



## **CONTENT:**

<b>Page 3</b>	-	<b>Policy Statement</b>
<b>Page 3</b>	-	<b>Supporting Statement of Intent</b>
<b>Page 5</b>	-	<b>Background &amp; Principles</b>
<b>Pages 5 - 8</b>	-	<b>What is Abuse &amp; Neglect?</b>
<b>Pages 9 - 18</b>	-	<b>Practice Arrangements</b>
<b>Pages 19 - 21</b>	-	<b>Reporting</b>
<b>Pages 22 - 23</b>	-	<b>Recording Information</b>
<b>Page 24</b>	-	<b>Sharing Information</b>
<b>Pages 25 - 26</b>	-	<b>GMC Guidance</b>
<b>Page 27</b>	-	<b>Declaration</b>
<b>Pages 28 - 29</b>	-	<b>Appendix 1 – Child development stages</b>
<b>Pages 30 - 31</b>	-	<b>Appendix 2 – Child Protection Incident Reporting Form</b>
<b>Pages 32 – 33</b>	-	<b>Appendix 3 – Child Protection – Significant Event Form</b>
<b>Page 34</b>	-	<b>Appendix 4 – Sample template for recording learning</b>
<b>Pages 35 – 36</b>	-	<b>Appendix 5 – Child Death Review Process</b>
<b>Pages 37 -38</b>	-	<b>Appendix 6 – Children Unknown to your Practice</b>
<b>Pages 39 - 40</b>	-	<b>Appendix 7 – Information Governance</b>
<b>Pages 41 – 47</b>	-	<b>Appendix 8 – Case Scenarios</b>
<b>Page 49</b>	-	<b>Appendix 9 – Referral Process</b>
<b>Pages 50 – 53</b>	-	<b>Appendix 10 – Practice Audit Tool</b>
<b>Page 54</b>	-	<b>Appendix 11: Additional Resource Material</b>
<b>Pages 55 – 60</b>	-	<b>Appendix 12 – CWDC Induction Standards</b>

## **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.

We intend to:

- 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 primary care trust appointed contacts.
- The practice will 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**

- 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 Sunnyside GP Surgery is 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, a copy of which can be downloaded here:

[http://www.gmc-uk.org/Raising\\_and\\_acting\\_on\\_concerns\\_about\\_patient\\_safety\\_FINAL.pdf\\_47223556.pdf](http://www.gmc-uk.org/Raising_and_acting_on_concerns_about_patient_safety_FINAL.pdf_47223556.pdf)

Sunniside GP Surgery 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. 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.

Sunniside GP Surgery is committed to implementing this policy and the Practices it sets out for all staff and will provide in-house learning opportunities, and make provision for appropriate child protection training to all staff and partners.

This policy will be made widely accessible to staff and reviewed annually.

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 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 independent contractors, volunteers, and the wider primary care team members need to:

- Be clear what their role and responsibility is;
- Be able to respond appropriately to concerns or disclosures of abuse;
- Understand what behaviour is acceptable;
- Understand what abuse is;
- 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.

## **Background and Principles**

Safeguarding children and young people is a fundamental goal for the Sunnyside GP Surgery. This policy has been written in conjunction with our legislative and government guidance requirements and other internal policies. These include:

- 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)
- The Data Protection Act 1998 (UK wide)
- Sexual Offences Act 2003
- Working Together to Safeguard Children 2006
- Practice Equal Opportunity Statement
- Practice Disciplinary Policy

## **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
2. Emotional Abuse
3. Sexual Abuse
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

- 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

*(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 causing, ill health to a child.

*Working Together 2006*

### **Indicators:**

- Unexplained injuries;
- Injuries of different ages/types;
- Improbable explanation;
- Reluctance to discuss injury/cause;
- Delay or refusal to seek treatment for injury;
- Bruising on young babies;
- Admission of punishment which seems severe;
- Child shows:
  - Arms and legs inappropriately covered in hot weather (concealing injury);
  - Withdrawal from physical contact;
  - Self-destructive tendencies;
  - Aggression towards others;
  - Fear of returning home;
  - Running away from home.

## **Emotional Abuse**

**Definition:** Emotional abuse is the persistent emotional ill-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, age or developmentally inappropriate expectations being imposed on children, causing children frequently to feel frightened, or the exploitation or corruption of children.

*Working Together 2006*

### **Indicators:**

- Physical/ Mental/ Emotional developmental delay;
- Overreaction to mistakes;
- Low self-esteem;
- Sudden speech disorder;
- Excessive fear of new situations;
- Neurotic behaviours;

- Self-harming/ mutilation;
- Extremes of aggression or passivity;
- Drug/ solvent abuse;
- Running away;
- Eating disorders;
- School refusal;
- Physical/ Mental/ Emotional developmental delay.

## ***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. The activities may involve physical contact, including penetrative (e.g. rape or buggery) or non-penetrative acts. They may include involving children in looking at, or in the production of, pornographic material, or encouraging children to behave in sexually inappropriate ways.

*Working Together 2006*

### **Indicators:**

- Genital itching/pain
- Unexplained abdominal pain
- Secondary enuresis (or daytime soiling/wetting)
- Genital discharge/ infection
- Behaviour changes
  - Sudden changes
  - Deterioration in school performance
  - Fear of undressing (e.g. for sports)
  - Sleep disturbance/nightmares
  - Inappropriate sexual display
  - Regressive (thumb sucking, babyish)
  - Secrecy, Distrust of familiar adult, anxiety left alone with particular person
  - Self-harm/mutilation/attempted suicide
  - Phobia/panic attacks
- Unexplained or concealed pregnancy
- Chronic illness (throat infections)
- Physical/ Mental/ Emotional developmental delay

## ***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, such as failing to provide adequate food, shelter and clothing, or neglect of, or unresponsiveness to, a child's basic emotional needs.

*Working Together 2006*

### **Indicators:**

- Poor personal hygiene, poor state of clothing;
- Constant hunger/thirst;
- Frequent accidental injuries;
- Untreated medical problems:

- Delayed presentation, concealed injuries;
- Low self-esteem;
- Lack of social relationships;
- Eating Disorders;
- Children left repeatedly without adequate supervision;
- Failing to engage with healthcare:
  - Non-attended appointments (Practice or wider health professional);
  - Frequent use of A&E / Out-of-Hours services;
  - Failing to arrange immunisations;

## ***Injury Patterns***

There are a number of injury patterns that cause immediate concern in terms of Child Protection: amongst which are:

- Multiple bruising, with bruises of different ages
- Facial bruising in non-motile baby
  - Baby rolls over at six months
  - Baby attempts to crawl at eight months  
(See [Appendix 1: Child Developmental Stages](#))
- Ear bruising
- Unexplained oral injury
- Fingertip pattern bruising
- Cigarette burns
  - Accidental burns are superficial, circular, with a tail
  - Deliberate burns are deeper and tend to scar
- Belt/ buckle marks
- Burns/ scalds
  - “Glove” and “stocking” scalds, with clear demarcation of forced immersion
  - Face, head, perineum, buttocks, genitalia
  - “Hole in the doughnut” scald: centre of buttocks is spared when child forcibly immersed in scalding water (surface of bath takes time to warm: hence flat surface relatively cooler than water. Absence of this sign might hint at premeditation?)
  - “Splash” pattern – while droplet burns may indicate splashing trying to escape (and therefore potentially accidental), they may also suggest hot liquid thrown at child (which might cover larger, more diffuse area)
- Bites
  - Animal bites puncture, cut and tear
  - Human bites are bruised, crescent-shaped, and often do not break the skin
- Fractures
  - Multiple rib fractures
  - Different age of fracture
  - Spiral fracture of long bones: twisting force

Further information on injury patterns can be found at:

[http://www.nspcc.org.uk/inform/trainingandconsultancy/learningresources/coreinfo/coreinfo\\_wda54369.html](http://www.nspcc.org.uk/inform/trainingandconsultancy/learningresources/coreinfo/coreinfo_wda54369.html)

## **Practice Arrangements**

### **Practice Safeguarding Lead**

The Practice Safeguarding Lead is Dr Mather.

This is not a full-time function but instead complements the individual's daily duties. The responsibilities are detailed below.

Sunniside GP Surgery recognises that it is not the role of the Practice to investigate or to decide whether or not a child has been abused

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

- Act as a focus for external contacts on safeguarding/ child protection matters;
- Be fully conversant with all aspects of the Sunniside GP Surgery child protection policy, operating procedures and incident handling procedures;
- Disseminate safeguarding / child protection information to all practice members;
- Act as a point of contact for practice members to bring any concerns that they have and record it;
- Assess the information promptly and carefully, clarifying or obtaining more information about the matter as appropriate;
- Know and establish links with local child protection agencies, such as the children's social care services (previously social services in England and Wales);
- Know and establish links, and when appropriate take advice from named and designated professionals in child protection;
- Take a lead role in planning and delivering regular staff training, reviewing policy and operating procedures, and conducting audit / review of safeguarding in the Practice;
- Ensure that the practice meets the contractual and clinical governance guidance on safeguarding children/ child protection;
- Ensure that the practice team records safeguarding incidents appropriately, (for example of significant event forms see [Appendix 2](#)) and analysis of significant events (see [Appendix 3](#));

### **Immediate Actions when Child abuse may be suspected**

- Concerns should immediately be reported to the Practice Safeguarding Lead;
- In the absence of one of the nominated persons, the matter should be brought to the attention of the Primary Care Trust appointed person, or, if it is an emergency, and the designated persons cannot be contacted, then the most senior clinician will make a decision to report the matter directly to social services or the police.
- If the suspicions relate to the designated person, then the deputy should be notified and the Primary Care Trust appointed person and / or social services 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, 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, social services 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 social services directly for advice.
- Where sexual abuse is suspected, the designated person will contact the Social Services or Police Child Protection 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.

## **Staff Employment & Training**

### **Training Information**

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.

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

- Head & Spinal Injuries;
- Fractures in children;
- Bruises on children;
- Oral injuries and bites on children;
- Thermal injuries on children;
- Neglect (guideline in development).

