North Street Medical Care

Safeguarding Children

Document Control

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CONTENT:

Policy Statement

Under the 1989 and the 2004 Children Acts a child or young person is anyone under the age of 18 years.

Safeguarding Children refers to the activity that is undertaken to protect specific children who are suffering or at risk of suffering significant harm. All agencies and individuals should be proactive in safeguarding and promoting the welfare of children.

The practice recognises that all children have a right to protection from abuse and the practice accepts its responsibility to protect and safeguard the welfare of children with whom staff may come into contact.

We intend to:

- Respond quickly and appropriately where abuse is suspected or allegations are made.
- Provide both parents and children with the chance to raise concerns over their own care or the care of others.
- Have a system for dealing with, escalating and reviewing concerns.
- Remain aware of child protection procedures and maintain links with other bodies, especially the primary care trust appointed contacts.
- The practice will ensure that all staff are trained to a level appropriate to their role, and that this is repeated on an annual refresher basis. New starters will receive training within 6 months of start date.

BASIC PRINCIPLES

- It is the responsibility of all adults to safeguard and promote the welfare of children and young people. This responsibility extends to a duty of care for those adults employed, commissioned or contracted to work with children and young people.
- Adults who work with children are responsible for their own actions and behaviour and should avoid any conduct which would lead any reasonable person to question their motivation and intentions.
- Adults should work and be seen to work, in an open and transparent way.
- The same professional standards should always be applied regardless of culture, disability, gender, language, racial origin, religious belief and/or sexual identity.
- Adults should continually monitor and review their practice and ensure they follow the guidance contained in this document and elsewhere.

Supporting Statement of Intent

The aim of this Document is to ensure that, throughout the Practice, children are protected from abuse and exploitation. This work may include direct and indirect contact with children (access to patient's details, communication via email, text message/phone).

We aim to achieve this by ensuring that North Street Medical Care is a child-safe Practice.

The Practice follows the guidelines suggested in the revised version of the GMC document "*Raising and acting on concerns about patient safety*", effective 12 March 2012, a copy of which can be downloaded here:

http://www.gmc-uk.org/Raising_and_acting_on_concerns_about_patient_safety_FINAL.pdf_47223556.pdf

North Street Medical Care is committed to a best Practice which safeguards children and young people irrespective of their background, and which recognises that a child may be abused regardless of their age, gender, religious beliefs, racial origin or ethnic identity, culture, class, disability or sexual orientation.

As a Practice, we have a duty of care to protect the children we work with and for. Research has shown that child abuse offenders target organisations that work with children and then seek to abuse their position. This policy seeks to minimise such risks.

In addition, this policy aims to protect individuals against false allegations of abuse and the reputation of the Practice and professionals. This will be achieved through clearly defined procedures, code of conduct, and an open culture of support.

North Street Medical Care is committed to implementing this policy and the Practices it sets out for all staff and partners, and will provide in-house learning opportunities, and make provision for appropriate child protection training to all staff and partners.

This policy will be made widely accessible to staff and partners and reviewed on 06.12.12.

This policy addresses the responsibilities of all Practice employees and those to whom we have arrangements with. It is the responsibility of the Practice Manager and Safeguarding Lead to brief the staff and partners on their responsibilities under the policy.

For employees, failure to adhere to the policy could lead to dismissal or constitute gross misconduct. For others (volunteers, supporters, donors, and partner organisations) their individual relationship with the Practice may be terminated.

To achieve a child-safe Practice, employees and partners (independent contractors, volunteers, and the wider primary care team members) need to:

- Be clear what their role and responsibility is;
- Be able to respond appropriately to concerns or disclosures of abuse;
- Understand what behaviour is acceptable;
- Understand what abuse is;
- Minimise any potential risks to children.
- Ensure that all information relating to Child Protection issues is regularly updated in the relevant patient record, with appropriate alerts being added to (and removed from) the records of the child/family member.
  The Read Codes for alerts in use in the practice are:
  13IS - Child in need
  13Id - On Child Protection Register
  13IV - Child is classed as a 'Looked after Child' (may still be living with a parent)
  13IO - Child has been removed from the Register

The code 13IM - Child on Child Protection Register will not be used on the record for the child (use 13Id above); however it may be used on a parent's / guardian's record to indicate that they have a child who is on the register.

