NHSGGC Public Protection Service

Child Protection and Multi-disciplinary Team Meetings in General Practice

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1. Introduction

This guidance has been developed to support GP practices and primary care teams to conduct effective, efficient multidisciplinary (MDT) meetings that support vulnerable families.

These meetings do not replace normal case management/supervision arrangements for health visitors (HVs) or escalation/conflict resolution routes. MDTs are also not a route for new child protection (CP) referrals into SW although discussions may result in a new referral being raised with SW. Should any health professional have a new CP concern, current child protection processes should be followed including submitting a notification of concern (NOC).

2. Key Principles

- All unborn babies, children and young people at risk of harm or where there are known child protection concerns should be considered for review within the MDT.
- The MDT exists to share information, assess risk and formulate plans but does not replace existing child protection processes or responsibilities of accountable professionals.
- Risk assessments in child protection need to consider all relevant information held by all professionals involved.
- They should encourage multi-disciplinary and multi-agency working, peer support and minimise the risk of isolated working.
- Any health professional can seek advice and support from the Public Protection Service

GP's, midwives, HVs, family nurses and school nurses have a critical role to play in protecting children and young people. They are in a strong position to identify wellbeing needs or child protection concerns and, where appropriate, provide support.

MDTs where vulnerable families may be discussed are integral to good child protection practice and it is known that participants in the meetings find them useful, particularly to share concerns and consider all relevant information.

In line with National Guidance for Child Protection this guidance relates to vulnerable unborn babies, and children and young people up to the age of 18 years.

Experience from MDTs in other areas of health and care recognise that the following key elements are important for the overall success of these meetings:

1. The meetings must occur regularly, at a frequency which is appropriate to the objectives of the meeting and is achievable within the resources available. They could be either face to face or virtual depending on local requirements.
2. Careful planning and co-ordination are important, with actions taken before and after meetings being just as important as the conversations and decisions made during the meeting.
3. Key processes need to be written down, evaluated and adjusted based on experience.
4. Risk assessments should be informed by appropriate guidelines/best practice, for example Child Protection National Guidance (2021).
5. Periodic evaluation is required to ensure that the meetings are valued by all attendees and result in better decisions and outcomes for children and young people.

3. Multi-disciplinary Team Meeting

For an effective meeting as a minimum the HV and GP(s) should meet with other key practice staff. Any existing relationships with midwives, school nurses or family nurses should be maintained and where possible information shared. It is acknowledged that formal communication structures with midwives, school nurses and family nurses requires further development.

As a minimum they should probably take place every 6-8 weeks, some practices may wish to meet more frequently for example monthly. Longer time frames are less likely to be of benefit.

Practices should consider creating a register that allows oversight of new referrals, activity and discharging patients. Where possible administrative support should be identified to support MDT.

a) <u>Which children and young people?</u>

Any member of the MDT can refer a child or young person to be discussed. The following list could be considered but not exhaustive:-

1. Unborn babies, children and young people currently on the child protection register (CPR)

2. Children and young people recently removed from CPR.
3. Children and young people recently placed in local authority care- kinship or foster care.
4. Children and young people recently subject to an interagency referral discussion (IRD)
5. New concerns being raised by HV, GP or other professional e.g. CPN, staff within ADRS.
6. Pregnant women where there may be concerns or risks within the family.
7. New NOCs submitted by HV or GP practice.
8. CP concerns being raised by OOH services or NHS 24.

Priority - there may be some children on the MDT register who are on the CPR and being actively managed by SW. It may be that practices wish to focus time to discussing cases where there are new and emerging risks, new IRDs or cases where there is no current active SW involvement but concerns remain.

b. <u>Organisation of MDT</u>

Processes within individual GP practices will vary but should be written down and understood by all contributing professionals.

Action to consider:-

1. Decide on frequency, duration and whether face to face or virtual.
2. Agree on which patients will be discussed and how these are identified.
3. Consider having a directory of local CP processes, SW and CPS contact details and other resources that may support the meeting.
4. Agree on a template or register to be used and how this will be maintained.
5. It may be beneficial to circulate in advance the register or any new referrals to be discussed.

c. <u>Cases Reviewed</u>

For each case discussed, consider and document in all the appropriate health records:-

1. Current concerns, risks and assessment.
2. Protective factors and mitigation of risk.
3. Current plan for example refer to SW, Early Help, support by HV.
4. Who is working with the family currently and contact details if possible.

5. Any actions that arise from the meeting and who is responsible for ensuring that the action(s) is completed.
6. HVs present at meeting can access Badgernet and EMIS to task a named practitioner i.e. FN or school nurse who is unable to attend to advise information shared with GP.
7. A note should be made in GP/HV chronology/record to indicate MDT took place with key actions/issues.

4. Discharging Patients

Practices should agree when the child/family should be removed from the MDT register and also any circumstances under which the patient should or could be re-referred.

Child protection advice and support is available from the Public Protection Service –

Tel: 0141 451 6605

Monday-Friday 09.00-17.00

Out of hours contact the Child Protection Consultant on call via switchboard at RHC on 0141 201 0000