Surrey Wide CCG Safeguarding Team

PRIMARY CARE SAFEGUARDING CHILDREN POLICY

Document Version Control

Version	Author	Date	Summary of changes
9	Dr Tara Jones, Dr Sharon Kefford	May 2019	Final Version
14	Dr Tara Jones, Dr Sharon Kefford	Sept 2019	Training requirements document update
15	Dr Tara Jones, Dr Sharon Kefford	October 2019	SSCP,Learning review and Child death process update
16	Dr Tara Jones, Dr Sharon Kefford	Nov 2019	Training requirements document update
17	Anna Miles	Nov 2019	Update of embedded pdf files in section 13.3 Effective family resilience and 24.5 safeguarding children information requests

To make changes to this document please contact Lisa Parry:-
Lisa.parry1@nhs.net

PRIMARY CARE SAFEGUARDING CHILDREN POLICY

North West Surrey Integrated Care Services (NICS) Ltd

November 2019

Contents

1 Introduction

1.1 Safeguarding is everyone's responsibility and aims to protect people's health, wellbeing and human rights, and enable them to live free from harm, abuse and neglect.

1.2 **The aims of safeguarding children are to:**

- Stop abuse, neglect and exploitation wherever possible
- Raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect
- Help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of a child; and address what has caused the abuse or neglect
- Prevent impairment of Childrens health or development
- Ensure that children grow up in circumstances consistent with the provision of safe and effective care
- Take action to enable all children to have the best outcomes

1.3 This policy has been written in accordance with relevant Legislation and Statutory Guidance, which should be read alongside this document:

- The Children Act 1989 and 2004
- Working Together to Safeguard Children 2018

- The UN Convention on the Rights of the Child
- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Intercollegiate Document, RCN 2019
- Looked After Children Intercollegiate, RCPCH 2014

1.4 This policy applies to all children, as defined in England, Northern Ireland and Wales, as those who have not yet reached their 18th birthday. Once they turn 18, they are legally an adult.

1.5 The support and protection of children cannot be achieved by a single agency, every service has a responsibility. Practice staff are not responsible for making a diagnosis of child abuse and neglect, however they are responsible to share concerns appropriately and refer to the LA who have the Statutory Lead.

1.6 This policy outlines how North West Surrey Integrated Care Services (NICS) Ltd will fulfil their legal duties and statutory responsibilities effectively and should be read in conjunction with Surrey Safeguarding Children's Partnership (SSCP) safeguarding children multiagency procedures:
https://www.surreyscb.org.uk/2016/10/05/contacting-the-multi-agency-safeguarding-hub/

2. Safeguarding Children in General Practice

2.1 General Practitioners (GPs) are the first point of contact for most people with health problems, this sometimes includes individuals who are not registered but seek medical attention.

2.2 GPs may be the first to recognise a child's health problems, parent or carer related stress issues, or someone whose behaviour may pose a risk to children. The Primary Health Care Team (PHCT) may be the only professionals to have contact with the child and it is important that any response taken is appropriate, proportionate and timely, thereby preventing the potential long term effects of abuse and neglect.

2.3 Efforts should be made to include children and young people in decisions that closely affect them. The views and wishes of children should therefore be listened to and respected according to their competence and the level of their understanding. In some cases

translation, interpreting and signing services suitable for children and young people may be needed. Wherever possible, the involvement and support of those who have parental responsibility for, or regular care of, a child should be encouraged, in so far as this is in keeping with the best interests of the child or children concerned. Older children and young people may have their own views about parental involvement.

3. Engagement

3.1 This policy was developed by the Surrey-wide CCG Safeguarding Team for use in General Practices within Surrey.

4. Impact Analyses

4.1 In line with the North West Surrey Integrated Care Services (NICS) Ltd Equality and Diversity Policies and Sustainability impact assessment, this policy aims to safeguard all children who may be at risk of abuse, irrespective of disability, race, religion/belief, colour, language, birth, nationality, ethnic or national origin, gender or sexual orientation.

4.2 All staff must respect the child's (and their family's/ carers) culture, religious beliefs, gender expression and sexuality. However this must not prevent action to safeguard children who are at risk of, or experiencing, abuse.

4.4. Due consideration has been given to the Bribery Act 2010 in the development of this policy and no specific risks were identified.

5. Scope

5.1. This policy applies to all staff employed by North West Surrey Integrated Care Services (NICS) Ltd , including; all employees (including those on fixed-term contracts), temporary staff, bank staff, locums, agency staff, contractors, volunteers (including celebrities), students and any other learners undertaking any type of work experience or work related activity.

5.2. All staff have an individual responsibility to safeguard and promote the welfare of children and must know what to do if concerned that a child is at risk of being abused or neglected.

6. Policy Aim

6.1. Nics adopts a zero tolerance approach to abuse and neglect and in doing so ensures that safeguarding the rights of children at risk of abuse is integral to all we do.

6.2 This policy outlines how Nics will fulfil its statutory responsibilities and ensure that there are in place robust structures, systems and quality standards for safeguarding and promoting the wellbeing of children, in line with SSCP safeguarding children procedures.

7. Safeguarding Children

7.1 All children (those under 18 years of age) have the right to live a life free from abuse and neglect. Abuse is a violation of an individual's human and civil rights by any other person or persons.

7.2 Where someone is 18 or over but is still receiving children's services and a safeguarding issue is raised, the matter should be dealt with through child safeguarding arrangements. For example, this could occur when a young person with substantial and complex needs continues to be supported in a residential educational setting until the age of 25. Where appropriate, child safeguarding services should involve the Local Authority children's safeguarding colleagues as well as any relevant partners.

7.3. Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological. It may be an act of neglect or an omission to act or it may occur when a child is persuaded to enter into a financial or sexual transaction to which he or she has not consented to, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the child subjected to it.

7.4. The safeguarding duties apply to all children, but specific considerations are made to the following groups who may be particularly vulnerable:

- Children who are Looked After
- Young Carers
- Children with Special Educational Needs and Disabilities

8. Principles of safeguarding children

8.1 NICS acknowledges the four general principles of safeguarding children and ensures these principles underpin safeguarding work:

- The child's needs must come first.
- The child's well-being and welfare is everyone's shared responsibility for achieving better outcomes for children.
- The opinions of the child and family will always be taken into account and documented.
- The child and family will not be discriminated against on the grounds of age, ethnicity, religion, culture, gender, disability, class or sexual orientation.

9. Categories of abuse

9.1 Domestic Violence and Abuse (DVA)

A pattern of incidents of controlling, coercive or threatening behaviour violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. Including:

- Psychological
- Physical
- Sexual
- Financial
- Emotional abuse
- Personal gain
- Modern slavery
- Radicalisation
- Harmful Traditional Practices

9.1.1 Effect on children witnessing Domestic Violence and Abuse

Domestic violence has a devastating impact on children and young people that can last into adulthood. Signs that may indicate a child is witnessing domestic violence may include:

- They may become anxious or depressed
- They may have difficulty sleeping
- They have nightmares or flashbacks
- They can be easily startled
- They may complain of physical symptoms such as tummy aches and may start to wet their bed
- They may have temper tantrums and problems with school
- They may behave as though they are much younger than they are
- They may become aggressive or they may internalise their distress and withdraw from other people
- They may have a lowered sense of self-worth
- Older children and teenagers may begin to play truant, start to misuse alcohol or drugs, begin to self-harm or develop an eating disorder (Women's Aid)

Surrey resources and guidance regarding domestic abuse can be found at:
Surrey resources domestic abuse

Nics DA Lead/Champion is:
Dr N. Mantel-Cooper nics.admin@nhs.net

9.2 Neglect and acts of omission

Neglect is the failure to meet a child's basic needs; it is usually a pattern of behaviour observed over time, but may be a one off event. Individual incidents often fail to reach the thresholds for social care or police intervention. Neglect can result in serious long-term damage, both physical and psychological, and even death. Neglect can include the behaviours of parents who are either unwilling or unable to provide adequate care to their child (ren). Neglectful behaviours can include:

- Ignoring a child's medical, emotional or physical care needs,
- Failure to provide access to appropriate health, care and support or educational services,
- The withholding of the necessities of life, such as medication, adequate nutrition and heating.

The SSCP neglect assessment tool is useful to aid for practitioners when they suspect neglect may be an issue, Neglect risk assessment tool and guidance

9.3 Psychological abuse

- Emotional abuse
- Verbal abuse
- Humiliation and ridicule
- Threats of punishment, abandonment, intimidation or exclusion from services.
- Isolation or withdrawal from services or supportive networks
- Deliberate denial of religious or cultural needs
- Forced marriage

9.4 Physical Abuse

- Hitting, slapping, scratching
- Pushing or rough handling
- Assault and battery
- Restraining without justifiable reasons
- Inappropriate and unauthorised use of medication
- Using medication as a chemical form of restraint
- Inappropriate sanctions including deprivation of food, clothing, warmth and health care needs
- Bruising in non-independently mobile infants,
  NICE guideline, When to Suspect Child Maltreatment (Clinical Guideline 89, July 2009) states that bruising in any child Not Independently Mobile should prompt suspicion of maltreatment. Not Independently Mobile (NIM): is an infant who is not yet crawling, bottom shuffling, or cruising. It includes all infants less than 6 months. The local Surrey protocol for NIM infants can be accessed through the following link:

Multiagency protocol for the management of actual or suspected bruising in infants who are not independently mobile

9.5 Sexual Abuse

The age of consent to sexual activity is 16. Children below the age of 13 cannot consent to **any** sexual activity; this can include, but is not limited to:

- Rape or attempted rape
- Sexual assault or harassment

- Non-contact abuse e.g. voyeurism, pornography

9.6 Harmful sexual behaviour

This describes the situation where a child (below the age of 18) engages in any form of sexual activity with another individual that they have powers over by virtue of age, emotional maturity, gender, physical strength, or intellect and where the victim in this relationship has suffered sexual exploitation or a betrayal of trust.

9.6.1 Particular concern should be raised if there is more than four years' difference in age or if one of the children is pre-pubescent and the other isn't (noting that a child under the age of 13 can never consent to any sexual activity). However, a younger child can abuse an older child, particularly if they have power over them; for example, if the older child is disabled. Examples of harmful sexual behaviour can include:

- using sexually explicit words and phrases
- inappropriate touching
- using sexual violence or threats
- indecent exposure or voyeurism
- full penetrative sex with other children or adults (NSPCC)

9.7 Child Sexual Exploitation

Child sexual exploitation is a form of child sexual abuse. It occurs where 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 also occur through the use of technology. Useful tools and resources to help practitioners identify child sexual exploitation can be accessed via the following link:

Surrey CSE resources

Nics CSE Lead/Champion is:

Dr N. Mantel-Cooper nics.admin@nhs.net

9.8 Missing, Trafficked or Exploited Children, including modern day slavery.

9.8.1 Criminal Exploitation & Gangs

Criminal Exploitation of children or young people involves being groomed, encouraged, cajoled or threatened to carry out criminal activity for the benefit of others. In return they are offered friendship or peer acceptance, but also cigarettes, drugs (especially cannabis), alcohol or even food and accommodation.

9.8.2 A gang is usually considered to be a group of people who spend time in public places that:

- see themselves (and are seen by others) as a noticeable group, and
- engage in criminal activity and violence.

County lines is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of "deal line". They are likely to exploit children and young people to move and store the drugs and money and they will often use coercion, intimidation, violence (including sexual violence) and weapons. They will often use intimidation, violence and weapons, including knives, corrosives and firearms. Further information and guidance can be accessed via the following link:

Surrey County Lines / Gangs resources

9.8.3 Child Trafficking including modern day slavery.

Child Trafficking is defined as the recruitment, transportation, transfer, harbouring or receipt of children for the purpose of exploitation. Many children are trafficked into the UK from abroad, but children can also be trafficked from one part of the UK to another. Children are trafficked for:

- Child sexual exploitation
- Benefit fraud
- Forced marriage
- Modern Day Slavery
    - Domestic servitude such as cleaning, childcare, cooking
    - Forced labour in factories or agriculture
- Criminal activity such as pickpocketing, begging, transporting drugs, working on cannabis farms, selling pirated DVDs and bag theft.

Further information regarding trafficking and modern day slavery can be accessed via:

Surrey Trafficking Resources

Surrey Modern Day Slavery Resources

9.8.4 Missing Children from Home and Care

Missing Child: a child/young person under 18, reported as missing to the police by family or Carer(s).

Missing from care: a Child in Care who is not at their placement or the place they are expected to be (e.g., school) and their whereabouts is not known.

Local resources regarding missing children can be found through the following link:

Surrey missing children resources

9.9 Harmful Traditional Practices

9.9.1 Female Genital Mutilation (FGM)

The FGM Act 2003 states that a person is guilty of an offence if they excise, infibulate or otherwise mutilate the whole or any part of a girl or woman's labia majora, labia minora or clitoris, but no offence is committed by an approved person who performs a surgical operation, necessary for physical or mental health, or surgical operation on a girl or woman in any stage of labour, or has just given birth. A person is also guilty of an offence if they, aid, abet counsel or procure a girl to excise infibulate or otherwise mutilate the whole or any part of her own labia majora, labia minora or clitoris. Penalties are up to 14 years in prison or a fine or both. National FGM risk assessments tools and guidance for health professionals these can be found at:

National Safeguarding guidance for women and girls at risk of FGM.

FGM Safeguarding and risk assessment

FGM risk assessment templates

Section 5b of the FGM Act 2003 introduces a mandatory reporting duty which requires regulated health and social care professionals and teachers in England and Wales to report "*known"* cases of FGM in under 18's which they identify in the course of their professional work to the police. The duty applies from 31st October 2015 onwards. For further information please see link below:

FGM Mandatory reporting duty for health care staff

Nics FGM Lead/Champion is:

Dr N. Mantel-Cooper nics.admin@nhs.net

9.9.2 'Honour'- based violence

The term HBV is the internationally recognised term describing cultural justifications for violence and abuse against women, men and children. There is no specific offence of "*honour based crime*". It is an umbrella term to encompass various offences covered by existing legislation. HBV can be described as a collection of practices, which are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour. It is a violation of human rights and may be a form of domestic and/or sexual violence. There is no, and cannot be, honour or justification for abusing the human rights of others.

HBV is normally associated with cultures and communities from Asia, the Middle East and Africa as well as Gypsies and Travellers, but in reality, HBV cuts across all cultures, nationalities, faith groups and communities and transcends national and international boundaries. HBV is also a Domestic Abuse issue, a Child Abuse concern and a crime. In terms of Domestic Abuse risk assessment, HBV is a significant risk factor for victims and must be regarded as a significant predictor of the likelihood of future harm or homicide.

9.10 Online Abuse

Online abuse is any type of abuse that happens on the web, whether through social networks, playing online games or using mobile phones. Children and young people may experience cyberbullying, grooming, sexual abuse, sexual exploitation or emotional abuse. Clinical and non-clinical staff must be aware of the risks associated with the internet and social networking and know how to respond to concerns. For further information please see link below.

Surrey Online Safety Resources

9.11 Fabricated or induced illness

When a parent or carer exaggerates or deliberately causes symptoms of illness in a child. Also known as "Munchausen's syndrome by proxy", fabricated or induced illness covers a wide range of symptoms and behaviours ranging extreme neglect by failing to seek medical

care to induced illness. Other behaviours associated with Fabricated or Induced Illness include any parent or care giver who:

- Persuades healthcare professionals that their child is ill when they're perfectly healthy
- Exaggerates or lies about their child's symptoms
- Manipulates test results to suggest the presence of illness – for example, by putting glucose in urine samples to suggest the child has diabetes
- Deliberately induces symptoms of illness – for example, by poisoning her child with unnecessary medication or other substances

Medical professionals who suspect FII is taking place should liaise with social services and the police, and must follow local child safeguarding procedures (NHS 2016).

Surrey Procedures Fabricated or induced illness

9.12 Financial or material abuse

- Having money misused or stolen
- Having property stolen
- Being defrauded
- Being put under pressure in relation to money or property
- Having money or property misused

9.13 Discrimination

- Discrimination demonstrated on any grounds including sex, race, colour, language, culture, religion, politics or sexual orientation
- Discrimination that is based on a person's disability or age
- Harassment and slurs which are degrading
- Hate crime

9.14 Organisational abuse

Including neglect and poor care practice within an institution or specific care setting such as a hospital or residential facility, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

10. Children in special circumstances

10.1 Children who are Looked After

GPs need to be aware of the special vulnerabilities and health needs of Looked After Children, young people and Care Leavers that may be registered at their practice. This includes acting as an advocate for the individual, identifying the specific risks associated with being in care and understanding the impact neglect, sexual, physical and emotional abuse can have on these children, young people and care leavers. Clinical and non-clinical staff should also be aware that children in care may still be vulnerable to the risk of abuse and neglect by their care-givers and may have an increased likelihood of becoming a victim of exploitation, trafficking or radicalisation. All staff should know what to do if there are safeguarding concerns regarding a looked after child, young person or care leaver.

Practices should ensure medical records are obtained, coded and summarised, as soon as the child, young person or care leaver registers. Health reviews and care plans should be fully documented and regularly reviewed to ensure recommended actions such as immunisations and specialist referrals happen.

Surrey Children who are Looked After Protocol

10.1.1 Unaccompanied Asylum Seeking Children

Unaccompanied children seeking asylum are young people under 18 years of age who have travelled to another country to ask for asylum due to fear of persecution in their home country, and have become separated from their usual parent or carer.

Unaccompanied asylum seeking children may have significant physical and mental health needs. Influenced by access to basic health care in their home country, their experience of hardship, including witnessing and experiencing traumatic events, and the duration of and conditions experienced on their journey to the UK.

Unaccompanied asylum seeking children are entitled access to universal primary care services regardless of their immigration status. All people who have an asylum application in process or who have been granted refugee status are entitled to register with a GP. It is the decision of the general practitioner / practice whether to register a person in whom an asylum application has been unsuccessful or who is deemed to be in the country unlawfully. However where registration is refused this must be done on reasonable grounds and irrespective of age, gender, race, socioeconomic status etc.

10.2 Young Carers

The term young carer includes children and young people who, from the age of 5 up to their 18th birthday, provide regular or ongoing care and emotional support to a family member who is physically or mentally ill, disabled or misuses substances. A young carer becomes vulnerable when the level of caregiving and responsibility to the person in need of care becomes excessive or inappropriate for that child, risking impacting on his or her emotional or physical well-being or educational achievement and life chances (Hidden from View - The Children's Society Report, 2013). A young carer may do some or all of the following for another person:

- Undertake practical tasks such as cooking, housework and shopping.
- Undertake physical care such as lifting, helping a parent on stairs, or with physiotherapy.
- Assist with personal care, such as dressing, washing, helping with toileting needs.
- Manage the family budget, collecting benefits and prescriptions.
- Administer medication.
- Look after or parent younger siblings.
- Provide emotional support.
- Interpret, due to a hearing or speech impairment, or because English is not the family's first language (Staffordshire Children Board, 2017).

The following are examples of good practice in the care of those children and young people who have a caring responsibility for another person:

- Hearing the voice of young carers by assessing their needs and identifying any inappropriate caring roles
- Consideration of wider family members and the support that they may require from Child Services.
- An intervention plan to include consideration of early help and appropriate signposting to other agencies.
- Identifying children and young people with a caring responsibility at patient registration to enable the earliest intervention.

For further information and resources, please see the Surrey Young Carers website:

https://www.surrey-youngcarers.org.uk/

10.3 Children with Special Educational Needs and Disabilities

Healthcare professionals should be alert to the additional vulnerabilities children and young people with disabilities have. Children and young people who meet the Equality Act 2010 definition of disability, namely those who have a physical or mental impairment that has a

substantial and long-term negative effect on their ability to do normal daily activities) are more vulnerable to abuse or neglect.

Furthermore, alerting features of maltreatment in children with disabilities may be features of the disability, making identification of maltreatment more difficult. Healthcare professionals may need to seek appropriate expertise if they are concerned about a child or young person with a disability (NICE 2017).

11. CONTEST and PREVENT (Radicalisation of children and young people)

11.1 Contest is the Government's Counter Terrorism Strategy, which aims to reduce the risk from terrorism, so that people can go about their lives freely and with confidence.

11.2 Contest has four strands which encompass:

1) **PREVENT** to stop people becoming terrorists or supporting violent extremism.
2) **PURSUE** to stop terrorist attacks through disruption, investigation and detection.
3) **PREPARE** where an attack cannot be stopped, to mitigate its impact.
4) **PROTECT** to strengthen against terrorist attack, including borders, utilities, transport infrastructure and crowded places.

11.3 PREVENT focuses on preventing people becoming involved in terrorism, supporting extreme violence or becoming susceptible to radicalisation. Alongside other agencies, such as education services, LAs and the police, healthcare services have been identified as a key strategic partner in supporting this strategy.

11.4. Healthcare professionals may meet and treat people who are vulnerable to radicalisation, such as people with mental health issues or learning disabilities who may have a heightened susceptibility to being influenced by others.

11.5. The key challenge for the health sector is to be vigilant for signs that someone has been or is being drawn into terrorism. GPs and their staff are the first point of contact for most people and are in a prime position to safeguard those people they feel may be at risk of radicalisation.

11.6 Practice staff who have concerns that someone may be becoming radicalised must seek advice and support from the Safeguarding and PREVENT Lead.

11.7 **Nics PREVENT Lead / Champion is:**
Dr N. Mantel-Cooper nics.admin@nhs.net

11.8 It is important to note that PREVENT operates within the pre-criminal space and is aligned to the multi-agency safeguarding agenda.

- **Notice:** if you have a cause for concern about someone, perhaps their altered attitude or change in behaviour
- **Check:** discuss concern with Safeguarding/PREVENT Lead
- **Share:** appropriate, proportionate information with Safeguarding/PREVENT Lead

PREVENT resources including the referral form can be found at:
Surrey PREVENT resources and referral form

12. Adverse Childhood Experiences (ACEs)

12.1 ACEs describe a broad range of **adverse childhood experiences** that can be stressful or traumatic events that children and young people can be exposed to.

12.2 ACEs range from experiences that directly harm a child, such as physical, verbal or sexual abuse, and physical or emotional neglect, to those that affect the environments in which children grow up, such as parental separation, domestic violence, mental illness, alcohol abuse, drug use or imprisonment (Cumbria Resilience Project).

12.3 ACEs have been found to have lifelong impacts on health and behaviour, an ACE survey with adults in Wales found that compared to people with no ACEs, those with 4 or more ACEs are more likely to

- have been in prison
- develop heart disease
- frequently visit the GP
- develop type 2 diabetes
- have committed violence in the last 12 months

- have health-harming behaviours (high-risk drinking, smoking, drug use)

(NHS Scotland, 2019)

13. Early Help & Family Resilience

13.1 Services for children with additional and more complex needs are sometimes known as early help or targeted help services, such as support for emotional wellbeing, additional help with learning in school, extra support to parents in early years or targeted help to involve young people through youth services.

13.2 Early help may be offered at any point in a child or young person's life. Children whose needs are more complex require support through a co-ordinated multi-disciplinary approach, involving an Early Help Plan and a Lead Professional to work closely with the child and family to ensure they receive all the support they require (SSCP 2019).

See Appendix 5 for further information.

13.3 In 2019, Surrey moved to a model of Early Help known as Family Resilience, backed by the social care practice model Family Safeguarding. The March 2019 SSCB document "Effective Family Resilience Surrey; every child in Surrey matters" provides more details and guidance regarding this model.

Effective-family-resil
ience-SSCB-Final-Ma

Families can be referred to early help using the Surrey Childrens Services Request for Support Form:

Surrey Childrens Services Request for Support form

14. Roles and Responsibilities

14.1 **The Surrey Safeguarding Children's Partnership (SSCP)** is responsible for ensuring that:

- Partner agencies including the LA, the NHS and the police, meet regularly to discuss and act upon local safeguarding issues.

- Shared plans for safeguarding, working with local people to decide how best to protect children in vulnerable situations are developed.
- A safeguarding plan is published to the public and reported on annually on its progress, so that different organisations can make sure they are working together in the best way.

14.2 **The Local Authority (LA)** is responsible for making enquires, or asking others to make enquiries, when they think a child may be at risk of abuse or neglect and to find out what, if any, action may be needed. This applies whether or not the authority is actually providing any care and support services to that child.

14.3 **Clinical Commissioning Groups** (CCGs) are statutory NHS bodies with a range of duties, including safeguarding children. CCGs as commissioners of local health services need to assure themselves that the organisations which they commission have effective safeguarding arrangements in place. CCGs are responsible for securing the expertise of Designated Professionals on behalf of the local health system. Designated Professionals and Child Safeguarding Leads undertake a whole health economy role and play an integral role in all parts of the commissioning cycle, from procurement to quality assurance if appropriate services are to be commissioned that support children at risk of abuse or neglect, as well as effectively safeguard their well-being. CCGs are required to demonstrate that they have appropriate systems in place for discharging their statutory duties in terms of safeguarding.

14.4 **Named GP for Safeguarding Children**

The Named GP works closely with the CCG to ensure through this role local practices are supported to develop effective safeguarding children arrangements.

14.5 **Designated Nurse Safeguarding Children role**:

As a clinical expert and a strategic leader for safeguarding their role is to work across the local health economy to support other professionals in their agencies on all aspects of safeguarding. Is a member of the SCB and will ensure the regular provision of training to the staff and Board of the CCG. He or she will advise the LA, police and other organisations on health matters in relation to child safeguarding.

14.6 **Designated Professionals for Looked After Children**

The Designated Doctor and Nurse for Children who are Looked After provide a strategic lead in the health aspects of children in care.

14.7 **Nics team** The Care Quality Commission (CQC) will want GPs and all other practice staff to demonstrate their competence in safeguarding children:

- Demonstrate their understanding of the risk posed to children and the types of abuse they may be subject to
- Be aware of the internal arrangements for recording a safeguarding children concern and this will be set out in this Safeguarding Children policy
- Be aware of the external process for reporting the concern and that this is in line with local multi-agency policy and procedures
- Disclosure and Barring System (DBS) checks are only one aspect of ensuring effective and safe recruitment practices and should not be used in isolation. GPs should also use other mechanisms, such as checking employment history and any gaps, reviewing references, etc. to assure themselves as far as possible that all employees are of good character and are fit to work in their health practice.
- Significant events and complaints analysis can be used to show quality improvements and should be part of GP revalidation.

14.8 Each practice should have a lead for safeguarding children who should be aware of the respective Designated Safeguarding Children Lead within the local CCG and the LA Safeguarding Children contact.

14.9 In a 'good' practice:

- There will be evidence that safeguarding children is given sufficient priority.
- Staff will take a proactive approach to safeguarding and focus on early identification.
- Steps are taken to protect people where there are known risks, with appropriate responses to any signs or allegations of abuse and effective work with other organisations to implement protection plans.
- There are active and appropriate engagement in local safeguarding procedures and effective work with other relevant organisations.
- All complaints are considered and screened for any safeguarding concerns
- Practitioners will take part in regular multidisciplinary meeting to discuss vulnerable children and adults

15. Practice Arrangements

15.1 North West Surrey Integrated Care Services (NICS) Ltd has clearly identified lines of accountability within Nics to promote the work of safeguarding children within Nics. Safeguarding responsibilities will be clearly defined in all job descriptions and there are nominated leads for safeguarding children.

15.2 **Nics Lead for Safeguarding Children) is:**
Dr N. Mantel-Cooper nics.admin@nhs.net
The Administration Lead for managing Safeguarding data is:
Claire Laing Claire.laing@nhs.net

15.3 **Nics Lead for Safeguarding Children** is responsible for ensuring that they are fully conversant with Nics safeguarding child policy, the policies and procedures of SCB and the integrated processes that support safeguarding:

- Facilitating training opportunities for staff groups
- Acting as a focus for external contacts on safeguarding children matters; this may include requests to contribute to sharing information required for Serious Case Reviews (SCRs), Child Death Reviews (CDOP) and multi-agency/Individual Management Reviews (IMRs). Section 17 and 47 Enquiries are generally the responsibility of the child's usual GP.
- Disseminating information in relation to safeguarding children to all practice members
- Act as a point of contact for practice members to bring any concerns that they have, to document those concerns and to take any necessary action to address concerns raised
- Assess information received on safeguarding concerns promptly and carefully, clarifying or obtaining more information about the matter as appropriate
- Facilitate access to support and supervision for staff working with children and families
- Ensure that Nics team completes Nics's agreed incident forms and analysis of significant events forms which are available to download from www.nicsfed.co.uk
- Is required to contribute to SCRs and CDOP reviews specifically
- Will respond to and write reports for LA Section 47 enquiries
- Will disseminate and develop action plans to ensure lessons learnt are embedded in best practice following publication of Serious Case Reviews and Child Death Reviews
- Supporting and facilitating practice participation in audit

15.4 **Nics Manager** is responsible for ensuring that safeguarding responsibilities are clearly defined in all job descriptions. For employees of Nics, failure to adhere to this policy and procedures could lead to action under the disciplinary policy. Nics

Manager has a responsibility to ensure that Nics has clear safer recruitment and whistleblowing policies and that these are adhered to.

15.5 **Partners** are responsible for ensuring that:

- Safeguarding children is integral to clinical governance and audit arrangements
- Nics meets the contractual and clinical governance arrangements on safeguarding children
- All staff are alert to the potential indicators of abuse or neglect, and know how to act on those concerns in line with local guidance

15.6 **GPs** have an important role to play in safeguarding and promoting the welfare of children**.** Identification of abuse has been likened to putting together a complex multi-dimensional jigsaw. GPs hold knowledge of family circumstances and can interpret multiple observations accurately recorded over time, and may be the only professionals holding vital pieces necessary to complete the picture. The General Medical Councils (GMC) '*Good medical practice code'* (2013) stresses the need for doctors to protect patients and take prompt action if "*patient safety, dignity or comfort is or may be seriously compromised".*

15.7 **Practice nurses** must ensure that Safeguarding is part of everyday nursing practice. The Nursing and Midwifery Council's (NMC) Code of Conduct states that Nurses should raise concerns immediately if they believe a person is vulnerable or at risk and needs extra support and protection. The Code states that Nurses must:

- Take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse
- Share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information
- Have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people

15.8 **Staff members, including partners, employed staff and volunteers** have an individual responsibility to:

- Be alert to the potential indicators of child abuse or neglect and know how to act on those concerns in line with national guidance and the safeguarding child procedures;
- Be aware of and know how to access SSCBPs policies and procedures
- Take part in training, including attending regular updates to maintain their skills and are familiar with procedures aimed at safeguarding children

- Understand the principles of confidentiality and information sharing in line with local and government guidance
- Contribute, when requested to do so, to the multi-agency meetings established to safeguard and protect vulnerable children

16. What to do if you have concerns about a child's welfare or a child tells you about abuse

16.1 Concerns about the wellbeing and safety of a child must always be taken seriously. Any member of practice staff who becomes aware of concerns of abuse must report those concerns as soon as possible and if possible within the same working day to the relevant senior manager/ safeguarding lead within Nics. Depending on the level of concern this may result in a referral to **Single Point of Access (SPA).** In certain circumstances (e.g. the concern is raised by a non-clinical staff member), the referrer may need additional support from their senior manager or Nics safeguarding lead.

See Appendix One Contact details & Appendix Two Child Safeguarding Referral Flowchart.

All referrals should be followed up in writing by completing the Surrey Childrens Services Request for support form (link below). Consent should be obtained from the family where ever it is possible to do so without increasing risk to the child. Lack of consent should not prevent a referral in the best interests of the child. For further information regarding information sharing see section 23.
Surrey Childrens Services Request for Support Form

16.2 When a child makes a disclosure it is important to reassure the child at risk and that the information will be taken seriously. It is good practice to ensure that the child is given information about what steps will be taken, including any emergency action to address their immediate safety or well-being.

16.3 The human rights and views of the child should be considered as a priority, with opportunities for their involvement in the safeguarding process to be sought in ensuring that the safeguarding process is person centred.

16.4 If a child in need of protection or any other person makes an allegation to you asking that you keep it confidential, you should inform the person that you will respect their right to

confidentiality as far as you are able to, but that you are not able to keep the matter secret and that you may need to inform other professionals. This may include your manager/safeguarding lead within Nics, the Designated Nurse Safeguarding Children and the Local Authority safeguarding team.

16.5 If it is suspected that a crime could have been committed, it is important that you do not contact the person alleged to have caused harm or anyone that might be in touch with them. Contact the police 999 in an emergency or 101 for non-emergencies. Ensure that steps are taken to preserve any forensic evidence as advised by the police.

16.6 The disclosed information must be recorded in the health records in the way that the child describes the events.

16.7 Where patients are mentally competent they should be included in any decision about disclosure of their information to a third party, such as the LA. If abuse is suspected, considerate discussions must take place with the patient. Patients often disclose matters to their doctor/nurse in the expectation that their information will be kept confidential and maintaining confidentiality can form the basis of valuable trust and support.

16.8 Ideally, the patient will give their consent before any of their personal information is disclosed to a third party. There are however some circumstances when disclosure is in the public interest and this may outweigh the potential harm of breaching confidentiality. This can occur when there is a risk of a serious crime or serious harm. When the child consents but the parent doesn't a decision would need to be made in the best interests of the child.

16.9 The GMC advises that:

"*Personal information may… be disclosed in the public interest, without patients' consent, and in exceptional cases where patients have withheld consent, if the benefits to an individual or to society of the disclosure outweigh both the public and the patient's interest in keeping the information confidential. You must weigh the harms that are likely to arise from non-disclosure of information against the possible harm both to the patient, and to the overall trust between doctors and patients, arising from the release of that information."*

16.10 If any member of Nics team is unsure how to proceed or is in doubt about raising a concern, the case can be discussed with a senior colleague/line manager, Safeguarding Practice lead,

Designated GP or Named GP Safeguarding Children or a member of the Child Safeguarding team. **See Appendix Three Surrey wide CCG Safeguarding Contact Details**

17. Risk Assessment

17.1 It is best practice to raise a concern at the earliest opportunity of the allegation from when the abuse or neglect was witnessed or suspected. A preliminary risk assessment should be undertaken with the main objective to act in the best interest of the child at risk and to prevent the further risk of potential harm. It is important to consider the following:

- Is the child at risk, still in the place where the abuse was alleged or suspected or is the child about to return to the place where the abuse was alleged or suspected.
- Will the person alleged to have caused harm have access to the child at risk or others who might be at risk?
- What degree of harm is likely to be suffered if the person alleged to have caused harm is able to come into contact with the child at risk or others again?

17.2 Once the concern has been raised and if appropriate to be managed by the safeguarding process, the safeguarding plan sets out an individual risk assessment plan to ascertain what steps can be taken to safeguard the child at risk, review their health or social care needs to ensure appropriate accessibility to relevant services and how best to support them through any action to seek justice or reduce the risk of further harm.

17.3 A child who has capacity may choose to stay in an abusive situation or choose to not take part in the safeguarding process. In such a case the plan may therefore be centred on managing the risk of the situation with the person ensuring that they are aware of options to support their safety. Such cases will require careful monitoring and recording so it is recommended to seek advice if this occurs.

18. Multi-Agency Risk Assessment Conference (MARAC)

18.1 A MARAC is the multi-agency meeting that manage high-risk cases of Domestic Abuse. At the heart of a MARAC is a working assumption that no single agency or individual can see the complete picture of the life of a person at risk, but all may have insights that are crucial to

their safety as part of the coordinated community response to DV and abuse. If a safeguarding child's referral indicates that there are issues of DV and abuse, stalking or honour-based violence, a decision must be taken about referral to the MARAC and who should make that referral. In most cases this would be Nics Lead for Safeguarding.

18.2 **Aims of a MARAC:**

- Increase the safety, health and well-being of victims, including children and their children
- Determine the level of risk that the perpetrator poses to the victim and associated children, and whether there is any risk to the general public
- Implement a risk management plan that provides professional support to all those at risk and reduce the likelihood of further harm
- Reduce repeat victimisation
- Improve agency accountability
- Improve support for staff involved in high risk domestic abuse cases
- Contribute to the development of best practice
- Identify policy issues arising from cases discussed at MARACs and address these through the appropriate channels

18.3 Consideration needs to be given when sharing information for these meeting with regard to appropriate information sharing i.e. with consent of child at risk; or overriding consent if life-threatening situation or in wider public interest.

18.4 Surrey Police MARAC Coordinators, based in the Surrey Police Safeguarding Investigation Units (SIU) can provide appropriate guidance for making a referral. Contact via 101 or telephone number: 01483 630015 or email: MARACCRU@surrey.pnn.police.uk).

18.5 Surrey MARAC Protocol

MARAC Protocol Refresh - FINAL 20-1

18.6

Safe Lives - Domestic Abuse Resources for GPs: www.savelives.org.uk

Guidance-on-recor
ding-of-domestic-vi

19. Multi-Agency Public Protection Arrangements (MAPPA)

19.1 Since June 2014 the National Probation Service (NPS) and Community Rehabilitation Company (CRC) are the responsible body to manage high risk offenders. NPS works in partnership with police, prison and local authorities through the MAPPA.

19.2 The purpose of MAPPA is to help reduce the re-offending behaviour of sexual and violent offenders in order to protect the public, including previous victims, from serious harm. It aims to do this by ensuring that all relevant agencies work together effectively to:

- Identify all relevant offenders complete comprehensive risk assessments that take advantage of coordinated information sharing across the agencies.
- Devise, implement and review robust risk management plans; and focus the available resources to best protect the public from serious harm.

19.3 The NPS, police and prison service are the responsible authorities required to ensure the effective management of offenders, however NHS, social services, education and housing all have a duty to cooperate under the Criminal Justice Act (2003).

20.0 Serious Case Review (SCR)

A Serious Case Review takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. It looks at lessons that can help prevent similar incidents from happening in the future. They are not inquiries into how a child died or was seriously harmed, or into who is culpable. These are matters for coroners and criminal courts, respectively, to determine as appropriate. Nor are SCRs part of any disciplinary inquiry or process relating to individual practitioners.

The process is detailed in the Surrey Safeguarding Children Partnership (SSCP) from local reviews page on the SSCP website.

Learning from local reviews

Other types of reviews may also be commissioned, including Partnership reviews and Single-Agency Reviews.

21.0 Domestic Homicide Reviews (DHR)

21.1 In 2013 the Home Office published the revised '*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews',* which was created as part of the framework of the over-arching '*Domestic Violence, Crime and Victims Act 2004'*

The purpose for undertaking DHRs is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

21.2 DHR means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

(a) A person to whom she/he was related or with whom she/he was or had been in an intimate personal relationship, or

(b) A member of the same household as her/himself.

21.3 It should be noted that an '*intimate personal relationship'* includes relationships between children who are or have been intimate partners or family members, regardless of gender or sexuality.

21.4 This legal requirement has been established to ensure agencies are responding appropriately to victims of DV by offering and putting in place appropriate support mechanisms, procedure, resources and interventions. The aim is to avoid future incidents of domestic homicide and violence.

22. Child Death Review Process

22.1. Overview

Child Death Review (CDR)
CDR is the process to be followed when responding to, investigating, and reviewing the death of any child under the age of 18, from any cause. It runs from the moment of a child's death to the completion of the review by the Child Death Overview Panel (CDOP). The process is designed to capture the expertise and thoughts of all individuals who have interacted with the case in order to identify changes that could save the lives of children.
Please remember it is a statutory requirement to notify CDOP of all child deaths from birth up to their 18th birthday.

A child death review must be carried out for all children regardless of the cause of death.

- This includes the death of **any live-born baby where a death certificate has been issued**. In the event that the birth is not attended by a healthcare professional, child death review partners may carry out initial enquiries to determine whether or not the baby was born alive. If these enquiries determine that the baby was born alive the death must be reviewed.
- For the avoidance of doubt, it does not include stillbirths, late foetal loss, or terminations of pregnancy (of any gestation) carried out within the law.
- Cases where there is a live birth after a planned termination of pregnancy carried out within the law are not subject to a child death review.

Joint Agency Response (JAR)
Joint Agency Response is the coordinated multi-agency response by the Named Nurse, Police investigator and duty Social Worker and should be triggered if a child's death:

- is or could be due to external causes;
- is sudden and there is no immediately apparent cause (including SUDI/C);
- occurs in custody, or where the child was detained under the Mental Health Act;
- where the initial circumstances raise any suspicions that the death may not have been natural; or
- in the case of a stillbirth where no healthcare professional was in attendance.

Child Death Review Meeting (CDRM)
Once the results of the post-mortem and other investigations are known, the CDRM will take place, ideally before the inquest so as to inform the coroner's investigation. All child deaths will now require a Child Death Review Meeting (CDRM).

The CDRM is a **multi-professional meeting** where all matters relating to an individual child's death are discussed by the professionals directly involved in the care of that child during life and their investigation after death.

The nature of this meeting will vary according to the circumstances of the child's death and the practitioners involved. For example, it could take the form of a final case discussion following a Joint Agency Response; a perinatal mortality review group meeting in the case of a baby who dies in a neonatal unit; a hospital-based mortality meeting following the death of a child with a long-term illness; or similar case discussion.

Child death overview panel (CDOP)

Surrey Child Death Review Partners (CDR) have an established Child Death Overview Panel (CDOP). The CDOP will review the deaths of children under the requirements of the Children Act, 2004 and Working Together to Safeguard Children, 2018. The CDOP will be a standing group of the Surrey Safeguarding Children Partnership.

This is a multi-agency panel who review the deaths of all children normally resident in Surrey, and, if appropriate and agreed between CDR partners, the deaths in their area of non-resident children, in order to learn lessons and share any findings for the prevention of future deaths.

The CDOP is comprised of professionals from various agencies such as Police, Ambulance, Hospital, Primary Care, Education, Hospice and is independently chaired by Public Health. The core standing members from the Child Death Review Team at all meetings will be the Designated Paediatrician for Child Death Reviews, Named Nurse for Child Death Reviews, CDOP Co-ordinator and Child Well-being Professional and Lead for Learning from Child Deaths.

This review will be informed by a standardised report from the CDRM, and ensures independent, multi-agency scrutiny by senior professionals with no named responsibility for the child's care during life. All criminal, coronial and case review process are to be completed prior to presentation at panel.

The purpose of the child death review process is to collect and analyse information about the death of each child who normally resides in Surrey with a view to identifying any matters of concern affecting the health, safety, or welfare of children, or any wider public health concerns. The overall purpose of the child death review process is to understand why children die, put in place interventions to protect other children, prevent future deaths and to support families.

In order to fulfil its responsibilities CDOP should be informed of all deaths of children, normally resident in the geographical area.

22.2. Notification of a child death

CDOP must be notified within 24 hours of a child's death. As soon as a professional becomes aware of a child death they must complete a Surrey eCDOP Notification Form A. The link for the eCDOP Notification Form A can be found on the Child Death page of the Surrey Safeguarding Partnership's website
https://www.surreyscb.org.uk/professionals/child-deaths/

22.3 Single Point of Contact

CDOP Coordinator
Email: cdop@surreycc.gov.uk
Tel: 01372 833319

23. Information Sharing

23.1 Sharing of information is vital for early intervention and is essential to protect children at risk from suffering harm from abuse or neglect. It is important that all practitioners understand when, why and how they should share information.

23.2 Always consider the safety and welfare of the child at risk when making decisions on whether to share information about them. Where there is concern that the child may be suffering or is at risk of suffering significant harm then their safety and welfare **must** be the overriding consideration.

23.3 Information may also be shared where a child is at risk of serious harm, or if it would undermine the prevention, detection, or prosecution of a serious crime including where consent might lead to interference with any potential investigation.

23.4 Sharing the right information, at the right time, with the right people, is fundamental to good practice in safeguarding children but has been highlighted as a difficult area of practice. It is important to keep a balance between the need to maintain confidentiality and the need to share information to protect others. Decisions to share information must always be based on professional judgement about the safety and wellbeing of the individual and in accordance with legal, ethical and professional obligations.

23.5 Ideally consent should be provided along with the request for child health information however there are times when the concerns/risks to the child are such that it is not appropriate to seek consent, principally as this may increase the risk of further abuse. A lack of consent should not prevent a GP or other practitioner within Nics from sharing information if there is sufficient need in the public interest to override the lack of consent.

Where the practitioner is uncertain advice about consent is available from their Practice Lead, Designated Nurse Safeguarding Children, Named GP Safeguarding, Surrey LAs, the GMC, NMC, LMC or medical and nursing defence organisations. GMC, national and local protocols can be found via the following links:

GMC children and young people, confidentiality and information sharing

Information sharing guidance for **safeguarding** practitioners

Surrey Information sharing resources

23.6 The '***Seven Golden Rules'*** of information sharing are set out in the "*Information Sharing Advice for practitioners*" providing safeguarding services to children, young people, parents and carers (2015)

https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice

This guidance is applicable to all professionals charged with the responsibility of sharing information, including in safeguarding children scenarios.

1. **The Data Protection Act is not a barrier**
2. **Be open and honest**
3. **Seek advice**
4. **Share with informed consent**
5. **Consider safety and well-being**
6. **Necessary, proportionate, relevant, accurate, timely and secure**
7. **Keep a record of your concerns**
8.

24. Recording Information

24.1 Where there are concerns about a child's welfare, discussions and decisions made and the reasons for those decisions must be recorded in writing in the person's medical records.

24.2 This Practice ensures that computer systems are used to identify those patients and families with risk factors or concerns using locally agreed Read Codes.

Read code lists are contained in Tool 3 of RCGP and NSPCC safeguarding children toolkit for general practice. See link below:

RCGP / NSPCC safeguarding children toolkit for general practice

24.3 It is recognised that it is as important to be alert to other children and members of the household as the child there are direct concerns about.

24.4 Nics has an Administration Team who are responsible for managing concern and Safeguarding Children information/correspondence held together within one health record.

24.5 Nics has a robust and secure system for recording and acting upon correspondence from external agencies such as secondary and social care. For example:

- Procedures for receiving in and handling information requests including Section 17 and Section 47 requests and Case Conference invitations and reports both initial and review
- Procedures for receiving in, acting upon, filing and storage of Child Protection information such as Case Conference reports.

The Surrey Countywide Safeguarding Team – Safeguarding Childrens Information Sharing Requests document 2018 provides further guidance to practices regarding sharing information with outside agencies.


Safeguarding children informatior

25. Implementation

25.1 Practice staff will be advised of this policy through Practice meetings. The Safeguarding Children's Policy will be available via the please insert per practice

25.2. Breaches of this policy may be investigated and may result in the matter being treated as a disciplinary offence under Nics disciplinary procedure.

26. Training and Awareness

26.1 Nics's induction for Directors and employees will include a briefing on the Safeguarding Children Policy by Nics Manager or Practice Lead for Safeguarding. At induction new

employees will be given information about who to inform if they have concerns about a Child's safety or welfare and how to access the Surrey Safeguarding Child procedures.

26.2 All staff must be trained and competent to be alert to potential indicators of abuse and neglect in Children, know how to act on their concerns and fulfil their responsibilities in line with SSAB policy and procedures; NHS England (2019) Safeguarding Children: Roles and competences for health care staff - Intercollegiate Document; and Looked after children: Knowledge, skills and competences of health care staff - Intercollegiate Role Framework (2019). Link: 2019 Intercollegiate document

26.3 Nics will enable staff to participate in training on child safeguarding and promoting their welfare provided on both a single and interagency basis. The training will be proportionate and relevant to the roles and responsibilities of each staff member.

26.4 Nics will keep a training database detailing the uptake of all staff training so that Nics Manager and Safeguarding Leads can be alerted to unmet training needs.

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

For further information please see the Primary Care Safeguarding Training Strategy and Safeguarding Training Requirements for Primary Care Staff documents.

RCGP update.
Safeguarding training

27. Safer Employment

27.1 The Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA) functions have now merged to create the DBS.

27.2 Nics recruitment process ensures that it undertakes appropriate criminal record checks on applicants for any position within Nics that qualifies for either an enhanced or standard level check. Any requirement for a check and eligibility for the level of check is dependent on the roles and responsibilities of the job.

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

27.4 For further information see
http://www.homeoffice.gov.uk/agencies-public-bodies/dbs
Or
https://www.nhsemployers.org/your-workforce/recruit/employment-checks

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

- Making clear statement in adverts and job descriptions regarding commitment to safeguarding
- Seeking proof of identity and qualifications
- Providing two references, one of which should be the most recent employer
- Evidence of the person's right to work in the UK is obtained

28. Local Authority Designated Officer (LADO)

28.1 Every local authority has a statutory responsibility to have a local authority designated officer (LADO), who is responsible for coordinating the response to concerns that an adult who works with children may have caused them harm. The LADO's key role is to:

- Provide advice/guidance to employers or voluntary organisations
- Liaise with the police and other agencies including OFSTED and professional bodies such as the General Medical Council, HCPC and the College for Teaching and Leadership
- Monitor the progress of referrals to ensure they are dealt with as quickly as possible, consistent with a thorough and fair process
- Seek to resolve any inter-agency issues
- Collect strategic data and maintain a confidential database in relation to allegations
- Disseminate learning from LADO enquiries throughout the children's workforce.

Regardless of the nature of allegations and who receives the allegation, it must be reported to the LADO. This must include situations where the worker resigns. Compromise agreements are not acceptable in such circumstances and may put others at risk in the future.

Complaints procedures are separate to the allegations process and just because someone does not wish to make a complaint, this does not mean the allegation should not be considered and investigated (SSCP)

To contact the Duty LADO please call: 0300 123 1650 (option 3)

LADO referral form

28.2 Children can be subjected to abuse by those who work with them in any and every setting. All allegations of abuse or maltreatment of vulnerable children by an employee, agency worker, independent contractor or volunteer will be taken seriously and treated in accordance with SAP policy and procedures. A referral to the Child Local Authority Designated Officer (LADO) must take place so consideration of the safety of children at risk to can be considered as a matter of urgency. For Surrey guidance follow the following link: Allegations against people who work with children

28.3 Nics Safeguarding Lead should, following consultation with the Designated Child Safeguarding Nurse, LA Safeguarding Children Enquiry Team and where appropriate the Police (and retain any evidence), inform the subject that allegations have been made against them without disclosing the nature of those allegations until further enquiry has taken place. If it is deemed appropriate to conduct an investigation prior to informing those who are implicated, clear record needs to be made of who took the decision and why.

28.4 Suspension of the employee concerned from their employment should not be automatic. Depending on the person's role within Nics and the nature of the allegation it may be possible to step the person aside from their regular duties to allow them to remain at work whilst ensuring that they are supervised or have no patient/public contact. This is known as suspension without prejudice. Suspension offers protection for them as well as the alleged victim and other service users, and enables a full and fair investigation/safeguarding risk assessment to take place. The manager will need to balance supporting the alleged victim,

the wider staff team, the investigation and being fair to the person alleged to have caused harm.

28.5 All allegations should be followed up regardless of whether the person involved resigns from their post, responsibilities or a position of trust, even if the person refuses to co-operate with the process. Compromise agreements, where a person agrees to resign without any disciplinary action and agreed future reference must not be used in these cases.

28.6 If it is concluded that there is insufficient evidence to determine whether the allegation is substantiated, the chair of the safeguarding strategy meeting will ensure that relevant information is passed to Nics Safeguarding lead. They will consider what further action, if any, should be taken in consultation with the LA Safeguarding Lead for Managing Allegations and in line with Nics Human Resources procedures.

28.7 When an allegation of abuse or neglect has been substantiated, Nics Safeguarding Lead will consult with the LA safeguarding team for advice and consider what further action, if any, should be taken in consultation with the LA Safeguarding Lead for Managing Allegations and in line with Nics Human Resources procedures. It may be necessary to make a referral to the professional or regulatory body and to the DBS, because the person concerned is considered unsuitable to work with children.

28.8 Every GP practice should have a chaperone policy in place for the benefit of both patients and staff. See the GMC guidance: Intimate examinations and chaperones: http://www.gmc-uk.org/guidance/ethical_guidance/21168.asp

29. Whistle blowing

29.1 Nics recognises that it is important to build a culture that allows practice staff to feel comfortable about sharing information, in confidence and with a lead person, regarding concerns about quality of care or a colleague's behaviour. Direct to or insert link to Nics Whistle Blowing Procedure.

30. Professional Challenge

30.1 This Practice enables and encourages any practice member that disagrees with an action taken and still has concerns regarding a child at risk of abuse to either contact the Safeguarding Practice Lead or the Designated or Named GP Safeguarding Children for independent reflection and support**.**

30.2 Surrey **Inter-Agency Escalation Procedure for Professionals with Child Welfare Concerns** SSCB Escalation Policy Flowchart: https://www.surreyscp.org.uk/?s=escalation+policy

31. Clinical and Safeguarding Supervision

31.1 Safeguarding Supervision an essential and integral component of good Clinical and safeguarding supervision for all clinical staff. In particular Nics recognises the need for heightened awareness of safeguarding issues regarding children, young people and vulnerable children in all services. This includes services in which staff do not regularly come into contact with these patient groups as they may still be the first to identify safeguarding issues relating to a non-service user. In order to provide safe and high quality services for children, young people and vulnerable children, practitioners require timely supervision which provides protected time to reflect on practice, make decisions, assess risks and improve the quality of practice.

31.2 Medical practitioners are responsible for maintaining their portfolio to support enhanced appraisal and revalidation. This includes a record of supervision sufficient to support their speciality's requirements which is evidenced at the revalidation appraisal.

31.3 In many practices, informal support and monitoring arrangements for staff may exist. Although this is very valuable, this should not be confused with clinical and safeguarding supervision. Clinical and safeguarding supervision is a formal arrangement, involving protected time for the supervisee to discuss issues relating to clinical practice. All clinical staff must receive regular protected clinical and safeguarding supervision time, including preparation time. Clinical and safeguarding supervision sessions should be free from interruptions and be prioritised by both supervisor and supervisee. Actions agreed as part of the clinical and safeguarding supervision process must be completed within an agreed

timescale by the supervisor/supervisee.

32. Monitoring and Audit

32.1 Audit of awareness of this safeguarding children policy and processes will be under taken by Nics Manager and Practice Safeguarding Lead and lessons learned disseminated to staff as with SCRs, DHRs and IMRs.

33. Policy Review

33.1 This policy will be reviewed two years from the date of issue. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation/guidance, as instructed by the senior manager responsible for this policy.

34. References

In developing this Policy account has been taken of the following statutory and non-statutory guidance, local and national policies and procedures.

British Medical Association Children and Young People Ethics Toolkit
https://www.bma.org.uk/advice/employment/ethics/children-and-young-people/children-and-young-peoples-ethics-tool-kit
City of York and North Yorkshire Safeguarding Children Boards, Cumbria Resilience Project, *Adverse Childhood Experiences.*
Health and Social Care Act (2008) (Regulated Activities) regulations (2014)
http://www.legislation.gov.uk/uksi/2014/2936/pdfs/uksi_20142936_en.pdf
HM Government (2015) Information Sharing Advice for practitioners providing safeguarding services to children, young people, parents and carers
https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice
HM Government (2015) Revised PREVENT Duty Guidance for England and Wales

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445977/3799_Revised_Prevent_Duty_Guidance__England_Wales_V2-Interactive.pdf
HM Government, 2014, *The Care Act,* available from: http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
Local Government Association (2014) Making Safeguarding Personal: https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal
NHS England (2019) Safeguarding Children: Roles and competences for health care staff Intercollegiate Document https://www.rcn.org.uk/professional-development/publications/007-366
NHS Health Scotland, 21st March 2019, *Adverse Childhood Experiences (ACEs)*, available from: http://www.healthscotland.scot/population-groups/children/adverse-childhood-experiences-aces/overview-of-aces
NICE, Updated 2017, *Child maltreatment: when to suspect maltreatment in under 18s,* available from: https://www.nice.org.uk/guidance/CG89/chapter/1-Guidance#emotional-behavioural-interpersonal-and-social-functioning
NSPCC, *Harmful Sexual Behaviour*, available from: https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/harmful-sexual-behaviour/
Mental Capacity Act, 2005, available from: http://www.legislation.gov.uk/ukpga/2005/9/contents
Royal College of Paediatrics and Child Health, 2015, *Looked after children: Knowledge, skills and competences of health care staff - Intercollegiate Role Framework,* Available from: https://www.rcpch.ac.uk/sites/default/files/Looked_after_children_Knowledge__skills_and_competence_of_healthcare_staff.pdf
Staffordshire and Stoke-on-Trent Safeguarding Children Board, 2017, *Safeguarding and Young Carers*, available from: https://www.staffsscb.org.uk/Professionals/Procedures/Section-Four/Section-Four-Docs/Section-4W-Safeguarding-Young-Carers-Policy.pdf
Surrey Safeguarding Children's Board, 2019, *Effective Family Resilience in Surrey: Effective Family Resilience Surrey - Every Child in Surrey Matters*, Available from: https://www.surreyscb.org.uk/wp-content/uploads/2018/12/Effective-family-resilience-SSCB-Final-v1.pdf

Appendix One – Single point of access (SPA)

The Single point of access (SPA) is the single point of contact **for reporting concerns about the safety of a child, young person or adult.** It aims to improve the safeguarding response for children at risk of abuse or neglect through better information sharing and high-quality and timely responses.

The SPA achieves this by co-locating agencies. It brings together Surrey County Council social care **workers for both children and adults**, early help services, health workers and police as well as a vast array of virtual partners across Surrey. Its aim is to identify need, risk and harm accurately to allow timely and the most appropriate intervention.

Availability: 9am to 5pm, Monday to Friday

Phone: 0300 470 9100

Out of hours phone: 01483 517898 to speak to our emergency duty team.

Email: emails are dealt with during normal office hours if you want to report concerns for a child or young person, please contact csmash@surreycc.gov.uk

For concerns for an adult: ascmash@surreycc.gov.uk

Fax number: 01483 519862

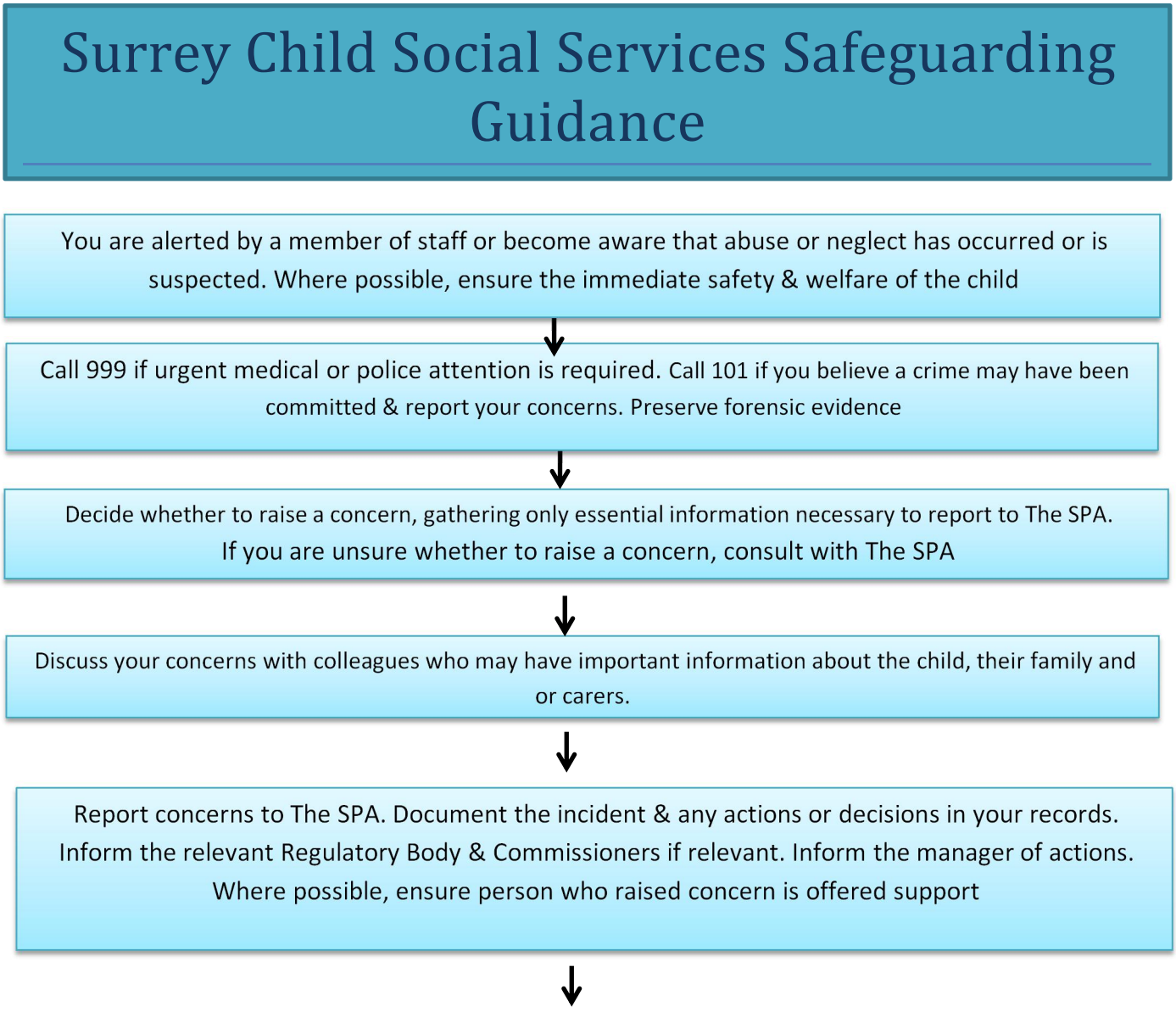
For local area contact details please see:

https://www.surreycc.gov.uk/social-care-and-health/childrens-social-care/contact-childrens-services

The SPA referral form (Surrey Childrens Services Request for support form) can be accessed via:

Surrey Childrens Services Request for support form

Appendix Two – Child Safeguarding Referral Flowchart



The SPA will acknowledge receipt of the initial form; will assess information & decide upon the most appropriate response to the concern. This may be a statutory or non-statutory enquiry.

↓

The SPA will advise you how your concerns will be addressed. You should advise The SPA of any changes to the child's situation.

↓

Whenever possible, Surrey Child Social Services will work in partnership with all agencies & services to address concerns, including informing regulatory bodies & relevant commissioners.

Appendix Three - Contact Details

Surrey wide Clinical Commissioning Group **Safeguarding Children**
Surrey Wide Associate Director of Safeguarding Amanda Boodhoo Email: Amanda.boodhoo@nhs.net Mobile: 07799 622327
Surrey-wide CCG Designated Nurse for Looked After Children | Deputy Designated Nurse Safeguarding Children Linda Cunningham Email: lindacunningham2@nhs.net Mobile: 07748 111917
Surrey-wide CCG Designated Nurse for Looked After Children | Deputy Designated Nurse Safeguarding Children Rachel Redwood Email: rachael.redwood@nhs.net Mobile: 07827 663745
Designated Nurse for Safeguarding Adults Helen Blunden Mobile: 07894 599133 Email: Helen.blunden@nhs.net
Designated Doctor for Looked After Children/named GP Safeguarding Children Dr Sharon Kefford Email: Sharon.kefford@nhs.net Mobile: 07768 107210

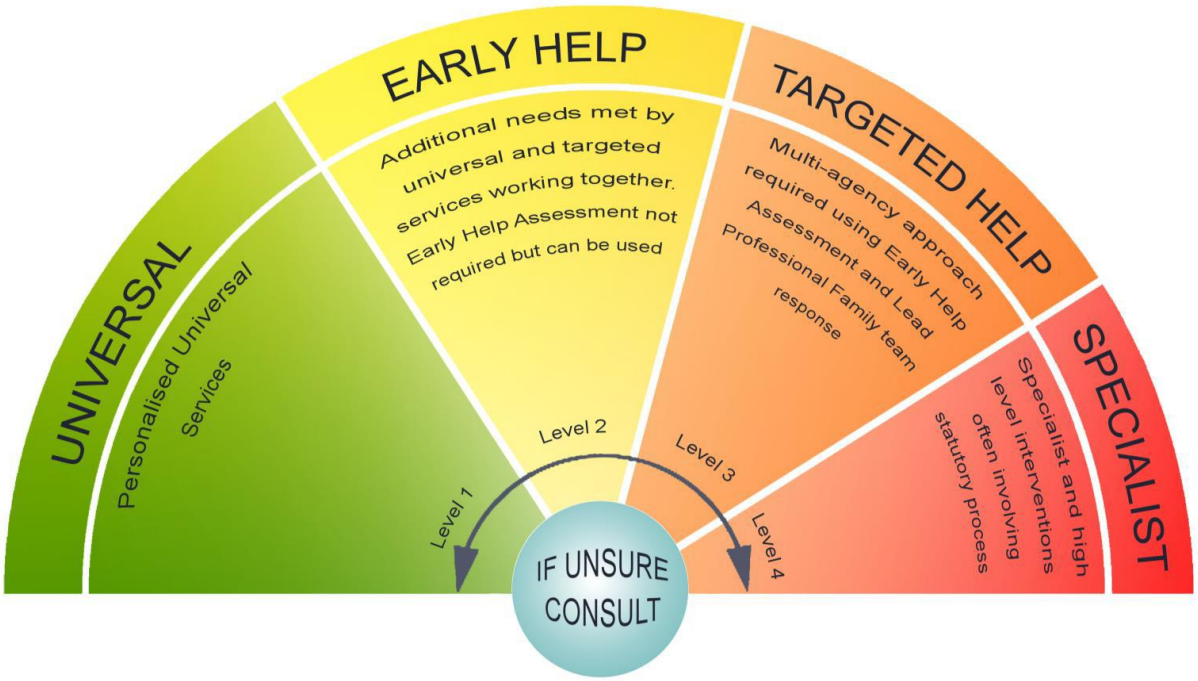
Designated Dr Safeguarding Children Dr Kate Brocklesby Email: Kate.Brocklesby@nhs.net
Designated GP Safeguarding Children and Adults Dr Tara Jones Email: Tara.jones@nhs.net Mobile: 07768 252202
Safeguarding Nurse Advisor for Children and Adults Noreen Gurner Mobile: 07824 350491 Email: noreen.gurner@nhs.net
Safeguarding Nurse Advisor for Children and Adults Rebecca Eells Mobile: 07392 273318 Email: Rebecca.eells@nhs.net
Designated Paediatricians for Child Death Reviews Dr Lisa Wall Tel: 07769-692281Email: lisa.wall@nhs.net Dr Kate BrocklesbyTel: 07876-148244Email: kate.brocklesby@nhs.net
Surrey Wide CCG Specialist Nurse for Child Death Reviews Nicola Eschbaecher Mobile 07824 350491 Email: n.eschbaecher@nhs.net
Safeguarding Children and Children Business Manager Lisa Parry Mobile: 0750 0990623 Email: lisa.parry1@nhs.net
Surrey Wide CCG Safeguarding Business Officer Anna Miles Mobile: 07500 953839 Email: Anna.Miles3@nhs.net

Appendix Four - Safeguarding Children Training Matrix

Training Level	CHILD SAFEGUARDING	PREVENT
Level 1	The minimum level of competence required of all staff working in any health care organization including Governing body members.	All staff working in the health sector. All non-clinical and clinical staff that have any contact with children, children and young people and/or parents/carers including: administrators for LAC children and safeguarding teams, child physicians, GP receptionists. e-Learning (e-Learning for Healthcare) Preventing Radicalisation https://portal.e-lfh.org.uk/Component/Details/459770
Level 2	All staff that have regular contact with patients, their families or carers, or the public. This is the minimum level of competence for all professionally Qualified healthcare staff. This may include - Receptionists, Domestic Assistants, Phlebotomists, Counter staff, as examples of staff who have regular contact with patients. Level 2 should be the minimum level of competence for all qualified healthcare staff.	
Level 3	Nominated primary care leads for safeguarding children.	**Level 3 Prevent training**. All clinical staff working with children, children and young people and/or their parents/carers including: GPs looked after children's nurses, community services (including Practice nurses), People providing services to migrants or asylum seekers, Practitioners working in child community services with children of a working age and Practitioners working in children's community services with young people. **Level 3** e-Learning (e-Learning for Healthcare) Preventing Radicalisation Level 3: https://portal.e-lfh.org.uk/Component/Details/511790
Level 4	Named Professionals including Doctors, Nurses, Allied Health Professionals, Lead Pediatricians and Consultant/Lead Nurses.	

Level 5	Designated Professionals including Doctors, Nurses, Allied Health Professionals, Lead Pediatricians and Consultant/Lead Nurses.	

Appendix 5 – The Surrey Effective Support Windscreen



Appendix Six – Additional Resources:

- GMC page for child safeguarding - http://www.gmc-uk.org/guidance/26855.asp
- RCGP – Safeguarding Children At Risk of Harm Toolkit - http://www.rcgp.org.uk/clinical-and-research/toolkits/safeguarding-children-at-risk-of-harm-toolkit.aspx
- SCIE Safeguarding resources - http://www.scie.org.uk/children/safeguarding/
- FGM mandatory reporting flowchart – https://www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare
- Primary Care Resources when coming into contact with domestic abuse http://www.safelives.org.uk/gp
- NHS Safeguarding Guide App - Available on:

- Google Play: https://play.google.com/store/apps/details?id=com.antbits.nhsSafeguardingGuide&hl=en_GB
- Apple: https://itunes.apple.com/gb/app/nhs-safeguarding-guide/id1112091419

Appendix Seven - Glossary

Care Quality Commission (CQC)
Child Death Overview Panel (CDOP)
Clinical Commissioning Group (CCG)
Community Rehabilitation Company (CRC)
Criminal Records Bureau (CRB)
Disclosure and Barring System (DBS)
Domestic Homicide Reviews (DHRs)
Domestic violence (DV)
Female Genital Mutilation (FGM)
Forced Marriage (FM)
General Medical Council (GMC)
General Practitioners (GP)
Honour Based Violence' (HBV)
Independent Safeguarding Authority (ISA)
Individual Management Review (IMR)
Surrey Safeguarding Child Board (SSAB).
Local Authority (LA)
Multi-Agency Public Protection Arrangements (MAPPA)
Multi-Agency Risk Assessment Conferences (MARAC)
National Probation Service (NPS)
Nursing and Midwifery Council's (NMC)
Primary Health Care Team (PHCT)
Safeguarding Children Board (SAB)
Serious Case Reviews (SCR)