Policy and Procedure for Safeguarding Children

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Clinical Partners

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Policy and Procedure for Safeguarding Children

1. Introduction

Clinical Partners is committed to ensuring that welfare and safety of children who meet the company services as patients or family members of patients is paramount and that all children without exception have the right to protection from abuse regardless of gender, ethnicity, disability, sexuality or beliefs.

Safeguarding, and promoting the welfare of children, is a broader term than child protection. It encompasses protecting children from the maltreatment, preventing impairment of children's health or development, and ensures children grow up in safe circumstances.

Child protection is part of this definition and refers to activities undertaken to prevent children suffering, or likely to suffer, significant harm. Each Safeguaring Partner and multi-agency safeguarding hub (MASH) has a detailed set of safeguarding procedures which includes actions to be taken in all child protection matters.

Clinical Partners recognises its responsibilities as set out in the Children's Act 2014: safeguarding children is everyone's responsibility and Clinical Partners have a duty to ensure their functions and those services contracted to others are discharged having full regard to the need to safeguard and provide for the welfare of children. All clinicians working with children and families via the company must be up to date in child protection practice. As a minimum, clinicians should have annual safeguarding training.

Clinical Partners will take seriously any concerns or allegations of abuse and responded to appropriately - this may require a referral to local authority children's services, Local Authority Designated Officer, and in emergencies, the Police.

This policy and procedure has been endorsed by the Company Directors and other senior managers involved in service provision for children. The policy is made available to all Clinical Partners who offer consultation services and treatment through the company and all Head Office staff.

Within our office we have copies of 'What to do if you are worried a Child is Being Abused' and 'Working together to Safeguard Children 2018'. This policy links in with those major sources of information and advice from the Government. Please ask if you wish to have a copy of these.

2. Purpose

The purpose of this policy and procedure is to detail the following:

- The Company's commitment to maintaining the safety and welfare of children that it is in contact with
- The procedures to be followed by staff and Clinical Partners if they identify any risks to children

3. Scope

This policy and procedures are to be followed by all staff and Clinical Partners working for the company.

4. Definitions

Throughout this document, where a child (aged 0- 12 years) is mentioned, this should be understood to include a young person (aged 13 – 18 years or in certain cases up to 21 years).

Please also see the Incident Policy. Any incident or issue that is concerning and meets the criteria of either the Safeguarding Policy or Incident Policy needs to be recorded. For clarity – the Incident Policy is to be followed for incidents that are not otherwise covered by the Safeguarding Policy.

5. Duties and Responsibilities

5.1 Chief Executive and Safeguarding Lead

The CEO should be kept informed of all safeguarding incidents and has overall responsibility for ensuring the implementation of effective Child Protection Procedures.

The Safeguarding lead is the person all safeguarding incidents should be reported to and then Clinicians will seek advice from the local MASH and make a referral if appropriate.

Reports from triage and Head Office will be sent to the Safeguarding Lead, who, if appropriate will report to MASH. The Safeguarding Lead will update the CEO.

5.2 Triage and Office staff

Please refer to Appendix C for the Safeguarding Procedure for Triage and Office staff

5.3 Clinicians

If any disclosure made in a session raises concerns about the safety of a child the clinician must make a referral to the Local Authority Children's Social Care immediately. The clinician must follow social service instructions on reporting concerns as a professional. This will usually involve completing a referral form which social services will send you. Three days after submitting your referral form social services should contact the clinician and if not satisfied with the response, follow the local authority escalation process

Immediately after making the referral to the Local Authority Children's Social Care lead, this the clinician should contact the Safeguarding lead at Clinical Partners and email them a copy of the Social Services form and when able the next steps and responses.

All Safeguarding concerns are discussed at the Clinical Governance meetings.

This Safeguarding procedure is outlined in Appendix D

6. Procedures to ensure selection of competent and suitable practitioners

Clinical Partners will follow strict selection practices to ensure that clinical staff invited to see patients via the company are appropriately trained in their speciality, have sound references and have received child protection training (usually via their core employer).

All Clinical Partners will be required to supply a DBS certificate that is less than one year old and sign an annual declaration confirming that they have no criminal record since the date of their DBS or have other matters in progress or under investigation that could compromise their suitability to work either directly or indirectly with children.

Clinical Partners will be registered with the online update service for checking DBS status. Full details of Clinical Partners selection and on- going monitoring of clinical staff is found in the 'Clinical Partners Selection and Ongoing Monitoring of Fitness to Practice Policy'.

7. Identifying child protection issues

7.1 Identifying child abuse

Summary guidelines on recognising child abuse can be found at Appendix A

7.2 Managing a disclosure in a session.

Staff must make it clear to the young person that any disclosure made may have to be discussed with a third party, because we have a responsibility to keep the young person safe. Reassurance should be given that only people who need to know will be informed of this information. It is important that young people and children know that we cannot keep secrets and the reasons for this should be explained.

- Do allow the young person to do the talking
- Do listen, take the young person seriously
- Do remain calm and caring
- Do allow the child to finish
- Do inform the young person that action is going to be taken
- Do make notes of the conversation as soon as possible afterwards, using the young person's spoken words where possible
- Do share concerns with the CEO and local MASH
- Don't postpone or delay the opportunity to listen
- Don't ask leading questions
- Don't allow your own feelings to surface
- Don't make false promises – for instance that you will keep the secret
- Don't interpret what you have been told, just record it

Once a referral is made it is the responsibility of the local authority children's service to determine what, if any, steps are to be taken. The referrer will cooperate with social services as possible. They should expect to be informed as to outcomes of the referral which must then be reported to the Safeguarding lead for Clinical Partners who will inform the CEO.

It is of paramount importance for all staff to act if you perceive a young person's welfare is at risk, however insignificant this may appear, that you act upon it. If this does not happen you could incur disciplinary procedures.

7.4 Confidentiality and sharing information

Effective sharing of information between practitioners and local organisations and agencies is essential for early identification of need, assessment and service provision to keep children safe.

Practitioners should be proactive in sharing information as early as possible to help identify, assess and respond to risks or concerns about the safety and welfare of children, whether this is when problems are first emerging, or where a child is already known to local authority children's social care (e.g. they are being supported as a child in need or have a child protection plan).

Practitioners should be alert to sharing important information about any adults with whom that child has contact, which may impact the child's safety or welfare.

In matters of suspected child abuse/ child at risk it may be important to share information with other agencies without the explicit permission of the child and/or parent. In summary the considerations that should be made in conjunction with Clinical Partners Data Protection policy are as follows:

- Is there a legitimate reason to share information?
- Is there a necessity to identify the individual?
- If the information is confidential, has consent been obtained?
- If consent to share information is refused, do the circumstances meet the 'public interest test'
- Ensure the right information is disclosed appropriately

Practitioners must have due regard to the relevant data protection principles which allow them to share personal information, as provided for in the Data Protection Act 2018 and the General Data Protection Regulation (GDPR). Further guidance on GDPR is available in the Data Protection Policy from Clinical Partners.

7.5 Recording Information

Detailed contemporaneous records (within 24 hours, ideally on the same day) must be kept by all involved in the suspected abuse and decision as to whether to refer to social services. Records must clearly differentiate between fact, reported information and opinion.

The reasons for any decisions made must be recorded clearly, including the decision(s) and reason(s) why the child was not referred to Children's Services.

8. Allegations against a Person in a position of Trust (member of staff or a Clinical Partner)

8.1 We recognise that the staff who work with children and young people are in positions of trust and therefore specific measures and consideration is put in place to make sure that any allegations made by a child, regarding the behaviour of a Person in a position of trust, must be taken as seriously as any other allegation and treated in the same way. See Appendix A

8.2 In all cases the Chief Executive and or the Safeguarding lead should be informed without delay by the staff member or the Clinical Partner. The CEO will consult with the Governance and Risk Adviser and other professionals as required and will ensure that a detailed factual record is maintained of the details shared and the actions taken.

