Safeguarding Children Policy

Version:	2	**Amendments** (from previous version)
Ratified by:	Partners	~~Reformatted into new policy format and added action algorithm (Ratified May 2015)~~ ~~New Policy LMP & VHS merger October 2016~~ Updated Safeguarding Contacts, Appendix A - Aug 2017
Date ratified:	25 April 2017	
Author:	George Thomas	
Review date:	April 2019	
Consultees:	Management Team	

Contents

1. Policy Statement

Under the 1989 and the 2004 Children Acts a child or young person is anyone under the age of 18 years.

Child Protection refers to the activity that is undertaken to protect specific children who are suffering or at risk of suffering significant harm. All agencies and individuals should be proactive in safeguarding and promoting the welfare of children.

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

- Respond quickly and appropriately where abuse is suspected or allegations are made.
- Provide both parents and children with the chance to raise concerns over their own care or the care of others.
- Have a system for dealing with, escalating and reviewing concerns.
- Remain aware of child protection procedures and maintain links with other bodies, especially the primary care trust appointed contacts.
- The practice will ensure that all staff are trained to a level appropriate to their role, and that this is repeated on a refresher basis. New starters will receive training within 1 month of start date.

Basic Principles

- The welfare of the child is paramount.
- It is the responsibility of all adults to safeguard and promote the welfare of children and young people. This responsibility extends to a duty of care for those adults employed, commissioned or contracted to work with children and young people.
- Adults who work with children are responsible for their own actions and behaviour and should avoid any conduct which would lead any reasonable person to question their motivation and intentions.
- Adults should work and be seen to work, in an open and transparent way.
- The same professional standards should always be applied regardless of culture, disability, gender, language, racial origin, religious belief and/or sexual identity.
- Adults should continually monitor and review their practice and ensure they follow the guidance contained in this document and elsewhere.

2. Explanation of Terms

There are 4 main categories of child abuse:

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

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

Physical abuse may include:

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

Sexual abuse may include:

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

Emotional abuse may include:

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

Neglect may include:

- Failure to meet the child's physical or psychological needs
- Failure to provide adequate food or shelter
- Failure to protect from physical harm
- Neglect of a child's emotional needs

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

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

Some other situations which need careful consideration are:

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

- Reluctant to accept medical help

Child Protection Conferences: The contribution of GPs to safeguarding children is invaluable and priority should be given to attendance and sending a report wherever possible. Consider liaising with your health visitor and school nurses in addition about your attendance. Even if attendance is not possible or judged necessary, the provision of the report, even to say that the child has not been seen, is essential.

3. Duties

Role	Duties
Dr Anderson	Safeguarding Lead for the practice providing support and advice to staff where required and to oversee the safeguarding processing and reporting within the practice.
Dr Doucas	Deputy Safeguarding Lead. Deputising for the Safeguarding Lead as above.
All staff	Maintain awareness and vigilance in relation safeguarding following up and where necessary reporting all concerns as set out within this policy and the Incident Management Policy.

4. Policy Detail

All Safeguarding incidents are to be reported as per the Practice Learning Events Policy.

To achieve a child-safe practice, employees and partners (independent contractors, volunteers and the wider Primary Care Team members) need to be able to:

- describe their role and responsibility
- describe acceptable behaviour
- recognise signs of abuse
- ensure practice 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.

Immediate Actions

- Concerns should immediately be reported to the Lead clinician within the practice or his deputy (above).
- In the absence of one of the nominated persons, the matter should be brought to the attention of the Clinical Commissioning Group appointed person, or, if it is an emergency, and the designated persons cannot be contacted, then the most senior clinician will make a decision to report the matter directly to social services or the police. (see appendix A)
- If the suspicions relate to the designated person, then the deputy should be notified and the primary care organisation appointed person and / or social services should be contacted directly.
- Suspicions should not be raised or discussed with third parties other than those named above.
- Any individual has the ability to make direct referrals to the child protection agencies; however, staff are encouraged to use the route described here where possible. In the event that the reporting staff member feels that the action taken is inadequate, untimely

or inappropriate they should report the matter direct. Staff members taking this action in good faith will not be penalised.

