

# Safeguarding Children Policy

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## Policy Statement

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

The practice is committed to working within agreed policies and procedures and in partnership with other agencies to ensure that the risks of harm to a child or adult are minimised.

## 1. INTRODUCTION

**The Junction Surgery** has a statutory duty of care towards children (Section 11 Children Act 2004) and to vulnerable adults who are resident in Kirklees. Having safeguards in place within any organisation not only protects and promotes the welfare of children and vulnerable adults, but also enhances the confidence of staff, volunteers, parents/carers and the general public. Protecting children and adults from abuse and neglect, preventing impairment of health and development, and ensuring children grow up in circumstances consistent with the provision of safe and effective care enables them to have optimum life chances and enter adulthood successfully. From an adult perspective, the experience of abuse and neglect is likely to have a significant impact on a person's health and wellbeing. By its very nature, the misuse of power by one person over another has a large impact on a person's independence. Neglect can prevent a person who is dependent on others for their basic needs exercising choice and control over the fundamental aspects of their life and can cause humiliation and the loss of dignity. (Association for Directors of Social Services 2005).

Abuse can be experienced or perpetrated by anyone and in any circumstances. It can be wilful or unintentional and can take many different forms including physical, sexual, emotional (including verbal), financial or material, neglect and discriminatory. People can however become at particular risk of abuse due to their personal circumstances including, children, those with a disability, illness or social isolation.

Effective safeguarding depends on a culture of zero tolerance of abuse, where concerns can be raised with confidence so that action will be timely, effective, proportionate and sensitive to the needs of those involved.

Public awareness continues to improve and there is an increasing expectation that service providers have systems in place to identify early indicators of abuse, prevent abuse and that they act quickly and effectively in partnership with other relevant agencies to safeguard children and adults when it is discovered that they are experiencing abuse.

## 2. ASSOCIATED POLICIES, PROCEDURES & GUIDANCE

This policy/procedure will be read in accordance with the following policies, procedures and guidance: **MCA, DoLs, Human trafficking, FGM, MASH, MSP, Domestic Abuse pathway.**

## 3. AIMS & OBJECTIVES

- Kirklees Safeguarding Adults Multi Agency Procedures ([www.kirklees.gov.uk/safeguardingadults](http://www.kirklees.gov.uk/safeguardingadults))
- West Yorkshire Consortium Safeguarding Children's procedures. ([www.kirklees.gov.uk/safeguardingchildren](http://www.kirklees.gov.uk/safeguardingchildren))
- 0-18years Guidance for all Doctors ([General Medical Council](#))
- Children and Young People; Doctor's Roles and Responsibilities ([General Medical Council](#))
- Safeguarding Children and Young People; Roles and Competences for Health Care Staff ( [Royal College of Paediatrics and Child Health](#) )

## 4. SCOPE OF THE POLICY/PROCEDURES

All Practice employees including those on temporary or honorary contracts, agency staff and students must follow the process set out in this document.

## 5. ACCOUNTABILITIES & RESPONSIBILITIES

The Junction Surgery will have clearly identified lines of accountability within the practice and will have a nominated GP safeguarding lead and a deputy to promote the work of safeguarding children and adults within the practice. Safeguarding responsibilities will be clearly defined in all job descriptions. *The Nominated Safeguarding lead in this Practice is Dr. Aneesha Ahmad. and the nominated Deputy is Dr. Razwan Ali*

## STANDARDS

### i) Induction

Safeguarding will form part of induction for **all staff within the practice**. Staff will be informed of the Nominated GP Safeguarding Lead and of how and who to report concerns to within the practice. Safeguarding training requirements will be discussed and agreed on induction and plans put in place to ensure appropriate training is undertaken. Staff will be made aware of local safeguarding procedures and other relevant contact numbers and sources of support and advice which is available.

### ii) Training

- The practice will ensure that all staff and volunteers undertake safeguarding training appropriate to their role and level of responsibility and that this will be identified in the practice training plan.

- The practice will ensure that all practice staff, contractors and volunteers are informed of how to report concerns within the practice or directly into children's or adult's social care (social services).
- The practice will ensure that all staff and volunteers are aware of mental Capacity Act, including the Deprivation of Liberty Safeguards and that relevant clinical staff undertake training appropriate to their role and level of responsibility.
- The practice will identify and record the training needs of all practice staff (including locum and agency staff) ensuring these are met, as set out in *Safeguarding Children and Young People; Roles and Competencies for Health Care Staff*.
- **Levels of Child Protection Training;**
  - **Level 1/ Induction.** Safeguarding will form part of induction for **all staff (Clinical and Non Clinical)**. HM Government '*What to do if you are worried a child is being abused*' will be discussed at induction and training needs assessed, agreed and recorded in relation to the role and responsibilities. Staff will be made aware of internal and local procedures and know what constitutes child abuse and know what to do if they are concerned about a child.
  - **Level 2. (All Clinical and Non Clinical Staff who have infrequent contact with parents, children and young people.)** As above but this group of staff will be able to recognise child abuse and be able to document their concerns. They will know who to contact and understand the next steps in the child protection process. They will understand which groups of children are at risk of harm, know who to inform and how to seek advice and how to contact them, know how and when to share information and who with, know what to record and be aware of own (and others) boundaries. Practice staff will also know how to identify adult abuse and know how to take action if they have concerns about a vulnerable adult. This training can be undertaken as face to face training (preferably multi-disciplinary) or e-learning.
  - **Level 3. (ALL staff working predominantly with children, young people and parents).** As above but this will include knowledge of the implications of key documents/reports, understanding of assessment of risk and harm, understanding of multi-agency framework/assessment/investigation/working, ability to present child/adult protection concerns in a child/adult protection conference, ability to work with families and know how to improve child/adult resilience and reduce risk of harm, an ability to advise other agencies regarding the health management of child/adult protection concerns and the ability to contribute to serious case reviews. This training will be multi-disciplinary/multi agency.

**All safeguarding training will be refreshed every three years.** It is the responsibility of the practice to ensure staff access appropriate safeguarding training. Annual refreshers/ updates will be provided by the Designated/Named Professionals via Practice Protected time events and the twice yearly safeguarding newsletter which

practice staff may choose to access. Information about Kirklees Safeguarding Children Board (KSCB) and Kirklees Safeguarding Adults Board (KSAB) training events will be circulated on a regular basis.

## **How to access training?**

Training can be accessed in a number of ways;

- E learning
- Via external providers
- Individual training on a practice basis if negotiated with the Named and Designated Professionals
- Annual Practice Protected Time training event
- Kirklees Safeguarding Children/Adults Board
- Safeguarding newsletters provide regular updates twice a year.

### **iii) Professional Development**

All staff within the practice will have an annual appraisal and will have the opportunity to discuss their professional development. This will include discussions about safeguarding and any areas for development will be clearly agreed, documented and monitored.

### **iv) Supervision**

All practice staff will know who to contact for advice and supervision within the practice if they have any safeguarding concerns. They will also know how to contact the Named and Designated Professionals for Child/Adult Protection within Kirklees. Regular monthly meetings will take place with the Practice Link Health Visitor to discuss vulnerable families/families of concern and these meetings will be clearly documented with clear actions demonstrated. Practices will also have established links with the District Community Nursing Service in order that concerns about vulnerable adults can be shared when appropriate. The practice as a whole will update its staff on at least an annual basis with regard to developments in child/Adult protection. The Named/ Designated Professionals will meet with the Nominated leads on an annual basis to discuss strategic developments within safeguarding. The nominated leads are responsible for cascading this information within their practice.

### **v) Named and Designated Professionals**

Practices will ensure that staff knows who and how to contact the Named and Designated Professionals for advice and support.

### **vi) Safe Working Practices**

Practices will verify the identity (and record the outcome) of all applicants for employment in accordance with *NHS Employment Check Standard (NHS Employers) 2008*. They will request, validate, copy and store right to work documents for all applicants for employment and will check relevant registration and qualifications of all applicants. They will ensure that interview panels for posts where staff may potentially come into contact with children or may have access to sensitive information relating

to children include at least one member who has undertaken safe recruitment training. Previous employment history will always be checked before any unconditional offer of employment is made and a standard disclosure Criminal Record Bureau (CRB) check for all new staff which involves the individual having access to patients will be made. The Practice will carry out an enhanced disclosure CRB for all new staff which are involved in regularly caring for, supervising, training or being in sole charge of children. They will also check the Independent Safeguarding Authority (ISA) status of all new staff. It only permits a barred individual to work in a 'controlled activity' if sufficient safeguards are put in place.

#### **vii) Leadership**

The practice will identify a nominated safeguarding lead and Deputy to promote the work of safeguarding children within the practice. They will meet with the Named/Designated Child Protection Professionals in Kirklees on an annual basis to discuss strategic developments in safeguarding both locally and nationally and in order to have an opportunity to discuss child protection issues/information. ***The nominated child protection lead and deputy in this practice is Dr. Aneesha Ahmad and Dr. Razwan Ali.***

#### **Partnership Working/Information Sharing**

Practices will participate fully in child/adult protection processes when appropriate and in line with local and national guidance. This includes information sharing (subject to normal confidentiality and data protection requirements) with children's and adult's social care when enquires are being made about a child or vulnerable adult, contributing to assessments, and involvement in child/adult protection plans to protect the child/vulnerable adult from harm. GP's and practice staff will make available to child and adult protection conferences relevant information whether or not they are able to attend. The practice will meet with the Named Link Health Visitor on a bi-monthly basis to have the opportunity to discuss vulnerable families who may be of concern. Established links with the community District Nursing Service will also be made. These meetings will be clearly recorded and clear actions will be developed which will be reviewed by both parties within agreed timescales. Patients records will be read-coded with 6AE – MDT review. Lists of children coded as a LAC or on the CP registered will be validated at these meetings. Any new patients, particularly patients coming in from other areas, will be discussed with the named Link Health visitor at the MDT. Patients who achieve the age of 18 will have the 'CP Flag' removed from their record appropriately. All children in need, LAC or on the CP who have failed to attend appointments on more than two occasions will be discussed at the MDT meeting.

#### **viii) Serious Case Reviews**

The practice will contribute to Serious Case Reviews, child death reviews and local management reviews when requested by providing information within the agreed timescales. Where there are recommendations involving or affecting the practice, the practice will produce an action plan to address the recommendations with support from

the Named and Designated Professionals. A Named individual within the practice will be responsible for implementing the action plan.

## **6. CHILD PROTECTION PROCEDURES**

### **i) Referrals into Children's Social care safeguarding provision**

If a child is thought to be at risk of harm the West Yorkshire Safeguarding Children's Procedures will be followed. [www.kirklees.gov.uk/safeguardingchildren](http://www.kirklees.gov.uk/safeguardingchildren). Referrals to children's social care must include details of all children and adult's resident within a child's household.

If a child discloses abuse, the disclosure must be taken seriously and no promises to 'keep a secret' can be made. It is important that the health practitioner explains to the child what must be done in order to protect the child from further abuse.

If a disclosure is made by an adult that they have abused a child, the practitioner must be clear from the beginning that the interest of the child is of paramount importance and that it will be necessary to contact other agencies and share information about the case. The child's record will be read-coded as **'Child is cause for safeguarding concern' – 83688100000105**

When allegations are made by a third party i.e. a relative or neighbour, the person making the allegation must be advised to make a referral direct to the children and Young Person's Service, but it is also important to try and encourage them to give the health practitioner comprehensive details, e.g.:

- The Referrer's name, address and contact details
- Children's details, if known
- If anonymity is requested reassurance must be given that every effort will be made to respect their wishes, however, there are occasions when this will not be possible.

**The practitioner must always try to encourage the caller to share information they have, directly with the children and young people's service. The health practitioner also has a responsibility to share the information with the Children and Young People's Service themselves, if details of the concerns have been shared.**

Remember it is always good practice to share your concerns and any proposed actions with the family or carer unless doing so would put the child at increased risk of harm.

Telephone referrals must always be followed up in writing within 48 hours. A copy of any referral must be retained in the health record.

### **(ii) Participation in the child protection process**



Participation in the child protection process must be a priority for members of staff, and must be made in compliance with West Yorkshire safeguarding Children procedures.

Attendance at child protection case conferences, child protection review meetings and core groups must be a priority for health practitioners, and if attendance is not possible a report will always be provided.

Contributions to child protection meetings will be made with reference to guidance provided in Information Sharing Guide for practitioners (2008). Health practitioners must also consider sharing relevant historical information that is held in child health records. Wherever possible it is good practice for families to be aware of information that health practitioners will be sharing in advance of meetings.

Staff must **always** complete a report prior to case conference.

It is best practice to share the contents of any reports provided for a Case Conference with the parents or carers and if applicable with the child.

There are occasionally reasons why this is not possible. The health professional will record in the records if they have been unable to speak to the parents concerned and the reason why it has not been possible.

### **(iii) Escalation of concerns regarding the welfare of a child/Adult**

When a practitioner continues to have concerns relating to the wellbeing of a child or adult that has been referred to Children and Young People's Service or Adult's Social Care and the practitioner judges that the concerns have not been addressed, the practitioner must discuss the matter with the Named safeguarding lead within the practice or they may seek advice from the named/designated professionals within NHS Kirklees Safeguarding Children Team. A record must be made of these discussions, and retained in the child's/Adult's health records.

### **(iv) Supporting the legal process and attending court**

Practice staff may be required to provide statements for court in a number of different circumstances. If a member of staff receives a request to provide a legal witness statement the safeguarding lead within the practice must be informed. A member of the safeguarding children's team will provide support **if requested**. Whilst legal timescales are often short, they must be adhered to.

Requests for statements may come from Solicitor's, Guardian AD Litem, Court Welfare Officer's or from the police.

Members of practice staff who are approached by any of the above must not disclose any information regarding the child or family over the telephone. Details of the request, namely, who the legal representative is acting on behalf of, and in what capacity, must be sought and the safeguarding lead within the practice will be informed.

