Guidance for Health Professionals Attending Child Protection Planning Meetings and Child Protection Case Conferences

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1. Introduction

This guidance applies to all health professionals in NHSGGC who may be invited to or receive information in relation to a Child Protection Planning Meeting or Child Protection Case Conference. Every person invited to or in attendance has a key role to play and health professionals are required to actively contribute to this important component of the child protection process.

2. Aims and Objectives

The purpose of the guidance is to:

- Describe and explain the purpose of a Child Protection Planning Meeting or Child Protection Case Conference, associated actions and decisions made at it.
- Define the role and responsibilities of health professionals who are invited and activities that are required both during and after the meeting.
- Provide guidance and support when health professionals do not agree with decisions made at the meeting.

3. Definitions

3.1 Child Protection Planning Meeting (CPPM)

A CPPM (previously known as a Child Protection Case Conference (CPCC)) is a multi-agency meeting which is usually convened when there are concern that a child is at risk or may be at risk of harm. It should follow within 28 calendar days of the concern being raised.

Core agencies must be present (social work, police and health) as well as other agencies or services working with the family. The child (where appropriate) and their family will be invited and should be supported to attend the meeting.

National Guidance for Child Protection (2023) notes a preference to use the terminology CPPM rather than CPCC as it plainly descibes the purpose of the meeting for families. For the purpose of this guidance both meetings have the same function and health contribution is identical.

3.2 Pre-birth Child Protection Planning Meeting

A Pre-birth CPPM/CPCC will consider concerns about the likelihood of significant harm to an unborn or recently born baby. In advance of the birth, an interagency plan should be created to meet the needs of both baby and parents and reduce the risk of harm. Careful consideration should be given to the planned discharge from hospital and midwife to HV/FN handover to ensure robust information sharing.

It is expected that HVs would attend and contribute to pre-birth CPPMs.

3.3 Child Protection Register

Every local authority in Scotland has a child protection register (CPR). This is a list of children who may be at risk or are experiencing harm and who are the subject of an inter-agency Child Protection Plan. This includes unborn babies following a pre-birth CPPM.

SW are responsible for maintaining the CPR. The decision to place child's name on the CPR follows a multi-agency assessment and a CPPM or CPCC.

The decision to remove a child's name from the CPR will be made following a review CPPM or CPCC. This would follow when all practitioners working with the family feel that the risk of significant harm has been sufficiently reduced and they are no longer in need of a child protection plan.

4. Role of Child Protection Planning Meetings

The purpose of the meeting is to:-

- Share relevant information about the concerns and listen to all information held by all agencies.
- Consider risk and discuss assessment of risk.
- Listen to what the family and/or the child wish and any supports they may require
- All agencies to agree a plan to reduce and minimise the risk of harm to the child.
- If the CPPM decides that the child or young person is at risk of significant harm then they require a multi-agency Child Protection Plan. When this is required the child's name must be added to the CPR.
- The CPPM must also consider whether a referral to the Principal Reporter (SCRA) is or is not required.

A written report is expected from all professionals invited, including those professionals able to attend the CPPM and these will be shared with all involved including the family.

Very occasionally urgent action may be required before or after a CPPM to protect a child from harm or until compulsory measures can be put in place. This may include following a core group where risks may have escalated.

CPPM will usually be organised and chaired by SW in their role as Lead Professional. All attending will be expected to take an active part, share information and support development of a plan to reduce risk.

4.1 Child Protection Plan

Every child on the CPR will have a Child's plan. The plan identifies what is required to happen to meet the child's needs and reduce the level of risk. All professionals working with the family may be asked to contribute to the plan to reduce the risk. This may include health professionals working within adult services.

4.2 Core Group

The core group is a meeting held after a CPMM with a smaller number of key professionals working with a family, for example a HV or family nurse is usually a core member for pre-5 children. It may also include professionals from adult services such as a CPN or addiction worker.

They are responsible for implementing and having oversight of the Child's plan and ensuring progress and when required escalation if changes in risk. It will usually be co-ordinated by SW (Lead Professional) and should meet for the first time 15 days after the CPPM.

5. Responsibilities of Health Professionals

All health professionals invited to a CPPM or CPCC have been invited as they have knowledge about the child and /or their family. It is essential that all who are invited contribute to the meeting and provide a report. The CPPM/CPCC should be prioritised to allow attendance. When it is not possible to attend a comprehensive report should be submitted and if possible, an appropriate colleague could attend to represent the health professional who is unable to attend i.e. if the child's HV is unable to attend another HV could attend or the HV team leader.

Health professionals must share all relevant and proportionate information with the CPPM and when possible, discuss with the family in advance of the meeting.

Health professionals working within children and family teams (HVs, family nurses and school nurses) should submit recently completed My World Triangle and a significant event chronology. If a pre-birth CPPM HVs may have limited information to share and family nurses should share a key issues summary.

Appendix 1 provides a report template and guidance notes other health professionals could use – for example staff within adult services or staff within acute paediatric services. Again, where possible a chronology should be submitted.

Appendix 2 provides report and guidance notes for GPs.

5.1 Reports for CPPM

It is important that the following information is included in a report-

- History of involvement with child or family and engagement history
- Why you are involved- including who referred the child or adult to your service and their concerns.
- Factual information and assessment of your involvement
- Analysis and an interpretation of the situation and information you have in your professional judgement.
- Strengths within the family and views of the family.
- Concerns that the health professional may have and any action taken to attempt to mitigate this.

Health professionals may be asked to contribute to assessments on capacity to change. This may be of particular importance in cases that are complex and persistent.

5.2 Health Leaders

Team leaders and those in health leadership roles should ensure health staff are supported to prioritise attendance and prepare for the meeting.

Local processes should be in place to manage invites and staff attendance.

6. Actions by Health Professionals following CPPM

6.1 Communication and Record Keeping

Decisions and actions taken should be recorded in all relevant health professional records and communicated to relevant professionals who may be involved with the child/family.

HVs may wish to consider through their multi-disciplinary arrangements with GP practices ensure GPs are aware of key decisions if unable to attend.

All CPPM and associated meetings should be recorded as a significant event in the chronology and records of all children in the family. All invites, reports and minutes should be filled in all relevant children's records.

Appropriate read codes and alerts should be added to relevant records.

6.2 Core Groups

Health professionals will be asked to contribute to core groups who will be identified following the creation of the child's plan. They require to communicate effectively with other services, agencies and the family reporting on progress and implementation of the plan. Health professionals must escalate when they believe there are escalating concerns. Where possible health professionals should prioritise attendance.

6.3 Review CPPMs

This should be held within 6 months of the initial CPPM unless that was a pre-birth CPPM where the review CPPM is recommended to be held earlier than 6 months. A core group can also ask for a review CPPM. All health professionals who are supporting the family and contributing to the child protection plan should contribute to the review CPPM.

6.4 Removal from CPR

When a child's name is removed from the CPR this should not necessarily result in a reduction or withdrawal in support or intervention from health services. For pre-5 children, assessment and care planning for a child in these circumstance highly unlikely to result in an early return to core due to additional need the family will have in order to maintain improvements made.

7. Disagreements and Dissent

If during the CPPM or CPCC the health professional disagrees with any decision taken they **must** ensure that their dissent is recorded and noted this may include whether or not to place the child's name on the CPR.

Following dissent being noted the chair of the meeting must bring this to the attention a senior social worker and they should respond directly to the person dissenting.

Health professionals may wish to inform their team leader about their dissent or raise within supervision arrangements. Advice and support can also be sought from the Public Protection Service particularly if concerns remain following the review by the senior social worker.

