Dr PJP Holden and Partners.

8 Imperial Road . Matlock . Derbyshire . DE4 3NL

Version Control Document.

Name of Policy: Safeguarding Children, Young Persons and Adults.			
Adopted Date	**Amendment Date**	**Reason for Amendment**	**Policy Renewal Date**
September 2015	5/11/2015	Changes to reporting of children safeguarding	September 2018
	9/11/2015	FGM information.	

Content:

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SAFEGUARDING CHILDREN, YOUNG PERSONS AND ADULTS.

Policy Statement

The practice clinicians and staff are aware of the need to consider the possibility of abuse or lack of appropriate care especially in relation to vulnerable groups of patients. This will apply both in the surgery premises and also where home visits / residential home visits are undertaken by staff, who will need to be alert to the possibility of abuse (or a lack of suitable care).

The practice has appointed a clinical lead who will be responsible for all aspects of training, awareness, liaison with external agencies and the coordination of appropriate action in relation to protection issues and the management (with the patient's own doctor) of individual cases of abuse or concern. The responsible person will ensure that they remain up to date and are suitably trained / refresher trained at appropriate intervals.

The appointed lead will be responsible for the arrangement of training for all staff which will be delivered 3 yearly and will focus on both adult and child safeguarding, the content of which will be appropriate to their role. Clinical staff will be trained to a minimum of Level 2 and Level 3 where possible with the Administrative Staff being trained to Level 1.

Cases of suspected abuse will be reported through the clinical lead and considered as part of the practice Significant Event procedures, however this will be dealt with in a confidential manner. The patient will be made fully aware wherever possible of the way in which the concerns will be dealt with, the nature and extent of external agency involvement, the sharing of information, and the observance of the confidential nature of the event.

For the purpose of this policy, the safeguarding lead is Dr Anthony Sinnott and the deputy is Dr Ralph Emmerson.

Annex A details the key contacts for the practice.

1. What is Abuse and Neglect.

Abuse and neglect are forms of maltreatment. Somebody may abuse or neglect a person by inflicting harm or by failing to act to prevent harm. People may be abused in a family or in an institutional or community setting by those known to them or by a stranger. Abuse may be deliberate or as a result of lack of attention or thought, and may involve combinations of all or any of the above forms. It may be regular or on an occasional or single event basis, however it will result in some degree of suffering to the individual concerned.

2. Forms of Abuse

- Neglect – ignoring mental or physical needs, care, education, or basic life necessities or rights
- Bullying – family, carers, friends
- Financial – theft or use of money or possessions
- Sexual – assault, rape, non-consensual acts (including acts where unable to give consent), touching, indecent exposure
- Physical – hitting, assault, man-handling, restraint, pain or forcing medication
- Psychological – threats, fear, being controlled, taunts, isolation
- Discrimination – abuse based on perceived differences and vulnerabilities
- Institutional abuse – in hospitals, care homes, support services or individuals within them, including inappropriate behaviours, discrimination, prejudice, and lack of essential safeguards

3. Indications

- Bruising
- Burns
- Falls
- Apparent lack of personal care
- Nervousness or withdrawn
- Avoidance of topics of discussion
- Inadequate living conditions or confinement to one room in their own home
- Inappropriate controlling by carers or family members
- Obstacles preventing personal visitors or one-to-one personal discussion
- Sudden changes in personality
- Lack of freedom to move outside the home, or to be on their own
- Refusal by carers to allow the patient into further care or to change environs
- Lack of access to own money
- Lack of mobility aids when needed

4. Safeguarding Adults.

The definition is wide, however this may be regarded as anyone over the age of 18 years who may be unable to protect themselves from abuse, harm or exploitation, which may be by reason of illness, age, mental illness, disability or other types of physical or mental impairment.

Those at risk may live alone, be dependent on others (care homes etc.), elderly, or socially isolated.

5. Child Protection.

Local authority social services departments working with other local authority departments and health services have a duty to safeguard and promote the welfare of children in their area who are in need. If you are considering making a referral to Social Services, it is essential to discuss the referral with the child's parents or carers and to obtain consent for the sharing of information. Social Services will then follow local procedures to undertake an assessment of the child and their family.