[http://www.nspcc.org.uk/inform/trainingandconsultancy/learningresources/coreinfo/coreinfo\\_wda54369.html](http://www.nspcc.org.uk/inform/trainingandconsultancy/learningresources/coreinfo/coreinfo_wda54369.html)

### **Minimum safety criteria for all staff**

The minimum safety criteria for all staff that work on the Sunnyside GP Surgery are:

- Have CRB check (enhanced for clinical staff);
- Have 2 references that have been followed up;
- Have been interviewed face to face.

### **The Independent Safeguarding Authority**

The ISA came into being as a result of the 2004 Richard Inquiry into the Soham murder of Holly Wells and Jessica Chapman by Ian Huntley. The Report called for a new Registration Scheme, vetting & barring unsuitable people from working with children or vulnerable adults.

The ISA works with the Criminal Records Bureau <http://www.isa-gov.org.uk/> to examine and vet:

- Criminal records or cautions
- Police intelligence
- Other appropriate sources

All staff working regularly with children & young people will have to be registered with ISA.

### **Staff training**

- All new members of staff will undergo in-house training or other basic awareness training, including CWDC Induction Standards (See Appendix 12), organised by the local PCO, under local arrangements;
- All members of staff will undergo child protection training as follows:
  - All Non-Clinical Staff must be at Level 1;
  - Nurses directly employed by the Practice must be at a minimum Level 2, working towards Level 3;
  - All GPs must be at Level 3.
- The Practice will also ensure that:
  - Those moving into a Level 3 position must receive a further 8 hours of safeguarding training within a year of appointment.
  - GPs should undertake a further 4-6 hours training each year, over a three-year period (up to 16 hours over three years) to refresh and build upon the learning.
- Practices will organise at least annually a training session at 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 (see Appendix 4 - sample learning log);
- The Practice will discuss and record at least one clinical incident involving safeguarding children.

### **Mentoring and supervision**

Practices should have given thought to how to support staff and doctors working in this complex and challenging area of clinical Practice.

Mentoring systems are just now beginning to emerge in general Practice: often run by GP Tutors or 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 and through some PCO Named Doctors for Child Protection.

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 or Child Protection Committee procedures.

Mentoring and supervision provide an opportunity to ensure understanding of roles, responsibilities and scope of professional discretion and authority. Key decisions should be recorded in the child records.

## **Whistleblowing**

Sunniside GP Surgery 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.

## **Complaints procedure**

Sunniside GP Surgery 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 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, 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 Practice 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 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.

## **Internet, mobile phones and electronic equipment**

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

### **Inappropriate types of sites**

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

### **Permitted personal use**

Reasonable personal use of the internet by Sunnyside GP Surgery is permitted, as long as it does not interfere with the performance of normal duties, and remains in accordance with the stated IT policies, including those on acceptable use of equipment and use of email.

Such limited, personal use of the internet should only be conducted when it doesn't interfere with the user's ability to carry out their normal duties, e.g. outside normal working hours. You should bear in mind that when visiting an internet site, information identifying your PC may be logged. Therefore any activity you engage in via the internet may affect the Practice Team.

Practice employees are strongly discouraged from using their Practice email address when using public web sites for non-Practice purposes. This must be kept to a minimum as it results in you, and the Practice, receiving large amounts of unwanted email (spam).

## **Recognition of abuse**

Recognising child abuse is not easy and it is not our responsibility to decide whether or not abuse has taken place. However, it is our responsibility to act if we have any concerns. Guidance follows on recognising the possible symptoms of abuse in the four main areas: physical, emotional, sexual and neglect.

## **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 procedures, which follow, set out those steps to be taken with respect to any concerns relating to child protection.

## **Disclosure of an allegation of abuse**

If a child discloses information 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. 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 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;
- 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;
- Reassure the child that they have done the right thing by telling you;
- 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 passing this information on to the Practice Safeguarding Lead or Deputy.
- Consider if it is safe for a child to return home to a potentially abusive situation. It might be necessary to immediately refer the matter to social services and/or the police to ensure the child's safety and that they do not return home.

### **Confidentiality**

In order to do their jobs, 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, 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.

***GMC guidance "Confidentiality: Protecting and Providing Information" (Sep 2000) describes the following circumstances when disclosure may be justified:***

**Disclosures to protect the patient or others – (Paras 36 & 37c)**

"Disclosure of personal information without consent may be justified where failure to do so may expose the patient or others to risk or death or serious harm.

Where third parties are exposed to a risk so serious that it outweighs the patient's privacy interest, you should seek consent to disclosure where practicable.

If it is not practicable, you should disclose information promptly to an appropriate person or authority. You should generally inform the patient before disclosing the information."

Such circumstances may arise, for example: where a disclosure may assist in the prevention or detection of a serious crime.

Serious crimes, in this context, will put someone at risk of death or serious harm, and will usually be crimes against the person such as abuse of children."

**Children and other patients who may lack competence to give consent (Para 39)**

"If you believe a patient to be a victim of neglect or physical, sexual or emotional abuse and that the patient cannot give or withhold consent to disclosure, you should give information promptly to an appropriate responsible person or statutory agency, where you believe that the disclosure is in the patient's best interests.

You should usually inform the patient that you intend to disclose the information before doing so. Such circumstances may arise in relation to children, where concerns about possible abuse need to be shared with other agencies such as social services.

Where appropriate you should inform those with parental responsibility about the disclosure. If, for any reason, you believe that disclosure of information is not in the best interests of an abused or neglected person, you must still be prepared to justify your decision."

**Key Points:**

- You can disclose information without consent if you are making a child protection referral (subject to the guidance above):
- You should always obtain consent if you are making a referral as a child in need:
- If you are in doubt about whether to refer a child as a 'child protection referral' versus a 'child in need' referral, ask advice from Designated Safeguarding Lead or their Deputy.
- Clear and comprehensive records relating to all events and decisions will be maintained

## **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.

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 Child Protection Co-ordinator 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 Child Protection Co-ordinator 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.

### **Reporting**

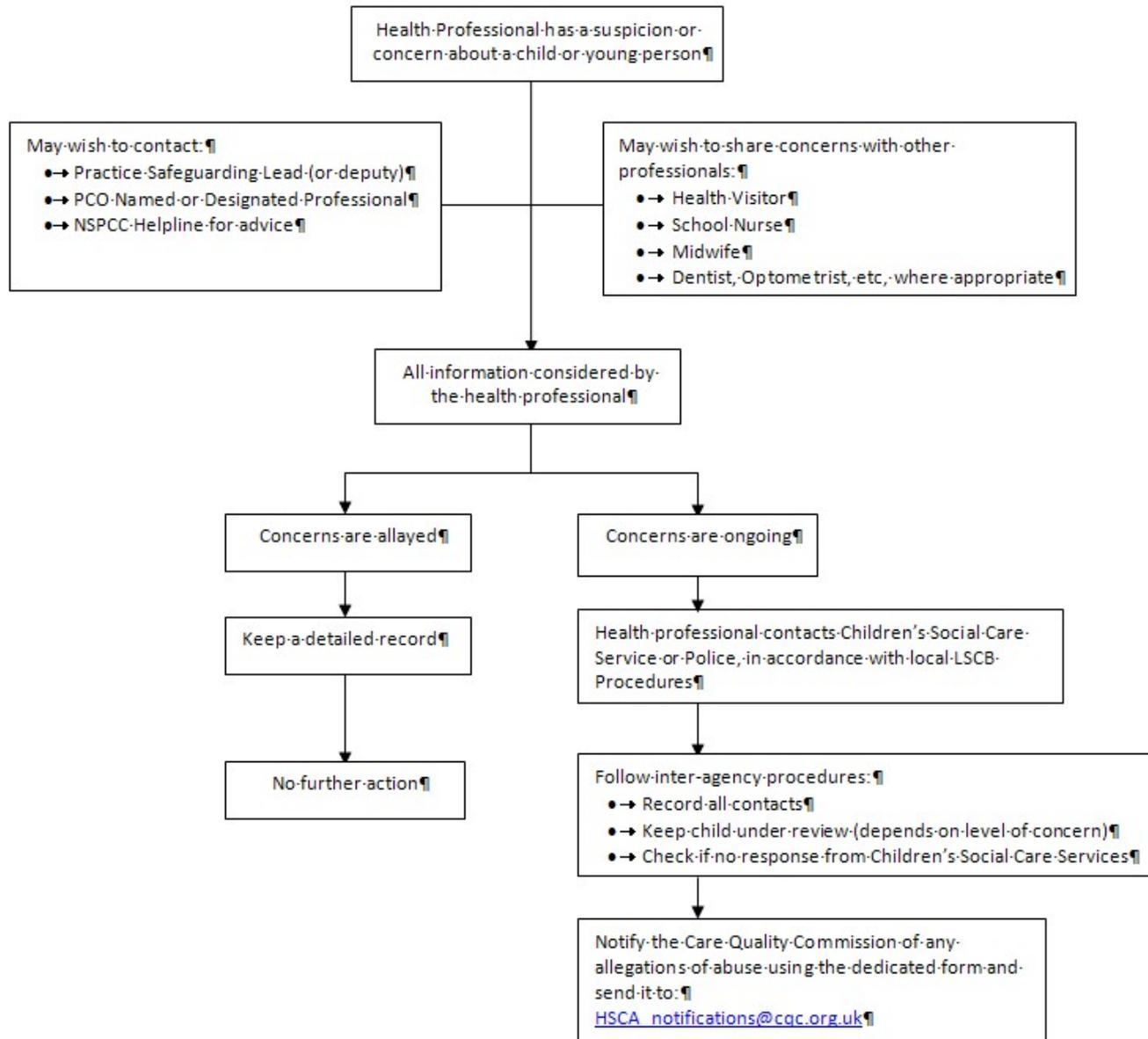
In the first instance, and if the risk to the child is not increased by doing so (situations such as Sexual Abuse or Fabricated & Induced Illness might increase risk; consult local guidance), the health professional or Practice Lead for Child protection will inform the child and accompanying carer / 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 in [Appendix 1](#).

When external authorities need to be contacted, the relevant details are below. As a general rule of thumb, you should contact the child social care services first unless the issue is more immediate.

