Churchside Medical Practice
SAFEGUARDING CHILDREN PROTOCOL

INTRODUCTION

The procedures set out in this document are to ensure that child protection or *safeguarding* concerns are recognised and addressed as they occur in the practice. By raising child protection issues within the practice all staff will be aware of how they may access advice, understand their role in safeguarding, and understand the importance of effective Inter-agency communication.

These guidelines draw primarily upon national guidance including those listed under the resources section below. It is however vital that practices are aware of, and comply with the procedures in place locally and these may be obtained, and advice sought, from the Consultant or Designated Nurse of Safeguarding Children.
Safeguarding is a difficult area for general practice, which must consider the welfare of the child first, but must also maintain a relationship with the family. It is very important that all staff understand the need to get help early when they have concerns about a child.
In addition all staff and those with substantial unsupervised access to children should have satisfactory DBS clearance including all reception staff dealing with children or child development clinics.

Education involving case discussion and encouraging reflective practice is helpful. Case discussion with named or designated staff can be especially valuable. Child protection issues in general practice need a robust system of note-keeping and recording, message handling and communication of concern. The protocol will address:

- Key staff training
- Documentation
- Reporting
- Local procedures

Key Factors
• The welfare of the child is paramount
• Be prepared to consult with colleagues
• Be prepared to take advice from local experts
• Keep comprehensive, clear, contemporaneous records
• Be aware of GMC guidance about sharing confidential information

RECOGNISING CHILD ABUSE

There are 4 main categories of child abuse:

- Physical abuse
- Sexual abuse
- Emotional abuse

- Neglect/failure to thrive

These are not however exclusive, and abuse in one of these areas may easily be accompanied by abuse in the others.

Physical abuse may include:

- Hitting, shaking, throwing, poisoning, burning or scalding, or other forms of physical harm
- Where a parent or carer deliberately causes ill-health of a child
- Single traumatic events or repeated incidents

Sexual abuse may include:

- Forcing or enticing a child under 18 to take part in sexual activities where the child is unaware of what is happening
- May include both physical contact acts and non—contact acts

Emotional abuse may include:

- Persistent ill-treatment which has an effect on emotional development
- Conveyance of a message of being un-loved, worthless or inadequate
- May instil feeling of danger, being afraid
- May involve child exploitation or corruption

Neglect may include:

- Failure to meet the child's physical or psychological needs
- Failure to provide adequate food or shelter
- Failure to protect from physical harm
- Neglect of a child's emotional needs

Common presentations and situations in which child abuse may be suspected include:

- Disclosure by a child or young person
- Physical signs and symptoms giving rise to suspicion of any category of abuse
- The history is inconsistent or changes.
- A delay in seeking medical help
- Extreme or worrying behaviour of a child, taking account of the developmental age of the child
- Accumulation of minor incidents giving rise to a level of concern, including frequent A&E attendances. The Practice should look at the background of children attending frequently (more than 3 times in 6 months or 5 times in a year) or if the discharge from A and E raises concerns.

Some other situations which need careful consideration are:

- Disclosure by an adult of abusive activities
- Girls under 16 presenting with pregnancy or sexually transmitted disease, especially those with learning difficulties
- Very young girls requesting contraception, especially emergency contraception
- Situations where parental mental health problems may impact on children
- Parental alcohol, drug or substance misuse which may impact on children
- Parents with learning difficulties
- Violence in the family

- Risk of radicalisation and involvement in terrorist activities
- Children, especially those from outside the UK, presenting alone or with an adult who does not have parental responsibility

RECOGNISING A CHILD IN NEED

A child in need is defined as a child whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development without the provision of services (section 17, Childrens' Act 1989). This includes disabled children. The Childrens' Acts 1984 and 2004 define a child as someone who has not reached their 18th birthday. The fact that a child has reached their 16th birthday, and may be living independently, working, or be members of the armed forces does not remove their childhood status under the Acts.
The Children's Act 2004, as amended by the Children & Social Work Act 2017, strengthens the duties of care towards children placed on the local authority and places new duties on key agencies in a local area. Specifically, the Police, CCGs and local authority re under a duty to make arrangements to work together, and with other partners locally to safeguard and promote the welfare of all children in their area.