8.3 In the following circumstances a referral to the Local Authority Children's Social Care team must be made one of the following criteria must be met, which should not be deterred by the staff member's or Clinical Partner's resignation:

(i) behaviour that has harmed a child or may have harmed a child;
(ii) possibly committed a criminal against or related to a child;
(iii) behaved towards a child or children in a way that indicates they are unsuitable to work with children

8.4 Where there is not sufficient substance in an allegation to warrant a referral, there should be an internal inquiry to consider whether the behaviour of the professional should be addressed by further training/supervision or disciplinary proceedings.

8.5 In addition staff and Clinical Partners can access an independent charity (Public Concern at Work) whose lawyers can provide free confidential advice about how to raise a concern about malpractice at work: www.pcaw.co.uk

9. Human trafficking and modern slavery

If a Clinical Partner or member of Clinical Partner's staff suspect a child may be victim of human trafficking or modern slavery, a referral should be made to the National Referal Mechanism.9. Process for monitoring compliance with the policy

If there is a significant event the CEO/Safeguarding lead for Clinical Partners will report to the Clinical Governance Committee, who will monitor any agreed action arising from the event.

We review this policy regularly and welcome feedback from those who read or use this policy. Please address feedback to the Designated Safeguarding lead and copy the CEO – barny@clinical-partners.co.uk.

10. References

Children's Act 2014

Working together to Safeguard children, 2018

Appendix A - What is Abuse and Neglect?

A Summary

Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting, by those known to them or, more rarely, by a stranger for example, via the internet. They may be abused by an adult or adults, or another child or children.

Physical abuse

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, 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.

Emotional abuse

Emotional abuse is 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

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of 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 (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Child Sexual abuse

Child sexual exploitation (CSE) is a type of sexual abuse. Children in exploitative situations and relationships receive something such as gifts, money or affection as a result of performing sexual activities or others performing sexual activities on them. Children or young people may be tricked into believing they're in a loving, consensual relationship. They might be invited to parties and given drugs and alcohol. They may also be groomed and exploited online. Some children and young people are trafficked into or within the UK for the purpose of sexual exploitation. Sexual exploitation can also happen to young people in gangs.

Female Genital Mutilation

Female genital mutilation (FGM) is the partial or total removal of external female genitalia for non-medical reasons. It's also known as female circumcision or cutting. Religious, social or cultural reasons are sometimes given for FGM. However, FGM is child abuse. It's dangerous and a criminal offence. There are no medical reasons to carry out FGM. It doesn't enhance fertility and it doesn't make childbirth safer. It is used to control female sexuality and can cause severe and long-lasting damage to physical and emotional health.

Grooming

Grooming is when someone builds an emotional connection with a child to gain their trust for the purposes of sexual abuse, sexual exploitation or trafficking. Children and young people can be groomed online or face-to-face, by a stranger or by someone they know - for example a family member, friend or professional. Groomers may be male or female. They could be any age. Many children and young people don't understand that they have been groomed or that what has happened is abuse.

Online Abuse

Online abuse is any type of abuse that happens on the web, whether through social networks, playing online games or using mobile phones. Children and young people may experience cyberbullying, grooming, sexual abuse, sexual exploitation or emotional abuse. Children can be at risk of online abuse from people they know, as well as from strangers. Online abuse may be part of abuse that is taking place in the real world (for example bullying or grooming). Or it may be that the abuse only happens online (for example persuading children to take part in sexual activity online). Children can feel like there is no escape from online abuse – abusers can contact them at any time of the day or night, the abuse can come into safe places like their bedrooms, and images and videos can be stored and shared with other people.

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

(Working Together to Safeguard Children, 2018)

Child Sexual Exploitation

Child sexual exploitation (CSE) involves exploitative situations, contexts and relationships where young people receive something (for example food, accommodation, drugs, alcohol, gifts, money or in some cases affection) because of engaging in sexual activities. Sexual exploitation can take many forms ranging from the seemingly 'consensual' relationship where sex is exchanged for affection or gifts to more serious organised crime by gangs and groups. What marks out exploitation is an imbalance of power in the relationship.

The perpetrator always holds power over the victim which increases as the exploitative relationship develops. Sexual exploitation involves varying degrees of coercion, intimidation, or enticement, including unwanted pressure from peers to have sex, sexual bullying including cyberbullying and grooming. However, it is also important to recognise that some young people who are being sexually exploited do not exhibit any external signs of this abuse.

Radicalisation

Staff need to be aware of children who may be prone to radicalisation from either family members or external organisations/groups. This can be extremist and fundamentalist groups.

Significant Harm

There are no absolute criteria on which to rely when judging what constitutes significant harm. Consideration of the severity of ill-treatment may include the degree and the extent of physical harm, the duration and frequency of abuse and neglect, the extent of premeditation, and the presence or degree of threat, coercion, sadism and bizarre or unusual elements.

Each of these elements has been associated with more severe effects on the child, and/or relatively greater difficulty in helping the child overcome the adverse impact of the maltreatment. Sometimes, a single traumatic event may constitute significant harm, for example, a violent assault, suffocation or poisoning. More often, significant harm is a compilation of significant events, both acute and long-standing, which interrupt, change or damage the child's physical and psychological development. Some children live in family and social circumstances where their health and development are neglected. For them, it is the corrosiveness of long-term emotional, physical or sexual abuse that causes impairment to the extent of constituting significant harm.

In each case, it is necessary to consider any maltreatment alongside the child's own assessment of his or her safety and welfare, the family's strengths and supports8, as well as an assessment of the likelihood and capacity for change and improvements in parenting and the care of children and young people.

Under section 31(9) of the Children Act 1989 as amended by the Adoption and Children Act 2002:

'harm' means ill-treatment or the impairment of health or development, including, for example, impairment suffered from seeing or hearing the ill-treatment of another;

'development' means physical, intellectual, emotional, social or behavioural development;

'health' means physical or mental health; and

'ill treatment' includes sexual abuse and forms of ill-treatment which are not physical.

Under section 31(10) of the Act: Where the question of whether harm suffered by a child is significant turns on the child's health and development, his health or development shall be compared with that which could reasonably be expected of a similar child.

To understand and identify significant harm, it is necessary to consider:

- the nature of harm, in terms of maltreatment or failure to provide adequate care;
- the impact on the child's health and development;
- the child's development within the context of their family and wider
- environment;
- any special needs, such as a medical condition, communication impairment or
- disability, that may affect the child's development and care within the family;
- the capacity of parents to meet adequately the child's needs; and
- the wider and environmental family context.

The child's reactions, his or her perceptions, and wishes and feelings should be ascertained, and the local authority should give them due consideration, so far as is reasonably practicable and consistent with the child's welfare and having regard to the child's age and understanding.

Appendix B – Written Confirmation

If you have concerns about a child Act Now Don't Delay.

This form may be used for you to make your own notes about the situation and should be sent to the Safeguarding Lead at Clinical Partners. You will also need to contact the relevant local Children's Services immediately by phone to make a referral using a form that they will send you. They will advise you as to how you should send this back email. Each local authority will have their own form and will not accept other forms.

