A GUIDE FOR
SAFEGUARDING CHILDREN
AND VULNERABLE ADULTS
IN GENERAL PRACTICE

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Purpose and Summary of Document: The purpose of this guidance is to clarify the roles and responsibilities of General Practitioners and Practice staff in promoting the safety and well-being of children, young people and vulnerable adults.
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1. INTRODUCTION

This document is intended as a concise guide for practices and practice staff. It draws on national guidelines, Public Health Wales Good Practice Guidance, and other sources listed in the reference section. Safeguarding practice leads and practice managers requiring more detailed information can access them directly from those sources.

The General Medical Council’s guidance entitled “Protecting Children and Young People: Responsibilities of all Doctors”1 is essential reading.

The general practitioner and members of the primary health care team (this includes receptionists and other administrative staff) are well placed to recognise when an individual is potentially in need of extra help or services to promote health and development, or is at risk of harm. They are also well placed to recognise when a parent or other adult has problems which may affect their capacity as a parent or carer or which may mean that they pose a risk of harm to a child or vulnerable person in their care.

Contacts from surgery consultations, home visits, health clinic attendances, together with information from hospital visits, A & E attendances and consultations with the Out of Hours Service all help to build up a picture of an individual’s situation and can alert the team of potential concerns.

It is regarded as essential that all primary care staff should be aware of child protection and vulnerable adult procedures.

The duty of care to promote the health and protection of Vulnerable Adults are identical to those for Children and Young People, and are included in this guidance.

This document modernises and replaces “A Guide for Safeguarding Children and Young People in General Practice” issued by National Public Health Service (NPHS) 25.05.2007.

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1 Protecting Children and Young People: Responsibilities of all Doctors (GMC)
2. DEFINITIONS

2.1 What is a Safeguarding Issue?

Safeguarding means preventing harm and acting to protect children and vulnerable adults from actual or potential maltreatment, neglect, abuse or exploitation and ensuring they receive proper care that promotes health and welfare.

Safeguarding concerns can arise within almost all areas of practice. It is important that all members of staff have an appropriate level of understanding of the signs and presentations of abuse and neglect and are able to implement the Child Protection or Protection of Vulnerable Adults (POVA) procedures.

2.2 Definition of a Child and Young Person

For the purpose of this guidance the Children’s Act 2004 defines a child as being anyone who has not reached their 18th birthday. The term child therefore includes ‘children’ and ‘young people’. The fact that a child has become sixteen years of age is living independently or is in Further Education, or is a member of the Armed Forces, or is in hospital, or in prison or a Young Offender’s institution does not change their status or their entitlement to services or protection under the Children’s Act 2004.

2.3 Definition of Vulnerable Adult

The Welsh Assembly Guidance, In Safe Hands 2000, specifies that:

A vulnerable adult is a person over 18 years of age who is or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of himself or herself, or unable to protect himself or herself against significant harm or serious exploitation.

This definition may include a person who has learning disabilities or mental health problems including dementia; an older person with support and or care needs; the physically frail and those with a chronic illness; those with physical or sensory disability; those who misuse drugs or alcohol; a person with an autistic spectrum disorder.

A person’s vulnerability will depend on his/her circumstances. There are many predisposing factors which may increase the likelihood of abuse occurring.
2.4 Neglect and Abuse of Children, Young People and Vulnerable Adults

Abuse is a violation of an individual’s human rights. It may be a single or repeated incident of neglect or abuse. It may be physical, verbal, psychological, financial or sexual. It can be an act of neglect or omission to act, or be the unintended result of a person’s actions. Self-neglect/self-abuse is a failure to provide for oneself, through inattention or dissipation.

The Local Health Board Lead Nurse for Safeguarding and POVA Lead are available to practice staff to provide guidance for specific concerns about individual cases and for general safeguarding advice. The Designated Doctors and Nurses (Safeguarding Service Public Health Wales) are a further available source of advice and support.

2.5 Children and Young People

A child is abused, maltreated or neglected when somebody inflicts harm or fails to act to prevent harm. Abuse may take place within the family or in an institutional or community setting: by those known to them or more rarely by a stranger. Signs and symptoms will vary but may be indicated through injury, the child’s presentation or the behaviour of parents or carers. Any observations that lead to concerns or uncertainty about abuse or neglect should be acted upon by implementing the All Wales Child Protection Procedures or by seeking advice and guidance at an appropriate level.²

Where professionals ‘consider’ child maltreatment they should record their concerns and liaise with other health professionals involved and seek advice.

However when they ‘suspect’ child maltreatment they should refer the child to social services. In the latter case they should follow the process as laid out in the ‘All Wales Child Protection Procedures’ (2008)².

Guidance from NICE (Clinical Guidelines 89) discusses possible signs of child maltreatment.⁴

2.6 Vulnerable Adults

Suspicions of abuse, neglect or exploitation of vulnerable adults may also be triggered by observations of the patients’ presentation or by concerns about lack of appropriate care at their home or in a community or residential placement.

It may also be reported by the adult themselves. Such reports need to be taken seriously and investigated carefully.

⁴ When to suspect child maltreatment. (NICE Guidance 89)
It is also important that caregivers realise that a consensus has emerged identifying 'neglect and acts of omission' as a form of abuse. This includes ignoring medical and physical care needs, failure to provide access to appropriate health services and withholding the necessities of life, such as medication, adequate nutrition and heating.

Practice staff are well placed to identify the risks to general health and well being that are associated with inadequate care, both in the short and long term. The assessment process must identify the factors that may cause problems or impact on the quality of life of the individual patient concerned. To reach such a decision, it is essential that the assessment is approached in a multi-professional way, in collaboration with all those involved in the care of the patient. This will enable appropriate management strategies to be identified and written into care plans.

Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse (updated January 2013) should be applied when there are suspicions of abuse.³

"Safeguarding Vulnerable Adults a Tool Kit for GPs" (BMA 2011) provides valuable information and further guidance to support practice.⁵

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⁵ Safeguarding Vulnerable Adults: A toolkit for General Practitioners (BMA 2011)
3. SAFEGUARDING PRACTICE LEAD

It is recommended that each practice should have a Safeguarding Practice Lead (SPL) who must be a general practitioner.

The SPL is not expected to be an expert in safeguarding or deal with all safeguarding issues but a central person who will have oversight of safeguarding matters for the practice. The SPL will enable the other members of the practice to be aware of and access relevant guidance, recognise training needs and appropriate training events and be able to access appropriate support and advice on safeguarding matters.

No individual within a practice should however feel unsupported and good practice organisation will support individuals as well as the whole team in raising concerns and dealing with them appropriately.

3.1 Key Tasks of the Safeguarding Practice Lead

The function of the SPL is to maintain an overview of safeguarding practice and will include:

- Ensuring that partners and all staff employed by the practice are aware of their duty to safeguard and are familiar with Safeguarding Children and POVA procedures.

- Ensuring all staff are trained to an appropriate level.

- Providing, within their normal capabilities, practical everyday support and guidance to staff who may have concerns about the welfare and safety of a child or vulnerable adult.

- Ensuring that they and all members of their practice are aware of whom to contact locally in the health service, social services and the police in the event of child protection and POVA concerns.

- Will when necessary advise and support practice staff in response:
  
  (a) To requests for assistance from Social Services in any child protection enquiry (Section 47) under the Children Act 1989
  
  (b) To requests for assistance from Social Services in any enquiry regarding their duty to safeguard and provide for the welfare of Children in Need (Section 17 – Children Act, 1989).

- Being aware of how sources of safeguarding support and advice can be accessed.
- Maintaining an overview of complaints against the practice in order to identify any which might have a safeguarding element, and consult with Health Board Named Professionals or Designated professionals about complaints where there are safeguarding issues particularly if there is an inferred allegation of professional abuse.

- Will alert practice staff to triggers for concern and critical incidents.

- Will ensure that all staff are aware of the national and local policies relating to professional abuse and raising concerns about professional practice (whistle blowing).

- Will ensure that systems are in place to facilitate case discussions by primary health care team about families where there are concerns.

### 3.2 Provision of a Safe and Appropriate Environment and Health Promotion

Within the Practice there is a need to ensure that the facilities are appropriate and staff are appropriately trained and qualified for the examination and treatment of children, young people and vulnerable adults.

