



Public Health  
England

Protecting and improving the nation's health

# **Safeguarding in general dental practice**

## **A toolkit for dental teams**

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Published April 2019  
PHE publications  
gateway number: GW-294

PHE supports the UN  
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## Foreword

All of us deserve to be safe and be away from harm.

Sadly, high profile cases in the media have highlighted that abuse is still happening, and often to the most vulnerable in society. We hear of child abuse, elder abuse, modern slavery. These cases are upsetting for all of us and we wonder how these events could occur without anyone noticing. Surely someone knew about the abuse or had noticed something? Why did no one act or why were they not listened to?

Sometimes a 'feeling' or noticing something that 'just doesn't seem right' can play a vital part in the jigsaw that can make the difference to someone in a vulnerable position.

In some cases of abuse, contacts with healthcare professionals could have made a difference at key moments in time.

It is the duty of all citizens to call out abuse where they see it, and act to protect those who are being harmed.

Dental teams should not feel inhibited to raise a concern. The dental team has a statutory duty of care to all patients and the wider public, which includes ensuring that safeguarding arrangements are in place and are acted on.

This document recognises the importance of understanding safeguarding issues, describes different forms of abuse, roles and responsibilities for dental teams, and signposting training and pathways to be followed if concerned.

We can all make a difference.

Sandra White  
National Lead for Dental Public Health

## Purpose and summary

The purpose of this document is to:



The concept of 'professional curiosity' should lie at the heart of the relationship between the dental team and patients/families/carers. It does not require anyone to be interrogated, but it does involve the critical evaluation of information and the maintenance of an open mind. The team should listen to what is being said but also look for non-verbal clues such as body language. They should also keep detailed records of their observations to help in the identification of safeguarding concerns.

It is recommended that:

- each dental practice have a named safeguarding practice lead
- all members of staff (clinical and non-clinical) undertake the appropriate level of safeguarding training
- there is a safeguarding reporting system in place and staff are familiar with this
- all members of staff know how to access the NHS Safeguarding app for local safeguarding contact details:

[www.myguideapps.com/nhs\\_safeguarding/default/index.html](http://www.myguideapps.com/nhs_safeguarding/default/index.html)



- all members of staff read this document as part of the induction process - this document does not replace any safeguarding training but is supplementary to it
- this document is discussed at team meetings to consider how training opportunities and resources may be utilised and embedded into practice

## Definitions

### Child

**A child is anyone who has not yet reached their 18th birthday.**

The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate, does not change his/her status or entitlements to services or protection.

### Adult at risk

A person aged 18 years or over with a need for care and support, as a result of which they are unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

### Serious Medical Treatment

Treatment which involves providing, withdrawing or withholding treatment in circumstances where one of the following applies:

- where a single treatment is being proposed, there is a fine balance between its benefits to the patient and the risks it is likely to entail for them
- where there is a choice of treatments, a decision as to which one to use is finely balanced, or
- what is proposed would be likely to involve serious consequences for the patient

### Abuse

Violation of an individual's human and civil rights and is perpetrated by a person or persons. It may consist of a single act or repeated acts and can take many or multiple forms.

| Form of abuse                        | Description  |
|--------------------------------------|--|
| <b>Physical abuse</b>                | May involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm.  |
| <b>Fabricated or induced illness</b> | Where someone, often a parent or carer, exaggerates or deliberately causes symptoms of illness in a child or adult at risk.  |
| <b>Emotional abuse</b>               | <p>Persistent emotional maltreatment involving:</p> <ul style="list-style-type: none"> <li>• conveying that someone is worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person.</li> <li>• not being given opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate.</li> <li>• age or developmentally inappropriate expectations being imposed on children.</li> <li>• seeing or hearing the ill-treatment of another.</li> <li>• serious bullying (including cyber bullying), causing someone to feel frightened or in danger.</li> </ul> <p>Some level of emotional abuse is involved in all types of maltreatment, though it may occur alone.</p>  |
| <b>Sexual abuse</b>                  | <p>Involves forcing or enticing someone to take part in sexual activities, not necessarily involving a high level of violence, whether or not they are aware of what is happening. The activities may involve physical contact, including assault by penetration (for example rape or oral sex), or non-penetrative acts (for example masturbation, kissing, rubbing and touching the outside of clothing).</p> <p><u>Child sexual abuse and exploitation</u> is when an individual/group takes advantage of an imbalance of power to coerce, manipulate or deceive a child into sexual activity in exchange for something the victim needs/wants/for the financial advantage or increased status of the perpetrator/facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. It does not always involve physical contact; it can also occur through the use of technology such as involving children in</p> |

|                             |   |
|-----------------------------|---|
|                             | <p>looking at sexual images or watching sexual activities. Further information is contained in Appendix 2.</p> <p>Sexual abuse can be perpetrated by adult males, females and also other children.</p>  |
| <b>Financial abuse</b>      | <p>Having money/other property stolen, being defrauded, being put under pressure in relation to money/other property, and having money/other property misused by others. Scams are a form of financial abuse and are particularly prevalent among adults at risk.</p>   |
| <b>Neglect</b>              | <p>The persistent failure to meet basic physical/psychological needs by not:</p> <ul style="list-style-type: none"> <li>• providing adequate food, clothing and shelter</li> <li>• protecting against physical and emotional harm or danger</li> <li>• ensuring adequate supervision</li> <li>• ensuring access to appropriate medical/dental care or treatment</li> <li>• responding to basic emotional needs</li> </ul> <p><b>Self-neglect:</b> this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surrounding and includes behaviour such as hoarding. It is important to consider capacity when self-neglect is suspected. Also consider how it may impact on other family members and whether this gives rise to a safeguarding concern.</p> |
| <b>Extremism</b>            | <p>Vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs.</p>   |
| <b>Discriminatory abuse</b> | <p>Harassment, deliberate exclusion or unequal treatment on the grounds of a protected characteristic.</p>  |
| <b>Institutional abuse</b>  | <p>The use of systems and routines which neglect a person receiving care. It does not have to be intentional.</p>   |

|   |   |
|---|---|
| <p><b>Domestic violence and abuse</b></p>     | <p>Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. It includes Honour Based Violence (HBV), an unwritten code of conduct that involves domination, aggression and control by 1 or several members of an individual’s extended family or community and may be physical, emotional, sexual or financial. The use of the term ‘Honour’ or ‘Izzat’ describes the concept of protecting the prestige and reputation of a family or community. The term embraces a variety of crimes of violence which are mainly, but not exclusively, against women. These include assault, imprisonment and murder, where the person is being punished by their family or community.</p> |
| <p><b>Female genital mutilation (FGM)</b></p> | <p>Constitutes all procedures which involve partial or total removal of the external female genitalia, or injury to the female genital organs for cultural or non-therapeutic reasons. FGM is illegal in the UK under the Female Genital Mutilation Act (2003) and the Children Act.</p>  |
| <p><b>Forced Marriage (FM)</b></p>            | <p>Describes a relationship in which 1 or more of the parties are married without consent or against their will which violates the principle of the freedom and the autonomy of individuals. FM differs from an arranged marriage in which both parties consent to someone helping them to find a partner. FM is illegal under the Forced Marriage Act (2007) which enables victims of forced marriage to apply for court orders for their protection or marriage termination.</p>  |
| <p><b>Modern Slavery</b></p>                  | <p>Includes holding a person in a position of slavery, servitude, or forced or compulsory labour. It is illegal under the Modern Slavery Act (2015) which includes human trafficking (the arrangement or facilitation of travel with a view to exploitation). Although human trafficking often involves a cross-border element, it is possible for someone to be a victim within their own country or even where consent has been given to be moved. The <b>Modern Slavery Helpline on 08000 121 700</b> can be contacted for any information that could lead to the identification, discovery and recovery of victims in the UK.</p>   |

## Section 1: Introduction

The dental team has a statutory duty of care to all patients which includes ensuring that safeguarding arrangements are in place.

“Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It's fundamental to high-quality health and social care.”<sup>1</sup>

Appendix 1 features a domestic abuse case which resulted in a death of a baby where the sole disclosure was made to a general dental practitioner. The case highlights the importance of information which members of the dental team may have and the need for good practice to be adopted. This guidance aims to support the whole dental team in understanding their responsibilities in order to establish and maintain effective safeguarding arrangements in general dental practice.

### 1.1 Care Quality Commission (CQC)

The CQC is the independent regulator of health and social care in England and requires all dental practices to have appropriate safeguarding arrangements in place. Regulation 13 from the CQC's 'Guidance for providers on meeting the regulations' concerns safeguarding.

#### **Regulation 13: Safeguarding service users from abuse and improper treatment**

1. Service users must be protected from abuse and improper treatment in accordance with this regulation.
2. Systems and processes must be established and operated effectively to prevent abuse of service users.
3. Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.
4. Care or treatment for service users must not be provided in a way that
  - a. includes discrimination against a service user on grounds of any protected characteristic (as defined in section 4 of the Equality Act 2010) of the service user,
  - b. includes acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint,
  - c. is degrading for the service user, or

- d. significantly disregards the needs of the service user for care or treatment.
5. A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority.

The CQC's key lines of enquiry on safeguarding guidance is available at: [www.cqc.org.uk/guidance-providers/healthcare/safeguarding-protection-abuse-healthcare-services](http://www.cqc.org.uk/guidance-providers/healthcare/safeguarding-protection-abuse-healthcare-services)

## 1.2. General Dental Council (GDC)

The GDC's 'Standards for the Dental Team' identifies 9 principles registered dental professionals must keep to at all times<sup>2</sup>. Principle 8 covers raising concerns if patients are at risk.

### Principle 8: Raise concerns if patients are at risk

- 8.1. Always put patients' safety first.
- 8.2. Act promptly if patients or colleagues are at risk and take measures to protect them.
- 8.3. Make sure if you employ, manage or lead a team that you encourage and support a culture where staff can raise concerns openly and without fear of reprisal.
- 8.4. Make sure if you employ, manage or lead a team that there is an effective procedure in place for raising concerns, that the procedure is readily available to all staff and that it is followed at all times.
- 8.5. Take appropriate action if you have concerns about the possible abuse of children or vulnerable adults (adults at risk).

All dental professionals must also report any cases of female genital mutilation (FGM) in girls who under 18 that they come across in their work. All cases of disclosure must be reported to the police by calling the non-emergency crime number, 101. FGM is child abuse and a crime. This is a mandatory reporting duty and failure to comply may result in an investigation of a dental professional's fitness to practise. Further information is available at: [www.gdc-uk.org/newsarticle?id=932](http://www.gdc-uk.org/newsarticle?id=932). Please see Appendix 5 for FGM Resources.

## 1.3. National Institute for Health and Care Excellence (NICE)

NICE publishes a range of guidance and resources on safeguarding which can be accessed at: [www.nice.org.uk/guidance/service-delivery--organisation-and-staffing/safeguarding](http://www.nice.org.uk/guidance/service-delivery--organisation-and-staffing/safeguarding). Of particular note is NICE guideline (NG 76) 'Child abuse and neglect' which states:

“Consider neglect if parents or carers have access to but persistently fail to obtain treatment for their child's dental caries (tooth decay).”

The guidance also states that family members should not be used as interpreters – for further information on interpreters and translators, please see 2.2.3.

#### 1.4. Public Interest Disclosure Act (1998)

In line with the GDC's Standards for the Dental Team, it is paramount that dental team members focus on putting patients' interests first and raise concerns if patients are at risk. This must take priority over any personal loyalty felt between team members. Raising a concern, or whistleblowing, is different from making a complaint in that there is no evidence of malpractice expected.

The Public Interest Disclosure Act (PIDA) protects workers who 'blow the whistle' from being subjected to a detriment (such as denial of promotion, facilities or training opportunities which would otherwise have been offered)<sup>3,4</sup>. Employees who are protected by these provisions may make a claim for unfair dismissal if they are dismissed for making a protected disclosure. This includes disclosing institutional abuse such as gross negligence, corporate manslaughter and duty of candour failures.

From September 2017, dental practices were required to implement a new approach to whistle blowing/raising concerns by introducing policies and procedures that require practices to eliminate discrimination, harassment and victimisation. The aim of the new policy is to define actions and responses for:

- staff with concerns about the delivery of services to patients
- the management of their concerns

Issues raised may include:

- poor clinical practice or other malpractice which may harm patients
- failure to safeguard patients
- untrained or poorly trained staff
- lack of policies creating a risk of harm

In addition, practices should also name a 'Freedom to Speak Up guardian' who is independent of the line management chain and not the direct employer, who can ensure that policies are in place and that staff know how to contact them.

NHS England can be contacted by any member of the dental team with a concern as they hold the status of a prescribed person under the PIDA. NHS England's integrated whistleblowing policy for primary care is available at: [www.england.nhs.uk/wp-content/uploads/2016/11/whistleblowing-guidance.pdf](http://www.england.nhs.uk/wp-content/uploads/2016/11/whistleblowing-guidance.pdf)

The GDC's confidential helpline on 0800 668 1329 can also be contacted by dental registrants if they are unsure whether they have a concern.

### 1.5. Children Act (2004)

The Children Act 2004 states that safeguarding is everyone's responsibility<sup>5</sup>. Section 11 places duties on organisations and individuals to make arrangements for ensuring their functions (including services that they contract to others), are discharged with due regard to the need to safeguard and promote the welfare of children.

### 1.6. Care Act (2014)

Chapter 14 of the Care Act provides guidance of adult safeguarding<sup>6</sup>. It cites neglect and acts of omission as behaviour which could give rise to a safeguarding concern. This includes:



This is particularly relevant in the dental setting given the potential impact on oral care and consequently the scope for dental team members to detect it.

The Act also includes self-neglect in the categories of abuse or neglect. In some circumstances, where there is a serious risk to the health and wellbeing of an individual, it may be appropriate to raise self-neglect as a safeguarding concern. It is vital to establish whether the person has capacity to make decisions about their own wellbeing, and whether they are able or willing to care for themselves.

An adult who can make choices may make decisions that others think of as self-neglect. Risk and capacity assessments are likely to be useful. The legislation makes clear that adult safeguarding responses should be guided by the adult themselves, to achieve the outcomes that they want to achieve.

## 1.7. Mental Capacity Act (2005)

The Mental Capacity Act (2005) states:

“a person lacks capacity in relation to a matter if at the material time they are unable to make a decision for themselves in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain”<sup>7</sup>

It does not matter whether the impairment or disturbance is permanent or temporary. It cannot be assumed that someone lacks capacity based upon age, disability, beliefs, condition and behaviour or because they make a decision that is considered inappropriate. In all cases the patient must be fully informed of the decision to be made, the consequences of decisions or the lack of decision. This requires professionals to have a frank and open conversation with patients to support their understanding.

The Mental Capacity Act 2005 does not apply to children under 16. Children under 16 are not presumed to have the capacity to consent but must demonstrate their competence. The principles of assessing capacity are the same as for adults. A child can give consent if the treatment or action is in their best interests and that they have the maturity and ability to fully understand the information given and what they are consenting to.

A person is unable to decide for themselves if they are unable to:

Understand the information relevant to the decision

Retain that information

Use or evaluate that information as part of the process of making the decision

Communicate their decision verbally, by sign language or another means

There is a legal duty to refer vulnerable people who may lack the capacity to make critical decisions to the Independent Mental Capacity Advocate (IMCA) service. To find contact details of local IMCA services, please see 3.2.1. An IMCA must be instructed for people in the following circumstances<sup>8</sup>:

|   |   |
|---|---|
| The person is aged 16 or over                   | A decision needs to be made about either a long term change in accommodation or serious medical treatment                 |
| The person lacks capacity to make that decision | There is no one outside the healthcare provider's organisation, such as a family member or friend, appropriate to consult |

The only situation when the duty to instruct an IMCA need not be followed is when an urgent decision is needed, for example, to save a person's life. However, if further serious treatment follows an emergency, an IMCA must be instructed.

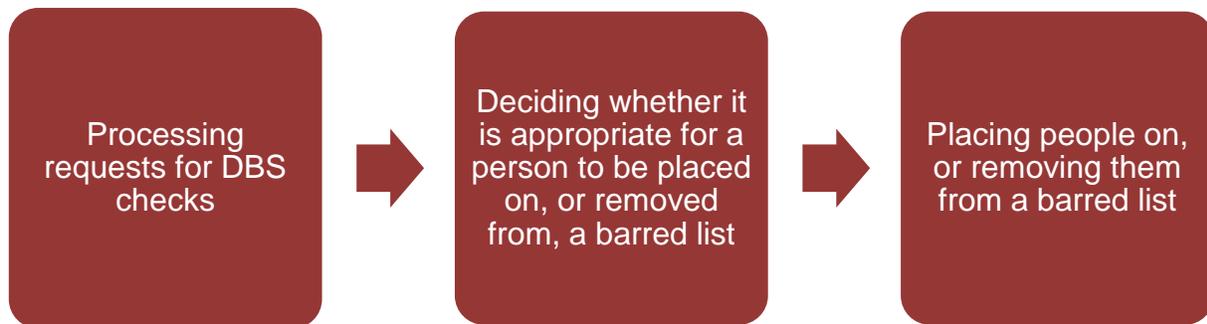
Lasting power of attorney (LPA) is where someone is instructed to make decisions on behalf of another and is valid when they lose mental capacity; without it they cannot legally make decisions for the individual concerned. There are two kinds of LPA:

- for financial decisions and
- for health and care decisions

Health professionals only have a legal duty to engage with LPAs for health and care decisions and not for financial decisions. Despite the widespread use of the phrase 'next of kin' this is neither defined, nor does it have formal legal status. A next of kin has no rights of access to a patient's records or to information on a patient's condition.

## 1.8. Disclosure and Barring Service (DBS)

The DBS helps employers to make safer recruitment decisions and prevent unsuitable people from working with people at risk, including children, and are responsible for<sup>9</sup>:



### CQC requirements

- Have a process in place for undertaking criminal record checks at the appropriate level for staff that require a check
- Assess the different responsibilities and activities of staff to determine if they are eligible for a DBS check and to what level. The eligibility for checks and the level of that check depends on the roles and responsibilities of the job, not the individual being recruited, and is based on the level of contact staff have with patients, particularly children and adults at risk

If practices are unsure about who is eligible for a check they can use the Disclosure and Barring Service eligibility tool at: [www.gov.uk/find-out-dbs-check](http://www.gov.uk/find-out-dbs-check)

#### 1.8.1 Rigorous Recruitment Practice

Referrals should be made to DBS when an employer or organisation believes a person:

- has caused harm
- poses a future risk of harm, to either adults at risk or children

An employer is breaking the law if they knowingly employ someone in a regulated activity with a group from which they are barred from working (this offence carries a prison sentence). A barred person is breaking the law if they seek, offer or engage in regulated activity with a group from which they are barred from working. An employee should understand that failure to disclose previous and any new convictions is a disciplinary issue. No employee should be given unsupervised access to children or adults at risk without all satisfactory recruitment checks having been made. Dental professionals are also required to disclose to the GDC if they have been barred from regulated activity.

Relevant conduct in relation to children and adults at risk requiring a referral includes that which:

- endangers or is likely to endanger them
- would, or would be likely to, endanger them if repeated against or in relation to them
- involves sexual material relating to children, including possession of such material
- involves sexually explicit images depicting violence against human beings, including possession of such images
- is of a sexual nature involving a child or adult at risk

A person satisfies the Harm Test if they may:

Harm a child or adult at risk

Cause a child or adult at risk to be harmed

Put a child or adult at risk at risk of harm

Attempt to harm a child or adult at risk

Incite another to harm a child or adult at risk

## 1.9. Prevent Duty Guidance (2015)

The Prevent Duty Guidance forms part of the UK government's counter-terrorism strategy. It identifies a key challenge for the healthcare sector to ensure that:

“where there are signs that someone has been or is being drawn into terrorism, the healthcare worker is trained to recognise those signs correctly and is aware of and can locate available support”

Prevent therefore plays a key part in ensuring children and adults are safeguarded by health professionals.

Dedicated resources for health professionals (including free e-learning packages) are available at: [www.england.nhs.uk/ourwork/safeguarding/our-work/prevent/](http://www.england.nhs.uk/ourwork/safeguarding/our-work/prevent/)

## Section 2: Roles and responsibilities

### 2.1 Local Safeguarding Adults Boards

The role of Local Safeguarding Adults Boards (LSABs) is to:

Provide assurance that local safeguarding arrangements are in place as defined by the Care Act 2014 and other statutory guidance

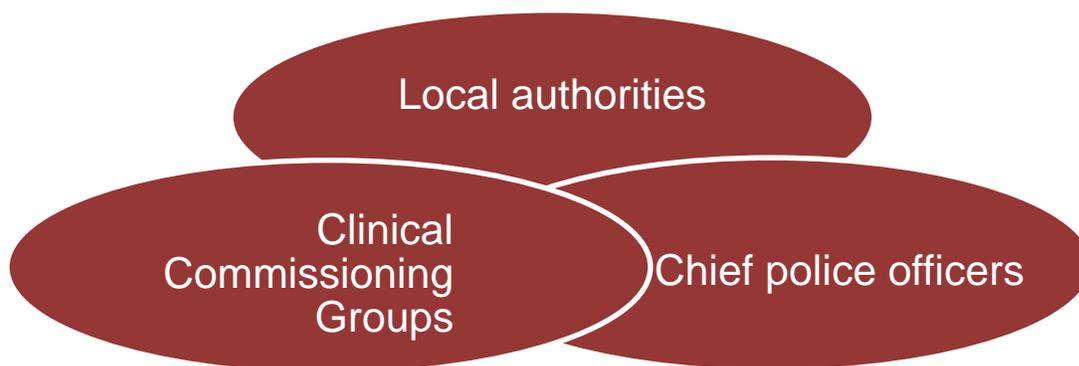
Help and safeguard adults with care and support needs

Work collaboratively to prevent abuse and neglect where possible

Ensure agencies and individuals give timely and proportionate responses when abuse or neglect has occurred, and that safeguarding practice is continuously improving and enhancing the lives of local adults

### 2.2 Local safeguarding partners

The Children and Social Work Act 2017 replaced Local Safeguarding Children Boards with new local safeguarding arrangements, led by 3 safeguarding partners:



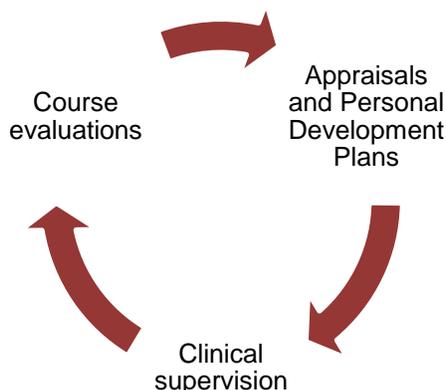
The Act places a duty on those partners to make arrangements for themselves and relevant agencies to work together for the purpose of safeguarding and promoting the welfare of children in their area.

### 2.2.1 Safeguarding Practice Lead

It is recommended that each dental practice should have a named Safeguarding Practice Lead (SPL). The SPL is not expected to be an expert in safeguarding or deal with all safeguarding issues, but rather a central person with oversight of safeguarding matters. The SPL ensures staff recognise their training needs, undertake appropriate training and can access appropriate support and advice on safeguarding matters.

### 2.2.2 Safeguarding training

The identification of training needs should not be an event, but an ongoing process conducted through:



An individual's training needs should form part of their Continuous Professional Development and therefore feature in their Personal Development Plan.

The Royal College of Nursing (2019) has recently updated guidance in determining the minimum level of training in the safeguarding of children and young people<sup>10</sup>. It identifies 5 levels, the first 3 which are relevant to the dental profession:

| Level | Staff   |
|-------|---|
| 1     | All non-clinical staff including receptionists, practice managers and staff without patient contact |
| 2     | Most dentists and dental care professionals   |

|   |  |
|---|--|
| 3 | To be determined locally in larger organisations (including hospital, community-based specialist services, paediatric dentistry or other relevant dental specialties such as orthodontics) based on an assessment of need and risk |
|---|--|

Adult Safeguarding: Roles and Competencies for Health Care Staff identify 6 groups of competence in the safeguarding of adults<sup>11</sup>. Members of the dental team fit into levels 1 and 2 as follows:

| Level | Staff   |
|-------|---|
| 1     | All non-clinical staff including receptionists, practice managers and staff without patient contact |
| 2     | Dentists and dental care professionals  |

The training frameworks in Appendices 7, 8 and 9 provide guidance in sourcing training at the appropriate level for dental team members. In addition to learning derived through specified training programmes, updates on current safeguarding and protection issues should be circulated by the SPL on a regular basis. The SPL should ensure that an up-to-date record of all staff members’ safeguarding training is held within the practice. The appropriate level of training for each staff member is determined by the level of contact which they have with patients, the nature of their work and their level of responsibility.

**2.2.3 Use of interpreters and translators**

Where a practitioner does not speak the same language as a patient, a patient has limited proficiency in English or requires British Sign Language, the services of an interpreter, either in person or through a telephone-based service (if appropriate), should be engaged. If an interpreter is not used, the reasons for this should be clearly recorded.

In some cases, patients may request that family members, friends or untrained members of their community interpret for them. However, the risk of relying on someone close to the patient, in what may be a highly personal and confidential situation, is that they may not be able to interpret accurately and may allow their own views of the situation to colour their translation. It may also be difficult, or even impossible, for the patient to disclose issues such as abuse in their presence. Therefore, it is not considered good practice to use family members, friends or untrained members of the community as interpreters as there can be

no assurance of exactly what is being said and translated, especially where abuse has occurred.

Not providing an interpreter can affect patient experience and health outcomes, increase missed appointments and make consultations less effective. Under the Equality Act 2010 it can also be considered indirect discrimination. Where a dental practice refuses to provide an interpreter for NHS care, they must have considered their interpreting provision and conclude that fulfils a test of 'due regard' under the public-sector equality duty.

The NHS guidance on the use of interpreters and translators in primary care is under development. The current draft can be found here:

[www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/03/it\\_principles.pdf](http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/03/it_principles.pdf)

## Section 3: Confidentiality, consent and information sharing

Ethical and statutory codes concerned with confidentiality serve to protect individual patients but are not intended to prevent exchange of information between different professionals and staff who have a responsibility for ensuring the protection of children, young people and adults at risk. In cases where there are safeguarding concerns, there is a duty to share all relevant information with professionals and agencies who need to know. This may include disclosing information with or without the permission of the child, young person, parents or carers or adult at risk, with other professionals for the purposes of safeguarding. Please see Appendix 6 for Safeguarding Flowchart.

Dental professionals are frequently uncertain as to whether their concerns reach a threshold for action. In these circumstances, advice should be sought from a professional with expertise in safeguarding. Furthermore, while consent is desirable, it is not essential for safeguarding referrals. If no consent is given by the child, parents or carers to share information, a risk assessment of the child or adult at risk concerned should be undertaken and further advice sought from the relevant local safeguarding contact. If it is felt that a patient may be a victim of neglect or physical, sexual or emotional abuse, that they lack capacity to consent to disclosure and where it is felt that the disclosure is in the patient's best interests or necessary to protect others from a risk of serious harm, such information should be shared with the appropriate professionals and agencies.

In the process of any subsequent investigations by the police and social services, it should be expected that the referral and its source will be made known to parents or carers. Therefore, any concerns about the impact of this on practice staff should be shared with the police or social services departments at the time of referral. Further details on information sharing are available at: <https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/information-governance-alliance-iga/information-governance-resources/information-sharing-resources>

### 3.1. Consent

Children under 16 are not presumed to have the capacity to consent and must demonstrate their competence. A child can give consent if practitioners are satisfied that the treatment or action is in their best interests and that they have the maturity and ability to fully understand the information given and what they are consenting to. However, as with adults, this consent is only valid if given voluntarily and not under undue influence or pressure by anyone else. Consideration should always be given to getting consent from a child under 16 years of age where they are felt to be competent. In such cases, consent from a person with parental responsibility is not required.

If a young person under the age of 16 presents to a member of the dental team and then discloses a history raising safeguarding concerns:

- if they are **not** deemed to have the capacity to consent, the member of staff is obliged to raise the issue as a safeguarding concern and escalate their concerns through the safeguarding process
- if they **are** deemed to have the capacity to consent and disclosure is considered essential to protect them from harm or to be in the public interest, the member of staff should escalate concerns through the safeguarding processes

In **both** cases, the member of staff should inform the young person of this action, unless doing so could pose significant additional risk to their safe care.

Further information on capacity to consent is available at: [www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines/](http://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines/)

### 3.2. Advice and referrals

All dental professionals have a responsibility to know who to contact for further advice and how to refer to an appropriate authority. It is of note that safeguarding procedures vary between areas and local contact details can also change with time. Relevant and up-to-date local points of contact for concerns can be accessed via the NHS safeguarding app:

[www.myguideapps.com/nhs\\_safeguarding/default/index.html](http://www.myguideapps.com/nhs_safeguarding/default/index.html)



Where someone appears to be the subject of suspected deliberate harm, it is the duty of the dental practitioner to provide essential emergency dental treatment and to arrange further medical treatment as indicated. If someone requires medical treatment or admission urgently, or is in immediate danger, dial: 999. Please see Appendix 6 for Safeguarding Flowchart.

### 3.2.1 Instructing an Independent Mental Capacity Advocate (IMCA) in dental treatment decisions

There is a legal duty to refer vulnerable people who may lack the capacity to make critical decisions to the Independent Mental Capacity Advocate (IMCA) service. Contact details of local IMCA services can be accessed via the Find an IMCA page: [www.scie.org.uk/mca/imca/find](http://www.scie.org.uk/mca/imca/find)

For further information on the criteria for those who need to be referred to a local IMCA service, please see 1.7.

## 3.3. Record keeping

### 3.3.1 Recording physical signs

Dental professionals are likely to observe and identify injuries to the head, eyes, ears, neck, face, mouth and teeth as well as other welfare concerns. Bruising, burns, bite marks and eye injuries are the types of injury that suggest a concern should be raised. Dental professionals are also well placed to identify the risks to oral and general health associated with poor oral hygiene and dental neglect. A patient may also disclose abuse or other indicators of it; such safeguarding concerns should always be recorded.

Accurate record keeping is an essential part of the accountability for safeguarding. Documentation within dental practices should accurately reflect not only the care provided but also any concerns in respect of a child, young person or adult at risk. It may feature information on anyone attending with the patient, any injury observed using diagrams where appropriate and a record of discussions concerning the patient. In cases of abuse records should include:

- description and location of injury
- nature of injury, such as bruise or laceration
- size and shape of injury
- comments and observations made by the patient, parent or carer

- the behaviour or presentation of, or comments concerning, the accompanying parent or carer

Concerns may also be raised in respect of how a parent or carer has related to, or behaves towards, a child or adult at risk. These should be recorded along with any actions taken including seeking advice and noting the advice given.

Appendix 3 includes facial, oral and body maps that could be used by dental professionals to accurately record observed injuries. If a decision is taken not to share safeguarding concerns, it is best to discuss this with a defence organisation or professional association.

### 3.3.2 Recording missed appointments

When a child or adult at risk misses an appointment, it should be recorded as “Was Not Brought” rather than “Did Not Attend”.

The purpose of the appointment and the consequences to the patient of it being missed are important considerations. Where there is a history of “Was Not Brought” for a particular patient it may indicate that action is needed to protect them, to ensure they get the treatment they require. This could involve talking to safeguarding services where there is a risk of neglect.

A video on the importance of recording “Was Not Brought” is available at:

[www.youtube.com/watch?v=dAdNL6d4lpk](http://www.youtube.com/watch?v=dAdNL6d4lpk)

### 3.3.3 Recording non-compliance

‘Disguised compliance’ involves a parent or carer giving the appearance of co-operating with a patient’s dental treatment to avoid raising suspicions of unsafe parenting or caring.

The aim is to avoid social care interventions by allaying professional concerns. Disguised compliance can make it very difficult for dental teams to maintain an objective view of the welfare of the patient by preventing an understanding of the severity of harm being experienced by the patient from being gained. Examples of behaviours which indicate disguised compliance include:

Repeated cancelling or rescheduling of appointments

Sporadic compliance, such as attending appointments or engaging with dental professionals for a limited period of time

Patients or carers agreeing to make the changes needed to improve the patient's oral health but then making little or no effort with this

**Next steps to consider:**

1. Have **all members of the dental team** (clinical and non-clinical) read this document?
2. Does the practice have a **named Safeguarding Practice Lead** and do all members of staff know who it is?
3. Does the practice have a named **Freedom to Speak Up guardian** who is independent of the line management chain and not the direct employer, who can ensure that policies are in place and that staff know how to contact them?
4. Do all members of staff know how to access the **NHS Safeguarding app** to search for local safeguarding contact details?  
[http://www.myguideapps.com/nhs\\_safeguarding/default/index.html](http://www.myguideapps.com/nhs_safeguarding/default/index.html)
5. Does the practice have a **Safeguarding Policy** and is it regularly reviewed?
6. How are members of **staff training needs** identified?
7. Have all members of staff undertaken the appropriate level of safeguarding training?
8. How will this document, along with the weblinks provided to pertinent supporting guidance, resources, free training opportunities and video links be **discussed in team meetings** to consider how they may be embedded into practice?

## Acknowledgements

The authors would also like to thank the following for their support in preparing this document:

Adrian Spanswick, Safeguarding Lead, NHS Central Midlands

Annelise Hillyer-Thake, Safeguarding Programme Manager, NHS England

Beverley Czyz, Safeguarding Children Board Manager, Leicester City Council

Chandni Patel, Fellow in Public Health, Northamptonshire County Council

David Culy, Safeguarding Adults Board Business Manager, Lincolnshire County Council

Diane Fenton, Dental and Optometry Contract Manager, NHS England Central Midlands

Eustace de Sousa, National Lead for the Life Course, Public Health England

Jenny Harris, Consultant in Paediatric Dentistry, Sheffield Teaching Hospitals NHS Foundation Trust

Jenny Harper, Designated Safeguarding Nurse, South West Lincolnshire Clinical Commissioning Group

Joanne Harrison, Regional Head of Safeguarding, NHS England Midlands and East

John Mair-Jenkins, Consultant in Healthcare Public Health (Oral Health), Public Health England (East Midlands)

Laura Carvell, Programme Officer (Children), Leicester City Council  
Leicestershire Local Dental Committee

Lincolnshire Local Dental Committee

Lisa Cooper, Deputy Director Quality and Safeguarding, NHS England North

Nadeem Ahmed, Local Dental Network Chair, Shropshire and Staffordshire

Nick Rudling, Deputy Safeguarding Lead, NHS England South (South West)

Nicola Hawkey, Senior Policy Advisor, British Dental Association

Sandra Morrell, Designated Safeguarding Nurse, Nottingham City Clinical Commissioning Group

Stephen Dixon, Associate Postgraduate Dental Dean and CPD Lead, NHS Health Education England, East Midlands

Tiffany Burch, Specialty Registrar in Public Health, Leicester City Council

Trish Crowson, Senior Public Health Manager, Rutland and Leicestershire County Councils

Treena Beard, Nurse Specialist Safeguarding Children, East and North Hertfordshire Clinical Commissioning Group

Tom Norfolk, Local Dental Network Chair, East Anglia

# Appendix 1: Domestic abuse case summary

Baby L was murdered by his father at the age of 5 weeks.

## Background

While Baby L's mother was pregnant, she was seen by her GP and attended the local accident and emergency unit on several occasions with minor injuries. This gave rise to suspicions that she was suffering domestic abuse. However, she consistently denied this on every occasion, providing credible explanations for how the injuries had occurred. As well as her injuries, there were several other indicators that were suggestive of domestic abuse.

A social worker and health visitor undertook a joint visit to Baby L's home. The visit was due to concerns about the parenting of Baby L's sibling and suspicions that the mother was being subjected to domestic abuse, something she continued to deny. Baby L was examined and was considered to be making normal developmental progress with no visible injuries. The following day Baby L died, with multiple bruises, fractured ribs, 'classic' head injuries from shaking and a split liver.

Baby L's mother described being subjected to sustained abuse and violence in her relationship with the children's father. Medical staff noted a catalogue of injuries including scarring from knife wounds, damage to joints from constant beatings and permanent damage to fingers and her wrist. The injuries included burn marks from an iron and injuries to her throat where she was regularly held. She also had a temporary denture due to her front teeth having previously been avulsed.

The father of Baby L was sentenced to life imprisonment by the Crown Court for Baby L's murder and grievous bodily harm of the mother. As a result of Baby L's death, a Local Safeguarding Children Board Serious Case Review was undertaken looking at all agencies' involvement with the case.

## Lessons learned

A number of key lessons came out of the review including the importance of information sharing and good record keeping. **During the investigation, Baby L's mother disclosed that the only health care professional she had confided in about the domestic abuse was her dentist.** This information was disclosed on several occasions, yet it was not shared with the relevant agencies. The dentist became a significant witness for the prosecution at Crown Court and gave evidence about the disclosures made by Baby L's mother. If the dentist had acted when the domestic abuse was disclosed to them Baby L's death could have been prevented.

Further **case summaries** are available from the NSPCC National case review repository at: [www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/national-case-review-repository/](http://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/national-case-review-repository/)

### Potential signs of domestic violence which might present at a dental appointment:

| General Signs   | Oral and Facial Signs  |
|---|--|
| <ul style="list-style-type: none"> <li>• Always accompanied by partner or family member, who frequently speaks for patient or cancels patient's appointments</li> <li>• Patient displays high levels of anxiety</li> <li>• Delay in seeking treatment</li> <li>• Presentation doesn't fit the explanation provided</li> </ul> | <ul style="list-style-type: none"> <li>• Facial or intraoral bruising or laceration</li> <li>• Teeth lost due to trauma</li> <li>• Fractures to nose, cheek or jaw</li> <li>• Torn fraenum</li> <li>• Bite marks</li> <li>• Hair loss</li> </ul> |

## **Make every contact count: Ask, Advise and Act**

### **Services to Signpost Patients to:**

- National 24h Domestic Violence helpline for Women: **0808 2000 247**
- National Domestic Violence Helpline for Men: **0808 8010 327**
- Honour Helpline for advice on forced marriage and honour-based violence: **0800 5999 247**
- Broken Rainbow for advice and support for LGBT victims of domestic abuse: **0845 2604 460**

Help to save lives by providing a safe environment to disclose and signpost patients to support services. Evidence shows that if a trusted professional asks about abuse, it will encourage those being abused to think about their situation and could empower them to act.

**The link between domestic abuse and child abuse is so strong that it is usual practice to always make a referral to Social Services in cases where there are children dependent on the perpetrator or victim.**

## Appendix 2: Child sexual abuse and exploitation

In contrast to other forms of sexual abuse, children and young people who are sexually exploited may not recognise that they are being abused as they perceive the perpetrator as giving them something they need or want. This may change over time as the perpetrator's behaviour becomes more coercive, but fear of consequences may stop them from disclosing. Child Sexual Abuse and Exploitation can therefore be very difficult to spot. Some additional facts about child sexual exploitation:

1 in 20 children and young people have experienced sexual exploitation or abuse

NHS dental services have regular contact with children and young people and therefore encounter children experiencing exploitation or abuse

Many young people who were unable to disclose their abuse said they would have liked someone to have noticed the signs and asked about it

Exploited children and young people may refuse help but still need to be safeguarded

It should not be assumed that children aged 16 and 17 years are safe from Child Sexual Abuse and Exploitation. A young person who has been subject to a complex pattern of life experiences including sophisticated grooming and priming processes that have brought them to a point where they are at risk of, or are abused, through Child Sexual Abuse and Exploitation, are often not able to recognise the exploitative relationships and situations they are in. They may even present as being in control.

## Spotting signs of child sexual exploitation:

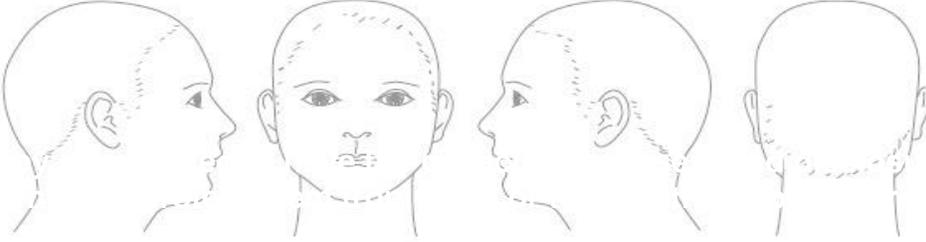
[www.youtube.com/watch?v=gix6pM7WK3E](https://www.youtube.com/watch?v=gix6pM7WK3E)

### Services providing support with child sexual abuse and exploitation

- For adults and professionals, NSPCC 24h helpline: **0808 800 5000**
- For children and young people, ChildLine 24h helpline: **0800 1111**

## Appendix 3: Facial, oral and body maps

**Record of facial Injury**

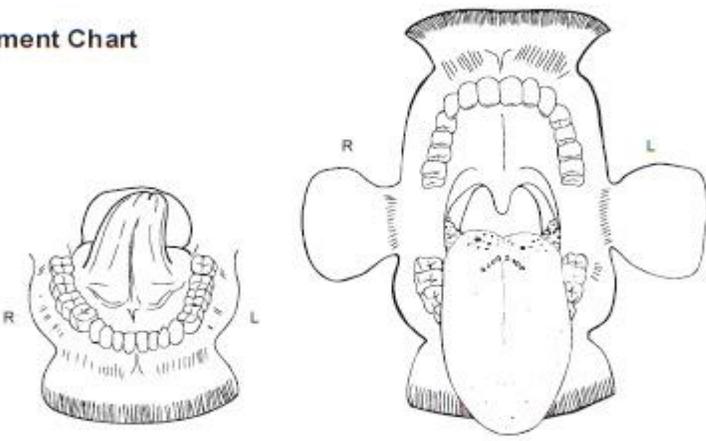


Description of findings: .....

Signature: ..... Date: ...../...../.....

Name: .....  
Date of Birth: .....  
Address: .....

**Oral Assessment Chart**



Description of findings: .....

Signature: ..... Date: ...../...../.....

Name: .....  
Date of Birth: .....  
Address: .....



## Appendix 4: Sample safeguarding policy

### Dental practice safeguarding policy

Our dental team accept and recognise their responsibility to develop their knowledge of the signs of abuse and neglect and to comply with the requirements of the General Dental Council (GDC) and the Care Quality Commission (CQC).

As a practice we are committed to protecting children, young people and adults at risk from harm of any kind by:

- responding promptly to all identified and suspected safeguarding concerns by making a referral using the appropriate local referral mechanism
- maintaining a culture where staff can raise concerns openly and without reproach
- providing an environment in which patients may discuss safeguarding
- using the Disclosure and Barring Service when recruiting staff to identify those with a history of causing harm
- ensuring staff undertake safeguarding training which is appropriate for their role on joining the practice and read the PHE and NHS Guidance for Safeguarding in General Dental Practice as part of their induction
- ensuring staff engage in periodic refresher training
- keeping accurate records of identified or suspected safeguarding concerns
- maintaining confidentiality, sharing patient information only with those who need it
- discussing safeguarding updates at practice meetings
- reviewing this policy at regular intervals

The Safeguarding Practice Lead (SPL) is:

The SPL's role is to oversee safeguarding within the practice, identify and support staff safeguarding training needs and to access appropriate support and advice on safeguarding matters.

**Key local safeguarding contacts:** (For local contact details - NHS safeguarding app: [www.myguideapps.com/nhs\\_safeguarding/default/index.html](http://www.myguideapps.com/nhs_safeguarding/default/index.html))

NHS Safeguarding



App/Tool

Policy review date:

Signed by SPL:

# Appendix 5: Female genital mutilation (FGM) resources

All dental professionals must report any cases of FGM in girls under 18 that they come across in their work to the police by calling the non-emergency crime number, 101.

Please go to: [www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare](http://www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare) for resources to support dental practices in carrying out this duty.

The resources available cover:

- a flowchart detailing the FGM mandatory reporting duty
- a poster explaining what the duty means for healthcare professionals
- a training package which can be used in practice meetings to introduce the duty to all members of the dental team
- a leaflet explaining the duty to patients

The images below showcase the resources that are available which can be printed out and used in dental practice:

**Female Genital Mutilation (FGM) Mandatory reporting duty**

Are you concerned that a child may have had FGM or be at risk of FGM?

**Mandatory reporting duty applies**

**When you are a healthcare professional who has seen or treated a girl under 18 who has had FGM, you must report it to the police or NSPCC.**

**When you are a healthcare professional who has seen or treated a girl under 18 who is at risk of FGM, you must report it to the police or NSPCC.**

**What does it mean for me?**  
Phone the police non-emergency crime number, 101, if a girl under 18 you treat:  
a) Tells you she has had FGM (female genital mutilation)  
b) Has signs which appear to show she has had FGM.

**Can someone else do this?**  
No. This is a personal duty: the professional who identifies FGM receives the disclosure must report.

**Why?**  
FGM is child abuse and a crime. Health professionals have a responsibility to care for and protect girls.

**What if I don't do this?**  
If you do not comply, your professional regulator may consider the circumstances under the existing 'Fitness to Practise' proceedings.

**When?**  
As soon as possible, normally by close of the next working day. Longer timeframes are allowed under exceptional circumstances but always discuss with your local safeguarding lead.

NSPCC FGM helpline: 0800 028 3550 [fgmhelp@nspcc.org.uk](mailto:fgmhelp@nspcc.org.uk)

**Quick guide for professionals: <https://www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare>**

**Department of Health NHS England**

**'Care, Protect, Prevent' #EndFGM**

**FGM Mandatory reporting duty - What you need to do**

**Strengthening Safeguarding - from 31 October 2015**

**What does it mean for me?**  
Phone the police non-emergency crime number, 101, if a girl under 18 you treat:  
a) Tells you she has had FGM (female genital mutilation)  
b) Has signs which appear to show she has had FGM.

**Can someone else do this?**  
No. This is a personal duty: the professional who identifies FGM receives the disclosure must report.

**Why?**  
FGM is child abuse and a crime. Health professionals have a responsibility to care for and protect girls.

**What if I don't do this?**  
If you do not comply, your professional regulator may consider the circumstances under the existing 'Fitness to Practise' proceedings.

**When?**  
As soon as possible, normally by close of the next working day. Longer timeframes are allowed under exceptional circumstances but always discuss with your local safeguarding lead.

NSPCC FGM helpline: 0800 028 3550 [fgmhelp@nspcc.org.uk](mailto:fgmhelp@nspcc.org.uk)

**Quick guide for professionals: <https://www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare>**

**Department of Health NHS England**

**FGM - supporting girls Information for patients**

**Duty of health professionals to report abuse against a girl under 18 - FGM**

Your healthcare professional is obliged under the law to report female genital mutilation (FGM) in a girl under 18.

This is no different from any other obligation on healthcare professionals to report abuse against children. FGM is child abuse so the healthcare professional must make a report to the police.

If a healthcare professional finds that a girl has had FGM, they will tell you they are going to make a report and they will discuss what this means for you. They may speak further with you depending on the circumstances.

When the police receive this information, they will speak with NHS and children's services professionals to determine what should be done, given the circumstances of the individual case.

Please ask questions and let your healthcare professional know if you require support or translation from an independent interpreter.

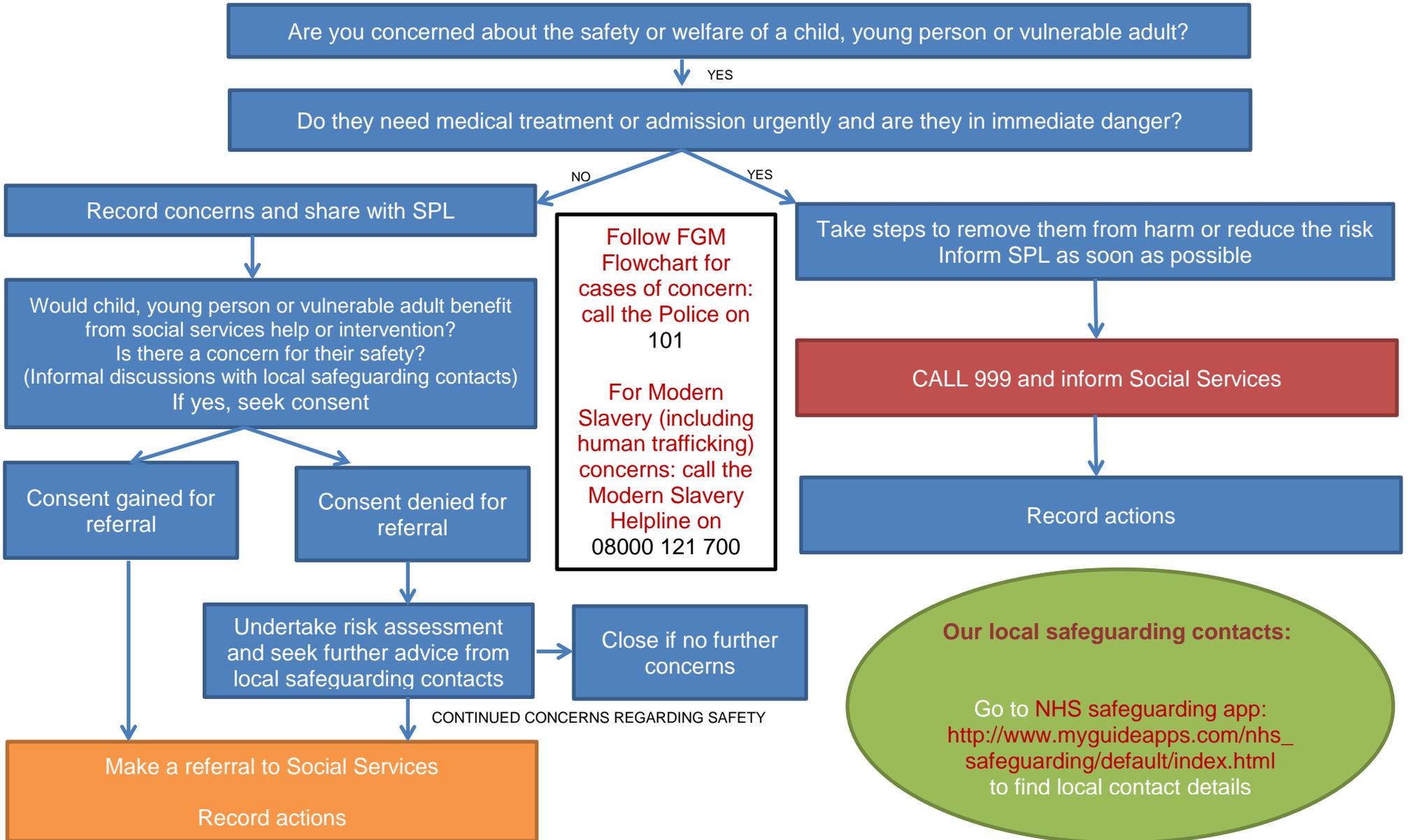
**Department of Health NHS England**

**'Care, Protect, Prevent' #EndFGM**

**Mandatory Reporting of FGM**  
A new professional duty

**Training Package for NHS Organisations**

## Appendix 6: Safeguarding flowchart



## Appendix 7: Safeguarding children and young people competencies

| Level  | Competencies  |
|--|---|
| <p><b>Level 1:</b> <u>Non-clinical staff including receptionists, practice managers and staff without patient contact for example practice cleaners</u></p> <p>E-learning is considered appropriate as the training modality for level 1.</p> <p>Training should be complete with 6 weeks of commencing in post.</p> <p>Competency should be reviewed annually and refresher training, totalling a minimum of 2 hours, should be undertaken every 3 years.</p> | <p><b>Having undertaken training those at level 1 should be able to:</b></p> <ul style="list-style-type: none"> <li>• Recognise potential indicators of child maltreatment including abuse, neglect, fabricated or induced illness and Female Genital Mutilation</li> <li>• Understand potential impact of parents' and carers' health on wellbeing and development of children and young people</li> <li>• Take appropriate action if there are concerns and how to report the concerns</li> </ul> |
| <p><b>Level 2:</b> <u>Dentists and dental care professionals</u></p> <p>Those at level 2 should also be competent in the training outcomes described for levels 1 and 2.</p> <p>E-learning is considered appropriate as the training modality for level 2.</p>   | <p><b>Having undertaken training those at level 2 should be able to:</b></p> <ul style="list-style-type: none"> <li>• Use professional and clinical knowledge and understanding of what constitutes child maltreatment, to identify signs of abuse or neglect</li> <li>• Identify and refer a child suspected of being a victim of trafficking or sexual exploitation; at risk of FGM or having been a victim of FGM; at risk of exploitation by radicalisers</li> </ul>                            |

Training should be completed within 6 months of commencing in post.

Competency should be reviewed annually and refresher training, totalling a minimum of 3 hours, should be undertaken every 3 years.

- Act as an effective advocate for the child or young person
- Recognise the potential impact of a parents' or carers' physical and mental health on the wellbeing of a child or young person, including possible speech, language and communication needs
- Be clear about their own and their colleagues' roles, responsibilities and professional boundaries, including professional abuse and raising concerns about the conduct of colleagues
- Refer to social care if a safeguarding or child protection concern is identified; even those whose roles do not encompass referrals should be aware of how to make a referral. Document safeguarding and child protection concerns, maintain appropriate records; differentiate between fact and opinion
- Share appropriate and relevant information
- Act in accordance with key statutory and non-statutory guidance and legislation including the UN Convention on the Rights of the Child and Human Rights Act

## Appendix 8: Safeguarding adults competencies

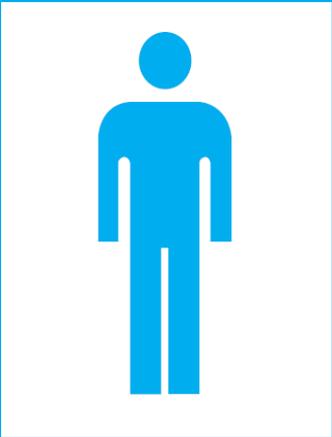
| Level  | Competencies   |
|--|--|
| <p><b>Level 1: <u>Non-clinical staff including receptionists, practice managers and staff without patient contact for example practice cleaners</u></b></p> <p>E-learning is considered appropriate as the training modality for level 1.</p> <p>Training should be complete with 6 weeks of commencing in post.</p> <p>Competency should be reviewed annually, and refresher training should be undertaken every 3 years.</p> | <p><b>Having undertaken training those at level 1 should know:</b></p> <ul style="list-style-type: none"> <li>• Understand and demonstrate what Adult Safeguarding is</li> <li>• Recognise adults in need of Safeguarding and take appropriate action</li> <li>• Understand dignity and respect when working with individuals</li> <li>• Understand the procedures for making a ‘Safeguarding Alert’</li> <li>• Have knowledge of policy, procedures and legislation that supports Safeguarding Adults activity</li> <li>• Ensuring effective administration and quality of safeguarding processes</li> </ul>  |
| <p><b>Level 2: <u>Dentists and dental care professionals</u></b></p> <p>Those at level 2 should also be competent in the training outcomes described for level 1.</p> <p>Training should be complete with 6 months of commencing in post.</p> <p>Competency should be reviewed annually, and refresher training should be undertaken every 3 years.</p>  | <p><b>Having undertaken training those at level 2 should be able to:</b></p> <ul style="list-style-type: none"> <li>• Ensure service users are informed and supported in their decision making around Safeguarding Adults concern</li> <li>• Ensure information is shared appropriately and all relevant partners are involved</li> <li>• Demonstrate appropriate responses to Safeguarding Adult concerns</li> <li>• Maintaining accurate and complete records and achieving best evidence</li> <li>• Managing Safeguarding Adult concerns and enquiries</li> <li>• Awareness and application of legislation, local and national policy and procedural frameworks</li> <li>• Demonstrates skills and knowledge to contribute effectively to the safeguarding process</li> </ul> |

## Appendix 9: Free safeguarding training opportunities

Please note that this is not an exhaustive list.

| Provider                                      | Title of course  | Weblink  |
|---|--|--|
| <b>British Dental Association</b>             | Child Protection and the dental team   | <a href="https://bda.org/childprotection">https://bda.org/childprotection</a>  |
| <b>e-Learning for Healthcare</b>              | Safeguarding Children and Young People   | <a href="http://www.e-lfh.org.uk/programmes/safeguarding-children/">www.e-lfh.org.uk/programmes/safeguarding-children/</a>   |
|   | Child Sexual Exploitation  | <a href="http://www.e-lfh.org.uk/programmes/child-sexual-exploitation/">www.e-lfh.org.uk/programmes/child-sexual-exploitation/</a>   |
|   | Female Genital Mutilation  | <a href="http://www.e-lfh.org.uk/programmes/female-genital-mutilation/">www.e-lfh.org.uk/programmes/female-genital-mutilation/</a>   |
|   | Child Sexual Abuse   | <a href="http://www.e-lfh.org.uk/programmes/child-sexual-abuse-awareness/">www.e-lfh.org.uk/programmes/child-sexual-abuse-awareness/</a>   |
|   | Safeguarding Adults  | <a href="http://www.e-lfh.org.uk/programmes/safeguarding-adults/">www.e-lfh.org.uk/programmes/safeguarding-adults/</a>   |
|   | Modern Slavery   | <a href="http://www.e-lfh.org.uk/programmes/modern-slavery/">www.e-lfh.org.uk/programmes/modern-slavery/</a>   |
|   | Domestic Violence and Abuse  | <a href="http://www.e-lfh.org.uk/programmes/domestic-violence-and-abuse/">www.e-lfh.org.uk/programmes/domestic-violence-and-abuse/</a>   |
|   | Deprivation of Liberty safeguards  | <a href="http://www.e-lfh.org.uk/programmes/deprivation-of-liberty-safeguards/">www.e-lfh.org.uk/programmes/deprivation-of-liberty-safeguards/</a>   |
|   | Freedom to Speak Up  | <a href="http://www.e-lfh.org.uk/programmes/freedom-to-speak-up/">www.e-lfh.org.uk/programmes/freedom-to-speak-up/</a>   |
| Disability Matters                            | <a href="http://www.e-lfh.org.uk/programmes/disability-matters/">www.e-lfh.org.uk/programmes/disability-matters/</a> |  |
| <b>Home Office</b>                            | Female Genital Mutilation  | <a href="http://www.fgmelearning.co.uk">www.fgmelearning.co.uk</a>   |
| <b>Virtual College</b>                        | Forced Marriage  | <a href="http://www.virtual-college.co.uk/resources/free-courses/awareness-of-forced-marriage">www.virtual-college.co.uk/resources/free-courses/awareness-of-forced-marriage</a>   |
|   | Female Genital Mutilation  | <a href="http://www.virtual-college.co.uk/resources/free-courses/recognising-and-preventing-fgm">www.virtual-college.co.uk/resources/free-courses/recognising-and-preventing-fgm</a>   |
|   | Child Sexual Exploitation  | <a href="http://www.virtual-college.co.uk/resources/free-courses/keep-them-safe">www.virtual-college.co.uk/resources/free-courses/keep-them-safe</a>   |
| <b>HM Government</b>                          | Prevent  | <a href="http://www.elearning.prevent.homeoffice.gov.uk/mentalhealth">www.elearning.prevent.homeoffice.gov.uk/mentalhealth</a>   |
| <b>Brook</b>                                  | Combatting Child Sexual Exploitation   | <a href="http://www.brook.org.uk/our-work/cse-e-learning-tool">www.brook.org.uk/our-work/cse-e-learning-tool</a>   |
| <b>Medical Protection</b>                     | Mental Capacity Act and Deprivation of Liberty safeguards  | <a href="http://www.medicalprotection.org/uk/articles/mca">www.medicalprotection.org/uk/articles/mca</a>   |
| <b>Department of Health and NHS England</b>   | Mandatory Reporting of FGM   | <a href="https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/472693/FGM_training_package.pdf">https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/472693/FGM_training_package.pdf</a>        |
| <b>Royal College of General Practitioners</b> | Safeguarding Toolkit for General Practice  | <a href="http://www.rcgp.org.uk/clinical-and-research/resources/toolkits/the-rcgp-nsppc-safeguarding-children-toolkit-for-general-practice.aspx">www.rcgp.org.uk/clinical-and-research/resources/toolkits/the-rcgp-nsppc-safeguarding-children-toolkit-for-general-practice.aspx</a> |

## Appendix 10: Domestic violence posters



www.blackprint.com

# Domestic violence affects men too Talk it over

Not sure what to do?  
Call the Men's Advice Line and talk it over.

**0808 801 0327**  
(Free from landlines and mobile phones)

**We are open**  
**Monday-Friday**  
**9am to 5pm.**

**Or email**  
**info@mensadviceline.org.uk**  
**www.mensadviceline.org.uk**

Calls are confidential. We do not use technology to identify callers, listening-in or call recording equipment. Calls may be monitored for quality and training purposes. Visit [www.mensadviceline.org.uk](http://www.mensadviceline.org.uk) for more info.

If English is not your first language, call us and ask for an interpreter

**Text Relay**

The Helplines  
Association  
Member  
Quality Standard



**Men's Advice Line**



IF  
YOU'RE  
FRIGHTENED  
OF YOUR  
PARTNER,  
CALL US.

**NATIONAL DOMESTIC VIOLENCE HELPLINE**

**0808 2000 247**

**24/7 CONFIDENTIAL FREEPHONE**

**women's aid**

until women & children are safe

[www.womensaid.org.uk](http://www.womensaid.org.uk)

**Refuge**



For women and children.  
Against domestic violence.

[www.refuge.org.uk](http://www.refuge.org.uk)

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## Further reading

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