Appendix 1

Confidential

Report for Child Protection Planning Meeting or Child Protection Case Conference

Date of conference/meeting:

Meeting type - Initial/review/pre-birth:

Name and CHI of child(ren):
Names of parents and of any other significant adults:
Name and role of report author: Who is the allocated worker for this family?
How and when were the contents of this report shared with the family? Have you sent the report to the Chair in advance of meeting?
1. Describe your (service) involvement with the family. *You could include the reason why you first became involved with the family, how long you have been involved, any relevant history, who in the family you are working with, the services that you have offered and are providing, how well the family has engaged, any. Services you have referred to for support and reasons why and what your care plan is if applicable.*
2. What do you know about the child's needs? *Include any information that you have about the child's needs, in particular, information that is specific to your service. Areas to consider might be the child's health, any disability, education (including attendance), presentation, behaviour, emotional wellbeing, identity, relationships with family, relationships with peers, and their self-care skills.* *SHANARRI indicators could be used to support identifying child's needs.* *Please make sure you include the child's strengths, as well as things that you may be worried about.* *Are you aware of frequent A&E attendances or significant contacts with OOH services that are of a concern?* *What is the level of engagement with appointments and intervention? Are there frequent 'Was Not Brought' episodes.*

3. What do you know about the parents and family?

Please make sure that you consider both of the child's parents or main carers if known.

Consider any information which is relevant to the adult in terms of their functioning as a parent. It is important that you include the parents' strengths and the things that make them more resilient, as well as any concerns.

Please consider factors such as the parents' support network, engagement with services, drug/alcohol use, disability, mental & physical health, literacy/education, employment history, domestic abuse incidents and criminal behaviours.

Comment, where possible, about the impact that this has on their parenting.

If there are others in the home, such as adult siblings or step parents/partners, please consider them and the impact that their presence in the home may have on the child(ren).

Have the parents themselves experienced childhood adversities and require support?

4. Do you know what the family's views are? What have they said to you?

- Child
- Mother
- Father
- Any other significant adults/family members.

Please include these verbatim, where possible. If the child is not able to communicate verbally then you may wish to include any relevant observations e.g. if the child is preverbal and appears comfortable in the care of his or her parents, then you may wish to include this, making it clear that this was established through observation rather than the child telling you. If you have not been able to get a view may be helpful to give a context.

5. What is your professional view?

Please include any observations or reflections of the family. What does the information that you hold tell you about the child, and their family?

It is important that, as well as noting concerns, we also consider the things that the family are doing well, and the things that make them more resilient.

6. Please attach any relevant documents that may help inform the decision of conference

You may wish to include attendance reports, risk assessments completed by your agency, or a chronology.

Date of report:
Signature of author:

Appendix 2

Child Protection Planning Meetings/Child Protection Case Conference Report Writing for GPs

Content of report

The template report contains four sections to be completed; these will be considered below with suggestions as to what information should be considered or included in each. GPs may use another format to provide a report - the issues and concerns highlighted below would be equally relevant to consider.

1. Please provide a short summary of the child's present health and indicate any current significant health issues including those not yet addressed.

   GP should consider-

   - Frequency of contact with GP practice.
   - Summary of main health needs.
   - Interventions provided (referrals, prescriptions etc) or planned including compliance with this.
   - Consider over use of emergency appointments both within primary and secondary care.
   - Does child attend with an appropriate adult?
   - Level of engagement – is there a pattern of non-engagement to meet health needs or for routine surveillance/immunisations?
   - History of any missed hospital appointments.
   - Child's view of issues facing them or concerns that the child has voiced.
   - Are you aware of any behavioral or emotional needs the child(ren) may have?
   - Have other members of the primary care team expressed any concerns about the child?
   - Has another agency contacted you as they are concerned about the health of the child(ren)?

2. Please specify any concerns, including historical concerns in relation to the child's care or well-being.

   GP should consider

   - Any specific incidents they have been involved with where they have had concerns i.e. seeing a child with an injury, a parent presenting intoxicated, parents being threatening or aggressive to staff, children who have made direct disclosures to primary care staff about potential abuse or neglect, HV raising concerns about possible abuse or neglect within the family home.
   - Periods of kinship care - in particular 'informal' arrangements where grandparents (or other family members) have provided care for parents/main carers
   - Have you previously made a referral to SW or raised concerns about the well being of the child(ren) with SW?

3. Are there any health issues that would mean this child is vulnerable or difficult to care for (for example any disability or chronic disease)?

   - Disabled children are not only vulnerable to the same types of abuse as their typically developing peers, but there are some forms of abuse to which they are more vulnerable.
   - GPs should consider noting children or young people with a comprehensive range of disabilities including physical, emotional, developmental, learning, communication and health care needs.
   - Neglect and emotional abuse are frequently reported concerns for children with any disability and therefore non-compliance with treatment plans and non-engagement are of particular importance.

4. Please provide information about the parent/carer's health which would impact on their care of the child/children (include comment on mental health/substance misuse/non-compliance with medication/domestic violence/learning disability or any other issue deemed relevant).

   GP should consider:-

   - Are both parents/carers registered with the practice?
   - GPs should consider risks from parents/main carers and other family members registered with the practice who have contact with the child(ren).
   - Is there a history of substance misuse - drugs and alcohol or other prescription medicines. Are they attending a specialist service or substitute prescribing from the GP practice? What is the impact of this on the child(ren)?

   - Is there a history of mental health difficulties in either parent or main carer? Are they attending or have they been referred to a mental health team? Are you prescribing anti-depressants or other medications for a mental illness? What is the impact of this on the child(ren)?
   - Do you have any concern about their compliance with treatment or engagement with services?

- Are you aware of any disclosures of domestic violence- in particular incidents that may not have been reported to the police or other agencies?
- Have you got concerns about the ability of the parent/main carer to provide care?
- Are you aware of any disability that may impact on a parents/main carers ability to care for a child(ren)?
- Do you feel they are young unsupported parents?
- Have they experienced poor parenting themselves - you may be aware of previous family difficulties.
- Are you aware of any new relationships that may impact on the child(ren)?
- Has another health service or other agency written to you about concerns they have about the parent/carer?
- Have they attended A&E with presentations that may indicate that there may be concerns within the household - i.e. injuries secondary to drug and alcohol misuse, episodes of self harm, violence both domestic and community.
- Are you aware of any environmental factors that may impact on the child - quality of housing, frequent moves, living in poverty, socially isolated, frequent changes of health staff?

This is not an exhaustive list and children and families can be vulnerable for many reasons and GPs should record any information they feel is relevant.

In families where there is more than one child, each child as part of the child protection process will have their own multi-agency care plan and therefore consideration should be made to considering the needs of each child individually. Although the risks that the children live with may be similar, the impact on the child may be different and they may have varying health requirements.

GPs should also be prepared to be part of a multi-agency risk assessment for the family and be willing to contribute to the recommendations and care plan for the family including the child's name being placed on the child protection register.

GENERAL PRACTITIONER CHILD PROTECTION REPORT

Private and Confidential

The information supplied in this form will form part of the multi-agency child protection risk assessment process.

Meeting Type		**Date of meeting**
Initial Child Protection Case Conference		
Review Child Protection Case Conference		
Child Protection Case Discussion		
Child's full name	Child's date of birth	Address
Parent/carer's name	Parent/carer's date of birth	Parent/carer's address
The child named above has been referred to social work for the following reason:		

1. Please provide a short summary of the child's present health and indicate any current significant health issues including those not yet addressed.

2. Please specify any concerns, including historical concerns in relation to the child's care or well-being.

3. Are there any health issues that would mean this child is vulnerable or difficult to care for (for example any disability or chronic disease)?
4. Please provide information about the parent/carer's health which would impact on their care of the child/children (include comment on mental health/substance misuse/non-compliance with medication/domestic violence/learning disability or any other issue deemed relevant).

Signature:

Name:

Address:

Telephone Number: