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Practice Nurses

Safeguarding Update Feb 2025

BNSSG ICB Primary Care Safeguarding Team

- Named GPs for Safeguarding:

Dr Vicky Donkin & **Dr Marie McVeigh**

- Named Professionals for Primary Care:

Kirsten Bowes & Louise Ledgerwood-Care

Safeguarding in Primary Care

Safeguarding is Everyone's Responsibility

- Practice nurses, along with all other primary care staff, must promote and protect the rights of patients who are not able to protect themselves from harm or abuse.
- PNs must not assume someone else will report a safeguarding concern and must not pass on the duty and responsibility to someone else.
- All clinical staff are empowered and expected to complete safeguarding referrals when needed, in a timely manner in accordance with local policies, procedures and legislation.
- **Do not hesitate, do not delegate – take action TODAY!**

Think Family Approach

‘Think Family’ isn’t a new or complicated idea. It is, however, a theme that we see raised repeatedly in both national and local reviews concerning children and adults.

- **The Think Family agenda** recognises and promotes the importance of a whole-family approach. A holistic view of **all members** of the household - Remember: children, young people and adults do not exist or live in isolation.

- **No wrong door:** all services should offer an ‘open door’ into a system of joined-up support. This is based on more coordination between adult and children's services.

- **Looking at the whole family:** services working with both adults and children take into account family circumstances and responsibilities.

- **Building on family strengths:** practitioners work in partnership with families recognising what is going well, collaborating and building skills to encourage self sufficiency.

The Myth of ‘Invisible Men’

Child Safeguarding Practice Review Panel research demonstrates that men are **2-15 times more** likely than women to perpetrate harm to children under one years old.

There is a societal, cultural and clinical practice pressures that result in mothers leading on children’s access to healthcare. This **results in fathers becoming ‘invisible’** in children’s records and they are often excluded from the process of caring for the child’s health.

It is important to understand the household composition and care arrangements for the child. We must identify which adults are responsible for the child’s care and they should be included as part of any assessment, treatment, care plans or information-sharing (e.g. delivery of ICON message during pregnancy and newborn phase).

It is essential for practices to record whether the child’s male carer is registered at the practice, and if so, link family records together. If male carers are registered elsewhere, consider how you document this information in the child’s records.

Things to consider...

Do I have a picture of the family as a whole?

Have I asked who is in the family and understood family members' roles and relationships to each other?	Do I know who else lives in the household or has regular contact?	Have I considered the strengths of the family and what is working well?	Have I considered their resilience to cope with the demands they face?
Have I considered if other family members are at risk or in need of support?	Have I explored caring responsibilities?	Do I know if other practitioners are working with the family?	Have I listened to what support the family want and explored what their solutions may be?
Have I been open and honest about my concerns?	Have I made assumptions about the family?	Have the family response helped my decision making?	Have I shared my concerns with my team / supervisor?

What is Professional Curiosity?

It is using your skills to explore and understand what is happening for an individual or family, rather than making assumptions or accepting things at face value.

“Thinking the unthinkable” - This is not about assuming the worst, but about keeping an open mind for all possible explanations. Practitioners need to think ‘outside the box’, and respond using respectful uncertainty rather than professional optimism.

Curious professionals engage with individuals and families through visits, conversations, observations and asking relevant questions to gather historical and current information. This involves triangulation of information from different sources and participating in wider MDT discussions.

Why is Professional Curiosity important?

A lack of Professional Curiosity can lead to:

- **Missed opportunities** to identify subtle signs of vulnerability or harm.
- **Incorrect assumptions** made leading to inaccurate risk assessment and inappropriate interventions.
- **Silo working resulting in missing the big picture.** Silo working could mean dealing with problems in isolation and/or working in isolation from colleagues.

Being respectfully nosey

It is common to feel awkward, worried and uncomfortable when asking additional questions or seeking alternative explanations.

Professionals need to be brave, understand why they are asking difficult questions and explore further with compassion.

It is our professional responsibility to build the skills and competence to do this confidently.

I — Infant crying is normal

C — Comforting methods can help

 — It's OK to walk away

N — Never, ever shake a baby

Many serious events + rapid reviews arise from 'shaken baby' NAI incidents.

