Child Protection Policy And Practice Guidance

The Garth Surgery

Reviewed: 12/11/2018 by Sharon Appleyard & Victoria Brooke

Review due: 12/11/2019

Contents

Statement of intent

The aim of this policy is to ensure that throughout the Practice children are protected from abuse and neglect. This work may include direct and indirect contact with children (access to patients' details, communication via email / fax/phone.) We aim to achieve this by ensuring that **The Garth Surgery** is a child safe Practice.

The Garth Surgery is committed to best practice, which safeguards children and young people irrespective of their background and which recognises that a child may be abused or neglected 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 to protect the children we work with and for. Research has shown that child abuse offenders target organisations that work with children and then seek to abuse their position. This policy seeks to minimise such risks. In addition the Practice seeks 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.

The Garth Surgery is committed to this policy and the practices it sets out for all staff and partners and will provide in-house learning opportunities, and make provision for appropriate child protection training to all staff and partners. The policy will be made readily accessible to all staff and partners and reviewed November 2019.

This policy addresses the responsibilities of all Practice partners and employees. It is the responsibility of the Child Protection Practice Leads to brief partners and staff regarding their responsibilities under the policy.

To achieve a child safe Practice, employees, partners and independent contractors, volunteers and the wider primary care team members, as appropriate to their role need to:

- Be clear about their role and responsibilities to safeguard children
- Be able to recognise child abuse and neglect
- Be able to respond appropriately to concerns, allegations or disclosures of child abuse and neglect.
- Minimise any potential risks to children.
- Understand what behaviour is acceptable.

Background and principles

Safeguarding children and young people is a fundamental goal for The Garth Surgery. This policy has been written in conjunction with legislative and government guidance requirements. These include:

- The Children Act 1989
- The Children Act 2004

- The United Nations Convention on the Rights of the Child (ratified by UK government in 1991)
- Working Together to Safeguard Children 2013
- The Data Protection Act 2018
- Records Management , NHS Code of Practice 2006
- The protection of Children Act 1999
- The Human Rights Act 1998
- Sexual Offences Act 2003
- Practice Equal Opportunity Statement
- Practice Disciplinary Policy

What is abuse and neglect?

Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting; by those known to them or, more rarely, by a stranger.
There are usually said to be four types of child abuse [with a fifth recognised in Scotland]

1. Physical Abuse
2. Emotional Abuse
3. Sexual Abuse
4. Neglect
5. Non-organic Failure to Thrive [Scotland only]

General Indicators

The risk of Child Maltreatment is recognised as being increased when there is:

- parental or carer drug or alcohol abuse
- parental or carer mental health
- intra-familial violence or history of violent offending
- previous child maltreatment in members of the family
- known maltreatment of animals by the parent or carer
- vulnerable and unsupported parents or carers
- pre-existing disability in the child

[NICE CG89: *When to suspect Child Maltreatment*, July 2009]

Physical Abuse

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

Working Together 2006 © Royal College of General Practitioners & National Society for the Prevention of Cruelty to Children, 2009 6

Indicators:

- Unexplained injuries
- Injuries of different ages/types
- Improbable explanation
- Reluctance to discuss injury/cause
- Delay or refusal to seek treatment for injury
- Bruising on young babies
- Admission of punishment which seems severe
- Child shows:
    - arms and legs inappropriately covered in hot weather [concealing injury]
    - withdrawal from physical contact
    - self-destructive tendencies
    - aggression towards others
    - fear of returning home
    - running away from home

Emotional Abuse

Definition
Emotional abuse is the persistent emotional ill-treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person, age or developmentally inappropriate expectations being imposed on children, causing children frequently to feel frightened, or the exploitation or corruption of children. *Working Together* 2006

Indicators:

- Physical/ Mental/ Emotional developmental delay
- Overreaction to mistakes
- Low self-esteem
- Sudden speech disorder
- Excessive fear of new situations
- Neurotic behaviours
- Self-harming/ mutilation
- Extremes of aggression or passivity
- Drug/ solvent abuse
- Running away
- Eating disorders
- School refusal
- Physical/ Mental/ Emotional developmental delay

Sexual Abuse

Definition

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape or buggery) or non-penetrative acts. They may include involving children in looking at, or in the production of, pornographic material, or encouraging children to behave in sexually inappropriate ways.

