Safeguarding Best Practice Example

Summary

St Lawrence Surgery in Worthing has reviewed and strengthened all its safeguarding protocols. The practice has a higher than average population of 'cared-for' children and safeguarding concerns are raised quite frequently. A whole-systems approach was therefore applied to address key issues regarding access, co-ordination, all-staff education and collaboration with other agencies to ensure they have in place a exemplar safeguarding system.

Extract from Independent Evaluation of the PACE Setter Award Framework for Children and Young People by Dr Mary Darking, School of Applied Social Science, University of Brighton, September 2016:

Section 5.3 Safeguarding

The second key activity for PACE Setter practices was safeguarding. The need to comply with CQC safeguarding requirements was reinforced at introductory **PACE Setter Award** meetings and safeguarding was also positioned as a mandatory key activity along with patient engagement.

Practices were at different stages of development with respect to safeguarding but all were cognisant of a productive overlap between the PACE Setter Award and CQC requirements. A strength of the award was that it took practices 'where they were' with safeguarding, encouraging them to take stock of what measures they had in place and suggest ways of improving on these.

For some surgeries, completing a **safeguarding audit** and putting in place an action plan was an improvement on existing practice. For other surgeries who had a regular audit cycle in

place their key activity was to reinforce **key safeguarding relationships** with health visitors and school nurses to support information sharing. There was acknowledgement that the IT systems used by GPs and those used by Health Visitors did not share information and so the only way of knowing which children and families had safeguarding or other complex needs was to meet with the relevant practitioners.

One practice noted that Health Visitors only look after children up to the age of 5 and so for them to improve their understanding of children over this age they needed to invite school nurses to these meetings too. Prioritising and putting in place such meeting structures was an **important and progressive** step for these surgeries to take.

One practice (St Lawrence Surgery, Worthing) had gone far beyond this and put in place 'whole system safeguarding' which they were able to articulate as part of their PACE Setter activities. This approach consisted of:

- A single point of contact in the form of a 'Practice Care Coordinator' who oversees, maintains and innovates
- Use of coding and EMIS patient record
- Meeting structure
- Reporting
- GP education
- Whole team education
- Links with health visitors and social workers
- Links with voluntary and community organisations

Each of these key elements is considered in more detail below and a diagram explaining these key relationships is included in the appendices for this report.

A cornerstone of the system in place was the **Practice Care Coordinator** role is one which had grown from a need to "engage with patients about their care" and which the practice now supports as a full-time position. The role emerged from the recognition that GP surgeries are increasingly expected to play a coordinating role on behalf of patients. Without such coordination patients encounter the experience being 'pushed from service-to-service' without anyone taking substantive action on their behalf, or worse still, they can fall through the gaps between services entirely and be left with no support at all. In the case of children in need, this scenario has been shown repeatedly to lead to lapses in care that leave children vulnerable and at risk of harm. To address this, the practice has