Your name:	Contact number:
Your role in relation to the child:	
Telephone referral made on: (Date/Time)	
to: Name of social worker:	
Department/Local authority:	

1 Childs Details

Child's full name:	
Date of birth:	
Gender of child:	
Address:	
Telephone contact:	

2 Reason for referral/concerns

(Please give details of injuries or other indicators observed)

3 Family details if known

Name	Relationship	Age (if known)	Address (if known)

4 Is the parent/carer/child aware of this referral? (Please give details)

5 Agreement reached with Children's Services regarding further action to be taken by Children's Services and referrer. (Please give details of your telephone discussion with social services)

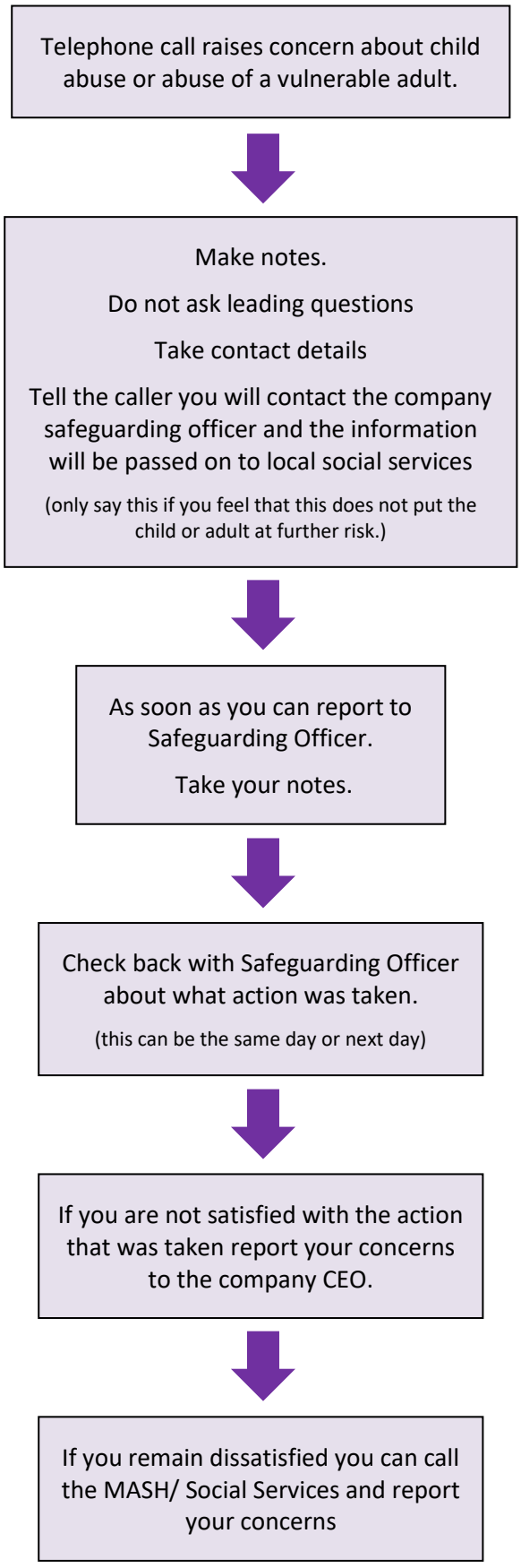
Signature		Date	

Note:

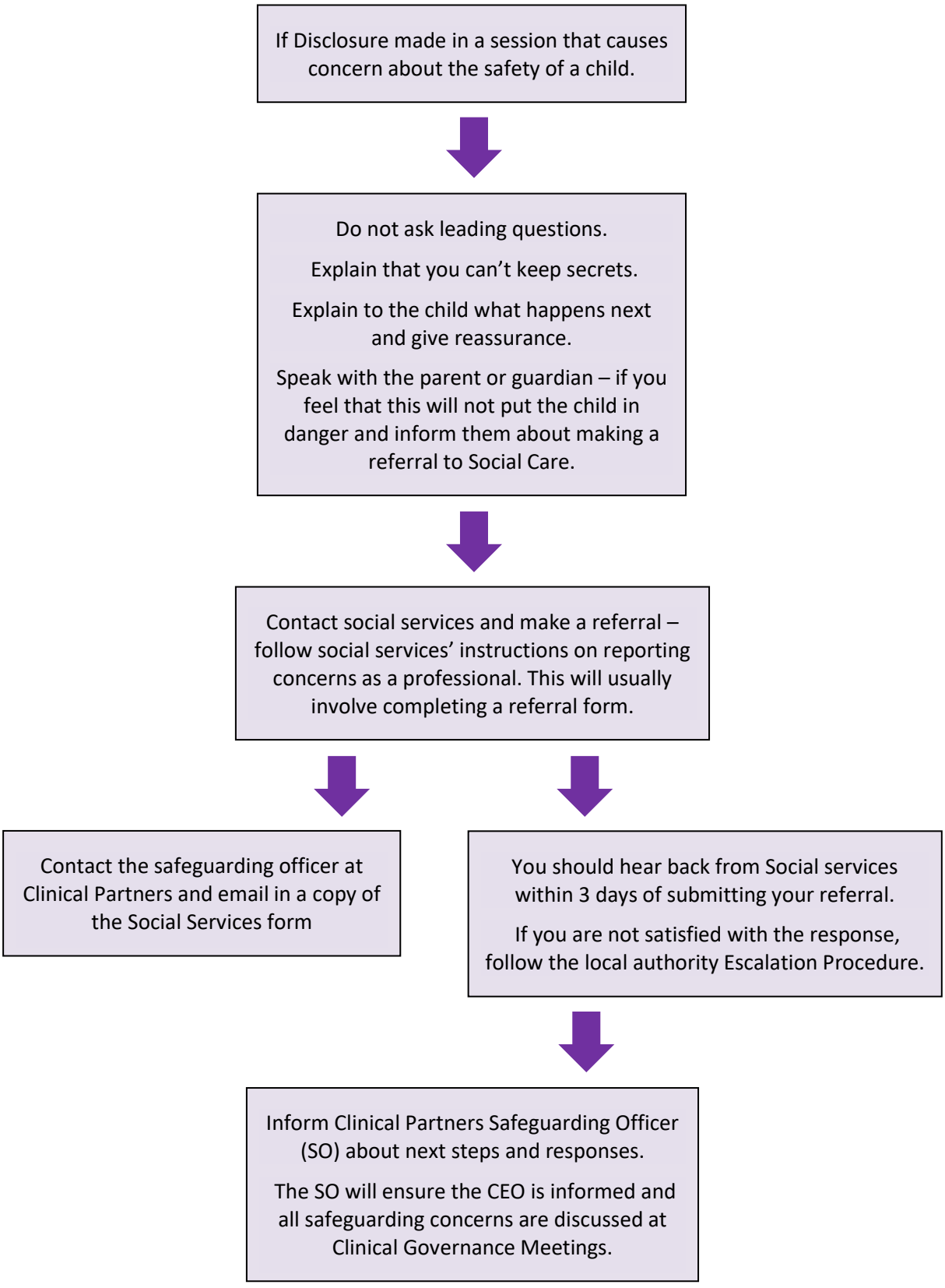
Children's Services should acknowledge your written referral within one day of receiving it. If you have not heard back within 3 working days, contact Children's Services again.

After sending this information to Children's Services please maintain a copy of this form on the child's record or in your agency file and complete details below.

Appendix C – Safeguarding Procedure – For Triage and Office Staff



Appendix D – Summary of Safeguarding Referral Process, For Clinical Partners



If you have a concern about a member of staff or Clinical Partner

If abuse is suspected by a member of staff or clinical partner report this immediately to the Safeguarding Officer (SO) or CEO.

SO will ensure CEO is informed and then contact will be made with the Local Authority Children's Social Care Officer (LADO) in the area of the country where the incident took place.

The LADO will issue instructions which must be followed.

This may include suspension of the adult, reporting to OFSTED or CQC or police.

The CEO will instigate an internal investigation into the allegations.

A Company investigation will take place irrespective of whether the member of staff or clinician resigns from post.

HR will be involved to support the member of staff or partner through the process.