The guidance Working Together to Safeguard Children 2006 announced the replacement of the Child Protection Register with the ICS – Integrated Childrens' System – from 1st April 2008, and more specifically this uses the mechanism of a Child Protection Plan. Every child on the register at the effective date will become the subject of a Plan. 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.

All Practice Partners 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.

The Health Visiting team is routinely copied in to all inter-agency child protection correspondence and conference outcomes relating to children at risk and child protection issues.

- GPs will familiarize themselves with the systems used in the practice for making child protection referrals.
- GPs 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 GP.
- GPs will ensure that the practice Health Visitors are aware of the child protection issues.

If a GP suspects that a child is at immediate risk, the GP should seek advice from the "Starting Point" Safeguarding Team or make a referral. Advice should 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.

All verbal referrals to "Starting Point" must be followed up in writing by the referrer, giving full details, within 48 hours.

5.1 Looked After Children.

"Looked After" Children are children and young people up to the age of 18 years who are in the care of the local authority.

- Children and young people subject to a care order
- Children and young people whose parents have agreed for them to be cared for by the local authority (under section 20 Children Act)
- Children and young people remanded to the care of the local authority
- Unaccompanied asylum seekers under 18 years

Looked after children and young people are a particularly vulnerable group in regards to their health. It is important that you are aware of these children and young people in the same way as you are aware of children on the child protection register.

All looked after children and young people have a health assessment soon after they become looked after, they also have review health assessments.
An Initial Health Assessment is normally completed by a paediatrician but can be completed by a GP. Copies of the health assessments are sent to the practice and will tell you what health needs have been highlighted. All looked after children will have a health care plan, which the social worker keeps.

Looked after children and young people are entitled to the same levels of confidentiality as any other child or young person. Concerns over the health or welfare of a looked-after child should be addressed to the child's Social Worker or, if you are unable to contact them a Health Liaison Worker if there is one.

All looked after children and young people have an allocated Social Worker who is responsible for ensuring their health needs are met.

5.2 CSE Information Report.

The Information Report Form (Annex B) offers a multi agency system of sharing information with Derbyshire Police to aid keeping young people safe.

This form should be used to provide details of any concerns about people who pose a risk to or target, groom or sexually exploit young people, about risk taking behaviours of a young person, or to provide information regarding locations or circumstances relating to CSE.

The information provided must be accurate, current and factual, and without opinion. However, reporting may include low level, unconfirmed information/suspicions but please highlight that if the submission is unconfirmed.

Full names and details of victims, and where possible perpetrators, should provided where known. If you are unsure of the information then make checks before completing the form and sending it to the Central Referral Unit (CRU). If the information is unconfirmed or you are uncertain about the content, you may wish to seek guidance from a line manager before completing the Information Report Form.

Completed forms should be submitted via email to the police CRU.

If the circumstances have already been reported to the police via another means and this is confirmed, this form is not necessary as details will be passed to the CRU or Child Exploitation Investigation Unit (CEIU) for their information.

If the circumstances on the form identify a young person and there is knowledge of other practitioners involved with them, this information should be shared with those professionals. If the young person is known to Children's Service's a copy of the form must be sent to the young person's Social Worker or Children's Practitioner.

If the information is about significant harm to a child or young person then normal Social Care referral systems must be used to report those concerns. These procedures are detailed viawww.derbyscb.org.uk or www.derbyshirescb.org.uk or via the direct link http://derbyshirescbs.proceduresonline.com/index.htm

Alternatively, contact police on 101 for non-emergency matters. (In an emergency always dial 999).

It should never be assumed that someone else has passed on the information held. Duplicate information is better than none.

6. Learning Disabilities.

People with learning disabilities have the right to the same level of medical and nursing care as that provided to the general population. This care must be flexible and responsive and any diagnosis or treatment must take into account any specific needs generated by their learning disability. The practice participates in the annual Learning Disabilities Health Checks Enhanced Service led by Dr Anthony Sinnott.

A person with a learning disability should be identified in order to ensure that advance planning is undertaken to address any specific needs and where necessary to modify investigations or treatment to meet those needs.

Where it is known that a person has a learning disability this will be coded into the clinical system using the relevant READ code as detailed in the Technical Requirements document. This will highlight to secretarial, clerical, nursing, medical and other professional staff that the person may require specific care or support.