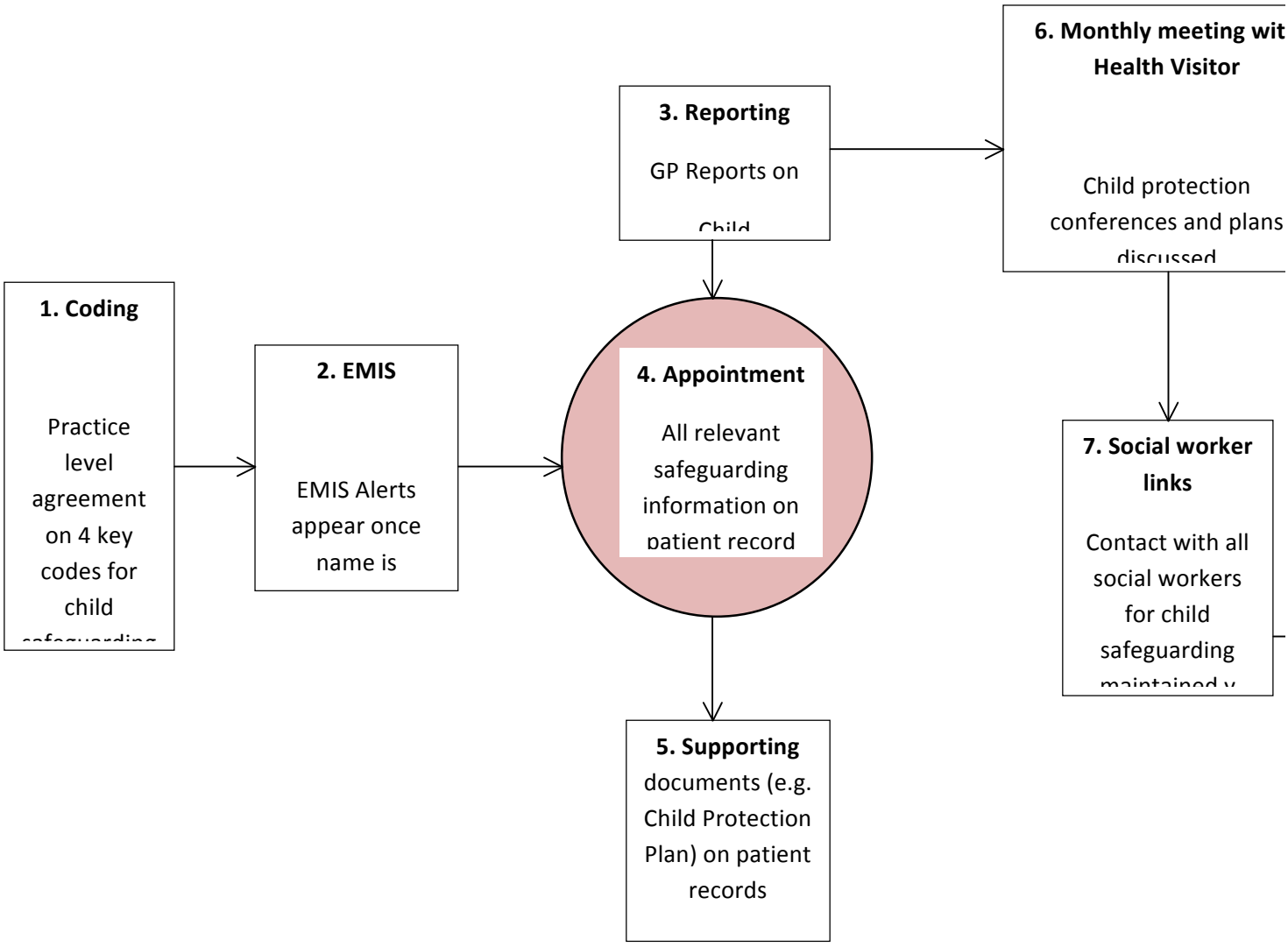
dedicated significant time and resource to the patient care coordinator role and to developing processes and systems to support robust, continuous and timely safeguarding practice across systems, processes, organisations, professional groups and patients.

Part of this role is to **maintain children in need's patient records** so that they reflect the very latest information and contact details for all those involved in the child's care including the school, health visitor, social worker, parent or carer. Where the child is in care or lives with a foster family this is noted on the record with contact details. Supporting documents such as the latest outcomes from child protection meetings and conferences are held on a shared drive which is accessible to GPs. Prior to a child in need's appointment notifications appear on EMIS to ensure the GP clearly identifies the patient as a child in need and to direct them to latest significant updates on that child's situation or status.

Coding 'Children in Need' (with a set of 4 codes) ensured that the patient care coordinator can search on these children, keep their records updated and be sure that all children in need are known to the practice. Coding children in need led the practice to consider coding children with additional needs and unborn children in need. Having a robust and responsive coding system for children maintained by a single individual (the practice coordinator) has and is leading to increasing improvements in safeguarding capacity.

Robust coding ensures that updates on children in need's situations are recorded and fed into a **cycle of meetings**. Where individual GPs cannot attend safeguarding meetings they provide written reports on latest contact with families, carers and children. Key issues and areas of concern are raised at multi-disciplinary team meetings where opportunities for GP education are also created, for example, on domestic violence and its impact on families.

Where issues arise for children, young people, families and carers that are not ones for which they can be referred to other statutory services or else are related to Children's and Adolescent Mental Health Services (CAMHS) for which it was noted there are limited resources and long waiting lists the patient care coordinator had developed **knowledge of local voluntary and community services** (VCS). For example, there may be a community group for children with autism a parent is unaware of or free support with anger management that is available for families experiencing difficulties. In the case of this surgery this is knowledge that has been sought out independently i.e. it is not coming to the surgery from a central organisation or resource such as a VCS infrastructure organisation or Healthwatch.


6. Monthly meeting wit
Health Visitor
Child protection
conferences and plans
discussed
3. Reporting
GP Reports on
Child
1. Coding
Practice
level
agreement
on 4 key
codes for
child
2. EMIS
EMIS Alerts
appear once
name is
4. Appointment
All relevant
safeguarding
information on
patient record
7. Social worker
links
Contact with all
social workers
for child
safeguarding
5. Supporting
documents (e.g.
Child Protection
Plan) on patient
records