NHS
Oxfordshire
Clinical Commissioning Group

Documenting Safeguarding Concerns / Correspondence Within GP Medical Records: An Overview Guide

Incorporating sample policies for recording episodes when a child or vulnerable adult 'was not brought'

Meriel Raine

Named GP for Safeguarding

Amended from a document produced by Dr James Higgins, Named GP for Safeguarding, Southport Clinical Commissioning Group.

February 2019

Contents

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 "neighbourhood" 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 coding. This handbook of flowcharts will hopefully help to clarify these processes and will then establish some consistency with regards the documentation in Oxfordshire.

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 Oxfordshire 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 document who by (ask, don't presume…)

4. Use standard Read 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 within a "neighbourhood".

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.

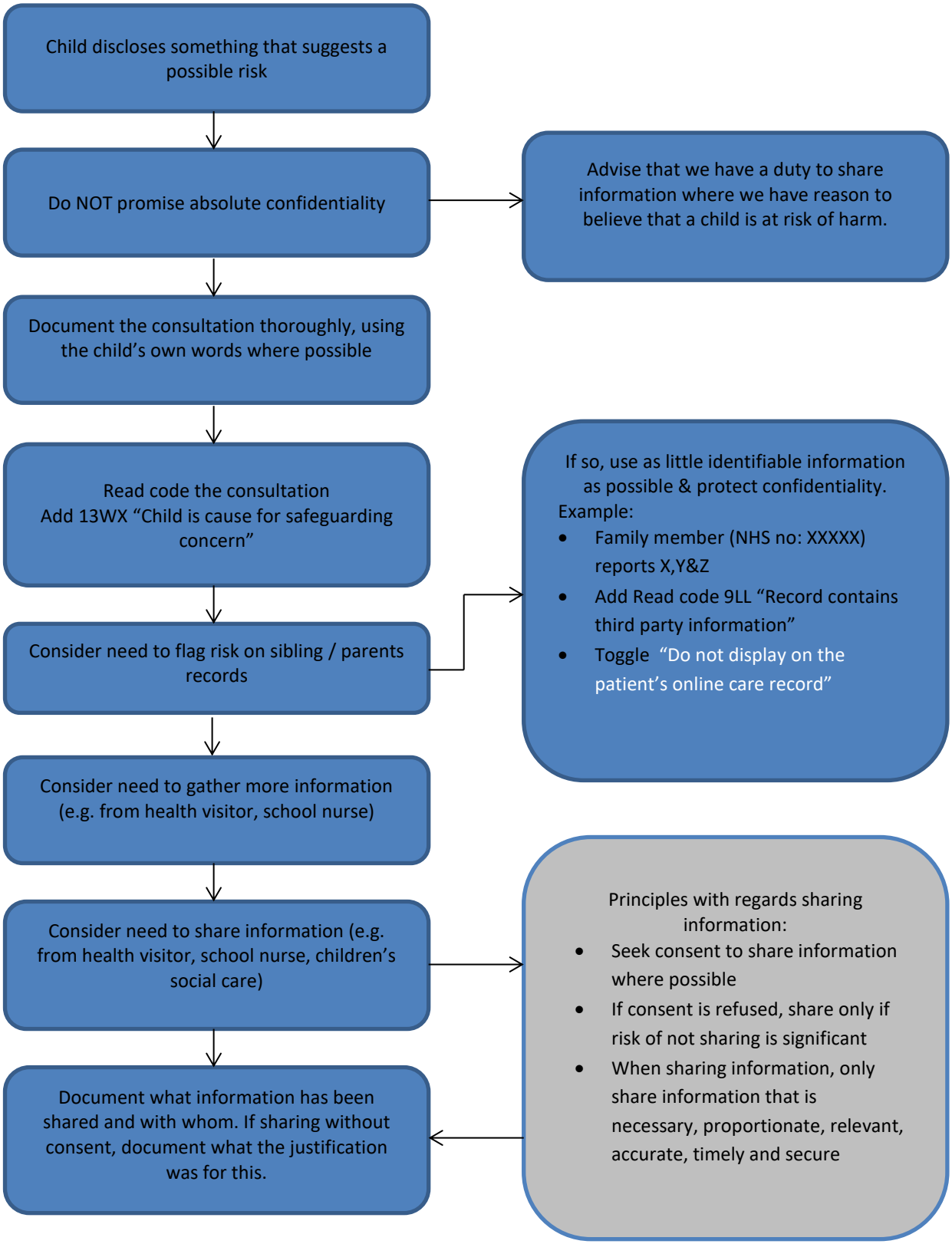
8. If it is felt necessary to record non-anonymous third party information, then ensure there are adequate flags to enable it to be redacted. The code 9LL "Record contains third party information" will help with this.

9. Where consultation 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.

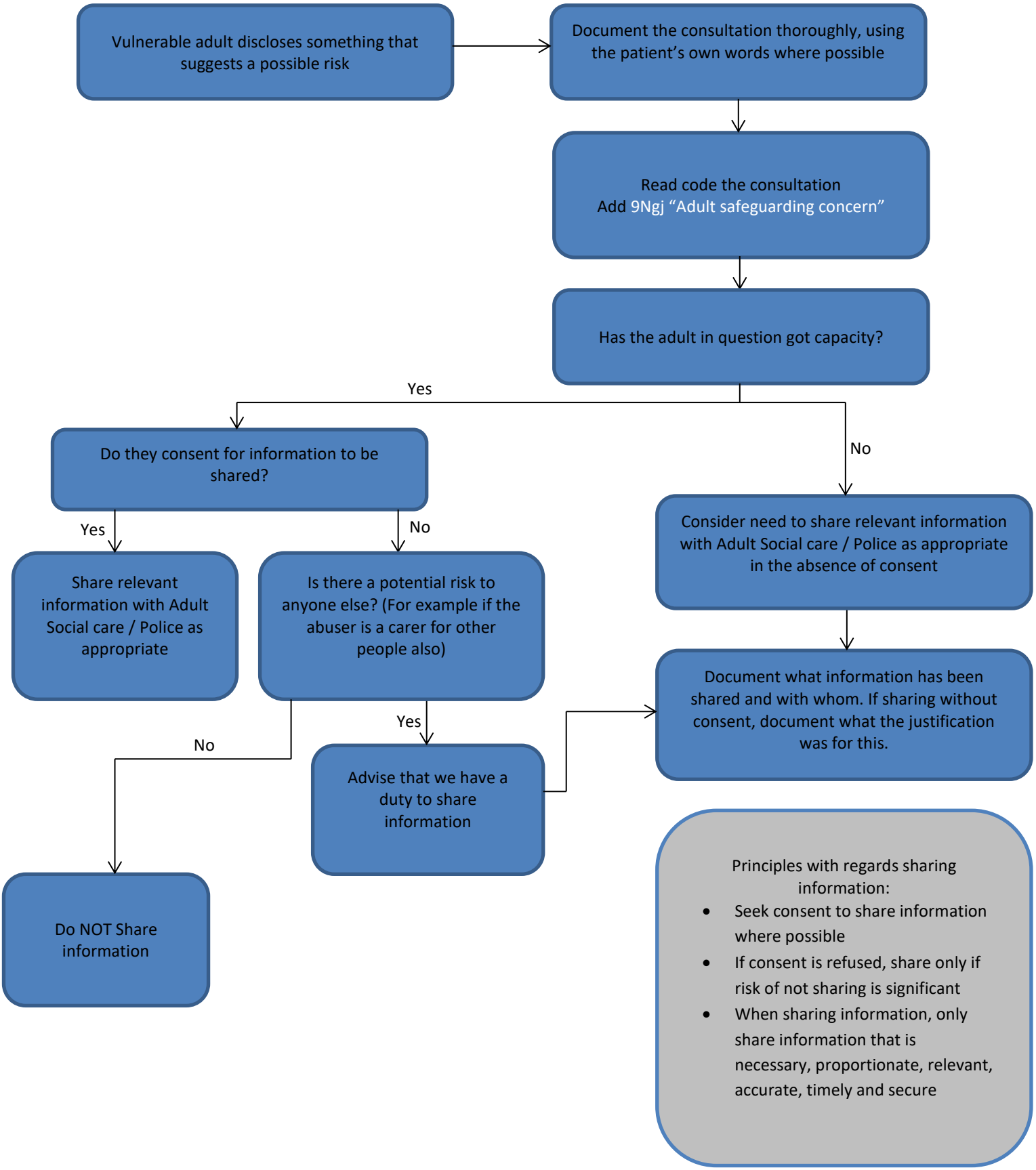
10. Ensure that before any records leave the practice to external agencies (e.g. solicitors etc.) that third party information is sought out and redacted as appropriate. This should include ALL entries with the 9LL read code attached, and any entries marked as unsuitable for online viewing. In addition, 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.

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 health, 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.

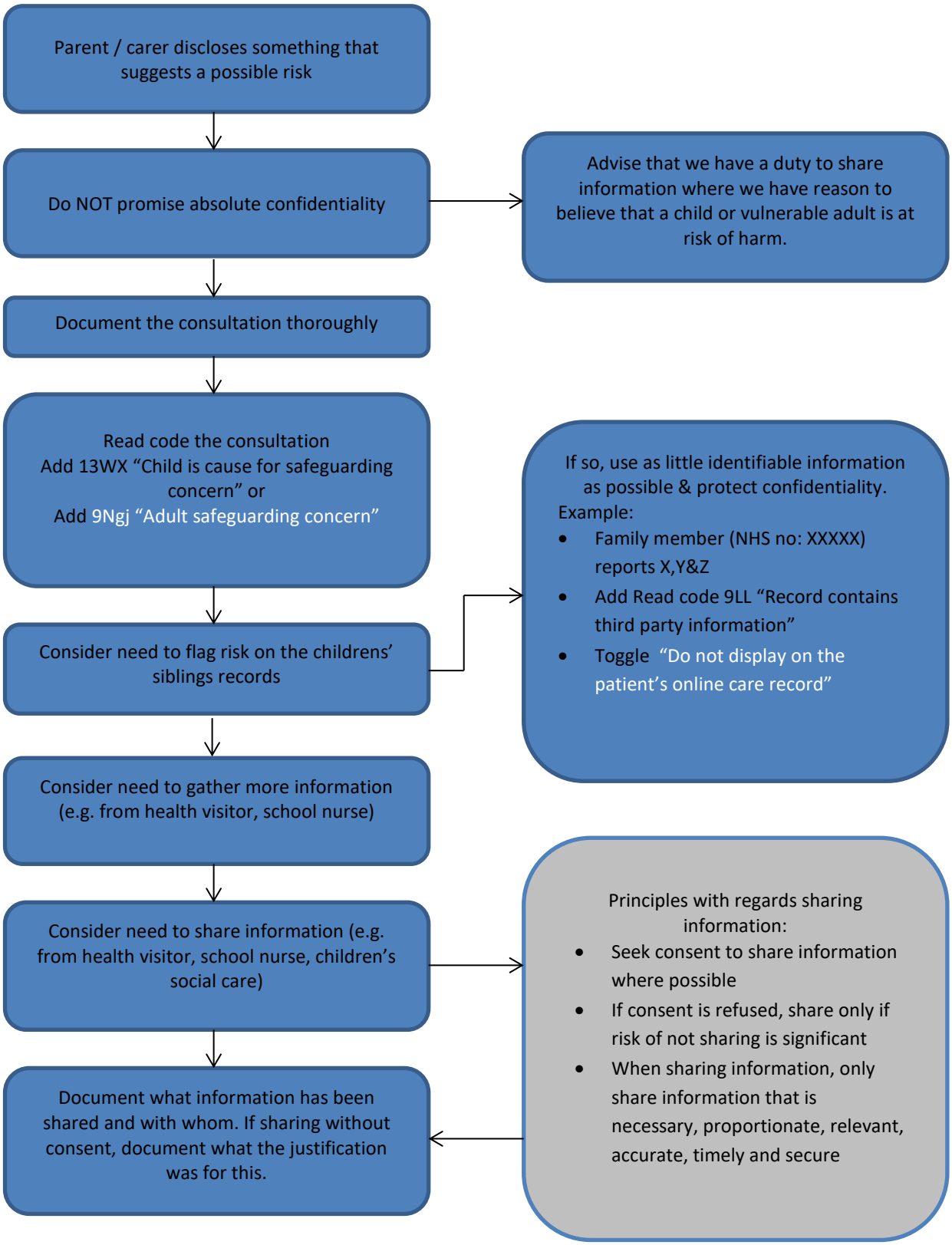


During a consultation in Primary Care it might become apparent that a vulnerable adult might be at risk as a result of something in their own health, or that of their caregiver(s). It is important to ensure that this consideration is documented and risks balanced / discussed / shared as appropriate.

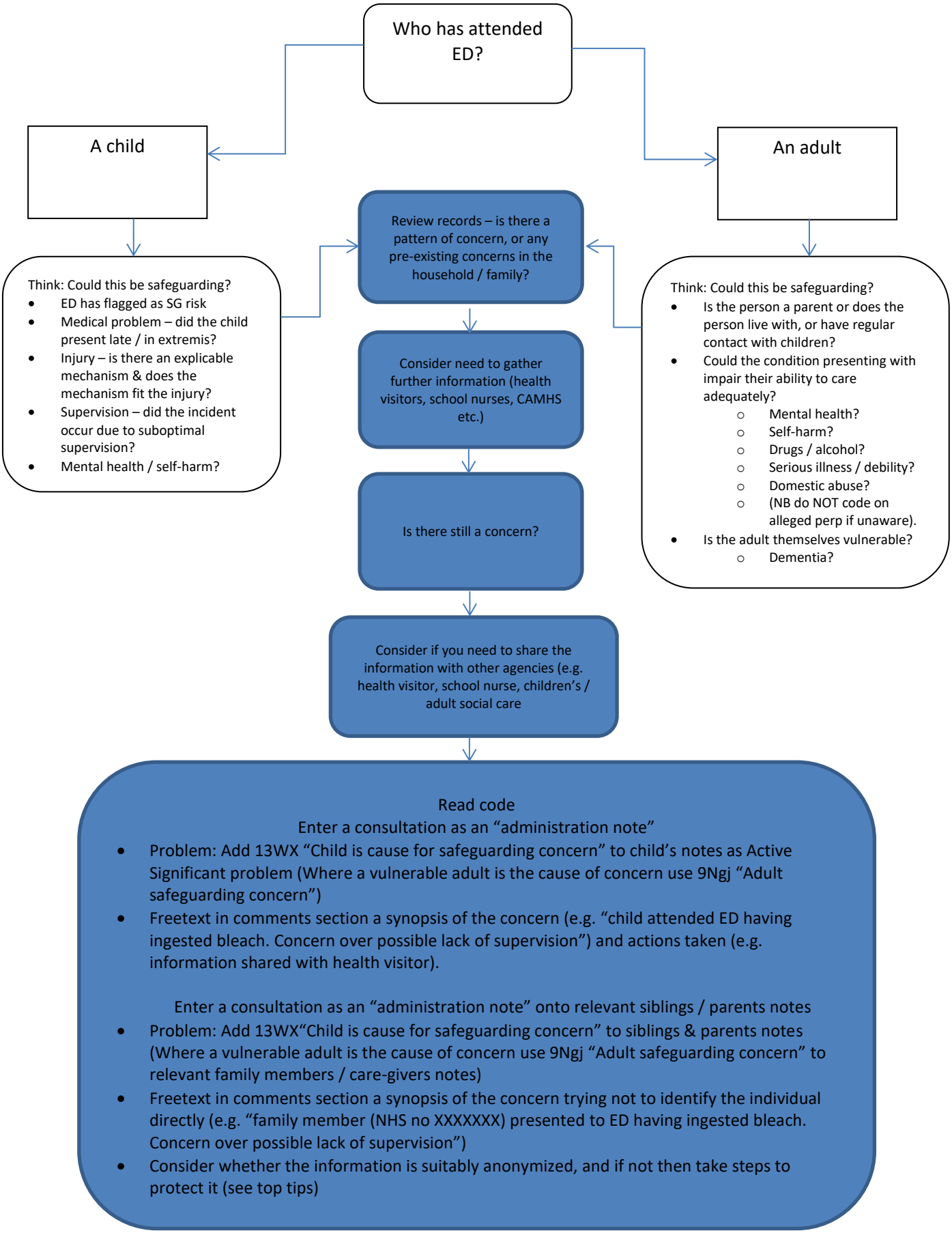


The GP consultation – Parent or carer posing a potential risk

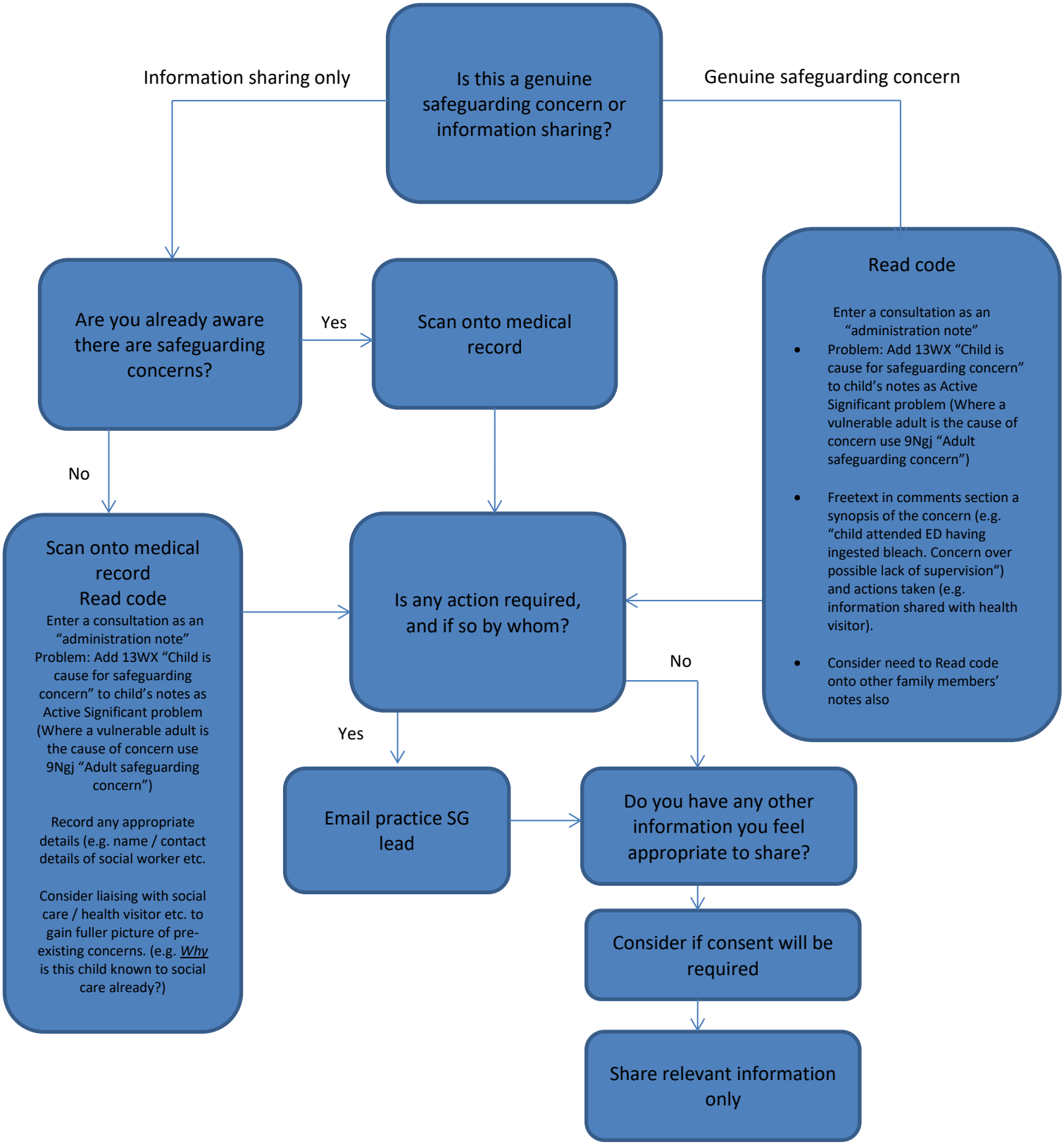
During a consultation in Primary Care it might become apparent that a child or vulnerable adult might be at risk as a result of the health of their parents or caregiver(s). Examples of circumstances where this may be relevant include (but are not limited to) cases of mental health, learning difficulties, 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.



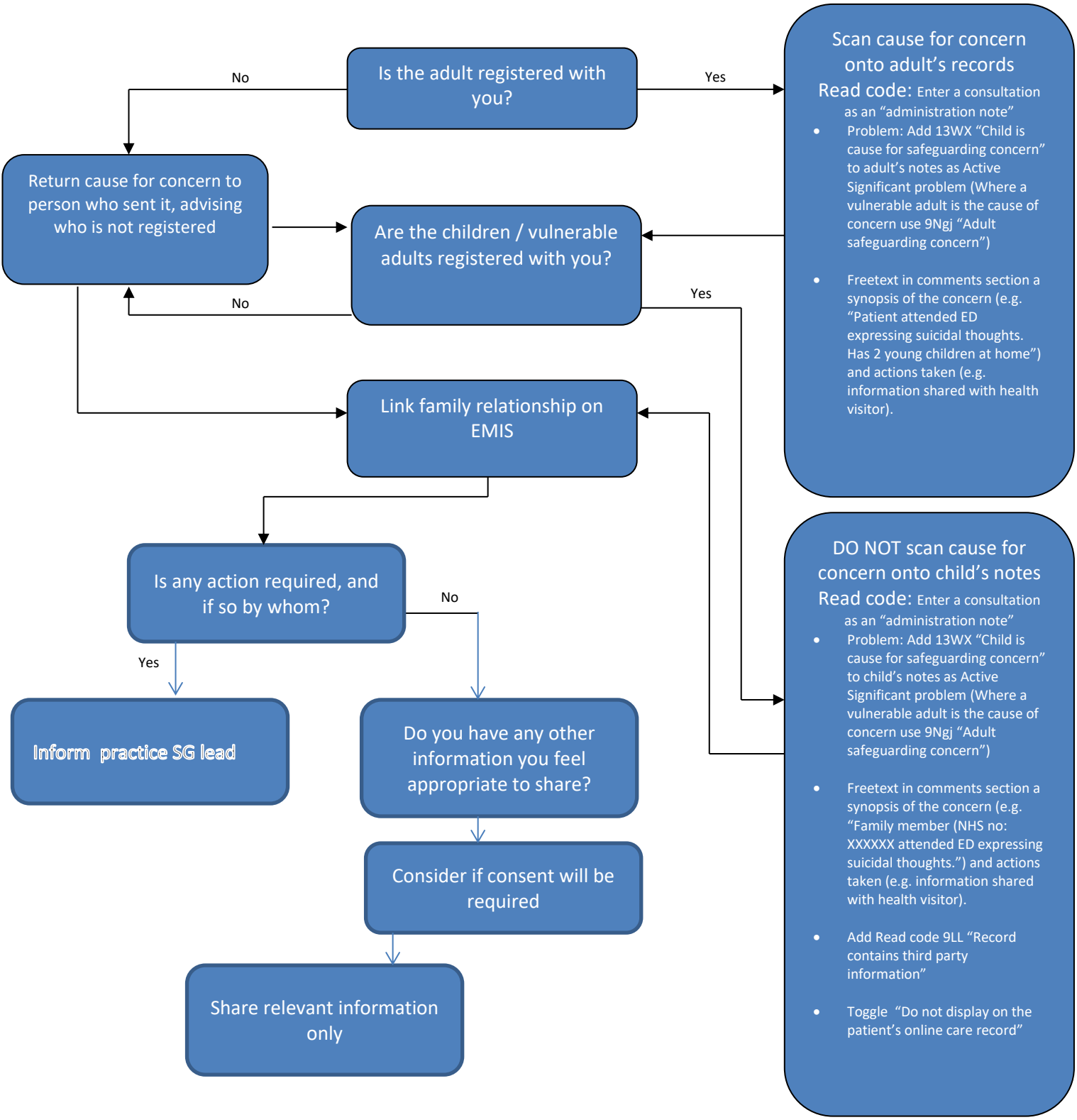
ED Attendance report received



What is this? A notification from another agency (usually the FT) 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.

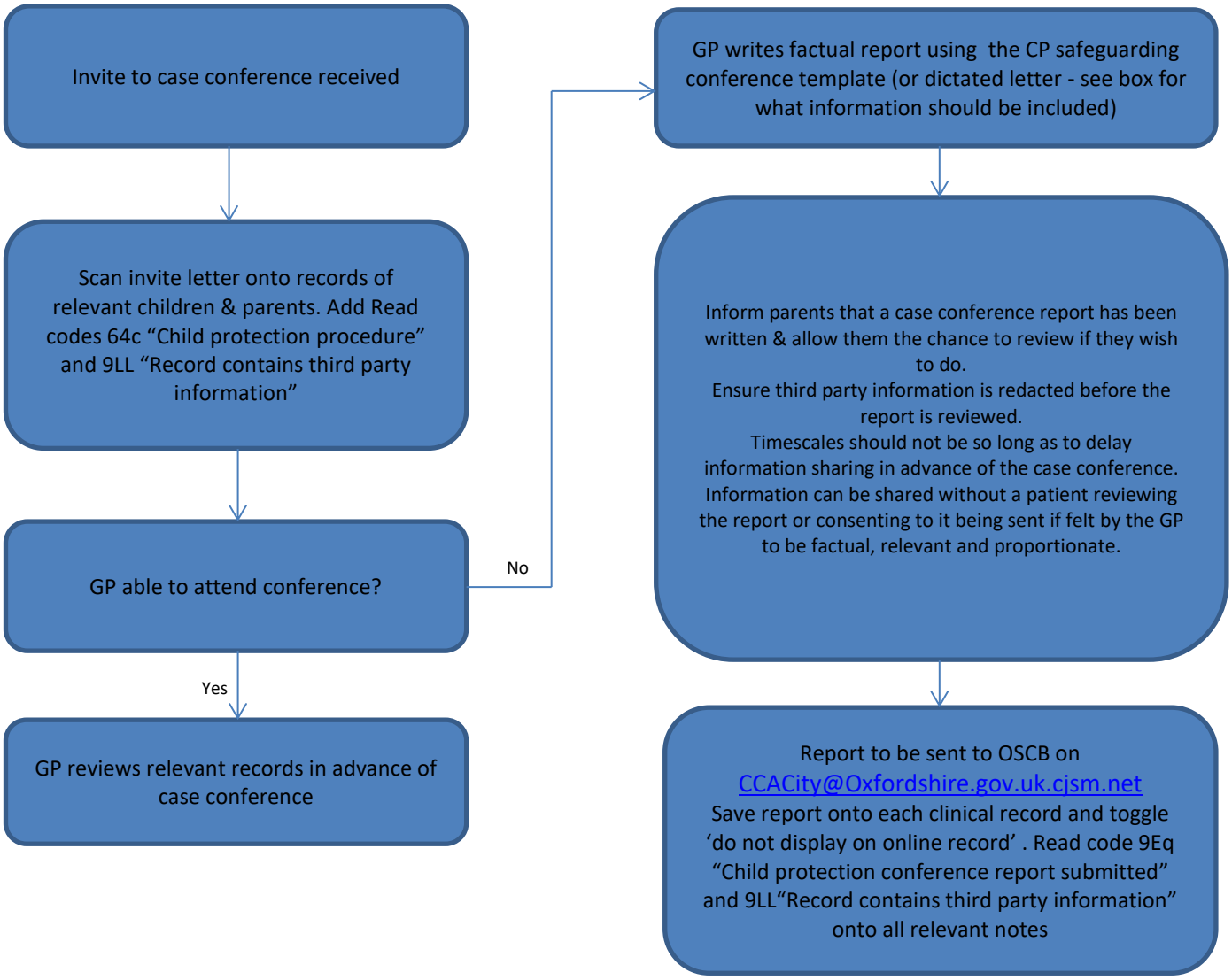


What is this? A notification from another agency (usually the FT) wherein a possible safeguarding issue has been identified. These usually relate to a presentation by an adult who has responsibilities as a parent/care giver that has given cause for concern. The cause for concern will usually list the 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, orthoptics, A&E / OOH attendances)
- Number of DNAs with other services
- Immunisation history
- Historic safeguarding involvement
- Current safeguarding concerns & overview

Adults:

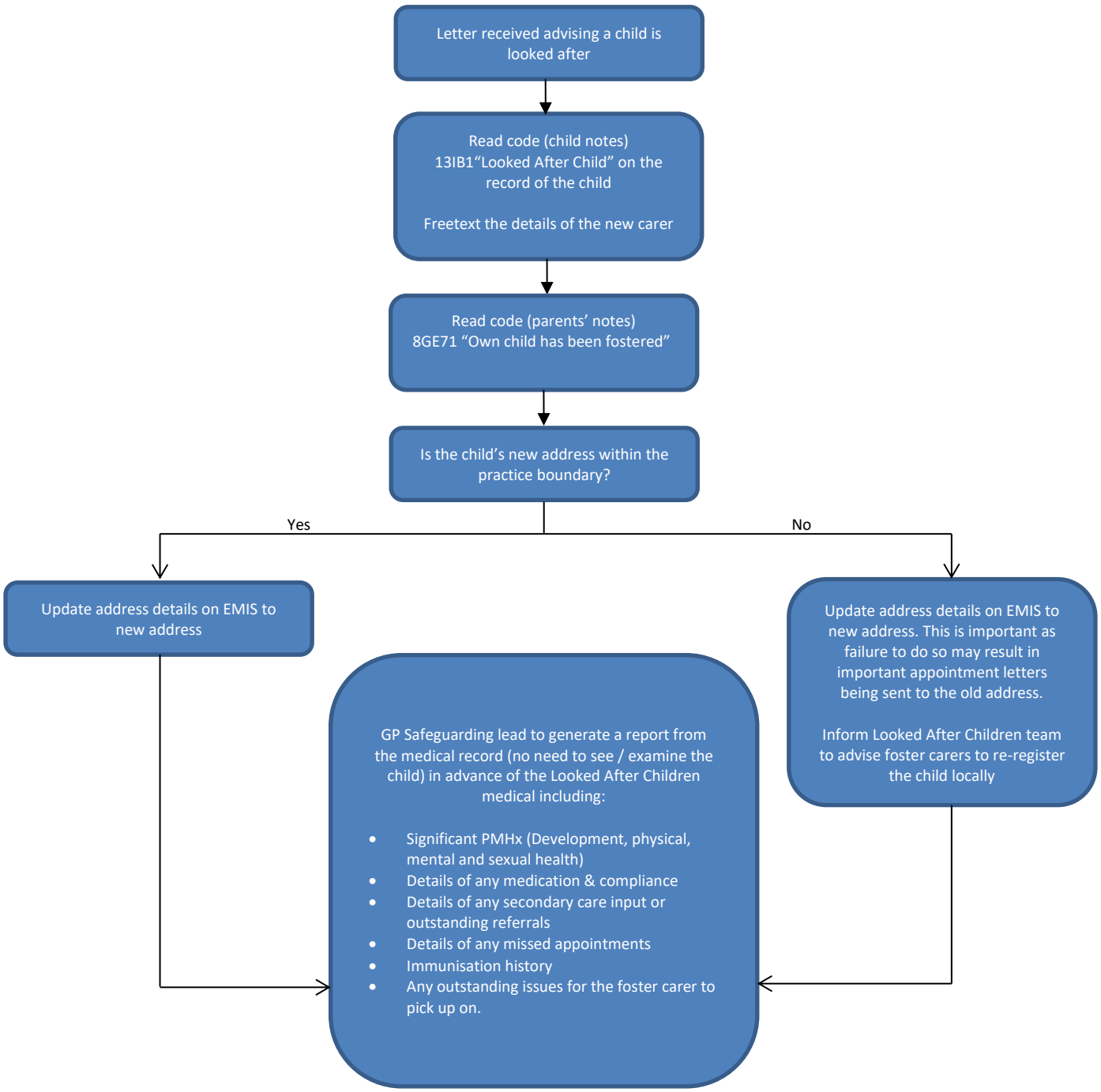
- Relationship to the child
- Significant health issues that might impact on ability to provide safe & consistent care (e.g. mental health issues, learning difficulties, physical health complaints that might impact on parenting capacity)
- Relevant medication that might impact on parenting capacity
-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

Overview:

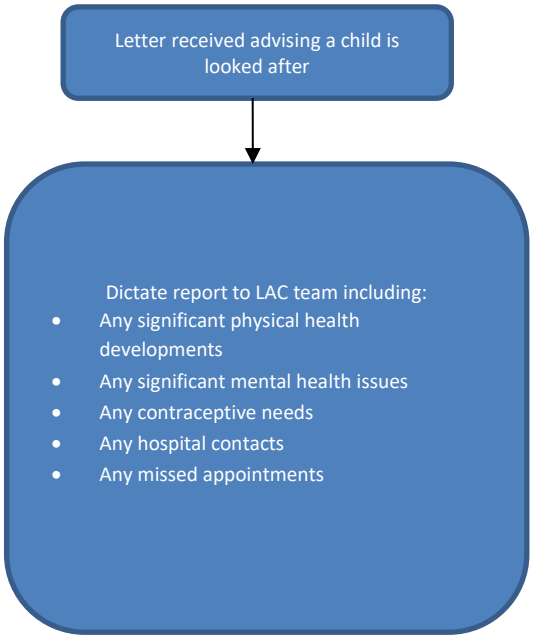
- Any specific actions that you would request the conference to address (e.g. asking to ensure the child is brought for imms / asthma review etc.)

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

The Looked After Children (LAC) team will 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.

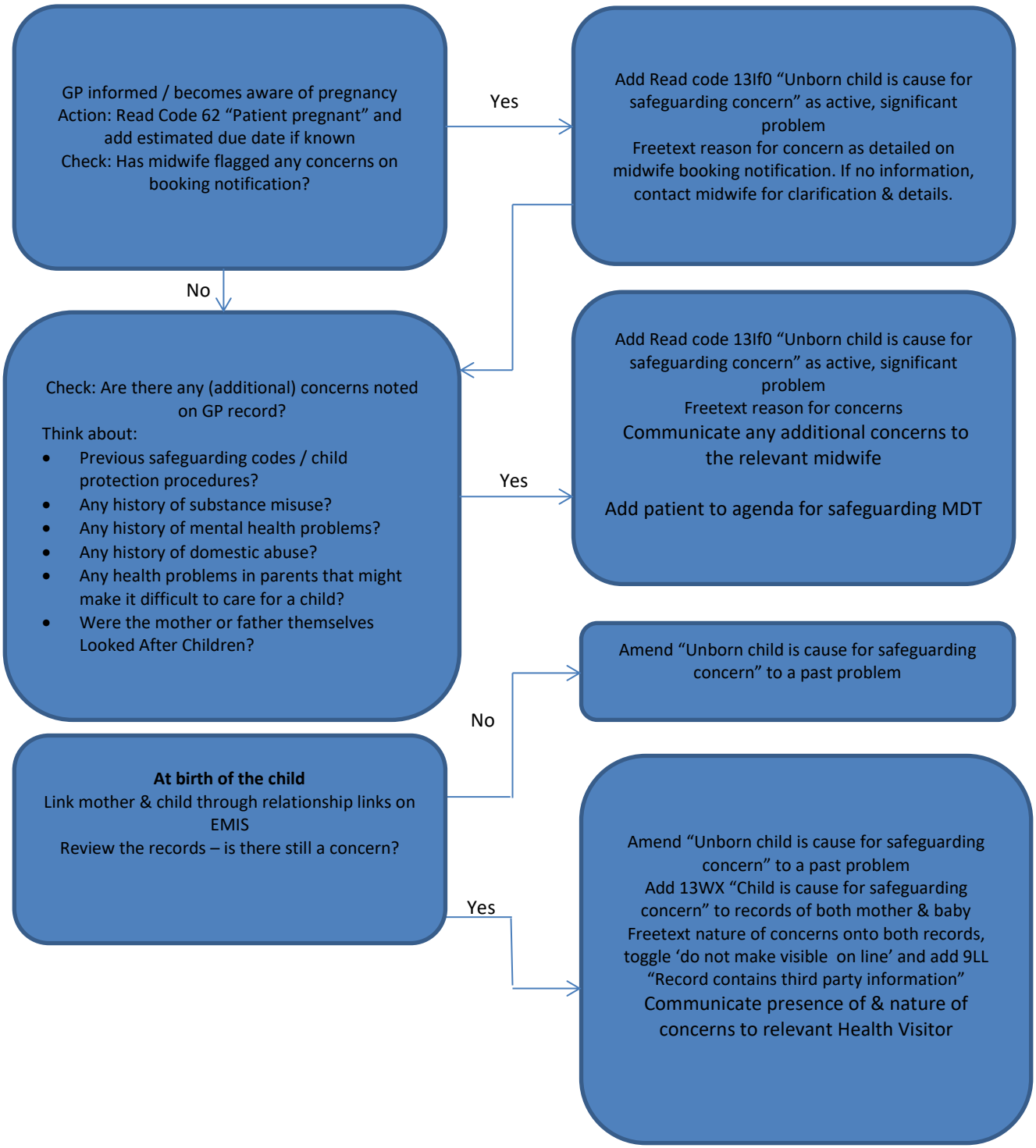


The Looked after Children team undertake a review every 12 months to ensure that the child's needs are being met. As part of this review they need to understand about any current or outstanding health issues. As the child will have had an initial medical, this report need only describe the care since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



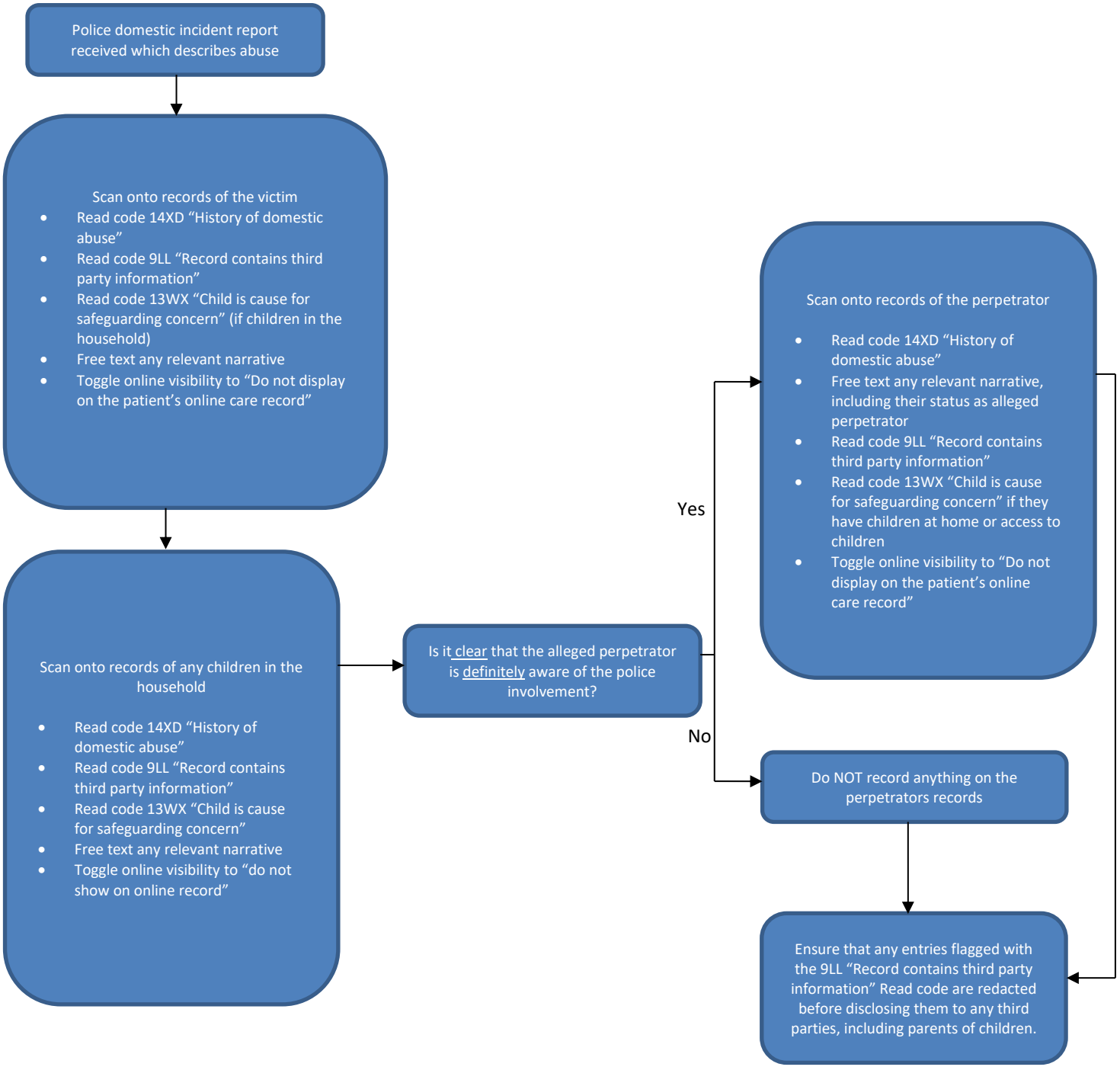
Ante-natal booking concerns

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 and the ante-natal booking blood results will also be sent to the GP practice via the lab-links system. 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.



When the police are called to a domestic incident they may choose to share this fact with the victim's GP. They will always send a report when there are children at home or if the level of risk to the victim is felt to be very high. This is based upon the DASH checklist. 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

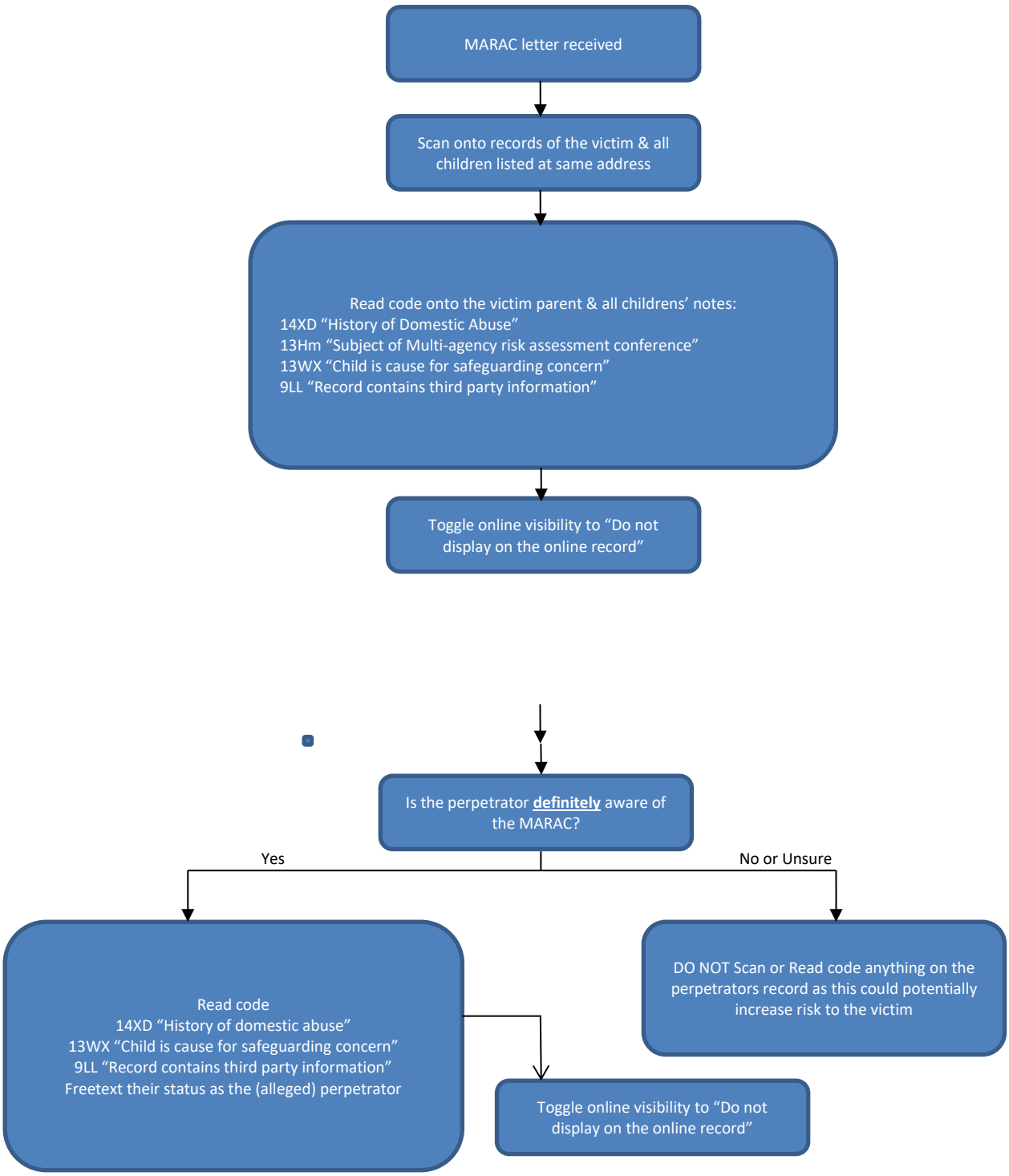
Perpetrator discloses DVA to clinician in the practice

