Safeguarding Children Policy

Version	V6.3
Supersedes:	All previous versions
Date Ratified by Board:	12 September 2012 (original policy)
Reference Number:	PC24POL23
Title & Department of originator:	Quality & Patient Safety
Title of responsible committee/department:	Quality & Workforce Committee
Effective Date:	September 2019
Next Review date:	September 2022
Target audience:	All PC24 Personnel
Impact Assessment Date:	02.02.2018
Summary	The aim of this policy is to ensure that, throughout Primary Care 24, children are protected from abuse and exploitation. The policy details roles and responsibilities of PC24 personnel.

Version	Date	Control Reason	Title of Accountable Person for this Version
V2.0	Jan 2018	Previous versions archived. Review of policy	Director of Nursing
V2.1	Feb 2018	Added information - recording of a safeguarding referral onto Risk Management system added into section 13.2	Director of Nursing
V2.2	Mar 2018	Information added for Sefton primary care staff	Director of Nursing
V3	October 2018	Review and addition of information for St Helens Extended Access Service Added	Director of Nursing
V4.0	June 2019	Addition of information for St Helens Out of Hours added. Logo changes and Primary Care 24 changed to Primary Care 24 throughout the document.	Deputy Director of Nursing
V5.0	September 2019	Review of previous versions with rearrangement of multiple sections	Director of Nursing

V6.0	March 2020	Update of training needs, 27.1	Director of Nursing
V6.1	September 2020	Addition of Warrington CCG Safeguarding referral information	Deputy Director of Nursing
V6.2	March 2021	Reviewed of information relating to new CCG areas. Updated Clinical Lead information in Appendix 3.	Deputy Director of Nursing
V6.3	May 2021	Updated processes for notification and appendix 7 and 13	Safeguarding Clinical Lead

Reference Documents	**Electronic Locations (Controlled Copy)**	**Location for Hard Copies**
Please refer to Section 20 of this document	Primary Care 24 Intranet / Policies/Governance & Risk	**Policy File, Wavertree Headquarters**

Consultation this version: Committees / Groups / Individual	**Date**
Director of Nursing, Associate Director of Nursing, Quality & Workforce Committee	**TBC**

PRIMARY CARE 24
SAFEGUARDING CHILDREN POLICY

	Children – Referral form to complete	Children - Phone Advice	Children - Out of Hours Advice
Liverpool (Careline)	Online MARF (https://liverpool.gov.uk/social-care/childrens-social-care/keeping-children-safe/children-at-risk/marf-form/)	0151 233 3700	0151 233 3700
Sefton (MASH)	Child Referral Form to be emailed (https://www.sefton.gov.uk/social-care/children-and-young-people/report-a-child-or-young-person-at-risk/information-for-professionals.aspx)	0151 934 4013 / 4481	0151 934 3555
St Helens (First Response Team)	Service Request Form to be emailed (https://www.sthelens.gov.uk/social-care-health/children-and-families/professionals-report-a-concern/guidance/)	01744 676767	0345 050 0148
Halton (Social Care)	0151 907 8305	0151 907 8305	Monday to Thursday after 5pm, Friday after 4:30pm, weekends: Emergency Duty Team 0345 0500 148
Knowsley (MASH)	Online MARF (https://marf.knowsley.gov.uk/Home)	0151 443 2600	0151 443 2600
Warrington MASH	MARS form https://ib.warrington.gov.uk/ (Opens in Internet Explorer only)	01925 443322 01925 443400	01925 444400

Please discuss any queries with your Manager or contact:
The PC24 Quality & Patient Safety Team on 0151 254 2553. For queries during the out of hours period please contact the Shift Manager on 0151 221 5837. A clinician is expected to draw on safeguarding training and clinical judgement, or contact social care directly, if only non-clinical support is available.

In the event of any changes to relevant legislation or statutory procedures this policy will be automatically updated to ensure compliancy without consultation. Such changes will be communicated.

CONTENTS

1.0 INTRODUCTION

1.1 Primary Care 24 (PC24) has a statutory duty to ensure it makes arrangements to safeguard and promote the welfare of children and young people and to protect adults at risk from abuse or the risk of abuse. The arrangements should reflect the needs of the vulnerable population they provide services for. Primary Care 24 is also required to contribute to multi-agency arrangements to protect children at risk from radicalisation. This strategy is known as Prevent.

1.2 PC24 is required to ensure that policies and procedures are in place that are compliant with current legislation to safeguard and promote the welfare of children at risk of abuse (i.e. Care Act 2014 and Working Together 2018 compliant). PC24 should also ensure they are linked into the local safeguarding children boards and that health workers contribute to multi-agency working.

1.3 This policy has two functions:

a) It details the roles and responsibilities of PC24 and its personnel
b) It provides clear service standards and compliance monitoring to ensure that all service users are protected from abuse and the risk of abuse.

2.0 SCOPE

This policy applies to all PC24 personnel, including temporary and agency staff. Every member of staff has an individual responsibility for the protection and safeguarding of children. All levels of management must understand and implement PC24 Safeguarding and Protection of Children Policy and Procedure.

3.0 RAISING CONCERNS

3.1 During office hours, if you require additional support or advice on whether to make a referral regarding a child, you should discuss initially with your manager. If they are unavailable, or more support is required, please contact the Quality and Patient Safety Team on 0151 254 2553. This team may then involve the Director of Nursing (Safeguarding Lead) to support you with this decision making process.

3.2 During Out of Hours, if an individual identifies a safeguarding concern and would like to discuss this, the Shift Manager on duty should be contacted (0151 221 5837). The call will then be directed to the Manager or Director on call for advice and support when:

- Where there is a potential for other people to be at risk.
- If the member of personnel is unsure whether to make a Safeguarding referral.
- Concerns are regarding a PC24 member of personnel.

3.3 If a clinician/staff member has identified a safeguarding concern, and there are no managers or directors with a clinical background available, then the clinician/staff member is expected to draw on their own safeguarding training and, if applicable, use clinical judgement to determine if social care should be contacted (for advice or for a referral). If there is any doubt, taking steps towards a referral is recommended. If a clinician/staff member is not sure which local authority they are working in, they should refer to Appendix 7. The Thresholds of Need should be referred to when making a decision about whether a referral is required (Appendix 12).

3.4 If a referral is the preferred outcome, the referrer is expected to use reasonable effort to discuss this with the parent/carer. Concerns should be shared with, and explained to, the parent/carer, and their consent to make a referral to social care should be sought. Parental agreement to referral should be documented. These discussions should not take place if the child or staff member's personal safety may be compromised.

3.5 Where there are concerns about a parent/carer's capacity to consent, they refuse consent, or it is not possible to discuss with the parent/carer at all, this should be clearly documented in the child's notes. If a staff member's personal safety may be compromised by documenting in patient-held notes, then documenting on PC24 records will suffice.

3.6 A flowchart of best practice including assessing capacity and seeking consent can be found in appendix 8 & 9. There are occasions when acting in a child's best interest or acting without consent is acceptable. This should be clearly documented, and if required, discussed with appropriate members of PC24 team. When there is a conflict of interest between the needs of the adult and those of a child, the welfare of the child is paramount (Paramountcy Principle, Children Act 1989). The Thresholds of Need document (appendix 12) is also helpful in determining whether parental consent is needed or not; Levels 1-3 require parental consent, Levels 4 can be referred without consent, although this should always be sought as best practice whenever possible.

3.7 If a safeguarding concern is identified, the identifying individual is responsible for completing the referral. A clinical concern should never be delegated to a non-clinician to complete the referral.

3.8 All Primary Care 24 staff, (clinical or medical) with an urgent child protection concern can make an immediate referral by calling one of the numbers below. There is a requirement to follow up the call by submitting an online Multi-Agency Referral Form (MARF, also known as a MASH form). The MARF/MASH form is to be completed by the person who is making the referral within 24 hours of the referral being made. Failure to complete the form could result in the referral not being accepted. There are separate forms for child safeguarding referrals depending on the area. These forms are electronic and available on PC24 desktops and should be completed as fully as possible and sent as directed by the respective form. Links to the forms are found below.

	Children – Referral	Children - Phone Advice	Children - Out of Hours Advice
Liverpool (Careline)	Online MARF (https://liverpool.gov.uk/social-care/childrens-social-care/keeping-children-safe/children-at-risk/marf-form/)	0151 233 3700	Same
Sefton (MASH)	Child Referral Form to be emailed (https://www.sefton.gov.uk/social-care/children-and-young-people/report-a-child-or-young-person-at-risk/information-for-professionals.aspx)	0151 934 4013 / 4481	Monday to Thursday after 5.30pm, Friday after 4pm, weekends: Emergency Duty Team 0151 934 3555
St Helens (First Response Team)	Service Request Form to be emailed (https://www.sthelens.gov.uk/social-care-health/children-and-families/professionals-report-a-concern/guidance/)	Duty Social Worker 01744 676767	0345 050 0148
Halton (Social Care)	0151 907 8305	0151 907 8305	Monday to Thursday after 5pm, Friday after 4:30pm, weekends: Emergency Duty Team 0345 0500 148
Knowsley (MASH)	Online MARF (https://marf.knowsley.gov.uk/Home) or MARF to be emailed (https://www.knowsley.gov.uk/residents/care/raise-concerns-about-a-child)	0151 443 2600	Same
Warrington MASH	MARS form https://ib.warrington.gov.uk/ (Opens in Internet Explorer only)	01925 443322 01925 443400	01925 444400

3.9 As a general rule, you should contact the child Social Care Services first unless the issue is more immediate and the child is in need of immediate medical attention or support from the Police.

3.10 Where a Safeguarding referral has been made by a member of PC24, a Datix incident form should be completed that same day. This is appropriate to delegate to another member of the team. An automatic notification will alert the service manager to the safeguarding incident.

3.11 Upon receipt of the Datix, the patient's usual GP practice will be informed of the safeguarding referral made by PC24 via letter.

3.12 If there is evidence of physical harm (eg unusual bruises) suspicious of non-accidental injury, a referral to Careline should be made as described above, but the clinician should also seek advice about referring the child for review at the Rainbow Centre at Alder Hey Hospital to assess injuries (0151 252 5609, 24/7 on call). Consent from the parent/carer should be sought and an explanation of the Rainbow Centre to the parent/carer is vital. If consent cannot be gained because the clinician feels there is a risk to the child, then the clinician must consider if the child is safe to leave with the adult at all, and may wish to involve the police. A follow up phone call to the Rainbow Centre to check that the child arrived is recommended.

3.13 If a teenager considered to be Gillick Competent refuses consent for a referral to social services, this must not be taken as a reason not to refer. This should be discussed with a safeguarding lead within PC24 and/or social services. It should be remembered that a child cannot be expected to safeguard themselves, and there may be issues of coercion or grooming underlying their refusal to consent.

3.14 In exceptional circumstances, if you feel your position may be compromised, you may wish to remain anonymous, however please inform your relevant Liverpool Careline, Sefton MASH, Knowsley MASH, Halton Social Care, St Helens Team or Warrington MASH.

3.15 Best Practice as outlined above can be found in Appendix 2.

4.0 REFERRAL PROCESS

4.1 Social Services are the statutory body for investigating all referrals, available 24 hours a day, 365 days a year.

4.2 If you have any problems making a referral contact your line manager or the Safeguarding Lead. Out of hours, contact the PC24 Shift Manager or PC24 Director on call when out of hours) for any support or assistance.

5.0 MANAGEMENT OF DISCLOSURE OF AN ALLEGATION OF ABUSE

5.1 If a child makes allegations about abuse, whether concerning themselves or a third party, PC24 personnel must immediately pass this information on to social services.

5.2 It is important to also remember that it can be more difficult for some children to tell than for others. Children who have experienced prejudice and discrimination through racism may well believe that people from other ethnic groups or backgrounds do not really care about them. They may have little reason to trust those they see as authority figures and may wonder whether you will be any different.

5.3 Children with a disability, especially a sensory deficit or communication disorder, will have to overcome additional barriers before disclosing abuse. They may well rely on the abuser for their daily care and have no knowledge of alternative sources. They may have come to believe they are of little worth and simply comply with the instructions of adults.

5.4 Responding to a Child Making an Allegation of Abuse:

- Stay calm.
- Listen carefully to what is being said.
- Reassure the child that they have done the right thing by telling you.
- Find an appropriate early opportunity to explain that it is likely the information will need to be shared with others – do not promise to keep secrets.
- Allow the child to continue at his/her own pace.
- Ask questions for clarification only and at all times avoid asking questions that are leading or suggest a particular answer.
- Tell them what you will do next and with whom the information will be shared.
- Record in writing what has been said using the child's own words as much as possible – note date, time, any names mentioned, to whom the information was given and ensure that paper and electronic records are signed and dated and subject to audit trails (see below re: recording information).
- Do not delay in discussing your concerns and if necessary passing this

information on.

6.0 RECORDING INFORMATION: GENERAL PRINCIPLES

- Concerns and information about vulnerable children should be recorded in the child's notes and where appropriate the notes of siblings and significant adults. The GMC document 'Protecting children and young people: guidance for doctors' advises doctors to record minor concerns, as well as their decisions and information given to parents/carers.
- Concerns and information from other agencies such as social care, education or the police or from other agencies including health visitors and midwives, should be recorded in the notes.
- Email should only be used when secure (e.g. nhs.net to nhs.net) and the email and any response(s) should be copied into the record.
- Conversations with and referrals to outside agencies should be recorded in the patients record.
- Records, storage and disposal must follow national guidance for example, Records Management, NHS Code of Practice 2009.
- If information is about a member of PC24 personnel, this will be recorded securely in the staff personnel file and in line with your HR guidance: Framework for the Assessment of Children in Need and their Families DH, DFEE 2000.

7.0 RECORDING THE INCIDENT

7.1 Where there are allegations or reports of abuse you must record what was said by the person who disclosed the information as soon as possible after the event. If you do not have access to the child's records, use the Datix Incident Reporting System to make your record.

Record:

- What was said?
- What was seen?
- Who you contacted?
- Actions taken.
- Rationale for decision making.

What not to do:

- **Do not** question the person about the incident.
- **Do not** ask the person questions relating to the incident such as Who, What, Why, Where or When.

