

SAFEGUARDING POLICY FOR CHILDREN AND YOUNG PERSONS

Background & Principles

Safeguarding children and young persons is a fundamental goal for Wessex Private GP Practice

What is Abuse and Neglect?

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

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

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

General Indicators

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

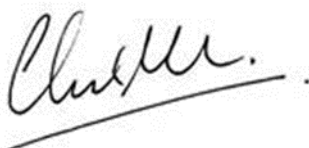
- Parental or carer drug or alcohol abuse;
- Parental or carer mental health disorders or disability of the mind;
- Intra-familial violence or history of violent offending;
- Previous child maltreatment in members of the family;
- Known maltreatment of animals by the parent or carer;
- Vulnerable and unsupported parents or carers;
- Pre-existing disability in the child, chronic or long-term illness.

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

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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 inducing illness in a child. *Working Together 2010*

Alerting features:

Abrasions	Eye Injuries	Lacerations	Spinal Injuries
Bites (human)	Fractures	Ligature marks	Strangulation
Bruises	Hypothermia	Oral Injuries	Subdural haemorrhage
Burns or scalds	Intra-abdominal injuries	Petechiae	Teeth marks
Cold injuries	Intra-cranial injuries	Retinal haemorrhage	
Cuts	Intra-thoracic injuries	Scars	

Or consider:

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

Emotional Abuse, Behavioural, Interpersonal & Social Functioning

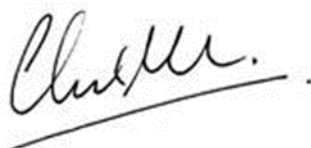
Definition: Emotional abuse is the persistent emotional mal-treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development.

- 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.

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- It may include not giving the child opportunities to express their views, deliberately silencing them or ‘making fun’ of what they say or how they communicate.
- It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child’s developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction.
- It may involve seeing or hearing the ill-treatment of another.
- It may involve serious bullying (including cyber-bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Alerting features:

Persistent harmful parent or carer – child interactions	Hiding or scavenging for food without medical explanation	Precocious or coercive sexualised behaviour
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Or consider:

Physical / mental / emotional developmental delay	Changes in behaviour or emotional state without explanation	Extremes of emotion, aggression or passivity	Drug/solvent abuse
Low self-esteem	Self-harming/mutilation	Secondary enuresis or encopresis	Running away
Responsibilities which interfere with normal daily activities (such as school)			School refusal

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 oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing.

They may also include non-contact activities, such as involving children in looking at sexual images or grooming a child in preparation for abuse (including via the internet).

Women can also commit acts of sexual abuse, as can other children.

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Alerting features:

Ano-genital symptom in a girl or boy that is associated with behavioural change	Hepatitis B or C in under 13s
Sexually transmitted infection	Pregnancy in under 13s

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Or consider:

Persistent unexplained ano-genital symptoms	Ano-genital warts (see CG89)
Sexually transmitted infection in 13-15 year olds	Marked power differential in relationship
BEHAVIOUR CHANGES:	
Sudden changes	
Inappropriate sexual display	
Secrecy, distrust of familiar adult, anxiety left alone with particular person	
Self-harm mutilation / attempted suicide	
	Unexplained or concealed pregnancy

Neglect

Definition: 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.

Neglect may occur during pregnancy as a result of maternal substance abuse.

Neglect involves failing to:

- Provide adequate food, clothing and shelter (including exclusion from home or abandonment).
- Protect a child from physical and emotional harm or danger; ensure adequate supervision (including the use of inadequate care-givers); or ensure access to appropriate medical care or treatment.

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

Alerting features:

Abandonment	Repeated injuries suggesting inadequate supervision	Failure to seek medical help appropriately
Repeatedly not responding to child or young person	Persistently smelly or dirty	

Or consider:

Poor personal hygiene, poor state of clothing	Untreated tooth decay	Poor attendance for immunisations
Frequent severe infestations (scabies, head lice)	Repeated animal bites, insect bites or sunburn	Low self-esteem

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Faltering growth (due to poor feeding)	Treatment for medical problems not being given consistently	Lack of social relationships; children left repeatedly without adequate supervision
Parents failing to engage with healthcare, attend appointments (practice or wider health professional) and / or use A&E / Out-of-Hours services frequently.		

Patterns of Maltreatment

The previous sections reflect the increasing emphasis on the importance of observation of patterns of possible maltreatment, including the interaction between the parent or carer and the child or young person, as well as physical signs which are inconsistent with their developmental stage (not always the same as the age in months or years) or the explanation given.