Practices should provide a safe and welcoming environment. This is particularly important where children are concerned. The waiting area should ideally provide appropriate play facilities for young children and allow for safe supervision by parents/carers.

There is an opportunity for practices to be a valuable resource for public information and to promote the rights of patients.

Posters and leaflets should be clearly visible and available and cover such topics as: drug and alcohol abuse, domestic violence, sexual and reproductive health clinics and young people clinics.

Clear information about confidential helplines should be visible and available within the waiting area, for example the contact numbers for Childline, NSPCC helplines, MEIC, Domestic Abuse helpline and any locally available advocacy services for children, young people and vulnerable adults.

Information should be available and accessible for young people who may also attend without their parents and carers.

Any practice policy or procedure relating to young people for example, on confidentiality, should be made readily available.

Information should be displayed to advise patients/public how to make a complaint and what response they should expect.
Parents/carers should be encouraged to remain with their child or the patient that they are accompanying at all times. Where this is not possible, or a young person or vulnerable adult wishes to attend alone, then a second member of the team should be present to act as a chaperone for the patient and to support the staff member. If either the doctor or patient does not wish a chaperone to be present the fact should be recorded. Also if an offer for a chaperone was made and declined.

This provides staff with security against false allegations, however it would not be acceptable for a practice to refuse to see an unaccompanied minor if they insisted on a private consultation.

Such safe practice should apply to any care environment including residential homes and the patients’ own home.

**3.3. Safe Recruitment Practice**

As employers, the practice must ensure all staff working with children and vulnerable adults are suitable for the post.

Prior to employment all staff with access to children and vulnerable adults, including staff with access to patient records should have a Disclosure and Barring Service (DBS) check carried out as set out in the policy of the Health Board and in line with current legislation.

If temporary staff are recruited from an agency then the practice should be assured that appropriate checks have been made by the agency.

Doctors in training should have been checked by the Post Graduate Deanery.

Advice must be sought from Safeguarding advisors following notice of a relevant criminal conviction for a member of the practice staff.

**3.3.1 Appointment Process**

It is recommended that in order to ensure the practice has adequate safeguards in place the following measures are taken when making an appointment.

- Checking of references and CV.
- A detailed CV is required with no unexplained gaps.
- At least two references should be requested, one of which would be from the present employer – if not this should be explored. References need to be taken up prior to the appointment.
- The referee should be clearly informed of the nature of the post. The referee should also be asked if they would be willing to employ the applicant again.
and whether they had any issues or concerns in the behaviour of the candidate.

- Wherever possible references should be available at/before the interview, but if this is not possible they must be available before appointment and taking up post. Unconditional offers of employment must not be made until references have been checked. It is recommended that the referee should be contacted directly. Telephone contact should be made when clarification of details given in references is required and a written record of the contact kept. This information must be made available to those responsible for making the appointment.

- Validation of date of birth and name (birth certificate original/passport).

- Check professional registration and qualifications. This is done by telephone directly or on-line if available eg (GMC, NMC etc) in addition to a paper check.

- DBS check depending on access to children and vulnerable adults.

- The appointment should be subject to all the above being in place. No employee should be given unsupervised access to children or vulnerable adults without all satisfactory recruitment checks having been made.

- The candidate should be clear that failure to disclose previous and any new convictions is a disciplinary issue.

- It is a criminal offence to appoint a person who is unsuitable to work with children or vulnerable adults by virtue of a previous relevant conviction. “Not Knowing” is not considered a defence if you did not undertake suitable pre employment checks and suitable checks thereafter.

### 3.4 Safe Working Practice

Practice staff do not expect allegations of abuse to be made against them, but it is important that they acknowledge that such a possibility exists. For this reason it is in the interest of the practice to develop strategies, which protect both patients from harm and professionals from false accusations.

It is important that all staff in contact with any patient always act in a professional manner and in ways in which their behaviour cannot be misinterpreted or lead any reasonable person to question their suitability to work with children, young people or vulnerable adults.

The practice should develop a policy, which considers the chaperoning of children and vulnerable adults undergoing physical examination and those who either attend or wish to be seen for consultations alone.
Children and young people wishing to consult without the presence of their parents could be encouraged to attend with a friend or a same sex member of staff could be present as chaperone.

Whether you work with children directly or indirectly as part of your job, or meet them as members of the public you have the same duty to ensure that they are protected from harm. You must ensure that your own behaviour does not cause a child distress and neither can it give rise to misinterpretation.

Staff should also be aware that behaviour in their personal lives and actions of their partner (or other family members) drawn to the attention of other agencies, may raise questions about their suitability to work with children, young people and vulnerable adults e.g. domestic violence or their own children being entered on the Child Protection Register.

3.4.1 Allegations of professional abuse

All allegations of abuse of children or vulnerable adults by an employed member of staff or partner should be taken seriously and managed in accordance with the All Wales Child Protection Procedures (2008) or the Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse (2013).

Practices must consider carefully how they empower staff and partners to raise concerns about the personal or professional behaviour of colleagues which lead to safeguarding concerns (whistle blowing).

3.4.1.1 Allegations against Employed Staff

Allegations or concerns about the behaviour of an employed member of staff should not be investigated internally and advice should be sought if uncertain about what action to take. A referral made under the All Wales Child Protection Procedures or POVA procedures may result in a multiagency strategy meeting being convened to consider and evaluate all risks and plan the next steps to be taken. If the individual concerned is an employee of the practice then it will be necessary for the practice to be represented. This should be the SPL or other partner.

The Health Board Named Professionals for Safeguarding/POVA should be contacted for advice and support regarding concerns of professional abuse. The Designated Doctor or Nurse for Safeguarding Public Health Wales are further sources of advice and support for the Health Board.

In the event of an individual employee being dismissed or moved to another position as a result of safeguarding enquiries and/or a criminal investigation, the investigation outcome meeting or final strategy meeting should advise the employer of the duty to submit their details to the Disclosure and Barring Service (DBS). Formerly the Independent Safeguarding Authority (ISA). This is a requirement of the Safeguarding Vulnerable Groups Act 2008. The DBS will
consider whether any further action needs to be taken in respect of barring the individual from further employment with vulnerable groups.

### 3.4.1.2 Allegations against a Practice Partner or Salaried GP

The Medical Director of the Local Health Board should attend or be represented at the Strategy meeting to consider the allegations of professional abuse. A member of the Primary Medical Care Advisory Team should be invited to attend the Strategy meeting in order to give help and professional advice. If a concern raised is about a doctor the Strategy meeting is a confidential exchange of information which is preliminary to deciding whether there are safeguarding concerns present regarding that individual. Information about the individual would be shared confidentially from all sources possible. It is in that context that the presence of PMCAT can provide important information about the practitioner even including such things as rudeness to staff and colleagues, inappropriate decision making and indeed poor clinical practice.

If a safeguarding enquiry leads to disciplinary action being taken for a practitioner either the Medical Director of the LHB or the Chair of the Performance Panel should refer the case to the General Medical Council and the DBS.

### 3.4.2 Staff Training

GMC guidance states that all Doctors must be competent in safeguarding children. The requirements for this are stated in, *Safeguarding Children and Young People: Roles and Competences for Health Care Staff, Intercollegiate Document*, March 2014 (ICD). 6

NHS Wales also requires all healthcare staff to satisfy, to the appropriate level, the competences in this document.

All health staff have to receive basic safeguarding training as part of their induction programme.

**The ICD Competence levels are as follows:**

- **Level 1**: Non-clinical staff working in health care settings, including receptionists and administrative staff.

- **Level 2**: Minimum level required for clinical staff who have some degree of contact with children and young people and/or parents/carers, including Practice Nurses, Health Care Assistants and Phlebotomists.

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6 *Safeguarding Children and Young People: Roles and Competences for Health Care Staff, Intercollegiate Document, March 2014 (ICD)*
• **Level 3:** Clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns, including GPs and Nurse Practitioners.

The Core Level 3 Competence for GPs as well as the knowledge, skills and attitudes that relate to these competences can be found in the ICD.

*N.B. Those requiring competences at Levels 2 and 3 should also possess the competences at each of the preceding levels but only need to update the highest level they achieve.*

*All of the ICD levels are different to the levels that have previously been used.*

**Access to Training**

Level 1 and 2 E-learning, compliant with the ICD competences, is now available free for all NHS staff. See below for details of how to find information and help to access this resource.