CHILD PROTECTION REGISTER / PROTECTION PLAN

Working together to safeguard children 2018 replaces all previous guidelines. The main changes are;

1) Local safeguarding Children Boards (LSCBs) replaced with safeguarding partners such as local authorities, Police & Clinical Commissioning Groups all having equal responsibility.
2) From June 2018, the Child Safeguarding Practice Review Panel has been responsible for identifying and overseeing reviews of serious child safeguarding incidents.
3) Child death Reviews undertaken by child Death Review Partners (made up of CCGs and local authorities).
4) Emphasises organisational responsibility "organisational and agencies working with children and families should have clear policies for dealing with allegations against people who work with children"

A list of children judged to be at continuing risk for whom there is a child protection plan in place, is maintained by social services. Social services, police and health professionals have 24 hour access to this. A child on the register has a "key worker" to whom reference can be made.

COVID19 PANDEMIC TEMPORARY CHANGES

In light of the covid19 pandemic there has been a significant increase in the use of remote consultation methods but use of these must also be carefully risk assessed when concerning consultations with children and young people and also with vulnerable adults. Much as it is important to reduce infection rates of coronavirus it is also important that clinicians continue to be able to hear the voice of a child or young person. It is also clear that clinicians need to be careful that they do not inadvertently send out mixed messages regarding on-line safety to vulnerable patients. It is important to consider if a remote consultation is strictly necessary and a clinician must be able to justify the use of it as being able to provide benefit to the patient. When choosing a remote consultation method rather than a F2F appointment it is important to remain vigilant to safeguarding concerns. If at any time during a remote consultation a clinician becomes concerned that they cannot fully explore all clinical issues or if a safeguarding concern becomes apparent it is advisable to convert to a F2F appointment. Further information

on this can be found on the RCGP website: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0479-principles-of-safe-video-consulting-in-general-practice-updated-29-may.pdf. It is also important to be fully aware of the guidance surrounding the receipt and use of intimate images in particular. There has been some debate regarding this at a national level but local policy is that this should be only used in exceptional circumstances. A link to the policy can be found above.

TRAINING IN SAFEGUARDING

All staff will be trained in Safeguarding within 3 months of induction and have an annual update. This will normally be via an external basic awareness course which all staff should complete or via the online training tool used by the practice Blue Stream Academy. All staff should know what constitutes to child abuse and the range of types. Admin and Health Care Assistants should have a minimum of level 2 training and GP's and Practice Nurses a minimum of level 3 training which is required to be renewed on a yearly basis. This includes how to document their concerns who to inform and the next steps in the process. Details of training dates are available from Nottinghamshire training board and an on line Safeguarding Children e-Academy module is also available. All staff should attend any locally arranged protected time events in child protection.

HCA's AND ADMINISTRATION STAFF

- All HCA's and Administration staff will be made aware of the practice procedures regarding child protection.
- If the Health Visitor is not immediately available, any member of staff who has concerns regarding the welfare of any child will report their concerns to the child's GP or, in their absence, to the duty doctor.
- Administration staff will be made aware of the need to look out for child protection related correspondence coming into the practice and ensure that it is dealt with appropriately and in strictest confidence.
- In the event of a member of the practice staff becoming aware of, or suspecting that a child has suffered significant harm, she/he should take appropriate action in accordance with the Practices Child Protection guidelines.

GENERAL PRACTITIONERS AND PRACTICE NURSES

- GPs and practice nurses will familiarize themselves with the systems used in the practice for making child protection referrals.
- They will know how to access information and advice, and the referral pathways.
- It may be appropriate to check the notes of a child's siblings, parents, and other household members and to consider adding computer alerts to their records.
- GPs should consider informing other clinicians and health care professionals as appropriate
- A clear written entry of any action taken will be made by the clinician.
- Clinicians will ensure that the practice Health Visitors are aware of the child protection issues.

CHILD PROTECTION ADMINISTRATORS (or "CPAs")

Dr Vanessa Pearce is child protection lead supported by Shelley Sherratt, Deputy Practice Manager are the designated CPAs for the practice and are responsible for ensuring that all information relating to Child Protection issues is regularly updated in the relevant patient record, with appropriate alerts being added to (and removed from) the records of the child/family member. Other responsibilities include.

