smartclinic

SAFEGUARDING AND RISK ASSESSMENT POLICY

Policy and Procedure

March 2019

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i) Introduction

Every organisation and practitioner who comes in contact with a child or vulnerable adult has a responsibility to help keep them safe, to enable them to live a life free from harm, abuse or neglect.

The company (Smart Clinic at APL Health) recognises the right of every individual to stay safe and we expect all our staff to make a positive contribution to a strong and safe community.

ii) Purpose

This document identifies our responsibilities in outlining safeguarding actions in the context of our work. All members of staff have the responsibility to adhere to the guidance laid out in this protocol and any related policy, to manage risk appropriately and to pass on any welfare concerns.

The protocol must be read alongside the safeguarding policy and procedure for staff.

iii) Background

We have a duty of care under safeguarding law to report harm, neglect or abuse of a child or vulnerable adult and this could relate to a client or a third party the client may allude to during a discussion. It is everyone's responsibility, and everyone should play his or her part.

The principles of child protection are similar within the four constituent countries of the UK (England, Scotland, Wales and Northern Ireland), but there are differences in the specific legislation. Additional guidance can be found on the National Society for the Prevention of Cruelty to Children website (NSPCC).[1]

A summary of the UN Convention on the rights of the child can be found at https://www.unicef.org.uk.

In terms of the history of UK law, the Poor Law was introduced in 1601 as a basic social security system. Since then various laws and significant cases have helped to develop UK law over the years to prevent harm, and to protect children and vulnerable adults.

The Children Act 1989[2] provides the legislative framework for child protection in England. Key principles established by the Act include the paramount nature of the child's welfare, and the expectations and requirements around duties of care to children.

[1] https://www.nspcc.org.uk
[2] https://www.legislation.gov.uk/ukpga/1989/41/contents

This Act was strengthened by the Children Act 2004[3] which brought all local government functions of children's welfare and education under the statutory authority of local Directors of Children's Services, with an aim to make the UK better and safer for all children.

A statutory guidance document for Working Together to Safeguard Children[4] was released in 2010, outlining the ways in which organisations and individuals should work together to safeguard and promote the welfare of children and young people, in accordance with the Children Act 1989 and the Children Act 2004. Guidance was updated in 2015 and again in 2018.

The definition of 'safeguarding children' is referenced by Ofsted[5] as:

'The process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care that enables children to have optimum life chances and enter adulthood successfully.

Each nation has its own laws and guidance that sets out the safeguarding responsibilities for schools.

For adults, the primary focus of the **Health and Social Care Act 2008** was to create a new regulator; the Care Quality Commission (CQC). The CQC was established to regulate and inspect health and adult social care services together with an aim of ensuring safety and quality of care for service users.

The Care Act 2014 came into force in early 2015, introducing a statutory framework for safeguarding adults in England, with a legal framework to integrate care and support between health and local authorities. Seeking to prevent abuse and neglect and to stop it quickly when it happened, a 'duty of candour' was introduced with the following key principles:

- prevent harm and reduce the risk of abuse and neglect to adults with care and support needs;
- safeguard the individual in a way that supports them in making choices and having control in how they choose to live their lives, making safeguarding personal;
- promote an outcomes approach that works for people resulting in the best experience possible;
- raise public awareness that professionals, other staff and communities as a whole play a part in preventing, identifying and responding to abuse and neglect.

[3] https://www.legislation/gov.uk/ukpga/2004/31/contents
[4] Working together to safeguard children July 2018/https://www.gov.uk
[5] Ofsted safeguarding policy/March 2018/https://www.gov.uk

For those experiencing mental illness, **The Mental Health Act (MHA) 1983**[6], which was updated in 2007, outlines the persons rights regarding assessment and treatment in hospital, treatment in the community and pathways into hospital, which can be civil or criminal.

The Mental Capacity Act 2005[7] (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment.

Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014[8] is designed to safeguard people who use services from suffering any form of abuse or improper treatment whilst receiving care and treatment. Improper treatment includes discrimination or unlawful restraint, which includes inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005.

iv) Timeline of relevant legislation

1839 - The Custody of Infants Act

1889 - The Prevention of Cruelty to and Protection of Children Act

1908 - The Children's Act

1932 - Children and Young Persons Act (revised 1933)

1948 - The Children Act

1968 – Social Work (Scotland) Act

1970 - The Local Authority's Social Services Act

1983 - Mental Health Act

1989 - The Children Act

1991 - Working Together under the Children Act

1995 – The Children (Scotland) Act

1997 - Police Act

1998 - Human Rights Act

1999 - The Protection of Children Act

2004 - Children Act

2005 - Mental Capacity Act and Code of Practice

2006 - Safeguarding Vulnerable Groups Act

2007 - Mental Health Act and Code of Practice (amended)

2008 - The Health and Social Care Act

[6] https://www.legislation.gov.uk/ukpga/1983/20/contents
[7] https://www.legislation.gov.uk/ukpga/2005/9/contents
[8] https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents

2010 - Equality Act

2010 - Working to Safeguard Children

2012 - Protection of Freedoms Act

2014 - The Health and Social Care Act 2008 (Regulated Activities) Regulations (amended)

2014 - The Children and Families Act

v) Regulatory and professional practice

The principles of effective safeguarding for nurses, midwives, health visitors and health care assistants are underpinned by the **Royal College of Nursing (RCN) Principles of Nursing Practice** [9].

The Nursing and Midwifery Council (NMC) Code of Practice [10] also reflects a commitment to prioritise people, practice effectively, preserve safety and promote professionalism and trust.

The General Medical Council (GMC) provide ethical guidance for doctors which places the care of the individual as the first concern, with prompt action if patient safety is compromised, with specific guidance for child protection and adult safety. [11]

The British Association for Counselling and Psychotherapy (BACP) adopted an ethical framework for counsellors in July 2018 [12], with a commitment to put clients first; to work to professional standards, show respect, build appropriate relationships, maintain integrity and demonstrate accountability and candour.

vi) The professional duty of candour

The professional duty of candour forms part of a joint statement from eight regulators of healthcare professionals in the UK. [13] It is our duty to be open and honest with people in our care when things go wrong.

Whilst our company is not presently subject to inspection from the Care Quality Commission (CQC), it wishes to uphold the quality of care expected in relation to the safeguarding of children and vulnerable adults [14], with the following key actions:

Protect and take prompt action if we think safety, dignity or comfort is or may be seriously compromised

[9] https://www.rcn.org.uk/clinical-topics/safeguarding
[10] https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf
[11] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice
[12] https://www.bacp.co.uk/events-and-resources/ethics-and-standards/ethical-framework-for-the-counselling-professions/
[13] https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour
[14] https://www.cqc.org.uk/what-we-do/how-we-do-our-job/safeguarding-people

Respect the individual's dignity and privacy

Disclose the minimum information necessary for the purpose

Reflect on the outcomes and learning

For adult safeguarding, these measures are underpinned by the six safeguarding principles enshrined for adults within The Care Act 2014 [15] , which takes an outcomes approach to involve the adult in decisions, unless the adult is unable to make the relevant decisions or are so intimidated or controlled by others that they are unable to protect themselves.

Principle 1 Empowerment	Personalisation, the presumption of person-led decisions and informed consent.	*'I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens'*
Principle 2 Action	It is better to act before harm occurs.	*'I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help'*
Principle 3 Proportionality	Proportionate and the least intrusive response appropriate to the risk presented.	*'I am sure the professionals will work for my best interests, as I see them, and they will only get involved as much as I require'*
Principle 4 Protection	Support and representation for those in greatest need.	*'I can get help and support to report abuse and I get help to take part in the safeguarding process to the extent to which I want and to which I am able'*
Principle 5 Partnership	Local solutions through services working with their communities.	*'I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary, and I am confident that the professionals will work together to get the best results for me'*
Principle 6 Accountability	Accountability and transparency in delivering safeguarding	*'I understand the role of everyone involved in my life'*

vii) Abuse and neglect

Abuse and neglect can take many forms. We should not be constrained in our view of what constitutes abuse and neglect, and we should always consider the circumstances of the individual case. Types and indicators of abuse can include the following examples and some forms of abuse can be a criminal offence.[16]

