

Morecambe Bay



Primary Care Collaborative

Safeguarding Children and Young People Policy

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1. INTRODUCTION

1.1 Summary

The Children Act 1989 and 2004 and the associated statutory guidance, 'Working Together to Safeguard Children' (HM Government, 2018) and 'Promoting the Health and Well-being of Looked After Children' (DH, 2015) set out the principles for safeguarding and promoting the welfare of children and young people. This policy outlines how MBPCC will fulfil their legal duties and statutory responsibilities effectively in accordance with safeguarding children procedures of safeguarding partnerships of Morecambe Bay (South Cumbria and North Lancashire).

It also ensures there is an infrastructure in place to equip and support all staff at MBPCC to fulfil their responsibilities for safeguarding and promoting the welfare of children confidently. This policy is underpinned by the following standards:

- The child's needs are paramount
- The child's welfare and safety is everyone's responsibility

The majority of children and their families in the UK are registered with a GP and general practice remains the first point of contact for most health related issues. The MBPCC recognises that GP's and their MBPCC teams have a key role not only in providing high-quality services for all children but also in identifying and responding to the needs of vulnerable children and their families, supporting victims of abuse and neglect and providing on-going care and assessment while contributing to case conferences and multi-agency plans. Identification of child abuse has been likened to putting together a complex multi-dimensional jigsaw. GP's and their teams, who hold knowledge of family circumstances and can interpret multiple observations accurately recorded over time, may be the only professionals holding vital pieces necessary to complete the picture.

This local policy should be read in conjunction with:

North Lancashire: <http://panlancashirescb.proceduresonline.com/index.htm>

Cumbria: <http://cumbrialscb.proceduresonline.com>

Should you have any suspicions or concerns relating to Children and Young People, please follow MBPCC's Safeguarding Procedures and inform the Medical Director, Steve McQuillan, Designated Safeguarding Lead on mbpcc.gpfed@nhs.net or call the head office on 01524 244348.

1.2 Purpose

The MBPCC adopts a zero-tolerance approach to child abuse and neglect.

This policy therefore outlines how the MBPCC will fulfil its statutory responsibilities and ensure that there are in place robust structures, systems and quality standards for safeguarding children and young people, and for promoting the health and welfare of Looked After Children which are in line with the multi-agency safeguarding children partnership boards of:

North Lancashire: <http://www.lancashiresafeguarding.org.uk/>

Cumbria: <https://www.cumbriasafeguardingchildren.co.uk/default.asp>



This policy provides guidelines to:

- Enable staff, volunteers, students, temporary or locum workers to define abuse, harm, exploitation or coercion and recognise and understand this can occur
- Enable staff to respond positively and appropriately to incidences of actual or suspected abuse
- Ensure that safeguarding concerns and enquiries are dealt with appropriately
- Ensure that all staff act in accordance with the MBPCC Safeguarding Children Policy and the relevant protocols
- Ensure that there is a consistent and effective response to safeguarding concerns

In line with the MBPCC Equality and Diversity Policy, this policy aims to safeguard all children and young people who may be at risk of abuse, irrespective of disability, race, religion/belief, colour, language, birth, nationality, ethnic or national origin, gender or sexual orientation. Approaches to safeguarding children and young people must be child centred, upholding the welfare of the child as paramount (Children Acts 1989 and 2004).

All MBPCC staff must respect the alleged victim's (and their family's/ carers) culture, religious beliefs, gender and sexuality. However, this must not prevent action to safeguard children and young people who are at risk of, or experiencing, abuse. All MBPCC staff have individual responsibility for the protection and welfare of children and must know what to do if they are concerned that a child is being abused or neglected.

All reasonable endeavours should be used to establish the child, young person and families/carer's preferred method of communication, and to communicate in a way they can understand. This will include ensuring access to an interpretation service where people use languages (including signing) other than English. Every effort must be made to respect the person's preferences regarding gender and background of the interpreter.

1.3 Scope

This policy applies to all MBPCC employees and directors.

From time to time MBPCC may utilise the resources of sub-contractors to deliver contractual obligations. For avoidance of doubt, where a sub-contractor is providing care to patients, as laid out in the contracts between MBPCC and subcontractors, they are solely responsible for delivery of the regulated activity they are providing, and must ensure all their employees operate under their own policies which must meet the relevant CQC standards. MBPCC will seek assurance from all sub-contractors that suitable policies are in place, and may at their discretion request copies of any relevant policies for review and for verification. In such cases this policy document does not apply.

2. PROCEDURE

2.1 Definitions

Definitions in relation to the following terms used within this document are taken from statutory guidance (HM Government, 2018):



“Child” or “young person”, as in the Children Act 1989 and 2004, is anyone who has not yet reached their 18th birthday. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate, does not change his/her status or entitlements to services or protection. Where ‘child’ or ‘children’ is used in this document, this refers to children and young people.

Safeguarding and promoting the welfare of children are defined as:

- protecting children from maltreatment
- preventing impairment of children’s health or development
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- taking action to enable all children to have the best outcomes

Child In Need is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services; or a child who is disabled. In such circumstances assessments by a social worker are carried out under Section 17 of the Children Act 1989 with parental consent.

Child Protection is one element of safeguarding and promoting children’s welfare. Child protection refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm.

Significant Harm is the concept introduced by the Children Act 1989 as the threshold that justifies compulsory intervention in family life in the best interests of children. It gives Local Authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer, significant harm.

There are no absolute criteria on which to rely when judging what constitutes significant harm; However the Children and Social Work Act (2017) make reference to when a child is seriously harmed for the criteria for a “Child Safeguarding Practice Review” (replaces Serious Case Reviews), and states that ‘serious harm’ includes serious or long-term impairment of mental health or intellectual, emotional, social or behavioural development.

Child Safeguarding Practice Reviews (previously Serious Case Reviews)

Serious child safeguarding cases are those in which:

- abuse or neglect of a child is known or suspected **and**
- the child has died or been seriously harmed

Serious harm includes (but is not limited to) serious **and/or** long-term impairment of a child’s mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health. This is not an exhaustive list. When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred.

The purpose of the reviews is to raise local issues of importance and aim to identify improvements to practice and protect children from harm.



Child Death Overview Panel (CDOP)

The Child Death Overview Panel (CDOP) is a multi-agency group which reviews all child deaths up to the age of 18 years. Procedures for each locality can be found here:

- North Lancashire: [LSCB CDOP](#)
- Cumbria: [CSCP CDOP](#)

Since April 2008 it has been a statutory requirement to notify all child deaths to a central point, regardless of the age of the child or the cause of death.

GPs are expected to contribute to the Child death Review process and may be asked to attend meetings where appropriate or be asked to complete a reporting form. See [Child death review: statutory and operational guidance \(England\)](#)

Multi-Agency Risk Assessment Conference (MARAC)

This section should be read in conjunction with the Domestic Abuse Policy. This is a multi-agency meeting where information is shared about high risk victims of domestic abuse (those at risk of murder or serious harm) and has the safety of these victims at the heart. This process may give rise to safeguarding concerns for children and young people.

Multi-agency Public Protection Arrangements (MAPPA)

These arrangements are designed to protect the public and previous victims from serious harm by sexual and violent offenders. GP Practices may be requested to provide health information to contribute to an up-to-date risk assessment to ensure that the offender is managed appropriately, which may include information provided to practices by MBPCC services.