Working Together 2006

Indicators

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

Neglect

Definition

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development, such as failing to provide adequate food, shelter and clothing, or neglect of, or unresponsiveness to, a child's basic emotional needs.

Indicators:

- Poor personal hygiene, poor state of clothing
- Constant hunger/thirst
- Frequent accidental injuries
- Untreated medical problems
  - Delayed presentation, concealed injuries
- Low self-esteem
- Lack of social relationships
- Eating Disorders
- Children left repeatedly without adequate supervision
- Failing to engage with healthcare
  - non-attended appointments [Practice or wider health professional]
  - frequent use of A&E/Out-of-Hours services
  - failing to arrange immunisations

Injury Patterns

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

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

Further information on injury patterns can be found at:

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

Practice arrangements

Practice Lead for Child Protection

The Practice Lead for Child Protection is: **Dr Patrick Gordon**

The Deputy Practice Lead for Child Protection is: **Any Practice Partner**

The Administration Lead for managing child protection data is: **Sharon Appleyard, Senior Admin Assistant.**

The Garth Surgery recognises it is not the role of the Practice to investigate or to decide whether or not a child has been abused or neglected

The responsibilities of Practice Leads for Child Protection

- Act as a focus for external contacts on child protection matters, particularly with other health colleagues to ensure concerns regarding a child are identified and shared in a timely manner to reduce further risk to the child.
- Be fully conversant with all aspects of the Garth Surgery child protection policy, child protection operating procedures and incident handling procedures.
- Establish links with Children's Social Care and Named and Designated Child Protection Doctors and Nurses.
- Ensure partners and staff have easy access to the Practice's Child Protection Policy and Local Safeguarding Children Board Procedures.
- Ensure that the Practice meets contractual and clinical governance guidance concerning child protection.
- Promote appropriate recording of child protection issues.
- Support arrangements to ensure continued accuracy of information where children's records are flagged to identify they are subject to a child protection plan
- Promote relevant child protection training for partners and staff
- Promote the provision of GP information to child protection conferences.
- Encourage regular discussion of child protection issues, including any relevant learning from serious case reviews, at Practice team meetings
- Act as a point of contact for Practice partners and staff to bring any concerns that they have and record this along with any subsequent action taken as a result. Understanding it is not the role of the Practice to decide whether or not a child has been abused or neglected.
- Assess the information promptly and carefully, clarifying or obtaining more information about the matter as appropriate
- Know and establish links, and when appropriate take advice from manned and designated professionals in Child Protection.

- Take a lead role in planning and delivering regular staff training, reviewing policy and operating procedures, and conducting audit/review of safeguarding in the practice.

Safe employment - The minimum safety criteria required for Practice partners and clinical staff is:

- Disclosing & Barring Service (DBS) check (Enhanced for clinical staff who have access to children)
- Two references, which are followed up.
- Face to face interview

For non-clinical staff:

- Two references, which are followed up.
- Face to face interview
- Disclosing & Barring Service (DBS) check (Enhanced for clinical staff who have access to children)

Training: Practice partners and employees

Child Protection training for staff should be undertaken as follows:

GPs & Nurse Practitioners should follow local guidance for keeping up to date. Currently this recommends a three year training cycle with one of each of the following updates each year;

- **Level 3 GP update in child protection**
- **On-line child protection update module**
- **Attendance at a multiagency child protection update.**

Practice Nurses/HCA's/Phlebotomist – It is now recommended that they complete Level 3 core training and do an update annually.

Non-clinical staff - Level 1 training - every 3 years which can be completed on-line.

https://www.redcar-cleveland.gov.uk/SafeguardingChildrenBoard/Pages/default.aspx - this link will take you to Redcar & Cleveland Safeguarding Children website, this has information on courses etc.

Induction: The Practice's induction for partners and employees will include a briefing on the Child Protection Policy by the Practice Manager/Senior Admin Assistant. Partners and employees will be given information about who to inform if they have concerns about a child's safety or welfare and how to access the Local Safeguarding Children Board procedures.

Safeguarding children competencies required for GPs and Practice employees are defined in '*Safeguarding Children and Young People: Roles and Competencies for Health Care Staff.'* Intercollegiate Document, 2010. This document can be accessed via https://www.rcpch.ac.uk/resources/safeguarding-children-young-people-roles-competences-healthcare-staff

For advice or information on training needs contact the Redcar & Cleveland Designated Nurse for Safeguarding Children or your local lead GP for Child Protection

All GPs and Practice staff should keep a learning log for their appraisals and or personal development plans.

The practice will keep a record of safeguarding training undertaken by GPs and Practice staff, this is monitored by Kelsey Roffe.

NSPCC produce a range of materials and educational tools for professionals, including the Educare – Health package, which has been extremely successful in many professional fields.
In collaboration with Cardiff University, NSPCC has developed a series called CORE – INFO covering:

- Head & Spinal Injuries
- Fractures in children
- Bruises on children
- Oral injuries and bites on children
- Thermal injuries on children
- Neglect

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

Supportive reflection on practice

The clinical staff have regular meetings with the Health Visitor & School Nurse about vulnerable families, Community midwife is also invited to these meetings.

Professional Challenge

If any practice member disagrees with an action taken and still has concerns regarding a child then they should contact the Designated Nurse or Practice Lead for independent reflection and support.

Whistle blowing

The Garth Surgery recognises the importance of building a culture that allows all Practice staff to feel comfortable about sharing information in confidence and with a lead person if they are concerned about a colleague's behaviour may result in a child been harmed. This will also include behaviour that is not linked to child abuse but that has pushed the boundaries beyond acceptable limits. The Garth Surgery Whistle Blowing policy can be located in the employee handbook.

Complaints procedure

The Garth Surgery has a clear procedure to deal with complaints from all patients (including children and young people) accompanying parent or adult and Practice staff. Please refer to: The Garth Surgery Complaints policy.

General guidelines for Practice partners and employees

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.

- **www.teescpp.org.uk – This website is the Tees Local Safeguarding Children Boards' Procedures – This website outlines the roles and responsibilities of staff working with children and is where all updated Local Safeguarding Child Protection Board Child Protection Procedures will be available.**

- Challenge any unacceptable behaviour by GPs and Practice staff.
- Never promise to keep a secret about any sensitive information disclosed to you but follow the Practice's guidance on confidentiality and sharing information. Remembering the safety of the child is paramount.
- 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.
- 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 offer a lift to a young person in your own car.
- Never exchange personal details such as your home address with a young person.
- Don't engage in or allow any sexually provocative games involving or observed by children, whether based on talking or touching.
- Provide an example of good conduct you wish others to follow.
- Involve children and young people in decision-making as appropriate.
- Never show favouritism or reject any individuals.

Personal use of the internet and mobile phones

See employee's handbook for internet and mobile phone policy.

Recognising child abuse

Refer to NICE flowchart 'When to suspect child maltreatment'
http://pathways.nice.org.uk/pathways/when-to-suspect-child-maltreatment

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

Reactive measures

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

Disclosure of an allegation of abuse

If a child discloses information about abuse, whether concerning themselves or a third party, our employees must immediately pass this information on to the lead for child Protection and follow the child protection procedures below.

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

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

Responding to a child making an allegation of abuse

- Stay calm
- Listen carefully to what is being said
- Find an appropriate early opportunity to explain that it is likely the information will need to be shared with others – do not promise to keep secrets
- Allow the child to continue at his/her own pace
- Ask questions for clarification only, and at all times avoid asking questions that are leading or suggest a particular answer.

