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**Sheerwater Health Centre**

Primary Care (GP) Safeguarding Adults and Children Policy

Version control sheet

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PRIMARY CARE (GP) SAFEGUARDING ADULTS & CHILDREN POLICY

*Sheerwater Health Centre*

August 2024

Contents

[1. Introduction and Policy Objective 4](#_Toc138332597)

[2. Legislative Framework / Core Standards 4](#_Toc138332598)

[3. Principles 6](#_Toc138332599)

[4. Scope 7](#_Toc138332600)

[5. Definitions 7](#_Toc138332601)

[6. Roles and Responsibilities 10](#_Toc138332602)

[7. Procedure 16](#_Toc138332603)

[8. Reporting concerns about the safety of a child or young person: Surrey 18](#_Toc138332604)

[9. Reporting concerns about the safety of a child or young person: Hampshire 20](#_Toc138332605)

[10. Reporting concerns about the safety of an adult at risk: Surrey 20](#_Toc138332606)

[11. Reporting concerns about the safety of an adult at risk: Hampshire 21](#_Toc138332607)

[12. Information sharing 24](#_Toc138332608)

[13. Recording Information 26](#_Toc138332609)

[14. Safeguarding Supervision 27](#_Toc138332610)

[15. Duty of Candour 28](#_Toc138332611)

[16. Managing Allegations 28](#_Toc138332612)

[17. Escalation Process 29](#_Toc138332613)

[18. Statutory Reviews 30](#_Toc138332614)

[19. Safeguarding Training 33](#_Toc138332615)

[20. Safer Recruitment 34](#_Toc138332616)

[21. Assurance and Governance 34](#_Toc138332617)

[22. Dissemination and Implementation of Policy 35](#_Toc138332618)

[23. Bibliography 36](#_Toc138332619)

[Appendix 1: Definitions 41](#_Toc138332620)

[Appendix 2: Local and National Safeguarding Issues for Children and Adults 51](#_Toc138332621)

[Appendix 3: ICB Safeguarding Team Contact Details 66](#_Toc138332622)

[Appendix 4: Managing Allegations against People who Work with Adults and Children 68](#_Toc138332623)

[Appendix 5: Rapid Review Process 70](#_Toc138332624)

[Appendix 6: Safeguarding Adult Review Process: 71](#_Toc138332625)

[Appendix 7: Child Death Review Process: 72](#_Toc138332626)

1. Introduction and Policy Objective

Safeguarding is central to the quality of care (NHS Outcomes Framework 2016/17) particularly:

* Domain 4: Ensuring people have a positive experience of care.
* Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.

Safeguarding is firmly embedded within the wider duties of all organisations across the health system. This policy represents the safeguarding responsibilities for Sheerwater Health Centre to ensure effective discharge of their duty to provide safe, high-quality care and support. All staff that come into contact with children and adults have a statutory duty to safeguard and promote their welfare; all staff should know what to do if they have any concerns.

All adults and children have the right to live lives free from abuse and neglect. Sheerwater Health Centre has particular responsibilities to safeguard the local population who may be unable to protect themselves from abuse or neglect.

Safeguarding is everyone’s responsibility. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the wellbeing, views, wishes and beliefs of adult’s children are promoted within safeguarding arrangements.

Trauma Informed Practice in Safeguarding recognises the prevalence of trauma in people’s lives and acknowledges the potential effects that this can have on individuals and their families, networks and communities. They are non-labelling, respectful and hopeful approaches that recognise people’s strengths and resilience and their potential for healing.

1. Legislative Framework / Core Standards

The corporate responsibilities for Safeguarding Children (including Looked After Children) are explicit and are predominantly informed by legislation and national directives. Sheerwater Health Centre is required to fulfil its legal duties under the Children Act 1989, Section 11 of the Children Act 2004 as amended by the Children and Social Work Act 2017 and The Care Act 2014.

The following key guidance and legislation informs how Sheerwater Health Centre will discharge its functions and duties to safeguard and promote the welfare of adults, children and looked after children and should be read in conjunction with [Surrey Safeguarding Children Partnership (SSCP) Procedures Manual](https://www.surreyscp.org.uk/professionals/sscp-procedures/) and [Surrey Safeguarding Adults Board (SSAB) Procedures Manual](https://www.surreysab.org.uk/information-for-professionals/ssab-policies-and-procedures/).

This policy sets out arrangements for safeguarding and promoting the welfare of our population within Surrey Heartlands ICB and Frimley ICB. It should be read in conjunction with the following:

**Policies and Procedures**

* Sheerwater Health Centre Complaints Policy
* Sheerwater Health Centre Consent Policy
* Sheerwater Health Centre Training Strategy
* Sheerwater Health Centre Raising concerns (Whistleblowing) Policy
* [Surrey Heartlands ICB Safeguarding Adult at Children Policy](https://www.surreyheartlands.org/policies-and-processes)
* [Frimley ICB Safeguarding Adult and Children Policy](https://www.frimleyccg.nhs.uk/policies-and-documents/corporate-policies/303-safeguarding-policy/file) [file (icb.nhs.uk)](https://www.frimley.icb.nhs.uk/policies-and-documents/corporate-policies/303-safeguarding-policy/file)
* [Surrey Safeguarding Children Partnership Procedures](https://surreyscb.procedures.org.uk/)
* [Surrey Safeguarding Adults Board Procedures](https://www.surreysab.org.uk/information-for-professionals/ssab-policies-and-procedures/) including Pressure Ulcer Protocol

**Children (including Looked after children)**

* [Children Act (1989)](https://www.legislation.gov.uk/ukpga/1989/41/contents)
* [Children Act (2004)](https://www.legislation.gov.uk/ukpga/2004/31/contents)
* [Children and Social Work Act (2017)](https://www.legislation.gov.uk/ukpga/2017/16/contents/enacted)
* [Care Act (2014)](https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted)
* [Working together to safeguard children 2023: statutory guidance (publishing.service.gov.uk)](https://assets.publishing.service.gov.uk/media/669e7501ab418ab055592a7b/Working_together_to_safeguard_children_2023.pdf)
* [Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework NHS (2022)](https://www.england.nhs.uk/publication/safeguarding-children-young-people-and-adults-at-risk-in-the-nhs-safeguarding-accountability-and-assurance-framework/)
* [Promoting the Health and Well-being of Looked After Children - statutory guidance (2015)](https://www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-looked-after-children--2)
* [Safeguarding children and young people: roles and competencies for health care staff, Intercollegiate document (2019)](https://www.rcn.org.uk/professional-development/publications/pub-007366)
* [Looked after children: Roles and competencies of health care staff Intercollegiate document (December 2020)](https://www.rcn.org.uk/professional-development/publications/rcn-looked-after-children-roles-and-competencies-of-healthcare-staff-uk-pub-009486)
* [Children and Families Act (2014)](https://www.legislation.gov.uk/ukpga/2014/6/contents/enacted)
* [Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers (2024)](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf)
* [Guide to the General Data Protection Regulation (GDPR)](https://ico.org.uk/media/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr-1-1.pdf), [Data protection information act how you information is used](https://www.gov.uk/data-protection) & [Data Protection Act (2018)](https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted)

**Adults**

* [Care Act 2014](https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted)
* [Care and Support Statutory Guidance (Chapter 14 – Safeguarding)](https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1)
* [Crime and Disorder Act 1998](https://www.legislation.gov.uk/ukpga/1998/37/contents)
* [Domestic Abuse Act 2021](https://www.legislation.gov.uk/ukpga/2021/17/contents)
* [Homelessness Reduction Act 2017](https://www.legislation.gov.uk/ukpga/2017/13/contents/enacted)
* [NHS Prevent Training and Competencies Framework (2022)](https://www.gov.uk/government/publications/nhs-prevent-training-and-competencies-framework/nhs-prevent-training-and-competencies-framework)
* [Mental Capacity Act (MCA) (2005)](https://www.legislation.gov.uk/ukpga/2005/9/contents)
* [Mental Capacity (Amendment) Act (2019)](https://www.legislation.gov.uk/ukpga/2019/18/enacted)
* [Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework NHS (2022)](https://www.england.nhs.uk/publication/safeguarding-children-young-people-and-adults-at-risk-in-the-nhs-safeguarding-accountability-and-assurance-framework/)
* [Adult Safeguarding: Roles and Competencies for Health Care Staff | Publications | Royal College of Nursing (rcn.org.uk)](https://www.rcn.org.uk/Professional-Development/publications/rcn-adult-safeguarding-roles-and-competencies-for-health-care-staff-011-256#:~:text=This%20updated%20document%20is%20designed,with%20education%20and%20training%20principles.)
* [Deprivation of Liberty Safeguards (2009)](https://www.gov.uk/government/collections/dh-mental-capacity-act-2005-deprivation-of-liberty-safeguards)

1. Principles

Effective safeguarding arrangements in every local area should be underpinned by the following key principles:

**Children (including Looked after children)**

* **Early Help/Continuum of Support/Family Safeguarding Model** recognises and promotes the importance of a whole-family approach
* **A co-ordinated approach - Safeguarding is everyone’s responsibility:** for services to be effective each professional and organisation should play their full part.
* **A child-centred approach to safeguarding:** Everyone should follow the principles of the Children Acts 1989 and 2004 as amended by the Children and Social Work Act 2017 - that state: *The child’s welfare and needs are paramount – A child centred approach means keeping the child in focus when making decisions about their lives and working in partnership with them and their families.* (Working Together to Safeguard Children, HM Government 2023).

**Adults**

* The Government has issued a policy statement on adult safeguarding which sets out six principles for safeguarding adults for use by statutory bodies, including health and other agencies for both developing and assessing the effectiveness of their local safeguarding arrangements. The principles represent best practice and provide a foundation for achieving good outcomes:
* Empowerment – presumption of person led decisions and consent.
* Protection – support and representation for those in greatest need.
* Prevention of harm or abuse.
* Proportionality and least intrusive response appropriate to the risk presented.
* Partnerships – local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
* Accountability and transparency in delivering safeguarding.

Sheerwater Health Centre will embrace the six principles of safeguarding as a thread of good practice running through all activities when discharging its duties at all levels of the organisation.

**Making Safeguarding Personal**

In addition to these principles, it is also important that all safeguarding partners take a broad community approach to establishing safeguarding arrangements. It is vital that all organisations recognise that adult safeguarding arrangements are there to protect individuals. We all have different preferences, histories, circumstances and lifestyles, so it is unhelpful to prescribe a process that must be followed whenever a concern is raised.

1. Scope

This policy aims to ensure that no act or omission by Sheerwater Health Centre puts a service user at risk; and that robust systems are in place to safeguard and promote the welfare of children and to protect adults at risk of harm.

This Policy is applicable to all staff and volunteers employed by or contracted to work for Sheerwater Health Centre (permanent and temporary) working in any location who may come into contact directly or indirectly with children and pregnant women and those working in settings whose main client / patient is an adult.

1. Definitions

The definition of safeguarding is necessarily broad as there is a wide range of risks of abuse or neglect that can result in harm to children and adults. Details of types of abuse can be found in **Appendix 1.** Details of Local and National Safeguarding Issues for Children and Adults are outlined in **Appendix 2**.

**Children (including Looked after children)**

For the purpose of this policy a child (including the unborn) is defined as anyone who has not yet reached their 18th birthday. ‘Children’ therefore means ‘children and looked after children’ throughout.

Safeguarding and promoting the welfare of children is defined as:

* Protecting children from maltreatment, whether that is within or outside the home, including online
* Preventing impairment of children’s mental and physical health or development
* Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and
* Taking action to enable all children to have the best outcomes in line with the outcomes set out in the Children’s Social care National Framework
  + 1. Looked After Children

In England and Wales, the term ‘looked after children’ is defined in law under the Children Act 1989. A child is looked after by a local authority if he or she is in their care or is provided with accommodation for more than 24 hours by the authority. Looked after children fall into four main groups:

* Children who are accommodated under voluntary agreement with their parents (section 20)
* Children who are the subject of a care order (section 31) or interim care order (section 38)
* Children who are the subject of emergency orders for their protection (section 44 and 46)
* Children who are compulsorily accommodated. This includes children remanded to the local authority or subject to a criminal justice supervision order with a residence requirement (section 21).

The term ‘looked after children’ includes unaccompanied asylum-seeking children, children in friends and family placements, and those children where the agency has authority to place the child for adoption. It does not include those children who have been permanently adopted or who are on a special guardianship order.

* 1. **Transitional Safeguarding** (Young people aged 14 – 25 years)
     1. Transitional Safeguarding describes the need for a seamless journey from adolescents into young adulthood through the collaboration of partners, having an emphasis on the resilience of developmental needs rather than solely focusing on physical care and support needs. This requires a holistic safeguarding approach, which should be person-led and outcome focused ensuring young people have control of what their future looks like.
     2. Transitional safeguarding is not a model or a framework. It is a systems and provider level change of culture in how we safeguard our young people more fluidly and effectively, understanding the individual’s safeguarding vulnerabilities and needs as our young people journey into adulthood. In health we need to consider vulnerability and the lived experience of our patients and how Transitional Safeguarding can be used effectively.

**Adults**

* + 1. For the purpose of this Policy an ‘adult’ is defined as a person who is aged 18 or over.
    2. Adult Safeguarding is about protecting a person’s right to live in safety, free from abuse and neglect. It is the promotion of the welfare of individuals and refers to the activity that is undertaken to protect specific adults who are at risk of harm or abuse as described in the Care Act 2014, which came into effect in April 2015, and which may affect an individual at different times during their lives.
    3. An adult at risk (previously referred to as a vulnerable adult), is defined as an adult who:
* Has needs for care and support (whether or not the local authority is meeting any of those needs); and
* Is experiencing, or at risk of, abuse or neglect; and
* As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse and neglect” (Care Act 2014)
  + 1. An adult at risk may be a person who:
* Is frail due to age, ill health, physical disability or cognitive impairment, or a combination of these,
* Has a learning disability,
* has a physical disability, a sensory impairment and/or speech, language and communication needs,
* Has mental health needs including dementia or a personality disorder,
* Has a long-term illness/condition,
* Misuses substances or alcohol.
  + 1. Neglect and abuse may occur within individuals’ homes and communities. Neglect and abuse may also occur through care provided by regulated health and social care services.

