RIVERSIDE SURGERY, Barnard Avenue, Brigg, DN20 8AS

Safeguarding Children Policy

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Target audience:	All staff employed by Riverside Surgery

Key Contacts

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North Lincolnshire Council Children's Social Care	01724 296500/ Out of Hours 01724 296555	
Humberside Police	101 and ask for Family Protection Unit	
Local Safeguarding Children Board (LSCB)	www.northlincslscb.co.uk click on the link '**visit the LSCB website'**	

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1. Introduction

Safeguarding children and young people is a responsibility for all of society (Children Act 2004).

This policy has been developed from Safeguarding Children and Young People: A Toolkit for General Practice (2011) which was produced by the Royal College of General Practitioners (RCGP) and the National Society for the Prevention of Cruelty to Children (NSPCC), with reference to NICE Clinical Guideline 89: When to suspect child maltreatment. The Toolkit for General Practice was designed, to ensure that practices were equipped to safeguard the children and young people in their care. It is supported by the RCGP curriculum (section 8), the RCGP Child Health Strategy 2010-15[1] and the Intercollegiate Guidelines (ICG) for Safeguarding Children and Young People 2010. Safeguarding is one of the Care Quality Commission's (CQC) essential standards for quality and safety,

General practices work within communities all members of the community can help to safeguard and promote the welfare of children and young people, if we keep the needs of children in mind and are willing and able to act if we have concerns about a child's welfare. We all share responsibility for safeguarding and promoting the welfare of children and young people.

Statement of Intent

The aim of this policy 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 and phone). We aim to achieve this by ensuring that Riverside Surgery is a child-safe practice.

Riverside Surgery 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[2]. 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.

Riverside Surgery is committed to implementing this policy. The protocols it sets out for all staff, and partners will provide in-house learning opportunities and make provision for appropriate Child Protection training to all Staff and partners. This policy will be made accessible to staff and partners via the practice intranet and paper copy and reviewed on 13.06.2020.

It addresses the responsibilities of all members of the practice team and those outside the team with whom we work. It is the role of the Business Manager and Safeguarding Lead to

[1] http://www.cddlmc.org.uk/wp-content/uploads/2013/01/GP-Toolkit-2011-CDD.pdf

[2] Grubin, D., (1998) Sex offending against children: Understanding the risk. London: Home Office; Abel,G.G., Becker, J.V., Mittelman, M.S., Cunningham-Rathner, J., Rouleau, J.L. and Murphy, W.D. (1987) 'Self-reported sex crimes of non incarcerated paraphilics', Journal of Interpersonal Violence 2: 3-25 cited in The NSPCC Response to the Home Office consultation on the Belgian proposal framework decision on the recognition and enforcement in the European Union of prohibitions arising from sexual offences committed against children published May 2005: NSPCC accessed on 13/4/11 via www.nspcc.org.uk/Inform/policyandpublicaffairs/Europe/Briefings/BelgianPropos-al_wdf48520.pdf

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 able to:

- describe their role and responsibility
- describe acceptable behaviour
- recognise signs of abuse
- ensure practice systems work well to minimise missing vital information or delay in communication
- describe what to do if worried about a child or a pregnant woman or a family
- respond appropriately to concerns or disclosures of abuse
- minimise any potential risks to children

2. Background & Principles

Safeguarding children and young people is a fundamental goal for Riverside Surgery. This policy has taken into account legislative and government guidance requirements and other internal policies. These include:

National drivers

- 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
- NICE CG89 Child Maltreatment Guidance 2009
- Working Together to Safeguard Children 2013
- General Medical Council (2012) Protecting children and young people: the responsibilities of all doctors.

Local drivers

Each Local Authority area has a Local Safeguarding Children Board (LSCB) whose purpose is to coordinate and monitor what is done by agencies who work together to safeguard children, protect them from harm and promote their welfare. In fulfilling this role, each LSCB have multi-agency Local Safeguarding Children Board procedures.

Where a professional has a concern regarding the welfare of a child, the LSCB procedures for the locality in which the child is resident should be followed. Therefore, practice staff need to be aware of how to access the relevant procedures for all children included in the practice population.

- North Lincolnshire Safeguarding Children Board procedures can be accessed at:

http://www.northlincs.gov.uk/people-health-and-care/information-for-professionals/safeguarding-procedures/lscb/

- Lincolnshire Safeguarding Children Board procedures can be accessed at:

http://lincolnshirescb.proceduresonline.com/index.htm

The practice should also be aware of North Lincolnshire CCG Safeguarding Children Policy and Northern Lincolnshire health economy Training strategy.

Practice Drivers.

Riverside Surgery has the following policies which are relevant to this policy
- [Practice Equal Opportunity Statement]
- [Practice Disciplinary Policy]

3. What is Maltreatment & 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. An unborn child may suffer harm if his/her mother is subject to domestic abuse, is a tobacco, drug or alcohol abuser or fails to attend for antenatal care.

There are four types of child abuse or maltreatment
- Physical Abuse
- Emotional Abuse
- Sexual Abuse
- Neglect

These often overlap and it is not unusual for a child or young person to have symptoms or signs from several categories. Definitions and alerting features can be found in Appendix 2.

General Indicators

The **risk** of child maltreatment is recognised as being increased and should be suspected/ considered when there is:
- parental or carer drug or alcohol abuse
- parental or carer mental health disorders or learning disability
- 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, chronic or long term illness

NICE CG89 uses a further aid to prioritising concerns: **suspecting**, **considering** and **excluding** maltreatment. These are the definitions used:
- **suspect** means a serious level of concern about the possibility of child maltreatment but not proof of it.
- **consider** means that maltreatment is one possible explanation for the alerting feature and so is included in the differential diagnosis;
- **exclude** maltreatment if a suitable explanation is found for the alerting feature, which might be after discussion with colleagues.

Patterns of Maltreatment

It is crucial that **all staff** are aware of the importance of observation of patterns of possible maltreatment including:
- interaction between the parent or carer and the child or young person.
- physical signs which are inconsistent with their developmental stage (not always the same as the age in months or years).
- multiple bruising, with unusual bruises of different ages, or
- inappropriate / inconsistent explanations given.

Practice staff who are not involved in clinical care may be more likely to observe inconsistent patterns e.g. practice receptionist may be alerted by abuse on the phone or observing altercations in the waiting room.

Providing inappropriate supervision (or none) leading to accidental injury or burns can also be forms of maltreatment.

Further information can be found at: Appendix 3.

4. Practice Arrangements

Practice Lead

GP practices should have a lead for safeguarding, who should work closely with named GPs and designated professionals[3].

The Practice Safeguarding Lead is **Dr Chinenye Ekpeh** 01652 650131

His deputy is

The Practice Safeguarding Lead for under 16 years is **Julia Shipley** 01652 650131

This is a necessary function complementing the individual's daily duties. The responsibilities are detailed below.

Riverside Surgery recognises that it is the role of the practice to be aware of maltreatment and share concerns but not to investigate or to decide whether or not a child has been abused

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

- implements Riverside Surgery's children policy
- ensures that the practice meets contractual guidance
- ensures safe recruitment procedures
- supports reporting and complaints procedures
- advises practice members about any concerns that they have
- ensures that practice members receive adequate support when dealing with child protection
- leads on analysis of relevant significant events
- determines training needs and ensures they are met
- makes recommendations for change or improvements in practice procedural policy
- acts as a focus for external contacts including North Lincolnshire CCG Named GP and Designated Professionals
- has regular meetings with others in the Primary Healthcare Team to discuss particular concerns

5. Staff Employment & Training

Safeguarding Competence

The RCGP is one of over twenty colleges and professional groups to collaborate in producing joint training guidelines for staff (Safeguarding children and young people: roles and competences for health care staff: RCPCH led Intercollegiate Document, September 2010).The emphasis is on flexibility and relevant learning commensurate with responsibilities. The concept of "levels" (of learning and competency requirements) is outlined, with

- level 1 being basic awareness/competence for all practice staff,

[3] http://www.kwango.com/documents/safeguarding_children/safeguarding-vulnerable-people.pdf

- level 2 for practice nurses and
- level 3 for GPs.