<b>Location</b>	<b>Social Care Services</b>	<b>Police</b>
	Children's Services Safeguarding Team Customer Services <b>01522 782111</b>	Sexual Assault Referral Centre <b>01522 524402</b> Police Central Referral Unit <b>01522 805775</b>
	Emergencies and OOH <b>01522 782333</b>	SARC OOH <b>01371 812686</b>
NSPCC	<b>National Helpline</b>	<b>0808 800 5000</b>

## Practice Reporting Process



## **Enquiry process**

Practice staff (particularly health professionals) may be asked to contribute information and will be expected to provide a written report in order to 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 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.

Different arrangements exist in different areas: consult your health authority or Local Medical Committee for details. Consider liaising with your Health Visitor and School Nurses in addition about your attendance.

## **General points for preparing reports**

The Assessment Framework Tool (*Framework for the Assessment of Children in Need and their Families DH, DFEE 2000*) recommends a triangle model of assessment:

- Child's developmental needs;
- Parenting capacity;
- Family & Environmental Factors.

### **Consider:**

- Missed appointments with GP, Practices 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?
- Share the report with the child if old enough, and the parents where appropriate.

## **Recording Information**

- Information about vulnerable children will be recorded in the child's notes, and where appropriate the notes of siblings and significant adults. This will be recorded using locally agreed Read codes (see [Appendix 7: Information Governance](#));
- Information supplied by all members of the Primary Care Team, including the Health Visitor, will be recorded in the notes under a Read code. Email should only be used when secure, 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 2006;
- 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;
- 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 violence in the household.

### **Information can be sought and entered from:**

- New patient health checks on all children, including enquiry about family, social and household circumstances – (a Climbie Inquiry recommendation);
- Any contact with a potential carer – 'seeing the child behind the adult' – so that a patient with a substance misuse problem is asked about any responsibility they may have for a child, and that child's record amended accordingly;
- 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 (*Care Quality Commission 2009: Review of the involvement and action taken by health bodies in relation to the case of Baby P*).

## Case conference minutes

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
<b>Child (subject of conference)</b>	Yes	Yes	Yes*
<b>Other Children (not subject of conference but living in same Household / same Carers)</b>	Yes	Yes	No
<b>Adults named in report</b>	Yes	Yes	No

*\*The minutes should be read by the relevant GP. The GP should identify any pertinent information in the minutes. 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 (i.e. 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; and,
- 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, in the Children's Acts of 1989 and 2004 give GPs a statutory duty to co-operate with other agencies (Children Act 1989 section 27) if there are concerns about a child's safety or welfare. Health authorities (PCOs) (section 47.9) have a duty to assist local authorities (Social/Child Care Services) with enquiries: Named Doctors for Child Protection can be powerful advocates for this function.

## General Principles

The 'Seven Golden Rules' of information sharing are set out in the government guidance, *Information Sharing: Pocket Guide*. 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** 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 decision and the reasons for it** – 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

## Working Collaboratively with other Agencies

Multi-agency policies and procedures are in place throughout the NHS to ensure the continued protection of vulnerable children.

These collaborative partnerships exist so that reporting of alleged offences and subsequent action between Local Authorities, Police and those who provide a range of services to vulnerable children can take place.

Children who have been abused, or it is suspected have been victims of abuse will have a protection plan agreed collaboratively with all the multi-agencies involved. Each plan is tailored to the child's individual case.

All actions in relation to each case are recorded on the individual protection plan which is shared by all agencies involved to enable them to co-operate effectively, and reduce the risk of further abuse.

## 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 their 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, or
- 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.

#### **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 policy is reviewed belongs to Dr Chander.

**We have reviewed and accepted this policy.**

Signed by: ..... Dated: .....

Signed: ..... Dated: .....

on behalf of the Practice.

**The Practice team have been consulted on how we implement this policy.**

Signed by: ..... Dated: .....

Signed: ..... Dated: .....

## Appendix 1: Child Developmental Stages

### A brief guide to developmental stages 0-5 years

When signs of injury are detected in young children it is useful to have a working knowledge of developmental stages to ascertain whether the findings may be explained by accidental injury.

Further information on childhood accidents may be found at:

<http://publications.teachernet.gov.uk/eOrderingDownload/00255-2009EN.pdf>

Babies who are too immature to be capable of independent movement are unable to sustain accidental injury due to their own activities.

Most babies begin to crawl at around 8 months of age from which point they may become capable of injuring themselves, this tendency increases as they attempt to learn to walk unsupported.

Toddlers when first learning to walk are often unsteady on their feet and frequently topple; injuries occur to bony prominences such as forehead and extensor surfaces of joints such as elbows and knees, usually on areas unprotected by clothing.

All young children require supervision in the bath, and around paddling and swimming pools. Children are individuals and do not all develop at the same pace.

The milestones listed here are a guideline only; some children will achieve these milestones earlier, others a little later.

Age	Physical	Social and Emotional	Cognitive	Language
Birth- 4 weeks	Lies in foetal position with legs flexed at hips and knees, joints relatively stiff; Weak neck muscles, unable to raise head, head requires support at all times when being handled; Requires head support in bath; considerable head lag if pulled to sitting position(not advised) <b>NB some may be able to wriggle, squirm and roll so require supervision if placed on raised surfaces</b>	Begins to bond with mother; total dependence	Can make eye contact, gaze intently at human faces, scan environment visually, will look at large visual patterns seemingly with appreciation, uses hands to begin exploring own body starting with face	Cries vigorously if hungry or in need; some babies also produce a variety of pleasurable high pitched coos and gurgles after feeding or when picked up
6- 8 weeks	Legs are no longer flexed at hips, lies with pelvis flat, begins to lose some primitive reflexes e.g. Moro; Joints less stiff; Can raise head momentarily when	Smiles at mother and possibly other familiar human faces, eyes and head turn to follow moving objects, people and animals	Turns head towards certain sounds, becomes aware of familiar household noises e.g. ringing of telephone or doorbell, voices of family members	Begins to use different cries for different needs, coos and gurgles when content

	placed prone.			
<b>3 months</b>	Can bring hands together; tries to reach for small objects When placed prone can raise head and look round, shoulders require support in bath Can usually roll in one direction	Smiles spontaneously Beginning to develop own routine and feeding pattern	Turns towards sound of familiar voice	Makes noises like ah-goo Squeals when happy Cries less
<b>4 months</b>	In prone position can use arms to raise trunk off surface Can grasp rattle, uses hands to explore own body Legs kick vigorously	Focuses on small objects	Recognises parents, siblings and others seen often, acknowledges them by smiling or emitting pleased noises	Can laugh out loud
<b>6 months</b>	Rolls in both directions Picks up small objects, brings them to mouth	Looks for dropped toys Recognises own name by turning when called	Holds out arms to be picked up	Uses vowel-consonant combinations
<b>8 months</b>	Sits up without support Transfers objects from one hand to another Can eat a biscuit Learning to bottom shuffle or crawl, some can pull to stand and cruise Eager to explore environment Can pull open drawers and cupboard doors near floor level	Begins to demonstrate separation anxiety when mother leaves room Becomes wary of strangers	Understands the meaning of 'no' Objects to toys being taken away Explores by putting found objects in mouth Explores genitals during nappy changes and bath time	Says da-da, ma-ma , tuneful babble
<b>12 months</b>	Picks up small objects using 'pincer' grasp i.e. thumb and forefinger Walks using furniture as support 'cruising'; may be capable of standing and walking without support	Responds to simple requests Waves good-bye	Communicates needs by sound and gesture rather than crying	Talks in jargon Says mama, dada, few one syllable words like 'no'
<b>18 months</b>	Can bend and crouch to pick up an object then rise without use of arms to support self Walk backwards a few steps Starting to attempt stair climbing, sometimes while carrying one or more objects Can kick a ball, attempts to push and / or pull large objects	Sense of self developing, Says definite 'no' or 'mine'  Interested in playing simple games	Looks at books  Helps with dressing self  Points to parts of body  Searches for lost objects Spontaneous scribble with pencil	Can say phrase of 4-8 words  Complex babble  Points to named objects  Tries to sing

2 years	Can run, Throw a ball, Walk up and down steps holding on to railing or support; Can pull large wheeled toy attached to a cord Can jump with two feet together Unwraps small sweets, can pick up tiny objects like pins	Plays side by side with other children Concept of sharing not yet developed Demands desired objects by loud single word articulations, will become insistent if requests not met	Begins to show imaginative play Interested in images and books Dresses and undresses self with help Dominant hand and foot apparent Beginning to play contentedly on own but prefers an adult to be near No longer taking toys and other objects encountered to mouth Remembers where objects belong	Comprehends at least 50 words, can articulate 20-50 clear words, clear 2 word sentences, names pictures and objects when asked Beginning to name small objects seen at a distance Beginning to sing, join in with nursery rhymes
3 years	Can walk heel to toe Stand on one leg Jumps off one step Climbs up stairs one step at a time without support Can use scissors Can use spoon and fork Can thread beads	Can separate from parents without crying Can begin to describe feelings e.g. happy, sad Imaginative play involving others Likes to help with household activities	Can follow three step instructions Can define objects by use Undresses and dresses self appropriately without assistance Understands concepts of size i.e. bigger, smaller Recognises money Draws a crude but recognisable face	Can give own name when asked  Can name objects and body parts  Can develop spontaneous non-repetitive sentences
4 years	Can catch, throw, bounce and kick a ball Can confidently walk up and down stairs one step at a time Can run well on flat surfaces Can climb playground ladders Can pedal tricycle	Takes turn and shares Play shows understanding of complex social situations Plays with rather than alongside other children Can play games with simple rules	Can understand some human feelings Can compare sizes of objects Can count from one to five with comprehension Can create play stories with different roles Can do up buttons, put on socks and shoes	Can use two or more personal pronouns Can tell a story Can hold conversations Understands prepositions Speech is easily understood by strangers
5 years	Can easily catch and throw a ball Can run well on tip-toes Skilfully climbs, slides, swings Can walk along narrow line Skips on alternate feet Stands on either foot for 10 seconds without losing balance Can use knife and fork Uses scissors to cut out simple shapes Holds pencil or crayon very precisely using thumb and index finger	Has learnt social skills: to negotiate, share, avoid conflict	Able to compare speed e.g. faster, slower Can count up to 20 Beginning to understand concept of time; morning, afternoon Knows home address: street number and name Money: beginning to recognise and remember values of coins and notes Can dress self appropriately without assistance	Able to hold a long, intelligible conversation Understands opposites, similarities between objects, prepositions, personal pronouns Learning to write

## Appendix 2: Child Protection Incident Reporting Form

Name of Child:	Venue:	Date:
Date of Birth:	Age:	Time:
Address:		
Postcode:		
Telephone Number:		Name of Parent/Guardian:
Are you reporting your own concerns or passing on those of someone else? Give details:		
Brief description of what has prompted the concerns: include dates, times etc. of any specific incidents:		
Are there any physical signs? Behavioral signs? Indirect signs?		

Have you spoken to the child, young person, and or persons present? If so, what was said to whom?	
Have you spoken to the parent(s) guardians? If so, what was said?	
Has anybody been alleged to be the abuser? If so, give details?	
Have you consulted anybody? Give details:	
Your Name:	Position
To whom reported:	Date of reporting:
Signature	Date

Source: Luce R Safeguarding Children: Legal Framework for Nurses, Midwifery and Community Practitioners. Publishers: John Wiley & Sons 2008

### **Appendix 3: Child Protection - Significant Event Form**

#### **Managing risk and minimising mistakes to children and families in general practice**

**Terms used** - You will need to adapt terminology used in your area in regards to incidents

Adverse event	An incident that did lead to harm
Near miss	An incident that did not lead to harm
Safeguarding incidents:	This term covers everything that could have or did cause harm to children and families. It focuses specifically on 'no harm' incidents or 'near misses'.
<p>Are you reflecting on or acting on safeguarding actions? For example, events occurring elsewhere. Reflection in this situation would be a proactive mechanism rather than reactive. Some adverse events occur infrequently and may only be detected every few years by organisations. Serious case reviews and child death reviews are other mechanisms for reflection.</p> <p>Question to ask here is "Could this adverse event/ safeguarding incident occur in our practice?"</p>	
Brief description of event:	
Issues raised by the event:	

What went well?
What did not go well?
What changes have you identified or made to clinical or administrative practices?
Are there any staff training and / or other performance management needs?

Consider in what other ways you could share what you have learned or where you could submit safeguarding incidents anonymously to a project lead.

*Source: Luce R Safeguarding Children: Legal Framework for Nurses, Midwifery and Community Practitioners. Publishers: John Wiley & Blackwell*

## Appendix 4: Sample template for recording learning

### Record of Learning

Learning activity:	Safeguarding Children and Young People in General Practice
Provider:	
Format used or venue: (delete as applicable)	
Dates of training and time spent (hours)	
Reflective notes/ conclusions:	How has my learning affected me? How will it affect others working with me? How will it affect the care of my patients?
Action plan:	What do I need to do now? When do I need to do it by? What help or resources will I need? How will I know when I've achieved it?
Have the training/ resources identified further learning needs?	Is there anything else I need to do as a result?
Relationship to Appraisals and Personal Development Plan	How does this fit with what I already know or need to know?

## **Appendix 5: Child Death Review Processes**

From April 2008, Local Authority and Health agencies have a responsibility to take part in review processes which look at the death of every child, irrespective of cause intended to generate lessons to reduce avoidable deaths.

Local Safeguarding Children Boards (LSCBs) may have their own guidance to guide General Practitioners and their staff towards understanding the extent of their responsibility to co-operate in these processes.

### **Child Death Review Processes**

Chapter 7 of Working Together to Safeguard Children 2006 sets out the procedures which LSCBs must follow in the event of the death of a child. Although these deaths are uncommon, it is expected that agencies will have standing arrangements in place. Guidance applies to all children from birth to 18 years.

There are two different pathways in place for:

- **Unexpected deaths**, where a group of key professionals come together to enquire into and evaluate the death; and
- **All deaths**, where an overview panel will review patterns or trends in local data.

### **Unexpected Deaths**

#### **Child Death Review Teams (CDRT)**

A multiprofessional team will be drawn together within days of the unexpected death of a child. In agreement with the Coroner, they will investigate the reasons for the death, liaise with those who have ongoing responsibility for other family members, collect standardised information, maintaining contact throughout with the family, and with professionals.

The CDRT will be made up of the following:

- Senior Investigating Police Officer
- Visiting Health Professional [Paediatrician, Named or Designated Nurse]
- Health Visitor or School Nurse
- Children's Social Care representative

#### **Immediate response to the unexpected death of a child in the community**

It is anticipated that babies and infants who die at home or in the community will always be taken to hospital, where resuscitation may be undertaken if appropriate.

Working Together offers the advice that "it is expected that the child's body will have already been held or moved by the carer, and that removal to A&E will not normally jeopardize an investigation."

### **Designated Paediatrician with responsibility for unexpected deaths in childhood**

Working Together also creates the new role for a Paediatric overview of deaths in childhood. This Doctor will ensure that relevant professionals are informed of the death of the child, collate their responses, and convene a meeting to discuss the findings of the post-mortem examination

Any GP confirming unexpected death of a child in the community would be expected to notify the Designated Paediatrician, who will then cascade the information to relevant professionals – coroner, police, and children’s social care services.

## **All Deaths**

### **Child Death Overview Panel (CDOP)**

The CDOP will be made up from among the following:

- Director of Public Health or representative
- Coroner or Coroner’s Officer
- Consultant Paediatrician (SUDI paediatrician)
- Children’s Social Care
- Police Child Abuse Investigation Unit
- Child Health Nurse
- Midwifery
- Bereavement Counsellor
- Lay representative; and
- Other ad hoc representation on particular issues as they arise, and this might from time to time include Primary Care, Obstetric, Emergency Department, Pathology or Mental Health personnel.

## Appendix 6: Children Unknown to your Practice

### Introduction

Most children in the United Kingdom are registered with an NHS General Practitioner. When children who are not known are seen, health professionals should take the opportunity to assess them for signs of abuse listed elsewhere in this document.

Children in both the following categories may be at risk of abuse and neglect, and may also present medico-legal risk to the Practice.

#### **1. Children who are registered with a practice but are never or rarely seen**

Children may not be brought for screening or immunisations appointments or not presented for care of acute conditions at the practice.

It should be noted that infants and young children depend on adults for provision of care, and failure to make and keep such appointments might be considered a feature of Neglect.

It should be considered good practice on the part of health professionals to follow up failure to attend for prophylactic care and to persuade reluctant parents to present children for such care.

Such children may be frequently presented to Out of Hours Services and Accident and Emergency Departments for care of acute conditions, yet fail to attend routine Out-Patients appointments. These are known indicators of risk (CEMACH 2008)

[http://www.cmace.org.uk/getattachment/72d46ead-b529-466d-b0c3-4794d6a30203/Why-Children-Die--A-pilot-study-\(2006\).aspx](http://www.cmace.org.uk/getattachment/72d46ead-b529-466d-b0c3-4794d6a30203/Why-Children-Die--A-pilot-study-(2006).aspx)

for which practices might wish to consider developing routine searches and flagging mechanisms so that such children might be identified and further action taken.

#### **2. Children presented for immediately necessary treatment or temporary registration.**

These may be

- Children already registered with another UK GP who are on holiday or visiting relatives,
- Children who are Looked After by the Local Authority and
  - Placed with foster carers or
  - In a Children's Home,
- Recent immigrants not yet registered,
- Asylum seekers,
- Illegal immigrants or
- Trafficked children.

Treatment of these children is already funded within General Medical Services and most Personal Medical Services contracts. The GP's duty is to provide any necessary medical treatment to the child regardless of place of origin or right to UK residence.

Detailed guidance may be found at:

[http://www.gmc-uk.org/guidance/archive/GMC\\_0-18.pdf](http://www.gmc-uk.org/guidance/archive/GMC_0-18.pdf).

An essential aspect of the duty of care to the child is that careful, detailed, contemporaneous records are maintained and accurate contact details be obtained in the event that follow-up for a medical condition is required or concern about the child's well-being has been aroused.

The child's full name, permanent address and telephone number, name of carer, name of usual GP and school if of school age, should be ascertained, in addition to the temporary address and telephone contact details.

If in the course of seeing such children the GP feels there is a possibility that the child may be at risk, it might be helpful to telephone the child's usual GP or school to obtain more information.

In most cases seeing children as Temporary Residents is a straightforward procedure. GPs practicing in resort towns with a regular influx of tourists every summer will be used to seeing a number of children with minor and straightforward ailments which do not cause great concern and this may also apply to children staying temporarily with relatives known to the Practice.

Children in the care of the Local Authority should be registered permanently; concerns around the length of the placement and possible changes of GP should be discussed with their Social Worker and every effort must be made to ensure that their records are transferred to the next GP in a timely and appropriate manner when they move.

However it is necessary to maintain continuing awareness of the existence of children who may have been trafficked, who are in this country illegally, or who are children of failed asylum seekers.

GPs have a responsibility to provide urgent and immediately necessary care for all children, even those of uncertain immigration status, while being conscious that carers of such children may seek to avoid attention of the authorities by providing assumed names and false addresses.

More information may be found at:

<http://publications.everychildmatters.gov.uk/eOrderingDownload/DCSF-Child%20Traffic-Complete.pdf>.

## Appendix 7: Information Governance

### Clinical Computer System Coding for Safeguarding Children

Practices may find the following helpful in recording safeguarding information. The intention is that some codes may be used regularly by a practice, so that they can be searched on.

Please check with your IT provider if you cannot find codes. Both Read codes (INPS/EMIS) as well as CTv3 codes (*italics*) (SystemOne) are included.

Code – Read ( <i>CTV3</i> )	Where entry is made	Freetext (information to be entered attached to the code)
<b>SOCIAL SERVICE CASE CONFERENCE</b>		
3875 ( <i>3875.</i> ) Social services case conference	every relevant child record	
13lv ( <i>XaOnx</i> ) Child subject to Child Protection Plan	every relevant child record	note the category of abuse
13lw ( <i>XaOtI</i> ) Discontinuation of Child Protection Plan	every relevant child record	
13ly ( <i>XaPkF</i> ) Family member subject to Child Protection Plan	every child in the close family/household of the index case	note the relationship to the index child and the category of abuse
13lz ( <i>XaPkG</i> ) Family member no longer subject to Child Protection Plan	every child in the close family/household of the index case	note the relationship to the index child
13ZT ( <i>XaKbR</i> ) At risk of physical abuse	every relevant child record	
13ZW ( <i>XaKbT</i> ) At risk of sexual abuse	every relevant child record	
13ZR ( <i>XaKbP</i> ) At risk of emotional abuse	every relevant child record	
13ZV ( <i>XaKbS</i> ) At risk of neglect	every relevant child record	
64c ( <i>Ub0ex%</i> ) Child protection procedure	every relevant child record	freetext nature of procedure (could be used for any meeting/outcome not coded above)
13W3 ( <i>13W3.</i> ) Child abuse in the family	every relevant child record, including close family/household contacts of index case	note the nature of the abuse and the relationship of the child to the index case

<b>DOMESTIC CIRCUMSTANCES</b>		
ZU ( <i>Ua0Hb%</i> ) Family details and housing composition	every child record	note who lives with the child, and any other significant contacts e.g. 'absent' father
13E ( <i>XE0oy%</i> ) Inadequate housing	every relevant child record	note what is inadequate about the accommodation
13VF ( <i>13VF.</i> ) At risk of violence in the home	every relevant adult or child record	note the nature of the DV, and the alleged victim and perpetrator
14X3 ( <i>XaJhe</i> ) History of domestic violence	every adult who has perpetrated DV	<i>be wary of recording allegations – code best used when perpetrator themselves discloses</i>

<b>Code – Read (CTV3)</b>	<b>Where entry is made</b>	<b>Freetext</b> (information to be entered attached to the code)
<b>PARENTAL ILLNESS/CAUSES FOR CONCERN</b>		
E...(E...%) mental disorders (virtually all codes in the hierarchy)	every relevant child record	note the nature of the mental illness
128Z (128..%) FH: mental disorder NOS	every relevant child record	note the nature of the mental illness, and the relationship to the child
1283 (1283.) FH: drug dependency	every relevant child record	note the relationship of the child to the individual with the drug misuse problem
1282 (XE0oB) FH: alcoholism	every relevant child record	note the relationship of the child to the individual with the alcohol problem
13Z4E (13Z4E) Learning difficulties	every relevant record	
12W1 (XaJie) FH: learning difficulties	every relevant child record	note the relationship of the child to the individual with learning difficulties
14X4 (XaKS6) On sex offenders register	every relevant adult record	
625 (625..%) A/N care: social risk	every relevant maternal record	note the nature of the risk
13If (XaMzr) Child is cause for concern	every relevant child record	
9FZ (9FZ..) Child exam/report NOS	every relevant child record	any other concern that might not of its own be significant but that may be part of a pattern of events/incidents e.g. an unexplained bruise

<b>RISK ASSESSMENT</b>		
Z4a(XaPJc) Discussion	every relevant child record	Note who the concern was discussed with and the outcome
8HHB (XaBva) Referral to social services	every relevant child record	note who the referral was made to and the agreed plan

***Be careful discriminating between 'O' and '0', and 'I', '1' and 'l'  
% = this is a top level code with sub codes***

## Appendix 8: Case Scenarios

### Practice Dilemmas

#### 1. THE GRANDMOTHER

Maria, one of your patients, brings her grandson age 18 months for his overdue MMR immunisation. Your Practice Nurse says that she cannot give this without the Parent's signature.

#### *What should you do?*

- a) Tell her that the nurse cannot give the immunisation today and one of the parents should bring the child?
- b) Tell her that you will give it?
- c) Allow the grandmother to sign for it?
- d) Phone the parent for consent or give grandmother the consent form to bring back next week with the parent's signature.

#### *Notes:*

- a) **Correct;** but you should consider the child's best interests (GMC 0-18 years 2007). It could be that the parents have given implied consent (for example if the child's mother hates watching) or both parents are at work.

Oral or texted consent should be obtained if possible and recorded in the notes.

- b) **You may be correct;** If you judge that the child's best interests are met by giving the immunisation (for example if a measles contact or in an epidemic) and the child is well, you should record the reasons for your decision in the notes.
- c) **You may be correct;** If the child's mother has agreed that the grandmother can bring the child, but where at all possible the mother's oral consent should also be obtained.

If you judge that the child's best interests are met by giving the immunisation (for example if a measles contact or in an epidemic) and the child is well, you should record the reasons for your decision in the notes.

A grandmother may acquire parental responsibility if she is appointed guardian if the child's parents die, if she acquires a Court Residence Order for the child, or if she adopts the child.

- d) **Correct;** Oral consent needs to be recorded in the notes. It may be in the child's best interests to immunise the same day.

## 2. THE BOY WITH THE CONGENITAL ICTHYOSIS

This four year old boy's mother asks for an extra prescription of his creams and Tubifast® garments. She confides that his itching is always worse when his father is around and that his father has an awful temper.

### **Should you**

- a) Report the matter immediately to the Children's Social Care?
- b) Ask the health visitor to call?
- c) Talk to the nursery school teacher and health visitor about the family?
- d) Arrange another appointment to talk to his mother next week?
- e) Phone or speak to the boy's father?

### **Notes:**

- a) **You may be correct.** If you judge that the boy is likely to suffer harm (s47 Children Act 1989) as well as being a child in need (s17) then you should refer immediately. Working Together to Safeguard Children Guidance (2006) advises speaking to a senior colleague with responsibilities in safeguarding; for example the practice safeguarding lead or the local NHS Named Nurse first to gather more information.
- b) **You may be correct.** The family may be known to the health visitor. She may already suspect or have asked the mother privately about domestic violence. Where there is no health visitor available, you should seek another opportunity to explore concerns privately. If then you judge that the boy is likely to suffer harm (s47 Children Act 1989) as well as being a child in need (s17) then you should refer immediately.
- c) **You may be correct,** although you should usually seek the mother's permission before doing this. If concerns for the child outweigh the mother's misgivings about this, latest information sharing guidance reminds us of the primacy of the child's wellbeing. (HM Government 2008 Information Sharing Guidance). You need to check with others who know the child about their observations. If then you judge that the boy is likely to suffer harm (s47 Children Act 1989) as well as being a child in need (s17) then you should refer immediately.
- d) **Correct.** The GP needs to ask, give information and It is important to support the child within the context of the family wherever possible (Children Act 1989). If as a result of talking further to mother, you judge that the boy is likely to suffer harm (s47 Children Act 1989) as well as being a child in need (s17) then you should refer immediately.
- e) **This is not current guidance.** By speaking to the father, you are breaking the child and mother's confidential disclosure to you which may make matters worse. If he subsequently seeks help, it may be possible to give him support and help in anger management, or a specialist perpetrator programme (<http://www.respect.uk.net/>)

### 3. THE UPSET MOTHER

You have a phone call at 3pm on a Friday afternoon from a mother who is worried about her 17 year old son. He smashed a plate over her boyfriend's head when he arrived back at the house this afternoon.

She wants you to come and see him. She is worried he (the son) might harm himself.

On checking the family's notes, you realise that the two younger half-brothers are subject to a Child Protection Plan.

#### ***Should you***

- a) Tell her to phone the police?
- b) Phone the police yourself?
- c) Visit the family yourself?
- d) Phone social care services?
- e) Arrange an ambulance to take the 17 year old to the Accident and Emergency Department?
- f) Say it is not a GP responsibility?

#### ***Notes:***

- a) **This may be correct.** As the younger two boys are subject to a Child Protection Plan, any incidents of violence in the home need to be notified to the police. There may be a threat of continuing violence in the house.

This may, however, take some time, and if the son is willing to see you, it may be possible to ask him to attend the surgery. If not, you have an option of visiting with or without police presence.

- b) **This may be correct.** It allows you the option of negotiating a police presence in order to give the 17 year old the care he needs.
- c) **Correct.** His mother has requested a visit, but, unless her son is not competent, he needs to agree to see you. You may be able to negotiate that he comes to surgery.
- d) **This may be correct.** If you judge that the boy is likely to suffer harm (s47 Children Act 1989). He is under 18. Local arrangements vary and he was not subject to the Child Protection Plan that his brothers were. You may be able to obtain more information about the family from the local PCO Named Nurse.
- e) **You may wish to consider that this might provoke further violence.** If the young man refuses to accompany the ambulance crew, they will ask you to make an assessment yourself anyway.

- f) **You do not have enough information yet to make this judgement.** The young man's mental state needs assessment.

#### 4. THE 10 YEAR OLD GIRL WITH "CUTS"

The Registrar comes to ask your advice and for you to act as a chaperone for him.

A 10 year old African girl has come with her mother complaining of a "cutting" feeling down below.

She has agreed for him to examine her.

##### **Do you**

- a) Tell the registrar that he can do it with the mother as chaperone?
- b) Advise him to refer the child without examination to a paediatrician?
- c) Advise the registrar to contact social care services immediately?
- d) Accompany him or her and examine the child with him?

##### **Notes:**

- a) **You need to check that the girl has agreed to another chaperone as well as her mother.** You do not have enough information about the registrar's specific concerns, although it seems a reasonable request. If you suspect abuse has taken place you will need to refer on. (Working Together 2006). A common cause of discomfort is vulvitis, although you should check that there is no unusual bruising or sign of female genital mutilation.
- b) **This is probably not necessary.** You could ask directly whether the girl had been harmed in any way. If she or her mother discloses harm, or risk of harm, then you should make an emergency referral to a specialist unit or a paediatrician. Otherwise, it is more likely that she has vulvitis.
- c) **You do not have enough evidence to substantiate a referral to Children's Social Care.** You could, however, ask them or the PCO Named Nurse whether the family are known.
- d) **Correct.** A common cause of discomfort is vulvitis, although you should check that there is no unusual bruising or sign of female genital mutilation. You could ask directly whether the girl had been harmed in any way. If she or her mother disclose harm, or risk of harm, then you should make an emergency referral to a specialist unit or a paediatrician.

The child agreed to the examination. There was nothing suspicious and vulvitis was diagnosed.

