NHS
University Health Service
Southampton

Adult and Child Safeguarding Policy 2025-2026

Version:	Review date:	Edited by:	Approved by:	Comments:
0002	10.10.2026	Rebecca Ellery-Ash	GP Partners and Safeguarding Lead Dr Suzy Bannister	

1 Introduction

1.1 Handbook statement

The purpose of this handbook is to set out the requirements for University Health Service to take the appropriate actions for safeguarding children, young people and adults at risk of harm or abuse, in line with extant legislation.

In addition to this handbook, staff should refer to any local authority safeguarding doctrine relating to safeguarding at this organisation.

This handbook should be read in conjunction with the RCGP Safeguarding standards for general practice and Safeguarding Toolkit. As in this handbook, RCGP have set out their standards to combine the safeguarding of both children and adults. Throughout the definitions, should any safeguarding concern be for both adults and children, the title will have (Adults and Children) detailed.

Further guidance is also provided by NHS England's Safeguarding accountability and assurance framework (SAFF) (version 4) as detailed within the Safeguarding children, young people and adults at risk in the NHS. The SAFF document includes the changes to healthcare systems with the introduction of integrated care partnerships, PCNs and provider collaboratives. Additionally, the latest Department for Education (DfE) Working together to safeguard children 2023: statutory guidance supports any actions that are required to be taken across the healthcare system, including within primary care at ICBs, PCNs and at practice levels.

1.2 About the RCGP Safeguarding standards for general practice

At the time of the release of this handbook in December 2024, the training requirements still differ slightly between the RCGP standards and the RCN's Intercollegiate guidance within their:

- Adult Safeguarding: Roles and Competencies for Health Care Staff
- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff

Likewise, CQC GP mythbusters have not been updated to reflect the new RCGP standards that support this subject, namely:

- GP mythbuster 25: Safeguarding adults at risk
- GP mythbuster 33: Safeguarding children

Furthermore, the CQC's Inspector's Handbook for Safeguarding still refers to the RCN Intercollegiate guidance

As the new guidance from RCGP states that their standards have been established to support 'all GPs and everyone working in a general practice setting within the UK,' the guidance for training has been taken from this document.

It is expected that all guidance will be updated soon to confirm the standardised approach to training. These changes will be reflected at the next update of this Safeguarding Handbook.

SAFEGUARDING LEADS
University Health Service Southampton:

Lead	Name and role
Safeguarding lead	Dr Suzy Bannister
Deputy safeguarding lead	GP Partners
Mental Capacity Act (MCA) lead	Dr Suzy Bannister
Looked After Children (LAC) lead	Dr Suzy Bannister
Prevent lead	Dr Suzy Bannister
Practice Manager	Wendy Fielder / Rebecca Ellery-Ash
Safeguarding administration lead	Yvette Poulton / Lindsay Djiann

If you have any concerns about safeguarding issues, please report them without delay.

If you think someone is in immediate danger, please call 999.

Adults

Hampshire:

- **Hampshire Safeguarding Adults Board**
- **Call Hampshire Adult Services on 0300 555 1386 (0300 555 1373 if out of hours), or the police on 101**

Southampton:

- **Southampton Adult Social Care**
- **Email: adultsocialcareconnect@southampton.gov.uk**
- **Telephone: 023 8083 3003 (023 8023 3344 if out of hours)**

Children

Hampshire:

- **Hampshire County Council**
- **Call Hampshire Children's Services on 0300 555 1384 (8:30am to 5pm Monday to Friday) or 0300 5551371 out of hours**
- **If you think a child or young person under the age of 18 has been or is being abused by a person in a position of trust, contact the County Council's Allegations Officer, call 01962 876364 or email child.protection@hants.gov.uk**

Southampton:

- **Southampton City Council**
- **Call 023 8083 3004 (02380 23 33 44 if out of hours)**

Top Ten Safeguarding Tips in Primary Care HIOW

1. Making a Child Safeguarding Referral

- Hampshire Isle of Wight Portsmouth and Southampton (HIPS) Child Safeguarding Procedure Manual – contains up to date information on child safeguarding protocols and procedures. If you are dealing with a specific safeguarding concern (e.g. CSA medicals/UBB protocol/ bruising protocol) use this to identify next steps.
- If you identify a safeguarding concern which you feel needs to be referred you need to complete an Inter Agency Referral Form into your local Multi-Agency Support Hub (MASH).
    - Be clear about your concerns and expectations
    - Remember to consider the voice of the child
    - Avoid jargon e.g. medical acronyms/terminology – the person reading your referral may not have a medical background
    - Beware of assumptions – do not assume that other agencies/professionals have the information you are sharing
- The use of the Threshold Guidance and discussion with your safeguarding lead/other team members should help inform the decision-making.
- Guide for having honest and difficult conversations with parent/carers/children: Practitioner Guide Honest Conversations

2. Early Help:

- If you identify that a family is in need of support you may consider referral for Early Help; depending on their level of need (see Threshold Guidance) you can refer directly Hampshire early help pathway or via Inter Agency Referral Form

3. Key Considerations in Information Sharing

- Useful links: Information sharing advice for safeguarding practitioners, Information Sharing Essentials, 7 Golden Rules - Information Sharing
- Be open
  - Where safe it is good practice to open with child and/or their carers about what information you intend to share, with whom, and why.
  - Do not inform them if by doing so could increase the child's risk of harm.
- Consent should be requested, but is not always required
  - You do **not** need consent to share personal information if a child is at risk or perceived to be at risk.
- Ask for help and advice when unsure
  - If uncertain, promptly seek guidance from your safeguarding lead, Caldicott Guardian or medicolegal team
- Share only relevant, accurate, and proportionate information
  - If you are asked to share information but do not feel you have enough information you should ask e.g. a Section 17 request comes through with no information on why Children's Services are making the request
- Record your decisions and add safeguarding coding
  - Document the rationale for your decision to share or not share information.

4. Chasing up referrals/queries with Children's Services

- We would advise you to use Inter Agency Referral Form or Hampshire Professionals Number: 01329 225379 to contact Children's Services directly
- We would also encourage you to use Child Protection-Information Sharing service (CP-IS). This will show looked after children, those on Child Protection (CP) plans and up to date social worker contact details who you may wish to contact directly.
- If you have made a referral and are not satisfied with the response you should always escalate these concerns (Escalation Policy).

5. Coding

- Clear and consistent safeguarding coding in clinical records is essential ensuring that anyone accessing the records is immediately aware of risks
- Use standardised codes
  - Using the Arden's template to code ensures the use of standardised coding. This allows for removal of codes if child comes off CP/CIN plan, or when they become adults
- Highlight in the problem list
  - Ensure safeguarding concerns are visible in the patient summary or problem list, not buried in consultation notes.
- Link and code in family members/household contacts where possible

5 *Coding continued* -

- Confidentiality and online access
  - Use online access restrictions or confidential notes for safeguarding information
- Domestic abuse coding should never be entered into the perpetrator's notes RCGP guidance on recording of domestic violence

6. Key considerations in Parental Conflict Cases

- Best interests of the child
- Parental responsibility (PR)
    - Who holds PR? This affects access to records and decision-making.
- Safeguarding history
    - Any history of domestic abuse or other safeguarding concerns must be factored in.
- Child's capacity and wishes
    - Assess whether the child has Gillick competence (ability to understand and make decisions).
    - If competent, their views should be respected—e.g., whether they want a parent to access their notes Consent to treatment - Children and Young People
- If unsure it is best to discuss with your medicolegal team, and if there are safeguarding concerns contact our team.

7. Post-Natal and 6 - 8 week Baby Checks

- Use of Arden's template – helps prompt you to enquire about and record key safeguarding information such as:
    - Routine enquiry about domestic abuse
    - Who has parental responsibility/who else is at home
    - Parental mental health review
    - Previous safeguarding risks/Children's Services involvement in the family
    - Prevention of abusive head traum: ICON
    - Safe sleep advice: Every Sleep Counts

8. Training

- The Royal College of General Practitioners (RCGP) updated its safeguarding training requirements in October 2024, introducing new standards that apply to all staff working in general practice across the UK. Information about training requirements and online learning material can be found: RCGP Safeguarding Hub
- Our safeguarding team provide level 3 and GP Safeguarding Leads training throughout the year – please contact hiowicb-hsi.safeguardingchildren@nhs.net for up to date details
- We would encourage that the safeguarding leads cascade the learning from the leads training within their primary care teams
- Regular case based safeguarding discussion with colleagues, supervisors and within your team is encouraged for reflection and learning

9. Local Authority Designated Officer (LADO)

- The LADO manages and oversees cases involving child safeguarding allegations against people who work with children e.g. doctors, teachers, volunteers
- You must inform the LADO if someone working with children:
    - Has harmed or may have harmed a child.
    - Possibly committed a criminal offence against or related to a child.

  - Behaved in a way that suggests they may pose a risk to children.
  - Acted in a way that raises concerns about their suitability to work with children
- For more information about referrals and advice: Hampshire LADO

10. Contacting our team

- If you need advice or need support with any of the above or a different child safeguarding query please contact our team: hiowicb-hsi.safeguardingchildren@nhs.net
- Please note we are not Children's Services, and we cannot support with urgent or emergency advice and we do not take referrals. All referrals need to be made to MASH as outlined above.

2 Definition of terms

2.1 Adults with care and support needs

The Care Act 2014 defines adults with care and support needs as those aged 18 and over who:

- Have needs for care and support (whether or not the local authority is meeting any of those needs); and
- Are experiencing, or at risk of, abuse or neglect; and
- As a result of those care and support needs, are unable to protect themselves from either the risk of or the experience of abuse or neglect

2.2 Advocacy

Advocates help to ensure that a person's rights are upheld and that their views, wishes and needs are heard, respected and acted on. The NHS webpage titled Someone to speak up for you (advocate) provides further detailed information.

2.3 Child

The Children Act 1989 defines that a child is a person under the age of 18 years.

2.4 Child criminal exploitation

Child criminal exploitation, or CCE, occurs when an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18. The victim may have been criminally exploited even if the activity appears to be consensual.

CCE does not always involve physical contact; it can also occur through the use of technology. Further reading on this subject can be found in the government document titled Protecting children from criminal exploitation, human trafficking and modern slavery.

2.5 Child in need

Under Section 17 of the Children Act 1989, a child will be considered in need if:

- They are unlikely to achieve or maintain, or to have the opportunity to achieve or maintain, a reasonable standard of health or development without the provision of services from the local authority
- Their health or development is likely to be significantly impaired, or further impaired, without the provision of services from the local authority
- They have a disability. Disability includes blindness, deafness or dumbness, mental disorders and permanent illnesses, injuries or congenital deformities

2.6 Child protection

Child protection sets out the clear actions needed to keep a child safe and well.

Where a child is at risk of harm, a conference with key agencies will share information, identify any risks to the child and outline the actions required to protect the child.