ICON teaches parents/carers it is **ok to leave baby in safe place & walk away,** buying time to regulate their own emotions and behaviours to prevent an avoidable incident.

- Are you discussing ICON at routine immunisations appointments and baby-checks?
- How is this discussion evidenced in the medical records?
- Have you considered sending ICON info as a text message?
- How can the message be shared with all adults caring for the baby, not just the parent/carer who can to this appointment?

ICON resources link + 3-minute video

NAI: injuries in non-mobile babies

A BNSSG-wide policy is been published on REMEDY: https://remedy.bnssg.icb.nhs.uk/media/6502/non-mobile-baby-injury-policy-july-2023.pdf -

This policy was produced following a Serious Case Review (SCR) into the death of a baby in South Gloucestershire and should be used when **any injury is identified in a baby who cannot move independently**.

- Please remember it is not the responsibility of the primary care practitioner to determine causality.

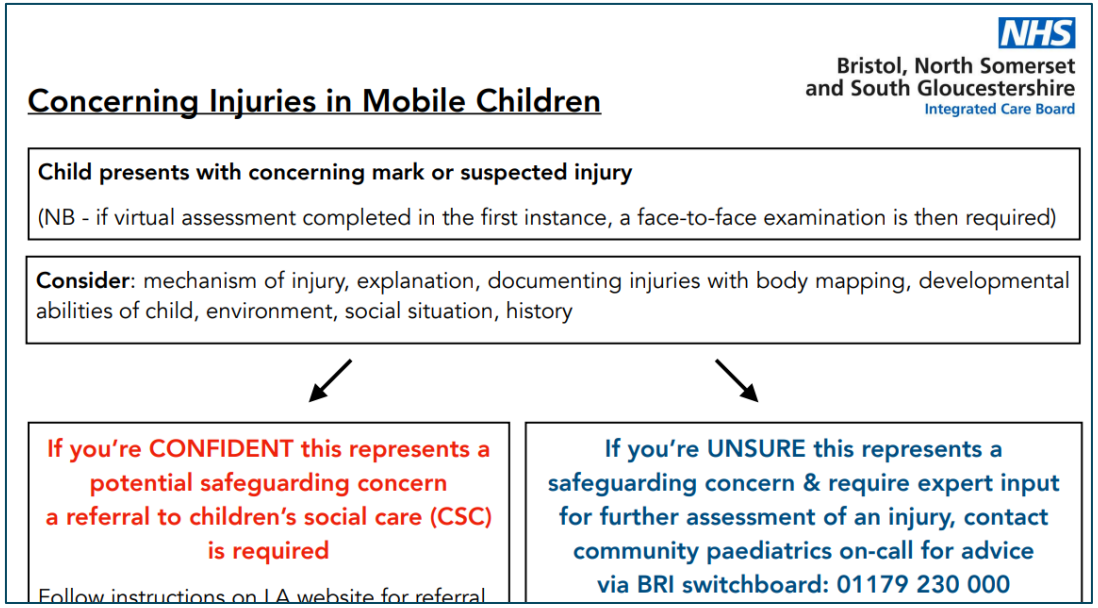
A Keeping Babies Safe leaflet explaining the process should be downloaded and printed, and given to the parents/carers. This leaflet is also available in EASY READ format.

NAI: injuries in mobile children

A BNSSG-wide policy is been published on REMEDY: https://remedy.bnssg.icb.nhs.uk/media/6106/bnssg-2022-concerning-injuries-in-mobile-children-pathway.pdf

This policy was produced following a Single Agency Review into the case of a mobile toddler who'd presented to primary care with ear bruising, later admitted with extensive injuries and subsequently taken into care. This policy should be used when **an injury is identified in a child who is able to mobilise independently**.

- Please remember it is not the role of the primary care practitioner to determine causality.



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Concerning Injuries in Mobile Children

Child presents with concerning mark or suspected injury

(NB - if virtual assessment completed in the first instance, a face-to-face examination is then required)

Consider: mechanism of injury, explanation, documenting injuries with body mapping, developmental abilities of child, environment, social situation, history

If you're CONFIDENT this represents a potential safeguarding concern a referral to children's social care (CSC) is required

Follow instructions on LA website for referral

If you're UNSURE this represents a safeguarding concern & require expert input for further assessment of an injury, contact community paediatrics on-call for advice via BRI switchboard: 01179 230 000

Rethinking
~~Did Not Attend~~
= Was Not Brought

Recent statutory review highlights cases where poor engagement with health and social care services was evident.

