Lambeth Safeguarding Children Partnership

NHS South East London Clinical Commissioning Group

An Overview Guide

Documenting Safeguarding Concerns and Correspondence within GP Medical Records

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October 2020

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Introduction

Safeguarding of children and vulnerable adults is a vital role of the General Practitioner (GP).

GPs are in a unique position with regard to safeguarding as they often have oversight of a whole family, and may therefore be privy to information both directly regarding a child or vulnerable adult, and also regarding their parents or caregivers. This information might give some insight into factors in the parent / carer that might impact on their ability to provide adequate care for that person.

As a result of the pivotal and "family focussed" role GPs play, they are frequently copied in to all manners of correspondence from a variety of agencies, and in some case might be in a strong position to piece together the jigsaw and identify a concerning pattern that might represent the risk of abuse.

Whilst a traditional "family doctor" or a single handed GP might well know their patients and their families intimately, the models within General Practice are ever changing: Different members of a family might now consult with different doctors within a practice; patients might consult with locum doctors deputising for a regular GP; patients might consult with GPs in the out-of-hours setting, or with different GPs in a 'hub' clinic and patients or families might move between GP practices. In view of this, it is vital that safeguarding concerns are adequately documented, in order to ensure that potential safeguarding concerns are recognised and steps taken to protect a child where necessary. Consistency in documentation across practices allows this information to be readily identified as patients move, or as GPs consult with patients from different practices.

GPs often ask how certain reports or information should be handled in terms of recording, scanning and Read/ SNOMED coding. This handbook of flowcharts will hopefully help to clarify these processes and will then establish some consistency with regards the documentation.

There may be correspondence received which is not detailed within these charts. There may also be times where the flowchart's suggestion does not seem appropriate for whatever reason. Where there are any concerns, please feel free to contact the Safeguarding team at Lambeth CCG for further discussion and clarification.

10 Top tips when documenting possible safeguarding concerns.

1. Document clearly what you have been told, by whom, and what you have done and plan to do with the information.

2. Record information factually. Where opinion must be stated, ensure it is clear that this is opinion.

3. When consulting with a child / vulnerable adult, document whether they have come alone, or if accompanied then document who by (ask, don't presume…)

4. Use standard Read/ SNOMED codes – this enables practitioners to see immediately if there have been historic concerns. Using consistent Read codes is also safer when patients move between practices, or consult other clinicians.

5. Use standard Read codes EVERY TIME there is new information. Adding a "review" to the pre-existing Read code enables practitioners to "pull together" all relevant consultations easily.

6. See the child / vulnerable adult within the context of their family / carers. See the child behind the adult and the adult behind the child. Where you have concerns about a child, explore the siblings and care-givers records to see if there is a pattern of concerns. Where relevant, document concerns on the notes of all close family members.

7. When documenting third party information on medical notes try to keep it anonymised (E.g. "family member (NHS no. XXXXXXXXX) in household is alcohol dependent"). **Only document third party issues that are significant**.

8. If it is felt necessary to record non-anonymous third party information, then ensure there are adequate flags to enable it to be redacted. The **code 9LL "Record contains third party information"** will help with this.

9. Where consultation or care history entries contain third party information, **toggle the online visibility to: "Do not display on the patient's online care record"** to ensure the information is kept confidential.

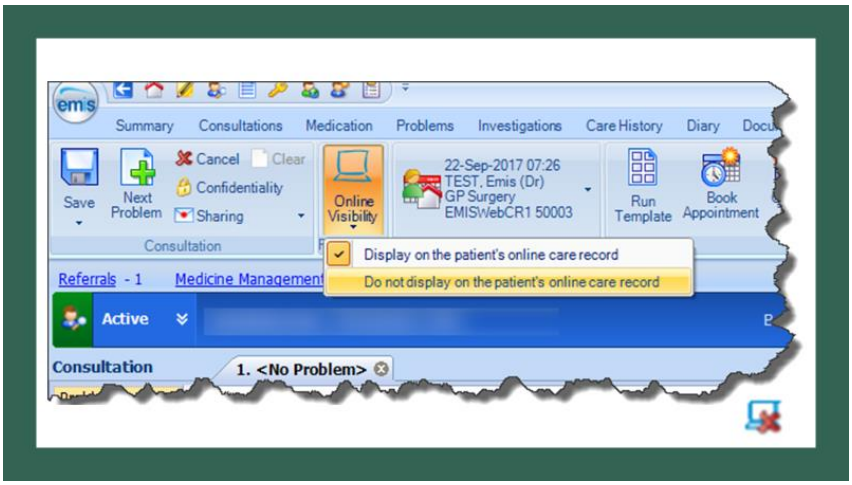
10. Ensure that before any records leave the practice to external agencies (e.g. solicitors etc.) that third party information is sought out and redacted as appropriate. This should include ALL entries with the 9LL read code attached, and any entries marked as unsuitable for online viewing. In addition, **child protection case conference minutes and MARAC reports do NOT belong to primary care and as such we have no right to share these with anyone and they must ALWAYS be removed.**

Online Access – Safeguarding Concerns

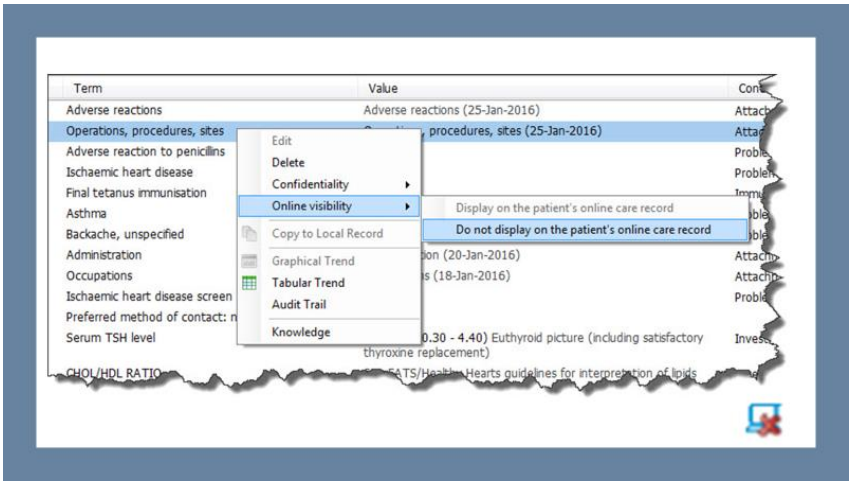
The particular concerns around online access, which is not exhaustive, surround:

- Risk of coercion in domestic abuse relationships, and risk of sharing information against a person's will.
- Third party access- consider for patients whose reading and writing skills are limited or language barriers
- Child proxy access and the point at which it is unsuitable for parents to access their child's notes.
- Alongside this our medical notes need to serve as a tool where we can safely record safeguarding information.

For anyone unsure **online visibility tools** are available in:



Open consultation-on the bar and consultation is saved with the little laptop and red cross icon at the righthand side.

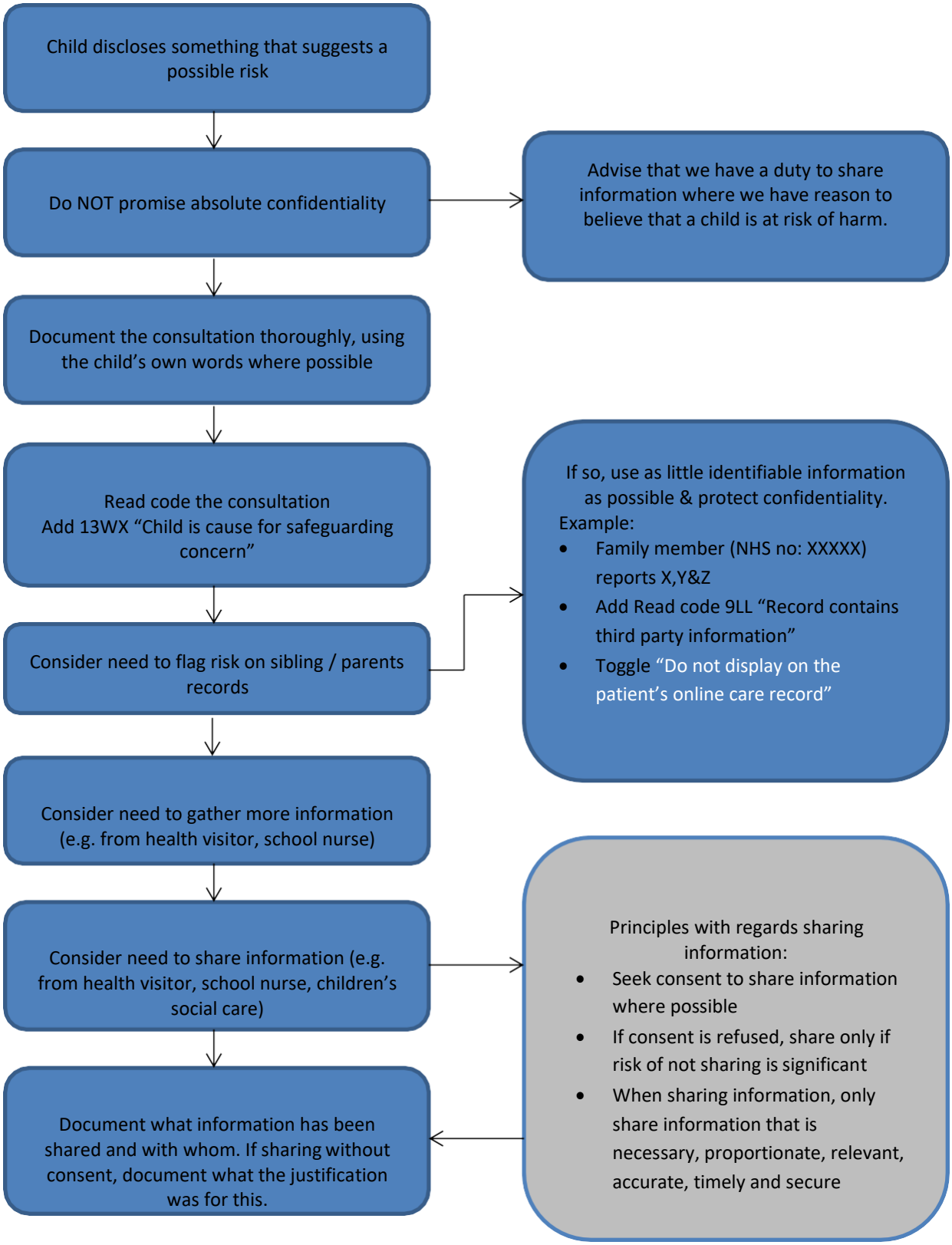


Care History- right click the item, code and documents. This is the function by which you can hide child protection documents which contain third party/family information
To note these only exist for online records and will not redact from printed records.

For our young people we must consider their confidentiality and the point at which it becomes unsuitable for parents to access their child's notes. When a young person comes in for a face to face appointment with their parent or carer, instinctively we consider whether we need to speak to the child alone. We must hold that same instinct for patient online access, considering the direct lack of control we may have in this arena and therefore plan ahead to ensure that for a child who is competent has their confidentiality maintained.

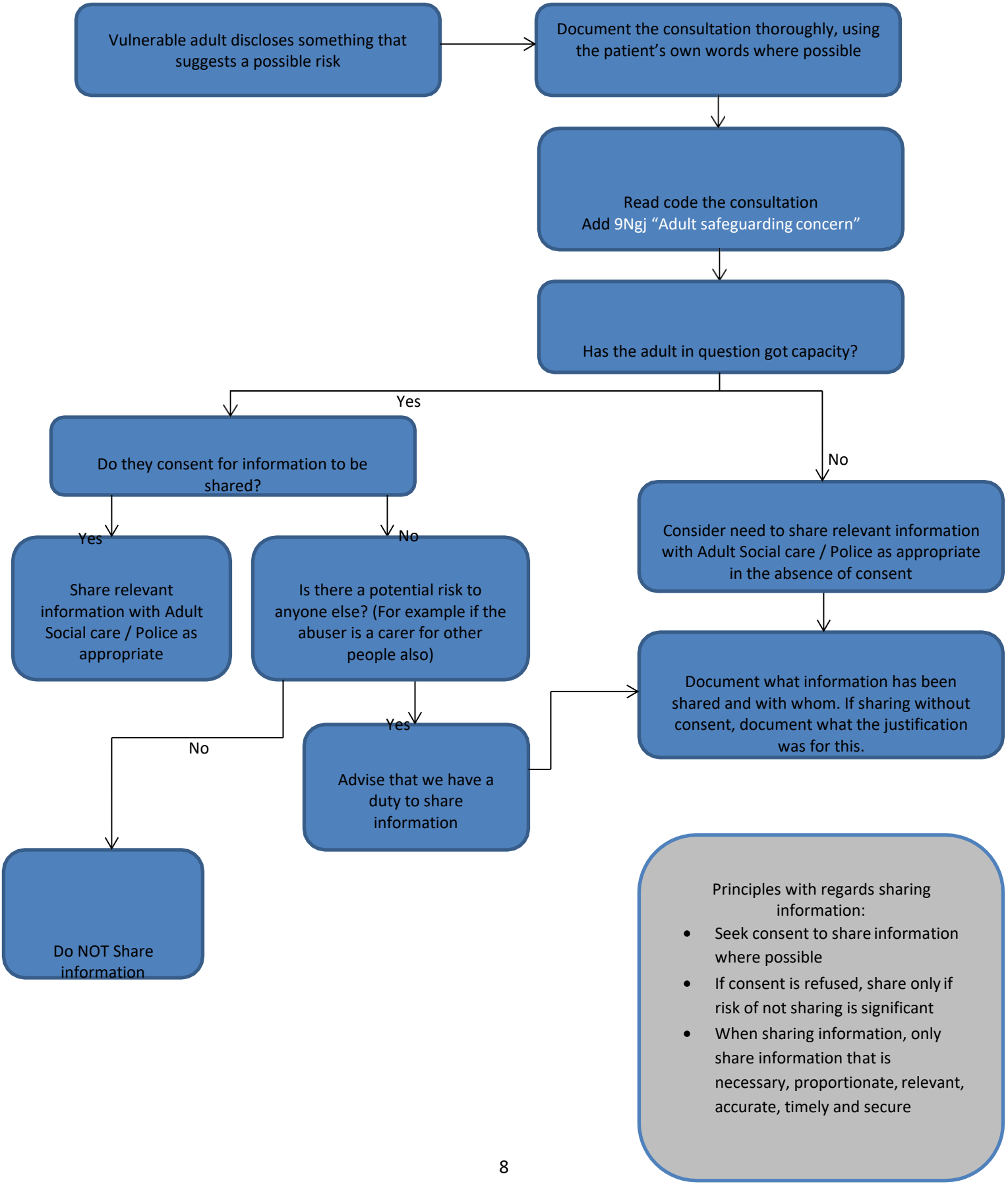
The GP consultation – Potentially vulnerable or "at risk" child

During a consultation in Primary Care it might become apparent that a child might be at risk as a result of something in their own history, or that of their parents or caregiver(s). It is important to ensure that this consideration is documented and risks balanced / discussed / shared as appropriate.



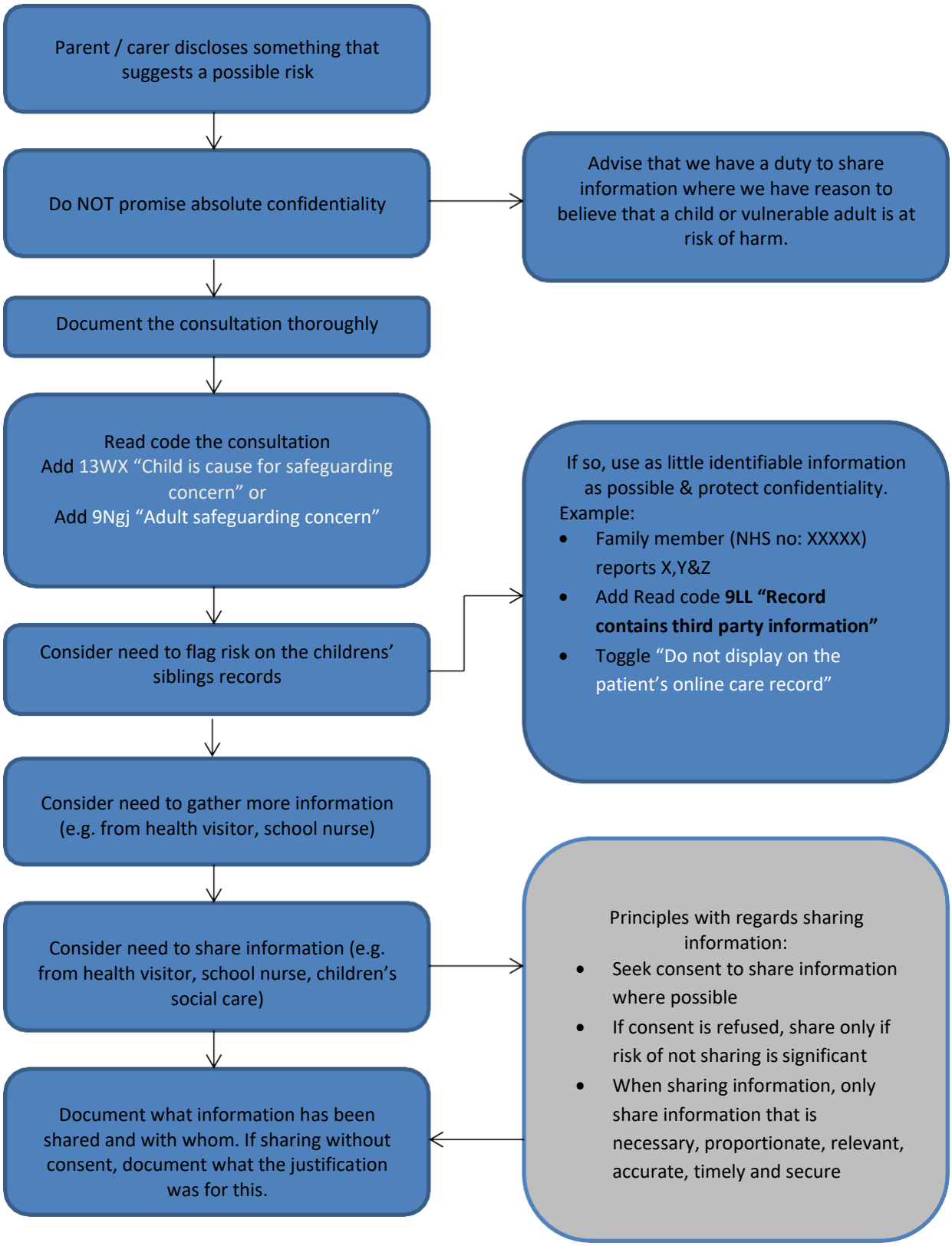
The GP consultation – Potentially vulnerable adult

During a consultation in Primary Care it might become apparent that a vulnerable adult might be at risk as a result of something in their own health, or that of their caregiver(s). It is important to ensure that this consideration is documented and risks balanced / discussed / shared as appropriate.

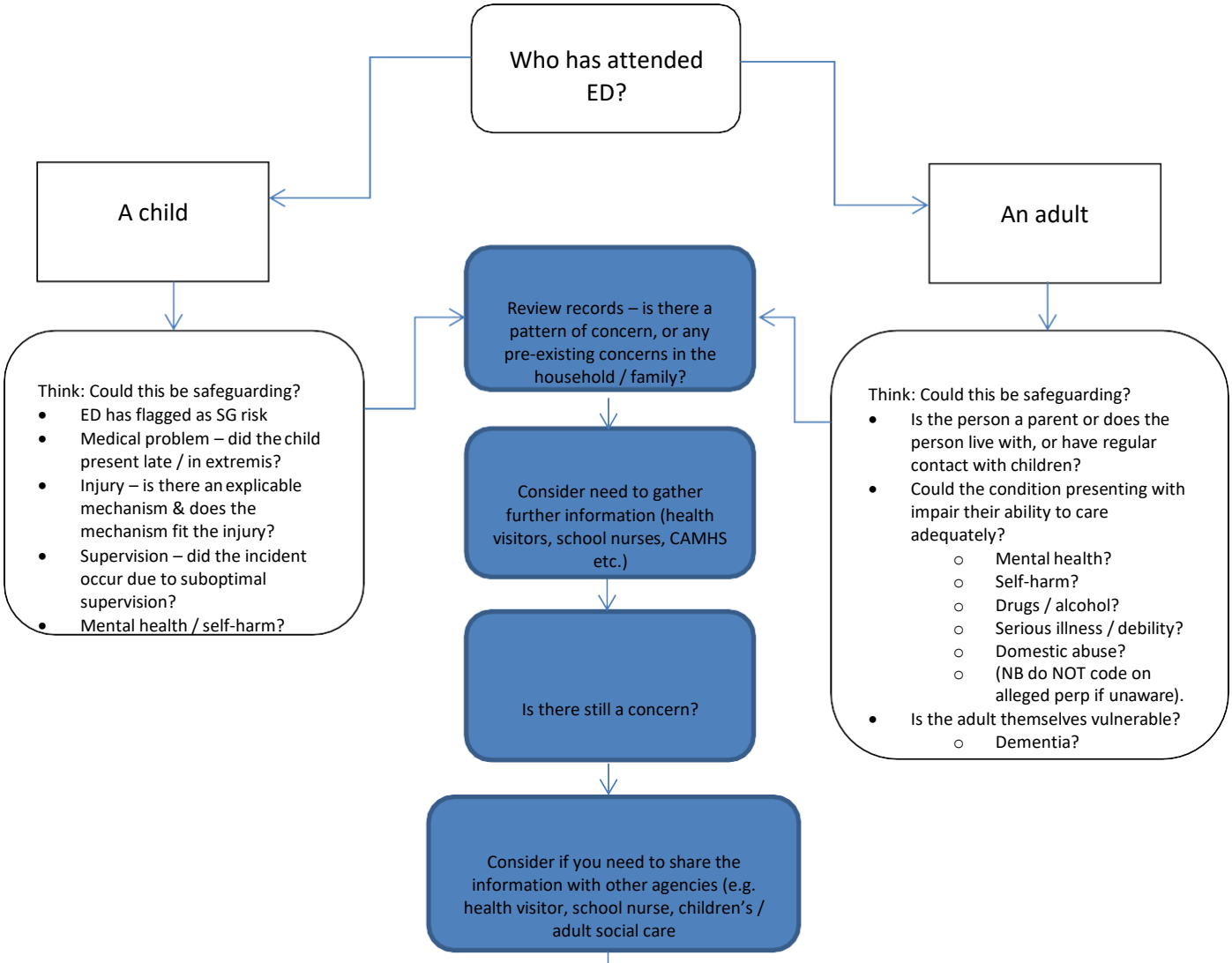


The GP consultation – Parent or carer posing a potential risk

During a consultation in Primary Care it might become apparent that a child or vulnerable adult might be at risk as a result of the health of their parents or caregiver(s). Examples of circumstances where this may be relevant include (but are not limited to) cases of mental health, learning difficulties, substance misuse and domestic abuse. It may also be relevant when a parent / carer has a significant physical illness that might impair their ability to fulfil their caring responsibilities.



ED Attendance report received



Read code

Enter a consultation as an "**administration note**"

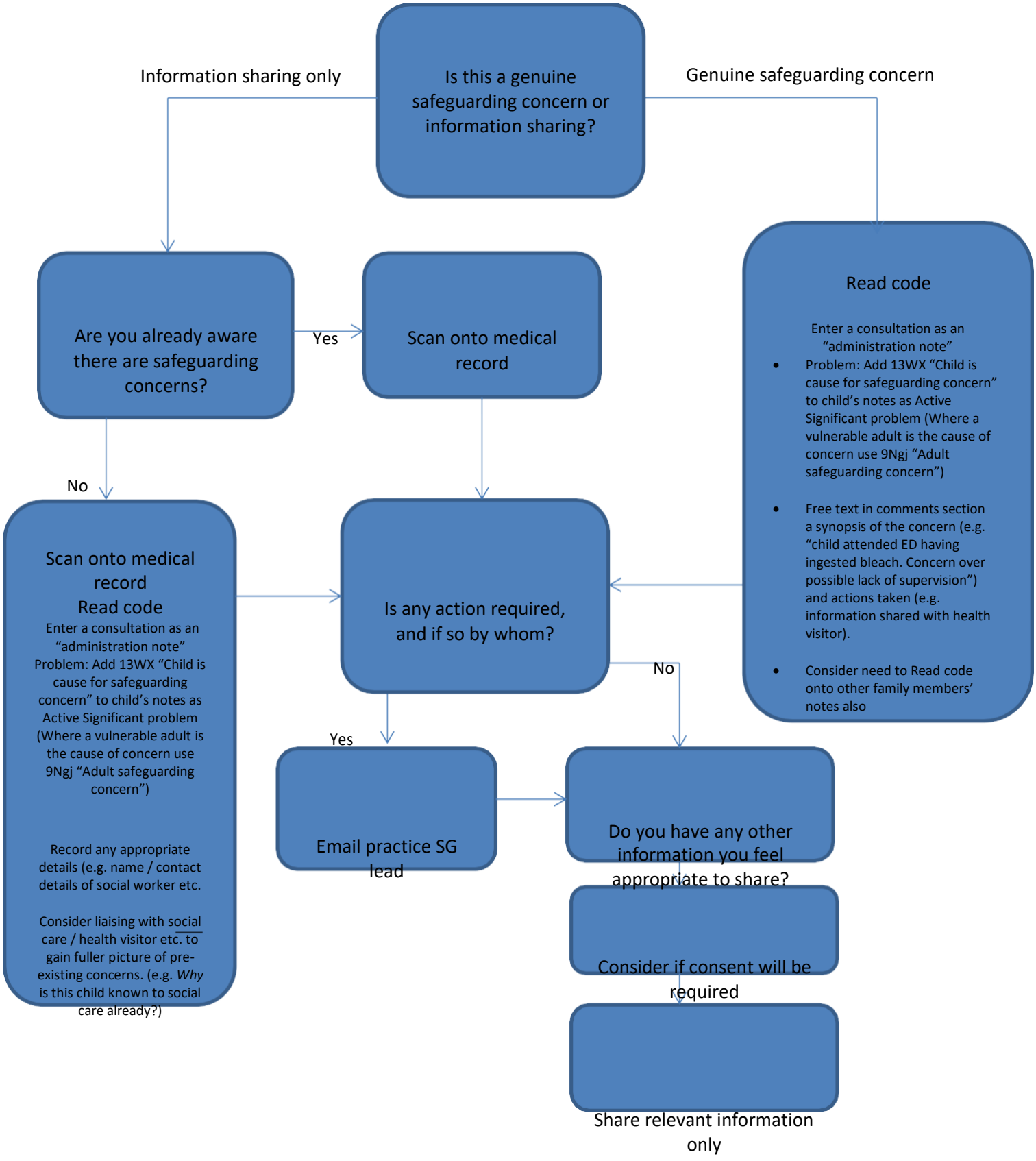
- Problem: Add 13WX "Child is cause for safeguarding concern" to child's notes as Active Significant problem (Where a vulnerable adult is the cause of concern use 9Ngj "Adult safeguarding concern")
- Free text in comments section a synopsis of the concern (e.g. "child attended ED having ingested bleach. Concern over possible lack of supervision") and actions taken (e.g. information shared with health visitor).

Enter a consultation as an "**administration note**" onto relevant siblings / parents notes

- Problem: Add 13WX"Child is cause for safeguarding concern" to siblings & parents notes (Where a vulnerable adult is the cause of concern use 9Ngj "Adult safeguarding concern" to relevant family members / care-givers notes)
- Free text in comments section a synopsis of the concern trying not to identify the individual directly (e.g. "family member (NHS no XXXXXXX) presented to ED having ingested bleach. Concern over possible lack of supervision")
- **Consider whether the information is suitably anonymized, and if not then take steps to protect it (see top tips)**

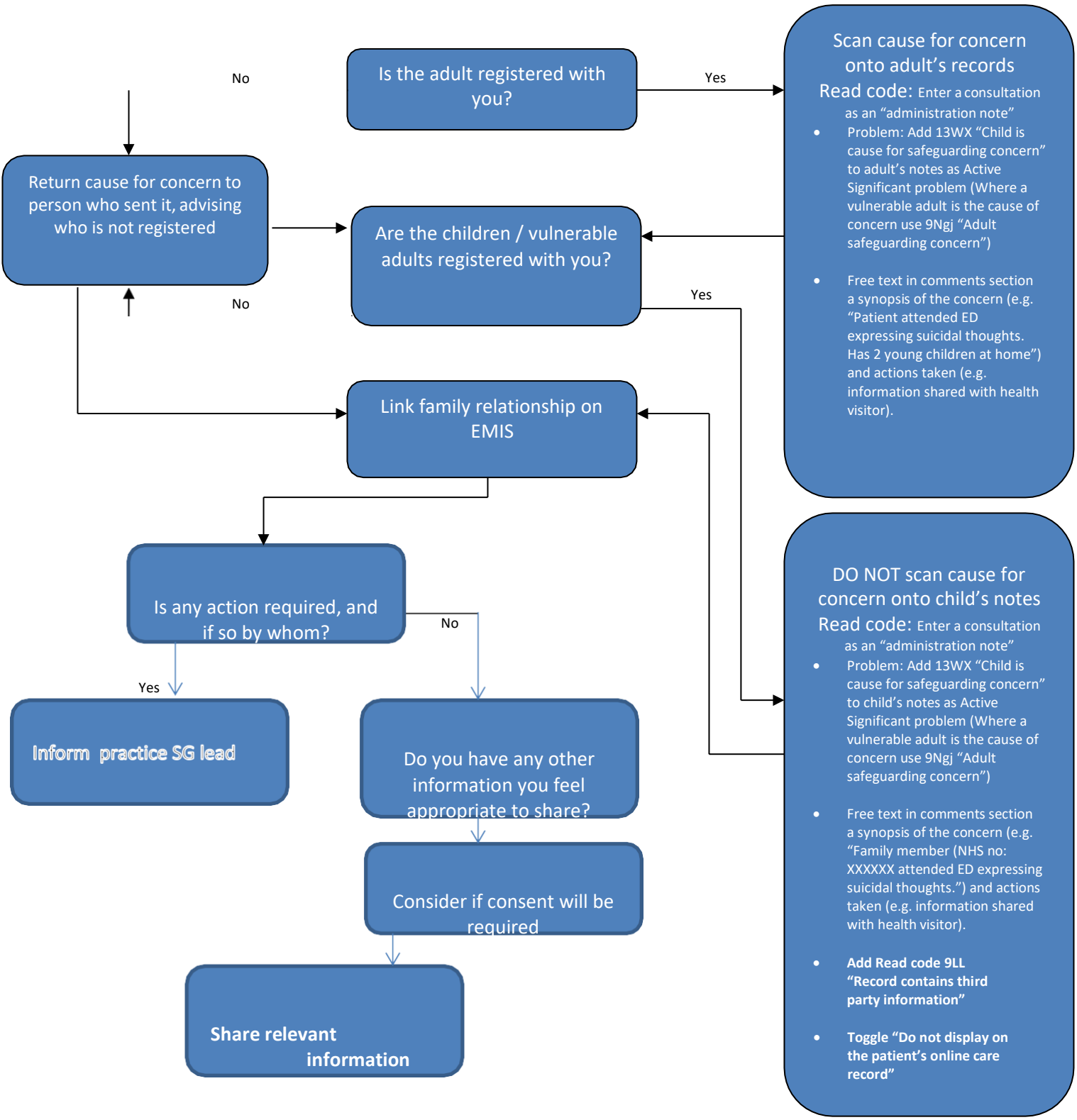
"Cause for Concern" - CHILD

What is this? A notification from another agency (usually children's social care) wherein a possible safeguarding issue has been identified. These might relate to a child, a vulnerable adult or a parent/care giver. They are sometimes also used to share non-safeguarding information about a child who has an allocated social worker.



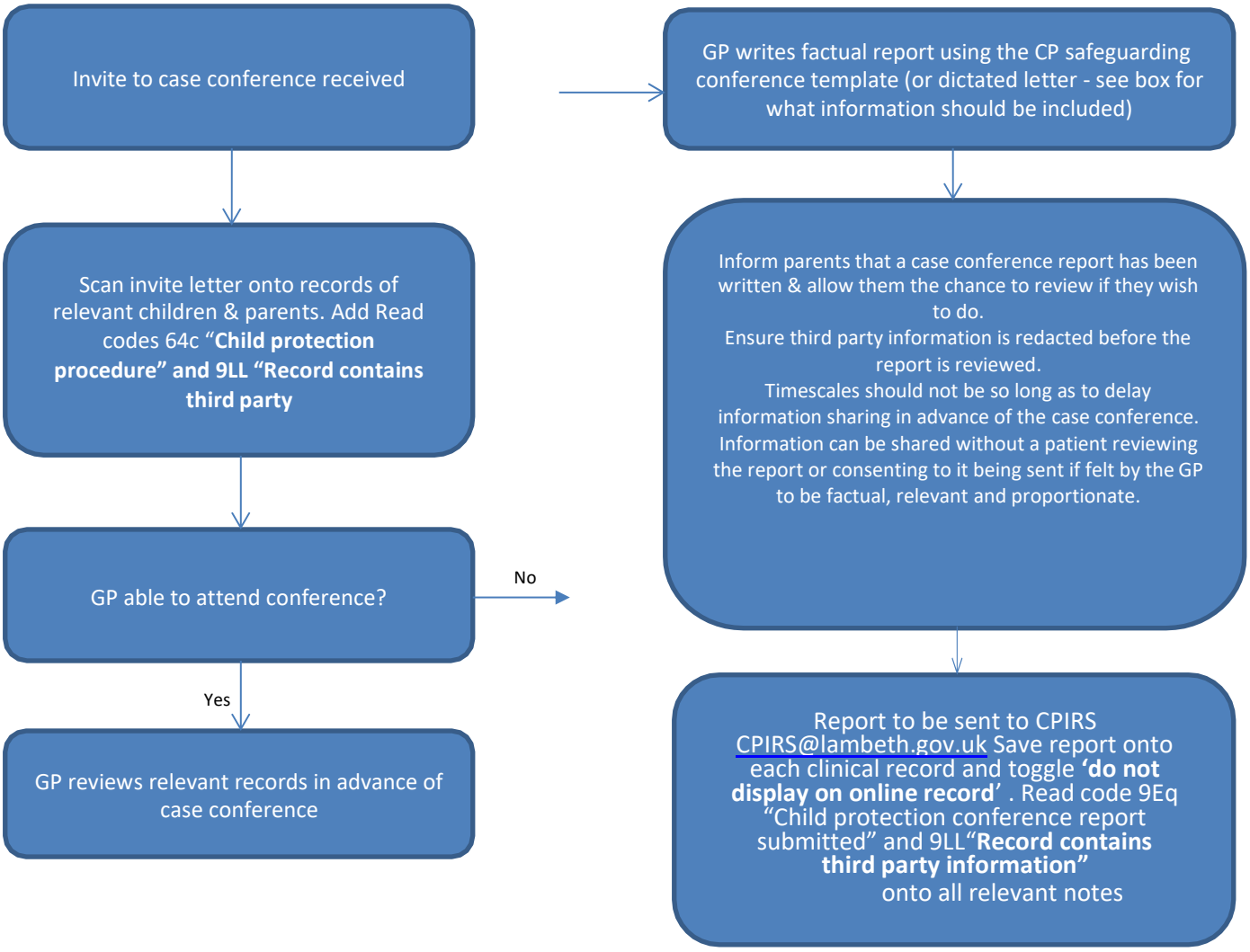
"Cause for Concern" – ADULT

What is this? A notification from another agency (usually social care) wherein a possible safeguarding issue has been identified. These usually relate to a presentation by an adult who has responsibilities as a parent/care giver that has given cause for concern. The cause for concern will usually list the names of the children, though will have the adult ED attendance note attached. They are commonly used if a parent attends with drug or alcohol use, mental health problems or self-harm, or if there is suspected or alleged domestic abuse.



Invitation to Child Protection Case Conference

Child Protection case conferences are multi-disciplinary meetings held to discuss individual children or families when there are significant concerns of abuse or neglect. GPs are informed when these meetings are to be held and are invited to attend. If unable to attend, the GP who knows the family best should make apologies and provide a factual report of the relevant information from the records of the relevant children and parents / significant caregivers. Whilst it is best practice to gain consent from the parents to disclose information, concerns are usually at a significant enough level to share relevant information without consent is refused or unobtainable.



Information to consider including in a CP case conference report:

Children:

- Birth history / neonatal history (if relevant)
- Development (if relevant)
- Current Medical problems, prescribed medication & compliance
- Significant past medical problems
- Current / past psychological & emotional problems
- Number of missed appointments / DNAs at practice.
- Other services involved in past & at present (e.g.: Paediatrician, CAMHS, SLT, orthoptist, A&E / OOH attendances)
- Number of DNAs with other services
- Immunisation history
- Historic safeguarding involvement
- Current safeguarding concerns & overview

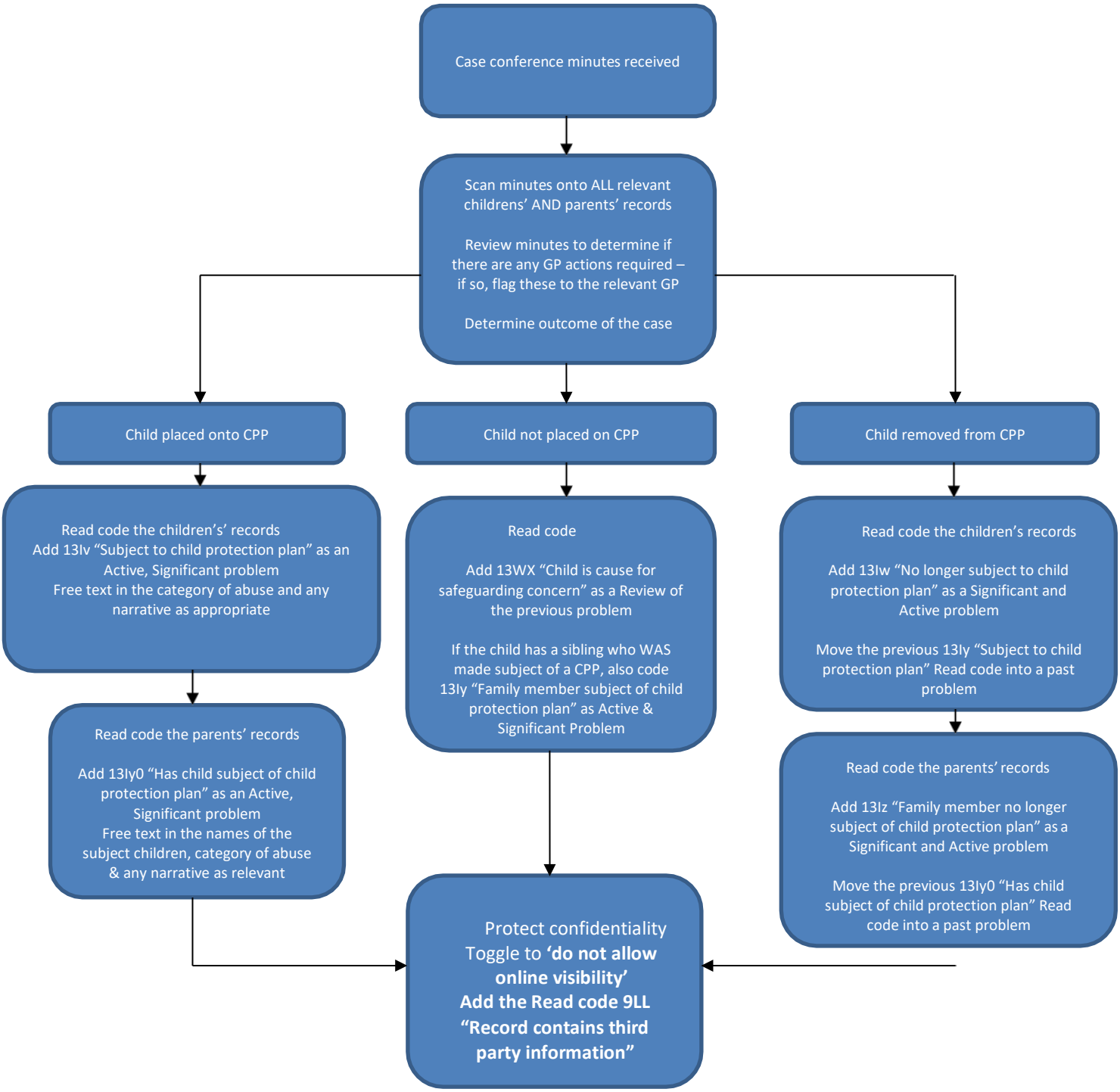
Adults:

- Relationship to the child
- Significant health issues that might impact on ability to provide safe & consistent care (e.g. mental health issues, learning difficulties, physical health complaints that might impact on parenting capacity)
- Relevant medication that might impact on parenting capacity
- Compliance with medication (where relevant)
- Any known drug and/or alcohol issues
- Any known domestic abuse
- Any other professionals working with the family

Overview:

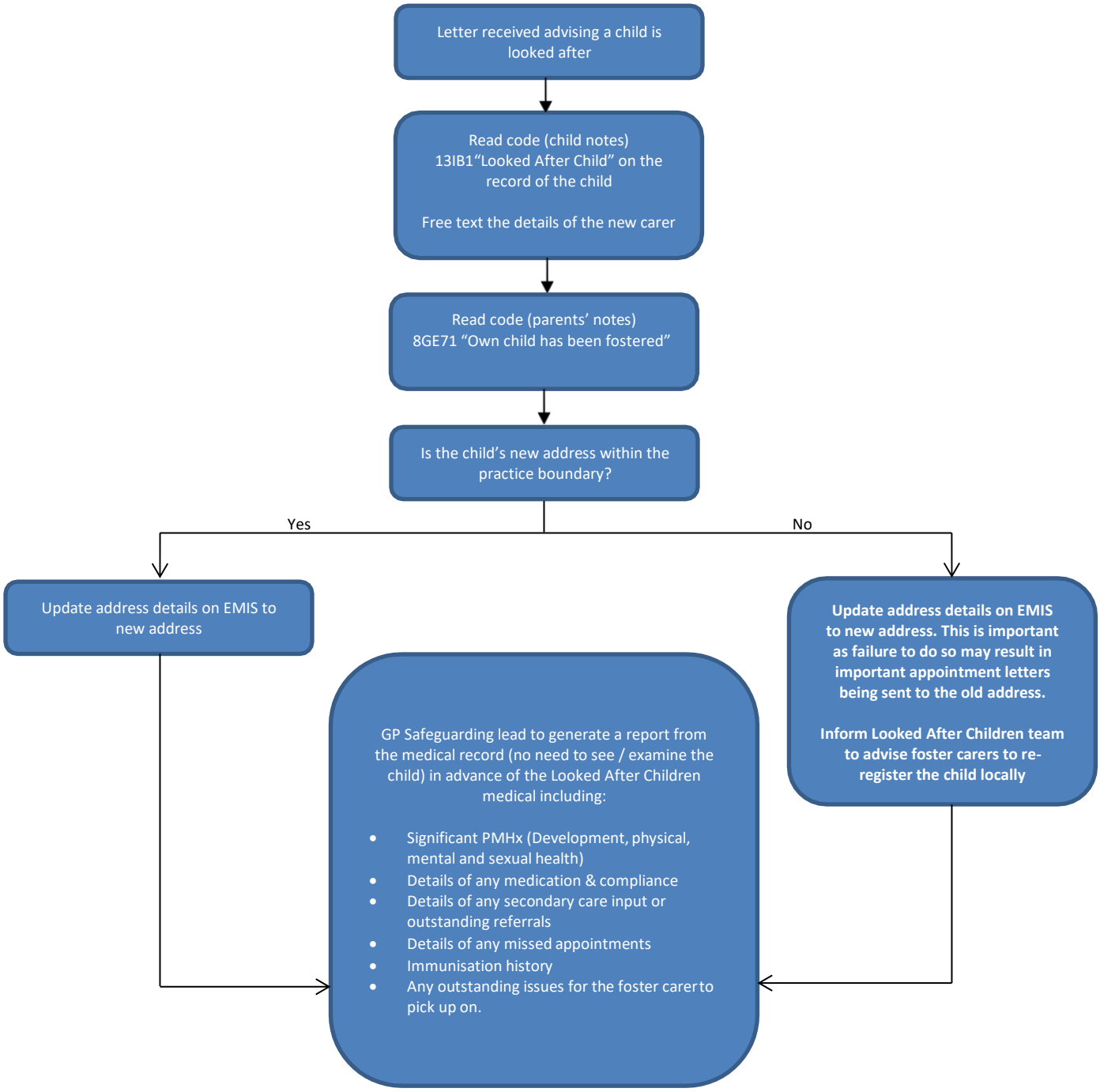
- Any specific actions that you would request the conference to address (e.g. asking to ensure the child is brought for imms / asthma review etc.)

These are the minutes taken during the child protection case conference. They will detail all of the issues that lead to convening the case conference as well as details about all of the strengths & concerns around the child that were discussed at the conference. Towards the end of the report it will be confirmed which children (if any) have been made subject to multi-agency child protection plans (CPPs), or which children have been stepped down from CPPs



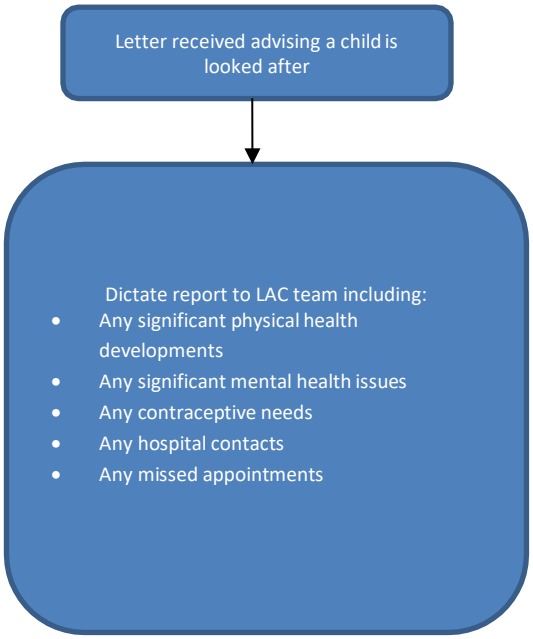
Looked after Child Notification

The Looked After Children (LAC) or Child Looked After (CLA) team may alert a GP practice when one of their patients becomes a “Looked after Child”. This usually means that they have been taken into foster care, which could be with a formal foster carer or with a family member. Sometimes they will be “looked after at home”, meaning that social services will have responsibility for the child, but they will still be living at home with their parent(s). Looked After Children are often very vulnerable & may have significant unmet health needs as a result of historic abuse or neglect.



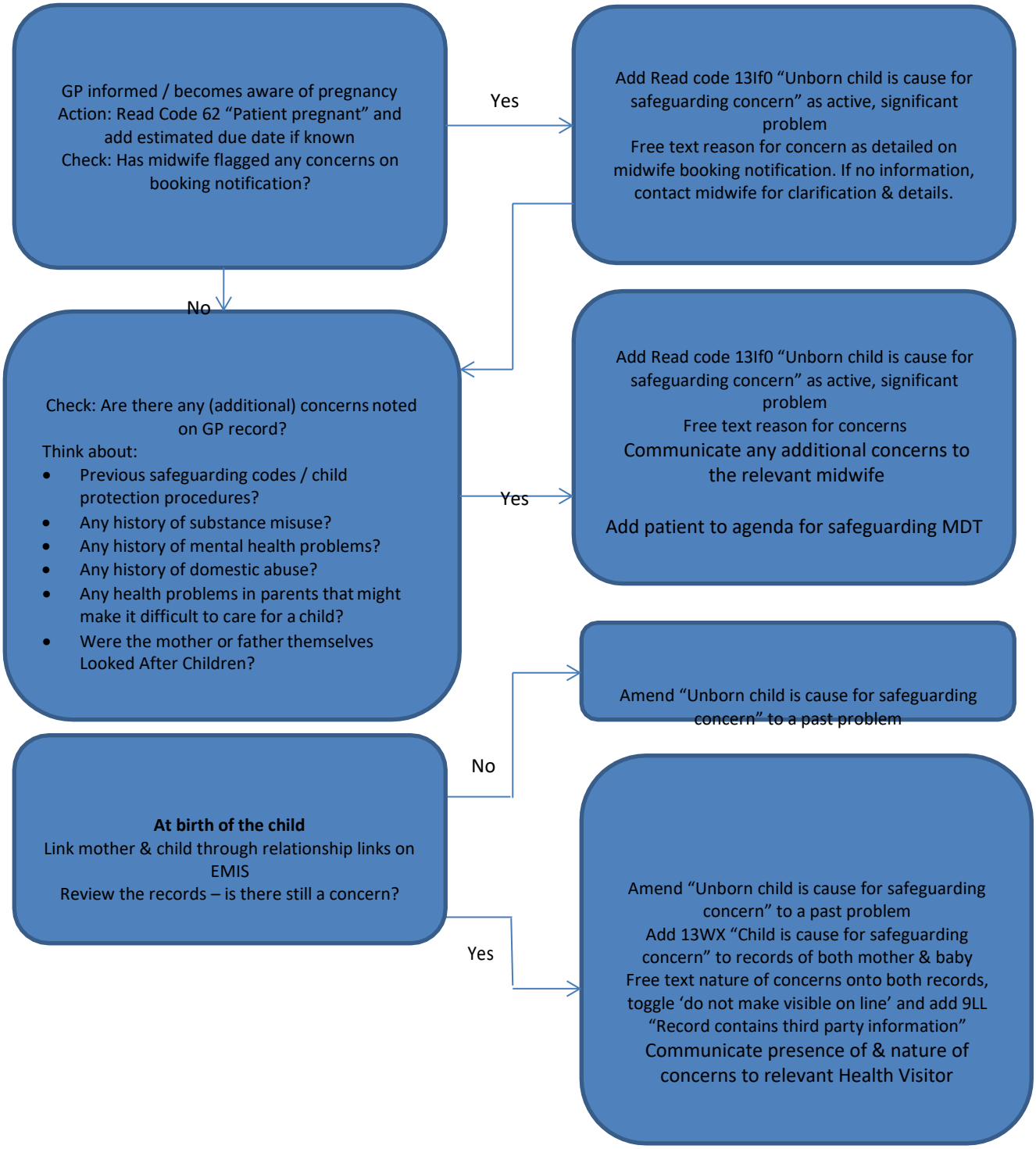
Looked after Child Review medical

The Looked after Children team undertake a review every 12 months to ensure that the child's needs are being met. As part of this review they need to understand about any current or outstanding health issues. As the child will have had an initial medical, this report need only describe the care since their last review.



Ante-natal booking concerns

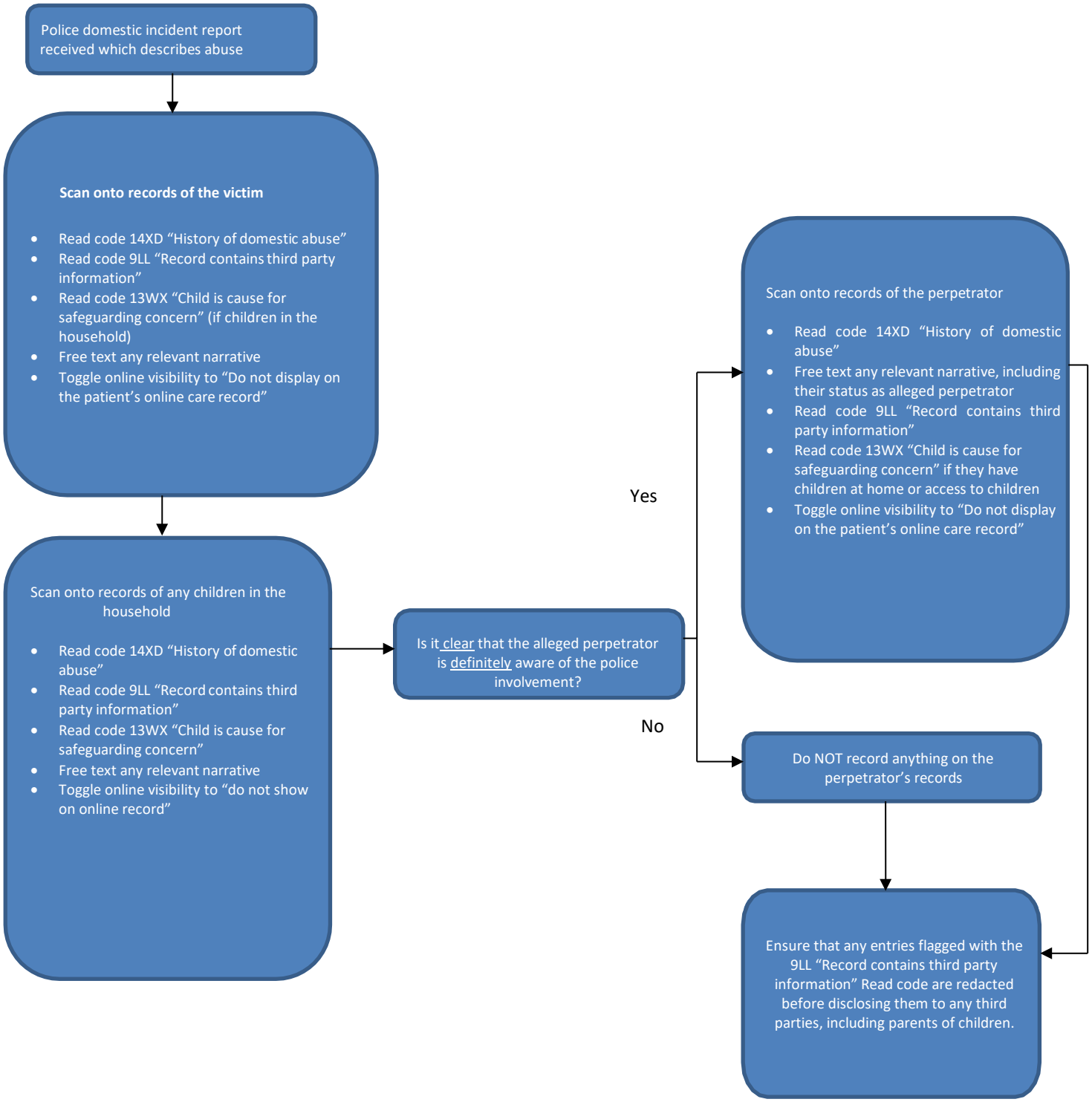
A GP may become aware that a woman is pregnant through a number of means: The patient may advise the GP themselves, or the pregnancy might be diagnosed by the GP in surgery. Alternatively the GP might receive a report from the Early Pregnancy Unit advising of a viable pregnancy. When a woman books with a midwife the midwife will communicate to the practice that a lady is pregnant. The midwives can communicate to the practice if they have concerns, but it is also important that the GP communicates with the midwife, as they may be aware of other concerns also.



Domestic abuse notification from police or other agency

When the police are called to a domestic incident they may choose to share this fact with the victim's GP. It is very important that any reports of domestic abuse are handled sensitively and that confidentiality is guarded closely, as accidental disclosure to the perpetrator could increase the risk to the victim dramatically.

If the report describes an unsubstantiated incident (eg allegation made and then withdrawn) then code this as 'Police report of domestic incident received'.



Management of information disclosed about domestic violence to clinicians in primary care

(source: RCGP Guidance on recording domestic violence, June 2017)

Victim discloses DVA to clinician in the practice

Person	Electronic health record
Victim	Record disclosure using **History of domestic abuse** Note nature of abuse as free text Hide the consultation from online access
Child or vulnerable adult	Record disclosure using **History of domestic abuse** Note nature of abuse as free text Hide the consultation from online access
Perpetrator	Do not record

Perpetrator discloses DVA to clinician in the practice

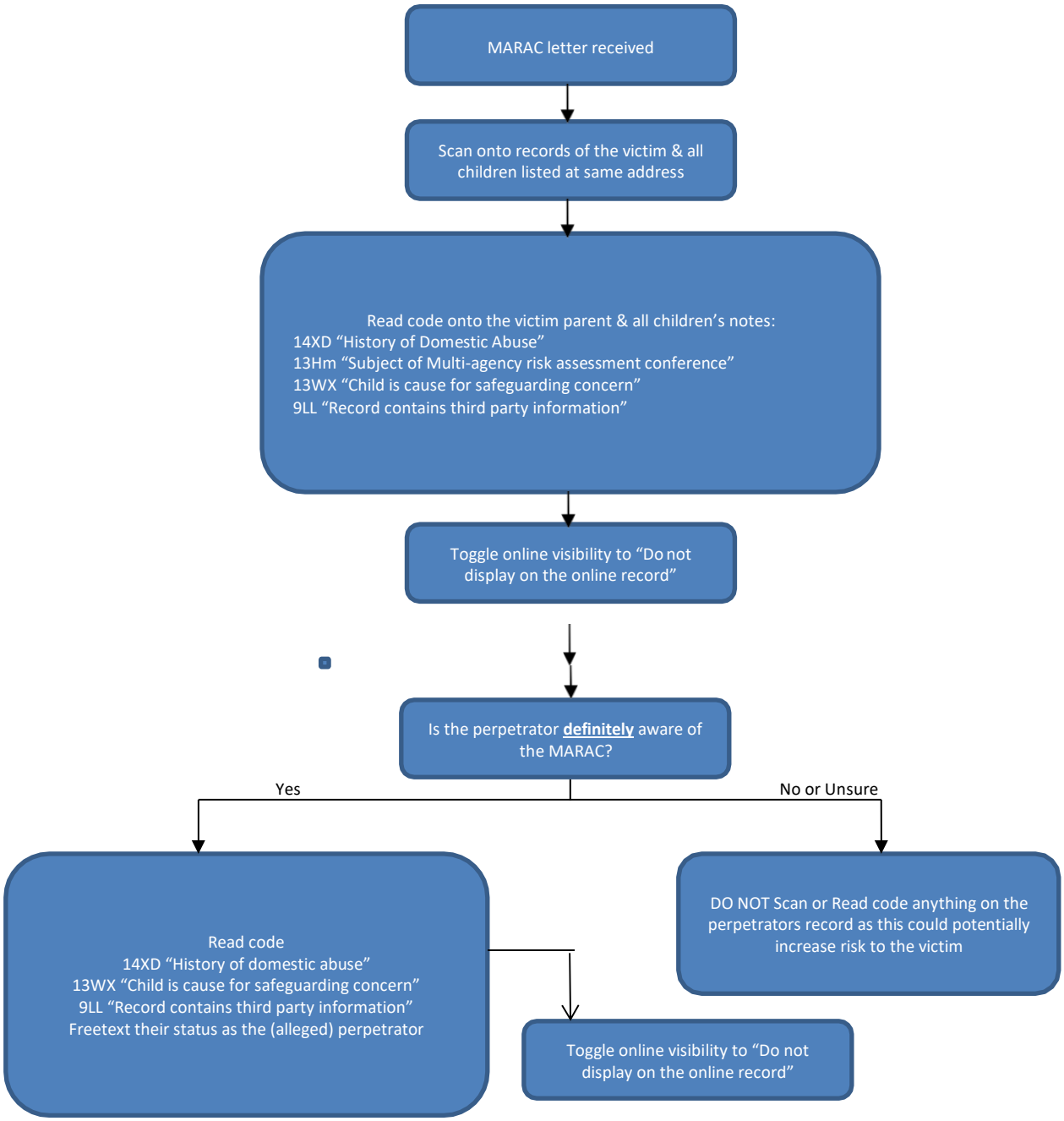
Person	Electronic health record
Victim	Record disclosure using **History of domestic abuse** Note disclosure by perpetrator and nature of abuse as free text Hide the consultation from online access
Child or vulnerable adult	Record disclosure using **History of domestic abuse** Note nature of abuse as free text Hide the consultation from online access
Perpetrator	Record disclosure using **History of domestic abuse** Note disclosure by perpetrator and nature of abuse as free text

Child discloses DVA to clinician in the practice

Person	Electronic health record
Victim	Record disclosure using **History of domestic abuse** Note source of disclosure as free text Hide the consultation from online access
Disclosing child or vulnerable adult	Record disclosure using **History of domestic abuse** Record disclosure verbatim as free text Hide the consultation from online access
Perpetrator	Do not record

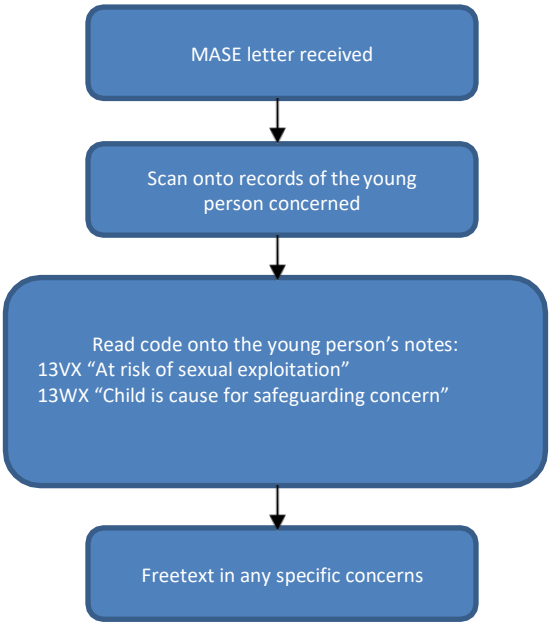
Multi-Agency Risk Assessment Conference (MARAC) Notification

MARAC (Multi-Agency Risk Assessment Conference) is a process wherein professionals from various agencies (health, social care, police etc.) meet to discuss cases of very high risk domestic abuse to help develop a safety plan for the victim & their children. The cases discussed at MARAC are those where there is felt to be a significant risk of severe harm or even domestic homicide. Full minutes of the meeting are not presently circulated to GPs.



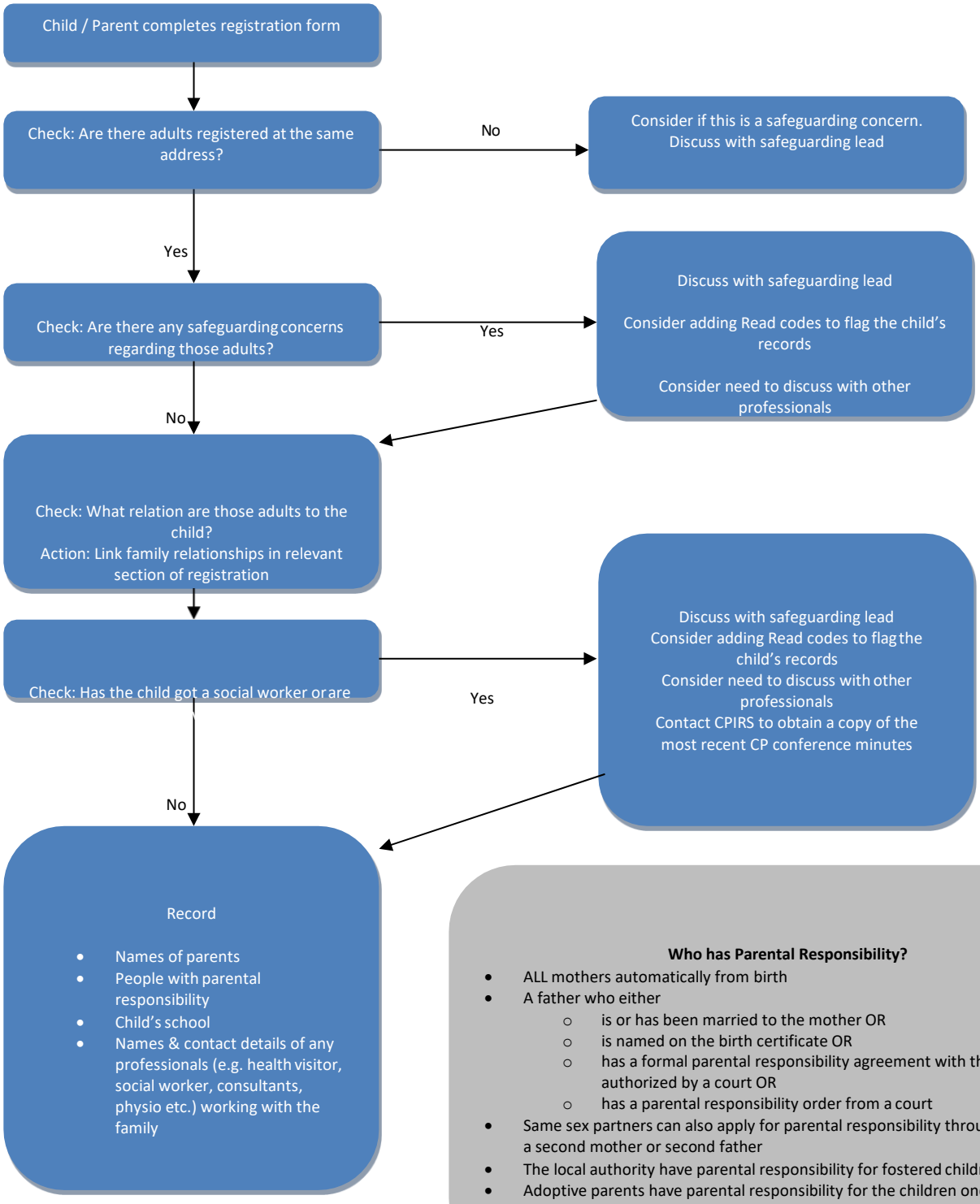
Multiagency Sexual Exploitation (MASE) Notification

MASE (Multi-Agency Sexual Exploitation) conferences are multi-agency meetings convened when a young person is felt to be at high risk of sexual exploitation. At present GPs are not asked to contribute to MASE conferences. If a letter is received -



New patient registration of a child

It is good practice to identify any possible safeguarding concerns as early as possible. This is especially true when a patient registers with a practice as the records can take many weeks before they are transferred and summarized. Registration can be a good opportunity to confirm who is living with a child & to determine the family relationships within a household.

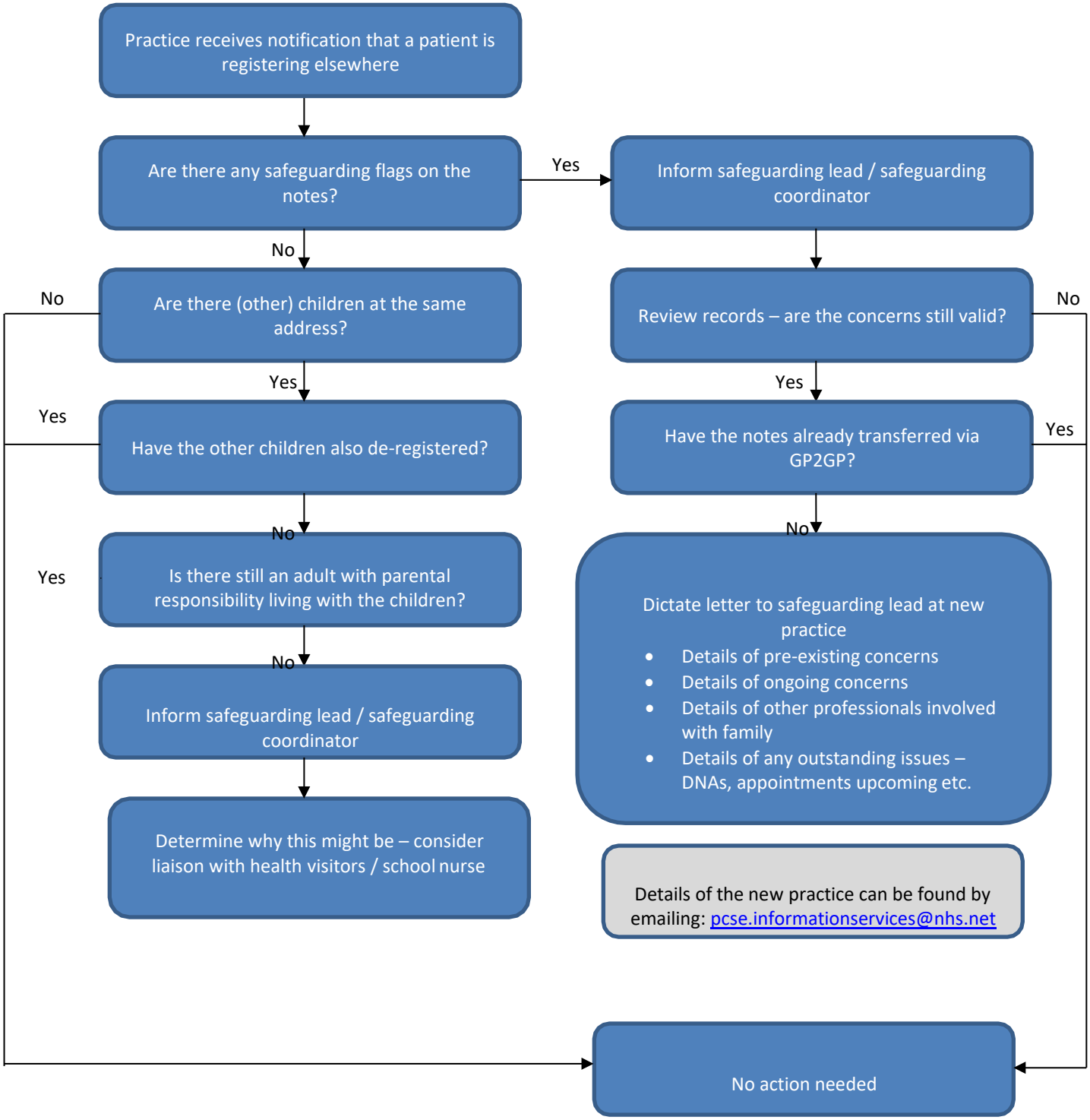


Who has Parental Responsibility?

- ALL mothers automatically from birth
- A father who either
  - is or has been married to the mother OR
  - is named on the birth certificate OR
  - has a formal parental responsibility agreement with the mother authorized by a court OR
  - has a parental responsibility order from a court
- Same sex partners can also apply for parental responsibility through the court as a second mother or second father
- The local authority have parental responsibility for fostered children
- Adoptive parents have parental responsibility for the children once formally adopted

Patient Leaving a Practice

The time when patients move between practices can be a risky time regarding safeguarding. Notes can sometimes take a while to transfer to the new surgery & there can be a further delay before these are summarized. Furthermore, some abusive families can deliberately move practices frequently and consult different healthcare providers in an attempt to avoid detection. It is imperative therefore that safeguarding concerns are communicated early to help reduce this potential risk.



Appendix 1

READ Codes for Safeguarding Children and Adults

Safeguarding clinical terms		Safeguarding removal clinical terms	
Vulnerable Adult	Read v2: 133P SNOMED: 417430008		
Adult Safeguarding Concern	Read v2: 9Ngj SNOMED: 766561000000109	No longer Adult Safeguarding Concern	Read v2:9Ngk SNOMED: 766601000000109
Subject to child protection plan (free text category)	Read v2:13Iv SNOMED: 342191000000109	No longer subject to child protection plan	Read v2:13Iw SNOMED: 342891000000105
Looked after child	Read v2:13IB1 SNOMED: 764841000000100	No longer subject of looked after child arrangement	Read v2:9NgF SNOMED: 764951000000107
Child is cause for safeguarding concern	Read v2:13WX SNOMED: 836881000000105	Child no longer safeguarding concern	Read v2:9NgB SNOMED: 810771000000107
Family is Cause for Concern	Read v2:13Ip SNOMED: 300731000000106	Family is no longer cause for concern	Read v2:13WS SNOMED: 817891000000102
Family member subject to child protection plan	Read v2:13Iy SNOMED: 375041000000100	Family member no longer subject to a child protection plan	Read v2:13Iz SNOMED: 375071000000106
Child in Need	Read v2:13IS SNOMED: 135891007	No longer Child in Need	Read v2:13IT SNOMED: 135890008
Unborn child is cause for safeguarding concern	Read v2:13If0 SNOMED: 878111000000109		
Unborn child is subject to child protection plan	Read v2:13Iv0 SNOMED: 818901000000100	Unborn child no longer subject to child protection plan	Read v2:13Iw0 SNOMED: 1025431000000104
Initial Case Conference	Read v2:387A SNOMED: 762761000000102		
Review Case Conference	Read v2:3879 SNOMED: 762781000000106		
Child protection report submitted	Read v2:9Eq SNOMED:1036511000000100		
Early Help Assessment	Read v2:389M SNOMED: 927481000000102		
Early Help Assessment Declined	Read v2:8IHN SNOMED:1047751000000108		
Child lives with another relative	Read v2:13Ic SNOMED: 248201000000109		
Child in foster care	Read v2:13IB0 SNOMED: 160871009		
Approved foster carer	Read v2:133N SNOMED: 314381008		
At risk of sexual exploitation	Read v2:13VX SNOMED: 919461000000108		
Victim of Child Sexual Exploitation	Read v2:14XH SNOMED: 713834002		
Family History of FGM	Read v2:12b SNOMED: 902961000000107		
History of FGM	Read v2:15K SNOMED: 715477006		
Subject of Multi-agency Risk Assessment Conference (MARAC)	Read v2:13Hm SNOMED: 758941000000108		
Subject of MAPPA	Read v2:13HI SNOMED: 495021000000105		
Victim of domestic abuse	Read v2:14XG SNOMED:879911000000102		
Alleged Perpetrator of Domestic Violence	Read v2:14XC SNOMED: 206411000000103		
Police Domestic Incident Report Received	Read v2:9NDJ SNOMED: 895141000000105		
Domestic Abuse Victim in Household	Read v2:13Wd SNOMED:881081000000100	*** ALL DOMESTIC ABUSE CODES TO BE HIDDEN FROM ONLINE VISIBILITY	