SAFEGUARDING CHILDREN: POLICY AND GUIDANCE FOR GENERAL PRACTICE
# Policy Document – Version Control Certificate

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SAFEGUARDING CHILDREN: POLICY AND PROCEDURES FOR GENERAL PRACTICE

1.0 INTRODUCTION AND SUPPORTING GUIDANCE

1.1 Effective safeguarding depends on a culture of zero tolerance of harm, where concerns can be raised with confidence so that action will be timely, effective, proportionate and sensitive to the needs of those involved.

1.2 Along with the statutory requirement to safeguard children, public awareness continues to improve and there is an increasing expectation that service providers have systems in place to identify early indicators of abuse, prevent harm and that they act quickly and effectively in partnership with other relevant agencies to safeguard children.

1.3 Children and young people are part of the general population – most are registered with a 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 someone whose behaviour may pose a risk to children. The primary health care team may be the only professionals to have contact with infants and pre-school children and young people.

1.4 Lack of sensitive responsive care from care givers in infancy can seriously impact on the developing infant. The long-term effects of abuse are widely documented and include a range of physical, psychological, emotional and social effects. In order to achieve 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 assessment of further support for example, early help, child in need or child protection.

1.5 It is crucial that a holistic approach is taken with families when treating a parent/carer who may be experiencing domestic abuse, mental health or learning difficulties or where there is substance misuse (including alcohol) – professionals should always consider how these vulnerabilities may impact on parenting capacity;

- What’s it like being a parent with these vulnerabilities?
- What might the child’s lived experience look like?

1.6 Keeping children safe from harm relies on professionals working together across the thresholds from universal services – early help-child in need-child protection and care proceedings.
2.0 KEY ASSOCIATED GUIDANCE

2.1 This local policy should be read in conjunction with the Trafford Safeguarding Children Board Safeguarding procedures:

http://www.tscb.co.uk/procedures/procedures.aspx

Practice staff should also access the Trafford CCG Safeguarding web page for further local guidance:


Other key relevant documents are:

➢ Working Together to Safeguard Children (2015):

➢ Information Sharing Guidance (2015):

➢ What to do if you're worried a child is being abused (2015):


➢ Trafford’s Threshold Criteria document:
  http://www.tscb.co.uk/docs/Threshold-Guidance---updated-101115.pdf

2.2 There are several other key documents written specifically for doctors and General Practice including:

  o Safeguarding Children and Young People. A Toolkit for General Practice 2014 (Royal College of General Practitioners & NSPCC)
3.0 SAFEGUARDING CHILDREN POLICY STATEMENT

3.1 This policy will enable the practice to demonstrate its commitment to safeguarding the health and well-being of children and young people of Trafford.

3.2 The policy provides guidance for practice staff to be confident to discharge their duty to respond appropriately to any suspicions, allegations or reports of harm, exploitation and/or neglect and abuse.

3.3 The practice should have this policy in place so that all employees, volunteers, students and contractors/temporary/locum workers engaged in work at the practice can identify, report and take appropriate action to prevent harm, exploitation and abuse.

3.4 This policy sets out for employees, volunteers, students and contractors/temporary/locum workers what to do in the event of identifying harm, exploitation, coercion and/or abuse. The term abuse includes Domestic Abuse, which is both a children and adult safeguarding concern.

3.5 This policy has been drawn up in order to enable practice staff to:

- promote good practice and work in a way that can prevent significant harm occurring.
- to ensure that any suspicions or allegations of abuse are dealt with appropriately.
3.6 This policy relates to the safeguarding of children. As defined in the Children Act 1989 and Children Act 2004, a child is anyone who has not yet reached their eighteenth birthday.

4.0 WHAT IS SAFEGUARDING?

4.1 In England, safeguarding and promoting the welfare of children derives from the Children Act 1989 and is defined in both The Children Act 2004 (and Section 11 guidance) and Working Together to Safeguard Children (2015) as:

- 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

4.2 Child protection: originates from section 47 of the Children Act 1989 and is part of the continuum of safeguarding and promoting welfare. Specifically, child protection refers to the recognition, referral and intervention processes in order to protect children who are suffering or likely to suffer significant harm¹.

5.0 ROLES AND RESPONSIBILITIES

5.1 The Trafford Safeguarding Children Board is responsible for developing local multi-agency procedures and ensuring multi-agency training is available. It has a role in scrutinising the safeguarding arrangements of statutory agencies and promoting effective joint working.

5.2 It is the responsibility of Children’s Social Care to investigate cases of child protection in conjunction, and with the participation of, other agencies. They also lead the Child in Need process.

¹There is no absolute criteria on which to rely when judging what is significant harm but in deciding this: That the child must be suffering, or likely to suffer, significant harm:

And that the harm or likelihood of harm must be attributable to one of the following:

- a) The care given to the child, or likely to be given if the order were not made, not being what it would be reasonable to expect a parent to give; or

- b) The child being beyond parental control.
5.3 Children’s Social Care services work with **health services**, education, police, prisons, probation services and other organisations such as the NSPCC, domestic violence forums, youth services and armed forces, all of whom contribute and work together to **share responsibility** for safeguarding children and promoting their welfare.

