CHILD PROTECTION PROTOCOL

Primary Healthcare Centre Chopwell

Newcastle Gateshead CCG

This Protocol should be READ in conjunction with the Safegaurding in Children Primary Care Resource Pack by Gateshead CCG

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| Version | 2.0 |
| Ratified by: | Partners at *Primary Healthcare Centre Chopwell* |
| Date Ratified: | 3/8/2015 |
| Name & title of Originator/Author: | Dr M S HassanSenior Partner and Safegaurding Lead, Primary Healthcare Centre, Chopwell |
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| Target Audience: | GP and practice employed staff |
| Consultation Process: | Discussed at practice meeting and ratified. |
| Mandatory/ Statutory Standards orRequirements | Section 11 Childrens Act 2014 |

**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 is the action we take to promote the welfare of all children and protect them from harm.
* Child Protection refers to the activity that is undertaken to protect specific children who are suffering or at risk of suffering significant harm.
* The Practice recognizes that all children have a right to protection from abuse and neglect and the Practice accepts its responsibility to safeguard the welfare of all children with whom staff may come into contact.

We intend to:

* Respond quickly and appropriately where information requests relating to child protection are made, abuse is suspected or allegations are made.
* Provide children and parents 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 commissioning body’s appointed contacts.
* The Practice will ensure that all staff are trained to a level appropriate to their role

**PRINCIPLES**

Safeguarding children is of paramount importance to ensure the safety of every child in the practice. All staff will be aware of how they may access advice, understand their role in protection, and understand the importance of effective Inter-agency communication.

Safeguarding children 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.  The Practice will ensure children and their families are able to share concerns and complaints and that there are mechanisms in place to ensure these are heard and acted upon.

The Practice must have safe recruitment practices including appropriate use of The disclosure and barring service https://www.gov.uk/government/organisations/disclosure-and-barringservice/about and safe whistle blowing processes.

Staff 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.

Staff 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, age, language, racial origin, religious belief and/or sexual identity.

Staff should continually monitor and review their practice and ensure they follow the guidance contained in this document and elsewhere.

It is very important that all staff understand the need to get help early when they have concerns about a child.

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.

These guidelines draw primarily upon national guidance including the RCGP Safeguarding Toolkit. 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 local safeguarding team. The Safeguarding in Children Primary Care Resource Pack by Gateshead CCG should be referenced.

The protocol will address:

·      Key staff training

·      Documentation

·      Reporting

·      Local procedures

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

**Some other situations which need careful consideration are**:

* Repeated attendance of young baby under 12 months of age.
* Any bruising or injury in child under 24 months of age.
* Very young girls or girls with learning difficulties or disability requesting contraception, especially emergency contraception.
* Girls under 16 presenting with pregnancy or sexually transmitted disease, especially those with learning difficulties, chronic long term illness, complex needs or disability.
* Situations where parental factors such as mental health problems, alcohol, drug or substance misuse, learning difficulties, domestic abuse may impact on children and family life.
* 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, delayed presentation, or which has not been adequately treated or followed up.
* 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.
* Disclosure by an adult of abusive activities, including activities related to internet and social media use.
* Reluctance to accept medical help.
* Fear of changing for PE or school activities.

**Attitude of parents or carers - Parental attitude may indicate cause for concern:**

* Unexpected delay in seeking treatment.
* Reluctance to have child immunised.
* Failure to take child for dental care.
* Failure to attend scheduled appointment with GP or other healthcare providers.
* 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.
* Domestic Abuse or Violence between adults in the household.
* Appearance or symptoms displayed by siblings or other household members.

**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.

**CHILD PROTECTION REGISTER / PROTECTION PLAN**

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.

**TRAINING**

All staff will be trained in child protection at least once every 2 years for clinical staff and once every 3 years for admin/reception staff, and within 6 months of induction. [see page 20 of the Gateshead CCG Safeguarding in Children resource pack]. This will normally be via e-learning on RCGP accredited Bluestream Academy which all staff should have access to. Certificates will be reviewed and kept in the practice. A training schedule for the different groups of staff is included in the resource pack [page 20] in the Safeguarding folder locked in the Practice Manager’s room. For example, clinicians will have to have face to face training in the three years.

**SAFEGUARDING LEAD**

**Dr Sabit Hassan is the designated lead for the practice and his Deputy is Dr Sameena Hassan.** **Ms Helen Cuskin is the Administrative Safeguarding Lead**. They are responsible for ensuring that all information relating to Child Protection issues is regularly updated within the Practice and in the relevant patient’s record, with appropriate alerts being added to (and removed from) the records of the child/family member.

