Royal College of General Practitioners

NSPCC
Cruelty to children must stop. FULL STOP.

Safeguarding Children & Young People

A Toolkit for General Practice

2011

Preface

Safeguarding children and young people is a responsibility for all of society (Children Act 2004).

This toolkit has been developed by the Royal College of General Practitioners (RCGP) and the National Society for the Prevention of Cruelty to Children (NSPCC), to ensure that as a practice, you safeguard the children and young people in your care. This is supported by the RCGP curriculum (section 8), the RCGP Child Health Strategy 2010-15 www.rcgp.org.uk/pdf/CIRC_RCGP_Child_Health_Strategy_2010_2015_FINAL.pdf and the Intercollegiate Guidelines (ICG) for Safeguarding Children and Young People 2010. Safeguarding is one of the Care Quality Commission's (CQC) essential standards for quality and safety,

Our hope is that this toolkit will be particularly useful in helping to ensure that general practices across the United Kingdom operate a safe environment, in which staff are comfortable working with children and young people and will reassure parents, carers and our partner agencies that general practices are committed to safeguarding and promoting the welfare of children and young people. A safeguarding plan implemented in your practice will help meet CQC requirements, although definite guidance is awaited.

General practices work within communities all members of the community can help to safeguard and promote the welfare of children and young people, if we keep the needs of children in mind and are willing and able to act if we have concerns about a child's welfare. We all share responsibility for safeguarding and promoting the welfare of children and young people.

We hope that you find this document useful. It should be read in conjunction with the training modules for Safeguarding Children and Young People in General Practice: Training Modules [2011], which are designed for use in in-house staff training to enable practice staff to recognise when a child may be at risk of abuse, to know what to do if there are concerns, to ensure that as a practice, you work with other disciplines and agencies to safeguard and promote the welfare of children.

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Introduction

“The support and protection of children cannot be achieved by a single agency… Every service has to play its part. All staff must have placed upon them the clear expectation that their primary responsibility is to the child and his or her family.”
Lord Laming in the Victoria Climbié Inquiry Report, 2003

Safeguarding Children and Young People: A Toolkit for General Practice contains guidance notes and sample templates of child protection policies, procedures, a good practice code and other guidance related to caring for children and young people in general practice. It will help your practice to prevent abuse and to protect children. This toolkit reflects where possible, the relevant jurisdictions in which members of the RCGP practice. Although at the time of writing we have referenced material used, we do advise practice teams to check for later versions in the light of changing practice and reforms. We have therefore signposted you to external links in Annexes A[1] & C[2] which were correct as dated.

The sister document to this toolkit is the Safeguarding Children and Young People in General Practice: Training Modules [2011] (available free to RCGP members). The trainer and module pack has been developed to enable practice staff to recognise when a child may be at risk of abuse, to know what to do if there are concerns and to ensure that, as a practice, we work with other disciplines and agencies to safeguard and promote the welfare of children.

1 www.rcgp.org.uk/pdf/CIRC_RCGP%20NSPCC%20Toolkit%202009%20Annex%20A%20Legislation_Guidance.pdf (accessed 08/08/11)
2 www.rcgp.org.uk/pdf/CIRC_RCGP%20NSPCC%20Toolkit%202009%20Annex%20C%20External%20Links.pdf (accessed 08/08/11)

Principles

The Safeguarding Children and Young People: A Toolkit for General Practice has been developed from a child-centred perspective. The duty to promote and secure the rights of all children (anyone under the age of 18), is an international one and common to all UK jurisdictions, defined in the United Nations Convention on the Rights of the Child (UNCRC)[3] which makes the assumption that most child abuse is preventable. This toolkit emphasises the importance of this issue for general practice while reflecting the UNCRC statement that all children have a right to be protected from "physical or mental violence, injury or abuse, neglect, maltreatment or exploitation including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child." (Article 19).

All of the relevant jurisdictions' legislation and welfare policies are equally underpinned by UNCRC and European Convention for the Protection of Human Rights and Fundamental Freedoms 1950. Annex A however, breaks down the domestic law and policy specific to the main jurisdictions.

Essentially a child-centred perspective means that children should:
- be able to express and have their views given due weight in all matters affecting them (UNCRC, article 12)
- be valued and respected as individuals
- be respected for their identity and uniqueness
- not be discriminated against
- have the principle of primary consideration for the best interests of the child reflected throughout national and local policy and legislation
- have the right to the highest standard of healthcare, including immunisations and care for disabilities (UNCRC article 23, 24, 25)

National Frameworks

England:
The Munro Review[4] & the ongoing Family Justice Review
"Delay and drift" have allowed vulnerable children and expectant mothers to suffer further harm, often irreparably. The recommended reforms will aim to put the welfare and rights of the child at the centre rather than over bureaucratic procedures and processes. If they are accepted, social care and the judiciary will improve their case management, consulting more with other professionals such as GPs and health visitors and most importantly children and young people themselves. (See an example of feedback in the Child Outcome and Rating Scales in appendix F of the Munro Review, subject to copyright).

Every Child Matters (Currently Under Review by Coalition Government)
Every Child Matters identifies 5 pillars of attainment for every child to achieve, with structures – Sure Start Centres, Young People's Fund, investment in Child & Adolescent Mental Health Services, Speech & Language therapies, tackling homelessness, reform youth justice system – to underpin them. They are:
- being healthy: enjoying good physical and mental health and living a healthy lifestyle
- staying safe: being protected from harm and neglect
- enjoying and achieving: getting the most out of life and developing the skills for adulthood
- making a positive contribution: being involved with the community and society and not engaging in anti-social or offending behaviour
- economic well-being: not being prevented by economic disadvantage from achieving their full potential in life.

3 www2.ohchr.org/english/law/crc.htm (accessed 08/08/11)
4 HM Gov (2011). The Munro Review final report– a child-centred system

Scotland: Getting it Right for Every Child (GIRFEC)[5]
Getting it right for every child is founded on 10 core components which can be applied in any setting and in any circumstance. They are at the heart of the “Getting It Right for Every Child” approach in practice and provide a benchmark from which practitioners may apply the approach to their areas of work.

Wales and Northern Ireland
Similar legislation exists to promote safeguarding - see Annex A[4].

Wales leads in that the UNCRC has been incorporated into Welsh statute from 2011.

5 www.scotland.gov.uk/Topics/People/Young-People/childrensservices/girfec (accessed 08/08/11)

Aim of the Toolkit

Safeguarding Children and Young People: a Toolkit for General Practice aims to equip practices in the UK with the knowledge and tools to integrate safeguarding children and young people into practice systems and processes.

By the end of working through both the Safeguarding Children and Young People: A Toolkit for General Practice and the Safeguarding Children and Young People: Training Modules [2011], we hope that each practice is able to determine what arrangements are in place, identify gaps and state what steps are necessary to safeguard and promote the welfare of children and young people in the care of the practice team.

What is Safeguarding?
All jurisdictions will have protective measures which include child protection procedures for the purposes "of providing necessary support for the child and for those who have the care of the child, as well as other forms of prevention and for the identification, reporting, referral, investigation, treatment and follow up of instances of child maltreatment" (UNCRC Article 19 (2)).

The term safeguarding has not been defined in law (except via statutory guidance, see below) but aspects of the duty to safeguard were first outlined in the Joint Chief Inspectors Report 2002.
"Arrangements to take all reasonable measures to ensure that risks of harm to children's welfare are minimised" [Joint Chief Inspectors 2002:7]

In England, safeguarding and promoting the welfare of children is defined in both [Children Act 2004] Section 11 guidance[6] and Working Together to Safeguard Children (2010).[7]

Safeguarding and promoting elements:
- protecting children from maltreatment
- preventing impairment of children's health or disability
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care;
- undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successfully

Child protection is defined as being part of safeguarding and promoting welfare. Child protection is the term used to refer to the activity taken to protect children who are suffering or at risk of suffering significant harm[8].

The Children Act 1989 [amended 2004] introduced 2 particular concepts in child protection in England.
- Child in Need (Section 17)
- Those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services, including those who are disabled
- Child at Risk (Section 47)
- Suffering or likely to suffer significant harm where the local authority have a duty to make enquires

Key features common to all jurisdictions are:
- senior management [partner] commitment to the importance of safeguarding and promoting children's welfare
- a clear statement of the organisation's responsibilities towards children available for all staff
- a clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children
- staff training on safeguarding and promoting the welfare of children for all staff working with or in contact

6 DfES (2005) statutory guidance on making arrangements under Section 11 of the Children Act 2004 at page 13, para 2.9
7 HM Government (2010) Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children at page 34, 1.20 www.education.gov.uk/publications/eOrderingDownload/00305-2010DOM-EN-v3.pdf (accessed 12/4/11
8 NICE 2009 When to suspect Child Maltreatment CG89

with children and families
• safe recruitment procedures in place (safe people – codes of conduct)
• external contracts, independent healthcare e.g. counsellors etc.
• whistle blowing
• dealing with complaints and allegations against staff
• leadership in safeguarding
• effective inter-agency working to safeguard and promote the welfare of children and young people
• effective information sharing
• involving young people
• monitoring and reviewing
However, it is noted that none of these in isolation will safeguard young people, but collectively and through your governance arrangements you can help to detect and deter those who may perpetrate harm on young people.

Who is Responsible for Safeguarding?
The role of the Primary Care Team in the protection of children from abuse and neglect was highlighted within the position paper for the RCGP (2002). This was re-affirmed within the 'Keep Me Safe', Strategy for Child Protection (2005) (Munro Review 2011).