Responding to concerns about child abuse

To seek further information/ share concerns contact as applicable:

- Midwife: 01642 854880 or advice line 01642 854876
- Health Visitor: 01287 612398
- School Nurse: 01642 444011

To consult contact:

Named Nurse Child Protection: **Redcar & Cleveland - Direct line: 01642 263026 Mobile: 07826914817**

Consultant Paediatrician on call – Daytime: **Redcar & Cleveland - (01642) 850850**

Consultant Paediatrician on call - Out of Hours: **Redcar & Cleveland - (01642) 850850**

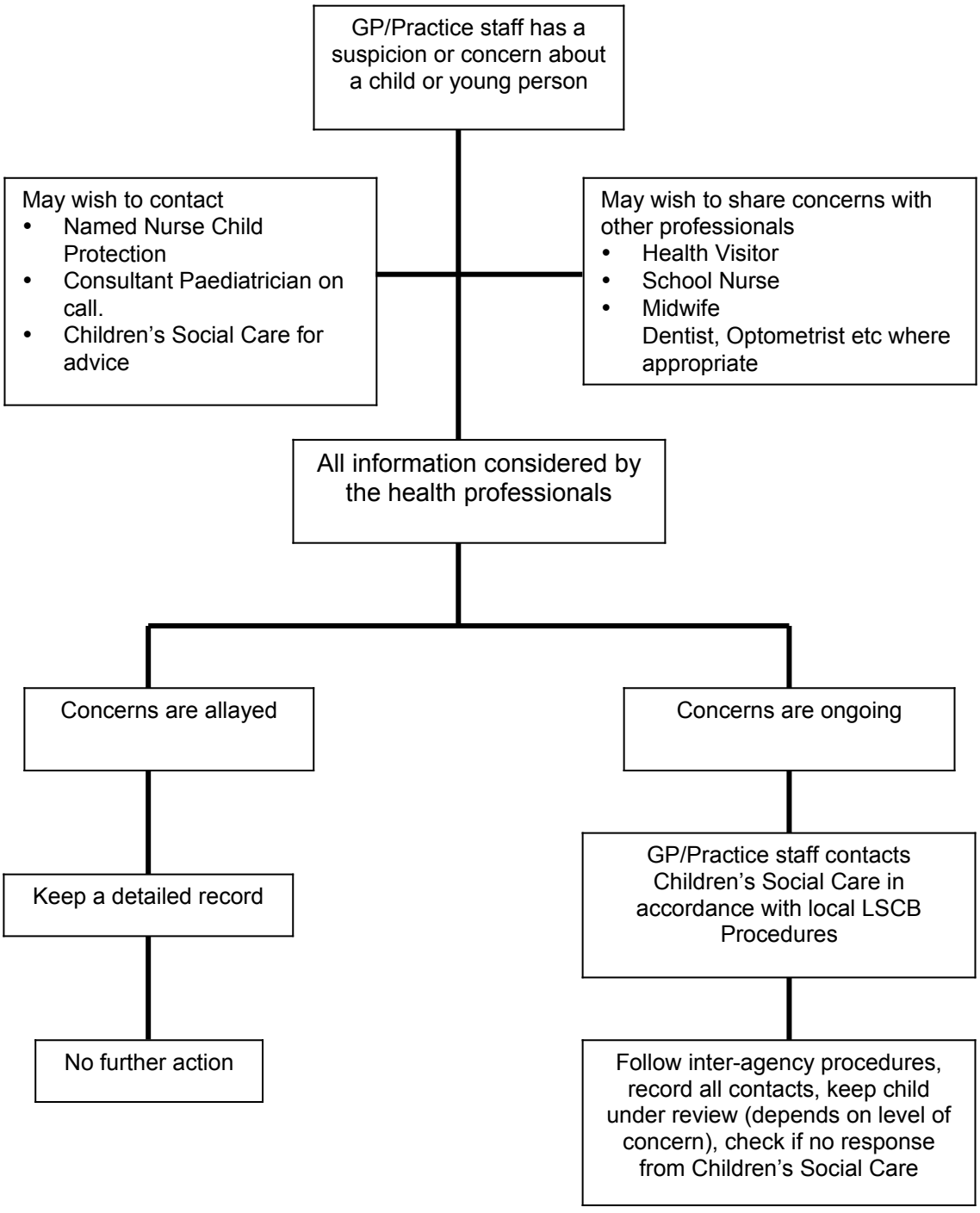
To make a referral to Social Care contact: **Redcar & Cleveland - (01642) 771500 – the Tees Multi Agency SAFER Referral Tool Form is available on the practice intranet**

Out of hours emergency duty team: 01642 524552

Local Safeguarding Children Board Procedures:

Redcar & Cleveland Safeguarding Children Procedures - **https://www.redcar-cleveland.gov.uk/SafeguardingChildrenBoard/LocalProceduresAndProtocols/Pages/default.aspx**

Practice reporting process



All staff are advised to save the Child Protection folder to their desktop and as a bookmark in Systmone for easy access, this folder is saved on the following file path S:\carol jackson\Child Protection and also includes:

- **Information sharing handbook**
- **Contact details when there are Child Protection concerns**
- **Flowchart – when to suspect child maltreatment**
- **Booklet – What to do if you're worried a child is being abused.**

Enquiry Process

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

Recording Information

- Information about vulnerable children to be recorded in the child's notes using locally agreed Read codes.
- Details of any disability for the child
- Details of mental health issues for the child
- Information supplied by all members of the Primary Care Team, including the Health Visitor, to be recorded in the notes under a Read code. Email should only be used when secure and the email and any responses should be copied into the record.
- Conversations with and referrals to outside agencies should be recorded under an appropriate Read code.
- Basic information is recorded for every child and checked for changes at every visit.
- Records, storage and disposal must follow national guidance for example, *Records Management, NHS Code of Practice* 2006. Please see The Garth Surgery protocol for Dealing with documentation relating to Child Protection
- Historical details of the parents experience as a child if concerns known
- Details of any housing problems.
- Details of significant illness or problems in the family, such as parental substance misuse or mental illness.
- History of domestic violence in the household.
- Details of any parental learning disabilities

Information can be sought and entered from:

- New patient health checks on all children, including enquiry about family, social and household circumstances *(A recommendation from Lord Laming following the Victoria Climbie Inquiry.)*
- Any contact with a potential carer – 'seeing the child behind the adult' – so that a patient with a substance misuse problem is asked about any responsibility they may have for a child, and that child's record amended accordingly.
- Opportunistic consultations:

- Antenatal booking
- Postnatal visit
- 6 week check

- Practice Team meetings, where regular discussion of all practice children subject to child protection plans, or any other children in whom there may be concerns, should highlight safeguarding issues in children and their families.
- Correspondence from outside agencies, such as A+E/OOH reports and other primary and secondary care providers. *****

*****Care Quality Commission 2009: *Review of the involvement and action taken by health bodies in relation to the case of Baby P.*

Sharing Information/disclosure of medical information

The Children Acts 1989 and 2004 give GPs a statutory duty to co-operate with other agencies if there are concerns about a child's safety or welfare. The 'seven golden rules 'of information sharing are set out in the Government guidance *Information Sharing: Pocket Guide,* 2008 and *applies* to all professionals charged with the responsibility of sharing information, a copy of this booklet is available s\carol jackson\Child Protection\Booklets & Guidance.

Ideally consent should be provided along with the request for patient information however there are times when the concerns/risks to the child are such that it is not appropriate to seek consent, principally as this may lead to the child being further abused. A lack of consent should not prevent a GP from sharing information if there is sufficient need in the public interest to override the lack of consent. In broad terms the welfare of the child is paramount and where there are child protection concerns this outweighs confidentiality. However where the GP is uncertain advice about consent is available from the designated/named child protection professionals, CCG, GMC, LMC or medical defence organisation.

General Medical Council Guidance

The GMC advises:

When treating children and young people doctors must also consider parents and others close to them but their patient must be the doctor's first concern.

When treating adults who care for, or pose risks to children and young people, the adult patient must be the doctor's first concern; but doctors must also consider and act in the best interests of children and young people.

See the adult behind the child and the child behind the adult.

Consent should be sought to disclose information unless:

- Obtaining consent would undermine the purpose of the disclosure. (Such as fabricated and induced Illness and sexual abuse.)
- It is impracticable to gain consent.
- Action must be taken quickly because delay would put the child at further risk of harm
- Information sharing handbook guidance available to all staff.

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 genuine reason to request information. Call back the switchboard or ask for a 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 enquires about them? Have they consented, and if not why not? If this doesn't cause harmful delay, you may wish to seek consent. You may share information without consent if in your judgement, the lack of consent can be overridden by the public interest – you will need to base your judgement on the facts of the case.**
- *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 shared, 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.**

GP information to child protection strategy meetings and conferences

Strategy meetings/discussions

A strategy meeting/discussion is the first response to a referral where there are believed to be child protection concerns and as a result Children's Social Care will ask the GP for information at very short notice. GPs should share information on all key aspects where a child is considered to be at risk however timeliness is the paramount issue.

Consider including:

- Missed appointments at the Practice
- Missed hospital appointments
- Failed immunisation
- Injuries
- Parental mental health or substance misuse
- Domestic violence
- Ability of the carer to parent
- Any relevant history
- Cruelty to animals in the family
- Are both parents registered with the practice
- Parental learning disabilities

In broad terms the welfare of the child is paramount and where there are child protection concerns this outweighs confidentiality.

Child protection conference

When a child protection conference is to be held Children's Social Care will require information about the child/family and will send a proforma, which is self-explanatory for the GP to complete. Ideally the proforma should be completed by the GP who knows the child/family best however this is not always possible in the short-time scale given (this is constrained by Government guidance) and in such cases a colleague of the GP should complete the form.

The Garth Surgery has the following arrangements in place to ensure proformas/reports are dealt with promptly so that information is provided to Children's Social Care in time for the planned child protection conference. **Please see The Garth Surgery Protocol for dealing with documentation relating to Child Protection.**

The completed proforma/report for the specific child should be retained in the child's record and this is best achieved by using either the 5 byte Read code 'Child is a cause for concern,' 13If. adding in free text 'case conference proforma completed,' or the CTv3 code YA619 'Child protection report submitted.'

Consider sharing the information within the proforma/report with the child if old enough and if appropriate and with the parents where appropriate.

From 4th January 2016 the Review & Inspection Unit will use their own secure email account to request information from the practice for Initial and Review Child Protection conferences. These requests come into the practice via the generic secure email and are also returned to the Review & Inspection Unit via email. The secure email address for Redcar & Cleveland's Review and Inspection Unit to return the completed reports to is:
Independent_review@redcar-cleveland.gcsx.gov.uk (please note there is an underscore between independent_review)

Child protection conference minutes – these are now also received via the practice generic email.

'Child Protection Conference-Information for GP records' forms are completed by Children's Social Care and shows the outcome of a child protection conference. That is whether the child has become subject of a child protection plan or the child ceases to be the subject of a child protection plan. Where the child is subject to a child protection plan the category of abuse will be shown and a copy of the protection plan included with the form.

The conference outcome should be coded as according to the appropriate read codes on the form. The form should be scanned into the child's GP records alongside clinical letters.

Information showing that the child is subject to a child protection plan should always be visible from the computer's main screen. The purpose of this is to alert the clinician that special care may be needed to safeguard the child and this cannot be done if the information is not where the clinician would normally look during a routine consultation.

Child protection information should not be stored separately from the child's records. Information is unlikely to be accessed unless part of the child's record, unlikely to be sent on to the new GP if the child registers elsewhere and may be mislaid leading to a potentially serious breach in patient confidentiality.

Third party information can be entered into medical records but must be removed if copies of the medical records are released for any reason.

Retention time for child protection information. Child protection information will be part of the child's medical records and retained until the patient's 26th birthday. The Practice will then consider what child protection information it is relevant to keep within the patient's records mindful of the importance of social history on the present where the adult becomes a parent. A report is generated every month to identify those patients who have reached their 26th birthday.

Action to take when a child who is subject to a child protection plan *leaves* the Practice

Child protection documents must be transferred with the general medical notes when a child transfers between Practices. Hence the importance of child protection information being part of the child's medical records and not stored separately, which is likely to lead to documentation not being sent on.

The child's medical notes should clearly identify that the child is subject to a child protection plan and should be flagged with the appropriate Read code.

Where the patient is not subject to a child protection plan but there is historical child protection documentation held all documentation should be transferred up to the patient's 26th birthday. After the patient's 26th birthday consideration should be given as to what child protection information it is relevant to keep within the patient's records, being mindful of the importance of social history where the adult becomes a parent.

Social Care must be informed that the child has left the Practice.

The Health Visitor must be made aware so there can be an effective hand-over.

Action to take when a child subject to a child protection plan *registers* with the Practice

The GP Practice Lead for Child Protection to have professional oversight of the child protection information.

The child's medical notes must clearly identify that the child is subject to a child protection plan and be flagged with the appropriate Read code.

A check must be made to ensure Social Care and the Health Visitor/School Nurse are aware that the child has registered with the Practice.

PCSE have advised the email address to use where you may be trying to fast track patient notes in cases relating to any safeguarding matters. Any record requests relating to safeguarding should be sent to pcse.safeguarding@nhs.net

Transfer of records to new GP practice where a child is subject to a child protection plan or is a looked after child

When a child with a protection plan or a looked after child registers with a new GP Practice it is essential that the child's GP records are transferred to the new practice as quickly as possible. This ensures that the child's new GP has all the relevant information about the child thereby enabling the GP to provide appropriate care.

In order for this to occur PCSE will request records from the child's previous GP as soon as the child has been registered at the new practice. It is therefore imperative that a quick turn around of the records is achieved and that they are sent within a day or two of request back to PCSE - Primary Care Services England where they will be re-labelled, processed and delivered to the new practice. This can occur within a few days if the new GP practice highlights the records as being requested urgently.

The Primary Care Services England is able to action urgent requests more easily when all relevant information is gathered e.g. NHS number, correct date of birth etc.

Serious Case Reviews

Serious case reviews have been set up by the Government to learn lessons where a child dies or suffers serious harm as a result of abuse or neglect. They must be conducted in accordance with statutory guidance, '*Working Together,'* HM Government 2013.

The prime purpose of a serious case review is for organisations and professionals to learn lessons to improve the way they work both individually and collectively to safeguard and protect the welfare of children.

As part of the serious case review each relevant organisation is required to undertake a comprehensive review of its involvement with the child (ren) /family. Designated professionals on behalf of the CCG must review and evaluate the practice of all involved health professionals including GPs and providers commissioned by the CCG. This involves the CCG requesting from the GP a copy of the child (ren) medical notes. In addition the GP will be asked for a report in respect of any information on the parents/carers. Generally the designated professional undertaking the review will seek an interview with the involved GP.

Cases which do not meet the criteria for a Serious Case Review can also be undertaken and are known as "Learning Lesson Reviews". Although not required by statute, these reviews are still important to identify good practice as well as highlighting areas which require improvement. Such reviews can be undertaken, via single or muti-agency arrangements which mirror the Serious Case Review format.

The GP will be informed of the findings of the serious case review and any recommendations made to the Practice. The Area Team, CCG and the LSCB have the responsibility of monitoring implementation of the recommendations

Child in foster care/looked after children

Any child that registers with the practice must register fully as a patient and NOT a temporary resident, this must also be made clear in the medical records, a suggested code is **XaXLt – Looked after child.** Adding this code also adds a flag to the patient status icons below the patient details in Systmone**.** Please see The Garth Surgery Looked after Children Policy.

Reviewing the Policy

Because of constant change this policy will be updated on a regular basis. This will need to be at the time of any significant change and at least bi-annually. The Practice Lead for Child Protection, Practice Manager & Senior Admin Assistant will have responsibility for doing this.

https://www.redcar-cleveland.gov.uk/SafeguardingChildrenBoard/Pages/default.aspx

Declaration

We have reviewed and accepted this policy

Signed by _____ on behalf of the Partnership. Dated:

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

Signed by _____ Dated: