HealthHarmonie
Quality and safety first.

Safeguarding children and young person's policy

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Name of responsible (ratifying) committee	Senior Management Team
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Contents

1. Summary

All HealthHarmonie staff who encounter children and families in their everyday work, including practitioners who do not have a specific role in relation to child protection, have a duty to safeguard and promote the welfare of children. Children and young people are defined as anyone who has not reached their 18th birthday. This includes the unborn.

Safeguarding Children – the action we take to promote the welfare of children and protect them from harm – is everyone's responsibility. Everyone who encounters children and families has a role to play (Working Together to Safeguard Children 2015).

Fundamental to safeguarding and promoting the welfare of each child is having a child centred approach. Seeing the child and keeping the child in focus throughout assessments, while working with the child and family is paramount.

Staff working with adults should actively consider the needs of any children with whom the patient has contact and whether they fulfil the definition of a child in need or a child at risk of significant harm.
Concerns that children are at risk of or suffering from child abuse or neglect must be discussed with a senior member of staff. Reasons for the concern and actions taken should be documented.

Help and advice can be sought from HealthHarmonie's safeguarding team, or the Local Authority Children's Social Care (CSC). See appendix 1

2. Introduction and aims

The abuse of a child, regardless of whether it is physical, sexual, emotional abuse or neglect, is damaging and can have serious and longstanding effects on all aspects of their health, development and wellbeing.
HealthHarmonie is committed to safeguarding and promoting the welfare of children and young people. As a statutory agency, HealthHarmonie has a duty and responsibility to proactively safeguard and promote the welfare of children in accordance with legislation (Children Act 1989 and 2004, Working Together to Safeguard Children 2015).
This policy has been produced in line with Working Together to Safeguard Children (2015) and should be read in conjunction with all the Safeguarding Children Board Policies and Procedures in each CCG area in which we operate in as per our contractual agreements. Working Together, informed by the requirements of the Children Act 1989 and 2004, is the key legislation for safeguarding children.

The aim of this policy is to provide clarity to all staff on how to safeguard and promote the welfare of children and young people. It provides guidance on processes for responding to and reporting safeguarding children cases and clarifies the responsibilities of all HealthHarmonie staff with the aim of ensuring a consistent approach to safeguarding children across all CCG contracts.
HealthHarmonie aim to ensure that no act or omission on the part of the organisation, or that of its staff, puts a child inadvertently at risk; and that rigorous systems are in place to proactively safeguard and promote the welfare of children and support staff in fulfilling their obligations.

This policy relates to all staff whose work brings them into contact with children, young people and their families/carers – clinical and non-clinical staff, bank, temporary, locum staff and those on special privileges contracts. It applies to all staff employed directly or indirectly by HealthHarmonie, including those on temporary contracts, secondments or other flexible working arrangements.

3. Definitions

A Child – children are defined as anyone who has not yet reached their 18th birthday. Throughout this document 'child' will mean 'children and young people'

Looked after Children – are defined in law under the Children Act 1989. 'A child is 'looked after' if they are in the care of the local authority for more than 24 hours. 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.

Safeguarding and Promoting the Welfare of Children –

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

Child Protection – the activity undertaken to protect specific children who are suffering, or likely to suffer, significant harm.

Significant harm - concept introduced in the Children Act 1989 and is the threshold that justifies compulsory intervention in family life in the best interests of children.

Vulnerable Child (VC) refers to a child who is at greater risk of harm than a 'universal child'.

Child in Need – is defined under section 17 of the Children Act 1989, as a child whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services. Vulnerability includes children with disabilities.

Multi-Agency Safeguarding Hub (MASH) provides triage and multi-agency assessment of safeguarding concerns. It brings together professionals from a range of agencies into an integrated multi-agency team.

Emergency Protection Order (EPO) - a court order under section 44 of the Children Act 1989 giving Children's Social Care and the police the power to protect a child by removing the child to suitable accommodation or preventing a child from being removed (e.g. from hospital).

A Did Not Attend (DNA) is defined as a scheduled appointment that is missed without prior arrangements by the service user. For most appointments a child is brought to an appointment by their parent/carer. If the adult does not bring the child to the appointment it is inaccurate to say that the child did not attend. Was not brought (WNB) rather than DNA promotes child-centred practice, reminding practitioners to think about the child's vulnerability and their daily lived experiences

4. Duties and Responsibilities

All those who encounter children and families in their everyday work, including people who do not have a specific role in relation to child protection have a duty to safeguard and promote the welfare of children. Safeguarding is everyone's responsibility

Whilst Children's Social Care has a lead role in working with children and families where children are at risk of, or have experienced significant harm from abuse and neglect, working to protect children is not their sole responsibly. It is shared by all those who work with children or parents/carers.

Health professionals and organisations have a key role to play in actively promoting the health and well-being of children.

Section 11 of the Children Act 2004 places a duty on HealthHarmonie as an NHS care provider to make arrangements, to ensure that in discharging their functions they have regard to the need to safeguard and promote the welfare of children.

All staff members therefore have a duty to follow this policy.

4.1 Board members

HealthHarmonie's Board of Directors has a responsibility to ensure that there is an overall policy and procedure in place to safeguard children. The Board is responsible for ensuring that there are robust arrangements for safeguarding children within the organisation and that the organisation works collaboratively with all the CCG Safeguarding Children Boards.

This includes ensuring that there is transparency and openness about clinical incidents and learning from safeguarding concerns that occur within the organisation.

4.2 Registered Manager

The Registered Manager devolves the responsibility for compliance and monitoring of Safeguarding procedures to the Managing Director through the Safeguarding Team, ensuring that the company meets its statutory and non-statutory obligations in respect of maintaining appropriate standards for Safeguarding Children.

4.3 The Managing Director

The Managing Director is the Executive Lead for Safeguarding at HealthHarmonie and is responsible for ensuring that the company upholds the principles of the Safeguarding Children Policy when dealing with patients and their families / carers.

The Managing Director has responsibility for providing advice and support to the Trust Board in relation to Safeguarding and for assuring the Board that HealthHarmonie has the correct processes in place to protect children; for ensuring that appropriate policies and procedures are developed, maintained and communicated throughout the organisation, and that those policies and procedures are developed and implemented in co-ordination with other relevant organisations and stakeholders.

The Managing Director represents the Company at any CCG Safeguarding Children Board with whom we have contracts with.

4.4 Named Doctor Safeguarding Children

The Gynaecology Lead Pallavi Latthe is the operational lead for safeguarding children within the company and includes:

- Professional lead on safeguarding and child protection matters.
- Being accessible to front line staff for advice and guidance within the multiagency guidelines and HealthHarmonie's Safeguarding Children policy.
- Ensuring a safeguarding-children training strategy is in place and training is delivered.
- Facilitate policies and procedures in relation to safeguarding Children.
- Provide assurance reports for the Executive Lead on Safeguarding Children.
- Liaising with Social Services to ensure that allegations of abuse are followed up and investigated, as appropriate
- Attending and contributing to sector wide safeguarding children forums and contributing to the relevant CCG Safeguarding Children Board subgroups and partnership meetings when required.

- Will ensure that all safeguarding concerns relating to a member of staff are effectively investigated (LADO and / or PIPOT), and that any disciplinary processes are concluded irrespective of a person's resignation, and that 'compromise agreements' are not be allowed in safeguarding cases.
- Ensure that organisational representatives / practitioners make an effective contribution to safeguarding case conferences / strategy meetings, Early Help Assessments, Information Sharing and Fabricated Illness cases where required as part of multiagency procedures and sub-groups.

4.5 Clinical Leads

Clinical Lead are responsible for:

- Ensuring that the requirements of HealthHarmonie's Safeguarding Children Policy are effectively managed within their Clinical disciplines and that staff are aware of, and implement, those requirements Ensuring that staff within their sphere of responsibility are aware of and comply with the local safeguarding children procedures and that they receive the level of training appropriate to their role.
- Attending Safeguarding enquiry / outcome meetings as required
- Monitoring of recommendations arising from investigations and ensuring that any actions required are followed up and implemented.

4.6 Senior Managers

Senior Managers are responsible for:

- Ensuring that staff are familiar with and adhere to this policy
- Managing any immediate protection issues
- Inform the Named Manager of any children that may have safeguarding implications
- Ensure that the services are provided in a way that ensures a safe environment for children and young people and minimizes any risks
- Ensuring that incidents are reported through company's Safeguard Incident Reporting system
- Ensure safeguarding responsibilities are identified in appraisal and Personal Development Plans
- Ensure that staff access safeguarding children training and supervision appropriate to their role and responsibility as per the Safeguarding Children Training Policy

HealthHarmonie will contact the LADO(Local Authority Designated Officer) within one working day in respect of all cases in which it is alleged that a person who works with children has:

- behaved in a way that has harmed, or may have harmed a child;
- possibly committed a criminal offence against or related to a child; or
- behaved towards a child or children in a way that indicates they may pose a risk of harm to children.
- There may be up to three strands in the consideration of an allegation:
- a police investigation of a possible criminal offence;
- enquiries and assessment by children's social care about whether a child is in need of protection or in need of services;
- consideration by an employer of disciplinary action in respect of the individual.

The LADO is responsible for:

- Providing advice, information and guidance to employers and voluntary organisations around allegations and concerns regarding paid and unpaid workers.
- Managing and overseeing individual cases from all partner agencies.
- Ensuring the child's voice is heard and that they are safeguarded.
- Ensuring there is a consistent, fair and thorough process for all adults working with children and young people against whom an allegation is made.
- Monitoring the progress of cases to ensure they are dealt with as quickly as possible.
- Recommending a referral and chairing the strategy meeting in cases where the allegation requires investigation by police and/or social care

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The LADO is involved from the initial phase of the allegation through to the conclusion of the case. The LADO is available to discuss any concerns and to assist you in deciding whether you need to make a referral and/or take any immediate management action to protect a child.

4.7 All staff

All staff employed by the HealthHarmonie has a duty to act promptly and report concerns if they are worried about the welfare of a child or believe the child to be at risk of, or suffering from, significant harm. All staff should:

- Have knowledge of safeguarding children procedures
- Know who to contact for advice and support, discuss or report concerns about a child's welfare.
- Receive appropriate training and supervision
- Contribute to the safeguarding process where appropriate

- Maintain accurate, comprehensive and legible records in line with professional guidelines and clinical record keeping policies.
- Inform the safeguarding team when aware / becomes aware of a child or young person who is known to the Local Authority Children's Services / has a known social worker and does not have a VC flag (see section 5.6)

5. Body of the policy

All staff members who have or become aware of concerns about the welfare or safety of a child or children should know:

- What sources of further advice and expertise are available
- Who to contact and how
- When and how to make a referral to the Local Authority Children's Social Care

There should always be the opportunity to discuss child welfare concerns and it is good practice to routinely discuss any concerns staff may have about a child, parents or carers and to seek advice from colleagues, managers, named professionals, or other agencies; this may be in multidisciplinary team meetings, team meetings, 'handovers', or in supervision.

Where there is any uncertainty about how to deal with a concern about a child, or about the appropriateness of making a referral to CSC, staff must seek advice from the Named Professionals for Safeguarding Children / Named Consultant. Contact details can be found in Appendix 1 and see Appendix 2 for the 'What to do flowchart'.

However, this should never delay any emergency action to protect a child from harm

Always record in writing any concerns or discussions about a child's welfare and at the close of a discussion, always reach a clear and explicit recorded agreement about who will take what action or that no further action will be taken and the basis for this decision.

If a child,

- Has suffered significant harm
- Is likely to suffer significant harm

- Has developmental and welfare needs which are likely only to be met though the provision of support services A referral must be made to the Local Authority Children's Social Care where the child lives. Referrals can be made 24 hours a day as there are Out of Hours Emergency Social Work Teams available.

If concerns arise about a child who is already known to Children's Social Care, the allocated Local Authority social worker should be informed immediately; and the discussion clearly recorded in the child's record.

5.1 What to do if you are concerned about a child/ child protection concern

- Obtain a clear history
- Be inquisitive

Discuss your concerns with your line manager and / or a named safeguarding professional to clarify the seriousness and urgency of the situation and then decide the next course of action. Reasons for the concern and actions taken must be documented in the patient's records. Consideration can be given to consulting with the Duty Social Worker at the Local Authority for advice. This can be done by presenting a 'what if' scenario without necessarily naming the child in question. This discussion should be recorded by both parties.

If you have a concern regarding an injury (physical abuse):

- Note the site, nature, extent of injuries and any explanation given for them
- If a medical opinion is required, the case must be discussed with a Paediatric Consultant. The Named Manager Safeguarding Children must also be informed.

If those concerns remain and are regarding a non-accidental injury:

- Children's Social Care must be contacted immediately by telephone.
- All advice and actions must be documented carefully.
- Inform the family of your concerns and actions, unless doing so will place the child at further risk
- Where possible involve the child throughout the process
- If you are advised to, complete and send a referral form
- CSC will then make a decision as to whether a non-accidental injury medical assessment is required, who will complete this and whether police involvement is required.

If it is believed that a child or young person's health or development is being impaired without the provision of services by the Local Authority, consideration should be given to making a referral to the Local Authority Children's Social Care.

5.2 Making a referral

The referrer should always advise the child's parent/carer about the concerns and inform them of the intention to refer the matter to Children's Social Care. However, agreement with a parent to make a referral should not be sought if doing so would place the child or young person at increased risk of significant harm. A decision not to seek parental permission to make a referral to Children's Social Care must be recorded and reasons given.

All referrals including, new referrals and referrals on closed cases should be made to the Local Authority Children's Social Care where the child lives, by telephoning the number stated on their web page and following it up in writing using the appropriated multi-agency referral form. The form can either be found on their web page or sent to you via email on request (see Appendix 1).

When sending a completed referral, it must be sent from a secure nhs.net account to a secure local authority gcsx.gov.uk account or via encrypted email.

HealthHarmonie children and families come from all over the country – a list of some of the Local Authority Children's Social Care team contact details can be found on Radar.

A copy of the completed referral to the Local Authority Children's Social Care must be retained in the relevant clinical records (PPS) and a further copy sent to the GP.

The Safeguarding Children Team can support staff with this action.

Always make sure that the referral has been received and understood in the manner intended. In addition to making a referral to Children's Social Care, consideration must be given to completing an Internal HealthHarmonie Incident Report.

5.3 Possible outcomes

A decision on the course of action will be made within one working day of the referral, followed by a timely Working Together single assessment based on the needs of the child within 45 working days of the point of referral.

HealthHarmonie staff members do not make the decision as to whether abuse has taken place. It is the duty of staff to share and report concerns, and to assist and provide

information in support of any child protection enquiries. The Local Authority (LA) has the statutory duty to decide whether abuse has taken place and decide on the course of action. The Local Authority will decide if:

- Assessment is required – Section 17 (child in need), Section 47 (risk of significant harm) or Section 20 / Section 31 (a child in need of, or requesting, accommodation), or
- No further Local Authority children's social care involvement at this stage – other action may be necessary e.g. early help assessment / services, signposting to other agencies and services, referral to a specialist support service.

If there are concerns about the child's immediate safety, action will be taken including a strategy discussion between local authority children's social care, police, health and other agencies as appropriate.

Following a strategy meeting or an assessment, a child protection conference may be called, and the child may be subject to a child protection plan.

5.4 Invitation to attend a Child Protections Strategy Discussion (meeting) or Child Protection Conference.

A Child Protection Conference is a meeting to discuss concerns about a child or children to consider if a child has been harmed or is at risk of being harmed, and the nature of the concern about the child. It will assess the degree of risk to the child and decide whether the child should be subject to a child protection plan; making recommendations about any further action necessary to help protect the child or young person.

The first Child Protection Conference is called an Initial Child Protection Conference, and this will take place within 15 working days of the last strategy meeting or discussion.

A Review Child Protection Conference is the subsequent meeting(s) held by core group members to review the child protection plan.

The Named Manager must be informed of the meeting as soon as the invitation is received.

A written report regarding involvement and knowledge of the family, including identification of risk factors, should be prepared with the support of the Named Manager for the meeting using the relevant Local Authority proforma. To support working in partnership with parent, it is good practice to share the report with the family and a copy must be sent to the Conference Chair in advance of the meeting.

A copy must be saved in the patient PPS records and a copy sent to the Named Manager Safeguarding Children

The Named Manager will attend a strategy meeting or case conference with the staff member to support them if required.

Following attendance at a child protection strategy meeting or child protection conference, safeguarding supervision must be attended – as per the Safeguarding Supervision Policy.

5.5 Safeguarding Children Alerts

Alerts are ONLY to be added onto the PPS systems by the Safeguarding Team.

HealthHarmonie has a system for flagging children with specific safeguarding or child protection vulnerability. Any child known to fit into one of the categories below will be flagged. If any staff member is aware or becomes aware of a child or young person who is known to the Local Authority Children's Services / has a known social worker and does not have a flag, they must inform the safeguarding team.

The Safeguarding Children Team will flag a child on ICS with the code 'VC' (Vulnerable Child). This appears in red at the top left-hand corner on PPS patient record. When a child is flagged as VC on ICS, a VC proforma will be found in the 'Alert' section of the patient's records on PPS, with details of why the child is vulnerable. This proforma is completed by a member of the Safeguarding Team.

Alerts are ONLY to be added onto PPS systems by the Safeguarding Team.

A child will have a VC flag if they fit into one or more of the following categories:

- A Child Protection Plan (CPP) is in place; under any category
- Child in Need Child in Care - Looked After Child - voluntary, foster care, family care, residential – not adopted children
- Child on Care Order – Interim, Full Care Order, Placement Order
- Child known and open to Local Authority Social Care services, e.g. subject to s17 or s47 assessment, known to the Local Authority Children with Disabilities Team
- Clear, outstanding concerns following Non-Accidental Injury concerns, whilst awaiting decisions from other agencies.
- Significant concerns from within health or other agencies (e.g. police, education, social care etc.), which do not fit into any of the above categories. These could include children whose parents have confirmed additional learning needs, mental health issues, substance

misuse or domestic abuse or any other safeguarding concern that can not necessarily be categorised. In these instances, an alert will not necessarily need to be added for all cases and the decision about the alert will be made by the Named Professionals.

The safeguarding team will document any updates on PPS or the Safeguarding folder on Radar as information is received / gathered.

The Safeguarding folder (used by the safeguarding team only) will contain any highly sensitive information regarding safeguarding and is available on request.

5.6 Add or remove alerts

Alerts are entered with an end date of 12 months' time, unless an alternative length of time is requested by the Named Manager and will automatically close on the end date unless for any other reason it has been updated within that period.

The Safeguarding Team will monitor those alerts coming to an end and on discussion with the Named Manager will close or update.

For those children with an alert and transitioning to adult services the Named Manager will liaise with the Adult Safeguarding Lead or the Local Authority Safeguarding Teams within that CCG

5.7 Record keeping

All staff should be compliant with the HealthHarmonie Records Management Policy in addition to the guidance issued by professional bodies. When there are concerns about the deliberate harm of a child or any safeguarding issue, comprehensive and contemporaneous notes must be made. Health professionals must ensure that they are working from a single set of records for each child (Laming, 2003)

5.8 Was not Brought (WNB) to the Appointment

The relationship between child maltreatment and non-attendance at appointments (and family disengagement from services more generally) is a potential indicator of neglect. When a child is not brought to appointment the involved staff must check PPS to see if there are any safeguarding alerts on the system and to check for previous non-attendance.

5.9 Training

To safeguard and promote the welfare of children effectively, it is crucial that members of staff can recognise children who may be at risk of harm and can respond appropriately to protect them and promote their welfare.

Safeguarding Children training is mandatory for all HealthHarmonie employees regardless of their role and responsibility. This applies to both permanent and temporary staff, locum and bank staff, contractual staff and all commissioned services. The Named Professionals monitor and report up take and compliance of training by staff.

All staff members have the responsibility to ensure that they meet their training requirements in line with HealthHarmonie's Safeguarding Children and Young People Training Process: roles and competences for health care staff Document (March 2014) and the CCG's Safeguarding Children Boards training requirements.

Safeguarding Children induction must be completed on commencing employment and is available during corporate induction.

Following induction, staff will require their specific level of training dependant on role. This must be completed within 3 months of commencing employment at HealthHarmonie followed by annual or three yearly updates depending on the level of training allocated. Managers should ensure that members of staff complete the level of training outlined in the Safeguarding Children Training Policy and framework set out in Appendix 3. The Named Manager will support managers in identifying the correct level of training needed for job role. Safeguarding Children training must be reviewed annually as part of the appraisal process.

5.10 Safeguarding children supervision

For practitioners involved in day to day work with children and families, effective supervision is important to promoting good standards of practice and to support individual staff members. Safeguarding children supervision should help to ensure that practice is soundly based and consistent with organisational and Local Safeguarding Children Board procedures. It is a specific type of supervision, separate from clinical supervision. It is a formal process of professional support and learning, which aims to ensure that clinical practice safeguards children and promotes their welfare.

The specific objectives of safeguarding supervision are as follows:

- To enable and empower practitioners to develop knowledge and competence.

- To provide a safe and structured environment for practitioners to reflect on, plan, review and account for their safeguarding work.
- To ensure that local and national policies and procedures are adhered to.
- To provide support and recognition of the stress and uncertainties that safeguarding work may cause.

This is achieved by facilitating reflective discussion, assessment, planning and review; thereby supporting the development of good quality, innovative practice provided by safe, knowledgeable and accountable practitioners.

All Health Care Professionals in HealthHarmonie will have access to safeguarding children supervision. Safeguarding supervision will be accessed by establishing partnerships with Local Safeguarding Children's Teams.

This process is different from, and in addition to, the discussion and seeking of advice regarding specific concerns or situations, which happens during everyday practice.

5.11 Managing allegations against staff

It is important that all adults working with children understand that the nature of their work and the responsibilities related to it, place them in a position of trust.

If there is an allegation of abuse, or concern of risk to a child, involving any member of staff, this policy document must be followed. Where it is alleged that any staff member has:

- Behaved in a way that has harmed a child, or may have harmed a child;
- Possibly committed a criminal offence against or related to a child; or,
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children

5.12 Individuals who pose a risk of harm to children

This includes children and adults who have been accused, finally warned about or convicted of sexual offences, or other serious offences, identify them as posing a risk, or potential risk, of harm to children (replacing the term 'Schedule 1 offender). If any staff member becomes aware that a person accessing the company, who is deemed to be a risk to children, must be dealt with on an individual basis, always advising the Line Manager and the relevant Named

Manager Safeguarding Children. An appropriate risk assessment and risk flagging to the electronic records must be completed

5.13 Consent

When consent is required for treatment or minor surgery, consideration must be given to who the parent or carer is with the child or young person and if they have parental responsibility. A young person aged 16 years or above has a right to provide consent to treatment, unless grounds exist for doubting her/his mental health. A child may be deemed to be Gillick competent to consent. See the Consent Policy for further information

5.14 Safer recruitment

HealthHarmonie recruitment policy must comply with National and Local Guidance. The NHS Employment Check Standards Guidance, Disclosure and Baring Service (DBS) and all the CCG's Local Safeguarding Children Board safer recruitment procedures. This includes but is not limited to:

- safeguarding statements in job descriptions and adverts
- seeking appropriate references (2 minimum, including most recent employer)
- checking ID and professional qualifications
- seeking appropriate DBS checks (formerly CRB) (repeat 3 yearly)
- checking employment history and accounting for anomalies
- The HR department in partnership with line managers have a responsibility to ensure that the safer recruitment process is followed. See Recruitment and Selection Policy.

5.15 Information sharing

Information sharing is vital for safeguarding children and young people from abuse or neglect and this overrides the duty of confidentiality to the carer. It is the duty of professionals, whether they are providing services to adults or children, to place the needs of the child first. Sharing of information in cases of concern about children's welfare will enable professionals to consider jointly how to proceed in the best interests of the child and to safeguard children generally. Effective information sharing underpins integrated working and is a vital element of both early intervention and safeguarding. Often, it is only when information from several

sources has been shared and is then put together that it becomes clear that a child is at risk or suffering harm.

- Information relevant to child protection will be about:
- Health and development of a child and his/her exposure to possible harm
- A parent/carer who is unable to care adequately for a child
- Other individuals who may present a risk of harm to the child

When deciding whether there is a need to share information inconsideration must be made as to whether the information is confidential, and if it is, whether there is a public interest enough to justify sharing. Confidential information can be shared if the person to whom it relates gives consent. Even where sharing of confidential information is not authorised you may lawfully share it if this can be justified in the public interest. Seeking consent should be the first option, if appropriate. Consent needs to be 'informed', which means that the person giving consent needs to understand why information needs to be shared, what will be shared, who will see their information, the purpose to which it will be put and the implications of sharing that information.

The child's best interest must be the overriding consideration in making any such decision of sharing information.

Practitioners often feel confused by different pieces of legislation relating to confidentiality and information sharing. Information Sharing; Advice for practitioners, providing safeguarding services to children, young people, parents and carers (2015) supports frontline practitioners who are required to make decisions about sharing information. See Appendix 2 for the 'Flowchart of when and how to share information'. Further information and guidance on information sharing can be found on Radar in the processes folder.

There may be situations when you are unsure whether to share information. In those cases, involving a vulnerable child you should speak with your manager, the Named Manager / Doctor for Safeguarding Children.

5.16 Photography or filming of children

Photographs, for child protection purposes, should not be taken without appropriate consent. When photographs are required for safeguarding / child protection they should be taken by the Police to ensure patient confidentiality and satisfy chain of evidence requirement. Under

no circumstances should photographs or videos, for child protection purposes, be taken with a mobile phone or iPad.

5.17 Use of Interpreters

A family member, child, friend or partner must never be used as an interpreter in a situation where there are child protection concerns as this could increase the risk to the child or adult parent or carer.

If interpreting services are required, a professional interpreter or 'Language Line' must be used.

5.18 The Voice of the Child

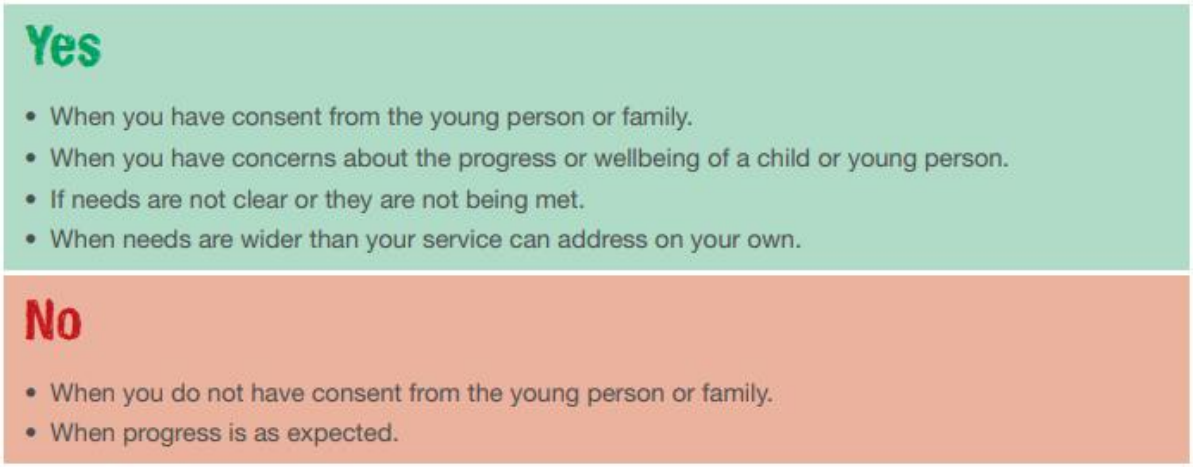
A child centred approach is supported by the Children Act 1989, The Equality Act 2010 and the United Nations Convention on the Rights of the Child.

Children want to be respected, their views to be heard, to have stable relationships with professionals built on trust and to have consistent support provided for their individual needs. This should guide the behaviour of professionals. Anyone working with children should see and speak to the child; listen to what they say; take their views seriously; and work with them collaboratively when deciding how to support their needs (Working Together 2015).

The voice of the child must be evidenced in the care provided to children and young people

5.19 Early Help Assessment

Any practitioner can complete an assessment with the child, young person and family when consent is given. HealthHarmonie will reinforce an Early Help Assessment should they have concerns. The table below summarises when an Early Help Assessment can be done and when it cannot.



The Early Help Assessment provides a consistent approach, using a common language and a holistic assessment of the child and family's needs, which is meaningful. The family should be involved in the assessment and encouraged to work in partnership with professionals to achieve their goals

The assessment follows the Signs of Safety (SofS) approach and explores: What is going well for the child and their family? • Child and family strengths • Safety factors What are we worried about? • What is happening now • Areas where needs are not being met • Presenting risks and concerns • Worries that are impacting on the child's health and wellbeing What needs to change to improve the outcomes for the child and their family? (Ensure the child and families views are captured within this). • Identify next steps, action required and desired outcomes • Well-being goals Consider each of the assessment areas from the whole perspective, starting with the strengths and then concentrating on the presenting issues/concerns. Wherever possible, base comments on evidence, not just opinion and indicate what the evidence is. It is important to distinguish between fact, opinion and observation when recording the information. The assessment must be completed with the child and their family to ensure their views are captured and they are at the centre of the assessment.

5.19 Serious Case Reviews (SCR's)

HealthHarmonie has a statutory duty to work in partnership with all Safeguarding Children Boards in conducting a review when:

- abuse or neglect of a child is known or suspected; and
- either - the child has died; or has been seriously harmed and there is cause for concern as to the way in which the authority, their board partners or relevant persons have worked together to safeguard children (Working Together to Safeguard Children 2015)

The purpose of a serious case review is to:

- Identify improvements which are needed
- To consolidate and promote good practice
- Translate findings from the review into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.
- Improve intra-agency and inter-agency working, leading to improved outcomes for children.

Case reviews are not inquiries into how a child died or was seriously injured, or who is culpable, that is a matter for coroners and criminal courts respectively to determine.

When a serious case review is commissioned the relevant Designated Nurse will inform HealthHarmonie Named Professionals. The Safeguarding team will then ensure that the records relating to the case are secured against loss or interference.

A review of the case will be conducted, looking openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made, and if so, to identify how these will be brought about. This is usually undertaken by the Named Manager. The person conducting the review should not have had been directly concerned with the child or family, or the immediate line manager of the practitioner(s) involved.

The content and format of the written report should be produced in line with the relevant Safeguarding Children Board terms of reference and template.

Where staff are interviewed by those preparing the review, a written record of such interviews should be made, and this should be shared with the relevant interviewee(s).

Feedback and de-briefing will be provided by the named professionals for all HealthHarmonie staff involved and their managers.

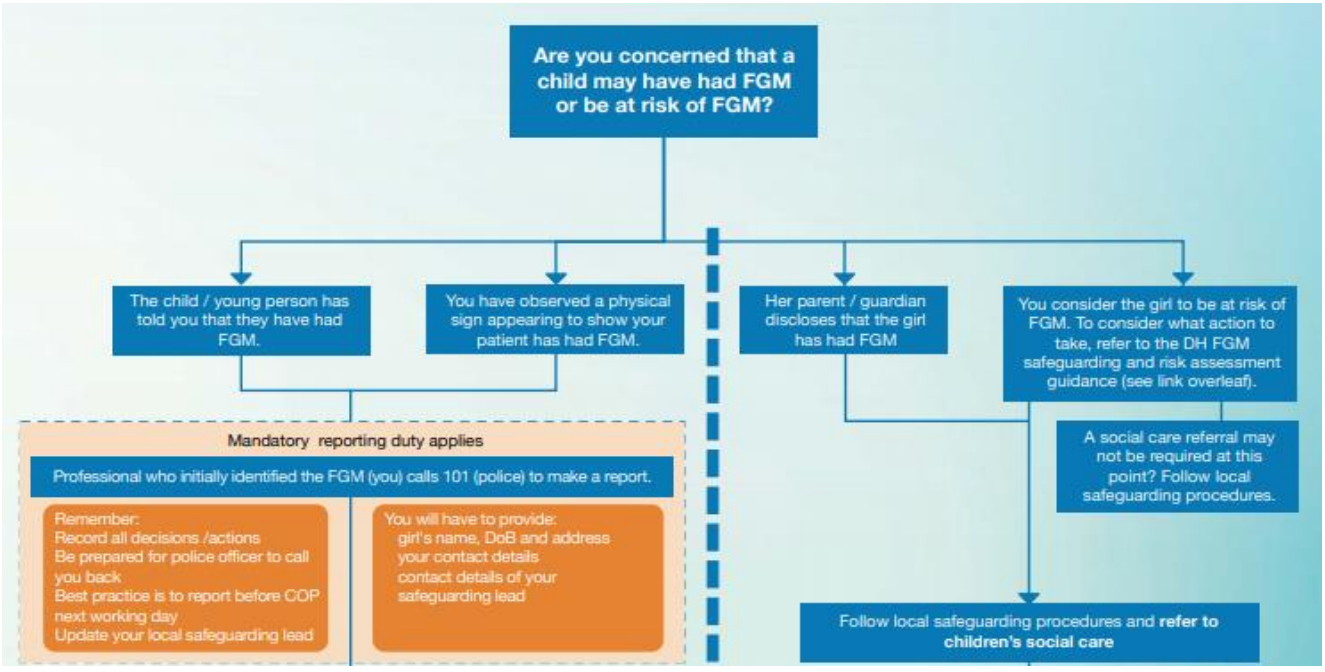
5.20 Restraint

We do not accept patients into the service that would require restraint. If any patient requires restrain, they should be onward referred to secondary care.

5.21 Specific Safeguarding Circumstances:

- Female Genital Mutilation (FGM)
- Fabricated Induced Illness
- Harmful Sexual Behaviour
- Child Sexual Exploitation
- Domestic and Sexual Violence
- Forced marriage
- Missing Children
- Radicalisation and Extremism
- Social Media, Internet risks and guidance

6. FGM



7. Monitoring this policy

The effectiveness of this policy will be assessed in several ways: through planned organisational audits, through investigation of serious incidents, complaints and allegations that are undertaken by HealthHarmonie. The policy will be amended as necessary in the light of learning from such reviews.

8. Related policies

Whistleblowing policy

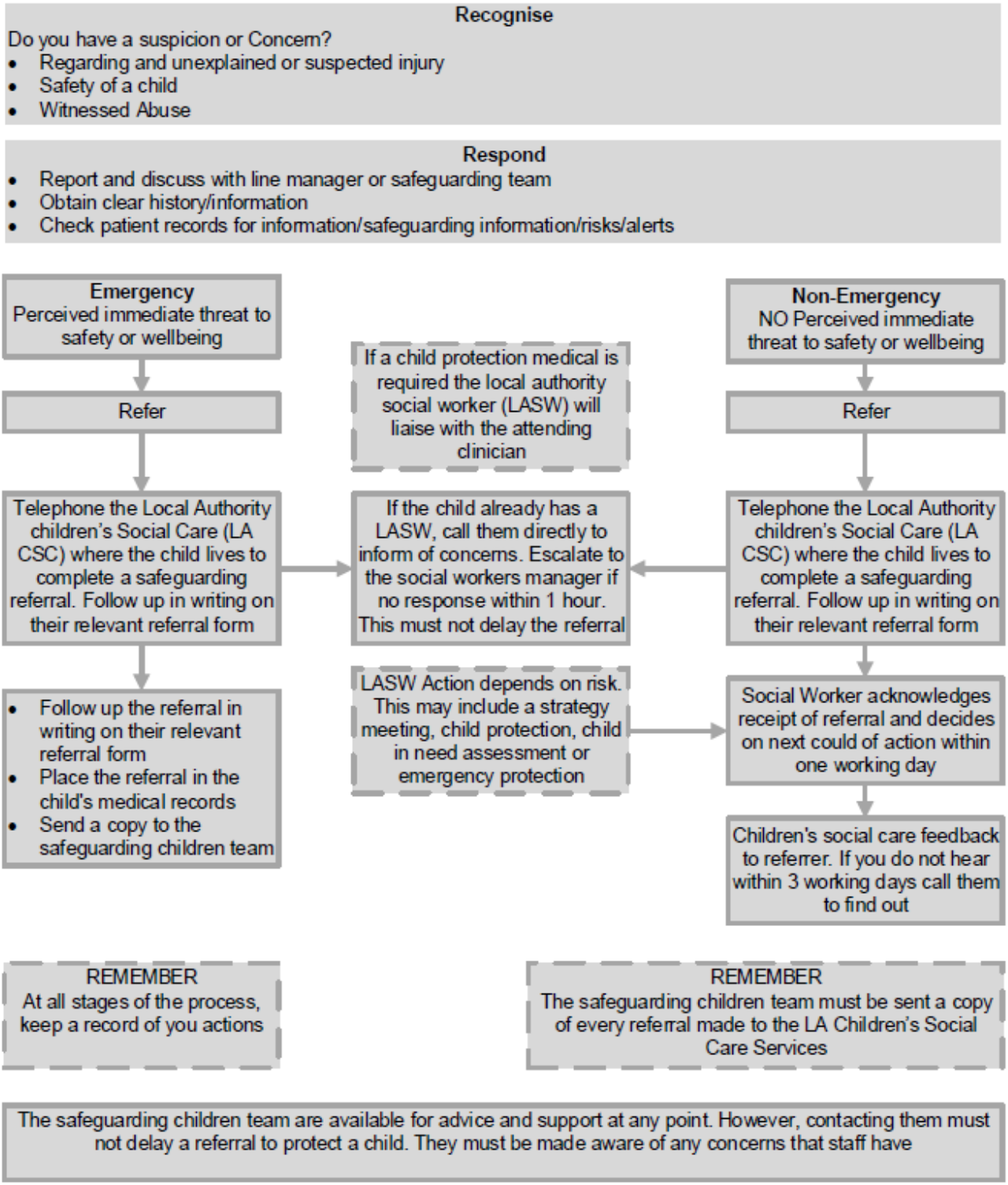
Consent policy

Chaperone policy

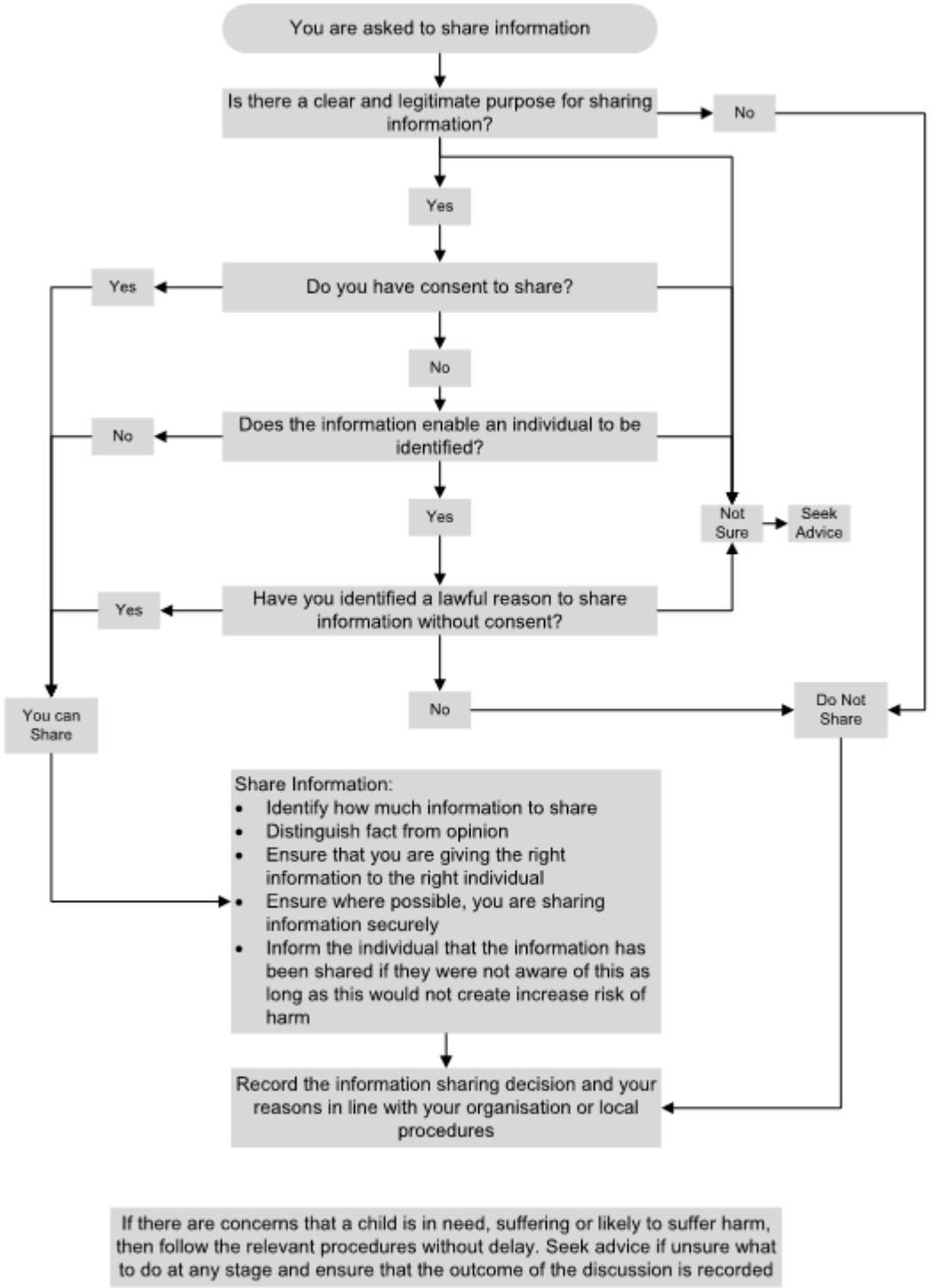
Recruitment and selection policy

Prevent policy

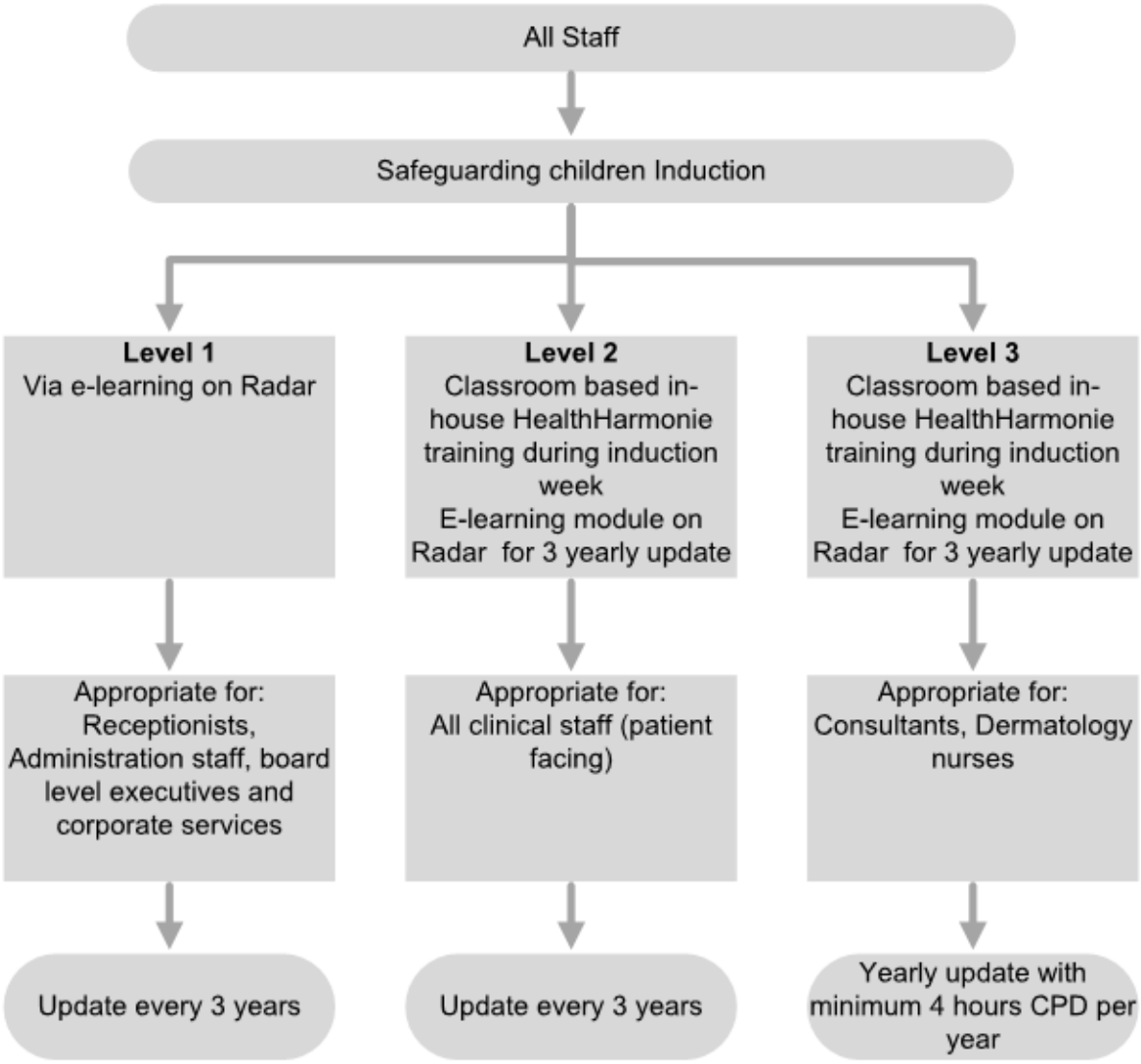
Appendix 1. Reporting concerns process



Appendix 2 Sharing Information Process



Appendix 3 Training matrix



9. Version Control

Version	Date	Author	Amendment(s)	Approved By
V2.0	17/11/2019	Mariann Mckay	Supersedes all other versions of Safeguarding Children Policy	Nicole McQueen
V2.1	08/09/2021	Mariann Mckay	Format changes only	Natalie Shield Head of Quality