The practice team however are not responsible for investigating child abuse and neglect; rather for the sharing of concerns and information appropriately, as in NICE guidance CG89[9] and referring onto the relevant responsible agency.

At a local level, your practice will fall within the area of a Local Authority [or equivalent] which has responsibility to co-ordinate the activity in regards to safeguarding and protecting children.

In England and Wales these are called Local Safeguarding Children Boards (LSCB). In the Channel Islands, Isle of Man, Northern Ireland & Scotland, responsibility for co-ordination falls under the respective Child Protection Committee[10]. LSCBs/Committees are responsible for developing local procedures and providing multi-agency training.

Social care services work with health services, education, police, prison and probation services, district councils and other organisations such as the NSPCC, domestic violence fora, youth services and armed forces, all of whom contribute and work together to share responsibility for safeguarding children and promoting their welfare.

It is the responsibility of children's social care to investigate cases of child protection in conjunction and with the participation, of other agencies.

Why is Safeguarding Necessary in General Practice?
Children and young people are part of the general population and it is unusual for a child not to be registered with a general practitioner (GP). GPs remain the first point of contact for most health problems. This sometimes includes families who are not registered but seek medical attention. A GP may be the first to recognise parental and or carer health problems, or behaviour in an individual which might pose a risk to children and young people.

According to a recent study by the NSPCC one in four young adults were severely maltreated in childhood (Child Cruelty in the UK 2011 – An NSPCC study into childhood abuse and neglect over the past 30 years[11]).
The long term effects of abuse are also widely documented and include a range of psychological, emotional and social effects[12]. In order to achieve the optimum life chances for children and young people, early detection and intervention is paramount. Depending on the circumstances of a particular case, intervention may be an

9 www.nice.org.uk/CG89 (accessed 08/08/11)
10 For example, see Interim Health and Social Care Board: www.hscboard.hscni.net/(accessed 12/04/11)
11 www.nspcc.org.uk/news-and-views/our-news/nspcc-news/11-02-15-report-launch/overview-report_wdf80875.pdf (accessed 08/08/11)
12 Leheup R, Implications of Abuse for the child in: child protection in primary care, Ed Polnay J. Radcliffe Medical: Oxford: 2001

assessment of further support needed for the child and family (for example, a child or family in need of services), or for a child in need of protection, implementation of a plan. It is however, important to stress that we must not stereotype vulnerable families, or adults with problems such as mental health or substance misuse.

What are the Policy Implications for General Practice?

General practitioners are independent contractor providers and the practice will have contracts with the relevant health body to provide services within your area. In some jurisdictions, such as England and Wales, there is statutory duty under section 11 of the Children Act 2004[9] placed on key persons or agencies to make arrangements to ensure that in discharging their functions, they must have regard to the need to safeguard and promote the welfare of children[13]. This duty extends to contracts and commissioning of services and as such, the Care Quality Commission (CQC) and relevant health authorities or Commissioning Boards may look at your arrangements with regard to safeguarding and promoting the welfare of children.

It is expected that the new Clinical Commissioning Groups as defined by the proposed new Health Bill 2011 for England, currently going through Parliament, will take over PCT's statutory responsibilities towards children in relation to the Children Acts 1989 and 2004 as well as other legislation relevant to Children's Services and will also be responsible for commissioning of specialist medical Safeguarding services.

Across all jurisdictions there will be guidance provided by the relevant government to promote effective inter-agency working to safeguard and promote the welfare of children and young people[14]. In addition, there are national strategies and frameworks that set out reforms for improving outcomes for children and young people, of which being safe will be one[15]. We would encourage your practice to maintain familiarity with what is going on in your area and ask, what does that mean for us? Use the links provided in Annexes A[4] & C[5].

13 Children Act 2004, Section 11 (England), Section 28 (Wales)

14 England see HM Government (2010) Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children; Wales see Welsh Assembly Government.2009 Getting it Right: An Action Plan for Wales; Scotland, Scottish Office (2002) Protecting Children A shared responsibility; www.scotland.gov.uk/Topics/People/Young-People/children-families/17834/10238 (accessed 12//04/11)

15 For example, Department of Health (2004) National service Framework for Children, Young People and Maternity Service, Core standards, standard

Barriers

There are many barriers that individuals often have to overcome before taking appropriate action when faced with a concern about a child's welfare. Keep me Safe; RCGP strategy for Child Protection identified the following barriers to recognising and responding to child abuse.

Not Seeing the Child
The needs of the child can easily be overshadowed by those of the parents. We must put the needs of the child above all others and see the child, not just the parents[16]. Keep the child in focus.

Not Looking
Child abuse is upsetting. It is easier to ignore the problem or seek other, more comfortable explanations for our observations, especially where the child has disabilities. Clinicians themselves may be or have been the victims of abuse or domestic violence so they think it is normal or not wish to be involved.

Looking for the Wrong Thing
Looking for signs of physical abuse as the only markers for child abuse misses behavioural or mood change. Child abuse comes in different forms and it is essential to have understanding of signs and symptoms, including concerning behaviour changes[17].

Underestimating the Problem
For example, failing to appreciate the danger to a child where there is domestic abuse, parental mental health problems, substance or alcohol abuse.

Condoning the Problem
We should not be more tolerant of neglectful behaviour where there is material deprivation. Neglect is more common where there is deprivation, but deprivation does not cause neglect[18].

Not Knowing What to do Next
The practitioner may be unaware of local procedures or contacts. Each practice should make these available to all clinicians together with instructions of how to communicate concerns. If you have concerns about a child, doing nothing is never an option

The Patchwork or Jigsaw Nature of Child Protection
Different people hold pieces of information, it is only when agencies share information together that the picture is complete. This involves effective record keeping and communication between agencies.[19]

The Problem is Hidden
Parents will bring their child with something other than abuse, such as an 'accident', or not bring their child at all. Parents may be frightened or feel ashamed. They may want help, but be unwilling to accept responsibility for their actions. We may not see "the adult behind the child" Rarely, a parent may actually induce illness: in fabricated and induced illness[20] (previously referred to as Munchausen's Syndrome by Proxy).

The Doctor-Patient Relationship
We are often concerned for our relationship with the family. We may assume they will be angry and upset and we may fear for our professional and personal safety if we raise the issue of child abuse. The family indeed may feel betrayed by us if we express our concerns, so it is crucial to have a non judgemental attitude and explain what needs to be done; there is evidence that families appreciate this[21]. Relationships may be fragile anyway or we

16 Laming. The Victoria Climbié Inquiry. The Stationery Office: London; 2003
17 Bannon MJ, Carter YH, Barwell F, Hicks C. Perceptions held by general practitioners in England regarding their training needs in child abuse and neglect. Child Abuse Review 1999; 8: 276-283
18 Stevenson O. Neglected children Issues and dilemmas Ch 3 pp20-29 Blackwell Science: London; 1999
19 GMC 0 -18 Guidance 2009
20 DH/Home Office/DfES/WAG: Safeguarding Children in Whom Illness is Fabricated or Induced 2002 (updated 2008)
21 Komulainen and Haines (2009) Understanding parents' information needs when concerns re NAI are not established

may feel that the family is doing their best under very difficult circumstances. Our relationship with our patients is founded on trust and mutual respect. Where there are suspicions of child abuse, we may have to adopt a much more assertive approach that will not ultimately cut across this relationship of trust.

Working Effectively with other Agencies and Developing Inter-professional Relationships
Working effectively in child protection demands an inter-professional approach involving at least health, education, social services and the police. This can create problems around confidentiality, consent and data protection. The different languages, cultures and expectations of the different agencies and the practical difficulties of finding the right professional at the right time and being able to talk to them can add to this[22].

Lack of Confidence in the System
Sometimes we feel that the cost of engaging the child and family in the child protection system outweighs the benefits. It can feel easier to do nothing[23].

Individual Freedom Versus the Nanny State
Child rearing practices vary; we all have a right to a private and family life without undue interference from the State. Judging someone else's child rearing practices is uncomfortable, In the Children Act 1989, society has reserved the right to interfere in family life to protect children and GMC guidance reflects this.

Cultural Relativism
This concept describes practitioners' acceptance of different childcare practices as normal and acceptable to the culture of the family and their decision not to intervene. For example, a practitioner assumes that female children are less valued in some cultures, so when a mother ignores the daughter, this is accepted.