Making a statement in child care proceedings is done through Kirklees Legal Services.

Occasionally this work is given out to external Solicitors.

It is advisable that any statement is made with close reference to health records that have been made contemporaneously. Requests for copies of health records must be made in writing.

Experienced members of staff are able to give statements for child care proceedings unaccompanied if they are confident but support can be provided by a member of the safeguarding team if requested. .

On occasions the police have requested statements, and implied that the situation is urgent.

Staff will not feel pressurized into providing a statement without discussions within the practice. Advice can also be sought from the Named and Designated professionals.

Staff will not sign any statement unless they are happy with its content. Where possible, a copy of the statement will be retained by the member of staff. In criminal matters this is not always permissible.

Guardian Ad Litem's may request access to children's health records. Whilst this is permissible, as they are acting on instruction of the court, it is important to consider the relevance of any disclosure in the record of information relating to a 3rd party. In general the following will be considered when preparing a statement:

- Provision of a summary of professional involvement
- Provision of a profile of each child
- A chronology of involvement
- A conclusion including, analysis of your involvement
- A final declaration

#### **v) Attendance at Court**

Staff will not attend court unaccompanied. **If requested**, a member of the safeguarding team will accompany members of staff who are required to attend court in order to offer support.

**If requested**, prior to attendance at court a member of the safeguarding team will provide support and advice and help the member of staff to familiarise themselves with the court process and to go through their statement.

When attending court it is important that members of staff consider particular aspects of their professional presentation, and

- Dress appropriately
- Bring relevant health records
- Arrive punctually
- Are familiar with prepared statements

#### **vi) Safeguarding children effectively when parental disengagement occurs**

Effective safeguarding children work is dependent on the maintenance of good collaborative partnerships between families and health professionals. Disengagement of parents from collaborative work with health professionals can indicate an increasing risk of harm to the child. Indications of parental disengagement may include;

- Failure to register the child with a general practitioner
- Missed health appointments
- Repeated no access visits
- Hostility to health professionals
- Agreeing to take action in respect of the child, but never achieving the required action
- Withdrawing from a health service

Parental disengagement is often a feature when there is domestic abuse, and when neglect is part of a child's experience. Disengagement may indicate that parental capacity is compromised, perhaps as a result of illness, substance misuse, criminality or learning disability.

Parental disengagement must therefore be actively addressed by all health practitioners by;

- Widened Assessment of the impact of the parental disengagement on the wellbeing of the child, involving family members, and other professionals, such as Health Visitors and School Nurses. Structured work under the common assessment framework is the preferred format for this work.
- Analysis of the child's circumstances and consideration of the risk to the wellbeing of the child from parental disengagement. Analysis of a child's circumstances will be made with reference to a structure such as those provided by the Assessment Framework (Department of Health 2000), or the Common Assessment Framework. (Department of children families and schools 2003). Analytical work will be continued in child protection supervision, which can be sought from a member of the safeguarding Children Team.
- Referral to children and young people's service safeguarding provision, when risks of harm to the child's welfare are established and linked to parental capacity.

When seeking to address parental disengagement, professionals will ensure that the following factors are considered, when attempting to secure work with parents;

- Approaches to the parents must be made in an honest, respectful manner, which takes into account cultural factors, and the need for appropriate high quality independent language services. A personal letter or telephone call from the practitioner to the family, which provides clear reasons for the requested contact, a suggested appointment, and which adopts strengths based approach, could be offered. A copy of any correspondence with the family must be retained in the child's health record.

- Health professionals must identify to the parents, the advantages to their children of positive engagement between parents and health professionals, and the significance that will be attributed to non-engagement
- Consideration must be given to the parent's level of understanding i.e. any learning disability, literacy, language, or communication difficulty. Consultation with the Community Learning Disability Team must be considered, in order that health care can be planned.
- Efforts must be made by the health professional to encourage collaborative work with the child's parents in order to both assess the child's circumstances and to secure the child's wellbeing. The common assessment framework is the preferred structure within which this work will take place.

## **7. DOMESTIC ABUSE**

NHS Kirklees recognises the serious, adverse effect that domestic abuse has on children who live in affected households and the potential for both short and long term damage to their health & development. Kirklees believes that victims of domestic abuse will receive the same high standard of care irrespective of age, race, gender, culture, sexuality, religion or ability and that equality underpins all its service provision.

Kirklees is committed to promoting the health and well-being of clients and staff and, as such, recognises that domestic abuse is a crime, which adversely affects the health of individuals, families and communities (HM Govt, 2009), Kirklees is therefore committed to ensuring that domestic abuse is recognised, and that both clients and staff are provided with information and support to minimise their risk. In order to carry this out effectively, depends on joint working between agencies and information sharing across organisational boundaries.

Health care professionals have an important role to play in aiding victims of domestic abuse as they are often the first or only contact a woman has, virtually all women will at some point interact with health services, either on their own or on their children's behalf. The nature of the issues arising from domestic abuse are manifold since the impact of abuse inevitably leads to women utilising a whole range of health services including Accident and Emergency Departments, Mental Health Services, Sexual Health Services Primary Care and Maternity Services. All health care professionals must be alert to the possibility of domestic abuse, but the main responsibility rests with the professional responsible for the woman's care (Responding to Domestic Abuse, A Handbook for Health Professionals DH 2005). They will be mindful of the overlap between domestic abuse and child abuse.

Routine enquiry about domestic abuse must take place when health assessments are being made. Staff must provide information about local services for families experiencing domestic abuse, and can do this by using domestic abuse information leaflets, and referring to the Kirklee's Domestic Violence Forum Domestic Violence Directory (2009). The National Service Framework for Children clearly states that

routinely enquiring about domestic abuse and developing appropriate pathways for referral is critical to children's health, safety and welfare.

The spirit of the Children Act 2004 is to regard these children as 'In Need', and to provide the family with a holistic approach to their problems. The Common Assessment Framework (CAF) or similar structured work must be used as a method of assessing needs as well as the level of risk, when domestic violence is a factor in a child's experience. Assessment must also include the member of staff accessing supervision for advice and support, with Child Protection Policy and Procedures being followed if child abuse is suspected.

### **Management of domestic violence notifications from West Yorkshire police**

It remains the responsibility of West Yorkshire Police to follow West Yorkshire Consortium Safeguarding Children Procedures 2007 where children are identified as being at risk of significant harm and to consider the safety of both the victim and their family.

*Staff within General Practice must consider whether there are younger or older children within the family who may be at risk and inform the appropriate members of the Primary Health Care Team and or Children's Social Care if they have any concerns..*

When considering the most appropriate course of action following receipt of a domestic violence notification, the following will be taken into account. If the health professional is already working with the child or family, consideration must be made about how assessment of the child's circumstances and safety can be safely and appropriately continued, and how collaborative work with family members and other agencies can ensure that the assessment provides an accurate reflection of the impact of the violence on the child's wellbeing. For families receiving universal services, where no immediate contact is scheduled, depending upon the severity of the incident and professional judgement (which includes considering any previous incidents or causes of concern about the child or family), and the Health practitioner must consider reassessment of the family. The Health professional must consider seeking supervision and document any discussion and subsequent agreed action.

If it is felt that the child is at risk of, or has suffered significant harm, parental permission to speak to a child or young person is not necessary, and West Yorkshire Safeguarding Children procedures must be followed.

## **9. Children at risk of sexual exploitation**

In 2009 the Government Guidance 'Safeguarding Children and Young People from Sexual Exploitation' defined Sexual as:-

*'Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the*

*use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability'.*

(This definition arises from joint work between project members of the National Working Group for Sexually Exploited Children and Young People (NWG) 2008.)

The Guidance states that persons and organisations subject to the duty to make arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004 will consider children and young people who are sexually exploited in fulfilling their statutory responsibilities.

In order to help children and young people achieve good outcomes it is important to identify issues and problems early and to take prompt preventative action. Early intervention is likely to be far more effective than intervention at a later stage when the impact on the child or young person's health or development is likely to have escalated.

Safeguarding and promoting the welfare of children and young people in this context, like safeguarding children more generally, depends on effective joint working between different agencies and professionals that work with children and young people, including education (e.g. schools and colleges), health services including sexual health services and therapeutic mental health services, youth services, Connexions and children's social care, together with criminal justice agencies and voluntary sector services supporting children and families. Their full involvement is vital if children and young people are to be effectively supported and action is to be taken against perpetrators of sexual exploitation. All agencies will be alert to the risks of sexual exploitation and be able to take action and work together when an issue is identified.

Action to safeguard and promote the welfare of children and young people who are sexually exploited will be child-centred and focus on the child's needs. Those working with children and young people will engage with them and their families throughout the process. The particular needs and sensitivities of girls and boys, children with a physical disability or learning disabilities, those from ethnic communities, or those for whom English is not their first language, will be reflected in the provision of services. The wishes and feelings of children and young people as well as the concerns of parents or carers will be sought and taken into account in reaching any decisions about the provision of services which affect them. However, professionals will be aware that children and young people do not always acknowledge what may be an exploitative and abusive situation.

It is important for cases to be managed so that interventions to safeguard children and young people also support the gathering of evidence to increase the chance of successful criminal prosecutions of their perpetrators, thereby safeguarding potential

future victims. Guidance in relation to the Sexual Exploitation of Children & Young People can be found through the West Yorkshire Consortium Safeguarding Children Procedures' along with a Risk Assessment Matrix which can be used to aid decision making.

The spirit of the Children Act 2004 is to regard these children as 'In Need', and to provide the family with a holistic approach to their problems. The use of the Common Assessment Framework (CAF) would provide a method of assessing needs as well as the level of risk. Assessment will also include the member of staff accessing supervision for advice and support, with Child Protection Policy and Procedures being followed if sexual exploitation is suspected.

### **10.Safeguarding children where there is concern about compromised parenting ability**

Parenting ability can be compromised by a number of factors;

- Mental ill health
- Poverty
- Alcohol and substance misuse
- Social isolation
- Learning disability

All are factors which can have a negative impact on parenting ability. When health assessment work identifies the presence of a specific parental factor, which is likely to negatively impact on a child, the health professional must consider their specific responsibility to widen their assessment of the impact of this vulnerability on the wellbeing of the child. This assessment work must have a clear child focus, and is most appropriately structured using either an assessment framework or the common assessment framework.

When child health assessments are made by health practitioners, consideration must also be made of the impact on the child's wellbeing of other individuals in the child's family and circumstances, when making decisions about interventions that need to be taken to ensure the child's health and safety.

### **11.Parental learning disability or learning difficulty**

Where parental learning disability or learning difficulty is thought to be a factor, that is having a negative impact on a child's wellbeing, the assistance of the community learning disability teams must be sought, in order to ensure that health information is offered to families in an accessible form, and to ensure that assessment and intervention work takes proper account of the capacity of the parents. The preferred method for linking with the community learning disability teams is by use of the "consultation request form," which is available on the NHS Kirklees Intranet, under "Safeguarding Children and Vulnerable adults" team information.

### **12.Principles when working with vulnerable families**

There is no agreed definition of what is meant by 'vulnerable'. Checklists and formulas are discouraged (Hall, 2003) because they do not measure resilience. Both GP and practitioners will exercise professional judgement in terms of what information on which individuals or families need to be communicated. All new referrals require holistic assessment by either a Health Visitor or School Nurse. All conversations will be documented. If there is any indication or suspicion that a child or adult is at risk of significant harm, child protection or vulnerable adult procedures must be followed.

Health Visitors and School Nurses must establish clear systems within GP practices and schools whereby information about individuals or families identified as vulnerable is communicated, documented and acted upon. Each GP practice must have an identified Health Visitor and School Nurse link.

Regular collaborative work between Health visitors, school nurses and general practitioners in respect of vulnerable children and families provides an indication of quality safeguarding children work.

The child protection communication template available on the electronic record must be used when conversations take place about vulnerable children between health visitors, school nurses and those working in general practice.

### **13.Management of accident and emergency slips**

The relevant information must be entered on Emis Web or the child's record by the practice.

Depending upon the circumstances and professional judgement (which includes considering any previous A & E attendances), the practice will consider reassessment of the family. Actions taken must be recorded on the health record.

It remains the responsibility of A & E staff to follow Child Protection Procedures where a child is considered at risk of significant harm.

### **14.EQUALITY IMPACT ASSESSMENT**

This policy has been assessed for the potential adverse impact as set out in Appendix 2. On initial screening the policy has not/has identified an impact.

### **15.TRAINING NEEDS ANALYSIS**

Practices will keep an accurate record of staff training and review it on an annual basis to provide assurances that practice staff are compliant with local and national policy.

### **16.MONITORING COMPLIANCE WITH THIS POLICY/PROCEDURE**

An annual declaration will be made to provide assurances that minimum standard are being met with regard to safeguarding.

### **17.REFERENCES**

HM Govt (2006) Working Together to safeguard Children London. The Stationery Office

Reviewed Aug 2025

Next Review due Aug 2026



Department of children schools and families (2010) Working together to Safeguard Children: [www.dcsf.gov.uk/consultations](http://www.dcsf.gov.uk/consultations)

Dept of Education and Skills (2006) The Common Assessment Framework for children and Young people: Practitioners Guide. [www.everychildmatters.gov.uk/caf](http://www.everychildmatters.gov.uk/caf)

Dept of Health (2000) Framework for the Assessment of children in need and their families. London. The Stationery Office.

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Safeguarding Vulnerable Groups Act (2006)

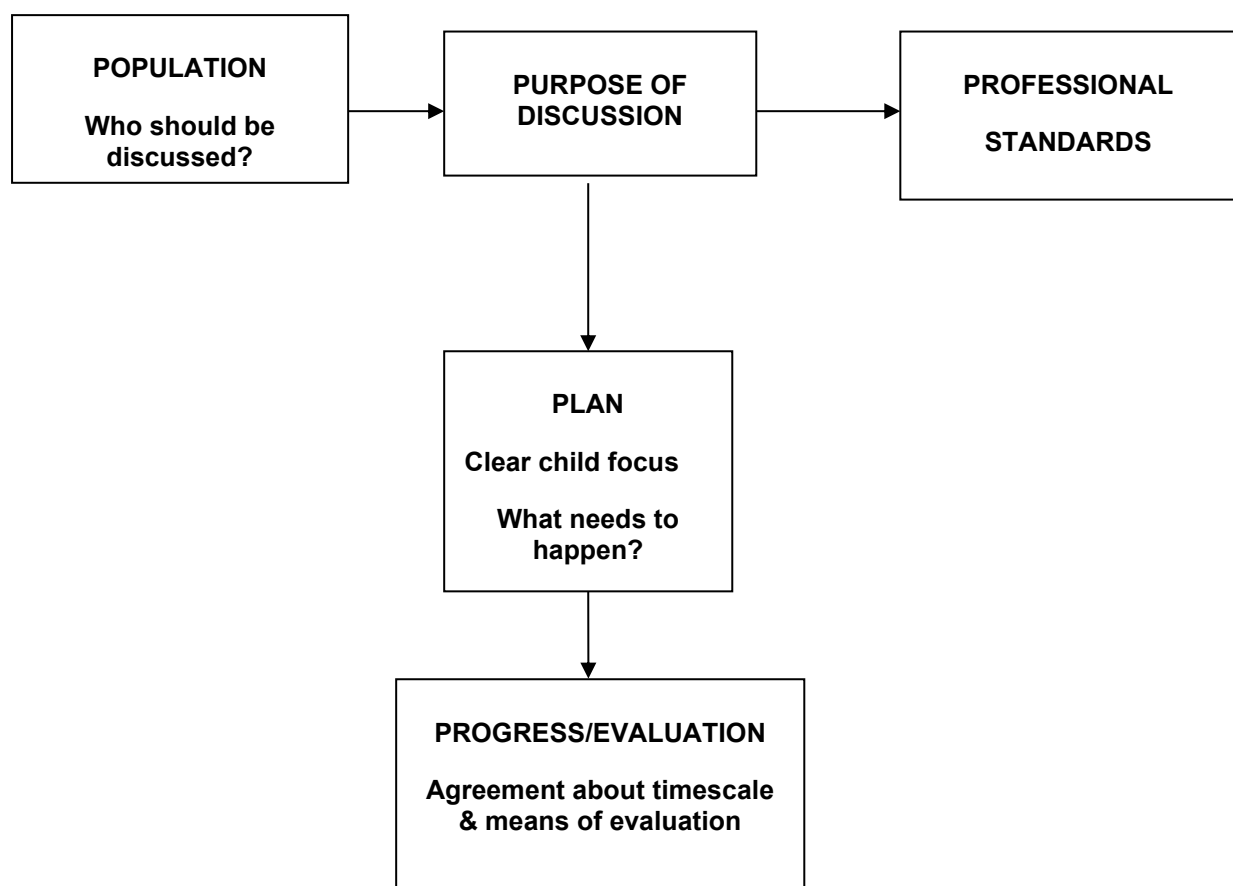
West Yorkshire Consortium safeguarding Children procedures.  
[www.kirkleessafeguardingchildren.com](http://www.kirkleessafeguardingchildren.com)

## Appendix 1

### Best Practice Framework for Sharing Information Effectively

The following diagram illustrates the elements of good practice in respect of information sharing must take place, when health visitors, school nurses and general practitioners share information about a child.

Further guidance on factors which will be considered when sharing information about a child, can be found in Information Sharing Guidance for professionals (HM Govt 2006).



- **Population.** What children will be the subjects of our conversations? What do we mean by the term “vulnerable children”?

For the meetings to be productive all health professionals need to be in agreement about the factors in a child's circumstances, which lead them to be vulnerable to harm.

Lists of vulnerability factors are helpfully made in a number of government documents. Working Together to Safeguard Children (HM Government 2006) considers the sources of stress for children and families at paragraph 9.11.

***“Undertaking assessments of children and families requires a thorough understanding of the factors which influence children's development: the developmental needs of children; the capacities of parents or caregivers to respond appropriately to those needs; and the impact of wider family and environmental factors on both children's development and parenting capacity. An analysis of how these three domains of children's lives interact will enable practitioners to understand the child's developmental needs within the context of the family and to provide appropriate services to respond to those needs”.***

Working Together provides a summary of research findings about factors in a child's circumstances which indicate vulnerability to harm, and include issues such as social exclusion, domestic violence, mental illness of parents or carers, drug and alcohol misuse and parental learning disability.

These are the children who must be the subjects of conversations between health professionals in order to widen mutual understanding of the child's circumstances and needs, and to enable appropriate interventions to be planned.

- **Purpose. What are we hoping to achieve as a result of sharing this information?**

When sharing information about a vulnerable child, both professionals need to be clear about the purpose of the information sharing, in order that the information sharing is appropriate and influential on the child's wellbeing. When recording the information sharing that takes place in the child's health record, the purpose of the information sharing will be clearly identified.

It is possible that professionals may view the purpose of the information sharing differently, and initially discussion may be necessary to explore different professional perspectives, in order to gain a consensus about the aim of the collaboration.

Issues, such as the way in which an appointment to discuss a child is requested, and the attention that is paid to mutually respectful practice, must influence and assist this process.

- **Professional Standards. How will the fact that a conversation about these children has taken place be evidenced? How will other team members in our surgery know what information has been shared, and what the expected outcome of the conversation is?**

Health visitors, school nurses and general practitioners rarely work in isolation, and it is likely that other professional colleagues from their particular team will be working with them to deliver care to the children who are the subjects of the discussion. For

example, practice nurses, nursery nurses, locum practitioners and others are likely a part to play in the care that is offered to a child, in any particular setting.

It is therefore essential that the documentation of the professional discussion in respect of a child is as comprehensive as possible, and is made in the health record of the child, that is held by **both** the general practitioner **and** health visitor/school nurse.

In some areas **a shared template** to record the discussion may be helpful, in order to ensure that there is no room for ambiguity about the information that has been shared, and the professional accountability for the plan generated as a result of the discussion.

- **Planning. What have we agreed? Who is responsible for the plan?**

Effective collaborative work in respect of a child can only take place if there is clarity about the plan of work that needs to take place, and if the accountability for actions agreed to be taken, is apparent.

- **Progress & Evaluation. How will we know if information sharing in respect of these children makes a difference to their wellbeing?**

Documentation must include identification of how planned work between the health visitor/school nurse and general practitioner will be evaluated, over what timescale. This will ensure that there is progression in respect of work with vulnerable children, both in assessment work and in interventions considered, so that vulnerabilities are addressed and ideally risks are reduced.

## Appendix 2

### Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

|    | Insert Name of Policy / Procedure   | Yes/No | Comments |
|----|---|--------|----------|
| 1. | <b>Does the policy/guidance affect one group less or more favourably than another on the basis of:</b>      |        |          |
|    | • Race  |        |          |
|    | • Ethnic origins (including gypsies and travellers)   |        |          |
|    | • Nationality   |        |          |
|    | • Gender  |        |          |
|    | • Culture   |        |          |
|    | • Religion or belief  |        |          |
|    | • Sexual orientation including lesbian, gay and bisexual people   |        |          |
|    | • Age   |        |          |
|    | • Disability - learning disabilities, physical disability, sensory impairment and mental health problems    |        |          |
| 2. | <b>Is there any evidence that some groups are affected differently?</b>                                     |        |          |
| 3. | <b>If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</b> |        |          |
| 4. | <b>Is the impact of the policy/guidance likely to be negative?</b>  |        |          |
| 5. | <b>If so can the impact be avoided?</b>   |        |          |
| 6. | <b>What alternatives are there to achieving the policy/guidance without the impact?</b>                     |        |          |
| 7. | <b>Can we reduce the impact by taking different action?</b>   |        |          |

If you have identified a potential discriminatory impact of this procedural document, please refer it to Dr Aneesha Ahmad, 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 **Dr Aneesha Ahmad**

### Appendix 3

#### Sign Off Sheet regarding Dissemination of Procedural Documents

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

|                     |  |
|---------------------|--|
| Title of Document:  | THE JUNCTION SURGERY – SAFEGUARDING POLICY |
| Lead Director:      | DR A AHMAD                                 |
| Date Approved:      | Aug 25                                     |
| Where approved:     | THE JUNCTION SURGERY                       |
| Dissemination Lead: | JULIE SUNDERLAND                           |
| Placed on Website:  |  |
| Review Date:        | Aug 26                                     |

## **SUMMARY OF PRACTICE ACTIONS TO SUPPORT PROTOCOL:**

### **NEW PATIENTS**

Ensure all previous practice information recorded onto record.

Ensure correct read codes are being used and the appropriate 'flag' is present on the record.

Cross check with MDT that they are known to services.

Discuss recent contact / issues identified.

Remove any person 18yrs or over.

### **EXISTING PATIENTS**

Validate LAC and CP registers at bi-monthly MDT meetings.

Remove any person 18yrs or over.

Discuss all LAC / CP 'did not attend' / Was Not Brought appointments at bi-monthly MDT.

Discuss all vulnerable adults as appropriate. (recent contact / issues identified)

Safeguarding lead or deputy to attend any case conferences.