Physical	Hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.
Domestic Violence/Sexual	Rape, sexual assault or sexual actions to which the adult has not consented or was pressured into.
Psychological or Emotional	Emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or unreasonable and unjustified withdrawal of services or supportive networks.
Financial or Material	Theft, fraud, exploitation, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

[15] www.legislation.gov.uk/ukpga/2014/23/enacted
[16] https://www.scie.org.uk/safeguarding/adults

Modern Slavery	The recruitment, movement, harbouring or receiving of children or adults through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. [17]
Organisational/Institutional	Neglect and poor care practice within an institution or specific care setting like a hospital or care home and this could range from isolated incidents or continuing ill treatment.
Neglect or Acts of Omission	Covering a wide range of behaviour, which neglects to care for personal hygiene, health or surroundings and includes behaviour such as hoarding. It is important to consider capacity when self-neglect is suspected, consider how it may impact on other family members and whether this gives rise to a safeguarding concern.
Discriminatory	Discrimination on grounds of race, gender and gender identity, disability, sexual orientation, religion and other forms of harassment, slurs or similar treatment.

viii) Suicide and self-harm

Generally, people who self-harm do not wish to kill themselves, whereas suicide is a way of ending life.

Both are inflections of pain and sometimes people who begin with self-harm may later commit suicide. The one significant difference between suicide and self-harm is intent.

Self-harm is the intentional and deliberate hurting of oneself, most commonly done by cutting, burning, hitting, picking at skin, pulling hair, biting and carving.

Self-harming can be a kind of 'survival strategy', providing a person with a way of coping with overwhelming emotions, and it is usually a sign that a person needs immediate help and support.[18]

ix) Risk factors

RISK FACTORS (NON-EXHAUSTIVE LIST)

Individual	Socio-cultural	Situational
• Previous suicide attempt • Mental disorder • Alcohol or drug abuse • Hopelessness • Sense of isolation • Lack of social support • Aggressive tendencies • Impulsivity • History of trauma or abuse • Acute emotional distress • Major physical or chronic illnesses, including chronic pain • Family history of suicide • Neurobiological factors	• Stigma associated with help-seeking behaviour • Barriers to accessing health care, especially mental health and substance abuse treatment • Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma) • Exposure to suicidal behaviours, including through the media, and influence of others who have died by suicide	• Job and financial losses • Relational or social losses • Easy access to lethal means • Local clusters of suicide that have a contagious influence • Stressful life events

[17] https://www.england.nhs.uk/ourwork/safeguarding
[18] https://www.nhsinform.scot/illnesses-and-conditions/mental-health/suicide

The following protective factors are equally critical in reducing the person's vulnerability to suicidal behaviours, in helping the individual cope with particularly difficult circumstances and minimising the risk of suicide.

PROTECTIVE FACTORS

- Strong connections to family and community support;
- Skills in problem solving, conflict resolution, and non-violent handling of disputes;
- Personal, social, cultural and religious beliefs that discourage suicide and support self-preservation;
- Restricted access to means of suicide;
- Seeking help and easy access to quality care for mental and physical illnesses.

x) Suicide myths and factors[19]

Myth: People who talk about suicide are only trying to get attention. They would not really do it.

Fact: Few commit suicide without first letting someone know how they feel. More than 70% of individuals who do threaten to commit suicide either try or complete the act.

Myth: Don't mention suicide to someone who is showing signs of depression – it will plant the idea in their mind, and they will act on it.

Fact: Talking about suicide does not cause someone to be suicidal; on the contrary, the individual can feel relief and has the opportunity to experience an empathetic contact.

Myth: Suicidal people just want to die.

Fact: Most of the time, suicidal people are torn between wanting to die and wanting to live. Most suicidal individuals do not want death; they just want to stop their unbearable psychological or emotional pain.

xi) Identification of suicide risk or serious self-harm

Intent to take one's life or carry out serious self-harm to self or others may be reported and or disclosed to us:

- during an occupational health assessment;
- during therapy;
- via a telephone call to the office;
- or by other means of communication e.g. email, text or letter.

