SAFEGUARDING CHILDREN AND VULNERABLE ADULTS

Practice Safeguarding Policy

Policy Updated 19.02.2018

[Please see Safeguarding folder in Consulting room 1 for additional information and advice]

Royal College of General Practitioners

Horndean Surgery 2013/14/15/16/18

Practice policy and procedure

Contents

Introduction

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/phone). We aim to achieve this by ensuring that Horndean Surgery is a child-safe practice.

Horndean 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[1]. 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.

Horndean Surgery 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 in January 2012.

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

1 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 30/03/2007 via http://www.nspcc.org.uk/Inform/Applications/PPA/documents/NSPCC%20response%20to%20the%20Home%20Office%20consultation%20on%20the%20Belgian%20proposal.doc

- understand what behaviour is acceptable
- understand what abuse is
- minimise any potential risks to children

Background and principles

Safeguarding children and young people is a fundamental goal for Horndean Surgery. 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

1. **Physical Abuse**
2. **Emotional Abuse**
3. **Sexual Abuse**
4. **Neglect**

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 Lead

The practice safeguarding lead is

Dr Clare Matthews

His/ her deputy is

Dr Coombe, Dr Z Hirmiz

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

Horndean Surgery 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 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
- ensures 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)

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

RCGP encourages publication of material on Safeguarding Children, including:

- Polnay: Child Protection in Primary Care [Radcliffe Medical Press, 2001][ISBN 1 85775 224 4]
- Bannon & Carter: Protecting Children from Abuse and Neglect in Primary Care [Oxford University Press 2003][ISBN 0 19 263276 0]
- Care of Children & Young People: A textbook for the nMRCGP (RCGP Publishing 2009)(in publication]

Minimum criteria for all staff

The minimum safety criteria for all staff that work at Horndean Surgery are:

- have CRB check [enhanced for clinical staff]
- have 2 references that have been followed up
- have been interviewed face to face

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 to examine and vet:

- criminal records or cautions
- police intelligence
- other appropriate sources

http://www.isa-gov.org.uk/

Practices may wish to note that 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, organised by the local PCO, under local arrangements
- All members of staff will undergo child protection training at least every three years
    - Non-clinical staff Level 1*
    - Clinical staff [GPs, Practice Nurses and others] Level 2*
    - Practice Safeguarding Lead Level 3*
- 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

*as defined in *Safeguarding Children and Young People: Roles and Competences for Health Care Staff.* Intercollegiate Document [RCPCH lead] April 2006 [currently in revision]. Some professionals and areas will aspire to more advanced training.

http://www.rcpch.ac.uk/doc.aspx?id_Resource=1535

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 (see *Working Together (2006*) Chapter 5, page 113, Para 5.160 – 5.162; Section 11 on making arrangements to safeguard and promote the welfare of children and young people (2005) page 22; *National Service Framework* standard 5, page 170 at Para 14.1).

Whistle blowing

Horndean 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.

Complaints procedure

Horndean Surgery 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 Manager and complaints procedures.

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 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 show 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 Horndean Surgery staff 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.

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.

Reporting

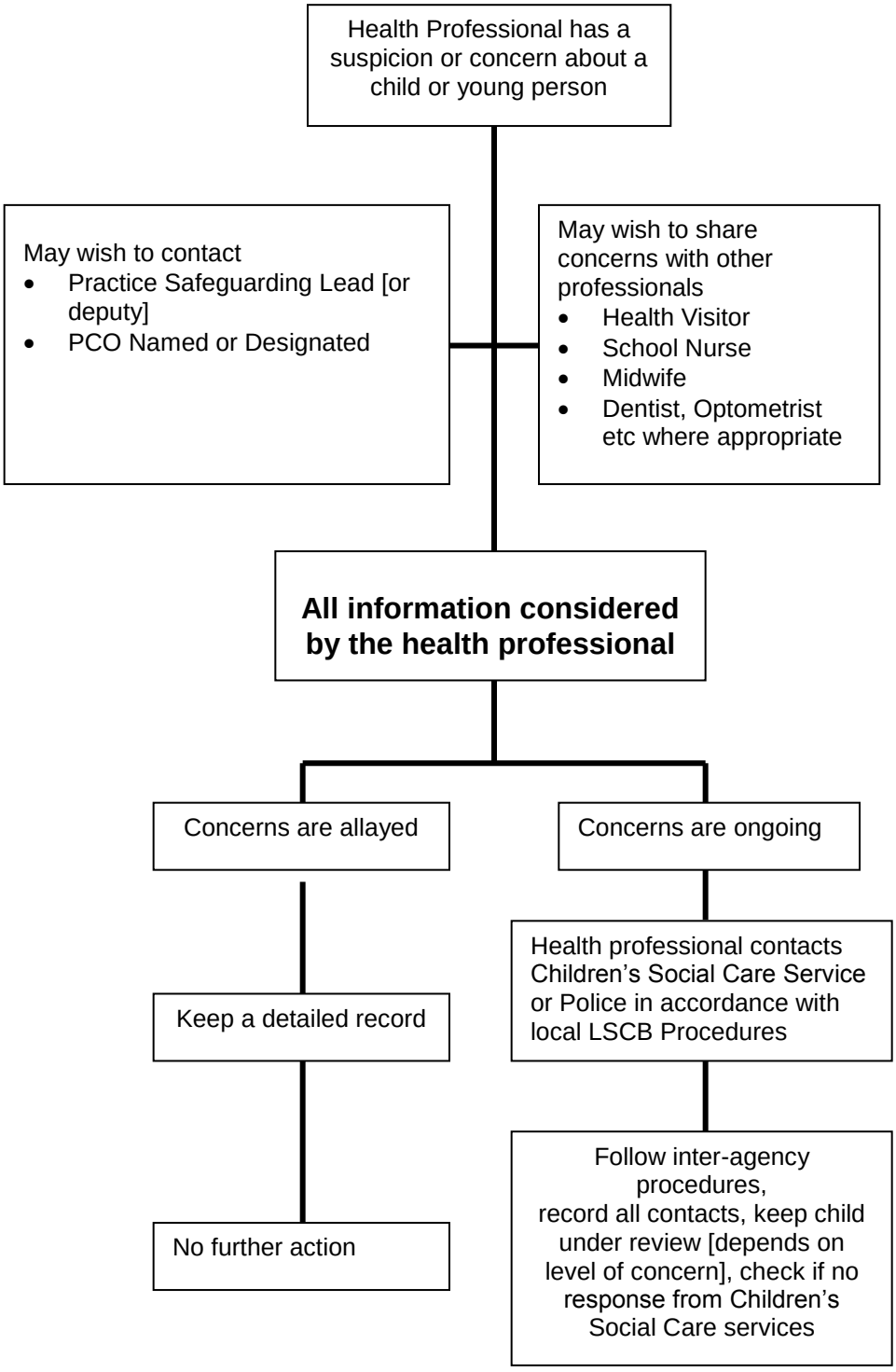
In the first instance, and if the risk to the child is not increased by doing so [situations such as Sexual Abuse or Fabricated & Induced Illness might increase risk; consult local guidance], the health professional or Practice Lead for Child protection will inform the child and accompanying carer/ parent 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
Hampshire County Council. Havant, Hampshire	Hampshire Professionals' Line Tel: 01329 225379	Hampshire Constabulary Tel: 0845 045 45 45
	Out of Hours Tel: 0300 555 1373	Out of Hours Tel: 0845 045 45 45
NSPCC	**National Helpline**	**0808 800 5000**

Practice reporting process



Enquiry process

.

Practice staff (particularly health professionals) may be asked to contribute information and will be expected to provide a written report in order to this process. It is possible that attendance at a case conference or court proceedings may be required in order to share the information. In these situations it may be advisable for a member of staff to be accompanied by a manager and seek support from the Designated and Named Health Professionals.

Child Protection Conferences

The contribution of GPs to safeguarding children is invaluable, and priority should be given to attendance wherever possible. GPs may claim a fee for attendance at Child Protection Conferences, under the *Collaborative Arrangements for Work for Local Authorities* 1974, to defray their expenses. Different arrangements exist in different areas: consult your health authority or Local Medical Committee for details. Consider liaising with your Health Visitor and School Nurses in addition about your attendance. Examples of different guidance exist (London wide LMCs, Isle of Man), but all are clear that no delay should occur in the provision of information while payment is sought.

General points for preparing reports

The Assessment Framework Tool* recommends a triangle model of assessment:

- Child's developmental needs
- Parenting capacity
- Family & Environmental Factors

Consider:

- missed appointments with GP, Practices Nurse, and Midwife
- failed immunisations
- missed hospital appointments
- education: discuss with School Nurse or Health Visitor
- parental mental health or substance abuse
- 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?
- share the report with the child if old enough, and the parents where appropriate

**Framework for the Assessment of Children in Need and their Families DH, DFEE 2000*

Recording Information

- Information about vulnerable children will be recorded in the child's notes, and where appropriate the notes of siblings and significant adults. This will be recorded using locally agreed Read codes (see **Appendix 7: Information Governance**)
- Information supplied by all members of the Primary Care Team, including the Health Visitor, will be recorded in the notes under a Read code. Email should only be used when secure, and the email and any response(s) should be copied into the record.
- Conversations with and referrals to outside agencies should be recorded under an appropriate Read code
- 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* 2006
- 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

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
- 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 violence in the household

Information can be sought and entered from;

- new patient health checks on all children, including enquiry about family, social and household circumstances – (a Climbie Inquiry recommendation[2])
- any contact with a potential carer – '**seeing the child behind the adult**' – so that a patient with a substance misuse problem is asked about any responsibility they may have for a child, and that child's record amended accordingly
- Opportunistic consultations:

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

    - 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*

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

Case conference minutes

Case conference minutes frequently raise concerns because of their size and content (much of it about third parties). They should be processed and stored in the following way:

	Read code significant details	Scan in summary	Scan in full minutes
Child (subject of conference)	Yes	Yes	Yes*
Other Children (not subject of conference but living in same household/ same carers)	Yes	Yes	No
Adults named in report	Yes	Yes	No

*The minutes should be read by the relevant GP. The GP should identify any pertinent information in the minutes. 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 (i.e. shredded).

Thanks to Dr Joanna Walsh for this material

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; and,
- 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.

These procedures are regarded as best practice, but may vary between UK jurisdictions. You are advised to consult local PCO policies for further details.

Sharing Information

The practice will follow the policy on sharing information in child protection cases which is as follows:

- In England and Wales, in the Children's Acts of 1989 and 2004 give GPs a statutory duty to co-operate with other agencies (*Children Act* 1989 section 27) if there are concerns about a child's safety or welfare. Health authorities (PCOs) (section 47.9) have a duty to assist local authorities (Social/Child Care Services) with enquiries: Named Doctors for Child Protection can be powerful advocates for this function.

General Principles

The 'Seven Golden Rules' of information sharing are set out in the government guidance, *Information Sharing: Pocket Guide*[3]. 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**[4] but provides a framework to ensure personal information about living persons is shared appropriately.
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.

[3] *Information Sharing : Pocket Guide* HM Government October 2008

[4] 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"

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 decision and the reasons for it** – 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 which is regularly reviewed. 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 their 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, or
- 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.

Restraint policy also known as 'Positive Handling Policy'

Restraint is where a child is being held, moved or prevented from moving, against their will, because not to do so would result in injury to themselves or others, or would cause significant damage to property.

Restraint must always be used as a last resort, when all other methods of controlling the situation have been tried and failed. Restraint should never be used as a punishment or to bring about compliance (except where there is a risk of injury).

Only employees who are properly trained in restraint techniques should carry it out. A person should be restrained for the shortest period necessary to bring the situation under control.

Declaration

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

We have reviewed and accepted this policy

Signed by: Dated:

Signed: _____

on behalf of the Partnership Dated:

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

Signed by: Dated:

Signed: _____