More information can be found at: [Multi-agency public protection arrangements \(MAPPA\) - GOV.UK](#)

Domestic Homicide Reviews

Domestic Homicide Reviews (DHR's) were established on a statutory basis under section 9 of the Domestic Violence Crime and Victims Act 2004. This provision came into force on 13th April 2011. All health organisations are obliged to participate in these reviews. Therefore, MBPCC acknowledges this obligation and will contribute in the same way as it does during the Child Safeguarding Practice reviews (previously known as serious case reviews)

2.2 Roles and Responsibilities

All professionals have a legal responsibility to safeguard all children under the age of 18 years in compliance with [Working Together \(2018\)](#) and local safeguarding procedures. This is also documented in [Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework \(2019\)](#)

The Safeguarding Children Strategic Partnership Board (previously LSCB)

The Local Safeguarding Children Boards have, since 2022, been replaced by Pan Lancashire Childrens Safeguarding Assurance Partnership (CSAP), as endorsed by The Children and Social Work Act (2017). The statutory partners of the Safeguarding Partnerships are the Police, NHS Clinical Commissioning Groups (CCG's) and the Local Authority. In accordance with Working Together (2018) the purpose of local safeguarding arrangements will be to support and enable local organisations to work together



in a system that delivers safeguarding arrangements of the highest quality, which promotes the welfare of children whatever their circumstances.

The Local Authority

The Local Authority is responsible to investigate allegations of child abuse in conjunction, and with the participation of, other agencies. It also lead the Child in Need process.

The Local Authority work with all health services, including Primary Care, education, police, prison and probation services, district councils and other organisations such as the NSPCC, domestic violence forums, youth services and armed forces, all of whom contribute and work together to share responsibility for safeguarding children and promoting their welfare.

Clinical Commissioning Groups

Clinical commissioning groups should employ, or have in place, a contractual agreement to secure the expertise of designated practitioners; such as dedicated designated doctors and nurses for safeguarding children and dedicated designated doctors and nurses for looked-after children (and designated doctor or paediatrician for unexpected deaths in childhood).

CCGs are required to employ a Named GP to advise and support GP Safeguarding Practice Leads. GPs should have a lead and deputy lead for safeguarding, who should work closely with the Named GP based in the clinical commissioning group (Working Together HM Government 2018) [Working together to safeguard children - GOV.UK](#)

Primary Care

Have a statutory duty under Working Together (2018) to contribute to the child protection process; this includes the provision of written reports and attendance where possible for child protection conferences and core groups.

General Medical Council (GMC) guidance aims to help doctors to protect children and young people who are living with their families or living away from home (e.g. children in care). It covers some areas which can be difficult and challenging for any practitioner encountering safeguarding concerns.

The Nursing and Midwifery Council's (NMC) Code of Conduct states that Nurses should raise concerns immediately if they believe a person is vulnerable or at risk and needs extra support and protection.

All MBPCC staff are expected to take reasonable steps to identify the possibility of abuse and prevent it before it occurs by sharing information, referring to children's social care in a timely manner where appropriate. All staff have a responsibility for raising concerns, sharing information and working together with statutory agencies to contribute to 'early help', child protection and child in need processes.

The CEO of MBPCC should ensure that safeguarding responsibilities are clearly defined in all job descriptions. For employees of MBPCC, failure to adhere to this policy and procedures could lead to dismissal and/or constitute gross misconduct.



Practice Safeguarding Lead/Deputy/Champion

All health care providers should have a Safeguarding Lead for both children and adult safeguarding (this may be the same person depending on the size and structure of the organisation). There should also be a deputy Safeguarding Lead/Champion as recommended in national guidance (Working Together 2018)

The MBPCC Safeguarding Lead is the GP who oversees the safeguarding work within the MBPCC. The MBPCC Safeguarding Lead will support safeguarding activity within MBPCC, work with the whole primary care team to embed safeguarding practice and ethos, provide some safeguarding training within MBPCC and act as a point of reference and guidance for their colleagues.

Lead roles do not take away the responsibility of any other member of staff to act on safeguarding concerns.

Designated and Named Professionals

It is important that MBPCC ensure that staff are aware who is, and how to contact the Designated and Named Professionals for Adult and Children's Safeguarding for advice and support (see Appendix 1 for contact details of all safeguarding children professionals)

Individual staff members, including all partners, employed staff and volunteers.

Must:

- Understand the principles of confidentiality and information sharing in line with local and government guidance at:
 - North Lancashire: [Information Sharing and Confidentiality](#)
 - South Cumbria: [Information Sharing \(Protocol\)](#)
- Contribute, when requested to do so, to the multi-agency meetings established to safeguard and protect children;
- Minimise any potential risk to children.

2.3 Recognition of Abuse

Recognising child abuse is not easy, however, it is our responsibility to act if we have any concerns and share relevant information where necessary.

Abuse is a form 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 an institutional or community setting, by those known to them or, more rarely, by strangers. Abuse can take place wholly online, or technology may be used to facilitate offline abuse. Children may be abused by an adult or adults, or another child or children and are categorised as the following:

Physical abuse: May involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, female genital mutilation (FGM) or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

If a child presents with an injury it is important to note whether the injury is consistent with:

- The history provided.



- The child's developmental age (remember that developmental age is not always related to chronological age).
- Be alert to **multiple bruises** with bruising in 'protected' areas or unusual bruises.

NB – Bruising in non-mobile children –

'All non-mobile children who are observed with injuries / bruises must be considered as possible subjects of non-accidental injury and referred for immediate paediatric assessment'

Lancashire

https://panlancashirescb.proceduresonline.com/chapters/p_recog_significant_harm.html#physical_abuse

Details of local referral pathways can be found using:

<http://panlancashirescb.proceduresonline.com/index.htm>

Cumbria https://cumbrialscb.proceduresonline.com/chapters/p_bruising_babies.html?zoom

Please also refer to 'Bruises on children': [NICE guidance](#)

Emotional abuse: Emotional abuse is a form of significant harm which involves the persistent emotional maltreatment 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. 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.

Sexual abuse: Involves forcing or enticing a child or young person to take part in sexual activities, this may not necessarily always involve a high level of violence, the child may not always be aware they are being abused or know what is happening. The activities may involve physical contact, including assault by penetration (for example, 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, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse. Sexual abuse can take place online, and technology can be used to facilitate offline abuse.

Sexual abuse can occur in many situations including interfamilial; and is not solely perpetrated by adult males, women can also commit acts of sexual abuse, as can other children. Child Sexual Exploitation (CSE) is also a form of sexual abuse; see below for further information around CSE.

Neglect: 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. Once a child is born, neglect may involve a parent or carer 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.
- Neglect may also include neglect of, or unresponsiveness to a child's basic emotional needs.

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

See Appendix 2 for indicators of Physical, Emotional, Sexual Abuse and Neglect

For more detailed guidance on how to recognise abuse and neglect refer to:

- North Lancashire: [Neglect](#)
- South Cumbria: [Neglect](#)

NICE guidance When to suspect child maltreatment accessed at: <http://guidance.nice.org.uk/CG89>

Professional Curiosity

Professional curiosity is the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value. This is a key facet of safeguarding and child protection work, so agencies must work together to ask the right questions, at the right time, ensuring that the voice of the child and their experience, is at the centre of what they do.

All practitioners whose work brings them into contact with children and families should be alert to the signs of abuse and neglect, know where to turn to if they need to ask for help, and able to make referrals to children's social care or to the police, if they suspect that a child is at risk of harm or is in danger.

Children will rarely disclose abuse and neglect themselves and, if they do, it will often be through unusual behaviour or comments. This makes identifying abuse and neglect difficult for professionals across agencies. We know that it is better to help children as early as possible, before issues get worse. That means that all agencies and practitioners need to work together –the first step is to be professionally curious.