For level 3 there is no set way to demonstrate attainment of the required competences. Rather the emphasis of any training should be on the importance of a multiplicity of approaches to learning to acquire and maintain knowledge and skills.

For instance:

- completing an e-learning module
- attending a training session in or out of the practice
- reading appropriate local guidelines
- case reviews and SEAs
- drawing upon lessons from research, case studies and child practice reviews,
- the importance of effective transfer of learning to the workplace
- demonstrating positive change in practice to improve outcomes.

**Some Useful Resources**

- The Safeguarding Children Service website has details of learning events and the NHS Wales e-learning as well as a dedicated GP section with useful links and documents*.
- LHBs put on level 3 training events and the Safeguarding Teams also provide regular training sessions.
- Local Safeguarding Childrens Boards run many training courses that are appropriate for level 3. Details are available on their websites.
- The RCGP in conjunction with NSPCC has developed a toolkit aimed at training for Primary Care. [Toolkit](#)
- Training sessions are regularly put on by Charities and Voluntary Organisations across Wales. e.g. [NSPCC, Children in Wales](#).
There are numerous e-learning modules readily available to doctors through sources such as the BMA, NSPCC and RCGP.

* The ICD and E-learning details are available on the Safeguarding Children Service (SCS) Web pages under Training and Events. There are other useful learning resources here:

**SCS Training and Events Intranet Page**
**SCS Training and Events Internet Page**

There is also a GP Guidance page:

**SCS GP Guidance Intranet Page**
**SCS GP Guidance Internet Page**

In addition to the level of training above, the Safeguarding Practice Lead (SPL) should ensure that they keep up to date with safeguarding developments through relevant bulletins and access to appropriate websites. The Practice should have in place a system to record whether the staff have received safeguarding training relating to children, young people and vulnerable adults.
4. CONFIDENTIALITY, CONSENT AND INFORMATION SHARING

4.1 Confidentiality and Consent

Ethical and statutory codes concerned with confidentiality are to protect individual patients, but are not intended to prevent the exchange of information between different professionals and staff who have a responsibility for ensuring the safeguarding of children and vulnerable adults.

The new GMC Guidance “Protecting Children and Young People: The responsibilities of all doctors” is essential reading.

In cases where there are safeguarding concerns there is a duty to share all relevant information with professionals and agencies who need to know. This may include disclosing information with or without the permission of the child or vulnerable adult or the parents or carers with other professionals who need access to that information for the purposes of safeguarding. The protection of the child and vulnerable adult must take precedence over all other considerations. Both children and parents/carers should be made aware that information, which has relevance to understanding any risks to children and in keeping them safe from harm, is shared appropriately. It is important not to promise absolute confidentiality in the hope of encouraging a disclosure of abuse.

Children are entitled to the same duty of confidence as adults provided that in the case of those under 16 years of age they have the ability to understand the choices and the consequences. Consideration should always be given to achieving consent of the child where the child is felt to be competent according to the Fraser Guidelines. In exceptional circumstances, confidentiality may be breached following discussion with the individual concerned.

In the case of vulnerable adults reference should be made to the Mental Capacity Act 2005 and it’s Code of Practice. There is a presumption of mental capacity unless a specific assessment suggests otherwise.

Working in partnership with families is essential to promoting the welfare of children and vulnerable adults. When making a child protection referral, it is good practice to inform the parents or carers. However if there is any possibility that this might place the vulnerable adult, the child or other children at additional risk of further harm, then the parents or carers should not be informed. The doctor is charged with the protection of the child or vulnerable adult not with the protection of the parent or carers.

Therefore, while consent is desirable it is not necessary for safeguarding referrals.
If no consent is given by the parent or carer to share information a risk assessment of the child or vulnerable adult concerns should be undertaken and further advice sought. as this may increase concerns.

In the process of any subsequent investigations by the police and social services it should be expected that the referral and its source will be made known to parents or carers. Therefore, any concerns about the impact of this on practice staff should be shared with the police or social services departments at the time of referral.

If there is uncertainty about whether to proceed with a breach of confidentiality, then the advice of the Named or Designated Professionals for Safeguarding should be sought.

### 4.2 Information Sharing

It is important to recognise the patchwork or jigsaw nature of safeguarding where different people hold separate pieces of information. It is only when these are put together that the picture is complete. Doing this involves sharing information.

Working effectively in safeguarding demands an inter-professional approach involving at least health, education, social services and the police.

For children in need of protection Health Professionals have a duty to respond to a request for assistance from Social Services in a child protection enquiry under Section 47 of the Children Act 1989. Consent is not required to share this information but is desirable. Information provided should be relevant and proportional. Any decision should be made on a case by case basis and where necessary the advice of the Health Board Named Professionals for Safeguarding can be sought.

Consent can be given by the biological father, if unmarried, if his name appears on the birth certificate.

Children in Need are defined under the Children Act 1989 and refers to children unlikely to achieve or maintain a reasonable standard of health or development without the provision of additional services. This would apply to most children with disabilities but may also apply to children living in circumstances where parenting capacity is impaired often through parental substance or alcohol abuse or domestic violence.

For Children in Need, Health Professionals have a duty to assist Social Services in respect of enquiries under Section 17 of the Children Act 1989. In this circumstance parental consent is required for sharing health information with Social Services who will undertake the initial assessment under the Framework for Assessment.
Lord Laming recommends that where there is a dilemma as to which of these two categories best fits the situation, it is better to proceed as if it is a child protection issue.

"There is nothing within the Caldicott Review, the Data Protection Act 1998 or the Human Rights Act 1998, which should prevent the justifiable and lawful exchange of information for the protection of children or prevention of serious crime”. *Carlile Review 2002*
5. RECORD KEEPING

Accurate record keeping is an essential part of the accountability for and effectiveness of child safeguarding and protection of vulnerable adults (POVA). It is an extremely important element to ensure effective inter-agency working. Documentation within practices should accurately reflect not only the care provided but also any concerns in respect of a child, young person or vulnerable adult. Concerns may be raised about the presentation or disclosures of a child or vulnerable adult or in respect of how a parent/carer has related or behaves towards a child or vulnerable adult. These concerns, observations or comments should be recorded in the relevant child/parent/carer’s records, along with the actions taken including the seeking of advice and the advice given. It is important that a record is made of:

1. When the advice and/or action was taken
2. Who the concerns were shared with
3. Any actions, if any, that flowed from such discussions.

It may be relevant to record concerns about the observations, presentation or comments of anyone accompanying the patient in the patient records. A record should always be made of who accompanied the young person in a consultation.

Findings from serious case reviews have highlighted the importance of linking information about adults for whom there are health concerns that have the potential to impact on their care of children and vulnerable others, for example those with serious mental ill health or those who misuse drugs or alcohol. In these circumstances it is important to consider whether or not the person is a carer or in a household with children and make a note to that effect, so that this can be kept in mind and information shared appropriately with others should the need arise. Children living in circumstances where their parents or carers have additional needs may be considered as children in need of additional services in their own right.

Recent cases have also demonstrated the importance of tracking children about whom there are concerns as closely as possible. Practices may have knowledge as to where such children are living and with whom. In order that a practice has discharged its responsibilities it is recommended that consideration is given to the following:

- Formulation of a system to ensure that the following categories of children can be easily identified:-
  1. Children on the Child Protection Register
  2. Children “looked after” by the Local Authority
  3. Children, defined under the Children Act 1989, as being in Need.
It is important that all general practices have a system in place to “flag” manual and computer records, which contain such information. There are a number of READ Codes available to assist in this process (see Appendix 5a).

- Where a child who is the subject of concern is known to have moved and the whereabouts are known it is good practice for the GP to telephone the new GP to alert them to any known concerns. Where there is social work involvement then the key worker should also be informed. If the new GP is not known, the Shared Service Partnership (previously known as Business Services) should be asked to trace the child through the NHS database.

- There may be times that a child’s record needs to be “fast tracked” to or from a general practice. This is especially important in the case of children for whom there are child protection concerns or for children looked after. Those responsible for the transfer of records must be aware of these procedures.

**Child Protection Documentation**

For those children subject to a Child Protection Case Conference, documentation will be produced and sent to the practice by the Local Authority. This usually includes the minutes of the case conference, including the outcome of whether the child’s name has been placed on the child protection register and the outline of the child protection plan. This information is necessary for the practice in order for the practice to understand the child’s circumstances, the level of risk/child welfare concerns and to maintain a safeguarding role. The documentation is also likely to contain individual reports from the agencies involved, including the Social Worker and other Health Professionals.

On receipt of this documentation it is important to note the content of the minutes and update the flag code on the electronic record in respect of child protection registration for all children concerned and the parents of those children if also registered at the practice.

It is recommended to scan the minutes of the conference into the electronic record for all family members concerned and who are registered at the practice. The front sheet of the conference minutes will state who these are. These will then constitute part of the lifelong patient medical record and should not subsequently be removed. The records do not need to be redacted prior to scanning.

Conference reports generated by health professionals in respect of individual family members should also be scanned onto the record of the patient to whom this applies. Other reports may be destroyed as a summary of each will be contained within the conference minutes.

If the full minutes of the conference have been scanned onto the electronic record, along with any relevant health reports then the hard paper copies can be destroyed.
Any minutes or health reports that have not been fully scanned should be safely stored inside the full paper GP patient record as a constituent part of the individual patient record and reference made on the electronic record that these copies exist. Case Conference minutes should not be filed separately but they should remain part of the clinical record as they will contain information that may be relevant to the provision of future health and social care and assist in a better understanding of the needs and circumstances of family members. Practitioners should however think carefully whether it is appropriate to disclose the content to third parties not directly involved in the case conference or in the provision of health care. If disclosure is considered necessary redaction of third party information would be required prior to their release.

Non disclosure might apply to the release of the child records to parents, where there is not parental responsibility for all of the children named in the conference minutes or where by so doing, this may place the child or family members at risk (e.g. where the current address should not be disclosed). In these circumstances advice should be sought from Health Board Named Professionals. As with all records, careful consideration should be given to the management and sharing of sensitive information with the patient who may wish to access their own records.

When a child moves, swift transfer of the electronic record will alert the new GP to the child’s child protection status and the name of their Social Worker (as on the front page of the minutes). However this should not deter a telephone call to the receiving GP if this is required and a record kept of this conversation / communication.

Any un-scanned records and reports held by the practice should be gathered together and secured. These should be placed in a sealed envelope and labelled with the child’s name and NHS number with the request to forward to the new GP. This should be placed in the ‘blue bag’ and sent to the regional Shared Services partnership (formerly BSC).

Any adult subject to multi agency risk assessment processes (i.e. Multi agency public protection arrangements ‘MAPPA’ or Multi-agency risk assessment conference ‘MARAC’) in relation to their behaviour that results in a public protection plan should have that noted within the individual’s own records.

**Case Audit and Review**

All relevant health records must be made available to those undertaking a case review on behalf of the Local Safeguarding Children Board. This will usually be the Designated or Health Board Named Professionals safeguarding.
6. CHILD PROTECTION LIAISON

6.1 A&E/MIU Attendances

Each General Practice is recommended to have a system in place to review and file A&E and minor injury unit (MIU) attendance forms when received as well as contacts by children with the Out of Hours Service.

Reports from Police, Health Visitors, School Nurses, Midwives and Social Care Liaison have to be recorded and reviewed in the same manner.

It is important that clerical staff ensure that all these forms are drawn to the attention of a General Practitioner and appropriate action taken before filing.

If the information on the form is insufficient to assist in forming an opinion the GP should follow up with the A&E Doctor or the Paediatric Liaison Health Visitor.

Information about A&E or MIU attendance should be considered in the light of known concerns and if necessary any further action taken, for example sharing this information with other health professionals or the social worker if involved.

If any GP sees a temporarily registered child with suspected non-accidental injury, in addition to making the child protection referral, contact should be made with the GP with whom the child is normally registered and relevant information sought as a matter of urgency.

If a child is Looked After then the Social Worker and the relevant LAC Nurse for the child should be informed.

New patient registration for children and young people should extend to include gathering information on wider social and developmental issues likely to affect the welfare of a child.

- The name of school attended. (Lord Laming, Victoria Climbie Inquiry, 2003) ⁹
- Is there or has there been a social worker involved with the family?
- Ideally the child should be seen, height and weight measured and any concerns ascertained.

Regular practice discussions with regard to vulnerable children will enable liaison between practice staff and community health staff. This should also include practice discussions with the midwifery service where there are concerns in pregnancy that may have future impact on parenting capacity.

⁹ The Voice of the Child: Learning from Serious Reviews; Ofsted 2011
6.2 Children Not Brought to Appointments

Missing appointments for some children may be an indicator that they are at an increased risk of abuse and neglect. There are many innocent reasons why children miss appointments but numerous studies have shown that missing healthcare appointments is a feature in many serious case reviews including those into child deaths. 0, 10

Within Health there is now a move towards the concept of Was Not Brought (WNB) rather than Did Not Attend (DNA) for children and young people. It is rarely the child’s fault that they miss appointments. The National Service Framework for Children (2004) 11 states that: Children or young people failing to attend clinic appointments “may trigger concern, given that they are reliant on their parent or carer to take them to the appointment. Failure to attend can be indicator of a family’s vulnerability, potentially placing the child’s welfare in jeopardy”. Not addressing missed appointments may disadvantage the child involved.

All Health Boards and Trusts have DNA or WNB policies that include informing Primary Care.

Many children are also not brought to appointments in Primary and Community healthcare.

CEMACH in their 2008 report into Serious Case Reviews noted how frequently children who died had previously been identified as recurrent non-attendees, including hospital and community appointments. They also commented on the deleterious consequences for children who had failed to attend out-patient appointments on one or more occasions and were not followed up.

Recommendations from CEMACH include:

- Health Services, including Child and Adolescent Mental Health Services should proactively follow up children who do not attend appointments.

- When a child or young person doesn’t attend an appointment with any health service, they should be contacted and the appointment should be rearranged.

- Children with chronic illnesses who do not attend hospital appointments should be followed up in primary care to discuss reasons for non-attendance.

10 Why Children Die: CEMACH 2008
The Care Quality Commission (CQC) review of safeguarding children arrangements in the NHS, July 2009\textsuperscript{12}, identified that there should be a process in place for following up children who fail to attend appointments.

The RCGP/NSPCC Toolkit 2014 \textsuperscript{13} makes the recommendations that practices have in place:

- Procedures for identifying and following children who do not attend scheduled appointments within the Practice or with other Agencies such as therapies, secondary or community care;
- Procedures to identify and follow up children with more than expected unscheduled appointments at the Practice, OOHs, A&E Departments, Walk-in Centres.

It should be remembered that parents have the right to make decisions in respect of their child’s health. The concept of Parental Responsibility gives a legal definition to the rights and responsibilities of a person with parental responsibility. Parental responsibility allows a parent or carer to accept or decline a health service or treatment on behalf of their child. However if by declining a health service or treatment this may be detrimental to the child or young person’s health, growth or development, an assessment should be made of the risk this poses to the child or young person.

The United Nations Convention on the Rights of the Child \textsuperscript{14} recognises the right of the child to enjoy the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. It requires that organisations strive to ensure that no child is deprived of his or her right of access to such health care services.

It is therefore important that Primary Care has processes in place to deal with children and young people who are not brought to appointments both in Secondary and Primary care.

**Guidance: Children not attending appointments with other Health Professionals**

Health Board Was Not Brought / Did Not Attend policies state that when children miss appointments the referring clinician is notified. It is recognised that missing appointments can be an indicator of neglect.

In Primary Care there should be a process in place to:

\textsuperscript{12} Safeguarding Children. A Review of arrangements in the NHS for safeguarding children; Care Quality Commission July 2009
\textsuperscript{13} The RCGP/NSPCC Safeguarding Children Toolkit 2014
\textsuperscript{14} The United Nations Convention on the Rights of the Child; Article 24
• Identify WNB/DNA notifications for children.

• Review the reason for referral and assess if any further action is required to manage the clinical problem that prompted the referral.

• Note if there have been any other episodes of missing appointments in any setting including Primary Care.

• Consider whether there are any safeguarding concerns and if there are take any appropriate action.

• Consider contacting the family about children not being brought for appointments especially if there are multiple instances.

• Document this process including any subsequent actions taken as a result.

