Tile House Surgery

Policy:	**Safeguarding Children and Young People**
Date:	28/08/18
Reviewed date:	
Next Review Date:	30 September 2020
Person Responsible	Dr S Natarajan
Scope:	The purpose of this protocol is to provide details of the Tile House safeguarding children policy.

Contents

Policy statement

Under the 1989 and the 2004 Childrens Acts, a child or young person is anyone under the age of 18 years. Safeguarding children is the action we take to promote the welfare of all children and protect them from harm.

Child Protection refers to the activity that is undertaken to protect specific children who are suffering or at risk of suffering significant harm.

The Practice recognises that all children have a right to protection from abuse and neglect and the Practice accepts its responsibility to safeguard the welfare of all children with whom staff may come into contact.

We intend to:

Respond quickly and appropriately where information requests relating to child protection are made, abuse is suspected or allegations are made.

Provide children and parents with the chance to raise concerns over their own care or the care of others.

Safeguarding Children and Young People:

Have a system for dealing with, escalating and reviewing concerns.

Remain aware of child protection procedures and maintain links with other bodies, especially the commissioning body's appointed contacts.

Practice Safeguarding Children and Young People Statement

The Tile House Surgery has a statutory duty of care towards children (Section 11 Children Act 2004) and young people at risk. We are committed to a best practice which safeguards children and young people irrespective of their background, and which recognises that a child may be abused regardless of their age, gender, religious beliefs, racial origin or ethnic identity, culture, class, disability or sexual orientation.

Having safeguards in place within any organisation not only protects and promotes the welfare of children and young people at risk, but also enhances the confidence of staff, volunteers, parents/carers and the general public. Protecting children and young people from abuse, neglect and exploitation, preventing impairment of health and development, and ensuring children grow up in circumstances consistent with the provision of safe and effective care enables them to have optimum life chances and enter adulthood successfully.

The Tile House Surgery is committed to safeguarding children, young people at risk and have a responsibility to ensure that their practice staff know what to do if they encounter child or adult abuse or have concerns that they may be at risk of harm.

The practice is committed to working within agreed policies and procedures and in partnership with other agencies to ensure that the risks of harm to a child or young person are minimised. This work may include direct and indirect contact with children (access to patient's details, communication via email, text message/phone).

We aim to ensure that The Tile House Surgery is a child safe practice.

The Practice will ensure that all staff are trained to a level appropriate to their role. New members of staff will receive induction training.

Definitions

Definitions in relation to the following terms used within this document are taken from statutory guidance (HM Government, 2015):

"Child" or "young person", as in the Children Act 1989 and 2004, is anyone who has not yet reached their 18th birthday. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate, does not change his/her status or entitlements to services or protection. Where *'child'* or *'children'* is used in this document, this refers to children and young people.

"Safeguarding" and "promoting the welfare of children" is the process of protecting children from abuse or neglect and/or preventing impairment of their health or development. This includes ensuring that children are growing up in circumstances consistent with the provision of safe and effective care and taking action to enable all children to have the best life chances.

"Child In Need" is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services; or a child who is disabled. In such circumstances assessments by a social worker are carried out under Section 17 of the Children Act 1989 with parental consent.

"Child Protection" is one element of safeguarding and promoting children's welfare. Child protection refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm.

"Significant Harm" is the concept introduced by the Children Act 1989 as the threshold that justifies compulsory intervention in family life in the best interests of children. It gives Local Authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer, significant harm.

"Abuse" and "Neglect:" are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others (e.g. via the internet). They may be abused by an adult or adults, or another child or children.

Statutory guidance defines four categories of abuse (HM Government, 2015):

Physical abuse: "A form of abuse which 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."
NB: Female genital mutilation is considered to be a form of physical abuse.

Emotional abuse: 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 a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a 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 (including cyber 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, though it may occur alone.

Sexual abuse: this involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. It may not necessarily involve a high level of violence. The sexual activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. Sexual abuse may also include non-contact activities, such as involving children in looking at or in the production of sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Women can also commit acts of sexual abuse, as can other children

NB: Child Sexual Exploitation is a form of child sexual abuse

Neglect: this 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;
- Neglect may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

Basic principles

- The welfare of the child is paramount.
- It is the responsibility of all adults to safeguard and promote the welfare of children and young people. This responsibility extends to a duty of care for those adults employed, commissioned or contracted to work with children and young people.
- The Practice must have safe recruitment practices including appropriate use of The disclosure and barring service https://www.gov.uk/government/organisations/disclosure-and-barringservice/ about and safe whistle blowing processes.
- Staff who work with children are responsible for their own actions and behaviour and should avoid any conduct which would lead any reasonable person to question their motivation and intentions.
- Staff should work and be seen to work, in an open and transparent way.
- The same professional standards should always be applied regardless of culture, disability, gender, age, language, racial origin, religious belief and/or sexual identity.
- Staff should continually monitor and review their practice and ensure they follow the guidance contained in this document and elsewhere.
- The Practice will ensure regular meetings are held to discuss vulnerable children and families and that such meetings include other Agencies such as Midwives and Public Health Nurses to ensure early recognition of circumstances leading to abuse and neglect and early intervention to help prevent abuse and neglect.
- The Practice will ensure children and their families are able to share concerns and complaints and that there are mechanisms in place to ensure these are heard and acted upon.

Paramount principles

The Children's Act 2004 supplemented the 1989 Act and reinforced the message that all organisations working with children have a duty to safeguard and promote the welfare of children.

Sections that are invoked frequently in relation to child safeguarding:

Section 1 "Paramountcy Principle"

- A child's welfare is paramount when making any decisions about a child's upbringing, known as the "paramountcy principle"
- The court must ascertain the wishes and feelings of the child and shall not make an Order unless this is "better for the child than making no Order at all"
- Every effort should be made to preserve the child's home and family links

Section 17 – Provision of Services for Children in Need

A child in need is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services; or a child who is disabled.
In these cases, assessments by a social worker are carried out under section 17 of the Children Act 1989.
Children in need may be assessed under section 17 of the Children Act 1989, in relation to their special educational needs, disabilities, or as a carer, or because they have committed a crime. The process for assessment should also be used for children whose parents are in prison and for asylum seeking children.
The definition will include any child or young person under the age of 18.
The services provided by a Local Authority under this section may include providing accommodation, giving assistance in kind, or in exceptional circumstances, in cash.

Section 47 – Duty to Investigate

Where there is reasonable cause to suspect that a child is suffering, or likely to suffer, significant harm, the local authority is required under section 47 of the Children Act 1989 to make enquiries, to enable it to decide whether it should take any action to safeguard and promote the welfare of the child.
The Children Act 1989 places a statutory duty on health, education and other services to help the local authority carry out its social services functions under Part 3 of the Children Act 1989 and section 47 enquiries. All agencies then have a duty to assist and provide information in support of child protection enquiries.

Responsibilities

Dr S Natarajan is the appointed Clinical Safeguarding Lead within the practice.
Dr J Indrakumar is the appointed Clinical Safeguarding Deputy within the practice.
Linda Upson is the Administrative Safeguarding Lead.
The Clinical Safeguarding Lead is responsible for all aspects of the implementation and review of the children's safeguarding procedure in this practice.

Child protection: sources of advice and support
Contact information

Practice Clinical Safeguarding Children Lead - contact the Practice
Practice Deputy Clinical Safeguarding Children Lead - contact the Practice
Practice Administrative Lead - contact the Practice
See CCG Contact Sheet for Safeguarding
NSPCC Child Line 0800 1111

Useful websites RCGP/NSPCC Safeguarding Children
Toolkit
Local Safeguarding Children's
Essex Child & Family Wellbeing Service http://essexfamilywellbeing.co.uk
Emotional Well-being and mental health service for young people up to the age of 18 living in Essex https://www.nelft.nhs.uk/services-ewmhs

Common presentations and situations in which child abuse may be suspected include:

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

Some other situations which need careful consideration are:

- Repeated attendance of young baby under 12 months of age.
- Any bruising or injury in child under 24 months of age.
- Very young girls or girls with learning difficulties or disability requesting contraception, especially emergency contraception.
- Girls under 16 presenting with pregnancy or sexually transmitted disease, especially those with learning difficulties, chronic long term illness, complex needs or disability.
- Situations where parental factors such as mental health problems, alcohol, drug or substance misuse, learning difficulties, domestic abuse may impact on children and family life.
- Unexplained or suspicious injuries such as bruising, bites or burns, particularly if situated unusually on the body.
- The child says that she or he is being abused, or another person reports this.
- The child has an injury for which the explanation seems inconsistent, delayed presentation, or which has not been adequately treated or followed up.
- The child's behaviour changes, either over time or quite suddenly, and he or she becomes quiet and withdrawn, or aggressive.
- Refusal to remove clothing for normal activities or keeping covered up in warm weather.
- The child appears not to trust particular adults, perhaps a parent or relative or other adult in regular contact.
- An inability to make close friends.
- Inappropriate sexual awareness or behaviour for the child's age.
- Fear of going home or parents being contacted.
- Disclosure by an adult of abusive activities, including activities related to internet and social media use.

- Reluctance to accept medical help.
- Fear of changing for PE or school activities.

Immediate actions

- Concerns should immediately be reported to the Lead clinician.
- Concerns should be discussed internally and an action plan decided.
- In the absence of one of the nominated persons, the matter should be brought to the attention of the local Safeguarding Team, or, if it is an emergency, and the Designated persons cannot be contacted, then the most senior clinician will make a decision whether to report the matter directly to Children's Social Care or the Police.
- If the suspicions relate to a member of staff there should be internal discussion with the Practice Safeguarding Lead, and a plan of action decided, the local Safeguarding Children team and / or Children's Social Care should be contacted directly. Consideration should be made to involving the LADO.
- Suspicions should not be raised or discussed with third parties other than those named above.
- Any individual staff member must know how to make direct referrals to the child protection agencies and should be encouraged to do so if they have directly witnessed an abuse action; however, staff are encouraged to use the route described here where possible. In the event that the reporting staff member feels that the action taken is inadequate, untimely or inappropriate they should report the matter directly. Staff members taking this action in good faith will not be penalised.
- Where emergency medical attention is necessary it should be given. If necessary as ascertained by clinical judgement the child should be admitted to the care of the emergency Paediatric service and a referral made to Children's Social Care . Any suspicious circumstances or evidence of abuse should be reported to the designated Clinical Lead.
- If a referral is being made to Children's Social Care without the parent's knowledge and urgent medical treatment is required, Children's Social Care should be informed of this need. Otherwise, if it is decided that the child is not at risk, suggest to the parent or carer that medical attention be sought immediately for the child.
- If appropriate the parent/carer should be encouraged to seek help from Children's Social Care prior to a referral being made. If parents do not consent to medical care or to a social care referral and they fail to do so in situations of real concern the safeguarding Lead will contact Children's Social Care directly for advice.
- Where sexual abuse is suspected the Practice Lead will contact Children's Social Care or Police Child Protection Team directly. The Lead will not speak to the parents if to do so might place the child at increased risk.
- Neither the Practice Safeguarding Lead or any other Practice team member should carry out any investigation into the allegations or suspicions of sexual abuse in any circumstances. The Practice Safeguarding Lead will collect exact details of the allegations or suspicion and provide this information to statutory child protection agencies: Social Care, the police or NSPCC, who have powers to investigate the matter under the Children Act 1989.
- Refer to Emotional Wellbeing and Mental Health Services (EWMHS) for children and YP with mental health and behaviour issues

- Refer to EWMHS contact list within policy and referral pathway

What to do with allegations of abuse from a child

Keep calm

- Reassure the child that they were right to tell you, and that they are not to blame and take what the child says seriously.
- Be careful not to lead the child or put words into the child's mouth – ask questions sensitively
- Do not promise confidentiality.
- Fully document the conversation on a word by word basis immediately following the conversation while the memory is fresh.
- Fully record dates and times of the events and when the record was made, and ensure that all notes are kept securely.
- Inform the child/ young person what you will do next.
- Refer to the Practice Safeguarding Lead clinician or Deputy.
- Decide if it is safe for a child to return home to a potentially abusive situation. It might be necessary to immediately refer the matter to Children's Social Care and/or the police to ensure the child's safety.

Safeguarding concerns/professional disagreement

Conflict resolution is an integral part of professional co-operation and joint working to safeguard children. Concern or disagreement may arise over another professional's decisions, actions or omissions in relation to a referral, an assessment or an enquiry. It is important to resolve difficulties quickly and openly by identifying areas in working together where there is a lack of clarity to promote resolution. Guidance should be sort from the most recent SET Safeguarding and Child Protection Procedures and there should be open dialogue with partner agencies when this process is being initiated. The safety and focus of individual children are the paramount consideration in any professional disagreement and unresolved issues should be escalated to the safeguarding lead with due consideration to the risks that may exist for the child. Advice should be sought from the Named Safeguarding Children Professional to promote resolution.

Confidentiality

Staff are required to have access to confidential information about children and young people in order to do their jobs, and this may be highly sensitive information. These details must be kept confidential at all times and only shared when it is in the best interests of the child to do so, and this may also apply to restriction of the information within the clinical team. Care must be taken to ensure that the child is not humiliated or embarrassed in any way.

If an adult who works with children is in any doubt about whether to share information or keep it confidential he or she should seek guidance from the practice clinical Safeguarding Children Lead.

Any actions should be in line with locally agreed information sharing protocols, and whilst the Data Protection Act applies it does not prevent sharing of safeguarding information. Whilst adults need to be aware of the need to listen and support children and young people, they must also understand the importance of not promising to keep secrets. Neither should they request this of a child or young person under any circumstances.

Additionally, concerns and allegations about adults should be treated as confidential and passed to the practice safeguarding lead or appointed person or agency without delay.

Responding to requests for safeguarding/child protection information
All requests for information relating to a child protection investigation or report for Case Conference will be passed to the Child Safeguarding Lead on the day received.
A response will be made in a timely manner, preferably within 48 hours, and if this is not possible the Agency requesting information will be informed and a reason given.

The seven principles to sharing information
1. Remember that the Data Protection Act 1998 and human rights law are not barriers to justified information sharing, but provide a framework to ensure that personal information about living individuals is shared appropriately.
2. Be open and honest with the individual (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
3. Seek advice from other practitioners if you are in any doubt about sharing the information concerned, without disclosing the identity of the individual where possible.
4. Share with informed consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, there is good reason to do so, such as where safety may be at risk. You will need to base your judgement on the facts of the case. When you are sharing or requesting personal information from someone, be certain of the basis upon which you are doing so. Where you have consent, be mindful that an individual might not expect information to be shared.
5. Consider safety and well-being: Base your information sharing decisions on considerations of the safety and well-being of the individual and others who may be affected by their actions.
6. Necessary, proportionate, relevant, adequate, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those individuals who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely (see principles).
7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

CONTEST and PREVENT (Radicalisation of vulnerable people)
Contest is the Government's Counter Terrorism Strategy, which aims to reduce the risk from international terrorism, so that people can go about their lives freely and with confidence. Contest has four strands which encompass;

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

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

Healthcare professionals may meet and treat children and young people who are vulnerable to radicalisation because they may have a heightened susceptibility to being influenced by others.

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.

Practice staff who have concerns that someone may be becoming radicalised should seek advice and support from the Safeguarding Lead.
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 appropriate other (safeguarding lead)
- **Share:** appropriate, proportionate information (safeguarding lead/PREVENT lead)

Hidden Harm
The Tile House Surgery is committed to a best practice which safeguards children and young people irrespective of their background, and which recognises that a child may be abused regardless of their age, gender, religious beliefs, racial origin or ethnic identity, culture, class, disability or sexual orientation.
Hidden harm is harm or abuse that is usually hidden from public view occurring behind closed doors, often not recognised or reported. The emphasis is about spotting signs early and helping to prevent the risk escalation. Staff must follow local SET Child Protection procedures if a hidden harm is identified and a child/young person is at risk of significant harm.

Domestic Abuse
The definition of domestic abuse used by the Home Office and most agencies is: Any incident or pattern of incidents of controlling, coercive, 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. The abuse can encompass but is not limited to: psychological, physical, sexual, financial, emotional.

Modern Day Slavery
Encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.
The impact of trafficking on children: Trafficked and exploited children are not only deprived of their rights to health and freedom from exploitation and abuse - they are usually also deprived of their right to an education and the life opportunities this brings.
Once children have been trafficked and exploited, they are vulnerable to all types of abuse Practice staff who has a concern regarding possible trafficking and exploitation of a child should contact the local authority children's social care for the area in which the child currently resides.

Female Genital Mutilation (FGM)
FGM is a procedure where the female genitals are deliberately cut, injured or changed but there is no medical reason for it to be done. FGM is child abuse and a form of violence against girls and women.

Serious Crime Act 2015 – FGM Mandatory Reporting Duty
It is now a mandatory requirement on all professionals to report FGM in under 18s. This came into effect on Saturday 31st October 2015. The link below provides information on the new Multiagency FGM Statutory Guidance as of 1st April 2016.
https://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation

Breast Ironing
Breast ironing, also known as breast flattening, is the pounding and massaging of a pubescent girl's breasts, using hard or heated objects, to try to make them stop developing or disappear.

Honour Based Abuse
Honour based abuse is a crime or incident which has or may have been committed to protect or defend the honour of the family and/or community. The child or young person may be subjected over a long period to a variety of different abusive and controlling behaviours ranging in severity. The abuse is often carried out by several members of a family including mothers, and female relatives/community members and may, therefore, increase the child's sense of powerlessness and be harder for professionals to identify and respond to.

Forced Marriage
A Forced Marriage (FM) is a marriage conducted without the valid consent of one or both parties and where duress is a factor. Duress cannot be justified on religious or cultural grounds, and forced marriage is an abuse of human rights.
Forced marriages of children must be regarded as a child protection issue. **You would not contact the parents in this situation** and you would make a referral direct to the Police Child Abuse Investigation Team (CAIT) who will liaise with social care.
You can also contact the Forced Marriage Unit on 020 7008 0230 or 020 7008 0151
www.fco.gov.uk

Child Sexual Exploitation (CSE)
Child sexual exploitation (CSE) is a type of sexual abuse.
The definition below is the widely-used definition published by the Government in 2009 (DCSF).
Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities.

In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources.

Gang Violence
Gang violence means criminal and non-political acts of violence committed by a group of people who regularly engage in criminal activity against innocent people. The term may also refer to physical hostile interactions between two or more gang.

Substance Misuse
Substance abuse, also known as drug abuse, is a patterned use of a drug in which the user consumes the substance in amounts or with methods which are harmful to themselves or others, and is a form of substance-related disorder.

Physical examination of a child or young person
A parent or carer should be present at all times, or a chaperone offered. Children should only be touched under supervision and in ways which are appropriate to, and essential for clinical care. See Practice Chaperone Policy.
Permission should always be sought from a child or young person before physical contact is made and an explanation of the reason should be given, clearly explaining the procedure in advance.
Where the child is very young, there should be a discussion with the parent or carer about what physical contact is required. Routine physical examination of an individual child or young person is normally part of an agreed treatment procedure and/or plan and should be understood and agreed by all concerned, justified in terms of the child's needs, consistently applied and open to scrutiny.
Physical contact should never be secretive or hidden. Where an action could be misinterpreted a chaperone should be used or a parent fully briefed beforehand, and present at the time.
Where a child seeks or initiates inappropriate physical contact with an adult, the situation should be handled sensitively and a colleague alerted.

Attitude of parents or carers
Parental attitude may indicate cause for concern:

- Unexpected delay in seeking treatment.

- Reluctance to have child immunised.
- Failure to take child for dental care.
- Failure to attend scheduled appointment with GP or other healthcare providers.
- Denial of injury, pain or ill-health.
- Incompatible explanations, different explanations or the child is said to have acted in a way that is inappropriate to his/her age and development.
- Reluctance to give information or failure to mention other known relevant injuries.
- Unrealistic expectations or constant complaints about the child.
- Alcohol misuse or drug/substance misuse.
- Domestic Abuse or Violence between adults in the household.
- Appearance or symptoms displayed by siblings or other household members.

Training

The Practice's induction for partners and employees will include a briefing on the Safeguarding Children Policy by the Practice Manager or Practice Clinical Lead for Safeguarding. Partners and employees will be given information about who to inform if they have concerns about a child's safety or welfare and how to access the Local Safeguarding Children procedures.

Safeguarding Children Updates are given regularly by Lead Safeguarding GP at Team meetings.

The Practice Safeguarding Children Lead is responsible for ensuring training records are kept and maintained and will liaise with the Practice Appraisal Lead to ensure training is aligned with identified staff development needs. Update and Refresher training is undertaken by all staff appropriate to requirements, in line with Safeguarding Children and Young People Competencies for Health Care Staff Intercollegiate Document (RCPCH, 2014)

- Level 1: All staff including non-clinical managers and staff working in healthcare settings. **This includes GP practice reception staff.**
- Level 2: Minimum level required for non-clinical and clinical staff who have some degree of contact with children and young people and/or parents/carer's. **This includes Healthcare Assistants**
- Level 3: Clinical staff working with children, young people and/or their parents/carer's and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns. **This includes GPs and Nurses.**
- Level 4: Named professionals
- Level 5: Designated professionals

The Practice will keep a training database detailing the uptake of all staff training so that the Practice Manager and Safeguarding Leads can be alerted to unmet training needs. All GPs and Practice staff should keep a learning log for their appraisals and or personal development plans

Record keeping

All information received regarding children from the Safeguarding Children Team and any other associated Services should be regarded as strictly confidential.

This information should be handled by staff members who will deal with such paperwork in the following way.

Child Protection Reports are as important as records of serious physical illness and should be recorded in the same way and with the same degree of permanence.

Case Conference Reports should ideally be scanned into that individual child's electronic General Practice records.

Appropriate coding and templates should be used in Active and Past Problem Lists and priority lists.

Read codes expressing that a child is on a Child Protection Plan, LAC or Vulnerable child should be entered into notes and those of other family members/guardians.

It is vital that when a child who is or has been on a Child Protection Plan moves to another area that the full clinical record including Case Conference Reports be sent to the next GP. Tragedies have resulted from Case Conference Records not being passed on to the child's current GP. (Pass on welfare concerns even if the child is not subject to a child protection plan.)

All contacts with any parties regarding any safeguarding children issues should be recorded on the patient's medical records and any necessary action taken immediately.

Missed Appointments

All letters received from other agencies, hospitals etc for the Practice are sorted each day and scanned and forwarded to a clinician for relevant action.

Appointments missed within the GP surgery are followed up by the clinician if required and the Missed Appointments policy is followed.

Safer Employment

The Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA) functions have now merged to create the Disclosure and Barring Service (DBS). The Practice recruitment process recognises that it has a responsibility to ensure that it undertakes appropriate criminal record checks on applicants for any position within the practice 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. It is also recognised that the Practice 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.

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

Managing Allegations against Staff

If an allegation is made against a member of practice staff and it relates to conduct towards a child, the Practice recognises that The Safeguarding Practice Lead or Practice Manager must ensure that the Local Authority Designated Officer (LADO) who is employed by the Local Authority is informed. The LADO assumes oversight of any subsequent investigation process from beginning to end and will give advice. They will also liaise with the police and social care if necessary. After taking any immediate action in line with practice policy, the Practice Safeguarding Lead or Practice Manager should ensure that the LADO is informed if the staff member has:

- behaved in a way that has harmed, or may have harmed, a child, or
- possibly committed a criminal offence against or related to a child, or
- behaved towards a child in a way that indicates unsuitability to work with children.

Mental Capacity Act (2005) – Capacity and competence in under 18 year olds

This applies to children who are 16 years and over. Mental capacity is present if a person can understand information given to them, retain the information given to them long enough to make a decision, can weigh up the advantages and disadvantages of the proposed course of treatment in order to make a decision, and can communicate their decision. The deprivation of liberty safeguards within the Mental Capacity Act 2005 (MCA) do not apply to under 18s.

In law, children aged 16 and over are presumed to have capacity and able to consent or refuse to treatment in their own right. If there are reasons to believe a child aged 16 or over lacks capacity, an assessment of capacity to consent should be conducted and recorded in their notes.

Children under 16 may be competent to consent to treatment (Gillick competence) and records should show that this has been assessed before starting treatment. The routine assessment of competence in under 16s should be appropriate to the child's age. For example, routine assessments of competence would not be expected in the case of eight and nine-year-olds, but would be more usual for children aged 14 and 15. Where treatment is going ahead on the basis of parental consent, records should show that the person(s) holding parental responsibility and legally capable of consenting on behalf of the child has been identified.

Evidence that valid consent to treatment has been obtained should always be recorded. Valid consent to treatment means that the medical professional has given the child and/or those with parental responsibility appropriate information about the purpose and nature of treatment, including any risks and any alternatives.

Safeguarding Children Toolkit

Royal College of General Practitioners Safeguarding Children Toolkit for General Practice

This RCGP toolkit takes account of new policies, legislation and emerging evidence , it is a workbook to help practice staff recognise when a child may be at risk of abuse, to know

what to do if there are concerns and to ensure that as a practice the team works with other disciplines and agencies to achieve the best possible outcomes for children by safeguarding and promoting their welfare.

Links

The Tile House Surgery follows the guidelines as laid down by Basildon and Brentwood Clinical Commissioning Group, to read the policy please go to:

http://www.basildonandbrentwoodccg.nhs.uk/

and enter into the search box: 'safeguarding children' where you can download and read the up to date policy.

http://basildonandbrentwoodccg.nhs.uk/about-us/policies-and-procedures/children-and-young-people/2164-3-5-b-bbccg-safeguarding-overarching-policy-17april-2016ya-amendedfinal/file

There is also more information on the Essex Safeguarding Children Boards' website which is as follows: A link icon is also on each computer desktop.

http://www.escb.co.uk/Home.aspx

The SET document can be accessed via the link below: - updated January 2018

http://www.escb.co.uk/Portals/67/Documents/Local%20Practices/SET%20Procedures-Jan2018-updated.pdf

Categories of Child Abuse
As outlined in the Working Together to Safeguard Children 2015
https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

Essex Child & Family Wellbeing Service
http://essexfamilywellbeing.co.uk

See also
Looked after Children Policy
Chaperone Policy
DNA (missed appointments) Policy
Whistle blowing Policy
Consent Policy
Gillick Policy
Violence Aggression Policy
Patient Privacy Policy
Dignity Policy
Identifying Patients with Learning Disabilities Policies
Duty or Candour/Being Open
Deprivation of Liberty Safeguards
Information Governance & Caldicott Policy
Confidentiality policy for under 18 years