BrisDoc Patient care by people who care

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Safeguarding Policy

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Introduction

Safeguarding is everybody's business. Keeping vulnerable people safe is at the core of "patient care by people who care".

The Safeguarding policy is intended for implementation by all BrisDoc employees, both clinical and non-clinical. It also applies to self-employed contractors. The policy has guidance on BrisDoc processes for Safeguarding Adults at Risk, Safeguarding Children, Prevent, Female Genital Mutilation and Non-mobile Baby Injury (NMBI).

Safeguarding can be wide-ranging, complex and difficult. Signs can be obvious or much more subtle. Serious safeguarding cases are thankfully rare, but "soft" signs can be the harbinger. All staff must be eternally vigilant.

Safeguarding in Brisdoc

This can be defined as a contribution to the protection of children and adults from abuse and neglect using the specific skills, resources and capacity available in general practice by

- Implementing professional safeguarding responsibilities which includes continual professional development in safeguarding
- Preventing abuse and neglect
- Identifying abuse and neglect
- Responding appropriately to abuse and neglect, including supporting victims and survivors of abuse
- Having governance systems and processes in place to support safeguarding
- Working collaboratively with other health colleagues, safeguarding partners and agencies.

Further guidance is available on the Royal College of General Practice Standards for General Practice (2024)

Your responsibility

Everyone in Brisdoc has a responsibility for safeguarding and each member of staff plays a crucial role.

Further guidance is available on the Royal College of General Practice Standards for General Practice (2024)and Bristol, North Somerset and South Gloucestershire (BNSSG) Remedy Adult Safeguarding and Child Safeguarding.

Clinical Staff

All regulated clinical staff have safeguarding roles and responsibilities set out in guidance from relevant professional regulators (for example, General Medical Council, Nursing and Midwifery Council, General Pharmaceutical Council, Health & Care Professions Council). All staff should have their safeguarding duties and responsibilities outlined in their terms of employment.

Administrative staff / Operational staff / Reception staff

Each service within Brisdoc will have their own unique way of how they handle information coming into the practice.

Front line, reception and operational play a key role in safeguarding as they may be ideally placed to raise a concern.

In the first instance, please act as appropriate with the safeguarding concern to hand. If there is uncertainty about next steps, then please discuss the concerns with a senior colleague in a timely manner. You may want to follow this up with a discussion with your manager later. Concerns can also be discussed with the Safeguarding Leads within each service.

Practice Manager / Head of Service

The Practice Manager or Head of Service are integral to effective safeguarding within the organisation. This role is integral to embedding a robust safeguarding ethos and culture including safe recruiting and management of any safeguarding concerns raised about staff members. The Practice Manager / Head of service must strive to empower all staff members to raise any safeguarding concerns they have about either patients of staff.

The Practice or Organisational Safeguarding Lead

The practices have a Safeguarding Lead with designated responsibilities outlined in the Appendices of this policy.

The Named Safeguarding Lead for Brisdoc is the Medical Director and delegated responsibility sits with the Director of Nursing, AHPs and Governance.

- Rhys Hancock – Director of Nursing & AHPs and Governance – rhys.hancock1@nhs.net

Governance Team

Brisdoc has a dedicated governance team to ensure stringent clinical governance and safeguarding processes are followed. They can be contacted on this email Brisdoc.governance@nhs.net

Your Well Being

Dealing with safeguarding cases can be emotionally and mentally difficult for individuals to work with and may impact you and colleagues. Please consider accessing the well-being service run by the People Team:

The Staff Wellbeing Hub – Radar (radar-brisdoc.co.uk)

Service and Training Specific SOPs

Severnside IUC

This appendix outlines the process for recording a safeguarding concern within Severnside Integrated Urgent Care and explains the monitoring and reporting process for the organisation.

There are also instructions on how to download the cases from Cleo onto the Safeguarding Spreadsheet.

Please see Appendix - SevernSide Safeguarding.

Broadmead Medical Centre

This appendix outlines the process for managing safeguarding concerns and safeguarding referrals within the Practice and how they are documented, reported to the Safeguarding Lead and monitored.

Please see Appendix - Broadmead Medical Centre Safeguarding.

Charlotte Keel

This appendix outlines the process for managing safeguarding concerns and safeguarding referrals within the Practice and how they are documented, reported to the Safeguarding Lead and monitored.

Please see Appendix - Charlotte Keel Safeguarding.

Homeless Health Service

This appendix outlines specific considerations regarding safeguarding for the Homeless Health Service as well as reporting safeguarding concerns and monitoring safeguarding referrals.

Please see Appendix - Homeless Health Safeguarding.

Safeguarding Training

This appendix outlines the Level 3 Training requirement for employed clinicians. It details the recording process for clinicians and the management process for managers.

Please see Appendix - Safeguarding Training.

Information Governance Principles for Safeguarding

Record Keeping

All usual care should be applied in relation to record-keeping. When safeguarding concerns (or potential concerns) arise during (or after) a consultation, the record kept must be as full as possible. Ask for a detailed account of events and record it, where necessary quoting verbatim.

Record the full names and roles of all those involved (where children are concerned, record the parents 'or carers' dob too). Record your concerns and their reasons, and any mitigating factors. Record by name any sources of advice. The record should be accurate and clear, and factual.

BrisDoc maintains a central record of all safeguarding activity in line with national reporting requirements.

BrisDoc will also ensure audits for safeguarding are performed annually in the schedule defined by the audit framework.

Sharing Information

BrisDoc supports external safeguarding investigations by providing additional information in a confidential, sensitive, and timely manner following the Data Protection, Confidentiality & Disclosure Policy.

Data Protection, Confidentiality & Disclosure Policy – Radar (radar-brisdoc.co.uk)

Please consider the following when asked for information about a child or family or an adult at risk:

Identity – check identity of the enquirer to see if they have a bona-fide reason to request information. Call the switchboard or ask for an email with credentials.

Purpose – ask about the exact purpose of the inquiry. What are the concerns?

Consent – is it a situation where a child needs to be protected? If it is, you should not delay while consent to share information is sought. If it is not, then you would normally wait for the informed consent of the child/ young person (as appropriate), or the person with parental responsibility/ carer.

Need-to-know basis – give information only to those who need to know.

Proportionality – give just enough information for the purpose of the enquiry, and no more. This may mean relevant information about parents/carers.

Keep a record – make sure that you record the details of the information sharing, including the identity of the person you are sharing information with, the reason for sharing and whether consent has been obtained and reason if no consent is obtained.

Safeguarding Adults at Risk

Introduction

The statutory guidance describes adult safeguarding as 'protecting an adult's right to live in safety, free from abuse and neglect'.

The intention of this section of the policy is to identify adults at risk, types of abuse, what to do if abuse is suspected, and roles and responsibilities in the safeguarding process.

Legislation

There are five main pieces of legislation that form the backbone of Adult Safeguarding:

- Human Rights Act (1998) states that every person living in UK has the right to live a life free from abuse and neglect. Under this Act, public agencies have a duty to intervene proportionately to protect the rights of citizens.
- The Care Act (2014) is the national legislation regarding safeguarding and Safeguarding Adults Board.
- The Mental Capacity Act (2005) helps and protects people who have limited mental capacity to make decisions. This includes people who have limited capacity due to illness, injury, or disability.
- Depravation of Liberty Safeguards (DoLS) (2014) protects adults in hospital or care home who may be deprived of their liberty.
- Domestic Abuse Act (2021) increases awareness, promotes standards and best practice.

Aims of Adult Safeguarding

The aims of safeguarding under the Care Act (2014) are both reactive and proactive:

- To prevent harm and reduce the risk of abuse or neglect to adults with Care and Support needs
- To stop abuse or neglect wherever possible
- To safeguard adults in a way that supports them to make choices and have control about the way they want to live
- To promote an approach that concentrates on improving life for the adult(s) concerned
- To raise public awareness so that communities, alongside professionals, play their part in preventing, identifying, and responding to abuse and neglect
- To provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and well and what to do to raise a concern about the safety or wellbeing of themselves of another adult
- To address what has caused the abuse or neglect

Principles of Adult Safeguarding

The Care Act statutory guidance defines six principles that should underpin all safeguarding functions, actions, and decisions. Each principle is accompanied by its own 'I' statement clearly explaining what the principle would feel like in action to an adult affected by a safeguarding matter. Often the principles are referred to solely as 'I' statements.

Principle	Meaning	I statement…
Empowerment	People being supported and encouraged to make their own decisions and informed consent.	"I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens"
Prevention	It is better to act before harm occurs.	"I receive clear and simple information about what abuse is,

		how to recognise the signs and what I can do to seek help"
Proportionality	The least intrusive response appropriate to the risk presented.	"I am sure that the professionals will work in my interest, as I see them, and they will only get involved as much as needed"
Protection	Support and representation for those in greatest need.	"I get help and support to report abuse and neglect. I get help so that I can take part in the safeguarding process to the extent to which I want"
Partnership	Local solutions through services working with their communities. Communities have a part to play in preventing, detecting, and reporting neglect and abuse.	I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me"
Accountability	Accountability and transparency in delivering safeguarding.	"I understand the role of everyone involved in my life and so do they"

Accountability for Adult Safeguarding

Safeguarding is everyone's business, and each individual is responsible for their actions and omissions. Accountability rests with BrisDoc's Medical Director, with delegated accountability to the Director of Nursing, AHPs and Governance. This is then delegated to the Safeguarding Lead within each individual BrisDoc service. These individuals are also the Prevent Leads for their business service.

Their duties include:

- Identifying multi-agency practice issues to be addressed by Safeguarding Adults Partnership Board (SAPB) members
- Representing BrisDoc services at SAPB meetings as required
- Maintaining a central record of all adult safeguarding activity in line with national reporting requirements (practice registers or the governance database)
- Supporting the adult safeguarding investigation process by providing advice and guidance from an NHS perspective
- Providing support and advice to BrisDoc co-owners regarding adult protection, which may include offering one to one supervision
- Ensuring referrals are made appropriately by the clinician identifying the concern
- Following up referrals as appropriate
- Ensuring referrals are recorded in a register/record or the governance database
- Undertaking audits that review the efficacy of the implementation of this policy

Who is an Adult at risk?

An adult at risk is an individual aged 18 years and over who has needs for care and support (whether or not the local authority is meeting any of those needs) **AND**;

is experiencing, or at risk of, abuse or neglect,* **AND**;

because of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

**** Consideration needs to be given to several factors; abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented to or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it.***

Safeguarding Adults Multi – Agency Policy (Safeguarding Adults Board in BANES, Bristol City, North Somerset, South Gloucestershire, and Somerset, 2019)

Categories of Adult abuse and harm

Abuse is a violation of an individual's human and civil rights by another person or persons. It can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it. Any or all of the following types of abuse may be perpetrated as the result of deliberate intent, negligence, omission or ignorance.

Please refer to Remedy Adult Safeguarding

Physical

Physical abuse includes assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions including female genital mutilation. BNSSG Remedy has guidance on non-fatal strangulation for adults and adolescent patients within 4 weeks or are presenting beyond 4 weeks but are symptomatic.

Sexual

Sexual abuse includes including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.

Emotional/psychological/mental

Emotional / psychological abuse includes emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.

Neglect and acts of omission

Neglect and acts of omission include ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating

Financial or material abuse

Financial or material abuse includes theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

Discriminatory

Discriminatory abuse includes forms of harassment, slurs or similar treatment because of race, gender and gender identity, age, disability, sexual orientation or religion.

Organisational or institutional

Organisational or institutional abuse includes neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice because of the structure, policies, processes and practices within an organisation.

Self-neglect

Self-neglect includes his covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

Domestic abuse (including coercive control)

This includes controlling behaviour, non-fatal strangulation, Organised Drug-Facilitated Sexual Assault, psychological, physical, sexual, financial, emotional abuse. So called 'honour' based violence and forced marriage. Also consider Medication and safeguarding considerations.

Please see Remedy for more information.

Modern slavery

Modern Slavery encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.

For more information please see RCGP Safeguarding Toolkit.

Making safeguarding personal

The following section explains the importance of making safeguarding user-specific and how to ensure this is done.

- The aim will be to support and minimise distress to any abused person
- Adults are considered autonomous and will be presumed to be able to make their own decisions unless it is proved that they are unable to do so.
- All Adults at Risk have the right to be protected and their decisions respected, even if that decision may place them at risk - assuming they have the mental capacity to make these specific decisions.
- All services will be provided in a manner that respects the rights, dignity, privacy and beliefs of all individuals concerned and will not discriminate on the basis of race, culture, religion, language, gender, disability, age or sexual orientation.
- Witnesses and those who disclose allegations of abuse will be treated sensitively and supported at all stages of an investigation.
- The importance of professionals working in partnership with the abused person and others involved will be recognised throughout the process.
- The responsibility to refer the person thought to be at safeguarding risk rests with the person who has the concern, although BrisDoc recognises that in certain settings, such as Integrated Urgent Care service, it can be very difficult to gauge the level of concern at times. If advice is needed, the case can be discussed with the Clinical Co-ordinator, Safeguarding Lead, or any senior clinician.
- BrisDoc recognises the value of acting on suspicion/gut feel/hunches and supports discussion with experts in the Emergency Duty Team (EDT) or Safeguarding Teams at this point to ascertain if the patient is “already known” or would benefit from a referral.
- Vulnerable adults have the right to have an independent advocate if they wish

Please refer to common themes and learning BNSSG Remedy

Mental Capacity

The Mental Capacity Act (2005) underpins the Safeguarding Policy. An adult at risk must have the ability to agree and provide informed consent to their safety, well-being, and any subsequent decisions regarding the potential safeguarding threat and a future plan.

A person’s capacity may be affected by factors such as learning disability, dementia, mental health needs, acquired brain injury and physical ill health. Most adults can make their own decisions, given the right support and right conditions.

The Mental Capacity Act sets out a two-stage test of capacity:

1) Does the person, making a decision, have an impairment of their mind or brain, whether as a result of illness, or external factors such as alcohol or drug use?
2) Does the impairment mean the person is unable to make a specific decision when they need to? It may be that a person can have capacity to make some decisions, but not have capacity to make others. Furthermore, mental capacity to make decisions can fluctuate with time, some individuals may be able to decide later at a future point in time. This may be an appropriate course of action if, for example, an individual is intoxicated or has a reversible infection and accompanying confusion.

The Law states that assessment of an individual's mental capacity to make a specific decision must entail consideration of the person's ability to:

- **Understand** information regarding the decision
- **Remember** the information for long enough
- **Think** about / weigh up the information and their options
- **Communicate** a decision

There are five key principles within the Mental Capacity Act (2005)

- **A presumption of capacity** – every adult has the right to make their own decisions and must be assumed to have capacity unless it is proved otherwise
- The right for individuals to be **supported** to make their own decisions – people must be given all appropriate help before anyone concludes that they cannot make their own decisions
- That individuals must retain the right to make what might be seen as **eccentric** or **unwise** decisions
- Best interests – anything done for or on behalf of people without capacity must be in their **best interests**
- **Least restrictive** intervention – anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms

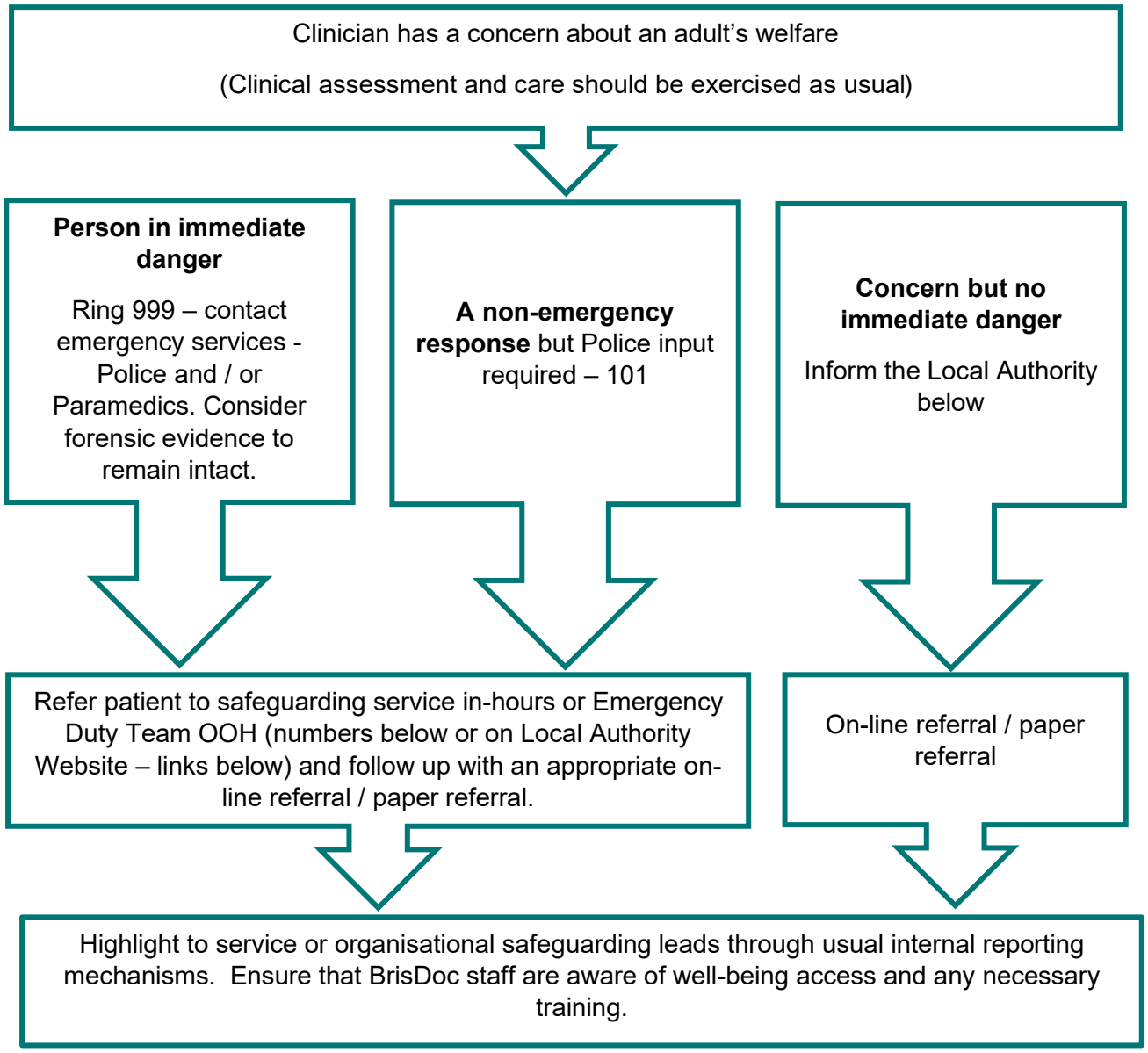
The Mental Capacity Act applies to all carers and clinicians. It is imperative that all clinical staff are aware of and able to conduct a mental capacity assessment. All decisions made by BrisDoc staff for Adults at Risk must have Mental Capacity Act (2005) acknowledged within the assessment.

An Independent Mental Capacity Advocate (IMCA) is an advocate used for people who lack capacity to make important decisions and have no one to speak on their behalf. The IMCA's role is to support and represent the person in the decision-making process and ensure that the Mental Capacity Act is being followed.

Please consider using the BNSSG Integrated Care Board Safeguarding Information for GPs and Primary Care Staff for updated guidance on Adults Safeguarding Practice Protocol.

Safeguarding information for GPs and primary care staff - NHS BNSSG ICB

How to report suspected adult abuse



Reporting to Social Care Safeguarding Team

	In hours	Out of Hours
Bristol	www.bristol.gov.uk/social-care-health/report-suspected-abuse-safeguarding-adults-at-risk 0117 922 2700	Emergency Duty Team (EDT) 01454 615165
North Somerset	Adult Safeguarding Board | Adult Safeguarding Board (nssab.co.uk) 01275 888801	01454 615165
South Gloucestershire	01454 868007 Category: Adults | SafeguardingSouth Gloucestershire Safeguarding (southglos.gov.uk)	01454 615165

Possible allegation against a Co-owner

There may be occasions when abuse by a co-owner or a contracted provider is alleged. Where this is the case, it is important that a senior manager is informed, verbally or by email, as soon as possible. This will enable any decisions to be made at a senior level about the possible actions required to safeguard everyone involved. The senior manager will liaise with HR (and others as needed) and the relevant BrisDoc policy should be followed.

Prevent

Prevent is the multi-agency suite of arrangements aimed at preventing individuals and groups from engaging in violent extremism. The Channel Panel is the multi-agency mechanism that oversees and co-ordinates Prevent interventions. The Panel has a statutory basis under the terms of the Counterterrorism and Security Act 2015. These arrangements are applicable to children and adults.

ICB BNSSG guidelines on Prevent as follows:

PREVENT (Remedy BNSSG ICB)

Introduction to Prevent

Healthcare professionals will meet and treat people who may be vulnerable to being drawn into terrorism. This is a complex area. Being drawn into terrorism can include both violent extremism and non-violent extremism, which can create an atmosphere conducive to terrorism and can popularise extreme views.

Aims of Prevent

Prevent aims for the healthcare sector to be aware of signs that possibly someone has been, or is being, drawn into terrorism. The healthcare worker has an awareness to recognise those signs and is aware of available support. Preventing someone from being drawn into terrorism can be comparable to safeguarding in other areas, including child abuse or domestic violence.

Principles of Prevent

People with mental health issues or learning disability may be more easily drawn into terrorism. The term extremist rationale (referred to as a narrative) is used to influence views, particularly in vulnerable individuals. Prevent is an ongoing initiative and designed to become part of the everyday safeguarding routine for NHS staff.

What factors might make someone vulnerable?

In terms of personal vulnerability, the following factors may make individuals susceptible to exploitation. None of these are sufficient in themselves and therefore should not be considered in isolation, but in conjunction with the particular circumstances and any other signs of radicalisation:

Identity Crisis

Adolescents/vulnerable adults who are exploring issues of identity can feel both distant from their parents/family and cultural and religious heritage, and uncomfortable with their place in society around them. Radicalisers can exploit this by providing a sense of purpose or feelings of belonging. Where this occurs, it can often manifest itself in a change in a person's behaviour, their circle of friends, and the way in which they interact with others and spend their time.

Personal Crisis

This may, for example, include significant tensions within the family that produce a sense of isolation of the vulnerable individual from the traditional support structures of family life.

Personal Circumstances

The experience of migration, local tensions or events affecting families in countries of origin may contribute to alienation from UK values and a decision to cause harm to symbols of the community or state.

Unemployment or under-employment

Individuals may perceive their aspirations for career and lifestyle to be undermined by limited achievements or employment prospects. This can translate to a generalised rejection of civic life and adoption of violence as a symbolic act.

Criminality

In some cases, a vulnerable individual may have been involved in a group that engages in criminal activity or, on occasion, a group that has links to organised crime and be further drawn to engagement in terrorist-related activity.

Grievances

The following are examples of grievances which may play an important in the early indoctrination of vulnerable individuals into the acceptance of a radical view and extremist ideology:

- Ideology and politics
- Provocation and anger (grievance)
- Need for protection
- Seeking excitement and action
- Fascination with violence, weapons and uniforms
- Youth rebellion
- Seeking family including father substitutes
- Seeking friends and community
- Seeking status and identity

BrisDoc Responsibility for Prevent

All staff (including bank/seconded staff/volunteers and self-employed clinicians) have an individual duty of responsibility to ensure that they:

- Attend Prevent training relevant to their role once every three years.
- Identify people who could be considered vulnerable to radicalisation and being drawn into violent extremism
- Be aware of the support which is available and be confident in referring people into Prevent Case Management/Channel processes and providing them with appropriate clinical support
- Report any such case as a Learning Event
- Ensure that the Prevent policy and procedures are followed and understood as appropriate to each staff member's role and function.

This information must be given to all new staff on induction along with an explanation of referral process for individuals considered vulnerable to radicalisation

How to report a concern for Prevent

If a member of staff has concerns that a patient or carer:

- May be at risk of being drawn into terrorism,
- Has begun to express radical extremist views or
- May be vulnerable to grooming or exploitation by others

The primary point of contact will be the Safeguarding Lead for their service who will manage such enquires with support from the ICB Safeguarding Lead.

Where possible, such concerns should be discussed with the patient's own GP prior to referral.

If agreed that escalation is appropriate, this should be done by referring the person to the BNSSG Channel Panel on **0117 945 5539** clearly identifying the precise nature of the concerns.

Complete a safeguarding referral to the Local Authority, a Learning Event and highlight a safeguarding concern using the local SOP outlined in this policy.

Prevent and Channel factsheet - 2023 - Home Office in the media (blog.gov.uk)

Prevent Training

There are differing levels of Prevent training according to staff roles within BrisDoc. All staff must undertake Basic Prevent Awareness training. Patient-facing staff and those providing clinical care will undertake higher levels of training.

Basic Prevent Awareness Training:

Basic Prevent Awareness training should be repeated on a three-yearly cycle to ensure that individuals are up to date with current procedures and approaches.

The training compliance target for Basic Prevent Awareness should be in line the current national requirements for safeguarding training at 100%.

Staff requiring Level 1 Prevent training - All staff working in the health sector (non-patient facing).

Staff requiring Level 2 Prevent training - All non-clinical (HCAs and Receptionists) and clinical staff who have any contact with adults, children and young people and/or parents/carers.

Level 3 staff groups

All clinical staff working directly with adults, children and young people and/or their parents/carers.

Safeguarding Children

Introduction

Safeguarding and promoting the welfare of children is everybody's business. All BrisDoc staff who encounters children and families has a role to play.

The Safeguarding Children section of this policy applies to all children under the age of 18 years whether living with their families, in state care, or living independently.

Safeguarding and promoting the welfare of children is defined as:

- protecting children from abuse and maltreatment
- preventing harm to children's health or development
- ensuring children grow up with the provision of safe and effective care
- taking action to enable all children and young people to have the best outcomes.

Legislation and local guidelines

The Children Act (2004) – ensures that the interests of children are paramount in their welfare and safeguarding. Other relevant acts or guidelines are:

- Bristol Safeguarding Partnership Procedures (2020)
- Working together to safeguard children (DoE, 2023) – statutory guidance on inter-agency working to safeguard and promote the welfare of children.
- Single assessment framework (2014) guidance for professionals assessing needs of families for early help.
- Children and Social Work Act (2017) – sets out specific duties for local authorities and strengthens relationships of key agencies such Police and Clinical commissioning Groups.

Aims of Child Safeguarding

All BrisDoc staff have a responsibility for keeping children safe and all BrisDoc staff who encounter children and families have a responsibility to share information and identify concerns. BrisDoc staff should do their utmost to recognise signs of child abuse and know the process for communicating their concerns to ensure the safety of the child.

Principles of Child Safeguarding

A child-centred approach is fundamental to safeguarding and promoting the welfare of every child. A child-centred approach means keeping the child in central focus when making decisions about their lives and working in partnership with them and their families. All BrisDoc staff should understand that the welfare of children is paramount and that they are best looked after within their families, with their parents playing a full part in their lives, unless compulsory intervention in family life is necessary.

Special provision should be put in place to support dialogue with children who have communication difficulties, unaccompanied children, refugees, and those children who are victims of modern slavery and/or trafficking.

The safeguarding partnerships of Bristol, South Gloucestershire and North Somerset are responsible for developing local procedures and ensuring multi-agency training is available. The safeguarding partnerships have a role in scrutinising the safeguarding arrangements of statutory agencies and promoting effective joint working.

It is the responsibility of Children's Social Care (CSC) to investigate allegations of child abuse in conjunction, and with the participation of, other agencies. They also lead the Child in Need process.

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

Integrated Care Boards are required to employ a Named GP to advise and support GP Safeguarding Practice Leads. GPs should have a lead and deputy lead for safeguarding, who should work closely with the Named GP

The practice team are not responsible for investigating child abuse and neglect but they do have a responsibility for sharing information, acting on concerns and contributing to the 'child in need', 'child protection', and 'looked after children' processes.

Safeguarding Children Policy General Practice. There is an expectation that the practice team contribute to the 'early help' agenda. Children and their families who receive coordinated early help are less likely to develop difficulties that require intervention through a statutory assessment under the Children Act 1989. An Early Intervention assessment can be completed with the agreement of parents so that local agencies can work with the family to identify what help the child and family might need to reduce an escalation of needs that could require statutory intervention.

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

"Safeguarding" and "promoting the welfare of children" is defined as: • protecting children from maltreatment • preventing impairment of children's health or development • ensuring that children are growing up in circumstances consistent with the provision of safe and effective care • taking action to enable all children to have the best outcomes

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

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

"Significant Harm" is the concept introduced by the Children Act 1989 as the threshold that justifies compulsory intervention in family life in the best interests of children. It gives Local

Authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer, significant harm.

“Abuse” – this is a form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others. Abuse can take place wholly online, or technology may be used to facilitate offline abuse. Children may be abused by an adult or adults, or another child or children.

Please refer to RCGP Safeguarding toolkit and RCGP safeguarding standards for general practice

BrisDoc Responsibility for Child Safeguarding

Everyone who works with children has a responsibility for keeping them safe. No single practitioner can have a full picture of a child’s needs and circumstances and, if children and families are to receive the right help at the right time, everyone who encounters them has a role to play in identifying concerns, sharing information, and taking prompt action.

In order that organisations, agencies, and practitioners collaborate effectively, it is vital that everyone working with children and families, including those who work with parents/carers, understands the role they should play and the role of other practitioners. They should be aware of, and comply with, the published arrangements set out by the local safeguarding partners.

Who is higher risk in Child Safeguarding?

All children could be subject to abuse and all staff must be eternally vigilant. Practitioners should be particularly alert to the potential need for early help for a child who:

- is disabled and has specific additional needs.
- has special educational needs (irrespective as to whether they have a statutory Education, Health, and Care Plan)
- is a young carer.
- is showing signs of being drawn into anti-social or criminal behaviour, including gang involvement and association with organised crime groups.
- is frequently missing/goes missing from care or from home.
- is at risk of modern slavery, trafficking, or exploitation.
- is at risk of being radicalised or exploited.
- is in a family circumstance presenting challenges for the child, such as drug and alcohol misuse, adult mental health issues and domestic abuse.
- is misusing drugs or alcohol themselves.
- has returned home to their family from care.
- is a privately fostered child.
- has a parent/carer in custody.

Categories of Child abuse and harm

There are broadly four types of child abuse:

1. Physical Abuse

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces illness in a child. Please see Concerning Injuries in Mobile Children from BNSSG.

concerning injuries pathway (icb.nhs.uk)

Femail Genital Mutilation (FGM) is the partial or total removal of external female genitalia for non-medical reasons. It's also known as female circumcision or “cutting”. Please see Section on FGM on this document.

2. Emotional Abuse

Emotional abuse is the persistent emotional maltreatment of a child, such as to cause severe and persistent adverse effects on the child’s emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child’s developmental capability, as well as over-protection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying causing children to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

3. Sexual Abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative 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.

4. Neglect

Neglect is the persistent failure to meet a child’s basic physical and/or psychological needs, likely to result in the serious impairment of the child’s health or development. Neglect may occur during pregnancy, for example, as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to provide adequate food and clothing, shelter, including exclusion from home or abandonment, failing to protect a child from physical and emotional harm or danger, failure to ensure adequate supervision, including the use of inadequate caretakers, 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.

An aspect of neglect, or potential neglect, which can be challenging is delayed (or missed) vaccinations (and other routine checks) or, an in-the-moment parental refusal to agree to an intervention, such as bringing a child in to be seen face-to-face or to take a child to hospital.

Careful consideration should be given, especially in the latter situation, to the parent's rationale before 'a safeguarding flag is raised', and, where possible, alternative options should be explored and offered.

Particular attention may be given to adverse childhood experiences (ACE) as these experiences directly affect the way young people feel, behave and view the outside world. The impact of ACE may be result in an increased safeguarding risk much as the use of illicit drugs or low levels of mental health. The Integrated Care Board has an all age safeguarding team to assist with complex babies, your children and adolescent issues. The team have an understanding of trauma-informed care, an approach to care that recognises the widespread impact of trauma and provided an environment of healing and recovery.

Dog Bites

When managing dog bites, it is essential to take a pragmatic approach, exercising clinical judgment and common sense. Consider the possibility of inadequate parenting and supervision if a child has been bitten by an animal. Follow local policies for referring children deemed at risk, and consider a children's safeguarding referral if any of the following criteria are met:

- The injured child is under two years of age.
- The child is under five years of age, and injuries have required medical treatment.
- The child is over five years old and under 18 and has been injured by the same dog more than once.
- If parents or caregivers persist in leaving a baby or young child unattended with a dog after being advised not to.
- When the child or young person is under 18 years of age, and the injuries necessitate acute medical intervention, requiring referral to secondary services for further assessment and management if wound closure is deemed necessary.
- In cases of facial injuries.
- When parents or caregivers are suspected of exposing a child to or failing to protect a child from, a dog considered dangerous or prohibited., In **ALL** cases contact the Police at 101 for assistance.
- Any concerns regarding the mistreatment of a dog or maintaining inappropriate conditions for care in a household with children (or extended family) should lead to a referral to Children's Social Care and the RSPCA. This is due to the clear link between animal cruelty and the potential for child cruelty.

Safeguarding Children in the Presence of Dogs (proceduresonline.com)

Controlling your dog in public: Overview - GOV.UK (www.gov.uk)

Dangerous Dogs Act 1991 (legislation.gov.uk)

Disclosure of an allegation of abuse

If a child discloses information about abuse, whether concerning themselves or a third party, make an immediately referral direct to the relevant Local Authority. **Please see Reporting Child Safeguarding**.

It is important to also remember that it can be more difficult for some children to disclose. Children who have experienced prejudice and discrimination may well believe that people from other ethnic groups or backgrounds do not really care about them. They may have little reason to trust those they see as authority figures and may wonder whether BrisDoc staff will be any different.

Children with a disability will have to overcome barriers before disclosing abuse. They may well rely on the abuser for their daily care and have no knowledge of alternative sources of support. They may have come to believe they are of little worth and simply comply with the instructions of adults.

Responding to a child making an allegation of abuse

It is uncommon that children disclose abuse unprompted. However, if that occurs, or if a child responds to a question in such a way that abuse is disclosed, then it is crucial to listen and be supportive, whilst not making promises which cannot be kept:

- Stay calm
- If another person is present (e.g., friend, parent), ask the child if they prefer that person to stay in the room
- Listen carefully to what is being said
- Find an appropriate early opportunity to explain that it is likely the information will need to be shared with others – do not promise to keep secrets
- Allow the child to continue at his/her own pace
- Ask questions for clarification only, and at all times avoid asking questions that are leading or suggest a particular answer
- Reassure the child that they have done the right thing by telling
- If another person is present, seek to understand their knowledge of the situation
- Tell them what will be done next and with whom the information will be shared
- Record in writing what has been said using the child's own words as much as possible – note date, time, any names mentioned, to whom the information was given and ensure that paper records are signed and dated, and electronic subject to audit trails
- Do not delay in passing this information on

Please consider using the BNSSG Integrated Care Board Safeguarding Information for GPs and Primary Care Staff for updated guidance on The Safeguarding Team for more advice

How to Report a Child Safeguarding

Please use the numbers below for the First Response Team if you are concerned about the well-being of a child:

Child Protection Contact Numbers	In Hours	Out of Hours
Bristol	Advice about making a referral to First Response (bristol.gov.uk) 01179036444	01454 615165
North Somerset	01275 888808 Child protection and safeguarding | North Somerset Online Directory (n-somerset.gov.uk)	01454 615165
South Gloucestershire	01454 866000 Category: I am a professional | SafeguardingSouth Gloucestershire Safeguarding (southglos.gov.uk)	01454 615165

Please refer to Sirona Children's services for all community children's services

Community Children's Health Partnership	
Bristol	0300 125 6905 or Single Point of Entry Services – Children and Young People's Services
South Gloucestershire	0300 125 6905 or Single Point of Entry Services – Children and Young People's Services
North Somerset	0300 125 6905 or Single Point of Entry Services – Children and Young People's Services

Please consider using the RCPG Toolkit for safeguarding children and NICE guidelines on BNSSG – Integrated Care Board – Safeguarding information for GPs and Primary Care Staff

Safeguarding information for GPs and primary care staff - NHS BNSSG ICB

Responding to Concerns about a Child

If a member of staff who is not a health professional has concerns about a child, they should immediately, and while the child is still in the building, speak to the most senior health professional, whether nurse or doctor, who is on duty. The health professional will then assess the urgency of the situation and may need to examine the child and obtain more information from adults accompanying the child.

In the first instance, and if the risk to the child is not increased by doing so (situations such as Sexual Abuse or Fabricated & Induced Illness might increase risk; consult local guidance), the health professional will inform the child and accompanying carer/ parent that they need to discuss or report their concern.

Information will be passed to the appropriate Local Authority whether the child is being seen in an out of hours setting or at a BrisDoc practice.

When external authorities need to be contacted, the relevant details are below. Staff should contact the relevant Local Authority by telephone first unless the issue is more **immediate**, in which case the Police should be called on **999**. **Please see Reporting Child Safeguarding**:

Non-Mobile Baby Injury (NMBI)

This guidance specifically applies to babies who cannot crawl, pull to standing or 'cruise' around furniture and who sustain injuries such as bruises, fractures, burns / scalds, eye injuries, bleeding from nose and mouth or bumps to the head.

On occasion an injury is reported, but there is no physical sign, or a mark is noted for which there is no apparent injury. If the patient in either of these circumstances is a non-mobile baby, then the policy should be consulted and followed where appropriate.

As these situations are often 'grey areas', there should be a low threshold for consulting a senior colleague.

BNSSG has provided multi professional guidance for non-mobile baby injuries.

The aim of this Guidance is to ensure that professionals:

- are aware that even minor injuries could be a pointer to serious abuse in non-mobile babies
- -know that such injuries, however plausible, must routinely lead to multi-agency information sharing
- -support professionals to identify potential concerns and make referrals as appropriate

This guidance is to guide the management of well babies presenting with an isolated bruise. If practitioners are concerned about the baby's immediate health they should follow usual procedures in seeking urgent medical assistance

non-mobile-baby-injury-policy-july-2023.pdf is within the BNSSG Remedy Safeguarding children referrasl and procedures. The page contains a useful table for concerning injuries in mobile children.

Severnside IUC NMBI guidance

This guidance was specifically created for Out of Hours Clinicians to ensure that correct process and procedures are followed out of hours of primary care.

Non-Mobile Babies Injuries – BrisDoc Clinical ToolKit

Training for NMBI

NMBI training is covered within Safeguarding Children training and during induction of IUC staff specifically addressing NMBI in the context of out of hours primary care.

concerning injuries pathway (icb.nhs.uk)

ICON

The ICON programme and subsequent interventions are to prevent abusive head trauma by carers in very young babies and neonates. Research points to persistent crying in babies being a potential trigger for some parents/caregivers to lose control and shake a baby. It also shows

that around 70% of babies who are shaken are shaken by men. So any prevention programme should include male caregivers and use the best opportunities to reach them as well as support all parents/caregivers with information about crying and how to cope with a crying baby.

Professionals - ICON Cope

ICON – stands for **i**nfant crying is normal, **c**omforting methods can help, its **O**K to wlk away and **n**ever, ever shake a baby.

Icon has resources for parents and is part of a touchpoint programme for midwives, health visitors and GPs in those first 12 weeks of bringing a young baby home. However, the research indicates that any professional involved with babies should provide opportunistic support / advice using the free resources on the website.

Female Genital Mutilation

Introduction

Female Genital Mutilation (FGM) is a criminal offence and a form of violence against women and girls. Cases should be dealt with as part of existing policies and procedures on Adult and Children safeguarding. There are some particular characteristics of FGM that front-line professionals should know to ensure that appropriate support and protection is provided.

What is FGM?

FGM is illegal in the UK.

FGM is a procedure where the female genital organs are surgically changed with no medical benefit or clinical rationale. It can a traumatic act for the recipient of FGM and may have long term medical, social and emotional consequences. The practice may cause severe pain and there may be immediate and/or long-term health consequences. On occasion FGM can be fatal. Other consequences can include chronic pain, sexual difficulties, relationship problems, mental health problems, difficulties in childbirth which themselves can cause harm leading to long term problems. The age at which FGM is carried out varies enormously according to the community. The procedure may be carried out shortly after birth, during childhood or adolescence, just before marriage or during a woman's first pregnancy.

FGM in Children

It is mandatory to report children or young people under the age of 18 who have had or are at risk of FGM. This may mean an observation of physical signs of FGM or a disclosure of FGM which you must report to the Police on 101. If a child is at risk of FGM, then an urgent safeguarding referral must be made.

FGM Professional Guidance for identifying children at risk.

FGM in children (<18) (Remedy BNSSG ICB)

FGM in adults (18 years and over)

Adults who have identified as having FGM should have access to high quality and sensitive healthcare and education. The services of the police, social care and voluntary sector services must underpin all interventions.

FGM is often an embedded social norm, therefore engagement with families and communities plays an important role in contributing to making it a questionable part of a culture.

The Rose clinic is a community-based service in Bristol that provides specialist care and support for women experiencing problems due to FGM.

Female Genital Mutilation (Remedy BNSSG ICB)

There is further guidance in the Department of health guidance of FGM:

Safeguarding women and girls at risk of FGM - GOV.UK (www.gov.uk)

Please discuss with your local Safeguarding Lead and follow local reporting process for Adults and Children Safeguarding.

Training for FGM

Training for FGM is mandatory for all clinicians and need to be completed every three years on-line. Non-clinical staff will be updated and made aware of developments via team meetings and newsletters.

Appendices

BrisDoc Patient care by people who care

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SevernSide Safeguarding

Version:	Owner:
2.6	Lynn Haywood (Lead Clinical Practitioner)

Broadmead Safeguarding SOP

Introduction

This Standard operating procedure (SOP) outlines the safeguarding process for adults and children accessing the Severnside Integrated Urgent Care service (IUC). This service incorporates the System Clinical Assessment Service (CAS), Mental Health Clinical Assessment Service (CAS), Weekday Professional Line (WPL) and the IUC Out of Hours (OOH).

This SOP sets out the process for alerting the Severnside Safeguarding team that a safeguarding (SG) concern has been identified during a consultation or that a presenting case has an existing Safeguarding (SG) concern.

This SOP should be read in conjunction with Brisdoc Safeguarding Policy and all staff should complete their safeguarding training as per training matrix.

Objectives of the Standard Operating Procedure

To standardise the process of reporting Safeguarding concerns and ensuring that the SGL is sighted on individual concerns and to help identify where there may be a theme or pattern of concern (for example, multiple concerns for patients living in the same address). This also allows an overview of themes within the BNSSG in the Out of Hours (OOH) period and ensures that our most vulnerable patients are identified and supported.

Safeguarding Leads

	Safeguarding Lead Severnside (SGL)	Supporting
ADULT	Lynn Haywood	Renuka Suriyaarachchi
CHILDREN	Lynn Haywood	Renuka Suriyaarachchi

Generating a safeguarding concern

Where a clinician identifies a new SG concern or that a SG concern exists, they should indicate 'yes' on the patients Cleo record when asked if they have a SG concern about the patient.

If the concern requires immediate action, the clinician should make a referral to the most appropriate SG service. It is essential that safeguarding referrals are completed by the clinician at the time of a consultation. The clinician should then indicate 'yes' to the 'Have you made a safeguarding referral for this patient?' question.

At the end of every consultation the following two questions will be asked:

- Do you have any safeguarding concerns relating to the current consultation?
- Have you made a safeguarding referral for this patient?

Where either of these questions has been indicated as 'yes', the case will be reviewed by the SG team every week. All safeguarding concerns cases will be reviewed by the end of the following week.

Clinicians are not required to complete a Learning Event for all concerns where the clinician feels the above process provides appropriate review of the case. If the clinician requires support and advice about the management of the case on shift, please speak to the Clinical Coordinator.

If the clinician would like to review the case with the SG Lead or if there are exceptional circumstances / learning relating to the case. a Learning Event form should be submitted, and the SG Lead or their manager will contact the clinician directly.

Where an operational staff member has a safeguarding concern, they should alert a clinical member of staff to seek advice. If a safeguarding incident is witnessed, a clinician should be immediately informed. After the event, operational staff members should complete a learning event to ensure the SG Lead is informed and that all follow up actions have been completed.

Safeguarding Audit

Extracting safeguarding Data from Cleo

Each week, a report will be run to extract all cases where either of the above questions have been marked as 'yes'. The case details will be added to a SG audit spreadsheet for the SG team to review. (See Appendix A). The data will be extracted weekly on a Monday.

Completing the safeguarding Audit

The SG team will review all referred cases on a weekly basis. This will involve reviewing the patients notes on Cleo, (perhaps Adastra retrospectively), EMIS and Connecting care to check that all SG concerns have been followed up with the appropriate action(s). The SG team may contact the patients GP, Social Services, Health Visitor, or local Police as part of the SG audit process.

All data will be recorded on the safeguarding audit spreadsheet. (See Appendix B)

Where a concern is found that has not been followed up with the appropriate action(s), the SG team will ensure that the actions are completed, and if appropriate, fed back to the clinician involved.

Monitoring

The SGL will review the cases of the SG Audit on a weekly basis to ensure that data fields are completed as expected and that any follow up actions are completed in accordance with the SG policy. The SGL will ensure that all safeguarding concerns are reviewed within the weekly timeframe.

Quality performance report

A monthly report will be submitted to the Head of Severnside IUC. The report will contain data on safeguarding training, the number of monthly cases of concerns reported for adults and children, trends for the number of concerns compared to the previous month and any narrative of note for the month.

Sharing Safeguarding Learning

Learning and trends from the safeguarding audit will be shared in Clinical Newsletters and Clinical Forums within Brisdoc.

Extracting safeguarding Data from Cleo

The Governance Team have access to a data tool from Cleo, the required dates are input into this first thing on a Monday morning. The data tool pulls all safeguarding cases, usually for the previous week. This is copied and pasted into the safeguarding audit spreadsheet.

Governance team to save and close the spreadsheet and email the SGL and LCPs to advise how many new cases have been added to spreadsheet for review.

The team will now review the list.

Dashboard Figures:

From the audit sample, count the number of ED Validation / 999 cases and enter the number onto to the following System CAS dashboard: S:\! System CAS\Dashboard /System CAS dashboard V1 WC 03.01.2022 (Input tab, row 118)

Safeguarding Audit Spreadsheet

CHARACTERISTIC	CONCERN	ISSUE
Baby		
	Organisational Abuse	Medication error Delayed presentation
	Psychological Abuse	Parental Mental Health
	Sexual Abuse	
	Domestic Abuse	Physical abuse Emotional Abuse Parental mental health
	Neglect	Failed contact Delayed medical presentation. Not registered with GP Poisoning (non-medical) Poisoning (medical) Parental mental health Prescribed meds not given Fall Poverty
	Physical Abuse	Harm from person Harm from animal Harm from other Harm from alcohol and drugs
	Contextual Abuse	
	Modern Slavery	Asylum / refugee other service.

	No SG concerns	Medical presentation Previous safeguarding Active safeguarding Attended other service. Injury
	Non-Mobile Baby Injury (NMBI)	
Child (Vulnerable/looked after/ learning disabilities)		
	Organisational abuse	Medication error Delayed presentation
	Psychological abuse	Mental health Self-harm Recreational drugs / alcohol Eating disorder Bullying behavioural
	Sexual Abuse	(none)
	Domestic Abuse	Physical abuse Emotional Abuse Coercion Parental mental health
	Neglect	Failed contact Delayed medical presentation. Not registered with GP Poisoning (non-medical) Poisoning (medical) Parental mental health Prescribed meds not given Poverty
	Physical Abuse	Harm from person Harm from animal Harm from other Harm from alcohol and drugs
	Contextual Abuse	None
	Modern Slavery	Asylum / refugee other service.
	No SG Concerns	Medical presentation Previous safeguarding Active safeguarding Attended other service. Injury
Adult (Vulnerable/ leaning Disability		
	Organisational abuse	Medication error Delayed presentation Physical injury Falls
	Psychological abuse	Mental health Self-harm Recreational drugs / alcohol Eating disorder

		Bullying behavioural
	Sexual abuse	FGM Assault
	Domestic abuse	Physical abuse Emotional Abuse Coercion Parental mental health
	Neglect	Failed contact Delayed medical presentation. Not registered with GP Poisoning (non-medical) Poisoning (medical) Parental mental health Prescribed meds not given Poverty
	physical	Harm from person Harm from animal Harm from other Harm from alcohol and drugs
	Contextual	
	Modern slavery	Asylum / refugee other service.
	No SG Concerns	Medical presentation Previous safeguarding Active safeguarding Attended other service. Fall

Additional notes:

Active Safeguarding Concern – Tick 'yes' if there are active safeguarding alerts/looked after child alerts on patients EMIS or Connecting Care notes.

Further Notes – Add additional comments in free text box. E.g., No SG concerns. F/U own GP etc

Additional Actions – Please document any outstanding actions connected to the case. E.g., GP surgery emailed, awaiting response.

Action Completed. Please complete once action completed, response received. Sign and record completion date.

HIU – High intensity user. Tick 'yes' if the patient is frequently contacting BrisDoc services.

Please contact Safeguarding team if any queries

Appendix Change Register

Date	Version	Author	Change Details
22/10/2019	1.0	SP	New SOP to outline new process
12/01/2022	2.0	SP	Updated to reflect addition to process

13/05/2022	2.1	JF	Reviewed & amended
19/10/2022	2.2	LM	Updated
01/02/2023	2.3	LM	Updated for new process
08/03/2023	2.4	LM	Updated the day change for when the audit needs to be run
25/04/2023	2.5	LM	Updated location of folder for the safeguarding audit data
13/06/2023	2.6	LH	Amended and rewritten to incorporate new safeguarding process
24/6/2025	2.7	RS	Added introductory paragraph and lead names

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Broadmead Medical Centre Safeguarding

Version:	Owner:
1.0	Jackie Wenden (Lead Nurse) & Jenny Schaefer (GP)

Broadmead Medical Centre Safeguarding SOP

Introduction

This SOP sets out the process for alerting the Safeguarding Lead (SGL) that a safeguarding, including Prevent, referral has been made and the process for managing safeguarding concerns for Adults and Children in the practice.

This SOP should be read in conjunction with Brisdoc Safeguarding Policy and all staff should complete their safeguarding training as per training matrix.

Objectives of the Standard Operating Procedure

To standardise the process of reporting Safeguarding concerns and ensuring that the SGL is sighted on individual concerns and to help identify where there may be a theme or pattern of concern (for example, multiple concerns for patients living in the same address). This is of relevance due to our large student population and population of migrants and asylum seekers.

The Standard Operating Procedure

When a clinician identifies that a safeguarding concern exists, they should discuss with the safeguarding lead in the practice.

	Safeguarding Lead BMC (SGL)	Supporting
ADULT	Dr Racheal Hardaker	
CHILDREN	Dr Racheal Hardaker	Jackie Wenden/Cally Slaughter

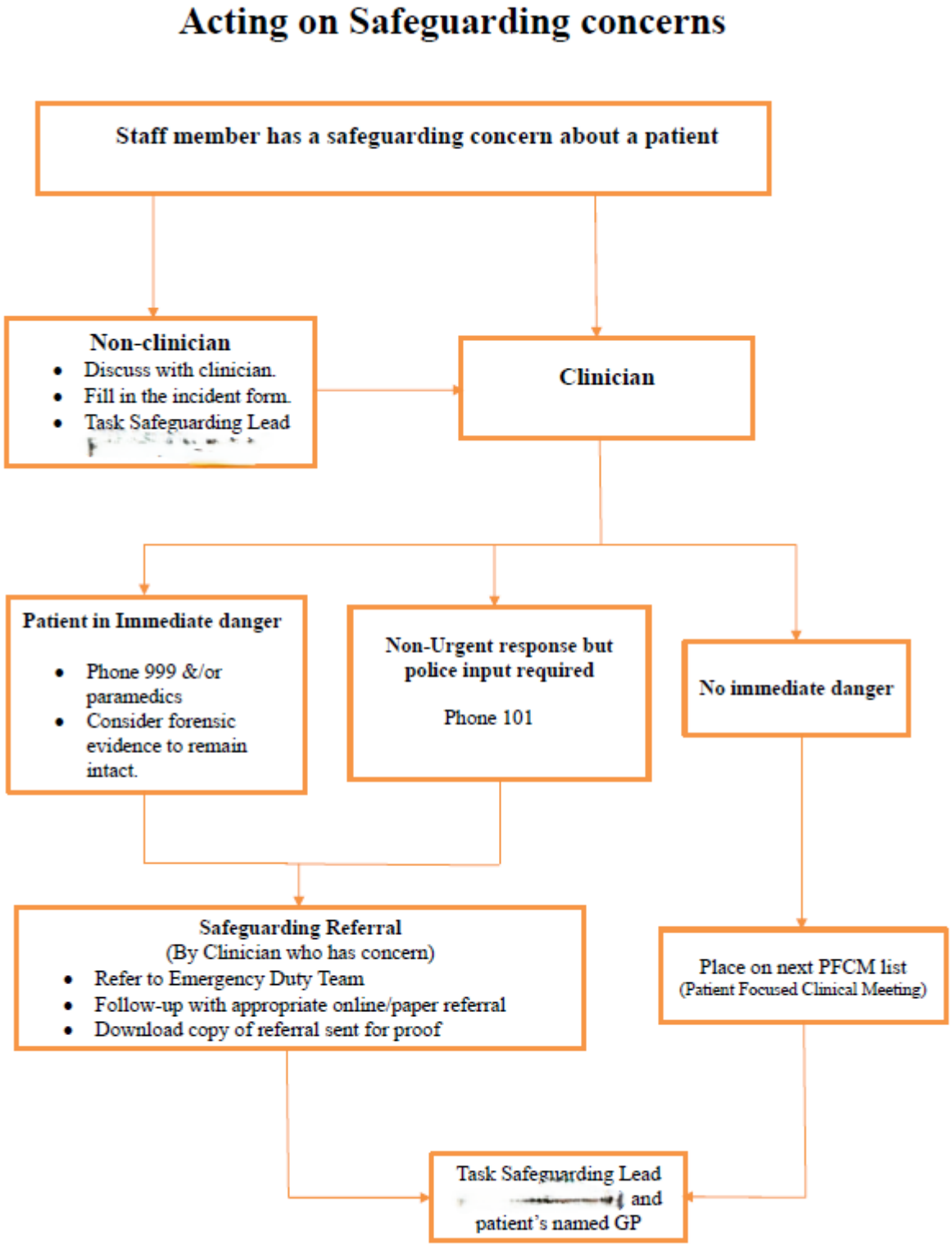
If the concern is an immediate one the clinician should make a referral to the most appropriate SG service, and it is essential that SG referrals are completed by the clinician at the time of a consultation and all records updated.

This may involve keeping the patient in the practice until a place of safety has been found.

If the concern is less immediate the patient can be added to the next clinical focus meeting for discuss or to Dr Schaefer's weekly safeguarding list, or a task sent to her and/or the named GP.

Where an operational staff member has a safeguarding concern, they should alert a clinical member of staff to seek advice. If a safeguarding incident is witnessed, a clinician should be immediately informed. After the event, operational staff members should complete an incident form to ensure the SGL has been informed at that all follow up actions have been completed.

The SGL (or deputy) will review cases on a weekly basis to check that all SG concerns have been followed up with the appropriate action(s), where a concern is found that has not been followed up with the appropriate action(s), the SG lead will ensure that actions are completed, and feedback is given to the clinician involved. All safeguarding information is recorded on EMIS.



Safeguarding Audit

SG audits will be completed on a 6 monthly basis by the SGL in Broadmead Medical Practice

Monitoring Audits

The governance team of Brisdoc Healthcare will review the audit process within Quality Board and will ensure they are completed in the agreed timeframe.

Appendix Change Register

Date	Version	Author	Change Details
04/10/2023	1.0	Jackie Wenden	New Appendix
24/06/2025	1.1	Renuka Suriyaarachchi	Update contact details

BrisDoc Patient care by people who care

Proudly employee owned.

Charlotte Keel Safeguarding

Version:	Owner:	Created:
V1.1	Jodie Godfrey (Nurse Lead) Dr Tahira Waraich (GP Lead) Jaci Monk (Nurse Lead) Jess Rowland (Coding only) Debbie Foss (Marac Requests Only)	06/03/25
Published:	**Approving Director:**	**Next Review**
22/04/2025	Rhys Hancock	22/09/2027

Safeguarding Children

Safeguarding Children leads at CKMP

GP lead (holding): Dr Andrea Priestley

Nurse lead: Jodie Godfrey

Safeguarding Adult leads at CKMP

GP lead: Dr Tahira Waraich

Nurse lead: Jess Rowland

Role of child & adult safeguarding leads

Act as a point of contact and support for practice members to bring any concerns they may have regarding safeguarding.

Keep up to date with training requirement for lead.

Attend 6 monthly Bristol Link GPs meeting (dates on Remedy)

Keep practice guidance and SOP up to date.

Disseminate info from meetings & communications to the practice team.

Ensure practice team are up to date with training (or work to ensure that Brisdoc HR complete taking on this process)

Take meeting notes and minute and record on Team net

Field queries from practice team on individual patient issues

Undertake (or delegate) audits as indicated in house or as requested by ICB safeguarding team.

Input into regular safeguarding case discussion meetings with GP team and at clinicians' meetings

Chase usual GP to provide an update if nil recent in notes.

Decide whether case should stay active or be moved to a past problem list.

Discuss patients of concern with the lead GP

Protected management time monthly to go through the safeguarding & vulnerable lists https://connectingcare.swcsu.nhs.uk/concerto/Login.htm

Child specific

Have a deeper understanding of the law relating to child protection as well as practice/BrisDoc/Primary Care Organisations policies and operating procedures.

Know and establish links with local child safeguarding agencies.

Field external e-mails/communications relating to Children's Safeguarding, assessing information promptly and carefully, clarifying or obtaining more information about the matter as appropriate.

Either contribute information or provide a written report in order to assist a safeguarding enquiry process (or support other staff to). It is possible that attendance at a child protection/ case conference or court proceedings may be required in order to share the information. (GPs may claim a fee for attendance at child protection conferences, under the Collaborative Arrangements for Work for Local Authorities 1974, to defray their expenses)

Keep an eye on registers of CKMP children on plans on connecting care and on EMIS & try to ensure they match.

Attend monthly meetings with Nurse Lead for Safeguarding Children and HVs & midwives

Take note of issues identified by Admin Assistant to Lead Nurse/workflow team who look at all incoming documentation relating to children to identify high risk presentations or recurrent lower risk presentations.

Important note: the Lead role is not to take on all the CP cases but to facilitate the usual GP to manage the case appropriately.

The Standard Operating Procedure – Nurse Lead Responsibilities:

Protected management time monthly to go through the children safeguarding & children at risk lists

Adult specific

Nomenclature – we use "adult safeguarding" codes for those few patients under the social services safeguarding team & "vulnerable adult" for the rest

Field external e-mails/communications relating to Adult Safeguarding

Keep an eye on registers of CKMP adults under social services safeguarding team on connecting care and on EMIS & try to ensure they match.

Attend 3monthly meetings with Safeguarding Adult Nurse Lead to discuss problem cases

Take note of issues identified by Admin asst to Lead Nurse/workflow team who look at all incoming documentation relating to adults to identify high risk presentations or recurrent lower risk presentations.

Safeguarding/Eary help referrals

Purpose

A consistent procedure for making a safeguarding/early help referrals and to ensure the referral is followed up and outcome recorded on patient records

Process for documenting and coding a safeguarding referral

Follow clinical protocol when deciding to make a safeguarding referral

Create a folder (if not done already) in your One Drive labelled “Patient forms” folder

Complete the online form:

Referral forms for care professionals Adults

Make a referral to First Response for professionals Children

Early help referral -Y:\Safeguarding\Childrens Safeguarding – Request for early help

Download the referral to your One Drive / Patient forms & fit notes folder

C:\Users\<username>\OneDrive - NHS\Patient forms

Submit the online form before navigating away from the website

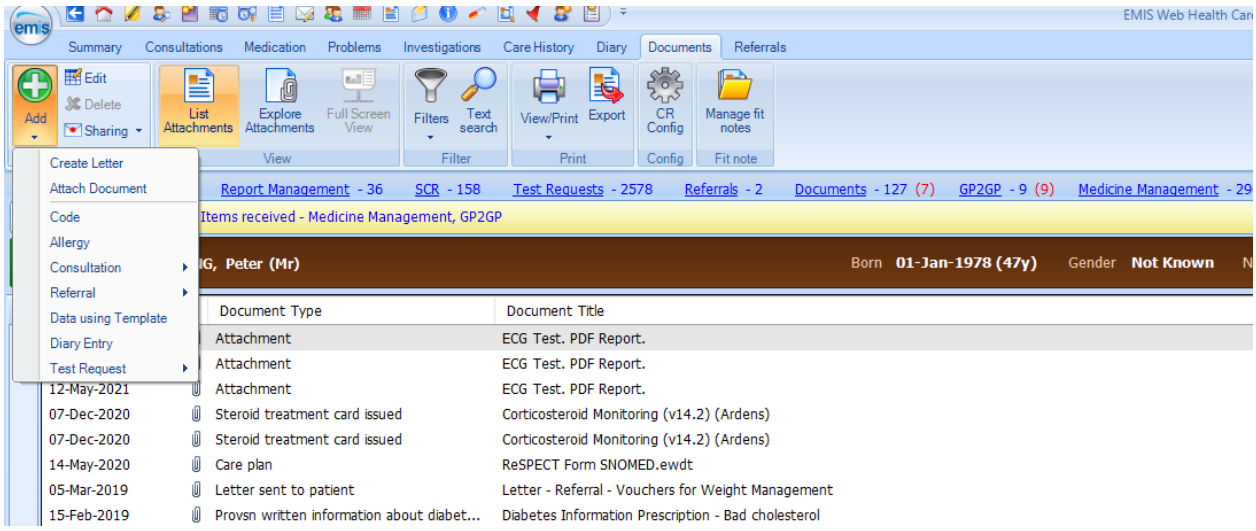
Upload the document to the patient record

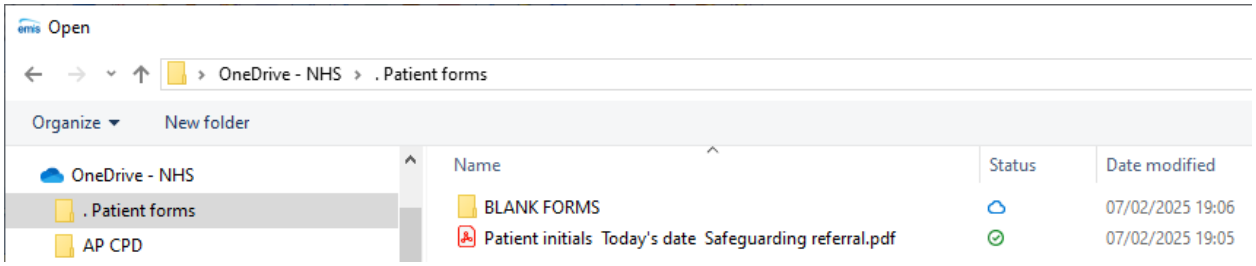
Type

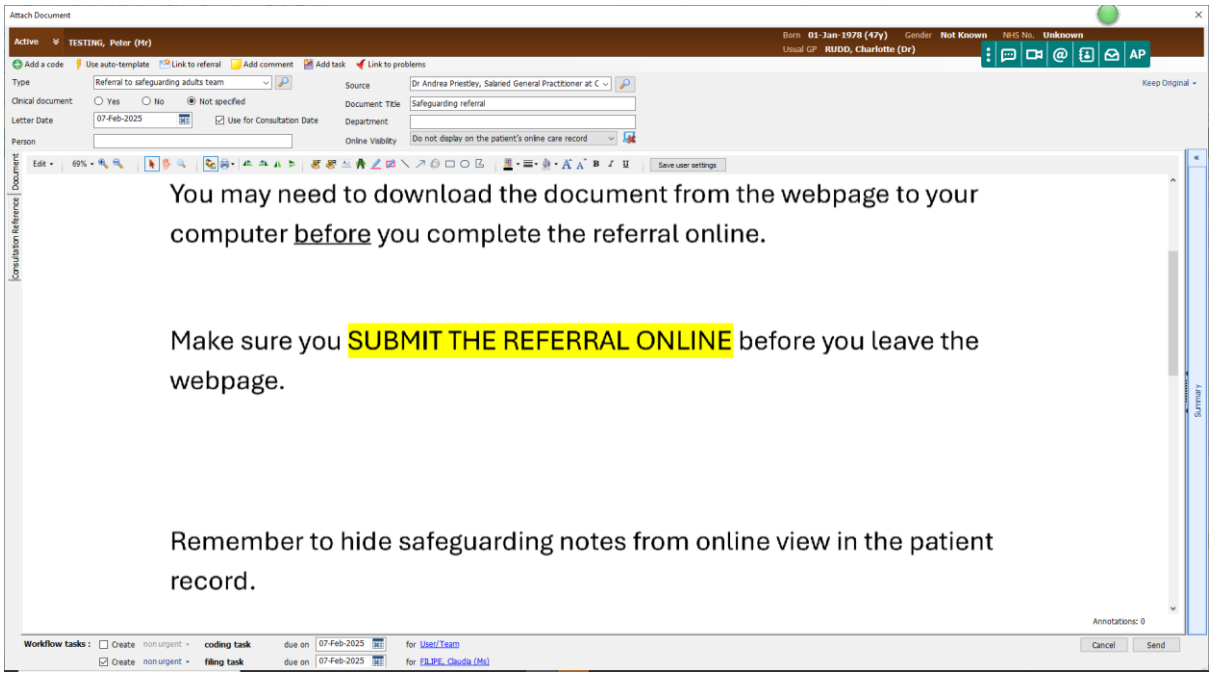
Source

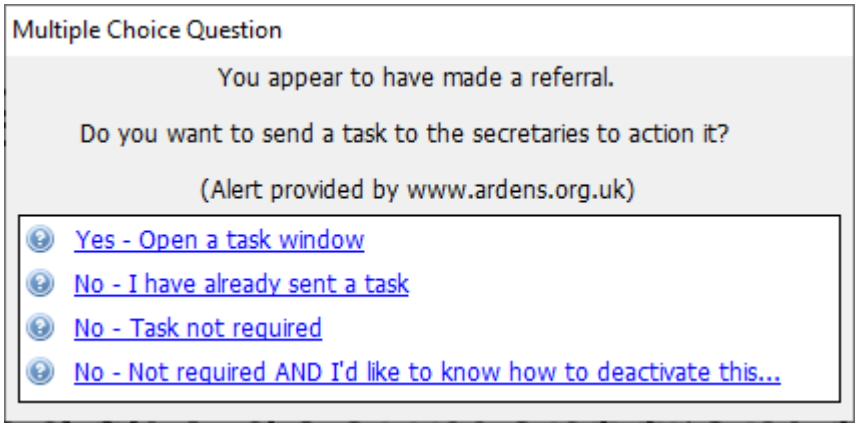
Document title

Online visibility



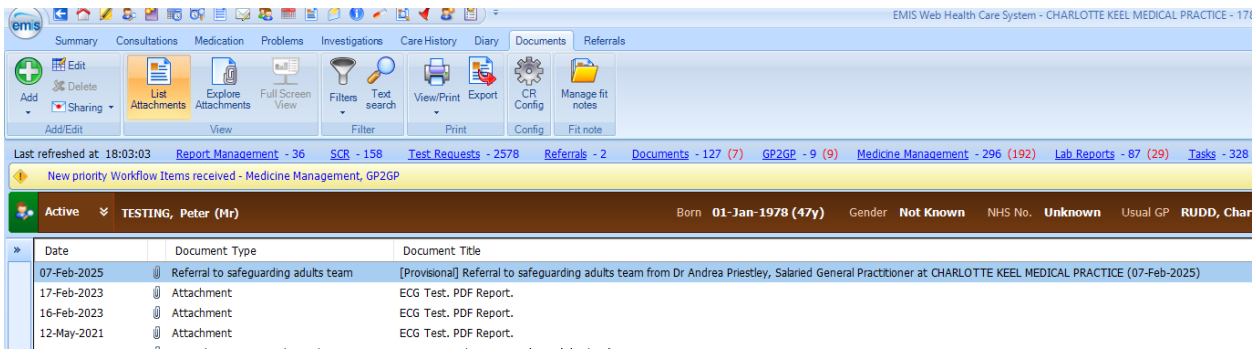


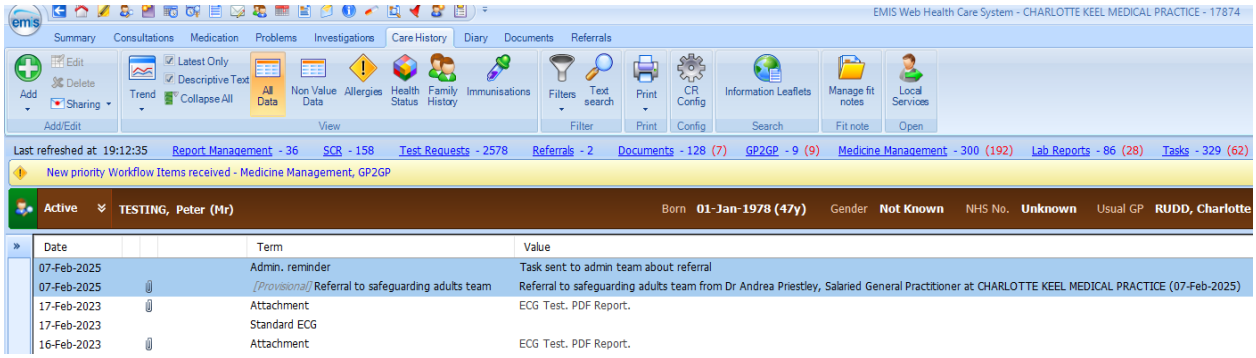




Send task to safeguarding team (adult/child) within the practice – so they are aware (however it will not be their responsibility to follow up the referal)

Send task to yourself – to ensure you follow up referall and outcome





Administrative process to safety net safeguarding referrals

The report for safeguarding /early help referrals is found in EMIS reports / Risk Registers / Safeguarding referrals.

This report will be run monthly by an administrator.

Each case will be checked for receipt of Bristol City Council safeguarding outcome.

If none is found, a task will be sent to the referring clinician for advice on next steps.

Oversight for this process lies with the Administration Team Leader and Practice Manager.

Safeguarding Codes

Purpose

For consistent coding for patient notes using EMIS system

Child Safeguarding Codes: -

Child protection Register

For children who are on the “child protection register” & then for when this end

Child on protection Register

Child removed from protection register

Following a CP case conference whereupon the children were placed onto a child protection plan

Family member on child protection register

Family member no longer on child protection register

Child in need

Following information from case conference

Section 17 of the Children Act 1989 imposes a general duty on local authorities to safeguard and promote the welfare of “children in need” in their area.

To fulfil this duty section 17 gives local authorities the power to provide support, including accommodation and financial subsistence to families with “children in need”, even if they have no recourse to public funds. The power under section 17 can be used to support the family as a whole and to promote the upbringing of the child within the family unit. This can be related to children with Severe Health needs as well as safeguarding concerns

Child in need

Child no longer in need

Child at Risk

Child at risk

This code replaces the “vulnerable child code” therefore it is what we shall use for those being investigated for Safeguarding concerns as well as those that do not fall under the other specific coding criteria

Code for Children may experience a range of emotional, psychological and physical problems and trauma as a result of being abused or neglected. All forms of abuse are likely to result in emotional problems for the child, in particular, a lack of self-esteem and distrust

History of Domestic Violence (this both combines Violence and Abuse)

Domestic violence is violence committed by someone in the victim's domestic circle. This includes partners and ex-partners, immediate family members, other relatives and family friends. The term 'domestic violence' is used when there is a close relationship between the offender and the victim

Will need to consider if other household members need coding

History of domestic violence

Looked after Child

When you are alerted that a child is now formally “Looked After”.

Looked after child

No longer subject of looked after child arrangement

MARAC

Subject to MultiAgency Risk Assessment Conference

Where you are advised that a family are being discussed at a Multi-Agency Risk Assessment Conference (MARAC) for high level domestic abuse.

When a parent has a MARAC we will code the children in the household as

Family cause for concern- with Parent Emis No. and date of document with no other details

Vulnerable child in family

Vulnerable child in family

This is for coding on family notes when there is a child identified in one of the above criteria. This identifies a potential risk but does not divulge information unnecessarily on patient records

FGM

For children with female relations (ie Mum /sister household links) whom have had FGM

Family history of FGM

For Survivors of FGM

Female genital mutilation

Other codes:-

Victim of modern slavery

At risk of Sexual Exploitation

Where it is identified that a child is a risk of CSE, for example if identified as high risk within the practice, or is discussed at a MASE (MultiAgency at risk of Sexual Exploitation) conference

Victim of sexual exploitation

When a child or adult is known to have been victim of SE

If child was not brought to appointment code as

Child not brought to appointment

Non-fatal Strangulation (NFS)

This insidious and lethal form of violence became a standalone criminal offence in the Domestic Abuse Act 2021.

**Any disclosure of NFS requires immediate assessment of physical symptoms, then further assessment of domestic and sexual abuse concerns, and automatic referral to MARAC. **

For anyone whom discloses an attempt pf strangulation (Adult or child) please send Safeguarding referral and code as Safeguarding concern on records. Advise patient of need to report and if possible gain consent.

Adult Safeguarding Codes:-

Referral to safeguarding adults team

Adult Safeguarding concern

Adult no longer safeguarding concern

Vulnerable adult

Adult no longer vulnerable

Not brought to appointment

Related codes

Victim of domestic violence

Victim of physical abuse

Victim of psychological abuse

Victim of financial abuse

Victim of neglect and acts of omission

Victim of organisational abuse

Victim of modern slavery

At risk of Sexual Exploitation

Victim of sexual exploitation

MARAC Report Requests

Process

Request comes through via email from safeguardingchildrenadmin@bristol.gov.uk via the main CKMP Inbox

or Medical Report Admin Inbox.

The email request is scanned to the child's EMIS record.

Report Request is passed to Relevant GP (GP who has been involved in child's care / Usual GP / Safeguarding GP / GP's Buddy)

Task is sent to GP to advise that there is a report for them to complete and the report is placed in the GP's box

A record of the request is added to the Medical Report Spreadsheet

Y:\Medical Records & Reports Requests\Medical Reports\Medical Report Requests 2025.url"

The Clinician will action these as a priority

Once the Report has been completed the GP will send back to Administration team. This is then scanned completed report to EMIS notes and email back to safeguardingchildrenadmin@bristol.gov.uk.

GPs attend the conference if able or send apologies

If the GP has not responded by the day before the meeting, a chase task is sent to the GP.

Document management of children's safeguarding

Assistant to lead nurses responsible for :-

Checking EMIS documents and tasks for incoming safeguarding documents/messages.

Documenting the event and passing it on to GP/safeguarding lead/health visitors if necessary

Using the relevant Safeguarding codes from the SOP: Y:\Policies & Procedures\SOPs\Sop65safeguardingcodes

When adding Safeguarding codes to consultations / documents, make sure to continue using the already present safeguarding codes (for continuity), unless a new code is needed after a conference, such as 'Child Protection register'

If child has left ED without being seen, checking that has been followed up. If not, send task to usual GP. Also letting GP know if NHS111/OOH report lists failed contact, or if they have had clear advice to follow up with GP/ED and have not.

Following the FGM – Protocol on Y drive, remembering to record family history on all female members of family

Coding all instances of pulled elbow (Official medical term is "Radial Head Subluxation"– common for children, but can be an indicator of neglect/abuse depending on circumstances. Important to look at the scenario & circumstances. If recurrent pulled elbow, then task Usual GP as patient may have some musculoskeletal issues that needs following up on

If alerted to a family where there are young carers, coding children as 'is a carer' AND 'is a young carer' and who they are caring for. Ensure all family relationships are added (on the 'Registration' tab). Ensure that Carer ticks NO for the "Carer" box in Reg links, but the Carer ticks YES.
This then automatically adds a code to both of their records once refreshed, so you can see if done incorrectly. Add an alert (on the 'Registration' tab) to all children's records.

When looking at an at-risk family, ensure all the family relationships/links are added

When looking at ED documents, ambulance reports, NHS111, OOH reports etc, check child and family for codes – Safeguarding concern, under child protection, child at risk, looked after child. Also check for past ED etc attendances to see if there are any patterns.

DNAs – if young child then code "Child not brough to appointment" and free text appointment. If older child then add code 'DNA hospital appointment' or "DNA ophthalmology" etc, and free text the appointment details.

Check address is correct and whether the letter says another appointment will be sent. If not, task to usual GP/referring GP to let them know that the child has not attended the follow up – the GP will decide whether there is a safeguarding/clinical need for child to be followed up. – See CKMP Procedure for children who DNA: Y:\Nurse Documents\Assistant to Lead Nurse\SOPs\Children who DNA hospital appt SOP - Mar-23.docx

Online visibility – Change the visibility of information so that it is not seen when patients see their notes online or printed out. Should use for all sensitive information or information pertaining to another patient.

Safeguarding documents/conferences/MARAC

MARAC – Victim is discussed a pre-MARAC consultation. Document that patient is at risk (using the appropriate codes). Send task to usual GP for information if receive a MARAC notification.

Ensure documentation is scanned to victim and all children named in report -Admin team responsible for this

Add appropriate codes and a brief summary of the incident/meeting. Change the Online visibility to not visible. If the plan has decided on a new status for the child (such as Child in Need, Looked After Child, Child Protection Plan) then add the appropriate code.

Inform GP by task of the incident/meeting. GP may ask you to inform Health Visitors

School Nurses/Health visitors

ED discharge summaries sometimes have which health visitors/school nurses the child is with. If this is not included, then go to health visitors/school nurses to ask who is the HV/SN

When you find the patient's Health Visitors/School Nurses, add to patients record

Current safeguarding meetings:-

Alternating monthly clinicians meeting – assistant to lead nurses to minute

Monthly health visitor meeting – Lead child safeguarding nurse to minute

Monthly Midwife meeting - Lead child safeguarding nurse to minute

Adult SG lead meeting (quarterly) – Adult SG nurses to minute

Minutes to be recorded and saved on Y drive as documented evidence of SG discussions – Y:\Meetings\Meeting Agendas\Safeguarding Meetings Emis numbers to be recorded & linked to team net

Safeguarding phone numbers:

First Response: 0117 903 6444

OOH: 01454 615165

Date	Version	Author	Change Details
04/10/2023	1.0	Liz Turner	New Appendix
22/04/25	1.1	Jodie Godfrey	Updated to merge all Safeguarding SOPs at CKMP
15/09/2026	1.2	Renuka Suri	Updated safeguarding leads

BrisDoc Patient care by people who care

Proudly employee owned.

Homeless Health Safeguarding

Version:	Owner:
1.0	Rosa Carter (Lead Nurse)

Introduction

This Standard operating procedure (SOP) outlines the safeguarding process for adults accessing the Homeless Health Services within BrisDoc Healthcare Services. This service is for clinical care of **adults only**. However, indirectly there may be child safeguarding concerns related to adults using the Homeless Health Services, perhaps with care responsibilities – please refer to Safeguarding Children within the Safeguarding policy.

Homeless Health Service (HHS) offers clinical services to a vulnerable cohort of adults in the community, this SOP acknowledges that most users of the service are Adults at risk. However, there are groups or situations within this cohort that will be highlighted within this SOP that require special consideration.

This SOP also sets out the process for alerting, actioning and recording a safeguarding (SG) concern has been identified during a consultation or that a presenting case has an existing Safeguarding (SG) concern.

Safeguarding Lead

	Safeguarding Lead Homeless Health (SGL)	Temporary SGL
ADULT	Rosa Carter	Catherine Patel
CHILDREN	Rosa Carter	Catherine Patel

Adults at Risk

Care of Unborn Children and Pregnancy

It is recognized that safeguarding concerns as an adult at risk increase during pregnancy and that this poses an increased risk of harm to both the pregnant person and unborn child.

Risks to unborn children indirectly via the pregnancy and in the context of Homeless Health Service are:

- Developmental harm occurring from substance ingestion.
- Developmental harm occurring from malnourishment / vitamin deficiency.
- Increased risk of domestic violence and other forms of violence
- Health impacts of sleeping rough
- Perinatal mental health difficulties

Early Pregnancy / First Presentation of Pregnant Patient

Pregnant patients presenting at HHS should have their pregnancy confirmed at the earliest opportunity using a high sensitivity HCG test.

Pregnant patients should be referred to the specialist community midwife team. A shared care or sole care approach will be put in place by the midwives depending on the patient's needs and wishes.

Referral Number for Specialist Community Midwife: **0117 970 3873**

Pregnant people who are rough sleeping or in unsafe accommodation should be immediately referred to Bristol City Council for housing support. Bristol City Council have no duty to provide until the second trimester of pregnancy.

Substance misuse should be stabilised using a harm reduction approach.

All pregnant women should be allocated a social worker with consent.

Agencies should work together closely to support the pregnant person to optimise their own health and the health of the unborn baby. The aim is to identify safeguarding concerns early.

Pregnant patients must be empowered and actively supported during this process.

Take home Opiate Substitute Therapy

The prescriber of Take-Home Opiate Substitute Therapy (OST) is responsible for ensuring that there are adequate safety measures in place at home to protect children and young people from accidental ingestion of OST.

The primary recommendation for OST is daily supervised consumption. However, in cases where Take Home OST is considered the prescriber must undertake and document a thorough risk assessment. Take Home OST should only be considered if there is an adequate lockable storage device available in the patient's home.

Patients with children can be considered for a monthly Buvidal injections to reduce risk of accidental ingestion.

See Homeless Health Services Substance Misuse SOP for further information.

Cuckooing

Cuckooing is when professional criminals target the homes of vulnerable adults so they can use the property for drug-dealing and other criminal activities. These criminals are very selective about who they target as 'cuckoo' victims and are often entrepreneurial.

Homeless health patients are vulnerable to cuckooing and other forms of criminal exploitation due to concurrent vulnerabilities such as addiction.

Consider a collaborative approach with the Police. This requires patient consent. Victims of cuckooing are often in fear of, and are at actual risk, of serious harm and death, from criminals. This is particularly the case if criminals are suspicious of patient's working with or reporting to the Police.

The Police can initiate safety plans, involving the local Police force, including alleviating suspicion of police collaboration if a patient is worried about their safety. If a statement of cuckooing is made to the Police, the Council have a duty to rehouse patients.

Actions for a disclosure of cuckooing should include the patient's consent for escalation, a referral to Social Care through adult safeguarding, and a referral to the patient's Housing Officer.

A multi-agency approach is required to support patients who have been cuckooed.

Patients who have been cuckooed are vulnerable to being repeatedly targeted by criminals therefore victims may require ongoing support to both recover from traumatic experiences arising from the result of cuckooing and to protect themselves from repeat offenses.

If there is any suspicion that a patient has been cuckooed, under no circumstances should they receive a home visit. They should be signposted to seek health care outside of the home.

Domestic Violence.

Clinicians should be aware that sometimes consulting with patients subject to Domestic Violence individually may put the patient at risk of further harm. However, if it is deemed safe to consult patients individually then it is recommended.

If domestic violence is suspected, this can be explored with the patient, however, the priority should be to create a safe and therapeutic relationship and address the presenting health care need.

If domestic violence is disclosed by a patient, clinicians must form a plan of safety centering this around the wishes and concerns of the patient. This may involve Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment (DASH) assessment and a referral to a Multi Agency Risk Assessment Co-ordinator (MARAC). This requires specialist referral by a clinician competent at completing these assessments.

Self-Neglect

A recent study into safeguarding adults review across England which have involved the deaths of homeless adults as a result of abuse or neglect found that self-neglect was present in over half of all cases (Martineu and Manthorpe 2020). Homelessness can be perceived as a form of self-neglect and therefore as a 'lifestyle choice' by many. Nether homelessness nor self-neglect are lifestyle choices and practitioners should show professional curiosity and attentiveness when exploring issues around self-neglect. Practitioners need to fully explore issues that may be preventing Homeless people from caring for themselves and there may be many reversible external factors that can be addressed and other levels of support that can be offered.

Escalating concerns around self-neglect to a safeguarding referral needs to involve the views and wishes of the person. If there are concerns about capacity this needs to be assessed and documented and referrals can be made in the best interests of the patient and safety planning should involve all agencies who know the patient.

Modern Slavery

There are many types of modern slavery and clinicians in Homeless Health Services need to be vigilant of the many presentations that may include criminal exploitation, sexual exploitation, domestic servitude, labor exploitation and child exploitation.

General signs can include isolation, restricted freedom of movement, reluctance to seek help, physical appearance, living and working at the same address.

Modern Slavery must be reported through the National Referral Mechanism (NRM)- Homeless Health Service is not a part of the NRM. Refer through the Modern Slavery charity:

https://www.modernslaveryhelpline.org/ or by calling 08000 121 700.

The police are part of the NRM and will refer as part of Police referral.

Police

If a staff member suspects immediate and imminent danger call 999.

Clinicians should work with police teams who have specialist knowledge and understanding of the needs of HHS service users, where possible. Specialist Police teams will have link workers for patients who are sex working, been cuckooed, criminally exploited or experiencing domestic violence.

Police referrals and discussion need to be handled sensitively, recognising, that although there may be benefits, there is a risk to the patient from within the community if there are signs of Police involvement. The patient's consent, views and understanding of the situation need to be considered.

Mental Capacity Act

The Mental Capacity Act must be adhered to as detailed in the BrisDoc Safeguarding Policy for all patients. Patients who attend Homeless Health Services may have recently used substances, however, this alone does not indicate a lack of capacity.

Multi agency Working & Consent

Multi-agency working is essential in successfully safeguarding HHS patients from across statutory and charitable sectors. These agencies often use different information systems which cannot be accessed by HHS. Therefore, regular meetings and telephone contact are recommended to ensure timely communication as part of the strategy to manage complex patients.

There are several different agencies who may have contact with HHS service users, practitioners need to be aware of these agencies and share information accessibly but appropriately with the patient's consent.

Patients registered at HHS can sign a consent document to share at the point of registration, but that consent can be withheld with regards to specified information by the patient.

Safeguarding Multidisciplinary team meetings should ideally be attended by the clinician who has made the referral or the staff member who knows the patient best, if this is not possible, then HHS safeguarding Lead can attend.

Generating a safeguarding concern

Who can refer.

All HHS staff can and should make safeguarding referrals for any safeguarding concerns. There is a daily team meeting and a larger weekly team meeting with dedicated time to discuss safeguarding concerns and referrals with the team and HHS Safeguarding Lead. This should be done at the earliest opportunity when safeguarding concerns are noticed. The referral is then monitored and actioned as appropriate by the referrer who will attend MDT and update the HHS Safeguarding Lead as necessary.

Please see Adult Safeguarding Section for making referrals.

HHS Staff working in other organisations

HHS staff run clinics and assess patients in alternative settings, working jointly with other organisations, sometimes as the sole clinician. These organisations will have their own internal safeguarding policies. HHS staff should follow BrisDoc and HHS safeguarding policies. HHS staff should however be aware of external organisational safeguarding policies and escalate to their safeguarding leads of any safeguarding concerns as appropriate.

HHS Safeguarding Lead

The Homeless Health Safeguarding Lead is Rosa Carter – Rosa.Carter1@nhs.net.

The HHS safeguarding lead should be made aware of all safeguarding referrals and will be available to offer advice and discuss clinician concerns as needed and at dedicated meetings.

HHS safeguarding lead will work jointly with safeguarding leads within other organisations and liaise as appropriate.

The HHS Lead will attend MDT meetings as required and escalate any concerns or referrals as appropriate.

Documentation of safeguarding concerns

Referrals should be coded on EMIS as ‘Adult safeguarding referral’ or ‘Child safeguarding referral’. Discussions and concerns where a safeguarding referral have not been made should be coded as ‘Adult safeguarding concern’ or ‘Child safeguarding concern’.

The Safeguarding Log is updated by the HHS Safeguarding Lead weekly. It has an on-going log of all safeguarding referrals and progress.

Training

Safeguarding training should be completed by staff as per BrisDoc Training and Safeguarding Policy. Specialist training may be needed to enhance knowledge in the areas detailed in this appendix.

Monitoring Safeguarding

There is a weekly meeting with dedicated safeguarding time allocated to discuss cases on the Safeguarding Log and new referrals and concerns. The nature of this cohort of individuals within HHS leads to individuals continually representing as adults at risk.

Reporting

Reporting will be done from EMIS from the patient data records. This data feeds into local picture and is reported when required.

Appendix Change Register

Date	Version	Author	Change Details
04/10/2023	1.0	Rosa Carter	New Appendix
24/06/2025	1.1	Renuka Suriyaarachchi	Temporary SGL added

BrisDoc Patient care by people who care

NHS

Brisdoc Safeguarding Training SOP

Version:	Owner:
1.1	Renuka Suriyaarachchi (Head of Nursing and AHPs)
December 2025	Rhys Hancock

Safeguarding Training SOP

Introduction

BrisDoc recognises the importance of all staff, co-owners, self-employed staff and independent contractors having the required safeguarding competencies and knowledge relevant to their role that enable them to recognise, support, escalate and report any concerns regarding children and adults at risk.

Brisdoc will follow the Royal College of General Practice (RCGP) standards that are for all staff working in a general practice setting including urgent care and Out of Hours. The standards are for all-ages and apply to both child and adult safeguarding.

This SOP is for all employed co-owners. This SOP will outline safeguarding training requirements, specifically in more detail, the level 3 safeguarding training. The SOP will clarify the process of how the standards of training are evidenced within Brisdoc and how this is monitored and reported as an organisation.

Self-employed staff will follow the following guidance: https://www.radar-brisdoc.co.uk/wp-content/uploads/2021/03/Self-Employed-Independent-GP-Recruitment-SOP-version-15.3.pdf

Training Requirements

Brisdoc will implement RCGP training requirements standards to evidence our safeguarding level 3 compliance in-line with Care Quality Commission (CQC) regulations and national guidelines.

The RCGP standards are applicable to all-ages and include both child and adult safeguarding. https://www.rcgp.org.uk/learning-resources/safeguarding-standards

These standards are for all GPs and clinicians working in a general practice setting in the UK including urgent care and Out of Hours.

The standards introduce competency-based assessment and in some publications have moved away from a requirement of a certain number of hours (please see note for Nurse requirement for level 3 safeguarding).

The focus of the standards is on demonstrating learning and the application of this in practice. The standards highlight the importance of multi-disciplinary team (MDT) working in a practice setting and the importance of all organisations engaging with local safeguarding partners and relevant authorities.

The standards are arranged into 5 areas of knowledge and capabilities:

- Responsibilities
- Identification of abuse and neglect
- Responding to Abuse and neglect
- Documenting
- Information sharing and multiagency working

Nurse requirements for level 3 safeguarding

The Royal College of Nursing (RCN) guidance states that a time-based approach for logging evidence of training hours continues.

The guidance for adult safeguarding suggests:

- a minimum total of **8 hours** training, education and learning related to adult safeguarding completed over the previous three years (inclusive of the current year).
- The eight hours will consist of a blended mixture of safeguarding training resource with at least **50**% of training being participatory.

The Guidance for child safeguarding suggests:

- a minimum of **16 hours** of education, training and learning related to safeguarding and child protection completed over the previous three years (inclusive of the current year) on an annual basis.
- The sixteen hours will consist of a blended mixture of safeguarding training resource with at least **50**% of training being participatory.

BrisDoc recommends that **all** clinicians document the RCGP standards when documenting safeguarding activity and learning and complete hours compliant with the RCN recommendations for these actions.

Types of Training

See Appendix A for a comprehensive list of how to achieve the knowledge, capabilities and competencies.

All BrisDoc Co-Owners

The requirements for each level, and to whom they apply is detailed below :

LEVEL	STAFF GROUPS (NHS and non-NHS general practice settings)	SAFEGUARDING TRAINING REQUIREMENTS
Level 1	• Receptionists, administrative and secretarial staff (with the exception of manager/lead roles of these groups who will need level 2). • Volunteer staff.	Induction: • Safeguarding included in practice/organisation induction AND completion of relevant safeguarding level 1 eLearning updates. Annually: • Level 1 safeguarding update.

Level 2	• Practice managers (including deputy managers) and equivalent leadership roles. [ALSO SEE ADDITIONAL REQUIREMENTS FOR THIS GROUP]
	• Care navigators.
	• Reception managers.
	• Safeguarding administrators.
	• Managers/leads of administrative/secretarial teams.
	• Health care assistants, pharmacy technicians.
		Induction:
		• Safeguarding included in practice/organisation induction AND completion of relevant safeguarding level 2 eLearning updates.
		
		New to role - any current staff member moving into a level 2 role should, within one month of starting:
		• Complete relevant safeguarding level 2 eLearning modules.
		• Have a safeguarding induction with an appropriate senior leader e.g. practice manager/practice safeguarding lead depending on nature of role. This induction should include:
		  ◦ discussion about the safeguarding structure, policies and procedures within the practice/organisation
		  ◦ identification of any areas of professional development related to safeguarding.
		
		Annually:
		• Level 2 safeguarding update

Level 3	• GPs, practice nurses, physician associates, nursing associates, pharmacists, paramedics, Advanced Care Practitioners, Advanced Nurse Practitioners, social prescribers, mental health workers, physiotherapists, podiatrists, dieticians and any similar ARRS (Additional Roles Reimbursement Scheme) roles.
	• Primary care network (PCN) safeguarding roles in England such as PCN safeguarding co-ordinators.
	• GP speciality trainees [who should refer to the specific safeguarding training requirements for the workplace based assessment (WBPA) part of the MRCGP exams]
		Induction:
		• Safeguarding included in practice/organisation induction.
		• Completion of relevant safeguarding level 3 eLearning updates (or provide evidence of prior completion) e.g. RCGP modules.
		• Meet with the practice/organisational safeguarding lead, their deputy, or other relevant senior leader within one month of starting their new role to:
		  ◦ discuss the safeguarding structure, policies and procedures within the practice/organisation
		  ◦ identify any areas of professional development need related to safeguarding.
		
		Annually:
		• Level 3 safeguarding update.
		• Completion of the Safeguarding Structured Reflective Template to demonstrate reflection and learning across the breadth of all the five areas of safeguarding knowledge and capabilities. This must include both child and adult safeguarding issues, even if a practitioner only works with adults.

	Practice Safeguarding Leads	These are **IN ADDITION TO LEVEL 3 TRAINING REQUIREMENTS** (Note that General Practice Safeguarding Leads **DO NOT** need Level 4 safeguarding training) Annually: • Safeguarding update. • Demonstrate regular attendance at the local practice safeguarding lead forums (if available in the locality). • Demonstrate an example of reflection/learning aligned with the practice/organisational role specific knowledge and capabilities.

Individual training requirements for safeguarding within BrisDoc roles are applied via the BrisDoc Development Hub and also stated on Radar Staff Training Matrix.

Level 1 and 2 training is all on-line and access via individual's Development Hub page.

Training Process - Level 3

Safeguarding Level 3 training will be accessed via the individual's Development Hub and consist of the following components:

Mandatory e-Learning

There are two parts to e-learning, both components need to be done **annually** and form mandatory safeguarding level 3 requirement:

- Safeguarding Self Declaration and Overview on the Brisdoc Development Hub.

- Level 3 e-learning modules for Adults at Risk and Children on the Brisdoc Development Hub

Other e-learning that contributes towards safeguarding training and is mandatory is Female Genital Mutilation, Mental Capacity, Prevent and Oliver McGowan.

Face to Face Training

- Once every three-year, face-to face, bespoke Brisdoc Adult safeguarding and Child Safeguarding training course.

Safeguarding Log

- The new Safeguarding Log will have a dual recording system of competencies and hours-based training to ensure that all thresholds for clinical national guidance are met. We therefore request all clinicians, GPs, Nurses and Allied Health Professionals to complete the Safeguarding Log fully in terms of competencies and hours annually.

Please see Appendix B for an exemplar of the Safeguarding Log.

The Log must be shown to your Line manager or the Clinical Admin Team. They will be responsible for uploading the Log on the Brisdoc Development Hub.

Evidencing Level 3 Safeguarding Training

CQC guidance states all clinicians need to demonstrate their competence for adults as follows:

- demonstrate their understanding of the definition of an adult at risk and the types of abuse they may be subject to
- show awareness of the internal arrangements for recording a safeguarding adult concern and how this is included within the practice's safeguarding adults policy
- show awareness of the external process for reporting the concern and how this is in line with local multi-agency policies and procedures.

CQC guidance states all clinicians need to demonstrate their competence for children as follows:

- the practice gives sufficient priority to safeguarding children
- staff take a proactive approach to safeguarding and focus on prevention and early identification
- staff take steps to protect children and young people where there are known risks, respond appropriately to any signs or allegations of abuse, and work effectively with other organisations to implement protection plans
- there is active and appropriate engagement in local safeguarding procedures and effective work with other relevant organisations.

Clinicians may wish to keep evidence of any safeguarding level 3 activities by keeping a portfolio of certificates, notes, logs, or a journal. The new standards highlight the importance of knowledge, capabilities and competency. This can be discussed with your line manager but there is no need to send these pieces of evidence to the People Team.

Training Offers

BrisDoc offers several different level 3 safeguarding training opportunities including face to face sessions and online learning. These are currently set out in the Development Hub.

It is the responsibility of the Clinician to ensure they undertake a variety of level 3 safeguarding learning (both participatory and self-directed) to meet the RCGP standards outlined. This must include knowledge and capabilities for both adult and child safeguarding even if a practitioner only works with adults.

Sharing Training records between Employers

In the event of a clinician holding substantive post elsewhere and not within BrisDoc, it is the clinician's responsibility to share evidence by completing the Level 3 Safeguarding Overview and Resources Declaration and the Safeguarding Log annually. There is **no** need to repeat training.

A request can be sent by the Clinician to seek evidence if required. See Appendix 3 - Email template to other employer requesting confirmation of Level 3 Safeguarding compliancy.

New Starters

The Clinical Administration Team will work with clinicians during their probationary period to ensure that safeguarding level 3 training is completed.

This will include the safeguarding level 3 e-learning as mandatory before starting unsupervised shifts.

The level 3 Safeguarding Log must be completed within the probationary period, but ideally **before** clinicians begin unsupervised shifts. There may be extenuating circumstances which must be agreed with the line manager in advance.

Recording Safeguarding Training

Clinicians' Responsibility

It is the Clinicians' responsibility to meet the standards outlined in this SOP and be able to evidence the required capabilities.

The evidence of this is the completion of mandatory Safeguarding Level 3 training as described in the Training Process -Level 3 within this SOP. Clinicians may keep documents evidencing these competencies using the following templates provided by RCGP:

Structured template for reflective practice

Structured template for case review

To clarify, safeguarding level 3 training focuses on capabilities and competence as well as education. It is a continual process of learning through practice as well as training and evidence of these learnings that need to be updated at least annually on the Safeguarding Log.

Monitoring Safeguarding Training for all clinicians

Line Manager Responsibility

This is a supportive process, ensuring clinicians understand the required Level 3 safeguarding training standards and signpost to resources.

Line Managers during their one to ones can have assurance of on-going safeguarding compliance by checking the Development Hub and having informal conversations via clinical discussions or a specific case review.

Line Manager should check compliance regularly but no less than annually.

People Team

The People Team will collate safeguarding compliance data from the development hub. Compliance of safeguarding Level 3 will be annual:

- Safeguarding Log with the requisite hours and Standards

- Safeguarding Overview and Resources Declaration indicating all standards are met

- Completion of e-learning for adults and children.

- 3-yearly face to face sessions for adults and children safeguarding updates

Clinical Admin Team

The Clinical Admin Team are the main contact for all IUC clinicians. The Clinical Admin Team will ensure compliance of safeguarding level 3 for all clinicians as listed above in the People Team section. Any concerns regarding this will be escalated to the line manager.

Reporting

The People Team will produce reports for Safeguarding Training compliance. The People Team will provide this information to Line Managers and Safeguarding Leads. This performance will be monitored by the relevant boards.

Appendix 1 - Safeguarding Training Evidence List

Activity	Training Type	Suggested Evidence
Courses, Seminars, workshops	Participatory	• Certificate/notice of attendance • Attendee list • Copy of the teaching material • Copy of any completed course assignments • Confirmation by an employer of participation
In-house development activities Clinical forums	Participatory	• Certificate/notice of attendance • Attendee list • Copy of the teaching material • Copy of any completed course assignments • Confirmation by HR department or director of participation
Conferences, events	Participatory	• Attendee list • Event programme • Confirmation letter or email • Copy of invitation to participate • Copy of speech

Specialist panels, forums, formal group meetings, system partner meetings
 	
MDT meetings
	Participatory	• Agenda
		• Attendee list
		• Copy of
		  ○ any documents distributed at the meeting
		  ○ the minutes
		  ○ invitation to participate
		  ○ speech Lecturing, teaching and addressing meetings
		  ○ any signed formal agreements
		  ○ letter/e-mail authorising activity
		  ○ timetable
		  ○ speech

Relevant work-based meetings	Participatory	• Agenda
		• Attendee list
		• Copy of
		  ○ any documents distributed at the meeting
		  ○ the minutes
		  ○ invitation to participate
		  ○ speech
		  ○ induction materials for new staff
		• Confirmation by HR department or director of your participation/attendance

Coaching, mentoring	Participatory	• Copy of any signed agreements • Copy of letter/e-mail authorising/requesting/agreeing to activity • Copy of timetable
Project work	Participatory	• Copy of the project proposal

		• Written detail of the research required • Copy of the project report • Confirmation by HR department or director of your participation
Acting as expert witness	Participatory	Evidence of participation including: • signed letters, • notes, observations and • practice related outcomes
Participation in clinical audits	Participatory	Evidence of participation and role including • signed letters, • notes, observations and • outcome
Structured professional clinical supervision	Participatory	Evidence of supervision including: • signed letters, • notes, • observations and • practice related outcomes
Visits	Participatory	Evidence of participation including: • signed letters, • notes, • observations and • outcomes
E-Learning	Self-directed	• Learning for Health
Safeguarding Policy	Self-directed	• Induction and revisiting Policy annually
Reading	Self-directed	• Use self-evidence sheet and confirm: ○ exact book/chapter/article/section read ○ author ○ publisher and date published ○ page numbers.
Reviewing books & articles	Self-directed	• Copy of any signed formal agreements • Copy of letter/e-mail authorising activity • Confirmation by HR department or director of your participation/attendance • Use self-evidence sheet and confirm: ○ exact book/chapter/article/section read ○ author ○ publisher and date published ○ page numbers.
Research	Self-directed	• Copy of the research proposal • Any written instructions/requests received • Copy of any funding applications • Copy of any documentation distributed as part of the research – i.e., consultation document • Confirmation by HR department or director of your participation/attendance

Writing books, articles, papers, documents	Self-directed	• Copy of any signed formal agreements • Copy of letter/e-mail requesting/authorising the writing of the piece • Copy of the document – dated and signed by yourself and a witness

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Appendix 2 – Safeguarding Log

Name:

Role: *'Link GP's and newly qualified practitioners must demonstrate 16hrs safeguarding children training*

'Link GP's and newly qualified practitioners must demonstrate 16hrs (for newly qualified practitioners some of these hrs may come from training completed as

Deadline 23/11/2025

hrs or more	0	Compulsory Safeguarding hours not fulfilled	**Competencies** Missing:
torg 4 hrs or more	0		0 Responsibilities; Identification of abuse and neglect; Responding to abuse and neglect; Documenting; Information sharing and multiagency working

Level 3 Safeguarding Adults - Training Log

Date	Type of Development / Training	Brief summary	Type of verification document	Length of time - hrs	Responsibilities	Identification of abuse and neglect	Responding to abuse and neglect	Documenting	Information sharing and multiagency working

hrs or more	0	Compulsory Safeguarding hours not fulfilled	**Competencies** Missing:
Participa torg 8 hrs or more	0		0 Responsibilities; Identification of abuse and neglect; Responding to abuse and neglect; Documenting; Information sharing and multiagency working

Level 3 Safeguarding Children - Training Log

Date	Type of Development / Training	Brief summary	Type of verification document	Length of time - hrs	Responsibilities	Identification of abuse and neglect	Responding to abuse and neglect	Documenting	Information sharing and multiagency working

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Appendix 3 - E-mail to primary employed

Email template to other employer requesting confirmation of Level 3 Safeguarding compliancy.

Subject: Request for evidence of Safeguarding Compliancy

Dear [Employer's Name],

I am writing to kindly request evidence of level 3 safeguarding compliancy during my employment at [Company Name] from [start date] to [end date/present]. This information will serve as a testament to my commitment to maintaining high professional standards which I wish to share with my [new/additional] employer, BrisDoc Healthcare Services.

If possible, I would appreciate it if you could send the requested evidence to my email address at [your NHS email address].

Please feel free to contact me at [your phone number] or [your NHS email address] if you require any additional information or have any questions regarding this request.

Many thanks in advance,

[your name]

Change Register

Date	Version	Author	Change Details
4th October 2023	1.0	RS & ND	New Appendix
August 2025	1.1	Renuka Suriyaarachchi	Amended and updated following RCGP (2024) guidance and further clairty

Supporting Documentation

This SOP incorporates and refers to the following national and local guidance:

BNSSG (2024) guidance for all practice services

BNSSG (2025) safeguarding Team and Training

CQC (2024) Myth Buster 25 Safeguarding Adults at Risk

CQC (2024) Myth Buster 33 Safeguarding children

RCGP (2024) Level 3 safeguarding training and standards

RCN (2024) Adult Safeguarding: Roles and competencies for health care staff

RCN (2025) children and Young People: Roles and competencies for healthcare staff (under review)

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Policy Version Control

Date	Version	Author	Comments
24th October 2023	1.0	R Suriyaarachchi	New Policy. Amalgamation of policies – Adult, children, Prevent, Domestic Violence & Abuse, non-mobile baby SOP and Female Genital Mutilation and update of local procedure for each service. Amendments / contact details updated / flow charts updated / Sops updated for individual organisations. Amendments for dog bites. All SOPs included for Homeless Health, SevernSide, Charlotte Keel & Broadmead. Also, additional SOP for Level 3 training for employed staff.
October 2024	1.1	R Suriyaarachchi	Amendments from ICB Policy walk through – all through policy
22/04/2025	1.2	J Brady	Updated CKMP section with changes from Jodie Godfrey V1.1.
19th June 2025	1.3	R Suriyaarachchi	Update non-fatal strangulation of adults and adolescents
24th June 2025	1.4	R Suriyaarachchi	Update LSG on Broadmead, Homeless Health and Severnside IUC
4th July 2025	1.5	R Suriyaarachchi	Update of Adastra to Cleo
16th January 2026	1.6	R Suriyaarachchi	Duplicate Prevent removed and TOC regenerated
11th February 2026	1.7	R Suriyaarachchi	Update of Level 3 safeguarding training SOP
15th September 2026	1.8	R Suriyaarachchi	Update and annual review, medication and safeguarding considerations, domestic violence and abuse, sexual assault / abuse support, CK named Leads