Regular contact should be made with the following organisations in order for their special needs register to be cross checked;

- Community Learning disability team
- Local Social Services
- Social Education Centres

All members of staff and clinicians dealing with incoming post from allied agencies are asked to bring to the attention of [Insert clinical Lead name] any comments regarding learning disabilities and the conditions listed above.

7. Actions

Where abuse of a vulnerable adult is suspected the welfare of the patient takes priority. In deciding whether to disclose concerns to a third party or other agency the GP will assess the risk to the patient. Ideally the matter should be discussed with the patient involved first, and attempt made to obtain consent to refer the matter to the appropriate agency. Where this is not possible, or in the case of emergency where serious harm is to be prevented, the doctor will balance the need to protect the patient with the duty of confidentiality before deciding whether to refer. The patient should usually be informed that the doctor intends to disclose information, and advice and support should be offered. Where time permits, the medical defence organisation will be telephoned before any action is taken.

Due regard will be taken of the patient's capacity to provide a valid consent.

In assessing the risk to the individual, the following factors will be considered:

- Nature of abuse, and severity
- Chance of recurrence, and when
- Frequency
- Vulnerability of the adult (frailty, age, physical condition etc.)
- Those involved – family, carers, strangers, visitors etc.
- Whether other third parties are also at risk (other members of the same household may being abused at the same time)

Consideration will also be given to:

- Report to Social Services Mental Health team
- Report to Police
- Report to CCG lead
- CQC if a member of staff is suspected of abuse to patients

The practice has a pro active approach to safeguarding and holds a monthly meeting between the safeguarding lead and the health visitor at which all cases of concern are discussed and an action plan formulated.

Where there is concern for about an individual, the Practice will ensure that an alert is made to the duty social services team. The Safeguarding Lead will trigger and urgent Multidisciplinary Team meeting at which a full and comprehensive action plan will be agreed and actioned.

8. Female Genital Mutilation (FGM)

Female Genital Mutilation (FGM), also known as female circumcision or cutting, is a procedure where the female genital organs are injured or changed when there is no medical reason for doing so. Any such procedure is illegal in the UK. It has no health benefits, causes severe harm and pain, and can have long-term physical and psychological effects for those affected.

FGM is prevalent in many African countries as well as in parts of the Middle East and Asia. The reasons behind such procedures are complex and varied, but they are often carried out in the misplaced belief that the procedure will be beneficial for the girl or woman.

The procedure may be carried out when the girl is newborn, during their childhood or adolescence, at marriage or during a first pregnancy. However, the majority of cases of FGM are thought to take place between the ages of 5 and 8, therefore girls within that age bracket are at a higher risk.

Identifying FGM

Health professionals are required to record the presence of FGM in a patient's healthcare whenever it is identified through the delivery of NHS healthcare. If it is

found that a patient has suffered FGM, referral to a specialist FGM clinic should always be considered.

Law and policy allow for disclosure where it is in the public interest or where a criminal act such as FGM has been perpetrated. However, health professionals must note the distinction between adults and children when reporting cases of FGM:

From October 31st 2015, it is mandatory for doctors and nurses to report cases of FGM in girls aged under 18 to the police where it has been 'visually confirmed' or 'verbally disclosed' and there is no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth. Such cases must be reported within a month unless there are found to be 'exceptional' circumstances involving safeguarding issues. The police should be contacted on 101.

FGM is child abuse and should be dealt with as such. Under section 47 of the Children Act 1989, anyone who has information that a child is potentially or actually at risk of significant harm is required to inform social care or the police. Professionals must always respond by informing social services or the police, who will then conduct their own enquiries.

It is important to note that as with domestic violence and rape, if an adult woman has had FGM and this is identified through the delivery of NHS healthcare, the patient's right to patient confidentiality must be respected if they do not wish any action to be taken. No reports to social services or the police should be made in these cases.

Prevention

A primary role of the practice in terms of FGM is prevention, and protecting girls or women at risk of FGM. If there is any concern that a child is at immediate risk of FGM or has had FGM, a referral must be made to social services or the police.

Where it is believed that an individual has undergone FGM, staff must also consider the risks to other girls and women who may be related to or living with her and/or her family.

Counselling

The practice will also endeavour to support those people living with the effects of FGM. All girls or women who have undergone FGM will be offered counselling to address any psychological or emotional problems they may have as a result of having FGM. Boyfriends, partners and husbands will also be offered counselling. The woman should be offered counselling sessions privately, taking into account that she may not want to make any such arrangements while her boyfriend, partner, husband or other family members are present. Professionals should be aware that there may be coercion and control involved in the situation, which may have repercussions for the girl or woman, and should have these discussions with the woman on her own whenever possible.

9. Disclosure of Patient Information.

Where a decision is to be made whether to release information to a third party in circumstances other than those laid down below, administrative and reception staff should refer the matter to a GP for an assessment of the situation before information is divulged. Reception and administration staff should not make confidentiality decisions where the authority is in doubt.

Although it is neither practicable nor necessary to seek an individual's consent each time that information needs to be shared or passed on for a particular purpose which is defined within this policy this is contingent on individuals having been fully informed of the uses to which information about them may be put.

Clarity about the purpose to which personal information is to be put is essential and only the minimum identifiable information necessary to satisfy that purpose should be made available. Access to personal information should be on a “need to know” basis.

If an individual wants information about themselves to be withheld from someone or some agency which might otherwise have received it, the individual’s wishes should be respected unless there are exceptional circumstances. Every effort should be made to explain to the individual the consequences for care and planning but the final decision should rest with the individual.

The exceptional circumstances which may override the above clause arises when information is required by statute or court order or where there is a serious public health risk or harm to other individuals or for the prevention, detection or prosecution of serious crime. The decision to release information in these circumstances, where judgment is required should be made by the senior partner and it may be necessary to seek legal advice.

There are also some statutory restrictions on the disclosure of information relating to AIDS, HIV and other sexually transmitted diseases, assisted conception and abortion.

Where information on individuals has been aggregated or anonymised, it should still only be used for justified purposes but is not governed by this policy. Care should be taken to ensure that individuals cannot be identified from this type of information as it is frequently possible to identify individuals from limited data e.g. age and post code may be sufficient.

The practice’s Data Protection Statement is attached at Annex D.

10. Missing Patients.

Where a vulnerable patient is reported missing by a carer or a member of the family there is a potential conflict between the need to respect patient confidentiality, and the need to co-operate as far as possible to help with what could be an emergency situation.

Patients suffering from depression, with a mental condition, or with a propensity to commit suicide are the most likely involve the Practice, and the first indication of this

may be when a family member or carer telephones to enquire whether the patient has seen a doctor or has turned up for an appointment.

Normal rules of confidentiality would initially dictate that information of this nature would not be provided to a third party who may well be acting independently or in a manipulative way. There is however the overriding need to ensure the safety and well-being of the patient which may take priority over the more normal rules, and the purpose of this protocol is to define the procedure to follow within the Practice when this circumstance applies.

- Immediately speak with the patient's usual doctor, who may be aware of the patient's condition and may also be aware of the caller and their involvement in the care of the patient. Interrupt the doctor in surgery if necessary, or telephone the doctor if out on calls.
- In the event that the patient's usual doctor is not available an alternative doctor may be consulted.
- Where the doctor gives consent to the information being provided the reception staff will ring the caller back within the required timescale and provide them with non-clinical information relating to the patient (e.g. whether they have been into the surgery or not, whether we have any further information as to their whereabouts etc).
- Where the caller requests clinical information in addition to non-clinical information the call is to be returned by the doctor in person.

Where the patient is not available to give express consent, the disclosure of information is made on the overriding basis that it is in the patient's best interests and is protecting them from harm. Ideally there should be reasonable grounds for assuming that this is the case. This decision is best made from a doctor's personal knowledge of the patient and / or their family, or failing that, by accurate patient clinical records.

The extent of the information provided to the caller will normally be the minimum necessary to ensure that this occurs. A full record of the decision taken, the extent of the disclosure (or not) and the reasons for it must be made as soon as possible following the event as there may be a need to justify this to the General Medical Council or the courts at a later date.

11. Mental Capacity Act

The Independent Mental Capacity Advocates (IMCA) is an independent service which provides safeguards for those people who lack capacity but have no-one else to make decisions for them or support them (other than paid persons).
An IMCA must be instructed and consulted, for people lacking capacity who have no-one else to support them whenever:

- an NHS body is proposing to provide serious medical treatment, or
- an NHS body or local authority is proposing to arrange accommodation (or a change of accommodation) in hospital or a care home, and
- the person will stay in hospital longer than 28 days, or
- they will stay in the care home for more than eight weeks.

An IMCA may be instructed to support someone who lacks capacity to make decisions concerning:

- care reviews, where no-one else is available to be consulted
- adult protection cases, whether or not family, friends or others are involved

The IMCA service is available in England and Wales.
In England the service is delivered through local authorities, who work in partnership with NHS organisations. In Wales the National Assembly for Wales delivers the service through local health boards.
Local authorities or NHS organisations are responsible for instructing an IMCA to represent a person who lacks capacity. In these circumstances they are called the 'responsible body'.
For decisions about serious medical treatment, the responsible body will be the NHS organisation providing the person's healthcare or treatment. Examples of serious treatment (amongst others) may be:

- chemotherapy and surgery for cancer
- electro-convulsive therapy
- therapeutic sterilisation
- major surgery (such as open-heart surgery or brain/neuro-surgery)
- major amputations (for example, loss of an arm or leg)
- treatments which will result in permanent loss of hearing or sight
- withholding or stopping artificial nutrition and hydration, and
- termination of pregnancy.

For decisions about admission to accommodation in hospital for 28 days or more, the responsible body will be the NHS body that manages the hospital.

Staff in the NHS, for example doctors or consultants (the "decision makers") all have a duty, under the Mental Capacity Act, to instruct an IMCA where the eligibility criteria are met. This duty started, in England, on 1st April 2007 and in Wales on 1st October 2007.

The "decision-maker" is the person who is proposing to take an action in relation to the care or treatment of an adult who lacks capacity, or who is contemplating making a decision on behalf of that person. Who the decision maker is will depend on the person's circumstances and the type of decision. For example, the decision-maker may be a care manager or a hospital consultant. Staff working in statutory organisations, in the local authority or NHS, who are involved in making best interests decisions should know when a person has a right to IMCA and when they have a duty to instruct an IMCA. This duty may fall on GPs from time to time.
The Practices undertakes referrals to IMCA through the Patient Advice and Liaison Service (PALS) operating within the NDPPG area.

12. Minimum safety criteria for staff members who have contact with children (in addition to the above)

The minimum safety criteria for safe recruitment for all staff who work at the practice are to:

- Have been interviewed face to face;
- Have two references that have been followed up;
- Have a standard DBS check (admin team);

- Have an enhanced DBS check (clinical team).

All staff working in positions exempt from the Rehabilitation of Offenders Act 1974 (Exceptions Order) 1975 or who perform a Regulated Activity must undertake DBS checks.

13. Staff Training

Those working with children and young people and / or parents should take part in clinical governance including holding regular case discussions, training and education. 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 and complaints and included in appraisal.

All new members of staff will undergo in-house training or other basic awareness training, including CWDC Induction Standards, organised by the local CCG, under local arrangements;

All members of staff will undergo child protection training as part of induction and renewed every three years as follows:

- All Non-Clinical Staff must be at Level 1
- Nurses directly employed by the practice must be at minimum Level 2, working towards Level 3;
- Practice safeguarding lead must be at Level 3
- All GPs need level 2 for the purposes of update, appraisal and revalidation, bearing in mind that level 3 includes training relevant to the inter-agency nature of their work

The practice policy will be renewed every three years.

All staff undergoing training will be expected to keep a learning log for their appraisals and or personal development. The practice will discuss and record at least one clinical incident involving safeguarding children.

CONTACT LIST (Annex A)	
SERVICE	CONTACT NUMBER
Safeguarding Clinical Lead Dr Anthony Sinnott	Mobile 07710 407006 anthony.sinnott@nhs.net
CCG Head of Adult Safeguarding Bill Nicol	Tel 01332 868810, Mob 07900 545345 bill.nicol@southernderbyshireccg.nhs.uk
CCG Adult Safeguarding Manager Michelle Grant	Tel 01246 514160 michelle.grant@southernderbyshireccg.nhs.uk
CCG Children and Young Persons Starting Point	01629 533190 www.derbyshire.gov.uk/starting point
Police (local)	101 or 0345 123 3333
NSPCC FGM Helpline	0800 028 3550
Community Mental Heath	01629 761600
Adult Support services	Call Derbyshire 01629 533190 Or 0845 605 8058
Adult Support services (Out of Hours)	Call Derbyshire 01629 533190 Or 0845 605 8058
Adult Protection Officer (safeguarding)	Call Derbyshire 01629 533190 Or 0845 605 8058
Age Concern	01773 768240
Social Services	Call Derbyshire 01629 533190 Or 0845 605 8058
Social services (out of Hours)	Call Derbyshire 01629 533190 Or 0845 605 8058
Drug Misuse	01773 744594
Medical Defence Organisation	MPS 0845 605 4000
PCO Adult protection lead	Call Derbyshire 01629 533190 Or 0845 605 8058
Midwife	Darley Maternity 01629 593244
Health Visitor	01629 593244
Community Matron	Peggy Hardern 07958134226

CSE Information Report Operation Liberty (Annex B)

Date/Time of report:

Details of Professional submitting

Name				
Post/Job Title				
Agency				
Contact details				
Is the witness	Member of Public		Professional	

Are you reporting the information as a third party?
If so, details of witness, if known:

Would they be willing to engage with the Police?

Please provide information about SPECIFIC EVENTS/INCIDENTS. Include as much detail as possible (where known) regarding name's / descriptions / nicknames / vehicle details / addresses. Do not use abbreviations. *(Please use one form for each victim)**:***
Note: Use this space to report an incident even if this ***does not*** *relate to a victim.*

Victim (if known): ***DOB:***
Address:

Details of Incident:

Details of others person present at the incident (if known):

Alleged offender(s) (if known):

Name(s) and contact details of persons/professionals this information has been shared with:

Send to: ***Central Referral Unit (CRU)***
Email address: childabuse.cru@derbyshire.pnn.police.uk
(NB please use a secure email address to send if the form contains personal details. If you do not have access to secure email, please ring your information through on 101).

PLEASE NOTE THIS IS NOT A REFERRAL FORM TO CHILDREN'S SOCIAL CARE.
If the information is about significant harm to a child or young person then normal Social Care referral systems must be used to report the concerns. If the young person is already known to Social Care you must also send a copy to their Social Worker or Children's Practitioner.

Checklist for Approaching the Topic of FGM – Annex C.

If you suspect someone is a victim or potential victim of FGM, the following guidelines can be used to approach the topic sensitively and discretely:

Create the opportunity to see the individual alone in a secure location, even if they are accompanied

Ensure a female professional is available to speak to the individual if this is their preference

Reassure the individual about confidentiality and explain that you will not pass on any information to their family, friends or members of the community

Explain all the options open to the individual and their possible outcomes

Be sensitive to the intimate nature of the subject, and recognise and respect the individual's wishes

Take detailed notes and record them safely

Affirm that the individual can return to speak to you at another time if they wish

Where necessary, provide contact details or help the individual to memorise your contact details and/or those of a support agency. Agree a way to make contact safely, e.g. agree a code word.

Collect information about the urgency of the situation to determine whether there is a need for immediate police involvement and if so phone 101

Seek advice if you are unsure how to proceed

DATA PROTECTION – PRACTICE STATEMENT (Annex D)

"We need to hold personal information about you on our Computer system and in paper records to help us to look after your health needs, and your doctor is responsible for their accuracy and safe-keeping. Please help to keep your record up to date by informing us of any changes to your circumstances.

Doctors and staff in the practice have access to your medical records to enable them to do their jobs. From time to time information may be shared with others involved in your care if it is necessary. Anyone with access to your record is properly trained in confidentiality issues and is governed by both a legal and contractual duty to keep your details private. All information about you is held securely and appropriate safeguards are in place to prevent accidental loss.

In some circumstances we may be required by law to release your details to statutory or other official bodies, for example if a court order is presented, or in the case of public health issues. In other circumstances you may be required to give written consent before information is released – such as for medical reports for insurance, solicitors etc.

To ensure your privacy, we will not disclose information over the telephone or fax unless we are sure that we are talking to you. Information will not be disclosed to family, friends, or spouses unless we have prior written consent, and we do not leave messages with others.

You have a right to see your records if you wish. Please ask at reception if you would like further details and our patient information leaflet. An appointment will be required. In some circumstances a fee may be payable."

Policy Adopted at Partners Meeting 21/9/2015
Review Date September 2018.