Note: reference in the Read Coding system to "Register" is assumed to identify children at risk under the recent guidance.

Background and Principles

Safeguarding children and young people is a fundamental goal for the North Street Medical Care. This policy has been written in conjunction with our legislative and government guidance requirements and other internal policies. These include:

- Adoption and Children Act 2002
- The Children Act 1989
- The Children Act 2004
- The Protection of Children Act 1999
- The Human Rights Act 1998
- The United Nations Convention on the Rights of the Child (ratified by UK Government in 1991)
- The Data Protection Act 1998 (UK wide)
- Sexual Offences Act 2003
- Working Together to Safeguard Children 2006
- Practice Equal Opportunity Statement
- Practice Disciplinary Policy

What is Abuse and Neglect?

Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting; by those known to them or, more rarely, by a stranger.

There are usually said to be four types of child abuse (with a fifth recognised in Scotland)

1. Physical Abuse
2. Emotional Abuse
3. Sexual Abuse
4. Neglect
5. Non-organic Failure to Thrive (Scotland only)

General Indicators

The risk of Child Maltreatment is recognised as being increased when there is:

- Parental or carer drug or alcohol abuse
- Parental or carer mental health
- Intra-familial violence or history of violent offending
- Previous child maltreatment in members of the family
- Known maltreatment of animals by the parent or carer
- Vulnerable and unsupported parents or carers
- Pre-existing disability in the child

(NICE CG89: When to suspect Child Maltreatment, July 2009)

Physical Abuse

Definition: Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child, including by fabricating the symptoms of, or deliberately causing, ill health to a child.
Working Together 2006

Indicators:
- Unexplained injuries;
- Injuries of different ages/types;
- Improbable explanation;
- Reluctance to discuss injury/cause;
- Delay or refusal to seek treatment for injury;
- Bruising on young babies;
- Admission of punishment which seems severe;
- Child shows:
    - Arms and legs inappropriately covered in hot weather (concealing injury);
    - Withdrawal from physical contact;
    - Self-destructive tendencies;
    - Aggression towards others;
    - Fear of returning home;
    - Running away from home.

Emotional Abuse

Definition: Emotional abuse is the persistent emotional ill-treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person, age or developmentally inappropriate expectations being imposed on children, causing children frequently to feel frightened, or the exploitation or corruption of children.
Working Together 2006

Indicators:
- Physical/ Mental/ Emotional developmental delay;
- Overreaction to mistakes;
- Low self-esteem;
- Sudden speech disorder;
- Excessive fear of new situations;
- Neurotic behaviours;
- Self-harming/ mutilation;
- Extremes of aggression or passivity;
- Drug/ solvent abuse;
- Running away;
- Eating disorders;
- School refusal;
- Physical/ Mental/ Emotional developmental delay.

Sexual Abuse

Definition: Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape or buggery) or non-penetrative acts. They may include involving children in looking at, or in the production of, pornographic material, or encouraging children to behave in sexually inappropriate ways.
Working Together 2006

Indicators:

- Genital itching/pain
- Unexplained abdominal pain
- Secondary enuresis (or daytime soiling/wetting)
- Genital discharge/ infection
- Behaviour changes
    - Sudden changes
    - Deterioration in school performance
    - Fear of undressing (e.g. for sports)
    - Sleep disturbance/nightmares
    - Inappropriate sexual display
    - Regressive (thumb sucking, babyish)
    - Secrecy, Distrust of familiar adult, anxiety left alone with particular person
    - Self-harm/mutilation/attempted suicide
    - Phobia/panic attacks
- Unexplained or concealed pregnancy
- Chronic illness (throat infections)
- Physical/ Mental/ Emotional developmental delay

Neglect

Definition: Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development, such as failing to provide adequate food, shelter and clothing, or neglect of, or unresponsiveness to, a child's basic emotional needs.
Working Together 2006

Indicators:

- Poor personal hygiene, poor state of clothing;
- Constant hunger/thirst;
- Frequent accidental injuries;
- Untreated medical problems:
    - Delayed presentation, concealed injuries;
- Low self-esteem;
- Lack of social relationships;
- Eating Disorders;
- Children left repeatedly without adequate supervision;
- Failing to engage with healthcare:
    - Non-attended appointments (Practice or wider health professional);
    - Frequent use of A&E / Out-of-Hours services;
    - Failing to arrange immunisations;

Injury Patterns

There are a number of injury patterns that cause immediate concern in terms of Child Protection: amongst which are:

- Multiple bruising, with bruises of different ages
- Facial bruising in non-motile baby
  - Baby rolls over at six months
  - Baby attempts to crawl at eight months
    *(See **Appendix 1**: Child Developmental Stages)*
- Ear bruising
- Unexplained oral injury
- Fingertip pattern bruising
- Cigarette burns
  - Accidental burns are superficial, circular, with a tail
  - Deliberate burns are deeper and tend to scar
- Belt/ buckle marks
- Burns/ scalds
  - "Glove" and "stocking" scalds, with clear demarcation of forced immersion
  - Face, head, perineum, buttocks, genitalia
  - "Hole in the doughnut" scald: centre of buttocks is spared when child forcibly immersed in scalding water (surface of bath takes time to warm: hence flat surface relatively cooler than water. Absence of this sign might hint at premeditation?)
  - "Splash" pattern – while droplet burns may indicate splashing trying to escape (and therefore potentially accidental), they may also suggest hot liquid thrown at child (which might cover larger, more diffuse area)
- Bites
  - Animal bites puncture, cut and tear
  - Human bites are bruised, crescent-shaped, and often do not break the skin
- Fractures
  - Multiple rib fractures
  - Different age of fracture
  - Spiral fracture of long bones: twisting force

Further information on injury patterns can be found at:
http://www.nspcc.org.uk/inform/trainingandconsultancy/learningresources/coreinfo/coreinfo_wda54369.html

Practice Arrangements

Practice Safeguarding Lead

The Practice Safeguarding Lead is: Dr Burack
The Deputy Practice Safeguarding Lead is: Dr Symon

This is not a full-time function but instead complements the individual's daily duties. The responsibilities are detailed below.

North Street Medical Care recognises that it is not the role of the Practice to investigate or to decide whether or not a child has been abused

The Practice Lead(s) for Safeguarding Children & Young People will:

- Act as a focus for external contacts on safeguarding/ child protection matters;
- Be fully conversant with all aspects of the North Street Medical Care child protection policy, operating procedures and incident handling procedures;
- Disseminate safeguarding / child protection information to all practice members;
- Act as a point of contact for practice members to bring any concerns that they have and record it;
- Assess the information promptly and carefully, clarifying or obtaining more information about the matter as appropriate;
- Know and establish links with local child protection agencies, such as the children's social care services (previously social services in England and Wales);
- Know and establish links, and when appropriate take advice from named and designated professionals in child protection;
- Take a lead role in planning and delivering regular staff training, reviewing policy and operating procedures, and conducting audit / review of safeguarding in the Practice;
- Ensure that the practice meets the contractual and clinical governance guidance on safeguarding children/ child protection;
- Ensure that the practice team records safeguarding incidents appropriately, (for example of significant event forms see Appendix 2) and analysis of significant events (see Appendix 3);

Immediate Actions when Child abuse may be suspected

- Concerns should immediately be reported to the Practice Safeguarding Lead or their deputy (as identified above).
- In the absence of one of the nominated persons, the matter should be brought to the attention of the Primary Care Trust appointed person, or, if it is an emergency, and the designated persons cannot be contacted, then the most senior clinician will make a decision to report the matter directly to social services or the police.
- If the suspicions relate to the designated person, then the deputy should be notified and the Primary Care Trust appointed person and / or social services should be contacted directly.
- Suspicions should not be raised or discussed with third parties other than those named above.
- Any individual has the ability to make direct referrals to the child protection agencies; however, staff are encouraged to use the route described here where possible. In the event that the reporting staff member feels that the action taken is inadequate, untimely or inappropriate they should report the matter direct. Staff members taking this action in good faith will not be penalised.
- Where emergency medical attention is necessary it should be given. Any suspicious circumstances or evidence of abuse should be reported to the designated clinical lead.

- If a referral is being made without the parent's knowledge and non-urgent medical treatment is required, social services should be informed. Otherwise, speak to the parent / carer and suggest medical attention be sought for the child.
- If appropriate, the parent / carer should be encouraged to seek help from the Social Services Department prior to a referral being made. If they fail to do so, in situations of real concern, the designated person will contact social services directly for advice.
- Where sexual abuse is suspected, the designated person will contact the Social Services or Police Child Protection Team directly. The designated person will not speak to the parents.
- Neither the designated person nor any other member of the practice team should carry out any investigation into the allegations or suspicions of sexual abuse in any circumstances. The designated person will collect exact details of the allegations or suspicion and provide this information to the child protection agencies that will investigate the matter under the Children Act 1989.

Notifying the CQC of allegations of abuse

The Practice Manager at the Practice is responsible for notifying the CQC without delay about allegations of abuse including:

- **Any suspicion, concern or allegation from any source that a person using the service has been or is being abused, or is abusing another person (of any age), including:**
  a) Details of the possible victim(s), where this is known, including:
  b) A unique identifier or code for the person.
  c) The date they were or will be admitted to the service.
  d) Their date of birth.
  e) Their gender.
  f) Their ethnicity.
  g) Any disability.
  h) Any religion or belief.
  i) Their sexual orientation.
  j) All relevant dates and circumstances, using unique identifiers and codes where relevant.
  k) Anything you have already done about the incident.
  - A unique identifier or code for the actual or possible abusers, together with, where it is known:
    - The personal information listed in a) > k) above
    - Their relationship to the abused person
  - A unique identifier or code for any person who has or may have been abused by a person using the service, together with (where known):
    - The same personal information listed in a) > k) above
    - Their relationship to the abused person
  - The person who originally expressed the suspicion, concern or allegation (using a unique identifier or code).
- **In relation to where the alleged or possible victim of abuse is a child or young person under 18 years, the notification must include details of the allegation, including:**
  - Any relevant dates, witnesses (using unique identifiers or codes) and circumstances.
  - The date the allegation was notified to the police, local safeguarding children board and the strategic health authority (where appropriate).
  - The type of abuse (using the categories in the Department for Children, Families and Schools document Working Together).
  - Anything the registered person has done as a result of the allegation.

Where the Registered Person is unavailable, for any reason, Shirley Case will be responsible for reporting the allegation to the CQC.

There is a dedicated Notification form for this type of incident. The form is contained in the ***Outcome 20 document "Notification of Other Incidents – Outcome 20 Composite Statements and Forms"***

Staff Employment & Training

Training Information

NSPCC produce a range of materials and educational tools for professionals, including the "Educare–Health package", which has been extremely successful in many professional fields.

In collaboration with Cardiff University, NSPCC has developed a series called CORE – INFO, covering:

- Head & Spinal Injuries;
- Fractures in children;
- Bruises on children;
- Oral injuries and bites on children;
- Thermal injuries on children;
- Neglect (guideline in development).

http://www.nspcc.org.uk/inform/trainingandconsultancy/learningresources/coreinfo/coreinfo_wda54369.html

Minimum safety criteria for all staff

The minimum safety criteria for all staff that work on the North Street Medical Care are:

- Have CRB check (enhanced for clinical staff);
- Have 2 references that have been followed up;
- Have been interviewed face to face.

The Independent Safeguarding Authority

The ISA came into being as a result of the 2004 Bichard Inquiry into the Soham murder of Holly Wells and Jessica Chapman by Ian Huntley. The Report called for a new Registration Scheme, vetting & barring unsuitable people from working with children or vulnerable adults.

The ISA works with the Criminal Records Bureau http://www.isa-gov.org.uk/ to examine and vet:

- Criminal records or cautions
- Police intelligence
- Other appropriate sources

All staff working regularly with children & young people will have to be registered with ISA.

Staff training

- All new members of staff will undergo in-house training or other basic awareness training, including CWDC Induction Standards (See Appendix 12), organised by the local PCO, under local arrangements;
- All members of staff will undergo child protection training as follows:
  - All Non-Clinical Staff must be at Level 1;
  - Nurses directly employed by the Practice must be at a minimum Level 2, working towards Level 3;
  - All GPs must be at Level 3.
- The Practice will also ensure that:
  - Those moving into a Level 3 position must receive a further 8 hours of safeguarding training within a year of appointment.
  - GPs should undertake a further 4-6 hours training each year, over a three-year period (up to 16 hours over three years) to refresh and build upon the learning.
- Practices will organise at least annually a training session at which:
  - All clinical and non-clinical staff are expected to attend;
  - Update training is available;
  - Significant events in safeguarding can be reviewed;
  - Practice safeguarding policy can be reviewed;
- All staff undergoing training will be expected to keep a learning log for their appraisals and or personal development (see Appendix 4 - sample learning log);
- The Practice will discuss and record at least one clinical incident involving safeguarding children.

Mentoring and supervision

Practices should have given thought to how to support staff and doctors working in this complex and challenging area of clinical Practice.

Mentoring systems are just now beginning to emerge in general Practice: often run by GP Tutors or Associate Directors in Postgraduate Medical Education, such schemes provide opportunity for safe supported reflection on Practice, and allow professionals to analyse problems and reflect on improvements which could be made. Similar opportunities may also be available through the GP Appraisal process and through some PCO Named Doctors for Child Protection.

Supervision, which has been an established part of Nursing Practice for many years, provides an opportunity both for supervisors and staff to share concerns about work. Supervision is important to promoting good standards of Practice, based on and consistent with LSCB or Child Protection Committee procedures.

Mentoring and supervision provide an opportunity to ensure understanding of roles, responsibilities and scope of professional discretion and authority. Key decisions should be recorded in the child records.

Whistleblowing

North Street Medical Care recognises the importance of building a culture that allows all Practice staff to feel comfortable about sharing information, in confidence and with a lead person, regarding concerns they have about a colleague's behaviour.

This will also include behaviour that is not linked to child abuse but that has pushed the boundaries beyond acceptable limits.

Complaints procedure

North Street Medical Care has a clear procedure that is capable of dealing with complaints from all patients (including children and young people), employee, accompanying adult or parent - please refer to the Practice's Complaints Policy.

General guidelines for staff behaviour

These guidelines are here to protect children and staff alike. The list below is by no means exhaustive and all staff should remember to conduct themselves in a manner appropriate to their position.

Wherever possible, you should be guided by the following advice. If it is necessary to carry out practices contrary to it, you should only do so after discussion with, and the approval of, your Practice Manager/ General Practitioner.

- You must challenge unacceptable behaviour;
- Provide an example of good conduct you wish others to follow;
- Respect a young person's right to personal privacy and encourage children, young people and adults to feel comfortable to point out attitudes or behaviours they do not like;
- Involve children and young people in decision-making as appropriate;
- Be aware that someone else might misinterpret your actions;
- Don't engage in or tolerate any bullying of a child, either by adults or other children;
- Never promise to keep a secret about any sensitive information that may be disclosed to you but do follow the Practice guidance on confidentiality and sharing information;
- Never offer a lift to a young person in your own car;
- Never exchange personal details such as your home address with a young person;
- Don't engage in or allow any sexually provocative games involving or observed by children, whether based on talking or touching;
- Never display favouritism or reject any individuals.

Internet, mobile phones and electronic equipment

You must always act responsibly with regard to internet, electronic and telecommunications equipment (including use of mobile phones), and use them in a professional, lawful and ethical manner.

Inappropriate types of sites
Accessing or downloading data from inappropriate websites, (e.g., pornographic websites or emails, racist, sexist or gambling websites or emails, sites promoting violence and illegal software) at any time is forbidden and may lead to disciplinary proceedings.

Permitted personal use
Reasonable personal use of the internet by North Street Medical Care is permitted, as long as it does not interfere with the performance of normal duties, and remains in accordance with the stated IT policies, including those on acceptable use of equipment and use of email.

Such limited, personal use of the internet should only be conducted when it doesn't interfere with the user's ability to carry out their normal duties, e.g. outside normal working hours. You should bear in mind that when visiting an internet site, information identifying your PC may be logged. Therefore any activity you engage in via the internet may affect the Practice Team.

Practice employees are strongly discouraged from using their Practice email address when using public web sites for non-Practice purposes. This must be kept to a minimum as it results in you, and the Practice, receiving large amounts of unwanted email (spam).

Recognition of abuse

Recognising child abuse is not easy and it is not our responsibility to decide whether or not abuse has taken place. However, it is our responsibility to act if we have any concerns. Guidance follows on recognising the possible symptoms of abuse in the four main areas: physical, emotional, sexual and neglect.

Reactive measures

While every precaution may be taken to prevent an incident from occurring, we recognise that thorough and professional reactive measures are necessary. The procedures, which follow, set out those steps to be taken with respect to any concerns relating to child protection.

Disclosure of an allegation of abuse

If a child discloses information about abuse, whether concerning themselves or a third party, our employees must immediately pass this information on to the lead for Child Protection and follow the child protection procedures below.

It is important to also remember that it can be more difficult for some children to tell than for others. Children who have experienced prejudice and discrimination through racism may well believe that people from other ethnic groups or backgrounds do not really care about them. They may have little reason to trust those they see as authority figures and may wonder whether you will be any different.

Children with a disability will have to overcome barriers before disclosing abuse. They may well rely on the abuser for their daily care and have no knowledge of alternative sources. They may have come to believe they are of little worth and simply comply with the instructions of adults.

When responding to a child making an allegation of abuse:

- Stay calm;
- Listen carefully to what is being said;
- Find an appropriate early opportunity to explain that it is likely the information will need to be shared with others – do not promise to keep secrets;
- Allow the child to continue at his/her own pace;
- Ask questions for clarification only, and at all times avoid asking questions that are leading or suggest a particular answer;
- Reassure the child that they have done the right thing by telling you;
- Tell them what you will do next and with whom the information will be shared;
- Record in writing what has been said using the child's own words as much as possible – note date, time, any names mentioned, to whom the information was given and ensure that paper records are signed and dated, and electronic subject to audit trails;
- Do not delay in passing this information on to the Practice Safeguarding Lead or Deputy.
- Consider if it is safe for a child to return home to a potentially abusive situation. It might be necessary to immediately refer the matter to social services and/or the police to ensure the child's safety and that they do not return home.

Confidentiality

In order to do their jobs, staff need access to confidential (perhaps highly sensitive) information about children and young people.

These details must be kept confidential within the clinical team at all times and only shared when it is in the interests of the child to do so, taking care to ensure that no humiliation or embarrassment is suffered by the child.

If an adult who works with children is in any doubt about whether to share information or keep it confidential he or she should seek guidance from the Practice Safeguarding Lead. Any actions should be in line with locally agreed information sharing protocols, and the Data Protection Act applies.

Whilst adults need to have an awareness of the need to listen and support children and young people, the importance of not promising to keep secrets or never requesting this of a child or young person must also be understood.

Additionally, concerns and allegations about adults should be treated as confidential and passed to a designated or appointed person or agency without delay.

In general, if a person decides to disclose confidential information without consent, they should be prepared to explain and justify their decision and they should only disclose as much information as is necessary for the purpose. The medical defence organisation will be consulted in all cases.

GMC guidance "Confidentiality: Protecting and Providing Information" (Sep 2000) describes the following circumstances when disclosure may be justified:

Disclosures to protect the patient or others – (Paras 36 & 37c)
"Disclosure of personal information without consent may be justified where failure to do so may expose the patient or others to risk or death or serious harm.

Where third parties are exposed to a risk so serious that it outweighs the patient's privacy interest, you should seek consent to disclosure where practicable.

If it is not practicable, you should disclose information promptly to an appropriate person or authority. You should generally inform the patient before disclosing the information."

Such circumstances may arise, for example: where a disclosure may assist in the prevention or detection of a serious crime.

Serious crimes, in this context, will put someone at risk of death or serious harm, and will usually be crimes against the person such as abuse of children."

Children and other patients who may lack competence to give consent (Para 39)
"If you believe a patient to be a victim of neglect or physical, sexual or emotional abuse and that the patient cannot give or withhold consent to disclosure, you should give information promptly to an appropriate responsible person or statutory agency, where you believe that the disclosure is in the patient's best interests.

You should usually inform the patient that you intend to disclose the information before doing so. Such circumstances may arise in relation to children, where concerns about possible abuse need to be shared with other agencies such as social services.

Where appropriate you should inform those with parental responsibility about the disclosure. If, for any reason, you believe that disclosure of information if not in the best interests of an abused or neglected person, you must still be prepared to justify your decision."

Key Points:

- You can disclose information without consent if you are making a child protection referral (subject to the guidance above):
- You should always obtain consent if you are making a referral as a child in need:
- If you are in doubt about whether to refer a child as a 'child protection referral' versus a 'child in need' referral, ask advice from Designated Safeguarding Lead or their Deputy.
- Clear and comprehensive records relating to all events and decisions will be maintained

Physical Contact

A parent or carer should be present at all times, or a chaperone offered. Children should only be touched under supervision and in ways which are appropriate to, and essential for clinical care.

Permission should always be sought from a child or young person before physical contact is made and an explanation of the reason should be given, clearly explaining the procedure in advance.

Where the child is young, there should be a discussion with the parent or carer about what physical contact is required. Regular contact with an individual child or young person is normally part of an agreed treatment plan and should be understood and agreed by all concerned, justified in terms of the child's needs, consistently applied and open to scrutiny.

Physical contact should never be secretive or hidden. Where an action could be misinterpreted a chaperone should be used or a parent fully briefed beforehand, and present at the time.

Where a child seeks or initiates inappropriate physical contact with an adult, the situation should be handled sensitively and a colleague alerted.

Attitude of Parents or Carers

Parental attitude may indicate cause for concern:

- Unexpected delay in seeking treatment
- Denial of injury pain or ill-health
- Incompatible explanations, different explanations or the child is said to have acted in a way that is inappropriate to his/her age and development
- Reluctance to give information or failure to mention other known relevant injuries
- Unrealistic expectations or constant complaints about the child
- Alcohol misuse or drug/substance misuse
- Violence between adults in the household
- Appearance or symptoms displayed by siblings or other household members

Records

Registration
It is good practice to offer a medical examination.