## 5. THE 10 YEAR OLD GIRL WITH HAEMATURIA

An Out of Hours report arrives about a 10 year old girl whose mother took her to the Out of Hours clinic on Saturday evening with blood in her knickers and her urine. The doctor who saw her gave her antibiotics and advised the GP to follow up.

### **Do you**

- a) Wait until the child comes to the surgery next time?
- b) Ask reception to ring the mother to bring in another urine sample?
- c) Ring the mother and ask her to make an appointment on her own?
- d) Ring the mother and ask her to bring the child to see you?
- e) Refer to paediatrician straight away?
- f) Refer to social care services straight away?
- g) Ask the health visitor?

### **Notes:**

**a) You may wish to consider potentially serious differential diagnoses if this is true haematuria, so a further urine sample is needed as soon as possible.** Unless the child has an appointment already in the next week, you should make arrangements to see her.

**b) Correct.** See a).

**c) You need to give both the mother and the child opportunities to talk on their own about what happened.** It may be easier to do this in the context of a consultation with both of them initially and then asking each to wait outside for a few minutes.

**d) Correct.** See c).

**e) It is good to check what the mother and the child are saying, the urine culture and microscopy at the lab, and relevant family details, before referral to a paediatrician.** You could ask directly whether the girl had been harmed in any way. If she or her mother discloses harm, or risk of harm, then you should make an emergency referral to a specialist unit or a paediatrician.

**f) You do not have enough evidence to substantiate a referral to Children's Social Care.** You could, however, ask them or the PCO Named Nurse whether the family are known.

**g) Health visitors in England now deal mainly with children under 5;** although she may know the family if it has a child of this age.

In this case, it was disclosed six months later that the child had suffered sexual abuse from a neighbour, a friend of the older sister's boyfriend.

## 6. THE 4 YEAR OLD WHO IS BEHIND WITH HIS IMMUNISATIONS

You have to do a couple more immunisations in order to meet your target so you visit a family who keep making appointments and then missing them.

The boy agrees, especially as his friends are there to watch.

As you leave, mum confides that she is pregnant again and is trying desperately to come off the alcohol and amphetamines.

### ***Do you***

- a) Make a referral to Social Care?
- b) Tell her to get a termination?
- c) Tell her that she should phone the midwife?
- d) Phone the police?
- e) Speak to the health visitor?

### ***Notes:***

**a) The mother is more likely to appreciate your care if she knows she will be supported through this process.** You have enough evidence to substantiate a referral to Children's Social Care. You should, however, ask the health visitor or midwife if they have more information which would help complete the picture. You could also ask the PCO Named Nurse whether the family are known.

**b) You may feel strongly either way. However, you have not explored her thoughts or feelings on this.** If she continues to smoke and abuse drugs and alcohol through pregnancy, the unborn child is already at risk. The mother already knows this and may be persuaded to have help in reduction whether or not she goes ahead with the pregnancy.

**c) This mother does not have a good history of keeping appointments.** Although it is right to try and get her to take responsibility, it would be preferable to inform the midwife yourself, who can then arrange contact and assessment.

**d) You do not have enough evidence for a referral to the police.**

**e) Correct.** The health visitor may have useful information and insights about this child and other children. See a) It is important to record in the medical notes the result of talking to the health visitor and the date of referral to Children's Social Care using the CAF form. (Working Together 2006).

It seems likely that this child and the unborn child may be subject to the child in need (Children Act 1989 section 17) or even a child at risk (Children Act 1989 section 47) procedure once all the information is collated.

This child, his older sister and the unborn child were made subject to a Child Protection Plan after all the evidence was collated. The children had often missed school and arrived hungry and dirty.

There were also concerns about their behaviour at school and learning difficulties.

## **7. THE BABY WHO IS DEVELOPMENTALLY AND PHYSICALLY SLOW TO PROGRESS**

You have concerns about a baby whom you have seen recently with a chest infection. The baby is 11 months old but is not sitting unaided and does not yet try to stand.

Her weight was 4lb 8oz when she was born at 38 weeks gestation and has climbed gradually along the 5th centile.

She is seen from time to time in the paediatric clinic but missed the last appointment.

You then hear from a GP partner that the baby's mother is expecting again. She is 24 years old and already has 5 children. The eldest is 8 years old.

### ***Do you:***

- a) Refer the family to Children's Social Care
- b) Speak to the health visitor about your concerns
- c) Do nothing
- d) Write to the paediatrician about your concerns
- e) Speak to the school nurse at the school which the older children attend.

### ***Notes:***

- a) **You do not have enough evidence to substantiate a referral to Social Care.** The local NHS Named Nurse may be able to tell you whether the family are known.
- b) **The health visitor should know this child and may know more about the background.**
- c) **Once you have concerns about a child you should record your concerns and follow them through until you are satisfied that the child's needs are being met.**
- d) **The paediatrician may have concerns and communicating may help clarify these.**
- e) **The school nurse will have valuable information about school attendance and concerns about the older children's progress.**

As a result of information gathering, it became clear that the mother was using the eldest girl who is 8 to get breakfast for the other children and see them to school, while she stayed in bed.

Several of the children had missed appointments for immunisations, spectacles and dental treatment. The mother had been abused herself as a child.

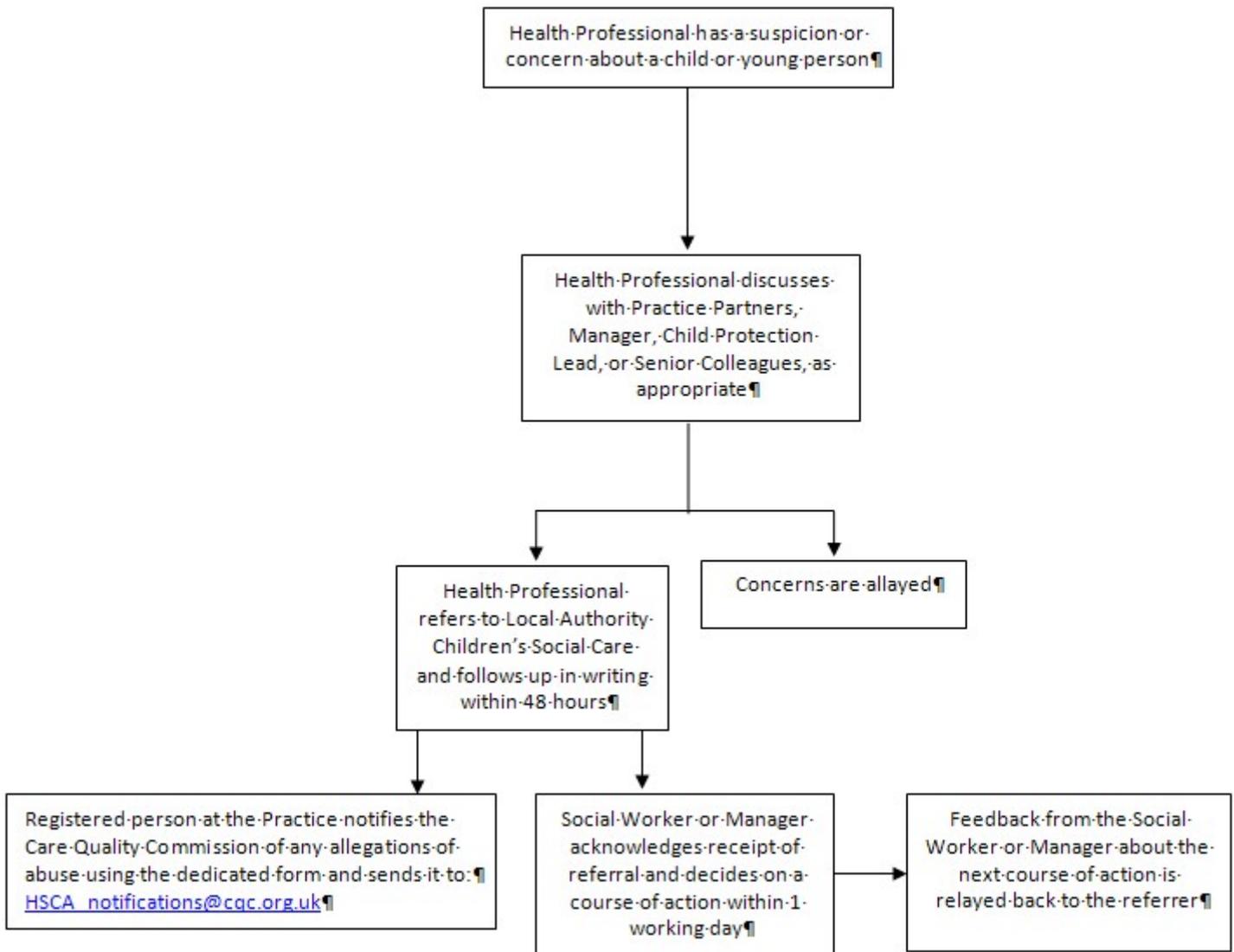
She was giving very little attention to the baby.

A CAF form was completed and a Case Conference was then held.

More evidence was presented from the police.

All the children, including the unborn child, became subject to a Child Protection Plan.

## Appendix 9: Referral Process



## Appendix 10: Practice Audit Tool

### 1. Introduction

1.1 Section 11 of the Children Act (2004) along with 'Working Together to Safeguard Children' (2006) sets out the statutory responsibilities of all services, including general practice, in relation to safeguarding of children and young people. Addressing domestic violence is an integral part of this process.

1.2 Serious Case Reviews undertaken in UK have highlighted a number of recommendations regarding systems and procedures undertaken in general practices, particularly in relation to record keeping, information sharing in relation to flagging 'child at risk'/ 'families at risk', information sharing regarding domestic violence and other medically held information that could have informed multi-agency working.

1.3 This is a tool for an audit of general practice systems and processes relating to safeguarding children and young people, intended to help Practices recognise where they may need to change.

This takes the form of a self-assessment tool for the Primary Health Care Team and forms a useful basis for a Child Protection training session or Team Meeting Agenda.

### 2. Audit of General Practice Systems and Procedures

2.1 Practices are advised to complete the enclosed self-assessment tool annually, providing notes on action taken and a rating against each item, using the following RAG (Red Amber Green) scoring definitions

- **Red** not yet achieved or little action taken to date
- **Amber** some action undertaken but further work needed to complete
- **Green** completed, procedures in place and monitored

2.2 It is anticipated that for some items steps will need to be taken to achieve improvement. As well as summarising action already taken, please also include any action underway or planned along with anticipated completion dates in the Progress Notes column.