**Carers**

* + 1. Circumstances in which a carer such as a family member or friend could be involved in a situation that may require safeguarding concerns to be raised include:
* A carer may witness or speak up about abuse or neglect,
* A carer may experience intentional or unintentional harm from the adult they are supporting or from professionals and organisations they are in contact with or,
* A carer may unintentionally or intentionally neglect or abuse the adult they support on their own or with others. ([Care and Support Statutory Guidance 2023: Section 14:45](https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance))
  + 1. The wellbeing of both carers and the adult they care for must be considered and included in assessments. A carer’s assessment or joint assessment provides the opportunity to look at the circumstances and establish if it is possible to provide information or support that prevents abuse or neglect occurring. For example, this could be through training or support for carers. Risk factors and change in circumstances should also be considered when looking at whether the likelihood of abuse and neglect is increased.
    2. It is important to listen if carers raise concerns about abuse or neglect and, as appropriate, carers should be involved in safeguarding enquiries for the people they care for.

1. Roles and Responsibilities

Section 11 of the Children Act 2004 and the Care Act 2014 places a duty on NHS organisations/providers to make arrangements to ensure that they have regard to the need to safeguard and promote the welfare of children and adults at risk. All staff share responsibility for safeguarding and promoting the welfare of children and adults at risk, irrespective of individual roles. All who come into contact with children and adults at risk have a duty to safeguard and promote their welfare and should know what to do if they have any concerns. Sheerwater Health Centre ensures services are in place to respond to children and adults at risk or who have been harmed and delivering improved outcomes and life chances for the most vulnerable.

**Children**

* + 1. Sheerwater Health Centre has a duty to ensure the following:
* A clear line of accountability for the provision of services designed to safeguard and promote the welfare of children.
* A designated safeguarding lead with the required knowledge, skills and expertise or sufficiently qualified and experienced to take leadership responsibility for Sheerwater Health Centre’s safeguarding arrangements. Their role is to support other professionals/staff in Sheerwater Health Centre to recognise the needs of children, including responding to possible abuse or neglect.
* A culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services.
* Arrangements which set out clearly the processes for sharing information, with other professionals and with the Surrey Safeguarding Children Partnership (SSCP).
* Safe recruitment practices and ongoing safe working practices for individuals whom the organisation or agency permit to work regularly with children, including policies on when to obtain a criminal record check.
* Appropriate Safeguarding supervision and support for staff, including undertaking safeguarding training.
* Employers are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role.
* Staff should be given a mandatory induction, which includes familiarisation with child protection responsibilities and procedures to be followed if anyone has any concerns about a child’s safety or welfare; and
* All professionals should have regular reviews of their own practice to ensure they improve over time.
* Clear whistleblowing procedures, which reflect the principles in Sir Robert Francis’ Freedom to Speak Up Review and are suitably referenced in staff training and codes of conduct, and a culture that enables issues about safeguarding and promoting the welfare of children to be addressed.
* Clear escalation policies for staff to follow when their child safeguarding concerns are not being addressed within their organisation or by other agencies.
* Creating a culture of safety, equality and protection within the services they provide.
* Clear policies in line with those from the SSCP for dealing with allegations against people who work with children. An allegation may relate to a person who works with children who has:
* Behaved in a way that has harmed a child, or may have harmed a child,
* Possibly committed a criminal offence against or related to a child; or
* Behaved towards a child or children in a way that indicates they may pose a risk of harm to children.
  + 1. In addition:
* County level and unitary local authorities should have a Local Authority Designated Officer (LADO) to be involved in the management and oversight of individual cases. The LADO should provide advice and guidance to employers and voluntary organisations, liaising with the police and other agencies and monitoring the progress of cases to ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process. See [Dealing with Allegations against People Working with Children - Surrey Safeguarding Children Partnership (surreyscp.org.uk)](https://www.surreyscp.org.uk/professionals/dealing-with-allegations-against-people-working-with-children/)
* Any allegation should be reported immediately to a senior manager within the organisation. The LADO should also be informed within one working day of all allegations that come to an employer’s attention or that are made directly to the police and
* If an organisation removes an individual (paid worker or unpaid volunteer) from work such as looking after children (or would have, had the person not left first) because the person poses a risk of harm to children, the organisation must make a referral to the [Disclosure and Barring Service.](https://www.gov.uk/guidance/barring-referrals)
* A bi-annual ICB Primary Care Safeguarding audit of Sheerwater Health Centre’s safeguarding arrangements and responsibilities is undertaken by the ICB Designated professionals.

**Adults**

* + 1. Under the **Care Act 2014,** the lead for adult safeguarding is the Local Authority, with a multi-agency approach, whereby health services are required to investigate and act to prevent harm.
    2. The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life. People have complex lives and being safe is only one of the things they want for themselves.
    3. Sheerwater Health Centre is also required to demonstrate that they have appropriate systems in place for discharging their statutory duties in terms of safeguarding.

**The Practice Lead for Safeguarding Children**

* + 1. The Practice Lead for Safeguarding Children is responsible for ensuring that they are fully conversant with the practice safeguarding adults and children policy, the policies and procedures of SSCP and the integrated processes that support safeguarding.

The responsibilities of the Practice Lead for Safeguarding Children are:

* Facilitating training opportunities for staff groups.
* Acting as a focus for external contacts on safeguarding children matters; this may include requests to contribute to sharing information required for Child Safeguarding Practice Reviews (CSPRs), Child Death Reviews (CDRs) and multi-agency/Individual Management Reviews (IMRs). Section 17 and 47 Enquiries are generally the responsibility of the child’s usual GP.
* Disseminating information in relation to safeguarding children to all practice members.
* Act as a point of contact for practice members to bring any concerns that they have, to document those concerns and to take any necessary action to address concerns raised.
* Supporting colleagues in their assessment of information received on safeguarding concerns. Such assessments to be undertaken promptly and carefully, clarifying or obtaining more information about the matter as appropriate, with the practice lead having professional oversight and input as required.
* Facilitate access to support and supervision for staff working with children and families.
* Ensure that the practice team completes the practice’s agreed incident forms and analysis of significant events forms which are available on internal practice website.
* Is required to contribute to CSPRs and Child Death Reviews or to ensure input by the most appropriate member of the clinical team.
* Will provide support to colleagues in their responses to and reports for Local Authority Section 47 and Section 42 enquiries.
* Will disseminate and develop action plans to ensure lessons learnt are embedded in best practice following publication of Child Safeguarding Practice Reviews and Child Death Reviews.
* Supporting and facilitating practice participation in audit.

The practice lead for safeguarding children is Dr Aaliya Mohamed

The practice lead for safeguarding adults is Dr Aaliya Mohamed

The deputy practice lead for safeguarding children is (if applicable) **……….**

The deputy practice lead for safeguarding adults is (if applicable) **…………**

The Practice Manager

* + 1. The Practice Manager is responsible for ensuring that safeguarding responsibilities are clearly defined in all job descriptions. For employees of the practice, failure to adhere to this policy and procedures could lead to action under the disciplinary policy. The practice manager is also responsible for ensuring that Sheerwater Health Centre has clear safer recruitment and whistleblowing policies, and that these are adhered to.

Partners

* + 1. Partners are responsible for ensuring that:
* Safeguarding children, adults and looked after children is integral to clinical governance and audit arrangements.
* The practice meets the contractual and clinical governance arrangements on safeguarding children, adults and looked after children.
* All practice staff are alert to the potential indicators of abuse or neglect and know how to act on those concerns in line with local guidance.

**General Practitioners (GPs) and those working in equivalent clinical roles.**

* + 1. GPs have an important role to play in safeguarding and promoting the welfare of children and adults at risk. Identification of abuse has been likened to putting together a complex multi-dimensional jigsaw. GPs hold knowledge of family circumstances and can interpret multiple observations accurately recorded over time and may be the only professionals holding vital pieces necessary to complete the picture. The General Medical Councils (GMC) [‘Good medical practice code’ (2013 updated 2019)](https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice) stresses the need for doctors to protect patients and take prompt action if “patient safety dignity or comfort is or may be seriously compromised”.

**Practice nurses**

* + 1. Practice nurses must ensure that Safeguarding is part of everyday nursing practice. [The Nursing and Midwifery Council’s (NMC) Code of Conduct](https://www.nmc.org.uk/standards/code/) states that Nurses should raise concerns immediately if they believe a person is vulnerable or at risk and needs extra support and protection. The Code states that Nurses must:
* Take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse.
* Share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information.
* Have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people.

**All staff members and volunteers**

* + 1. Staff members, including partners, employed staff and volunteers have an individual responsibility to:
* Be alert to the potential indicators of child/adult abuse or neglect and know how to act on those concerns in line with national guidance and the safeguarding child and adult procedures.
* Be aware of and know how to access SSCP and SSAB policies and procedures.
* Take part in training, including attending regular updates to maintain their skills and are familiar with procedures aimed at safeguarding adults and children.
* Understand the principles of confidentiality and information sharing in line with local and government guidance.
* Contribute, when requested to do so, to the multi-agency meetings established to safeguard and protect vulnerable children and adults.

**Surrey Wide ICB Safeguarding Team**

* + 1. Designated and Named Nurses and Doctors are in post as required by legislation and statutory guidance to offer professional safeguarding expertise and advice across the health economy including the following:
* Provide advice to ensure the range of services commissioned by the ICB takes account of the need to safeguard and promote the welfare of children and adults at risk.
* Provide advice on the monitoring of the safeguarding aspects of ICB contracts.
* Provide advice, support and trauma informed safeguarding supervision to the named and lead professionals in each provider organisation.
* Provide skilled advice to the SSCP and SSAB on health issues.
* Play an important role in promoting, influencing and developing relevant training, on both a single and inter-agency basis, to ensure the training needs to health staff are addressed.
* Provide skilled professional involvement in child and adult safeguarding processes in line with SSCP and SSAB procedures.
* Review and evaluate the practice and learning from all involved health professionals and providers commissioned by the ICB, as part of Child Safeguarding Practice Reviews, DHRs / DARDRs, SARs and https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance
* Inform the SSCP and SSAB of any relevant https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance where social care has not been involved.
* In line with CQC requirements, it is the responsibility of practice staff to know who their designates are to receive calls from Surrey Heartlands ICB Safeguarding team designates and share information with them as appropriate.

Contact details for the Surrey county-wide ICB Safeguarding team are in **Appendix 3**

1. Procedure

All staff and volunteers, whatever the setting, have a key role in preventing abuse or neglect occurring and in taking action when concerns arise. Findings from Local Child Safeguarding Practice Reviews (LSCPRs), previously Serious Case Reviews, and Safeguarding Adults Reviews (SARs) have sometimes stated that if professionals or other staff had acted upon their concerns or sought more information, then death or serious harm might have been prevented.

Where an adult at risk or child is experiencing, or at risk of being abused, neglected or where an adult may be being harmed by others usually in a position of trust, power or authority, this must always be reported immediately. The concern may arise from:

* A direct disclosure by the adult or child,
* A concern raised by staff or volunteers, others using the service, a carer or a member of the public,
* An observation of the behaviour of the adult or child, of the behaviour of another person(s) towards the adult at risk or child, or of one adult towards another.

If you think that someone you know, adult or child, is being abused or is at risk of abuse you should inform the Sheerwater Health Centre Safeguarding Lead and/or deputy lead (or another senior clinician if the safeguarding lead or deputy is not available) who are responsible for advising on concerns of abuse withinSheerwater Health Centre.

It is not for staff or volunteers to second-guess the outcome of an enquiry in deciding whether or not to share their concerns.

All Sheerwater Health Centre staff **MUST** adhere to this policy in conjunction with SSAB Procedures information and guidance, and SSCP Procedures Manual, accessible via the following links:

* Surrey Safeguarding Children Partnership Procedures <https://surreyscb.procedures.org.uk/>
* [Surrey Safeguarding adults multi agency procedures, information and guidance](https://www.surreycc.gov.uk/social-care-and-health/safeguarding-boards/surrey-safeguarding-adults-board/surrey-safeguarding-adults-board-information-for-professionals/surrey-safeguarding-adults-multi-agency-procedures-information-and-guidance) <https://www.surreysab.org.uk/information-for-professionals/ssab-policies-and-procedures/>

The Surrey CSPA (Children’s single point of access) is the single point of contact for reporting concerns about the safety of a child or young person. The Surrey MASH (Multi agency safeguarding hub) is the single point of contact for reporting concerns about the safety of an adult at risk. Both aim to improve the safeguarding response for children and adults at risk of abuse or neglect through better information sharing and high-quality and timely responses.

When an adult or child makes a disclosure, it is important to reassure the adult at risk or child that the information will be taken seriously. It is good practice to ensure that the adult or child is given information about what steps will be taken, including any emergency action to address their immediate safety or well-being.

The human rights and views of the adult or child should be considered as a priority, with opportunities for their involvement in the safeguarding process to be sought in ensuring that the safeguarding process is person centred.

If an adult or child in need of protection or any other person makes an allegation to you asking that you keep it confidential, you should inform the person that you will respect their right to confidentiality as far as you are able to, but that you are not able to keep the matter secret and that you may need to inform other professionals. This may include your manager / safeguarding lead within the practice, the Surrey-wide ICB safeguarding team, and the Local Authority safeguarding team.

If it is suspected that a crime could have been committed, it is important that you do not contact the person alleged to have caused harm or anyone that might be in touch with them. Contact the police 999 in an emergency or 101 for non-emergencies. Ensure that steps are taken to preserve any forensic evidence as advised by the police.

The disclosed information must be recorded in the health records in the way that the adult or child describes the events.

Where patients are mentally competent, they should be included in any decision about disclosure of their information to a third party, such as the Local Authority. If abuse is suspected, considerate discussions must take place with the patient. Patients often disclose matters to their doctor / nurse in the expectation that their information will be kept confidential and maintaining confidentiality can form the basis of valuable trust and support.

Ideally, the patient will give their consent before any of their personal information is disclosed to a third party. There are however some circumstances when disclosure is in the public interest, and this may outweigh the potential harm of breaching confidentiality. This can occur when there is a risk of a serious crime or serious harm. When a child consents but the parent doesn’t, a decision would need to be made in the best interests of the child.

The GMC advises that: “*Personal information may… be disclosed in the public interest, without patients’ consent, and in exceptional cases where patients have withheld consent, if the benefits to an individual or to society of the disclosure outweigh both the public and the patient’s interest in keeping the information confidential. You must weigh the harms that are likely to arise from non-disclosure of information against the possible harm both to the patient, and to the overall trust between doctors and patients, arising from the release of that information.”*

If any member of the Practice team is unsure how to proceed or is in doubt about raising a concern, the case can be discussed with a senior colleague / line manager, Safeguarding Practice lead, Designated GP or Named GP Safeguarding or a member of the Safeguarding team. **See Appendix 3** for details of Surrey wide ICB Safeguarding Team.

