.

1. The Data Protection Act is not a barrier to sharing information[5] but provides a framework to ensure

[4] The minutes should be read by the relevant GP. If the minutes contain a majority of pertinent information that other professionals are likely to need to know, particularly where they are taking the case on cold (such as a locum, or GP receiving the patient on a transfer) then the full minutes can be scanned. If there is little pertinent information, this should be entered as free text notes on the child's record. Following either the scanning, or entry of pertinent information, the paper copy should be securely disposed of (e.g. shredded). Thanks to Dr Joanna Walsh for this material

[5] It could reasonably be said that neither is the common law duty of confidentiality, or the Human Rights Act see Re F (Adult: Court's Jurisdiction) [2000] 1 Fam 38, per Sedley LJ - "The family life for which Article 8 [the right to respect for private and family life] requires respect is not a proprietary right vested in either parent or child: it is as much an interest of society as of individual family members and its principal purpose, at least where there are children, must be the safety and welfare of the child"

personal information about living persons is shared appropriately.
2. Be open and honest with the person/family from the outset about why, what, how and with whom information will be shared and seek their agreement, unless it is unsafe or inappropriate to do so.
3. Seek advice if you have any doubt, without disclosing the identity of the person if possible.
4. Share with consent where appropriate and where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent, if, in your judgement, that lack of consent can be overridden by the public interest. You will need to base your judgement on the facts of the case.
5. Consider safety and well-being, base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.
6. Necessary, proportionate, relevant, accurate, timely and secure, ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up to date, is shared in a timely fashion and is shared securely.
7. Keep a record of your concerns, the reasons for them and decisions Whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose

General Medical Council Guidance

The General Medical Council offers guidance on Confidentiality and Information Sharing which is regularly reviewed. 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 2007: 0-18 years

This might be phrased:
"see the adult behind the child" and "see the child behind the adult"

Consent should be sought to disclosures unless:

- that would undermine the purpose of the disclosure [such as fabricated & induced illness and sexual abuse]
- action must be taken quickly because delay would put the child at further risk of harm
- it is impracticable to gain consent

When asked for information about a child or family, practice staff should consider the following:

- identity, check identity of the enquirer to see if they have a bona fide reason to request information. Call back the switchboard or ask for a faxed request on headed notepaper
- purpose, ask about the exact purpose of the inquiry. What are the concerns?
- consent, does the family know that there are enquiries about them? Have they consented and if not why not? Consent is not necessary if there is felt to be a risk of harm to the child from seeking it. Receiving a signed consent form from Social Services does not imply consent given to you to share. If this doesn't cause harmful delay, you may also wish to seek consent from the family
- need-to-know basis, give information only to those who need to know
- proportionality, give just enough information for the purpose of the enquiry and no more. This may mean relevant information about parents/carers
- keep a record, make sure that you record the details of the information sharing, including the identity of the person you are sharing information with, the reason for sharing and whether consent has been obtained and if not why not

GMC advice includes:

- sharing information with the right people can help to protect children and young people from harm and ensure that they get the help they need. It can also reduce the number of times they are asked the same questions by different professionals. By asking for their consent to share relevant information, you are showing them respect and involving them in decisions about their care

- if a child or young person does not agree to disclosure there are still circumstances in which you should disclose information:

a. when there is an overriding public interest in the disclosure
b. when you judge that the disclosure is in the best interests of a child or young person who does not have the maturity or understanding to make a decision about disclosure
c. when disclosure is required by law.

Restraint Policy also known as 'Positive Handling Policy'

You will need to amend this section according to your local governmental guidance. Restraint is where a child is being held, moved or prevented from moving, against their will, because not to do so would result in injury to themselves or others, or would cause significant damage to property. Restraint must always be used as a last resort, when all other methods of controlling the situation have been tried and failed. Restraint should never be used as a punishment or to bring about compliance (except where there is a risk of injury).

Only employees who are properly trained in restraint techniques should carry it out. A person should be restrained for the shortest period necessary to bring the situation under control.
(Insert links to any guidance already in place to your jurisdiction)

Declaration

In law, the responsibility for ensuring that this policy is reviewed belongs to the partners.
The partners may delegate this responsibility (insert name/designation here).

We have reviewed and accepted this policy

Signed by: Date:

Signed: _____

on behalf of the Partnership

The practice team have been consulted on how we implement this policy

Signed by: Date:

Signed: _____