Reviewed 03.10.24

# HEATON MERSEY MEDICAL PRACTICE
# Child Safeguarding and Child Protection Policy

**Contents**



**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 recognises 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, and that this is repeated on an annual refresher basis. New members of staff will receive induction 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.
- 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.
- The Practice will ensure regular meetings are held to discuss vulnerable children and families and that such meetings include other Agencies such as Midwives and Public Health Nurses to ensure early recognition of circumstances leading to abuse and neglect and early intervention to help prevent abuse and neglect.
- 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.

**Responsibilities**

Dr Graeme Dent is the appointed Clinical Child Safeguarding Lead within the practice.

Dr Victoria Stott is the appointed Clinical Child Safeguarding Deputy Lead within the practice.

The Practice Manager is the Administrative Child Safeguarding Lead.

The Clinical Child Safeguarding Lead and Clinical Child Safeguarding Deputy Lead are responsible for all aspects of the implementation and review of the children's safeguarding procedure in this practice.

**Child protection: sources of advice and support**

**Contact information**

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| Practice Clinical Child Safeguarding Lead | Dr Graeme Dent | |
| Practice Clinical Child Safeguarding Deputy Lead | Dr Victoria Stott | |
| Practice Administrative Child Safeguarding Lead | Practice Manager | |
| Local Authority Designated Officer - LADO | Gerard Sweeney | 0161 474 5657 https://www.stockport.gov.uk/start/contact-the-lado |
| Named GP Safeguarding Lead | Dr James Higgins, Brinnington Surgery | James.higgins2@nhs.net |

**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 and/or inconsistent with the history provided.
- A history which is inconsistent or changes over time.
- A delay in seeking medical help.
- Extreme or worrying behaviour of a child, taking account of the developmental age of the child.
- Self-harm.
- 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 another 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.

**Immediate actions**

- Concerns should immediately be reported to the Lead clinician within the Practice or his / her deputy (above).
- Concerns should be discussed internally, and an action plan decided.
- 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.
- 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.
- 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 any 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.

**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.

**Confidentiality**

Staff are required to have access to confidential information about children and young people in order to do their jobs, and this may be highly sensitive information. These details must be kept confidential at all times and only shared when it is in the interests of the child to do so, and this may also apply to restricting the information within the clinical team. Care must be taken to ensure that the child is not humiliated or embarrassed in any way.

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 clinical Safeguarding Children Lead. Any actions should be in line with locally agreed information sharing protocols, and whilst the Data Protection Act applies it does not prevent sharing of safeguarding information.
Whilst adults need to be aware of the need to listen and support children and young people, they must also understand the importance of not promising to keep secrets. Neither should they request this of a child or young person under any circumstances.

Additionally, concerns and allegations about adults should be treated as confidential and passed to the practice safeguarding lead or appointed person or agency without delay.

**Responding to requests for safeguarding/child protection information**

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.
A response will be made in a timely manner, preferably within 48 hours, and if this is not possible the Agency requesting information will be informed and a reason given.

**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.

**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.

**Training – in house**

Safeguarding Children Updates are given regularly by Lead Safeguarding GP at Team meetings. The Practice Safeguarding Children Lead is responsible for ensuring training records are kept and maintained and will liaise with the Practice Appraisal Lead to ensure training is aligned with identified staff development needs. An annual Update and Refresher is given by a member of the Local Safeguarding Children Team.

**Record keeping**

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:** Mrs Michelle Davenport.

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 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.

Appropriate coding and templates should be used in Active and Past Problem Lists and priority lists. The child's records should be linked in some way to parents even if not living at the same address, siblings and others in household by use of appropriate templates and codes.

Read codes expressing that a child is on a Child Protection Plan should be entered into notes of all individuals living at same address.

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.)

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

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 and summarised by a GP.
- 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.