A comprehensive guide to read codes is available as part of the Gateshead CCG Safeguarding in Children resource pack [page 17] from the RCGP Toolkit. Any information regarding the patient must be recorded. Ensure any documents received are recorded and scanned in each child’s notes (even if there are multiple children in family).

Family members must also have the correct code in their notes if they are related to a child on the register regardless of whether they live at the same address or share the same surname. Read codes expressing that a child is on a Child Protection Plan should be entered into notes of all individuals living at same address.

Note: reference in the Read Coding system to “Register” is assumed to identify children at risk under the recent guidance.

The Health Visiting team at Briarwood Sector Base should routinely be 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 practice lead will always check with the Health Visitor that she is aware of the case at the monthly safeguarding meetings.

**NURSING AND ADMINISTRATION STAFF**

* All Nursing and Administration staff will be made aware of the practice procedures regarding child protection and be aware of the local safeguarding team. A list of all contacts is available in the practice reception and each consulting room.

Any member of staff who has concerns regarding the welfare of any child will report their concerns IMMEDIATELY to Dr Sabit Hassan, Dr Sameena Hassan or, in their absence, to the duty doctor and Ms Helen Cuskin, Administrative Safeguarding Lead.

In the absence of one of the nominated persons, the matter should be brought to the attention of the local Safeguarding Team, or, if it is an emergency, and the Designated persons cannot be contacted, then the most senior clinician will make a decision whether to report the matter directly to Social Services or the Police.

* Administration staff will be made aware of the need to look out for ANY child protection related correspondence coming into the practice and ensure that it is dealt with appropriately i.e. placed in the urgent post folder for the GP to workflow on THE SAME DAY and in strictest confidence. Ms Helen Cuskin, Administrative Safeguarding Lead will ensure this process is robust.
* If the suspicions relate to a member of staff there should be internal discussion with the Practice Safeguarding Lead or deputy, and a plan of action decided, the local Safeguarding Children team and / or social services should be contacted directly. Consideration should be made to involving the LADO. Suspicions should not be raised or discussed with third parties other than those named above.
* Any individual staff member must know how to make direct referrals to the child protection agencies and should be encouraged to do so if they have directly witnessed an abuse action; however, staff are encouraged to use the route described here where possible. In the event that the reporting staff member feels that the action taken is inadequate, untimely or inappropriate they should report the matter directly. Staff members taking this action in good faith will not be penalised.

**GENERAL PRACTITIONERS**

* GPs will familiarise themselves with the local safeguarding team contacts as attached. GPs will know how to access information and advice, and the referral pathways available at https://www.gateshead.gov.uk/lscb/Child-protection-procedures/ (Safeguarding Children’s Board for Gateshead)
* 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. [see page 13 of the Gateshead CCG Safeguarding in Children resource pack]
* 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 safeguarding issues and hold regular monthly meetings to discuss actions. All meetings to be documented. [See minutes of the meetings in the shared folder]. The minutes of the meeting are available to view upon e-mail notification by the practice manager.
* A child protection register be held and kept up to date. This is in a confidential folder held in a locked cupboard in the reception area. The partners have the responsibility to keep this up to date.

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

* The GP should seek advice or make a referral. Please refer to the referral flowchart for all health staff made available in all of the consulting rooms and reception.
* 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 the local safeguarding team **Gateshead Safeguarding Team** on **0191 433 2410/433 2349**or e-mail a Child care concern form [available on GIN] to R&ADuty@gateshead.gov.uk. **Retain a copy of the child care concern form in the patient’s medical records by saving the form in EMIS WEB medical records.**
* **Outside of normal office hours please call 0191 477 4806/fax 0191 433 3355 for the Emergency Duty Team**
* **The social worker will inform the referrer in writing of their decision within 48 hrs. If no feedback is received within 3 working days contact the social worker to confirm the outcome. If you are unable to obtain feedback contact the safeguarding team.**
* All health care professionals must ensure that they keep a complete and accurate record of the nature of the injury, suspicion and all actions taken.
* Where emergency medical attention is necessary it should be given. If necessary as ascertained by clinical judgement the child should be admitted to the care of the emergency Paediatric service and a social services referral made. Any suspicious circumstances or evidence of abuse should be reported to the designated clinical Lead.
* If a Social Services referral is being made without the parent's knowledge and urgent medical treatment is required, social services should be informed of this need. Otherwise, if it is decided that the child is not at risk, suggest to the parent or carer that medical attention be sought immediately for the child.
* If appropriate the parent/carer should be encouraged to seek help from the Social Services Department prior to a referral being made. If parents do not consent to medical care or to a social care referral and they fail to do so in situations of real concern the safeguarding Lead will contact social services directly for advice.
* Where sexual abuse is suspected the Practice Lead or Deputy will contact the Social Services or Police Child Protection Team directly. The Lead will not speak to the parents if to do so might place the child at increased risk.
* Neither the Practice Safeguarding Lead or any other Practice team member should carry out an investigation into the allegations or suspicions of sexual abuse in any circumstances. The Practice Safeguarding Lead will collect exact details of the allegations or suspicion and provide this information to statutory child protection agencies: Social Care, the police or NSPCC, who have powers to investigate the matter under the Children Act 1989.

**PHYSICAL EXAMINATION OF A CHILD OR YOUNG PERSON**

* 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 very young, there should be a discussion with the parent or carer about what physical contact is required. Routine physical examination of an individual child or young person is normally part of an agreed treatment procedure and/or 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.

**What to do with allegations of abuse from a child**

* Keep calm
* Reassure the child that they were right to tell you, and that they are not to blame and take what the child says seriously.
* Be careful not to lead the child or put words into the child’s mouth – ask questions sensitively
* Do not promise confidentiality.
* Fully document the conversation on a word by word basis immediately following the conversation while the memory is fresh.
* Fully record dates and times of the events and when the record was made, and ensure that all notes are kept securely.
* Inform the child/ young person what you will do next.
* Refer to the Practice Safeguarding Lead clinician or Deputy.
* Decide if it is safe for a child to return home to a potentially abusive situation. It might be necessary to immediately refer the matter to social services and/or the police to ensure the child’s safety.

**ATTENDENCE AT CHILD PROTECTION CONFERENCES**

* All requests for information relating to a child protection investigation or report for Case Conference will be passed to the Child Safeguarding Lead or Deputy on the day received.
* GPs have a duty to attend conferences as they can provide useful information about the family and child over a period of years.
* If the GP cannot attend, then a report or letter will be submitted, to include all relevant information. A response will be made in a timely manner. If this is not possible the Agency requesting information will be informed and a reason given.

**NOTIFICATIONS**

* Any abuse or alleged abuse of a child requires notification to the Care Quality Commission. GPs are responsible for completing appropriate forms.

**CONFIDENTIALITY**

Doctors 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

[see page 13 of the Gateshead CCG Safeguarding in Children resource pack – Information Sharing]

"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."

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."

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
* Clear and comprehensive records relating to all events and decisions will be maintained

**RECORDS**

All information received regarding children from the Safeguarding Children Team and any other associated Services should be regarded as strictly confidential.

This information should be handled by the designated member of staff who will deal with such paperwork in the following way.

Designated member of staff for record keeping: **Ms Helen Cuskin**

Child Protection Reports are as important as records of serious physical illness and should be recorded in the same way and with the same degree of permanence.

Case Conference Reports should be ideally be scanned into that individual child’s electronic General Practice records. If necessary third party references must be blanked out or anonymised before scanning or sharing with appropriate agencies.

It is vital that when a child who is or has been on a Child Protection Plan moves to another area that the full clinical record including Case Conference Reports be sent to the next GP. Therefore they must NOT be kept separate or isolated from the child’s written or computer records.

Tragedies have resulted from Case Conference Records not being passed on to the child’s current GP. (Pass on welfare concerns even if the child is not subject to a protection plan.)

**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.**

**Important Case conference records must NEVER be destroyed e.g. by deleting electronic records or shredding hard copies.**

Registration of new patients

All children will have a registration form filled in by the parent/guardian.

Children may only be registered if at least 1 parent/legal guardian is registered with the practice.

It is good practice to offer a new patient appointment. 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 / guardian 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

An alert placed on the clinical system – see coding issues above. The medical record relating to child protection issues must include the aspects below:

·         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

Associated Policies and correspondence

* The Practice DNA policy is guidance for all staff to flag up any concerns regarding DNA of GP/nurse appointments.
* The Practice Child Immunisation Policy is guidance for all staff about DNA of immunisations.
* All correspondence regarding children’s safeguarding (faxes, letters, phone calls) are passed immediately to the lead GP or his Deputy who then passes it on to the practice manager Ms. Helen Cuskin for coding [as per the Safegaurding in Children Primary Care Resource Pack by Gateshead CCG]
* The Practice Coding and Summarising Policy is guidance for all GPs for recognising repeated A&E attendance and DNA of hospital appointments.
* Where a child moves away or changes GP the practice will inform the health visitor at the regular safeguarding meeting or as soon as possible should the clinician be concerned.

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. 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 in all instances.
* 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 safeguarding team is notified, normally by the Health Visitor.   The Practice lead will ensure that the Health Visitor is made aware that the child is moving out of the area. This will normally be discussed at the regular safeguarding meetings that are held monthly.
* The Gateshead’s Children Safeguarding Team will contact the child’s new GP or Health Visitor and will arrange for the transfer of any necessary records. An additional form available in the folder and RCGP toolkit must be faxed to the new GP/HV team in the interim.

Therefore:

* All reports will be scanned onto the relevant child’s records.
* These reports will be vetted to remove any 3rd party information especially if external agencies request these medical records.
* All reports/correspondence will be seen by the GP and summarised by the Administrative Safeguarding Lead and checked by the GP if necessary.
* All contacts with any parties regarding any safeguarding children issues should be recorded on the patient’s medical records and any necessary action taken immediately.

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

We have reviewed and accepted this policy

Signed by: Dr M S Hassan Date: 1/12/2015

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On behalf of the partnership

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

Signed by: Ms Helen Cuskin Date: 1/12/2015

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This policy will be reviewed on DATE**: 1/12/2016**

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**SAFEGUARDING CHILDREN CONTACT DETAILS**

**EMERGENCY**

**In an emergency contact the police on ‘999’**

**Other Numbers for Advice and Referral**

If you have any concerns about the safety and/or welfare of a child or young person telephone::

Office Hrs: Tel: 0191 4332410/4332349

 Children and Families, Learning & Children Admin

Tel: 0191 4332515/4332653

Fax: 0191 4332040

Out of Hours: Tel: 0191 4770844 Fax: 0191 4333355

For advice on symptoms or injuries of concern:

Contact *consultant paediatrician on call* at the QE Hospital:

Tel: 0191 482 000

For advice on general children safeguarding issues:

Contact the *Safeguarding Advice and Support Team* including;

The Named GP Dr Brian Liddle - alexander.liddle@nhs.net – 07584162366

Safeguarding named nurse Maggie Lilburn – 0191 283 1374

Your **Primary Health Care Teams** contact details are:

GP child safeguarding lead Dr. M S Hassan

**GP Deputy** child safeguarding lead **Dr Sameena Hassan**

**Administrative Safeguarding Lead Ms Helen Cuskin**

PHCT attached health visitors Joanne Kirkup 07944255530/ Rebecca Mawston 07958470490/ Helen Byfield 07958474954

Base Telephone Number:0191 414 1421

Team NHS Email Address: sty-tr.WestLocBriarwood@nhs.net

Clinical Operations Manager (Health Visiting): Sue Fraser

Email Address: suzanne.fraser@stft.nhs.uk

Telephone Number: 0191 283 1327

Secretaries: Vicki Harford / Jackie Collins

Telephone Numbers: 0191 283 2204 / 0191 283 1936

School nurse link\*\*Lynne Oliver 0191 497 1548

The practice child safeguarding policy is located\* in a safeguarding folder locked cupboard in the Practice Manager’s office.

**SAFEGUARDING ADULTS CONTACT DETAILS**

**Adult Social Care Direct – To make a referral** (Mon – Thurs 9am-5pm, Friday 9am-4.30pm)

Tel: 0191 4337033

**Emergency Duty Team – Gateshead Council – Referrals and advice out of hours** (24 hours)

Tel: 0191 4770844

**Northumbria Police**

Tel: 101 – Ask for local police station or Protecting Vulnerable Persons Unit

**Safeguarding Adults Co-ordination Team**

(Mon – Thurs 9am-5pm, Friday 9am-4.30pm)

Tel: 0191 433 2378/ 3929/ 3928 / 3361

**Fax: 0191 4332487**

Available daily, Monday to Friday 09:00 – 16:00hrs. **Please note that this is an advice service ONLY**. All concerns should be raised with Adult Social Care Direct.

**Designated Nurse Safeguarding Children and Adults**

Maggie Lilburn

Tel: 4971571

**GP Lead for Adult Safeguarding**

Steve Blades

07764196398

stephen.blades@nhs.net