- They should ensure all staff are aware of national child protection procedures.
- Ensure new staff have an introduction to child protection at induction
- Keep reporting procedures up to date and in line with any changes in national or local guidance
- Ensure clinical or reception staff with unsupervised access to children are DBS checked

In her absence Dr Claire Harrison should be approached for advice. Registrars should approach their relevant trainer. The Read Codes for alerts in use in the practice are:

135891007	Child in need
229054004	Child Protection Register/Plan
7648410000	Child is classed as a 'Looked after Child' (may still be living with a parent)
160889005	Child has been removed from the Register

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

160887007	Child on Child Protection Register (Parents)

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

The Health Visiting team is (normally) routinely copied in to all inter-agency child protection correspondence and conference outcomes relating to children at risk and child protection issues. However, as a precaution, the CPAs will always check with the Health Visitor that she is aware of the case.

WAS NOT BROUGHT CHILD PROTECTION AUDIT

There are 2 monthly safeguarding audits that are run by Shelley Sherratt Deputy Practice Manager.

1) *Accident & Emergency Attendances*
   This is based on a 3 month rolling rota and highlights children that have had more than 1 attendance to Accident & Emergency in the previous 3 months.

2) *Was Not Brought*
   This is based on the previous month and highlights children that failed to be brought to an appointment within practice.

Once Shelley Sherratt has completed both audits they are sent to Dr Vanessa Pearce Safeguarding Lead to review and highlight any repeated activity which is then brought for discussion at the Quarterly Safeguarding Meeting.

In addition if a child fails to be taken to a secondary or community care appointment once we are notified the clinical coder will try to make contact with the parent/guardian to ascertain why the child was not taken and if the appointment is still required.

Also, if a child fails to attend an appointment with a clinician within practice the clinician will try to make contact with the parent/guardian to ascertain why the child was not brought and if the appointment is still required.

Dr Vanessa Pearce Safeguarding Lead will be notified of concerns highlighted by staff members.

On an annual basis in December Sharon Atherton Practice Manager completes the **Nottingham and Nottinghamshire ICB's General Practice Safeguarding Self-Assessment Framework (SSAF)** to ensure the practice complies with all national and local guidance and protocols.

CHILD PROTECTION MEETINGS

- Carried out quarterly in Practice
- Safeguarding Lead to be in attendance
- Representative from Healthy Families in attendance
- Lists of children to be discussed kept on SystmOne ONLY
- List sent to health Families 10 days before the meeting
- No written minutes
- All notes should be coded within the child's records with appropriate actions where necessary

IF A GP SUSPECTS THAT A CHILD IS AT IMMEDIATE RISK:

- The GP should seek advice or make a referral.
- Advice may be sought on a 'what if?' basis, which avoids consent issues.
- Advice sought on a named patient basis should have appropriate consent unless there are good reasons why this cannot be obtained.
- Advice may be sought from Social Services. Out-of-hours advice may be sought from a senior hospital paediatrician.

ATTENDENCE AT CHILD PROTECTION CONFERENCES

"GPs should make available to child protection conferences relevant information about a child and family whether or not they, or a member of the primary health care team, are able to attend."

Working Together to Safeguard Children 1999 Para 3.30

The input of the GP at a Child Protection Conference can be extremely valuable. Often the GP is the only professional who has known the family and child over a period of years, and the GP can be in possession of relevant information not known to other professionals e.g. mental health of parents, or drug use. If the GP cannot attend, then a report or letter will be submitted, to include all relevant information. There is a proforma available to enable the GP to submit the relevant information.

REFFERRALS, GUIDANCE AND OTHER AGENCIES

- All verbal referrals to Social Services or any other agencies must be followed up in writing by the referrer, giving full details, within 48 hours.
- All health care professionals must ensure that they keep a complete contemporaneous and accurate record of the nature of the injury, suspicion and all actions taken. Notes must be made as soon as possible, giving date, time and full legible signature.

The flow chart in Appendix A documents the referral process for Churchside Medical Practice.

