Broomfield Park Medical Centre

Last Reviewed / Edited: March 2024
By: Lynne O' Connor; Safeguarding Co-Ordinator

VULNERABLE CHILDREN AND YOUNG PERSONS (SAFEGUARDING) POLICY / PROCEDURE

BACKGROUND & PRINCIPLES

Safeguarding children and young persons is a fundamental goal at Broomfield Park Medical Centre.

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

All children, regardless of their circumstances, are entitled to an efficient, full-time education that is suitable for their age, ability, aptitude and any special educational needs they have. Research shows that children who are missing education are greater risk of underachieving, becoming victims of abuse or neglect and becoming **NEET (not in education, employment or training) in later life.**

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

SUPPORTING STATEMENT OF INTENT

The aim of this Document is to ensure that, throughout the Practice, children are protected from abuse and exploitation. This work may include direct and indirect contact with children (access to patient's details, communication via email, text message / phone).

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

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

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

As a Practice, we have a duty of care to protect the children we work with and for. Research has shown that child abuse offenders target organisations that work with children and then seek to abuse their position. This policy seeks to minimise such risks

In addition, this policy aims to protect individuals against false allegations of abuse and the reputation of the Practice and professionals. This will be achieved through clearly defined procedures, code of conduct, and an open culture of support.

We are committed to implementing this policy and the protocols it sets out for all staff and partners will provide in-house learning opportunities and make provision for appropriate child protection training to all staff and partners.

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This policy will be made widely accessible to staff and partners and reviewed on a minimum annual basis.

This policy addresses the responsibilities of all Practice employees and those to whom we have arrangements with. It is the responsibility of the Practice Manager and Safeguarding Lead to brief the staff and partners on their responsibilities under the policy.

For employees, failure to adhere to the policy could lead to dismissal or constitute gross misconduct. For others (volunteers, supporters, donors, and partner organisations) their individual relationship with the Practice may be terminated.

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 disorders or disability of the mind.
- Intra-familial violence or history of violent offending.
- Previous child maltreatment in members of the family.
- Known maltreatment of animals by the parent or carer.
- Vulnerable and unsupported parents or carers.
- Pre-existing disability in the child, chronic or long-term illness.

(NICE CG89: When to suspect Child Maltreatment, July 2009)

SIGNS OF ABUSE IN INFANTS

Infants aged under a year old are considered to be at the highest risk of maltreatment and are more at risk of being killed at the hands of another person than any other single year age group in England and Wales. On average, in England and Wales, one baby is killed every 20 days, and 80% of these infants were killed by a parent.

(From: England and Wales: Office for National Statistics (2013) Focus on: violent crime and sexual offences, 2011/12. [Newport]: Office for National Statistics (ONS)).

GPs must be especially alert in the ante-natal period to parental risk factors such as domestic abuse, depression, and substance abuse, and to also look for signs of parental stress, post-natal depression, or other mental illness in the post-natal period.

The six-to-eight-week developmental check is an extremely important opportunity to assess the

parent-child relationship and how well parents are managing the transition to new parenthood, see also NICE CG37.

- Alerting factors to infant abuse may be:
- Inconsistent history
- Late presentation of injury/injuries to practitioner
- Injuries that are not consistent with history or age/stage of child
- Unexplained injuries in non-mobile children particularly (but applies to all children)
- Presence of other injuries – full examination of infant always indicated
- Patterns of repeat injuries

PERSONS IN A POSITION OF TRUST

A person in a position of trust is someone who has a position of power or influence over another person, and who is therefore expected to act in the best interests of that other person. This includes people such as:

- Healthcare professionals, such as doctors, nurses, and social workers
- Teachers
- Police officers
- Care workers
- Religious leaders
- Sports coaches
- Foster carers

People in positions of trust have a responsibility to protect the people in their care from abuse and neglect. This includes both physical and emotional abuse.

GP practices should:

- Be aware of the definition of a person in a position of trust and the risks they may pose to patients.
- Have a policy and procedure in place for dealing with concerns about persons in a position of trust.
- Train all staff on the policy and procedure.
- Provide support to staff who raise concerns.

If you have a concern about a person in a position of trust, you should:

Report the concern to your supervisor or manager.
If you are not satisfied with the response you receive, you can escalate the concern to a more senior person or agency.
You can also contact a safeguarding whistleblower hotline.

Escalation

Escalation is the process of taking a safeguarding concern to a more senior person or agency if it cannot be resolved at the local level. This may be necessary if:

- The concern is serious and there is a risk of immediate harm to the patient.
- The person responsible for safeguarding the patient is not taking appropriate action.
- The person raising the concern is not satisfied with the response they have received.
- The concern is about a person in a position of trust.

To escalate a safeguarding concern, you should:

Follow your organization's safeguarding policy and procedure. This will usually involve reporting the concern to your supervisor or manager. If you are not satisfied with the response you receive, you can escalate the concern to a more senior person or agency.

In the UK, the following agencies are responsible for safeguarding patients:

- Local authorities
- The police
- The Care Quality Commission (CQC)
- The NHS England Safeguarding Team

You can also contact a safeguarding whistleblower hotline if you have concerns about a person in a position of trust.

Here are some examples of situations where you might need to escalate a safeguarding concern:

- A patient tells you that they have been abused by a healthcare professional.
- You notice that a patient is showing signs of physical or emotional abuse, but the person responsible for their care is not taking action.
- You have concerns about the safety of a patient who is being cared for in a care home or other residential setting.
- You believe that a person in a position of trust is exploiting a patient.

If you have any concerns about the safety of a patient, it is important to speak up.

Even if you are not sure whether or not the concern is serious, it is always best to err on the side of caution and report it.

Remember, you do not have to have proof of abuse to report a concern. If you have any suspicions or worries, it is important to speak up.

Additional Guidance

GP practices should develop a safeguarding policy and procedure that is tailored to their specific needs. The policy should be based on the NHS Safeguarding Handbook and other relevant guidance.
The policy and procedure should be regularly reviewed and updated to ensure that it is up-to-date and effective.
All staff should be trained on the safeguarding policy and procedure. This training should be refreshed regularly.
GP practices should provide support to staff who raise concerns about safeguarding. This support may include access to counselling or other professional help.

THE SNOMED CT CODES FOR ALERTS IN USE IN THE PRACTICE ARE:

OLD READ CODE	SNOMED CT CODE	DESCRIPTION
13IS	135891007	Child in need
13Id	160887007	On Child Protection Register
13IV	764841000000100	Child is classed as a 'Looked after Child' (may still be living with a parent)
13IO	160889005	Child has been removed from the Register

The SNOMED description search for 'Child on Child Protection Register' will show the same SNOMED code as above ('On Child Protection Register'); however, it may be used on a parent's / guardian's record to indicate that they have a child who is on the register.

References in the Coding system to "Register" is assumed to identify children at risk under the recent guidance.

Practices should check for any changes to terminology now that the SNOMED system has been adopted in the UK.

MINIMUM SAFETY CRITERIA FOR STAFF MEMBERS WHO HAVE CONTACT WITH CHILDREN

The minimum additional safety criteria require relevant staff who work at the Practice:

- Have a standard DBS check (e.g., Receptionists, Dispensers).
- Have an enhanced DBS check (e.g., Clinicians, Nurses, Phlebotomists, HCSWs).

WHISTLEBLOWING

Our Practice recognises the importance of building a culture that allows all our staff to feel comfortable about sharing information, in confidence and with a lead person, regarding concerns they have about a colleague's behaviour.

This will also include behaviour that is not linked to child abuse, but that has pushed the boundaries beyond acceptable limits.

Open honest working cultures where people feel they can challenge unacceptable colleague behaviour and be supported in doing so, help keep everyone safe.