It is important to recognise that no culture advocates or condones abuse of children. Over action and inaction have both been shown to be based on misunderstanding and misinterpretation of different cultural patterns, which have led to failure to meet children's needs. Culture, race nor any other diversity issue should prevent action being taken to safeguard a child.
Sometimes we:
• find it hard to believe what we are hearing
• incorrectly accept hearsay as fact
• cannot believe the suspicion that may be about someone we know
• fear 'getting it wrong' for the child and family
• worry we may make it worse for the child
• believe the services are stigmatising
• simply 'don't want to get involved'
• do not have the information on what to do and who to contact
• fear retribution
• have been victims ourselves

22 HM Government, 2006. What to Do If You Are Worried A Child Is Being Abused accessed via www.everychildmatters.gov.uk/_files/34C39F24E7EF47FBA9139FA01C7B0370.pdf
23 Haeringen, Dadds and Armstrong, 1998, Russell M et al Child physical abuse: health professional perceptions, diagnosis and responses British Journal of Community Nursing 2004; 9(8) 332-336)

Barriers to Children Telling

A number of common barriers exist that prevent children from telling or if they do, often lead to them retracting their statements. Children often don't tell because they:

- are scared because they have been mistreated
- believe they will be taken away from home
- believe they are to blame/they will break up family feel guilty
- may not realise what abuse is and think it happens to all children
- feel embarrassed/don't want the shame
- don't want the abuser to get into trouble
- have communication difficulties
- may not have opportunity – always with abuser
- have learning disabilities
- may not know how to say what has happened for example, they may not have the vocabulary
- are afraid they will not be believed
- believe they have 'told' (by dropping hints that an adult has missed) and or haven't been believed, "so what's the point"
- don't have a trusted person they can tell

Monitoring & Reviewing

Monitoring and reviewing are vital aspects of good governance. The Significant Event Analysis (Appendix 3) has proven usefulness and can be used to discuss a safeguarding event that went well or could be improved. Practices also need to register with the Care Quality Commission before April 2013 and review its list of essential quality and safety standards. Reviewing the new legislation and guidance would test whether or not the Practice systems continue to meet the needs of children and young people, parents and carers, staff.

This Toolkit also provides (Appendix 10) an audit tool so that you can identify what you are doing well, what the gaps are and what actions are needed. Within your area, the LSCB or Child Protection Committee will be ensuring that your systems are effective. The Health organisations responsible for commissioning, under section 11 of the Children Act 2004, will need to assure themselves that you fulfil the obligation for the need to safeguard and promote the welfare of children.

It is possible to be become overwhelmed by the range of tasks described. Some practices will already be well advanced, others just beginning. The 11 steps listed will assist you in prioritising tasks based on audit and/or risk assessment.
An alternative checklist is available from NSPCC Safe Network www.safenetwork.org.uk/Pages/default.aspx

The 11 steps are:
1. be aware of, understand and recognise child abuse
2. develop and maintain a culture of openness and awareness
3. identify and manage the risks and dangers to children and young people in your practice and activities
4. develop a child protection policy
5. create clear boundaries for example with the limits to confidentiality
6. follow safe recruitment practice including obtaining references for all team members
7. support and supervise staff and volunteers
8. ensure there is a clear procedure for addressing concerns
9. know your legal responsibilities
10. have a practice policy which welcomes and encourages children and young people to participate in your practice
11. provide safeguarding education and training to all members of the team[24]

24 Adapted from 12 steps to a Child Safe organisation from Chose with Care, ECPAT (End Child Prostitution and Trafficking) Australia, 2001

Working in Partnership with Parents

It is important to recognise the responsibility of the parents and carers for the protection of Children and Young People. Generally the most effective way of ensuring that children are safeguarded is by working in partnership with parents and carers. This might include:

- identifying vulnerable mothers and families in difficulty e.g at the ante-natal booking appointment
- acknowledging parental risk factors such as domestic abuse, drug and alcohol abuse and a history of abuse or offending which might impact on parenting quality and child care abilities
- encouraging the involvement of parents as much as possible with their child's care
- knowing the names of parents, carers or those with parental responsibility
- recording the name of the accompanying adult and if possible identifying the relationship to the child
- ensuring that communications between the practice and parents take account of communication difficulties
- involving parents, as well as children, in developing policies relating to them

Do not make assumptions about the child's family based on your own beliefs or experiences. Ask, as appropriate, about the child's experience and arrangements for care or parenting.
Where there is a concern, professionals should seek to discuss with parents and seek agreement to a referral being made, unless to do so would place the child at increased risk of suffering significant harm.

Parental Responsibility

If a child requires urgent and immediately necessary medical intervention, this may be provided without ascertaining whether the carer has parental responsibility and therefore the right to consent to treatment. However non-urgent or prophylactic treatment such as immunisations or elective surgical procedures will require consent from a carer with parental responsibility, see:
www.gmc-uk.org/guidance/ethical_guidance/children_guidance_appendix_2.asp
www.bma.org.uk/ethics/consent_and_capacity/childrentoolkit.jsp
www.medicalprotection.org/uk/factsheets/parentalresponsibility (accessed 13/4/11)

You should make yourselves familiar with the risks associated with not gaining informed consent for procedures involving children and young people.

Looked After Children (LAC) or Children in Care
LAC is the term used for a child who is being looked after or accommodated by local authorities/Health and Social Care Trusts and includes unaccompanied asylum seeking children and those awaiting adoption. In the case of accommodated children parental responsibility is retained by the parents under section 20 of the Children's Act 1989, however, if a full care order is granted the local authority has parental responsibility.

The views of the child or young person should always be taken into account as well and those of the person(s) responsible for their care.

All practices will have a duty of care for children and young people to whom they provide care and services. You may already have safeguards in place and be taking all precautions necessary to ensure children's safety on your premises. Safeguarding Children and Young People: A Toolkit for General Practice is designed to help you take all reasonable steps to protect them from maltreatment and ensure early help for difficulty.

However, all practices will have differences. The toolkit provides a model plan (p22-43) and p74 for summary "dashboard", guidance, templates and basic information that are relevant to the practice team. Each practice will need to produce their own protocols and guidance. Monitoring and reviewing sets out 11 steps that will assist your practice with a strategic action plan for amending policy, procedures and for training the whole team.

Practice Safeguards

As mentioned above, the Primary Care Organisation (PCO) and the Care Quality Commission may require evidence of a child protection policy and procedure as a condition of contracting and commissioning but these arrangements will not protect young people from harm per se. Ensuring that all those who work within the practice know what your practice statement of intent is, what is expected of them and what to do if a concern arises will. The following section provides a sample template for a policy and procedure within general practice needs.

Introduction

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

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

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

As a practice, we have a duty of care to protect the children we work with and for. Research has shown that child abuse offenders target organisations that work with children and then seek to abuse their position[25]. This policy seeks to minimise such risks. In addition, this policy aims to protect individuals against false allegations of abuse and the reputation of the practice and professionals. This will be achieved through clearly defined procedures, code of conduct and an open culture of support.

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

It addresses the responsibilities of all members of the practice team and those outside the team with whom we work. It is the role of the practice manager and Safeguarding Lead to brief the staff and partners on their responsibilities under the policy. For employees, failure to adhere to the policy could lead to dismissal or constitute gross misconduct. For others (volunteers, supporters, donors and partner organisations) their individual relationship with the Practice may be terminated.

To achieve a child-safe practice, employees and partners (independent contractors, volunteers and the wider Primary Care Team members) need to be able to:
• describe their role and responsibility
• describe acceptable behaviour
• recognise signs of abuse
• ensure practice systems work well to minimise missing vital information or delay in communication
• describe what to do if worried about a child or a pregnant woman or a family
• respond appropriately to concerns or disclosures of abuse
• minimise any potential risks to children

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

Background & Principles

Safeguarding children and young people is a fundamental goal for the (insert name of practice). This policy has taken into account legislative and government guidance requirements and other internal policies. These include: (Insert relevant legislative and government guidance to your jurisdiction; see Annex A and link your own existing related documents here)

In England the relevant legislation and guidance is:
• Adoption and Children Act 2002
• The Children Act 1989
• The Children Act 2004
• The Protection of Children Act 1999
• The Human Rights Act 1998
• The United Nations Convention on the Rights of the Child (ratified by UK Government in 1991 and became statutory in Wales 2011)
• The Data Protection Act 1998 (UK wide)
• Sexual Offences Act 2003
• NICE CG89 Child Maltreatment Guidance 2009[11]
• Working Together to Safeguard Children 2010
• Practice Equal Opportunity Statement
• Practice Disciplinary Policy
• Accidents and Child Development 2009 (www.capt.org.uk)

What is Maltreatment & Neglect?

Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by a stranger. An unborn child may suffer harm if his/her mother is subject to domestic abuse, is a tobacco, drug or alcohol abuser or fails to attend for antenatal care.

There are usually said to be four types of child abuse or maltreatment [with a fifth recognised in Scotland] but they often overlap and it is not unusual for a child or young person to have symptoms or signs from several categories (for full descriptions see the NICE guidance[11]).
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 and should be suspected or considered when there is:
• parental or carer drug or alcohol abuse
• parental or carer mental health disorders or disability of the mind
• intra-familial violence or history of violent offending
• previous child maltreatment in members of the family
• known maltreatment of animals by the parent or carer
• vulnerable and unsupported parents or carers
• preexisting disability in the child, chronic or long term illness

NICE CG89 uses a further aid to prioritising concerns: suspecting, considering and excluding maltreatment. These are the definitions used:
- suspect means a serious level of concern about the possibility of child maltreatment but not proof of it.
- consider means that maltreatment is one possible explanation for the alerting feature and so is included in the differential diagnosis;
- exclude maltreatment if a suitable explanation is found for the alerting feature, which might be after discussion with colleagues.

