SAFEGUARDING POLICY FOR CHILDREN AND YOUNG PERSONS

Background & Principles

Safeguarding children and young persons is a fundamental goal for the Goring & Woodcote Medical Practice.

This policy has been written in conjunction with legislative and government guidance requirements, local Clinical Commissioning Group child protection procedures and relevant internal policies.

This policy document is the Practice-agreed policy, applicable to all clinicians and staff as well as official visitors to the premises, and it represents the means by which the Practice intends to keep children safe.

What is Abuse and 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.

There are usually said to be four types of child abuse (with a fifth recognised in Scotland):

1. Physical Abuse including FGM
2. Emotional Abuse
3. Sexual Abuse / sexual exploitation
4. Neglect
5. Non-organic Failure to Thrive (Scotland only)

General Indicators

The risk of Child Maltreatment is recognised as being increased 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: When to suspect Child Maltreatment, July 2009)

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 or subjecting them to FGM. *Working Together 2010*

Alerting features:

Abrasions	Eye Injuries	Lacerations	Spinal Injuries
Bites (human)	Fractures	Ligature marks	Strangulation
Bruises	Hypothermia	Oral Injuries	Subdural haemorrhage
Burns or scalds	Intra-abdominal injuries	Petechiae	Teeth marks
Cold injuries	Intra-cranial injuries	Retinal haemorrhage	
Cuts	Intra-thoracic injuries	Scars	

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 Functioning

Definition: Emotional abuse is the persistent emotional mal-treatment 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

Alerting features:

Persistent harmful parent or carer – child interactions	Hiding or scavenging for food without medical explanation	Precocious or coercive sexualised behaviour

Or consider:

Physical / mental /	Changes in behaviour or	Extremes of emotion,	Drug/solvent abuse

emotional developmental delay	emotional state without explanation	aggression or passivity	
Low self-esteem	Self-harming/mutilation	Secondary enuresis or encopresis	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, whether or not the child is aware of what is happening. Children can be subject to sexual exploitation.

The activities may involve physical contact, including penetrative (e.g. 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.

Alerting features:

Ano-genital symptom in a girl or boy that is associated with behavioural change	Hepatitis B or C in under 13s
Sexually transmitted infection	Pregnancy in under 13s

Or consider:

Persistent unexplained ano-genital symptoms	Ano-genital warts (see CG89)
Sexually transmitted infection in 13-15 year olds	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.

Neglect 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.

Alerting features:

Abandonment	Repeated injuries suggesting inadequate supervision	Failure to seek medical help appropriately
Repeatedly not responding to child or young person	Persistently smelly or dirty	

Or consider:

Poor personal hygiene, poor state of clothing	Untreated tooth decay	Poor attendance for immunisations
Frequent severe infestations (scabies, head lice)	Repeated animal bites, insect bites or sunburn	Low self-esteem
Faltering growth (due to poor feeding)	Treatment for medical problems not being given consistently	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 previous sections 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.

In addition, 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 nonmotile baby, particularly facial bruising
- Baby rolls over at six months
- Baby attempts to crawl at eight months

Common presentations and situations in which child abuse may be suspected include:

- Disclosure by a child or young person
- Physical signs and symptoms giving rise to suspicion of any category of abuse
- The history is inconsistent or changes
- A delay in seeking medical help
- Extreme or worrying behaviour of a child, taking account of their developmental age

- Accumulation of minor incidents giving rise to a level of concern, including frequent A&E attendances

Some other situations which need careful consideration are:

- Disclosure by an adult of abusive activities
- Girls under 16 presenting with pregnancy or sexually transmitted disease, especially those with learning difficulties
- Very young girls requesting contraception, especially emergency contraception
- Situations where parental mental health problems may impact on children
- Parental alcohol, drug or substance misuse which may impact on children
- Parents with learning difficulties
- Violence in the family
- Unexplained or suspicious injuries such as bruising, bites or burns, particularly if situated unusually on the body
- The child says that she or he is being abused, or another person reports this
- The child has an injury for which the explanation seems inconsistent or which has not been adequately treated
- The child's behaviour changes, either over time or quite suddenly, and he or she becomes quiet and withdrawn, or aggressive
- Refusal to remove clothing for normal activities or keeping covered up in warm weather
- The child appears not to trust particular adults, perhaps a parent or relative or other adult in regular contact
- An inability to make close friends
- Inappropriate sexual awareness or behaviour for the child's age
- Fear of going home or parents being contacted
- Reluctant to accept medical help
- Fear of changing for PE or school activities

Policy Statement

Under the 1989 and the 2004 Children Acts a child or young person is anyone under the age of 18 years.

Safeguarding Children refers to the activity that is undertaken to protect specific children who are suffering or at risk of suffering significant harm. All agencies and individuals should be proactive in safeguarding and promoting the welfare of children.

The Practice recognises that all children have a right to protection from abuse and the Practice accepts its responsibility to protect and safeguard the welfare of children with whom staff may come into contact.

The Practice will:

- Respond quickly and appropriately where abuse is suspected or allegations are made

- Provide both parents and children with the chance to raise concerns over their own care or the care of others
- Have a system for dealing with, escalating and reviewing concerns
- Remain aware of child protection procedures and maintain links with other bodies, especially the CCG-appointed contacts
- Ensure that all staff are trained to a level appropriate to their role, and that this is repeated on an annual refresher basis. New starters will receive training within 6 months of start date

Basic Principles

- The welfare of the child is paramount
- It is the responsibility of all adults to safeguard and promote the welfare of children and young people. This responsibility extends to a duty of care for those adults employed, commissioned or contracted to work with children and young people
- Adults who work with children are responsible for their own actions and behaviour and should avoid any conduct which would lead any reasonable person to question their motivation and intentions
- Adults should work and be seen to work, in an open and transparent way
- The same professional standards should always be applied regardless of culture, disability, gender, language, racial origin, religious belief and/or sexual identity
- Adults should continually monitor and review their practice and ensure they follow the guidance contained in this document and elsewhere

Supporting Statement of Intent

The aim of this document 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 / phone).

We aim to achieve this by ensuring that we are a child-safe Practice.

The Practice follows the guidelines suggested in the revised version of the GMC document "*Raising and acting on concerns about patient safety*", effective 12 March 2012.

We are 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. 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.

We are committed to implementing this policy and 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 addresses the responsibilities of all Practice employees and those to whom we have arrangements with. It is the responsibility 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
- Ensure that all information relating to Child Protection issues is regularly updated in the relevant patient record, with appropriate alerts being added to (and removed from) the records of the child/family member.

  The Read Codes for alerts in use in the Practice are:

  13IS - Child in need
  13Id - On Child Protection Register
  13IV - Child is classed as a 'Looked after Child' (may still be living with a parent)
  13IO - Child has been removed from the Register

The code **13IM** - Child on Child Protection Register will not be used on the record for the child (use **13Id** above); however it may be used on a parent's / guardian's record to indicate that they have a child who is on the register.

Note: reference in the Read Coding system to "Register" is assumed to identify children at risk under the recent guidance.

RESPONSIBILITIES

Dr Amanda Gemmill is the appointed Practice Safeguarding lead.

Dr Jessica Reed is the appointed Practice Safeguarding Deputy.

These are not full-time functions, but instead complement the individual's daily duties. The responsibilities are detailed below.

We recognise that it is our role 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 the Practice's 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 2010-2015; http://www.rcgp.org.uk/clinical-and-research/clinical-resources/child-and-adolescent-health.aspx)
- 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

Immediate Actions When Child Abuse May Be Suspected

- Concerns should immediately be reported to the Practice Safeguarding Lead or one of the Partners who will make a decision to report the matter directly to the MASH team
- If the suspicions relate to the designated person, then one of the other Partners should be notified and the MASH team should be contacted directly
- Suspicions should not be raised or discussed with third parties other than those named above
- Any individual has the ability to make direct referrals to the child protection agencies; however, members of staff are encouraged to use the route described here where possible. In the event that the reporting staff member feels that the action taken is inadequate, untimely or inappropriate they should report the matter direct. Staff members taking this action in good faith will not be penalised
- Where emergency medical attention is necessary it should be given. Any suspicious circumstances or evidence of abuse should be reported to the designated clinical lead
- If a referral is being made without the parent's knowledge and non-urgent medical treatment is required, the MASH team should be informed. Otherwise, speak to the parent / carer and suggest medical attention be sought for the child

- If appropriate, the parent / carer should be encouraged to seek help from the social services department prior to a referral being made. If they fail to do so, in situations of real concern, the designated person will contact the MASH team directly for advice
- Where sexual abuse is suspected, the designated person will contact the MASH team directly. The designated person will not speak to the parents
- Neither the designated person nor any other member of the Practice team should carry out any investigation into the allegations or suspicions of sexual abuse in any circumstances. The designated person will collect exact details of the allegations or suspicion and provide this information to the child protection agencies that will investigate the matter under the Children Act 1989

Minimum safety criteria for all staff

The minimum safety criteria for safe recruitment of all staff who work at the Practice are:

- Have been interviewed face to face
- Have two references that have been followed up

Minimum safety criteria for staff members who have contact with children (in addition to the above)

The minimum additional safety criteria require relevant members of staff who work at the Practice is for them to have an up to date DBS check at the time of appointment (renewed every three years). All staff at the Practice undergo a DBS check on appointment and thereafter every three years.

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

Staff Training

Those working with children and young people and / or parents should take part in clinical governance including holding regular case discussions, training and education. 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 and complaints and included in appraisal.

All new members of staff will undergo in-house training and / or online training in safeguarding policies and procedures.

All members of staff will undergo child protection training as part of induction and renewed annually, as follows:

- All Non-Clinical Staff must be at Level 1
- Nurses directly employed by the Practice must be at minimum Level 2, working towards Level 3
- Practice safeguarding lead must be at Level 3

- All GPs need level 2 for the purposes of update, appraisal and revalidation, bearing in mind that level 3 includes training relevant to the inter-agency nature of their work

The Practice organises regular safeguarding updates for clinical and non-clinical staff at which the Practice policies are discussed and any learning from significant events shared.

All clinical staff undergoing training will be expected to keep a learning log for their appraisals and or personal development. The Practice will discuss and record any clinical incident involving safeguarding children as part of our Significant Event process and any learning shared.

Whistleblowing

Our Practice recognises the importance of building a culture that allows all our 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 allegations have been made against staff, the standard disciplinary procedure and the early involvement of the Local Authority Designated Officer (LADO) may be necessary (*section 11 Children Act 2004*).

Complaints Procedure

The Practice has a clear procedure that is capable of dealing with complaints from all patients (including children and young people), employee, accompanying adult or parent - *Please refer to the Practice's Complaints & Concerns Policy.*

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, staff 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, our Practice Manager/ Partners.

- 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 do 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 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 display favouritism or reject any individuals

Practice Systems and Early Help

- New child registrations includes names of parents or carers, school attended and any 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' Section.

Reactive measures

While every precaution may be taken to prevent an incident from occurring, we recognise that thorough and professional reactive measures are necessary. The following procedures set out the steps to be taken with respect to any concerns relating to child protection.

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 (Dr Angela Lamb) 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. 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 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.

When 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 to the Practice Safeguarding Lead or one of the Practice Partners

Confidentiality

In order to do their jobs, members of staff need access to confidential (perhaps highly sensitive) information about children and young people.

These details must be kept confidential within the clinical team at all times and only shared when it is in the interests of the child to do so and ensuring that – when domestic violence is involved – risk of harm to the non-abusive parent is not increased, and taking care to ensure that no humiliation or embarrassment is suffered by the child.

If an adult who works with children is in any doubt about whether to share information or keep it confidential he or she should seek guidance from the Practice Safeguarding Lead. Any actions should be in line with locally agreed information sharing protocols, and the Data Protection Act applies.

Whilst adults need to have an awareness of the need to listen and support children and young people, the importance of not promising to keep secrets or never requesting this of a child or young person must also be understood.

Additionally, concerns and allegations about adults should be treated as confidential and passed to a designated or appointed person or agency without delay.

In general, if a person decides to disclose confidential information without consent, they should be prepared to explain and justify their decision and they should only disclose as much information as is necessary for the purpose. The medical defence organisation will be consulted in all cases.

Physical Contact

A parent or carer should be present at all times, or a chaperone offered. Children should only be touched under supervision and in ways which are appropriate to, and essential for clinical care.

Permission should always be sought from a child or young person before physical contact is made and an explanation of the reason should be given, clearly explaining the procedure in advance.

Where the child is young, there should be a discussion with the parent or carer about what physical contact is required. Regular contact with an individual child or young person is normally part of an

agreed treatment plan and should be understood and agreed by all concerned, justified in terms of the child's needs, consistently applied and open to scrutiny.

Physical contact should never be secretive or hidden. Where an action could be misinterpreted, a chaperone should be used or a parent fully briefed beforehand, and present at the time.

Where a child seeks or initiates inappropriate physical contact with an adult, the situation should be handled sensitively and a colleague alerted.

ATTITUDE OF PARENTS OR CARERS

Parental attitude may indicate cause for concern:

- Unexpected delay in seeking treatment
- Denial of injury pain or ill-health
- Incompatible explanations, different explanations or the child is said to have acted in a way that is inappropriate to his/her age and development
- Reluctance to give information or failure to mention other known relevant injuries;
- Unrealistic expectations or constant complaints about the child
- Alcohol misuse or drug/substance misuse
- Violence between adults in the household
- Appearance or symptoms displayed by siblings or other household members

Records

Registration

It is good practice to offer a medical examination and record the following additional information:

- Child's name and all previous names
- Current and previous address detail
- Present school and all previous schools
- Previous GP, health visitor and / or school nurse
- Mother and father's names, dates of birth and addresses if different to the child's
- Name of primary carer and any significant other persons
- Name of person(s) with parental responsibility

The Practice will expect full co-operation in the supply of these details from the parent / carer, otherwise registration will be refused. The health visitor will be informed within 5 days of registration of all children under 16 who register with the Practice, including temporary registrations.

Staff should be vigilant in the instance of multiple short-term temporary registrations for the same child, especially if consecutive. In the event of concern the permanent GP should be contacted.

Medical Record

A paper based note will be prominently made and an alert placed on the clinical system.

The medical record relating to child protection issues may also include clinical photography / video recordings, and it is recommended that a significant event form be utilised within the medical record where a clinician identifies issues leading to increasing concern for the patient, or where an event occurs of particular note.

Other aspects which may be recorded are:

- Evidence of abuse
- Criminal offences
- A&E attendances
- Child protection plan
- Case Conferences
- Meetings
- Drug / substance abuse
- Mental health issues
- Non-attendance at meetings or appointments
- Hostility or lack of cooperation
- Cumulative minor concerns

Where a child moves away or changes GP the Practice will inform both social services and the health visitor within 5 working days.

Data Protection

- Current guidance suggests that written records relating to child protection issues should be stored as part of the child's permanent medical records, either manually or on computer, or both - a change to the previous recommendation
- The Practice should be alert to the fact that this guidance may be reviewed or amended in the future and must seek the guidance of the local CCG in all instances
- It is expected that Practices will have permanent access to the local child protection instructions as part of the routine CCG pathway procedures
- As a normal part of compliance with the data protection act it is likely that third party information will be stored within these records, and the normal duty of non-disclosure of this third party information may apply when information is to be released – it may be appropriate at such times to take advice

De-registration

- When a child whose record contains a child protection alert moves to a new surgery, the designated responsible person at the CCG is notified, normally by the health visitor
- The Practice will ensure that the health visitor is made aware that the child is moving out of the area
- The designated responsible person at the CCG will contact the child's new GP or health visitor and will arrange for the transfer of any necessary records

- Child Protection files forming part of the Practice computer system will remain in place after the patient has de-registered in line with all other permanent medical records
- Particular care must be taken by the transferring practice to ensure that all child protection documents and information is passed over to the receiving Practice. This also applies to any confidential files which may (according to the needs of the case be filed separately

Referral

In the first instance, and if the risk to the child is not increased by doing so (situations such as sexual abuse or fabricated & induced illness might increase risk; consult local guidance), the health professional or Practice lead for Child Protection will inform the child and accompanying carer / parent that you need to discuss or report your concern.

When the child concerned is not a patient of the Practice, the policy is to speak to the Practice Lead, who should pass that information in accordance with the disclosure of information requirements.

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. 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.

When external authorities need to be contacted, see contact information displayed in the silver frame on the wall in the back reception offices.

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.

GPs may claim a fee for attendance at Child Protection Conferences, under the Collaborative Arrangements for Work for Local Authorities 1974, to defray their expenses - consult your Health Authority or Local Medical Committee for details. Consider liaising with your health visitor and school nurses in addition about your attendance.

No delay should occur in the provision of information while payment is sought. Even if attendance is not possible or judged necessary, the provision of the report, even to say that the child has not been seen, is essential. (*GMC Protecting children and young people 2011*).

General Points for Preparing Reports for Child Protection Conferences

The Assessment Framework Tool recommends a triangle model of assessment:

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

Consider:

Missed appointments with GP, practice nurse and midwife	Parental mental health or substance abuse	Are both parents registered with your practice?
Failed immunisations	Ability of the carer to parent	Who has parental responsibility?

	[disability, physical or intellectual]	
Missed hospital appointments	Evidence of domestic violence	Sharing the report with the child if old enough and the parents where appropriate.
Education: discuss with school nurse or health visitor	Cruelty to animals in the family	

Recording Information

- 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', 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
- 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

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)
- 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
- 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 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

Case Conference Requests for attendance, summaries & minutes

The Practice's system for dealing with requests to attend case conferences and requests for report for review conferences is as below. Any request for attendance at a case conference should first be direct to the patient's usual doctor or the doctor currently caring for the patient. In the absence of this doctor, the request should be passed to the doctor's buddy.

Case conference minutes frequently raise concerns because of their size and content (much of it about third parties). They should be processed and stored in the following way:

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

- *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).*

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 as they may vary between UK jurisdictions, you are advised to consult local CCG / LMC policies for further details.

Sharing Information

The default position is that the Practice will share information with Social Care as it recognises that not doing so maybe legally indefensible.

The Practice will implement the following policy on sharing information in child protection cases:

- In England and Wales, GPs have 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.

  CCGs (*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 function.

General principles for sharing information

The 'Seven Golden Rules' of information sharing as set out in the government guidance, *Information Sharing: Pocket Guide* 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*** but provides a framework to ensure 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 and 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

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'

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.

Declaration

In law, the responsibility for ensuring that this Safeguarding Children and Young Persons Policy is reviewed and implemented belongs to the Practice Partners.

***The* Partners have decided to delegate this responsibility to:**

Dr Amanda Gemmill (Lead Partner for Safeguarding)
Dr Jessica Reed (Deputy)
Assisted by Julia Beasley (Practice Manager)

REFERENCE DOCUMENTS and RESOURCES

- General Medical Council – Protecting Children & Young People

  www.gmc-uk.org/childprotection

- RCGP – Toolkit for General Practice

- http://www.rcgp.org.uk/clinical-and-research/clinical-resources/the-rcgp-nspcc-safeguarding-children-toolkit-for-general-practice.aspx

  http://www.cqc.org.uk/content/safeguarding-children

- Royal College of Paediatrics and Child Health

  www.rcpch.ac.uk