

# Safeguarding: the missing seat at the table

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**G**Ps should be at the heart of a system established to protect children from abuse. GPs are better placed than many specialist agencies to recognise when children fail to thrive or develop. Their involvement with children and families is not time-limited unlike health visitors, they often know the child from birth and are engaged with the whole family, and unlike social workers they do not carry the threat of possible removal of children. While schools are a universal service their focus is the individual child and their educational attainment, rather than addressing the needs of the whole family. But despite these factors GPs have been marginal figures in safeguarding, in contrast with their fast, developing role as practice-based commissioners

Where does the word safeguarding come from? The need for collaborative working in child protection has long been recognised. Twenty five years ago Area Child Protection Committees were established drawing together the key agencies engaged in working with vulnerable children and their families. The Children Act 2004 led to the statutory development of inter-agency approaches to child protection, with the establishment of Local Safeguarding Children Boards from April 2006. The Boards role was wider as it embraced the Staying Safe outcome (one of the five outcomes for children) set out in Every Child Matters<sup>1</sup>. Boards therefore were to look at bullying in schools, safety, safe recruitment, internet bullying, gang violence and trafficking as well as the core areas of physical and emotional abuse.

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The Baby P case generated huge media coverage and led the Government to initiate a review of the effectiveness of the changes in safeguarding practice. It was carried out by Lord Laming, who had produced the Climbié report that preceded the legislative changes in 2004<sup>2</sup>. While some criticised the anomaly of asking the same author to review its implementation, the report<sup>3</sup> was widely welcomed.

Laming concluded that the basic framework for inter agency working was correct. He stressed the key role of health professionals, but noted the drop in the number of health visitors of 10% in the last three years and the 'very varied' engagement of GPs in Children's Trusts, Local Safeguarding Boards and multi agency working. He concluded that "the safeguarding of vulnerable children is often not viewed as a GP priority in some areas"<sup>4</sup>. He urged the Department of Health to promote the duty of GPs to comply with child protection legislation and to undertake action to raise the profile and expertise within GP practices.

The Government's response<sup>5</sup> was to endorse all of Laming's recommendations. The National Directors for Children and Young People, and Primary care were given the task together with the Royal College of GPs to enhance GP training and development. GPs would be subject to the Vetting and Barring Scheme coming into operation in 2010.

The relatively mild criticism of Laming on safeguarding was followed up by more damning findings in the Care Quality Commission survey of safeguarding arrangements<sup>6</sup>. Although on average around one in ten consultations in GP practices were with children aged 14 years or under, only one in three GPs eligible in each PCT were recorded as having up-to-date child protection training (35%, level two).

Coupled with a strong letter from the NHS Chief Executive to all Trusts stressing the importance of improving NHS engagement with safeguarding, and the Care Quality Commission's inspection programme, there is now unprecedented pressure on primary care to become more fully involved in the safeguarding structures.

All these measures are welcome but they do not address why there has been a lack of GP engagement. There are a number of possible explanations, some more persuasive than others.

The first are the conflicting priorities faced by GPs. GPs as part of their contract are measured and monitored on their performance against targets set out in the Quality and Outcomes Framework, which does not set targets for safeguarding. Until last year there has not been sustained pressure from within the Department of Health on PCTs or GPs to improve their performance in this area. Confronted with the requirements of practice based commissioning and the tariff of payment by results, few practices have made safeguarding work a priority.

Second there are practical difficulties. Strategy meetings and case conferences are held often at short notice and at times when GPs have surgery commitments. When GPs have referred concerns they have sometimes found that the cases fall short of the thresholds used for child protection inquiries. And the thresholds have sometimes been used by children's services as barricades against taking on more work rather than clear written guidelines.

Third who is the patient to whom a duty is owed? And what are the limits of confidentiality? When a twelve month old child is seen at the surgery with a rash but also with bumps and bruises, having been brought to the surgery by a mother with five other young children and depressed by her overcrowded and damp housing conditions, what is the responsibility of the GP? The potential consequences of triggering the safeguarding procedures and investigation by children's services could be devastating for the family and certainly threaten the trust relationship with the mother. But

the welfare of the individual child has to be paramount, a principle enshrined in the Children Act, and sometimes families under stress value additional support from social care.

Fourth confidentiality is sometimes presented as a difficulty. The key issue in child protection is the welfare of the child. The Royal College of Paediatrics and Child Health takes a robust view in its guidance<sup>7</sup>. "the doctor's primary duty is to act in the child's best interests. If there is conflict between doctor and parents or parents and child, then the child's needs are paramount". Confidentiality has never been an absolute. The legislative trigger for investigation is where the local authority "has reasonable cause to suspect that a child is suffering or is likely to suffer significant harm" (s47(1) Children Act 1989). Local Safeguarding Children Boards would expect clinicians to apply that test to confidentiality if the safety and well being of children was at stake.

The Department of Health, General Medical Council, and Royal College of general Practitioners have subsequently endorsed that view.

Another reason for the gap between GPs and the safeguarding agencies is more basic. The procedures governing safeguarding are bureaucratic. They require the appointment of designated and named professionals; set timescales for completing assessments; and require consistent multi agency involvement in strategy meetings, core groups, case conferences and review meetings. This approach to dealing with social problems is one alien to many GPs.

The current furore over the Independent Safeguarding Authority role, and the vetting and barring scheme, which will require GP's to be registered with the ISA may reinforce the prejudices of GPs about the bureaucracy which surrounds safeguarding.

So how can we bridge the gulf? First every PCT should have a named GP taking the lead in developing training for GPs, including the delivery of training on site for all within the practice where this is the best way of delivering effective training. These posts have often been difficult to fill for the reasons set out above, but are a necessary precondition to bringing about change.

Second, the designated doctor drawing on the local experience of clinicians should raise the difficulties being experienced with those responsible for commissioning safeguarding services. Third, health professionals including GPs should be involved in

sub groups of Local Safeguarding Children Boards particularly the audit function where they have much to contribute.

Fourth, GPs with concerns about the wellbeing and safety of children should pass on those concerns to children's services, if necessary checking out the views of the designated doctor on the thresholds in place.

Fifth, when GPs are unable to attend a case conference they should provide a written report and then read the case conference minutes when they come through as this will often help to flesh out the social history of the family and help the GP to be better informed.

In this way GPs could begin to fill their rightful role in the network of protection for vulnerable children.

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## REFERENCES

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Submitted 13 November 2009

Comments to author 27 November 2009

Revised 5 February 2010

Accepted for publication 15 February 2010