5.4 The Primary Care team are not responsible for investigating child abuse and neglect but they do have a responsibility for **sharing information, acting on concerns** and contributing to the ‘child protection’, ‘child in need’ and ‘children in care processes’. There is also an expectation that the practice team contribute to the ‘early help’ agenda.

5.5 It is important that GPs contribute to the case conference process so that decisions about children can be made with as much relevant information as possible. This includes information about both children and their parents/carers. It will not always be possible for a GP to attend the case conference and if this is the case do the following:

- contact the conference organiser and give apologies for attendance
- complete and send a case conference report – even if the children and parents don’t attend surgery often -this is still relevant


5.6 It is the role of the Practice Manager and Safeguarding Children Lead to brief the staff and partners on their responsibilities under the policy, including new starters, clinical and non-clinical members of the team and locum GPs.

5.7 The Practice Manager should ensure that safeguarding responsibilities are clearly defined in all job descriptions. For employees of the practice, failure to adhere to this policy and procedures could lead to dismissal and/or constitute gross misconduct.

5.8 In order to implement the policy and procedures the practice will work:

- to promote the rights of all children and young people to live free from fear of harm
- to manage services in a way which promotes safety and prevents harm
• to ensure safe recruitment practices are implemented and executed for every appointment, ensuring all necessary checks are made. For agency/locum/temporary staff the responsibility to undertake due diligence and check with the employer of the agency/locum/temporary employee remains with the practice.

• to provide effective management for staff through supervision, support and training. The practice will meet the requirements outlined in the Intercollegiate Document\textsuperscript{2}

• with other agencies within the framework of the Trafford Safeguarding Children Board Procedures

• to maintain an accurate record of staff training and review it on an annual basis to provide assurances to NHS England and the CCG that practice staff are compliant with local and national policy.

• To share relevant information within the requirements of the Data Protection Act, 1998 and the Human Rights Act, 1998 as well as guidance issued by the GMC, NMC or HCPC regarding confidentiality and will where appropriate gain permission from patients before sharing information about them with another agency. However, there will be situations where a public interest disclosure has to be made. For advice or guidance regarding the disclosure of information contact the local Designated Nurse Safeguarding Children (see Key Contacts p.30).

• to inform parents (unless it is unsafe to do so) that where a child is considered to be at risk of significant harm or a crime has been (or may have been) committed a decision must be taken to pass any such information to another agency without the parent’s consent.

• to keep children and young people safe by making a safeguarding referral to Children’s Social Care where it is appropriate to do so.

6.0 GP PRACTICE SAFEGUARDING LEADS

6.1 It is the expectation that each practice identifies one of the GPs as a Safeguarding Children Lead

6.2 Role Description:

\textsuperscript{2} Safeguarding children and young people: roles and competencies for health care staff: Royal College of Paediatrics and Child Health (2014)
 implements the practice’s safeguarding children policy

 ensures that the practice meets contractual requirements

 ensures safe recruitment procedures

 ensures and supports robust reporting and complaints procedures

 advises practice members about any concerns that they have

 ensures that practice members receive adequate support when dealing with safeguarding children concerns

 seeks appropriate advice and support from the local Designated Professionals for Safeguarding Children and/or Named GP Safeguarding Children as required

 leads on analysis of relevant significant events/root cause

 determines training needs and ensures they are met

 makes recommendations for change or improvements in practice policy and procedure

 acts as a focus for external contacts

 has regular meetings with others in the Primary Healthcare Team to discuss particular concerns regarding individuals or services (see also section 21)

 signposts colleagues to sources of advice and understand the referral process to Children’s Social Care.

 Attends the quarterly GP Safeguarding Leads meeting with the Designated Nurse and Named GP

6.3 The Practice recognises that it is the role of all employees, volunteers, students, locums, contractors and others working within the practice to share concerns regarding any allegation, report or disclosure of harm, exploitation or abuse, including domestic abuse.

6.4 It is not the role of any person within the practice to begin any form of investigation relating to an allegation, report or disclosure of abuse. All
allegations, reports or disclosures/concerns about a child suffering or likely to suffer significant harm should be referred to Children’s Social Care.

7.0 REVIEWING YOUR PRACTICE SAFEGUARDING ARRANGEMENTS

7.1 Effective safeguarding arrangements help ensure that patients are protected from abuse and staff understand their safeguarding responsibilities and know what to do when they have a safeguarding concern. There are several ways you can review your practice safeguarding arrangements.

7.2 The RCGP toolkit\(^3\) suggests steps to help you prioritise tasks based on self-audit and/or risk assessment. It includes information on many of the areas key to establishing effective arrangements, including an audit tool and templates for reviewing significant events.

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: Health & Safety Executive http://www.hse.gov.uk/index.htm

4. Develop a child protection policy: Toolkit for GPs, p16-31

5. Create clear boundaries, for example, with the limits to confidentiality: BMA Toolkit, p7 &15

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


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\(^3\) Safeguarding Children and Young People. A Toolkit for General Practice (2014). Royal College of General Practitioners & NSPCC.

11. Provide safeguarding education and training to all members of the team.

8.0 CQC GUIDANCE

8.1 Outcome 7 of the essential standards relates to safeguarding patients (children and adults) from abuse. Staff should be in a position to identify abuse and act appropriately in cases of alleged or suspected abuse.

8.2 Your practice is likely to be compliant if it does the following:

- Ensures that staff have had safeguarding training, if appropriate to their role, so that they can recognise the signs of possible abuse.
- Takes appropriate action to protect patients in the event that any member of staff exploits a child in any way. Healthcare professionals in GP practices should be reported to the GMC/Nursing Midwifery Council/HPC in cases where they are in possible breach of their professional guidelines. Performers should be reported to the relevant CCG.

- Ensures that patients can raise concerns and make complaints related to abuse. The practice should have a mechanism for patients to make comments and a publicised complaints procedure.

- Shares relevant information with other providers, in accordance with local safeguarding procedures, when there are safeguarding concerns about a patient.

- Complies with the Vetting and Barring Scheme: Practices that knowingly employ someone who is barred to work with children or vulnerable adults will be breaking the law. Practices that dismiss or remove a member of staff/volunteer from working with children and/or vulnerable adults (in what is legally defined as regulated activity) are under a legal duty to notify the DBS* of relevant information, so that individuals who pose a threat to vulnerable groups can be identified and barred from working with these groups.

- Your practice has the following:
  - A safeguarding children (child protection) policy
- A safeguarding adults policy
- A patient information leaflet about abuse, containing information on what patients should do if they have suspicions that another person has been abused and what they might expect to happen under safeguarding procedures, is available in your practice.

9.0 SAFER EMPLOYMENT

9.1 The Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA) functions have now merged to create the Disclosure and Barring Service (DBS)*.

9.2 All GPs applying to join the medical performers list under Performers List Regulations have to provide an enhanced disclosure as part of their application.

9.3 General practices also have a responsibility to ensure that they carry out appropriate criminal record checks on applicants for any position within their practice that qualifies for either an enhanced or standard level check. Any requirement for a check (and eligibility) is dependent on the roles and responsibilities of the job.

9.4 NHS employers also have a legal duty to refer information to the DBS if an employee has harmed, or poses a risk of harm, to vulnerable groups and where they have dismissed them or are considering dismissal. This includes situations where an employee has resigned before a decision to dismiss them has been made.

9.5 For further information see http://www.homeoffice.gov.uk/agencies-public-bodies/dbs or http://www.nhsemployers.org/RecruitmentAndRetention/Employmentchecks/Pages/Employment-checks.aspx

9.6 Safer employment extends beyond criminal record checks to other aspects of the recruitment process including:

- making clear statements in adverts and job descriptions regarding commitment to safeguarding
- seeking proof of identity and qualifications
- providing two references, one of which should be the most recent employer
- obtaining evidence of the person's right to work in the UK
9.7 If a serious allegation is made against a member of practice staff and it relates to conduct towards a child, you must inform the Local Area Designated Officer (LADO) who is employed by the Local Authority. This person assumes oversight of your investigation process from beginning to end and will give you advice. They will also liaise with the Police and Children’s Social Care if necessary.

9.8 After taking any immediate action in line with your practice policy, you should inform the LADO if the staff member has:

- behaved in a way that has harmed, or may have harmed, a child, or
- possibly committed a criminal offence against or related to a child, or
- behaved towards a child in a way that indicates unsuitability to work with children.

LADO for Trafford: Anita Hopkins
Safeguarding Unit, Trafford Town Hall
Talbot Road, Stretford, M32 0TH
Tel: 0161 912 5024

9.9 **Whistle Blowing:** It is important to build a culture that allows practice staff to feel comfortable about sharing information regarding concerns about quality of care or a colleague’s behaviour.

9.10 **Staff Behaviour and Professional Boundaries:** The practice should have clear expectations for staff behaviour e.g. attitude, respecting privacy, use of internet/mobile technology and confidentiality.

10.0 **TRAINING/ADDITIONAL RESOURCES**

- **Level 1 - All the staff in your practice**

  This can be done online at [http://www.e-lfh.org.uk/projects/safeguarding-children/](http://www.e-lfh.org.uk/projects/safeguarding-children/)

- **Level 2 - All clinical staff**

  Should be completed by e learning using the above links.

- **Level 3 - All GPs**

  GPs should be trained to level 3. Once level 1 and 2 have been completed GPs do not have to repeat these.
Over a three-year period, professionals should receive refresher training equivalent to a **minimum** of 6 hours (for those at Level 3 core this equates to a **minimum** of 2 hours per annum) and a **minimum** of 12-16 hours (for those at Level 3 requiring specialist knowledge and skill)\(^4\)

E learning is not appropriate for level 3 training

- **Trafford Safeguarding Children Board multi-agency training**

Courses, seminars and a conference on a variety of relevant topics

[http://www.tscb.co.uk/professionals/training-and-development-for-professionals.aspx](http://www.tscb.co.uk/professionals/training-and-development-for-professionals.aspx)

- **Other useful resources**

**Human trafficking:**


**Forced marriage:**

- [www.gov.uk/forced-marriage](http://www.gov.uk/forced-marriage)
- [http://www.karmanirvana.org.uk](http://www.karmanirvana.org.uk)

**Female genital mutilation:**

- [http://www.tscb.co.uk/docs/Multi-Agency-Statutory-Guidance-on-FGM-FINAL.pdf](http://www.tscb.co.uk/docs/Multi-Agency-Statutory-Guidance-on-FGM-FINAL.pdf)
- [http://greatermanchesterscb.proceduresonline.com/chapters/p_fgm.html](http://greatermanchesterscb.proceduresonline.com/chapters/p_fgm.html)
- [www.fqmelearning.co.uk](http://www.fqmelearning.co.uk)

**Harmful Practices:**

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11.0 SAFEGUARDING CHILDREN IN CARE (CIC)

11.1 It is well known that children and young people in care share the same health risks and problems as their peers, but often to a greater degree due to the impact of poverty, abuse and neglect. Children in care are among society’s most vulnerable in terms of safeguarding.

11.2 The Designated Doctor and Designated Nurse for CiC hold strategic responsibility to improve the health and wellbeing of children in the care system and ‘on the edge of care’ e.g. care leavers.

11.3 General Practitioners and Primary Care Teams have a vital role in the identification of the healthcare needs of children and young people who are in care. The primary care record may be essential in ensuring needs are met.

- **Top Tip:** “Look out for the child in care”.

11.4 Accept any child in care as a registered patient seeking the urgent transfer of the medical records if the child is placed over three months.
11.5 Act as advocates for the child, contribute and provide summaries of the health history of a child who is in care, including their family history where relevant and appropriate.

11.6 Ensure that referrals to specialist services are timely, taking into account the needs and high mobility of children who are looked after.

11.7 Ensure that information is provided in a timely way to inform the initial health assessment (IHA). When a child is received into care and an IHA is being arranged, GP practices will receive a letter requesting health information (see APPX A).

11.8 Ensure the clinical records make the ‘looked after’ status of the child clear, so that particular needs are acknowledged and forwarded for each statutory health review.

11.9 Ensure that actions from initial and review health assessments are actioned in a timely way. For example: ensuring children who have missed immunisations and vaccinated in line with health assessment action plan.

11.10 Children are sometimes placed in Trafford by other Local Authorities. Once placed in Trafford these children are likely to register with a local GP. Practices may have difficulty obtaining medical records including immunisation records. If practice staff need advice regarding looked after children contact:

- **Sharon Martin** Specialist Nurse for Children in Care,
- Telephone: **0161 912 3518**. Email: **sharon.martin@trafford.gov.uk**

12.0 EARLY HELP STRATEGY

12.1 Trafford Safeguarding Children Board (TSCB) has adopted Professor Munro’s definition of Early Help, meaning help provided early in the life of a child and early in the emergence of a problem. In Trafford, services are considered to be providing Early Help when the child or young person’s needs are assessed to be at tiers 1 to 3 (Universal and Prevention, Targeted and Coordinated, Medium and Complex Services) within the Threshold Document (see section 2).

12.2 Services that provide early help to children and families in Trafford include a wide range of services such as Early Help Hubs, Targeted Support Services, Young People’s Services (youth service), early years settings, schools, colleges, services for children with special educational needs and disabilities,
midwives, health visitors, school nurses, GPs, Family Nurse Partnership, Child and Adolescent Mental Health Services, community paediatrics, physiotherapy, occupational therapy, speech and language therapy, contraceptive and sexual health services, the police, voluntary and community sector providers and the Faith sector.

12.3 These services provide a range of support and interventions to children and families including evidence based parenting programmes, breastfeeding support, learning support, help to find education and employment, short breaks for disabled children as well as community based activities as described in the Trafford Service Directory.

12.4 Early Help is the responsibility of the whole community and all the agencies related to children and young people, including GPs. It is built into Public Service Reform principles of integrated, multi-agency approaches.

12.5 Trafford’s Early Help guidance for practitioners can be found at: http://www.tscb.co.uk/docs/Early-Help-Assessment-Guide-121115.pdf

12.6 Trafford’s Early Help Assessment document can be found at: http://www.tscb.co.uk/docs/EHAP-V1.docx

13.0 SECTION 47 (CHILD PROTECTION) MEDICAL PROCEDURE

13.1 A paediatric medical assessment should always be considered when there is a suspicion or a disclosure of child abuse and/or neglect involving injury, suspected sexual abuse or serious neglect. This is often referred to as a child protection medical or section 47 medical.

13.2 In such instances, a referral must be made to Children’s Social Care (CSC). As part of the strategy discussion, CSC will consult with Community Paediatrics before arranging the medical. It is NOT the role of a GP to undertake section 47 medicals. Please refer to the multi-agency section 47 procedure:

http://www.tscb.co.uk/docs/S47-medical-procedure-may-2013.pdf

14.0 BRUISING IN PRE-MOBILE BABIES

14.1 Bruising in a baby who has no independent mobility is very uncommon – less than 1% of non-mobile babies will have bruises. It may be an indicator of a serious medical condition or physical abuse.
14.2 Accidental bruising occurs in approximately 17% of babies who are cruising (1 to 5 bruises).