**Guidance: Children not attending appointments in Primary Care**

It is clear that a lot of missed appointments in Primary Care are due to the transient nature of many conditions and do not give rise to concerns. However if we do not have a process in place we cannot recognise when vulnerable children are not brought or there are multiple missed appointments.

Therefore Primary Care Practices need to have a Was Not Brought policy for children that should include:

• Identifying when children are not brought for appointments.

• If the appointment is known to be as a consequence of a referral/recommendation of other Healthcare Professionals, notifying them of the failure to attend.

• If the reason for the appointment is known, consideration as to whether there are any clinical consequences and if any actions are required.

• Consideration of any safeguarding concerns, especially when there are multiple episodes of WNB in Primary Care or other settings.

• Appropriate action if there are clinical or safeguarding concerns.

• Consideration of contacting the family about children not being brought for appointments especially if there are multiple instances.

• Documenting this process including any actions taken as a result.
7. LATERAL THINKING REQUIRED

7.1 Parenting and Caring Relationships

Practitioners should always consider the effect on children of family members presenting with issues related to:-

- Domestic abuse.
- Drug and alcohol problems
- Mental health issues – not only in the direct impact on children but also that a significant proportion (30%) of all young carers care for a person with a mental disorder.
- Recognition of cultural practices common in the patient’s country of origin but not acceptable in the UK such as forced marriages and female genital mutilation (FGM).
- Criminal records.

Children of adults with chronic physical disease can also be significantly affected, particularly in their role as carers for their ill parents.

Parents and vulnerable adults with learning disability may need extra care and understanding in helping them to support their families and should not be excluded from any decision making processes.

Vulnerable groups such as hard to engage individuals, refugees, asylum seekers and trafficked individuals will pose particular problems.

7.2 Looked After Children

Children and young people who are looked after are amongst the most socially excluded groups in England and Wales. They have profoundly increased health needs in comparison with other children and young people from comparable socio-economic background. Due to their poor educational, health and social outcomes they are very vulnerable.

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16 Statutory Guidance on Promoting the Health and Wellbeing of Looked after Children: DOH
17 Supporting and promoting the Health needs of Looked after Children in Wales: The Looked after Children Health Exchange (LACHE)
18 Lost After Care 2011: Children’s Commissioner for Wales
19 Sexual Offences Act 2003
Their high levels of health need are often related to their experiences prior to coming into care. These can include neglect, abandonment, and abuse - physical, mental or sexual.

- Just 9% of Looked After Children attain 5 GCSE grades A* to C compared to 63% of 15 year olds who are not in the care system.

- Studies have shown that young people moving on to independent living are at an increased risk of homelessness relatively soon after leaving care.

- The prevalence of mental disorders is 40% for children in the looked after system compared with 12% in children from the private household survey.

This means that they have specific needs and should be treated in a empathic and responsive manner by Primary Care.

The Local Authority must ensure that all Looked After children are promptly registered with a GP. There needs to be clear guidance for all primary care staff on how to deal with a young person wishing to register or access their services with or without involving a parent or carer.

The nature of their care means that they are highly mobile and this can impact on the continuity and hence quality of their care. To deliver the best possible medical care to the child or young person General Practice needs to have the best possible access to the relevant medical records. Treating a patient as a temporary resident is not ideal as the medical record is not available to the treating practitioner and any new information may not be added to the health record. In circumstances where children are seen without their medical records it is suggested that the treating practitioner will normally wish to talk to the child or young person’s registered practitioner to avoid treating the patient “blind”.

Each looked after child should be regularly assessed by a specialist nurse for Looked After Children and a copy of the care plan sent to the GP. The GP-held clinical record is unique and can integrate all known information about health and health events during the life of any child or young person. This enables an overview of health priorities and to know whether health care decisions have been planned and implemented. This makes the GP record the lead record for Looked After children and young people.

**Primary Care Teams are expected to ensure that:**

- Looked after children are registered with the carer’s GP within 10 working days of the date of placement.

- The registration status of looked after children becomes permanent no later than 4 weeks following the date of placement.
• GP records of a child who is looked after are requested and transferred using the ‘Fast Tracking’ system.

• GP records make the “looked after” status of the child or young person clear, so that their particular needs can be acknowledged.

• Details of the carer and social worker or personal advisor should be recorded.

• There is timely, sensitive access to a GP or other appropriate health professional when a child or young person who is looked after requires a consultation.

• Young people requesting medical help without a carer to assist or register them should initially be seen, assessed and any medical needs dealt with. It is important to note that they are entitled to confidential appointments with the doctor without involving their foster carer or social worker if they are Fraser competent.

• Healthcare professionals are able to assess the competence of young people.

• Young people who are capable are able to register without any involvement of carers or parents. This is particularly important as physical and mental health problems can increase after a young person leaves care.

• Young people are entitled to attend any GP surgery for sexual health issues, emergency contraception and other urgent problems including preventative care e.g. immunisations, without necessarily being registered there.

• Referrals made to specialist services are timely, taking into account the needs and high mobility of many children and young people who are looked after.

• GP services, when requested, provide summaries of the health history of a child or young person who is looked after, including their family history and ensure that this information is passed promptly to health professionals undertaking health assessments, subject to appropriate consents.

• They maintain a record of the health assessment and contribute to any necessary action within the health plan.

• Copies of any existing health reports and any subsequent reports are forwarded to the existing GP and any GP with whom the child will be registered following placement, so that the GP record remains the lead health record for the child.

7.3 Men and Boys

Practitioners and practice staff should be particularly sensitive to the needs of boys and young men who attend the surgery. Men have different help seeking behaviours from women.
Fathers and other males are often overlooked in the safeguarding process and it is important to involve them in the information gathering.

It is appropriate to make direct enquiries as to the status of any male attending with the family at an appointment i.e. biological father, step-father, boyfriend etc, to establish who has Parental responsibility for the child

- Biological fathers who are unmarried to the mother can give consent if their name is on the birth certificate but cannot do so if their name is not on the certificate.

- Often fathers or those acting in a father’s role are registered with other practices and, therefore, their health and personal details are not available unless enquiry is made. Appropriate enquiry regarding their status and relevant health issues is reasonable in any safeguarding context during the process of clinical history taking.

- Any situation where an adult male attending for a family consultation seems to be “taking over” the consultation should prompt some consideration as to the appropriateness of his actions.

- The same concerns apply to inappropriate behaviour by any other accompanying adult of either sex, whether related (e.g. grandparents) or not (e.g. partner).

### 7.4. Working with Sexually Active Young People

Doctors have a responsibility to provide a confidential sexual health service in which young people have trust but also have a duty to act to safeguard children. Striking a balance between what on the surface appears to be conflicting needs can cause significant dilemmas to professional staff.

Young people, including those under 13, will present with specific health needs ranging from advice on contraception and pregnancy, through to the treatment of sexual transmitted disease. It is the prime responsibility of the health professional to deal with these issues without delay.

**Children aged 13 – 16**

Providing advice and treatment to young people under 16 years of age can be given under the [Fraser guidelines](#) without parental consent providing that the young person understands the advice being given and cannot be persuaded to inform or seek support from their parents. All decisions must be made within the best interest of the child balanced against the need to protect the rights and freedom of others. This could pose a major dilemma for health professionals in that the Sexual Offences Act 2003 states that sexual activity under the age of 16 is illegal.

It is not in the best interests of the child or young person to have an automatic referral made to Police or Social Services when knowledge about their sexual
activity becomes known to a health professional. Once information has been shared with authorities it may remain on databases even if no convictions occur.

The valid reasons for the existence of the Act however, is to safeguard the welfare of the young person in circumstances where the sexual activity suggests that that young person is being exploited. The law is not intended to prosecute mutually agreed sexual activity between two young people of similar age.

For children aged 13 to 16 the decision not to refer can be made by the health professional alone if they are satisfied that the activity is acceptable. It is essential that the reasoning behind the decision and the decision taken is recorded clearly by the practitioner in the young persons’ medical record.

In all situations decisions would clearly be influenced by knowledge of power or age imbalances between the partners, suggestions of abuse of trust or the use of sex favours. Particular sensitivity must be employed when considering the needs of young people and vulnerable adults with learning disabilities, mental disorders or communication difficulties. Confidentiality can not be absolute in these circumstances and sharing information without consent might be necessary in the above circumstances. Action will also need to be taken when the young persons own behaviour places them at risk including vulnerability due to the abuse of drugs and alcohol or denial or minimising concerns regarding their activity.

Children under the age of 13

The All Wales Child Protection Procedures in section 5.4.6.1 states:

"Under the Sexual Offences Act 2003, children under the age of 13 are of insufficient age to give consent to sexual activity.

In all cases where the sexually active young person is under the age of 13, a full assessment must be undertaken by the agency involved. Each case must be assessed individually and consideration must be given to making a child protection referral to social services. In order for this to be meaningful, the young person will need to be identified, as will their sexual partner if details are known.

A decision not to refer to social services can only be made following a discussion of the case, with the designated / named lead for child protection within the professional’s employing agency. When a referral is not made, the professional and agency concerned is fully accountable for the decision and the reasons for the decision must be clearly recorded.

When a girl under the age of 13 is found to be pregnant, a referral must be made to social services where an initial assessment will be completed and a All Wales Child Protection Procedures 2008 strategy meeting/discussion will take place, which will include representatives from health and education.
The Bichard Inquiry Report’s recommendation 12 stated that the Government should reaffirm the guidance that the police are notified as soon as possible when a criminal offence has been committed, or is suspected of having been committed, against a child – unless there are exceptional reasons not to do so. The Welsh Assembly Government reaffirmed this recommendation in the guidance Safeguarding Children: Working Together Under the Children Act 2004 in Chapter 8, para 8.29”.

Any offence under the Sexual Offences Act 2003 involving a child under 13 years is very serious and should be taken to indicate a risk of significant harm. However, although the legislation is clear in respect of under 13s this group of children are still entitled to the right of confidential advice on contraception, condoms, pregnancy and abortion.

Professionals’ assessment in this age group needs to be more in depth and their thresholds for referral much lower. This assessment should be undertaken every time the child is seen or information is received which escalates potential risk to the child. In all cases professionals should discuss with the safeguarding practice lead and seek advice from the named or designated professionals. If following that discussion a decision not to make a referral is arrived at the professionals must be prepared to fully justify, record and make available for review if necessary, any decision not to make a referral to Social Services and the Police.

**Young People aged 17 – 18**

Although sexual activity in itself is no longer an offence over the age of 16, young people under the age of 18 are still offered the protection of Child Protection Procedures under the Children Act 1989. Consideration still needs to be given to issues of sexual exploitation through abuse of power or trust in circumstances outlined above. Young people, of course, can still be subject to offences of rape and assault and the circumstances of an incident may need to be explored with a young person. Young people over the age of 16 and under the age of 18 are not deemed able to give consent if the sexual activity is with an adult in a position of trust or a family member as defined by the Sexual Offences Act 2003.

It is illegal to pay for the sexual services of a young person under 18 years of age.

**Vulnerable Adults**

The general management and support of vulnerable adults engaged in sexual activity should be reviewed in the general context of all the sections outlined above.

**7.5 Prescribing and Dispensing Practices**

Practices dispensing emergency contraception should be aware of their responsibilities for safeguarding issues as outlined in section 7.3.
The doctor needs to assess if a child under 16 has competence to understand instructions regarding prescribed medicines. Most prescriptions are likely to be for antibiotics, skin applications or inhalers. Prescriptions for substances which could potentially be used for self harm need further consideration. Children Looked After may be one category of young person who are more likely to attend the surgery unattended and may have been in receipt of repeat prescriptions previously.
8. CHILD PROTECTION CONFERENCES

The primary care team can be well placed to provide information about a child and his/her family who has been referred to the local social services department as being in need of protection. It is recognised that the level of involvement of the practice can vary according to the circumstances. If the family is well known to the practice, then attendance by the GP at the child protection conference would be of assistance to the conference. This also benefits the practice through a greater understanding of the concerns of other professionals and knowledge of any protection plan that may be put in place. It is good practice for primary health care staff to discuss the case and share information prior to the conference.

GPs may also be required to provide appropriate information concerning a patient to support decision making at a safeguarding vulnerable adults conference (Appendix 3 and 4).

The Carlile Review\(^0\) stated that attendance by GPs at case conferences is desirable to provide relevant medical information and participate in the decision making process wherever possible but that in all cases a written report was essential.

If it is decided to send a written report it may be sent directly to the Chair of the Child protection Conference within the social services department or the GP could request that it be presented to the conference by a Named Doctor or Senior Nurse Safeguarding for the LHB, a Community paediatrician or by another member of the primary healthcare team.

If the practice has little or no knowledge about the child a written report should be provided in order for the conference to be assured that there are no information gaps (Appendix 1 and 2). There must be clear agreement between professionals about the information to be shared if for example a member of the Primary Health Care Team other than the GP is to share relevant information relating to the child or family members held in GP records. While meetings will be arranged at a time to ensure maximum attendance most importantly time and venue are arranged to suit the availability of the family.

The fees for this work come under collaborative arrangements and may be paid via the LHB. However, there are no national fee scales, and the fees for the work will need to be agreed on an individual basis between the practice and the LHB.

Attendance at conferences or provision of reports should not be delayed by disputes regarding payment of fees.
9. MONITORING, AUDIT AND CLINICAL GOVERNANCE

The Safeguarding Practice Lead (SPL) will:-

- seek her/his own professional support and supervision. The Health Board Named Professionals will be available for advice and guidance on child protection matters or specific cases.

- maintain an awareness of changes in legislation and government guidance.

- be responsible for contributing to the development of practice policies and protocols in order that they are sensitive to the needs and rights of children and vulnerable adults.

- support Safeguarding audit as appropriate within the practice and ensure systems are in place to enable an annual audit.

- review significant events that are recommended as part of good clinical governance could include child protection cases and other issues to do with vulnerable children and adults.

- review issues relevant to the safeguarding of children and vulnerable adults as part of the practice’s critical incident mechanisms including significant event analysis.

- ensure safeguarding is recognised and included in practice clinical governance arrangements. This would include keeping information likely to be requested by the Local Health Board through any QOF enquiries or clinical governance arrangements.

- ensure safeguarding concerns are recorded in a retrievable and auditable form so that cases can be followed and reviewed.

For Children and Young People this would include:

a. Children with child protection plan: children in need; children who are in the looked after system; children living with a parent who has a substance misuse or severe mental health problem or where domestic violence has been recognised.

b. Number of contacts by social services/other agencies, requests for child protection case conference reports/number of reports completed; case conferences/number attended.

c. Completion of child protection training at appropriate level for all practice staff

For vulnerable adults this will involve many of the above elements where the practice has been involved.
10. REFERENCES

1. Protecting Children and Young People: Responsibilities of all Doctors (GMC)
2. All Wales Child Protection Procedures
3. Wales Interim Policy and Procedures for the Protection of vulnerable adults from abuse (Updated Jan 2013)
4. When to suspect child maltreatment. (NICE Guidance 89):
5. Safeguarding Vulnerable Adults: A Toolkit for General Practitioners (BMA 2011)
7. Carlile Review 2002
9. The Voice of the Child: Learning from Serious Reviews; Ofsted 2011
10. Why Children Die; CEMACH 2008
13. The RCGP/NSPCC Safeguarding Children Toolkit 2014
15. Towards a Stable Life and a Brighter Future 2007: Welsh Assembly Government
17. Supporting and promoting the Health needs of Looked after Children in Wales: The Looked After Children Health Exchange (LACHE)
18. Lost After Care 2011: Children’s Commissioner For Wales
APPENDIX 1

CHILD PROTECTION REFERRAL GUIDANCE

Health Professional or Member of Staff has concerns about child’s welfare

Discuss with lead for Safeguarding practice lead and/or Senior Member of Staff. Consider checking the Child Protection Register

Are you concerned that this is a child protection issue?

YES

Professional/Staff Member refer by telephone to Social Services Duty Social Worker- Follow up in writing within 48 hours.

No referral necessary. Agree Health Plan with appropriate professionals

Children in need referral made with consent

Still Concerned

YES

Maintain contact with Social Services & input to Child Protection Process as necessary

No/No response within 10 working days

Discuss further with Social Services

Still Concerned

YES

Consider the Child & Family may benefit from Social Services help & if necessary make a referral with parental consent

Re-evaluate the risks to the child/children

NO

YES

In an emergency or when the injury is severe a 999 Police and Ambulance call should be made and Social Services informed.

REMEMBER THE SAFETY OF THE CHILD IS PARAMOUNT – IF IN DOUBT SHARE YOUR CONCERNS WITHOUT DELAY. PLEASE REFER TO THE “ALL WALES CHILD PROTECTION PROCEDURES” FOR FULL REFERRAL INFORMATION.

Support and advice can be sought from the LHB Named Doctor or Nurse for Safeguarding at any stage in the process. Record the outcome of all discussions & actions
APPENDIX 2

LOCAL HEALTH BOARD

GP Report for Child Protection Case Conference

(N.B. please complete and return a separate form for each child)

To be shared at Child Protection Case Conference at: ..........................................................

Date of conference: ........................................... Time: .....................................................

Name of Child: .......................................................... DOB: .....................................................

Address: ..................................................................................

1. Are you the regular attending GP? Yes / No
   If not – who is?

2. (a) When was the last time you or one of your colleagues saw the child?
   • Date:
   • Presenting problem:
   (b) How many times has the child been seen in the past 12 months?

3. Does the child have any health problems/ hospital admissions?
   Please give details:

4. Is the child’s physical and mental health satisfactory?

5. Have you or a colleague seen the child for any child protection issue or had any child protection concerns?
6. Have you received any information from any other source regarding any child protection concerns?

7. Have you any other concerns relating to the child? Yes / No
   If yes - What are the concerns

8. (a) Are you aware of any issues affecting the parents/carers of the child, which may have an impact on their parenting capacity e.g. domestic abuse/substance and/or alcohol abuse/mental health concerns/learning difficulties?

(b) Do you have any other relevant concerns/knowledge about the parents/carers?

9. Do you have any knowledge of or concerns about any other adults and/or children connected to the index child?
   Please detail:

10. Do you have any further information you want the Community Paediatrician or the Chair of the conference to be aware of?

    Name of GP: ...........................................................................................................

    Address: ...................................................................................................................

    Signature of GP: ...............................................................

    Date of report: ...............................................................

APPENDIX 3

Traffic Chart: Protection of Vulnerable Adults

1. Alert: Abuse alleged, disclosed, or suspected

2. Referral made to Social Services, Health, Police or CSSIW

   YES
   Is there immediate physical danger?
   NO
   Is a crime suspected?
   YES
   Preserve evidence
   NO
   Take steps to remove person from danger and/or to remove or reduce the risk

   YES
   5. Strategy Meeting
   Investigation needed? If yes, decide who leads. Individual and General Protection Plans may be continued or initiated
   NO
   Agree other actions

   YES
   Can client make an informed decision?
   NO
   YES
   6. Investigation
   NO
   YES
   7. Further Strategy Meetings and Final Strategy meetings
   There may be several Further Strategy Meetings before the end of the case as required
   NO
   The Final Strategy Meeting receives the investigation report; agrees the status of the allegation and agrees outcomes for those involved, including if required Individual and General Protection Plans.

   YES
   8. Case Conference
   Confirms actions / Protection Plan usually with victim and/or their representative

   YES
   9a. Individual Protection Plan Review within 6 weeks and thereafter as necessary
   NO
   9b. General Protection Plan Review
   Within 6 weeks and thereafter as necessary. Consider use of WAG Escalating Concerns Guidance

   YES
   10. Closure

Version: 5  Date 24.02.15  Status: FINAL
Author: Safeguarding Children Service  Page: 39 of 48
## APPENDIX 4

**Adult Protection Referral Form – Confidential**

*(Please complete as fully as possible, especially ensuring that risks are identified)*

### 1 About the Vulnerable Adult (Subject of referral)

<table>
<thead>
<tr>
<th>Date Referral Received</th>
<th>Date(s) of Incident(s) if known</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Client/Patient ID Number:</td>
<td>Gender: Male</td>
</tr>
<tr>
<td>Date of birth:</td>
<td></td>
</tr>
<tr>
<td>Vulnerable Adult/Client’s Current Address:</td>
<td>Other Vulnerable Adults / Children living at the property:</td>
</tr>
<tr>
<td>Tel Number:</td>
<td></td>
</tr>
<tr>
<td>Marital Status:</td>
<td>Elderly Mentally Infirm</td>
</tr>
<tr>
<td>Ethnicity:</td>
<td>Visual Impairment</td>
</tr>
<tr>
<td>First Language:</td>
<td>Learning Disability</td>
</tr>
<tr>
<td>Need Interpreter: Yes</td>
<td>No</td>
</tr>
<tr>
<td>GP’s Name:</td>
<td>Main Client Group:</td>
</tr>
<tr>
<td>Telephone Number:</td>
<td>Elderly Mentally Infirm</td>
</tr>
<tr>
<td>Surgery Address:</td>
<td>Visual Impairment</td>
</tr>
<tr>
<td></td>
<td>Learning Disability</td>
</tr>
<tr>
<td></td>
<td>Mental Health</td>
</tr>
<tr>
<td></td>
<td>Substance Misuse</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Next of kin:</td>
<td>Client Category:</td>
</tr>
<tr>
<td>Address:</td>
<td>Open/active</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>Closed</td>
</tr>
<tr>
<td></td>
<td>Other County</td>
</tr>
<tr>
<td>Is the vulnerable adult aware of the referral?</td>
<td>Yes</td>
</tr>
<tr>
<td>Has the vulnerable adult consented to the referral?</td>
<td>Yes</td>
</tr>
<tr>
<td>Is there any evidence to suggest that the vulnerable adult lacks mental capacity to consent to this referral?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### 2 About the alleged abuse

<table>
<thead>
<tr>
<th>Type of alleged abuse (tick all relevant boxes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
</tr>
</tbody>
</table>

---

Version: 5   Date: 24.02.15   Status: **FINAL**
Author: Safeguarding Children Service   Page: 40 of 48
Personal circumstances – Is the alleged victim subject to any legislative powers, e.g. Mental Health Act, Power of Attorney?

Where did the alleged abuse occur? Own Home [] Care Home - Residential [] Care Home – Nursing [] Care Home – Respite [] Relative’s Home [] Supported Tenancy [] Hospital [] Hospital – Independent [] NHS Trust Group Home [] Home of Perpetrator [] Daycare [] Educational [] Sheltered Accommodation [] Hospice [] Public Place [] Other [] Please State:

Is the abuse: Historical [ ] Current [ ]

Description of alleged abuse/injuries:
What steps have been taken to safeguard the vulnerable adult and by whom:

3 About the person(s) allegedly responsible for the abuse

Person 1:

<table>
<thead>
<tr>
<th>Unknown at present:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Address:</td>
</tr>
<tr>
<td>Tel No:</td>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Age:</td>
<td>Relationship to Alleged Victim:</td>
</tr>
<tr>
<td>Employing Agencies. List all known:</td>
<td></td>
</tr>
<tr>
<td>Is alleged perpetrator a vulnerable adult?</td>
<td>Yes ☐ No ☐ Don’t know ☐</td>
</tr>
<tr>
<td>Is alleged perpetrator a child?</td>
<td>Yes ☐ No ☐ Don’t know ☐</td>
</tr>
<tr>
<td>Is alleged perpetrator aware of the referral?</td>
<td>Yes ☐ No ☐ Don’t know ☐</td>
</tr>
<tr>
<td>Is the alleged perpetrator known to social services, health or police? Please give appropriate details</td>
<td></td>
</tr>
</tbody>
</table>

Person 2:

<table>
<thead>
<tr>
<th>Unknown at present:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Address:</td>
</tr>
<tr>
<td>Tel No:</td>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Age:</td>
<td>Relationship to Alleged Victim:</td>
</tr>
<tr>
<td>Employing Agencies. List all known:</td>
<td></td>
</tr>
<tr>
<td>Is Alleged perpetrator a vulnerable adult?</td>
<td>Yes ☐ No ☐ Don’t know ☐</td>
</tr>
</tbody>
</table>
### Is Alleged perpetrator a Child?
- [ ] Yes
- [ ] No
- [ ] Don’t know

### Is Alleged perpetrator aware of the referral?
- [ ] Yes
- [ ] No
- [ ] Don’t know

### Is the Alleged perpetrator known to social services?
- [ ] Yes
- [ ] No
- [ ] Don’t know

If yes, Client/Patient Database Number: ____________

Team responsible: ____________

---

If more than two alleged perpetrators have been identified please photocopy this page or at details in Section 8 – Additional information.

### About the people who witnessed the incident(s)

#### Witness 1:
- **Name:** ____________
- **Address:** ____________
- **Tel No:** ____________
- **Relationship to victim (if any):** ____________

- [ ] Yes
- [ ] No
- [ ] Don’t know

- [ ] Yes
- [ ] No
- [ ] Don’t know

- [ ] Yes
- [ ] No
- [ ] Don’t know

#### Witness 2:
- **Name:** ____________
- **Address:** ____________
- **Tel No:** ____________
- **Relationship to victim (if any):** ____________

- [ ] Yes
- [ ] No
- [ ] Don’t know

- [ ] Yes
- [ ] No
- [ ] Don’t know

- [ ] Yes
- [ ] No
- [ ] Don’t know

#### Witness 3:
- **Name:** ____________
- **Address:** ____________
- **Tel No:** ____________
- **Relationship to victim (if any):** ____________

- [ ] Yes
- [ ] No
- [ ] Don’t know

- [ ] Yes
- [ ] No
- [ ] Don’t know

- [ ] Yes
- [ ] No
- [ ] Don’t know

---
<table>
<thead>
<tr>
<th><strong>Is witness a vulnerable adult?</strong></th>
<th><strong>Yes</strong></th>
<th><strong>No</strong></th>
<th><strong>Don’t know</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Is witness aware of referral?</strong></td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
<td><strong>Don’t know</strong></td>
</tr>
</tbody>
</table>

5 About the person who first raised the concern

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tel No:</td>
<td>Occupation/Relationship:</td>
</tr>
<tr>
<td>Date/Time report:</td>
<td></td>
</tr>
<tr>
<td>Does the referrer wish to remain anonymous?</td>
<td><strong>Yes</strong></td>
</tr>
<tr>
<td>If yes, please state why:</td>
<td></td>
</tr>
</tbody>
</table>

6 About the person who is reporting the incident(s) to Social Services

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tel No:</td>
<td>Occupation/Relationship:</td>
</tr>
<tr>
<td>Date/Time reported:</td>
<td></td>
</tr>
<tr>
<td>Does the referrer wish to remain anonymous?</td>
<td><strong>Yes</strong></td>
</tr>
<tr>
<td>If yes, please state why:</td>
<td></td>
</tr>
</tbody>
</table>

7 Details of person completing this form

<table>
<thead>
<tr>
<th>Name:</th>
<th>Designation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency:</td>
<td>Time/Date completed:</td>
</tr>
<tr>
<td>Signature:</td>
<td>Telephone number:</td>
</tr>
</tbody>
</table>

Where applicable, details of countersigning line manager:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Designation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature:</td>
<td>Time/Date countersigned:</td>
</tr>
</tbody>
</table>
8 Additional Information
APPENDIX 5a

Computer (READ) Codes in Safeguarding Children and Vulnerable Adults

Good communication is vital to safeguarding those who are vulnerable. Modern GP software systems now mean that this happens through electronic means and there is a regular transfer of information with out of hours services and emergency departments as well as between practices. It is therefore helpful if there is a consensus on what READ Codes to use. Our intention was to update and clarify the list of recommended READ Codes to make their use more consistent across Primary Care.

We recently looked at the current use of the codes recommended in the Royal College of General Practitioners and Public Health Wales guidance. A questionnaire was sent to all GP practices in Wales asking about which of these codes they currently use regularly. There were responses from 113 practices in total, with replies from all Health Board areas. It was evident from the data collected that the vast majority of practices code when children or adults are vulnerable and when children are subject to the child protection process. Most practices however do not seem to use the codes that indicate the risk factors present in family members of vulnerable people or those that indicate who these people are.

We know that the strongest risk factors for child abuse are the so-called “Toxic Trio” of substance misuse, mental health problems and domestic abuse in the parents or carers of children. Evidence also shows that GPs are likely to suspect abuse from the problems of and consultations with the wider family as well as with the abused person or child. Coding that allows us to know about these risk factors and the relationship between carers with these problems and vulnerable patients is therefore important.

Below are the READ Codes that are most commonly used by the practices that responded to our survey. Also included are those READ Codes that allow us to indicate the wider family members of those who are vulnerable or have been abused. This list does not cover all situations and Practitioners are encouraged to use other codes that they feel are helpful to their practice.

It is our hope that this updated list of recommended READ Codes will improve the consistency of coding within Primary Care to identify vulnerable and abused children and adults and improve the transfer of this information between practices and other health care providers.
<table>
<thead>
<tr>
<th><strong>Safeguarding Children Codes</strong></th>
<th><strong>READ 2</strong></th>
<th><strong>READ 3</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Child on Protection Register</td>
<td>13IM</td>
<td>13IM</td>
</tr>
<tr>
<td>Child removed from Protection Register</td>
<td>13IO</td>
<td>13IO</td>
</tr>
<tr>
<td>Vulnerable child</td>
<td>13IF</td>
<td>13IF</td>
</tr>
<tr>
<td>Child in need</td>
<td>13IS</td>
<td>XaIO8</td>
</tr>
<tr>
<td>Child in care</td>
<td>13IB</td>
<td>13IB</td>
</tr>
<tr>
<td>Non accidental injury to child</td>
<td>SN552</td>
<td>XE1ov</td>
</tr>
<tr>
<td>Child Referral-social services</td>
<td>64RA</td>
<td>XaBva</td>
</tr>
</tbody>
</table>

**Read Codes Regarding Risk Factors in Parents / Carers**

| Family history of substance misuse | 12X | XaMzo |
| Family history of alcohol misuse  | 12XO | XaN28 |
| Family history of psychiatric condition | ZV170 | ZV170 |
| History of domestic violence      | 14X3 | XaJhe |
| Family history of learning disability | 12W2 | XM1Je |

**Read Codes for the Records of Family/Household Members**

<p>| Family member on Child Protection Register | 13Ig | XaN2w |
| Family member removed from Protection Register | 13IP | 13IP |
| Vulnerable child in family                | 13IQ | 13IQ |
| Child Abuse in Family                     | 13W3 | 13W  |</p>
<table>
<thead>
<tr>
<th>Safeguarding Adult Codes</th>
<th>READ 2</th>
<th>READ 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult safeguarding concern</td>
<td>9Ngj</td>
<td>XaXP4</td>
</tr>
<tr>
<td>Adult no longer safeguarding concern</td>
<td>9Ngk</td>
<td>XaXP7</td>
</tr>
<tr>
<td>Referral to safeguarding adults team</td>
<td>8Hkc</td>
<td>XaQok</td>
</tr>
<tr>
<td>Referral to social services for Adult Protection</td>
<td>8HHg</td>
<td>XaKbU</td>
</tr>
<tr>
<td>Vulnerable adult</td>
<td>133P</td>
<td>XaKXXv</td>
</tr>
<tr>
<td>Learning disability</td>
<td>X00TL</td>
<td>Eu81z</td>
</tr>
<tr>
<td>Substance misuse</td>
<td>13cM</td>
<td>Xa1bX</td>
</tr>
<tr>
<td>H/O: Psychiatric Disorder</td>
<td>146</td>
<td>146</td>
</tr>
</tbody>
</table>

**Read Codes for the Records of Family/Household Members**

<table>
<thead>
<tr>
<th>Record Description</th>
<th>READ 2</th>
<th>READ 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family member on Protection Register</td>
<td>13IN</td>
<td>13IN</td>
</tr>
<tr>
<td>Family member removed from Protection Register</td>
<td>13IP</td>
<td>13IP</td>
</tr>
</tbody>
</table>

**Read Codes Related to Risk Factors in Carers**

<table>
<thead>
<tr>
<th>Risk Factor Description</th>
<th>READ 2</th>
<th>READ 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family history of substance misuse</td>
<td>12X</td>
<td>XaMzo</td>
</tr>
<tr>
<td>Family history of alcohol misuse</td>
<td>12XO</td>
<td>XaN28</td>
</tr>
<tr>
<td>Family history of psychiatric condition</td>
<td>ZV170</td>
<td>ZV170</td>
</tr>
<tr>
<td>History of domestic violence</td>
<td>14X3</td>
<td>XaJhe</td>
</tr>
<tr>
<td>Family history of learning disability</td>
<td>12W2</td>
<td>XM1Je</td>
</tr>
</tbody>
</table>