- **Do not** promise to keep secrets.
- **Do not** make promises you cannot keep.
- **Do not** contact the alleged abuser.
- **Do not** be judgemental.
- **Do not** gossip about the incident.
- **Do not** touch or move anything in the room.

7.2 **The 'One Chance Rule'**

The primary concern is for the safety of the victim. Staff may only get one chance to talk to the victim (eg due to the nature of forced marriage). Staff should consider the following:

What to do:

- Ensure the victim is seen in a safe and private place.
- See the victim on their own, if an interpreter is required take steps to ensure the interpreter is not connected with the individual or the community.
- Risk assess and discuss a safety plan.
- Establish a safe way of contacting the victim, document any information given in relation to perpetrators, potential/immediate risks and any current contacts with agencies.
- Consider the need for immediate protection and placement away from the family.

What not to do:

- Attempt to mediate.

8.0 INVESTIGATION PROCESS

8.1 Primary Care 24 personnel may be asked to contribute information to a Social Care enquiry and will be expected to provide a written report in order to support this process.

It is possible that attendance at a case conference or court proceedings may be required in order to share the information. In these situations it may be advisable for the member of personnel to be accompanied by an appropriate manager and seek support from a designated health professional.

9.0 GENERAL GUIDELINES FOR PC24 PERSONNEL BEHAVIOUR

9.1 These guidelines are here to protect children and personnel alike. The list below is by no means exhaustive and all personnel should remember to conduct themselves in a manner appropriate to their position.

9.2 Wherever possible, you should be guided by the following advice. If it is necessary to carry out practices contrary to it, you should only do so after discussion with and the approval of, your Manager or Medical/Clinical Lead.

- You must challenge unacceptable behaviour.
- Provide an example of good conduct you wish others to follow.
- Respect a young person's right to personal privacy and encourage children, young people and adults to feel comfortable to point out attitudes or behaviours they do not like.
- Involve children and young people in decision-making as appropriate.
- Be aware that someone else might misinterpret your actions.
- Don't engage in or tolerate any bullying of a child, either by adults or other children.
- Never promise to keep a secret about any sensitive information that may be disclosed to you but follow the practice guidance on confidentiality and sharing information.
- Never offer a lift to a young person in your own car.
- Never exchange personal details such as your home address, personal phone number or any social networking details with a young person.
- Don't engage in or allow any sexually provocative games involving or observed by children, whether based on talking or touching.
- Never show favouritism or reject any individuals.

10.0 MANAGEMENT OF ALLEGATIONS AGAINST A PC24 MEMBER OF STAFF

10.1 *Working Together to Safeguard Children* (2018) details the responsibility of all organisations to have a process for managing allegations against professionals who work with children. This requires PC24 to inform the Local Authority Designated Officer and follow internal processes as per policy.

11.0 GOOD PRACTICE SPECIFIC TO SEFTON PRACTICES

A safeguarding poster will be displayed in all rooms, clinical and administration, to make it clear who is the practice safeguarding lead (appendix 10).
Staff working within the Sefton GP practices must follow the South Sefton Clinical

Commissioning Group Safeguarding Children & Adults at risk Policy accessed from the Sefton CCG intranet.

11.1 Safeguarding Concerns

- Clear codes listed within the problem list should be used when a child is subject to a child protection plan, is considered a child in need, becomes a looked-after child, or the family is cause for concern.
- Counter-codes should also be entered when the child is no longer subject to a child protection plan, is no longer considered a child in need, is no longer a looked-after child, or the family is no longer cause for concern.
- A regular audit of these codes should be completed to ensure accuracy. When an adult has active codes listed from childhood that flag up during an audit, a counter-code should be added from their 18th birthday to remove any associated alerts linked with the out of date codes.

11.2 Adults related to children with safeguarding concerns

Clear codes listed within the problem list should be used when the parent has a child who is subject to a child protection plan, has a child considered a child in need, or the family is cause for concern. There should always be a code added if the parent has had their child removed from their care. This enables further pregnancies to be safeguarded effectively, particularly in the parent moves to a new practice where previous involvement of social services may not be known. Counter-codes should also be added as detailed in section 11.1.

11.3 Correspondence regarding safeguarding meetings/invitations

The full report received should be scanned to a child's notes. Where the report refers to more than one registered child, it should be scanned in full to each child's notes. A summary page should be scanned to each parent/carer's notes.

11.4 Working as a multi-disciplinary team

All staff can liaise with health visitors, school nurses and midwives to share information of concern and to support children and their families.

11.5 Safeguarding Administrators

- Each practice should appoint a member of the administration team to take a lead role with safeguarding. This individual will be given additional training as per section 27.1. This person may be involved in tasks such as supporting clinicians with chasing up reports, alerting a member of the MDT to a vulnerable family, assisting with coding queries for other admin team members, keeping minutes of practice safeguarding

meetings, etc. They are not responsible for submitting a referral to social services when a clinician has identified a concern.

- Administrators may be directly involved in audit work, including any recommended audit platforms provided by the CCG.

11.6 Female Genital Mutilation (FGM)

- Any child (under 18) who discloses she has had FGM performed on her (or when FGM is noticed during examination), has had a crime committed against them. The clinician is obligated to inform the police, even if the FGM occurred many years earlier, or in another country. Further information about this mandatory reporting can be found in gov.uk literature online.
- A female child whose mother has had FGM is considered to be at risk, and discussion should always be had with the parents about this. The parents should be informed that FGM is considered illegal in this country, and seeking FGM, or taking a child out of the country to have it performed, is a crime.
- If there are suspicions that a child at risk may soon be harmed, the clinician must discuss with social services and/or the police. In some cases, passports may be seized by the authorities.
- A history of, or a risk of, FGM should be coded in the problem list.
- The practice should report via Datix when there is a report of FGM, and data will be submitted to the Department of Health via a Clinical Audit Platform by PC24.

11.7 Working with those who do not speak English

- A child should never be used to translate for their parents.
- When a child speaks English and a parent attending with their child does not speak English, an interpreter should be arranged for the parent to be fully involved in the consultation. If a Gillick competent English-speaking child attends a consultation without their parent, their non-English-speaking parent does not need to be present.
- When a parent speaks English, and the child does not, consideration should be made by the clinician whether to involve an independent translator or not. If the child is at an age where a parent would talk for them anyway (consider consultations with English speaking families as a frame of reference, these will mainly be primary school age and younger), a translator may not be needed. Remember to consider the 'voice of the child' at all ages, and a translator arranged as required.

11.8 Private Fostering

South Sefton CCG staff have a responsibility to notify Children's Social Care of any private fostering arrangements that they become aware of. Clinicians should also ensure they are clear if the adult that the child is living with has parental responsibility

or not, particularly for consenting to immunisations and other treatment.

11.9 **6 Week Baby Check**

The clinician carrying out this physical check on a new baby should also routinely ask the accompanying parent/carer about adults who are significant to the child and record these in the consultation entry, eg name of the father of the baby, other adults in the home, involvement of a social worker. These sensitive questions adopt the 'professional curiosity' principle and receive the best response when framed as routine.

11.10 New Registrations

- Each practice will implement methods to identify vulnerable families at the point of registration. These will include children with cause for concern, unborn babies of adults with previous interaction with social services, and those with health needs in the family affecting either the child or the parent/carer. An example of a flowchart that could be adopted is found in appendix 11.
- Once identified, the coding and problem list should be reviewed and potentially updated for accuracy, and the family may be invited for an appointment if necessary.
- Liaising with the health visitor that a vulnerable pre-school child has now registered with the practice is recommended.

11.11 **Consideration should be given to recording the following information in the child record.**

- Record of abuse in the child or any other child in the household.
- Record of whether the child or any other child in the household is or has been subject to a child protection plan.
- Observed and alleged harmful parent – child interactions.
- Basic family details (e.g. adults in the family, other siblings etc., including individuals who may not live at the address but who have regular contact with the child e.g. father, grandparents etc.).
- Details of any housing problems.
- Details of significant illness or problems in the family, such as parental substance misuse or mental illness.
- Young carers.
- History of domestic abuse in the household.
- House fires.
- Ante-natal concern.
- Multiple new registrations.

- Multiple consultations especially emergencies.

12.0 GOOD PRACTICE SPECIFIC TO OOH/PCS/EXTENDED ACCESS/PATHFINDER ADVICE

12.1 Adults with responsibility for a child

- When a patient makes contact with a condition or circumstance that may cause concern for their welfare or wellbeing (eg suicidal thoughts, anxiety, intoxication), the patient should be asked about contact with children. This may be to ascertain whether any children they have responsibility for are with them presently, whether any other adults are also there, how their condition/circumstance may impact on a child generally even if they are not with them presently. The ages of the children may also be helpful.
- If there are children present, the staff member is responsible for deciding whether to contact social services, the police, or whether to arrange a face to face appointment. Where the welfare of a child is a cause for concern, any appointments or future contact with the patient, should be considered to be urgent. Clear time frames (eg 'patient must be contacted within an hour') and plans should be recorded in the notes, and decisions taken to minimise any risk to a child.
- Any clinician who identifies an unresolved potential safeguarding concern from an unfinished case must alert the shift manager to the case and discuss the time frames and plan detailed in the written notes (eg a case forwarded for UCC appointment that is therefore not completed). This handover means that cases should not be missed on busy days or if the clinician finishes their shift.

12.2 Non-English speakers

- An independent translator should always be offered. During urgent care appointments, this is likely to be via Language Line.
- A child should never be used as a translator, whether the consultation is for the child or the adult. If an English-speaking child presents with a non-English speaking parent/carer, a translator should be arranged to involve the parent/carer in the consultation.
- When a parent/carer contacts urgent care by phone and telephone interpreting services are unavailable, it may be necessary to offer the patient an UCC appointment when this may not otherwise have been the triage outcome. This ensures independent translating via Language Line and a safer patient experience.

13.0 GOOD PRACTICE SPECIFIC TO INTERMEDIATE CARE

Children are not directly looked after in this service, but the children and grandchildren of

patients will be safeguarded by our staff, and any concerns for welfare will be raised with social services. Documentation for these concerns will be recorded in the related adult's notes and on Datix.

14.0 GOOD PRACTICE SPECIFIC TO ASYLUM PRACTICE

14.1 Working with those who do not speak English

See section 11.7

14.2 Female Genital Mutilation

- See section 11.6
- At Asylum Practice, fear of FGM may be part of an adult's asylum claim as they seek to protect their children from FGM prevalent in a community they have left behind. In these cases, even if the mother has had FGM herself, the parent is a protective factor.

14.3 Forced Marriage/Modern Slavery/Trafficking/Honour-based Violence

- If a child or family discloses they remain at risk of any of the above while living in initial accommodation, the Asylum Practice is committed to raising this with accommodation providers to ensure safety is given a priority and advocating for the patient/family to be moved accommodation as soon as possible. Social services and/or the police will also be informed.

14.4 MDT

- Children and families with safeguarding concerns are discussed at a monthly MDT as part of a safeguarding standing agenda item. Any children discussed should have an appropriate code added by the admin team following the meeting (if not already present).

14.5 Coding

- When a safeguarding concern has been raised by a clinician or a member of the MDT, this will be coded on the records in the problem list.
- Usual practice is for the patient records to be printed and given to a patient to take with them to their next practice. Where there are safeguarding concerns for a child, it may be more appropriate not to print the records for the child and give them to the parent, but rather for the admin team to liaise with the child health team about where the child has registered once dispersed, and secure fax/email the records to the new practice.

14.6 **Audit Tools**

Asylum Practice will engage with any CCG audit tool platform provided and use this tool to monitor practice and as a prompt to improve/maintain standards of care.

15.0 DEFINITIONS OF CARE

15.1 Children

In accordance with the Children Act 1989 and 2004, within this policy, a **'child'** is anyone who has not yet reached their 18th birthday. **'Children'** will mean children and young people throughout.

'Safeguarding and promoting the welfare of children is defined in *Working Together to Safeguard Children (2018)* as:

- Protecting children from maltreatment.
- Preventing impairment of children's health or development.
- 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.

15.2 Children in Need / Early Help

Under Section 17 (10) of the Children Act 1989, a child is a Child in Need if:

- He/she is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a local authority.
- His/her health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services.
- He/she is a Disabled Child.

Professionals should, in particular, be alert to the potential need for early help for a child who:

- Has specific additional needs.
- Has special educational needs.
- Is a young carer.
- Is showing signs of engaging in anti-social or criminal behavior.
- Is in a family circumstance presenting challenges for the child, such as substance abuse, adult mental health problems and domestic violence.

- Has particular spiritual or religious beliefs.
- Is a migrant/unaccompanied asylum seeker.
- Child victim of trafficking.
- Victim of child sexual exploitation.
- Has returned home to their family from care; and/or
- Is showing early signs of abuse and/or neglect.

15.3 Looked After Children are those children and young people who are looked after by the state under one of the following sections of the Children Act 1989 including:

- Section 31 - Care Order
- Section 38 - Interim Care Order
- Section 20 -Voluntary accommodation at the request of or by agreement with their parents or carers.
- Section 44 - Emergency Protection Order.

Following the implementation of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 all children who are remanded into custody in England automatically also become looked after. A period of remand should only last for a short time and the automatic looked after status ends upon conviction, acquittal or grant of bail.

15.4 Private Fostering – this is a private arrangement made between a child's parents and someone who is not a close relative to care for a child for 28 days or more: where the child lives with the carer. Close relatives include aunt, uncle, brother, sister or grandparents but not a great aunt or uncle. South Sefton CCG staff have a responsibility to notify Children's Social Care of any private fostering arrangements that they become aware of.

16.0 DEFINITIONS OF ABUSE

16.1 Domestic Abuse

The cross-government definition of domestic violence and abuse is:-

"Any incident or pattern 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 or emotional". (Home Office circular 003/2013).

This is regardless of race, culture, religion, gender, age and disability. It is also important to note that domestic abuse can also occur in lesbian, gay, bisexual and transgender relationships. Heterosexual females can also abuse heterosexual males and children can also abuse adults. Domestic abuse also features highly in cases of child abuse and in an analysis of serious case reviews, both past and present, it is present in over half (53%) of cases (HM Government 2010). Approximately 200,000 children in England live in households where there is a known risk of domestic violence (Brandon et al, 2009).

The term "domestic abuse" includes issues such as female genital mutilation (FGM), so called honour based crimes, forced marriage and other acts of gender based violence, as well as elder abuse and spiritual abuse (where someone uses a person's spiritual beliefs to manipulate, dominate or control the person) when committed within the family or by an intimate partner. Family members are defined as mother, father, son, daughter, brother, sister, and grandparents whether directly related or stepfamily.

Whilst an adult is defined as any person aged 18 or over, the new definition for domestic violence has been altered to include 16 and 17 year olds. Despite this change in definition, domestic abuse involving any young person under 18 years, even if they are parents, should be treated as child abuse with local Safeguarding Children Board procedures applicable.

16.2 Forced Marriage

"Marriage shall be entered into only with the free and full consent of the intending spouses" (Universal Declaration of human Rights, Article 16 (2).

A forced marriage is where one or both people do not (or in the case of some people with learning or physical disabilities, cannot as they do not have mental capacity to make the decision) consent to the marriage and pressure or abuse is used. The pressure put on women and men to marry against their will can be physical, (including threats, actual physical violence and sexual violence), emotional or psychological (for example when a person is made to feel like they are bringing shame on their family) and financial abuse (taking money from a person or not providing money).

16.3 Female Genital Mutilation (FGM)

Female genital mutilation is a collective term used for procedures which include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. FGM is typically performed on girls between the ages of 4 and 13 years, although it may also be performed on infants, and prior to marriage or pregnancy. The Prohibition of Female Circumcision Act 1985 made this practice illegal in this country and the Female Genital Mutilation Act 2003 which replaced it has now made it illegal for girls to be taken abroad for the purpose of performing this procedure.

From 1st October 2015 there is a mandatory reporting duty, provided for in the FGM Act 2003 (as amended by the Serious Crime Act 2015) requiring health care professionals to report where, in the course of their professional duties, they either:

- Are informed by a girl under 18 that an act of FGM has been carried out on her; or
- Observe physical signs which appear to show that an act of FGM has been carried out on a girl under 18 and have no reason to believe that the act was necessary for the girl's physical or mental health or for the purposes connected with labour or birth.

16.4 Radicalisation /PREVENT

PREVENT (radicalisation of vulnerable people): one of the 4 key principles of the CONTEST strategy, which aims to stop people becoming terrorists or supporting terrorism. The PREVENT Strategy addresses all forms of terrorism including extreme right wing but continues to prioritise according to the threat posed to our national security. The aim of Prevent is to stop people from becoming terrorists or supporting terrorism and operates in the pre-criminal space before any criminal activity has taken place.

Terrorist groups often draw on extremist ideology, developed by extremist organisations. Some people who join terrorist groups have previously been members of extremist organisations and have been radicalised by them. The Government has defined extremism in the PREVENT strategy as: "vocal or active opposition to fundamental British values (including calls for death of members of British armed forces), including democracy, the rule of law, individual liberty, mutual respect and tolerance of different faiths and beliefs.

Section 26 of the Counter-Terrorism and Security Act 2015 (the Act) places a duty on "health" bodies, in the exercise of their functions, to have "due regard to the

need to prevent people from being drawn into terrorism".

All relevant health staff should be able to recognise vulnerable individuals who appear to be being drawn into terrorism, including extremist ideas which can be used to legitimise terrorism and are shared by terrorist groups. Staff should be aware of what action to take in response, including local processes and policies that will enable them to make referrals to the Channel programme and how to receive additional advice and support.

The government counter terrorism strategy is called **CONTEST** and is divided into four priority objectives:-

Pursue – stop terrorist attacks.
Prepare – where we cannot stop an attack, mitigate its impact.
Protect – strengthen overall protection against terrorist attacks.
Prevent – stop people becoming terrorists and supporting violent extremism.

The PREVENT Strategy addresses all forms of terrorism including extreme right wing but continues to prioritise according to the threat posed to our national security. The aim of PREVENT is to stop people from becoming terrorists or supporting terrorism and operates in the pre-criminal space before any criminal activity has taken place. PREVENT aims to protect those who are vulnerable to exploitation from those who seek to encourage people to support or commit acts of violence.

16.5 Child Sexual Exploitation

Child sexual exploitation is a form of sexual abuse where children are sexually exploited for money, power or status. It can involve violent, humiliating and degrading sexual assaults. In some cases, young people are persuaded or forced into exchanging sexual activity for money, drugs, gifts, affection or status. Consent cannot be given, even where a child may believe they are voluntarily engaging in sexual activity with the person who is exploiting them. Child sexual exploitation does not always involve physical contact and can happen online. A significant number of children who are victims of sexual exploitation go missing from home, care and education at some point (HM Government, 2015).

16.6 Maltreatment and Neglect

Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may

be abused in a family or in an institutional or community setting by those known to them or, more rarely, by a stranger. An unborn child may suffer harm if his/her mother is subject to domestic abuse, is a tobacco, drug or alcohol abuser or fails to attend for antenatal care.

There are usually said to be four types of child abuse or maltreatment [with a fifth recognised in Scotland] but they often overlap and it is not unusual for a child or young person to have symptoms or signs from several categories.

1. Physical Abuse
2. Emotional Abuse
3. Sexual Abuse
4. Neglect

General Indicators:

The risk of child maltreatment is recognised as being increased and should be suspected or considered when there is:

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

NICE CG89 uses a further aid to prioritising concerns: suspecting, considering and excluding maltreatment. For further information see the following links:
http://www.nice.org.uk
www.**nice**.org.uk/**nice**media/pdf/cg89**nice**guidelineword.doc
http://pathways.nice.org.uk/pathways/when-to-suspect-child-maltreatment

16.7 Physical Abuse

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child, including by fabricating the symptoms of, or deliberately inducing, illness in a child. *Working Together to Safeguard Children 2010*

Alerting features to suspect include:

- abrasions
- bites (human)
- bruises
- burns or scalds
- cold injuries
- cuts
- eye injuries
- fractures
- hypothermia
- intra-abdominal injuries
- intracranial injuries
- intrathoracic injuries
- lacerations
- ligature marks
- oral injuries
- petechiae
- retinal haemorrhage
- scars
- spinal injuries
- strangulation
- subdural haemorrhage
- teeth marks

Or consider:

- Child with hypothermia and legs inappropriately covered in hot weather (concealing injury).
- For fabricated illness discrepancy in the clinical picture with one or more of the following:

    - Reported signs or symptoms only in the presence of the carer.
    - Multiple second opinions being sought.
    - Inexplicably poor response to medication.
    - Excessive use of aids.
    - Biologically unlikely history of events even if the child has a current or past physical or psychological condition.

16.8 Sexual Abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The 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. They may also include non-contact activities, such as involving children in looking at sexual images or grooming a child in preparation for abuse (including via the internet). Women can also commit acts of sexual abuse, as can other children (*Working Together to Safeguard Children 2018).*

Alerting features to suspect include:

- Ano-genital symptom in a girl or boy that is associated with behavioural change.
- Sexually transmitted infection.
- Hepatitis B or C in under 13.
- Pregnancy in under 13s.

Or consider:

- Persistent unexplained ano-genital symptoms.
- Sexually transmitted infection in 13-15yr old.
- Ano-genital warts.
- Marked power differential in relationship.
- Behaviour changes.
- Sudden changes.
- Inappropriate sexual display.
- Secrecy, distrust of familiar adult, anxiety left alone with particular person.
- Self-harm/mutilation/attempted suicide.
- Unexplained or concealed pregnancy.

16.9 Neglect

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. It involves 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); or ensure access to appropriate medical care or treatment.

It may also include neglect of or unresponsiveness to a child's basic emotional needs (*Working Together to Safeguard Children 2018).*

Alerting features to suspect include:

- Abandonment.
- Repeatedly not responding to child or young person.
- Repeated injuries suggesting inadequate supervision.

- Persistently smelly or dirty.
- Failure to seek medical help appropriately.

Or consider:

- Poor personal hygiene, poor state of clothing.
- Frequent severe infestations (scabies, head lice).
- Faltering growth (due to poor feeding).
- Untreated tooth decay.
- Repeated animal bites, insect bites or sunburn.
- Treatment for medical problems not being given consistently.
- Poor attendance for immunisations.
- Low self-esteem.
- Lack of social relationships; children left repeatedly without adequate supervision.
- Parents failing to engage with healthcare, attend appointments (practice or wider health professional) and/ or use A&E/Out-of-Hours services frequently.

16.10 Patterns of Maltreatment

The sections above have been significantly altered to reflect the increasing emphasis on the importance of observation of patterns of possible maltreatment including the interaction between the parent or carer and the child or young person, as well as physical signs which are inconsistent with their developmental stage (not always the same as the age in months or years) or the explanation given.

Providing inappropriate supervision (or none) leading to accidental injury or burns can also be forms of maltreatment.

As well there are a number of injury patterns that cause immediate concern in terms of child protection including:

- Multiple bruising, with unusual bruises of different ages.
- Bruising in non-motile baby particularly facial bruising (baby rolls over at six months, baby attempts to crawl at eight months).

The Clinician observes these when the child is brought with an incidental respiratory infection, nappy rash or apparently minor illness, although distinguishing cigarette burns from impetigo can be difficult. The PC24 receptionist may be alerted by abuse on the phone or observing altercations in the waiting room.

Please refer to Appendix 1: What to do if you are worried a child is being abused and Appendix 3: Possible signs of child abuse and neglect.

Further information can be found at: Accidents and Child Development 2009 (Child Accident Prevention trust).

www.education.gov.uk/search/results?q=accidents+and+Child+Development
www.nspcc.org.uk/inform/trainingandconsultancy/learningresources/coreinfo/coreinfo_wda54369.htm

17.0 RESTRAINT PROCEDURE

17.1 Restraint is where a child is being held, moved or prevented from moving, against their will, because not to do so would result in injury to themselves or others, or would cause significant damage to property. Restraint must always be used as a last resort, when all other methods of controlling the situation have been tried and failed. Restraint should never be used as a punishment or to bring about compliance (except where there is a risk of injury).

17.2 Only people who are properly trained in restraint techniques should carry it out. A person should be restrained for the shortest period necessary to bring the situation under control.

18.0 INFORMATION SHARING

Service users/patients are aware of the limitations of and exceptions to confidentiality in relation to child protection.

18.1 PC24 will follow the policy on sharing information in child protection cases which is as follows:

- In England and Wales, the Children's Acts of 1989 and 2004 give GPs a statutory duty to co-operate with other agencies (Children Act 1989 section 27, 2004 section 11) if there are concerns about a child's safety or welfare. Health authorities (PCOs) (section 47.9) have a duty to assist local authorities (Social/Childcare Services) with enquiries, named Doctors for child protection can be powerful advocates for this function.
- The Children, Schools and Families Act 2010 section 8 amends The Children Act 2004 providing further statutory requirements for information sharing when the LSCB requires such information to allow it to carry out its functions adding

Section 14b see www.legislation.gov.uk/ukpga/2010/978010542103/section/8

This means that the default position is that PC24 will share information with Social Care and not doing so maybe legally indefensible.

18.2 It is recognised that responsible information sharing plays a key role in safeguarding and there is evidence from Serious Case Reviews and Adult Reviews that children have come to harm when services do not openly share the concerns or information they have.

18.3 The need to distinguish between the principles of confidentiality and the need to share information must be in accordance with legislation and the guidance provided by the Organisation.

18.4 PC24 staff are required to adhere to the legislation in relation to patient confidentiality and the disclosure of information.

19.0 GENERAL PRINICIPLES OF INFORMATION SHARING

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

1 The Data Protection Act is not a barrier to sharing information but provides a framework to ensure personal information about living persons is shared appropriately.
2 Be open and honest with the person/family from the outset about why, what, how and with who information will be shared and seek their agreement, unless it is unsafe or inappropriate to do so.
3 Seek advice if you have any doubt, without disclosing the identity of the person if possible.
4 Share with consent where appropriate and where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent, if, in your judgement, that lack of consent can be overridden by the public interest. You will need to base your judgement on the facts of the case.
5 Consider safety and well-being, base your information sharing decisions on considerations of the safety and well-being of the person and others who may

be affected by their actions.

6 Ensure that the information you share is necessary for the purpose for which you are sharing it, and it is shared only with those people who need to have it, it is accurate and up to date, is shared in a timely fashion and is shared securely.

7 Keep a record of your concerns, the reasons for them and decisions whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

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

- When treating children and young people, doctors must also consider parents and others close to them, but the patient must be the doctor's first concern.
- When treating adults who care for, or pose risks to, children and young people, the adult patient must be the doctor's first concern, but doctors must also consider and act in the best interests of children and young people GMC 2007: 0-18 years.

This might be phrased:

"see the adult behind the child" and "see the child behind the adult"

19.3 Consent should be sought to disclosures unless**:**

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

19.4 Requests for information about a child or family should immediately be referred to the PC24 Company Sectary. PC24 should consider the following:

- Identity - check identity of the enquirer to see if they have a bona fide reason to request information. Call back the switchboard or ask for a faxed request on headed notepaper.
- Purpose - ask about the exact purpose of the inquiry. What are the concerns?

- Consent - does the family know that there are enquiries about them? Have they consented and if not why not? Consent is not necessary if there is felt to be a risk of harm to the child from seeking it. Receiving a signed consent form from Social Services does not imply consent given to you to share. If this doesn't cause harmful delay, you may also wish to seek consent from the family.
- Need-to-know basis, give information only to those who need to know.
- Proportionality - give just enough information for the purpose of the enquiry and no more. This may mean relevant information about parents/carers.
- Keep a record - make sure that you record the details of the information sharing, including the identity of the person you are sharing information with, the reason for sharing and whether consent has been obtained and if not why not.

19.5 GMC advice includes:

- Sharing information with the right people can help to protect children and young people from harm and ensure that they get the help they need. It can also reduce the number of times they are asked the same questions by different professionals. By asking for their consent to share relevant information, you are showing them respect and involving them in decisions about their care.
- If a child or young person does not agree to disclosure there are still circumstances in which you should disclose information:
  a. When there is an overriding public interest in the disclosure.
  b. When you judge that the disclosure is in the best interests of a child or young person who does not have the maturity or understanding to make a decision about disclosure.
  c. When disclosure is required by law.

