

Child Protection Pack

September 2009

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CHILD SAFEGUARDING AND PROTECTION FOR GENERAL PRACTICE

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Introduction

“Everybody shares some responsibility for promoting the welfare of children, as a parent or family member or volunteer. Members of the community can help safeguard children if they are mindful of children’s needs, and willing and able to act if they have concerns about a child’s welfare.”

Working Together to Safeguard Children

Safeguarding and promoting the welfare of children encompasses:-

- protecting children from maltreatment
- preventing impairment of children’s health or development
- ensuring children grow up in safe environments with good provision of care
- undertaking this role in order to enable children to have optimum life options

Child safeguarding in terms of child protection is a highly emotive subject which invokes strong feelings. However, all those working in health have a professional responsibility to safeguard and protect children. This guide has been prepared to provide advice to primary care professionals on child safeguarding and protection issues in line with current recommendations.

Roles of general practitioners and the primary healthcare team

The roles of GPs and other primary healthcare staff are described in *Working Together to Safeguard Children*.

General practitioners, other members of the primary healthcare team and practice-employed staff have key roles to play in the identification of children who may have been abused and of those who are at risk of abuse, and in subsequent intervention and protection. Surgery consultations, home visits, treatment room sessions, child health clinic attendance, drop-in centres and information from staff such as health visitors, midwives, school nurses and practice nurses may all help to build up a picture of the child’s situation, and can alert the team if there is some concern.

All primary healthcare team members and practice-employed staff should know when it is appropriate to refer a child to children’s social care for help as a “child in need”, and know how to act on concerns that a child may be at risk of significant harm through abuse or neglect. In addition, the child’s GP should be informed at the earliest opportunity, if he or she is not making the referral.

The GP, practice-employed staff and the primary healthcare team are also well placed to recognise when a parent or other adult has problems that may affect their capacity as a parent or carer, or that may mean they pose a risk of harm to a child. While GPs have responsibilities to all their patients, children may be particularly vulnerable and their welfare is paramount. If the primary healthcare team has concerns that an adult’s illness or behaviour may be causing, or putting a child at risk of, significant harm, they should follow the procedures set out in Chapter 5 of this guidance.

Because of their knowledge of children and families, GPs, together with other practice staff and primary healthcare team members, have an important role in all stages of child protection processes. This includes appropriate information sharing (subject to normal confidentiality requirements) with children’s social care when enquiries are being made about a child, contributing to assessments, and

involvement in a child protection plan to protect a child from harm. GPs, practice staff and other primary healthcare team practitioners should make available to child protection conferences relevant information about a child and family, whether or not they – or a member of the primary healthcare team – are able to attend.

All GPs have a duty to maintain their skills in the recognition of abuse, and to be familiar with the procedures to be followed if abuse is suspected. GPs should take part in training about safeguarding and promoting the welfare of children, and should have regular updates as part of their postgraduate educational programme. As employers, they should ensure that practice nurses, practice managers, receptionists and any other staff whom they employ are given the opportunity to attend local courses in safeguarding and promoting the welfare of children, or ensure that safeguarding training is provided within the team.

Primary healthcare teams should have a clear means of identifying, in records, those children (together with their parents and siblings) who are the subject of a child protection plan. This enables the children to be recognised by the partners of the practice, and by any other doctor, practice nurse or health visitor who may be involved in their care. There should be good communication between GPs, health visitors, school nurses, practice nurses and midwives in respect of all children about whom there are concerns.

Policy and Procedure

All practices have a duty of care for children and young people to whom they provide care and services. Hence all should have policy and procedures with regard to child safeguarding and protection.

General practices have a duty of care to protect the children under their care and should be committed to implementing a safeguarding policy which should be available to all staff members, along with a commitment to training and review of procedures at regular intervals.

General practices should appoint a Lead Practitioner with respect to safeguarding children, who is responsible for practice policy regarding safeguarding and protection issues and ensures the practice meets contractual and clinical governance guidance, along with responsibility for training needs of staff members.

This guidance will be updated on a regular basis in line with local and national changes in policy, and published on the NHS Lincolnshire website (www.lpct.nhs.uk) and the Lincolnshire Safeguarding Children Board website (www.lincolnshire.gov.uk/lscb).

I hope that you find this guidance helpful, and would welcome your feedback and comments.

Dr Vindi Bhandal
Named Doctor for Child Safeguarding and Protection

September 2009

DIRECTORY OF CHILD SAFEGUARDING PROFESSIONALS

Designated Doctor for Safeguarding Children (Countywide)	Dr Margaret Crawford	01205 364801
Named Doctor for Safeguarding Children	Dr Vindi Bhandal	01529 303301 s.bhandal@lpct.nhs.uk
Consultant in Public Health Medicine	Dr Robert Wilson	01522 515317 Robert.wilson@lpct.nhs.uk
Acting Designated Nurse Safeguarding Children & Adults	Jan Gunter	01529 416090

All named nurses in child protection are employed by Lincolnshire Community Health Services but are co-located with staff from Lincolnshire County Council.

Named Nurse Safeguarding Children – Lincolnshire Community Health Services (Countywide)

Joy Gilbert
Bridge House
The Point
Sleaford
Lincolnshire
NG34 8GG
Tel: 01529 220387
Mobile: 07879 630651
Email: joy.gilbert@lpct.nhs.uk

Deputy Named Nurse Safeguarding Children - North Kesteven

Paula Moody
Lincolnshire County Council
Orchard House
Orchard Street
Lincoln
LN1 1BA
Tel: 01522 554159
Mobile: 07789 948940
Email: paula.moody@lpct.nhs.uk

Deputy Named Nurse Safeguarding Children - West Lindsey

Beverley Kitchen
Lincolnshire County Council Childrens Services Area Office
156 Trinity Street, Gainsborough
DN21 1JP
Tel: 01427 615331
Mobile: 07879 630627
Email: beverley.kitchen@lpct.nhs.uk

Deputy Named Nurse Safeguarding Children - East Lindsey except Skegness/Spilsby and Coastal Area

Debbie Boulton
Lincolnshire County Council
Holmeleigh House
Foundry Street
Horncastle
LN9 6AQ
Tel: 01522 554621
Mobile: 07785 722953
Email: Debbie.boulton@lpct.nhs.uk

Deputy Named Nurse Safeguarding Children - Boston Borough plus Skegness/Spilsby/coastal area

Ali Balderstone
Lincolnshire County Council
County Hall
Boston
PE21 6DY
Tel: 01522 554850
Mobile: 07900 681430
Email: ali.balderstone@lpct.nhs.uk

Deputy Named Nurse Safeguarding - South Holland plus Bourne, The Deepings and Corby Glen

Vacant post
Lincolnshire County Council
The Vista, Churchgate
Spalding
PE11 2RA
Tel: 01522 555906
Mobile: 07768 658131
Email: Eileen.marshall@lpct.nhs.uk

Deputy Named Nurse Safeguarding Children - South Kesteven except Bourne, The Deepings and Corby Glen

Christine Edwards
Lincolnshire County Council
46 Union Street
Grantham
NG31 6NZ
Tel: 01522 554362
Mobile: 07717 851728
Email: Christine.edwards@lpct.nhs.uk

USEFUL CONTACT NUMBERS

If you are concerned about a child, you can contact your local Police or Childrens Services office on these numbers:

Lincolnshire Childrens Services

Customer Services Centre

All referrals must come through this number: 01522 782111

Out of hours: Emergency Duty Team: 01522 782333

Child Protection Register/Integrated Children's System enquiries

Telephone: 01522 554061

Out of hours: 01522 782333

Lincolnshire Police

Telephone 01522 805775

or the Divisional Special Investigation Unit on:-

Lincoln 01522 885316/7

Gainsborough 01427 816316/7

Sleaford 01529 302420 ext 3873

Grantham 01476 403316/7

Spalding 01775 722233 ext 2655/6

Boston 01205 312241/2

Skegness 01754 764316/7.

DEFINITION OF CHILD ABUSE

Recognising child abuse is not easy and is not solely our responsibility. It is our responsibility to act if we have concerns. Abuse and neglect are forms of maltreatment of children.