2.7 County lines (Adults and Children)

County lines is a term used to describe gangs, groups or drug networks that supply drugs from urban to suburban areas across the country, including market and coastal towns, using dedicated mobile phone lines or 'deal lines'.

It involves exploiting children and vulnerable adults to move drugs and money to and from the urban area and to store the drugs in local markets. It involves intimidation, violence and the use of weapons including knives, corrosives and firearms.

Further reading can be found at Section 5.2.

2.8 Discriminatory abuse

Discriminatory abuse occurs when values, beliefs or culture result in a misuse of power, causing denied opportunities. Motivating factors include age, gender, sexuality, disability, religion, class, culture, language, race or ethnic origin.

2.9 Domestic violence or abuse (Adults and Children)

Domestic violence is also called domestic abuse and includes physical, emotional and sexual abuse in close relationships or between family members. Domestic violence can happen against anyone, and anyone can be an abuser.

Further reading on this subject including support can be found on the NHS webpage titled Domestic violence and abuse and at Sections 4.1 and 5.1.

2.10 Emotional abuse (Adults and Children)

For a child, emotional abuse is constant emotional mistreatment, the intention of which is to cause significant adverse effects on the emotional development of the child.

Emotional abuse also includes overprotection and the restriction of a child's learning or partaking in normal social interaction.

For all, emotional abuse is behaviour that has a detrimental effect on the individual's emotional wellbeing and may result in distress, e.g., bullying, verbal abuse, intimidation, isolation, over-protection or the restriction or withdrawal of an individual's human and/or civil rights.

Further reading can be found at Sections 4.1 and 5.1.

2.11 Female genital mutilation (Adults and Children)

Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.

Further reading can be sought in the Female genital mutilation guidance document and in the WHO document titled Female Genital Mutilation and at Section 4.4.

2.12 Financial abuse

Financial abuse is the use of an individual's funds, property, assets, income or other resources without their informed consent or authorisation. Financial abuse includes theft, fraud, exploitation, misuse of benefits or the misappropriation of property, inheritance or financial transactions.

2.13 Forced marriage

Forced marriage became illegal in June 2014 under the Anti-social Behaviour Crime and Policing Act 2014 and it is a form of domestic abuse. It is primarily against women, although not exclusively, and most cases involve females aged between 13 and 30.

Forced marriage is a marriage conducted without the consent of one or both parties or where consent is obtained under duress, and is markedly different from an arranged marriage in which the individuals retain free will and have the choice to accept the arrangement or not. In forced marriage, perpetrators use physical, sexual, psychological or financial abuse to pressurise people to marry against their will.

Rubie's story is a YouTube video clip by the University of Derby.

Further reading can be found at Section 4.2.

2.14 Homeless patients (Adults and Children)

PHE guidance tilted Homelessness: applying All Our Health advises that the following housing circumstances are examples of homelessness:

- Rooflessness (without a shelter of any kind, sleeping rough)

- Houselessness (with a place to sleep but temporary, in institutions or a shelter)
- Living in insecure housing (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence, or staying with family and friends, known as 'sofa surfing')
- Living in inadequate housing (in caravans on illegal campsites, in unfit housing, in extreme overcrowding)

Shelter provide the legal definition of homelessness and threatened homelessness.

For further reading, refer to Chapter 9.

2.15 Honour-based abuse

This term is used to describe abuse, threatening behaviour or violence which is committed to protect or defend perceived cultural beliefs or the honour of the family. Honour-based abuse is not acceptable behaviour and is illegal. Some of those who commit this crime mistakenly believe that someone has brought shame on their family or community that compromises their traditional beliefs or culture.

Further advice can be found in the charity Karma Nirvana's YouTube video clip and at Section 4.3.

2.16 Human rights

The United Nations defines these rights as being inherent to all human beings, regardless of race, sex, nationality, ethnicity, language, religion or any other status.

2.17 Institutional abuse

Institutional abuse refers to a lack of respect in a health or care setting which involves routines that meet the needs of staff as opposed to the needs of the individual at risk and which violate the individual's dignity and human rights.

2.18 Learning difficulty

The NHS explains that a learning difficulty is a type of Special Educational Needs (SEN) that affects areas of learning such as reading, writing, spelling, mathematics, etc. There are several levels of learning difficulties as detailed within the link.

Learning difficulties can include dyslexia, attention deficit-hyperactivity disorder (ADHD), dyspraxia and dyscalculia. A learning difficulty is different from a learning disability, as a learning difficulty does not affect general intellect.

2.19 Learning disability

The Department of Health and Social Care (DHSC) defines a learning disability as "a significantly reduced ability to understand new or complex information, to learn new

skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood."

Learning disabilities vary and include:

- Mild disabilities (such as minor difficulties with speech or writing)
- Moderate disabilities
- Severe disabilities (where an individual requires support in most, or all areas of daily life)
- Profound and multiple learning disabilities (these are diagnosed when an individual has a severe learning disability combined with other disabilities which consequently affect their overall ability to communicate with others and be independent)

It should be noted that a learning disability is not a physical disability.

Further reading to support learning disabilities can be found at Chapter 7.

2.20 Looked after children and young people

A looked after child (LAC) may also be referred to as a 'child in care', and this refers to a child or young person placed in the care of their local authority for more than 24 hours. Looked after children may be living with foster parents, in residential children's homes or other residential settings, e.g., a secure unit.

Further reading on looked after children can be found at Chapter 8.

2.21 Local authority designated officer

A Local Authority Designated Officer (LADO) is a person who would be notified should there ever be an allegation that a member of staff behaved in an inappropriate manner towards a child. The purpose and duties of the role are set out in the DfE statutory guidance Working Together to Safeguard Children.

Further reading about this role can be found in the National LADO Network guidance titled The role of the LADO.

2.22 Making safeguarding personal

This is a Local Government Association initiative that aims to develop an outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances.

2.23 Modern slavery (Adults and Children)

This includes slavery, human trafficking, servitude and forced labour. Individuals are coerced, deceived and forced into a life of abusive and inhumane treatment.

Further information and guidance can be found in the Modern Slavery and Human Trafficking Guidance document.

2.24 Multi-agency safeguarding hub

This is a collaborative approach where professionals from different agencies work together to identify and prevent safeguarding concerns. The goal is to:

- Protect children and vulnerable adults from harm and abuse
- Identify and address risks to vulnerable people quickly
- Share information
- Coordinate activities

Each local authority will have guidance for their own Multi Agency Safeguarding Hub, or MASH. Further reading can be found in the Home Office guidance titled Working together to safeguard children: Multi-Agency Safeguarding Hubs.

2.25 Neglect (Adults and Children)

For a child, neglect is the continued failure to ensure that a child's physical and psychological needs are met, resulting in significant impairment of the development of the child. Examples of neglect include failing to provide adequate supervision, failing to respond to emotional needs, a lack of protection (from emotional or physical harm), failing to provide clothing, accommodation and food.

Drug and alcohol misuse is a factor in a significant number of children in need and child protection cases, as detailed within the PHE guidance titled Supporting information for developing local joint protocols between drug and alcohol partnerships and children and family services.

Further reading on neglect can be found at Sections 4.1 and 5.1.

2.26 Person in a position of trust

Any person who may be in a position of trust (PiPoT). In a healthcare setting, this is more likely to be a clinical member of the team, although this could be any staff member who provides support to adults.

The Care Act 2014 refers to this role. Note PiPoT and the Act only refer to adults.

2.27 Physical abuse (Adults and Children)

For adults and children, physical abuse can involve burning or scalding, drowning, suffocating, hitting, shaking, throwing, pushing, pinching, exposure to extreme temperatures (hot and cold), female genital mutilation, inappropriate use of medication, poisoning or other means of causing physical harm

For adults, it could also involve inappropriate restraint and deprivation of liberty. Further reading can be found at Sections 4.1 and 5.1.

2.28 Private fostering

The Children Act 1989 advises that private fostering is a private arrangement (without the involvement of a local authority) to care for a child under 16, or under 18 if

disabled, by a person other than the parent or close relative for an expected period of more than 28 days.

2.29 Regional safeguarding leads

The national safeguarding team and regional safeguarding leads (RSLs), known as NHS Safeguarding, work to improve safeguarding practices across the NHS to produce positive health outcomes for victims and survivors of abuse and exploitation within all communities.

Further guidance can be sought in the Safeguarding children, young people and adults at risk in the NHS document.

2.30 Safeguarding

The CQC guidance titled Safeguarding People defines safeguarding as protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It is fundamental to high-quality health and social care.

2.31 Safeguarding leads

Named professionals responsible for oversight and leadership of all safeguarding matters. The role may be split between the safeguarding of adults and children, or there can be a single lead role.

The lead(s) is responsible for ensuring that the safeguarding processes, including infrastructure and governance, conform to the practice or organisational safeguarding lead requirements as detailed within the RCGP Safeguarding Standards. Additionally, the safeguarding lead responsible for adults is usually the named MCA Lead. This role is to ensure compliance with the Mental Capacity Act.

Furthermore, there is a Safeguarding administration lead who supports the other safeguarding roles in ensuring that the administration and governance processes are being maintained.

Further information on all safeguarding roles can be found at Chapter 14.

2.32 Self-neglect (Adults and Children)

Self-neglect includes a lack of self-care, a lack of care of one's environment and the refusal of services that would reduce the risk of harm. Self-neglect may occur because the individual is unable to care for or manage themselves, they are unwilling to manage themselves, or both.

Further reading can be found at Sections 4.1 and 5.1.

2.33 Sexual abuse (Adults and Children)

For a child, sexual abuse is the enticement or forcing of a child/young person to participate in sexual activities. This involves penetration or non-penetrative acts, physical contact or non-contact activities such as the encouraging of a child or young person to watch sexually inappropriate content.

For all, sexual abuse includes sexual exploitation, including the involvement of an adult in a sexual activity they have not consented to, the encouragement to watch any form of sexual activity, coercion into any form of sexual activity or the involvement of the adult in such scenarios when they lack the capacity to consent.

Further reading can be found at Sections 4.1 and 5.1.

2.34 Sexual exploitation

Child sexual exploitation occurs when an individual takes sexual advantage of a child or young person, this is anyone under the age of 18, for his or her own benefit.

Power is developed over the child or young person through threats, bribes, violence and humiliation, or by telling the child or young person that he or she is loved by the exploiter. This power is then used to induce the child or young person to take part in sexual activity, as detailed within the NHS E guidance titled Child sexual exploitation.

2.35 Significant harm

The Children Act 1989 Section 31 (3c) (9) defines 'harm' as the ill-treatment or impairment of the child. Whilst 'significant' harm is not defined under the Act, this will be decided by the local authorities working with family members to assess the child.

2.36 Young carers

A young carer is a person who regularly provides emotional and/or practical support and assistance for a family member who is disabled, physically or mentally unwell or who misuses substances.

3 Guidance

3.1 Overview

The safeguarding of children, young people and adults at risk is paramount for healthcare professionals and all team members working at this organisation. It is essential that all staff are fully aware of their responsibilities to detect individuals at risk, provide the necessary support to those affected by safeguarding issues and ensure a high-quality service, including the appropriate sharing of information.