The RCGP recommends GPs give evidence of a significant event in safeguarding and of learning being integrated into practice for appraisal. Level 2 is required for MRCGP and GPs need to gain experience and confidence in multi-agency working (achieving level 3)[4]. The requirement for GPs to be trained to hold level 3 competencies is reiterated in the GMC Protecting children and young people guidance in 2012. (para 71)

Minimum Criteria for recruitment of all Staff

Riverside Surgery ensures the minimum safety criteria for safe recruitment are applied and all staff that work within the practice have:

- been interviewed face to face
- 2 references that have been followed up
- been subject to Disclosure and Barring Service checks commensurate with their role.

Disclosure and Barring Service

The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA). They are responsible for:

- processing requests for criminal records checks
- deciding whether it is appropriate for a person to be placed on or removed from a barred list
- placing or removing people from the DBS children's barred list and adults' barred list for England, Wales and Northern Ireland

https://www.gov.uk/government/organisations/disclosure-and-barring-service/about

Staff Training and Development

Those working with children and young people and/or parents should take part in clinical governance including holding regular case discussions, training, education and learning opportunities should be flexible with a multi-disciplinary component. They include e-learning but also personal reflection and scenario based discussion, drawing on case studies and lessons from research, critical event analysis, analysis of feedback, complaints and included in appraisal.

Riverside Surgery ensures

- All new members of staff receive an induction to safeguarding children responsibilities within 6 weeks of commencing employment.
- All members of staff receive safeguarding children training in accordance with their responsibilities, which is reviewed at least 3 yearly in accordance with the Intercollegiate Document and the Northern Lincolnshire health economy Safeguarding Children Training Strategy:
  - Non-clinical staff Level 1
  - Clinical staff [practice nurses and others] Level 2
  - General Practitioner: Level 3
- All staff undergoing training will be expected to keep a learning log for their appraisals and or personal development. For the CQC. (A sample template for a learning log can be found at Appendix 8)

Riverside Surgery will undertake an **annual** safeguarding review which:

[4] see www.fflm.ac.uk/librarydetail/4000116

- all clinical and non-clinical staff are expected to attend
- update training is available
- significant events in safeguarding can be reviewed
  - The practice will discuss and record at least one clinical incident involving safeguarding children
- practice safeguarding policy can be reviewed

Mentoring/Supervision

Riverside Surgery recognises the importance of supporting staff, including doctors working in this complex area of clinical practice, particularly those in training or within the first five years of practice.

Staff are given opportunities to reflect on complex cases, allowing professionals to analyse problems and reflect on improvements which could be made. (A Child Protection Significant Events template for reflection on events is included at Appendix 7) All members of the practice team are encouraged/ supported in accessing specialist safeguarding children advice from Named and Designated Health Professionals.

Whistle Blowing

Riverside Surgery 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. Open honest working cultures where people feel they can challenge unacceptable colleague behaviour and be supported in doing so, help keep everyone safe. Where allegations have been made against staff, the standard disciplinary procedure and the early involvement of the CCG Senior Officer for Allegations/ Local Authority Designated Officer (LADO) may be necessary.

Contact details for these officers are included at Appendix 1.

Complaints Procedure

Riverside Surgery has a clear procedure that deals with complaints from all patients (including children and young people), as well as employees, accompanying adult/parent or other professionals.

6. 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 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 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, personal phone number or any social networking details 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 show favouritism or reject any individuals

Internet, Mobile Phone Information Governance

See Practice information Governance Policy.

Practice Systems & Early Help

Riverside Surgery ensures that for each child at the point of registration with the practice details of

- Names of parents or carers
- Child's school
- Social care involvement are sought and recorded.

Riverside Surgery has

- arrangements for the scanning and coding of reports/ letters from other agencies into child's records.
- a clear procedure for the follow up of
    - repeated A&E attendances
    - missed appointments with the practice
    - missed appointments with other health professionals.

a clear process for recording all information in respect to the welfare of a child/ren. Further guidance is included at Section 9.

Riverside Surgery has

- a clear process for the management of children presented for immediate necessary treatment or temporary registration. (as per Appendix 9).

Management of Disclosure of an Allegation of Abuse

If a child makes allegations about abuse, whether concerning themselves or a third party, all staff must immediately pass this information on to the Practice Lead for safeguarding children and follow the safeguarding children pathway below.

Responding to a Child Making an Allegation of Abuse

It is important to 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, especially a sensory deficit or communication disorder, will have to overcome additional 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.

Handling a Disclosure

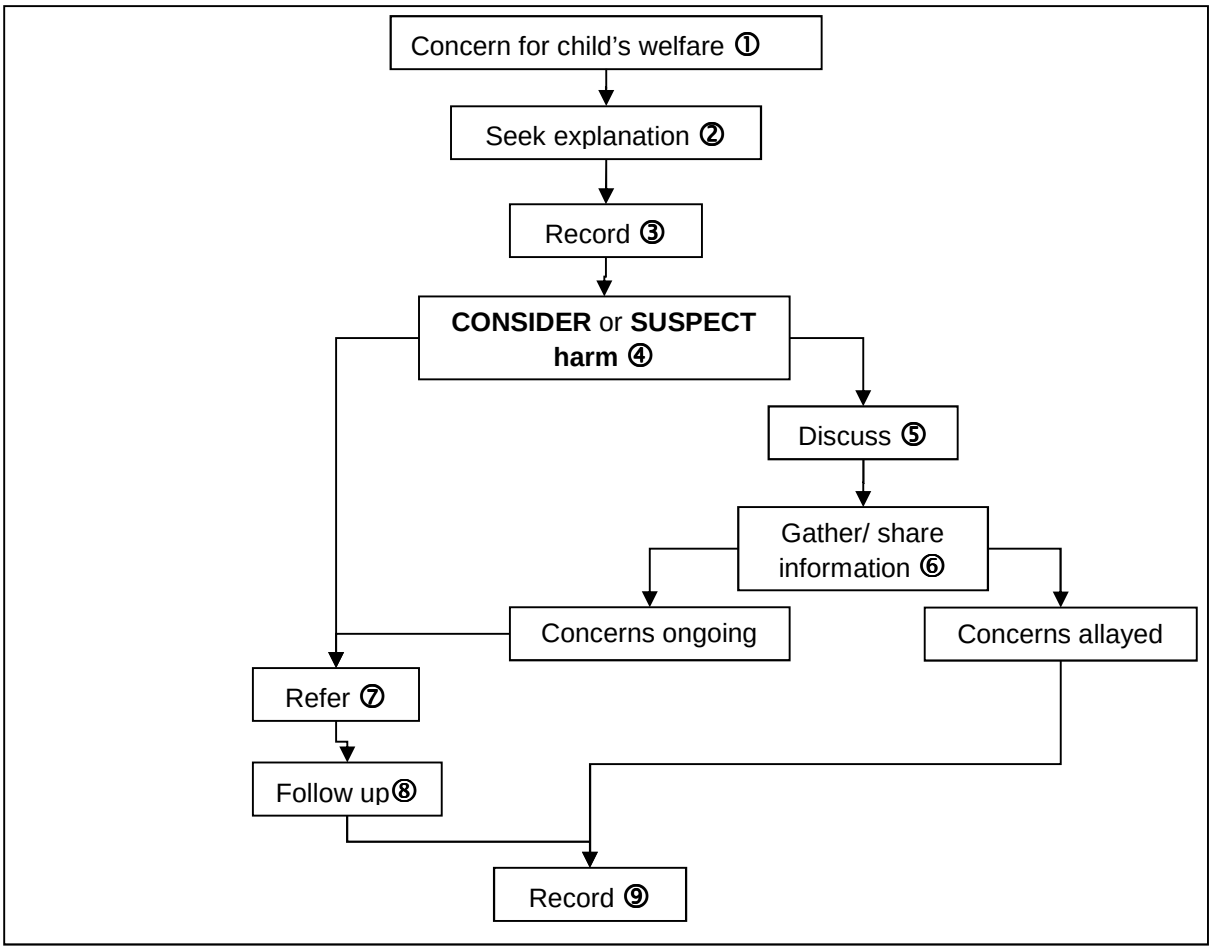
- Stay calm
- Listen carefully to what is being said
- Reassure the child that they have done the right thing by telling you
- Find an appropriate early opportunity to explain that it is likely the information will need to be shared with others – do not promise to keep secrets
- Allow the child to continue 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
- 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 discussing your concerns and if necessary passing this information on

Practice Early Help – Recognition, Response, Record

If a member of the practice team identifies concerns regarding a child's welfare, the following process, based on NICE clinical guideline 89 is helpful to follow.

A flowchart for the process is included below. ①, ② etc. reference notes below the flowchart.



No.	Notes
①	<u>Non-clinical practice staff.</u> It is highly likely that a non-clinical member of the practice team may observe, hear or become aware of issues which may lead to concerns about child maltreatment. Non-clinical staff must discuss concerns with a clinical member of the practice team, as a matter of urgency. A non-clinical member of staff who has identified concerns should continue to be involved, as appropriate, to ensure an accurate reflection of initial concerns.
②	Seek an explanation (if appropriate) for any injury or presentation from both the parent

	or carer and the child or young person in an open and non-judgemental manner. **An unsuitable explanation** is one that is implausible, inadequate or inconsistent: • with the child or young person's presentation, normal activities, existing medical condition, age or developmental stage, or account compared to that given by parent and carers • between parents or carers or between accounts over time **Cultural practice is an unsuitable explanation for hurting a child or young person.**
③	Record in the child or young person's clinical record • exactly what is observed and heard from whom and when. • why this is of concern.
④	**CONSIDER** means maltreatment is one possible explanation for the alerting feature or is included in the differential diagnosis. **SUSPECT** means serious level of concern about the possibility of child maltreatment but not proof of it.
⑤	Discuss your concerns with one or more of the following • Practice Safeguarding Lead (or deputy) • Named or Designated Professional Contact details at Appendix 1
⑥	Share concerns with and/or gather information from other professionals • Health Visitor • School Nurse • Midwife • Dentist, Optometrist, Pharmacist where appropriate.
⑦	Refer the child or young person to North Lincolnshire Council Children's Social Care Contact details at Appendix 1
⑧	See "After Referral" below
⑨	Keep a detailed record of all actions taken and outcome

A template for recording a child protection incident by practice staff is attached at Appendix 6, and could be used to be included in records, or used as an immediate record before information transferred into main records at a later stage.

Referral

It is best practice to inform parents/carers and/or the child of your concerns and next steps, unless to do so may put the child, another person, or yourself at risk.

As a general rule, you should contact Children's Social Care Services first unless the issue is more immediate and the child is in need of immediate medical attention or support from the Police.

Referrals should be made by telephone in the first instance.

Details of local Children's Social Care are below.

Locality		**Contacts**
North Lincolnshire	Office Hours Out of Hours	01724 296500 01724 296555 / 296444

Lincolnshire	Office Hours Out of Hours	01522 782111 01522 782333
Other localities	Contact North Lincolnshire Council Children's Social Service and request contact details for relevant local authority Referral point of contact.	

Police can be contacted on **999** in an emergency, or otherwise on **101** (ask for local Family Protection/Child Protection unit)

Details of other key professionals are included at Appendix 1.

After the Referral

All referrals should be followed up in writing within 48 hours.

Enquiry Process

Whether a member of practice staff, or another person has made a referral to Children's Social Care, practice staff (particularly clinical staff) may be asked to contribute information to Social Care's enquiry and will be expected to provide a written report in order to support this process. Staff should recognize the principles in respect to information sharing as per section on Confidentiality and Information Sharing below.

Referral Outcome

Children's Social Care should advise referrers of the outcome of their referral. However, if the referrer does not receive confirmation of the outcome, they cannot assume that their referral has been received, understood and acted on. Referrers are responsible for ensuring/clarifying the outcome of referrers and challenging the outcome if appropriate.

Escalation of issues

If any member of the practice staff is not happy with the outcome of discussions, referral, single agency, or multi-agency activity to safeguard a child they should discuss concerns with the Practice Safeguarding Lead, their deputy, or Named or Designated Professionals.

7. Child Protection Conferences

The contribution of GPs to safeguarding children is invaluable and priority should be given to attendance, in particular where a member of the practice team has been involved in the identification or direct management of abuse/neglect. If attendance is not possible or judged necessary, the provision of the report, even to say that the child has not been seen, is essential. (GMC Protecting children and young people 2012).

General Points for Preparing Reports for Conference

The Assessment Framework[5] recommends a three domain model of assessment.

- Child's developmental needs
- Parenting capacity
- Family & environmental factors

Consider:

- missed appointments with GP, practice nurse and midwife
- failed immunisations
- missed hospital appointments
- education: discuss with school nurse or health visitor
- parental mental health or substance abuse

[5] As referenced in Working Together to Safeguard Children (2013) Chapter 1 para 33

- ability of the carer to parent [disability, physical or intellectual]
- evidence of domestic violence
- cruelty to animals in the family
- are both parents registered with your practice?
- who has parental responsibility?
- sharing the report with the child if old enough and the parents where appropriate

8. Recording Information

Riverside Surgery will follow RCGP, GMC and other key guidance in respect to recording child protection issues.

Key principles

- Concerns and information about vulnerable children should be recorded in the child's notes and where appropriate, or available, the notes of siblings and significant adults, as soon as possible. The GMC document 'Protecting children and young people: the responsibilities of all doctors, (2012) states that doctors must record all concerns, including minor ones, as well as the details of any action taken, information shared, and decisions made relating to those concerns. .
- Concerns and information from other agencies such as social care, education or the police or from other members of the Primary Care Team, including health visitors and midwives, should be recorded in the notes.
- Email should only be used when secure, [e.g. nhs.net to nhs.net[6]] and the email and any response(s) should be copied into the record.
- Case Conference notes may be scanned in to electronic patient records as described below. This will usually involve the summary/actions, appropriately annotated by the child's usual doctor or Practice Safeguarding Lead
- Records, storage and disposal must follow national guidance for example, *Records Management, NHS Code of Practice* 2009
- If information is about a member of staff this will be recorded securely in the staff personnel file and in line with your own jurisdiction guidance

Information to be recorded

Consideration should be given to recording the following information in the child record.

- Record of abuse in the child or any other child in the household
- Record of whether the child or any other child in the household is or has been subject to a child protection plan
- Observed and alleged harmful parent – child interactions
- Basic family details (e.g. adults in the family, other siblings etc., including individuals who may not live at the address but who have regular contact with the child e.g. father, grandparents etc.)
- Details of any housing problems
- Details of significant illness or problems in the family, such as parental substance misuse or mental illness
- History of domestic abuse in the household
- House fires
- Ante-natal concern
- Multiple new registrations
- Multiple consultations especially emergencies

[6] Local Authority e-mails addresses including gcsx.gov.uk, or police e-mail addresses including pnn.police.uk are part of the government secure infrastructure, and as such are secure.

Sources of information

Information can be sought and entered from:

- the new patient health checks on all children, including enquiry about family, social and household circumstances – (a Climbié Inquiry recommendation[7])
- any contact with a potential carer – **'seeing the child behind the adult'** – so that a patient with a substance misuse problem for example is asked about any responsibility they may have for a child, and that child's record amended accordingly, so that such families' progress can be reviewed.
- opportunistic consultations
  - Antenatal booking
  - Postnatal visit
  - 6 week check
- Practice Team meetings, where regular discussion of all practice children subject to child protection plans, or any other children in whom there may be concerns, should highlight safeguarding issues in children and their families
- correspondence from outside agencies, such as A&E/OOH reports and other primary and secondary care providers[8]

Case Conference Summaries & Minutes

The RCGP recommends that case conference summaries and minutes are processed and stored in the following way[9]:

	Read code significant details	**Scan in summary**	**Scan in full minutes**
Child (subject of conference)	Yes	Yes	Yes
Adults & other household members named in report	Yes	Yes	No

Conference minutes should not be stored separately from the medical records because:

- they are unlikely to be accessed unless part of the record
- they are unlikely to be sent on to the new GP should the child register elsewhere
- they may possibly become mislaid and lead to a potentially serious breach in patient confidentiality.