Where allegations have been made against staff, the standard disciplinary procedure and the early involvement of the Local Authority Designated Officer (LADO) may be necessary (*section 11 Children Act 2004*).

Training you to recognize risk
There is very detailed national guidance on what type of training is required for each role in the organization. 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.

STAFF TRAINING

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

- All Non-Clinical Staff must be at Level 1.
- Nurses directly employed by the Practice must be at a minimum Level 2, working towards Level 3.
- Practice Safeguarding Lead must be at Level 3 and the Named Safeguarding Professional
- All GPs need level 2 for the purposes of update, appraisal and revalidation bearing in mind that level 3 includes training relevant to the inter-agency nature of their work.

How do we assess risk as a team?
Everyone in this organization is asked to recognize and escalate children who are at risk to our safeguarding Multi-Disciplinary Team meeting. This team of healthcare professionals (Midwife, Health Visitor, School Nurse and GP lead) will meet once a month to discuss cases and agree an action plan and follow up the issue you have identified. For cases of any concern (Levels 2, 3 or 4) please send a message through the computer system to the Named Safeguarding Professional who manages the safeguarding meeting.

Is the child at immediate risk?
In cases of risk that you feel there is immediate risk to the child you should not hesitate to contact any of the partners in the business, any member of senior management or the GP Lead for Safeguarding. The most severe cases require immediate referral to the Police or Social Services, you should always feel that this organization will support you if you have any doubt in assigning a level of risk and please feel free to ask, its better to be safe than sorry. If you have any doubt as to how severe the risk is to the children you should ask for advice from the GP Lead, the Named Safeguarding Professional, consult the A3 Guide to Recognizing Safeguarding Concerns or contact the regional Named GP.

MAKING A REFERRAL TO SERVICES

A referral to Social Services is taken by completing the form that is available via the Local Authority website www.coventry.gov.uk/lscb and tick the box for How to Report a concern about a child or young person and then go down to For Professionals and then tick the Multi-Agency Referral Form link to complete the form.

If you have any doubt, you can ring them first to discuss the case to see if this escalation is needed on 02476 832568. If you would prefer to seek advice within health, you can always ring the CCG and speak to a safeguarding professional. If there is no immediate danger or you need advice or information, you should call the Multi-Agency Safeguarding Hub on 024 7678 8555.

It may take 30 minutes to compete the referral process, this may be frustrating as we are all busy but detailing your concerns very accurately helps the agencies decide on the most appropriate action to undertake and allocate a degree of urgency.

The MASH team works with a RAG rating for referrals
Red – Urgent – 2 hours
Amber – chance of significant harm dealt with within 24 hours
Green – no significant issues
If the family already has a Social Worker assigned to them there is no necessity to refer to MASH.

CONFIDENTUALITY

Detail exactly what you have seen and the fact that you have escalated your concerns to the safeguarding MDT. The organization will add the appropriate Snomed Codes to the medical records to highlight this concern to help others in the future; guidance is available in the RCGP Safeguarding Toolkit at https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/child-safeguarding-toolkit.aspx

This escalation of concern is not breaking confidentiality, it is simply contributing to our system of safeguarding children which is transcends confidentiality. If you wish to advise the patient that you are escalating their case this is fine, but it is also acceptable to take this action without their permission.

In order to do their jobs, members of staff need access to confidential (perhaps highly sensitive) information about children and young people. To effectively ensure that all relevant information is available to appropriate persons at all times, no records relating to child abuse or protection will be maintained separately from the main clinical record.

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

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

Whilst adults need to have an awareness of the need to listen and support children and young people, the importance of not promising to keep secrets or never requesting this of a child or young person must also be understood.
Additionally, concerns and allegations about adults should be treated as confidential and passed to a designated or appointed person or agency without delay.

In general, if a person decides to disclose confidential information without consent, they should be prepared to explain and justify their decision and they should only disclose as much information as is necessary for the purpose.

SHARING INFORMATION

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

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

- In England and Wales, GPs have a statutory duty to co-operate with other agencies (Children Act 1989 section 27, 2004 section 11) if there are concerns about a child's safety or welfare.

CCGs (*section 47.9*) have a duty to assist local authorities (Social / Childcare Services) with enquiries; Named Doctors for child protection can be powerful advocates for this function.

- The Children, Schools and Families Act 2010 (section 8) amends The Children Act 2004 providing further statutory requirements for information sharing when the LSCB requires such information to allow it to carry out its function.

General principles for sharing information

The 'Seven Golden Rules' of information sharing as set out in the government guidance, *Information Sharing: Pocket Guide* is applicable to all professionals charged with the responsibility of sharing information, including in child protection scenarios:

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

Better safe than sorry:

The GP lead for this organization is Dr M. Green and the Named Safeguarding Professional is Lynne O’Connor, and they are both available on the telephone number of Tel: 02476 228606

COMMON SAFEGUARDING EVENTS & THE ROLE OF PRACTICE STAFF

The practice will respond to requests for information from the MASH, Local Authority or any professional who has concerns for a child by:

- The receptionist taking steps to authenticate caller’s professional role in safeguarding by ringing the person back through their organization switchboard.
- When this has been achieved the receptionist should allocate the telephone call to an appropriate professional, firstly the Named Safeguarding Professional who will share necessary information to safeguard the child or if they are not available the GP Safeguarding Lead. Either via telephone if they are free or Patient Note if they are not.

The practice will respond to requests for a report to a Child Protection Case Conference by:

- The request is sent via secure email and the Named Safeguarding Professional has been allocated as the administrator to check the email account every day. In her absence this email would be manned by the Practice Manager who is aware that these requests are important and pass them to the GP Lead to complete.
- The practice has allocated the safeguarding team to be responsible for managing the successful return of case conference reports. If any GP states, they are unable to complete the report in time for the conference escalate this issue to the Practice Manager.
- The safeguarding administrator will provide the GP with the appropriate case conference template that should be used to guide quality.
- Reports should arrive at the Local Authority at least two days before the allocated time for the Child Protection Case Conference.
- The GP or the Named Safeguarding Professional – will support the successful submission of this action.
- Once the report has been created and submitted the practice finance team should create an invoice for the work and submit this to the Local Authority or CCG.

Case Conference Summaries & Minutes

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

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

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

These procedures are regarded as best practice, but as they may vary between UK jurisdictions, you are advised to consult local CCG / LMC policies for further details.

The practice will respond to any documentation relating to Looked After Children including health assessments, Common Assessment Framework (CAF) that arrives either by post or fax or by electronic means by:

- Ensuring that the posted document is put into the Named Safeguarding Professionals tray or scanned straight to her. Or in her absence they are sent to the GP Lead.
- Also, any documents that arrive detailing "Was not taken to" outpatients appointments or repeated A&E attendances should also be scanned or passed to the Named Safeguarding Professional, to decide if they need taking to the MDT meetings.

Registration

The practice records the following additional information:

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

The practice will expect full co-operation in the supply of these details from the parent / carer, otherwise registration will be delayed. The Health Visitor will be informed within 2 weeks of registration of all children under 5 who register with the practice, including temporary registrations.

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

Registration and support for vulnerable children joining the practice

- The practice receptionists should recognize the challenges for some children in producing birth certificates and proof of address especially in cases of children coming into care, children seeking asylum.
- Please escalate this scenario to the Named Safeguarding Professional who can make a case-by-case decision on whether to register the child.

Looked After Children

- The practice aims to deliver an additional layer of service for Looked After Children
- The practice will allocate a LAC to a specific GP, who will be allocated time to read the medical notes of that child and understand the story of their life and the abuse they suffered.

- The practice should agree to give that child additional continuity whenever they ring, where necessary this means overbooking a GPs clinic to ensure continuity is achieved.

De-Registration

Where a child **under 5** moves away or changes GP the practice will inform both social services (if applicable i.e. if the child has an alert on their record) and the health visitor within 2 weeks. Children **over 5** the practice will inform social services only (where the child has an alert on their record). This communication is generally carried out by the administration person. Also, the communication to the Social Workers and Health Visitors will be recorded in the patient's record.

Child Protection files forming part of the practice computer system will remain in place after the patient has de-registered in line with all other permanent medical records.

Particular care must be taken by the transferring practice to ensure that all child protection documents, and information is passed over to the receiving practice.

This also applies to any confidential files which may (according to the needs of the case) be filed separately.

PRIVATE FOSTERING

Following the death of Victoria Climbié* legislation was strengthened to protect children (under 16 or under 18 if disabled). A private fostering arrangement is one that is unknown to the local authority (LA).

The Children (Private Arrangements for Fostering) Regulation 2005 sets out the role of the local authority, the parents, the private foster carer and related professionals including general practice. A private fostering situation is one that has been, or will be, in existence for 28 consecutive days or more and the foster persons are not the parents, or close relative** or a person with parental responsibility.

Privately fostered children remain a diverse and potentially vulnerable group of children.
Legislation puts a duty on related professionals to assist with LA registration of those missing statistics. Failure to notify the LA is an offence by fine or imprisonment of both.
As clinicians we have a duty to establish who has parental responsibility for children registered with the practice. Where a private fostering arrangement is established then the clinician should firstly encourage the fosterers to register the arrangement with the LA. At the next meeting with the fosterer if they have not registered with the LA then there is a duty on the clinician to contact the LA themselves to establish the correct arrangement.

If you come across a private fostering arrangement, you must encourage the carer and parent to notify the council: Referral and Assessment Service (RAS) on 024 7678 8555
It is also vital that you contact the RAS team to make sure they know about the arrangement.
If you suspect a private fostering arrangement but feel unsure, you can find out more on the Coventry Safeguarding Children Board website:
www.coventry.gov.uk/lscb
or you can call the RAS team to talk through your concerns.

** Victoria Climbié died on 25th February 2000, aged 8 years and 3 months. Her death was caused by multiple injuries from months of ill treatment and abuse by her great-aunt, Marie-Therese Kouao and her great-aunt's partner, Carl John Manning. She was sent to England by*

her family in the Ivory Coast, in the hope of a good education and a better life, however she ended her days the victim of almost imaginable cruelty.

Close relative is a grandparent, brother, sister, aunt, uncle and stepparent.

DATE PROTECTION

Current guidance suggests that written records relating to child protection issues should be stored as part of the child's permanent medical records, either manually or on computer, or both - a change to the previous recommendation.

- The practice should be alert to the fact that this guidance may be reviewed or amended in the future and must seek the guidance of the local CCG in all instances.
- Practices have permanent access to the local child protection instructions on the local safeguarding children's board website (see address on following pages)

As a normal part of compliance with the data protection act it is likely that third party information will be stored within these records, and the normal duty of non-disclosure of this third-party information may apply when information is to be released – it may be appropriate at such times to take advice.

Safeguarding Process Guide for Incidents

Below is a guide for how safeguarding incidents are managed at the practice.

1. Incident received by a any member of staff in practice, social worker, carer, patient, friend of a friend, MASH etc. Any urgent actions are immediately dealt with by Safeguarding Officer or on call GP (e.g. – Book in with GP for telephone consultation or home visit, refer to OT's, Dietician, MH etc.)
2. MDT and Safeguarding Tracker updated by Safeguarding Lead.
3. This incident is placed on our MDTs for discussion. Recorded on the Incident log and discussion spreadsheet. Safeguarding Officer will notify GP Safeguarding Lead of the Incident immediately.
4. Cases discussed at our MDTs and appropriate actions taken by either Safeguarding Officer, GP, OT's, SPs, MH etc.
5. Update minutes from meeting, send out Minutes to GPs & Nurses. Add comments from minutes on to pts records in EMIS securely. Update Incident Log and discussion spreadsheet.
6. Chase up Social Worker, Care Home, Hospital etc. for updates – Update all comments/discussions on to patients records into EMIS securely.
7. Discuss case again at next month's MDTs – Remove from MDTs if resolved.

GENERAL MEDICAL COUNCIL GUIDANCE

http://www.gmc-uk.org/guidance/ethical_guidance/13257.asp
http://www.gmc-uk.org/guidance/ethical_guidance/13382.asp

The General Medical Council offers guidance on recording of allegations and Confidentiality and Information Sharing which is regularly reviewed and advises that the first duty of doctors is to make the care of their patients their first concern:

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

Consent should be sought to disclosures unless:

- That would undermine the purpose of the disclosure [such as fabricated & induced illness and sexual abuse]
- Action must be taken quickly because delay would put the child at further risk of harm.
- It is impracticable to gain consent.

When asked for information about a child or family, Practice staff should consider the following:

- **Identity:** check identity of the enquirer to see if they have a bona fide reason to request information. Call back the switchboard or ask for a faxed request on headed notepaper.
- **Purpose:** ask about the exact purpose of the inquiry. What are the concerns?
- **Consent:** does the family know that there are enquiries about them? Have they consented and if not why? 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.

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 decide about disclosure.

c) When disclosure is required by law.

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CHILD SEXUAL EXPLOITATION - CSE

Child sexual exploitation (CSE) is a form of sexual abuse. It occurs when an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can occur through the use of technology. Often, victims are not aware they are being exploited and so cannot protect themselves.

If you suspect a child is at risk or experiencing child sexual exploitation and so cannot protect themselves, call the police on 101 or 999 in an emergency or The Referral and Assessment Centre.

AGENCY	CONTACT INFORMATION
Practice Clinical Safeguarding Children Lead	Dr Monica Green 02476 228606 monica.green2@nhs.net
Adult & Children's Safeguarding Co-ordinator	Lynne O'Connor 02476 228606 lynne.oconnor2@nhs.net
Named GP for Safeguarding Coventry and Warwickshire	Dr Sarah Raistrick 07971452680 Email: sarahraistrick@nhs.net
Head of Safeguarding Warwickshire – Children's, Adults and LAC	Sharon Mikhael 07917 828 442 Email: sharon.mikhael@nhs.net
Designated Dr for Child Protection Coventry and Warwickshire	Jo Gifford 07880793249 Email: Joanne.Gifford@covwarpt.nhs.uk
Designated Dr for LAC	Anita Morgan Email: Anita.morgan@nhs.net
Police Child Protection Unit	Phone 101 ask for Public Protection
Police Domestic Violence Unit	Phone 101 ask for Public Protection
Referral and Assessment Team	Tel: 024 76788555
Designated Nurse for Child & Adult Coventry	Anne Marie Kennedy Email: annemarie.kennedy@nhs.net
Designated Dr for Child Death (Cov & Warks)	Hannah Fallon - hannh.fallon@covwarkpt.nhs.uk
Health Visitors Local Team	Tel: 02475 189 190 (single point of entry)

Safeguarding Children Council website	https://www.coventry.gov.uk/safeguardingchildren
Paediatric department for admissions (Discuss with senior paediatrician)	Consultant Paediatrician Tel:024 76964000 (out of hours)
Coventry Local Safeguarding Board Is now replaced by **Coventry Safeguarding Children's Partnership (CSCP)**	Email: CoventryCSCP@coventry.gov.uk Tel: 024 7697 5477 https://www.coventry.gov.uk/cscpcontacts
MASH (Multi Agency Safeguarding Hub)	Mash@coventry.gov.uk Tel: 024 7678 8555
NSPCC National Helpline (for adults who have a concern about a child)	Email: help@nspcc.org.uk Tel: 0808 800 5000 M-F 8-10, Weekends 9-6
Children's Social Care Referrals (Out of Hours)	Tel: 024 76832222
Whistle Blowing Advice Line	Tel: 0800 028 0285