[19] https://www.gponline.com/suicide-risk-assessment-management/neurology/article/1282716

For occupational health nurses and doctors, intent could be disclosed during a routine assessment and the risk factors; level of risk and any immediate safeguarding measures must be considered.

For administrators, intent may be disclosed during a telephone conversation or by other means of correspondence, and any concerns must be raised with senior management immediately.

For counsellors and psychotherapists, the therapeutic relationship can be a multi-dimensional process, which incorporates fluctuating states of being and shades of uncertainty, in that the client is offered a safe and confidential space to consider difficult painful thoughts and feelings in relation to risk.

The client must be offered sufficient containment and boundaries within the therapeutic relationship to ensure risk does not become overwhelming or life threatening.

xii) Management

There are 5 key components to suicide:

'ideation, intent, plan, access to lethal means, and history of past suicide attempts'

It is important to listen, to be aware of warning signs and not rush the conversation. You may not be able to take your next appointment and help can be summoned by sending a message to colleagues stating:

'I have a risk assessment – please help out'

- Talk openly about suicide/serious self-harm;
- show interest and support;
- be non-judgmental;
- offer empathy, not sympathy;
- don't make decisions for the person;
- express your concerns about the person's safety;
- offer hope that alternatives are available;
- act and involve the person in decision making.

If the person is not at immediate risk, it is advisable to ask if they have stored any harmful drugs or are in possession of other lethal means and discuss appropriate support and signposting.

If you judge that the person is high risk and in need of immediate assistance, dial 999. The police will visit someone who is believed to be vulnerable or at risk, please ensure you have the location/address ready.

Refer urgently if: intention is present, plans are present, and the individual has attempted suicide before.

xiii) Safeguarding risk assessment

A thorough risk assessment will help you make the right clinical decision and the risk assessment process should start at the point of concern.

Your risk assessment must be recorded, and any necessary safeguarding measures must be evidenced and concluded, documenting your reasons for disclosing information with or without consent.

You must document any steps you have taken to seek consent to inform the individual about the disclosure, or your reasons for not doing so. You must be able to justify your decision.

If you are in any doubt at all, discuss this with a member of the senior management team.

Identification of risk

- Who/what is at risk;
- identify the factors that might put them at risk;
- what is the impact of harm occurring, if it were to occur;
- duration, frequency and extent of harm, abuse or neglect already occurred;
- level of personal support needed;
- whether support is normally provided by the potential source of risk;
- potential risk to other adults or children;
- what is currently in place to reduce or remove the level of risk.

What is to be done about it?

- what level of intervention is needed;
- is the intervention proportionate to the risk;
- what risks are associated with the intervention;
- for adults, what is the outcome the adult wishes for;
- what other outcomes might be desirable;
- does the adult have capacity to consent;
- if not, what will be in the adult's best interests;
- are all the professionals in agreement with the interventions;
- can it be agreed that no intervention is required or possible;

- are any formal assessments or statutory interventions indicated e.g. Mental Health Act?

xiv) Confidentiality and disclosure

Confidentiality is an important ethical and legal duty, but it is not absolute. You may disclose personal information without breaching duties of confidentiality when any of the following circumstances apply:

- the person consents, whether implicitly or explicitly for the sake of his or her own care;
- the person has given their explicit consent to disclosure for other purposes;
- the disclosure is of overall benefit to the person who lacks the capacity to consent;
- the disclosure is required by law;
- the disclosure can be justified in the public interest.

You must carefully consider any actions that contravene the person's known wishes, if you judge that the person is at immediate risk and in need of urgent attention and you have no consent for onward referral or notification to the appropriate authorities.

xv) Disclosing information about children who may be at risk

The General Medical Council provides clear guidance for doctors who are concerned about the safety or welfare of a child or young person.[20]

For the purposes of this document and our practice, we will adopt the following principles:

- we must consider the needs and wellbeing of children and young people;
- all children and young people have a right to be protected from abuse and neglect;
- decisions about children and young people must be made in their best interests.

Decisions about child protection are best made with others; consulting with colleagues and other agencies that have appropriate expertise. Concerns must be discussed with the senior management team before disclosure unless you feel the child is in immediate danger, when it is necessary to dial 999 and ask for the police.

xvi) Safeguarding children: guidelines for occupational health

The Faculty of Occupational Medicine working with the Royal College of Paediatrics and Child Health published guidelines for occupational health professionals in May 2014.[21]

[20] https://www.gmc-uk.org/ethical-guidance-for-doctors/protecting-children-and-young-people
[21] https://www.rcpch.ac.uk/resources/safeguarding-children-guidelines-occupational-health-professionals

The following situations are identified in which an occupational health professional may need to consider safeguarding child issues (this is not an exhaustive list).

1. Where there is a clear statement by the client of the occupational health service that the client's own child or another (outside of the workplace) may be at risk of abuse or neglect.
2. When the client's medical condition or circumstances may put a child or children at risk (outside of the workplace).
3. When information comes to light that suggests the client is a risk to children in the workplace.
4. In the situation where a client discloses their own past abuse, they should be encouraged to tell the Police. If they do not wish to do this and it seems likely that the perpetrator of the abuse against the client could be continuing to harm children, we should consider if this matter needs to be reported to either the Police or Children's Social Care, despite the client's lack of consent.
5. When the client of the occupational health service is a health or social care professional or police officer who works in the complex arena of safeguarding children or vulnerable adults.

xvii) Disclosing information about adults who may be at risk

As a rule, we should make decisions about how best to support and protect the adult in partnership with them, with a focus on empowering them to make decisions in their own interests. Supporting and encouraging them to be involved as far as they want and are able, in decisions about disclosing their personal information.

xviii) Disclosures required or permitted by law

We must disclose information if it is required by statute, or if ordered to do so by a judge or presiding officer of court and we must be satisfied that the disclosure is required by law, and only disclose information that is relevant to the request.

Any request for disclosure must be passed directly to the Data Protection Officer for processing.

Wherever practicable, you should tell the adult (data subject) about such disclosures, unless that would undermine the purpose, for example by prejudicing the prevention, detection or prosecution of serious crime.

xix) Tipping off

It is almost always preferable to obtain a client's consent to share safeguarding information unless it is to 'tip off' that criminal information is going to be shared that could critically endanger life or seriously disrupt a police investigation. There are numerous examples such as in the case of human trafficking or

in the case of terrorist activity where the perpetrator could make alternative arrangements if we 'tipped off' to them in advance that the police are to be informed.

xx) Glossary of terms

Adult: applies to all individuals who are 18 years of age or over.

Adult at risk: applies to any individual aged 18 years or over and at risk of abuse or neglect because of their need for care and or support. [22]

Child/Children: applies to all children and young people up to the age of 18 years, including unborn babies. [23]

Child at Risk: is a child that is suffering or is likely to suffer significant harm.

Duty of Candour: to be honest and open with patients or service users.

Hazard: is anything that may cause harm. [24]

Relevant Authorities – Any organisation, authority or agency responsible for the safeguarding of children, young people and vulnerable adults such as Social Services, Police, GP/Ambulance Service, Psychiatrist.

Risk: is the chance, high or low, that someone could be harmed by the hazard. [25] In the context of child protection and adult safeguarding the focus of the risk judgement will be on the likelihood and the consequence of abuse or neglect.

Police Welfare Check: where an external agency requests that the police visit someone, who is believed to be vulnerable, or at risk for a wide variety of reasons.

Safeguarding: is a term we use to describe how we protect adults and children from abuse or neglect. [26]

Vulnerable Adult: examples of vulnerable adults include the elderly, those with mental health issues, learning disabilities or physical disabilities.

xxi) Review of policy and procedure

This policy and procedure will be reviewed on an annual basis and updated as appropriate.

[22] The Care Act 2014
[23] Children's Act 1989 and 2004
[24] www.hse.gov.uk
[25] www.hse.gov.uk
[26] GOV.UK, Office of the Public Guardian/safeguarding policy

xxii) Appendices

1. Safeguarding risk assessment template
2. Safeguarding and risk management – quick guide
3. Safeguarding policy and procedure for staff