Whilst GPs may have concerns about third party information contained in case conference minutes, part of the solution is to remove this information if copies of medical records are released for any reason, rather than not permitting its entry into the medical record in the first place.

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[7] The Victoria Climbie Inquiry – report of an inquiry by Lord Laming Jan 2003, Recommendation 86

[8] Care Quality Commission 2009: Review of the involvement and action taken by health bodies in relation to the case of Baby P

[9] The minutes should be read by the relevant GP. If the minutes contain a majority of pertinent information that other professionals are likely to need to know, particularly where they are taking the case on cold (such as a locum, or GP receiving the patient on a transfer) then the full minutes can be scanned. If there is little pertinent information, this should be entered as free text notes on the child's record. Following either the scanning, or entry of pertinent information, the paper copy should be securely disposed of (e.g. shredded).
Thanks to Dr Joanna Walsh for this material

Delayed recording of information.

In some circumstances, information which needs including in a child's, or significant adult's records may not be available to be immediately added to the record:

- correspondence from other health providers or agencies may not be received for some days/weeks
- change of GP practice, may lead to change in electronic recording system e.g. EMIS to SystmOne, or vice versa.

Specific consideration should be taken with information added to a record, where there is a delay between the intervention/ episode of care which the information relates to, and the inclusion of the information on the record. If the child or adult has received a service from a member of the practice, or from another clinician recording on a shared record, i.e. using SystmOne, in the "delay period", the individual clinician should be advised of the new entry/information on the record.

Further information on Record keeping can be found in Appendix 4

9. Confidentiality and Sharing Information

Riverside Surgery will follow the statutory guidance on sharing information in child protection cases which is as follows.

- In England and Wales, the Children's Acts of 1989 and 2004 give GPs a statutory duty to co-operate with other agencies (Children Act 1989 section 27, 2004 section 11) if there are concerns about a child's safety or welfare.
- The Children, Schools and Families Act 2010 section 8 amends The Children Act 2004 providing further statutory requirements for information sharing when the LSCB requires such information to allow it to carry out its functions.
    - This includes sharing information for the purpose of Serious Case Reviews, Child Death Reviews and joint audit of case files[10].

This means that the default position is that the practice will share information with

- Social Care where there are concerns about a child's safety or welfare; and
- the LSCB directly, or via Named/Designated health professionals (see details at Appendix 1)

Not doing so may be legally indefensible.

General Principles

The 'Seven Golden Rules' of information sharing are set out in the government guidance, Information Sharing: Pocket Guide[11]. This guidance is applicable to all professionals charged with the responsibility of sharing information, including in child protection scenarios.

1. **The Data Protection Act is not a barrier to sharing information**[12] but provides a framework to ensure personal information about living persons is shared appropriately.

[10] http://www.legislation.gov.uk/ukpga/2010/26/section/8 and Working Together to Safeguard Children 2013 Chapter 3, paragraph 2.

[11] Information Sharing : Pocket Guide HM Government October 2008

[12] It could reasonably be said that neither is the common law duty of confidentiality, or the Human Rights Act see Re F (Adult: Court's Jurisdiction) [2000] 1 Fam 38, per Sedley LJ - "The family life for which Article 8 [the right to respect for private and family life] requires respect is not a proprietary right vested in either parent or child: it is as much an interest of society as of individual family members and its principal purpose, at least where there are children, must be the safety and welfare of the child"

2. **Be open and honest** with the person/family from the outset about why, what, how and with whom information will be shared and seek their agreement, unless it is unsafe or inappropriate to do so.
3. **Seek advice** if you have any doubt, without disclosing the identity of the person if possible.
4. **Share with consent where appropriate** and where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent, if, in your judgement, that lack of consent can be overridden by the public interest. You will need to base your judgement on the facts of the case.
5. **Consider safety and well-being**, base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.
6. **Necessary, proportionate, relevant, accurate, timely and secure**, ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up to date, is shared in a timely fashion and is shared securely.
7. **Keep a record of your concerns, the reasons for them and decisions** Whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose

General Medical Council Guidance

The General Medical Council offers guidance on confidentiality and information sharing in Protecting children and young people, 2012). The GMC advises that the first duty of doctors is to make the care of their patients their first concern:

- when treating children and young people, doctors must also consider parents and others close to them, but the patient must be the doctor's first concern
- when treating adults who care for, or pose risks to, children and young people, the adult patient must be the doctor's first concern, but doctors must also consider and act in the best interests of children and young people GMC 2007: 0-18 years

This might be phrased:
"see the adult behind the child" and ***"see the child behind the adult"***

Consent should be sought to disclosures unless:

- that would undermine the purpose of the disclosure [such as fabricated & induced illness and sexual abuse]
- action must be taken quickly because delay would put the child at further risk of harm
- it is impracticable to gain consent

When asked for information about a child or family, practice staff should consider the following:

- **identity**, check identity of the enquirer to see if they have a bona fide reason to request information. Call back the switchboard or ask for a faxed request on headed notepaper
- **purpose**, ask about the exact purpose of the inquiry. What are the concerns?
- **consent**, does the family know that there are enquiries about them? Have they consented and if not why not? Consent is not necessary if there is felt to be a risk of harm to the child from seeking it. Receiving a signed consent form from Social Services does not imply consent given to you to share. If this doesn't cause harmful delay, you may also wish to seek consent from the family
- **need-to-know basis**, give information only to those who need to know
- **proportionality**, give just enough information for the purpose of the enquiry and no more. This may mean relevant information about parents/carers

- **keep a record**, make sure that you record the details of the information sharing, including the identity of the person you are sharing information with, the reason for sharing and whether consent has been obtained and if not why not

GMC advice includes:

- sharing information with the right people can help to protect children and young people from harm and ensure that they get the help they need. It can also reduce the number of times they are asked the same questions by different professionals. By asking for their consent to share relevant information, you are showing them respect and involving them in decisions about their care
- if a child or young person does not agree to disclosure, there are still circumstances in which you should disclose information:
  a. when there is an overriding public interest in the disclosure
  b. when you judge that the disclosure is in the best interests of a child or young person who does not have the maturity or understanding to make a decision about disclosure
  c. when disclosure is required by law.

Further guidance on confidentiality and information sharing can be found in Appendix 5.

10. Declaration

In law, the responsibility for ensuring that this policy is reviewed belongs to the partners.

The partners may delegate this responsibility to Dr Avinash Pillai

We have reviewed and accepted this policy

Signed by: Date:

Signed: _____

on behalf of the Partnership

The practice team have been consulted on how we implement this policy

Signed by: Date:

Signed: _____

Appendix 1: Safeguarding Contact details

The following professionals may be contacted for advice in North Lincolnshire

North Lincolnshire and Goole NHS (NLAG)		
Dr Suresh Nelapatla	***Designated DR***	(01724)387974 sureshnelapatla@nhs.net
Dr Etuwewe	***Named DR***	(01724) 387974
Craig Ferris	***HEAD OF SAFEGUARDING***	*07887656918* craig.ferris@nhs.net
Lisa Robinson/Jane Westoby	***NAMED NURSE FOR CHILDREN (acute)***	jane.westoby@nhs.net lisa.robinson5@nhs.net
Mandy Irvine	***SPECIALIST NURSE (community)***	mandy.irvine@nhs.net
Mike Griffiths	***NAMED NURSE FOR ADULTS (acute)***	michaelgriffiths1@nhs.net
Joanne Lewis	***SPECIALIST NURSE FOR ADULTS AND CHILDREN (acute)***	joanne.lewis4@nhs.net
Richard Painter	***MCA lead***	r.painter@nhs.net
Katie Bentham	***NAMED MIDWIFE***	katie.bentham@nhs.net
Carol Whitlam	***Paediatric liaison***	c.whitlam@nhs.net

Rotherham, Doncaster and South Humber NHS Trust		
Julie Lodge	***RDASH consultant nurse for safeguarding***	01302798198 julie.lodge12@nhs.net
Charlotte Harrison	***RDASH named nurse for safeguarding***	07789864789 charlotte.harrison7@nhs.net

North Lincolnshire Clinical Commissioning Group (CCG)		
Dr Jaggs-Fowler	***MEDICAL DIRECTOR***	01652 251000
Sarah Glossop	***DESIGNATED NURSE FOR CHILDREN & ADULTS***	**07789615434** **sarah.glossop@nhs.net** **01652 251216**
Sally Bainbridge	***SPECIALIST SAFEGUARDING NURSE FOR ADULTS AND CHILDREN***	07702975637 Sally.bainbridge3@nhs.net
Liz Baxter	***SPECIALIST SAFEGUARDING NURSE*** ***REFERRAL MANAGEMENT***	07474 275202 liz.baxter@nhs.net

Appendix 2: Types of Child Maltreatment

Physical Abuse

Definition:

A form of abuse which may involve: hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.
Working Together 2013

Alerting features to suspect Physical Harm include:

- abrasions
- bites (human)
- bruises
- burns or scalds
- cold injuries
- cuts
- eye injuries
- fractures
- hypothermia
- intra-abdominal injuries
- intracranial injuries
- intrathoracic injuries
- lacerations
- ligature marks
- oral injuries
- petechiae
- retinal haemorrhage
- scars
- spinal injuries
- strangulation
- subdural haemorrhage
- teeth marks

Or consider

- Child with hypothermia and legs inappropriately covered in hot weather [concealing injury]
- For fabricated illness discrepancy in the clinical picture with one or more of the following:
    - Reported signs or symptoms only in the presence of the carer, multiple second opinions being sought, inexplicably poor response to medication or excessive use of aids, biologically unlikely history of events even if the child has a current or past physical or psychological condition.

Emotional Abuse, Behavioural, Interpersonal & Social Functioning

Definition:

The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.
Working Together 2013

Alerting features to suspect include:

- persistent harmful parent or carer – child interactions
- hiding or scavenging for food without medical explanation
- precocious or coercive sexualised behaviour

Or consider:

- physical/mental/emotional developmental delay
- low self-esteem
- changes in behaviour or emotional state without explanation
- self-harming/mutilation
- extremes of emotion, aggression or passivity
- secondary enuresis or encopresis
- drug/solvent abuse
- running away
- responsibilities which interfere with normal daily activities (such as school)
- school refusal

Sexual Abuse

Definition:

Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.
Working Together 2013

Alerting features to suspect include:
- ano-genital symptom in a girl or boy that is associated with behavioural change
- sexually transmitted infection
- hepatitis B or C in under 13
- pregnancy in under 13s

Or consider:
- persistent unexplained ano-genital symptoms
- sexually transmitted infection in 13-15yr old
- ano-genital warts (see CG89)
- marked power differential in relationship
- behaviour changes
- sudden changes
- inappropriate sexual display
- secrecy, distrust of familiar adult, anxiety left alone with particular person
- self-harm/mutilation/attempted suicide
- unexplained or concealed pregnancy

Neglect

Definition:

The persistent failure to meet a child's basic physical and/or psychological needs is likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:
- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of inadequate care-givers); or
- ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.
Working Together 2013

Alerting features to suspect include:
- abandonment
- repeatedly not responding to child or young person
- repeated injuries suggesting inadequate supervision
- persistently smelly or dirty
- failure to seek medical help appropriately

Or consider:
- poor personal hygiene, poor state of clothing
- frequent severe infestations (scabies, head lice)
- faltering growth (due to poor feeding)
- untreated tooth decay
- repeated animal bites, insect bites or sunburn
- treatment for medical problems not being given consistently
- poor attendance for immunisations
- low self-esteem
- lack of social relationships; children left repeatedly without adequate supervision
- parents failing to engage with healthcare attend appointments [practice or wider health professional] and/or use A&E/Out-of-Hours services frequently.

Clinical presentations

Alerting features that should prompt you to **CONSIDER** child maltreatment:
- Unusual pattern of presentation to and contact with healthcare professionals, or frequent presentations or reports of injuries.
- Poor school attendance that the child's parents or carers know about that is not justified on health (including mental health) grounds, and formally approved home education is not being provided.
- Bleeding from the nose or mouth in an infant who has an apparent life-threatening event and a medical explanation has not been identified.
- Hypernatraemia if a medical explanation has not been identified.
- A near-drowning incident that suggests a lack of supervision.

Alerting features that should prompt you to **SUSPECT** child maltreatment:
- Repeated apparent life-threatening events in a child, if the onset is witnessed only by one parent or carer and a medical explanation has not been identified.
- Poisoning in a child in any of the following circumstances:
    - deliberate administration of inappropriate substances, including prescribed and non-prescribed drugs
    - unexpected blood levels of drugs not prescribed for the child
    - reported or biochemical evidence of ingestions of one or more toxic substances
    - the child could not access the substance independently
    - repeated presentations of ingestions of substances in the child or other children in the household
    - there is an absent or unsuitable explanation.
- Child has a near-drowning incident with an absent or unsuitable explanation.

Fabricated or induced illness

Alerting features that should prompt you to **CONSIDER** fabricated or induced illness:
- Child's history, physical or psychological presentation, or findings of assessments, examinations or investigations, leads to a discrepancy with a recognised clinical picture, even if the child has a past or concurrent physical or psychological condition.

Alerting features that should prompt you to **SUSPECT** fabricated or induced illness:

- Child's history, physical or psychological presentation, or findings of assessments, examinations or investigations leads to a discrepancy with a recognised clinical picture plus one or more of the following, even if the child has a past or concurrent physical or psychological condition:
    - reported symptoms and signs are only observed by, or appear in the presence of, the parent or carer
    - an inexplicably poor response to prescribed medication or other treatment
    - new symptoms are reported as soon as previous symptoms stop
    - biologically unlikely history of events
    - despite a definitive clinical opinion being reached, multiple opinions from both primary and secondary care are sought and disputed by the parent or carer and the child continues to be presented for investigation and treatment with a range of signs and symptoms
    - child's normal daily activities (for example, school attendance) are limited, or they are using aids to daily living (for example, wheelchairs) more than expected from any medical condition that the child has.

Parent – or carer – child interactions

Alerting features that should prompt you to **CONSIDER** child maltreatment:

- Potentially harmful parent– or carer–child interactions (emotional abuse), including:
    - negativity or hostility towards a child or young person
    - rejection or scapegoating of a child or young person
    - developmentally inappropriate expectations of or interactions with a child, including inappropriate threats or methods of disciplining
    - exposure to frightening or traumatic experiences, including domestic abuse
    - using the child to fulfil the adult's needs (for example, in marital disputes)
    - failure to promote the child's appropriate socialisation (for example, not providing stimulation or education, isolation or involving them in unlawful activities).
- Emotional unavailability and unresponsiveness from the parent or carer towards a child (in particular towards an infant) (emotional neglect).
- Parent or carer prevents you or another healthcare professional from speaking to the child or young person alone when it is necessary for the assessment of the child or young person.
- Parents or carers punishing a child for wetting despite professional advice that the wetting is involuntary.

Alerting features that should prompt you to **SUSPECT** child maltreatment:

- Persistent harmful parent– or carer–child interactions (emotional abuse).
- Persistent emotional unavailability and unresponsiveness from the parent or carer towards a child (in particular towards an infant) (emotional neglect).

Appendix 3: Child Developmental Stages

A brief guide to developmental stages 0-5 years

When signs of injury are detected in young children it is useful to have a working knowledge of developmental stages to ascertain whether the findings may be explained by accidental injury. Babies who are too immature to be capable of independent movement are unable to sustain accidental injury due to their own activities.

Most babies begin to crawl at around 8 months of age from which point they may become capable of injuring themselves, this tendency increases as they attempt to learn to walk unsupported. Toddlers when first learning to walk are often unsteady on their feet and frequently topple; injuries occur to bony prominences such as forehead and extensor surfaces of joints such as elbows and knees, usually on areas unprotected by clothing. All young children require supervision in the bath and around paddling and swimming pools.

Children are individuals and do not all develop at the same pace. The milestones listed here are a guideline only; some children will achieve these milestones earlier, others a little later.

Age	Physical	Social and Emotional	Cognitive	Language
Birth-4 weeks	• Lies in foetal position with legs flexed at hips and knees joints relatively stiff • Weak neck muscles, unable to raise head, head requires support at all times when being handled • Requires head support in bath, considerable head lag if pulled to sitting position(not advised) N.B. some may be able to wriggle, squirm and roll so require supervision if placed on raised surfaces	• Begins to bond with mother • Total dependence	• Can make eye contact • Gaze intently at human faces • Scan environment visually • Will look at large visual patterns seemingly with appreciation • Uses hands to begin exploring own body starting with face	• Cries vigorously if hungry or in need • Some babies produce a variety of pleasurable high pitched coos and gurgles after feeding or when picked up

Age	Physical	Social and Emotional	Cognitive	Language
6- 8 weeks	• Legs are no longer flexed at hips • Lies with pelvis flat • Begins to lose some primitive reflexes e.g. Moro • Joints less stiff • Can raise head momentarily when placed prone.	• Smiles at mother and possibly other familiar human faces • Eyes and head turn to follow moving objects, people and animals	• Turns head towards certain sounds • Becomes aware of familiar household noises e.g. ringing of telephone or doorbell, voices of family members	• Begins to use different cries for different needs • Coos and gurgles when content
3 months	• Can bring hands together • Tries to reach for small objects • When placed prone can raise head and look round, • Shoulders require support in bath • Can usually roll in one direction	• Smiles spontaneously • Beginning to develop own routine and feeding pattern	• Turns towards sound of familiar voice	• Makes noises like ah-goo • Squeals when happy • Cries less
4 months	• In prone position can use arms to raise trunk off surface • Can grasp rattle, uses hands to explore own body • Legs kick vigorously	• Focuses on small objects	• Recognises parents, siblings and others seen often • Acknowledges them by smiling or emitting pleased noises	• Can laugh out loud
6 months	• Rolls in both directions • Picks up small objects, brings them to mouth	• Looks for dropped toys • Recognises own name by turning when called	• Holds out arms to be picked up	• Uses vowel-consonant combinations

Age	Physical	Social and Emotional	Cognitive	Language
8 months	• Sits up without support • Transfers objects from one hand to another • Can eat a biscuit • Learning to bottom shuffle or crawl, some can pull to stand and cruise • Eager to explore environment • Can pull open drawers and cupboard doors near floor level	• Begins to demonstrate separation anxiety when mother leaves room • Becomes wary of strangers	• Understands the meaning of 'no' • Objects to toys being taken away • Explores by putting found objects in mouth • Explores genitals during nappy changes and bath time	• Says da-da, ma-ma • Tuneful babble
12 months	• Picks up small objects using 'pincer' grasp e.g. thumb and forefinger • Walks using furniture as support 'cruising' • May be capable of standing and walking without support	• Responds to simple requests • Waves goodbye	• Communicates needs by sound and gesture rather than crying	• Talks in jargon • Says mama, dada, few one syllable words like 'no'
18 months	• Can bend and crouch to pick up an object then rise without use of arms to support self • Walk backwards a few steps • Starting to attempt stair climbing, sometimes while carrying one or more objects • Can kick a ball, attempts to push and/or pull large objects	• Sense of self developing, Says definite 'no' or 'mine' • Interested in playing simple games	• Looks at books • Helps with dressing self • Points to parts of body • Searches for lost objects • Spontaneous scribble with pencil	• Can say phrase of 4-8 words • Complex babble • Points to named objects • Tries to sing

Age	Physical	Social and Emotional	Cognitive	Language
2 years	• Can run • Throw a ball, • Walk up and down steps holding on to railing or support; • Can pull large wheeled toy attached to a cord • Can jump with two feet together • Unwraps small sweets, can pick up tiny objects like pins	• Plays side by side with other children • Concept of sharing not yet developed • Demands desired objects by loud single word articulations, will become insistent if requests not met	• Begins to show imaginative play • Interested in images and books • Dresses and undresses self with help • Dominant hand and foot apparent • Beginning to play contentedly on own but prefers an adult to be near • No longer taking toys and other objects encountered to mouth • Remembers where objects belong	• Comprehends at least 50 words, can articulate 20-50 clear words, clear 2 word sentences • Names pictures and objects when asked • Beginning to name small objects seen at a distance • Beginning to sing, join in with nursery rhymes
3 years	• Can walk heel to toe • Stand on one leg • Jumps off one step • Climbs upstairs one step at a time without support • Can use scissors • Can use spoon and fork • Can thread beads	• Can separate from parents without crying • Can begin to describe feelings e.g. happy, sad • Imaginative play involving others • Likes to help with household activities	• Can follow three step instructions • Can define objects by use • Undresses and dresses self appropriately without assistance • Understands concepts of size e.g. bigger, smaller • Recognises money • Draws a crude but recognisable face	• Can give own name when asked • Can name objects and body parts • Can develop spontaneous non-repetitive sentences

Age	Physical	Social and Emotional	Cognitive	Language
4 years	• Can catch, throw, bounce and kick a ball • Can confidently walk up and down stairs one step at a time • Can run well on flat surfaces • Can climb playground ladders • Can pedal tricycle	• Takes turn and shares • Play shows understanding of complex social situations • Plays with rather than alongside other children • Can play games with simple rules	• Can understand some human feelings • Can compare sizes of objects • Can count from one to five with comprehension • Can create play stories with different roles • Can do up buttons, put on socks and shoes	• Can use two or more personal pronouns • Can tell a story • Can hold conversations • Understands prepositions • Speech is easily understood by strangers
5 years	• Can easily catch and throw a ball • Can run well on tiptoes • Skilfully climbs, slides, swings • Can walk along narrow line • Skips on alternate feet • Stands on either foot for 10 seconds without losing balance • Can use knife and fork • Uses scissors to cut out simple shapes • Holds pencil or crayon very precisely using thumb and index finger	• Has learnt social skills: to negotiate, share, avoid conflict	• Able to compare speed e.g. faster, slower • Can count up to 20 • Beginning to understand concept of time; morning, afternoon • Knows home address: street number and name • Money: beginning to recognise and remember values of coins and notes • Can dress self appropriately without assistance	• Able to hold a long, intelligible conversation • Understands opposites, similarities between objects, prepositions, personal pronouns • Learning to write

This guide is by no means comprehensive. Further and more detailed guidance may be obtained from the following:

References

1. Sheridan, M., Sharma, A., Cockerill, H., (2007) From Birth to Five Years: Children's Developmental Progress 3rd Ed Routledge

2. Polnay L, Hull D. (1993) Community Paediatrics 2nd Ed Churchill Livingstone

3. Queensland Government (2008) Child Development Milestones available online at www.health.qld.gov.au/ph/documents/childhealth/28133.pdf

Appendix 4: Keeping records

Key points

- Keep clear, accurate and legible records.
- Make records at the time the events happen, or as soon as possible afterwards.
- Record your concerns, including any minor concerns, and the details of any action you have taken, information you have shared and decisions you have made relating to those concerns.
- Make sure information that may be relevant to keeping a child or young person safe is available to other clinicians providing care to them.

What you should record

52. You must keep clear, accurate and legible records. You must record your concerns, including minor ones, in the child's or young person's records (and in their parents' records if you have access to them). You must also record clinical findings, decisions you have made, actions you have taken, information you have given and received, and conversations you have had with the child, young person, their parents or other family members. You must make the records at the time that the events you are recording happen, or as soon as possible afterwards.

53. If you share information, you must record this in the child's or young person's records. If you share information about members of the child's or young person's family, you should include this in their records if you have access to them. You should include details of the information you shared, who you shared it with and why. You should also include whether consent was given and, if so, who gave it.

54. If you share confidential information without consent, you must record the reasons for your decision. You should also record any steps you took to try to get consent or your reasons for not doing so, and details of any advice you received.

55. If, after getting advice, you decide not to share information, you must be prepared to justify that decision. You must record your decision and your reasons for not sharing information.

56. Medical records are made to support safe and effective care but they may be used for other purposes. For example, they may be used when making decisions about a child's or young person's safety or welfare, as they can help build up a picture over time. They may also be used as evidence in court. It is particularly important that records relating to the possible abuse or neglect of a child or young person are full, accurate, dated and timed, and distinguish between clinical findings, your opinions and information provided by others. You should clearly record any continuing uncertainty about the risk of abuse or neglect to a child or young person because this information may be relevant if put together with other information about the child or young person or their family.

57. If there is not enough evidence to support your concerns that a child or young person is being abused or neglected, or the evidence shows that your concerns are not correct, you should record this clearly in the child's or young person's medical record and in their parents' records. You should explain to the child or young person and their parents why information about these events will remain on their medical records.

Storage and access to records

58. You should store information or records from other organisations, such as minutes from child protection conferences, with the child's or young person's medical record, or make sure that this information will be available to clinicians who may take over the care of the child or young person. If you provide care for several family members, you should include information about family relationships in their medical records, or links between the records of a child or young person and their parents, siblings or other people they have close contact with.

59. Patients, including children and young people, have a legal right to see their own medical records unless this would be likely to cause serious harm to their physical or mental health or to that of someone else. A parent may see their child's medical records if the child or young person gives their consent, or does not have the capacity to give consent, and it does not go against the child's best interests[13].

60. If you are responsible for storing and disposing of medical records, you must make sure this is done in line with official guidance on managing records, including the retention schedules published by the UK health departments. This applies whether or not you work in the National Health Service (NHS).[14]

[13] For more advice, see paragraphs 53–55 of General Medical Council (2007) 0–18 years: guidance for all doctors, London, General Medical Council, available at www.gmc-uk.org/0-18

[14] For advice on storing and disposing of recordings made as part of a patient's care, see *Department of Health (2006) Records management: NHS code of practice London, Department of Health, available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4131747*

Appendix 5: Confidentiality and sharing information

From General Medical Council (2012) Protecting children and young people.

Confidentiality

Whilst confidentiality is central to the trust between doctors and patients and an essential part of good care, sharing information appropriately is essential to providing safe, effective care, both for the individual and for the wider community. It is also at the heart of effective child protection. It is vital that all doctors have the confidence to act on their concerns about the possible abuse or neglect of a child or young person.

31. Confidentiality is not an absolute duty[15] You can share confidential information about a person if any of the following apply.
   a. You must do so by law or in response to a court order.[16]
   b. The person the information relates to has given you their consent to share the information (or a person with parental responsibility has given consent if the information is about a child who does not have the capacity to give consent).[17]
   c. It is justified in the public interest – for example, if the benefits to a child or young person that will arise from sharing the information outweigh both the public and the individual's interest in keeping the information confidential.

Sharing information where you are concerned that a child or young person is at risk of, or is suffering, abuse or neglect

32. You must inform children's social care services, or the police, promptly if you are concerned that a child or young person is at risk of, or is suffering, abuse or neglect. You do not need to be certain that the child or young person is at risk of significant harm to take this step. If a child or young person is at risk of, or is suffering, abuse or neglect, the possible consequences of not sharing relevant information will, in the overwhelming majority of cases, outweigh any harm that sharing your concerns with an appropriate agency might cause.

33. When telling an appropriate agency about your concerns, you should provide information about both of the following:
   a. the identities of the child or young person, their parents and any other person who may pose a risk to them
   b. the reasons for your concerns, including information about the child's or young person's health, and any relevant information about their parents or carers.

34. You should ask for consent before sharing confidential information unless there is a compelling reason for not doing so. For example, because:
   a. delay in sharing relevant information with an appropriate person or authority would increase the risk of harm to the child or young person
   b. asking for consent may increase the risk of harm to the child, young person, you or anyone else.

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[15] See General Medical Council (2009) Confidentiality London, General Medical Council, available at www.gmc-uk.org/confidentiality

[16] It is not always straightforward to assess whether there is a legal requirement to disclose information. If in doubt, you should seek legal advice. If disclosure has been ordered by the court, and you are unsure about the relevance of information or records, you should seek clarification from your instructing solicitors or the court.

[17] See appendix 1 to this guidance for advice on assessing capacity. There is more guidance in General Medical Council (2007) 0–18 years: guidance for all doctors London, General Medical Council, available at www.gmc-uk.org/0-18

35. You should ask the child or young person for consent if they have the capacity to give it. If not, you should ask a person with parental responsibility. You should also ask for consent from any adults you want to share information about. When asking for consent, you should explain why you want to share information and how it will benefit the child or young person. You should also explain all of the following:
   a. what information you will share
   b. who you will share it with
   c. how the information will be used
   d. where they can go for independent advice and support (see pages 57–58 of this guidance for examples of organisations).

Sharing information without consent

36. You can share confidential information without consent if it is required by law, or directed by a court, or if the benefits to a child or young person that will arise from sharing the information outweigh both the public and the individual's interest in keeping the information confidential. You must weigh the harm that is likely to arise from not sharing the information against the possible harm, both to the person and to the overall trust between doctors and patients of all ages, arising from releasing that information.

37. If a child or young person with capacity, or a parent, refuses to give consent to share information, you should consider their reasons for refusing, and weigh the possible consequences of not sharing the information against the harm that sharing the information might cause. If a child or young person is at risk of, or is suffering, abuse or neglect, it will usually be in their best interests to share information with the appropriate agency.

38. If you share information without consent, you should explain why you have done so to the people the information relates to, and provide the information described in paragraph 35, unless doing this would put the child, young person or anyone else at increased risk. You should also record your decision as set out in paragraph 54. (see Appendix 4).

Delay in sharing information

39. Any decision to delay sharing information with an appropriate agency where a child or young person is at risk of, or is suffering, abuse or neglect must be taken cautiously and only in circumstances where the increased risk to the safety or welfare of the child or young person clearly outweighs the benefits of sharing information. You must be able to justify your decision. You must record the decision not to immediately share information, along with your reasons and any advice you have received.

40. If, exceptionally, you decide that sharing information immediately with the local authority children's services or another appropriate agency would not be in the child's or young person's best interests, you should discuss this with the child or young person, or their parents. You must keep in contact with the child or young person and regularly review the decision to delay sharing information. You must try to make sure that the child or young person gets the care and support they need.

41. **In sharing concerns about possible abuse or neglect, you are not making the final decision about how best to protect a child or young person**. That is the role of the local authority children's services and, ultimately, the courts. Even if it turns out that the child or young person is not at risk of, or suffering, abuse or neglect, sharing information will be justified as long as your concerns are honestly held and reasonable, you share the information with the appropriate agency, and you only share relevant information.

Following up your concerns

42. You should follow up your concerns and take them to the next level of authority if you believe that the person or agency you told about your concerns has not acted on them appropriately and a child or young person is still at risk of, or is suffering, abuse or neglect.

Minor concerns that might be part of a wider picture

43. Risks to children's or young people's safety and welfare often become apparent only when a number of people share what seem to be minor concerns. This may include people from different agencies. If a child's or young person's condition or behaviour leads you to consider abuse or neglect as one possible explanation[18] but you do not think that they are at risk of significant harm, you should discuss your concerns with your named or designated professional or lead clinician or, if they are not available, an experienced colleague. If possible, you should do this without revealing the identity of the child or young person.

44. If your discussions do not provide a clear view about the possibility of abuse or neglect, you should consider sharing limited relevant information with other agencies that are in contact with the child or young person to decide whether there is a risk that would justify sharing further information. Relevant information would include the identity of the child or young person and a brief summary of the cause for concern. You must ask for consent to do this as described in paragraph 35. If the person or people you ask refuse to give consent, you should assess whether the possible benefits of sharing information outweigh those of keeping the information confidential as described as in paragraph 37.