While the presence of a potential indicator of neglect/abuse does not necessarily mean that a child is being harmed, it will always warrant further investigation. Practitioners must be 'professionally curious' to determine further information in the interests of the child. It is essential that professionals exercise professional curiosity at all times as it is likely that signs of any form of abuse including neglect will be identified when dealing with an un-associated incident.

Parenting Capacity

Parenting capacity is defined as "the ability of parents or caregivers to ensure that the child's developmental needs are being appropriately and adequately responded to, and to (be able to) adapt to (the child's) changing needs over time". This includes providing for the child's basic physical needs, ensuring their safety, "ensuring the child's emotional needs are met and giving the child a



sense of being specially valued", "promoting the child's intellectual development through encouragement and stimulation, demonstrating and modelling appropriate behaviour and control of emotions, and providing a sufficiently stable family environment.

When dealing with parents with additional needs MBPCC will consider the impact that this behaviour has on children, in particular their emotional development, and the parent's capacity to protect a child from harm and meet their identified needs. In cases where parental additional needs may impact on the parent's ability to meet the needs of their child MBPCC will work with other statutory agencies whenever necessary to support the family and improve the outcomes for these children.

Adverse Childhood Experiences (ACE's)

Adverse Childhood Experiences (ACEs) are stressful or traumatic events that happen in childhood and can affect people as adults. They include events that affect a child or young person directly, such as abuse or neglect. ACEs also include experiences that affect children indirectly through the environment they live in. This could be living with a parent or caregiver who has poor mental health, where there is domestic abuse, or where parents have divorced or separated. ACEs can be single events, long-term or repeated experiences.

The documents below have been developed by Public Health colleagues to assist organisations in Lancashire and South Cumbria to become ACE-aware and Trauma-Informed. It provides a lexicon of descriptions and explanations of key terms and is intended they will be adopted across organisations to help communicate the concepts more clearly and consistently.

North Lancashire & South Cumbria

- [A Shared Language for ACEs and Trauma Informed Practice](#)
- [Summary of Shared Language](#)

2.4 Safeguarding Children in Special Circumstances

Looked After Children (LAC) and Care Leavers

Most children become looked after as a result of abuse and neglect; evidence and learning from serious case reviews highlights that looked after children are therefore more likely to suffer further abuse and neglect once entering the care system. Ensuring they are adequately safeguarded is therefore everyone's responsibility. Although they have many of the same health issues as their peers, the extent of these is often greater because of their past experiences. For example, almost half of children in care have a diagnosable mental health disorder and two-thirds have special educational needs. Delays in identifying and meeting their emotional well-being and mental health needs can have far reaching effects on all aspects of their lives, including their chances of reaching their potential and leading happy and healthy lives as adults (DfE, DH 2015). Care leavers are a cohort of young people who are vulnerable to abuse due to their previous experiences and often their lack of 'belonging'. They are particularly targeted by contextual forms of abuse such as sexual and criminal exploitation. When considering trauma informed practice, care leavers often have a high number of ACE's that will influence their transition into an adult world.

Please refer to guidance for Looked After Children.



Private Fostering

Private fostering is when a child's parent or guardian arranges for them to be cared for and live with someone else, who is not a close relative.

This applies where:

- The child is under 16, or if disabled is under 18.
- The arrangement will be for 28 days or more or
- The arrangement is for less than 28 days but is one of a series of days that all together add up to 28 days.
- The person who will look after them is not a close relative of the child (for example is not a brother, aunt or grandparent).

Privately fostered children can be vulnerable as they may not see their families very often. It is therefore important that their needs are assessed and their situation monitored to safeguard their wellbeing.

Professionals should determine where the child is living, with whom and whether the parent/carers have informed the local authority of any private fostering arrangements. If professionals feel that Children's Social Care have not been informed, then they should notify Children's Social Care themselves.

Please also see:

- Lancashire: [Private Fostering](#)
- South Cumbria: [Private Fostering](#)

Children not accessing education.

Where it is discovered that a child is not receiving any form of education a referral must be made to the local authority in which the child lives. Some parents choose to home educate their children and procedures for each locality can be found here:

- North Lancashire: [Educating Your Child at Home](#)
- South Cumbria: [Home Education in Cumbria](#)

Fabricated or Induced Illness (FII)

Fabricated or Induced Illness (previously referred to as Munchausen Syndrome by Proxy) is a rare and potentially dangerous form of child abuse in which the parent/carer fabricates symptoms in their child or induces them by a variety of means. Research has shown that the way in which a case of FII is managed can have a major impact on the outcome for the child. The key issues are to assess the impact of FII on the outcome for the child's health and development and to consider how best to safeguard that child. This requires a clear and sound multi-agency approach, ensuring that all appropriate professionals are involved. Multi-agency guidance for managing children where FII is suspected can be found here:

- North Lancashire: [Fabricated or Induced Illness](#)
- South Cumbria: [Safeguarding Children in whom Illness is Fabricated or Induced](#)

There may be a discrepancy in the clinical presentation and one or more of the following;



- Reported signs and symptoms only in the presence of the carer.
- Multiple second opinions sought (other GPs, secondary/tertiary centres).
- Inexplicable poor response to medication or excessive use of aids.
- Biologically unlikely history of events even if the child has a current or past psychological condition.

Where a GP has concerns that a child may be subject to FII they must discuss their concerns with the Designated /Named Doctor for Safeguarding or where relevant, with the consultant providing care for the child.

In **all** cases of suspected FII, professionals **should not** discuss the referral with the parents/carers until a multi-agency action plan has been agreed.

Domestic Violence and Abuse

Domestic Abuse is a complex issue; this section should be read in conjunction with the policy for Domestic Abuse. It is a serious crime that can occur across all sections of society, in all social classes and cultures and is not age specific. One in four women and one in six men will experience domestic abuse in their lifetime.

Domestic abuse can seriously harm children and young people. Witnessing domestic abuse is considered emotional abuse and can impact on the safety, health and wellbeing of a child; including how they establish future relationships. For further information see [NSPCC](#) around spotting the signs in children and [Department of Health guidance on responding to Domestic Abuse](#).

Honour Based Abuse/Violence

This section should be read in conjunction with the MBPCC Domestic Abuse Policy. In some cultural groups there may be added complexities related to domestic abuse that are termed Honour Based Abuse/Violence. Cultural issues should be recognised in situations when people from different racial groups disclose domestic abuse. Added pressures may be evident for these victims e.g. language barriers, dishonour of family, unfamiliarity with British culture, no British citizenship, no recourse to public funds and professionals should be mindful that there may be added safety factors to consider.

Safeguarding and protection of children and young people must still be addressed in accordance with locality procedures:

- North Lancashire: [Honour Based Abuse](#)
- South Cumbria: [Honour Based Violence](#)

Forced Marriage

This section should be read in conjunction with the policy for Domestic Abuse. Forced Marriage is not an arranged marriage. A forced marriage is a marriage where one or both parties do not give willing consent and where there is duress involved, often resulting in domestic abuse which will impact on children living within the household.

Forced marriage is a criminal offence and has been illegal since June 2014 it is not condoned by any major religion and is considered a form of abuse. Forced marriage is recognised as an abuse of human rights and it can be categorised as domestic abuse or child abuse depending on age. Forced Marriage is abusive and when it occurs in children under the age of 18yrs it should be dealt with by

following child protection procedures, multi-agency guidance can be found [here](#). However extreme caution should be exercised and expert advice sought as soon as possible by any professional dealing with cases of this nature.