Physical Abuse

Definition:
Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child, including by fabricating the symptoms of, or deliberately inducing, illness in a child.
Working Together 2010

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

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

Emotional Abuse, Behavioural, Interpersonal & Social Functioning

(Full definition from WT 2010)
Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development.
It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber-bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.
Working Together 2010

Alerting features to suspect include:
• persistent harmful parent or carer – child interactions
• hiding or scavenging for food without medical explanation
• precocious or coercive sexualised behaviour

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

Sexual Abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at sexual images or grooming a child in preparation for abuse (including via the internet). Women can also commit acts of sexual abuse, as can other children.
Working Together 2010

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

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

Neglect

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development.
Neglect may occur during pregnancy as a result of maternal substance abuse. It involves failing to:
• provide adequate food, clothing and shelter (including exclusion from home or abandonment)
• protect a child from physical and emotional harm or danger; ensure adequate supervision (including the use of inadequate care-givers); or ensure access to appropriate medical care or treatment
It may also include neglect of or unresponsiveness to, a child's basic emotional needs.
Working Together 2010

Alerting features to suspect include:
• abandonment
• repeatedly not responding to child or young person
• repeated injuries suggesting inadequate supervision
• persistently smelly or dirty
• failure to seek medical help appropriately
Or consider:
• poor personal hygiene, poor state of clothing
• frequent severe infestations (scabies, head lice)
• faltering growth (due to poor feeding)
• untreated tooth decay
• repeated animal bites, insect bites or sunburn
• treatment for medical problems not being given consistently
• poor attendance for immunisations
• low self-esteem
• lack of social relationships; children left repeatedly without adequate supervision
• parents failing to engage with healthcare, attend appointments [practice or wider health professional] and/ or use A&E/Out-of-Hours services frequently.

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

As well there are a number of injury patterns that cause immediate concern in terms of child protection including:
• multiple bruising, with unusual bruises of different ages
• bruising in nonmotile baby particularly facial bruising
• baby rolls over at six months
• baby attempts to crawl at eight months
The alert practitioner observes these when the child is brought with an incidental respiratory infection, nappy rash or apparently minor illness, although distinguishing cigarette burns from impetigo can be difficult!

Further information can be found at:
Appendix 1: Child Developmental Stages

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

Practice Arrangements

Practice Lead

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

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

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

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

The Practice Lead(s) for Safeguarding Children & Young People:
• implements (insert name of practice) child protection policy
• ensures that the practice meets contractual guidance
• ensures safe recruitment procedures
• engages the Primary Healthcare Team to establish "You're Welcome" policies (see RCGP Child Health Strategy www.rcgp.org.uk/pdf/CIRC_RCGP_Child_Health_Strategy_2010_2015_FINAL.pdf)
• supports reporting and complaints procedures
• advises practice members about any concerns that they have
• ensures that practice members receive adequate support when dealing with child protection
• leads on analysis of relevant significant events
• determines training needs and ensures they are met
• makes recommendations for change or improvements in practice procedural policy
• acts as a focus for external contacts including the named GP
• has regular meetings with others in the Primary Healthcare Team to discuss particular concerns

Staff Employment & Training

Inter Collegiate Guidance (ICG) for Safeguarding Competencies
The RCGP is one of over twenty colleges and professional groups to collaborate in producing joint training guidelines for staff updated in October 2010. The emphasis is on flexibility and relevant learning commensurate with responsibilities. The concept of "levels" (of learning requirements) is preserved, with level 1 being basic induction for all practice staff, level 2 for practice nurses and level 3 for GPs.
The RCGP recommends GPs give evidence of a significant event in safeguarding and of learning being integrated into practice for appraisal. Level 2 is required for MRCGP and it is hoped that GPs will gain experience and confidence in multi-agency working (level 3).
see fflm.ac.uk/librarydetail/4000116

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

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

Spotting the Sick Child
www.spottingthesickchild.com/

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

In collaboration with Cardiff University, NSPCC has developed a series called CORE – INFO, including:
• head & spinal Injuries
• fractures in children
• bruises on children
• oral injuries and bites on children
• thermal injuries on children
www.nspcc.org.uk/inform/trainingandconsultancy/learningresources/coreinfo/coreinfo_wda54369.html

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

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

Independent Safeguarding Authority
The ISA came into being as a result of the 2004 Bichard Inquiry into the Soham murder of Holly Wells and Jessica Chapman by Ian Huntley. It 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 to examine and vet:
• criminal records or cautions
• police intelligence
• other appropriate sources
www.isa.homeoffice.gov.uk/

Staff Training
Those working with children and young people and/or parents should take part in clinical governance including holding regular case discussions, training, education and learning opportunities should be flexible with a multi-disciplinary component. They include e-learning but also personal reflection and scenario based discussion, drawing on case studies and lessons from research, critical event analysis, analysis of feedback, complaints and included in appraisal.
• All new members of Staff need in-house training or other basic awareness training, organised by the practice or local PCO, under local arrangements
• All members of staff require child protection training as part of induction and renewed annually
• Non-clinical staff Level 1*

- Clinical staff [practice nurses and others] Level 2*
- Practice Safeguarding Lead Level 3*; GPs need level 2 for the purposes of update, appraisal and revalidation bearing in mind that level 3 includes training relevant to the inter-agency nature of their work
- Practices need an annual training session of which:
  - all clinical and non-clinical staff are expected to attend
  - update training is available
  - significant events in safeguarding can be reviewed
  - practice safeguarding policy can be reviewed
- All staff undergoing training will be expected to keep a learning log for their appraisals and or personal development (Appendix 4) for CQC
- The practice will discuss and record at least one clinical incident involving safeguarding children

*as defined in Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff. Intercollegiate Document [RCPCH lead] Nov 2010 fflm.ac.uk/librarydetail/4000116

Mentoring/Supervision

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

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

Whistle Blowing

(Insert name of practice) recognises the importance of building a culture that allows all Practice Staff to feel comfortable about sharing information, in confidence and with a lead person, regarding concerns they have about a colleague's behaviour. This will also include behaviour that is not linked to child abuse but that has pushed the boundaries beyond acceptable limits. Open honest working cultures where people feel they can challenge unacceptable colleague behaviour and be supported in doing so, help keep everyone safe. Where allegations have been made against staff, the standard disciplinary procedure and the early involvement of the Local Authority Designated Officer (LADO) may be necessary (section 11 Children Act 2004).

Complaints Procedure

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

General Guidelines for Staff Behaviour

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

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

- You must challenge unacceptable behaviour
- Provide an example of good conduct you wish others to follow
- Respect a young person's right to personal privacy and encourage children, young people and adults to feel comfortable to point out attitudes or behaviours they do not like
- Involve children and young people in decision-making as appropriate
- Be aware that someone else might misinterpret your actions
- Don't engage in or tolerate any bullying of a child, either by adults or other children

- Never promise to keep a secret about any sensitive information that may be disclosed to you but follow the practice guidance on confidentiality and sharing information
- Never offer a lift to a young person in your own car
- Never exchange personal details such as your home address, personal phone number or any social networking details with a young person
- Don't engage in or allow any sexually provocative games involving or observed by children, whether based on talking or touching
- Never show favouritism or reject any individuals

Internet, Mobile Phone Information Governance
See Practice information Governance Policy

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

Management of Disclosure of an Allegation of Abuse
If a child makes allegations about abuse, whether concerning themselves or a third party, our employees must immediately pass this information on to the lead for child protection and follow the child protection procedures below.

It is important to also remember that it can be more difficult for some children to tell than for others (see earlier section on barriers). Children who have experienced prejudice and discrimination through racism may well believe that people from other ethnic groups or backgrounds do not really care about them. They may have little reason to trust those they see as authority figures and may wonder whether you will be any different.

Children with a disability, especially a sensory deficit or communication disorder, will have to overcome additional barriers before disclosing abuse. They may well rely on the abuser for their daily care and have no knowledge of alternative sources. They may have come to believe they are of little worth and simply comply with the instructions of adults.

Responding to a Child Making an Allegation of Abuse
- Stay calm
- Listen carefully to what is being said
- Reassure the child that they have done the right thing by telling you
- Find an appropriate early opportunity to explain that it is likely the information will need to be shared with others – do not promise to keep secrets
- Allow the child to continue at his/her own pace
- Ask questions for clarification only and at all times avoid asking questions that are leading or suggest a particular answer
- Tell them what you will do next and with whom the information will be shared
- Record in writing what has been said using the child's own words as much as possible – note date, time, any names mentioned, to whom the information was given and ensure that paper records are signed and dated and electronic subject to audit trails
- Do not delay in discussing your concerns and if necessary passing this information on

Referral
Best practice is to inform parents/carers of your concerns and next steps unless to do so may put the child or yourself at risk (Appendix 1).
When external authorities need to be contacted, the relevant details are below. As a general rule, you should contact the child Social Care Services first unless the issue is more immediate and the child is indeed of immediate medical attention or support from the Police.

(a) Insert your local arrangements here (Appendix 11)

Location	Social Care Services	Police
	Children's Services	Police (Switchboard) and or local Child Protection Unit
	Tel:	
	Out of Hours Tel:	Tel: (check if 24 hr)
NSPCC	National Helpline – for adults who have concerns about a child.	0808 800 5000
Practice safeguarding lead		
Local Safeguarding Board/ Panel Website	For local procedures	
Local Authority Designated Officer (England)	For staff allegations	

Name	Title	Tel:	Email:	Fax No
Diane Richardson	Designated Nurse Child Protection	0191 371 3654	diane.richardson3@nhs.net	0191 3744133
Carole Atherton	Lead Named Nurse Safeguarding Children	0191 371 3655	carole.atherton@nhs.net	0191 3744133
Marie Baister	Named Nurse Safeguarding Children - Derwentside	0191 387 6366	marie.baister@nhs.net	0191 3876369
Kay Bickle	Named Nurse Safeguarding Children - Durham and Chester-le-St	0191 387 6365	kay.bickle@nhs.net	0191 3876369
Trina Holcroft	Named Nurse Safeguarding Children - Easington	0191 569 2915	tholcroft@nhs.net	0191 5692947
Karen Hedgley	Named Nurse Safeguarding Children - Easington/North Tees and Harlepool	0191 569 2955	karenhedgley@nhs.net	0191 5692947
Gillian Worland	Named Nurse Safeguarding Children - Sedgefield	01388 452 275	gworland@nhs.net	
Lesley Shuster	Named Nurse Safeguarding Children - Durham Dales	01388 452 276	lesley.schuster@nhs.net	
Sue Hairsine	Named Nurse Safeguarding Children - Darlington	01325 735 052	sue.hairsine@nhs.net	01325 735050

AREA	TEAM MANAGER	Fax No
Bishop Auckland	Lesley Caile	01388 454840
Chester-le-Street	Judith Rayne	0191 3836127
Crook		01388 766287
Stanley 1	Doris Freeman	0191 3706363
Stanley 2	Helen Williams	0191 3706363
Durham	Tracie Metcalfe	0191 3836108

AREA	TEAM MANAGER	Fax No
Peterlee		0191 5864130
Seaham	Aidan Blades	0191 5136095
Easington South	Vacant	0191 5136095
Aycliffe 1 Aycliffe 2	Carole Jolley	01325 301023
Spennymoor	Nick Booth	01388 424242
Darlington East	Carol Brunt	01325 346474
Darlington West	Nik Flavell	01325 346474

Named GP for Safeguarding Children		**Email:**
Dr Geoff Welsh	Durham and Chester-le-Street	geoffwelsh@nhs.net
Dr Barbara Gallwey	Derwentside	barbara.gallwey@nhs.net
Dr Naomi Hopper	Sedgefield	naomi.hopper@nhs.net
Dr Geoff Welsh	Easington	geoffwelsh@nhs.net
Dr John Gledhill	Durham Dales	johngledhill1@nhs.net
Dr John Gledhill	Darlington	johngledhill1@nhs.net
Designated Doctor for Child Protection[1]		
Dr Stephen Cronin	Consultant Paediatrician	stephencronin@nhs.net

[1] The designated doctor takes a strategic and professional lead on all aspects of the health service contribution to safeguarding children across County Durham and Darlington and amongst other things, ensures that expert health advice on child protection is available to all specialties of health (including, but not limited to, GPs). Initial advice on individual cases should be sought from the on-call consultant paediatrician.

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

TIMESCALES

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

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

Immediately

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

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

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

Check if child has protection plan (Child protection list)

Same day

Make a telephone referral to **Initial Response Service**: **0845 8505010**

Without delay

Follow up with written confirmation of referral (attach Genogram and Ecomap if available): FAX/SEND to Team Manager of Child and Families Team. FAX/SEND copy to Named Nurse Safeguarding Children (NNSC). Retain copy for records.

As soon as possible and within 48hrs

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

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

Same day

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

No further action
Referral to other services
Undertake S47 enquiry

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

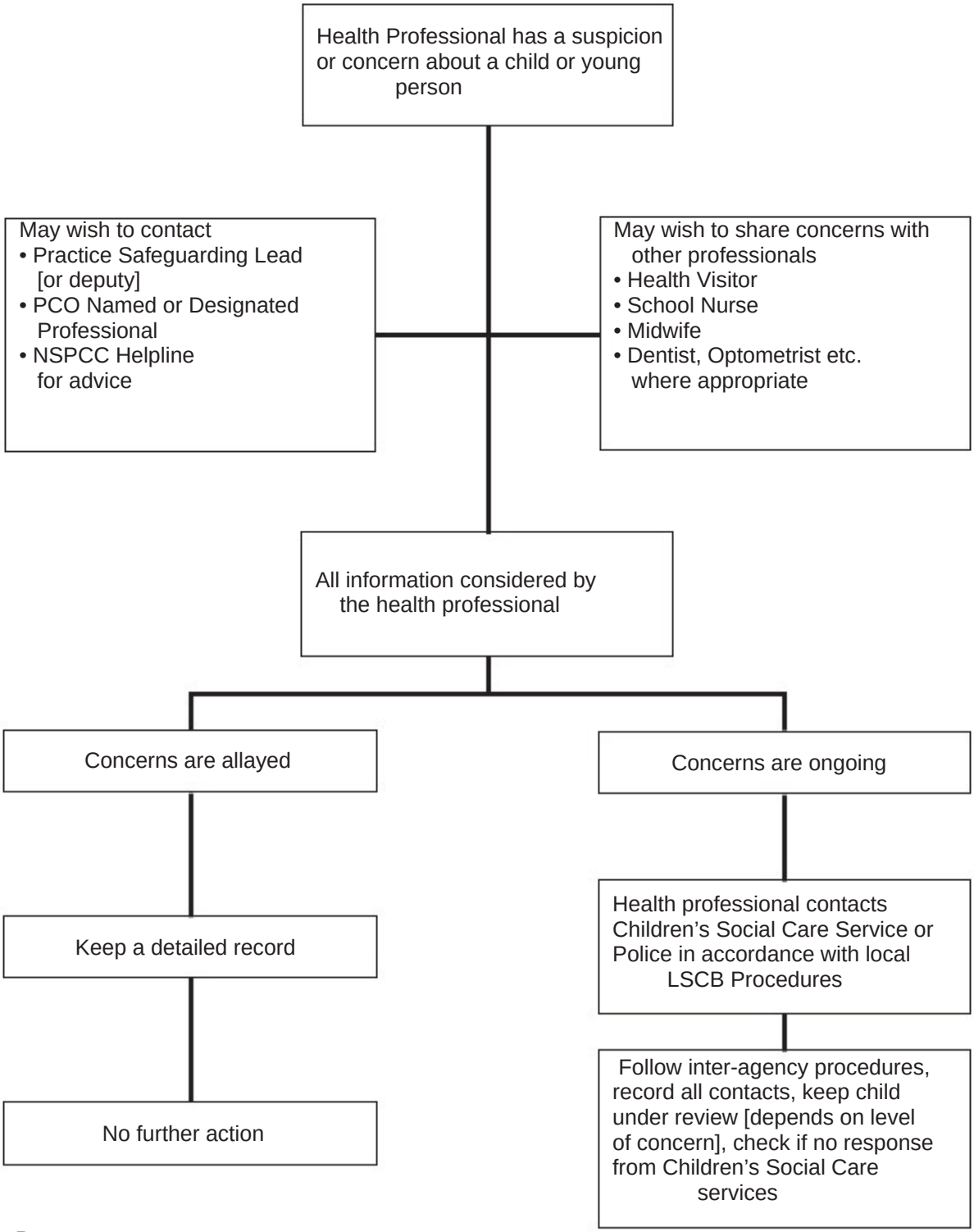
SAFEGUARDING CHILDREN REFERRAL TO
DARLINGTON CHILDREN'S SERVICES
ACTIONS FOR ALL HEALTH STAFF INCLUDING GPs AND OUT OF HOURS

	TIMESCALES
Staff must take **immediate and appropriate** action to protect the child when • A member of staff observes signs of abuse • Information is received from any source of suspected alleged abuse • A member of staff is concerned about the welfare and safety of a child/children	Immediately
Be **open and honest with parents and carers**, particularly if you have concerns about a child's welfare and intend to share this with other professional colleagues, unless the professional assessment of the situation indicates that it is not in the child's best interest to inform parents i.e. immediate safety or risk issues to any children/ or affecting a possible criminal investigation or risks to staff safety	
May need to **consult for advice and support** with 1. Designated or named professionals 2. Consultant Paediatrician on call 3. Children's Services ⟺ Check if child has protection plan	Same day
Make a telephone referral to: **Darlington Children's Services Tel: 01325 346200 / 346867** **Out of Hours contact:** **The Emergency Duty Team Tel: 08702 402994 / 01642 631123**	Without delay
Follow up with written confirmation of referral (attach Genogram and Ecomap if available): FAX/SEND to Team Manager of Child and Families Team. FAX/SEND copy to Named Nurse Safeguarding Children (NNSC). Retain copy for records.	As soon as possible and within 48hrs
• **Send copy of referral to GP** • **Inform Health Visitor or School Nurse** **Record** information on child's records (including Significant Events form if available).	Same day

Children's Services Department should **inform referrer** in writing of their decision. This can include:
- No further action
- Referral to other services
- Undertake S47 enquiry

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

Practice Early Help – Recognition, Response, Record



Enquiry Process

Practice staff (particularly health professionals) may be asked to contribute information to Social Care's enquiry and will be expected to provide a written report in order to support this process. It is possible that attendance at a case conference or court proceedings may be required in order to share the information. In these situations it may be advisable for a member of staff to be accompanied by a manager and seek support from the designated and named health professionals.

Child Protection Conferences

The contribution of GPs to safeguarding children is invaluable and priority should be given to attendance and sending a report wherever possible. 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. Examples of different guidance exist (London wide LMCs, Isle of Man), but all are clear that no delay should occur in the provision of information while payment is sought. Even if attendance is not possible or judged necessary, the provision of the report, even to say that the child has not been seen, is essential. (GMC Protecting children and young people 2011).

General Points for Preparing Reports for Conference

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

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

Consider:

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

Recording Information

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

- Concerns and information about vulnerable children should be recorded in the child's notes and where appropriate the notes of siblings and significant adults. These should be recorded using agreed Read codes (Appendix 8: Recording Concerns). The GMC document 'Protecting children and young people: guidance for doctors',(2011) advises doctors to record minor concerns, as well as their decisions and information given to parents/carers. More will be available in 2012-13 after the completion of the RCGP multi-site audit
- Concerns and information from other agencies such as social care, education or the police or from other members of the Primary Care Team, including health visitors and midwives, should be recorded in the notes under a read code
- Email should only be used when secure, [e.g. nhs.net to nhs.net] and the email and any response(s) should be copied into the record
- Conversations with and referrals to outside agencies should be recorded under an appropriate Read code
- Case Conference notes may be scanned in to electronic patient records as described below. This will usually involve the summary/actions, appropriately annotated by the child's usual doctor or Practice Safeguarding Lead
- Records, storage and disposal must follow national guidance for example, Records Management, NHS Code of Practice 2009
- 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

26 Framework for the Assessment of Children in Need and their Families DH, DFEE 2000

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

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

Information can be sought and entered from:

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

Case Conference Summaries & Minutes
Case conference minutes frequently raise concerns - much of it about third parties.

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

27 The Victoria Climbie Inquiry – report of an inquiry by Lord Laming Jan 2003, Recommendation 86
28 Care Quality Commission 2009: Review of the involvement and action taken by health bodies in relation to the case of Baby P

Until further guidance, they should be processed and stored in the following way:

	Read code significant details	Scan in summary	Scan in full minutes
Child (subject of conference)	Yes	Yes	Yes[32]
Adults & other household members named in report	Yes	Yes	No

Conference minutes should not be stored separately from the medical records because:
• they are unlikely to be accessed unless part of the record
• they are unlikely to be sent on to the new GP should the child register elsewhere
• they may possibly become mislaid and lead to a potentially serious breach in patient confidentiality.

Whilst GPs may have concerns about third party information contained in case conference minutes, part of the solution is to remove this information if copies of medical records are released for any reason, rather than not permitting its entry into the medical record in the first place.

These procedures are regarded as best practice, but may vary between UK jurisdictions. You are advised to consult local PCO policies for further details.

Sharing Information

The practice will follow the policy on sharing information in child protection cases which is as follows.
• In England and Wales, the Children's Acts of 1989 and 2004 give GPs a statutory duty to co-operate with other agencies (Children Act 1989 section 27, 2004 section 11) if there are concerns about a child's safety or welfare. Health authorities (PCOs) (section 47.9) have a duty to assist local authorities (Social/Childcare Services) with enquiries, named Doctors for child protection can be powerful advocates for this function.
• The Children, Schools and Families Act 2010 section 8 amends The Children Act 2004 providing further statutory requirements for information sharing when the LSCB requires such information to allow it to carry out its functions adding Section 14b see www.legislation.gov.uk/ukpga/2010/978010542103/section/8.

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

General Principles
The 'Seven Golden Rules' of information sharing are set out in the government guidance, Information Sharing: Pocket Guide[30]. 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[31] but provides a framework to ensure

29 The minutes should be read by the relevant GP. If the minutes contain a majority of pertinent information that other professionals are likely to need to know, particularly where they are taking the case on cold (such as a locum, or GP receiving the patient on a transfer) then the full minutes can be scanned. If there is little pertinent information, this should be entered as free text notes on the child's record. Following either the scanning, or entry of pertinent information, the paper copy should be securely disposed of (e.g. shredded). Thanks to Dr Joanna Walsh for this material
30 Information Sharing : Pocket Guide HM Government October 2008
31 It could reasonably be said that neither is the common law duty of confidentiality, or the Human Rights Act see Re F (Adult: Court's Jurisdiction) [2000] 1 Fam 38, per Sedley LJ - "The family life for which Article 8 [the right to respect for private and family life] requires respect is not a proprietary right vested in either parent or child: it is as much an interest of society as of individual family members and its principal purpose, at least where there are children, must be the safety and welfare of the child"

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

General Medical Council Guidance

The General Medical Council offers guidance on Confidentiality and Information Sharing which is regularly reviewed. The GMC advises that the first duty of doctors is to make the care of their patients their first concern:
- when treating children and young people, doctors must also consider parents and others close to them, but the patient must be the doctor's first concern
- when treating adults who care for, or pose risks to, children and young people, the adult patient must be the doctor's first concern, but doctors must also consider and act in the best interests of children and young people GMC 2007: 0-18 years

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

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

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

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

them respect and involving them in decisions about their care
- if a child or young person does not agree to disclosure there are still circumstances in which you should disclose information:
  a. when there is an overriding public interest in the disclosure
  b. when you judge that the disclosure is in the best interests of a child or young person who does not have the maturity or understanding to make a decision about disclosure
  c. when disclosure is required by law.

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

Only employees who are properly trained in restraint techniques should carry it out. A person should be restrained for the shortest period necessary to bring the situation under control.

(Insert links to any guidance already in place to your jurisdiction)

Declaration

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

We have reviewed and accepted this policy

Signed by: Date:

Signed: _____

on behalf of the Partnership

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

Signed by: Date:

Signed: _____

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: 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) N.B. some may be able to wriggle, squirm and roll so require supervision if placed on raised surfaces	• 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 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 placed prone.	• 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
3 months	• 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
4 months	• 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
6 months	• 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

8 months	• 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
12 months	• Picks up small objects using 'pincer' grasp e.g. thumb and forefinger • Walks using furniture as support 'cruising' • May be capable of standing and walking without support	• Responds to sim-ple 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'
18 months	• 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 e.g. 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	• Able to hold a long, intelligible conversation • Understands opposites, similarities between objects, prepositions, personal pronouns • Learning to write • Knows home address: street number and name • Money: beginning to recognise and remember values of coins and notes • Can dress self appropriately without assistance

This guide is by no means comprehensive. Further and more detailed guidance may be obtained from the following:

References

1. Sheridan, M., Sharma, A., Cockerill, H., (2007) From Birth to Five Years: Children's Developmental Progress 3rd Ed Routledge
2. Polnay L, Hull D. (1993) Community Paediatrics 2nd Ed Churchill Livingstone
3. Queensland Government (2008) Child Development Milestones available online at www.health.qld.gov.au/ph/documents/childhealth/28133.pdf (accessed 16/4/11)

Appendix 2a: DURHAM Child Protection Incident Reporting Form

Please complete as many details as possible

Confirmation of Referral to Children's Services				☐	
Information for Named Nurse Safeguarding Children only				☐	
					(Please tick as appropriate)
Details of Subject/s of Referral/ Children in household					
Surname / Also Known As	Forenames	Gender	DOB/EDD	Nursery/School	Subject of referral (yes/no)
Usual Home Address			Current Address (if different)		
Postcode			Postcode		
Telephone			Telephone		
Family Structure					
Surname / Also Known As	Forenames	DOB	Relationship to Child(ren)	Nursery / School / Occupation	Address (If different from above)
Other Agencies Involved					
Profession	Name			Contact Number (if known)	Copy of form sent (Tick & Sign)
GP					
Consultant					
Midwife					
Health Visitor					
School Nurse					
Social Worker					
Cause for Concern / Reason for referral (include details of previous referrals if known):					
				Yes	No
Has there been a check of whether child has a child protection plan?				☐	☐
Are Parents aware of the referral?				☐	☐
					(Please tick as appropriate)
To confirm Parent(s) are aware of referral:					
Signature of Parent					
If parents are not aware of referral, please explain why not:					
Action agreed to be taken by the receiver of the referral and action taken by referrer					
Details of Referrer:					
Name (Printed):			Telephone:		
Signed:			Designation:		
Date:					

Form to be Faxed or sent to:		Yes	No	Date
Named Nurse Safeguarding Children		☐	☐	
Team Manager, Child in Need Team		☐	☐	
Please contact Named Nurse Safeguarding Children with outcome of referral				

Copies of the referral should also be sent to:

- Health Visitor
- School Nurse
- Midwife (if relevant)

One copy should be retained for our own records.

Appendix 2b: DARLINGTON Child Protection Incident Reporting Form

DARLINGTON Safeguarding Children Board

REFERRAL AND INITIAL INFORMATION RECORD

CareFirst Case Number/s			
Is the parent/carer aware of the referral?	Yes ☐	No ☐	Re-referral ☐
Is the child aware of the referral?	Yes ☐	No ☐	

`Child/Young Person's name, address and responsible Local Authority		
Family name	Also Known as:	
Forenames	Dob	Gender
Address		
Postcode	Tel:	
Current address if different from above		
Postcode	Tel:	
Previous address		
Postcode	Tel:	
Responsible Local Authority		

Child/Young Person's Principal Carers		
Name	Relationship to child/young person	Parental Responsibility
		Yes ☐ No ☐
		Yes ☐ No ☐

Referred by	Agency/rel. to child/young person	
Address		
Postcode	Tel:	Date of Referral:

Child/young person's religion		Child/young person's ethnicity			
Caribbean ☐	Indian ☐	White British ☐	White & Black Caribbean ☐	Chinese ☐	
African ☐	Pakistani ☐	White Irish ☐	White & Black African ☐	Any other ethnic group ☐	
Any other Black background ☐	Bangladeshi ☐	Any other White Background ☐	White and Asian ☐	Not given ☐	
Any other Asian background ☐		Any other Mixed background ☐			
If other, please specify	Child's first language		Parent(s) first language		

Is an interpreter or signer required? Yes ☐ No ☐ Has this been arranged? Yes ☐ No ☐

Other household members (including non-family members)

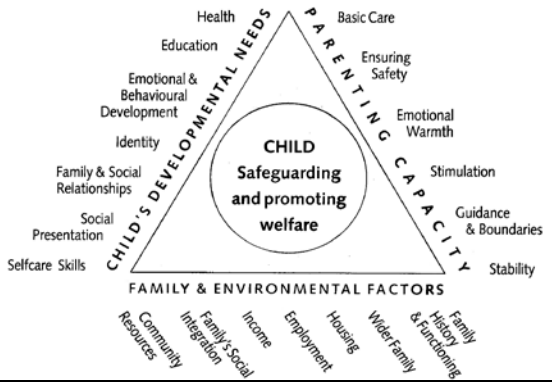
Surname	Forename	DoB	Nursery/School	Relationship to child

Significant family members who are not members of child's household	
Name	Name
Relationship	Relationship
Address	Address
Tel:	Tel:

Information on statutory status	Yes	No	Please give details
Child/young person or other child(ren)/young person(s) in family is/has been on a disability register	☐	☐	Name Date(s)
Child/young person or other child(ren)/young person(s) in family is/has been on a child protection register	☐	☐	Name Date(s) Category
Child/young person or other family member(s) has/have been looked after by a local authority	☐	☐	Name Date(s)

Reason for referral/request for services:
Identify strengths as well as needs
Considering: Parenting capacity, child development, Family and environmental factors

What supports are currently in place



Key agencies (please tick if currently working with the family)					
G.P.	☐	Tel:	E.W.O.	☐	Tel:
School Nurse	☐	Tel:	Police	☐	Tel:
Community Paediatrician	☐	Tel:	Community Mental Health	☐	Tel:
Dentist	☐	Tel:	Other C.S. Dept	☐	Tel:
School	☐	Tel:	Y.O.S.	☐	Tel:
Nursery	☐	Tel:	Other	☐	Tel:
Education Psychologist	☐	Tel:		☐	Tel:

Signature of child:	Date:

Signature of parent:	Date:

Name of worker completing this referral:	Date:
Agency:	

Children's Services Receiving Worker:	Date:
Team:	
Time:	

Children's Service			
Provision of information and advice	☐	Referral to other agencies (please state which)	☐
Initial assessment (to be completed within 7 working days)	☐	No further action	☐
Initial Assessment Child Protection Section 47	☐	Information Only	☐
Allocation Date: **Worker Name:** **NFA Date:**		Signature of Manager	

Please return this form by fax: 01325 346479 or secure email: CCDREF@darlington.gov.uk

Copies of the referral should also be sent to:

- Health Visitor
- School Nurse
- Midwife (if relevant)

One copy should be retained for our own records.

Appendix 3: Child Protection Significant Events

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'[1].
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. Question to ask here is "Could this adverse event/safeguarding incident occur in our practice?"	
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 had 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 2010 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 different pathways for:
• unexpected deaths, where a group of key professionals come together to enquire into and evaluate the death
• all deaths, where an overview panel will review patterns or trends in local data

Unexpected Deaths

Child Death Review Teams
A multi-professional 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[32] 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 2010 para 7.77) 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
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)

32 The death of a child which was not anticipated as a significant possibility 24 hours before the death or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death. Working Together 2010

- Children’s Social Care
- Police Child Abuse Investigation Unit
- Child Health Nurse
- Midwifery
- Bereavement Counsellor
- Lay representative
- 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 - The Serious Case Review (SCR)

SCRs are statutory multi-agency reviews undertaken when a child dies (including suicide), or is seriously injured and abuse or neglect is known or suspected to be a factor in the death. Chapter 8 of Working Together to Safeguard Children sets out the purpose and process of a SCR. It is an analysis, not only of one event, but the series of events leading to the crisis. The purpose is as with Significant Event Analysis, not to apportion blame, but to improve the services.

Implications for Primary Care – those at risk

- The child who is missed, “lost” or not seen, such as the child who is not brought for immunisations, or is lost to follow up of chronic illness
- Babies of mothers who fail to attend their antenatal appointments
- Children who are ‘invisible’ through the assumption that others are seeing them
- Children from large families
- Families subject to multiple moves, house fires and generally poor living conditions
- Professionals making efforts not to be ‘judgemental’, especially in relation to other cultures, religions and ethnicities
- Professionals uncertain about what can/can’t or should/shouldn’t be done, apparent lack of confidence in own judgement and principles
- Those with fixed views on neglect, rough handling
- Men in the family ‘off the radar’ and unknown to professionals working with the family
- Professionals with different thresholds for action
- Professionals with boundary disputes
- Professionals who have low expectations of certain families such as overwhelmed, chaotic families, with involvement with drugs or violence, history of mental ill health and/or criminality
- Parent/s who need to engage with mental health services, but do not

References: Brandon,M., et al(2009)
www.clusterweb.org.uk/UserFiles/KSCB/File/Resources_and_Library/SCR_Analysis_Summary.pdf
www.nspcc.org.uk/inform/research/questions/serious_case_reviews_wda70252.html

Appendix 7: 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 A&E departments for care of acute conditions, yet fail to attend routine Out-Patients appointments. These are known indicators of risk (CEMACH 2008). Practices might wish to develop routine searches and flagging to identify such children.www.cmace.org.uk/Publications-Press-Releases/Report-Publications/Child-Health.aspx

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 'privately' fostered
- children who are looked after by the local authority
  - placed with foster carers
  - in a children's home,
- recent immigrants not yet registered
- asylum seekers
- illegal immigrants
- trafficked children

Treatment of these children is already funded within General Medical Services and most Personal Medical Services contracts. The GPs 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:
www.gmc-uk.org/static/documents/content/0-18_0510.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 practising 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 www.nhserewash.com /safeguarding/latest/page17.html

Appendix 8: Recording Concerns

Computer Coding for Safeguarding Children
Practices may find the following helpful in recording safeguarding concerns. 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) (SystmOne) are included.

Child Protection Procedures		
Code – Read (CTV3)	Where entry is made	Discretionary freetext (information to be entered attached to the code)
3875 (3875.) Case conference	Every relevant child record	
13IM.00 Child on protection register	Every relevant child record	Note the category of abuse
8CM6.00 Child Protection plan	Every relevant child record	
13Iw (XaOtl) Discontinuation of child protection plan	Every relevant child record	
13Iy (XaPkF) 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
13Iz (XaPkG) 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
64c (Ub0ex%) Child protection procedure	Every relevant child record	Freetext nature of procedure (could be used for any meeting/outcome not coded above)
Reference to Maltreatment		
U3.11 Non accidental injury	Every relevant child record	
13IB000 Child in foster care	Every relevant child record	These children often need high levels of continuing care
13W3 (13W3.) 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
13VF (13VF.) At risk of violence in the home	Every relevant adult or child record	Note the nature of the abuse
14X3 (XaJhe) History of domestic Violence	Every adult who has perpetrated DV	Be wary of recording allegations, code best used when perpetrator Themselves discloses

History/Causes for Concern		
13IS child in need	every relevant child record	
13IF.00 child at risk	every relevant child record	
13If (XaMzr) Child is cause for concern	every relevant child record	
625 (625.%) A/N care: social risk	every relevant maternal record	note the nature of the risk
63CA.00 h.v mother not managing wellrecord	every relevant maternal and child	note the nature of the risk
Z613.00 other parent-child problems	every relevant child record	
Contact with Social Care		
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
8HHB (XaBva) Referral to social services	every relevant child record	note who the referral was made to and the agreed plan
6982 Fostering medical	every relevant child record	
13IB000 Child in foster care	every relevant child record	These children often need high levels of continuing care
Risk Assessment		
Z4a(XaPJc) Discussion	every relevant child record	Note who the concern was discussed with and the outcome

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

Appendix 9: Case Scenarios

Practice dilemmas

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.

Should you:
i. tell her that the nurse cannot give the immunisation today and one of the parents should bring the child?
ii. tell her that you will give it?
iii. allow the grandmother to sign for it?
iv. phone the parent for consent or give grandmother the consent form to bring back next week with the parent's signature?

Notes
i. 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 written consent should be obtained if possible and recorded in the notes
ii. 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
iii. 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
iv. Correct. Oral consent needs to be recorded in the notes. It may be in the child's best interests to immunise the same day

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:
i. report the matter immediately to the Children's Social Care?
ii. ask the health visitor to call?
iii. talk to the nursery school teacher and health visitor about the family?
iv. arrange another appointment to talk to his mother next week?
v. phone or speak to the boy's father?

Notes
i. 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
ii. 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
iii. 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 well being. (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

iv. 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 the 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

v. 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 (www.respect.uk.net/)

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:

i. tell her to phone the police?
ii. phone the police yourself?
iii. visit the family yourself?
iv. phone social care services?
v. arrange an ambulance to take the 17 year old to the A&E Department?
vi. say it is not a GP responsibility?

Notes

i. 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

ii. 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

iii. 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

iv. 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

v. 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

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

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.

Should you:

i. tell the registrar that he can do it with the mother as chaperone?
ii. advise him to refer the child without examination to a paediatrician?
iii. advise the registrar to contact social care services immediately?
iv. accompany him or her and examine the child with him.

Notes.

i. 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.

ii. 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.

iii. 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.

iv. 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.

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.

Should you:

i. wait until the child comes to the surgery next time?

ii. ask reception to ring the mother to bring in another urine sample?

iii. ring the mother and ask her to make an appointment on her own?

iv. ring the mother and ask her to bring the child to see you?

v. refer to paediatrician straight away?

vi. refer to social care services straight away?

vii. ask the health visitor?

Notes

i. 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

ii. Correct. See i

iii. 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

iv. Correct. See iii

v. 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

vi. 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

vii. 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.

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, his mother confides that she is pregnant again and is trying desperately to come off the alcohol and amphetamines.

Should you:
i. make a referral to social care?
ii. tell her to get a termination?
iii. tell her that she should phone the midwife?
iv. phone the police?
v. speak to the health visitor?

Notes
i. 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
ii. 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
iii. 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
iv. You do not have enough evidence for a referral to the police
v. Correct. The health visitor may have useful information and insights about this child and other children. See i) 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.

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 percentile. 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.

Should you:
i. refer the family to children's social care?
ii. speak to the health visitor about your concerns?
iii. do nothing?
iv. write to the paediatrician about your concerns?
v. speak to the school nurse at the school which the older children attend?
Notes
i. 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
ii. The health visitor should know this child and may know more about the background

iii. 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
iv. The paediatrician may have concerns and communicating may help clarify these
v. 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 10: Practice Audit Tool

1. Introduction
   1. Section 11 of the Children Act (2004) along with 'Working Together to Safeguard Children' (2010) 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
   2. SCRs undertaken in the 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
   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 Healthcare Team and forms a useful basis for a child protection training session or team meeting agenda

2. Audit of General Practice Systems & Procedures
   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
      - Rednot yet achieved or little action taken to date
      - Ambersome action undertaken but further work needed to complete
      - Greencompleted, procedures in place and monitored
   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

Outcome	Task(s)	Progress Notes Actions Planned	RAG
Practice Policy & Procedures			
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 can access these documents whenever required.	• Develop a safeguarding practice policy which is regularly reviewed an updated.		
2. Safeguarding and domestic violence are regularly addressed in practice meetings.	• Include safeguarding and domestic violence as regular agenda items in practice meetings.		
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	• Ensure that hospital communications to the practice about children subject to a child protection plan are regarded as 'urgent' and followed up accordingly.		

Outcome	Task(s)	Progress Notes Actions Planned	RAG
4. Children regularly reported as not attending routine hospital or practice appointments should be followed up even if not subject to a child protection plan.	• The practice should consider putting a system in place to 'flag-up' children who regularly default from attendance at routine appointments.		
5. When a woman becomes pregnant whose existing children are or have been in the past subject to a child protection plan or Child in Need, or have been taken into care, GPs notify other relevant professionals (e.g. health visitor, midwife and social worker).into care.	• Notify other relevant professionals when a woman becomes pregnant whose existing children are or have been subject to a child protection or Child in Need plan, or taken		
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 when there are any childcare or child protection concerns.	• Identify a lead practice member of staff as responsible for each family which is in recognised challenging circumstances (a vulnerable family). • Follow up such families when a family member misses an appointment, or where there are any childcare or child protection concerns.		
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.	• Risk assessment process in place to consider the need to share information with other agencies where indicated. • Record made of actions taken by the practice.		

Outcome	Task(s)	Progress Notes Actions Planned	RAG
Staff Recruitment & Training			
8. 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 CQC.	• Check that all staff and volunteers working in the practice are suitably qualified and competent.		
	• Ensure that all staff and volunteers working for the practice are CRB checked.		
	• Ensure all staff who undertake regulated and controlled activity with vulnerable people are ISA registered		
9. All practice staff receive training and regular updates in relation to safeguarding – as a minimum 3 yearly [see Toolkit].safeguarding.	• Ensure that all staff receive regular training in relation to		
Patient Record Systems			
10. 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)	• Ensure that a facility for flagging a 'child at risk' in electronic patient records is in place and ensure that this is consistently used.		
	• 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.		
11. In all cases when an individual seeks advice from a GP regarding their partner in relation to domestic violence, the consultation details should not be obvious on the front screen. Such records may use Read Codes such as 'Domestic Violence in Home'. The name of the perpetrator should be recorded in the notes of the alleged victim	• Put in place a facility for ensuring that entries are made in both partners' electronic patient record, when domestic violence is disclosed. Ensure that this procedure is understood and used by all GPs and practice staff.		

Outcome	Task(s)	Progress Notes Actions Planned	RAG
12. 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.	• Practice systems include a time entry to indicate when consultations took place		
	• Professionals making an entry into medical record are identi-fied.		
	• Staff avoid using abbreviations and jargon in records.		
13. 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.	• 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		
14. 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	• Put in place a procedure to ensure child protection plans are recorded in the child's notes and also when plan is removed.		

Outcome	Task(s)	Progress Notes Actions Planned	RAG
Information for Patients			
15. 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.	• Ensure that printed material is made available when it is thought an individual may have a problem with domestic violence, even if denied.		

Practice:			
Audit Completed by:		Audit Approved by Practice Safeguarding Lead:	
Name:		Name:	
Position:		Signature:	
Date:		Date:	

Children Social Care Referrals Hotline (Day) – ***** ******
(Phone referrals must be followed up in writing)

Duty Social Care Out of Hours	
Social Care	
Police	(or 999)
NSPCC National line	0808 800500
Paediatric department for admissions	Discuss with senior doctor on call

NHS Advisors

Community Paediatrician Child Protection	
Designated Nurse/Doctor	
Named Nurse	
Named Doctor	

Appendix 11: Safeguarding Contacts & Links for GP Practices

Insert your local contact arrangements here, modified as required, and consider using this table for rapid access in the practice for example in reception and on your intranet.

Agency	Number/Website
Children's Social Care Referrals (Day)	Durham 0845 8505010 / Darlington 01325 346200 and 346867
Children's Social Care Referrals (Out of Hours)	Durham as above / Darlington 08702 402994 and 01642 631123
On Line Child Protection Procedures (Local Safeguarding Children's Board/Panel)	www.durham-lscb.gov.uk
Police (Switchboard) and/or Local Child Protection Unit (check if 24 hour)	03456060365
NSPCC National Helpline (for adults who have a concern about a child)	0808 800500
Practice safeguarding lead	
Paediatric department for admissions (Discuss with senior paediatrician)	
Community paediatrician child protection	
Designated doctor/equivalent	
Designated nurse/ equivalent	
Named doctor/ equivalent	
Named nurse/ equivalent	
Local Authority Designated Officer (for staff allegations)	Durham Marilyn Brown-0101 3834063

Appendix 12: Violence Against Women & Children (VAWC) (2010)

Female Genital Mutilation
crime/violence-against-women1/index.html
cross government strategy seeking to end violence against women and children. It includes a young people's consultation by the National Children's Bureau. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124551 (accessed 29/8/11)

The practice of Female Genital Mutilation, procedures in which part of all of the female external genitalia may be traumatised or removed, is not only medically unnecessary, extremely painful and associated with serious health consequences, but is a criminal offence under the Prohibition of Female Circumcision Act 1985, superseded by the Female Genital Mutilation Act 2003. This Act prohibits UK nationals or UK residents to procure, aid, abet or perform FGM, even abroad in countries where it may be legal.

Practitioners are advised in Working Together 2010 to be aware of communities in which FGM is practiced, and to be alert for prolonged absence from school, possibly with behaviour change, bladder or menstrual problems on return.

Forced Marriage
In 2004 the Government's definition of domestic violence was extended to include acts perpetrated by extended family members as well as intimate partners. Consequently, acts such as forced marriage and other ignoble violence [so-called "honour crime"], which can include abduction and homicide, can now come under the definition of domestic violence. Many of these acts are committed against children. The Government's Forced Marriage Unit produced guidelines in conjunction with children's social care and the Department for Education and Skills on how to identify and support young people threatened by forced marriage. The guidelines are available at

www.nhserewash.com/tag/safeguarding/
Practitioners concerned should contact the Forced Marriage Unit on 020 7008 0230.

Appendix 13: Health Visitor SAFER Tool 2010

To support efficient and appropriate telephone referrals of children who may be suffering or are likely to suffer significant harm.

Situation	• This is the health visitor [give name] for [give area]. I am calling about [child's name and address • I am calling because I believe this child is at risk of significant harm • The parents are/are not aware of this referral
Assessments & Actions	• I have assess the child personally [and done a CAF] and the specific concerns are [provide specific facts, what you have seen, heard and/or been told and when you last saw the child and it's parent] Or • I fear for the child's safety because [provide specific facts, what you have seen, heard and/or been told and when you last saw the child and its parents] • A CAF has/has not been followed • There is a change since I last saw him/her/them [give number of] days/weeks/ months ago • The child is now [describe current condition and whereabouts] • I have not been able to assess the child but I am concerned because [give reasons for concerns] • I have [actions taken to make the child safe]
Family Factors	• Specific family factors putting this child at risk of specific harm are [base on the Assessment of Need Framework and cover specific points in section A] • Additional factors creating vulnerability are [explain additional factors] • Although not enough to make this child safe now, the strength in the family situation are [explain strengths in family situation]
Expected Response	• In line with WT 2010, NICE CG89 and section 17 and/or section 47 of the Children Act I recommend that a specialist Social Care Assessment is undertaken [urgently] • Other recommendations • Ask, do you need me to do anything now?
Referral & Recording	• I will follow up with a written referral and would appreciate it if you could get back to me as soon as you have decided your course of action • Exchange names and contact details with the person taking the referral • Now refer in writing as per local procedures and record details, time and outcomes of telephone referral

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Notes