45. If you are not satisfied that sharing information is justified in the circumstances, you should regularly review the position, considering the safety and welfare of the child or young person. You should encourage the parents, or child or young person, to get help and support. If you later become concerned that the child or young person is at risk of, or is suffering, abuse or neglect, you must tell an appropriate agency as set out in paragraph 32.

Responding to requests for information

46. You should consider all requests for information for child protection purposes seriously and quickly, bearing in mind that refusing to give this information, or a delay in doing so, could increase the risk of harm to a child or young person or undermine efforts to protect them.

47. You must respond fully and quickly to a court order asking for information. You must also cooperate with requests for information needed for formal reviews[19] carried out after a child or young person has died or been seriously harmed and abuse or neglect is known, or is suspected, to have been a factor. The purpose of such a review is to learn lessons from mistakes and to improve systems and services for children and

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[18] You can find a detailed discussion of situations where abuse or neglect may explain the person's condition or behaviour or be part of the differential diagnosis in the National Institute for Health and Clinical Excellence (2009) When to suspect child maltreatment London, National Institute for Health and Clinical Excellence, available at http://guidance.nice.org.uk/CG89

[19] For example, serious case reviews in England and Wales, significant case reviews in Scotland, case management reviews in Northern Ireland, inquests and inquiries, and inquiries into sudden or unexpected child deaths.

young people. You should also cooperate with procedures set up to protect the public from violent and sex offenders.[20]

48. Before sharing confidential information, you should do all of the following.

a. Check the identity of the person who has asked for the information – for example, by calling them back if you receive a telephone request from a person or agency you do not recognise.
b. Check that the request is valid, understand why the person or agency is asking for the information, what information they need, and how they may use the information in the future.
c. Make sure that you have met one of the conditions for sharing information set out in paragraph (31).

49. You should only share information that is relevant to the request. This will include information about the child or young person, their parents and any other relevant people in contact with the child or young person. Relevant information will include family risk factors, such as drug and alcohol misuse, or previous instances of abuse or neglect, but you should not usually share complete records.[21] If you share information without consent you should follow the advice in paragraph 38.

50. If you are not sure whether to share information, you should discuss your concerns and the best way to manage any risk to a child or young person with your named or designated professional or lead clinician or, if they are not available, an experienced colleague.

[20] For example, multi-agency public protection arrangements (MAPPA).For further guidance, see paragraph 56 of General Medical Council (2009) Confidentiality London, General Medical Council, available at www.gmc-uk.org/confidentiality

[21] If you are not sure whether information is relevant and whether or not to share certain information, see paragraphs 42–52 of *General Medical Council (2007) 0–18 years: guidance for all doctors London, General Medical Council, available at www.gmc-uk.org/0-18*

Appendix 6: Child Protection Incident Reporting Form

Name of Child	Venue	Date
Date of Birth	Age	Time
Address Postcode		
Telephone Number	Name of Parent/Guardian	
Are you reporting your own concerns or passing on those of someone else? Give details		
Brief description of what has prompted the concerns: include dates, times etc. of any specific incidents		
Are there any physical signs? Behavioural signs? Indirect signs?		
Have you spoken to the child, young person and or persons present? If so, what was said to whom?		
Have you spoken to the parent(s) guardians? If so, what was said?		

Has anybody been alleged to be the abuser? If so, give details?	
Have you consulted anybody? Give details	
Your name	Position
To whom reported	Date of reporting
Signature	Date

Source: Luce R Safeguarding Children: Legal Framework for Nurses, Midwifery and Community Practitioners. Publishers: John Wiley & Sons 2008

Appendix 7: Child Protection Significant Events

Adverse event;	An incident that did lead to harm
Near miss:	An incident that did not lead to harm
Safeguarding incidents:	This term covers everything that could have or did cause harm to children and families. It focuses specifically on 'no harm' incidents or 'near misses'.

Are you reflecting on or acting on safeguarding actions? For example, events occurring elsewhere. Reflection in this situation would be a proactive mechanism rather than reactive. Some adverse events occur infrequently and may only be detected every few years by organisations. Serious case reviews and child death reviews are other mechanisms for reflection.

Question to ask here is "Could this adverse event/safeguarding incident occur in our practice?"

Brief description of event:

Issues raised by the event:

What went well?:

What did not go well?
What changes have you identified or made to clinical or administrative practices?
Are there any staff training and/or other performance management needs?
Consider in what other ways you could share what you have learned or where you could submit safeguarding incidents anonymously to a project lead.

Source: Luce R Safeguarding Children: Legal Framework for Nurses, Midwifery and Community Practitioners. Publishers: John Wiley & Blackwell

Appendix 8: Sample Template for Recording Learning

Record of Learning

Learning activity:	Safeguarding Children and Young People in General Practice
Provider	
Format used or venue: (delete as applicable)	
Dates of training and time spent (hours):	
Reflective notes/ conclusions:	How has my learning affected me? How will it affect others working with me? How will it affect the care of my patients?
Action plan:	What do I need to do now? When do I need to do it by? What help or resources will I need? How will I know when I've achieved it?
Have the training/ resources identified further learning needs?	Is there anything else I need to do as a result?
Relationship to Appraisals and Personal Development Plan:	How does this fit with what I already know or need to know?

Appendix 9: Children Unknown to Your Practice

Introduction

Most children in the United Kingdom are registered with an NHS general practitioner. When children who are not known are seen, health professionals should take the opportunity to assess them for signs of abuse listed elsewhere in this document.

Children in both the following categories may be at risk of abuse and neglect and may also present medico-legal risk to the practice.

1. Children who are registered with a practice but are never or rarely seen

Children may not be brought for screening or immunisations appointments or not presented for care of acute conditions at the practice. It should be noted that infants and young children depend on adults for provision of care and failure to make and keep such appointments might be considered a feature of neglect. It should be considered good practice on the part of health professionals to follow up failure to attend for prophylactic care and to persuade reluctant parents to present children for such care.

Such children may be frequently presented to Out of Hours Services and A&E departments for care of acute conditions, yet fail to attend routine Out-Patients appointments. These are known indicators of risk (CEMACH 2008). Practices might wish to develop routine searches and flagging to identify such children. www.cmace.org.uk/Publications-Press-Releases/Report-Publications/Child-Health.aspx

2. Children presented for immediately necessary treatment or temporary registration.

These may be:

- children already registered with another UK GP who are on holiday or visiting relatives
- children who are 'privately' fostered
- children who are looked after by the local authority
  - placed with foster carers
  - in a children's home,
- recent immigrants not yet registered
- asylum seekers
- illegal immigrants
- trafficked children

Treatment of these children is already funded within General Medical Services and most Personal Medical Services contracts. The GPs duty is to provide any necessary medical treatment to the child regardless of place of origin or right to UK residence. Detailed guidance may be found at:
https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/protecting-children-and-young-people

An essential aspect of the duty of care to the child is that careful, detailed, contemporaneous records are maintained and accurate contact details be obtained in the event that follow-up for a medical condition is required or concern about the child's well-being has been aroused. The child's full name, permanent address and telephone number, name of carer, name of usual GP and school if of school age, should be ascertained, in addition to the temporary address and telephone contact details.

If in the course of seeing such children the GP feels there is a possibility that the child may be at risk, it might be helpful to telephone the child's usual GP or school to obtain more information.

In most cases seeing children as temporary residents is a straightforward procedure. GPs practising in resort towns with a regular influx of tourists every summer will be used to seeing a number of children with minor and straightforward ailments which do not cause great concern and this may also apply to children staying temporarily with relatives known to the practice.

Children in the care of the local authority should be registered permanently, concerns around the length of the placement and possible changes of GP should be discussed with their social worker and every effort must be made to ensure that their records are transferred to the next GP in a timely and appropriate manner when they move.

However, it is necessary to maintain continuing awareness of the existence of children who may have been trafficked, who are in this country illegally or who are children of failed asylum seekers. GPs have a responsibility to provide urgent and immediately necessary care for all children, even those of uncertain immigration status while being conscious that carers of such children may seek to avoid attention of the authorities by providing assumed names and false addresses.

Reviewed June 2018