20.0 SERIOUS CASE REVIEWS AND LEARNING LESSONS

When a child dies or suffers significant harm, and abuse or neglect is known or suspected to be a factor, the Local Safeguarding Children Board (LCSB may recommend that a Serious Case Review (SCR) is undertaken. Community Safety Partnerships may request a Domestic Homicide Review (DHR) is undertaken. The Safeguarding Lead (or nominated deputy) as the named professional for the organisation, contributes to the SCR process by writing the Individual Management Review report and ensures that any organisational learning outcomes are implemented in their organisation (See Appendix 4).

PC24 recognises its role to be aware of maltreatment and share concerns but not to investigate or to decide whether or not a child has been abused.

The PC24 Lead(s) for Safeguarding Children & Young People:

- Implements PC24 Safeguarding Children Policy.
- Ensures that PC24 meets contractual guidance.
- Ensures safe recruitment procedures.
- Supports reporting and complaints procedures.
- Ensures that PC24 personnel receive adequate support when dealing with child protection.
- Leads on analysis of relevant significant events.
- Determines training needs and ensures they are met.
- Makes recommendations for change or improvements in Primary Care 24 procedural policy.
- Acts as a focus for external contacts.

21.0 STATEMENT OF INTENT

21.1 The aim of this policy is to ensure that, throughout PC24, children are protected from abuse and exploitation. This work may include direct and indirect contact with children (access to patient's details, communication via email, text message and phone). We aim to achieve this by ensuring that PC24 is child safe. The policy is designed to advise staff of their safeguarding responsibilities and provide accessible guidance and information.

21.2 PC24 is committed to 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.

21.3 As a healthcare organisation, PC24 has a duty of care to protect the children we work with and for. Research has shown that child abuse offenders target organisations that work with children and then seek to abuse their position. This policy seeks to minimise such risks. In addition, this policy aims to protect individuals against false allegations of abuse and the reputation of PC24 and professionals. This will be achieved through clearly defined procedures, standards for professional practice and an open culture of support and being open.

21.4 PC24 is committed to implementing this policy. PC24 will provide in-house learning opportunities and make provision for appropriate Safeguarding training to all personnel and associated personnel.

21.5 It addresses the responsibilities of all personnel. It is the role of the Director of Nursing who acts as the Safeguarding Lead to brief personnel on their responsibilities under the policy. For personnel, failure to adhere to this policy could lead to dismissal or constitute gross misconduct.

21.6 To achieve child-safe practice, personnel need to be able to:

- Describe their role and responsibility.
- Describe acceptable behaviour.
- Recognise signs of abuse.
- Ensure PC24 systems work well to minimise missing vital information or delay in communication.
- Describe what to do if worried about a child or a pregnant woman or a family.
- Respond appropriately to concerns or disclosures of abuse.
- Minimise any potential risks to children.

22.0 BACKGROUND & PRINCIPLES

22.1 Safeguarding children and young people is a fundamental goal for PC24. This policy has taken into account legislative and government guidance requirements and other internal policies and our local Clinical Commissioning Groups (CCG) Local Safeguarding Children's Boards.

22.2 These include:

In England the relevant legislation and guidance is:

- Adoption and Children Act 2002.
- The Children Act 1989.
- The Children Act 2004.
- The Protection of Children Act 1999.
- The Human Rights Act 1998.
- The United Nations Convention on the Rights of the Child (ratified by UK Government in 1991 and became statutory in Wales 2011).

- The Data Protection Act 1998 (UK wide).
- Sexual Offences Act 2003.
- NICE CG89 Child Maltreatment Guidance 200911.
- Working Together to Safeguard Children 2018.
- Primary Care 24 Disciplinary Policy.
- Accidents and Child Development 2009 (www.capt.org.uk).

This policy is based on the expectation that staff are able to ensure the welfare of children in the course of their daily work.

23.0 IMPLEMENTATION

23.1 This policy will be displayed on the staff intranet and promoted within PC24. New starters will be made aware of the policy on induction.

Clinical/Medical Leads will ensure that all healthcare professionals are aware of and how to access this policy.

23.2 Monitoring compliance

The effectiveness of this policy must be routinely monitored to ensure that the objectives of the policy are met. Compliance and effectiveness of this policy will be monitored by a combination of:

- Monitoring against this policy via the Quality & Patient Safety department who will note and report the number of safeguarding incidents/complaints reported through the Datix Risk Management system.
- Service Delivery Units will be required to monitor local compliance against this policy at an operational level which includes reporting incidents through the Datix Risk Management System.
- Safeguarding mandatory training for all staff.
- Annual performance review of all staff.
- All safeguarding incidents will be included in the Quality and Workforce Committee which reports to Board.

23.3 Policy Review

This policy will be reviewed within 1 year of implementation and every 3 years thereafter or sooner if there is a change in policy or organisational change.

23.4 Breaches of policy

This policy is mandatory. Where it is not possible to comply with the policy, or a decision is taken to depart from it, this must be notified to the PC24 Safeguarding Lead so that the level of risk can be assessed and an action plan can be formulated.

24.0 PRIMARY CARE 24 RESPONSIBILITIES

24.1 Board of Directors

Primary Care 24 Board is responsible for ensuring that the organisation fulfils the requirements of Child Protection legislation, safeguarding contracted standards and regulation standards via scrutiny of the assurance and performance reports submitted to the appropriate Board sub-Committees.

24.2 The Director of Nursing

The Director of Nursing is responsible for ensuring Caldicott Principles are followed in relation to safeguarding and information sharing. The Director of Nursing acts as the PC24 Safeguarding Lead and is responsible for:

- Ensuring Safeguarding of Children activity and compliance is reported to PC24 Board via relevant Committees.
- The content of all serious case review submissions is in line with the local safeguarding children board regulations (2006).
- Strategic responsibility for safeguarding development.
- Ensuring safeguarding reports and audits are received by the organisation.
- Reporting to and advising the Executive Leadership Team and the Board on all matters relating to safeguarding.
- Representing the organisation at appropriate external safeguarding meetings.
- Responsible for Board Leadership for safeguarding.
- Liaising with external stakeholders and the sharing of information where appropriate.
- Engagement with Safeguarding Boards and the Lead Commissioner (Halton, Knowsley and Liverpool Clinical Commissioning Group) to ensure PC24 practice, policies and procedures are compliant and effective and monitored.
- Producing safeguarding reports for relevant PC24 committees and the PC24 Board.
- Ensuring that, as required, that PC24 contribute to Serious Case Review

(SCR) and Domestic Homicide Review (Domestic Homicide Review) reports and co-ordination of requests for information for legal cases.

- Ensure access to the provision of specialist Safeguarding advice and support to PC24 personnel.
- Attendance, where required, to case conferences and court hearings on behalf of PC24.
- Promoting compliance with safeguarding policies and procedures.

24.3 Director, Associate Directors, Medical and Clinical Leads

- Ensure appropriate monitoring and reporting mechanisms are developed, reviewed and communicated to PC24 Quality & Workforce Committee and other relevant Committees.
- Responsibility for making appropriate recommendations to ensure that the Service Delivery Units remain compliant with safeguarding policy, procedure and practice.
- Ensure the process for Learning Lessons from Serious Case Reviews and other safeguarding related incidents becomes embedded within the Service Delivery Units and Incident Learning Procedures.

24.4 All Clinically Trained Personnel of PC24

Must take appropriate action if they suspect or know a child or adult is being abused or is likely to come to significant harm. It is a professional duty to refer concerns appropriately and failure to act on concerns is a breach of the Safeguarding Children's Policy and Procedures and could result in further harm or death to the patient. This is important even if other agencies are involved in the incident. The Police and other agencies are expected to raise their concerns separately.

24.5 All Personnel

- Personnel of PC24 are responsible for the safety and well-being of patients and have a duty of care for those patients who are less able to protect themselves from harm, abuse or neglect. This also includes 'avoidable harm' which may be caused to a patient for example through inappropriate positioning, moving or handling.
- It is the responsibility of all PC24 personnel to be familiar with the Safeguarding Children's Policy and Procedures, and to implement them when abuse is known or suspected.

25.0 RAISING A CONCERN (WHISTLEBLOWING)

Where allegations have been made against PC24 personnel, PC24 HR policies will be followed and the involvement of the Local Authority Designated Officer (LADO) may be considered as necessary (section 11 Children Act 2004).

26.0 COMPLAINTS PROCEDURE

PC24 has a clear procedure that deals with complaints from all patients (including children and young people), employee, accompanying adult or parent. Please refer to the Primary Care 24 Complaints Policy (PC24POL34) located on the Intranet.

27.0 TRAINING

As part of the PC24 mandatory training programme, each member of PC24 personnel will undertake Safeguarding Children training using the approved training tool. The level of Safeguarding training is determined by the role of individual members of personnel. The training schedule detailed below is based upon guidance from the RCGP toolkit.

27.1 Training Needs Analysis

	Requirements	**Delivery Method**	**Staff Group**	**Recording**	**Strategic & Operational Responsibility**
Safeguarding Children Level 1	Minimum 2 hours over 3 years (Total combined with adults = 4 hours in 3 years)	50% participatory (face to face training/group discussion) 50% non-participatory (e-learning)	Reception, admin, domestic staff, drivers	Training database	Director of Nursing and Executive Safeguarding Lead
Safeguarding Children Level 2	Minimum 4 hours over 3 years (Total combined with adults = 8 hours in 3 years)	50% participatory (face to face training/group discussion) 50% non-participatory (e-learning)	Practice managers, reception managers, safeguarding administrators, healthcare assistants	Training database	Director of Nursing and Executive Safeguarding Lead

Safeguarding Children Level 3	Minimum 12 hours over 3 years (Total combined with adults = 20 hours in 3 years)	50% participatory (face to face training/group discussion) 50% non-participatory (e-learning)	GPs, Practice Nurses, ANPs, Clinical Pharmacists, GP registrars	Training database	Director of Nursing and Executive Safeguarding Lead
Safeguarding Children Level 3 (additional)	Minimum 16 hours over 3 years (Total combined with adults = 24 hours in 3 years)	50% participatory (face to face training/group discussion) 50% non-participatory (e-learning)	GP Safeguarding Practice Leads	Training database	Director of Nursing and Executive Safeguarding Lead

27.2 PC24 commit to providing the e-learning toolkit and will arrange some training and updates throughout each year, but clinicians requiring Level 3 training will also be responsible for ensuring they reach the target number of hours to maintain their own Level 3 training. This can be accessed via Protected Learning Time events held locally or delivered by CCGs. As per RCGP and CQC guidance, it is not a requirement to have all hours certificated (reflection and minutes from meetings may be sufficient). The individual GP/nurse should review this at an annual appraisal.

28.0 EQUALITY AND DIVERSITY

28.1 The population PC24 serves is diverse and includes areas of high deprivation. Children and adults from all cultures are subject to abuse and neglect. All children and adults have a right to grow up and live safe from harm. In order to make sensitive and informed professional judgments about the needs of children (including their parents' capacity to respond to those needs) and the needs of adults at risk, it is important that professionals are sensitive to differing family patterns and lifestyles that vary across different racial, ethnic and cultural groups. Professionals need to be aware of the broader social factors that serve to discriminate against black and minority ethnic populations. Working in a multi-cultural society requires professionals and organisations to be committed to equality in meeting the needs of all children and adults at risk and to understand the effects of harassment, discrimination or institutional racism, cultural misunderstandings or misinterpretation.

28.2 The assessment process should maintain a focus on the needs of the individual child or adult at risk. It should always include consideration of how the religious beliefs and cultural traditions influence values, attitudes and behaviours and the way in which family and community life is structured and organised. Cultural factors neither explain nor condone acts of omission or commission that place a child or adult at risk of significant harm. Professionals should be aware of and work with the strengths and support systems available within families, ethnic groups and communities, which can be built upon to help safeguard and promote their welfare.

29.0 EQUALITIES AND HEALTH INEQUALITIES STATEMENT

PC24 is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality and diversity principles through its policies, procedures and processes. This policy has been implemented with due regard to this commitment. To ensure that the implementation of this policy does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact analysis conducted where necessary. PC24 will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented. See Appendix 6.

30.0 PERSONAL INFORMATION STATEMENT

PC24 is committed to an environment that protects personal information aspects in the development of any policy. When proposing change there is a new requirement for policy writers to investigate when the personal information aspect of the policy complies with the data protection principles in Schedule 1 of the Data Protection Act 1998. All individuals with responsibility for reviewing/writing policies should consider Privacy Impact Assessment compliance.

This policy complies with the Data Protection Act 1998, therefore no Privacy Impact Assessment is necessary.

31.0 REFERENCES

The following statutory, non-statutory, best practice guidance and the policies and procedures of the Sefton LSCB and SAB have been taken into account:

31.1 Statutory Guidance

Department for Constitutional Affairs (2007) *Mental Capacity Act 2005: Code of Practice.* London: TSO

Department of Health (2000) *Framework for the Assessment of Children in Need and their Families.* London: HMSO

Department of Health (2014) Care Act. Care and Support Statutory Guidance
DfE/DH (2015) Promoting the health and welfare of looked-after children. Statutory guidance for local authorities, clinical commissioning groups and NHS England. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/378482/Promoting_the_health_of_looked-after_children_statutory_guidance_consult....pdf

HM Government (2007) *Statutory guidance on making arrangements to safeguard and promote the welfare of children under Section 11 of the Children Act 2004.* DCSF Publications

HM Government (2008) *Safeguarding children in whom illness is fabricated or induced.* DCSF Publications

HM Government (2009) *The Right to Choose: multi-agency statutory guidance for dealing with forced marriage.* Forced Marriage Unit: London

HM Government (2018) *Working Together to Safeguard Children.* Nottingham: DCSF Publications

HM Government (2015) *What to do if you're worried a child is being abused.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/ 419604/What_to_do_if_you_re_worried_a_child_is_being_abused.pdf

Ministry of Justice (2008) *Deprivation of Liberty Safeguards Code of Practice to supplement Mental Capacity Act 2005.* London: TSO

Home Office (2015) Counter Terrorism and Security Act

HM Gov (2015) Revised Prevent Duty Guidance: for England and Wale https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445977/3799_Revised_Prevent_Duty_Guidance England_Wales_V2-Interactive.pdf

Home Office (2015) Mandatory Reporting of female Genital Mutilation – procedural information.