1. Reporting concerns about the safety of a child or young person: Surrey

**Surrey Children’s Single Point of Access (CSPA)** is the single point of contact for reporting concerns about the safety of a child or young person. It aims to improve the safeguarding response for children at risk of abuse or neglect through better information sharing and high-quality and timely responses. It achieves this by co-locating agencies. It brings together Surrey County Council children’s social care workers, early help services, health workers and police as well as a vast array of virtual partners across Surrey. Its aim is to identify need, risk and harm accurately to allow timely and the most appropriate intervention.

* The CSPA acts as the front door to children's services in Surrey. It is the conduit for access to services using the Continuum of Support for children and families living in Surrey [4.2 Continuum of Support for children and families living in Surrey | Surrey Safeguarding Children Partnership (procedures.org.uk)](https://surreyscb.procedures.org.uk/zkyqqt/managing-individual-cases/continuum-of-support-for-children-and-families-living-in-surrey)
* It provides residents and people who work with children in Surrey with direct information, advice and guidance about where and how to find the appropriate support for children and families.
* The CSPA operates Monday to Friday from 9am to 5pm.
* **Surrey children’s services request for support form** can be accessed via the link: <https://www.surreyscp.org.uk/professionals/resources-for-professionals/multi-agency-safeguarding-forms/>
* **Phone number:** 0300 470 9100
* **Email:** [cspa@surreycc.gov.uk](mailto:cspa@surreycc.gov.uk)

**Out of hours Emergency Duty Team (Children)**

* **Tel:** 01483 517898
* **SMS number:** 07800000388 (for deaf and hard of hearing callers online)
* **Email:** [edt.ssd@surreycc.gov.uk](mailto:edt.ssd@surreycc.gov.uk)

**Reporting concerns about the safety of a child or looked after children flowchart: Surrey Children’s services**

**Surrey Police**

You can contact the police using the non-emergency number, 101, or in an emergency where the safety of a child or adult is at immediate risk, dial 999

**Continuum of Support diagram.**

A diagram of children and adults

Description automatically generated

1. Reporting concerns about the safety of a child or young person: Hampshire

Professionals should complete the [New Inter-Agency Referral Form (IARF) - Hampshire SCP](https://www.hampshirescp.org.uk/new-inter-agency-referral-form-iarf/) for all social care referrals, information shares/requests and updates. We no longer accept these by email.

If you are enquiring about the Homes for Ukraine, please email: [childrens.services@hants.gov.uk](mailto:childrens.services@hants.gov.uk)

If it is an emergency and a child is in immediate danger, call 999

**Reporting concerns and general guidance**

* reporting concerns for child welfare
* general education enquiries
* finding childcare
* sources of help and support
* adoption and fostering
* children with special needs

Phone 0300 555 1384

Monday to Thursday 8.30am to 5pm

Friday 8.30am to 4.30pm

Email [childrens.services@hants.gov.uk](mailto:childrens.services@hants.gov.uk)

Please note: Emails are dealt with during normal office hours Monday to Friday, 9am to 5pm. At other times phone our out of hours number.

**Out of hours**

Out of hours contact telephone number for Hampshire Children's Services

Phone 0300 555 1373

Please note – in an emergency call 999

1. Reporting concerns about the safety of an adult at risk: Surrey

**The Surrey Multi-Agency Safeguarding Hub (MASH)** is the single point of contact for reporting concerns about the safety of an adult at risk.

* It aims to improve the safeguarding response for adults at risk of abuse or neglect through better information sharing and high-quality and timely responses.
* The Surrey MASH achieves this by co-locating agencies. It brings together Surrey County Council social care workers adults, early help services, health workers and police as well as a vast array of virtual partners across Surrey. Its aim is to identify need, risk and harm accurately to allow timely and the most appropriate intervention.
* During office hours, contact the Multi Agency Safeguarding Hub (MASH)
* **Tel:** 0300 470 9100
* **Email:** [ascmash@surreycc.gov.uk](mailto:ascmash@surreycc.gov.uk)
* Or complete the [MASH Referral Form](https://www.surreysab.org.uk/concerned-about-an-adult/) and email to Adults MASH

**Out of hours Adult Social Care Emergency duty team**

* **Tel:** 01483 517898
* **Fax:** 01483 517895
* **SMS number**: 07800000388 (for deaf and hard of hearing callers online)
* **Email:** [edt.ssd@surreycc.gov.uk](mailto:edt.ssd@surreycc.gov.uk)

**Surrey Police**

* You can contact the police using the non-emergency number, 101, or in an emergency where the safety of a child, looked after child or adult is at immediate risk, dial 999.

1. Reporting concerns about the safety of an adult at risk: Hampshire

If you are concerned that you or another adult is being neglected, harmed, or abused in any way, please do not ignore it. Any suspicion of abuse or neglect should be reported to Hampshire County Council Adults’ Health and Care.

**If you or someone else is in imminent danger, phone the police on 999, or call them on 101 if it is less urgent.**

**If your request is urgent and you need support in the next 24 hours contact Adult Services:**

* Please be aware, at busy times, there may be a wait for your call to be answered.
* Tel:0300 555 1386

**Monday to Thursday 8.30am to 5pm**

**Friday 8.30am to 4.30pm**

**Out of hours:**

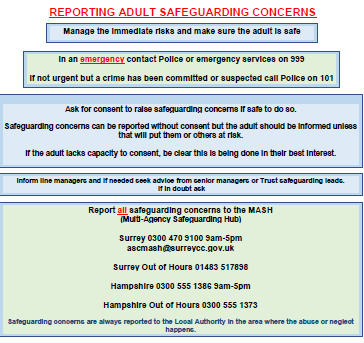
* Tel: 0300 555 1373

**Monday to Thursday 5pm to 8.30am**

**Friday 4.30pm to Monday 8.30am**

All day on Bank Holidays

* [**Online form**](https://www.hants.gov.uk/socialcareandhealth/adultsocialcare/contact/professional-referral)

**Reporting concerns about the safety of an adult at risk flowchart (Surrey and Hampshire)**

If you are concerned that you have not been believed or taken seriously refer to Sheerwater health Centre Raising concerns (Whistleblowing) Policy or:

* Surrey Safeguarding Children Partnership Interagency Escalation Policy and procedure accessible at; <https://www.surreyscp.org.uk/resources-category/escalation/>
* Surrey Safeguarding Adults Board Interagency Escalation Policy and Procedure at: <https://www.surreysab.org.uk/information-for-professionals/ssab-policies-and-procedures/>
* Hampshire Safeguarding Children Partnership Escalation Policy for the Resolution of Professional disagreement at: [Escalation Policy for the Resolution of Professional disagreement](https://hipsprocedures.org.uk/skyyty/safeguarding-partnerships-and-organisational-responsibilities/escalation-policy-for-the-resolution-of-professional-disagreement)
* Hampshire Safeguarding Adults Board Multi-agency escalation protocol at : [4LSAB Multi-Agency Safeguarding Adults Escalation Protocol June 2023 (hampshiresab.org.uk)](https://www.hampshiresab.org.uk/wp-content/uploads/4LSAB-Multi-Agency-Escalation-Protocol-June-2023.pdf)

**Mental Capacity Act 2005 (MCA)**

**Adults who lack capacity**

* + 1. The Mental Capacity Act 2005 (MCA) provides a statutory framework which empowers and protects people aged 16 or over, who may lack capacity to make decisions for themselves. The MCA clearly states that there is a presumption of mental capacity unless an assessment of capacity shows otherwise. Adults who have capacity have the right to make their own decisions irrespective of how unwise that may appear to others. However, staff will need to be aware of the safeguarding implications around MCA and how this relate to situations where the person may lack capacity, and be unable to protect themselves, therefore, at risk of harm and abuse.
    2. Sheerwater Health Centre Staff must ensure that any systems and processes in place demonstrate that the rights of people who lack capacity are protected and there is evidence of an MCA assessment completed and any care implemented should be in the person’s best interest. Therefore, under the MCA decisions will need to be made on the person’s behalf if they lack capacity.

**The Deprivation of Liberty Safeguards (2009) (DoLS)**

* + 1. DoLS was introduced to protect a person who refuses care and treatment and has been deemed to lack capacity under the MCA. Therefore,Sheerwater Health Centre staff will need to be aware that these provisions require a more detailed assessment, to determine if the person meets the criteria for a Deprivation of Liberty Safeguard (DoLS) authorisation. The DoLS authorisation will require more restrictive interventions to be implemented to protect the person. However, prior to doing this, the rights of the person need to be protected and any restrictive treatment deemed to be in their best interest should demonstrate that the least restrictive options were considered first before applying for a DoLS authorisation.
    2. Mental Capacity (amendment) Act (2019) introduces reform to the process for authorising arrangements which enable people, who lack capacity to consent, to be deprived of their liberty for the purpose of delivering their care or treatment. Deprivation of Liberty Safeguards (DoLS) will be replaced by Liberty Protection Safeguards (LPS) but implementation of LPS has been postponed until the next parliament. It is anticipated that DoLs will run alongside LPS for the 1st year to support transition. A revised MCA Code of Practice will be published. Additional Guidance on **Mental Capacity Act** and the **Deprivation of Liberty Safeguards** is available on the Surrey County Council website, details of which can be accessed via the following links:

1. https://www.surreycc.gov.uk/adults/professionals/information-and-resources/social-care-legislation/mental-capacity-act/deprivation-of-liberty-safeguards
2. <https://www.surreycc.gov.uk/adults/professionals/information-and-resources/social-care-legislation/mental-capacity-act/submission-of-dols-forms>
3. Information sharing

Robust information sharing is at the heart of safe and effective safeguarding practice. Information sharing is covered by legislation principally the General Data Protection Act 2018 (GDPR) and the Data Protection Act 2018 (DPA).

Practitioners must have due regard to the relevant data protection principles which allow them to share personal information, The GDPR and Data Protection Act 2018 place greater significance on organisations being transparent and accountable in relation to their use of data. All organisations handling personal data need to have comprehensive and proportionate arrangements for collecting, storing, and sharing information.

Where there are safeguarding concerns, staff have a duty to share information. It is important to remember that in most serious case reviews, lack of information sharing can be a significant contributor when things go wrong. Information should be shared with consent wherever possible. A person’s right to confidentiality is not absolute and may be overridden where there is evidence that sharing information is necessary to support an investigation or where there is a risk to others e.g. in the interests of public safety, police investigation, implications for regulated service. Guidance from the Government, Information sharing advice for safeguarding practitioners, describes key principles for deciding what to share, the ‘seven golden rules for information sharing’:

* Remember that the Data Protection Act is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately.
* Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
* Seek advice if you are in any doubt, without disclosing the identity of the person where possible.
* Where possible share with consent and, where possible, respect the wishes of those who do not consent to having their information shared. Under the GDPR and Data Protection Act (2018) you may share information without consent if, in your judgement, there is a lawful reason to do so, such as where safety may be at risk. You will need to base your judgment on the facts of the case. When you are sharing or requesting personal information from someone, be clear of the basis upon which you are doing so. Where you do not have consent, be mindful that an individual might not expect information to be shared.
* Consider safety and well-being: Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.
* Sharing should be necessary, proportionate, relevant, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up to date, is shared in a timely fashion, and is shared securely.
* Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose Any information disclosed should be:
* clear regarding the nature of the problem and the purpose of sharing information
* based on fact, not assumption
* restricted to those with a legitimate need to know
* relevant to specific incidents
* strictly limited to the needs of the situation at that time
* recorded in writing with reasons stated
  1. Ideally consent should be provided along with the request for child health information however there are times when the concerns / risks to the child are such that it is not appropriate to seek consent, principally as this may increase the risk of further abuse. A lack of consent should not prevent a GP or other practitioner within the Practice from sharing information if there is sufficient need in the public interest to override the lack of consent. Where the practitioner is uncertain advice about consent is available from their Practice Lead, the Surrey-wide ICB safeguarding team, Surrey Local Authority, the GMC, NMC, LMC or medical and nursing defence organisations. GMC, national and local protocols can be found via the following links:

1. [Confidentiality Policy (proceduresonline.com)](https://www.proceduresonline.com/surrey/cs/p_confid_pol.html?zoom_highlight=information+sharing)
2. [GMC children and young people, confidentiality and information sharing](https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/protecting-children-and-young-people/confidentiality-and-sharing-information)

**Sharing data when someone lacks mental capacity**

* Can the individual give consent to disclosure of information?
* You have a responsibility to explore approaches to help them understand
* In some instances, the individual will not have the capacity to consent to disclosure of personal information relating to them. Where this is the case any disclosure of information needs to be considered against the conditions set out in the GDPR and DPA and a decision made about whether it is in their best interests to be shared.
* [Information sharing advice for safeguarding practitioners: May 2024](https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice)

1. Recording Information

Where there are concerns about an adult’s or child’s welfare, discussions and decisions made and the reasons for those decisions must be recorded in writing in the person’s medical records.

Sheerwater Health Centre ensures that computer systems are used to identify those patients and families with risk factors or concerns using locally agreed Read Codes.

In 2023, the nationally approved list of safeguarding Snomed codes was unified and updated to ensure consistency and accuracy across general practice. These new codes are attached here.



Snomed code lists are contained in Tool 3 of RCGP and NSPCC safeguarding children toolkit for general practice, but as of July 2023, this document has not been amended to reflect the updated list.

[RCGP / NSPCC safeguarding children toolkit for general practice](https://elearning.rcgp.org.uk/mod/book/view.php?id=12531)

It is recognised that it is as important to be alert to other children and members of the household as the child there are direct concerns about.

Sheerwater Health Centre has an Administration Team who are responsible for the handling of Safeguarding information/correspondence ensuring this is held within the electronic medical record.

Sheerwater Health Centre has a robust and secure system for recording and acting upon correspondence from external agencies such as secondary and social care. For example:

* Procedures for receiving in and handling information requests including Section 17 and Section 47 requests and Case Conference invitations and reports both initial and review.
* Procedures for receiving in, acting upon, filing and storage of Child Protection information such as Case Conference reports.