Non-engagement or non-compliance may be a parent or carer's choice, but it is not the choice of the vulnerable adult or child.

Practice admin and clinical staff should treat repeated cancellations and/or rescheduling of appointments with professional curiosity and the same degree of concern as repeated non-attendance.

Changing language from the term DNA to WNB helps maintain a focus on vulnerability and dependence, and the carers' responsibilities to prioritise the individual's needs.

2-minute WNB video:
https://youtu.be/dAdNL6d4lpk?si=OdusrkoWkQtU87Ew

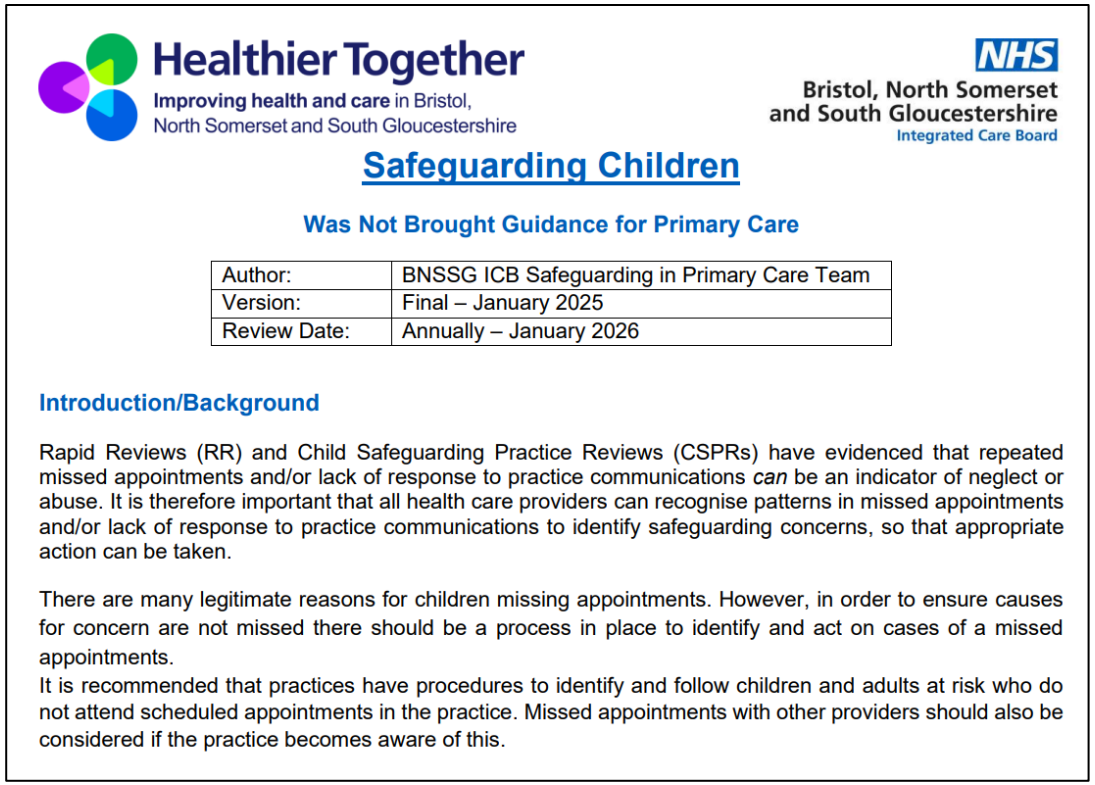
Children's WNB policy

A new BNSSG-wide policy has been published on REMEDY:

https://remedy.bnssg.icb.nhs.uk/media/v4tbugcl/bnssg-childrens-wnb-policy-v3-jan25.pdf -

- Children rely on adults to attend their health appointments. When a child fails to attend an appointment, the 'did not attend' (DNA) terminology is potentially both incorrect and punitive.

- Across BNSSG the phrase 'was not brought' (WNB) is being promoted and missed appointments should be coded as such. A WNB event should trigger a review of the child's health and care needs, with an appropriate response required from clinicians.



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Safeguarding Children

Was Not Brought Guidance for Primary Care

Author:	BNSSG ICB Safeguarding in Primary Care Team
Version:	Final – January 2025
Review Date:	Annually – January 2026

Introduction/Background

Rapid Reviews (RR) and Child Safeguarding Practice Reviews (CSPRs) have evidenced that repeated missed appointments and/or lack of response to practice communications *can* be an indicator of neglect or abuse. It is therefore important that all health care providers can recognise patterns in missed appointments and/or lack of response to practice communications to identify safeguarding concerns, so that appropriate action can be taken.

There are many legitimate reasons for children missing appointments. However, in order to ensure causes for concern are not missed there should be a process in place to identify and act on cases of a missed appointments.
It is recommended that practices have procedures to identify and follow children and adults at risk who do not attend scheduled appointments in the practice. Missed appointments with other providers should also be considered if the practice becomes aware of this.

Adults at Risk – 'vulnerable adults'

An adult at risk is someone who:

- Has **care and support needs** (whether or not those needs are met and regardless of who meets them) and
- Is **experiencing / at risk of abuse or neglect** and
- As a result of those care and support needs is **unable to protect themselves**

If an adult who appears to be at risk of harm refuses help, and there are no *legal requirement* to disclose information, ask yourself the following questions:

- Do they have **capacity** (decision and time specific) to decide whether or not to accept help?
- Is **anyone else at risk** of harm (think family approach, is a child is involved and at risk)?
- **Could disclosure (without consent) be justified**, even if no one else is at risk of harm?

Assessing Capacity

All staff delivering care / interventions must be aware of the capacity assessment principles, this is fundamental to the informed consent process - eg. patients must have capacity to consent to a dressing change, wound care, injections, immunisations, medication changes, referrals, third-party discussions.

There are 5 principles of the MCA 2005:

1. A presumption of capacity.
2. The right to be supported when making decisions.
3. An unwise decision cannot be seen as a wrong decision.
4. Best interests must be at the heart of all decision making.
5. Any intervention must be with the least restriction possible.

- A patient has capacity until you prove they don't
- Reasonable adjustments – reading+writing difficulties, language barriers, visual or hearing difficulties, time of day, time to process etc
- A patient with capacity is able to make whatever choice they believe is right for them, personal autonomy – your opinion doesn't trump theirs
- A patient lacking capacity must be the centre of all decision-making regarding their own well-being and safety, e.g. family opinions or desires don't trump patient's best interest
- Least invasive, restrictive, permanent option possible at the time – temporary compromise when buying time might help patient regain capacity

Adult safeguarding – self neglect

This is a complex issue and covers a wide range of behaviours, such as neglecting to care for one's personal hygiene, health, or surroundings

Indicators of Self-Neglect:

- Poor personal hygiene or unsuitable clothing
- Missed appointments (DNA / WNB)
- Forgetfulness or known memory impairment
- Poor diet, vitamin deficiencies, dehydration, unexplained or unintentional weight loss
- Hoarding or collecting many animals
- Non-compliance with health or care services
- Inability or unwillingness to take medication or treat illness and injury

Consider fire risk in self neglect, with hoarding, and where there is cognitive impairment *e.g. forgetting hob is on, forgetting cigarettes*.

You can request a home Fire Safety visit: https://www.avonfire.gov.uk/safety/home/home-fire-safety/request-a-visit/ -

Self-Neglect guidance and referral pathways via REMEDY: https://remedy.bnssg.icb.nhs.uk/adults/safeguarding/adult-safeguarding/#i11

Vulnerable Adults WNB policy

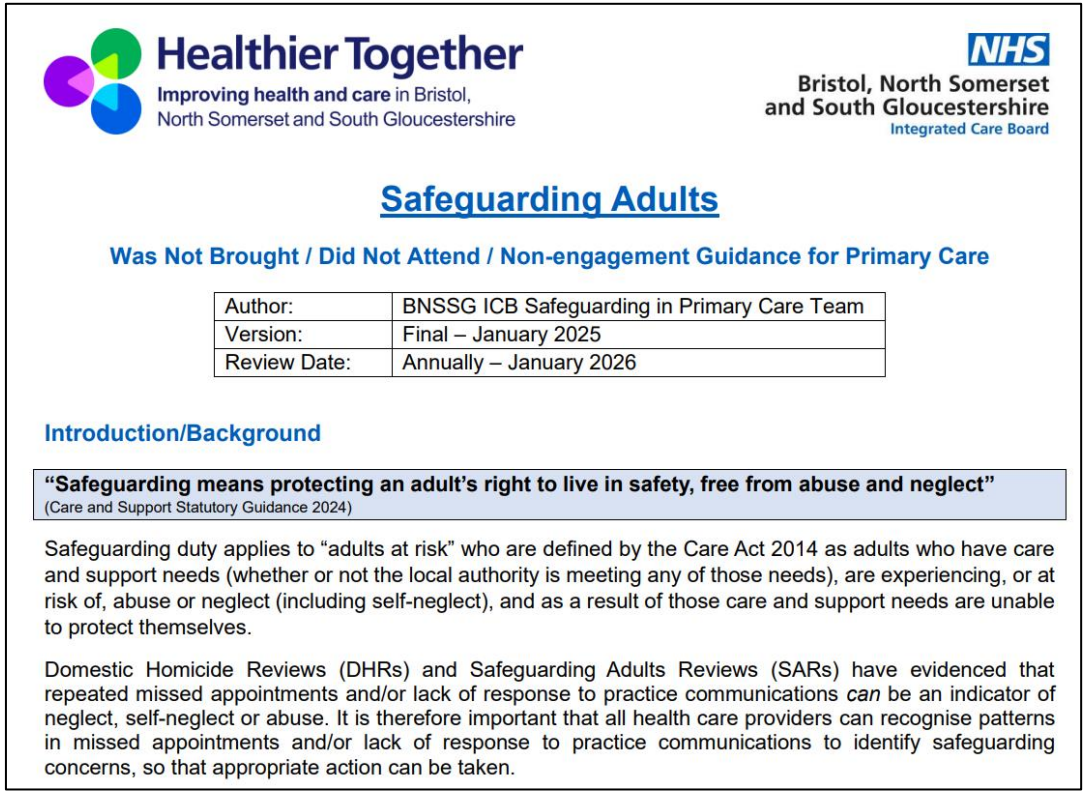
A new BNSSG-wide policy has been published on REMEDY:

https://remedy.bnssg.icb.nhs.uk/media/4kyfchwq/bnssg-vulnerable-adult-wnb-policy-v3-jan25.pdf -

Please help us ensure every practice has considered implementing this new policy and discuss with your line manager how this is applies to your individual role and scope of practice.

↪ Do you know how to add the relevant codes and updates to your consultation?

↪ Do you know how to notify / escalate concerns to the relevant GP (named GP or safeguarding lead)?



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Safeguarding Adults

Was Not Brought / Did Not Attend / Non-engagement Guidance for Primary Care

Author:	BNSSG ICB Safeguarding in Primary Care Team
Version:	Final – January 2025
Review Date:	Annually – January 2026

Introduction/Background

"Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect"
(Care and Support Statutory Guidance 2024)

Safeguarding duty applies to "adults at risk" who are defined by the Care Act 2014 as adults who have care and support needs (whether or not the local authority is meeting any of those needs), are experiencing, or at risk of, abuse or neglect (including self-neglect), and as a result of those care and support needs are unable to protect themselves.

Domestic Homicide Reviews (DHRs) and Safeguarding Adults Reviews (SARs) have evidenced that repeated missed appointments and/or lack of response to practice communications *can* be an indicator of neglect, self-neglect or abuse. It is therefore important that all health care providers can recognise patterns in missed appointments and/or lack of response to practice communications to identify safeguarding concerns, so that appropriate action can be taken.

Making a safeguarding referral

CHILDREN'S SOCIAL CARE REFERRALS

https://remedy.bnssg.icb.nhs.uk/children-young-people/safeguarding-children/referrals-procedures/

If you have concerns about a child/family, please refer to the relevant local authority in which they live

The decision whether to refer a child or young person to social care depends on whether a threshold has been met. This involves assessing the impact of the family situation on the child, considering the child's lived experience and voice.

Each LA has issued their own threshold guidance, to assist decision-making when considering the level of concern and expected level of response.

ADULT SOCIAL CARE REFERRALS

https://remedy.bnssg.icb.nhs.uk/adults/safeguarding/adult-safeguarding/

If you have concerns about an adult at risk of harm, please refer to the relevant local authority in which the adult lives

BRISTOL – Care Direct 0117 922 2700

SOUTH GLOS – Adult Social Care 01454 868007

NORTH SOMERSET – Care Connect 01275 888801

Professional advice and case discussion is possible via telephone, however, a **written referral is always required** following a telephone discussion.

Safeguarding training requirements – new RCGP standards (Oct'24)

The **RCGP** expect all staff working in GP setting to comply with their **new all-age safeguarding training standards**, and document this in the way they have specified. This is a **competency-based approach**, with **case-based reflective practice and learning logged**.

1. All staff must access safeguarding training and supervision relevant to their role, at the correct level 1/2/3 and covering adult/children/all-age knowledge + skills.
2. All staff to be supported to achieve the expected standards for their role and have this evidence available for inspection at CQC/appraisal/revalidation.
3. All staff must be supported to engage with CPD/training in an 'adult-learning approach', identifying learning needs then meeting those on an individualised basis - there is **no** one-size-fits-all training package!

The **RCN** expect nurses to comply with their own safeguarding training standards, as per the **intercollegiate documents** for children and adults. This is a **time-based approach**, with training **hours logged**.

Therefore; primary care staff should follow the RCGP competence-based reflective learning expectations on an annual basis, and those who need to count the hours spent should also include that number in their reflective log entry. This ensures that over the course of 3/5 years, staff will have covered both the whole RCGP standards (curriculum) and will also have logged more than enough hours to meet the RCN / ICD expectations as well.

Safeguarding supervision

Supervision leads to **improving decision-making, accountability, and supporting professional development** among practitioners.

It also provides an opportunity for **self-reflection, peer support and pastoral care**.

- 1:1 supervision – Case based discussion with a colleague, manager or safeguarding lead within your practice.
- Group supervision – Case based discussion with multi-disciplinary teams within your practice (e.g. at practice meetings).

↪ What is the safeguarding supervision structure at your surgery?

↪ Do you know who to talk to for support?

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BNSSG ICB Safeguarding in Primary Care Team Training Offer 2025

Safeguarding Supervision

13:00 -14:00

Online via MS Teams – click link to register

Wed 19th February
Tues 1st April
Tues 1st July
Wed 17th September
Tues 4th November

Open to all - Please bring cases / queries for peer discussion and support

ICB Primary Care Safeguarding Team

Named GP Dr Marie McVeigh
Wednesdays & Alternate Fridays
Named GP Dr Vicky Donkin
Tuesdays & Alternate Wednesdays
Named Professional Kirsten Bowes
North Somerset, South Bristol and BIC (34 hours/week)
Named Nurse Louise Ledgerwood-Care
South Glos, North Bristol FABB & FOSS (Full-time)

All training & safeguarding enquiries:
bnssg.safeguardingadmin@nhs.net

GP Link Meetings

13:00 -14:30

Online via MS Teams – click link to register

Wed 5th March
Wed 25th June
Wed 3rd September
Wed 3rd December

Local updates, topic-based presentations and peer-support for safeguarding lead GPs

Bitesize Webinars

13:00 -14:00

Online via MS Teams – click link to register

Tues 25th March – Domestic Abuse
Tues 29th April
Tues 15th July
Wed 24th September
Wed 19th November

Open to all – Topics selected from local Statutory Review learning themes and outcomes

Level 3 Training 'Local Update'

9:30 -12:30

*Online via MS Teams – please **email** to register*

Wednesday 5th February - L3 Safeguarding Children

Wednesday 8th October - L3 Safeguarding Adults

Open to all – Topics selected from local Statutory Review learning themes and outcomes

Safeguarding Conference

All-age Level 3 update
Wednesday 4th June

All day, in-person
At BAWA, Bristol

Agenda TBC

*Please **email** to register interest*

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Thank you

Contact:
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Any questions ?