Safeguarding Newsletter February 2022

NHS Northamptonshire Clinical Commissioning Group

Dear Safeguarding Lead
To complement our regular educational events, here is a newsletter which we hope you will find informative.

Educational Needs; working together with Local Schools

The 2015 DfE publication "*Supporting Pupils at School with Medical Conditions*" provides guidance to help schools meet their statutory duties which are set out in section 100 of the Children and Families Act 2014. The legislation places a duty on schools to provide appropriate support to pupils with medical conditions to optimise their access to education, and to fulfil this duty, schools are expected to communicate effectively with health professionals working in the NHS. As a result, practices are not uncommonly approached by either the school or the parents, and occasionally an older child, to provide information about health in relation to learning.

When responding to such a request, here are some pointers to best practice.

1. The legal duty to ensure that a child attends school falls on the adults with parental responsibility. This holds even if the child has capacity.
2. The practice should always notify the Education, Inclusion and Partnership team (EIPT) of any child who is without a school place and is being electively home educated (EHE). The local authority has a duty to ensure that the child is provided with an adequate education. It is better to seek direct confirmation from EIPT rather than simply taking a parent's word that the local authority is aware of the situation.
3. Fit notes should not be used to endorse a child's absence from school.
4. Absence from school for more than 2 weeks should be in exceptional circumstances and based on the observations/assessment of a doctor and never on the word/wishes of either or both parents.
5. It is good practice to provide the school with the following information in relation to illness/absence
    - The condition preventing attendance (suspected or confirmed)
    - How this condition is preventing access to learning
    - The plan to improve the condition and its likely duration
    - When the child was last seen by a health professional and when review will occur
    - Details of any other health professional that can provide additional information (if appropriate)
6. The following should be undertaken/considered even if the child is under or waiting to see a specialist
    - Suggest adjustments that the school could make to improve access to learning
    - Review the child at regular intervals to monitor recovery
    - Manage the child proactively to avoid drift and minimise any secondary gain
    - Consider whether an Early Health Plan would support recovery
    - Consider discussing the child at your practice MDT
    - Consider speaking to the head of year and/or safeguarding lead at the child's school
7. Remember, the longer a child is away from school with anxiety or emotional difficulties, the more difficult a return becomes. Always differentiate between a child's anxiety and that of their parents.
8. Consider undiagnosed developmental conditions such as ASD and ADHD which might need referral for specialist assessment and advice.
9. Consider fabricated illness if indicators are present and seek advice from the CCG safeguarding team.
10. Our team has created a template which schools may use to communicate with practices and GPs can (if they wish) use to provide information, however a simple letter ± telephone call can be just as effective.

Contact the West EIP team by email eiptriage.NCC@westnorthants.gov.uk (no number yet available)
Contact the North EIP team by email eiptriage.ncc@northnorthants.gov.uk or telephone 01604365054
For more information follow this link Attendance and Behaviour Support for Schools

Sharing Information with Child Services

Our team has worked with the Children's Trust to agree an **Information Sharing Consent Form**. Our expectation is that social workers will send a completed proforma to practices when requesting information about a family. Its purpose is to clarify the legal basis for sharing, for example consent or public interest, and to explain the reason for the request so that the practice can decide what information is relevant. Should a young person have capacity to consent to the release of their own medical data, then an additional document will be forwarded, signed by the young person. Link to Portal

GP Risk Assessment Control/Coercion Escalation

GRACE, the local assessment framework for victims of domestic abuse has an improved format and the accompanying guidance has also been updated. Link to Portal

NSPCC helpline

The NSPCC have a **Help Line** for health professionals which can be used to discuss situations where there is a safeguarding concern involving a child or young person. Our team is happy to have similar discussions but wanted to make you aware of this additional resource. Link to Portal

Physical Abuse considered; Child sent to A/E

A recent local authority safeguarding case review (083) concerns a child who presented with an injury, NAI was considered in the differential diagnosis and the child was referred to A/E for assessment. The parents agreed to take the child for assessment but failed to attend A/E leading to a delay in the diagnosis of physical abuse. Best practice in these situations would be for the GP to contact A/E to confirm attendance. It is also prudent to send safeguarding information direct to the hospital clinician in case a written letter provided to the parent is not presented. In response to the publication of 083, our team have revised the NAI infographic on the portal to include advice on safety-netting. Link to Appendix 1

Adult Risk Management (ARM)

ARM is a local safeguarding process for adults who are at significant and imminent risk of harm, who have capacity but nonetheless are not taking adequate steps to protect themselves or others from risk. In situations like this the GP may have already discussed the patient at a practice MDT and/or shared information with other health or care providers who also have concerns. The ARM process is set out in detail on the Northamptonshire Adult Safeguarding Board's website. Our team understands that the process might at first sight appear onerous and time consuming, but we would like to highlight that in practice the timely initiation of ARM not only improves outcomes for the vulnerable adult, but the structured communication pathway has the potential to reduce clinician effort as compared with a less coordinated approach which falters or meanders without focus. As they say, 'a stitch in time saves nine'! Furthermore, the process provides the opportunity for the initiating team (say, primary care) to hand over the organising and chairing to another agency, if agreed and appropriate. This hand-over would typically occur at the first inter-agency meeting. Our team would encourage the practice safeguarding lead for adults to familiarise themselves with the ARM process and to consider if any of the patients discussed at recent practice MDTs would meet the criteria for initiation of an ARM. Link to Portal

Child Exploitation

The team has created 2 presentations on the Criminal and Sexual exploitation of children. Link to Portal
These are accompanied by infographics describing local referral pathways. Link to Portal

Vulnerable Adolescent Panel (VAP)

VAP is a multi-agency information sharing and consultative process. The panel does not hold accountability for the cases heard, this remains with the lead professional and/or team working directly with the young person. The purpose of panel is to reduce risk and vulnerabilities in children who may be subject to exploitation by:

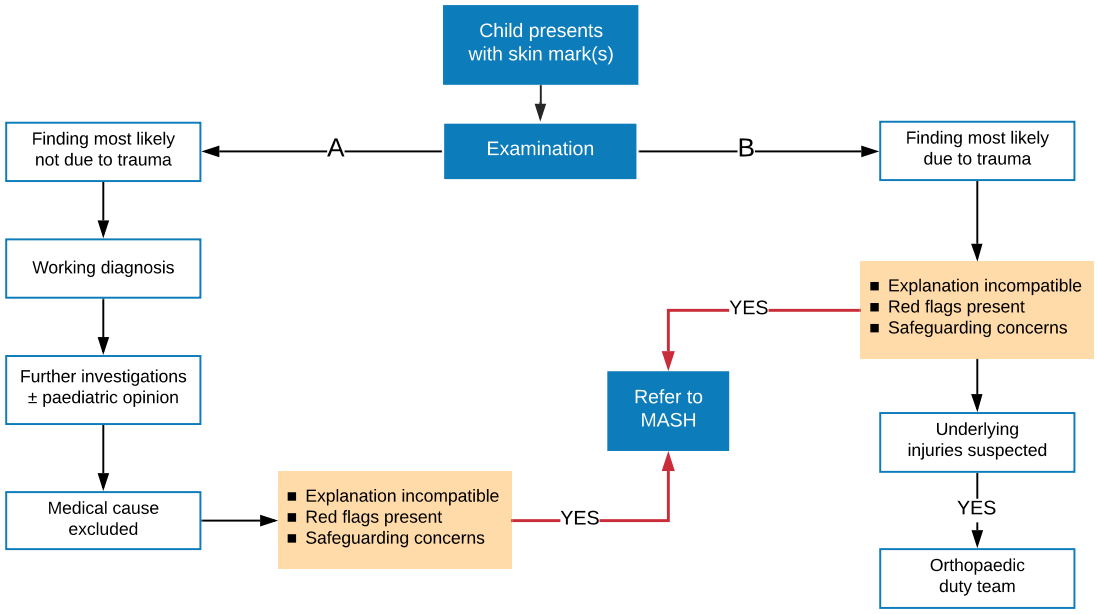
- Providing expert, evidence-based advice and guidance to professionals working with young people who are subject to various forms of exploitation.
- Providing a forum for appropriate multi-agency information sharing, consistent with Working Together 2018 guidance, to ensure that all agencies have oversight of these young people, and that needs/risks are fully understood.
- Utilising the multi-agency knowledge and experience of the panel to identify actions over and above existing risk management plans to complement such plans and help address contextual risk.

What does this mean for you in primary care?

You will receive notification in a task if a SystmOne user or by nhs.net email if an EMIS user, when a young person registered with yourselves is "heard" at a panel meeting. VAP will stratify the risk of extra-familiar harm as low, medium, or high and share this assessment along with the lead professionals name and contact details. The panel aims to assist primary care in providing a holistic risk management approach. If you require further details do not hesitate to contact or invite the lead professional to your MDT.
Link to Portal

Appendix 1

Child Bruising Pathway Jan2022



Red Flags for Bruising

- Infant especially if pre-mobile
- Child not independently mobile
- Away from bony prominences
- Head except over midline prominences
- Neck
- Abdomen and buttocks
- Bruises in a cluster
- Bruises of uniform shape
- Imprint left of ligature/hand/shoe etc
- Human bite
- Accompanied by petechiae

Safety-Netting

1. Consider risk of parental non-compliance and need to safety-net child
2. Consider sending child by ambulance if significant injury is suspected
3. Contact hospital to check arrival if child conveyed by parent(s)
4. Ensure that safeguarding information reaches relevant clinician (telephone)
5. Route A - children not referred to MASH require follow up if no medical cause is found for the presenting mark(s) - practices should have a system in place.

Referral to MASH

1. Refer child to MASH even if same-day hospital assessment is necessary
2. Seek parental consent but override dissent if abuse is suspected
3. Submit on-line form and then contact MASH to agree next steps
4. MASH will advise when and where a safeguarding examination will take place

TEN4 rule (Torso Ear Neck ≤ 4yrs)

arose from a Canadian study finding that bruises in these locations in a child under 5 were likely to be due to NAI with a high sensitivity and specificity.

What to say to Parents

1. Tell parent(s) that you cannot explain the bruise from a medical perspective
2. Ask if they are worried that someone might have harmed their child
3. Explain that you are following local guidelines and referring child to MASH
4. Say that a medical examination by a paediatrician is part of the care pathway

Findings from Studies

Bruising has been reported as an antecedent 'sentinel' finding in a third of children with subsequent fractures due to NAI. In a study of infants under 6 months with a solitary bruise of concern, 25% had a positive skeletal survey and 25% had positive neuroimaging.

Notes

1. Burns are unlikely to be accidental when located on the backs of hands, soles of feet, buttocks and back.
2. Scalds consistent with forced immersion are typically found symmetrically on the buttocks, perineum and lower limbs with sharply delineated borders.
3. Limbs are affected in a glove and stocking distribution.
4. Overlying bruising rarely accompanies fractures in children.
5. Absence of bruising does not exclude a serious head injury.
6. Violently pulling hair (scalping) can cause oedema of forehead and around eyes.

Ref: Systematic review of Bruising 2017 RCPCH