31.2 Non-Statutory Guidance:

Children's Workforce Development Council (March 2010) *Early identification, assessment of needs and intervention. The Common Assessment Framework for Children and Young People: A practitioner's guide.* CWDC

Department of Health (June 2012) *The Functions of Clinical Commissioning Groups* (updated to reflect the final Health and Social Care Act 2012)

HM Government (2015) Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419628/Information_sharing_advice_safeguarding_practitioners.pdf

Royal College of Paediatrics and Child Health et al (2014) *Safeguarding Children and Young People: Roles and Competences for Health Care Staff.Intercollegiate Document*

NICE (2013) The health and wellbeing of looked-after children and young people http://www.nice.org.uk/guidance/qs31

NICE (2015) Looked-after children and young people http://www.nice.org.uk/guidance/ph28

NICE (2014) Domestic violence and abuse: multi-agency working http://www.nice.org.uk/guidance/ph50

RCPCH (2015) Looked after children: knowledge, skills and competence of health care staff http://www.rcpch.ac.uk/improving-child-health/child- protection/looked-after-children-lac/looked-after-children-lac

31.3 Best Practice Guidance

Department of Health (2004) *National Service Framework for Children, Young People and Maternity Services Standard 5* (plus including relevant elements that aren't contained in Core Standard 5)

Department of Health (2009) *Responding to domestic abuse: a handbook for health professionals*

Ending violence against women and girls. March 2014. www.gov.uk/government/policies/ending-violence-against-women-and-girls-in-the-uk

Department of Health (2010) *Clinical governance and adult safeguarding: an integrated approach.* Department of Health

HM Government (2009) *Multi-agency practice guidelines: Handling cases of Forced Marriage.* Forced Marriage Unit: London

National Institute for Health and Clinical Excellence (2009) *When to suspect child maltreatment.* NICE Clinical Guideline 89

Department of Health (2006) *Mental Capacity Act Best Practice Tool.* Gateway reference: 6703

HM Government (2011) *Multi-agency practice guidelines: Female Genital Mutilation*

32 APPENDICES

	Appendix 1 What to do if you are worried a child is being abused
	Appendix 2 PC24 Best Practice
	Appendix 3 Possible signs of child abuse and neglect
	Appendix 4 Child Review Process
	Appendix 5 Children as Temporary Residents

	Appendix 6 Equalities & Health Inequalities Screening
	Appendix 7 PC24 Directory of Services
	Appendix 8 Considering consent of parent/carer
	Appendix 9 Determining capacity
	Appendix 10 Information poster
	Appendix 11 Registration flowchart
	Appendix 12 Thresholds of Need indicators
	Appendix 13 Warrington Referral Flowchart

END OF POLICY

APPENDIX 1: What to do if you are worried a child is being abused.

Any member of staff who believes or suspects that a child may be suffering or is likely to suffer significant harm should always refer their concerns to Children's Social Care. Never delay emergency action to protect a child whilst waiting for an opportunity to discuss your concerns first.

Are you concerned a child is suffering or likely to suffer harm?

- You may observe an injury or signs of neglect
- You may be given information or observe emotional abuse
- A child may disclose abuse
- You may be concerned for the safety of a child or unborn baby

Step 1

Inform parents / carers that you will refer to Children's social care UNLESS

The child may be put at increased risk of further harm (e.g. suspected sexual abuse, suspected fabricated or induced illness, female genital mutilation, increased risk to child, forced marriage or there is a risk to your own personal safety)

Step 2

- Complete referral form
- Document all discussions held, actions taken, decisions made, including who was spoken to and who is responsible for undertaking actions agreed.
- For physical abuse document injuries observed
- Report incident on Datix

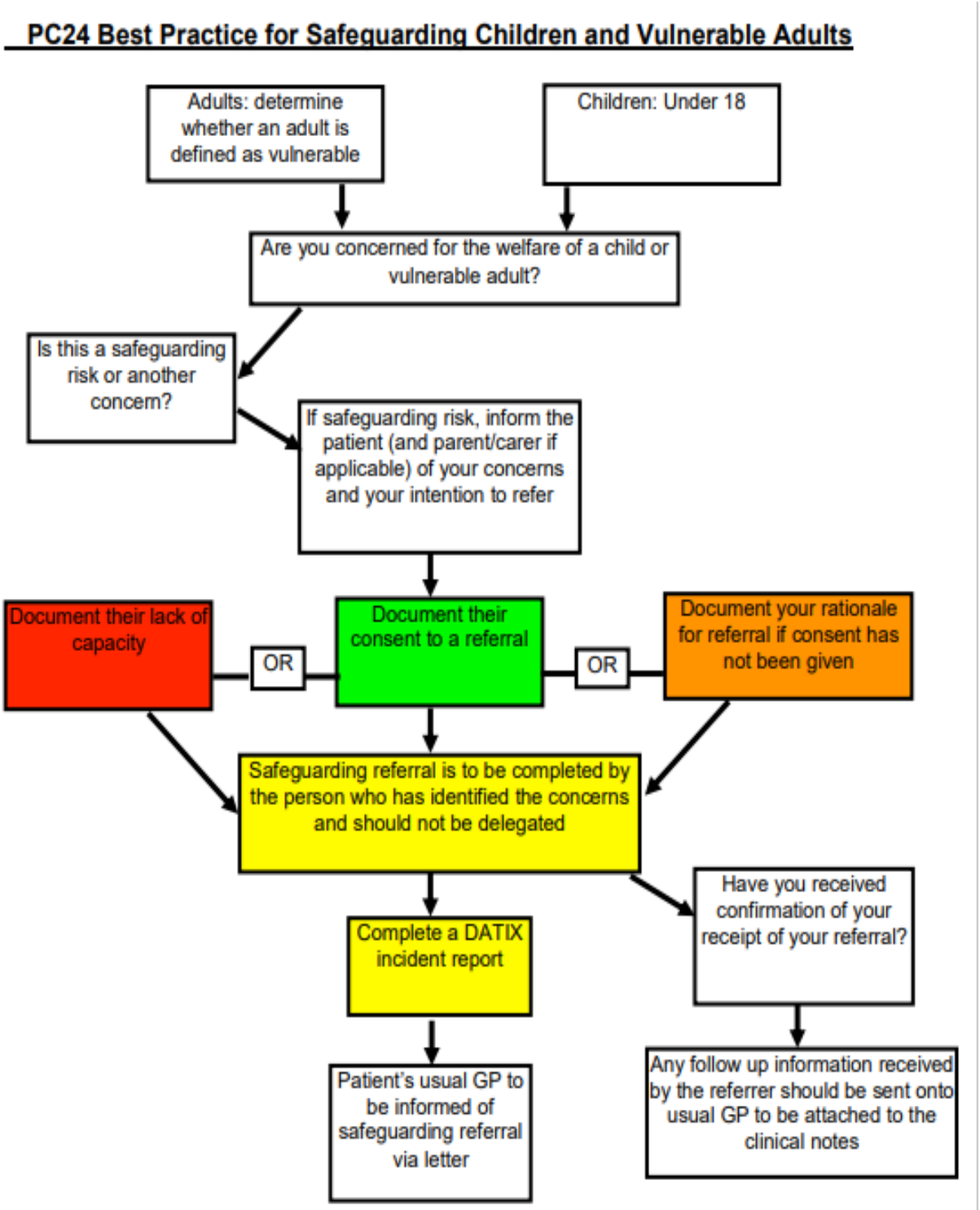
Step 3

Children's Social Care acknowledges receipt of referral and decides on next course of action

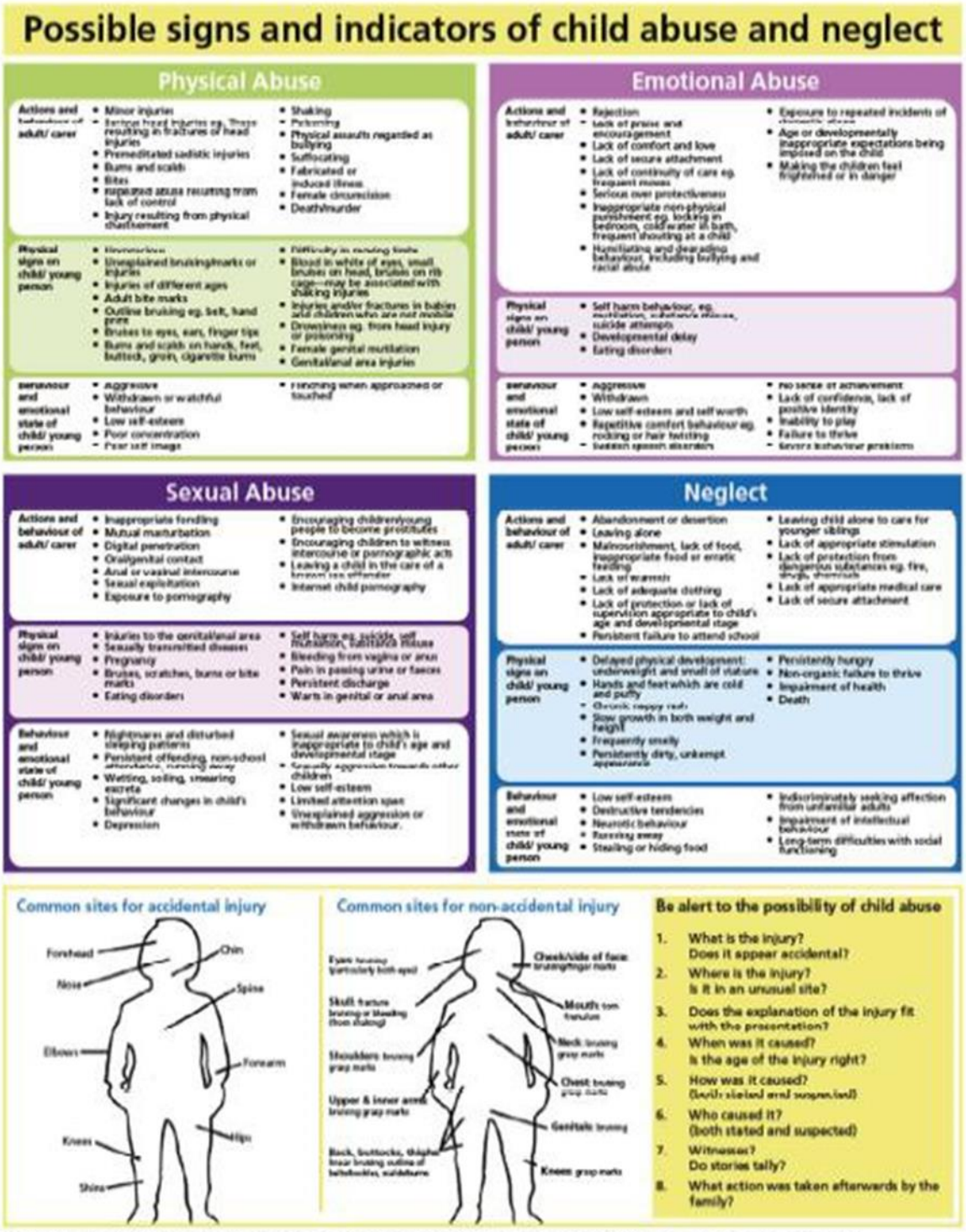
Step 4

You may be requested to provide further reports / information or attend multi-agency meetings

Appendix 2


PC24 Best Practice for Safeguarding Children and Vulnerable Adults
Adults: determine whether an adult is defined as vulnerable
Children: Under 18
Are you concerned for the welfare of a child or vulnerable adult?
Is this a safeguarding risk or another concern?
If safeguarding risk, inform the patient (and parent/carer if applicable) of your concerns and your intention to refer
Document their lack of capacity
OR
Document their consent to a referral
OR
Document your rationale for referral if consent has not been given
Safeguarding referral is to be completed by the person who has identified the concerns and should not be delegated
Complete a DATIX incident report
Have you received confirmation of your receipt of your referral?
Patient's usual GP to be informed of safeguarding referral via letter
Any follow up information received by the referrer should be sent onto usual GP to be attached to the clinical notes

Appendix 3 Possible signs and indicators of child abuse and neglect



Appendix 4 Child Review Processes

From April 2008, local authority and health agencies have had a responsibility to take part in review processes which look at the death of every child, irrespective of cause intended to generate lessons to reduce avoidable deaths.

Local Safeguarding Children Boards (LSCBs) may have their own guidance to guide general practitioners and their staff towards understanding the extent of their responsibility to co-operate in these processes.

Child Death Review Processes

Chapter 7 of *Working Together to Safeguard Children 2010* sets out the procedures which LSCBs must follow in the event of the death of a child. Although these deaths are uncommon, it is expected that agencies will have standing arrangements in place. Guidance applies to all children from birth to 18 years.

There are different pathways for:

- **unexpected** deaths, where a group of key professionals come together to enquire into and evaluate the death
- **all** deaths, where an overview panel will review patterns or trends in local data

Unexpected Deaths - Child Death Review Teams (CDRT)

A multi-professional team will be drawn together within days of the unexpected death of a child. In agreement with the coroner, they will investigate the reasons for the death, liaise with those who have ongoing responsibility for other family members, collect standardised information, maintaining contact throughout with the family and with professionals.

The CDRT will be made up of the following:

- Senior Investigating Police Officer
- Visiting Health Professional [Paediatrician, Named or Designated Nurse]
- Health Visitor or School Nurse
- Children's Social Care representative

Immediate response to the unexpected death of a child in the community

It is anticipated that babies and infants who die at home or in the community will always be taken to hospital, where resuscitation may be undertaken if appropriate. (*Working Together*

2018) offers the advice that *"it is expected that the child's body will have already been held or moved by the carer and that removal to A&E will not normally jeopardize an investigation."*

Designated Paediatrician with responsibility for unexpected deaths in childhood

Working Together also creates the new role for a paediatric overview of deaths in childhood. This doctor will ensure that relevant professionals are informed of the death of the child, collate their responses and convene a meeting to discuss the findings of the post-mortem examination.

Any GP confirming unexpected death of a child in the community would be expected to notify the designated paediatrician, who will then cascade the information to relevant professionals – coroner, police and children's social care services.