Contact details for the Lead Child Protection details within MASH:

Generic CCG Safeguarding team email: **mailto: nncccg.nottsccpsafeguarding@nhs.net**

CCG MASH Health team generic email: **NSHCCG.NottsMASH@nhs.net**

Stephanie Berry MASH Health Specialist Safeguarding Practitioner and MASH Health Manager (Full time) 07789921487

Rose Lindsay MASH Health Specialist Safeguarding Practitioner (Part time) 07799582809

Liz Braisby MASH Practitioner (Part time) 07341097189

Joanne Senior MASH Practitioner (Full time) 07880294341

Libby Quinn Safeguarding Administrator (Full time) 07880294334

Rachel Rodriquez Safeguarding Administrator (Full time) 07880295053

Dr. Lucy Genillard Named GP : Safeguarding Children 07823954955

John Scaysbrook Specialist Safeguarding Practitioner : Primary Care & LAC 07867157586

NOTTINGHAMSHIRE COUNTY COUNCIL CARE LEAVING TEAM

The Nottinghamshire Care Leaving Team offers a range of services for children and young people when they leave care. The type of help they provide depends on the age of the child and how long they were in care.

The leaving care service offers advice, support and guidance to 16- to 25-year-old young people who are eligible for support when they leave care. Young people who meet the criteria will be allocated a personal adviser who will co-ordinate a package of support.

This may include support in these areas:

- health and development
- accommodation
- education, training and employment
- maintaining positive relationships
- financial management
- independent living skills.

To get more information about our leaving care services contact the:
Leaving Care 18+ Team North (Mansfield, Newark and Bassetlaw), telephone: 01158041236
Leaving Care 18+ Team South (Broxtowe, Rushcliffe, Gedling and Ashfield), telephone: 01158546318.

PREVENT

All health professionals working with children must have " due regard to the need to prevent people from being drawn into terrorism" as set out in the document " Revised Prevent duty guidance: for England and Wales" www.gov.uk/government/publications/prevent-duty-guidance

All STAFF need to undergone channel awareness training on an annual basis. This gives insight into the risks for radicalisation and be aware that additional training also takes place in schools.

For advice on a patient who is causing concern, contact 0115 883 1849 who is the PREVENT lead for the county

For anyone who presents an immediate risk of committing an act of terrorism, contact the police on 101 (999)

FEMALE GENITAL MUTILATION (FGM)

The DoH issued a new mandatory reporting duty with regard to children who have had or who are at risk of FGM (www.gov.uk/government/publications/mandatory-reporting-of-female-genital-mutilation-procedural-information)

Note that FGM in a child should be treated as sexual abuse. The professional identifying FGM should call 101 (999)

See also: www.notts.nhs.uk/ccgpathways
Or from SystmOne –intranet-Mansfield and Ashfield CCG- Clinical pathways-Adult and Child safeguarding

CHILD SEXUAL EXPLOITATION

What is child sexual exploitation?

Child sexual exploitation (CSE) is a form of child abuse where children and young people are forced or manipulated into sexual activity. The abuser may groom the young person into trusting them – this can be done face-to-face or online – and they then exploit this trust for their own gain. Child sexual exploitation can take many forms and victims and perpetrators can be from any social or ethnic background. Sometimes offenders may get the young person to engage in sexual activity by giving them attention, treats, alcohol, drugs or a place to stay. Sometimes they may manipulate the young person into believing they are in a consensual relationship and that they love them. Either way, the young person is being taken advantage of through this controlling behaviour; it is child abuse and the victims face huge risks to their physical, emotional and psychological health. Nottinghamshire Police is committed to preventing child sexual abuse, helping victims and bringing offenders to justice.
Sexual offences against children are some of the most serious that the Force has to tackle. The effects of sexual exploitation on victims can be long-term and last long into adulthood.

Spot the signs

Some children are more at risk then others; it is the responsibility of everyone to spot the signs that a child may be vulnerable to sexual exploitation.

- Is the young person regularly missing from home or care?
- Do they have physical injuries?
- Are they taking drugs or misusing alcohol?
- Are they withdrawn from their family?
- Have they had repeated sexually transmitted infections or pregnancies?
- Are they regularly absent from school?

- Are they regularly offending?
- Have they received gifts from unknown sources?
- Are they self harming?
- Is there evidence of sexual bullying?
- Are they experiencing mental health problems?
- Have they attempted suicide?
- Is there evidence of online abuse through the internet and social networking sites?
- Are they trying to coax friends into exploitative situations?

How can I report it?
Anyone with concerns about child sexual exploitation should contact Crimestoppers anonymously on 0800 555 111, or call police on 101. Always call 999 in an emergency.

CHILD TRAFFICKING
Child trafficking is child abuse. Many children and young people are trafficked into the UK from other countries like Vietnam, Albania and Romania. Children are also trafficked around the UK. Trafficking is where children and young people tricked, forced or persuaded to leave their homes and are moved or transported and then exploited, forced to work or sold. Children are trafficked for:

- sexual exploitation
- benefit fraud
- forced marriage
- domestic slavery like cleaning, cooking and childcare
- forced labour in factories or agriculture
- committing crimes, like begging, theft, working on cannabis farms or moving drugs.

Trafficked children experience many types of abuse and neglect. Traffickers use physical, sexual and emotional abuse as a form of control. Children and young people are also likely to be physically and emotionally neglected and may be sexually exploited.
Signs of child trafficking are:

- Living apart from family
- Spend a lot of time doing household chores
- Are unsure of where they live
- Not be registered with a school or GP
- Seen in inappropriate places
- Have workplace injuries or injuries that are unusual for children
- Rarely leave the house or are seen playing
- Live in low standard accommodation
- Reluctant to share personal information
- No access to parents or guardians
- Have money and possessions that you wouldn't expect a child to have
- Give a prepared well-rehearsed story

How can I report it?

- Anyone with concerns about child sexual exploitation should contact Crimestoppers anonymously on 0800 555 111, or call police on 101. Always call 999 in an emergency.
- Contact your local child protection services. You can find their contact details on the website for the local authority.

MODERN DAY SLAVERY

Modern slavery is where one person controls another, sometimes children by exploiting a vulnerability. It is often linked with human trafficking, where a person is forced into a service against their will – usually forced work or prostitution. The control can be:

Sexual Exploitation
A person trafficked for sex may be controlled by violence, threats, substance abuse, deception or grooming, with extreme physical or psychological domination.

Forced Labour
Forced labour is work done under the threat of a penalty such as violence or harm to family. Victims are often further controlled by debt bondage.

Domestic Servitude
A person is forced to provide services with the obligation to live on or in a property without the possibility of changing those circumstances.

Organ Harvesting
A person who is trafficked and specifically chosen for the harvesting of organs or tissues, such as kidneys, liver etc. without consent, to be sold.

Victims are often hidden away, but it is possible you will encounter individuals or situations of concern. Knowing how to 'spot the signs' could save lives.

General Indicators
Trafficking victims are often lured into another country by false promises and so may not easily trust others. They may:

- Be fearful of police/authorities
- Be fearful of the trafficker, believing their lives or family members' lives are at risk if they escape
- Exhibit signs of physical and psychological trauma e.g. anxiety, lack of memory of recent events, bruising, untreated conditions
- Be fearful of telling others about their situation
- Be unaware they have been trafficked and believe they are simply in a bad job
- Have limited freedom of movement
- Be unpaid or paid very little
- Have limited access to medical care
- Seem to be in debt to someone
- Have no passport or mention that someone else is holding their passport
- Be regularly moved to avoid detection
- Believe they are being controlled by use of witchcraft

Sexual Exploitation
Be aware: ordinary residential housing/hotels are being used more and more for brothels. People forced into sexual exploitation may:

- Be moved between brothels, sometimes from city to city
- Sleeping on work premises
- Display a limited amount of clothing, of which a large proportion is sexual
- Display substance misuse
- Be forced, intimidated or coerced into providing sexual services
- Be subjected to abduction, assault or rape

- Be unable to travel freely e.g. picked up and dropped off at work location by another person
- Have money for their services provided collected by another person

Forced Labor
Where all the work is done under the menace of a penalty or the person has not offered himself voluntarily and is now unable to leave. They may experience:

- Threat or actual physical harm
- Restriction of movement or confinement
- Debt bondage i.e. working to pay off a debt or loan, often the victim is paid very little or nothing at all for their services because of deductions
- Withholding of pay or excessive reductions
- Withholding of documents e.g. passport/security card
- Threat of revealing to authorities an irregular immigration status
- Their employer is unable to produce documents required
- Poor or non-existent health and safety standards
- Requirement to pay for tools and food
- Imposed place of accommodation (and deductions made for it)
- Pay that is less than minimum wage
- Dependence on employer for services
- No access to labor contract
- Excessive work hours/few breaks

Child Abuse
"An abuse of a child's vulnerability by a person's position of power or trust, exploiting that position to obtain sexual services in exchange for some form of favour such as alcohol, drugs, attention or gifts" – Engage Team, Blackburn. You may notice a child that is:

- Often going missing/truanting
- Secretive
- Has unexplained money/presents
- Experimenting with drugs/alcohol
- Associating with/being groomed by older people (not in normal networks)
- In relationships with significantly older people
- Taking part in social activities with no plausible explanation
- Seen entering or leaving vehicles with unknown adults
- Showing evidence of physical/sexual assault (including STD's)
- Showing signs of low self image/self harm/eating disorder

Criminal Activities
The person is recruited and forced/deceived into conducting some form of criminal activity such as pick pocketing, begging, cannabis cultivation and benefit fraud. Same indicators as for forced labour but for cannabis cultivation you may also notice:

- Windows of property are permanently covered from the inside
- Visits to property are at unusual times
- Property may be residential
- Unusual noises coming from the property e.g. machinery
- Pungent smells coming from the property

Domestic Servitude
A particularly serious form of denial of freedom; this includes the obligation to provide certain services and the obligation to live on another person property without the possibility of changing those circumstances. They may:

- Be living and working for a family in a private home
- Not be eating with the rest of the family
- Have no bedroom or proper sleeping place
- Have no private space
- Be forced to work excessive hours; “on call” 24 hours a day
- Never leave the house without the ‘employer’
- Be malnourished
- Be reported as missing or accused of crime by their ‘employer’ if they try to escape

If you have a concern about someone you think is being forced into modern slavery please contact Crimestoppers anonymously on 0800 555 111, or call police on 101. Always call 999 in an emergency. Alternatively you can also call the Modern Slavery helpline number on 08000 121 700.

NON RECENT ABUSE
Churchside Medical Practice also recognises that there may be victims of abuse dating back many years that are only just coming to light. A dedicated helpline has been established for victims and survivors of child sexual abuse in Nottinghamshire.

Survivor Support Service

The service helps those who have experienced childhood sexual abuse. Specialists work with survivors to improve their health and wellbeing through coping strategies, emotional support and help accessing a range of services such as health (including mental health), housing, substance misuse and benefits.

How to contact the Survivor Support Service – 0115 941 0440

- Call the helpline (above) or 0115 947 0064 Option 2 (9am-5pm Mon-Fri)
- **https://nottssvss.org.uk/contact/** (secure web-based referral form)
- Notts SVSS will respond to contacts within one working day

DoLS Applications & enquiries to;
Safeguarding Adults Practice Team
Lawn View House
Station Road
Sutton in Ashfield
Nottinghamshire
NG17 5GA
Tel: 01623 434747
Advice & guidance also available on this number regarding Mental capacity Act, deprivation of Liberty Safeguards and ongoing Safeguarding Adults cases.
www.nottinghamshire.gov.uk/media/111852/safeguardingadultseasyreadguide20160203.pdf
www.nottinghamshire.gov.uk/ncsp

CONFIDENTIALITY

GP's and all staff have a duty of confidentiality, and patients have a right to expect that information given to a doctor in a professional context will not be shared without their permission. The GMC emphasises the importance in most circumstances of obtaining a patient's consent to disclosure of personal information. In general, if you decide to disclose confidential information without consent, you should be prepared to explain and justify your decision and you should only disclose as much information as is necessary for the purpose. The medical defence organisation will be consulted in all cases.
GMC guidance "Confidentiality: Protecting and Providing Information" (Sep 2000) describes the following circumstances when disclosure may be justified:

Disclosures to protect the patient or others

"Disclosure of personal information without consent may be justified where failure to do so may expose the patient or others to risk or death or serious harm. Where third parties are exposed to a risk so serious that it outweighs the patient's privacy interest, you should seek consent to disclosure where practicable. If it is not practicable, you should disclose information promptly to an appropriate person or authority. You should generally inform the patient before disclosing the information."

"Such circumstances may arise, for example:
Where a disclosure may assist in the prevention or detection of a serious crime. Serious crimes, in this context, will put someone at risk of death or serious harm, and will usually be crimes against the person such as abuse of children."

Paras 36 & 37c

Children and other patients who may lack competence to give consent

"If you believe a patient to be a victim of neglect or physical, sexual or emotional abuse and that the patient cannot give or withhold consent to disclosure, you should give information promptly to an appropriate responsible person or statutory agency, where you believe that the disclosure is in the patient's best interests. You should usually inform the patient that you intend to disclose the information before doing so. Such circumstances may arise in relation to children, where concerns about possible abuse need to be shared with other agencies such as social services. Where appropriate you should inform those with parental responsibility about the disclosure. If, for any reason, you believe that disclosure of information if not in the best interests of an abused or neglected person, you must still be prepared to justify your decision."

Para 39

Key Points:

- You can disclose information without consent if you are making a child protection referral (subject to the guidance above)
- You should always obtain consent if you are making a referral as a child in need
- If you are in doubt about whether to refer a child as a 'child protection referral' versus a 'child in need' referral, ask advice from one of your local advisers such as the Designated or Named Doctor or Nurse.
- Clear and comprehensive records relating to all events and decisions will be maintained

RECORDS

Registration

It is good practice to offer a medical examination. Record the following additional information:

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

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

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

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

Medical Record of Safeguarding Issues

An electronic record will be made and an Systmone and a major alert placed on the clinical system – see coding issues above. The medical record relating to child protection issues may also include clinical photography / video recordings, and it is recommended that a significant event form [*] be utilised within the medical record where a clinician identifies issues leading to increasing concern for the patient, or where an event occurs of particular note. Other aspects which may be recorded are:

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

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

Data Protection

- Current guidance suggests that written records relating to child protection issues ***should*** be stored as part of the child's permanent medical records, either manually or on computer, or both. This is a change to the previous recommendation. The practice should be alert to the fact that this guidance may be reviewed or amended in the future and must seek the guidance of the local NHS England Area Team in all instances. It is expected that practices will have permanent access to the local child protection instructions as part of the routine pathway procedures.

- As a normal part of compliance with the data protection act it is likely that third party information will be stored within these records, and the normal duty of non-disclosure of this third party information may apply when information is to be released – it may be appropriate at such times to take advice.

De-Registration

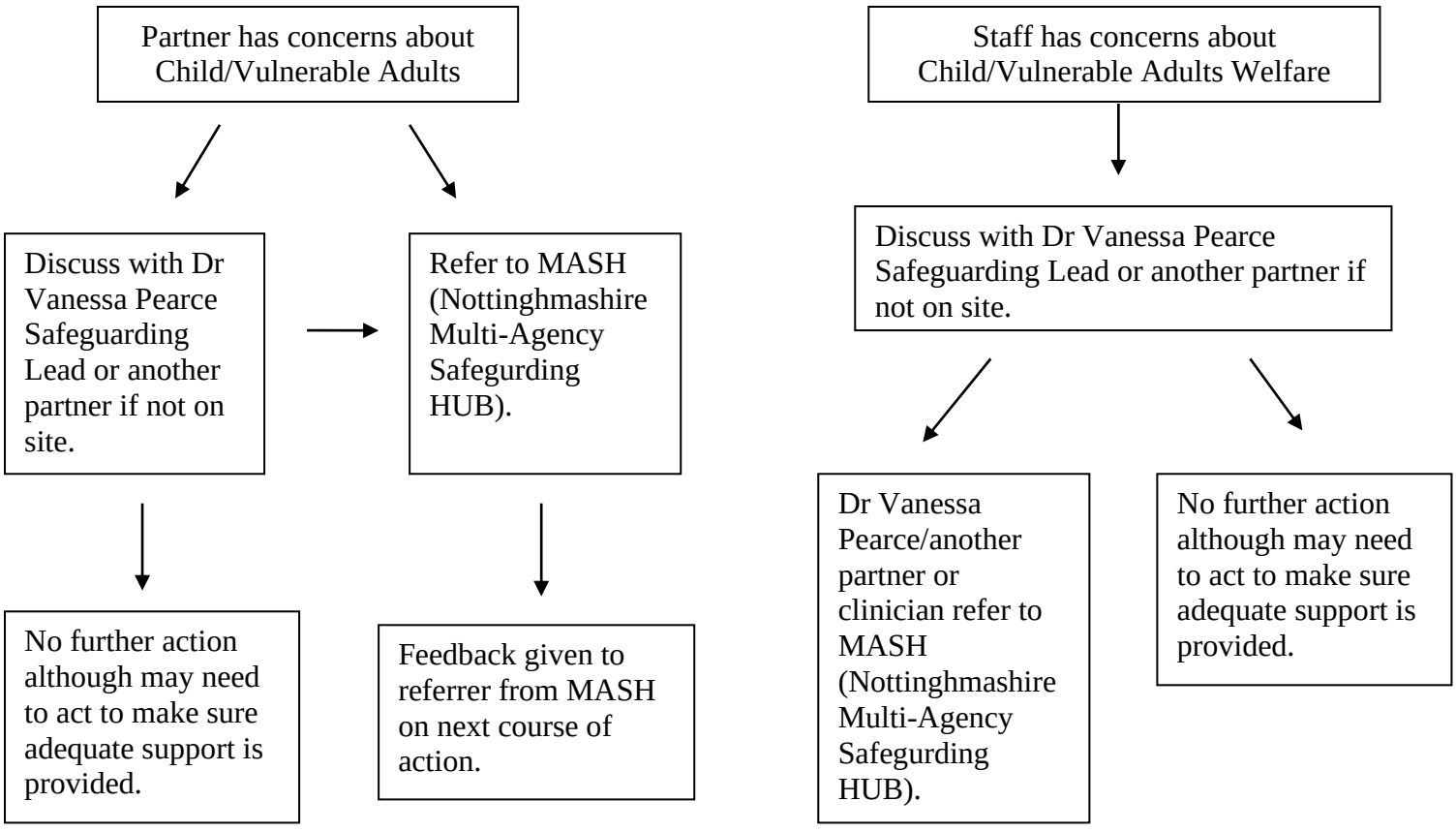
- When a child whose record contains a child protection alert, moves to a new surgery, the Child Protection Co-ordinator at the CCG is notified, normally by the Health Visitor. The Practice CPAs will ensure that the Health Visitor is made aware that the child is moving out of the area.
- The Child Protection Co-ordinator will contact the child's new GP or Health Visitor and will arrange for the transfer of any necessary records.

CP files forming part of the practice computer system will remain in place after the patient has de-registered in line with all other permanent medical records. Particular care must be taken by the transferring practice to ensure that all child protection documents and information is passed over to the receiving practice. This is again a departure from previous guidelines. This also applies to any confidential files which may (according to the needs of the case be filed separately.

Date: October 2022
Review Date: October 2024

Appendix A

Churchside Medical Practice Safeguarding Referral Procedure in Brief



Based on an extract from HM Government publication Working Together to Safeguard Children 2018.

Feedback given to referrer from MASH on next course of action.

CHURCHSIDE MEDICAL PRACTICE CHILD PROTECTION CONTACTS

- If you have concerns about the safety or wellbeing of a child or young person, or
- If you suspect a child or young person is being abused contact MASH (Nottinghamshire Multi-Agency Safeguarding Hub:
  Telephone Number: 0300 500 8090 during the following hours:
  8.30am-5.00pm Monday – Thursday
  8.30am – 4.30pm Friday

  Fax Number: 01623 483 295
  To submit an online concern form log onto www.nottinghamshire.gov.uk/MASH

In an emergency outside the hours stated above contact the Emergency Duty Team on 0300 456 4546To access information on early help services, guidance and to download service request forms please visit www.nottinghamshire.gov.uk/pathway-to-provision. If a child is in immediate danger of harm call: **999**