The Surrey Countywide Safeguarding Team Safeguarding Children’s Information Sharing Requests document 2018 provides further guidance to practices regarding sharing information with outside agencies. See embedded document below:



1. Safeguarding Supervision

Supervision is a process of professional support, peer support, peer review and learning, enabling staff to develop competencies, and to assume responsibility for their own practice. The purpose of clinical governance and supervision within safeguarding practice is to strengthen the protection of children and adults by actively promoting a safe standard and excellence of practice and preventing further poor practice. Trauma informed safeguarding supervision supports, assures and develops the knowledge, skills and values of an individual worker and provides accountability for decision-making. The trauma informed supervision model incorporates many of the same elements as the practice model that we are asking practitioners to implement with the adoption of trauma-informed care. High quality supervision is the cornerstone of effective working with all children and adults; informal supervision is available to Sheerwater Health Centre staff by the Designated and Named professionals. Formal group supervision sessions are offered to Sheerwater Health Centre safeguarding lead/s by the designated and named GPs for safeguarding.

1. Duty of Candour
   * 1. The Care Act 2014 sets out that the CQC registration requirement places a duty on providers to be open with patients and their families about failings in their care. Sheerwater Health Centre will ensure that all services provided by them promote dignity in care and adhere to local multiagency safeguarding policies and procedures.
     2. The Duty of Candour requires all health and adult social care providers registered with the Care Quality Commission (CQC) to be open with people when things go wrong. The regulations impose a specific and detailed duty on all providers where any harm to a service user from their care or treatment is above a certain harm threshold. The Duty of Candour is a legal requirement and CQC will be able to take enforcement action when it finds breaches. Details can be accessed at:

* [Duty of candour - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/nhs-screening-programmes-duty-of-candour/duty-of-candour)

1. Managing Allegations

Managing allegations against people who work with children and adults is a requirement of *Working Together to Safeguard Children* (2023) *(children)* and The Care Act 2014 *(adults)*

The procedure for managing allegations against people who work with children and adults at risk applies to a wider range of allegations than those in which there is reasonable cause to believe a child or adult at risk is suffering, or likely to suffer, significant harm. They also apply in cases where allegations indicate someone is unsuitable to continue to work or volunteer with children and adults at risk in his/her present position, or in any capacity.

The procedures for managing allegations should be read in conjunction with relevant policies of SSCP and SSAB. In particular, Sheerwater Health Centre practice manager and/or safeguarding lead will be responsible for ensuring consistency with Sheerwater Health Centre Disciplinary and Capability Policy and where appropriate will support the partners and other managers.

SSAB, Dealing with Allegations in the workplace is available at:

* <https://www.surreysab.org.uk/wp-content/uploads/2021/02/SSAB-Policy-and-Procedure-2018-FINAL-v4.0-agreed-on-240518-updated-14.09.2020-accessibility-1.pdf>

SSCP, Dealing with Allegations Against People Who Work with Children is available at:

* <https://www.surreyscp.org.uk/professionals/dealing-with-allegations-against-people-working-with-children/>

These procedures are complementary to, and do not replace any Sheerwater Health Centre policies and procedures in relation to governance and risk. Where appropriate, adverse incidents and Patient Safety Incident Response Framework (PSIRF) reporting will take place in accordance with policy.

In relation to adults and children, Sheerwater Health Centre has designated Nine Taylor as the Senior Manager to whom allegations or concerns about employees and contractors can be raised.

See also **Appendix 4**

1. Escalation Process

Effective working together depends upon an open approach and honest relationships between agencies and a belief in genuine partnership working. Any disputes about the safety and well-being of a child or adult at risk should be resolved in a timely way with all agencies working together in the best interests of the child or adult so that the welfare of the child or adult remains paramount.

SSCP and SSAB recognise that complexity of need and range of intervention/support will not always fit into a simple formula that leads to *‘the right solution’.* Often there may be no right or wrong answer and quite legitimately practitioners may exercise their professional judgement differently. It is also the case that exceptionally, the needs of some children, families and adults at risk may not easily fit within a conventional application of thresholds. The purpose of the SSCP and SSAB Escalation Process is to create a transparent process that enables multi-agency practitioners to exercise their professional judgement and provide the best possible service in a timely and safe way.

It is of vital importance that children, their families and adults at risk do not become entangled in professional disagreements. Neither should disputes detract from the focus on the child/adult at risk, delay effective decision making, nor lead to protracted disputes that negatively impact upon the child/adult at risk and/or family andon inter-agency relationships and working practice. In reaching resolution, it is essential that, at all times, disputes are approached in a considerate manner and one which both respects and seeks to understand the views and concerns of others from their experience and perspective when engaging with the child/young person/adult at risk/family.

Disagreements should be resolved through child/adult at risk centred discussion between agencies.

SSCP escalation procedure outlines the process to be followed when professionals are unable to agree about what is in the best interests of the child/ren at risk. The policy can be accessed here: [Surrey Procedures and Escalation - Surrey Safeguarding Children Partnership (surreyscp.org.uk)](https://www.surreyscp.org.uk/professionals/resources-for-professionals/escalation/) and [7.2 Inter-Agency Escalation Policy and Procedure | Surrey Safeguarding Children Partnership (procedures.org.uk)](https://surreyscb.procedures.org.uk/skyqox/complaints-and-disagreements/inter-agency-escalation-policy-and-procedure)

SSAB Inter-agency escalation policy outlines the process to be followed when professionals are unable to agree about what is in the best interests of an adult. The detailed policy can be accessed here: <https://www.surreysab.org.uk/information-for-professionals/ssab-policies-and-procedures/>

1. Statutory Reviews

**Child Safeguarding Practice Reviews (CSPR), Safeguarding Adults Reviews (SAR) Domestic Homicide Reviews (DHR) / Domestic Abuse Related Death Reviews (DARDRs), Case Reviews (CR) and Child Death Reviews (CDR)**

* + 1. Sheerwater Health Centre has a statutory duty to participate in partnership with the SSCP, the SSAB and/or any other Safeguarding Children Partnership / Safeguarding Adult Board or Community Safety Partnership in supporting these statutory reviews.

**Child Safeguarding Practice Reviews (CSPR)**

* + 1. In England, in accordance with the guidance in [Working together to safeguard children 2023: statutory guidance (publishing.service.gov.uk)](https://assets.publishing.service.gov.uk/media/669e7501ab418ab055592a7b/Working_together_to_safeguard_children_2023.pdf) , Child Safeguarding Practice Reviews (CSPRs) should be considered for serious child safeguarding cases. Serious child safeguarding cases are those in which:
* Abuse or neglect of a child is known or suspected; **and**
* The child has died or been seriously harmed.
  + 1. The overall purpose of a CSPR is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively; to explore how practice can be improved more generally through changes to the system as a whole in order to safeguard and promote the welfare of children.
    2. There are 2 types of reviews.
* **Local reviews** – where safeguarding partners consider that a case raises issues of importance in relation to their area.
* **National reviews** – In 2018 a new [**National Panel for Child Safeguarding Practice Review Panel**](https://www.gov.uk/government/organisations/child-safeguarding-practice-review-panel)was set up by the Department for Education. This is an independent panel which can commission reviews of serious child safeguarding cases where they are complex and /or in the national interest.
  + 1. Reviews should seek to prevent or reduce the risk of recurrence of similar incidents.
    2. These reviews are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that purpose, including through employment law and disciplinary procedures, professional regulation and, in exceptional cases, criminal proceedings. The process is detailed on the Surrey Safeguarding Children Partnership (SSCP) website: <https://www.surreyscp.org.uk/about-us/national-and-local-safeguarding-reviews/>
    3. **Appendix 5** illustrates the Rapid Review Process

**Case Reviews**

* + 1. Some cases may not meet the definition of a ‘serious child safeguarding case’, but nevertheless raise issues of importance to the local area. That might, for example, include where there has been good practice, poor practice or where there have been ‘near miss events. SSCP may choose to undertake a local Case Review in these or other circumstances which do not meet the criteria for a child safeguarding practice review but are considered to offer good opportunities to identify lessons for learning and ways in which multi-agency practice to safeguard children can be improved locally. As with Child Safeguarding Practice Reviews, the lessons learned from a Case Review should also be disseminated effectively, and the recommendations should be implemented in a timely manner so that the changes required result, wherever possible, in children being protected from suffering or being likely to suffer harm in the future.

**Safeguarding Adults Reviews**

* + 1. A Safeguarding Adults Review (SAR) is carried out when an adult dies as a result of abuse or neglect whether known or suspected or it is known or suspected that the adult has experienced serious abuse or neglect, and there is concern that partner agencies could have worked more effectively to protect the adult, the process is detailed in the [The Safeguarding Adults Review Process - Surrey Safeguarding Adults Board (surreysab.org.uk)](https://www.surreysab.org.uk/professionals/the-safeguarding-adults-review-process/#:~:text=A%20Safeguarding%20Adults%20Review%20(SAR,a%20death%20from%20taking%20place.)
    2. Whether a SAR or CSPR, the appropriate Designated Safeguarding Professional will inform relevant agencies including the Care Quality Commission (CQC) and NHS England Regional Team when a Review is commissioned.
    3. **Appendix 6** illustrates the Safeguarding Adult Review Process

**Domestic Homicide Review (DHR) / Domestic Abuse Related Death Reviews (DHRDRs).**

* + 1. Statutory guidance places a duty on Community Safety Partnerships to make arrangements for Domestic Homicide Reviews (DHR) / Domestic Abuse Related Death Reviews (DARDRs). Health bodies are required to participate in these as requested (NHSE 2015).
    2. DHRs / DARDRs are statutory reviews commissioned in response to deaths caused through domestic violence including in suicide cases, in line with the legal definition of domestic abuse as introduced in the Domestic Abuse Act 2021 . They are subject to the guidance issued by the Home Office in 2006 under the Domestic Violence Crime and Victims Act 2004. The basis for the Domestic Homicide Review (DHR) / Domestic Abuse Related Death Review DARDR process is to ensure agencies are responding appropriately to victims of domestic abuse offering and/or putting in place suitable support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence. ([Home Office 2013](https://www.gov.uk/guidance/conducting-a-domestic-homicide-review-online-learning#:~:text=The%20basis%20for%20the%20domestic,of%20domestic%20homicide%20and%20violence.))
    3. When victims of domestic homicide are aged between 16 and 18, there are separate requirements in statutory guidance for both a Child Safeguarding Practice Review (CSPR) and a Domestic Homicide Review (DHR) / Domestic Abuse Related Death Review (DARDR). Where such reviews may be relevant to SAR (for example, because they concern the same perpetrator), consideration should be given to how SARs, DHRs / DARDRs and CSPRs can be managed in parallel in the most effective manner possible so that organisations and professionals can learn from the case (Care Act 2014).
* <https://www.gov.uk/government/collections/domestic-homicide-review>

**Child Death Review (Statutory requirement)**

* + 1. The death of a child is a devastating loss that profoundly affects all those involved. The process of systematically reviewing the deaths of children is grounded in respect for the rights of children and their families, with the intention of learning what happened and why, and preventing future child deaths.
    2. Revised statutory guidance *Working Together to Safeguard Children* (2023) details that child death reviews are undertaken by a child death overview panel (CDOP) with the requirement for “child death review partners” (consisting of local authorities and any ICBs for the local area) to make arrangements to review child deaths. The statutory responsibilities for child death review partners are set out in *Working Together to Safeguard Children* (2023).
    3. **Appendix 7** illustrates the main stages of the child death review process.

**Action Plans and Monitoring of Action Plans**

* + 1. For health services there are at least three points at which concerns about the conduct of safeguarding arrangements may result in actions for improvement being identified. These are:
* At a time after the first notification of the case is made, usually but not exclusively, by way of responding to the report of a Serious or Adverse Incident.
* Following completion of Sheerwater Health Centre involvement chronology / report for rapid review process.
* On publication of the recommendations of the final CSPR / SAR / DHR / DARDR reports.
  + 1. Sheerwater Health Centre may be required to submit action plans and learning from safeguarding significant events, as a part of the above review processes. Oversight and advice on implementation will be provided by the named / designated GPs for safeguarding, or other members of the Surrey-wide ICB safeguarding team.
    2. Sheerwater Health Centre is also required to report progress against CSPR, CR, SAR, DHR / DARDR and IMR action plans to the SSCP and SSAB on request. Progress against all safeguarding action plans will be routinely monitored by SSCP Health Forum and SSAB Health and Adult Safeguarding sub-group meeting.

1. Safeguarding Training

Sheerwater Health Centre and all health organisations have a legal duty under Section 11 of the Children Act 2004 and the Care Act 2014 to ensure that their staff, and staff employed by services they commission to deliver health services, are trained to be alert to potential indicators of abuse and neglect of children and adults at risk, and to be able to respond appropriately to their role in addressing such concerns for the care and safety of a child/ren and adults at risk.

The safeguarding training framework details what training and competencies are expected of all healthcare staff in order to safeguard adults, children and looked after children. All Safeguarding training is consistent with the *Intercollegiate Document* *Safeguarding Children and Young people: roles and competences for health care staff* (2019), and *Working Together* (HM Government 2023), Looked after children: Knowledge, skills and competences of health care staff Intercollegiate Role Framework (2020) and *Safeguarding Adults: Roles and competences for health care staff – Intercollegiate Document* (2018) and *Prevent training and Competencies framework: Safeguarding vulnerable individuals from being drawn into terrorism* (2022).

The training for safeguarding adults is underpinned by The Care Act 2014. This guidance requires statutory, voluntary and independent sector agencies to work together to produce policy, guidance and training about working with adults in need of safeguarding, including Mental Capacity Act and domestic abuse competencies.

It is the responsibility of managers to evaluate the different roles within Sheerwater Health Centre at the recruitment stage to determine the level of safeguarding adults and child training that is commensurate with the job role. Adherence to the levels will be reviewed through the Performance and Development Review process (PDR).

1. Safer **Recruitment**

Sheerwater Health Centre has a duty to ensure that safer recruitment processes are complied with and will act in accordance with the NHS employer’s regulations, including the Safeguarding Vulnerable Groups Act (HM Government, 2006), SSCP and SSAB procedures and the local HR recruitment policies.

This will apply to all staff and volunteers undertaking activities with children and adults at risk. The purpose of safer recruitment is to ensure:

* Applicants who may wish to harm adults at risk or children are deterred from applying for jobs or volunteering opportunities.
* Any unsuitable applicants are rejected by scrutinising applications and exploring potential areas for concern at interview.
* Unsuitable appointments are not made by having at least one member of the interview panel trained in safer recruitment; carrying out all relevant pre-employment checks (e.g. DBS) and ensuring all new staff and volunteers are given an appropriate induction.
* To identify and manage any identified risks.
* Maintain a safe and vigilant culture.

Multi-agency training on safer recruitment is available through the Surrey Children’s Services Academy: [Surrey Children's Services Academy (SCSA) - Surrey County Council (surreycc.gov.uk)](https://www.surreycc.gov.uk/children/professionals/academy)

**Disclosure and Barring Service (DBS) Checks**

* + 1. All new staff and volunteers are to have a DBS check before commencing employment. Any failure to disclose convictions may result in disciplinary action or dismissal. Any positive disclosures will be discussed with the practice manager and partners. All this information will be kept on the personnel file. The DBS number and date of processing will be held securely.

1. Assurance and Governance

All provider health organisations are required to have effective arrangements in place to safeguard adults and children and to assure themselves, regulators and their commissioners that these are working. Key examples of health work to support the safeguarding of adults at risk and children are outlined in **Appendix 8**

Assurance will be required by Surrey Heartlands ICB, the SSCP and SSAB that all Sheerwater Health Centre staff have been trained to an appropriate level in safeguarding adults, children and looked after children. Assurance will be sought through the biennial primary care safeguarding audit.

1. Dissemination and Implementation of Policy

This Policy will to be circulated to all staff within Sheerwater Health Centre

**Approval and Ratification Process**

* + 1. The Policy will be approved by the Partners, Practice Manager and Safeguarding Lead and ratified by the Sheerwater Health Centre Partners.
    2. **Policy Review**
    3. This policy will be subject to a routine annual review and will also be subject to alteration if required through the creation of additional national policy, legislation or guidance and / or local guidance. If revised, all stakeholders will be alerted to the new version. The review will be conducted by the Surrey Wide ICB Safeguarding team.

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Appendix 1: Definitions

**Children**

Child protection

Is a part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or likely to suffer significant harm.

Child in need

Children who are defined as being ‘in need’ under section 17 of the Children Act 1989 are those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services; or a child who is disabled. The critical factors to be taken into account in deciding whether a child is in need under the Children Act 1989 are:

* What will happen to a child’s health or development without services being provided:
* and the likely effect the services will have on the child’s standard of health and development.

Children in need under section 17 may be assessed by children’s services in relation to their special educational needs, disabilities, or as a carer, or because they have committed a crime. A section 17 assessment should also be undertaken for children whose parents are in prison and for asylum seeking children.

Significant Harm

* Some children are in need of protection because they are suffering, or likely to suffer significant harm. The Children Act (1989) section 47 places a duty on a Local Authority Children’s Services to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering or is likely to suffer significant harm. It identifies significant harm as the threshold that justifies compulsory intervention in family life in the best interest of the child.

What is Abuse and Neglect?

* Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting, by those known to them or, more rarely by a stranger. They may be abused by an adult or adults or another child or children. Forms of abuse are:

**Physical abuse**:

May involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, restraining without justifiable reasons, inappropriate and unauthorised use of medication, using medication as a chemical form of restraint, inappropriate sanctions including deprivation of food, clothing, warmth and health care needs or otherwise causing physical harm to child

Bruising in non-independently mobile infants**,** NICE guideline, [When to suspect child maltreatment (nice.org.uk)](https://www.nice.org.uk/guidance/cg89/resources/when-to-suspect-child-maltreatment-pdf-315824869573) states that bruising in any child Not Independently Mobile should prompt suspicion of maltreatment. Not Independently Mobile (NIM): is an infant who is not yet crawling, bottom shuffling, or cruising. It includes all infants less than 6 months. The local Surrey protocol for NIM infants can be accessed through the following link: [Multiagency protocol for the management of actual or suspected bruising in infants who are not independently mobile](https://surreyscb.procedures.org.uk/hkpzh/procedures-for-specific-circumstances/a-multi-agency-protocol-for-the-management-of-actual-or-suspected-bruising-in-infants-who-are-not-independently-mobile/#s1241)

**Sexual abuse**:

Involves forcing or enticing a child or young person to take part in sexual activities including prostitution whether or not the child is aware of what is happening.

Harmful sexual behaviour: This describes the situation where a child (below the age of 18) engages in any form of sexual activity with another individual that they have powers over by virtue of age, emotional maturity, gender, physical strength, or intellect and where the victim in this relationship has suffered sexual exploitation or a betrayal of trust.

Particular concern should be raised if there is more than four years’ difference in age or if one of the children is pre-pubescent and the other isn’t (noting that a child under the age of 13 can never consent to any sexual activity). However, a younger child can abuse an older child, particularly if they have power over them; for example, if the older child is disabled. Examples of harmful sexual behaviour can include:

* using sexually explicit words and phrases
* inappropriate touching
* using sexual violence or threats
* indecent exposure or voyeurism
* full penetrative sex with other children or adults (NSPCC)

**Neglect**:

Persistent failure to meet a child’s basic physical and/or psychological needs, likely to result in the serious impairment of the child’s health or development. The Graded Care Profile 2 (GCP2) tool has been adopted by SSCP to assess the quality of care a child is receiving where there is known or suspected neglect. Link to GCP2 resources are accessible via the following link: [Neglect risk assessment tools](https://www.surreyscp.org.uk/professionals/resources-for-professionals/abuse-neglect/)

**Emotional abuse**:

Persistent emotional maltreatment of a child such as to cause severe and persistent adverse effect on the child’s emotional development. This includes a child witnessing or seeing the ill-treatment of another.

**Transition to adulthood**

Young people refers to people aged mid-teens to mid-twenties, though some flexibility is important as Transitional Safeguarding encourages a shift away from age-determined boundaries. Considering vulnerability rather than eligibility, building relationships and understanding that harm continues past the age of 18 is key.

The process of moving from childhood to adulthood is a difficult time for most young people. As Heslop et al (2002) put it:

'We make many transitions in our lives, but perhaps the one with the most far-reaching consequences is the transition into adulthood.' (Heslop et al, 2002)

As young people transition to adulthood support and planning should be in place to support the transition from Children’s to adult services. Transition should support young people that recognise them as a distinct group, subject to constantly changing circumstances. Developmentally appropriate care and support considers the young person as a whole, addressing their biological, psychological and social development in the broadest terms. This approach will need joined-up service provision, and for the young person to be informed about, and supported to play an active role in, their care and support (Farre et al. [2015] NICE 2017).

A co-ordinated multi-agency approach to safeguarding transition planning should commence as early as possible and the care needs and views of the young person should be at the forefront of any support planning (a person centred approach). Any risks both historical and current should be considered carefully and in proportion to individual circumstances. Young people should be considered experts in their own lives and lived experience.

Care planning needs to ensure that the young person’s safety is not put at risk through delays in providing the services they need. Young people should be empowered to maintain their independence, well-being and choice which will require some degree of flexibility from agencies. For transition guidance please see [Transition from children’s to adults’ services for young people using health or social care services (nice.org.uk)](https://www.nice.org.uk/guidance/ng43/resources/transition-from-childrens-to-adults-services-for-young-people-using-health-or-social-care-services-pdf-1837451149765).

Key principles of the transitional safeguarding approach are:

**Contextual** – to include working with the young person to help them understand how to keep themselves safe. Keep professionally curious at the forefront of engagement with young people.

**Developmental** – understanding that the prefrontal cortex is responsible for a person’s rational decision making, emotional development and memory as well as being responsible for impulse control. This area of the brain is not fully mature until an individual’s early 20s

**Relational** – ensuring practice is person centred and trauma informed. Building an empowering resilience so that the young person has positive control in their life. Recognising that meaningful relationships are an important aspect of this work.

**Participative** – taking into account the person’s views enabling them to co-produce the solutions and developing autonomy and agency.

**Evidence informed** – based on fact and taking care to avoid confirmation bias.

**Trauma informed** – understanding the impact of past and present trauma on a young people and the additional vulnerabilities caused by this which requires them to have support to live safely and *all* professionals to have a trauma informed approach.

**Attends to the issues of equality, diversity and inclusion** – Understand the impact of poverty, inequality and diversity on social and economic opportunities and how these relate to people’s health and wellbeing as well as the functioning of their families, particularly in connection with child protection, adult safeguarding and also empowering individuals who may lack mental capacity.

**Looked After Children / Children in Care**

* Looked after children are a particularly vulnerable group who may have greater health needs than their peers. It is essential practitioners know who these children and young people and are aware of their needs and vulnerabilities. Looked after children are removed from the situation that made them vulnerable to make them safer. That does not mean they aren’t vulnerable when they are in care. All safeguarding legislation for children also applies to looked after children.
* Looked after children may also be known as children in care or children looked after. Children and young people prefer to be called by their name and do not like being referred to by acronyms such as LAC.
* In England and Wales, the term ‘looked after children’ is defined in law under the Children Act 1989. A child is looked after by a local authority if he or she is in their care or is provided with accommodation for more than 24 hours by the authority.
* Each UK nation has a slightly different definition of a looked after child and follows its own legislation and guidance.
* The term ‘looked after children’ is generally used to mean those looked after by the state, according to relevant national legislation
* This includes those who are:

1. Subject to an interim care order, (Section 31 The Children Act 1989)
2. Subject to a care order (Section 38, The children Act 1989)
3. Temporarily classed as looked after on a planned basis for short breaks or respite care
4. Children and young people who are ‘accommodated’ on a voluntary basis at the request of or by agreement with their parents. (Section 20, The Children Act 1989).
5. Unaccompanied asylum-seeking children
6. Living in friends and family placements
7. Living in foster care
8. Living in a residential children’s home
9. Living in residential settings such as schools or secure units
10. Living with a future adoptive parent whilst awaiting adoption.

Special guardianship order (SGO)

* Children and young people who are issued a special guardianship order are not looked after children. A special guardianship order is an order appointing one or more individuals to be a child’s “special guardian”. It is a private law order made under the Children Act 1989 and is intended for those children who cannot live with their birth parents and who would benefit from a legally secure placement.

There are a variety of reasons why a child or young person comes into care:

1. The child’s parents might have agreed to this – for example if the parent is too unwell to look after the child or the child has a disability and needs long term support of respite care.
2. The young person is an unaccompanied asylum seeker with no adult to look after them
3. Children’s services may have intervened as the child was assessed to be at risk of significant harm

A child stops being looked after when they are adopted, return home or turn18.

Health needs of Looked After Children

* Looked after children often come into care with poorer physical and mental health than their peers. As a group they are more likely to struggle with behaviour and emotional needs, they are also more likely to bed-wet, have coordination difficulties and problems with their sight, speech and language. Looked after children are also more likely to have special educational needs or a disability than their peers.
* Supporting health needs and recognising looked after children as individuals helps to overcome disadvantage, improves life chances and assists children to reach their full potential.
* Looked after children have an Initial Health Assessment (IHA) within 20 working days of becoming looked after.
* Children under 5 years old have a review health assessment (RHA) every 6 months.
* Children aged 5–17 years old have annual health assessments.
* Every 17-year-old looked after child should have a care leaver health summary compiled, which includes details of relevant transition planning into adult health.
* NSPCC research has identified five priorities for change to improve the emotional and mental health of looked after children:

1. Embed an emphasis on emotional wellbeing throughout the system.
2. Take a proactive and preventative approach.
3. Give children and young people voice and influence.
4. Support and sustain children's relationships.
5. Support care leavers' emotional needs.

Supporting looked after children in primary care

There are a number of actions primary care can take to support Looked after Children.

* Ensuring the child’s medical record is flagged and coded as a looked after child.
* Ensuring the child appears on the practice’s vulnerable persons register
* Ensuring ALL staff are aware of the vulnerability of Looked After Children and that they use flags to prioritise healthcare appointments and provide continuity of care.
* Provide proactive healthcare when a Looked after Child attends the surgery. Evidence highlights where a Looked After Child has access to specialist health practitioners their health outcomes are improved.
* Ensuring the practice recommendations from statutory health assessments are followed up.
* Assisting young people when they are transitioning from adult to children’s services.
* Ensuring that foster carers have an appropriate code on their records also so that clinicians are aware that additional support may be needed.

Care leavers

The Children (Leaving Care) Act 2000 which amended the Children Act 1989 defines a care leaver as:

* “a person who has been in the care of the Local Authority for a period of 13 weeks or more spanning their 16th birthday.”

Growing up in care can affect an individual for their whole life. As frontline staff we need to consider a care leaver as anyone who has spent any time in care of the state (such as foster care or residential children’s home).

Care experienced young people may live in supported accommodation or alone from the age of 16. A looked after child becomes a care leaver when they reach their 18th birthday.

Young people who have had experience in care need support throughout their lives.

Many young people entering care have experienced abuse and neglect. As a result, care leavers can experience a range of mental and physical health issues that continue into adulthood and affect their entire lives. Supporting the physical and mental health needs of care leavers helps individuals to reach their full potential and write their own future.

Personal advisers (PA):

The personal adviser (PA) will be introduced to the young person alongside their social worker when they turn 16.

At 18, the PA will become the care leaver’s worker. They will work with the young person until they turn 21 or up to 25 if in full-time education, or if the young person has requested additional support and advice.

As young adults, care leavers can make their own decisions. The PA is there to support and advise the young person to make decisions that are right for them.

Supporting care leavers in primary care

There are a number of actions that primary care can take to support care leavers:

* Ask new patients if they are care experienced and code them as care leavers with their agreement.
* Register care leavers even if they do not have identification when they first present.
* Provided health promotion advice regarding drugs, alcohol, sexual health, smoking, lifestyle.
* Be aware that a young person is care experienced during their pregnancy and communicate this to appropriate members of the health care team.
* Support care leavers to navigate health care services.
* Support care leavers with referrals when transitioning from child to adult services.
* Provide access to health records if a care leaver comes to you to find out about their health or family history.
* Ensure staff are trained to recognise the trauma experience of care leavers and ensure care experienced adults feel safe and welcome in the surgery.

Looked after children and care leaver primary care guides for professionals can be accessed through the link below:

[Supporting looked after children and care leavers in primary care - Best For You](https://bestforyou.org.uk/supporting-looked-after-children-and-care-leavers-in-primary-care/)

References.

* NSPCC, Looked After Children
* Looked After Children: Roles and Competencies of Healthcare Staff (2020)

Young Carers

Young carers are children and young people who assume important caring responsibilities for parents or siblings, who are disabled, have physical or mental ill health problems, or misuse drugs or alcohol. For further information and resources, please see the Surrey Young Carers website:

<https://www.actionforcarers.org.uk/who-we-help/young-carers-under-18/>

Private Fostering

Private fostering is when children and young people under the age of 16 years, or under 18 if they are disabled, are cared for on a full-time basis by a person who is not their parent, who does not have parental responsibility or who is not a "close relative" for 28 days or more. Close relatives are defined as:

* grandparents
* brothers and sisters
* uncles and aunts, or
* step-parents (if married to the partner or in civil partnership).

Under the Private Fostering Arrangements (2005), professionals who come into contact with children, for example teachers, religious leaders, health care staff are under a duty to inform the Children and Families Service about any private fostering arrangements they are made aware of.

**Further information:**

<https://www.surreyscp.org.uk/wp-content/uploads/2021/04/A5-Private-Fostering-leaflet.pdf>

**Adults**

Abuse occurs in many forms and can occur in any relationship. It may result in significant harm of the person subjected to it. Abuse or neglect can take many forms and the circumstances of the individual case should always be considered. It can include the following examples:

* **Neglect and acts of omission:** such as ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.
* **Physical Abuse:** such as assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.
* **Psychological Abuse:** such emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.
* **Sexual Abuse:** such as rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.
* **Domestic Abuse:** which includes psychological, coercive controlling behaviour, physical, sexual, financial, emotional abuse; so-called ‘honour’ based violence.
* **Forced Marriage:** when one or both spouses do not consent to the marriage. This differs from an arranged marriage, which has been consented to by both parties.
* **Financial or Material Possessions:** such as theft, fraud, internet scamming, coercion in relation to an adult’s financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.
* **Discrimination:** includes forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion
* **Organisational Abuse:** including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one’s own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.
* **Civil Rights:** denial of the right to be treated with dignity and respect, freedom of speech and movement.
* **Hate Crime:** defined as any crime that is perceived by the victim, or another person, to be due to a person’s race, religious belief, gender identity or disability. This is based on the perception of the victim or another person and is not reliant on evidence.
* **Mate Crime:** when someone has faked a friendship in order to take advantage of a vulnerable person, committed by someone known to the victim, either for a long time or a more recent friendship.
* **Female Genital Mutilation (FGM):** a procedure that involves the partial or total removal of the external female genial organs for cultural or other non-therapeutic reasons.
* **Modern Slavery:** encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.
* **Self-neglect:** this covers a wide range of behaviour neglecting to care for one’s personal hygiene, health or surroundings and includes behaviour such as hoarding.

Appendix 2: Local and National Safeguarding Issues for Children and Adults

**Early Help/ Continuum of Support Family Safeguarding Model** In Surrey, the approach for helping families early is embedded within the Continuum of Support and the Social Work practice model ‘Family Safeguarding.’ Within this model we have identified five types of support: Universal and community, Emerging Needs, Targeted Support, Intensive Support and Statutory services. We will be using The Thrive Framework for system change an essential framework for everyone who are supporting the mental health and wellbeing of children and families. as a way of having shared problem solving and a common language that supports us to work in partnership together and in an open and honest way with the child and their family to gain their confidence, identify strengths and needs, to find practical and achievable solutions, providing the right amount of information, advice, and support.

The Early Help Strategy Families First sets out the vision, principles, and ambitions for working together so we can act as soon as problems emerge, share information, and provide effective, timely support to enable children and their families to overcome difficulties and become more resilient so that they can manage future life challenges independently.

The ‘Continuum of Support’ offered to children and families in Surrey provides clarity to practitioners of the type of support available below the threshold for statutory children’s safeguarding services. It promotes earlier help for families to address emerging issues before they escalate to crisis point and aims to ensure that children are kept safe from harm. This Continuum of Support provides examples to help identify of some of the factors that may indicate a child requires additional support to achieve their full potential. There is a focus on relationships through partnership working, shared decision making, needs based and evidence-based support.

The chosen model of practice for Statutory Social work in Surrey is Family Safeguarding this is a partnership approach to working with families, its principles are rooted in understanding family needs.

* Promoting the upbringing of children in their families, by identifying, supporting, and meeting the needs of the children and parents to make a difference for the child or young person.
* Is strengths-based, needs-led, and seeks to work in partnership with families to facilitate sustained change.
* Using a motivational interviewing approach to find out and draw out people's own motivation for positive change.
* Has multi-disciplinary teams providing services to CIN (Children in Need) & those in need of protection and their families. Working to create change for children, not monitoring their circumstances / enforcing compliance.
* One of the key objectives is Supporting more families to create sustained change that supports capacity to parent at the earliest opportunity.
* A trauma-informed approach to care requires that workers develop true partnerships with clients while maintaining healthy personal boundaries. The goal of this partnership should be to empower clients to come up with their own solutions to problems. Focusing on client generated solutions is a much more effective way for clients to learn healthy coping skills than are strategies that rely on the worker controlling the client and their choices.

Further information can be accessed on the Surrey Safeguarding Children Partnership (SSCP) website: [Continuum of Support for children and families living in Surrey - Surrey Safeguarding Children Partnership (surreyscp.org.uk)](https://surreyscb.procedures.org.uk/zkyqqt/managing-individual-cases/continuum-of-support-for-children-and-families-living-in-surrey/#s7353)

Responding to Neglect in Surrey Neglect is the most prevalent type of harm affecting around 10% of all children (Radford, L. et al (2011). It is the reason most children in Surrey, and across the UK, are on child protection plans. To try and address this, Surrey is implementing tools across the partnership to support the assessment, interventions, and response to concerns regarding neglect and the quality of parenting provided to children.

Link to neglect screening tools and other resources is accessible via the following link: [Neglect risk assessment tools](https://www.surreyscp.org.uk/professionals/resources-for-professionals/abuse-neglect/)

**Contextual Safeguarding**

Contextual Safeguarding is an approach to understanding, and responding to, young people’s experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse. Parents and carers have little influence over these contexts, and young people’s experiences of extra-familial abuse can undermine parent-child relationships. Therefore, children’s social care practitioners, child protection systems and wider partnerships need to engage with individuals and sectors who do have influence over/within extra-familial contexts, and recognise that assessment of, and intervention with, these spaces are a critical part of safeguarding practices Contextual Safeguarding, therefore, expands the objectives of child protection systems in recognition that young people are vulnerable to abuse beyond their front doors.

Further information can be accessed on the Surrey Safeguarding Children Partnership (SSCP) website:

[Crime - Surrey Safeguarding Children Partnership (surreyscp.org.uk)](https://www.surreyscp.org.uk/professionals/resources-for-professionals/crime/)

**Child Criminal Exploitation (CCE)**

As well as threats to the welfare of children from within their families, children may be vulnerable to abuse or exploitation from outside their families. These extra-familial threats might arise at school and other educational establishments, from within peer groups, or more widely from within the wider community and/or online. These threats can take a variety of different forms and children can be vulnerable to multiple threats, including exploitation by criminal gangs and organised crime groups such as county lines; societal violence, trafficking, online abuse; sexual exploitation and the influences of extremism leading to radicalisation. Extremist groups make use of the internet to radicalise and recruit and to promote extremist materials. Any potential harmful effects to individuals identified as vulnerable to extremist ideologies or being drawn into terrorism should also be considered.

Assessments of children in such cases should consider whether wider environmental factors are present in a child’s life and are a threat to their safety and/or welfare. Children who may be alleged perpetrators should also be assessed to understand the impact of contextual issues on their safety and welfare.

Interventions should focus on addressing these wider environmental factors, which are likely to be a threat to the safety and welfare of a number of different children who may or may not be known to local authority children’s social care.

Assessments of children in such cases should consider the individual needs and vulnerabilities of each child. They should look at the parental capacity to support the child, including helping the parents and carers to understand any risks and support them to keep children safe and assess potential risk to child. Local arrangements for reducing the risk of CCE include the Risk Management Meetings (RMM) These meetings are held to share information and intelligence to develop a detailed profile of child criminal exploitation in Surrey. Partnership strategic oversight is via Exploitation and Missing Children Oversight Group (EMCOG) with representation by the Designated Nurse for Safeguarding Children.

ICBs will also need to ensure that its commissioned services have in place effective arrangements to identify and support young people at risk of CCE.

Further information can be accessed on the Surrey Safeguarding Children Partnership (SSCP) website: [Crime - Surrey Safeguarding Children Partnership (surreyscp.org.uk)](https://www.surreyscp.org.uk/professionals/resources-for-professionals/crime/)

**Child sexual exploitation (CSE)**

CSE is a form of sexual abuse. There is increasing awareness nationally and locally of the risks posed to children from sexual exploitation. When a child or young person is sexually abused, they are forced or tricked into sexual activities. They might not understand that what is happening is abuse or that it is wrong. And they might be afraid to tell someone. Sexual abuse can happen anywhere – and it can happen in person or online. It is never a child's fault they were sexually abused – it is important to make sure children know this.

When a child or young person is exploited, they are given things, like gifts, drugs, money, status and affection, in exchange for performing sexual activities. Children and young people are often tricked into believing they are in a loving and consensual relationship. This is called grooming. They may trust their abuser and not understand that they're being abused. Children and young people can be trafficked into or within the UK to be sexually exploited. They are moved around the country and abused by being forced to take part in sexual activities, often with more than one person. Young people in gangs can also be sexually exploited. Sometimes abusers use violence and intimidation to frighten or force a child or young person, making them feel as if they've no choice. They may lend them large sums of money they know can't be repaid or use financial abuse to control them.

Anybody can be a perpetrator of CSE, no matter their age, gender or race. The relationship could be framed as friendship, someone to look up to or romantic. Children and young people who are exploited may also be used to 'find' or coerce others to join groups.

ICBs also need to ensure that its commissioned services have in place effective arrangements to identify and support young people at risk of CSE. The ICB’s identified lead officer for CSE is the Designated Doctor for Safeguarding Children.

Further information on CSE and can be accessed on the Surrey Safeguarding Children Partnership (SSCP) website:

[[Crime - Surrey Safeguarding Children Partnership (surreyscp.org.uk)](https://www.surreyscp.org.uk/professionals/resources-for-professionals/crime/)](https://www.surreyscp.org.uk/professionals/resources-for-professionals/crime)

**Human Trafficking, Modern Slavery and Missing Children**

Children/adults are recruited, moved or transported and then exploited, forced to work or sold. Children/adults are trafficked for sexual exploitation, benefit fraud, forced marriage, domestic servitude (cleaning, childcare, cooking); forced labour in factories or agriculture and criminal activity such as pickpocketing, begging, transporting drugs, working on cannabis farms, selling pirated DVDs and bag theft. Many children/adults are trafficked into the UK from abroad, but children/adults can also be trafficked from one part of the UK to another.

Further information on Modern Slavery and Human Trafficking and can be accessed on the Surrey Safeguarding Children Partnership (SSCP) website:

[Crime - Surrey Safeguarding Children Partnership (surreyscp.org.uk)](https://www.surreyscp.org.uk/professionals/resources-for-professionals/crime/)

**Missing Children from Home and Care**

**Missing Child:** a child/young person under 18, reported as missing to the police by family or Carer(s).

**Missing from care:** a Child in Care who is not at their placement or the place they are expected to be (e.g., school) and their whereabouts is not known.

Local resources regarding missing children can be found through the [SSCP procedures](https://surreyscb.procedures.org.uk/hkyqlt/procedures-for-specific-circumstances/children-missing-from-care-and-home-under-review) manual

**Serious Youth Violence/Gangs/County Lines**

Groups of children often gather together in public places to socialise, and peer association is an essential feature of most children's transition to adulthood. Groups of children can be disorderly and/or anti-social without engaging in criminal activity and defining a gang is difficult, however it can be broadly described as a relatively durable, predominantly street-based group of children who see themselves (and are seen by others) as a discernible group for whom crime and violence is integral to the group's identity. Violence is a way for gang members to gain recognition and respect by asserting their power and authority in the street, with a large proportion of street crime perpetrated against members of other gangs or the relatives of gang members. Youth violence, serious or otherwise, may be a function of gang activity. However, it could equally represent the behaviour of a child acting individually in response to his or her particular history and circumstances.

**County lines** (also known as ‘going country’) is a tactic used by individuals, or more commonly by groups/criminal gangs to establish a drug dealing operation in an area outside of their usual localities. This typically involves gangs moving their operations from large urban cities out into more remote rural areas – particularly coastal towns, market towns, or commuter towns close to large cities.

County lines operators often groom and use young people as ‘runners’, making them carry drugs or money to and from the areas where the operation has been established. Children are also often made to stay over at the location (known as ‘the trap’ or ‘trap house’) and made to distribute the drugs in the area.

**Cuckooing**: refers to the process through which county lines operators take over a local property to use as a base for their criminal activity. The operators usually target and exploit vulnerable people.

Further information on Gangs and County Lines and can be accessed on the Surrey Safeguarding Children Partnership (SSCP) website:

[Crime - Surrey Safeguarding Children Partnership (surreyscp.org.uk)](https://www.surreyscp.org.uk/professionals/resources-for-professionals/crime/)

**Perplexing Presentations (PP) / Fabricated or induced illness (FII)**

When a parent or carer exaggerates or deliberately causes symptoms of illness in a child. Also known as “Munchausen’s syndrome by proxy”, fabricated or induced illness covers a wide range of symptoms and behaviours ranging extreme neglect by failing to seek medical care to induced illness. Other behaviours associated with Fabricated or Induced Illness include any parent or care giver who:

* Persuades healthcare professionals that their child is ill when they're perfectly healthy
* Exaggerates or lies about their child's symptoms
* Manipulates test results to suggest the presence of illness – for example, by putting glucose in urine samples to suggest the child has diabetes
* Deliberately induces symptoms of illness – for example, by poisoning their child with unnecessary medication or other substances

Medical professionals who suspect FII is taking place should liaise with social services and the police and must follow local child safeguarding procedures (NHS 2016).

[Surrey Procedures Fabricated or induced illness](https://surreyscb.procedures.org.uk/hkphz/procedures-for-specific-circumstances/fabricated-or-induced-illness)

**Radicalisation/Prevent**

Contest is the UK’s counter-terrorism strategy that aims to reduce the risk we face from terrorism so that people can go about their lives freely and with confidence. The Prevent strategy is one work stream within this agenda and it aims to stop people becoming terrorists or supporting terrorism. Prevent is different from the other work streams as it operates in the pre-criminal space.

The three revised Prevent key objectives as contained in the CONTEST review (2023) are to:

* tackle the ideological causes of terrorism
* intervene early to support people susceptible to radicalisation
* enable people who have already engaged in terrorism to disengage and rehabilitate

There is no single profile of a terrorist, and it is not about race, religion or ethnicity. The many contacts staff have with people through their work in the NHS mean that they may well come across someone who is being exploited for terrorism.

There are factors which can make individuals susceptible to the terrorist message, including factors personal to the individual, such as low self-esteem and rejection, and external factors such as foreign policy and group identity.

Radicalisation is a process and not an event and at points through the process it is possible to intervene. Frontline staff in the NHS can potentially make a difference to supporting and redirecting individuals who are being exploited in this way.

The Prevent strategy aims to stop people becoming terrorists or supporting terrorism. The health sector is involved in two key objectives:

1. To prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support.
2. To work with sectors and institutions where there are risks of radicalisation that we need to address.

Healthcare professionals will meet and treat people who may be susceptible to being drawn into terrorism. Being drawn into terrorism includes not just violent extremism but also non-violent extremism, which can create an atmosphere conducive to terrorism and can popularise views which terrorists exploit.

[Revised Prevent duty statutory guidance: for England and Wales](https://www.gov.uk/government/publications/prevent-duty-guidance/revised-prevent-duty-guidance-for-england-and-wales#e-sector-specific-guidance) updated in April 2021 details the key challenge for the healthcare sector is to ensure that, where there are signs that someone has been or is being drawn into terrorism, the healthcare worker is trained to recognise those signs correctly and is aware of and can locate available support, including the Channel programme where necessary. Preventing someone from being drawn into terrorism is substantially comparable to safeguarding in other areas, including child abuse or domestic violence.

Prevent is part of existing safeguarding responsibilities for the health sector, not an additional responsibility. Healthcare workers have the opportunity to refer vulnerable individuals for support in a pre-criminal space by:

* Recognising adults at risk, children and young people who may be at risk of radicalisation.
* Working in partnership to reduce risk and protect the individual and
* Providing adequate and necessary support as part of a proportionate multi-agency response to any concerns.

Further information on Prevent and can be accessed on the Surrey Safeguarding Children Partnership (SSCP) website:

[Crime - Surrey Safeguarding Children Partnership (surreyscp.org.uk)](https://www.surreyscp.org.uk/professionals/resources-for-professionals/crime/)

**Domestic Abuse – Coercive Control**

The [Domestic Abuse Act 2021](https://www.legislation.gov.uk/ukpga/2021/17/contents/enacted) creates a statutory definition of domestic abuse based on the existing cross-government definition.

‘Abusive behaviour’ is defined in the act as any of the following:

* physical or sexual abuse
* violent or threatening behaviour
* controlling or coercive behaviour
* economic abuse
* psychological, emotional or other abuse

For the definition to apply, both parties must be aged 16 or over and ‘personally connected’.

‘Personally connected’ is defined in the act as parties who:

* are married to each other
* are civil partners of each other
* have agreed to marry one another (whether or not the agreement has been terminated)
* have entered into a civil partnership agreement (whether or not the agreement has been terminated)
* are or have been in an intimate personal relationship with each other
* have, or there has been a time when they each have had, a parental relationship in relation to the same child
* are relatives

The Domestic Abuse Act

* establishes the office of Domestic Abuse Commissioner
* recognises children as victims of domestic abuse in their own right if they see, hear, or experience the effects of the abuse, and are related to either the victim or perpetrator
* prohibits offenders from cross-examining their victims in person in the family courts
* creates a domestic abuse protection notice (DAPN) and domestic abuse protection order (DAPO)
* provides a statutory basis for the Domestic Violence Disclosure Scheme (Clare’s law) guidance
* creates a new domestic abuse offence in Northern Ireland to criminalise controlling or coercive behaviour
* creates a statutory presumption that victims of domestic abuse are eligible for special measures in the criminal courts
* enables domestic abuse offenders to be subject to polygraph testing as a licence condition following release from custody
* places a duty on local authorities to give support to victims of domestic abuse and their children in refuges and safe accommodation
* requires local authorities to grant new secure tenancies to social tenants leaving existing secure tenancies for reasons connected with domestic abuse
* extends the extra-territorial jurisdiction of the criminal courts of England and Wales, Scotland and Northern Ireland to further violent and sexual offences

The Serious Crime Act 2015 (the 2015 Act) created a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76). The new offence closed a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of 5 years’ imprisonment, a fine or both. Further information can be accessed at:

<https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/482528/Controlling_or_coercive_behaviour_-_statutory_guidance.pdf>

[Violence Against Women Strategy and Action Plans | The Crown Prosecution Service (cps.gov.uk)](https://www.cps.gov.uk/publication/violence-against-women-strategy-and-action-plans) is an overarching framework to address crimes that have been identified as being committed primarily but not exclusively by men against women.

These crimes include domestic abuse, rape, sexual offences, stalking, harassment, so-called ‘honour-based’ violence including forced marriage, female genital mutilation, child abuse, human trafficking focusing on sexual exploitation, prostitution, pornography, non-fatal strangulation, suffocation and obscenity.

**Multi-Agency Risk Assessment Conference (MARAC)**

To protect adults who experience domestic abuse, and their children will require inter-agency working and information sharing. The use of Multiagency Risk Assessment Conference (MARAC) process should be part of the multi-agency working framework. The MARAC is an information sharing process that focuses on developing safety planning for adults assessed to be at high risk of domestic violence. At the heart of a MARAC is a working assumption that no single agency or individual can see the complete picture of the life of a person at risk, but all may have insights that are crucial to their safety as part of the coordinated community response to domestic violence and abuse. If a safeguarding child’s referral indicates that there are issues of domestic violence and abuse, stalking or honour-based violence, a decision must be taken about referral to the MARAC and who should make that referral. In most cases this would be the Practice Lead for Safeguarding.

**Aims of a MARAC:**

* Increase the safety, health and well-being of victims, including children and their children.
* Determine the level of risk that the perpetrator poses to the victim and associated children, and whether there is any risk to the general public.
* Implement a risk management plan that provides professional support to all those at risk and reduce the likelihood of further harm.
* Reduce repeat victimisation.
* Improve agency accountability.
* Improve support for staff involved in high-risk domestic abuse cases.
* Contribute to the development of best practice.
* Identify policy issues arising from cases discussed at MARACs and address these through the appropriate channels.

Consideration needs to be given when sharing information for these meeting with regard to appropriate information sharing i.e. with consent of child at risk; or overriding consent if life-threatening situation or in wider public interest.

Surrey Police MARAC Coordinators, based in the Surrey Police Safeguarding Investigation Units (SIU) can provide appropriate guidance for making a referral. Contact via 101 or telephone number: 01483 630015 or email: [MARACCRU@surrey.police.uk](mailto:MARACCRU@surrey.police.uk)

Surrey MARAC Protocol can be found here:

<https://www.healthysurrey.org.uk/domestic-abuse/professionals/risk-assessment>

Safe Lives - Domestic Abuse Resources for GPs: <https://safelives.org.uk/gp>

Guidance on the recording of domestic abuse can be found here:

<https://elearning.rcgp.org.uk/pluginfile.php/170658/mod_book/chapter/349/Guidance-on-recording-of-domestic-violence-June-2017.pdf> (Updated January 2021)

**What is the GP’s role in relation to MARAC?**

* To share relevant information and expertise with MARAC agencies to assist safety planning.
* To record relevant information shared at MARAC on the survivor and children’s records, only if safe to do so[[1]](#footnote-1).
* To consider domestic abuse and safety when you next see the victim/survivor, children, or perpetrator.

GPs can refer directly to MARAC if they have serious concerns about a patient, using the [SafeLives DASH risk assessment criteria](https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL_1.pdf), however this assessment is best undertaken by Surrey’s specialist domestic abuse services. You can find out more about the services available in Surrey here: [How to get help - Healthy Surrey](https://www.healthysurrey.org.uk/domestic-abuse/help) or by phoning the Surrey Domestic Abuse Helpline 01483 776822, 9am to 9pm, 7 days a week.

Sheerwater Health Centre recognises that staff may experience domestic abuse in their personal relationships and will take steps to provide support and onward referral in accordance with the Domestic Abuse Support for Staff Workforce Policy.

Further information on Domestic Abuse/Coercive Control can be accessed on the Surrey Safeguarding Children Partnership (SSCP) website:

[Crime - Surrey Safeguarding Children Partnership (surreyscp.org.uk)](https://www.surreyscp.org.uk/professionals/resources-for-professionals/crime/)

**Multi-Agency Public Protection Arrangements (MAPPA)**

Since June 2014 the National Probation Service (NPS) the responsible body to manage high risk offenders. NPS works in partnership with police, prison and local authorities through the MAPPA.

The purpose of MAPPA is to help reduce the re-offending behaviour of sexual and violent offenders in order to protect the public, including previous victims, from serious harm. It aims to do this by ensuring that all relevant agencies work together effectively to:

* Identify all relevant offenders complete comprehensive risk assessments that take advantage of coordinated information sharing across the agencies.
* Devise, implement and review robust risk management plans; and focus the available resources to best protect the public from serious harm.

The NPS, police and prison service are the responsible authorities required to ensure the effective management of offenders, however NHS, social services, education and housing all have a duty to cooperate under the Criminal Justice Act (2003).

**Honour Based Violence**

This is a form of domestic abuse which is perpetrated in the name of so called ‘honour'. The honour code which it refers to is set at the discretion of male relatives and women who do not abide by the ‘rules' are then punished for bringing shame on the family. Infringements may include a woman having a boyfriend; rejecting a forced marriage; pregnancy outside of marriage; interfaith relationships; seeking divorce, inappropriate dress or make-up and even kissing in a public place.

**Forced Marriage**

Force Marriage is where one or both people do not (or in cases of people with learning disabilities or reduced capacity, cannot) consent to the marriage as they are pressurised, or abuse is used, to force them to do so. It is recognised in the UK as a form of domestic or child abuse and a serious abuse of human rights.

The pressure put on people to marry against their will may be:

* physical – for example, threats, physical violence or sexual violence
* emotional and psychological – for example, making someone feel like they are bringing ‘shame’ on their family

Financial abuse, for example taking someone’s wages, may also be a factor.

[The Anti-social Behaviour, Crime and Policing Act 2014](http://www.legislation.gov.uk/ukpga/2014/12/contents/enacted) made it a criminal offence in England, Wales and Scotland to force someone to marry. (It is a criminal offence in Northern Ireland under separate legislation). This includes:

* taking someone overseas to force them to marry (whether or not the forced marriage takes place)
* marrying someone who lacks the mental capacity to consent to the marriage (whether they are pressured to or not)

Forcing someone to marry can result in a sentence of up to 7 years in prison.

Breaching the terms of a Forced Marriage Protection Order, imposed under the Family Act 1996, can result in a sentence of up to 5 years in prison.

It is also possible for victims or those at risk to apply for a Forced Marriage Protection Order (FMPO). As a civil law measure, an application for a FMPO would be made in the family court. Failure to comply with the requirements or terms set out in a FMPO granted by the Family Court, is a criminal offence and can result in a sentence of up to 5 years in prison.

In 2017 the government introduced lifelong anonymity for victims of forced marriage to encourage more victims of this hidden crime to come forward.

The government is committed to ensuring that professionals who are made aware of a forced marriage victim have the training and guidance they need to provide effective advice and support. This includes police officers, social workers, teachers, and safeguarding professionals. The Force Marriage Unit (FMU) has created:

* [multi-agency practice guidelines: handling cases of forced marriage](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322307/HMG_MULTI_AGENCY_PRACTICE_GUIDELINES_v1_180614_FINAL.pdf), which provides step-by-step advice for frontline workers, including health professionals, educational staff, police, children’s social care, adult social services and local authority housing.
* [multi-agency statutory guidance for dealing with forced marriage](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322310/HMG_Statutory_Guidance_publication_180614_Final.pdf), which provides guidance for all persons and bodies who exercise public functions in relation to safeguarding and promoting the welfare of children and vulnerable adults.

**Female Genital Mutilation (FGM)**

Female genital mutilation (sometimes referred to as female circumcision) refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. FGM is an illegal practice that causes significant physical, mental and emotional harm.

In March 2015 the Department of Health published “Commissioning Services to support women and girls with Female Genital Mutilation” which sets out some elements that make up a successful and safe service to support women and girls with female genital mutilation (FGM)

Mandatory Reporting duty for FGM came into force as of 31st October 2015 as part of the Serious Crime Act 2015. All regulated health and social care professionals and teachers in England and Wales have a duty to report ‘known’ (visually identified or verbally disclosed) cases of FGM in under-18s to the police. The duty will not apply in relation to at risk or suspected cases or in cases where the woman is over 18.

In these cases, professionals need to follow existing local safeguarding procedures. A Department of Health leaflet has been developed that professionals can use with patients and or families, to help when discussing making a report to the police. Please click on the link to view FGM mandatory reporting resources FGM mandatory reporting resources.

<https://www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare>

On the 1 April 2016 the government published new national statutory multiagency guidance on FGM. Please click on the link to for full details statutory multi-agency guidance on FGM:

<https://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation>

Other useful resources can be accessed at the following links below:

[National Safeguarding guidance for women and girls at risk of FGM](https://www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm)

[FGM Safeguarding and risk assessment](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585083/FGM_safeguarding_and_risk_assessment.pdf)

[FGM risk assessment templates](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/576051/FGM_risk_assessment_templates.pdf)

**Virginity testing and hymenoplasty**

“Virginity Testing” is the examination of the female genitalia, with or without consent, for the purpose, or purported purpose, of determining virginity. Virginity testing would usually take place in person but could also be carried out remotely. Women and girls are coerced into undergoing a virginity test which is a degrading and intrusive abuse which dehumanises the victim. As such, it is irrelevant whether or not the victim of the testing ‘consents’ to the carrying out of the test. This is particularly important as virginity tests are used as a pre-cursor to other honour-based abuses, such as child marriage or forced marriage.

The Health and Care Bill 2022 makes it an offence for anyone to carry out virginity testing in the UK, and for a UK national or habitual resident of the UK to carry out virginity testing outside the UK. In response to concerns that women or girls will be taken abroad and subjected to a virginity test (as is often seen with honour-based abuse offences, such as FGM or forced marriage), the Bill will make the offences extra-territorial. This means that a person who is a UK national who carries out virginity testing outside the UK would be guilty of the offences and could be tried in the UK. A person who is not a UK national, but who is a habitual resident of the UK, could be tried in the part of the UK where they live. The victim of the testing does not need to be a UK national or habitual resident.

The offence of offering a virginity offence has been included as a separate offence so that people who are offering the service can be prevented from going ahead with testing and potential victims can be protected. In addition to this, it is an offence for a UK national or habitual resident to make an offer outside the UK to carry out virginity testing anywhere. The offer does not need to be for testing of a UK national or habitual resident.

The Bill also makes it an offence to aid and abet the carrying out of virginity testing. This is aimed at preventing family members from arranging the testing of women and girls, or assisting with it, for example by accompanying the woman or girl to the test.

<https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted>

<https://www.gov.uk/government/publications/health-and-care-bill-factsheets/health-and-care-bill-banning-virginity-testing>

**Internet/Social Media and Online Safety**

Online abuse is any type of abuse that happens on the internet. It can happen across any device that is connected to the web, e.g., computers, tablets and mobile phones. It can happen anywhere online, including social media, text messages and messaging apps, emails, online chats, online gaming and live streaming sites.

Children and young people may experience cyberbullying, grooming, sexting, sexual abuse, sexual exploitation or emotional abuse.

Children can be at risk of online abuse from people they know, as well as from strangers. Online abuse may be part of abuse that is taking place in the real world (for example bullying or grooming). Or it may be that the abuse only happens online (for example persuading children to take part in sexual activity online).

Children can feel like there is no escape from online abuse – abusers can contact them at any time of the day or night, the abuse can come into safe places like their bedrooms, and images and videos can be stored and shared with other people.

The Online Safety Act 2023 marks a milestone in the Government’s fight to make the internet safe. help protect young people and clamp down on racist abuse online, while safeguarding freedom of expression. The Online Safety Act follows the publication of the [Online Harms White Paper](https://www.gov.uk/government/consultations/online-harms-white-paper) in April 2019.

The Online Safety Act introduces measures to make sure that children and adults are protected online. Ofcom is now the regulator of online safety and must make sure that platforms are protecting their users. Ofcom will have powers to take action against companies which do not follow their new measures this law sets out include:

* introducing age assurance and age verification to ensure that children cannot access services not designed for them. This includes pornography sites and social media companies having to check you are 18 or over before you can access pornographic material, and social media sites having to prevent children accessing them before the minimum age (often 13 years old)
* placing a duty on the largest social media platforms to publish risk assessments, so that the risks and dangers posed to children on the platform are transparent
* placing a duty on social media sites to take action to prevent illegal and harmful content from being shared on their platform and making sure it is quickly removed. This includes content like videos and images of child sexual abuse and exploitation
* introducing new criminal offences, so that things like encouraging others to self-harm; 'trolling' or purposefully targeting people who have epilepsy with harmful flashing content and sending people unsolicited nude images, sometimes called 'cyberflashing', will all be a crime
* giving bereaved parents the right to access their child’s data
* providing parents and children with accessible ways to report any problems online if they do arise
* introducing punishment and sanctions for social media platforms that do not follow the Online Safety Act
* As well as providing protection for children, the Act will also give adult users the option to opt out of seeing harmful material on the largest platforms

Further information on Online Safety and can be accessed on the Surrey Safeguarding Children Partnership (SSCP) website:

<https://www.surreyscp.org.uk/professionals/resources-for-professionals/other/>

**Remote consultations (including intimate examinations undertaken remotely)**

When assessing patients via remote consultation remain professionally curious and vigilant. Consider safeguarding issues and whether you can explore these fully via remote consultation. Have a very low threshold for converting a remote consultation to a face-to-face assessment if you have concerns.

An opportunity to speak to adolescents alone may be more difficult if they are at home. Consider how you will still have these vital conversations.

Use colleagues for support to discuss safeguarding issues and peer review decision making.

Concerns about the wellbeing and safety of a child or adult at risk must always be taken seriously.

Further guidance on video consultations is available via the RCGP document embedded below:



Particular care is required when considering intimate images and/or examinations in the context of remote consultations. National guidance was issued during the first wave of the Covid pandemic (embedded below), but professionals should exercise extreme caution if choosing to undertake such consultations remotely.



**Was Not Brought**

Children not being brought to health appointments can be a sign of neglect or other abuse. There are, of course, many simple reasons why a child may not be brought to a health appointment e.g. parent forgot the appointment, the child is now better, parent got the wrong appointment time/date. Generally, in most cases, a one-off missed appointment would not be a concern. However, patterns and context are very important. For example, a child who is on a child protection plan for neglect who is not brought to one health appointment should raise the practitioner's level of concern and prompt action to ensure the welfare of the child. Practices should consider having a practice procedure or policy relating to children not being brought to appointments prompt action to ensure the welfare of the child. Practices should consider having a practice procedure or policy relating to children not being brought to appointments.

Children not brought to appointments should be coded 'child was not brought' rather than 'did not attend'.

Every time a child is not brought to a health appointment, the practitioner should consider what the impact on the welfare of the child could be, whether there are any other concerns within the family and take action if necessary. A checklist of issues to consider when a child is not brought to an appointment: (practices may consider doing this with the admin/reception team to aid the clinician):

* What was the purpose of the appointment (may not be known)? If the purpose is known, what could the potential impact of the missed appointment be on the child's welfare?
* Does the child have any ongoing physical or mental health problems?
* Are there other health appointments that the child has not been brought to? Is there a pattern of missed appointments?
* Are there a high volume of Emergency Department and GP Out of Hours attendances?
* Is the child on a child protection plan or a Looked After Child?
* Are there any safeguarding concerns documented in the child's records?
* Are there any siblings and if so, is there a pattern of health appointments that the children have not been brought to?
* Are there any concerns about the parent/carer that could impact on their ability to bring the children to health appointments, for example physical or mental health problems, drug and alcohol issues, domestic abuse, safeguarding concerns.

If there is any concern about the child following the completion of the checklist, action needs to be taken proportionate to the level of concern. This could include:

* asking the reception staff to contact the parents to arrange another appointment.
* contacting the parent/child yourself to discuss why the child has not been brought and make a further assessment.
* contacting other health professionals such as a health visitor, to share information and concerns to aid further decisions.
* contacting Children's Social Care.

In all cases, it is important to document your actions and reasons for them.

Concerns may also arise in respect to adults at risk and dependent on others to bring them to appointments, and the principles of assessing any episode of “was not brought” in these patients should be considered as above.

Appendix 3: ICB Safeguarding Team Contact Details

Email: syheartlandsicb.surrey.safeguarding@nhs.net

Phone: 0300 561 1555

|  |  |
| --- | --- |
| **Surrey Wide ICB**  **Associate Director for Safeguarding Children and Adults**  Audrey Scott-Ryan | **Surrey Wide ICB**  **Designated Nurse for Safeguarding Children**  Tracey Bogalski |
| **Surrey Wide ICB**  **Designated Nurse for Safeguarding Children**  Eileen White | **Surrey Wide ICB**  **Designated Doctor Safeguarding Children**  Dr Kate Brocklesby |
| **Surrey Wide ICB**  **Designated GP Safeguarding Children and Adults**  Dr Tara Jones | **Surrey Wide ICB**  **Named GP for Safeguarding Children**  Dr Saba Khan (Until end of August 2024. New postholder TBC) |
| **Surrey Wide ICB**  **Designated Nurse for Safeguarding Adults**  Helen Milton | **Surrey Wide ICB**  **Designated Nurse for Safeguarding Adults**  Rebecca Eells |
| **Surrey Wide ICB**  **Transition Safeguarding Advisor**  Julie Wadham | **Surrey Wide ICB**  **Designated Doctor for Looked after Children**  Dr Sharon Kefford |
| **Surrey Wide ICB**  **Designated Nurse Looked after Children**  Linda Cunningham | **Surrey Wide ICB**  **Designated Nurse Looked after Children**  Rachel Redwood |
| **Surrey Wide ICB**  **Designated Nurse for Child Death Reviews**  Noreen Gurner-Smith | **Surrey Wide ICB**  **Designated Nurse for Child Death Reviews**  Nicola Eschbaecher |
| **Surrey Wide ICB**  **Surrey Wide ICB Named Nurse for Child Death Review Nurse & Health Lead for ICB Joint Agency response**  Suzanne Huddy | **Surrey Wide ICB**  **Specialist Nurse Child Death Review**  Anna Chai |
| **Surrey Wide ICB**  **Specialist Nurse Child Death Review**  Clare Kemp | **Surrey Wide ICB**  **Specialist Nurse Child Death Review**  Liz Manwaring |
| **Surrey Wide ICB**  **Specialist Nurse Child Death Review**  Natalie Price | **Surrey Wide ICB**  **Child Wellbeing Professional and Lead for Learning from Child Deaths**  Nicola Mundy |
| **Surrey Wide ICB**  **Safeguarding Business Manager / PA to Associate Director Safeguarding**  Lisa Parry | **Surrey Wide ICB**  **Child Death Review Coordinator**  Emily Welch |
| **Surrey Wide ICB**  **Deputy Safeguarding Business Manager**  Caroline Holmes | **Surrey Wide ICB**  **Surrey Wide ICB Safeguarding Children and Looked After Children Administrator**  Tara Hyde |
| **Surrey Wide ICB**  **Child Death Review Administrator**  Anna Miles | **Surrey Wide ICB**  **Safeguarding Business Support**  Tania Steeples |

Appendix 4: Managing Allegations against People who Work with Adults and Children

**Senior Manager** to whom allegations or concerns should be reported to

* Insert Name and Title here

|  |  |
| --- | --- |
| **Email** | **Mobile** |
| [Please Insert] | [Please Insert] |
| [Please Insert] | [Please Insert] |

**Deputy Senior Manager** to who reports should be made in the absence of the designated senior manager or where that person is the subject of the allegation or concern

* Insert Name and Title here

|  |  |
| --- | --- |
| **Email** | **Mobile** |
| [Please Insert] | [Please Insert] |
| [Please Insert] | [Please Insert] |

**Local Authority Designated Officer (LADO): Surrey**

* Allegations consultations: Every local authority has a statutory responsibility to have a local authority designated officer (LADO), who is responsible for coordinating the response to concerns that an adult who works with children may have caused them harm.
* **Phone number:** 0300 1231650 Select option 3 LADO. You will be directed to the duty LADO.
* **LADO referral form** can be accessed via the link below: <https://www.surreyscp.org.uk/professionals/dealing-with-allegations-against-people-working-with-children/>
* **Email:** LADO business support: [**LADO@surreycc.gov.uk**](mailto:LADO@surreycc.gov.uk)

**Surrey Children’s Single Point of Access (CSPA)** operates Monday – Friday 9am to 5pm

* **Phone number:** 0300 470 9100
* **Email:** [**cspa@surreycc.gov.uk**](mailto:cspa@surreycc.gov.uk)
* emails are dealt with during normal office hours.

**Surrey County Council Emergency Duty Team (Out of Hours Service)**

* **Tel:** 01483 517898
* **Fax:** 01483 517895
* SMS number: 07800000388 (for deaf and hard of hearing callers online)
* **Email:** [**edt.ssd@surreycc.gov.uk**](mailto:edt.ssd@surreycc.gov.uk)

**Hampshire Children’s Services**

* **Tel:** 0300 555 1384
* Monday to Thursday 8.30am to 5pm
* Friday 8.30am to 4.30pm
* Email [childrens.services@hants.gov.uk](mailto:childrens.services@hants.gov.uk)

Please note: Emails are dealt with during normal office hours Monday to Friday, 9am to 5pm. At other times phone our out of hours number: Tel: 0300 555 1373

Local Authority Designated Officer (LADO): Hampshire

If you need to report an allegation you can contact the LADO.

* [LADO notification form](https://forms.hants.gov.uk/en/AchieveForms/?form_uri=sandbox-publish://AF-Process-c8d4175e-e440-4cdd-9968-349c655374b9/AF-Stage-64282b4d-4083-4e7c-9c4e-1a25a6a74599/definition.json&redirectlink=/en&cancelRedirectLink=/en&_gl=1*1i6jd3n*_ga*MTg1MzYxMDYyMS4xNjUyMjgxNTM2*_ga_8ZVSPZWL5T*MTY1MjI4MzgwNi4xLjAuMTY1MjI4MzgzMi4w)
* **Tel:** 01962 876364
* **Email** [child.protection@hants.gov.uk](mailto:child.protection@hants.gov.uk)

Appendix 5: Rapid Review Process

**Agency submits Serious Incident referral form**

Within 2 working days of referral

* Initial scoping and information sharing template sent to all relevant agencies
* Date set for Rapid Review Meeting (This could be a Standing group responsible for overseeing learning from serious incidents or an extraordinary meeting to undertake the Rapid Review)

Within 5 working days of referral

* Completed Initial scoping and information sharing template returned by agencies and then shared with those attending the Rapid Review Meeting along with the referral form and any LA notification

Between 7 and 13 working days of receiving the referral

**Rapid Review meeting** held to

* Review the facts about the case presented in the documentation
* Agree any immediate action
* Consider the case against the criteria for \ child Safeguarding Practice Review
* Decide whether a practice review or other learning review should take place
* Complete the Rapid Review template and agree the recommendation

Within 2 days of the Rapid Review Meeting

* Panel Review template and accompanying letter sent to National panel agencies (including the agency who made the referral) are informed of the outcome of the Rapid Review

Appendix 6: Safeguarding Adult Review Process:

Receipt of Notification of death / serious incident concerning adult at risk

SSAB administrator sends notification to all members of the SAR group and arranges date for teleconference

If no further action:

Chair of SAR group to notify referrer

If documentation is requested from agencies – this is to be received within 2 weeks

Documentation from agencies emailed by administrator to SAR group members and a further teleconference or meeting is held (to be agreed by SAR Group Chair)

Decision made as to whether criteria for SAR is met or not

Criteria for SAR met:

Chair of SAR Group refers the case to the SSAB chair

Multi-Agency Case Review may be undertaken

If SSAB chair decides no SAR required:

Decision is documented by SSAB Chair and sent to SAR Group Chair

If SSAB chair agrees with decision:

SSAR panel is convened

Teleconference takes place resulting in agreement on what action is required within given timeframes

No further action required

Criteria for SAR not met:

Chair of SAR group notifies referrer

Appendix 7: Child Death Review Process:



1. For further guidance please refer to: Royal College of General Practitioners: ‘Guidance on recording domestic abuse in the electronic medical record’. [Guidance-on-recording-of-domestic-violence-June-2017.ashx (rcgp.org.uk)](https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/-/media/Files/CIRC/Toolkits-2017/Safeguarding-adults-at-risk-Toolkit/Guidance-on-recording-of-domestic-violence-June-2017.ashx) [↑](#footnote-ref-1)