WELLS HEALTH CENTRE

PROTOCOL FOR CHILD PROTECTION IN GENERAL PRACTICE

All staff within the practice need to have clear knowledge of how concerns should be passed on within the team, how specialist advice can be obtained and how and who should make referrals outside the practice.

RECOGNISING CHILD ABUSE

There are 4 main categories of child abuse:

- Physical abuse
- Sexual abuse
- Emotional abuse
- Neglect/failure to thrive

These are not however exclusive, and abuse in one of these areas may easily be accompanied by abuse in the others.

Physical abuse may include:

- Hitting, shaking, throwing, poisoning, burning or scalding, or other forms of physical harm
- Where a parent or carer deliberately causes ill-health of a child
- Single traumatic events or repeated incidents

Sexual abuse may include:

- Forcing or enticing a child under 18 to take part in sexual activities where the child is unaware of what is happening
- May include both physical contact acts and non—contact acts

Emotional abuse may include:

- Persistent ill-treatment which has an effect on emotional development
- Conveyance of a message of being un-loved, worthless or inadequate
- May instil feeling of danger, being afraid
- May involve child exploitation or corruption

Neglect may include:

- Failure to meet the child’s physical or psychological needs
- Failure to provide adequate food or shelter
- Failure to protect from physical harm
- Neglect of a child’s emotional needs
Common presentations and situations in which child abuse may be suspected include:

- Disclosure by a child or young person
- Physical signs and symptoms giving rise to suspicion of any category of abuse
- The history is inconsistent or changes.
- A delay in seeking medical help
- Extreme or worrying behaviour of a child, taking account of the developmental age of the child
- Accumulation of minor incidents giving rise to a level of concern, including frequent A&E attendances

Some other situations which need careful consideration are:

- Disclosure by an adult of abusive activities
- Girls under 16 presenting with pregnancy or sexually transmitted disease, especially those with learning difficulties
- Very young girls requesting contraception, especially emergency contraception
- Situations where parental mental health problems may impact on children
- Parental alcohol, drug or substance misuse which may impact on children
- Parents with learning difficulties
- Violence in the family

RECOGNISING A CHILD IN NEED

A child in need is defined as a child whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development without the provision of services (section 17, Childrens’ Act 1989).

- This includes disabled children.
- The Childrens’ Acts 1984 and 2004 define a child as someone who has not reached their 18th birthday.
- The fact that a child has reached their 16th birthday, and may be living independently, working, or be members of the armed forces does not remove their childhood status under the Acts.

Local authority social services departments working with other local authority departments and health services have a duty to safeguard and promote the welfare of children in their area who are in need. If you are considering making a referral to Social Services as a child in need, it is essential to discuss the referral with the child's parents or carers and to obtain consent for the sharing of information. Social Services will then follow local procedures to undertake an assessment of the child and their family.
CHILD PROTECTION REGISTER / PROTECTION PLAN

The guidance Working Together to Safeguard Children 2006 announced the replacement of the Child Protection Register with the ICS – Integrated Childrens’ System. From 1st April 2008, and more specifically this uses the mechanism of a Child Protection Plan. Every child on the register at the effective date will become the subject of a Plan.

- A list of children judged to be at continuing risk for whom there is a child protection plan in place, is maintained by social services.
- Social services, police and health professionals have 24 hour access to this.
- A child on the register has a “key worker” to whom reference can be made.

TRAINING

All staff will be trained in child protection at least once every 3 years, and within 6 months of induction. This will normally be via basic awareness course (minimum standard)

CONTACT NUMBERS

Child Protection contact names and numbers are available on the surgery intranet.

It is suggested that there are three levels of responsibility within the team. This means that those with the fullest training and experience carry the responsibility for making direct referrals.

Group 1: GPs, Health Visitors and Midwives

GENERAL PRACTITIONERS
- Dr. Helen Crawley is lead GP in Child Protection matters for the practice, with Dr. Alex Gundry being Deputy.
- GPs will familiarize themselves with the systems used in the practice for making child protection referrals.
- GPs will know how to access information and advice, and the referral pathways.
- It may be appropriate to check the notes of a child’s siblings, parents, and other household members and to consider adding computer alerts to their records.
- GPs should consider informing other clinicians and health care professionals as appropriate
- A clear written entry of any action taken will be made by the GP.
- GPs will ensure that the practice Health Visitors are aware of the child protection issues.
- All GPs and clinical staff should have an enhanced DBS check.
IF A GP SUSPECTS THAT A CHILD IS AT IMMEDIATE RISK:

- The GP should seek advice or make a referral.
- Advice may be sought on a 'what if?' basis, which avoids consent issues.
- Advice sought on a named patient basis should have appropriate consent unless there are good reasons why this cannot be obtained.
- Advice may be sought from Social Services. Out-of-hours advice may be sought from a senior hospital paediatrician.

Referral to Children’s Social Care

If concerns are not allayed the GP will need to make a referral to Children’s Social Care (and to a Paediatrician if acute medical treatment is required or to the Police if the child is in immediate risk of harm).

Best practice is to inform the parents/carers of your concerns and the next steps you plan to take unless to do so may put the child or yourself at risk.

Lack of consent to share information or to refer should not prevent you from taking appropriate action if you assess that the child is at risk of harm.
ATTENDENCE AT CHILD PROTECTION CONFERENCES

The GMC states that doctors must cooperate fully with child protection procedures, including attending case conferences, strategy meetings and reviews, and if attendance is not possible must try to provide relevant information about the child or young person and their family to the meeting.
Doctors do not need parental consent to submit a report for a Case Conference, but it is good practice to let the parents know you are doing this, (they will see it anyway), and to provide them with a copy of the report before the conference.

Please use the template ‘GPs report to child protection conference’

CONFIDENTIALITY

- Doctors have a duty of confidentiality, and patients have a right to expect that information given to a doctor in a professional context will not be shared without their permission.
- The GMC emphasises the importance in most circumstances of obtaining a patient's consent to disclosure of personal information.
- In general, if you decide to disclose confidential information without consent, you should be prepared to explain and justify your decision and you should only disclose as much information as is necessary for the purpose.
- The medical defence organisation will be consulted in all cases.

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

Disclosures to protect the patient or others

"Disclosure of personal information without consent may be justified where failure to do so may expose the patient or others to risk or death or serious harm. Where third parties are exposed to a risk so serious that it outweighs the patient's privacy interest, you should seek consent to disclosure where practicable. If it is not practicable, you should disclose information promptly to an appropriate person or authority. You should generally inform the patient before disclosing the information."

"Such circumstances may arise, for example:

Where a disclosure may assist in the prevention or detection of a serious crime. Serious crimes, in this context, will put someone at risk of death or serious harm, and will usually be crimes against the person such as abuse of children."

GENERAL

- All verbal referrals to Social Services must be followed up in writing by the referrer, giving full details, within 48 hours.
- All health care professionals must ensure that they keep a complete contemporaneous and accurate record of the nature of the injury, suspicion and all actions taken. Notes must be made as soon as possible, giving date, time and full legible signature.
Group 2: Practice Nurses, District Nurses, Counsellors and other PHCT members.

All professional health staff, however, will retain a professional responsibility to refer when they see a possible risk to a child and there may be circumstances in which they do make a referral and inform the Registered GP.

All clinical staff, (including doctors, nurses, health care assistants and chaperones), should have an enhanced DBS check.

Group 3: Administrative staff – will usually need to pass information to others.

All members of the team to record information as soon as possible after it is received or observed and this should be on the computerised patients medical record.

Please also refer to Child Protection Contacts Somerset list on the intranet

And the Somerset Safe Guarding Children Board and South West Child Protection Procedures
  • www.swcpp.org.uk
  • www.somersetsafeguardingchildrenboard.org.uk

Identification of children on the Child Protection Register

As notification is received by the practice a warning/alert message will be put on the child’s medical record and also on records of mother/father/carers and siblings. When dealing with administration please refer to these protocols on the intranet:

  • Child Protection Admin Protocol
  • Child Protection LMC Keeping Policy

Please ensure that any notification received is passed to Records Clerk who will set up the alert message and enter the appropriate read codes.

CHILD PROTECTION READ CODES
Social Services Case conference 3875
Subject to Child Protection Plan 13Iv
No Longer subject to Child Protection Plan 13Iw
Family member subject of child Protection Plan  13Iw
Family member no longer subject to Child Protection Plan 13Iz
Child in need 13IS
Child no longer in need 13IT
Identification of children on Family Support Group

Please follow the procedure as above for ensuring that any children supported within the Family Support Group are also noted with an alert message.

For Example: “On Family Support Group”

Identification of children on HV caseload for whom there are concerns.

The Health Visitors for any children for whom they have concerns will also use this alert.

For example: “On H/V caseload”

Alert messages should only be removed with great caution and only with the permission of a doctor or health visitor:

Recording information

Information is recorded in line with the Joint Somerset Local Medical Committee and Somerset CCG Policy for administration of Child Protection records in General Practice:

- Concerns and information about vulnerable children should be recorded in the child’s notes and where appropriate the notes of siblings, other children in the same household, and significant adults. These should be recorded using agreed Read codes. The GMC document ‘Protecting children and young people: The responsibilities of all doctors (2012)’ advises doctors to record minor concerns, as well as their decisions and the information given to parents/carers.
- Concerns and information from other agencies such as social care; education; the police, or from other members of the Primary Care Team, including health visitors and midwives, should be recorded in the notes under a Read code.
- Conversations with, and referrals to, outside agencies should be recorded under an appropriate Read code.
- The summary and action plan of Case Conference notes may be scanned in to electronic patient records, at Wells Health Centre case notes are kept in a separate file for each child. Refer to the Child Protection Admin Protocol.
- Records, storage and disposal must follow national guidance for example Records Management, NHS Code of Practice 2009.
- If information is about a member of staff this will be recorded securely in the staff personnel file and in line with your own jurisdiction guidance.

Other aspects which may be recorded are:

- Evidence of abuse
- Criminal offences
- A&E attendances
- Child Protection Plan
- Case Conferences
• Meetings
• Drug / substance abuse
• Mental Health issues
• Non-attendance at meetings or appointments
• Hostility or lack of cooperation
• Cumulative minor concerns

Where a child moves away or changes GP the practice will inform both social services and the health visitor within 5 working days.

Case Conference Minutes

Case conference notes together with letters from health care professionals will be securely filed until which time the child is either removed from the register or leaves the practice. Refer to the Child Protection Admin Protocol on the intranet.

Information flow regarding newly registered children between the practice and health visitors / school nurses.

A Search for all new child registrations will be run weekly. The health visitor will be informed of all registrations of children under 5, including temporary registrations. The School nurse will be informed of all registrations of children of school age.

The health visitor or school nurse will make contact and if appropriate make face to face contact to assess the physical and emotional needs of the child and refer back to the GP if necessary.

Removing a Child from the Child Protection Register.

The Somerset Patient Services notify in writing when a child is removed from the Register. At this stage the Read code 13I0 (child removed from child protection register) should be entered via the template and the alert box deleted. All EMIS documentation relating to child protection should be removed from family records.

Data Protection

• Current guidance suggests that written records relating to child protection issues should be stored as part of the child’s permanent medical records, either manually or on computer, or both. This is 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 CCG.
• 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.
Reference Documents and Resources

- Working Together to Safeguard children. Department of Health (2006) [http://www.dh.gov.uk\assettRoot\04\07\58\24\04075824.pdf](http://www.dh.gov.uk\assettRoot\04\07\58\24\04075824.pdf)

- Confidentiality: Protecting and Providing Information. GMC (Sep 2000) [www.gmc.uk.org\guidance\library\confidentiality.asp](www.gmc.uk.org\guidance\library\confidentiality.asp)

- Recommendations for Administration of child protection records in General Practice. LMC/CCG (February 2013)

- Children Act 2004 Section 11

- Your Surgery, safeguarding children and young people in General Practice. Somerset CCG (February 2014).

- SW safeguarding [www.swcpp.org.uk](www.swcpp.org.uk)

- Somerset LSCB [www.somersetsafeguardingchildrenboard.org.uk](www.somersetsafeguardingchildrenboard.org.uk)

- Safeguarding Children – information sharing guidance for GPs. Somerset LMC (March 2014)

Last updated July 2016
Last reviewed July 2016