14.3 Severe child abuse is 6 times more common in babies aged under 1 year than in older children.

14.4 Infant deaths from non-accidental injuries often have a history of minor injuries prior to hospital admission

**Top Tip: “Those That Don’t Cruise, Rarely Bruise”**

Refer Children under 1 year with bruises

Please read: ‘Bruises on children’: [www.nspcc.org.uk/core-info](http://www.nspcc.org.uk/core-info)

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15.0 CHILD SEXUAL EXPLOITATION (CSE)

15.1 Recent reports by the Children’s Commissioner into CSE\(^5\) found that over the past 20 years evidence has shown that large numbers of children are being sexually exploited in the UK. It called for urgent action to ensure practitioners recognise the many warning signs that children display when being subjected to sexual exploitation at the hands of gangs and groups and that they know how to act.

15.2 The Barnado’s definition of child sexual exploitation:

1. **Inappropriate relationships**: Usually involving one perpetrator who has inappropriate power or control over a young person (physical, emotional or financial). One indicator maybe a significant age gap. The young person may believe they are in a loving relationship.

2. ‘Boyfriend’ model of exploitation and peer exploitation: The perpetrator befriends and grooms a young person into a ‘relationship’ and then coerces or forces them to have sex with friends or associates. Our services have reported a rise in peer exploitation where young people are forced or coerced into sexual activity by peers and associates. Sometimes this can be associated with gang activity but not always.

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\(^5\) ‘I thought I was the only one in the world’: Inquiry into CSE and Gangs & Groups: Children’s Commissioner’s Office (2012) and ‘If it’s not better it’s not the end’: Inquiry into CSE and Gangs & Groups- one year on (2015)
3. Organised/networked sexual exploitation or trafficking: Young people (often connected) are passed through networks, possibly over geographical distances, between towns and cities where they may be forced/coerced into sexual activity with multiple men. Often this occurs at ‘sex parties’ and young people who are involved may be used as agents to recruit others into the network. Some of this activity is described as serious organised crime and can involve the organised ‘buying and selling’ of young people by perpetrators.

Note: CSE is a form of sexual abuse. Act on your concerns in the same way as you would for other safeguarding concerns by seeking advice and contacting Children’s Social Care.

16.0 PREVENT

16.1 Prevent is part of the Government’s counter terrorism strategy and aims to stop people becoming terrorists or supporting terrorism. The NHS has an important role to play in supporting the Government’s Prevent Strategy and has been a key partner in delivering it, nationally and locally.

16.2 PREVENT aims to protect those who are vulnerable to exploitation from those who seek to get people to support or commit acts of violence. This could be staff as well as patients.

16.3 Healthcare staff are well placed to recognise individuals, whether patients or staff, who may be vulnerable and therefore more susceptible to radicalisation by violent extremists or terrorists. It is fundamental to our ‘duty of care’ and falls within our statutory safeguarding responsibilities. Every member of staff has a role to play in protecting and supporting vulnerable individuals who pass through our care.

16.4 Please see Trafford CCG web site for further information:

http://www.traffordccg.nhs.uk/safeguarding/prevent/

17.0 CHILD DEATH OVERVIEW PROCESS (CDOP) - UNEXPECTED AND EXPECTED DEATHS

17.1 The Child Death Overview Panel (CDOP) is a multi-agency group which reviews all child deaths up to the age of 18 years. It is a sub-committee of the Trafford Safeguarding Children Board.
17.2 Since April 2008 there has been a statutory requirement to notify all child deaths to a central point, regardless of the age of the child or the cause of death.

17.3 Anonymous data is collected on all child deaths including expected deaths. The information collected needs to be as complete as possible (particularly when the death was unexpected) in order to ascertain whether there are any modifiable factors. The CDOP makes recommendations when there are lessons to be learned, and informs local planning on how best to safeguard and promote the welfare of children in their area.

17.4 **Unexpected Deaths**: When a child dies unexpectedly (i.e. the death was not anticipated as a possibility 24 hours before the death or the event that preceded the death), there is an immediate information sharing and planning discussion between the lead agencies (Health, Police and Social Care). Usually there will be a joint home visit between a police officer and a senior health professional (Rapid Response Team) to take a detailed history from the family and also to keep the family informed about the next steps. This visit is made as soon as possible and the information is passed onto the pathologist when a post mortem is to be held.

17.5 Depending on the circumstances, a multi-agency professionals meeting is convened, usually within a few days of the death, involving relevant agencies (e.g. primary health care, midwives, police, paediatrician, education). The purpose of this meeting is to share information, to consider whether there is a possibility of abuse or neglect having contributed to the child’s death and to ensure that the family are supported.

17.6 **All** child deaths are reviewed at the Child Death Overview Panel. CDOPs include the following functions:

- Review the appropriateness of professionals responses and give thorough consideration to how such deaths might be prevented in the future.

- Maintain a database to collate an agreed minimum data set.

- Identify any patterns or trends in the local data.

- Refer to the chair of the LSCB any case where it is felt there may be grounds to undertake further investigations or a Serious Case Review (SCR) and explore why this had not previously been recognised.
Develop a work plan approved by the LSCB.

GPs are expected to contribute to this process by completing a ‘Form B’ on request.

More details can be obtained from the LSCB website: 
http://www.tscb.co.uk/about-us/child-death-overview-panel.aspx

18.0 DOMESTIC ABUSE

18.1 Domestic abuse can have a devastating impact on children and young people, affecting their health, well-being and development, as well as their educational achievement.

18.2 Domestic abuse is defined as:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- Psychological
- Physical;
- Sexual;
- Financial;
- Emotional.

18.3 Research has made clear links between domestic abuse and the abuse and neglect of children. An analysis of Serious Case Reviews found evidence of past or present domestic abuse present in over half (53%) of cases. Child death inquiries have highlighted the need for workers to acknowledge the issue of domestic abuse and incorporate it into their interventions and child protection plans.

18.4 Domestic abuse rarely exists in isolation. The impact of living with adult violence has detrimental emotional and psychological effects on children. In most circumstances these children can be defined as children in need. All agencies, have a duty to safeguard and promote the welfare of children, wherever possible keeping them within their families.

18.5 Children may be exposed to Domestic Abuse in a number of ways. Children are at increased risk of physical injury during an incident, either by accident or because they attempt to intervene. Even when not directly injured, children
are greatly distressed by witnessing the physical and emotional suffering of a parent. Children's exposure to parental conflict, even where violence is not present, can lead to serious anxiety and distress which may express itself in many different ways. The child may become withdrawn or extraverted and this may lead to them becoming involved in anti-social or criminal behaviour. There is also the risk of direct physical harm to the child and this should be considered in all assessments.

18.6 Although separating from a violent partner should result in safety from harm, the danger does not automatically end; the point of leaving an abusive relationship is the time of highest risk for a victim and their children. Contact arrangements can be used by perpetrators of violence not only to continue their controlling, manipulative, violent and abusive behaviour but also as a way of establishing the whereabouts of the victim(s).

18.7 Please refer to the GM Domestic Abuse procedure: http://greatermanchesterscb.proceduresonline.com/chapters/p_dom_abu.html

19.0 SUBSTANCE MISUSE

19.1 Not all families affected by drug and/or alcohol misuse will experience difficulties, although research indicates that parental drug and/or alcohol misuse can have significant, damaging, and long lasting consequences for children.

19.2 The children of such parents are entitled to help, support and protection within their own families wherever possible. Parental drug and/or alcohol misuse, per se, should not be taken as an indication of the need for action under child protection procedures. Nor should it prevent them from seeking advice and support from appropriate services through fear of unwarranted intrusion from child protection agencies.

19.3 Drug and/or alcohol misusing parents are entitled to expect that they will be treated in just the same way as other parents whose personal circumstances lead them to seek help. However, such parents need professionals to take responsibility for their children’s welfare when they are no longer in a position to care for them adequately. This may mean intervening against their wishes.

19.4 Key messages in this context include:

- children’s welfare is the overriding concern
- it is everyone’s responsibility to ensure that children are protected from harm
- agencies should support children and their families earlier and not wait for crises or tragedies to occur
- agencies must work together, in assessment and care planning with families
- multi-agency training is one of the foundations of successful inter-agency working
19.5 Drug and alcohol misuse is a factor in a significant number of children in need and child protection cases. Research suggests alcohol is a factor in at least 33% of child protection cases and drug and alcohol misuse is a factor in up to 70% of care proceedings. (Harwin and Forrester, 2003) Parental substance misuse has been found to feature in 25% of serious case reviews. Bi-annual Analysis of Serious Case Reviews 2005-07 (DCSF, 2009).

19.6 The full Trafford Drug and Alcohol procedure can be viewed at:
http://www.tscb.co.uk/docs/guidance-assessments-of-parents-carers-who-are-drug-and-or-alcohol-misusers.doc

20.0 PARENTAL MENTAL HEALTH

20.1 Mental ill health in a parent or carer does not necessarily have an adverse impact on a child's development. Just as there is a range in severity of illness, so there is a range of potential impact on families. The majority of parents with a history of mental ill health present no risk to their children, however even in cases of low level concern, the needs of the child/ren should be paramount.

20.2 It is important to recognise other issues that can exacerbate the risk presented by mental health issues. For example, the presence of drug or alcohol dependency and domestic violence and abuse in addition to mental health problems with little or no family or community support would indicate an increased likelihood of risk of harm to the child, and to a parent's mental health and wellbeing. Relying on a diagnosis is not sufficient to assess levels of risk. This requires an assessment of every individual's level of impairment and the impact on the family.

20.3 It is essential that the diagnosis of a parent/carer's mental health is not seen as defining the level of risk. Similarly, the absence of a diagnosis does not equate to there being little or no risk. An assessment should consider the impact on the child of behaviour and support services.

20.4 There is also a well-established relationship between mental ill health and domestic abuse and abuse. Between 50% and 60% of women mental health service users have experienced domestic abuse and up to 20% will be experiencing current abuse. Domestic abuse is one of the most prevalent causes of depression and other mental health difficulties in women. The GM Parental Mental Health document can be viewed at:

http://greatermanchesterscb.proceduresonline.com/chapters/p_ch_par_mental_health_diff.html
21.0 INFORMATION SHARING

21.1 Keeping children and young people safe from harm requires professionals and others to share information about their health and development and exposure to possible harm. Often, it is only when information from a number of sources has been shared that the level of need or risk becomes apparent.

21.2 Consideration should be given regarding the balance between the need to maintain confidentiality and the need to share information to protect others. Decisions to share information must always be based on professional judgement about the safety and wellbeing of the child.


21.3 GPs and other health professionals, for example Health Visitors (HV) are providing a service for children and families known to both disciplines. It is therefore important for GPs and HVs to work together with children and families that are common to both

21.4 The National Health Visiting Core Service Specification 2015-16 states:

_The service will provide a named HV for each GP practice to facilitate liaison, information sharing and joint working in the best interests of families. There will be an agreed schedule of regular contact meetings for collaborative service delivery which must be audited and actioned on a regular basis_

21.5 In that light, a communication standard has been developed to strengthen liaison and information sharing between HVs and GPs (see Appx A)

22.0 ACTING ON CURRENT CONCERNS

22.1 You have a concern about a child:

Is this a child protection issue?
Do you suspect maltreatment?
Has the child experienced or likely to experience significant harm?

No: the child and family may still be in need of additional support. Consider,

- an Early Help Assessment (with parental consent)
- a referral to Children’s Social Care as a ‘child in need’ (with parental consent)
**Not sure:** Discuss with a senior practitioner – GP Safeguarding Children Lead, Named GP or Designated Professionals. You can also discuss your concerns with Children’s Social Care. Ask for a “what if” (or ‘no name’) conversation with the duty social worker.

**Yes:** A referral must be made to Children’s Social Care. Delay should be avoided. Use the link below to access the online referral form to MARAT


22.2 Referrals can be made by phone but must be followed up in writing within 48 hours. For information: the person answering the initial phone call is part of the multi-agency referral and assessment team (MARAT), however is not a social worker.

22.3 NB: It is good practice to discuss your concerns with the parents at this stage unless there is a good reason for not doing so. Research shows that parents will find it easier to work with professionals to ensure the welfare of their child if they are dealt with openly from the outset.

22.4 It is the responsibility of social care to acknowledge the receipt of your referral and decide on the next course of action within one working day. This may include an assessment or they may decide that Children’s Social Care has no role at this stage. In either circumstance you should be informed of their decision. If the outcome of the referral is not clear it is the referrer’s responsibility to chase this up.

22.5 Note: If you have a disagreement with another agency (e.g. Children’s Social Care), consider escalating your concerns. The Safeguarding Children Health Team can help with this.

**23.0 BARRIERS TO SAFEGUARDING**

23.1 Safeguarding is a difficult area of practice which can present a range of challenges, both emotional and practical.

23.2 Practitioners may fail to recognise, underestimate or even condone the problem. Stemming from a desire to help, professionals can sometimes over-identify with the abusing parent to the detriment of the child or find it hard to ‘think the unthinkable’, seeking more comfortable explanations for what they see (Rule of Optimism).

23.3 Often the needs of the child are overshadowed by those of the parents. Parents can be very effective at deflecting the attention from the real problem or presenting a picture of change when in fact there is none (disguised compliance).
23.4 Decisions to act may be hindered by perceived or actual problems in the child protection system. Disagreements can arise between agencies about the best course of action for a child. Practice staff may lack confidence that concerns will be taken seriously based on past experience.

If you encounter any barriers it is important to act to resolve them, either through discussion within the team or by seeking advice. The Safeguarding Children Health Team can help you. For example, escalating cases with Children's Social Care, tackling systemic problems or helping you to address a practice issue.

24.0 GP RECORDS

24.1 Identifying those with Potential Safeguarding Concerns

Practice computer systems are used to identify those patients and families with risk factors or concerns and especially when the patient or their family consults a range of practitioners.

Top Tips for your surgery:

- Have someone who is responsible for putting the alerts on the computer
- Use the computer alert system
- Use a standard set of Read codes

It is important to be alert to the siblings and other members of the household as the child there are direct concerns about.

Detailed instructions from EMIS on how to set up alerts are available: Title: TH869 EMIS Web Patient warnings

24.2 Safeguarding CHIS clinical terms

Child Protection codes

- 131v (XaOnx) Subject to CP plan
- 131w (XaPkF) Plan discontinued
- 131f (XaMzr) Child cause for concern
- 131S (Xa108) Child in need
- 3875 Case Conference
- 64C (UbOex%) Safeguarding procedure
- 13VJ (Y04b3) Looked after child
- 3VF at risk of violence in the home
- 13W3 child abuse in the family
- 13W4 child/parent violence
- 13ZR at risk of emotional abuse
- 13Iq vulnerable family
- 13Ip family is a cause of concern
- 1J3 suspected child abuse
- 14X history of abuse

25.0 KEY CONTACTS

MARAT (Multi-Agency Referral and Assessment Team - Children’s Social Care): 0161 912 5125

Out of Hours: Emergency Duty Team (EDT): 0161 912 2020
Early Help team: 0161 912 2922

The Safeguarding Children Team (Health)
Never hesitate to ask for advice.

<table>
<thead>
<tr>
<th>Role / Title</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Designated Nurse for Safeguarding Children</td>
<td>0161 912 3828</td>
</tr>
<tr>
<td>Named Nurse for Safeguarding Children</td>
<td>0161 912 4699</td>
</tr>
<tr>
<td>Named Nurse for Safeguarding Children</td>
<td>0161 912 4541</td>
</tr>
<tr>
<td>Safeguarding Children Business Support (PA)</td>
<td>0161 912 4385</td>
</tr>
<tr>
<td>Safeguarding Children Business Support (Secretary)</td>
<td>0161 912 4134</td>
</tr>
<tr>
<td>Specialist Nurse for Children in Care</td>
<td>0161 912 3518</td>
</tr>
<tr>
<td>Business Support Children in Care health team</td>
<td>0161 912 3152</td>
</tr>
<tr>
<td>Named GP for Safeguarding Children</td>
<td>Tel 0161 972 9999</td>
</tr>
<tr>
<td>Designated doctor for Safeguarding Children</td>
<td>Tel: 0161 912 5845</td>
</tr>
<tr>
<td>Named nurse for Safeguarding Children - Trafford General Hospital</td>
<td>Tel: 0161 748 4022 (switchboard)</td>
</tr>
<tr>
<td>Named Doctor (THG division of CMFT) for Safeguarding Children</td>
<td>Via switchboard at Trafford General Hospital</td>
</tr>
<tr>
<td>Named Doctor Safeguarding Children Community</td>
<td>Tel: 0161 912 5847</td>
</tr>
</tbody>
</table>
Dear Doctor

Re:

Children in Care of Trafford Local Authority

You may be aware that the above child/children recently came into care and will have an initial health assessment for children in care within the next couple of weeks.

In order to ensure that this assessment is as comprehensive as possible I am writing to kindly ask that you send a summary of the medical information you have on the above child including medical history, relevant family history, hospital referrals and attendances, and immunisation history. A printed summary will suffice.

We have a statutory responsibility to provide a health summary and plan to the Local Authority within 28 days of the child/young person entering the care system.

We would therefore appreciate it if you could return the information to us within 5 working days from receipt of this letter.

Please email the information to my secretary Jill Teasdale on jillian.teasdale@nhs.net or send by post as soon as possible.
Many thanks for your assistance.

Yours sincerely

PP

Dr RM Nawaz

Consultant Community Paediatrician

Lead for Adoption/Fostering and Looked After Children.
HEALTH VISITOR COMMUNICATION WITH GPs

STANDARD

Guidance Notes:

1.1 There is a wealth of information available which dictates the need for professionals to work together in order to safeguard and promote the welfare of children and young people.\(^6\)

1.2 Working Together\(^7\) is clear about the need for joint working and to this end states the following:

- Everyone who comes into contact with children and families has a role to play
- The actions taken by professionals to meet the needs of children as early as possible can be critical to their future
- Children are best protected when professionals are clear about what is required of them individually and how they need to work together….and what they can expect of one another
- Effective safeguarding systems are those where professionals share appropriate information in a timely way and can discuss any concerns about an individual child with colleagues…
- Professionals working in universal services have a responsibility to identify the symptoms and triggers of abuse and neglect and to share information…

1.3 The National Health Visiting Core Service Specification 2015-16 states:

- The service will provide a named HV for each GP practice to facilitate liaison, information sharing and joint working in the best interests of families. There will be an agreed schedule of regular contact meetings for collaborative service delivery which must be audited and actioned on a regular basis.

1.4 This communication standard is designed to strengthen liaison and information sharing between HVs and GPs - whether or not the child(ren) is subject to a child protection plan or a child in care.

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\(^6\) See for example but not restricted to: Biennial Messages from Research/Laming Reports/Munro Report/Working Together 2013

\(^7\) Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (2013) HM Government
1.5 It is expected that the HV and the GP practice safeguarding lead will agree how often contact will take place, and in what manner. Contact should take place at least 2 monthly

1.6 This guidance does not replace existing working practices nor does it place additional case responsibility on HVs or GPs

1.7 The link HV is not responsible for ‘gathering’ the concerns of other HVs in the team to discuss with the GP safeguarding Lead

1.8 Where a GP wishes to discuss a child/family with a HV and the family is known to a particular HV in any team, the GP should be given contact details of the relevant HV

1.9 It may be appropriate for the HV to ‘signpost’ the GP to others in the Area family Support Teams e.g. School Nurse or EWO

1.10 This pathway does not negate the GP’s responsibility to refer to MARAT (and/or other services) where this is needed

1.11 Where any specific case discussion has taken place, both the HV and GP have a responsibility to record such discussions
**Communication Pathway:**

The GP practice link Health visitor will ensure at least two monthly contact with relevant GP practice safeguarding lead/other GPs in the practice

This should be in the form of a face to face contact at a mutually agreed time/venue (ideally at the GP practice)

This may take the form of the Health Visitor attending a practice meeting

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**Consider:**

- Have any case discussions been recorded?
- Where cases are discussed – be clear about who maintains case responsibility (see above guidance)
- HVs should be able to evidence how and when they attempted contact with a GP practice
- Signposting GP to others in the AFST where appropriate

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**Audit Suggestions:**

- Record of meetings
- Entry in relevant notes
- Evidence of joint working with CAFs
- Case discussions: emerging themes