The safeguarding leads within this organisation are:

Lead	Name and role
Safeguarding lead	Dr Suzy Bannister
Deputy safeguarding lead	GP Partners
Mental Capacity Act (MCA) lead	Dr Suzy Bannister
Looked After Children (LAC) lead	Dr Suzy Bannister

Prevent lead	Dr Suzy Bannister
Practice Manager	Wendy Fielder / Rebecca Ellery-Ash
Safeguarding administration lead	Yvette Poulton

Local external safeguarding leads for both adults and children can be found at Chapter 14.

3.2 Organisation statement

This organisation recognises that all children, young people and adults at risk have a right to protection from abuse and neglect, and the organisation accepts its responsibility to safeguard the welfare of such persons with whom staff may come into contact.

We will respond quickly and appropriately where information requests are made, abuse is suspected, or allegations are made in relation to children, young people or adults at risk. Furthermore, we will give children, young people, their parents and adults at risk the chance to raise concerns over their own care or the care of others, and have in place a system for managing, escalating and reviewing concerns.

The organisation will ensure that all staff are given the appropriate safeguarding training, proportionate to their role, and that they attend annual refresher training. New members of staff will receive safeguarding training as part of their induction programme.

For quality assurance purposes, any information that accompanies a safeguarding referral is subject to audit. Audits will confirm content and that any relevant SNOMED CT code has been added to the clinical system.

Safeguarding responsibilities are defined in job descriptions, and there are nominated leads for safeguarding adults and children.

3.3 Principles of safeguarding

It is possible that the GP may be the individual who identifies a child, young person or adult as being at risk. It is therefore essential that clinicians act appropriately and in a timely manner to reduce the risk of long-term abuse, in accordance with the six principles of safeguarding.

The organisation supports the safeguarding principles by ensuring that:

- There is a safe recruitment procedure in place, including the effective use of the Disclosure Barring Service (DBS) as detailed within the DBS Policy
- Clear lines of accountability exist within the organisation for safeguarding
- All staff are aware of the safe whistleblowing process
- All staff understand the requirement to work in an open and transparent way

- All patients are treated with dignity and respect regardless of culture, disability, gender, age, language, racial origin, religion or sexuality

- All staff adhere to the guidance in this handbook and that given in the referenced texts

- All staff effectively interact with the relevant agencies, sharing information appropriately

- All staff who work with children, young people and adults at risk are responsible for their own actions and behaviour and should avoid conduct that may lead another responsible person to question their motivation and/or intentions

3.4 Mental capacity

The Mental Capacity Act (MCA) 2005 offers a framework that details the rights of individuals should their capacity be questioned. The principles of the MCA must be adhered to and are applicable to safeguarding.

Should an individual at risk opt to remain in an abusive situation, it is essential that they choose to do so without duress or undue influence and are fully aware of the risks they may encounter. Should it transpire that the individual has been threatened or coerced, safeguarding interventions must override their decision to ensure that the safety of the individual is protected.

NICE has published guidance titled Decision-making and mental capacity to assess mental capacity, together with practical resources to enable organisations to put the guidelines into practice. The pathway covers a wide breadth of scenarios for practitioners to utilise, including executive decisions in cases such as traumatic brain injury when capacity is more difficult to establish.

The five statutory principles of this Act are as detailed within the Department of Constitutional Affairs document titled Code of Practice.

To support the best interests of any patient with a mental capacity concern, a designated professional will be assigned the role of Mental Capacity Act lead, or MCA lead. This person is ordinarily the safeguarding lead, as the two roles are intertwined. Further information on this role can be found at Section 14.8.

The NHS document titled Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework dictates that all NHS providers are required to have an MCA Lead.

3.5 Liberty Protection Standards

In addition to the MCA 2005 and the later Mental Capacity (Amendment) Act 2019, the organisation will determine if a person is deemed to have been deprived of their liberty as detailed in the DHSC Liberty Protection Safeguards: What they are guidance. Where it is suspected that the deprivation is unlawful, the organisation will report this to the local authority within 48 hours.

A local authority has the legal power to sanction and issue a Deprivation of Liberty Safeguard Order should it be deemed necessary to restrict the freedom of an

individual if it is in their best interest. This Safeguard Order would support patients who lack capacity to consent to their care arrangements, i.e., those suffering from a disorder or disability of the mind, for whom care and treatment can only be provided in circumstances that amount to a deprivation of liberty.

3.6 Emotional Wellbeing Mental Health Services (EWMHS)

Children and vulnerable adults (up to the age of 25 years with Special Educational Needs) will be offered referral to EWMHS if they need support with any of the following wellbeing or mental health difficulties:

Anxiety	Suicide
Depression	ADHD
Stress	Autism spectrum
Eating disorders	Emotional and behavioural difficulties

Referral will be made via the EWMHS referral process.

3.7 CONTEST and Prevent

In 2011, the Government introduced the Prevent strategy as part of the counter-terrorism strategy, CONTEST. The purpose of Prevent is to stop individuals becoming involved in terrorism. This includes violent and non-violent extremism which can create an atmosphere conducive to terrorism. Channel is a support programme that helps those individuals who are at risk of being drawn into terrorism.

It is possible that staff will meet and treat people who are at risk of being drawn into terrorism, including supporting violent or non-violent extremism, or being susceptible to radicalisation. If a member of staff suspects that an individual is at risk, they should speak to the safeguarding lead or, in their absence, to the deputy safeguarding lead.

Further guidance can be found at the Gov.uk webpages titled Channel and Prevent Multi-Agency Panel (PMAP) guidance and Regional Prevent educational coordinators.

4 Adults

4.1 Indicators of abuse in adults

Indicators of the different types of abuse are detailed within the Social Care Institute for Excellence (SCIE) guidance titled Types and indicators of abuse. Other types of abuse that fall outside of these categories are detailed throughout this chapter.

4.2 Forced marriage (Adults and Children)

This crime remains largely under-reported as many victims are too frightened to come forward for fear of the repercussions on their families. The joint Home Office and FCO guidance titled Forced marriage provides guidance and contact details should there be any concerns.

For further information on forced marriage refer to the Gov.uk webpage titled Forced marriage, this guidance includes how to raise Form FL401A: Application for a Forced Marriage Protection Order.

4.3 Honour based abuse

Honour-based abuse is a crime or incident committed to protect or defend the 'honour' of a family or community. It may take several different forms, as detailed within the Metropolitan Police guidance titled What is honour-based abuse?

Details and support for patients, safeguarding professionals and those who are worried about a person who may be a potential victim can be found in the charity Karma Nirvana's guidance.

4.4 Female genital mutilation (FGM) (Adults and Children)

FGM has been illegal in the UK since 1985. The Serious Crime Act 2015 strengthened legislation by adding extra requirements for healthcare professionals to report FGM.

The Act details that:

- It grants lifelong anonymity to alleged FGM victims
- It is an offence for parents to fail to protect their child from FGM
- FGM Protection Orders can be introduced to prevent potential victims from travelling abroad
- It is a mandatory reporting duty for nurses, midwives, doctors, social workers and teachers to report to the police whenever they observe physical signs of FGM on a person under the age of 18, or where a girl tells them it has been carried out on her
- It is an offence for FGM to be committed abroad against UK residents

In addition to the requirements of the Serious Crime Act, it is now mandatory for all GP practices and Acute and Mental Health Trusts to submit data to NHS Digital. Under 18s who may be at risk of FGM should be referred using standard existing safeguarding procedures, usually to children's services.

The following SNOMED CT codes should be used for FGM:

Heading	Code
Female genital cutting	429744008
Discussion about female genital mutilation	713255007
Family history of female genital mutilation	902961000000107
Discussion about female genital mutilation with carer	932301000000101

Further detailed information can be sought in the Female Genital Mutilation Guidance document and GP mythbuster 80: Female genital mutilation (FGM).

5 Children

5.1 Indicators of abuse in children

The signs of child abuse can be difficult to spot. The NSPCC provide detailed advice on recognising the signs of abuse and on the support and actions that can be carried out should there be a concern about a child.

Refer to their guidance titled Spotting the signs of child abuse. In this document, it also refers to the signs and the many types of abuse a child may have been exposed to such as:

- Bullying and cyberbullying
- Child sexual exploitation
- Child trafficking
- Criminal exploitation and gangs
- Domestic abuse
- Emotional abuse
- Female genital mutilation (also refer to Section 4.4)
- Grooming
- Neglect
- Non-recent abuse
- Online abuse
- Physical abuse
- Sexual abuse

5.2 County lines (Adults and Children)

The National Crime Agency guidance defines county lines as being where illegal drugs are transported from one area to another, often across police and local authority boundaries (although not exclusively), usually by children or vulnerable people who are coerced into it by gangs.

The ‘county line’ is the mobile phone line used to take the orders of drugs. Importing areas (areas where the drugs are taken to) are reporting increased levels of violence and weapons-related crimes as a result of this trend.

Possible indicators of county lines involvement include:

Becoming more secretive, aggressive or violent	Loss of interest in work and a decline in performance
Meeting with unfamiliar people	Suspicion of physical assault or unexplained injuries
Excessive receipt of texts/phone calls	Significant decline in school results/performance

Unexplained acquisition of money, clothes or mobile phones	Using language relating to drug dealing, violence or gangs
Persistently going missing from their home, school or local area	Carrying a weapon
Relationships with controlling/older individuals or groups	Association with a gang
Leaving home or care without an explanation, or staying out unusually late	Having a friendship or relationship with someone who appears controlling
Becoming isolated from peers and social networks	Gang association or isolation from peers or social networks
Self-harm or significant changes in emotional wellbeing	Using drugs, especially if their drug use has increased

5.3 Unborn child

Pregnancy can, in some cases, create circumstances and influences for both parents which need to be understood by all professionals who come into contact with these families. These include where:

Previous children in the family have been removed because they have suffered harm	Either or both parents have mental health problems
Concerns exist regarding the mother's ability to protect	Either or both parents have a learning disability
There are concerns regarding domestic violence and abuse	Either or both parents are under 18 years
A parent or other adult in the household, or regular visitor, has been identified as posing a risk to children	Any other concerns exist that the baby may be at risk of significant harm including a parent previously suspected of fabricating or inducing illness in a child or harming a child
A child in the household is the subject of a Child Protection Plan	A child is aged under 16 and found to be pregnant
A sibling has previously been removed from the household either temporarily or by court order	If the pregnancy is denied or concealed
Either parent is a Looked After Child or known to children's social care	Either or both parents abuse substances, alcohol or drugs

A child protection plan may be required to be put in place for an unborn baby when a decision is made that the baby will be at risk of significant harm when born. The plan will include a discharge plan and contingency arrangements to ensure the baby's safe delivery and immediate care.

Information to support arrangements for an unborn child is available from the local authority safeguarding team.

Additional reading is available from Coram Child Law for both the Child protection conference and plan and the Legal position relating to the unborn child.

6 Raising a concern – action to be taken by staff

6.1 General

Should any member of staff have cause for concern, or a person has disclosed abuse to them, they are to report it to the following and in this order:

1	Safeguarding lead
2	In their absence, the deputy safeguarding lead
3	In the absence of one or both leads, or where safeguarding leads are uncertain as to the action required, the senior clinician present must raise the matter with the local authority safeguarding team. In emergency cases, a decision will be made about contacting the police or social services
4	In all instances of safeguarding concerns, the safeguarding lead will be updated to ensure that they can effectively respond to any external interested parties

6.2 Adult at risk – action to be taken

When it is suspected that an adult at risk is suffering from abuse, staff are to:

- Remain focused
- Act in a non-judgemental manner
- Offer support and empathy, and remain engaged with the individual
- Reassure the individual throughout the consultation
- Ensure that all information is recorded accurately
- Secure any evidence where possible
- Ensure that they do not give the adult at risk any promises or press them for further information

6.3 Managing concerns about a person in a position of trust

The Care Act 2014 requires local safeguarding adult boards to establish a framework and process to respond to allegations against anyone who works, either paid or unpaid, with adults who have care and support needs.

Any service where there is a Person(s) in a Position of Trust (PiPoT) is to have a procedure to manage any concern that has been raised against them. The local authority safeguarding adult team need to be appraised should there be an allegation of any incident where:

- Adults are harmed where they have care and support needs, or
- A criminal act has been committed towards an adult with care and support needs, or

- There is behaviour that raises concern about the suitability of a person to work with adults with care and support needs

Where any such allegation is made, the safeguarding lead will complete a PiPoT referral to the local authority safeguarding adult team. The referral form can be found on the local Safeguarding Board website, coupled with correspondence details. It is preferable to speak to a member of the Safeguarding Adults Team to raise a safeguarding concern and to inform them that this is about a person who is in a position of trust.

Any allegation against a PiPoT will be taken seriously and dealt with fairly and in a way that protects both the adult with care and support needs and the PiPoT. Therefore, when an allegation is received by the local area safeguarding team, the safeguarding adults manager will contact the safeguarding lead (or referrer, if different) for an initial discussion.

Depending on the circumstances, the safeguarding adults manager may discuss the content and further considerations with key agencies including:

- Police
- Adult safeguarding leads from other health agencies
- Local authority designated officer (LADO)

Initial discussions may lead to a meeting involving all appropriate agencies where the focus of the meeting will be to determine what actions are required, who will undertake those actions and by when. It will also be agreed who will be responsible for contacting and updating the PiPoT, and the meeting will decide what information can be shared at this point.

A possible outcome of an allegation of inappropriate behaviour may be to consider actions under the Disciplinary Policy and Procedure, and to make a referral to an appropriate professional body. Furthermore, a recommendation may be made for the person to undertake further training or duties or for their responsibilities to be changed. Timescales for actions will be agreed to ensure the process is concluded in a timely way.

Should any decision be made to suspend the PiPoT, then this is to be viewed as a neutral act to protect and support, and is not to be viewed as any decision of guilt.

Note that the HM Government guidance titled Working together to safeguard children stipulates that information must be shared with the LADO where it is considered that a member of health staff poses a risk to children or might have committed a criminal offence against one or more children.

6.4 Child at risk – action to be taken

The Children Act 2004, as an expansion of the 1989 Children Act, reinforces that all people and organisations working with children have a duty to help safeguard children.

When it is suspected that a child or young person is suffering from abuse, staff should:

- Remain focused, take time, slow down

- Reassure the child, explaining to them that they have done the right thing, and they are not to blame
- Offer support and empathy, and remain engaged with the child/young person
- Explain what needs to be done next
- Ensure that all information is recorded accurately, paying particular attention to dates and times of events
- Not ask leading questions or promise confidentiality

Detailed guidance on Looked After Children (LAC) can be found at Chapter 8. Further guidance and resources for recognising and responding to abuse in children can be found in the NSPCC's Recognising and responding to abuse guidance.

6.5 Parental responsibility

It should be noted that each parent has parental responsibility and, as such, anyone with parental responsibility for a child has a right to seek access to that child's medical records. Parents do not lose parental responsibility if they divorce, however, parental access can be restricted by the court.

Parental responsibility is defined in the Children Act 1989.

Additional guidance can be found within:

- Gov.uk document titled Parental rights and responsibilities
- MDU guidance Parental Responsibility document. This discusses access and also when there are disputes between parents
- Access to Medical Records Policy

6.6 Risks to the child following parents separating

Occasionally, there may be a request from a single parent suggesting that the other parent must not be allowed to access the child(ren)'s medical records and/or must not be involved in the medical care of that child(ren).

Should this organisation receive any such requests from estranged parents, then the advice from MDU titled Children whose parents are separated offers sound guidance. This can be further endorsed by contacting the defence union to obtain their medico-legal considerations.

In all situations, this organisation will do what is in the best interest of the child and this may involve discussing any concerns with the safeguarding lead should any staff member believe that the parents do not have best interests of the child(ren) in mind.

6.7 Child who contacts the organisation to make an appointment

Should a child contact the organisation and ask to make an appointment, the staff member receiving the call is to consider both the age and competence of that child. Often it may be appropriate for the child to do so, but it should be discussed with the safeguarding lead should there be any concerns, such as:

- The child seems to be too young, or
- What they are asking for is inappropriate, or

- The staff member feels that this may be a safeguarding concern

Further information on competence can be sought in:

- NSPCC guidance titled Gillick competency and Fraser guidelines
- CQC's GP mythbuster 8: Gillick competency and Fraser guidelines

6.8 Registering children

The same registration process as for adults should be followed when registering children (0–18 years of age). However, there are certain circumstances that this organisation should be aware of in relation to safeguarding guidance.

As detailed in the Primary medical services policy and guidance manual (PGM) at Section 4.12.3, if a child under the age of 16 attempts to register alone, or with an adult who does not have parental responsibility, the safeguarding lead should be alerted.

It is recommended that the organisation gains assurance by the means detailed at Section 4.12.5, although when doubt exists, the safeguarding lead is to be informed, and appropriate actions taken.

Further reading can be found in the New Patient Registration and Health Check Policy.

6.9 Raising an alert

When it is necessary to raise an alert, a risk assessment should be undertaken to prevent further risk of immediate harm to the child, young person or adult at risk.
The initial assessment should consider:

- Whether the individual is still at risk if they return to the place where the abuse is alleged or suspected to have taken place
- The extent of harm that is likely to occur if the child, young person or adult at risk encounters the person who is alleged to have caused harm
- Whether the alleged person still has access to any person at risk

Once raised, the alert will be managed according to the local authority's safeguarding process to ensure the needs of the individual are met and that the risk of further harm is significantly reduced.
The process will detail the actions to be taken to safeguard the individual at risk, ensuring that those involved are aware of the options available and how they can support the individual throughout the process.

6.10 Challenging a decision made by the local authority

Local safeguarding boards will have a process to support any disagreement arising from a number of areas following any safeguarding decision. Whilst disagreements can come from a variety of scenarios, those most likely to arise are around:

- A safeguarding concern where the threshold for intervention is contested

- Concerns about safeguarding case management
- Lack of engagement of key partners in the multi-agency risk management process
- A lack of understanding regarding respective roles and responsibilities
- An absence of action, or the case has been closed
- The views of the patient or their representative being at odds with those of healthcare or safeguarding professionals, and/or where the decision places the adult, or child at on-going risk of harm

Whilst noting that the local authority safeguarding escalation process must be followed, the following four-stage process can be used as a guide when challenging any local safeguarding decision.

Stage 1	Initial attempts to resolve low-level problems should be made between practitioners and agencies when a disagreement arises. Note that all members of staff have a professional duty to raise concerns about the safety and well-being of service users and to act promptly. The safeguarding lead should be appraised of the issue.
Stage 2	If the problem is not resolved at Stage 1, the staff member is to escalate their concerns to the Practice Manager, clearly outlining what the disagreement refers to, and the preferred outcome. The Practice Manager will liaise with the Safeguarding Lead who will speak with the other agency involved, aiming for resolution.
Stage 3	If the problem is not resolved at Stage 2, the Practice Manager must escalate the concern with the safeguarding lead who will discuss with the local authority safeguarding lead.
Stage 4	Should there be no resolve at Stage 3, the matter is to be referred to the ICB Designated Safeguarding Lead.

At each stage, and wherever possible, the person who has raised the concern, including a patient, family member or carer, is to be involved. Should a decision be made that the family member, carer or patient disagree with, then they can be offered the following guidance:

- Mencap: Challenging decisions on social care
- Citizens Advice: Complain about a local council's involvement with your family
- Scope: Challenging or complaining about your social care
- Local Governments and Social Care Ombudsman: Child protection issues

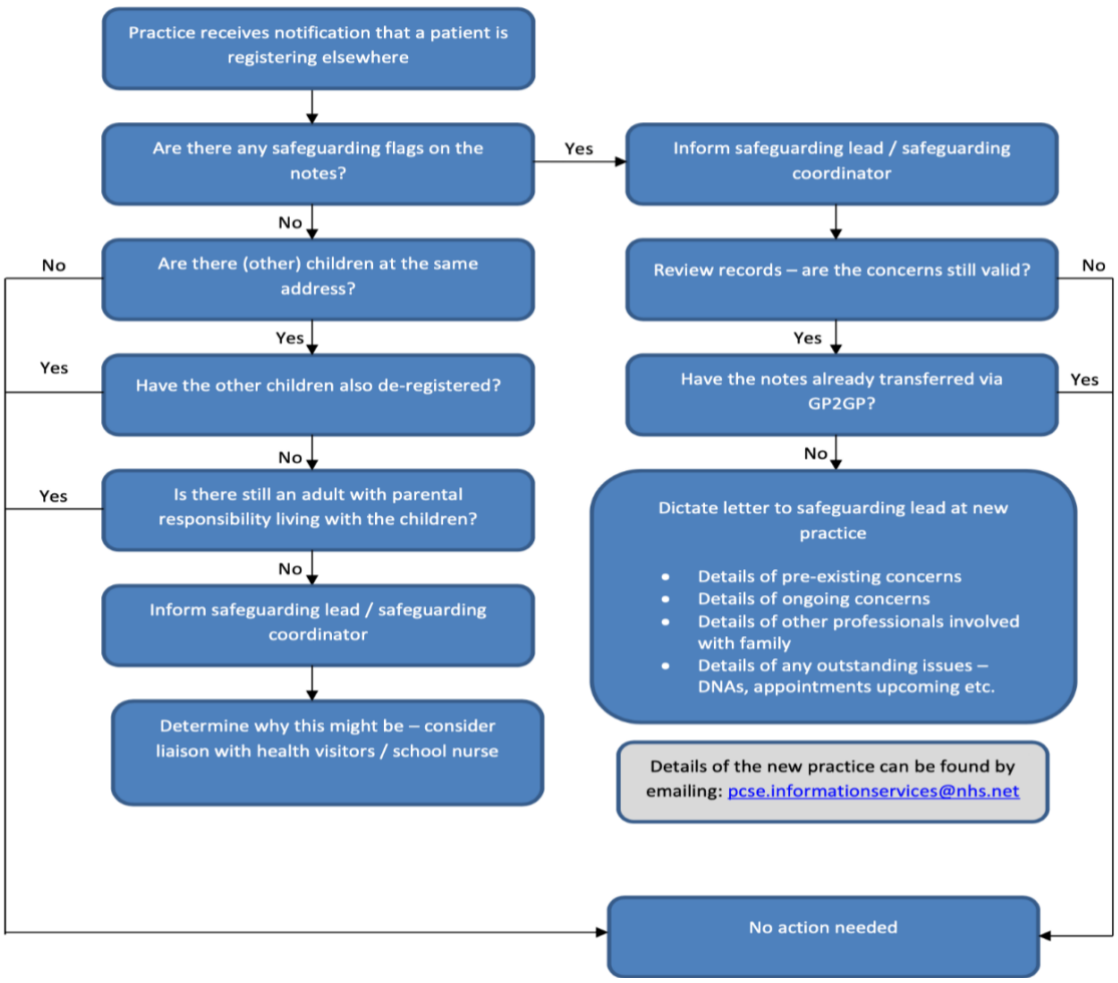
Supporting reading for the framework to support practice, reporting and recording can be found within the Local Government Association guidance titled Making decisions on

the duty to carry out Safeguarding Adults enquiries. This advises upon the duties of the Care Act 2014 Section 42.

6.11 Movement of at-risk patients

At this organisation, a register of all at-risk children, young people and adults is maintained, allowing close oversight of this vulnerable group should there be any request to leave the practice. Should any patient who has a safeguarding flag request to change practices, there is a risk that, as notes may take time to be transferred, there can be a delay in summarising. Furthermore, it has been known for families to deliberately move practices frequently and consult different healthcare providers to avoid detection.

To minimise any risk, it is imperative that safeguarding concerns are communicated promptly, and the following process is to be undertaken:



Source: Brighton and Hove CCG – Documenting Safeguarding Concerns (Jan 2020)

Further information can be sought in the Removal of Patients Policy.

6.12 Other considerations

Staff must ensure that they stay calm and liaise with the clinical safeguarding lead or nominated deputy to make certain the child, young person or adult at risk is offered the

most appropriate level of care. Concerns must be discussed immediately, and an action plan devised.

Staff must understand that there are circumstances where a safeguarding alert may be made without consent, e.g., circumstances involving other at-risk groups or where a crime may have been committed. Disclosing this information is referred to as a public interest disclosure to share information.

6.13 Record-keeping

It is essential that all concerns, discussions and decisions are recorded in the individual's healthcare record and that the appropriate SNOMED codes for abuse are used. Any documentation relating to safeguarding should be factual, contemporaneous and should be immediately obvious on a patient's record to any health professional involved in the patient's direct care. There should be no more than 48 hours delay in entering safeguarding information to records.

Audits will be conducted to ensure that all appropriate SNOMED CT codes have been used to support any safeguarding concern, or referral. Furthermore, the audit will confirm that all codes have been added to any outcome from any safeguarding referral.

All correspondence relating to any safeguarding matters for a child, young person or adult at risk is to be scanned into the individual's electronic healthcare record. Staff are to ensure that, prior to sharing information, any sensitive third-party information is redacted if necessary and the entry marked as "safeguarding relevant" to ensure information is restricted to a "need-to-know" basis.

Child protection reports are also to be scanned into the healthcare record and the appropriate coding used. In such circumstances, the SNOMED code used to illustrate that the child is on a child protection plan should be entered into the notes of all individuals living at the same address. This is further detailed at Section 8.7.

The administration safeguarding lead will be able to advise staff accordingly if they have any queries or concerns.

6.14 Sharing of information

The sharing of information is essential to establish early intervention and the protection of children, young people and adults at risk. Clinicians must understand the need to share information, when it is appropriate to share information, and how they should share it.

The UK Government guidance titled Information sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers discusses the importance of sharing information.

The above link advises that there is a need to have a lawful basis to share information under data protection law, but when the intention is to share information as part of action to safeguard a child at possible risk of harm, consent may not be an appropriate basis for sharing. However, it is good practice to ensure transparency about any decision and seek to work cooperatively with a child and their carer(s) wherever possible. This means staff should consider any objection the child or their carers may

have to proposed information sharing, but should there be a belief that sharing the information is necessary to protect the child from harm, then that should be considered to override any such objection.

Where doubt exists, the safeguarding lead or nominated deputy should be approached for advice.

There are eight Caldicott Principles to sharing information. With these principles in mind, staff are advised to follow the rules within NHS E guidance titled Safeguarding.

Further information in relation to sharing information can be sought from the following:

- ICO guidance Data sharing code of practice
- ICO guidance A 10 step guide to sharing information to safeguard children
- Data Protection and Confidentiality Handbook
- UK General Data Protection Regulation (UK GDPR) Policy
- Consent Policy

6.15 Ongoing monitoring of vulnerable patients

This organisation will be responsible for ensuring that a register of all at-risk children, young people and adults is maintained, allowing close oversight of this vulnerable group. The following regular checks will be carried out:

- The register will be cross-referenced with family members and significant others and relationships recorded and highlighted, where indicated

- The register will be regularly checked to ensure the status of all vulnerable patients is current and those responsible for direct care will be notified of any changes, e.g., child no longer in need or child now subject to a plan. The correct codes will be entered and entries marked as safeguarding relevant

- The register will be checked for occasions where a vulnerable patient has missed an appointment or has not attended secondary care following a referral

- The register will be checked for movement of vulnerable patients, both into and out of the organisation

- Newly registered vulnerable patients will be flagged to the registered clinician and records will be summarised as a priority to ensure accuracy. If not already offered, the patient/carer/guardian will be offered a face-to-face new patient check appointment with their GP

- Where patients have moved outside of the practice, records will be checked against the national spine to confirm registration elsewhere and paper records will be returned via PCSE as a priority. Where there are concerns that there may be a gap in registration, the safeguarding lead will be advised and will consider if further action is required

6.16 External support for victims

There are several organisations that provide specific support. Some of the main national charities include:

- Action for Children
- Citizens Advice
- Crimestoppers
- Justice and Care
- Karma Nirvana
- Mind
- NSPCC
- Rape Crisis
- Refuge
- The Salvation Army
- The Survivors Trust
- Women's Aid

7 Learning disability

7.1 About

A learning disability (LD) is defined by the DHSC as "A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood."

LD is caused by something which affects the development of the brain either before birth, during birth or in early childhood.

Possible causes may include:

- An inherited condition such as Fragile X syndrome
- Abnormal chromosomes, e.g., Down's syndrome or Turner syndrome
- Exposure to environmental toxins or infections and illness during pregnancy
- A very premature birth
- Complications during birth, resulting in a lack of oxygen to the baby's brain
- Illness such as meningitis or measles; or injury or trauma to the brain in early childhood
- Sometimes the cause of a learning disability remains unknown

7.2 Supporting health inequalities

There are approximately 1.3 million people with an LD in England, who tend to experience:

- Poorer physical health, as found within the King's College research titled Learning from Lives and Deaths – people with learning disability and autistic people. Note, this is further detailed within the NHS E guidance titled Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) policy 2021
- Poorer mental health, as detailed in NICE Guidelines NG54
- Significant health inequalities as detailed by Mencap in their guidance titled Health inequalities
- Death at an age up to 29 years younger than the general population

PHE guidance titled Learning disability – applying All Our Health promotes awareness and details how staff in a healthcare setting can support those patients attending the organisation who have a learning disability.

The charity Dimensions' campaign called #MyGPandMe highlights the serious gap in accessible treatment and preventative healthcare for those with an LD, and they have produced free resources aimed at supporting those working within general practice.

Keele University have produced a toolkit that is detailed within the NHS E document titled, Learning disabilities: Making a difference toolkit.

Supporting CQC GP mythbusters include:

- GP mythbuster 53: Care of people with a learning disability in GP practices
- GP mythbuster 67: Reasonable adjustments for disabled people
- GP mythbuster 90: Population groups
- GP mythbuster 108: Involving and engaging with the patient population and local communities

Patient guidance can be sought from the Mencap document titled The importance of joining the GP Learning Disability Register.

Further reading includes the Learning disabilities guidance document, which includes guidance on the annual NHS Learning Disability health check that is available to anyone over the age of 14 years who is registered as having a learning disability.

8 Looked after children

8.1 About

A looked after child (LAC), may also be referred to as a 'child in care', and the term refers to a child, or young person placed in the care of their local authority for more than 24 hours. Looked after children may be living with foster parents, in residential children's homes or other residential settings, e.g., a secure unit.

NICE Guidance 205, guidance in relation to safeguarding, recommends that organisations, practitioners and carers work together to deliver high-quality care, stable placements and nurturing relationships for looked after children.
Further reading can be found in the following:

- Gov.uk Looked-after children and children in care
- RCPCH Looked After Children (LAC) – Resources and guidance
- RCN Looked After Children: Roles and Competencies of Healthcare Staff
- NSPCC guidance titled Children in care

Should a child be 'looked after', then they would ordinarily have been subject to being accommodated under Section 20, or being made the subject of a Care Order under Section 31 of the Children Act 1989. There are other routes into the looked after system, these being where either a child or juvenile:

- Has been removed from their home under an Emergency Protection Order
- Has been removed from their home under a Child Assessment Order
- Has been removed to suitable accommodation by the police through their powers of protection under Section 46 of the Children Act 1989
- Has been remanded in care and refused bail
- Is subject to a Supervision Order which includes a provision that they reside in local authority accommodation
- Is made the subject of an Interim Care Order under Section 38 of the Children Act

Further reading can be found in the Coram Child Law guidance titled Local authorities' duties in relation to looked after children.

8.2 Types of orders and plans

There are various types of Orders that can be made by the Local Authority to take action to protect a child who is suffering harm, or who is at risk of suffering harm. The table below details these, although more detailed reading on Care Orders can be sought from the Coram child law guidance titled Care Orders.

A plan will be drawn up by the local authority, and this will establish how the child can be kept safe, how circumstances can be made better for the family and what support they will need. Should a Child Protection Plan (CPP) be established, the parents will be advised of the requirements as detailed within the Citizen Advice guidance titled If there's a child protection plan for your child.

Type	Definition
Care Order	When a child is placed under the care of the local authority, the local authority is given parental responsibility and shares it with current parental responsibility holders, such as the child's parents. However, in order to protect a child's welfare, the local authority may exercise parental responsibility beyond that of the current parental responsibility holders.
Child Assessment Order	If a local authority is concerned about a child, they may apply for a Child Assessment Order. For detailed reading on this process, which can only be used for a maximum of seven days, refer to the Citizens Advice guidance tilted Child abuse – child assessment.
Interim Care Order	While care proceedings are ongoing, the court can consider making an Interim Care Order, which places the child temporarily under the care or supervision of the local authority.

	An Interim Care Order will be issued if the court believes the threshold criteria have been met. On the first occasion, an Interim Care Order can last up to 8 weeks and can be renewed for up to 28 days. The number of Interim Care Orders that can be issued is unlimited. When an Interim Care Order is in place, the local authority assumes parental responsibility for the child.
Supervision Order	A supervision order gives the local authority the legal power to monitor the child's needs and progress while the child lives at home or somewhere else. A social worker will advise, help and befriend the child and provide help and support to the family as a whole. Conditions can be attached to a supervision order, for example, the parent may have to tell the supervisor of any change of address and allow the supervisor to visit the child at home. A supervision order does not give the local authority parental responsibility, nor allow them any special right to remove the child from their parent. The parents keep parental responsibility but must not act in any way against the supervision order. For further reading refer to the Citizens Advice webpage titled Child abuse – supervision orders.
Emergency Protection Order	These are only used in exceptionally serious situations. It gives limited parental responsibility for the child to whoever applied for the order, and this parental responsibility is limited to whatever is needed for the child's welfare, and the right to remove the child (or prevent their removal) from where they are now. For further reading, refer to the Citizens Advice webpage titled Child abuse – emergency protection orders.

8.3 Supporting algorithms

The HM Government Working Together to Safeguard Children 2023 guidance provides flowcharts to support the following:

Flow chart 1	Action taken when a child is referred to LA children's social care
Flow chart 2	LAC returning home to their families
Flow chart 3	Immediate protection
Flow chart 4	Action taken for an assessment of a child under the Children Act
Flow chart 5	Action following a strategy meeting

Flow chart 6	What happens after the child protection conference?

8.4 Registering a looked after child

Patient registration is to follow the process outlined in the New Patient Registration and Health Check Policy. In addition, when the LAC status is highlighted, the organisation must ensure that the following information is provided from the carer(s):

- Full name of carer(s)
- Full name of social worker(s)
- Contact details of social worker(s)
- Summary of other agencies involved with the child
- Parental responsibility status

Where there is any doubt regarding information, the safeguarding lead is to be informed, and their advice adhered to. It may be necessary to contact the local safeguarding team for further information about the child.

The patient record for all LAC must have an alert set so that when anyone at this organisation views the record, an alert is displayed. This alert is to state: “This patient is an LAC,” or “This patient has a family member who is an LAC.”

In order to gain awareness of any potential ongoing safeguarding requirements, if the patient records from their previous practice have not already been received, these are to be expedited. Following receipt, these should be forwarded to the safeguarding lead for review and, if appropriate, to summarise.

Further information can be found in the Summarising Policy.

When registering the patient, the record of the LAC should be linked to their parents, even if they are not living at the same address, and also to siblings and others in their household, by use of the appropriate SNOMED CT code and templates. Coding should also detail information should the patient be on a CPP. This should be applied to the records of all individuals living at the same address.
To support an LAC who is registering having moved from another UK country, refer to the following:

- Scottish Government Looked after children
- Wales Centre for Public Policy Children looked after in Wales
- Northern Ireland Department of Health Looked after children

8.5 Proxy access

When requesting proxy access, the individual classified as the person with parental responsibility is to provide identification to confirm that they are the person that they say they are.

A legal consideration is that, should the LAC be over the age of 11 years, then consent for the proxy access must be provided and must be recorded by either of the following means:

Verbal consent	To the clinician witnessing the consent

Written consent	A signed consent form, or a letter from the child, requesting that the individual with parental responsibility is given proxy access. This form should also detail the level of access required

If the child is over 11 but is not competent to give consent, the organisation will gain confirmation that the person requesting proxy access is the right person to act on the child's behalf as a proxy.

Further detailed reading on age and competences can be sought within the Consent guidance. Additional guidance on establishing proxy access on clinical IT systems is available for both EMIS and System One.

8.6 New patient health checks

As with all new registrants, all LAC patients and those on any CPP must be invited for a new patient health check. Given the sensitive nature of such patients, it has been decided that it will be either a practice nurse or GP who conducts the health check.

8.7 Supporting SNOMED CT codes

Any child who is either looked after or on a protection plan is to have an entry stating this fact within the clinical system and given the relevant SNOMED CT code. As there is a higher probability that this group may have sensitive information contained within their medical record, this is of particular relevance, especially as it is easier for patients to access their online record and as detailed in Section 8.8.

To ensure that confidence is maintained, a flag should also be added to the home screen on the clinical system identifying that a patient is an LAC, or is from a family that has an LAC, or is or has family members who are on a protection plan.

The following SNOMED CT codes are to be used when making entries in clinical records for those with either LAC or CPP involvement.

SNOMED CT code	Descriptor
160870005	Child in care
135891007	Child in need
160871009	Foster care
342191000000101	Subject to child protection plan
375041000000100	Family member subject to child protection plan
375071000000106	Family member no longer subject to a protection plan
342891000000105	No longer subject to child protection plan
864491000000105	Has a child subject to child protection plan
818901000000100	Unborn child subject to child protection plan
762761000000102	Initial case conference
762781000000106	Review case conference

For further codes, refer to the SNOMED CT browser.

8.8 Accessing online services

Since 2022, GP practices in England are required to enable access for patients over the age of 16 to any new health record entries once they have been entered or filed onto their IT clinical record.

The NHS App that is available to download on either an iOS or Android device allows patients or their carers to access a range of NHS services on a smartphone or tablet, and is available for anyone who is aged 13 or over and is registered with a GP practice in England. Those who do not have a device they can use to download the NHS App, or do not want to download it, can log into the NHS website to access their NHS account.

Patients can access information on the NHS App, including those patients who are classed as 'looked-after' and for whom parental responsibility rests with foster parents or carers who may require proxy access to their medical record. Due to the risk of harm, discomfort, upset or danger to the patient, it may be inappropriate for certain content to be available to read. Therefore, it is important that this information is not made available, and/or any sensitive material is redacted.

Further reading, including around children and young persons' access, the milestone birthdays that need to be considered for a child, and the requirements for proxy access can be found in:

- NHS E guidance About GP online services
- Surrey County Council guidance A professional's guide to online and proxy access to medical records for children and young people
- Access to Medical Records Policy

8.9 Redaction timeframes

Redaction can be temporary or permanent. This is dependent on the nature and sensitivity of the information and the potential harm to the patient should this information be disclosed. It is therefore imperative that reviews are undertaken of all LAC records to ensure that all relevant sensitive information has been and remains redacted.

Clinicians must ensure they have discussions with their patients regarding the status of redacted information and whether it remains necessary to redact that data at the request of the patient or on the advice of the clinician.

8.10 Searches

To ensure that accurate records are maintained, and to make certain no LAC, their relative or carer has access to sensitive information, there is a need to conduct a search of the above SNOMED CT codes on a regular basis.

The safeguarding lead will ensure that this is one of the regular audits that is conducted.

8.11 Information sharing

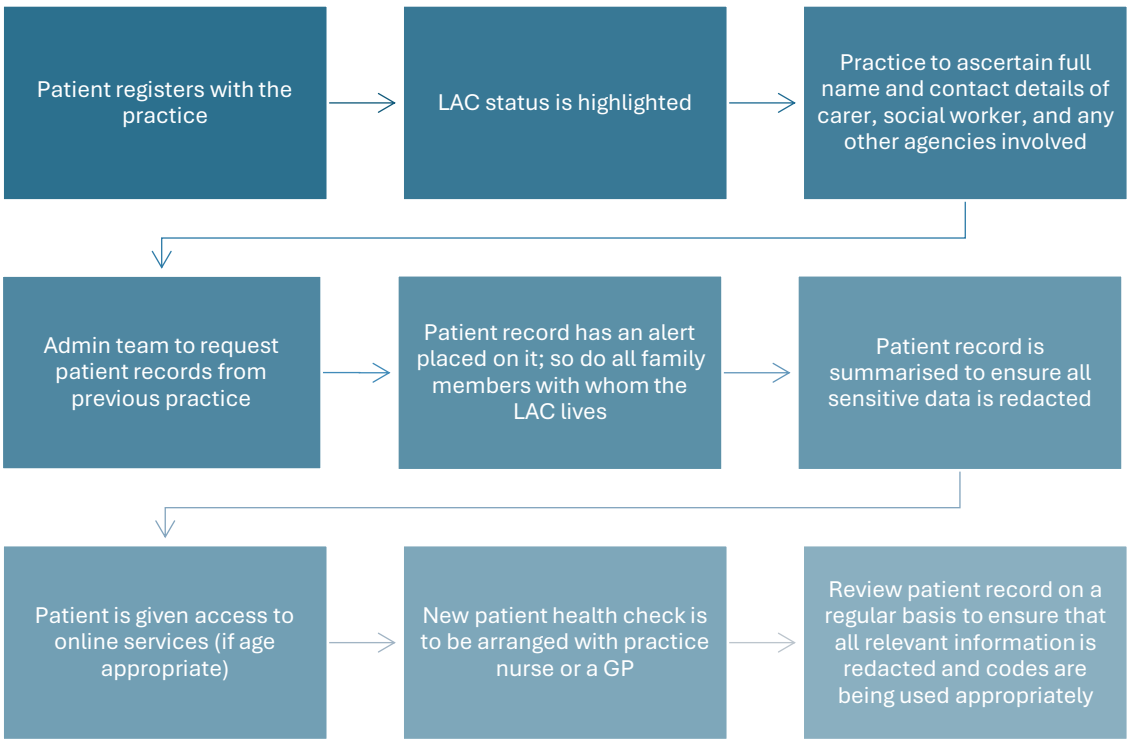
The DfE guidance titled Information Sharing – Advice for practitioners providing safeguarding services for children, young people, parents and carers (May 2024) details the Seven golden rules (pg 4) to support sharing information.

Furthermore, it details the legal basis for disclosing information with all agencies involved in the care of the patient in order to receive the most effective patient-centred care. In support of information sharing, it is imperative that the healthcare records are accurate, current and coded appropriately.

To support this requirement, all staff will adhere to the direction given in the Good Practice Guidelines for Electronic Patient Records (GPGv5).

8.12 Process map for a looked after child

This organisation will follow the process as detailed:



9 Homelessness

9.1 About

Primary care services are frequently the first point of contact for people experiencing homelessness, and other vulnerable groups, when they are faced with a health

problem. However, people experiencing homelessness may often face barriers to access, in addition to a lack of understanding as to their rights to care.

The NHS E document titled Supporting people experiencing homelessness and rough sleeping details the following health inequalities for this group of patients:

- People experiencing homelessness and rough sleeping have a greatly reduced life expectancy
- 73% of people experiencing homelessness suffer from a physical health problem and 80% from a mental health problem
- Homeless people are significantly less likely to be registered with a GP, meaning preventable healthcare issues are not treated in a timely fashion, making ED attendance more likely

The NHS E policy titled Primary Medical Care Policy and Guidance Manual (PGM) states the following:

- Anybody in England may register and consult with a GP without charge (section 4.4.1)
- This includes asylum seekers and refugees, students, people on work visas and those who are homeless, overseas visitors, whether lawfully in the UK or not (section 4.4.8)
- There is no regulatory requirement to prove identity, address or immigration status to register at a GP surgery (section 4.9.4)

Further supporting guidance can be found in the New Patient Registration and Health Check Policy.

9.2 Supporting actions within general practice

Being homeless increases the prevalence of the following health related issues:

- Diabetes
- Mental health
- Substance abuse
- Infectious diseases such as HIV, tuberculosis and hepatitis C
- Lung diseases, such as bronchitis, tuberculosis, asthma and pneumonia
- Malnutrition
- Wounds and skin infections

Therefore, the following actions can be adopted to support those patients who are homeless, or who are at risk of becoming homeless:

- Introducing double appointments
- Keeping prescriptions to as short a duration as possible
- Ensuring clear boundaries for consultations are in place
- Giving fast access to a named GP
- Waiving any charges for housing letters or medical reports

The Homelessness Reduction Act (2017) places emphasis on homelessness prevention, and Section 10 requires public authorities in England to notify a local housing authority (LHA) of service users who they think may be homeless or at risk of becoming homeless. While it is not a mandatory duty for any GP practice to refer to a LHA for further support, it would be beneficial to do so.

Any referrals to an LHA must include:

- The service user's name
- Any contact details
- An agreed reason for referring the user

A referral may be made without consent to safeguard children and vulnerable adults. The governmental guidance titled A guide to the duty to refer provides detailed information. Further reading about homelessness, rough sleeping and solutions to support can be sought from:

- NICE guidance titled Integrated health and social care for people experiencing homelessness [NG214]

- CQC GP mythbuster 29: Looking after homeless patients in general practice

- The charity Pathway provides useful primary care guidance and resources for both patients and practice staff including the Standards for GP receptionists in primary care.

- The charity Homeless link

10 Domestic abuse

10.1 Domestic Abuse Act 2021

The prevention of domestic abuse and the protection of all victims lies at the heart of the Domestic Abuse Act 2021 ('the 2021 Act') and its wider programme of work.

As detailed within the Home Office Domestic Abuse Statutory Guidance document, the measures seek to:

- Promote awareness
- Protect and support victims
- Hold perpetrators to account
- Transform the justice response
- Improve performance

Domestic abuse is a high harm, high volume crime that remains largely hidden, and anyone can be affected by domestic abuse, regardless of age, disability, sex, sexual orientation, gender identity, gender reassignment, race, religion or belief.

Domestic abuse is defined as follows:

The behaviour of a person ("A") towards another person ("B") is domestic abuse if both A and B are aged 16 or over and are personally connected to each other, and the behaviour is abusive. It should be noted that it does not matter whether the behaviour consists of a single incident or a course of conduct.

10.2 Recognising domestic abuse

To ensure victims of domestic abuse are well supported, all staff should be aware of, and recognise the signs of domestic abuse, as detailed at Chapter 3 of the Domestic Abuse Statutory Guidance.

A Domestic abuse awareness poster can be used to highlight that staff can provide support to victims, or listen to the concerns of those who feel a person may be a victim of domestic abuse. There are various support groups, including numerous charities as detailed at Section 6.16 that also provide their own posters with contact, or emergency telephone numbers. Often these are placed in prominent areas such as a waiting room, but equally, these may be placed in more discrete areas such as the patient toilets.

Note, whilst this handbook supports service users, there could also be a safeguarding concern with a member of the team. Further information on this can be found in the Staff Domestic Abuse Policy.

Domestic Violence Awareness eLearning is available in the HUB.

10.3 Understanding the impact of domestic abuse

Domestic abuse can cause serious and devastating long and short-term physical, mental, emotional and psychological health impacts for both adults and children.

A victim's day to day life can be affected by trying to manage the abuse, leading to increased anxiety and a focus on adapting their behaviour to appease the perpetrator. The psychological impact of domestic abuse can be so severe that it leads to suicide ideation and attempt.

10.4 Multi-agency response to domestic abuse

Responding to domestic abuse often involves many agencies such as local authorities, community-based agencies, children's services, housing, drug and alcohol services, specialist domestic abuse agencies, the police and the criminal justice system.

Working together is pivotal if domestic abuse is to be identified at the earliest opportunity and dealt with effectively, thereby minimising the risk of escalation.

The DH and UK Council of Caldicott Guardians document titled Striking the balance provides useful guidance regarding both domestic violence and MARACs (Multi Agency Risk Assessment Conferences). Appendix A to this document is a Co-

ordinated Action Against Domestic Abuse (CAADA) template checklist that can be used to support victims of domestic abuse.

Further reading relating to muti-agency responses to domestic abuse, be it MARAC or Multi-Agency Safeguarding Hub (MASH), can be found in the Home Office guidance titled Domestic Abuse Statutory Guidance at Chapter 7.

Standing Together has produced In Search of Excellence, a guide for facilitating Coordinated Community Response (CCR) partnerships that reiterate the importance of coordinated work between frontline service providers.

11 Other safeguarding matters

11.1 Safer recruitment

This organisation will ensure that the appropriate pre-employment checks are conducted prior to any individual commencing work at the organisation.

This organisation will mirror the six NHS Employment Check Standards which are:

1. Identity checks
2. Employment history and reference checks
3. Work health assessments
4. Professional registration and qualification checks
5. Right to work checks
6. Criminal record checks

All checks will be conducted before staff are recruited into positions. Applicants will be required to undergo either an enhanced or standard DBS check, depending on the position applied for. The management team has a legal duty to refer information to the DBS if any employee has harmed, or is deemed to be a risk of harm, to children, young people or adults at risk.

11.2 Freedom to speak up

Freedom to speak up, otherwise known as whistleblowing, means that any staff member can raise a concern they have about the conduct of others within the organisation or about how the organisation is run, in confidence.

11.3 Allegations against a member of staff

All allegations will be investigated thoroughly. The safeguarding lead is to be informed, and they will consult with the local authority's safeguarding team (child or adult) and, if necessary, the local police.

The safeguarding lead will advise the individual concerned that an allegation has been made against them but will not disclose any information at this stage. In line with the seriousness of any allegation, the individual concerned must be managed appropriately in accordance with HR procedures. Allegations do not necessarily merit immediate suspension. This will depend on the person's role within the organisation and the nature of the allegation.

Allegations are distressing for all concerned, the individual making the allegation, the organisation's staff and the alleged perpetrator. It is imperative that appropriate advice is sought from the outset. The local authority's designated officer (LADO) for managing allegations will be able to provide guidance to ensure that the correct process is followed. Medico-legal advice may also be sought from the defence union.

11.4 Chaperone

It may be appropriate to offer a chaperone for a variety of reasons. Clinicians should consider the use of chaperones for some consultations, and not solely for the purpose of intimate examinations or procedures.

Further guidance on chaperones can be sought from the Chaperone Policy and also from the Medical Protection Society's article titled Chaperones.

11.5 Professional challenge

Professional challenge is an encouraging action taken in the best interests of a child, young person or adult at risk. It enables the challenging of decisions or actions by a member of staff if they consider the stated decisions or actions not to be effective enough for those deemed to be at risk.

Should a member of staff disagree with any element of care offered to an at-risk individual, they are encouraged to discuss their concerns with the organisation's safeguarding lead, their nominated deputy or the local authority safeguarding lead who will provide independent guidance. It is envisaged that most professional challenges will be resolved informally and at a local level.

12 Failure to attend an appointment

12.1 Did Not Attend (DNA) and Was Not Brought (WNB)

Whilst it is acknowledged that there are many reasons for a child, young person or adult at risk to miss an appointment, there may be occasions when failure to attend appointments is a cause for concern. Appropriate actions can be pivotal in safeguarding the child, young person or adult at risk and, where appropriate, can trigger early interventions to reduce risk.

In known cases where safeguarding is a concern, if a child, young person or adult at risk fails to attend an appointment, it is the responsibility of the clinician to ensure that the relatives or carer of the patient have been contacted to establish the reasons why the appointment was not attended, and that a further appointment is offered based on clinical need.

It should be noted that the BJGP explains that, while all missed appointments have traditionally been classified as a DNA, children who miss appointments need to be classified as WNB, as it is not their responsibility to attend the appointment, it is the responsibility of their parents or carers to take them. Awareness must be given to this, and to the consideration that this could be termed as medical neglect. To ensure those

at risk are offered the most appropriate level of support, the safeguarding lead is to be informed of any vulnerable person, be they an adult, young person or child.

12.2 Referring a WNB

If a clinician has significant concerns, they are to initiate a child protection referral by telephoning Children's Social Care, or the Emergency Duty Team if after normal office working hours, as detailed within the table at Section 14.1.

Any word-of-mouth referral is to be followed up in writing, ordinarily within 24 hours, by the referring clinician. Where the clinician believes that harm is imminent, they should call the police immediately.

All staff are to retain accurate records at all times, ensuring that all actions are annotated, outlining any actions taken. Whilst there is no definitive SNOMED code for WNB, several others are available under 'Did Not Attend'.

- Did not attend – Reason given – 185326000
- Did not attend – No reason given – 270426007
- Did not attend – appointment mix-up – 185329007

13 Training

13.1 Training overview

This organisation is committed to having arrangements in place to ensure that all staff are trained effectively for safeguarding both adults and children, and to the level commensurate with their role.

13.2 Training guidance and recent updates

At the time of this update, the current training guidelines are contradictory between the recently published RCGP guidance, and the CQC's GP mythbuster 25: Safeguarding adults at risk and GP mythbuster 33: Safeguarding children as the mythbusters still both refer to the RCN intercollegiate guidance document.

The RCGP safeguarding standards for general practice provides full guidance for any staff member within a general practice setting and are referred to as being best practice in this chapter. Furthermore, RCGP advise at the Development of the RCGP safeguarding standards section that their standards now replace the previous guidance for GPs and general practice roles in the RCN intercollegiate documents:

- Adult Safeguarding: Roles and Competencies for Health Care Staff
- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff) which are being updated by the Royal College of Paediatricians and Child Health (RCPCH) and the RCN

Note that RCGP, RCPCH and the RCN are working collaboratively in the production and updating of standards for safeguarding across health.

13.3 Training requirements

The organisation will ensure that staff are specifically trained according to RCGP's Safeguarding standards for general practice. Where staff are required to complete a higher level of training, there is no requirement to also complete the previous levels of training. Therefore, a GP would not need to complete Safeguarding Levels 1, 2 and 3 training, they are only required to complete Level 3.

All are applicable to both NHS and non-NHS general practice settings.

13.4 Supporting reading and training

In addition to the above links, the following support the RCGP safeguarding standards.

- GMC: Good medical practice 2024
- GMC: Protecting children and young people: the responsibilities of all doctors
- GMC: 0-18 years: Guidance for all doctors
- GMC: Adult safeguarding ethical hub
- Looked After Children: Roles and Competencies of Healthcare Staff

Safeguarding NHS YouTube video clips:

- Domestic violence
- Child sexual abuse
- Child abuse
- Child protection
- Adult safeguarding

13.5 Practice safeguarding responsibilities

During any inspection, the CQC will expect that fundamental processes are adopted and embedded at this organisation. Failure to meet any of these points may cause unacceptable harm to our patient population. Organisations are to follow the RCGP safeguarding standards for general practice guidance and in particular the section titled 'The role of GPs and general practice in safeguarding'.

Further information can also be found within the CQC's GP mythbuster 25: Safeguarding adults at risk and GP mythbuster 33: Safeguarding children.

13.6 Safeguarding leads

The organisation's safeguarding lead and deputy are responsible for:

- Ensuring that they are familiar with the internal, regional and national policies and procedures that underpin safeguarding

- Acting as the focal point within the organisation for staff who may have concerns, addressing these concerns and acting as necessary

- Reviewing any information regarding safeguarding concerns, investigating matters further if necessary and taking the appropriate action

- Acting as the liaison between the organisation and the local safeguarding teams, facilitating the sharing of information, attending multi-agency meetings (MASH) and supporting any local safeguarding investigations as necessary

- Processing and sharing information within the organisation in the most effective manner

- Continually reviewing the organisation's safeguarding processes and guidance, making recommendations for change as necessary

- Ensuring, in conjunction with the Practice Manager, compliance with requirements and processes by means of audit

- Encouraging training for all staff groups, as detailed within the current RCGP guidance. Note that there are additional training requirements for safeguarding leads

- Ensuring that staff are supported appropriately when dealing with any safeguarding matter

  The role Safeguarding Lead or Deputy Safeguarding Lead is to be added to the respective job descriptions

The deputy safeguarding lead will assume the above responsibilities in the absence of the safeguarding lead.

13.7 Partners

The partners are responsible for:

- Ensuring that the safeguarding of children, young people and adults at risk is central to clinical governance

- Contractual compliance with clinical governance arrangements for effective safeguarding policies and procedures

- Ensuring that all staff are trained and know how to react to concerns raised and recognise potential indicators for abuse

Additionally, the partners are to comply with the guidance detailed at Section 14.7.

13.8 Practice Manager

The Practice Manager is responsible for:

- Ensuring that safeguarding responsibilities are clearly defined in the job descriptions of all staff
- Adhering to the pre-employment requirements and ensuring that an effective safe recruitment process is in place
- Reaffirming the significance of safeguarding to all staff within the organisation
- Ensuring all staff have completed the relevant training and subsequent updates as detailed within the RCGP safeguarding standards for general practice
- Completing additional supporting training as detailed within the RCGP guidance
- Retaining a record of all completed safeguarding training by staff members or those healthcare personnel that undertake a service within the organisation
- Supporting the safeguarding lead in undertaking compliance audit, and supporting them with other areas of governance and compliance

Due to its importance, safeguarding is to feature within the Practice Manager's job description.

13.9 Healthcare professionals

All healthcare professionals are to ensure that they comply with their respective regulatory bodies' guidance in support of safeguarding:

GMC	Good Medical Practice
NMC	The Code
HCPC	Standards of conduct, performance and ethics
GPhC	Standards and guidance for pharmacy professionals

Furthermore, they are to:

- Take prompt action if they think that patient safety, dignity or comfort is being compromised
- Protect and promote the health of patients and the public
- Support the safeguarding leads and Practice Manager in undertaking safeguarding compliance audits
- Act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

- Share necessary information with other healthcare professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality

- Share information to identify and reduce risk

- Raise concerns immediately if they believe a person is vulnerable or at risk and needs extra support and protection

All clinicians will be afforded the necessary time to effectively contribute to safeguarding matters that are relevant to them.

13.10 Mental Capacity Act lead

The MCA lead is responsible for:

- Providing support and advice to clinicians in individual cases, and supervision for staff in areas where these issues may be particularly prevalent and/or complex

- To highlight the extent to which this organisation is compliant with the MCA

- To ensure that there are governance structures, such as training and audit to confirm the understanding of this subject within the team

- To work closely with, and in support of named adult safeguarding leads

Note this role may also be the safeguarding lead.

13.11 Safeguarding administration lead

This role is responsible for:

- The recording and coding of safeguarding information coming in and out of the organisation

- Supporting the Practice Manager in both coordinating and arranging any safeguarding meetings between the practice and external organisations

- Assisting clinicians and the Practice Manager with the preparation of safeguarding reports. This includes completing demographics and factual information such as missing vaccinations, WNB information and any outstanding health referrals

- Supporting the Practice Manager in ensuring that there are established and robust safeguarding governance structures in place within the organisation

- Preparing any reports to ensure appropriate, relevant and proportionate information is shared with interested parties

Note, this role is not to interpret clinical information within a record for the purpose of a safeguarding report. The responsibility for the completion of safeguarding reports remains with the safeguarding lead.

Further information about this role can be found in the RCGP Safeguarding toolkit.

13.12 All staff

All staff have a responsibility to:

- Know how to act should they recognise potential indicators of abuse or neglect
- Understand the organisation's and local safeguarding policies and procedures
- Partake in meetings and case conferences regarding safeguarding matters when requested
- Attend and/or complete regular training commensurate with their role in accordance with their individual terms of reference and practice policy

13.13 Audit

To ensure compliance with this handbook and the processes contained within it, the organisation's safeguarding lead, deputy safeguarding lead and the Practice Manager will ensure that regular audits are undertaken.

Guidance and supporting legislation

The following A-Z guidance supports safeguarding:

Organisation	Guidance
CQC	Culturally appropriate care
CQC	Equality and human rights – Good practice resource
CQC	GP mythbuster 25: Safeguarding adults at risk
CQC	GP mythbuster 33: Safeguarding children
CQC	Inspector's Handbook for Safeguarding
DHSC	Care and Support Statutory Guidance
DHSC	FGM: mandatory reporting in healthcare
DHSC	Liberty Protection Safeguards factsheets
DHSC	Safeguarding women and girls at risk of FGM
DHSC	Striking the Balance – Application of Caldicott Guardian Principles to Domestic Violence and MARACs
DHSC	The NHS Constitution
DfE	Working together to safeguard children
DfE	Child abuse concerns: guide for practitioners
DfE	Children's social care: reform statement
DfE	Information Sharing
DfE	Promoting the health and wellbeing of looked-after children
EHRC	Equality and Human Rights Commission – Public Sector Equality Duty
FCO	Forced marriage
GMC	0-18 years: guidance for all doctors
GMC	Adult safeguarding ethical hub
GMC	Good Medical Practice
GMC	Protecting children and young people: The responsibilities of all doctors
GPhC	Standards and guidance for pharmacy professionals
Gov.uk	Looked-after children and children in care
Gov.uk	Parental rights and responsibilities
HCPC	Standards of conduct, performance and ethics
Home Office	Channel and Prevent Multi-Agency Panel (PMAP) guidance
Home Office	Controlling or coercive behaviour: statutory guidance framework

Home Office	Domestic Abuse Statutory Guidance
Home Office	Modern slavery
Home Office	Multi-agency statutory guidance – Female genital mutilation
ICO	Data sharing code of practice
LGA	Local Government Association – Making Safeguarding Personal
NCA	County Lines
NHS E	Child sexual exploitation
NHS E	The Good Practice Guidelines for GP electronic patient records
NHS E	Learning from lives and deaths – People with a learning difficulty and autistic people (LeDeR)
NHS E	Primary medical services policy and guidance manual (PGM)
NHS E	Safeguarding
NHS E	Safeguarding children, young people and adults at risk in the NHS (SAFF)
NHS E	Supporting people experiencing homelessness and rough sleeping
NMC	The Code
OPG	Office of Public Guardian Mental Capacity Act Code of Practice
PHE	Learning disability – applying All Our Health
RCGP	Good practice safeguarding in general practice
RCGP	Safeguarding standards for general practice
RCGP	Safeguarding toolkit
RCN	Adult Safeguarding: Roles and Competencies for Health Care Staff
RCN	Looked After Children: Roles and Competencies of Healthcare Staff
RCN	Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff
RCPCH	Safeguarding children and young people – Roles and competencies

NICE guidance and supporting documentation

Safeguarding guidance and quality standards	
Bipolar disorder: assessment and management	CG185
Child abuse and negligence	NG67
Child abuse and neglect	QS179
Domestic violence and abuse: multi-agency working	PH50

Harmful sexual behaviour among children and young people	NG55
Integrated health and social care for people experiencing homelessness	NG214
Learning disability: behaviour that challenges	QS101
Looked-after children and young people	NG205
Mental health problems in people with learning disabilities: prevention, assessment and management	NG54
Self-harm: assessment, management and preventing recurrence	NG225
Social and emotional wellbeing: early years	PH40
Social work with adults experiencing complex needs	NG216

The following A-Z legislation supports safeguarding:

Legislation
Childcare Act 2006
Children Act 1989
Children Act 2004
Children and Families Act 2014
Children and Social Work Act 2017
Domestic Abuse Act 2021
Equality Act 2010
European Convention on Human Rights
Female Genital Mutilation Act 2003
Health and Social Care Act 2008
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Mental Capacity Act 2005
Mental Capacity (Amendment) Act 2019
Mental Health Act 2007
Modern Slavery Act 2015
Prevent Duty 2023
Serious Crime Act 2015
Serious Violence Duty 2023
Sexual Offences Act 2003
The Care Act 2014
The Crime and Disorder Act 1998
UN Convention on the Rights of the Child 1989
UN Convention on the Rights of Persons with Disabilities 2006

Was not brought (WNB) letter

[Insert organisation address]
[Date]

Dear [insert parent or carer name],

At [insert organisation name], we are committed to ensuring that all our patients receive quality, evidence-based care always. Such is our desire to facilitate the effective delivery of care, we have in place policies and protocols which support our aim in achieving this.

Our safeguarding policy has been written to ensure that our patient population receives the necessary care and support when it is needed. As young children rely on their parents or carers to bring them for appointments, we monitor and follow up any missed appointments for children, thereby ensuring they receive the care they need, when they need it.

We note from our records that [insert patient name] missed their appointment on [insert date] at [insert time] with [insert GP name].

It is acknowledged that missed appointments can be genuine oversights, but repeated missed appointments give us cause for concern and we use the term “Was Not Brought” to describe this.

We are writing to request that you [contact the organisation and arrange an appointment for [insert patient name] as soon as possible **or** you request that the named clinician calls you to discuss [insert patient name]. The organisation telephone number is [insert telephone number] or alternatively you can arrange an appointment using our online service.

Yours sincerely,

[Insert signature]

for

[Insert named clinician