- National Forced Marriage Unit - 020 7008 0151
- North Lancashire: [Forced Marriages](#)
- South Cumbria: [Forced Marriage](#)

Female Genital Mutilation (FGM)

This section should be read in conjunction with MBPCC Domestic Abuse Policy. FGM is illegal and is a form of gender based violence, child abuse and considered a non-accidental injury that causes significant physical and emotional harm, violating human rights and the rights of the child.

The World Health Organisation (WHO) states that female genital mutilation (FGM):

“Comprises of all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons” (WHO 2014)

Female Genital Mutilation (FGM) is illegal in England and Wales under the FGM Act 2003. The FGM Act (2003) makes it unlawful for UK nationals or habitual UK residents to carry out FGM in the UK or abroad, or to aid, abet, counsel or procure the carrying out of FGM even in countries where FGM is legal.

If a child (<18 yrs.) tells you they have FGM (however described) or you visualise during a routine investigation what appears to be FGM, including genital piercing :

Mandatory Reporting applies (Section 5B of the FGM 2003 Act) and your suspicions do not have to be confirmed; click [mandatory reporting processes](#) for clear guidance of what to do; this needs to be reported to the police on 101 before end of play of the next day, and complete a children’s social care referral. For further procedural information around mandatory reporting for FGM [click here](#).

Evidence tells us that girls born to mothers with FGM are also at risk of being subjected to FGM for further information [click here](#). A child safeguarding referral is therefore required if a woman is known to have FGM and pregnant or has female children associated with her. A multi-agency strategy discussion will then take place between Police, Social Care & Health to assess the risk to any females associated with a woman identified with FGM see:

- Lancashire: [FGM Pathway](#)
- Cumbria: [Female Genital Mutilation](#)

Primary Care have a mandatory duty to record all cases of FGM to the department of health under the [Female Genital Mutilation Datasets - NHS Digital](#)

Contextual Safeguarding

As well as threats to the welfare of children from within their families, children may be vulnerable to abuse or exploitation from outside their families. These extra-familial threats might arise at school and other educational establishments, from within peer groups, or more widely from within the wider community and/or online. These threats can take a variety of different forms and children can be vulnerable to multiple threats, including: exploitation by criminal gangs and organised crime groups such as county lines; trafficking, online abuse; sexual exploitation and the influences of



extremism leading to radicalisation. Extremist groups make use of the internet to radicalise and recruit and to promote extremist materials. Any potential harmful effects to individuals identified as vulnerable to extremist ideologies or being drawn into terrorism should also be considered.

Child Criminal Exploitation (CCE)

As set out in the [Serious Violence Strategy](#), published by the Home Office, where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18 into any criminal activity. Child criminal exploitation, like other forms of abuse and exploitation, is a safeguarding concern and constitutes abuse even if the young person appears to have readily become involved.

Child criminal exploitation is typified by some form of power imbalance in favour of those perpetrating the exploitation and usually involves some form of exchange, for example County Lines may use vulnerable children to carry drugs in return for something. The exchange can include both tangible (such as money, drugs or clothes) and intangible rewards (such as status, protection or perceived friendship or affection). Young people who are criminally exploited are at a high risk of experiencing violence and intimidation and threats to family members may also be made.

Child criminal exploitation does not always involve physical contact; it can also occur through the use of technology.

See local safeguarding procedures for

- North Lancashire [Gang, Group Activity and Criminal Exploitation Affecting Children](#)
- South Cumbria [Child Criminal Exploitation and County Lines](#)

Where there are concerns that children are victims of child criminal exploitation they should be referred to the National Referral Mechanism, see:

- North Lancashire: [Modern Slavery](#)
- South Cumbria: [Child Trafficking and Modern Slavery](#)

County lines

County lines is a national issue involving the use of mobile phone 'lines' by organised crime groups to extend their drug dealing business into new locations. These groups exploit vulnerable persons which involve both children and adults who require safeguarding. [Fearless.org](#) has further information and tips on how to spot a child who might be involved.

Child Sexual Exploitation (CSE)

It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology (Working Together 2018).

Child sexual exploitation affects all ethnic groups and both girls and boys, most frequently observed amongst young females, boys are also at risk. Practitioners should be alert to the fact that boys may be less likely than females to disclose experiences of child sexual exploitation and less likely to have



these identified by others. Children as young as 8 have been identified at risk of CSE particularly in relation to online concerns, children aged 12-15 years however are most at risk of sexual exploitation. Equally, those aged 16 or above can also experience CSE and it is important that such abuse is not overlooked due to assumed capacity to consent.

See local safeguarding procedures for CSE

North Lancashire: [Child Sexual Exploitation](#)

South Cumbria: [Child Sexual Exploitation](#)

Safeguarding issues where technology is involved

Children and Young People's relationship to technology is increasingly embedded across all walks of life and as such, we cannot address their wellbeing and safety effectively without considering the potential risks that this can bring. Technology by its nature is constantly evolving, bringing both new opportunities and new risks for all but particularly, for our Children and Young People.

We can no longer adequately consider the safeguarding or wellbeing of our Children and Young People without considering their relationship to technology. For further information see Pan-Lancashire LSCB On-line Safeguarding Strategy 2017-2019 [here](#).

Modern Slavery and Human Trafficking

Modern slavery is a complex crime that takes a number of different forms. It encompasses slavery, servitude, forced and compulsory labour and human trafficking. Traffickers and slave drivers coerce, deceive and force individuals against their will into a life of abuse, servitude and inhumane treatment. Victims may be sexually exploited, forced to work for little or no pay or forced to commit criminal activities against their will. Victims are often pressured into debt bondage and are likely to be fearful of those who exploit them, who will often threaten and abuse victims and their families. All of these factors make it very difficult for victims to escape." (HM Government 2014)

The Modern Slavery Act (2015) was introduced in the UK with the intention of combatting slavery and human trafficking. British and foreign nationals can be trafficked into, around and out of the UK. Children, women and men can all be victims of modern slavery and are trafficked for a wide range of reasons including:

- Sexual exploitation.
- Domestic servitude.
- Forced labour including in the agricultural, construction, food processing, hospitality industries and in factories.
- Criminal activity including cannabis cultivation, street crime, forced begging and benefits fraud.
- Organ harvesting.

Any child transported for exploitative reasons is considered to be a trafficking victim, whether or not they have been forced or deceived. This is partly because it is not considered possible for children in this situation to give informed consent. Even when a child understands what has happened, they may still appear to submit willingly to what they believe to be the will of their parents or accompanying adults. It is important that these children are also protected .

What to do next (In all cases of children, young people and adults):



Do not raise your trafficking concerns with anyone accompanying the person and ensure you address the health needs of the person by continuing to provide care. Only use an independent and qualified interpreter through a professionally recognised interpreting service.

Any agency, individual or volunteer who comes into contact with a child who may have been exploited or trafficked regardless of their immigration status must make a children's safeguarding referral. In addition a referral into the NRM (National Referral Mechanism) must also be completed. This should continue in tandem with the local safeguarding procedures. Click here for the NRM referral form.

2.5 PREVENT

PREVENT is part of the Government's counter-terrorism strategy CONTEST, which is led by the Home Office. The health sector has a non-enforcement approach to Prevent and focuses on support for vulnerable individuals and healthcare organisations. The Department of Health and the health sector are key partners in working to prevent vulnerable individuals from being drawn into terrorist-related activities. Prevent is about recognising when vulnerable individuals are being exploited for terrorist-related activities, it follows that it is most appropriately managed within existing safeguarding structures, working closely with emergency planning.