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

In addition, there are a number of injury patterns that cause immediate concern in terms of child protection including:

- Multiple bruising, with unusual bruises of different ages;
- Bruising in nonmotile baby, particularly facial bruising;
- Baby rolls over at six months;
- Baby attempts to crawl at eight months.

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 their developmental age;
- Accumulation of minor incidents giving rise to a level of concern, including frequent A&E attendances.

Some other situations which need careful consideration are:

- Disclosure by an adult of abusive activities;

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- 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;
- Unexplained or suspicious injuries such as bruising, bites or burns, particularly if situated unusually on the body;
- The child says that she or he is being abused, or another person reports this;
- The child has an injury for which the explanation seems inconsistent or which has not been adequately treated;
- The child's behaviour changes, either over time or quite suddenly, and he or she becomes quiet and withdrawn, or aggressive;
- Refusal to remove clothing for normal activities or keeping covered up in warm weather;
- The child appears not to trust particular adults, perhaps a parent or relative or other adult in regular contact;
- An inability to make close friends;
- Inappropriate sexual awareness or behaviour for the child's age;
- Fear of going home or parents being contacted;
- Reluctant to accept medical help;
- Fear of changing for PE or school activities.

Policy Statement

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

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

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

The practice will:

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

Basic Principles

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

Action Required

- Where abuse of any child or young person is suspected, the welfare of the patient takes priority. Any suspected cases of abuse must in the first instance be brought to the

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attention of Dr Middle or the Practice Manager without delay, who will make an initial assessment of the risk to the patient.

- If, in the opinion of the staff member, immediate intervention is required then action to minimise the harm to the victim should be taken if it does not unduly increase the risk to the staff member. Staff should however remember that intervention in cases of assault wherever possible should be with utmost caution and with support from other staff and the Police.
- A decision as to the urgency in referring any suspected cases to the Local Authority or Police will be made by Dr Middle
- A written record of the circumstances leading to a suspicion of abuse should be made by the person raising the issue as soon after the occasion as possible
- If a suspicion has been assessed and the matter is one that needs further investigation and action the following referral pathway should be used :
DORSET CHILDREN'S SAFEGUARDING CONTACT NUMBER in-hours: 01305 228558
EMERGENCY OUT OF HOURS NUMBER: 01202 228866
DORSET CHILDREN'S DESIGNATED SAFEGUARDING DOCTOR: Dr D'Arrigo 01305 253730
- The need for further investigation and enquiry will then rest with the local Safeguarding team and all staff will co-operate with any subsequent enquiries and provide truthful and factual information on request. Non-clinical staff must not however provide any opinion or judgement for which they have no training or experience.
- Staff must not under any circumstances take any action unless it is immediately necessary to prevent harm which might alert the perpetrator that their actions have been noted and are in question or would lead to onward referral. This would not apply to GPs, who are trained in advanced responses to safeguarding and may deal with cases according to that training.

RESPONSIBILITIES

Dr Middle is the appointed practice safeguarding lead.

These are not full-time functions, but instead complement the individual's daily duties. The responsibilities are detailed below.

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It is recognised that it is an individual's role to be aware of maltreatment and share concerns, but not to investigate or to decide whether or not a child has been abused.

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

- Implements the practice's child protection policy;
- Ensures that the practice meets contractual guidance;
- Ensures safe recruitment procedures;
- Engages the primary healthcare team to establish "You're Welcome" policies -
(See RCGP Child Health Strategy 2010-2015; <http://www.rcgp.org.uk/clinical-and-research/clinical-resources/child-and-adolescent-health.aspx>)
- Supports reporting and complaints procedures;
- Advises practice members about any concerns that they have;
- Ensures that practice members receive adequate support when dealing with child protection;
- Leads on analysis of relevant significant events;
- Determines training needs and ensures they are met;
- Makes recommendations for change or improvements in practice procedural policy;
- Acts as a focus for external contact

Detailed Actions When Child Abuse May Be Suspected

- Concerns should immediately be reported
- In an emergency, and the designated persons cannot be contacted, then the most senior member of staff will make a decision to report the matter directly to social services or the police.
- If the suspicions relate to the designated person, then the deputy should be notified and the CCG-appointed person and / or social services should be contacted directly.
- Suspicions should not be raised or discussed with third parties other than those named above and in particular it is important that the perpetrator is not alerted in any way to the fact that their actions have been noted. This is important to prevent an offender being able to pre-empt any investigation and threaten or coerce the victim into denying the activity has taken place or interfering with forensic evidence
- Any individual has the ability to make direct referrals to the child protection agencies; however, members of staff are encouraged to use the route described here where

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possible. In the event that the reporting staff member feels that the action taken is inadequate, untimely or inappropriate they should report the matter direct. Staff members taking this action in good faith will not be penalised.

- If a referral is being made without the parent's knowledge and non-urgent medical treatment is required, social services should be informed.
- If appropriate, the parent / carer should be encouraged to seek help from the social services department prior to a referral being made however this is always best left to a GP who is trained to make such interventions. Non-clinical staff should confine themselves to reporting concerns `upwards`.
- Where sexual abuse is suspected, the practice lead will contact the social services or Police Child Protection Team directly. The designated person must not normally speak to the parents.
- Neither the designated person nor any other member of the practice team should carry out any investigation into the allegations or suspicions of sexual abuse in any circumstances. The designated person will collect exact details of the allegations or suspicion and provide this information to the child protection agencies that will investigate the matter under the Children Act 1989.

Protection of Children & Young Persons in the practice

The Practice will undertake a Risk Assessment of the need for anyone working in the practice to undergo a Disclosure and Barring Service (DBS) check based on the role they perform (as opposed to an assessment of the individual). The Risk Assessment will take into consideration any occasions where a staff member has access to children such as minding a child while a patient undergoes an examination or procedure as well as clinical contact.

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.

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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 as a minimum undergo in-house training in how to recognise abuse and how to report it or other basic awareness training, including online training and any classroom sessions that may be organised either in-house or by the CCG or Local Authority.

All members of staff will undergo child protection training as part of induction and renewed annually, 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 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. The practice should discuss and record at least one clinical incident each year involving safeguarding children and that discussion should involve as wide a number of roles within the Practice as possible.

Whistleblowing

The practice recognises the importance of building a culture that allows staff to feel comfortable about sharing information, in confidence and with a lead person, regarding concerns they have about a colleague's behaviour. In cases where that issue involves a child or young person, the practice recognise the difficulty staff may be placed in and would reinforce the degree of absolute discretion the whistleblowing policy requires.

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This will also include behaviour that is not linked to child abuse, but that has pushed the boundaries beyond acceptable limits. Open, honest working cultures where people feel they can challenge unacceptable colleague behaviour and be supported in doing so, help keep everyone safe.

Where allegations have been made against staff, the standard disciplinary procedure and the early involvement of the Local Authority Designated Officer (LADO) may be necessary (*section 11 Children Act 2004*).

Complaints Procedure

The practice has a clear procedure that is capable of dealing with complaints from all patients (including children and young people), employee, accompanying adult or parent .

General guidelines for staff behaviour

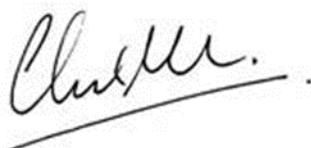
These guidelines are here to protect children and staff alike. The list below is by no means exhaustive and all staff should remember to conduct themselves in a manner appropriate to their position. Wherever possible, staff should be guided by the following advice. If it is necessary to carry out practices contrary to it, you should only do so after discussion with, and the approval of Dr Middle.

- You must not ignore unacceptable behaviour and should challenge it – accepting that there may be occasions when to do so directly may not be possible;
- 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;

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- Don't engage in or allow any sexually provocative games involving or observed by children, whether based on talking or touching;
- Never display favouritism or reject any individuals.

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 following procedures set out the steps to be taken with respect to any concerns relating to child protection.

Management of Disclosure of an Allegation of Abuse

If a child makes allegations about abuse, whether concerning themselves or a third party, employees must immediately pass this information on to Dr Middle 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, especially a sensory deficit or communication disorder, will have to overcome barriers before disclosing abuse. They may well rely on the abuser for their daily care and have no knowledge of alternative sources. They may have come to believe they are of little worth and simply comply with the instructions of adults.

When responding to a child making an allegation of abuse:

- Stay calm;
- Listen carefully to what is being said;
- Reassure the child that they have done the right thing by telling you;
- Find an appropriate early opportunity to explain that it is likely the information will need to be shared with others – do not promise to keep secrets;
- Allow the child to continue at his / her own pace;
- Ask questions for clarification only, and at all times avoid asking questions that are leading or suggest a particular answer;

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- Tell them what you will do next and with whom the information will be shared;
- Record in writing what has been said using the child's own words as much as possible – note date, time, any names mentioned, to whom the information was given and ensure that paper records are signed and dated, and electronic subject to audit trails;
- Do not delay in discussing your concerns and if necessary, passing this information on to the practice safeguarding lead or deputy.