*(Copyright for this Appendix rests with NHS Bournemouth and Poole)*

OUTCOME	TASK(S)	PROGRESS NOTES Actions planned	RAG
<b>Practice Policy and Procedures</b>			
1. The practice has a clearly defined and understood policy in place regarding safeguarding children, young people and vulnerable adults that also addresses domestic violence and elder abuse issues. This policy is known to all members of the Primary Care Team, who are aware of where in the practice the Policy and all supporting documents are stored and can access these documents whenever required.	<ul style="list-style-type: none"> <li>Develop a safeguarding practice policy which is regularly reviewed and updated.</li> </ul>		
2. Safeguarding and domestic violence are regularly addressed in practice meetings.	<ul style="list-style-type: none"> <li>Include safeguarding and domestic violence as regular agenda items in practice meetings.</li> </ul>		
3. Any hospital communications to GPs raising potential concerns about children subject to a Child Protection Plan should be regarded as 'urgent' rather than 'routine' and followed up accordingly	<ul style="list-style-type: none"> <li>Ensure that hospital communications to the practice about children subject to a Child Protection Plan are regarded as 'urgent' and followed up accordingly.</li> </ul>		
4. Children regularly reported as not attending routine hospital or practice appointments should be followed up even if not subject to a CP Plan.	<ul style="list-style-type: none"> <li>The Practice should consider putting a system in place to 'flag-up' children who regularly default from attendance at routine appointments</li> </ul>		
5. When a woman becomes pregnant whose existing children are or have been in the past subject to a Child Protection Plan, or have been taken into care, GPs notify other relevant professionals (e.g. health visitor, midwife and social worker).	<ul style="list-style-type: none"> <li>Notify other relevant professionals when a woman becomes pregnant whose existing children are or have been subject to a Child Protection Plan, or taken into care.</li> </ul>		
6. The practice member of staff responsible for a particular family in recognised challenging circumstances (a vulnerable family) follows up the family when a member(s) misses appointments, or where there are any child care or child protection concerns.	<ul style="list-style-type: none"> <li>Identify a lead practice member of staff as responsible for each family which is in recognised challenging circumstances (a vulnerable family).</li> </ul>		
	<ul style="list-style-type: none"> <li>Follow up such families up when a family member misses an appointment, or where there are any child care or child protection concerns.</li> </ul>		

7. Reports received by GP practices from other health providers [A&E services] should take into account the content of the report and consider any actions required to safeguard children and/or vulnerable adults within the household.	<ul style="list-style-type: none"> <li>Risk assessment process in place to consider the need to share information with other agencies where indicated.</li> </ul>		
	<ul style="list-style-type: none"> <li>Record made of actions taken by the practice</li> </ul>		
8. In the event that a GP practice has either direct or indirect consultations relating to an infant or child who has not yet been registered with the practice, a temporary file should be made. Any direct or indirect discussion/consultation relating to that individual should be recorded in this temporary file. If the child is not then registered with the surgery these notes should be forwarded on to the registered GP.	<ul style="list-style-type: none"> <li>Set up temporary file for any child not yet registered with the practice and use to record any direct/indirect consultations regarding that child.</li> </ul>		
	<ul style="list-style-type: none"> <li>If the child is not then registered with the surgery, forward the temporary notes on to the registered GP.</li> </ul>		
<b>Staff Recruitment &amp; Training</b>			
9. The practice, prior to employing or engaging any person (staff and volunteers) to work in the practice, takes reasonable care to satisfy itself that the person in question is both suitably qualified and competent to discharge the duties which they are to be employed or engaged to perform, is CRB checked, and is registered with the Independent Safeguarding Authority if they carry out regulated or controlled activity in their role. <a href="http://www.isa.gov.org.uk/">http://www.isa.gov.org.uk/</a>	<ul style="list-style-type: none"> <li>Check that all staff and volunteers working in the practice are suitably qualified and competent.</li> </ul>		
	<ul style="list-style-type: none"> <li>Ensure that all staff and volunteers working for the practice are CRB checked.</li> </ul>		
	<ul style="list-style-type: none"> <li>Ensure all staff who undertake regulated and controlled activity with vulnerable people are ISA registered</li> </ul>		
10. All practice staff receive training and regular updates in relation to safeguarding – as a minimum 3 yearly [see Toolkit].	<ul style="list-style-type: none"> <li>Ensure that all staff receive regular training in relation to safeguarding.</li> </ul>		
<b>Patient Record Systems</b>			
11. Each general practice has a facility for flagging 'child at risk'/'vulnerable family' which can be seen and acted upon by all health professionals involved in the care of at risk/or potentially at risk children and their parents/carers. Action is taken immediately a domestic violence issue arises and processes for ensuring this is followed up in the longer-term are in place (see also item 13)	<ul style="list-style-type: none"> <li>Ensure that a facility for flagging a 'child at risk' in electronic patient records is in place and ensure that this is consistently used.</li> </ul>		
	<ul style="list-style-type: none"> <li>Put in place a process for following up domestic violence issues in both the short, and longer-term. Ensure that this procedure is understood and used by all GPs and practice staff.</li> </ul>		

<p>12. Practices link family members in medical records, especially if they have different surnames so they can be flagged. Including for example drug dependent parents or children subject to a Child Protection Plan, their parents, or others living at the same address.</p>	<ul style="list-style-type: none"> <li>• Ensure family members medical records are flagged to indicate links, especially if they have different surnames, including if children are subject to a Child Protection Plan.</li> </ul>		
<p>13. Whenever there is a disclosure of a domestic violence incident this is recorded using appropriate Read codes in the children’s medical records as well as the adults’ medical records. A note is made for the health visitor to follow-up. (<i>see item 11</i>)</p>	<ul style="list-style-type: none"> <li>• Put in place a procedure to ensure that domestic violence disclosures by adults are also recorded in children's medical records. Ensure that this procedure is understood and used by all GPs and practice staff.</li> </ul>		
<p>14. When there are a number of children in a family who become subject to a Child in Need Plan it is recorded in each child’s medical record with all the documentation (i.e. the Child in Need Plan) scanned in to each child’s medical record.</p>	<ul style="list-style-type: none"> <li>• Ensure a record is made and all documentation is scanned into each child's medical records where there are a number of children in a family subject to a Child in Need Plan</li> </ul>		
<p>15. In all cases when an individual seeks advice from a GP regarding their partner in relation to domestic violence, the consultation details are placed in the notes of the partner and a cross reference is be placed in the notes of the reporter of the incident(s) and in the records of any child or children present in the home at the time of the incident. Such records may use object Read Codes (e.g. ‘Domestic Violence in home’).</p>	<ul style="list-style-type: none"> <li>• Put in place a facility for ensuring that entries are made in both partners’ electronic patient records when domestic violence is disclosed. Ensure that this procedure is understood and used by all GPs and practice staff.</li> </ul>		
<p>16. Electronic GP records software packages include a time entry so it is clear when the consultation took place; entries made by other practitioners identify who the professional is; medical jargon and abbreviations are avoided or written in full.</p>	<ul style="list-style-type: none"> <li>• Practice systems include a time entry to indicate when consultations took place</li> </ul>		
	<ul style="list-style-type: none"> <li>• Professionals making an entry into medical record are identified.</li> </ul>		
	<ul style="list-style-type: none"> <li>• Staff avoid using abbreviations and jargon in records.</li> </ul>		
<p>17. When a printed copy of records from the electronic records system is transferred to another practice, or made available for serious case reviews, steps are taken to ensure that the copy includes all relevant entries and scanned summaries from the records.</p>	<ul style="list-style-type: none"> <li>• Take steps to ensure that any printed copy of records transferred to another practice or provided for a serious case review include all relevant correspondence and Case Conference summaries</li> </ul>		

18. When a child is made subject to a Child Protection Plan a record, including the category of the Child Protection Plan, is made in their medical notes and also when they are removed from a Child Protection Plan	<ul style="list-style-type: none"> <li>Put in place a procedure to ensure Child Protection Plans are recorded in the child's notes, and also when Plan is removed.</li> </ul>		
---	---	--	--

**Information for Patients**

19. When it is thought that individuals may have a problem with domestic violence, they are offered some printed material that includes contact phone numbers. This occurs where there is evidence about domestic violence, even when denied by the patient.	<ul style="list-style-type: none"> <li>Ensure that printed material is made available when it is thought an individual may have a problem with domestic violence, even if denied.</li> </ul>		
--	--	--	--

<b>PRACTICE</b>			
<b>AUDIT COMPLETED BY:</b>		<b>AUDIT APPROVED BY PRACTICE SAFEGUARDING LEAD</b>	
<i>Name:</i>		<i>Name:</i>	
<i>Position:</i>		<i>Signature:</i>	
<i>Date:</i>		<i>Date:</i>	

## Appendix 11: Additional Resource Material

To support Safeguarding Policies, the following websites are able to offer posters which can be used in the Practice to raise awareness of abuse potential and where to obtain help if they are being abused

<http://www.parentsprotect.co.uk/resources.htm>

The Parents Protect Website features a wide range of “Stop it Now” materials, all available free of charge, including free postage.

<http://www.endthefear.co.uk/practitioners/publicity-material/>

The End the Fear website features a number of downloadable posters which can be printed off.

[http://www.nspcc.org.uk/inform/publications/posters\\_wda56272.html](http://www.nspcc.org.uk/inform/publications/posters_wda56272.html)

The NSPCC website features a suite of A4 Posters which can be downloaded and printed off.

## Appendix 12: CWDC Induction Standards

These standards set out clearly what new workers should know, understand and be able to do within six months of starting work.

### **Principles and Values**

These Principles and Values underpin all the Induction Standards and apply to all work with children, young people and their families.

#### **Principles**

- The welfare of the child and young person is paramount.
- Workers contribute to children's care, learning and development, and safeguarding and this is reflected in every aspect of practice and service provision.
- Workers work with parents and families who are partners in the care, learning and development and safeguarding of their children recognising they are the child's first and most enduring carers and educators.

#### **Values**

- The needs, rights and views of the child are at the centre of all practice and provision.
- Individuality, difference and diversity are valued and celebrated.
- Equality of opportunity and anti-discriminatory practice are actively promoted.
- Children's health and well-being are actively promoted.
- Children's personal and physical safety is safeguarded, whilst allowing for risk and challenge as appropriate to the capabilities of the child.
- Self-esteem and resilience are recognised as essential to every child's development.
- Confidentiality and agreements about confidential information are respected as appropriate unless a child's protection and well-being are at stake.
- Professional knowledge, skills and values are shared appropriately in order to enrich the experience of children more widely.
- Best practice requires a continuous search for improvement and self-awareness of how workers are perceived by others.

## The CWDC Induction Standards

<b>Standard 1: understand the principles and values essential for working with children and young people.</b>	
Main areas	Outcomes
<b>1 Principles and values</b>	<p>a Show how you promote the principles and values essential for working with children, young people, their families and their carers.</p> <p>b Know the service standards or codes of practice concerning principles and values relevant to your work</p>
<b>2 Equality, inclusion and anti-discriminatory practice</b>	<p>a Show how you include people and act fairly.</p> <p>b Support and respect people's differences in your day-to-day work.</p> <p>c Understand different types of prejudice and discrimination and how they can be challenged.</p>
<b>3 Person-centred approaches</b>	<p>a Explain how your work relates to any of the five outcomes in 'Every Child Matters'.</p> <p>b Take account of the experiences, preferences, wishes and needs of children and young people, and their families, when providing your service.</p> <p>c Listen to children's and young people's views about risk and safety, and take these into account in your work.</p>
<b>4 Confidentiality and sharing information</b>	<p>a Understand the importance of confidentiality.</p> <p>b Understand the limits of confidentiality.</p> <p>c Know how to apply policies and procedures about sharing information.</p>

<b>Standard 2: understand your role as a worker (employed or self-employed).</b>	
Main areas	Outcomes
<b>1 Work role</b>	<p>a Know your own role and the aims of your work.</p> <p>b Know the overall aims of the setting you work in.</p> <p>c Know the purpose of organisations you come into contact with during your work.</p>
<b>2 Legislation, policies and procedures</b>	<p>a Know about important laws relating to children and young people, and where you can get further information.</p> <p>b Understand why it is important for you to follow policies and procedures.</p> <p>c Know where to find the policies and procedures relating to the work you do.</p>
<b>3 Relationships with carers, parents and others</b>	<p>a Understand the valuable role families and carers play in supporting their children so they can achieve positive outcomes.</p> <p>b Understand how you can support children and young people who are carers.</p>
<b>4 Team working</b>	<p>a Know who else is working with the children, young people and families you work with.</p> <p>b Know who you are accountable to, and who is accountable to you (if appropriate), in your working environment.</p> <p>c Know the principles of effective teamwork.</p>
<b>5 Being organised</b>	<p>a Show that you are well organised, reliable and dependable in your work.</p> <p>b Make sure you provide well-organised and safe activities or environments for the children, young people and families you work with.</p>
<b>6 Complaints and compliments</b>	<p>a Know about, and be able to follow, the grievance, complaints, compliments procedures relevant to your work.</p> <p>b Know how children, young people and their families can get access to the complaints procedure for your work.</p> <p>c Understand what to do if you receive a complaint or compliment from people you work with.</p> <p>d Understand how you can support people making complaints.</p>

**Standard 3: understand health and safety requirements.**

Main areas	Outcomes
<b>1 Laws, policies and procedures</b>	a Know about health and safety laws which apply to your working environment. b Know your personal responsibility for the health and safety of the children, young people and families you work with.
<b>2 Moving, lifting and handling people and objects</b>	a Know about the laws that govern moving, lifting and handling people and objects. b Know how to assess risks relating to moving and handling people or objects. c Know the safe moving and handling techniques relating to people and objects.
<b>3 Premises</b>	a Know the security measures in place in your work environment. b Understand how to promote fire safety in your work environment. c Understand and apply the safe-working practices of your workplace when visiting other places.
<b>4 Medication and health-care procedures</b>	a Know what 'healthy care' means for your work with children and young people. b Know about any infection-control needs and allergies of the children and young people you work with, and about any medication they are on. c Know how to get or arrange first aid or medical treatment in an emergency. d Know what you are not allowed to do, in relation to medication and health-care procedures, at this stage in your learning.
<b>5 Personal safety and security</b>	a Know about the range of challenging behaviours presented by particular children and young people you work with. b Understand how you manage challenging behaviour. c Understand how you encourage positive behaviour.
<b>6 Risk assessment</b>	a Identify examples of risks to children and young people in your work environment, and know about appropriate action to reduce or manage the risks. b Know how to apply risk-assessment procedures in your work environment.

**Standard 4: know how to communicate effectively**

Main areas	Outcomes
<b>1 Encourage communication</b>	a Show that you understand the children and young people you work with, particularly their views and feelings. b Respond appropriately to what children and young people are communicating to you (in speech, in writing, by body language and so on). c Communicate with children and young people in clear, jargon-free language, without patronising them. d Help children and young people to make their own decisions.
<b>2 Knowing about communication</b>	a Know about and describe effective ways of communicating with children, young people and their families. b Show how you use effective communication in your work. c Know about the main barriers to communicating with children and young people.
<b>3 Communication with parents and carers</b>	a Know when to provide information to parents and carers. b Understand how to raise concerns with parents and carers in an appropriate way. c Respond appropriately to what parents and carers are communicating to you. d When making decisions about the children and young people you work with, consult their parents and carers (if appropriate).
<b>4 Principles of keeping good records</b>	a Show a basic understanding of the importance of keeping accurate records. b Know the purpose of each record or report you use in your work. c Know how to record information that is understandable, relevant, clear and concise, factual, and can be checked. d Share the information you record with the relevant young people, children, parents and carers (in line with the policy of your work environment). e Understand and explain the difference between observation, facts, information gained from others, and opinion. f Know about formally assessing need and the reporting frameworks which apply to your work environment.

**Standard 5: understand the development of children and young people.**

Main areas	Outcomes
<b>1 Attachment and stages of development</b>	a Have a basic understanding of how children of all ages form attachments, and how these attachments affect their development. b Understand the important developmental needs of the children and young people you work with.
<b>2 Supporting play, activities and learning</b>	a Know how to encourage learning and development in the children and young people you work with. b Explain how play, hobbies and interests are important in children's and young people's learning and development. c Explain the importance of setting appropriate routines for children and young people.
<b>3 Observation and judgement</b>	a Know the purpose of observing a child's or young person's behaviour. b Understand why children and young people you work with might behave in unexpected ways.
<b>4 Understanding contexts</b>	a Understand the importance of seeing a child or young person you work with as part of a wider family, caring or social network. b Understand the contribution family, caring and social networks make to the development of children and young people.
<b>5 Transitions (Transitions are stages in children's lives – some are general, some are individual)</b>	a Have a broad understanding of what 'transition' means in relation to the children and young people you work with. b Understand the significant milestones which mark transition in the lives of the children and young people you work with. c Know how the children and young people you work with respond to the social changes they face in their lives. d Understand how to support individual children and young people through transition.
<b>6 Supporting disabled children and children with special educational needs</b>	a Know what the 'social model of disability' means in relation to your work. b Understand the needs of children and young people who are disabled or have learning difficulties. c Understand the need to adapt activities and experiences so individual children and young people can take part. d Understand how you might support children and young people with special educational needs, and their families, in relation to your work.

**Standard 6: safeguard children (keep them safe from harm).**

Main areas	Outcomes
<b>1 Laws, policies and procedures</b>	a Know about laws and national guidance relating to protecting (safeguarding) children. b Describe your workplace's policies and procedures on helping children and young people who have been abused.
<b>2 Providing safe environments</b>	a Understand what children and young people want and need to feel safe. b Have an awareness of what contributes towards a safe environment for the children and young people you work with.
<b>3 Recognising and responding to abuse</b>	a Understand the different ways in which children and young people can be harmed by adults, other children and young people, or through the internet. b Understand what is meant by the following. • Physical abuse • Sexual abuse • Emotional abuse • Domestic abuse • Faltering growth • Institutional abuse • Bullying • Self-harm c Describe signs and indicators of possible abuse and neglect. d Describe the procedure you need to follow if you suspect any child is being abused, neglected or bullied. e Understand that parental problems (for example, domestic violence or drug and alcohol abuse) can increase the risk of harm to a child. f Describe what emergency action needs to be taken to protect a child, including outside normal office hours.
<b>4 Working with other agencies</b>	a Understand what 'multi-agency working' means for you and your work environment. b Understand other agencies' roles and responsibilities in keeping children safe from harm. c Know about your local Safeguarding Board and any role your agency, organisation or employer has on it.
<b>5 'Whistle-blowing' (reporting failures in duty)</b>	a Know when and how to refer a concern you have about child protection. b Explain who to consult in relation a child-protection or child-welfare concern. c Understand your duty to report the unsafe practice of others. d Know what to do if you have followed your own workplace's policies and procedures on reporting concerns, and you are not satisfied with the response. e Identify what to do when you do not get a satisfactory response from other organisations or agencies.

**Standard 7: develop yourself.**

Main areas	Outcomes
<b>1 Your role and registration</b>	a Understand the current or planned requirements (if any) for you to be registered with a relevant regulatory body. b Know what the relevant regulatory body for your work says about your continuing personal and professional development.
<b>2 Using support and supervision to develop your role</b>	a Understand the purpose of staff supervision in your work environment. b Know the staff support or supervision arrangements available to you. c Understand how your work may affect you personally, and where you can get support in dealing with this if necessary.

<b>3 Meeting learning needs as part of continuing professional development (CPD)</b>	<p>a Show how your day-to-day work has been influenced by feedback from your colleagues or from children, young people and their families.</p> <p>b Work with your manager, or other relevant person, to agree and follow a professional development plan.</p> <p>c Understand the methods you can use to improve your work.</p>
<b>4 Career progression</b>	<p>a Understand the importance of continuing professional development.</p> <p>b Understand the opportunities for your career to progress and identify who can help you make the most of those opportunities.</p>