THAMES VALLEY AIR AMBULANCE

SAFEGUARDING CHILDREN POLICY
OP010

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Version	Date ratified	Brief summary of changes	Author
1.0	01/03/2018	• Policy written	Gavin Casey, Head of Clinical Services
1.7	31/07/2018	• Policy Published	Mark Hodkinson, Clinical Shift Manager
2.0	11/09/2019	• Formal review and amendments	Adam Crosby, Patient Liaison Manager

1. INTRODUCTION

1.1 TVAA is committed to safeguarding and promoting the welfare of children and young people in our community and continues to work closely with partner organisations to improve this process.

1.2 Safeguarding is everyone's responsibility. Our legislative responsibilities to safeguard children and young people require us to be vigilant and responsive every time we engage with service users and families *(Children Act 1989, 2004).* For those children who are suffering, or likely to suffer, significant harm, joint working is essential to safeguard and promote their welfare and, where necessary, to help bring to justice the perpetrators of crimes against children.

1.3 TVAA safeguarding structure is designed to ensure that all staff working to safeguard children and young people understand fully their responsibilities and duties as set out in primary legislation and associated regulations and guidance and ensure staff are familiar with national guidance.

1.4 This policy offers a mechanism to enable staff to raise any concerns which are then reported to the appropriate agency, usually the Local Authority Children's Services Department, for consideration of further action. Children's Services and Thames Valley Police have statutory authority and responsibility to investigate allegations or suspicions about child abuse or neglect.

1.5 This policy should be read in conjunction with the list of related documents and forms detailed in the appendices.

2. PURPOSE

2.1 To ensure that all TVAA, contractors and volunteers are aware of their duties to uphold the welfare and rights of children and young people and fulfil their professional responsibilities to take action to prevent them from experiencing neglect, harm or abuse.

2.2 To ensure that all TVAA employees, contractors and volunteers can recognise the signs of suspected neglect, harm or abuse and know how to report it in a timely manner.

3. SCOPE

3.1 This policy applies to all staff, contractors, voluntary agencies and volunteers who work for, in conjunction with or on behalf of TVAA including those staff, observers and visitors who may not come into direct contact with patients.

4. DEFINITIONS

4.1 Safeguarding

Working Together to Safeguard Children (DCSF, 2015), defines safeguarding 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."

4.2 Child or Young Person

Where the term **child**, **children** or **young person** is stated, this relate to a person who has not yet reached their 18th birthday *(Children Act 1989,2004).* 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 for children and young people, does not change his or her status or entitlement to services or protection under the Children Act 1989.

4.3 Categories of abuse

There are four categories of child abuse. They are defined in the UK Government Guidance Working Together to Safeguard Children 2015 as follows:

- Physical abuse
- Emotional abuse
- Sexual abuse
- Neglect

Bullying is not defined as a form of abuse in Working Together but there is clear evidence that it is abusive and will include at least one, if not two, three or all four, of the defined categories of abuse.

5. RESPONSIBILITIES

5.1 Board of Trustees

To scrutinise and ensure safeguarding obligations are met. The Board of Trustees also ensures that safeguarding remains integral to TVAA and is not compromised by operational or financial pressures.

5.2 Chief Executive Officer

To provide executive leadership for safeguarding across the organisation, ensuring safeguarding is a priority and a regular agenda item at a senior level and are accountable for the governance of safeguarding to the Board of Trustees, regulators and partners. Make referrals to the Independent Safeguarding Authority or its successors.

5.3 Director of Operations

Ensures operational implementation and adherence to this policy. To authorise the release of operational staff to contribute to external safeguarding investigations. TVAA Caldicott Guardian and will provide advice if required regarding release of records.

5.4 Safeguarding Lead

To ensure consistent and robust management of safeguarding requests via dedicated TVAA email tvaa.safeguarding@nhs.net. The Safeguarding Lead has two nominated deputies. The Head of Clinical Services and the Head of Compliance and Patient Safety.

5.1 Named Professional

Responsible for promoting good professional practice within TVAA, providing advice and expertise for fellow professionals, and ensuring TVAA is compliant with all safeguarding training requirements and that all staff receive the appropriate level of training. To ensure that records are kept on the required training statistics.

Named Professional for TVAA is Hannah Bryan – Head of Compliance & Patient Safety (HCPC registered Paramedic)

5.6 Human Resources

TVAA's recruitment process follows that of the Safer Recruitment guidelines.

5.7 Operational Staff

Assess patient's safeguarding needs and in discussion with the patient where safe obtains their desired outcome and consent for raising a safeguarding concern and where appropriate to complete safeguarding referrals about suspected neglect, harm or abuse; contribute to investigations as required and directed.

5.8 Workforce, Contractors and Volunteers

All staff and volunteers have a duty to act and respond to concerns about safeguarding in a timely manner and undertake safeguarding training to the required levels.

6. LEGISLATION

The Children Act (1989, 2004) outlines the statutory and legal frameworks for the provision and delivery of child welfare services in England. Further guidance and legislation is available in the Government publication: Working Together to Safeguarding Children (DCSF, 2015 – now the DFE)

TVAA are required under legislative statutory duties to comply with the Children Act (2004, Section 11) which stipulate:

"*That organisations will make arrangements for ensuring their functions and services provided on the behalf, are discharged with regard to the need to safeguard and promote the welfare of children.*"

"All those working in the field of health have a commitment to protect children, and their participation in inter-agency support to Social Services departments is essential if the interests of the children are to be safeguarded."

7. KEY PRINICIPLES

All children deserve the opportunity to achieve their full potential. In 2003, the Government published the Every Child Matters Green Paper alongside the formal response to the report into the death of Victoria Climbié. The Green Paper set out five outcomes that are key to children and young people's wellbeing:

- be healthy
- stay safe
- enjoy and achieve
- make a positive contribution
- achieve economic wellbeing

8. SAFEGUARDING GUIDANCE

Appendix one details further information and guidance notes on safeguarding children.

8.1 Domestic Abuse

Domestic abuse is defined as 'any incident of threatening behavior, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members regardless of gender or sexuality' (family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family; see ACPO, 2004).

Domestic abuse is by no means experienced only by adults at risk; children will be affected by the behavior of violence and abuse by adults in their home either directly or indirectly. Domestic abuse occurs across geographical boundaries, age, wealth, social status, gender and ethnicity.

Children who reside in a household where domestic abuse occurs are affected either directly or indirectly. It is imperative that all staff make a safeguarding children referral, in all circumstances where a child(ren) is present when the abuse took place; or where the child(ren) may reside at the property but is/are absent at the time of the incident.

Domestic abuse where there are no children in the family are assessed on individual basis regarding safeguarding referral or police referral if the abuse suspected is a crime. However, operational staff should be mindful of this when attending calls of this nature; they may be the first agency to become aware of the risk to the patient and can initiate

the work with other agencies to safeguard the children, young people and any adults at risk.

8.3 Refusal and Consent

Children and young people will be able to participate in many decisions involving their care (please refer to Gillick Competency notes within OP008 Consent Policy) provided they have capacity to understand and process the information given to them. Children and young people can't refuse treatment in an emergency and it may be necessary to use good communication techniques to reach agreement that ensures they are adequately protected, and their best interests are taken in to account.

8.4 Sudden Unexpected Death of an Infant, Child or Adolescent (SUDICA) In all cases of SUDICA a safeguarding referral form must be completed for the child affected and also one form for each other child or sibling of the household, regardless of whether they were present during the episode leading to the death of the patient. In addition a safeguarding statement must be completed and passed via the Safeguarding Lead to the South Central Ambulance Service (SCAS) safeguarding team.

8.5 Safeguarding, Alcohol and Recreational Drug use

8.5.1 *Children*

The routine standard is that all under 18-year-old who are intoxicated or under the influence of recreational drugs need to have a pre-hospital assessment and are also conveyed to hospital for a wider assessment. However, there are occasions when a patient's true age may not be known until much later in the care episode and it becomes inappropriate to convey to hospital.

This is particularly true if the patient has been admitted to an alcohol recovery service. In such instances the patient is likely to be less intoxicated at the end of their care and the responsible clinician may consider it inappropriate to automatically convey the patient.

In all cases of discovering a patient is under 18 years of age the following principles need to be considered:

If a patient is intoxicated or under the influence of recreational drugs and it appears that they may be under 18 they should be conveyed to hospital. They should not be admitted

to another service (such as the alcohol recovery service). However, no one, regardless of age, should be refused entry to a temporary holding area under service supervision whilst waiting for transfer to a definitive safe place (i.e. hospital).

Full assessment needs to be made around the vulnerabilities of the child or young person based on their specific circumstances and if there are safeguarding concerns then a safeguarding referral must be made. If in doubt clinical support should be sought at the time via the Clinical Shift Manager.
It is not necessary to criminalise individuals and our prime concern is for the welfare of the child or young person, however, if a crime is suspected due consideration should be given to the need to inform the police.

A patient intoxicated or under the influence of recreational drugs under 18 years of age is not to be left at home or discharged into the community unaccompanied. A responsible adult, ideally a parent or legal guardian, must be contacted and asked to collect the patient.

All demographic details must be captured on the electronic patient record including the patient's name, address, contact number, school or college, GP and next-of-kin name and contact number. If it is not possible to establish the information this must be declared on the PRF.

The patient's age must be communicated to all other clinicians who are subsequently involved in the patient's care including other ambulance clinicians or receiving hospitals.

8.5.2 *Adults*

Situations where adults who are intoxicated or under the influence of recreational drugs and who are supervising minors (under 18) need additional safeguarding consideration. It is against the law to be drunk and in charge of a child under seven years of age in a public place or on licensed premises. There is less clarity on intoxicated adults in the home. Nevertheless, safeguarding needs to be at the top of the assessment process in all such cases and the welfare of the child needs to be considered as part of the assessment.

Clinicians need to evidence that they have considered the needs of the child on the PRF and what action has been taken. It would be appropriate to complete a safeguarding form on behalf of the child in all cases where the child is under seven. It is considered best practice to refer in cases where the child is older than seven unless there was absolute

clarity on the circumstances. If in doubt, advice can be sought at the time from the on duty Clinical Shift Manager.

8.5.3 *Alcohol Intoxication and Alcohol and Drug Poisoning*

Indications of alcohol intoxication may include signs such as facial flushing, slurred speech, unsteady gait, euphoria, increased activity, volubility, disorderly conduct, slowed reaction, impaired judgment and motor coordination, insensibility or reduced level of responsiveness. Alcohol or drug poisoning may manifest itself by signs including reduced level of consciousness, confusion, vomiting, dangerous anger, seizures, cardiac arrhythmias, respiratory rate <8 or >20, pale cyanosed skin or cold clammy skin.

8.6 Prevent

Prevent is the UK Government national counter terrorism strategy, which aims to reduce the risk from national and international terrorism, through preventing people becoming terrorists or supporting terrorism related offences. Prevent covers all forms of terrorism and/ or extremism, and some aspects of non-violent extremism. For example;

- Al-Qaida influenced groups
- Environmental extremism
- Animal rights extremism
- Faith based influenced groups
- Extreme right-wing political groups
- Republican or loyalist Irish groups

The Home Office works with local authorities, a wide range of Government departments, and community organisations to deliver the Prevent strategy. The police also play a significant role in Prevent, in much the same way as they do when taking a preventative approach to other crimes. In order to achieve this, there are five national strategic objectives;

1. Challenge the ideology behind violent extremism and support mainstream voices
2. Disrupt those who promote violent extremism and support the places where they operate
3. Support individuals who are vulnerable to recruit or have already been recruited by violent extremists
4. Increase the resilience of communities to violent extremism
5. Address grievances that ideologies are exploiting

Staff may observe or identify particular behaviours or actions of individuals during the course of day to day operations. Although not exhaustive, the following list gives examples of such behaviours;

- Graffiti symbols, artwork or other written material promoting violent extremist messages (including but not limited to a patient's belongings or home environment)
- Patients/ staff accessing violent extremist material online (including but not limited to social networking sites)
- Parental/ family/ friends' disclosure of changing behaviours, friendships or actions
- Patients voicing opinions pertaining to violent or extremist ideologies or narratives
- Use of extremist or hate terms to incite violence or exclude others
- Harmful influences on vulnerable individuals (adults and children) from any source
- Inappropriate use of TVAA internet, social media and other media by staff members

Where staff identify or have concerns about any person(s), including patients, staff and public, with regard to Prevent indicators, a safeguarding referral form must be completed capturing all relevant information, via the safeguarding tab on HEMSbase. A follow up email as soon as practicable to safeguarding@scas.nhs.uk

If any staff member has concerns of a Prevent nature regarding any individual working for TVAA (including contractors), these should be emailed to safeguarding@tvairambulance.org.uk. These concerns will then be passed to the relevant authorities to support the individual concerned.

It is important to remember that reporting any individual through Prevent is not making them criminal. Both local authorities and the police have processes in place to support these individuals outside of the criminal process. Further information on Prevent is available in the Government revised duty guidance on Prevent and the Department of Health guidance for healthcare workers.

8.7 Female Genital Mutation (FGM)

Female genital mutilation (FGM) comprises 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. The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths. However, more than 18% of all FGM is performed by health care providers, and the trend towards medicalisation is increasing.

Female Genital Mutilation (FGM) mandatory reporting duty is a legal duty provided for in the FGM Act 2003 (as amended by the Serious Crime Act 2015). The legislation requires regulated health and social care professionals and teachers in England and Wales to make a report to the police where, in the course of their professional duties, they either:

- are informed by a girl under 18 that an act of FGM has been carried out on her; or
- observe physical signs which appear to show that an act of FGM has been carried out on a girl under 18 and they have no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth.

For the purposes of the duty, the relevant age is the girl's age at the time of the disclosure/identification of FGM (i.e. it does not apply where a woman aged 18 or over discloses she had FGM when she was under 18). However, Health professionals have a duty to consider the risk to any female child associated with an adult who has undergone FGM.

FGM key facts:

- Female genital mutilation (FGM) includes procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons.
- The procedure has no health benefits for girls and women.
- The procedure has no religious foundation
- Procedures can cause severe bleeding and problems urinating, and later cysts, infections, infertility as well as complications in childbirth and increased risk of new born deaths.
- More than 125 million girls and women alive today have been cut in the 29 countries in Africa and Middle East where FGM is concentrated.
- FGM is mostly carried out on young girls sometime between infancy and age 15.
- FGM is a violation of the human rights of girls and women.
- It is illegal in the UK under the Female Genital Mutilation Act 2003

More information can be found at http://www.nhs.uk/Conditions/female-genital-mutilation/Pages/Introduction.aspx

8.8 Missing, Exploited and Trafficked children (MET) (4LSCB, June 2018)

Missing Children

Children and young people who go missing from home or care are at serious risk of being targeted for involvement in gangs, trafficking, criminalisation, sexual exploitation and violence. Recognising the risk at the time a child is reported as missing and offering a child appropriate support on return may prevent the situation escalating and further exploitation of vulnerable children and young people.

Research estimates that some 100,000 children and young people run away each year including 10,000 reported as missing from care. These children are vulnerable and can be exposed to the risks of being physically or sexually abused or exploited.

For those children living within the local authority care system their vulnerability to these risks are even greater and are disproportionately represented within the group of children known to be exploited. This may be for sexual or criminal purposes, trafficking, or for the purposes of radicalisation. Within the care system those living in residential care homes are at an even higher level of risk.

Agencies and professionals should also be aware of the potential risks to children and young people who are not yet reported as missing. Within this cohort could be children who are victims of exploitation but attract less attention - perhaps they are only gone for a short period of time, or their whereabouts is known and therefore they are not formally reported as missing by the persons responsible for their care at that time. It is important for those working with children and young people, and those within the school environment, to be aware that not all children at risk of exploitation go missing. In such cases it will be other information about the young person, changes in their behaviour and presentation that will be the trigger for concern. Going missing may be an early warning sign of gang exploitation.

When a person makes a report of a child that is missing the responsible Police Service will ask that person whether they have conducted any enquiries themselves to establish the whereabouts of the person. This will assist with prioritising police resources and with the assessment of risk.

It is important to remember that:-

• A child under the age of 13 is not legally capable of consenting to sex (it is statutory rape) or any other type of sexual touching; Sexual activity in older children (i.e. from 13 to 18 years) needs to be considered in relation to both the giving, and the getting of consent, with the promotion of mutual negotiation as the norm being an important aspect of preventative activity (NSPCC, 2018)

• Sexual activity with a child under 16 is an offence. Practitioners have a responsibility to undertake an assessment of young people aged 13 to 15 years who are engaged in sexual activity following Fraser competencies guidelines (NSPCC, 2018), to determine the risk of sexual and other forms of exploitation or coercion including trafficking. This assessment will inform the decision-making process relating to the appropriateness of a referral to Children's Social Care and the Police. Risk assessment is a complex process and practitioners are encouraged to discuss concerns with a member of the Safeguarding Children Team whenever they are unsure about the appropriate course of action

• Those aged 16 and 17 years may be viewed by health professionals and others as being of 'the age of consent' in terms of the Sexual Offences Act (2003), but this age group are particularly vulnerable to CSE being missed precisely because of the legalities of sexual consent in this age group (NSPCC, 2018)

• It is an offence for a person to have a sexual relationship with a 16- or 17- year old if they hold a position of trust or authority in relation to them;

• Where sexual activity with a 16- or 17- year old does not result in an offence being committed, it may still result in harm, or the likelihood of harm being suffered;

• Non-consensual sex is rape whatever the age of the victim; and

• If the victim is incapacitated through drink or drugs, or the victim or his or her family has been subject to violence or the threat of it, they cannot be considered to have given true consent and therefore offences may have been committed

• No individual, whatever their age, can give consent in a situation where there is intoxication, duress, violence, power imbalances and/or vulnerabilities through age differences, learning difficulties or mental health issues. A child under 18 years of age cannot consent to their own abuse through exploitation (NSPCC, 2018).

8.9 County Lines

(Home Office, 2018) is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of 'deal line'. They are likely to exploit children and vulnerable adults to move and store the drugs and money and they will often use coercion, intimidation, violence (including sexual violence) and weapons.

County lines activity and the associated violence, drug dealing and exploitation has a devastating impact on young people, vulnerable adults and local communities.

8.10 Trafficking

Human trafficking involves men, women or children being brought into a situation of exploitation through the use of violence, deception or coercion and forced to work against their will. People can be trafficked for many different forms of exploitation such as forced prostitution, forced labour, forced begging, and forced criminality, domestic servitude, forced marriage, forced organ removal.

It is important to note that when children are trafficked, no violence, deception or coercion needs to be involved: simply bringing them into exploitative conditions constitutes trafficking.

Modern slavery, including child trafficking, is child abuse. When an agency comes into contact with a child who may have been exploited or trafficked, Local Authority Children's Services and the police should be notified immediately.

All children, irrespective of their immigration status, are entitled to safeguarding and protection under the law.

When there is reason to believe a victim of trafficking or modern slavery could be a child, the individual must be given the benefit of the doubt and treated as a child until an assessment is carried out.

8.11 Domestic abuse

In 2013, the Home Office announced changes to the definition of domestic abuse. Domestic abuse is defined as: incidents or patterns of incidents of controlling, coercive or threatening

behaviour violence or abuse, by someone who is or has been an intimate partner or family member regardless of gender or sexuality.

Domestic abuse includes psychological, physical, sexual, financial, emotional abuse or so-called honour-based violence, female genital mutilation, forced marriage. The age range for domestic abuse has been extended to include 16-year olds.

Domestic abuse is by no means experienced only by adults in need; children will be affected by the behaviour of violence and abuse by adults in their home either directly or indirectly. Domestic abuse occurs across geographical boundaries, age, wealth, social status, gender and ethnicity.

Where domestic abuse is evident with children in the family, or if the mother is pregnant, it is imperative that staff make a safeguarding children referral via the procedures set out in this policy in all circumstances where a child(ren) is present when the abuse took place; or where the child(ren) may reside at the property but is/are absent at the time of the incident.

9. SAFEGUARDING REFERRAL PROCESS

9.1 General referral process (clinical staff)

Staff who have concerns that a child in need is at risk of or has been abused will raise a safeguarding concern. Appendix two outlines the process to follow for raising a safeguarding concern. Where it is believed that a crime has been committed or a patient is at immediate risk, the police should be contacted via 999 systems.

Concerns for the child should normally be shared with the parent or carer responsible for the child, unless this is likely to jeopardise the clinical outcome or place the child at increasing risk. There should also be a consideration of risk to the staff if concerns are shared.

Where a safeguarding referral is being made for a patient, the safeguarding tab of the electronic patient record (HEMSbase) should be completed, with as much detail as possible. Once complete, this will automatically send a secure notification to the TVAA nhs.net email to be processed. Further detail on the referral process is outlined in appendix two. A copy of the safeguarding referral form is available at appendix three.

The Safeguarding Lead (or nominated deputy in their absence) will check the TVAA Safeguarding secure email account for safeguarding notifications, review these and make the referral to the appropriate local authority. Once a referral is received, the local authority will consider making an enquiry. An enquiry should establish whether any action needs to be taken and if so, by whom. This could range from an informal conversation with the adult in need to a more formal multi agency discussion. Enquiries do not have to follow a formal safeguarding process.

If the safeguarding lead determines that there is insufficient information to make a referral then they will follow up with the crew raising the request prior to any referral being made.

The safeguarding lead will also review all calls attended on HEMSBase to check for 'missed referrals.'

It is TVAA policy that a safeguarding referral should be completed as soon as reasonably practicable for any paediatric patients with significant injury, or where pre-hospital emergency anaesthesia is undertaken.

Feedback on each safeguarding referral will be sought from the local authority via the Safeguarding Lead and feedback passed to the referring crew if received.

9.2 Referral process (non-clinical staff)

TVAA recognise the need for non-clinical, non-patient facing staff (e.g. fundraising staff, volunteers and office staff) to have a mechanism to report safeguarding concerns that may arise through the course of their normal duties.

The overarching principles of referral should follow the processes outlined in appendix two. Where it is believed a crime has been committed, the police should be contacted immediately via the 999 system.

Details of any safeguarding concerns from non-clinical staff should be emailed directly to tvaa.safeguarding@nhs.net. The Safeguarding Lead will then make the referral direct to the relevant local safeguarding board and obtain feedback as appropriate.

Advice and support for non-clinical staff should be obtained via the TVAA Safeguarding lead in the first instance.

9.3 Access to Support

Staff can access advice and support in a number of ways;

Advice:

- Via Safeguarding Lead (M-F 0900-1700)
- Clinical Shift Manager on call 24/7
- Senior On Call Manaager (SMOC) – on call 24/7
- Named Professional

Support

- Clinical Shift Manager on call 24/7
- Senior On Call Manaager (SMOC) – on call 24/7
- Via Occupational Health
- Via the confidential Employee Assistance Programme

In addition, staff can email the Safeguarding Lead for expert advice or information on policy and procedures at tvaa.safeguarding@nhs.net

TVAA is provided with external safeguarding support through the Ann Craft Trust. https://www.anncrafttrust.org/help-advice/

The Ann Craft Trust can be contacted through the Safeguarding Lead.

10. INFORMATION SHARING

No-one in TVAA should assume that someone else will pass on information which they think may be critical to the safety and wellbeing of the child. If you have concerns about a child and believe they are suffering or likely to suffer abuse or neglect, then they should share the information with the local authority and/or the Police if they believe or suspect that a crime has been committed.

10.1 Good Practice Point

The Data Protection Act, 1998 and General Data Protection Regulation (GDPR) (Regulation (EU) 2016/679) and Care Act 2014 enable information to be shared to safeguard children in need. Failing to do so may result in abuse going undetected or prolonging the suffering of patients.

Information sharing between statutory organisations is fundamental to safeguarding children and young people, failing to do so may result in abuse going undetected or prolonging the suffering of patients.

Staff should endeavour to obtain the parent or carer's written consent to share information about the child and should explain what the information will be used for, wherever possible. Young people may be considered to be competent to provide consent to information sharing.

Whilst it is good practice to share with families your intention to make a referral to Children's Social Care about their child's welfare, it is not a prerequisite. It is particularly important that parents/carers should *not* be informed of staff concern in circumstances when this may result in a refusal to attend hospital or any situation where a child may be placed at further risk. The safety of the child is paramount.

The following principles should be followed:

- The information should be necessary for the purpose for which it is being shared
- Shared only with those who need it
- Be accurate and up to date
- Be timely
- Shared securely

Any particular concerns about sharing information should be referred to TVAA Caldicott Guardian caldicotguardian@tvairambulance.org.uk

10.2 Sharing information in cases of domestic abuse

Where there is domestic abuse, priority must be given to any children or young people in the household; regardless of whether they were present or not during this or any other episode a safeguarding referral must be made.

If the risk presented by the perpetrator is high, consideration can be given to sharing information without the consent of the parent/ carer of the child in need. This is supported by Data Protection Act 1998 (schedules 2 and 3), General Data Protection Regulation (GDPR) (Regulation (EU) 2016/679) the Crime and Disorder Act 1998, the Human Rights Act 1998 and the Care Act 2014.

TVAA has governance arrangements in place which sets out the principles for sharing information between each other and other professionals.

11. WHISTLE-BLOWING

Employees, who have concerns about a colleague's conduct in their personal life or their professional practice, in the context of safeguarding, should report this under the Whistle-blowing Policy HR001.

Employees are entitled to protection under the Whistle-blowing Policy and the Public Interest Disclosure Act 1998.

12. COMMISSIONED SERVICES

TVAA requires that all commissioned service providers produce their own guidelines that reflect TVAA on safeguarding children and young people.

The guidelines should set out staff responsibilities, reporting concerns and recruitment processes with regard to the requirements set out in the Vulnerable Groups Act 2006.

13. ALLEGATIONS MADE AGAINST EMPLOYEES

TVAA will take all necessary measures to ensure that it recruits staff who uphold the principles of the Children Act 2015 and Care Act 2014. However, it is acknowledged that some staff may conduct themselves in a manner that is at odds with TVAA policy and legislation, in this instance the TVAA will treat all allegations against staff seriously.

When an allegation is made about a member of staff at TVAA should follow and investigate it under the Disciplinary Procedure HR004.

The manager who has been alerted to the allegation against a member of staff has responsibility to ensure that the appropriate course of action is taken without delay, giving consideration to the following:

- Suspend the member of staff from regulated activity, for example, patient facing duties. Ensure that any staff or volunteer who has caused risk or harm is not in contact with patients and others who may be at risk, for example, whistle-blowers
- Notify the Safeguarding Lead via email and phone tvaa.safeguarding@nhs.net

- TVAA will ensure that all allegations of neglect or abuse against members of staff (including staff on fixed term contracts, temporary staff, locums, agency staff, volunteers, students and trainees) are referred according to local multi-agency safeguarding procedures and the Head of / Designated Nurse for Safeguarding Children/Adults within the CCG is informed immediately (via SCAS).
- Additionally, will ensure that all safeguarding concerns relating to a member of staff are effectively investigated and that any disciplinary processes are concluded irrespective of a person's resignation and that "compromise agreements" are not allowed in safeguarding cases. Where a member of staff resigns prior to the conclusion of such proceeding's consideration should be given to the need for a referral to registration bodies (e.g. General Medical Council (GMC), Nursing & Midwifery Council (NMC)), Health and Care Professions Council and the Disclosure and Barring Service
- Where appropriate the Safeguarding Lead will advise on referring the case to the police if the suspected abuse is a crime. In cases of emergency, the police must be alerted using the usual channels (999)
- Notify the relevant local authority safeguarding board (via Safeguarding Lead)
- Commence internal investigation (serious incident requiring investigation)
- Inform the Care Quality Commission (CQC)
- Inform the member of staff as they have a right to know in broad terms what allegations or concerns have been made about them
- Support member of staff through Employee Assistance Programme
- Maintain a high level of confidentiality

13.1 Support for staff involved in the safeguarding children process

TVAA recognises that an allegation of this nature can have a profound effect on the member of staff.

As such, TVAA will provide support to staff whom allegations have been made against, in accordance with advice from the relevant social services department and the police so as not to jeopardise the investigation.

The member of staff will be treated with respect and honesty in all matters and confidentiality will be maintained on a need to know basis.

14. TRAINING AND SUPERVISION

Current guidance means that TVAA specify safeguarding children and adults in need training as mandatory. Training should take place at all levels of TVAA and be updated regularly to reflect best practice. TVAA will ensure that all staff receive training that is appropriate to their level of responsibility.

All Staff - Basic Mandatory- awareness training, with respect to awareness that abuse can take place and duty to report.

Clinical Staff - Detailed awareness- recognition of abuse, responsibilities and TVAA policy, procedures.

Local Managers and Safeguarding Lead - Specialist training

TVAA will align these levels to the child levels for easy reference. Basic Mandatory- Level One, Detailed awareness- Level Two, Specialist- Level Three/Four.

Training is a continuing responsibility and TVAA will provide a rolling programme of safeguarding training in line with best practice and guidance.

TVAA will ensure that staff received appropriate support which allows the, to reflect on a challenging or traumatic call as well as reflect on their practice.

TVAA staff may obtain access to advice and support from Safeguarding Lead within the organisation safeguarding@tvairambulance.org.uk or via the on duty Clinical Shift Manager.

For a missed referral, staff will be provided with a Staff Safeguarding Action Plan (appendix four) to address the issues. The plan will outline the reasons for the action plan and what learning or development needs to take place. On completion of the action plan staff and local management need to complete and sign the plan and return to the safeguarding@tvairambulance.org.uk email address.

Further details on supervision are provided in the Safeguarding Supervision Policy.

15. MONITORING AND GOVERNANCE

TVAA is regulated by the Care Quality Commission (CQC) who have devised 'Essential Standards for Quality and Safety', of which safeguarding is one aspect. Strong governance

is fundamental to enable the Charity to comply with requirements set out by the Department of Health and CQC so as to challenge existing arrangements and ensure robust safeguarding procedures, which should reflect current best practice and encompass learning from any incidents the Charity may have been involved in.

The CQC has the authority to take enforcement action against organisations that do not comply with the Essential Standards.

As such safeguarding adults' activity will be reported to the board bi-monthly and scrutinised by the Director of Operations. This provides a mechanism to improve practice ensuring appropriate outcomes for patients and carers are achieved.

In addition to periodic reporting and providing assurance to CQC that the Charity has robust safeguarding arrangements, the Charity will be subject to inspection and will continually provide assurance to commissioners.

16. EQUALITY IMPACT STATEMENT

16.1 Thames Valley Air Ambulance is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

16.2 Equality impact must be considered when developing a new or amending an existing policy. If it is considered that there may be an impact, then an Equality Impact Assessment should be undertaken (as below). If it is considered that there will be no impact, then this should be stated within the policy to evidence that a dynamic EIA has been undertaken.

16.3 This policy has been assessed accordingly in line with the Equality Impact Screening Tool and is not considered to impact upon the groups outlined within the tool.

Equality Impact Screening Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval for service and policy changes/amendments.

Stage 1 - Screening			
Title of Procedural Document: Safeguarding Children Policy OP010			
Date of Assessment	01/03/2018	**Responsible Department**	Operations
Name of person completing assessment	Gavin Casey	**Job Title**	Head of Clinical Services

Does the policy/function affect one group less or more favorably than another on the basis of:		
	Yes/No	**Comments**
• Age	No	
• Disability Learning disability; physical disability; sensory impairment and/or mental health problems e.g. dementia	No	
• Ethnic Origin (including gypsies and travellers)	No	
• Gender reassignment	No	
• Pregnancy or Maternity	No	
• Race	No	
• Sex	No	
• Religion and Belief	No	
• Sexual Orientation	No	
If the answer to all the above questions is NO, the EIA is complete. If YES, a full impact assessment is required: go on to stage 2, page 2		
More Information can be found be following the link below www.legislation.gov.uk/ukpga/2010/15/contents		

Stage 2 – Full Impact Assessment			
What is the impact	**Level of impact**	**Mitigating actions (what needs to be done to minimise / remove the impact)**	**Responsible manager**
Monitoring of actions			
The monitoring of actions to mitigate any impact will be undertaken at the appropriate level (CEO and Director level)			

Appendix 1; Additional guidance notes on safeguarding children

Safeguarding Children Guidance Notes

The current guidance is outlined in the document "Working Together to Safeguard Children" 2015 and it is from this document that much of the following advice and information is taken. The Children Act 1989 places two specific duties on agencies to co-operate in the interests of vulnerable children:

Section 27 provides that a local authority may request help from: any health authority, Special Health Authority or National Health Service Trust;

In exercising the local authority's functions under Part III of the Act. This part of the Act places a duty on local authorities to provide support and services for children in need, including children looked after by the local authority and those in secure accommodation.

The authority whose help is requested in these circumstances has a duty to comply with the request, provided it is compatible with its other duties and functions.

Section 47 places a duty on: any health authority, Special Health Authority or National Health Service Trust; to help a local authority with its enquiries in cases where there is reasonable cause to suspect that a child is suffering, or is likely to suffer, **significant harm**.

The Concept of Significant Harm

The Children Act 1989 introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children. The local authority is under a duty to make enquiries, or cause enquiries to be made, where it has reasonable cause to suspect that a child is suffering, or likely to suffer significant harm (s.47).

A court may only make a care order (committing the child to the care of the local authority) or supervision order (putting the child under the supervision of a social worker, or a probation officer) in respect of a child if it is satisfied that:

- the child is suffering, or is likely to suffer, significant harm; *and*
- the harm or likelihood of harm is attributable to a lack of adequate parental care or control (s.31).

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, and the extent of premeditation, etc.

Additional triggers which can impact on safeguarding children

Many families although under great stress nonetheless manage to bring up their children in a warm, loving and supportive environment in which the children's needs are met and they are safe from harm. Sources of stress within families may, however, have a negative impact on a child's health, development and well-being, either directly, or because they affect the capacity

of parents to respond to their child's needs. This is particularly the case when there is no other significant adult who is able to respond to the child's needs.

The Mental Illness of a Parent or Carer

Mental illness in a parent or carer does not necessarily have an adverse impact on a child, but it is essential always to assess its implications for any children involved in the family. Parental illness may markedly restrict children's social and recreational activities. With both mental and physical illness in a parent, children may have caring responsibilities placed upon them inappropriate to their years, leading them to be worried and anxious. If they are depressed, parents may neglect their own and their children's physical and emotional needs.

In some circumstances, some forms of mental illness may blunt parents' emotions and feelings or cause them to behave towards their children in bizarre or violent ways. Unusually, but at the extreme, a child may be at risk of severe injury, profound neglect, or even death.

A study of 100 reviews of child deaths where abuse and neglect had been a factor in the death, showed clear evidence of parental mental illness in one-third of cases. In addition, postnatal depression can also be linked to both behavioural and physiological problems in the infants of such mothers.

Drug and Alcohol Misuse

As with mental illness in a parent, it is important not to generalise, or make assumptions about the impact on a child of parental drug and alcohol misuse. It is, however, important that the implications for the child are properly assessed. Maternal substance misuse in pregnancy may impair the development of an unborn child. A parent's practical caring skills may be diminished by misuse of drugs and/or alcohol.

Some substance misuse may give rise to mental states or behaviour that put children at risk of injury, psychological distress or neglect. Children are particularly vulnerable when parents are withdrawing from drugs. The risk will be greater when the adult's substance misuse is chaotic or otherwise out of control. Some substance-misusing parents may find it difficult to give priority to the needs of their children and finding money for drugs and/or alcohol may reduce the money available to the household to meet basic needs or may draw families into criminal activities. Children may be at risk of physical harm if drugs and paraphernalia (e.g. needles) are not kept safely out of reach. Some children have been killed through inadvertent access to drugs (e.g. methadone stored in a fridge).

Role of Social Services

Local authorities, acting in order to fulfil their social services functions, have specific legal duties in respect of children under the Children Act 1989. They have a general duty to safeguard and promote the welfare of children in their area who are in need.

Social services departments also have a duty to make enquiries if they have reason to suspect that a child in their area is suffering, or likely to suffer significant harm, to enable them to decide whether they should take any action to safeguard or promote the child's welfare (s.47). They need the help of other agencies in order to do this effectively.

A child who is at risk of significant harm will invariably be a child in need. The social services department is responsible for co-ordinating an assessment of the child's needs, the parents' capacity to keep the child safe and promote his or her welfare, and of the wider family circumstances.

In the great majority of cases, children are safeguarded from harm by working with parents, family members and other significant adults in the child's life to make the child safe, and to promote his or her development, within the family setting. Where a child is at continuing risk of significant harm, social services are responsible for coordinating an inter-agency plan to safeguard the child, which sets out and draws upon the contributions of family members, professionals and other agencies.

In a few cases, the social services department, in consultation with other involved agencies and professionals, may judge that a child's welfare cannot be sufficiently safeguarded if he or she remains at home. In these circumstances, the social services department may apply to the courts for a Care Order, which commits the child to the care of the local authority. Where the child is thought to be in immediate danger, the social services department may apply to the courts for an Emergency Protection Order, which places the child under the protection of the local authority for a maximum of eight days, alternatively the police may be called to take out a Police Protection Order (PPO) which allows the child to be removed to a place of safety for a period of up to 72 hours.

Because of their responsibilities, duties and powers in relation to vulnerable children, social services departments act as the principal point of contact for children about whom there are child welfare concerns. Social Services may be contacted directly by parents or family members seeking help, concerned friends and neighbours, or by professionals and others from statutory and voluntary agencies.

Classification of Child Abuse

- Neglect
- Physical injury
- Sexual abuse
- Emotional abuse

In summary, a child is considered to be at risk of significant harm if he or she is treated by another person in a way that is unacceptable. This can be by an act or omission (failure to protect).

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.

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 feigns the symptoms of, or deliberately causes ill health to a child whom they are looking after.

Emotional Abuse

Emotional abuse is the persistent emotional ill-treatment 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 feature age or develop-mentally inappropriate expectations being imposed on children. It may involve 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 ill-treatment 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, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape or buggery) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

Child Sexual Abuse CSE) is a form 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 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.

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. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

Recognition of Non-Accidental Injuries within Children:

Bruises:
To the soft part of the ear which could be caused by slaps to the side of the head.
For further information regarding bruises in non-mobile children see NICE guideline 89 (https://www.nice.org.uk/guidance/cg89)

Black Eye:
Bruising around one or both eyes could be caused by a fist or blow or, in the case of both eyes, possibly a blow across the bridge of the nose with something like a feeding bottle.

Suspicious Patterns of Bruising
For example finger marks which could be caused by hard slaps to the body or the child being forcibly gripped and shaken.

Abnormal Bruising
Over areas of the body not normally injured for example, abdomen, chest, back and perineum.

Different Stages of Bruising:
Could mean repeated assaults over a period of time.

Torn Frenulum:
(The tissue attaching the inside of the top lip to the inner upper jaw). Not a common injury but may be caused by a feeding bottle being rammed into a child's mouth, this would also cause dark red spots of blood beneath the membrane (petechial spotting) on the inside of the top lip.

Frozen Awareness
Where a child's eyes have a frozen look but follow your every move. The child's fears that you will abuse them if you approach.

Burn Marks:
Caused by hot objects placed on the child's body for example keys, poker ends, hot iron, etc.

Cigarette Burns:
In various stages of healing. A combination of fresh, raw burns or healed pink circles. These are normally deep burns.

Scalds with Inconsistent History:
"The child stepped into a bath of hot water". If only the tops of the child's feet are scalded, is this history plausible?

Bite Patterns:
Bruising and abrasions in bite patterns on the child's limbs.

Looked After Children & Care Leavers
Most children become looked after as a result of abuse and neglect. 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)

In accordance with The Statutory Guidance for Promoting the Health & Wellbeing of Looked After Children (DfE DH 2015) The NHS has a major role in ensuring the timely and effective delivery of health services to looked-after children. The Mandate to NHS England, Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies and The NHS Constitution for England make clear the responsibilities of CCGs and NHS England to looked-after children (and, by extension, to care leavers).

In fulfilling those responsibilities, the NHS contributes to meeting the health needs of looked-after children in three ways: commissioning effective services, delivering through provider organisations, and through individual practitioners providing coordinated care for each child.

The Government's Mandate to NHS England includes an explicit expectation that the NHS, working together with schools and children's social services, will support and safeguard looked-after children (and other vulnerable groups) through a more joined-up approach to addressing their emotional, mental and physical health needs.

Every local authority should have agreed local mechanisms with CCGs to ensure that they comply with NHS England's guidance on establishing the responsible commissioner in relation to secondary health care when making placement decisions for looked-after children and to resolve any funding issues that arise.

Looked After Children and Care Leavers – Definition
In England and Wales the term 'looked after children' is defined in law under the Children Act 1989. A child is looked after by a local authority if he or she is in their care or is provided with accommodation for more than 24 hours by the authority.

Looked after children fall into four main groups:

- Children who are accommodated under voluntary agreement with their parents (section 20);
- Children who are the subject of a care order (section 31) or interim care order (section 38);
- Children who are the subject of emergency orders for their protection (section 44 and 46);
- Children who are compulsorily accommodated. This includes children remanded to the local authority or subject to a criminal justice supervision order with a residence requirement (section 21).

The term 'looked after children' includes unaccompanied asylum-seeking children, children in friends and family placements, and those children where the agency has authority to place the child for adoption.

It does not include those children who have been permanently adopted or who are on a special guardianship order.

The Children (Leaving Care) Act 2000 states that a Care Leaver is someone who has been in the care of the Local Authority for a period of 13 weeks or more spanning their 16th birthday. CCG's should ensure that there are effective plans in place to enable Looked After Children aged 16 – 17 to make a smooth transition into adult hood. (Dfe DH 2015)

Forced Marriage
A marriage conducted without the freely given consent of both parties where duress is a factor. Duress includes emotional pressure and the use of violence (Foreign and Commonwealth Office).

There is a difference between an arranged marriage and a forced marriage. In arranged marriages, families arrange the match but the choice of whether or not to accept the arrangement remains with the individual. Arranged marriage is a valuable, long established tradition based on compatibility, consent and retaining choice. In forced marriages, there is no choice. No culture or religion sanctions forced marriage.

Planned or actual forced marriage places children and young people at risk of significant harm, which may include sexual, physical and emotional abuse, and is contrary to the United Nations Convention on the Rights of the Child.

Whilst it is unlikely, it is possible that TVAA personnel may become aware of such cases, as there is an increased risk of self-harm, attempted suicide, eating disorders and depression. It is imperative that any concerns are referred as a safeguarding matter and that normal procedures are followed.

In the interests of the child/young person's safety, staff making a referral **should not** inform the young person's family. The decision regarding contact with parents/carers will be taken by Social Services at the strategy discussion stage, based on a risk assessment regarding likelihood of immediate harm to that young person.

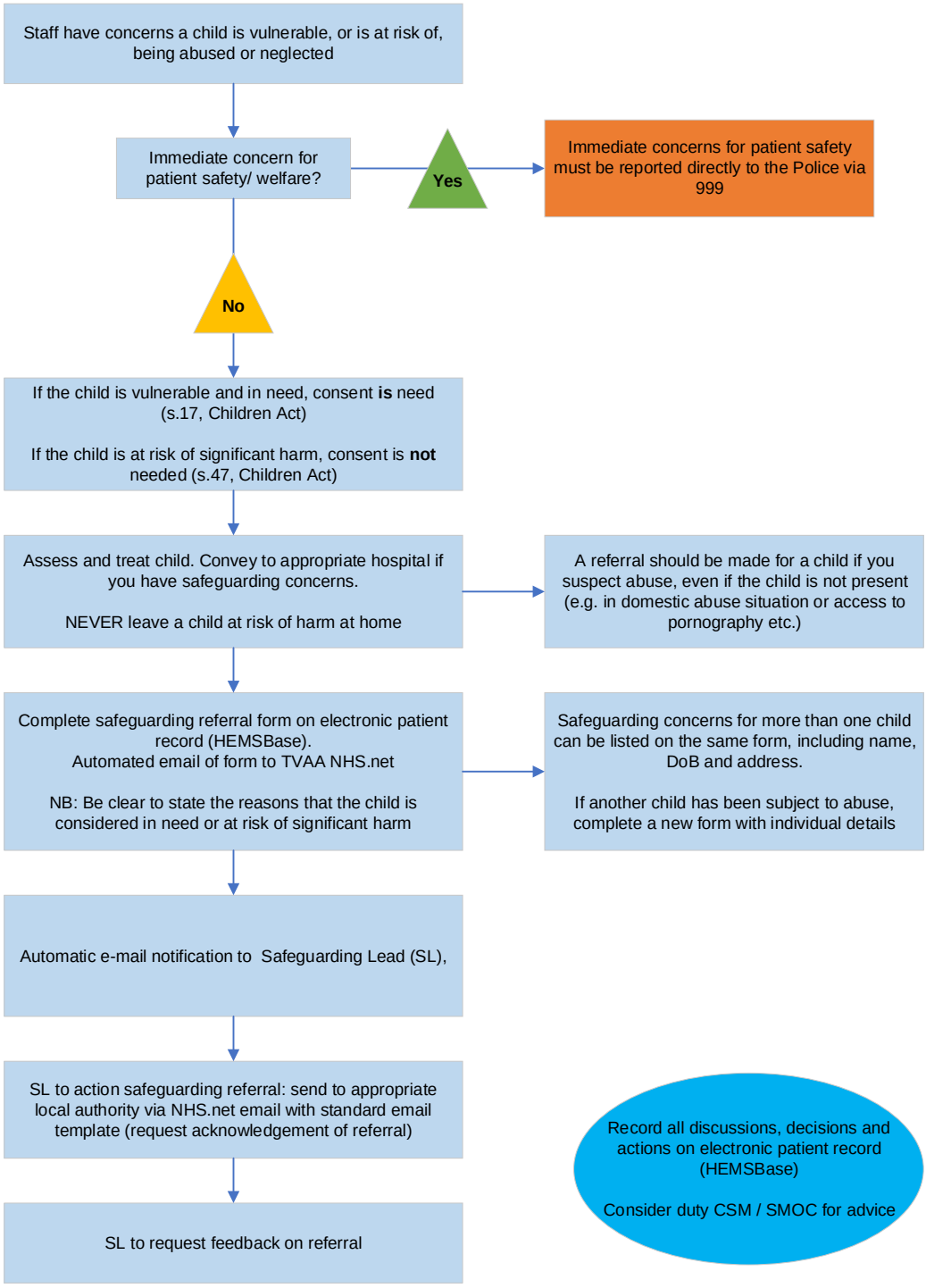
Further sources of information

Oxfordshire Safeguarding Children Board

Buckinghamshire Safeguarding Children Board

Pan-Berkshire Local Safeguarding Children Board

Appendix 1, Child/ young person safeguarding referral process



Appendix 2; OP009

SAFEGUARDING ACTON PLAN FOR STAFF

Reason for action: ☐ Missed referral	☐ Insufficient information	☐ Learning need identified	☐ Other (state)
Further information case no:			
CAD no:			
Date of call:			
Issues identified:			
Safeguarding Name:			
Date sent:			

Points to be covered with staff:

How points have been addressed (Need to provide evidence for each point. To be completed by local manager): **Date completed:**

Staff comments:

Staff follow up/review to confirm all actions have been completed (to be completed by local manager):

Safeguarding Lead/ Clinical Shift Manager name: _____

Signed: _____

Date: _____