Raising concerns:

Should any staff member have a concern relating to an individual's behaviour which indicates that they may be being drawn into terrorist-related activity, they will need to take into consideration how reliable or significant these indicators are. Indicators may include:

- Graffiti symbols, writing or artwork promoting extremist messages or images.
- Patients/staff accessing terrorist-related material online, including through social networking sites.
- Parental/family reports of changes in behaviour, friendships or actions and requests for assistance.
- Partner healthcare organisations', local authority services' and police reports of issues affecting patients in other healthcare organisations.
- Patients voicing opinions drawn from terrorist-related ideologies and narratives.
- Use of extremist or hate terms to exclude others or incite violence.

It may be that a patient or staff member is facing multiple challenges in their life, of which exposure to terrorist-related influences is just one. Healthcare workers will need to use their judgement in determining the significance of any changes in behaviour where sufficient concerns are present. These should be reported in accordance with the MBPCCs policies and procedures.

Concerns that an individual may be vulnerable to radicalisation, does not mean that you think the person is a terrorist, it means that you are concerned they are prone to being exploited by others, and so the concern is a safeguarding concern.

If a member of staff feels that they have a concern that someone is being radicalised, then they should discuss their concerns with their manager and the safeguarding lead.

If staff suspect any such incidents they must discuss with their line manager/CCG designated nurse/professional for safeguarding and make arrangements to report their suspicions accordingly:



- In an emergency 999
- National Anti-Terrorist Hotline -0800 789 321
- Crime Stoppers -0800 555 111
- See flow chart for referral pathway in appendix No ***
- In addition children's social care if the young person is under 18yrs old

<https://www.gov.uk/government/policies/protecting-the-uk-against-terrorism>

What to do if you have concerns about a child's welfare

Follow link for referral pathways and contact details across localities (also at Appendix 1):

North Lancashire: [Making Assessments and Referrals](#)

Cumbria: <https://www.cumbriasafeguardingchildren.co.uk/LSCB/procedures>

Discuss your safeguarding concerns with your practice safeguarding lead. If there are immediate risks to a child or young person's safety call 999 for police assistance.

Where a decision is taken not to seek parental permission before making a referral to Children's Social Care/Safeguarding Team the decision must be recorded in the child's record and include reasons for that decision, and confirmed in the written referral. There are specific circumstances whereby parental consent is not required as doing so may place the child/young person at increased risk of harm. This includes:

- Suspected sexual abuse
- Honour based abuse including FGM
- Suspected physical abuse
- Suspected Fabricated Illnesses

It is the responsibility of social care/safeguarding team to acknowledge the receipt of your referral and decide on the next course of action or no action within one working day. This may include an assessment or they may decide that Children's Social Care has no role at this stage. In either circumstance you should be informed of their decision.

If you have not heard anything from the social care safeguarding team within three working days it is the referrer's responsibility to follow this up with the team.

If you have a disagreement with another agency (e.g. Children's Social Care) regarding the outcome of the referral you can escalate your concerns by following the professional disagreement process via:

- North Lancashire: [Resolving Professional Disagreements](#)
- South Cumbria: [Escalation Policy](#)

The CCG Safeguarding teams can provide additional support and should be notified of these circumstances.



Responding to a child who discloses abuse

Whenever a child reports that they are experiencing abuse or neglect, or have caused or are causing physical or sexual harm to others, the initial response from all professionals should be:

- Clarify the concerns;
- Offer re-assurance about how the child will be kept safe and that you believe them;
- Explain what action will be taken.

If the child can understand the significance and consequences of making a referral to Children's Social Care safeguarding team, they should be asked their view.

However, it should be explained to the child that whilst their view will be taken into account, the professional has a responsibility to take whatever action is required to ensure the child's safety and the safety of other children.

It is important to remember that other children in the family should always be considered for assessment when abuse of one child is uncovered.

What to do if members of the public raise concerns

Members of the public may talk to GPs and MBPCC staff about the abuse of children known to them. They may specifically allege incidents or knowledge of abuse to a child or may refer to it when discussing other issues. The child may be well known to them, or may be the child of neighbours or others less well known. The type and nature of the abuse may be quite specific or it may be described only in very general terms.

It is important that all such allegations or references to abuse are taken seriously and relevant details should be referred to Children's Social Care safeguarding team for further enquires to be made. In such circumstances, you should be clear with that person that you have a duty to report any alleged abuse, and encourage the person to make a direct referral to Children's Social Care themselves: remember, safeguarding is everyone's responsibility.

If the member of public refuses to refer to Children's Social Care, the professional to whom the disclosure was made has a responsibility to refer if a disclosure in respect of 'significant harm' has been made. It is essential that clear notes of any such allegation are kept within the child's, parents or carers record if one is available and if possible, clarify details.

2.6 Information Sharing

Keeping children and young people safe from harm requires professionals and others to share information about their health and development and exposure to possible harm. Often, it is only when information from a number of sources has been shared and pulled together that it becomes clear that there are concerns a child is in need of protection or services.

Information sharing: Advice for Practitioners (HM Government 2018) accessed at:

[Information sharing advice practitioners safeguarding services.pdf](#)

2.7 GP Contribution at Child Protection Case Conferences

The contribution of GPs to safeguarding children is part of their statutory functions and responsibilities for safeguarding children under the age of 18; MBPCC recognise this and so will look to release a relevant GP from MBPCC duties wherever possible so priority can be given to



attendance wherever possible. In all circumstances a written report should be made available for the conference. The report will inform the child protection decision making, the use of locally agreed templates for CP conferences are widely agreed between partner agencies. Initial Child Protection Case conferences are required to be convened within 15 working days of a strategy meeting being convened. Please see below link:

2.8 Recording Information

For electronic records see also <https://www.gov.uk/government/publications/the-good-practice-guidelines-for-gp-electronic-patient-records-version-4-2011>

If information is about a member of staff this is recorded securely in the staff member's file in line with HR policies, digitally stored within the Line Managers secure folders.

- Regulated practitioners must also have regard to their regulatory body guidance, for example, Nursing & Midwifery Council Record Keeping Guidance 2009; General Medical Council, Good Medical Practice (2013).

Identifying those with Potential Safeguarding Concerns - Coding

MBPCC computer systems are used to identify those patients and families with risk factors or concerns and especially when the patient or their family consults a range of practitioners.

RCGP guidance:

- Processing and Storing of Safeguarding Information in Primary Care
- Guidance on Recording of Domestic Violence and Abuse Information in General Practice Medical Records

Available from the [RCGP Child Safeguarding Toolkit](#)

MBPCC will:

- Use the computer alert system
- Use a standard set of Read codes
- Have an agreed process and identified person who is responsible for applying and reviewing the alerts on the child's record.

It is important to be alert to the siblings and other members of the household as the child there are direct concerns about.

Creating a Safer Environment

The Disclosure and Barring service (DBS) enables organisations in the public, private and voluntary sectors to make safer recruitment decisions by identifying candidates who may be unsuitable for certain work, especially that involving children or vulnerable adults, and provides wider access to criminal record information through its disclosure service for England and Wales.

MBPCC has a responsibility to ensure that it undertakes appropriate criminal record checks on applicants for any position within MBPCC, either an enhanced or standard level check dependant on job role. MBPCC also has a legal duty to refer information to the DBS if an employee has harmed, or poses a risk of harm, to vulnerable groups and where they have dismissed them or are considering



dismissal. This includes situations where an employee has resigned before a decision to dismiss them has been made.

For further information, visit [DBS checks: detailed guidance - GOV.UK](#)

Safer employment extends beyond criminal record checks to other aspects of the recruitment process including:

- Making clear statement in adverts and job descriptions regarding commitment to safeguarding.
- Seeking photographic proof of identity and qualifications and keeping evidence on staff files.
- Providing two references, one of which should be the most recent employer.
- Evidence of the person's right to work in the UK is obtained.

Managing Allegations against Staff

If an allegation is made against a member of MBPCC staff and it relates to conduct towards a child, MBPCC recognises that its Safeguarding Lead or CEO of MBPCC must ensure that the Local Area Designated Officer (LADO) who is employed by the Local Authority (contact details available on the relevant Safeguarding Partnership website as referenced above), is informed. The LADO assumes oversight of any subsequent investigation process from beginning to end and will give advice. They will also liaise with the police and social care if necessary.

After taking any immediate action in line with MBPCC policy, the MBPCC Safeguarding Lead or CEO of MBPCC should ensure that the LADO is informed if the staff member has:

- Behaved in a way that has harmed, or may have harmed, a child, or
- possibly committed a criminal offence against or related to a child, or
- behaved towards a child in a way that indicates unsuitability to work with children.

LADO details by locality:

- North Lancashire: [Local Authority Designated Officer](#)
- South Cumbria: [Local Authority Designated Officer](#)

Whistle Blowing

MBPCC recognises that it is important to build a culture that allows MBPCC staff to feel comfortable about sharing information, in confidence and with a lead person, regarding concerns about quality of care or a colleague's behaviour. Please refer to MBPCC Whistle blowing policy.

Complaints procedure

MBPCC has a robust mechanism for dealing with complaints from all patients (including children and young people), employees, accompanying adult or parent in line with Lampard recommendations. Please refer to MBPCC Complaints Policy. Consideration should always be given to whether a complainant meets the criteria for managing allegations procedures.

Consent Guidance and Procedure

MBPCC has a clear consent guidance and chaperone procedure which all practitioners are aware of. Please refer to MBPCC Consent, Chaperone and Confidentiality Policy.



Children under the age of 16 can consent to their own treatment if they're believed to have competence and understanding to fully appreciate what's involved in their treatment. This is known as being 'Gillick competent'.

Otherwise, someone with 'parental responsibility' can consent for them. This could be:

- The child's mother or father.
- The child's legally appointed guardian.
- A person with a residence order concerning the child.
- A local authority designated to care for the child.
- A local authority or person with an emergency protection order for the child.

The person with parental responsibility must have capacity to give consent. If one person with parental responsibility gives consent and another doesn't, the healthcare professionals can choose to accept the consent and perform the treatment in most cases.

If the people with parental responsibility disagree about what's in the child's best interests, the courts can make a decision.

In an emergency, where treatment is vital and waiting to obtain parental consent would place the child at risk, treatment can proceed without consent.

The Mental Capacity Act (MCA) 2005 provides a legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. The MCA does not apply to under 16s but does apply to 16 and 17 year olds.

Training

To protect children and young people from harm, all health staff must have the competences to recognise child maltreatment and to take effective action as appropriate to their role as identified by the [Intercollegiate Document 2019](#).

All staff undergoing training are expected to keep a learning log for their appraisals and/or professional development. Please refer to the CCG safeguarding training brochure for all MBPCC staff safeguarding training requirements.

Safeguarding supervision

Staff working with children, young people and families to have access to support and supervision; this will provide an opportunity for practitioners to share their concerns and to enable them to manage the stresses inherent in this work. It also promotes good standards of practice, which are soundly based and consistent with local and national guidance for safeguarding children.

Key decisions taken during supervision must be recorded in the child's records.

Safeguarding supervision for staff can be given individually or on a one to one basis for clinical staff. Professionals offering safeguarding supervision should have the relevant experience and training for offering supervision; this would normally be the safeguarding lead for MBPCC or local specialist safeguarding teams for case discussions/supervision. The safeguarding lead may access safeguarding supervision through peer support or through the named GP for safeguarding children, designated professionals and through the safeguarding lead/champion workshops.



3. REFERENCES

BMA Child Protection Toolkit <https://www.gov.uk/government/publications/building-partnerships-staying-safe-guidance-for-healthcare-organisations>

Care Quality Commission (CQC) (2009) Guidance about compliance: Essential Standards of Quality and Safety

Department for Education (2017) Child Sexual Exploitation. Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation.

Department of Health et al (2000) Framework for the Assessment of Children in Need and their Families, London, HMSO

Department of Health and Department of Education (2015) Promoting the health and well-being of looked-after children.

DH (Nov, 2011), Building Partnerships, Staying Safe. - The Health Sector Contribution to HM Governments Prevent Strategy. Guidance for Healthcare organisations.

DH (2015) Identifying and supporting victims of modern slavery: guidance for health staff. <https://www.gov.uk/government/publications/identifying-and-supporting-victims-of-human-trafficking-guidance-for-health-staff/identifying-and-supporting-victims-of-modern-slavery-guidance-for-health-staff>

GMC (2018) Protecting Children and Young People. GMC

HM Government (2008) Safeguarding Children in whom illness is fabricated or induced, DCSF publications

HM Government (2009) The Right to Choose: multi-agency statutory guidance for dealing with Forced marriage, Forced Marriage Unit: London

HM Government (2011) Safeguarding children who may have been trafficked. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/177033/DFE-00084-2011.pdf

HM Government (2014) Modern Slavery Strategy. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/383764/Modern_Slavery_Strategy_FINAL_DEC2015.pdf

HM Government (2015) What to do if you're worried a child is being abused, DSCF publications

HM Government (2018) Information sharing. Advice for practitioners providing safeguarding services to children, young people, parents and carers

HM Government (2016) Keep on Caring, supporting Young People from Care to Independence.

National Institute for Health and Clinical Excellence (2009) When to suspect child maltreatment, Nice clinical guideline 89

NHS Employment Check standards (2013)

<http://www.nhsemployers.org/recruitmentandretention/employment-checks/employment-check-standards/pages/employment-check-standards.aspx>

Royal College Paediatrics and Child Health et al (2019) Safeguarding Children and Young people: Roles and Competencies for Health Care Staff. Intercollegiate Document Safeguarding children and young people: roles and competencies | RCPCH

NHS England and NHS Improvement (2019) Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework

Useful links

RCGP/NSPCC (2019) Safeguarding Children and Young people: The RCGP/NSPCC Safeguarding Children Toolkit [Revised guidance on child safeguarding: GP Toolkit](#)

Victims of human trafficking www.gov.uk/government/publications/identifying-and-supporting-victims-of-human-trafficking-guidance-for-health-staff

Forced marriage www.gov.uk/forced-marriage

Female genital mutilation [Female genital mutilation \(FGM\) - NHS](#)

Advice and links for young people, parents, teachers, and organisations:

www.childnet.com/sorted A site designed by young people.

www.ceop.gov.uk Child Exploitation and Online Protection. Linked to a Virtual Global Taskforce, enabling police to investigate reported, actual or attempted abuse.

www.iwf.org.uk The Internet Watch Foundation. Hotline for reporting illegal online content.

www.digizen.org Information about the safe use of social networking sites

4. DEFINITIONS/GLOSSARY OF TERMS

Abbreviation or Term	Definition
MBPCC	Morecambe Bay Primary Care Collaborative
CEO	Chief Executive Officer
CQC	Care Quality Commission
CDOP	Child Death Overview Panel
DH	Department of Health
MARAC	Multi Agency Risk Assessment Conference
MAPPA	Multi Agency Public Protection Arrangements
DHR	Domestic Homicide Reviews
CCG	Clinical Commissioning Group
GMC	General Medical Council
NMC	Nursing and Midwifery Council
CSE	Child Sexual Exploitation
FGM	Female Genital Mutilation
ACE's	Adverse Childhood Experiences
LAC	Looked After Children



DfE	Department for Education
FII	Fabricated or Induced Illness
WHO	World Health Organisation
NRM	National Referral Mechanism
RCGP	Royal College of General Practitioners
LADO	Local Area Designated Officer
NICE	National Institute for Health and Care Excellence
CCE	Child Criminal Exploitation

5. CONSULTATION WITH STAFF, PRACTICES AND PATIENTS

Name	Job Title	Date Consulted
Emma O'Kane	Safeguarding and Quality Practitioner	27/08/2020

6. DISSEMINATION/TRAINING PLAN

Action by	Action Required	Implementation Date
Jo Knight/Boyana Konar	Upload policy to MBPCC website	Following approval of V1.1 end Sept 2020
Jo Knight	Delete out of date copies and host current copy on Federation G Drive (supporting induction process), updating Policy tracker	Following approval of V1.1 end Sept 2020
Andrew Giles	Ensure all employees are aware of the policy and are asked to read and understand it	MBPCC Board Meeting 22/09/20
Liz Stedman	Upload to TeamNet	Jan 2021

7. AMENDMENT HISTORY

Version No.	Date of Issue	Section/Page changed	Description of change	Review Date
V1.0	27/07/20	Approved Policy	Updated policy in line with latest guidance	22/10/2023
V1.1	20/09/20	All	New format and full adoption of the CCG model policy	N/A
V2.0	22/09/20	N/A	MBPCC Board Approval	22/09/2022
V2.1	25/11/20	1.1, 2.3, 4, 8 (Appendix 1)	Updates following CCG review	22/09/2022
V2.1	20/01/21	N/A	MBPCC Board Approval following updates	22/09/2022
V2.2	07/02/22	N/A	Updated contact details	
V2.3		1.1 1.2 2.2 2.5 Appendix 8	Updated	



8. APPENDICES

Appendix 1: Local Safeguarding Contacts

The numbers below are for non-urgent advice:

UHMBT Safeguarding Team	01524 512425
Morecambe Bay CCG's Quality and Safeguarding Team	01524 518957 MBCCG.QST@nhs.net
MBPCC Safeguarding Lead	015242 44348

Social Care:

Lancashire: 0300 123 6720 9am-5pm; 0300 123 6722 out of office hours

Blackpool: 01253 477299

Cumbria Safeguarding Hub: 0333 240 1727

Police:

Emergency: 999

Non-urgent: 101



Appendix 2: Possible Signs and Indicators of Child Abuse and Neglect

Possible signs and indicators of child abuse and neglect

<h3>Physical Abuse</h3> <p>Actions and behaviour of adult/ carer</p> <ul style="list-style-type: none"> Minor injuries Serious head injuries eg. Those resulting in fractures or head injuries Premeditated sadistic injuries Burns and scalds Bites Repeated abuse resulting from lack of control Injury resulting from physical chastisement <p>Physical signs on child/ young person</p> <ul style="list-style-type: none"> Unconscious Unexplained bruising/marks or injuries Injuries of different ages Adult bite marks Outline bruising eg. belt, hand print Bruises to eyes, ears, finger tips Burns and scalds on hands, feet, buttock, groin, cigarette burns <p>Behaviour and emotional state of child/ young person</p> <ul style="list-style-type: none"> Aggressive Withdrawn or watchful Low self-esteem Poor concentration Poor self image 	<h3>Emotional Abuse</h3> <p>Actions and behaviour of adult/ carer</p> <ul style="list-style-type: none"> Rejection Lack of praise and encouragement Lack of comfort and love Lack of secure attachment Lack of continuity of care eg. frequent moves Serious over protectiveness Inappropriate non-physical punishment eg. locking in bedroom, cold water in bath, frequent shouting at a child Humiliating and degrading behaviour, including bullying and racial abuse <p>Physical signs on child/ young person</p> <ul style="list-style-type: none"> Difficulty in moving limbs Blood in white of eyes, small bruises on head, bruises on rib cage—may be associated with shaking injuries Injuries and/or fractures in babies and children who are not mobile or poisoning Drowsiness eg. from head injury or poisoning Female genital mutilation Genital/anal area injuries <p>Behaviour and emotional state of child/ young person</p> <ul style="list-style-type: none"> Self harm behaviour, eg. mutilation, substance misuse, suicide attempts Developmental delay Eating disorders
<h3>Sexual Abuse</h3> <p>Actions and behaviour of adult/ carer</p> <ul style="list-style-type: none"> Inappropriate fondling Mutual masturbation Digital penetration Oral/genital contact Anal or vaginal intercourse Sexual exploitation Exposure to pornography <p>Physical signs on child/ young person</p> <ul style="list-style-type: none"> Injuries to the genital/anal area Sexually transmitted diseases Pregnancy Bruises, scratches, burns or bite marks Eating disorders <p>Behaviour and emotional state of child/ young person</p> <ul style="list-style-type: none"> Nightmares and disturbed sleeping patterns Persistent offending, non-school attendance, running away Wetting, soiling, smearing excreta Significant changes in child's behaviour Depression 	<h3>Neglect</h3> <p>Actions and behaviour of adult/ carer</p> <ul style="list-style-type: none"> Abandonment or desertion Leaving alone Malnourishment, lack of food, inappropriate food or erratic feeding Lack of warmth Lack of adequate clothing Repetitive comfort behaviour eg. rocking or hair twisting Sudden speech disorders <p>Physical signs on child/ young person</p> <ul style="list-style-type: none"> Delayed physical development: underweight and small of stature Hands and feet which are cold and puffy Chronic nappy rash Slow growth in both weight and height Frequently smelly Persistently dirty, unkempt appearance <p>Behaviour and emotional state of child/ young person</p> <ul style="list-style-type: none"> Aggressive Withdrawn Low self-esteem and self worth Repetitive comfort behaviour eg. rocking or hair twisting Sudden speech disorders

<h3>Common sites for accidental injury</h3>	<h3>Common sites for non-accidental injury</h3>	<h3>Be alert to the possibility of child abuse</h3> <ol style="list-style-type: none"> What is the injury? Does it appear accidental? Where is the injury? Is it in an unusual site? Does the explanation of the injury fit with the presentation? When was it caused? Is the age of the injury right? How was it caused? (both stated and suspected) Who caused it? (both stated and suspected) Witnesses? Do stories tally? What action was taken afterwards by the family?
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Implications for practice - signs and symptoms of abuse should never be interpreted in isolation and must always be assessed in the context of the child's medical and social history, developmental stage and explanation given

Appendix 3: What to do if you are worried a child is being abused

(Abuse may take the form of physical abuse, sexual abuse, emotional abuse or neglect)

Any member of staff who believes or suspects that a child may be suffering, or is likely to suffer significant harm should always refer their concerns to Children's Social Care. (There should always be an opportunity to discuss concerns with a manager, named professional or qualified social worker, but never delay emergency action to protect a child)

Are you concerned a child is suffering or likely to suffer harm, for example:

- You may observe an injury or signs of neglect
- You are given information or observe emotional abuse
- A child discloses abuse

Step One

Inform parents/carers that you will refer to Children's Social Care

UNLESS

The child may be put at increased risk of further harm (e.g. suspected sexual abuse, suspected fabricated or induced illness, immediate female genital mutilation, exploitation, increased risk to a child, forced marriage) or there is a risk to your own personal safety.



Step Two

Make a telephone call to Children's Social Care

Follow up with a written referral within 24 hours

Document all discussions held, actions taken, decisions made including who was spoken to (for physical injuries document injuries observed) and who was informed
 Where an early help assessment has been completed forward this also.

Step Three

Children's Social Care acknowledges receipt of referral and decides on next course of action. If the referrer has not received an acknowledgement within 3 working days contact Children's Social Care again.



Step Four

You may be requested to provide further reports/information or attend multi-agency meetings

Who to contact in Children's Social Care

North Lancs: 0300 123 6720; out of hours 0300 123 6722

South Cumbria: 0333 240 1727; out of hours 0333 240 1727

North Yorkshire: 01609 780 780; out of hours 999

In an emergency contact the police on 999

Who to contact for local NHS advice:

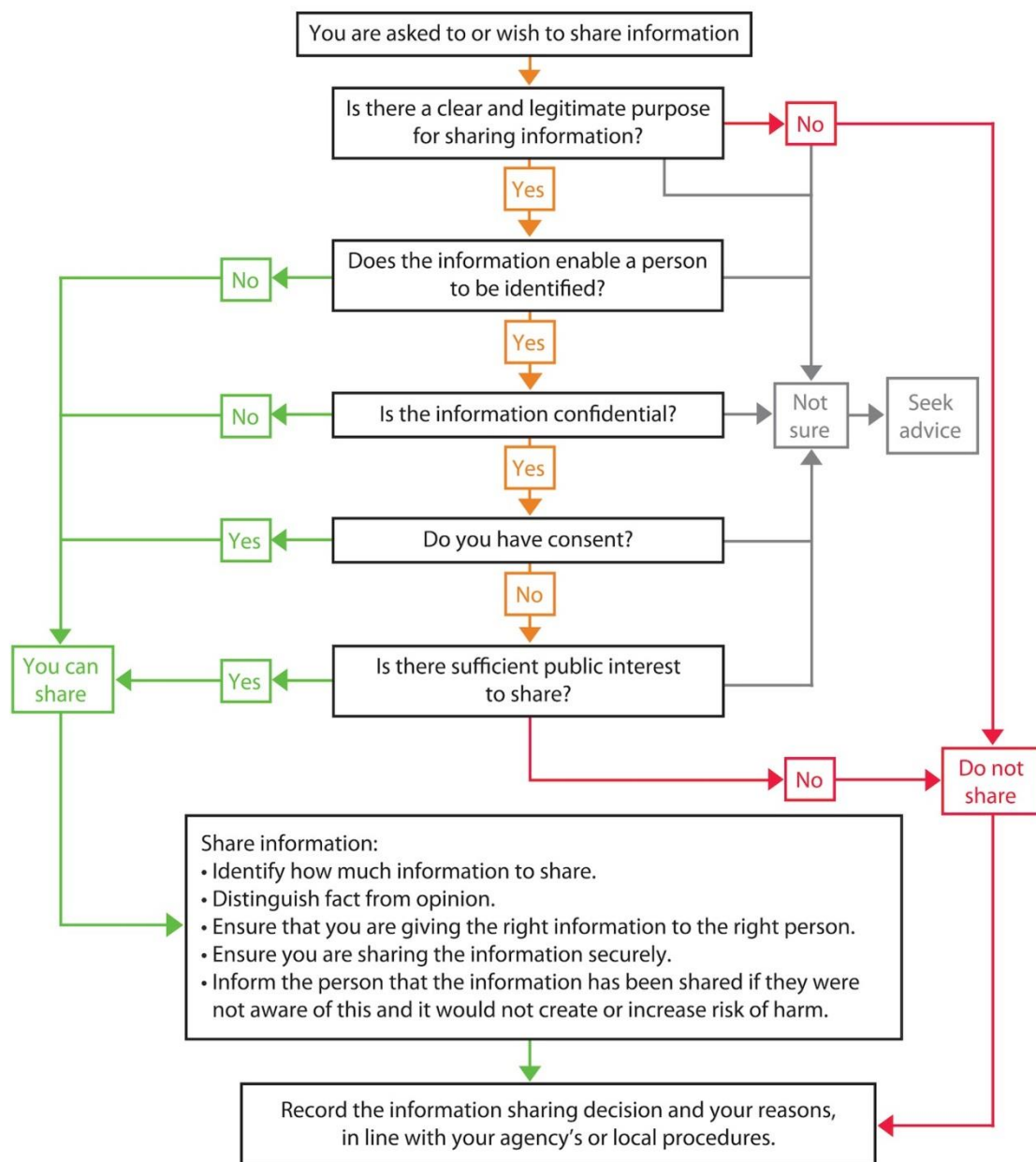
Morecambe CCG Safeguarding Team:
 01524 518957

Staff should update their knowledge by accessing regular training and be familiar with local safeguarding policies, including those of the Local Safeguarding Children Partnerships.

Appendix 4: Flowchart of Key Questions for Information Sharing



Flowchart of key questions for information sharing



If there are concerns that a child may be at risk of significant harm or an adult may be at risk of serious harm, then follow the relevant procedures without delay.
 Seek advice if you are not sure what to do at any stage and ensure that the outcome of the discussion is recorded.



Appendix 5: 7 Golden Rules for Information Sharing



Seven golden rules for information sharing

1. Remember that the Data Protection Act is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately.
2. Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
3. Seek advice if you are in any doubt, without disclosing the identity of the person where possible.
4. Share with consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, that lack of consent can be overridden in the public interest. You will need to base your judgement on the facts of the case.
5. Consider safety and well-being: Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.
6. Necessary, proportionate, relevant, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.
7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

Extract from HM Government Information Sharing: Guidance for practitioners and managers.
Copies can be obtained from www.ecm.gov.uk/informationsharing



The seven golden rules to sharing information

Remember that the General Data Protection Regulation (GDPR), Data Protection Act 2018 and human rights law are not barriers to justified information sharing, but provide a framework to ensure that personal information about living individuals is shared appropriately.

1. Be open and honest with the individual (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
2. Seek advice from other practitioners, or your information governance lead, if you are in any doubt about sharing the information concerned, without disclosing the identity of the individual where possible.
3. Where possible, share information with consent, and where possible, respect the wishes of those who do not consent to having their information shared. Under the GDPR and Data Protection Act 2018 you may share information without consent if, in your judgement, there is a lawful basis to do so, such as where safety may be at risk. You will need to base your judgement on the facts of the case. When you are sharing or requesting personal information from someone, be clear of the basis upon which you are doing so. Where you do not have consent, be mindful that an individual might not expect information to be shared.
4. Consider safety and well-being: base your information sharing decisions on considerations of the safety and well-being of the individual and others who may be affected by their actions.
5. Necessary, proportionate, relevant, adequate, accurate, timely and secure: ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those individuals who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely (see principles).
6. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

Remember:

Where practitioners need to share special category personal data, they should be aware that the Data Protection Act 2018 includes 'safeguarding of children and individuals at risk' as a condition that allows practitioners to share information **without consent**

- Information can **be shared legally without consent**, if a practitioner is unable to, cannot be reasonably expected to gain consent from the individual, or if to gain consent could place a child at risk.
- Relevant personal information can be shared lawfully if it is to keep a child or individual at risk safe from neglect or physical, emotional or mental harm, or if it is protecting their physical, mental, or emotional well-being.