Record the following additional information:
- Child's name and all previous names
- Current and previous address detail
- Present school and all previous schools
- Previous GP, Health visitor and / or school nurse
- Mother and father's names, dates of birth and addresses if different to the child's
- Name of primary carer and any significant other persons
- Name of person (s) with parental responsibility

The practice will expect full co-operation in the supply of these details from the parent/carer otherwise registration will be refused.

The Health Visitor will be informed within 5 days of registration of all children under 16 who register with the practice, including temporary registrations.

Staff should be vigilant in the instance of multiple short-term temporary registrations for the same child, especially if consecutive. In the event of concern the permanent GP should be contacted.

Medical Record
A paper based note will be prominently made and an alert placed on the clinical system.

The medical record relating to child protection issues may also include clinical photography / video recordings, and it is recommended that a significant event form be utilised within the medical record where a clinician identifies issues leading to increasing concern for the patient, or where an event occurs of particular note.

Other aspects which may be recorded are:
- Evidence of abuse
- Criminal offences
- A & E attendances
- Child Protection Plan
- Case Conferences
- Meetings
- Drug / substance abuse
- Mental Health issues
- Non-attendance at meetings or appointments
- Hostility or lack of cooperation
- Cumulative minor concerns

Where a child moves away or changes GP the practice will inform both social services and the health visitor within 5 working days.

Data Protection

- Current guidance suggests that written records relating to child protection issues should be stored as part of the child's permanent medical records, either manually or on computer, or both - a change to the previous recommendation.

  The practice should be alert to the fact that this guidance may be reviewed or amended in the future and must seek the guidance of the local PCT in all instances.

  It is expected that practices will have permanent access to the local child protection instructions as part of the routine PCT pathway procedures.
- As a normal part of compliance with the data protection act it is likely that third party information will be stored within these records, and the normal duty of non-disclosure of this third party information may apply when information is to be released – it may be appropriate at such times to take advice.

De-Registration

- When a child whose record contains a child protection alert, moves to a new surgery, the Child Protection Co-ordinator at the PCT is notified, normally by the Health Visitor.

  The Practice will ensure that the Health Visitor is made aware that the child is moving out of the area.
- The Child Protection Co-ordinator at the PCT will contact the child's new GP or Health Visitor and will arrange for the transfer of any necessary records.

  Child Protection files forming part of the practice computer system will remain in place after the patient has de-registered in line with all other permanent medical records.

  Particular care must be taken by the transferring practice to ensure that all child protection documents and information is passed over to the receiving practice.

  This also applies to any confidential files which may (according to the needs of the case be filed separately.

Reporting

In the first instance, and if the risk to the child is not increased by doing so (situations such as Sexual Abuse or Fabricated & Induced Illness might increase risk; consult local guidance), the health professional or Practice Lead for Child protection will inform the child and accompanying carer / parent that you need to discuss or report your concern.

When the child concerned is not a patient of the Practice, the policy is to speak to the Practice Lead, who should pass that information in accordance with the disclosure of information in Appendix 1.

When external authorities need to be contacted, the relevant details are below. As a general rule of thumb, you should contact the child social care services first unless the issue is more immediate.

Location	Social Care Services	Police
	Children's Services Safeguarding Team Customer Services **01522 782111**	Sexual Assault Referral Centre **01522 524402** Police Central Referral Unit **01522 805775**
	Emergencies and OOH **01522 782333**	SARC OOH **01371 812686**
NSPCC	**National Helpline**	**0808 800 5000**
CQC	Refer to the Section **"Notifying the CQC of allegations of abuse"** on Pages 10 & 11 for detailed information. Complete the relevant Form in the Outcome 20 document ***"Notification of Other Incidents – Outcome 20 Composite Statements and Forms"*** and E-mail it without delay to: **HSCA_notifications@cqc.org.uk.**	