- Where emergency medical attention is necessary it should be given. Any suspicious circumstances or evidence of abuse should be reported to the designated clinical lead.
- If a referral is being made without the parent's knowledge and non-urgent medical treatment is required, social services should be informed. Otherwise, speak to the parent/carer and suggest medical attention be sought for the child.
- If appropriate the parent/carer should be encouraged to seek help from the Social Services Department prior to a referral being made. If they fail to do so in situations of real concern the designated person will contact social services directly for advice.
- Where sexual abuse is suspected the designated person will contact the Social Services or Police Child Protection Team directly. The designated person will not speak to the parents.
- Neither the designated person nor any other practice team should carry out any investigation into the allegations or suspicions of sexual abuse in any circumstances. The designated person will collect exact details of the allegations or suspicion and to provide this information to the child protection agencies that will investigate the matter under the Children Act 1989.

Abuse Reported Or Allegations Received From A Child

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

Confidentiality

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

If an adult who works with children is in any doubt about whether to share information or keep it confidential he or she should seek guidance from the designated clinical Safeguarding Children lead. Any actions should be in line with locally agreed information sharing protocols, and the Data Protection Act applies.

Whilst adults need to be aware of the need to listen and support children and young people, they must also understand the importance of not promising to keep secrets. Neither should they request this of a child or young person under any circumstances.

Additionally, concerns and allegations about adults should be treated as confidential and passed to a designated or appointed person or agency without delay.

Physical Contact
A parent or carer should be present at all times, or a chaperone offered. Children should only be touched under supervision and in ways which are appropriate to, and essential for clinical care.

Permission should always be sought from a child or young person before physical contact is made and an explanation of the reason should be given, clearly explaining the procedure in advance. Where the child is young, there should be a discussion with the parent or carer about what physical contact is required. Regular contact with an individual child or young person is normally part of an agreed treatment plan and should be understood and agreed by all concerned, justified in terms of the child's needs, consistently applied and open to scrutiny.

Physical contact should never be secretive or hidden. Where an action could be misinterpreted a chaperone should be used or a parent fully briefed beforehand, and present at the time. Where a child seeks or initiates inappropriate physical contact with an adult, the situation should be handled sensitively and a colleague alerted.

Attitude Of Parents Or Carers
Parental attitude may indicate cause for concern:

- Unexpected delay in seeking treatment
- Denial of injury pain or ill-health
- Incompatible explanations, different explanations or the child is said to have acted in a way that is inappropriate to his/her age and development
- Reluctance to give information or failure to mention other known relevant injuries
- Unrealistic expectations or constant complaints about the child
- Alcohol misuse or drug/substance misuse
- Violence between adults in the household
- Appearance or symptoms displayed by siblings or other household members

5. Training

All staff undergo mandatory training as per their role. All partners are to undergo Level 3 safeguarding training, other clinical staff Level 2 and all other staff Level 1.

6. Process for Monitoring Compliance

All safeguarding issues are to be discussed as part of Incident reviews within the Partners Meetings.

7. References

- The Children Act 1989
- The Children Act 2004
- The Protection of Children Act 1999
- The Human Rights Act 1998
- The UN Convention on the Rights of the Child (ratified by the UK Government 1991)
- The Data Protection Act 1998 (UK wide)

• Sexual Offences Act 2003
• NICE CG89 Child Maltreatment Guidance 200911
• Working Together to Safeguard Children 2010

8. Equality Impact Assessment

There is a statutory duty under The Equality Act 2010 to undertake Equality Impact Assessments (EqIA) on all procedural documents and practices.

Appendix A - Safeguarding Children Key Contacts

Child safeguarding contacts for Primary Care professionals

NHS
Oxfordshire
Clinical Commissioning Group

In an EMERGENCY:

POLICE 999	If immediate risk of harm
POLICE 101	For concerns that do not need an immediate response
CHILDRENS' SOCIAL CARE Ring Multi-Agency Safeguarding Hub on 0345 0507666 Social Care Out of Hours Emergency Duty Team (5pm-9am) on 0800 833 408	For **immediate** concerns eg: • A child or young person discloses physical abuse • If there are signs of physical abuse e.g. injury • A child or young person discloses sexual abuse • A child presents as very different/scared to go home anxious and you are aware home could be risky
MEDICAL John Radcliffe Hospital on-call paediatrics bleep 1392 via Switch Horton General Hospital on-call paediatric consultant bleep 403 via Switch	Urgent medical assessment • Acute injury under 1 year including bruising in non-mobile child • Severe injury

To make a safeguarding referral or discuss an issue:

MEDICAL Referral or advice John Radcliffe Community Paediatrics 01865 231994 (9am to 5pm Monday to Friday) John Radcliffe on-call acute paeds registrar bleep 1392 (out of hours) Horton General Hospital on call consultant bleep 403 (24/7)	For acute, non-severe injury in older children AND non-acute concerns. For sexual abuse concerns, ring JR Community Paeds NOT the HGH.
CHILDRENS' SOCIAL CARE Locality and Community Support Service LCSS (TBC from 1.3.17) For a no names consultation call: LCSS North Tel: 0345 2412703 LCSS Central Tel: 0345 2412705 LCSS South Tel: 0345 2412608	• Emerging concerns for a child that does not require an **immediate** safeguarding response • Need support or guidance with an Early Help Assessment or Team Around the Family • Wish to complete a No Names Consultation

Version 2 13 July 2017

Child safeguarding contacts for Primary Care professionals

NHS
Oxfordshire
Clinical Commissioning Group

	Email contacts: LCSS North: LCSS.North@oxfordshire.gov.uk LCSS Central: LCSS.Central@oxfordshire.gov.uk LCSS South: LCSS.South@oxfordshire.gov.uk LCSS will advise re a MASH referral if this is required
DOMESTIC VIOLENCE – Reducing the Risk 0800 731 0055 (Mon-Sat 10-4)	For professionals and survivors, advice and help

Key Oxfordshire CCG child safeguarding contacts:

Clare Robertson	Designated Doctor	01865 231994 or via John Radcliffe switch
Alison Chapman	Designated Nurse and Safeguarding Lead (Adults and Children)	07775 760798
Sarah Ledingham	Named GP	Meriel.raine@nhs.net
Meriel Raine	Named GP	Sarah.ledingham@nhs.net
Pauline Burke	General Safeguarding Telephone Enquiries and VAM	01865 336709
Cat d'Angelo	General Safeguarding Telephone Enquiries and CDOP	01865 337023

OUH and Oxford Health also have named nurses who can be contacted via their switchboards, for concerns involving patients under their care.

Allegations concerns:

Alison Beasley	Oxfordshire County Council Designated Officer for Allegations	01865 815956

Looked After Children:

Maggie MacKenzie	Designated Nurse, Looked-After Children	East Oxford Health Centre 01865 904973 Maggie.mackenzie@oxfordhealth.nhs.uk

Version 2 13 July 2017

Appendix B – Link to our Safeguarding Folder on our Shared Drive

 < this folder links to our Safeguarding folder on our shared drive, which has further Safeguarding documents in there.

Appendix C - Equality Impact Assessment Tool

To be completed prior to consideration for ratification.

		Yes/No	Comments
1.	**Does the document/guidance affect one group less or more favourably than another on the basis of:**		
	• Race		
	• Ethnic origins (including roma and/or travelling community)	Y	Those who have difficulty in reading English may require additional support in understanding policy requirements.
	• Nationality	N	
	• Gender (including gender reassignment)	N	
	• Culture	N	
	• Religion or belief	N	
	• Sexual orientation	N	
	• Age	N	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	Y	Those staff who have difficulties in accessing the Computer Network and or reading may require additional support in understanding policy requirements.
2.	**Is there any evidence that some groups are affected differently?**	Y	As above
3.	**If you have identified potential discrimination, are there any valid exceptions, legal and/or justifiable?**	Y	There are currently no staff who come into the groups identified and pre-emptive action is not feasible
4.	**Is the impact of the document/guidance likely to be negative?**	N	
5.	**If so, can the impact be avoided?**	N	
6.	**What alternative is there to achieving the document/guidance without the impact?**	N	
7.	**Can we reduce the impact by taking different action?**	Y	Colleague and management support if required

If you have identified a potential discriminatory impact of this procedural document, please refer it to George Thomas, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Practice Manager.