Confidentiality

In order to do their jobs, members of staff need access to confidential (perhaps highly sensitive) information about children and young people. To effectively ensure that all relevant information is available to appropriate persons at all times, no records relating to child abuse or protection will be maintained separately from the main clinical record.

These details must be kept confidential within the clinical team at all times and only shared when it is in the interests of the child to do so and ensuring that – when domestic violence is involved – risk of harm to the non-abusive parent is not increased, and taking care to ensure that no humiliation or embarrassment is suffered by the child.

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

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

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

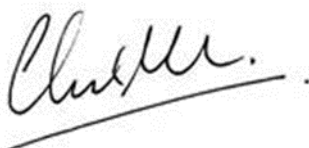
In general, if a person decides to disclose confidential information without consent, they should be prepared to explain and justify their decision and they should only disclose as much information as is necessary for the purpose. The medical defence organisation will be consulted in all cases.

Physical Contact

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

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

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

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

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

ATTITUDE OF PARENTS OR CARERS

Parental attitude may indicate cause for concern:

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

Records

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It is good practice to offer a medical examination and 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.

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

Medical Record

A record of the facts giving rise to the suspicion must be made and signed by the person reporting the issue as soon as possible and an alert placed on the clinical system. The original statement must be kept secure and a scanned copy placed on the clinical record. This statement will constitute a third party reference and must not be disclosed to the patient or others not involved in the investigation should a subject access request ever be made.

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;

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- Child protection plan;
- Case Conferences;
- Meetings;
- Drug / substance abuse;
- Mental health issues;
- Non-attendance at meetings or appointments;
- Hostility or lack of cooperation;
- Cumulative minor concerns;

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

Data Protection

- Current guidance suggests that written records relating to child protection issues should be stored as part of the child's permanent medical records, either manually or on computer, or both - a change to previous guidance.
- 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 CCG and Child Protection staff of the Local Authority in all instances. The practice will have permanent access to the local child protection instructions as part of the routine CCG Safeguarding 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 designated responsible person at the CCG is notified, normally by the health visitor.
- The practice will ensure that the health visitor is made aware that the child is moving out of the area.

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- The designated responsible person at the CCG will contact the child's new GP or health visitor and will arrange for the transfer of any necessary records.
- Child Protection files forming part of the practice computer system will remain in place after the patient has de-registered in line with all other permanent medical records.
- Particular care must be taken by the transferring practice to ensure that all child protection documents and information is passed over to the receiving practice.

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

Referral

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 requirements.

Best practice is to inform parents/carers of your concerns and next steps unless to do so may put the child or yourself at risk. As a general rule, you should contact the child social care services first unless the issue is more immediate and the child is indeed of immediate medical attention or support from the police.

Dorset CCG Children's Safeguarding Team	CONTACT INFORMATION
Head of Safeguarding:	Liz Plastow: 01305 213644/07970250986
Deputy Head of Safeguarding	Janice West: 07866795555
Designated Nurse LAC	Louise Smith: 01305 213626/0786 7467783
Designated Nurse for Children	Shiela Willoughby: 01305 213644
Children's Safeguarding Named GP	Dr Isi Sosa. Dr Sam Abdollahian. Dr Raquel Bechka 01305 213644/07831 774906

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REFERENCE DOCUMENTS AND RESOURCES

General Medical Council – Protecting Children & Young People

- http://www.gmc-uk.org/static/documents/content/Protecting_children_and_young_people_-_English_1015.pdf

RCGP – Toolkit for General Practice

- <http://www.rcgp.org.uk/clinical-and-research/toolkits/the-rcgp-nspcc-safeguarding-children-toolkit-for-general-practice.aspx>

CQC – Mythbusters and general guidance

- <http://www.rcgp.org.uk/clinical-and-research/toolkits/the-rcgp-nspcc-safeguarding-children-toolkit-for-general-practice.aspx>
- <http://www.cqc.org.uk/news/stories/cqc-updates-information-safeguarding-children-adults-england>
- <http://www.cqc.org.uk/guidance-providers/gp-services/nigels-surgery-33-safeguarding-children>
- Royal College of Paediatrics and Child Health
www.rcpch.ac.uk

Version: 1

Date: 10/4/2022

Authorised 20

A handwritten signature in black ink, appearing to read 'Chris M.', is written over a horizontal line.

by: