BrisDoc Patient care by people who care

NHS

Safeguarding Policy

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Contents

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.

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.

BrisDoc takes safeguarding seriously. The Named Safeguarding Lead 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

Other points of escalation and contact for Advice/ Support are:

- Governance team on Brisdoc.governance@nhs.net
- The Integrated Care Board for Bristol, North Somerset & South Gloucestershire (BNSSG) Safeguarding Page:

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

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 Adastra 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 four 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.

- Liberty Protection Safeguards (amendment to Mental Capacity Act, 2019) – replaced the Depravation of Liberty Safeguards (DoLS) that protects adults in hospital or care home who may be deprived of their liberty.

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	I know that staff treat any personal and sensitive information in confidence, only

	in preventing, detecting, and reporting neglect and abuse.	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.

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.

- Physical
- Sexual
- Emotional/psychological/mental
- Neglect and acts of omission
- Financial or material abuse
- Discriminatory
- Organisational or institutional
- Self-neglect
- Domestic abuse (including coercive control)
- Modern slavery

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

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 Bris Doc staff for Adults at Risk must have Mental Capacity Act (2005) acknowledged within the assessment.

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

Clinician has a concern about an adult's welfare

(Clinical assessment and care should be exercised as usual)

Highlight to service or organisational safeguarding leads through usual internal reporting mechanisms. Ensure that BrisDoc staff are aware of well-being access and any necessary training.

Person in immediate danger		**Concern but no immediate danger**
Ring 999 – contact emergency services - Police and / or Paramedics. Consider	**A non-emergency response** but Police input required – 101	Inform the Local Authority below

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.

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, 2018) – 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.

Children may be vulnerable to neglect and abuse or exploitation from within their family and from individuals they come across in their day-to-day lives. These threats can take a variety of different forms, including sexual, physical, emotional abuse, neglect, or exposure to domestic abuse, controlling or coercive behaviour, exploitation by criminal gangs and organised crime

groups, trafficking, online abuse, and the influences of extremism leading to radicalisation. Whatever the form of abuse or neglect, practitioners should put the needs of children first when determining what action to take.

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.

Local organisations and agencies should have in place effective ways to identify emerging problems and potential unmet needs of individual children and families. Local Authorities should work with organisations and agencies to develop joined-up early help services based on a clear understanding of local needs. This requires all practitioners, including those in universal services and those providing services to adults with children, to understand their role in identifying emerging problems and to share information with other practitioners to support early identification and assessment.

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 (e.g., rape, buggery or oral sex) 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.

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)

Making safeguarding Personal

Providing early help is more effective in promoting the welfare of children than reacting later. Early help means providing support as soon as a problem emerges, at any point in a child's life, from the foundation years through to the teenage years. Early help can also prevent further problems arising; for example, if it is provided as part of a support plan where a child has returned home to their family from care, or in families where there are emerging parental mental health issues or drug and alcohol misuse

Effective early help relies upon local organisations and agencies working together to:

- identify children and families who would benefit from early help
- undertake an assessment of the need for early help
- provide targeted early help services to address the assessed needs of a child and their family which focuses on activity to improve the outcomes for the child

Please use the following NICE guidelines to help your decision-making:

Overview | Child maltreatment: when to suspect maltreatment in under 18s | Guidance | NICE

Overview | Child abuse and neglect | Guidance | NICE

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. **Please see Reporting Child Safeguarding**:

- 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**:

Reporting 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 Make a referral (bristol.gov.uk)	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 use the numbers below to refer to or make contact with Community Children's Services:
Clinicians - CCHP | Community Children's Health Partnership

Community Children's Health Partnership	
Bristol **South Gloucestershire**	0300 125 6905 or Single Point of Entry Single-Point-of-Entry-Form March 2023.docx (live.com)
North Somerset	Single Point of Entry Single-Point-of-Entry-Form March 2023.docx (live.com) or email referral sirona.childservicesdroveroad@nhs.net

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

The Remedy Guidance for referrals is as follows:

Referrals & Procedures (Remedy BNSSG ICB)

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.

https://bristolsafeguarding.org/media/f1nn0dos/non-mobile-baby-injury-kbsp-policy-reviewed-may-2020.pdf

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)

Responding to concerns about Child Sexual Exploitation

Referrals & Procedures (Remedy BNSSG ICB)

Each Local Authority has individual guidance which can be accessed from the ICB BNSSG website.

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.

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 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.

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Appendices

BrisDoc Patient care by people who care

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SevernSide Safeguarding

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

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.

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 Adastra 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 Adastra

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 Adastra, 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.

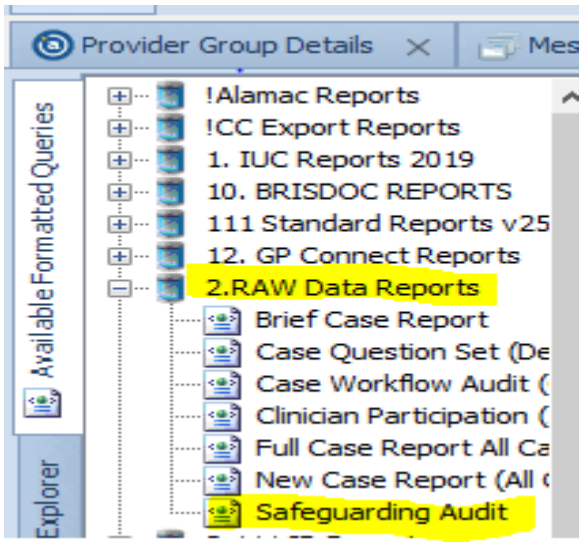
Sharing Safeguarding Learning

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

Extracting safeguarding Data from Adastra

OPEN Adastra / query builder

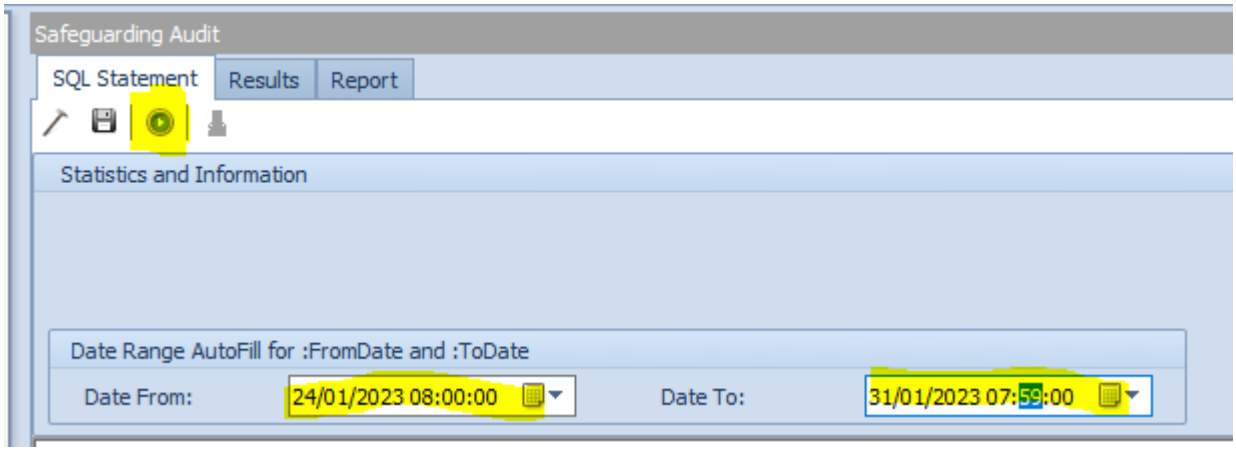
Select query: 2. Raw Data Reports / Safeguarding Audit



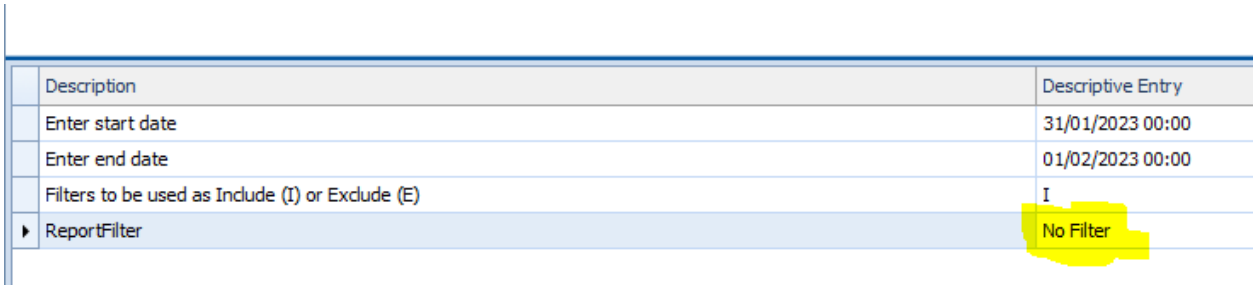
Enter the date range for the previous seven days, Monday 08:00 till Monday 07:59.

EG: 04/02/2020 08:00 TO 11/02/2020 07:59

Select the run icon.

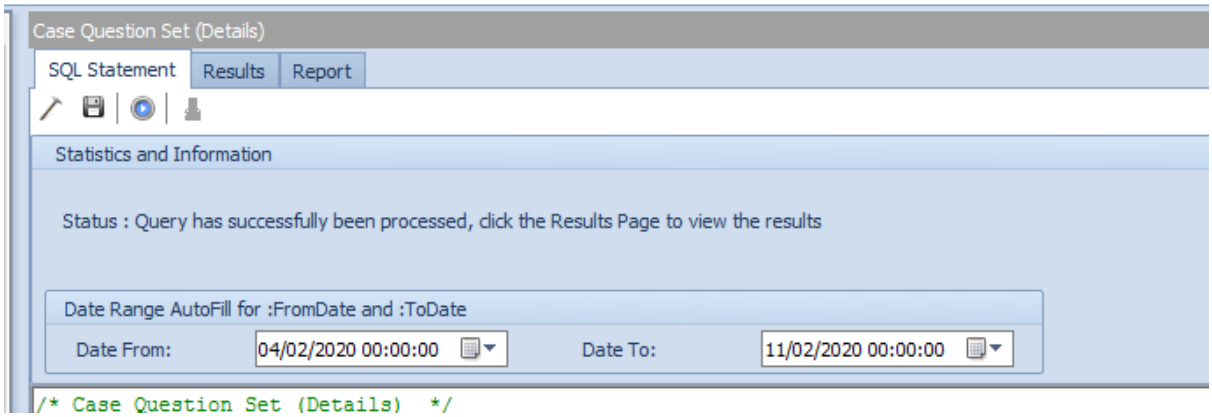


Select Report Filter: **NO FILTER**

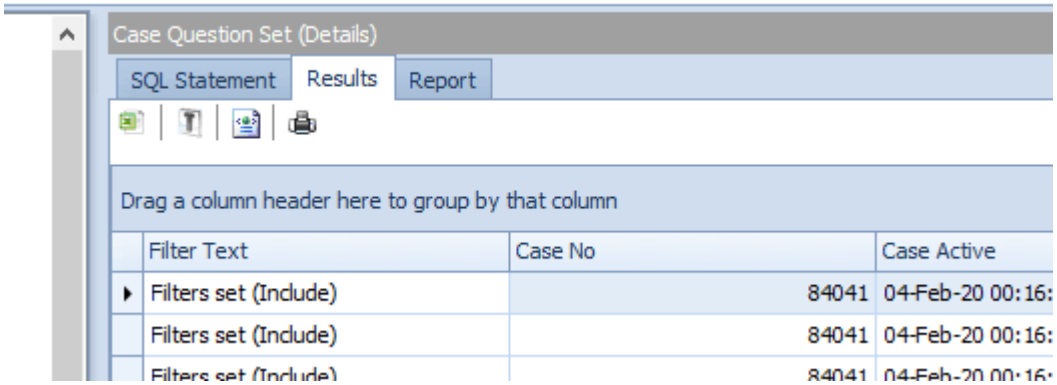


Click OK

Wait for query to run and then select the results tab.



When list displays, export to the following folder: S:\GOVERNANCE TEAM\CONFIDENTIAL - DAC\Safeguarding\2023-24\Data



Save as: Audit Sample - todays date.

Open the sample, copy, and paste the records into the Safeguarding Audit Spreadsheet (S:\GOVERNANCE TEAM\CONFIDENTIAL - DAC\Safeguarding/1. Safeguarding Weekly Audit V2.2) As a very rough guide, you should expect to see in the region of 40-50 records.

Save and Close. Email the SGL and LCPs to advise 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

BrisDoc Patient care by people who care

NHS

Broadmead Medical Centre Safeguarding

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

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 Jenny Schaefer	
CHILDREN	Dr Jenny Schaefer	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.

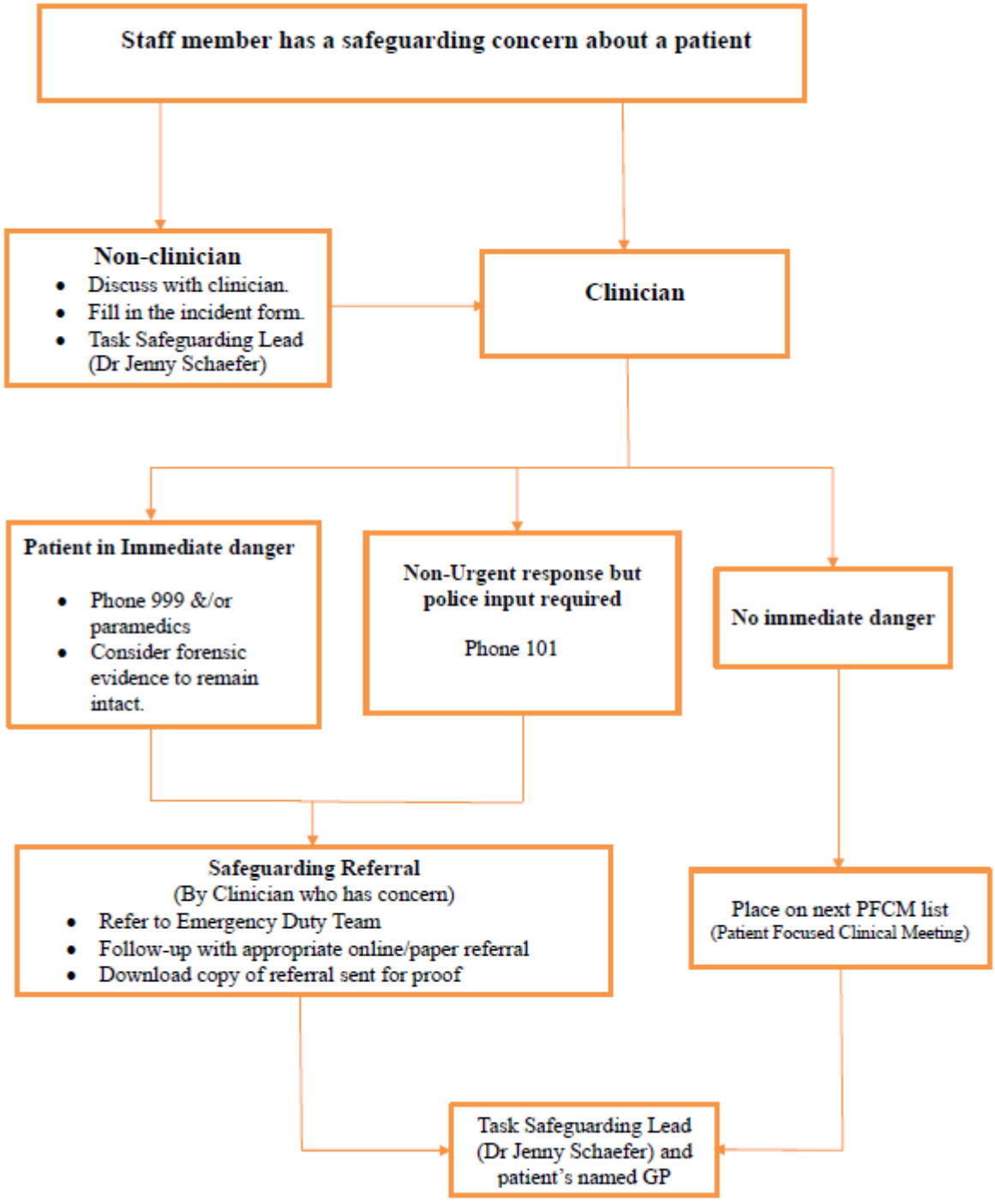
This may involve keeping the patient in the practice until a place of safety has been found.

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.

Acting on Safeguarding concerns



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

BrisDoc Patient care by people who care

NHS

Charlotte Keel Safeguarding

Version:	Owner:
1.0	Liz Turner

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).

Safeguarding Children

Safeguarding Children leads at CKMP

GP lead: Dr Tahira Waraich

Nurse lead: Jodie Godfrey

The Standard Operating Procedure – GP Lead Responsibilities:

- 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.
- 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.
- Attend 6 monthly Bristol Link GPs meeting (dates on Remedy)
- Field external e-mails/communications relating to Childrens 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 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)
- 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 & school nurses). NB advertise to HVs just before each meeting inviting input if any concerns.

- At these meetings make a note in the child's record that the discussion happened & briefly the issues/plan discussed
- At these meetings take minutes of system issues discussed & record EMIS numbers of patients discussed
- Field queries from practice team on individual patient issues
- 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.
- 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
- 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
- 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
- Attend monthly meetings with GP Lead Safeguarding children and Health Visitors as appropriate.
- Input into regular safeguarding case discussion meetings with nurse team and at clinician's meetings

Recording Information

- Information about vulnerable children will be recorded in the child's notes and, where appropriate, the notes of siblings and significant adults. This is recorded using Snomed Codes.
- Information supplied by all members of the primary care team, including the health visitor, is recorded in the notes under a Snomed code. The use of unlinked correspondence is discouraged other than for the purpose of alerting individuals to new information in notes. Conversations with, and referrals to, outside agencies are recorded under an appropriate Snomed Code. Child protection conference notes and documented concerns are scanned into the notes of all the children and adults named in the conference report.
- All consultations related to safeguarding should have the online visibility not to be displayed ticked due to potential risk with patient access to notes.

List of recommended codes (in line with ICB)

Code description	Snomed description code ID	Comments
Child protection register		
Child on protection register	250836014	

Child removed from protection register	1840401000006114	For children who are on the "child protection register" & then for when this ends
Family member on child protection register	515271000000110	Following a CP case conference whereupon the children were placed onto a child protection plan
Family member no longer on child protection register	2588691000000117	

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	216661015	
Child no longer in need	216660019	

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

Child at risk	250819018	

History of domestic Violence

this term 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

History of domestic Violence	2474290010	Will need to consider if other household members need coding

Looked after child

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

Looked after child	1703601000000115	
No longer subject of looked after child arrangement	1703821000000113	

MARAC		
Subject to MultiAgency Risk Assessment Conference	1674041000000113	Where you are advised that a family are being discussed at a Multi-Agency Risk Assessment Conference (MARAC) for high level domestic abuse.
Family cause for concern	532781000000119	When a parent has a MARAC we will code the children in the household Freetext to code parent Emis No. and date of document with no other details
Vulnerable child in family		
Vulnerable child in family	250840017	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		
Family history of FGM	2322311000000110	For children with female relations (ie Mum /sister household links) whom have had FGM
Female genital mutilation	2995039011	For Survivors of FGM
Other codes		
Victim of modern slavery	2635331000000117	
At risk of Sexual Exploitation	2360571000000118	
Victim of sexual exploitation	1755511000000112	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 When a child or adult is known to have been victim of SE

List of codes we choose to no longer use

Code description	Comments
Vulnerable child	This code will automatically switch to "Child at risk"
History of domestic abuse	We will use "History of domestic violence" to streamline Domestic abuse comprises of broad categories of behaviour including physical or sexual abuse, violent or threatening behaviour, controlling or coercive behaviour, economic abuse and psychological, emotional, or other abuse

Monitoring Concerns

If a concern has been raised or a referral for safeguarding done, the clinician who has raised the concern or done the referral should check for a response to query/referral.

Current concerns are discussed in the monthly meeting of the child safeguarding leads.

A monthly meeting with safeguarding leads and the midwives is held to discuss midwife concerns. A quarterly meeting with the health visitors is held to discuss health visitor concerns.

Any discussions are to be recorded in the notes so there is an audit trail.

Nurse lead for safeguarding children has protected time every week to review concerns and to work through and review risk register.

Information gathering may need discussion with health visitor team:

- Finding Health visitor sirona.charlottekeelhealthvisiting@nhs.net
- Or put postcode into CCHP postcode checker
- https://cchp.nhs.uk/cchp/explore-cchp/health-visiting/how-get-help-a-health-visitor

Part of the routine review of notes is to check on the Connecting Care Portal for updates:

- List can be obtained via Connecting Care Portal
- https://connectingcare.swcsu.nhs.uk/concerto/Login.htm
- User ID is e-mail address
- Password obtained by e-mailing ConnectingCare_admin@swcsu.nhs.uk

Safeguarding Adults

Safeguarding Adult leads at CKMP

GP lead: Dr Tahira Waraich

Nurse lead: Jaci Monk

GP Lead Responsibilities:

- Nomenclature – we use "adult safeguarding" codes for those few patients under the social services safeguarding team & "vulnerable adult" for the rest
- Keep up to date with training requirement for lead.
- Field external e-mails/communications relating to Adult Safeguarding
- Keep practice protocols 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)
- 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
- At these meetings make a note in the patient record that the discussion happened & briefly the issues/plan discussed
- At these meetings take minutes of system issues discussed & record EMIS numbers of patients discussed
- Field queries from practice team on individual patient issues
- 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.
- 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
- Important note: your role is not to take on all the safeguarding cases but to facilitate the usual GP to manage the case appropriately.

Nurse Lead Responsibilities:

- Protected management time monthly to go through the adult safeguarding & vulnerable adult lists
- 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
- Attend 3monthly meetings with Safeguarding Adult GP Lead to discuss problem cases
- Input into regular safeguarding case discussion meetings with nurse team and at clinicians meetings

Recording Information

Information about vulnerable adults will be recorded in the individual notes. This is recorded using Snomed Codes.

Information supplied by all members of the primary healthcare care team, is recorded in the notes under a Snomed code. The use of unlinked correspondence is discouraged other than for the purpose of alerting individuals to new information in notes.

Conversations with, and referrals to, outside agencies are recorded under an appropriate Snomed Code.

List of recommended codes

Code description	Snomed description code ID	Comments
Adult Safeguarding concern	4212044015	
Adult no longer safeguarding concern	1707391000000113	
Vulnerable adult	2548392010	
Adult no longer vulnerable	1674061000000114	
FGM		
Female genital mutilation	2995039011	For Survivors of FGM
History of female genital mutilation	3302765017	
Other codes		
Victim of domestic violence	314681000000113	
Victim of physical abuse	339324014	
Victim of sexual abuse	339326011	
Victim of psychological abuse	2635291000000112	
Victim of financial abuse	339327019	This could include material abuse
Victim of neglect and acts of omission	2635571000000110	
Victim of organisational abuse	2635531000000113	
Victim of modern slavery	2635331000000117	
At risk of Sexual Exploitation	2360571000000118	
Victim of sexual exploitation	1755511000000112	

Monitoring Concerns

If a concern has been raised or a referral for safeguarding done, the clinician who has raised the concern or done the referral should check for a response to query/referral

Current concerns are discussed in the quarterly meeting of the adult safeguarding leads.

Any discussions are to be recorded in the notes so there is an audit trail. Online visibility will be switched off for these entries.

A list of the patient discussed in the meetings is kept on Y:\Safeguarding\Adult safeguarding.

The Nurse lead for safeguarding adults has protected time every month to review concerns and to work through and review risk register.

Part of the routine review of notes is to check on the Connecting Care Portal for updates:

- List can be obtained via Connecting Care Portal
- https://connectingcare.swcsu.nhs.uk/concerto/Login.htm
- User ID is e-mail address
- Password obtained by e-mailing: ConnectingCare_admin@swcsu.nhs.uk

Appendix Change Register

Date	Version	Author	Change Details
04/10/2023	1.0	Liz Turner	New Appendix

BrisDoc Patient care by people who care

NHS

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.

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

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Brisdoc Safeguarding Training

Version:	Owner:
1.0	Nicky Dowding (ODBP) / Renuka Suriyaarachchi (Head of Nursing and AHPs)

Introduction

BrisDoc recognises the importance of all co-owners and independent contractors having the competencies and knowledge relevant to their role that enable them to recognise and prevent abuse and neglect; and to support people who are at risk or experiencing abuse and neglect.

This SOP sets out the process of Safeguarding Training within BrisDoc Healthcare Services for all employed staff.

This guidance follows the ICB BNSSG intercollegiate standards for training requirements for Primary Care Staff.

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

Specific individual training requirements for safeguarding with Brisdoc Healthcare roles can be found on Radar on the Brisdoc Staff Training Matrix:

Training Information – Radar (radar-brisdoc.co.uk)

The Named Safeguarding Lead will undertake level 4 Safeguarding Adults training which incorporates Liberty Protection and Mental Capacity Act training annually.

This SOP is to be used in conjunction with the BrisDoc Healthcare Training Policy.

The Safeguarding Training Process for Level 3

For clarity and brevity, Safeguarding Training within this SOP and the proceeding text will refer to Adult and Children's Level 3 training unless specified.

The safeguarding training process for level 3 clarifies the following areas:

- How clinicians access, document and maintain Level 3 Safeguarding Training for evidence of statutory requirements and regulatory registered body
- How Line Managers monitor and record Level 3 Safeguarding Training within their Team
- The People Team process of monitoring and reporting Safeguarding Training for all employed Clinicians
- Reporting on Safeguarding Training compliance data within the Organisations fulfilling statutory obligations as a healthcare provider and ensuring this reflects our BrisDoc Values

Clinician Training Requirements for Level 3 Safeguarding

Adults

Clinicians will demonstrate a minimum total of **8 hrs** training completed over the previous three years (inclusive of the current year) on an annual basis. The eight hours will consist of a blended mixture of safeguarding training resource with at least **50**% of training being participatory. For example, a Level 3 face-to-face session, Level 3 E-learning (via SfH, elfh or other platform) and webinars or topical guidance from a reputable source. See Appendix for Safeguarding Training Evidence List.

Children

Clinicians will demonstrate a minimum total of **12 hrs** training completed over the previous three years (inclusive of the current year) on an annual basis. The 12 hours will consist of a blended mixture of safeguarding training resource with at least **50**% of training being participatory. For example, al a Level 3 face-to-face session, E-learning (via SfH, elfh or other platform) and webinars or topical guidance from a reputable source. See Appendix Safeguarding Training Evidence List.

Evidence of Safeguarding Training

All Safeguarding Training will be evidenced by certificates, notes, logs, or a journal. Clinicians are recommended to keep a log of Level 3 training. The People Team recommend the use of a Safeguarding Log for recording the hours of Level 3 Safeguarding Training. Please see Appendix for an exemplar of the Safeguarding Log and Example Template. There is also a link to the log for use.

Safeguarding Training for Clinicians

BrisDoc offers several different level 3 Safeguarding Training opportunities including face to face sessions and online learning. These are set out in the Safeguarding Hub on Radar.

Safeguarding Training – Radar (radar-brisdoc.co.uk)

A list of acceptable evidence can be found in the Safeguarding Training Evidence List.

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 standards outlined.

It is a mandatory Brisdoc requirement, to complete the Level 3 Safeguarding e-learning for Adults and Children every 3 years or show evidence of e-learning from another employer.

All mandatory and statutory training requirements are outlined in detail in the Training Matrices on Radar.

Training Information – Radar (radar-brisdoc.co.uk)

Sharing Training records between Employers

Where a Clinician has a substantive post elsewhere, it is the clinician's responsibility to share evidence of completed training with their Line Manager to satisfy Brisdoc training compliancy. There is **no** need to repeat training.

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

New Starters

On commencing employment with BrisDoc, Clinicians must provide evidence to their appointed Line Managers that they are fully compliant and up to date with Level 3 Safeguarding Training for both Adults and Children.

If the requisite number of hours are not completed, please see Safeguarding Training for Clinicians section of this SOP, to top up the hours. Level 3 Safeguarding Training must be

completed within the probationary period of taking up the post, ideally **before** clinicians begin unsupervised shifts. There may be extenuating circumstances which will be agreed with your line manager in advance.

Recording Safeguarding Training

New Starters- Responsibility of Line Manager

Once Line Managers are satisfied that a clinician is compliant, it is the line managers responsibility to inform the People Team via e-mail. All evidence of Level 3 Safeguarding Training will be forwarded to the People Team.

It is the Line Manager's responsibility to ensure that the clinician is compliant with the requisite number of hours Level 3 Safeguarding Training, has evidence of E-learning Safeguarding Training, Safeguarding Training evidence of the training hours and a log of hours recorded. Line Managers will consider deferring the start date and support the clinician with the completion of statutory training if this is not completed in the first four weeks.

Clinicians' Responsibility

It is the Clinicians' responsibility to complete Safeguarding training of the requisite hours as stated in Clinician training requirements for level 3 safeguarding to be done annually. It is also the clinician's responsibility to keep a record of all safeguarding training through the year. See Appendix for Examples of Level 3 safeguarding evidence.

Additional Safeguarding Training hours which will be required annually as a top-up, please see Safeguarding Training for Clinicians within SOP

The People Team recommend the use of a Safeguarding Log for recording the hours of Safeguarding Training. Please see Appendix for an exemplar of the safeguarding log and template. There is also a link to the log for use.

Although it is strongly recommended that clinicians use the Safeguarding Log – any document recording Safeguarding Training hours will be acceptable. Clinicians are advised to keep all evidence as stated in Appendix Safeguarding Training Evidence List if a Safeguarding Log is not compiled.

It is the responsibility of the Clinician to evidence Safeguarding Level Training and be up to date as a statutory requirement of employment with Brisdoc Healthcare. The evidence, as a Safeguarding Log or similar or certificates, will be required to be submitted annually to the individual's Line Manager at a specified date (usually the PDR).

Clinicians who are unable to show evidence of Safeguarding Training when requested by their manager will ultimately be unable to work for Brisdoc Healthcare.

Monitoring Safeguarding Training for all clinicians

Line Manager Responsibility

Line Managers are responsible for on-going safeguarding compliance during their one to ones with the clinical team. This can be done during the clinician's individual one to one. Line Manager are recommended to check safeguarding training each quarter but are by no means

restricted to or limited by this recommendation. Ensure the conversation is documented and recorded. This is a supportive process, ensuring clinicians understand the Level 3 Safeguarding Training requirement and process.

Annually (as part of the PDR process), clinician's will be requested to submit their Safeguarding Log. Evidence from Appendix Safeguarding Training Evidence List, including E-Learning to evidence the training (if a different platform to Brisdoc) will be required if the Safeguarding Log is not completed. The Line Manager will then be able to ascertain the date Safeguarding Training will expire for either, Adults of Children, which ever presents first.

The line manager will then email the People Team stating they are up to date with their annual statutory requirement and the date Safeguarding Training will expire. The line manager will also email the Safeguarding Log and Safeguarding training evidence (if required) to the People Team.

People Team

The People Team will collate safeguarding compliance. In the eventuality of receiving a completed Safeguarding Log, the People Team will confirm receipt of the Log to the Clinician and email the Clinician's Line Manger.

The logging of Safeguarding compliance will be evidenced by a completed Safeguarding Log and a date of expiration of either Adult of Child safeguarding training, the nearest date to expiry. The date will be recorded on Rota Master.

E-Learning for Safeguarding will not be reported on separately and will form part of the Safeguarding Log hours.

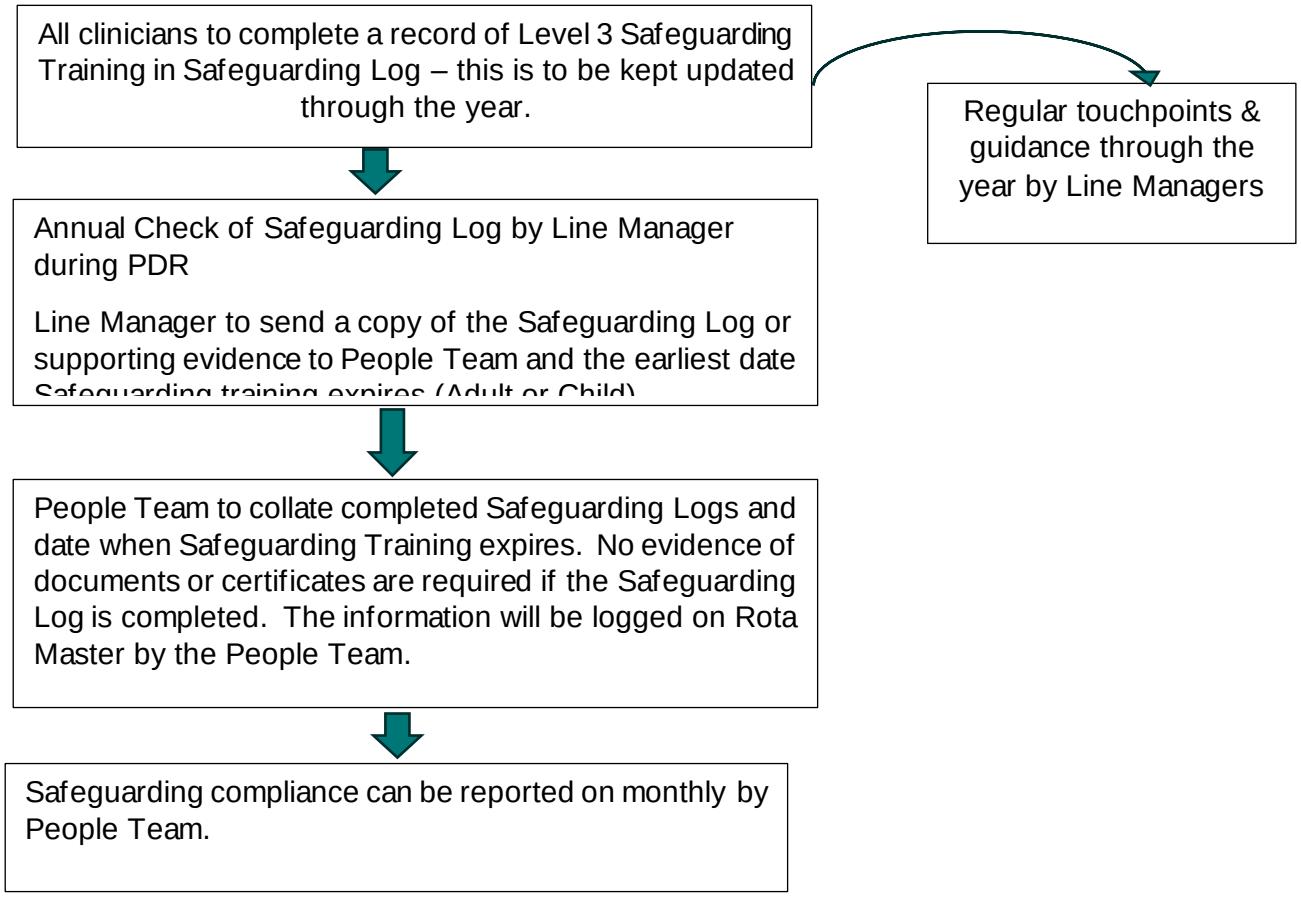
Internal audits will be carried out by the People Team as a continuous improvement process.

Reporting

The People Team will produce reports of the auditing process and Safeguarding Training compliance.

All Reports undertaken by the People Team will be generated by Rota Master and used to assess the success of the full compliancy process. The People Team will provide this information to the Line Managers and Safeguarding Lead. This performance will be monitored by the relevant boards.

Safeguarding Training, Monitoring & Reporting Process



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]

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Safeguarding Log Example and Template

Name:

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

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

TOTAL 8 hrs or more	0	Compulsory Safeguarding hours not fulfilled
Participatory 4 hrs or more	0	

Level 3 Safeguarding Adults - Training Log

Date	Type of Development / Training	Brief summary	Type of verification document	Length of time - hrs

TOTAL 12 hrs or more	0	Compulsory Safeguarding hours not fulfilled
Participatory 6 hrs or more	0	

Level 3 Safeguarding Children - Training Log

Date	Type of Development / Training	Brief summary	Type of verification document	Length of time - hrs

Click here to access on Radar [Example Safeguarding Log.]

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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	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, group 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,	Self-directed	• Copy of any signed formal agreements

papers, documents		• Copy of letter/e-mail requesting/authorising the writing of the piece • Copy of the document – dated and signed by yourself and a witness

Guidance on Checkpoints (new starter and existing staff)

Safeguarding Checkpoint (New Starters)			
To be completed by manager and new recruit by end of week one of start date			
Name of New Starter:			
Job title and Dept:			
Line Manager Name:			
TO BE COVERED BY THE END OF WEEK ONE			
Safeguarding Training – level 3			
CRITERIA	DETAIL	DATE	COMMENTS
Safeguarding Training Compliancy	Has the new starter completed Level 3 SG e-learning element (both child and adult)? - this must be completed within the first 4 weeks of employment. It can form part of the Log hours		
	Has the new starter completed Level 3 face to face session (adult and children)? If not, contact the People Team ASAP to arrange for training within the first 4 weeks		
	Discuss options of how to record it - e.g., spreadsheet log		
	Go through acceptable evidence list if required.		
	Can the new starter confirm full compliancy for a minimum adult SG of 8 hours (rolling 3 years) and minimum children SG of 12 hours.		
	Signpost to Staff Training plan on Radar to book future courses.		
	Signpost to Safeguarding Training Hub for options of other safeguarding training and learning opportunities (webinars, articles etc)		
Signed	Staff member:	Date:	
Signed	Line Manager:	Date:	

Safeguarding Checkpoint (Existing staff)			
To be completed by manager and clinician at least once during the course of a year			
Name of Clinician			
Job title and Dept:			
Line Manager Name:			
Mid-year safeguarding check			
Safeguarding Training – level 3			
CRITERIA	DETAIL	DATE	COMMENTS
Safeguarding Training compliancy	Has the clinician completed Level 3 SG e-learning element (both child and adult)? – this is a 3 yearly requirement & recorded on Log		
	Has the clinician completed Level 3 face to face session (adult and children)? If not, signpost to staff training plan on Radar to book.		
	Address any concerns or queries relating to logging - diary, spreadsheet log, certificates etc.		
	Go through acceptable evidence list if required.		
	Check for full and blended compliancy - minimum adult SG of 8 hours (rolling 3 years) and minimum children SG of 12 hours.		
	Signpost to Safeguarding Training Hub for options of other safeguarding training and learning opportunities (webinars, articles etc) if required.		
Signed	Staff member:	Date:	
Signed	Line Manager:	Date:	

Appendix Change Register

Date	Version	Author	Change Details
04/10/2023	1.0	RS & ND	New Appendix

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.