Children with a Child Protection Plan are registered under one or more of the following categories of child abuse:

a) **Physical Abuse**

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

b) **Sexual Abuse**

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (eg rape, buggery or oral sex) or non-penetrative acts. They may include con-contact activities, such as involving children in looking at, or in the production of, sexual online images, watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

c) **Emotional Abuse**

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying, causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, although it may occur alone.

d) **Neglect**

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- Provide adequate food, clothing and shelter (including exclusion from home or abandonment)
- Protect a child from physical and emotional harm or danger
- Ensure adequate supervision (including the use of inadequate care-givers)
- Ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

The National Institute for Health and Clinical Excellence (NICE) have recently published a clinical guideline, *When to Suspect Child Maltreatment*.

CHILD SAFEGUARDING RESPONSIBILITIES

NHS Lincolnshire has a strong commitment to safeguarding and protecting children and employs the designated and named professionals to:

1. Provide advice and support to staff employed by NHS Lincolnshire, in relation to child protection issues
2. Ensure that there are internal procedures for safeguarding children
3. Provide child protection training for health professionals employed by NHS Lincolnshire, and to independent contractors and their staff
4. Work with other agencies to develop child protection issues
5. Ensure that there is a system of child protection audit which monitors the agreed child protection standard
6. Provision of clinical supervision for health professionals employed by NHS Lincolnshire
7. Establish effective communication pathways with the Lincolnshire Safeguarding Children Board
8. Provide appropriate professional advice about safeguarding and protecting children in wider context in planning of child health strategies
9. Raise awareness amongst PCT board, managers and practitioners of the responsibility and accountability for safeguarding and protecting children

For advice about child protection issues, or individual children, please contact Dr Vindi Bhandal on 01529 303301.

GP – Roles and Responsibilities

In relation to child protection, all general practitioners should be able to offer the following (from *Working Together*)

- ❖ **Recognising** children in need of support and/or safeguarding, and parents who may need extra help in bringing about a child and family
- ❖ **Contributing to enquiries** about a child and family
- ❖ **Assessing the needs of children** and the capacity of parents to meet the children's needs
- ❖ **Planning and providing** support to vulnerable children and families
- ❖ **Participating** in child protection conferences
- ❖ **Planning support** for children at risk of significant harm
- ❖ Providing **therapeutic help** to abused children and parents under stress (e.g. mental illness)
- ❖ Playing a part, through **the child protection plan**, in safeguarding children from harm
- ❖ **Contributing to case reviews**
- ❖ Know about **local child protection procedures** in keeping with their status and role in the protection of children from abuse or neglect, supported by training in child protection
- ❖ Have in place **robust systems** within the practice for identifying and following the progress of a child on the child protection register, and to be able to recognise the siblings and household members of that child.
- ❖ **Identify concerns** regarding both children in need and parent's ability to meet these needs
- ❖ All employers should ensure that relevant staff have **Criminal Records Bureau** checks prior to employment if their job entails contact with children

CHILD SAFEGUARDING AND PROTECTION PROCESS

- ❖ RECOGNITION - identification/suspicion of child at risk, of abuse or neglect.
- ❖ REPORTING - report/discussion with Childrens Services/Police/child protection agencies, whereby concerns regarding child/family become public (represents difficult threshold for practitioners).
- ❖ INQUIRY & ASSESSMENT - concerns/allegations explored, multi-agency with information gathering.
- ❖ INTERVENTION - supportive in order for child development.

DIFFICULT ISSUES FOR HEALTH PROFESSIONALS IN CHILD PROTECTION

- ❖ Confidentiality
- ❖ Sharing information – parents/carers upon referral to Childrens Services.
- ❖ Damage to doctor/patient relationship, causing family disruption
- ❖ Dealing with other agencies (Police/Social Care/Education)
- ❖ Being mistaken and repercussions (family/media/profession)
- ❖ Time

HOW TO DEAL WITH CHILD PROTECTION CONFIDENTLY

- ❖ Be familiar with local child safeguarding and protection procedures
- ❖ Share concerns with colleagues, and use shared documentation
- ❖ Attend child safeguarding and protection training

WHAT SHOULD YOU DO

- 1 Take a careful history
- 2 Enquire about home circumstances and other children
- 3 Do a full physical examination – Height, weight, signs of abuse
- 4 Look at past medical history of child e.g. A & E attendances
- 5 May need to look at parents/siblings notes
- 6 Discuss case with other professionals who may know child
- 7 Check if child is subject to a Child Protection Plan or is on the Integrated Children's System
- 8 Record findings and concerns and whom you have contacted
- 9 Follow practice child protection procedures which should be readily available

- 10 May need to contact named nurse or named doctor for child protection for advice
- 11 **Contact the Customer Services Centre if you feel this is a child protection issue. – Follow up a telephone referral with written referral within 24 hours – using the CAF form. You should receive confirmation of your referral within 1 to 3 days – if you do not, then please contact them again**
- 12 You can refer directly to Lincolnshire Police – especially if you feel emergency action may be required to protect the child.

Common Assessment Framework form CAF (Appendix 1)

(please read in conjunction with the advice on information sharing on page 12 of this pack)

Has specific sections –

First page – essentially information regarding patient – reason for referral

Subsequent pages collect information regarding

- Other agency involvement
- Child needs
- Parenting capacity
- Family and environmental factors
- Analysis of need/views of assessment
- Consent details – aim to get consent from child/ carer if not obtained explain reason why not
- Senders details

Use CAF form as referral form - fill in as much as you can – as minimum complete details of patient and reason for referral. The CAF form should follow a verbal referral within 24 hours of that referral.

CAF RESPONSE FORM (Appendix 2)

The response form is used to document the outcome of a CAF referral. It should be returned within 5 days of CAF referral form. **If it is not returned, you should contact the Customer Services Centre to chase up the referral.**

CHILD SAFEGUARDING RECORDS

ACCURATE up to date records are never more vital than in child protection.

Inquiries into deaths or serious injury have in the past highlighted poor record keeping as a factor in situations where a child has been harmed.

Records constitute:

- ❖ A contract between practitioner and family
- ❖ A rationale for care
- ❖ An accurate reflection of practice (practice should also reflect the records)
- ❖ A focus point for standard setting, quality assessment and audit
- ❖ A baseline against which to measure progress or deterioration
- ❖ An indication of the way forward.

RECORD KEEPING

Information contained:

- ❖ Assists you with completing the CAF form contributing to the assessments with partner agencies
- ❖ Is crucial to procedures to protect
- ❖ Forms basis for your contribution to child protection conferences
- ❖ Forms basis for your evidence in court.

The records themselves may be subpoenaed by the court

Record Keeping should be:

Accurate
Indelible and in black ink
Unambiguous – distinguishing between fact and fiction
Maintained in chronological order
Completed within 24 hours of contact/incident
Altered only within professional guidelines
Signed – not initialled. Your first signature must have your name and title printed alongside it.
Dated and timed
Confidential.

Specific aspects on note keeping

Information about vulnerable children should be recorded in the child's notes and where appropriate, the siblings and significant adults. It should be recorded using locally agreed READ codes [Appendix 3].

Information supplied by any member of the primary health care team should be recorded in the notes.

Communications with and referrals to outside agencies should be recorded under appropriate READ codes.

Child protection conference notes and other documents related to safeguarding should be scanned into the notes of all children and adults under READ code 64c.

A paper copy should be kept with the records of all those named in the conference report.

Records, storage and disposal must follow National Guidance [Records Management, NHS Code of Practice 2006].

Practitioners must also comply to their regulatory body guidance, eg General Medical Council – Good Medical Practice [2006].

INFORMATION SHARING

INTRODUCTION

The Guidance for the Assessment Framework for Children in Need and their families is clear about:

- ❖ the importance of working in partnership with the child, family and all agencies
- ❖ the need to involve parents/carers in decisions/discussions about sharing information between agencies.

This message is reinforced in *Working Together to Safeguard Children*, and reflects both:

- ❖ legal requirements under the Data Protection and Human Rights Acts; and
- ❖ good practice, aiming to involve and empower families in assessments of, and decision making about, their own children.

LEGAL CONSIDERATIONS

The **Data Protection Act 1998** has particular safeguards in respect of “sensitive data” which includes the (alleged) commission of any criminal offence, and any information about his or her ‘sexual life’ or physical or mental health or condition.

Such information can be disclosed without the consent of the individual where it is necessary to safeguard the welfare of the child. This is because the act allows information to be processed if it is necessary for the exercise of Children Act functions, e.g. an investigation under Section 47.

Overlaying this is the **Human Rights Act 1998** and, in particular, Article 8, which requires all public authorities to have respect for an individuals (both children and adults) private and family life. Interference with that right can be justified provided it is “in accordance with the law and is necessary in a democratic society for the protection of health or morals, or for the protection of the rights and freedoms of others”. However, any action that is taken must be proportional to the identified legitimate aim. **This means that only so much information as is necessary to safeguard the child(ren)s welfare should be disclosed.**

Children over 16, and those considered “Fraser competent” are able to consent to or refuse information being shared themselves.

PRACTICE ISSUES

Sharing of personal information is a delicate and sensitive subject, particularly in the area of Child Protection work. Professionals from all agencies need guidelines on when it is (and is not) appropriate to share information, and when to do so despite the absence of parental consent.

All agencies should **aim to be open and honest with families** about the professional assessment and analysis of their child's situation. For the majority of families this open approach will be an important strategy in helping the family take control of the situation and, with support services, effect whatever changes are necessary to meet their child's needs.

Involving young people, parents and carers in decisions about **which agencies** need to be involved, and **what information should be shared with whom**, will help empower families, and promote anti discriminatory practice.

As a general principle the consent of the parent(s) should always be sought. However, in certain circumstances it may be inappropriate to seek the consent of the parent(s) to obtain such information, particularly if it would prejudice a criminal investigation or place the child(ren) at further risk of harm.

INFORMATION SHARING PROCESS

All professionals should be clear about:-

- ❖ Is the enquiry part of a Section 47 investigation?
- ❖ Are there sufficient concerns to approach the agency and for that agency to agree to share information without the parent/carers knowledge?
- ❖ Why is information needed from another agency?
- ❖ Is the information sought the minimum necessary to achieve the aim?
- ❖ Could the child be at risk of continuing significant harm if agencies do not share information?

If agencies are clear that information sharing is necessary to prevent criminal activity, or that the circumstances of the child warrant sharing of information prior to engagement with the family, then the reasons for these decisions should be recorded, giving clear explanations as to why this action was felt necessary.

In the majority of cases where a referral has been made to Childrens Services, particularly requesting services under Section 17 of the Children Act, the **Social Worker will aim to contact the family before other agencies**, and clarify what the family's perception of the referral is. The only check, which will continue to be done first routinely, will be to check whether the child is the subject of a Child Protection Plan.

The worker will then need to agree with the family what additional information, and from what agencies, will be required to help complete the Initial Assessment, and/or request appropriate resources to meet the child's needs.

The worker will need to carefully analyse the child's situation and make an informed decision about whether:-

- ❖ Information from other agencies is needed, and should be sought whether or not the family agree

- ❖ The refusal to consent heightens concerns sufficiently to warrant an investigation under Section 47
- ❖ Information is not needed, e.g. the referral was malicious, or the perceived need does not meet eligibility criteria, or the family agrees to a referral to another agency e.g. Homestart
- ❖ The child is a child in need, but there are no suggestions that any abuse or criminal activity has taken place, and the family wish to address the issues with Childrens Services and do not believe other agencies can play a role.

CONFIDENTIALITY

“It is a question of balance and proportionality”.

The General Medical Council states:

If you believe a patient to be a victim of neglect, physical or sexual abuse and unable to give or withhold consent to disclosure, you should usually give this information to an appropriate responsible person / statutory agency in order to further prevent harm to the patient. In these and similar circumstances you may release information without the patients consent, but only if you consider that the patient is unable to give consent and the disclosure is in the patients best medical interests.

Disclosure may be necessary in the “public interest” where a failure to disclose information may expose the patient or others to risk of death or serious harm. In such circumstances you should disclose the information promptly to the authority requesting. The GMC confirms that disclosure of information which may assist in the prevention or detection of abuse applies to information regarding third parties.

General practitioners have a statutory duty to share information if there are concerns about child safety or welfare². The Data Protection Act 1998 allows GPs to share confidential information without consent if one of the following conditions applies:-

1. if there is a statutory obligation
2. if the court orders it
3. if the child's or public interest overrides that of the individual.

Information Requests

When requests for information about a child or family are made staff should:-

1. **Check identity** of enquirer – get switchboard to take a number and call enquirer back or ask for written /faxed request on headed notepaper
2. **Pose of inquiry** - ask regarding the nature of the inquiry
3. **Consent** - is it a situation of immediate child protection in which case you should not delay to seek consent. If it is not then wait for informed consent of child/parent [GMC 2007 0-18YRS Guidance for all Doctors]
4. **Need to know basis** - give information on a need to know basis only to those who need it
5. **Proportionality** - give just enough information for the purpose of the enquiry
6. **Keep a record** of -
 - details of information sharing
 - identity of person information shared with
 - reason for sharing information
 - whether consent obtained and if not why not.

REFERRALS TO CHILDRENS SERVICES WHERE THERE ARE CHILD WELFARE CONCERNS

If somebody believes that a child may be suffering, or may be at risk of suffering, significant harm then s/he should always refer his or her concerns to Childrens Services and/or the Police.

To avoid any confusion, where the referral relates to a child living or found in Lincolnshire, however temporarily, the primary responsibility for any further action lies with Lincolnshire Childrens Services and Lincolnshire Police. Liaison should take place with the "home" authority but Lincolnshire will retain responsibility unless the "home" authority agrees to take the lead.

It is good practice for professionals to discuss any concerns they have with the family and, where possible, to seek the family's agreement to making a referral to Childrens Services. However there are exceptional circumstances where such discussion and agreement-seeking would place the child at increased risk of significant harm. In these circumstances it can be appropriate to refer without discussion or agreement from the family although the source of referral will subsequently be disclosed to the family by Childrens Services. In cases where a professional is acting in good faith in passing on third party information it may not be appropriate for Childrens Services to reveal the source of the referral.

Other factors relevant to the decision whether to refer without prior discussion with the family include:

- issues of staff safety
- the risk of destroying evidence
- the likelihood of children or other family members being intimidated
- the possibility of an increased risk of domestic violence
- the possibility of the family moving to avoid professional scrutiny.

When a parent, professional or other person contacts Childrens Services with concerns about a child's welfare, it is the responsibility of Childrens Services to clarify with the referrer:

- the nature of the concerns
- how and why they have arisen
- what appear to be the needs of the child and family, including any special needs arising from cultural, physical, psychological, medical or other factors
- whether the identity of the referrer can be shared with the family – in the case of professional referrals the assumption is that the family will be told where the referral has come from
- if known, what other agencies and professionals are involved with the child and family.

This process should always identify clearly whether there are concerns about abuse or neglect, what is their foundation and whether the child/ren may need urgent action to make them safe from harm.

At the end of any discussion about a child, both the referrer and Childrens Services should be clear about who will be taking what action, or that no further action will be taken. The decision will be recorded by Childrens Services on the agreed referral form and by the referrer if a professional in another service.

All staff making a referral by phone should confirm the referral in writing within 24 working hours, repeating all relevant information and agreed actions.

Whenever Childrens Services receive a referral which may constitute a criminal offence against a child, they must inform Lincolnshire Police at the earliest possible opportunity.

See Flow chart 1: Referral and Flow chart 3: Urgent action to safeguard children on pages 24 and 26 as per *Working Together to Safeguard Children*.

NB: All flow charts from *Working Together to Safeguard Children* have been included for information.

MAKING A REFERRAL

INFORMATION REQUIRED WHEN MAKING A REFERRAL

When making a referral it is important that you have accurate information available and have thought through your concerns

However, the lack of availability of some of the information below is not reason to delay the referral

Factual Information

- Names and dates of birth/ages of family members
- Ethnicity
- Home address
- Names of those who hold parental responsibility
- State your involvement
- Is the child/family aware that you are making this referral?
- Is it something you have seen?
- Is it based on the concern of another, if so, whom?
- Is it based on the child's behaviour, an injury, what the child has said?
- Has this concern developed over time or just today?
- What evidence do you have to support your concern? This may include what the child has said to you directly. If so, are you aware if the child has also spoken to anyone else?
- Whom do you believe to be the source of harm/potential harm to the child?
- Are there other children in the family or other children about whom you have concerns?
- In your opinion does the child need immediate protection?

Referrer's connection to Family

Source and nature of concerns

MAKING A REFERRAL

Procedures for
making a Referral

If somebody believes that a child may be suffering, or may be at risk of suffering, significant harm she/he should always refer his or her concern to the relevant Social Services. In addition the Police and NSPCC have powers to intervene in these circumstances

References
CHILDREN ACT
1989 Section 47

Sometimes concerns will arise within Childrens Services as new information comes to light about a child and family with whom the service is already in contact

While professionals should seek, in general, to discuss any concerns with the family and, where possible, seek their agreement to making referrals to Childrens Services, **this should only be done where such discussion and agreement seeking will not place a child at increased risk of significant harm**

All referrals, whether on new or closed cases, should be the subject of discussion with the Initial Assessment Team

References
Agency Addresses

The Initial Assessment Team Manager will decide, before beginning the formal inquiry, on the need for consultation with the police to determine whether a joint assessment and investigation is required

Referrals outside normal office hours should be made to the Emergency Duty Team who will take action when an emergency response is required and record the information

MAKING A REFERRAL

These procedures refer to the making of referrals about child welfare concerns.

Consultation Process

Everybody who works with children, parents, and other adults in contact with children should be able to recognise, and know how to act upon, indicators that a child's welfare or safety may be at risk. Professionals, foster carers, staff members and managers should be mindful always of the welfare and safety of children, including unborn children and older children in their work

Anyone who has concerns about a child but is unclear about whether a referral is appropriate should discuss their concerns promptly with a senior colleague or staff member with a responsibility for Child Safeguarding and Protection

If there is any doubt, there should be consultation with the Initial Assessment Team, which covers the area in which the child lives

The Duty Officer will ensure that the case is considered by the Team Manager or Senior Social Worker and advice given as to whether other actions could be taken or whether a referral should in fact be made.

Standard:

Concerns that a child might be at risk of significant harm should always lead to CONSULTATION

MAKING A REFERRAL

Establish action that will be taken

The referrer and Childrens Services should be clear about the next course of action that will be taken. The discussion should be clearly recorded by both parties

Follow-up Actions

Ensure that senior staff in your Agency are informed that a referral has been made, if not already aware, and that any other procedures of your Agency are followed

Forward the referral and any other recording (in writing) within 24 hours

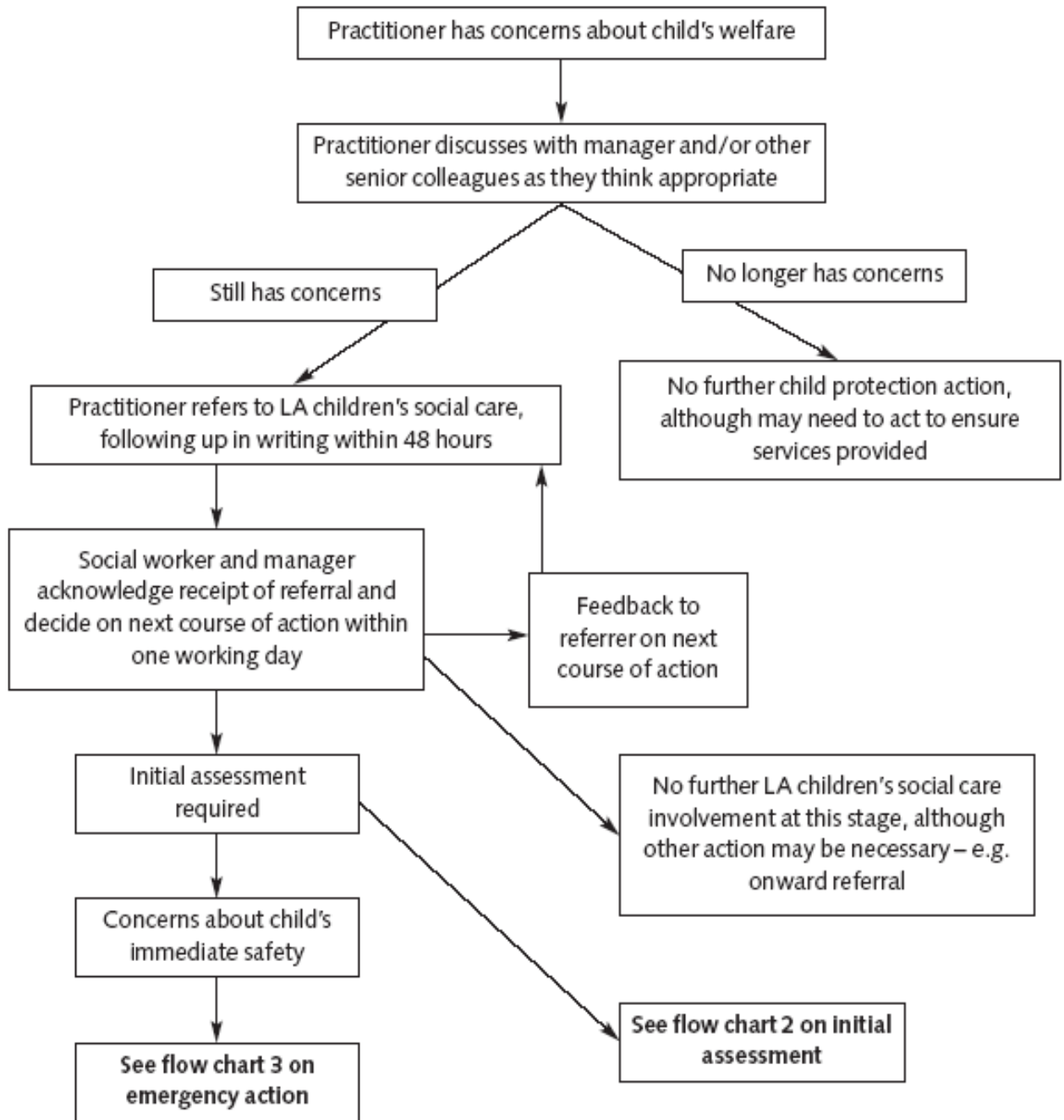
Be prepared to attend a strategy meeting if required

Standards:

Referrals should be made without undue delay

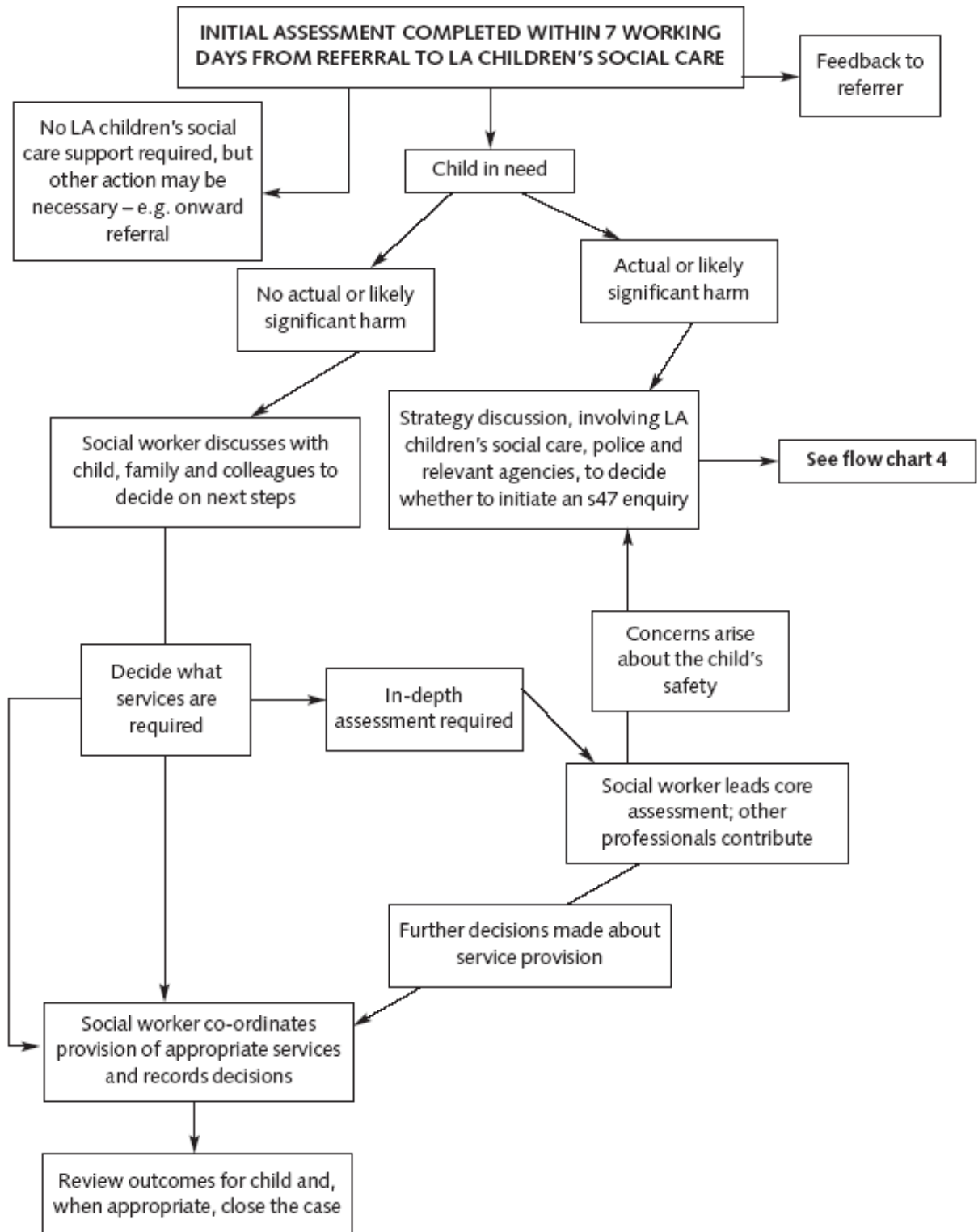
Referrals should be followed up in writing within 24 hours

Flow chart 1: Referral



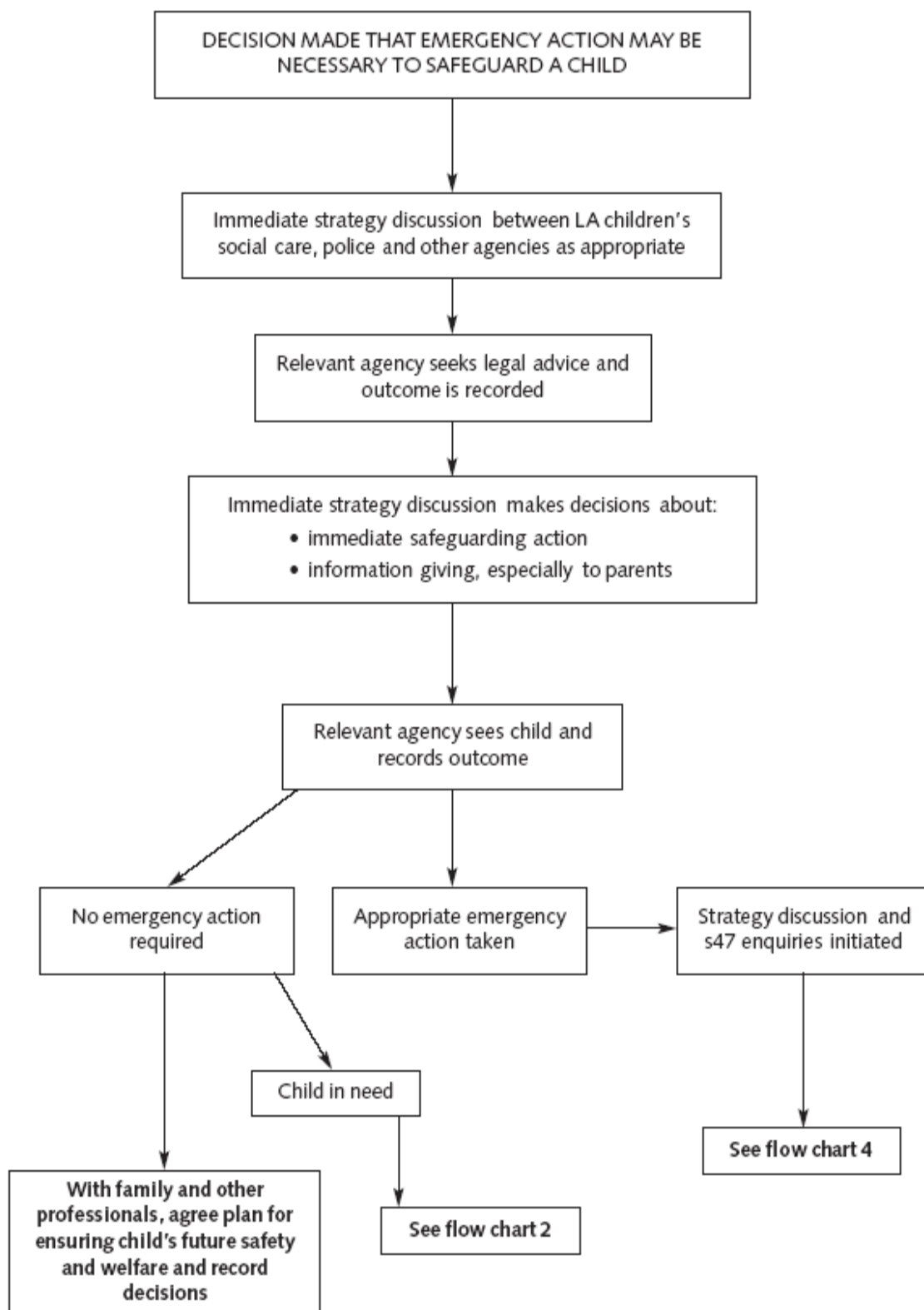
Working Together to Safeguard Children

Flow chart 2: What happens following initial assessment?



Working Together to Safeguard Children

Flow chart 3: Urgent action to safeguard children



Working Together to Safeguard Children

CHILD PROTECTION PATHWAY

Knowledge of an allegation or suspicion of child abuse confers a responsibility on the part of any worker whatever their role to ensure concerns are referred to one of the statutory agencies: Police or Childrens Services

Where a child welfare concern is identified, a careful holistic assessment of all findings should be undertaken using the Framework for the Assessment of Children in Need and their families

If a child welfare concern exists, practitioners may seek further advice from supervisor/manager or named nurse / doctor

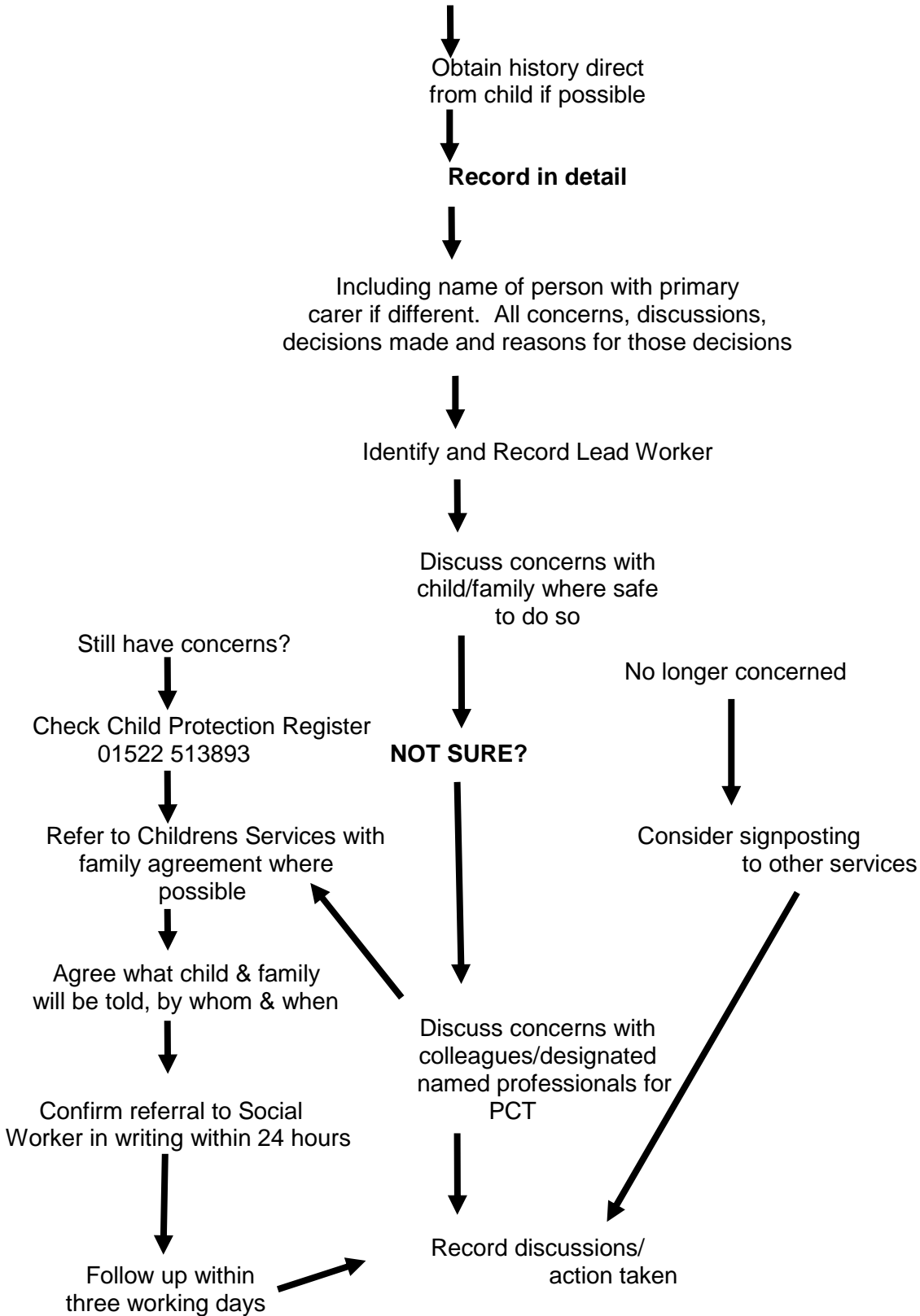
General Practitioners can also seek additional advice from the **On Call Paediatrician** at Lincoln County Hospital 01522 512512 or Pilgrim Hospital 01205 364801

Instigate appropriate action to ensure immediate safety of child if at immediate risk of harm

Consideration should be given as to whether to interrogate the
Integrated Children's System/Child Protection Register 01522 513793
Out of Hours – Emergency Duty Team 01522 782333
Lincolnshire Police 01522 882222

Concerns Re Fabricated or Induced Illness	Sexual Abuse	Physical Abuse, Neglect & Emotional Abuse	Uncertain Unproven Cases Where Concern Exists
<p>Document in Child's record</p> <p>Discuss concerns with named/designated nurse/doctor and agree further actions in accordance with Child Protection Practice Guidance</p>	<p>All children under the age of 16 who are suspected of having a sexual relationship with an adult should be seen as a possible victim of exploitation</p> <p>Do not make gender based assumptions about the nature of a sexual relationship between adult women and boys when assessing a relationship</p> <p>Do not question the alleged victim other than to ascertain the key facts</p> <p>Ensure the young person knows that you are taking the matter seriously and do not make promises you cannot keep</p>	<p>The investigation and management of a case of possible deliberate harm to a child must be approached in the same systematic and rigorous manner as would be appropriate to the investigation and management of any other potentially fatal disease</p> <p>Babies presenting with an injury should be viewed with a high index of concern and referred to Childrens Services for investigation</p> <p>When a child presents with unusual/bizarre marks or bruising, for which there is no adequate or satisfactory explanation, then advice of named or designated professionals should be sought</p> <p>Seek parent's permission before discussing a referral about them with other agencies, unless permission seeking increases risk of harm/staff safety/contamination of evidence/domestic violence/intimidation of witnesses/ absconding</p>	<p>Discuss with other health professionals or manager</p> <p>The Duty Social Worker available for consultation</p> <p>Decide upon subsequent action to ensure best outcomes for child</p> <p>The views of a child or young person should be elicited dependant on age and understanding, particularly when there is family disharmony</p>

CHILD WELFARE CONCERNS



CASE REVIEWS

CASE CONFERENCES

- Called as a result of query if a child considered at risk
- Aim is to achieve a consensus behind decisions reached
- Decisions are whether to put in place a Child Protection Plan
- If consensus not achieved case can be referred to Case Monitoring Group for input
- Involved professionals/agencies invited to case conference. If you are directly involved you should either attend or should submit an informative report on the case.

Issues for GP

- Time
- Place
- Accepting that they have an important role in safeguarding if unable to attend the case conference, GPs must send written report with relevant information, fulfilling responsibility of sharing information at case conferences – allowing chair at case conference to use information in deciding whether to put child on Child Protection Register or not.

SERIOUS CASE REVIEWS

Serious Case Reviews may be held when a child has died or suffered significant harm.

The purpose of a Serious Case Review (also known as Part 8 reviews) is to establish whether there are any lessons to be learned about the way in which local professionals and agencies work together to safeguard a child, and having identified clearly what these lessons are, to recommend changes as a result, to improve interagency working to better safeguard children in future. There is always at least one NHS staff member on the review panel.

Where it has been decided to hold a serious case review the lead public health professional will write to GPs seeking copies of the relevant casenotes (Appendix 3). A chronology of these casenotes will then be prepared for the panel by the named doctor for child protection. An executive summary of the panel report is published but no professional staff are identified within these reports.

TRAINING

All members of staff should complete in house training/basic awareness training in relation to child protection.

Record of training for staff documented – re appraisal/personal development.

Each practice's Lead Professional should attend multi-agency training provided by LSCB, at least every three years.

Practice staff meetings should be held at least once a year to update on safeguarding of children eg review of policy and procedures, ensure that all staff members aware of policy and procedures, and to provide an opportunity for training [in-house/other].

Training Options

Local

- Practices who wish further training in Child Protection issues can contact the Named Doctor/Named Nurses to access specific training courses. The Named Doctor and Named Nurses may be able to come out to practices to provide training regarding Child Protection issues on behalf of the PCT
- LSCB provision of multi-agency training in child safeguarding
- E-learning module available to all staff via the NHS Lincolnshire website link: <http://elearning.xlincs.nhs.uk/eLearning/courses.htm>

Practices who require training in child protection can contact named doctor or nurses directly OR register their request for training at NHS Lincolnshire by contacting 01522 515317.

National

- NSPCC - ALSG Safeguarding Children
- RCGP Safeguarding Children and Young People in General Practice-Training Modules 2007
- BMJ web learning modules
- Doctors.net

Suggested Training Schedules for Healthcare Workers

Staff	Level	Mode	Frequency
Non –clinical HCW/Administration Staff/Receptionists	1. Foundation	E-learning module	Induction and every 3 years 30 minutes
Clinical Staff - with regular contact with children DN/Managers/Physio/A&E Staff (OOH Drs)	2. Core Basic Awareness	: E-learning module Multi agency training	Induction and every 3 years 2-3 hours
Clinical Staff - who work regularly with children GP/PN/HV/MW/Paediatricians	3. Core Basic Awareness Multi-agency training	E-Learning module Multi-agency training PCT training [named/designated Dr/Nurse]	Induction and annually 1 day every year
Clinical Staff - with responsibility for safeguarding designated/named health professionals and Senior Managers	4. Core Basic Awareness Multi-agency training Specialist training	Multi-agency training Specialist training	Induction and annually 2-4 days every year

Elements covered within training module

Foundation:

Aware of child safeguarding policies
Categories of abuse
Roles and Responsibilities
What to do - seek support/advice

Core:

Knowledge of Child Safeguarding policy and Procedures
Legislation- Children Act 1989
Identification of abuse
Record keeping
Roles and Responsibilities- understanding the roles of other agencies
CAF
Understanding the necessity for interagency working
Sharing information

Core and Multi-agency

Knowledge of Child Safeguarding policy and Procedures
Legislation – Children ACT 1989 –its implications for practice
Roles and Responsibilities
CAF
Information sharing
Interagency collaboration
Knowledge of CP processes and thresholds for intervention- able to participate in inter-agency work
Referral – CP plan

Specialist

Responsibility to advise and support
In depth knowledge of Government guidance and legislation
Skills in consultation of complex cases, ethical and confidential issues and legal statements
Interagency working
Analysis/review of procedures.
Aware of national and strategic issues around child protection
Awareness of how other agencies work – good communication and negotiation skills
Undertake case reviews

Delivery Options

Induction Pack – e Learning

CD-Rom

Courses

In – house training in General Practice – presentations

LPCT Training – multi agency /GP orientated courses – rolling programme

Reading

Role play within multi- agency training

Multi-agency Training Schedule

Training days for multi-agency training in child safeguarding will be organised on a rolling programme throughout the year via the local Cluster Teams. Alternatively, more specialised training can be accessed through the Lincolnshire Safeguarding Children Board:-

Contact: 01522 553975.

AUDIT

Audit will be applicable to Child Safeguarding and will provide in the first instance a baseline of the level of service provision within Primary Care. It will allow for review and planning of services incorporating improving support and training for staff in dealing with safeguarding and child protection issues.

Practices can carry out their own audit, using either:-

- RCGP audit template from the toolkit
- LPCT audit template – [Appendix 6].



Every Child Matters

COMMON ASSESSMENT FORM

This form should be used to enable the common assessment of a child or young person in Lincolnshire who may have additional needs.

- All sections should be completed as fully as possible.
- Please complete this form in **BLACK INK**.
- If sections are not completed then reasons must be stated.
- The notifying agency should retain a copy for their own records.
- Please complete in conjunction with the CAF guidance.

Have you considered a Family Group Conference & what was the outcome?

If a Family Group Conference was not considered, why was this?

REASON FOR USING THIS FORM:

What is the purpose of completing this CAF Form (please tick one box only)?	
Referral to...	<input type="checkbox"/> Common Assessment Framework, Team Around the Child <input type="checkbox"/> Youth Inclusion Support Panel <input type="checkbox"/> Children with Disabilities – Team Around the Child <input type="checkbox"/> Social Care <input type="checkbox"/> other agency: <input type="checkbox"/> CAF completed for logging only
Describe why you have completed a common assessment on the child or young person, including any concerns that you may have and why you think that they have additional needs that cannot be met by you or your agency:	
<p>Is this CAF Form about a child or young person at risk of significant harm and in need of protection? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, has the matter been discussed with your manager, senior leader or equivalent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
Please ensure a telephone call is made to CSC before faxing/passing to the team.	
Please give date of call: _____ and record to whom call made: _____	
For <u>CAF</u>, <u>YISP</u>, <u>CWD-TAC</u> and <u>Social Care</u>, please ring 0 15 22 – 78 21 11.	

INFORMATION ABOUT THE CHILD OR YOUNG PERSON:

Surname:		Forenames:	
DoB/EDD:	Unique Identification Number:	Gender: Male/Female	Child or Young Person's First Language: Is an interpreter required? <input type="checkbox"/>
Religion:	Ethnicity:	Parent/carer's First Language: Is an interpreter required? <input type="checkbox"/>	School/Pre School/Other Education:
Address: Post Code: Tel No: Mobile:		Previous Address: Post Code: Tel No:	

Household Members	Relationship to Child or Young Person	DoB	School/Pre School/Other Education	Parental Responsibility	Tick if subject to separate CAF form
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>

Other Significant Adults	Relationship to Child or Young Person	DoB	Address	Tick if they have parental responsibility
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>

Is the child or young person on the Register? <input type="checkbox"/>	
If YES, give details	
Disabled? <input type="checkbox"/>	If YES, state the nature of the disability, including communication needs:

INFORMATION ABOUT THE LEAD PROFESSIONAL & INVOLVEMENT OF OTHER AGENCIES:

Record whether the child already has a Lead Professional and the involvement of other agencies that you are aware of. Two or more agencies need to be involved to satisfy YISP criteria.

Does the child already have a Lead Professional? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known					
Name of Lead Professional (if known):			Contact Telephone Number:		
Agency	Contact Name	Telephone	Agency	Contact Name	Telephone
<input type="checkbox"/> Connexions			<input type="checkbox"/> Mental Health		
<input type="checkbox"/> Nursery			<input type="checkbox"/> School Nurse		
<input type="checkbox"/> School			<input type="checkbox"/> Hospital		
<input type="checkbox"/> Youth Offending Service			<input type="checkbox"/> Youth Service		
<input type="checkbox"/> Health Visitor			<input type="checkbox"/> Paediatrician		
<input type="checkbox"/> Education Welfare Service			<input type="checkbox"/> Midwifery		
<input type="checkbox"/> Police			<input type="checkbox"/> GP		
<input type="checkbox"/> Social Services			<input type="checkbox"/> Other:		
<input type="checkbox"/> 'Buzzz': Young Persons Drug & Alcohol Treatment Service			<input type="checkbox"/> Other		

CHILD OR YOUNG PERSON'S NEEDS:

Based on your involvement with the child or young person, use the CAF Guidance to identify their strengths and needs and to complete the following sections.

<p>Health:</p>
<p>Education & Learning:</p>
<p>Emotional and behavioural development: Self-care skills:</p>

Family and Social Relationships:

Identity, including self-esteem, self image and social presentation:

PARENTS OR CARERS CAPACITY TO MEET THE CHILD OR YOUNG PERSON'S NEEDS:

Based on your involvement, use the CAF Guidance to describe the ability of the parents/carers to meet the child or young person's needs, including any strengths that they may have:

Basic Care:
Ensuring safety:
Emotional warmth:
Stimulation:
Guidance and boundaries:
Stability:

FAMILY AND ENVIRONMENTAL FACTORS WHICH IMPACT ON THE CHILD OR YOUNG PERSON AND THE PARENTS OR CARERS CAPACITY TO MEET THEIR NEEDS:

Based on your involvement, use the CAF Guidance to describe any factors that may affect the family, including any strengths that the family may have:

Family History, Functioning & Social Integration:
Wider Family and Social & Community Resources:

Housing:

Employment & Income, including any information concerning financial difficulties:

ANALYSIS OF NEED AND OTHER SUPPORTING INFORMATION:
In conjunction with the family, summarise information about the needs of the child or young person, conclusions, anticipated solutions and outcomes. Remember to record any major differences.

Positives & Strengths identified by the assessment:

Needs identified:

- Conclusions of assessment (tick one box only):**
- Additional needs can be met within agency => Please forward completed CAF form to the Customer Service Centre so that it can be recorded.
 - Additional needs can be met by family &/or community support
 - Additional needs which require a multi-agency response
 - Common Assessment Framework
 - Youth Inclusion Support Panel
 - Children with Disabilities – Team Around the Child
 - Social Care
 - Referral to single agency

Incidents of Harm or likely Harm:

Action (if any) required immediately, including details of referrals to other agencies:

Anticipated Outcome(s) of completing a Common Assessment/possible action plan:

REVIEW (if additional needs can be met within agency)

How will this assessment & plan be reviewed?

How will you and the family know that things have improved?

Date for the review (where arranged):

VIEWS OF THE PARENT/CARER AND THE CHILD OR YOUNG PERSON ABOUT THIS ASSESSMENT & PLAN

Parent/Carer	Child or Young person

CONSENT NB. For older young people, the person completing this Form may consider whether the young person is able to give their own consent. YISP requires signed consent from the parents/carers and the young person.

I agree to the information contained in this -paged Common Assessment being recorded and processed by (name of agency) in line with the requirements of the 1998 Data Protection Act and for it to be shared with other relevant service providers. Other service providers may also provide details held by their respective agencies about my child. This is in order to achieve a positive outcome to meet the needs of my child or young person.

Signed:	Name of person signing – state if parent or guardian:	Date:
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I agree to the information contained in this -paged Common Assessment being recorded and processed by (name of agency) in line with the requirements of the 1998 Data Protection Act and for it to be shared with other relevant service providers in order to achieve a positive outcome to meet my needs.

Signed:	Name of person signing – state if parent or guardian:	Date:
---------	---	-------

If you have sought consent and have had this refused, you should seek the advice of your line manager. Referrals that do not have consent should normally only be processed if you consider that the child or young person is either at risk of or has already experienced significant harm and that this complies with the LSCB Code of Practice. In such cases please record the reasons:

SENDER'S DETAILS

Name:	Tel:	E-mail address:
Agency:	Address:	

Have you visited the family home? Yes/No	If YES, when?
When did you last see the child or young person?	Date: Where:

I confirm that I have discussed and gained the consent of the parents &/or young person to complete this assessment:

Signed: _____ Designation: Date:

Name:

Possible dates for a meeting to be scheduled:	Possible venue (ensure accessible by family):

Is there a need for child care? YES NO

WHERE TO SEND THIS FORM:

- For **CAF, YISP and CWD-TAC**, please **fax to Customer Service Centre on 0 15 22 – 51 61 19**.
- For **Social Care**, please **fax/post to nearest Social Care Office**, details of which will be provided by the Customer Services Centre.



Every Child Matters

COMMON ASSESSMENT FRAMEWORK

This form should be used by an agency receiving an CAF Form to notify the agency that sent it about what happened as a result.

- The agency that received the CAF Form should retain a copy of this Response Form for their own records.
- **THIS FORM MUST BE RETURNED TO THE SENDER WITHIN 5 DAYS.**

RESPONSE FORM

TO: SENDER

Name:	Agency:
Address:	
Post Code:	

Thank you for sending the CAF Form about the child or young person named below. This Response Form is intended to tell you what action we have taken as a result. If you have any further query please do not hesitate to get in touch with the worker named below.

CHILD OR YOUNG PERSON

Surname:	Forenames:
Address:	
Post Code:	

RESULT OF USING THIS FORM

The result of sending the CAF Form was that:

The information has been noted but no further action is to be taken.

The information has led to a referral being recorded by this agency and the matter is currently awaiting an assessment.

The information has led to a referral being recorded by this agency However, before we can decide what needs to be done, we need the following additional information as detailed below.

The information has led to a referral being recorded by this agency and the services detailed below are to be provided to the child or young person and their family.

The assessment has been accepted and a CAF meeting will be arranged.

The referral to YISP has been accepted.

The referral to CWD-TAC has been accepted.

REASON(S) FOR OUR RESPONSE

FROM: RECEIVER

Name:	Tel:	E-mail address:
Agency:	Address:	
Signed:	Designation:	Date:



Lincolnshire Teaching Primary Care Trust

Our Ref: RW/MD/CP
 Your Ref:
 Please ask for: Dr Robert Wilson
 Telephone: 01522 515317
 E-mail address: robert.wilson@lpct.nhs.uk
 Date:

Cross O'Cliff
 Bracebridge Heath
 Lincoln
 LN4 2HN

Tel: 01522 513355
 Calls via Typetalk are welcome
 Fax: 01522 515337
 Website: www.lpct.nhs.uk

Dear Sir

Re:
Date of Birth:
Address:

A Serious Case Review (also known as a Part 8 review) is in progress for the above child. The purpose of these reviews is to:

- Establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children
- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and as a consequence, and
- To improve inter-agency working and better safeguard children.

Recent guidance from the General Medical Council (Children and Young People: Doctors' Roles and Responsibilities) states:

"You should co-operate with requests for information about child abuse and neglect, including case reviews set up to identify why a child has been seriously harmed, to learn lessons from mistakes and to improve systems and services for children and their families. Where the overall purpose of a review can reasonably be regarded as serving to protect other children or young people from a risk of serious harm, you should share relevant information, even where a child or young person or their parents do not consent, or if it is not practicable to seek consent. You must be prepared to justify a decision not to share information in such cases."

I would be grateful therefore if you could supply me with a photocopy of this patient's notes, to assist with the review. Please be assured that at no time will these notes be seen by anyone outside of the Public Health directorate.

If you have any queries regarding this matter then do not hesitate to contact me on 01522 515376.

Yours faithfully

DR ROBERT WILSON
Consultant in Public Health Medicine

Read Codes for recording ---- 2008

Risks /reports for coding	Read Code
Vulnerable child in family	.13IQ vulnerable child in family
Patient who has been physically abused	.14X5 victim of physical abuse
Patient who has been alleged to be an abuser	.14X9 alleged perpetrator of physical abuse
Patient who has been emotionally abused	.14X7 victim of emotional abuse
Patient who has been alleged to be an abuser	.14XB alleged perpetrator of emotional abuse
Adult on sex offenders register	.14X4 sex offenders register
Patient who has been sexually abused	.14X5 victim of sexual abuse
Patient who has been alleged to be an abuser	.14XA alleged perpetrator of sexual abuse
Patient who has been a victim of domestic violence	.14X8 victim of domestic violence
Patient who has a record of perpetrating domestic violence	.14X3 history of domestic violence
Child who is considered at risk	. 13IF Child at Risk
Looked after child	. 13IB Child in Care
Use to highlight <u>risk</u> to other children in families	.13W3 child abuse in the family
Substandard Housing	.13E Inadequate housing
Children Referred to Social Services	. 8HHB Referral to Social Services
Recording Case Conference	. 64C Case Conference
Antenatal Care Risk identified	.625 Antenatal Care social risk
Parent with Learning Difficulty	. 12W1 FH learning difficulties
Parental Drug Misuse	. 1283 FH drug dependency
Parental alcohol problem	. 1282 FH alcoholism
Parent with Mental Illness	. 128Z FH Mental Disorder
Adult on sex offenders register	.14X4 sex offenders register

This has been taken from the Royal College of General Practitioners/NSPCC toolkit for child protection.

Flow Chart of Enquiry Process for Children in Need of Services or Protection

Referral



Formal request to Childrens Services to undertake assessment regarding safeguarding or protection.

Initial Assessment of need for Social Care Services



To clarify the need of services or protection Childrens Services will carry out record and file checks, consult with parents, family, child, professional agencies on level of concern and risk to child. If consulting family at this stage puts child at increased risk, then will inform family later.

Plan and Strategy Meeting



Convened by lead agency to decide what plan/action to take.

Investigation and Assessment



Childrens Services or Police investigate and assess the situation.

Child at Risk of Significant Harm



Child Protection Conference



Multi-agency meeting to decide if child is at continuing risk of significant harm, if so what are the protection needs of child and family.

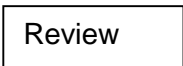
Child at risk of significant harm is registered onto the Integrated Childrens System.

Child Protection Plan



Clear action plan identified by key worker so that professionals and family can work to reduce risks.

Review



Regular follow up meetings to monitor progress and deregister if child is safe.

Audit of Standards of General Practice in Child Safeguarding

Name of Practice	-----		
Date	-----		
		Yes	No
Practice Clinical Lead in Safeguarding children		----	----
Name of clinical lead	-----		

Administration

All staff have been CRB checked		----	----
Registration of patients under 16 years			
Check whether there is a parent/carer with parental responsibility Registered with the practice		----	----
Ask to record the school the child is attending		----	----
If child is under private fostering, we check if Social Services are aware re suitability		----	----
Health visitors are notified when new children under age 5 register		----	----

Record Keeping and Summarising

We READ code children who have a Child Protection Plan .13IM		----	----
We READ code the notes of all family members who have a child on the CPR		----	----
We READ code the notes of children who come off the CPR		----	----
We READ code children who may be in need or have complex needs		----	----
We use 13IQ [Vulnerable child in family] in notes of all household members		----	----
We have a Vulnerable Child template – linked to codes 13IQ and 13IM		----	----
We would like a copy of such a template		----	----
We have a system whereby these families are reviewed and their records updated		----	----

	Yes	No
--	-----	----

We scan case conference notes into the child records and highlight its existence in other family member's notes ---- ----

We have a policy for dealing with third party information in children's records when patients request access to notes ---- ----

Communication

As a practice we are familiar with our responsibilities under the Data Protection Act and information sharing ---- ----

Families are aware of our policy of sharing information with Outside agencies if a need arises to protect a child ---- ----

We meet on a regular basis with other primary care professionals to discuss our vulnerable families ---- ----

We are aware of how to make a referral to Social Services ---- ----

We HAVE a policy on how to handle requests from outside agencies for sharing information about vulnerable children ---- ----

Our medical staff is clear about good record keeping ---- ----

Our doctors provide a report if they are unable to attend a Case conference meeting ---- ----

We are aware of the Common Assessment Framework [CAF] ---- ----

We would like more information on CAF ---- ----

Education and Training

Our last practice training in child safeguarding was ----- ----

Type of event / course -----

All staff are aware of the PCT's Child Safeguarding Policy or Where to access a copy of this in the practice ---- ----

All staff knows who to contact when they have a query on Child Safeguarding matters ---- ----

We would like more details on available courses [locally] ---- ----

References

1. Protecting Children and Young People. www.dh.gov.uk/en/Healthcare/Children/DH_4089111
2. Read Code Data
3. RCGP and NSPCC toolkit
4. When to suspect child maltreatment. NICE Guidance 2009
5. What to do if you are worried a child is being abused. [2003 revised 2006]. Doh et al. www.doh.gov.uk/safeguardingchildren/index.htm
6. Every Child Matters HMSO 2003
7. The National Service Framework for Children, Young People and Maternity Services. DoH 2004
8. General Medical Council. www.gmc-uk.org
9. Royal College of Paediatricians and Child Health. www.rcpch.ac.uk
10. HM Government [2006] Working Together to Safeguard Children. Department of Health . London Stationery Office. www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00060/
11. HMSO [1989] The Children's Act 1989
12. HMSO 2004 The Children's Act 2004
13. HMSO 2003 The Victoria Climbié Inquiry. Report of an Inquiry by Lord Laming.