All Deaths

Child Death Overview Panel

The CDOP will be made up from among the following:

- Director of Public Health or representative
- Coroner or Coroner's Officer
- Consultant Paediatrician (SUDI paediatrician)

The death of a child which was not anticipated as a significant possibility 24 hours before the death or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death.
Working Together 2010

- Children's Social Care
- Police Child Abuse Investigation Unit
- Child Health Nurse
- Midwifery
- Bereavement Counsellor
- Lay representative
- Other ad hoc representation on particular issues as they arise and this might from time to time include Primary Care, Obstetric, Emergency Department, Pathology or Mental Health personnel.

SCRs are statutory multi-agency reviews undertaken when a child dies (including suicide),

or is seriously injured and abuse or neglect is known or suspected to be a factor in the death. Chapter 8 of *Working Together to Safeguard Children* sets out the purpose and process of a SCR. It is an analysis, not only of one event, but the series of events leading to the crisis. The purpose is as with Significant Event Analysis, not to apportion blame, but to improve the services.

Implications for Primary Care – those at risk

- The child who is missed, “lost” or not seen, such as the child who is not brought for immunisations, or is lost to follow up of chronic illness
- Babies of mothers who fail to attend their antenatal appointments
- Children who are ‘invisible’ through the assumption that others are seeing them
- Children from large families
- Families subject to multiple moves, house fires and generally poor living conditions
- Professionals making efforts not to be ‘judgemental’, especially in relation to other cultures, religions and ethnicities
- Professionals uncertain about what can/can’t or should/shouldn’t be done, apparent lack of confidence in own judgement and principles
- Those with fixed views on neglect, rough handling
- Men in the family ‘off the radar’ and unknown to professionals working with the family
- Professionals with different thresholds for action
- Professionals with boundary disputes
- Professionals who have low expectations of certain families such as overwhelmed, chaotic families, with involvement with drugs or violence, history of mental ill health and/or criminality
- Parent/s who need to engage with mental health services, but do not.

Appendix 5 Children as Temporary Residents

Most children in the United Kingdom are registered with an NHS general practitioner. When children who are not known are seen by a health professional, health professionals should take the opportunity to assess them for signs of abuse listed elsewhere in this document.

Children in both the following categories may be at risk of abuse and neglect and may also present medico-legal risk.

1. Children who are registered with a practice but are never or rarely seen

Children may not be brought for screening or immunisations appointments or not presented for care of acute conditions at the practice. It should be noted that infants and young children depend on adults for provision of care and failure to make and keep such appointments might be considered a feature of neglect. It should be considered good practice on the part of health professionals to follow up failure to attend for prophylactic care and to persuade reluctant parents to present children for such care.

Such children may be frequently presented to Out of Hours Services and A&E departments for care of acute conditions, yet fail to attend routine Out-Patients appointments. These are known indicators of risk (CEMACH 2008).
www.cmace.org.uk/Publications-Press-Releases/Report-Publications/Child-Health.aspx

2. Children presented for immediately necessary treatment or temporary registration

These may be:

- children already registered with another UK GP who are on holiday or visiting relatives
- children who are ‘privately’ fostered
- children who are looked after by the local authority
- placed with foster carers
- in a children’s home
- recent immigrants not yet registered
- asylum seekers
- illegal immigrants
- trafficked children

An essential aspect of the duty of care to the child is that careful, detailed, contemporaneous records are maintained and accurate contact details be obtained in the event that follow-up for a medical condition is required or concern about the child’s well-being has been aroused.

The child's full name, permanent address and telephone number, name of carer, name of usual GP and school if of school age, should be ascertained, in addition to the temporary address and telephone contact details.

If in the course of seeing such children the GP feels there is a possibility that the child may be at risk, it might be helpful to telephone the child's usual GP or school to obtain more information.

In most cases seeing children as temporary residents is a straightforward procedure. GPs practising in resort towns with a regular influx of tourists every summer will be used to seeing a number of children with minor and straightforward ailments which do not cause great concern and this may also apply to children staying temporarily with relatives known to the practice.

Children in the care of the local authority should be registered permanently, concerns around the length of the placement and possible changes of GP should be discussed with their social worker and every effort must be made to ensure that their records are transferred to the next GP in a timely and appropriate manner when they move.

However, it is necessary to maintain continuing awareness of the existence of children who may have been trafficked, who are in this country illegally or who are children of failed asylum seekers. GPs have a responsibility to provide urgent and immediately necessary care for all children, even those of uncertain immigration status while being conscious that carers of such children may seek to avoid attention of the authorities by providing assumed names and false addresses. More information may be found at www.nhserewash.com/safeguarding/latest/page17.html

Appendix 6 Equalities and Health Inequalities

Equalities and Health Inequalities – Screening Tool

Name of Policy: Safeguarding Children Policy
Date of Ratification: September 2012

Version number: V1.0

First published: November 2016

To be read in conjunction with Equalities and Health Inequalities Analysis Guidance, Quality & Patient Safety Team, Primary Care 24, 2016.

Prepared by: Quality & Patient Safety Team.

Introduction

The purpose of this Screening Tool is to help you decide whether or not you need to undertake an Equality and Health Inequalities Analysis (EHIA) for your project, policy or piece of work. It is your responsibility to take this decision once you have worked through the Screening Tool. Once completed, the Head of your SDU or the Quality & Patient Safety Team will need to sign off the Screening Tool and approve your decision i.e. to either undertake an EHIA or not to undertake an EHIA.

The Quality and Patient Safety Team can offer support where needed. It is advisable to contact us as early as possible so that we are aware of your project.

When completing the Screening Tool, consider the nine protected characteristics and how your work would benefit one or more of these groups. The nine protected characteristics are as follows:

1. Age
2. Disability
3. Gender reassignment
4. Marriage and civil partnership
5. Pregnancy and maternity
6. Race
7. Religion and belief
8. Sex
9. Sexual orientation

A number of groups of people who are not usually provided for by healthcare services and includes people who are homeless, rough sleepers, vulnerable migrants, sex workers, Gypsies and Travellers, Female Genital Mutilation (FGM), human trafficking and people in recovery. Primary Care 24 will also consider these groups when completing the Screening Tool:

The **guidance** which accompanies this tool will support you to ensure you are completing this document properly. It can be found at: http://extranet.Primarycare24.co.uk/

Equality and Health Inequalities: Screening Tool

A	General information
A1	Title: **Safeguarding Children Policy** What is the title of the activity, project or programme?
A2.	What are the intended outcomes of this work? Please outline why this work is being undertaken and the objectives. **The Policy is designed to ensure that, throughout Primary Care 24, children are protected from abuse and exploitation. The policy details roles and responsibilities of PC24 personnel.**
A3.	Who will be affected by this project, programme or work? Please identify whether the project will affect staff, patients, service users, partner organisations or others. **This policy applies to all PC24 personnel only**

B	**The Public Sector Equality Duty**		
B1	Could the initiative help to reduce unlawful discrimination or prevent any other conduct prohibited by the Equality Act 2010? If yes, for which of the nine protected characteristics (see above)?		
	Yes	No	Do not know
	Summary response and your reasons: **As the policy equally applies to all PC24 personnel**		
B2	Could the initiative undermine steps to reduce unlawful discrimination or prevent any other conduct prohibited by the Equality Act 2010? If yes, for which of the nine protected characteristics? If yes, for which of the nine protected characteristics?		
	Yes	**No**	Do not know
	Summary response and your reasons: **The Policy equally applies to all PC24 personnel**		
B3	Could the initiative help to advance equality of opportunity? If yes, for which of the nine protected characteristics?		
	Yes	No	Do not know
	Summary response and your reasons: **All nine characteristics as the policy equally applies to all PC24 personnel**		
B4	Could the initiative undermine the advancement of equality of opportunity? If yes, for which of the nine protected characteristics?		
	Yes	**No**	Do not know
	Summary response and your reasons: **Policy equally applies to all PC24 personnel**		
B5	Could the initiative help to foster good relations between groups who share protected characteristics? If yes, for which of the nine protected characteristics?		
	Yes	No	Do not know
	Summary reasons: **Policy equally applies to all PC24 personnel**		
B6	Could the initiative undermine the fostering of good relations between groups who share protected characteristics? If yes, for which of the nine protected characteristics?		
	Yes	**No**	Do not know
	Summary response and your reasons**:** **Policy equally applies to all PC24 personnel**		
C	**The duty to have regard to reduce health inequalities**		
C1	Will the initiative contribute to the duties to reduce health inequalities?		

	Could the initiative reduce inequalities in access to health care for any groups which face health inequalities? If yes for which groups?		
	Yes	**No**	Do not know
	Summary response and your reasons: **Organisational policy that applies to PC24 personnel only**		
C2	Could the initiative reduce inequalities in health outcomes for any groups which face health inequalities? If yes, for which groups?		
	Yes	**No**	Do not know
	Summary response and your reasons: **Organisational policy that applies to PC24 personnel only**		
D	Will a full Equality and Health Inequalities Analysis (EHIA) be completed?		
D1	Will a full EHIA be completed? Bearing in mind your previous responses, have you decided that an EHIA should be completed? Please see notes. [1] Please place an X below in the correct box below. Please then complete part E of this form.		
	Yes	Cannot decide	**No**
E	Action required and next steps		
E1	If a full EHIA is planned: Please state when the EHIA will be completed and by whom. Name: Date:		
E2	If no decision is possible at this stage: If it is not possible to state whether an EHIA will be completed, please summarise your reasons below and clearly state what additional information or work is required, when that work will be undertaken and when a decision about whether an EHIA will be completed will be made. Summary reasons: Additional information required: When will it be possible to make a decision about an EHIA?		
E3	If no EHIA is recommended:		

[1] Yes: If the answers to the previous questions show the PSED or the duties to reduce health inequalities are engaged/in play a full EHIA will normally be produced. No: If the PSED and/or the duties to reduce health inequalities are not engaged/in play then you normally will not need to produce a full EHIA.

	If your recommendation or decision is that an EHIA is not required then please summarise the rationale for this decision below. Summary reasons: This policy has been consulted on by the Quality & Patient Safety Tem. There is no negative impact with respect to the characteristics as defined by the Equality Act.

F	*Record Keeping*		
Lead originator:	Director of Nursing	Date:	02.02.218
Director signing off screening:	Director of Nursing	Date:	02.02.18
Directorate:	Quality & Patient Safety		
Screening published:	Staff intranet.	Date:	Feb 2018

Appendix 7 - PC24 Directory of Services

Location	Clinical Lead for Service	Service Manager	CCG Policy	Local Authority for Referral	PC24 Advice/ Support
Primary Care, Sefton GP					
Crossways, Waterloo	Dr Daniel Ellis	Claire Linnan	South Sefton CCG	Sefton Social Care	9-5 Director of Nursing, Paul Kavanagh-Fields 5-6:30 Shift Manager (call centre)
Crosby Village	Dr Daniel Ellis	Claire Linnan	South Sefton CCG	Sefton Social Care	9-5 Director of Nursing, Paul Kavanagh-Fields 5-6:30 Shift Manager (call centre)
Litherland Practice	Dr Daniel Ellis	Claire Linnan	South Sefton CCG	Sefton Social Care	9-5 Director of Nursing, Paul Kavanagh-Fields 5-6:30 Shift Manager (call centre)
Maghull Practice	Dr Daniel Ellis	Claire Linnan	South Sefton CCG	Sefton Social Care	9-5 Director of Nursing, Paul Kavanagh-Fields 5-6:30 Shift Manager (call centre)

Netherton Health Centre	Dr Daniel Ellis	Claire Linnan	South Sefton CCG	Sefton Social Care	9-5 Director of Nursing, Paul Kavanagh-Fields 5-6:30 Shift Manager (call centre)
Seaforth Village Practice	Dr Daniel Ellis	Claire Linnan	South Sefton CCG	Sefton Social Care	9-5 Director of Nursing, Paul Kavanagh-Fields 5-6:30 Shift Manager (call centre)
Thornton Practice	Dr Daniel Ellis	Claire Linnan	South Sefton CCG	Sefton Social Care	9-5 Director of Nursing, Paul Kavanagh-Fields 5-6:30 Shift Manager (call centre)
Intermediate Care					
Knowsley	Dr Tatiana Tchikhiaeva	Gemma Kearns	Knowsley CCG	Knowsley MASH	9-5 Mon-Fri Director of Nursing, Paul Kavanagh-Fields OOH Shift Manager (call centre)
Other					
Asylum Service	Dr Jon Reynolds	Julie Omar	NHSE	Liverpool Careline	9-5 Mon-Fri Director of Nursing, Paul Kavanagh-Fields
Out of Hours					
UCC Old Swan	Dr Jon Reynolds	Julie Omar	Liverpool CCG	Liverpool Careline	Shift Manager (call centre)

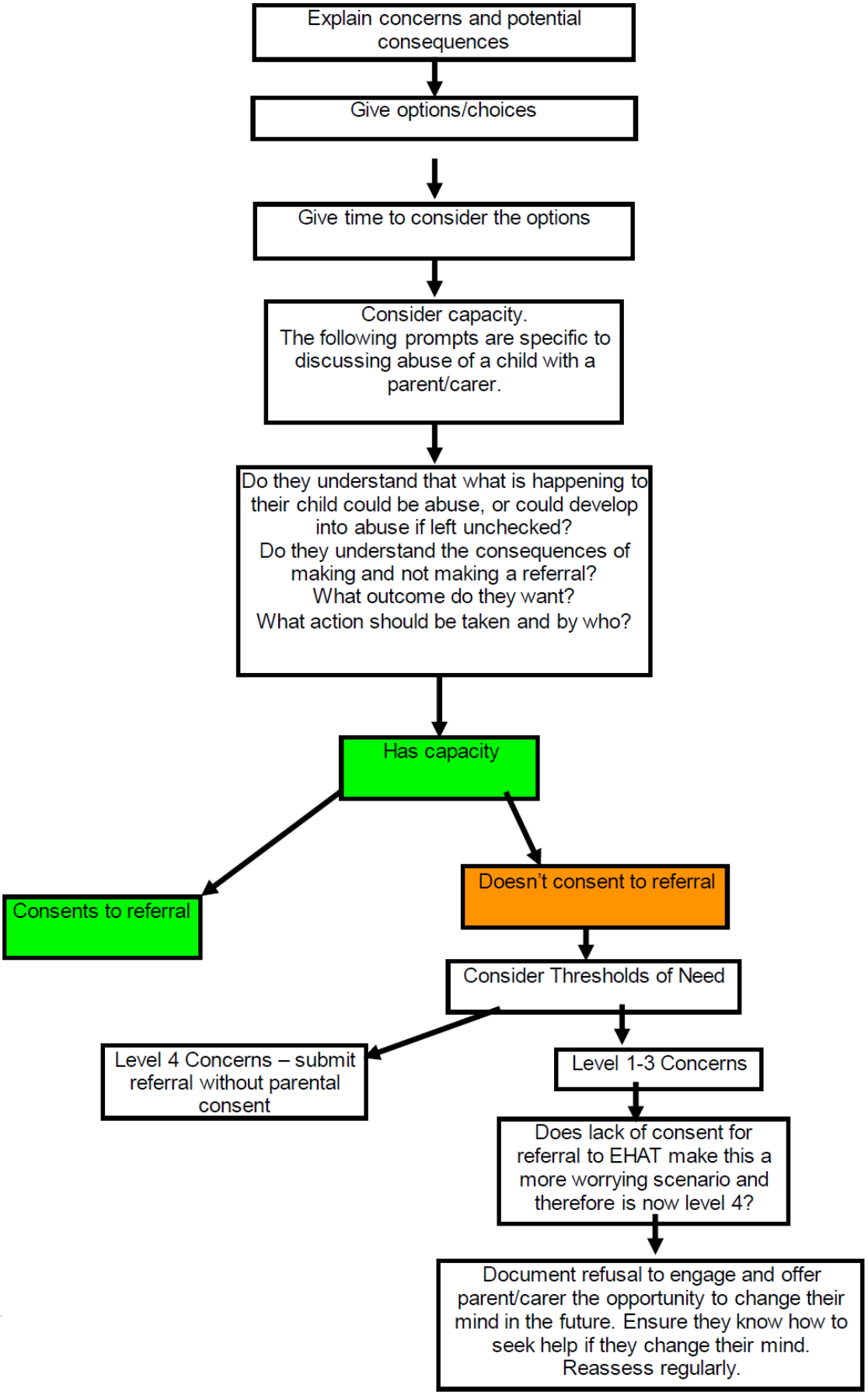
UCC Runcorn	Dr Sharmila Armitage	Dominique Fearis	Halton CCG	Halton Social Care	Shift Manager (call centre)
UCC RLUH	Dr Jon Reynolds	Julie Omar	Liverpool CCG	Liverpool Careline	Shift Manager (call centre)
UCC UHA	Dr Jon Reynolds	Julie Omar	Liverpool CCG	Liverpool Careline	Shift Manager (call centre)
UCC Huyton	Dr Tatiana Tchikhiaeva	Gemma Kearns	Knowsley CCG	Knowsley MASH	Shift Manager (call centre)
UCC Lowe House, St Helens	Dr Tatiana Tchikhiaeva	Gemma Kearns	St Helens CCG	St Helens First Response Team	Shift Manager (call centre)
UCC Bath Street	Dr Sharmila Armitage	Vicky Gorman	Warrington CCG	Warrington MASH	Shift Manager (call centre)
Out of Hours Triage (including NWAS Pathfinder) and Home Visits, as per address of patient					
Primary Care Streaming					
UHA	Dr Jon Reynolds	Julie Omar	Liverpool CCG	Liverpool Careline	10-5 Director of Nursing, Paul Kavanagh-Fields 5-7 Shift Manager (call centre)
RLUH	Dr Jon Reynolds	Julie Omar	Liverpool CCG	Liverpool Careline	11-5 Director of Nursing, Paul Kavanagh-Fields 5-7 Shift Manager (call centre)
GP Extended Access					
Childwall	Dr Jon Reynolds	Julie Omar	Liverpool CCG	Liverpool Careline	Shift Manager (call centre)

Townsend	Dr Jon Reynolds	Julie Omar	Liverpool CCG	Liverpool Careline	Shift Manager (call centre)
Abercromby	Dr Jon Reynolds	Julie Omar	Liverpool CCG	Liverpool Careline	Shift Manager (call centre)
Garston	Dr Jon Reynolds	Julie Omar	Liverpool CCG	Liverpool Careline	Shift Manager (call centre)
Millennium Centre	Dr Tatiana Tchikhiaeva	Gemma Kearns	St Helens CCG	St Helens First Response Team	Shift Manager (call centre)
Rainford	Dr Tatiana Tchikhiaeva	Gemma Kearns	St Helens CCG	St Helens First Response Team	Shift Manager (call centre)
Rainhill	Dr Tatiana Tchikhiaeva	Gemma Kearns	St Helens CCG	St Helens First Response Team	Shift Manager (call centre)
Woodside	Dr Tatiana Tchikhiaeva	Gemma Kearns	St Helens CCG	St Helens First Response Team	Shift Manager (call centre)
Huyton	Dr Tatiana Tchikhiaeva	Gemma Kearns	Knowsley CCG	Knowsley MASH	9-5 Director of Nursing, Paul Kavanagh-Fields 5-8 Shift Manager (call centre)
Kirkby	Dr Tatiana Tchikhiaeva	Gemma Kearns	Knowsley CCG	Knowsley MASH	9-5 Director of Nursing, Paul Kavanagh-Fields 5-8 Shift Manager (call centre)

Halewood	Dr Tatiana Tchikhiaeva	Gemma Kearns	Knowsley CCG	Knowsley MASH	9-5 Director of Nursing, Paul Kavanagh-Fields 5-8 Shift Manager (call centre)
Whiston	Dr Tatiana Tchikhiaeva	Gemma Kearns	Knowsley CCG	Knowsley MASH	9-5 Director of Nursing, Paul Kavanagh-Fields 5-8 Shift Manager (call centre)
Triage, as per address of patient					

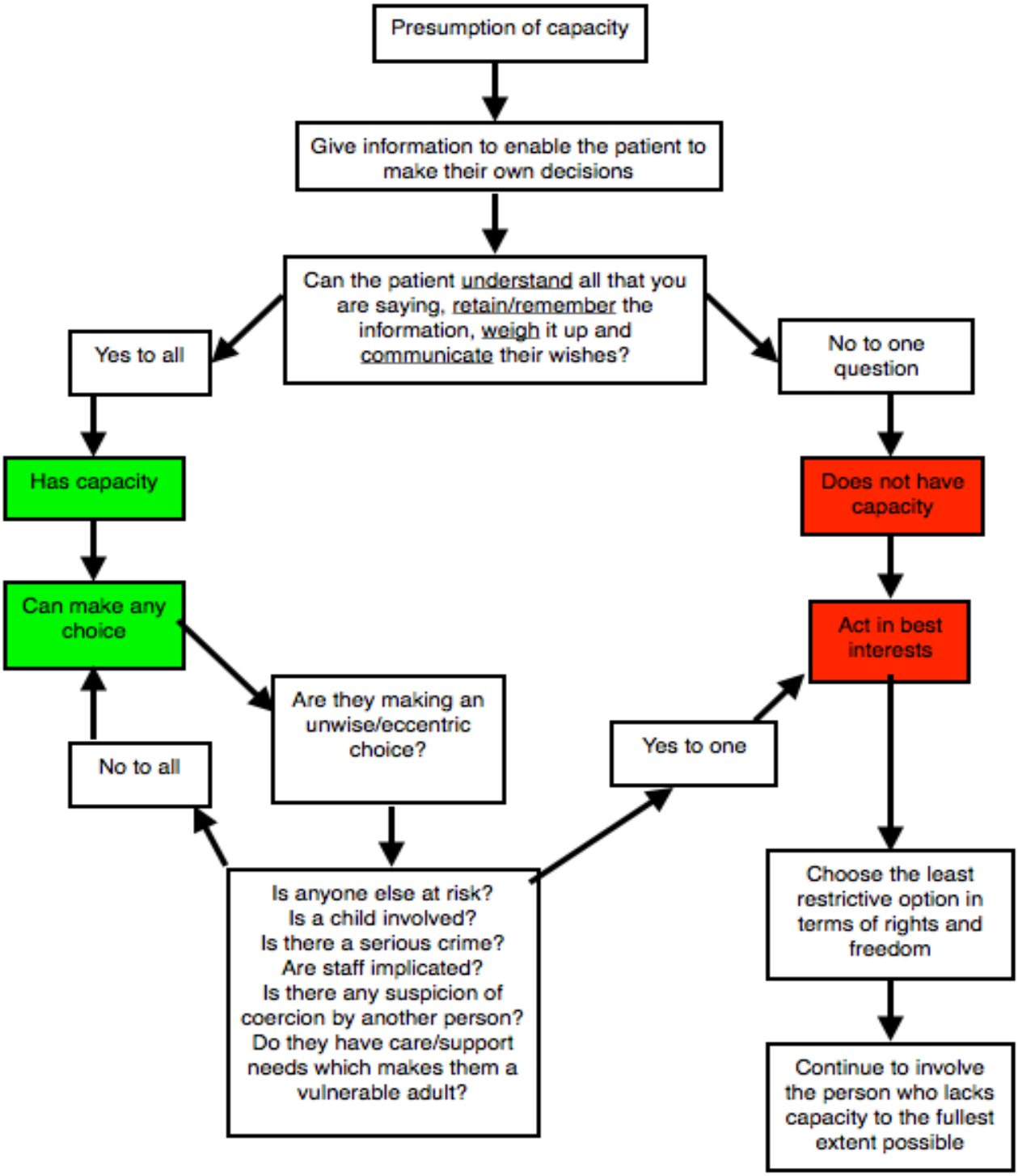
Appendix 8

Considering Consent of Parent/Carer when Safeguarding Children



Appendix 9

Determining Capacity



Appendix 10

[NAME] MEDICAL PRACTICE

SAFEGUARDING

PRACTICE LEAD – Dr [NAME]

If Dr [NAME] is not available please share your concerns with another member of the practice clinical team or with the practice manager

Remember safeguarding is everyone's responsibility

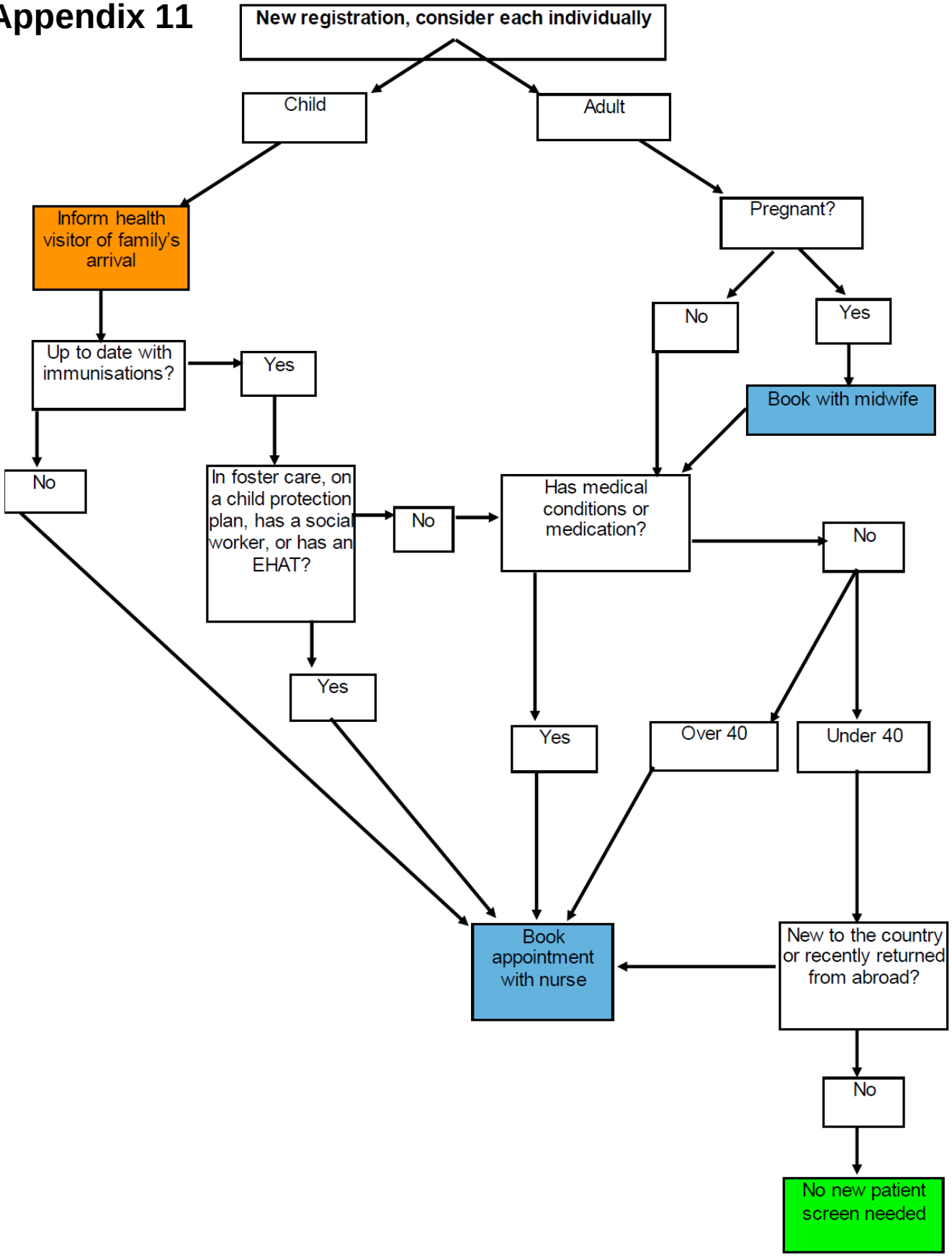
ADULT SAFEGUARDING – [LOCAL NUMBER]
CHILD SAFEGUARDING – [LOCAL NUMBER]

For advice on safeguarding children or adults at risk:

PC24 Safeguarding Lead: Paul Kavanagh-Fields (Director of Nursing) – 0151 254 2553

All Safeguarding referrals to be reported via Datix

Appendix 11


New registration, consider each individually
Child
Adult
Inform health visitor of family's arrival
Pregnant?
No
Yes
Up to date with immunisations?
Yes
Book with midwife
No
In foster care, on a child protection plan, has a social worker, or has an EHAT?
No
Has medical conditions or medication?
No
Yes
Yes
Over 40
Under 40
Book appointment with nurse
New to the country or recently returned from abroad?
No
No new patient screen needed

Appendix 12

A. Development needs of baby, child or young person (including unborn child)

Determinant	Level 1	Level 2	Level 3	Level 4
	Universal	Additional Needs / Multi-Agency Response / Early Help Assessment	Complex Needs/ Multi-Agency Response / Early Help Assessment	Acute Needs / Statutory Intervention (CIN / CP) / MARF
Health	• Physically well • Adequate diet/hygiene/clothing • Developmental checks/immunisations up to date • Regular dental/optical care • Health appointments kept • Speech and language development met	• Defaulting on immunisation checks • Susceptible to minor health problems • Slow in reaching developmental milestones • Minor concerns re: diet/hygiene/lack of sleep • Smokes/ alcohol concerns • Starting to default on health appointments • Presenting with inappropriate sexualised behaviour • Teenage pregnancy (consider age and social circumstances)	• Concerns re: diet, hygiene, clothing • Some chronic health problems • Missing routine and non-routine health appointments • Substances misuse • Developmental milestones are unlikely to be met • Concerns around mental health • Teenage pregnancy (multi agency response) (consider age and social circumstance) • Significant change in mood • Recurring health problems • Promiscuity	• Severe/chronic health problems • Persistent substance misuse • Developmental milestones are unlikely to be met • Teenage pregnancy (acute level of need) • Serious mental health issues • No engagement with Health professionals
Education and Learning	• Skills in/need • Success/achievement • Cognitive development • Access to books and toys, play • Choices and encouragement	• Some identified learning or physical disability needs, requiring support • Poor punctuality • Pattern of school absences • Not always engaged in learning – poor concentration/low motivation/interest • Not reaching educational potential • Limited access to books/toys • High levels of school mobility	• Significant learning needs and may have Statement or Educational needs (or Education Health Care Plan) • Escalating poor school attendance and punctuality • Some fixed term exclusions • Not engaged in education or reaching educational potential • Fear of holidays, leaving school • Pre-occupied with ideology	• Non-attendance / chronic absence seriously impacting development • Permanently excluded / No school place • No access to leisure activities
Emotional and Behavioural Development	• Feelings/actions demonstrate appropriate responses • Good quality early attachments • Able to adapt to change • Able to demonstrate empathy	• Some difficulties with peer group relationships and adults • Concern of self-harm (including substance misuse) • Some evidence of inappropriate responses and actions • Can find managing change difficult • Starting to show difficulties expressing empathy • Low self-esteem/self confidence • Feelings: Grievance/ injustice/oppression	• Finds it difficult to cope with anger, frustration and upset • Disruptive/challenging behaviour at school or in neighbourhood • Cannot manage change • Unable to demonstrate empathy • Repeated episodes of self-harm and/or substance misuse	• Regularly involved in anti-social/criminal activities • Puts self or others in danger e.g.missing from home or in care • Suffers from periods of depression • Suicide attempts • Children at risk of sexual or criminal exploitation • Harmful objectives • Manipulation and coercion into negative cultural, religious activities
Identity	• Positive sense of self and abilities • Demonstrates feelings of belonging and acceptance • Sense of self • Ability to express needs	• Some insecurities around identity expressed • Confusion linked to culture, isolation, threatened, low self-esteem for learning • May experience bullying around "difference" • Unsure or unable to disclose sexual orientation • May be affected by peer/gang pressure • Strong negative gender identification and role	• Is subject to discrimination e.g. racial, sexual orientation or disabilities • Demonstrates significantly low self-esteem in a range of situations • Is subject to peer/gang pressure • Serious negative belief systems about gender • Marginalised/over identification with group or ideology • Us and them mindset	• Experiences persistent discrimination e.g. racial, sexual orientation or disability • Involved with organised gangs or criminal activity • Discriminating on grounds of gender, culture, religious identity
Family and Social Relationships	• Stable, affectionate with care given • Good relationships with siblings • Positive relationships with peers	• Some support from family and friends • Some difficulties sustaining relationships • Gang association/s through relative, peers or relationship • Signs of being bullied • Age inappropriate relationships • Self isolation from family • Family attitude justify offending	• Has lack of positive role models • Misuse school or leisure activities • Peers also involved in challenging behaviour • Involved in conflict with peers/siblings • Regularly needed to care for another family member • Manipulation and coercion to comply with negative gender, religion, cultural behaviours • Known gang involvement • Little social relationships outside the home • Family/Friends involved in extremism • Access to extremist networks	• Periods of being accommodated by the Local Authority • Family breakdown related in some way to child's behavioural difficulties • Subject to physical, emotional or sexual abuse or neglect • Main carer for family member • Unaccompanied asylum seeker • Where parents have made private fostering arrangements • Involved in manipulation and coercion of others • Known involvement with extremist group
Social Presentation	• Appropriate dress for different circumstances • Good level of personal hygiene • Can choose own clothing	• Can be over-friendly or withdrawn with strangers • Can be provocative in appearance and behaviour • Personal hygiene starting to be a problem • Unexplained change in peer group – can be dominated	• Is provocative in behaviour/appearance • Clothing is regularly unwashed • Hygiene problems • Sudden display of unexplained gifts / clothing • Attitude justify offending • Intolerant of other's views – resulting in de-humanising of perceived enemies	• Poor and inappropriate self presentation
Self-care Skills	• Growing level of competencies in practical and emotional skills such as feeding, dressing and independent living skills	• Not always adequate self care e.g. poor hygiene, self neglect • Slow to develop age appropriate self care skills	• Poor self care for age, including hygiene • Inappropriately able to care for self • Pre-occupation with the internet • Inappropriate use of technology	• Neglects to use self-care skills due to alternative priorities e.g. substance misuse • Inappropriate use of technology and poses a risk to self or others

This is a user friendly guide, outlining determinants of need. This is by no means exhaustive, and your professional judgement should be used when assessing need.

B. Parents and Carers

Determinant	Level 1 Universal	Level 2 Additional Needs/ Multi-Agency Response / Early Help Assessment	Level 3 Complex Needs / Multi-Agency Response / Early Help Assessment	Level 4 Acute Needs / Statutory Intervention (CIN / CP) / MARF
Basic Care	• Provides for child's physical needs e.g. food, drink, appropriate clothing, medical and dental care	• Engagement with services is poor • Requires advice on parenting issues • Professionals are beginning to have some concerns around child's physical needs being met • Parental decisions affecting child safety	• Difficulty engaging parents with services • Struggling to provide adequate care • Previously looked after by Local Authority • Professionals have serious concerns e.g. parental drug/alcohol misuse, learning difficulties/mental health etc. • Serious concerns re extremist viewpoint of parents	• Unable to provide "good enough" parenting that is adequate and safe including unborn child • Mental health problems/substance misuse significantly affects care of child • Parents unable to care for previous children • Parents support and encourage extremist ideology
Ensuring Safety	• Protects from danger or significant harm in the home and elsewhere • Restricts/monitors internet access	• Some exposure to dangerous situations in the home or community including on-line violent and/or extremist web sites or influencers • Parental stresses starting to affect ability to ensure child's safety	• Perceived to be a problem by parents • May be subject to neglect • Experiencing unsafe situations • Parents hold extremist views and condone behaviours	• Instability/violence in the home continually • Parents involved in crime • Parents unable to keep child safe • Victim of crime • Travel to areas of conflict • Engagement with extremist activity • Subject to traditional unsafe practices (FGM, Forces Marriage, HSV)
Emotional Warmth	• Shows warm regard, praise and encouragement	• Inconsistent responses to child by parent(s) • Able to develop other positive relationships • Feelings of worthlessness	• Receives erratic or inconsistent care • Has episodes of poor quality of care • Instability affects capacity to nurture • Has no other positive relationships	• Parents inconsistent, highly critical or apathetic towards child
Stimulation	• Facilitates cognitive development through interaction and play • Enables child to experience success	• Spends considerable time alone e.g. watching television/ computer games • Child is not often exposed to new experiences • Child is exposed to extremist views or organisations	• Not receiving positive stimulation, with lack of new experiences or activities • Deliberate restricting access to positive activities and experiences • Parents fail to challenge extremist viewpoint advocating violence	• No constructive leisure time or guided play • Encourage to view / promote extremist ideology • Positively denying access to positive activities and experiences
Guidance and Boundaries	• Provides guidance so that child can develop an appropriate internal model of values and conscience	• Can behave in an anti-social way in the neighbourhood e.g. petty crime • Parent/carer offers inconsistent boundaries • Parents offering a distorted perspective of expected boundaries • Parents fail to challenge extremist viewpoint	• Erratic/inadequate guidance provided • Parent not offering good role model e.g. behaving in an anti-social way • Parents enforcing unrealistic boundaries and guidance • No restrictions imposed re access to extreme sites/groups	• No effective boundaries set • Regularly behaves in an anti-social way in the neighbourhood • Exposure to extremist influences • Exhibiting behaviours to manage unrealistic and negative boundaries
Stability	• Ensures that secure attachments are not disrupted • Consistency of emotional warmth over time • Ensures child accesses education available to them	• Key relationships with family members not always maintained • Starting to demonstrate difficulties with attachments • Unstable family environment	• Has multiple carers • Has been looked after by Local Authority • Limited attachments that are controlled by parents • Family relationships impose negative influence	• Beyond parental control • Has no-one to care for child • Concerns regarding family travel to areas of conflict • Engagement in extremist activity • Relationships and attachments based on negative influences

C. Family and Environmental Factors

Determinant	Level 1 Universal	Level 2 Additional Needs Multi Agency Early Help Assessment	Level 3 Complex Targeted Early Help Assessment	Level 4 Acute / Specialist Caroline
Family History or Functioning	• Good relationships within family, even when parents are separated • Few significant changes in family composition	• Parents have some conflicts or difficulties that can involve the children • Has experienced loss of significant adult e.g. through bereavement or separation • Looked after by younger sibling • Parent has physical or mental health issues • Multiple changes of address • History of abuse • Parents ability to cope with needs of disabled child • Family history of criminal gang involvement, FGM, Forces Marriage or HSV • Poor relationships (siblings / child to parent) including violent or aggressive outbursts • Extended family live in areas of conflict • Family Religious/cultural beliefs affect role and responsibilities of child • Poor relationships between siblings	• Incidents of domestic violence (parents / siblings / child to parent) • Acrimonious divorce/separation • Family have serious physical and mental health difficulties • Family associated with extremist group / ideology	• Significant parental discord and persistent domestic violence (parents / siblings / child to parent) • Family member has Terrorism conviction • Family Member is known to be a significant risk to children • Parents negative cultural, religious beliefs and practices
Wider Family	• Sense of larger familial network / good friendships outside of the family unit	• Some support from friends and family • Caring responsibilities • Child depressed, alone, anxious or feeling unhappy/misunderstood	• Family has poor relationship with extended family/little communication • Caring responsibilities with no agency support • Parents influenced by negative family, community, cultural, religious beliefs and practices • Access to extremist networks • Over identification with group/ideology	• No effective support from extended family • Destructive/unhelpful involvement from extended family • Intention to travel to area of conflict • Engagement in terrorist activity • Parents unable to protect from negative, manipulative influences
Housing	• Has basic amenities and appropriate facilities	• Adequate/poor housing • Living in gang neighbourhood • Living in an area where extremist groups (violent/non violent) operate	• Poor state of repair, temporary or overcrowded • Homeless, living in Hostel • Exposure to victimisation/racism • Known extremism in wider family	• Physical accommodation places child in danger
Employment	• Parents able to manage working/unemployed and do not perceive them as unduly stressful	• Periods of unemployment of the wage earning parent(s) • Parents have limited formal education • Parents starting to feel stressed around unemployment or working situation • Barriers to employment opportunities	• Parents experience stress due to unemployment or "overworking" • Parents find it difficult to obtain employment due to poor/basic skills • Grievance resulting from inability to obtain employment	• Chronic unemployment, severely affecting parent's own identity • Unable to gain employment due to lack of basic skills or long-term difficulties e.g. substance misuse
Income	• Reasonable income over time, resources used appropriately to meet needs	• Low income	• Serious debts/poverty impact on ability to meet basic needs	• Extreme poverty/debt impacting on ability to care for child
Family Social Integration	• Family integrated into community • Good social and friendship networks	• Family may be new to the area • Some social exclusion experiences • Negative influences from peer groups or friends • Marginalised from community	• Parents socially excluded • Lack of support networks • Associating with young people who are exploited (sexually or criminally) • Negative support networks • Association with extremist groups	• Family chronically socially excluded • No supportive network • Family Members associated with extremist views • Family coerced into acts of abuse
Community Resources	• Good universal services in neighbourhood	• Adequate universal resources but family may have access issues	• Poor quality universal resources and access problems to these and targeted services	• Poor quality services with long-term difficulties with accessing target populations

Appendix 13

What To Do If You're Worried A Child Is Being Maltreated

Safeguarding Children
Flowchart for Referral in Warrington

PRACTITIONER HAS CONCERNS ABOUT
CHILD'S WELFARE

Practitioner discusses with manager and/or other senior colleagues as they think appropriate

Children's Social Care
Multi-Agency Safeguarding Hub (MASH)
01925 443400/442468

Still has concerns

No longer has concerns

Practitioner refers to children's social services, following up in writing within 48 hours

No further safeguarding action, although may need to act to ensure services provided

Children's Social Care Out of Hours 01925 444400

Social worker and manager acknowledge receipt of referral and decide on next course of action within one working day

Feedback to referrer on next course of action

No further social services involvement at this stage, although other action may be necessary, eg. onward referral

Initial assessment required

Concerns about child's immediate safety

Police
Tel: 101 and ask for the Public Protection Directorate, Warrington Operations Team

Acknowledge response and reply whether you are happy with the outcome/response. Seek advice if you are not happy.

For advice prior to referral
(9 am-5pm Monday – Friday)

Pauline Owens – 07733 892066
Designated Nurse
Safeguarding Children and Children in Care

Named GP Safeguarding Children
Vacant Post

Hannah Bryan – 07436 280955
Named Nurse Safeguarding Children, Primary Care
(From 22.02.21)

Dr Delyth Webb – 01925 662643
Designated Doctor
Safeguarding Children

Dr Folasade (Sade) Smith
01925 867887
Named Doctor
Safeguarding Children

Sharon Chisnall – 01925 867877
Named Nurse Safeguarding Children

After hours contact:
Consultant Paediatrician on call
01925 635911