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

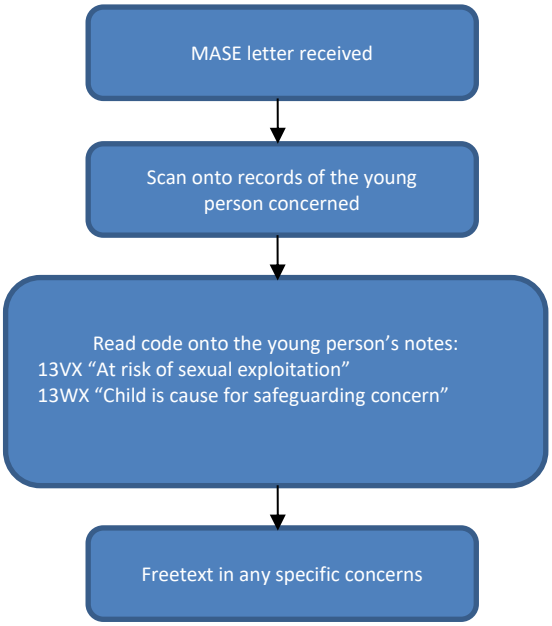
Person	Electronic health record
Victim	Record disclosure using **History of domestic abuse** Note source of disclosure as free text Hide the consultation from online access
Disclosing child or vulnerable adult	Record disclosure using **History of domestic abuse** Record disclosure verbatim as free text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

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, but can be obtained by contacting OxfordHealth Safeguarding team (who support Health Visitors) if required.

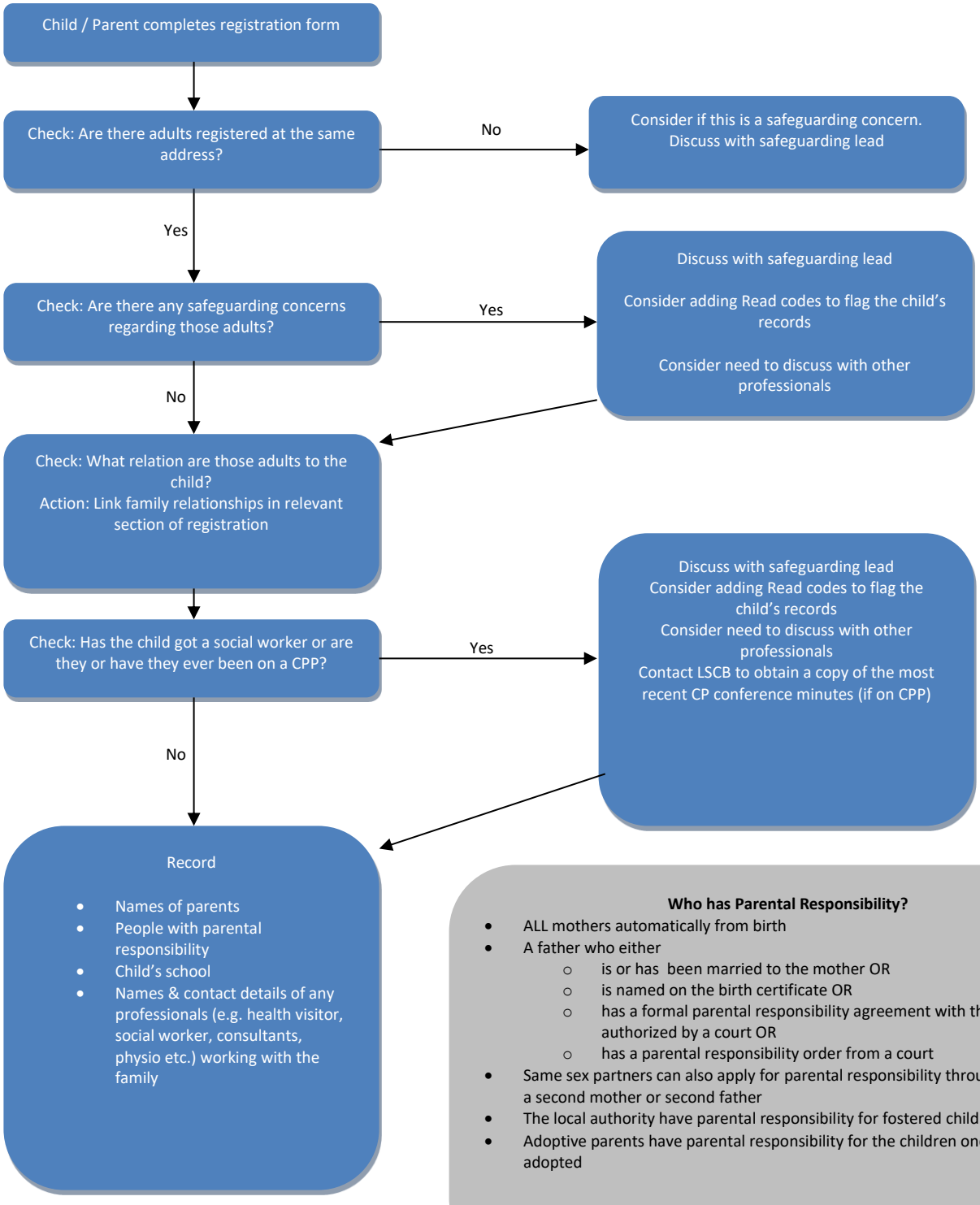


Multiagency Sexual Exploitation (MASE) Notification

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 but are informed after one has taken place. Full minutes are not presently circulated to GPs but can be obtained by contacting Kingfisher Team on 01865 309196 if required.



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.

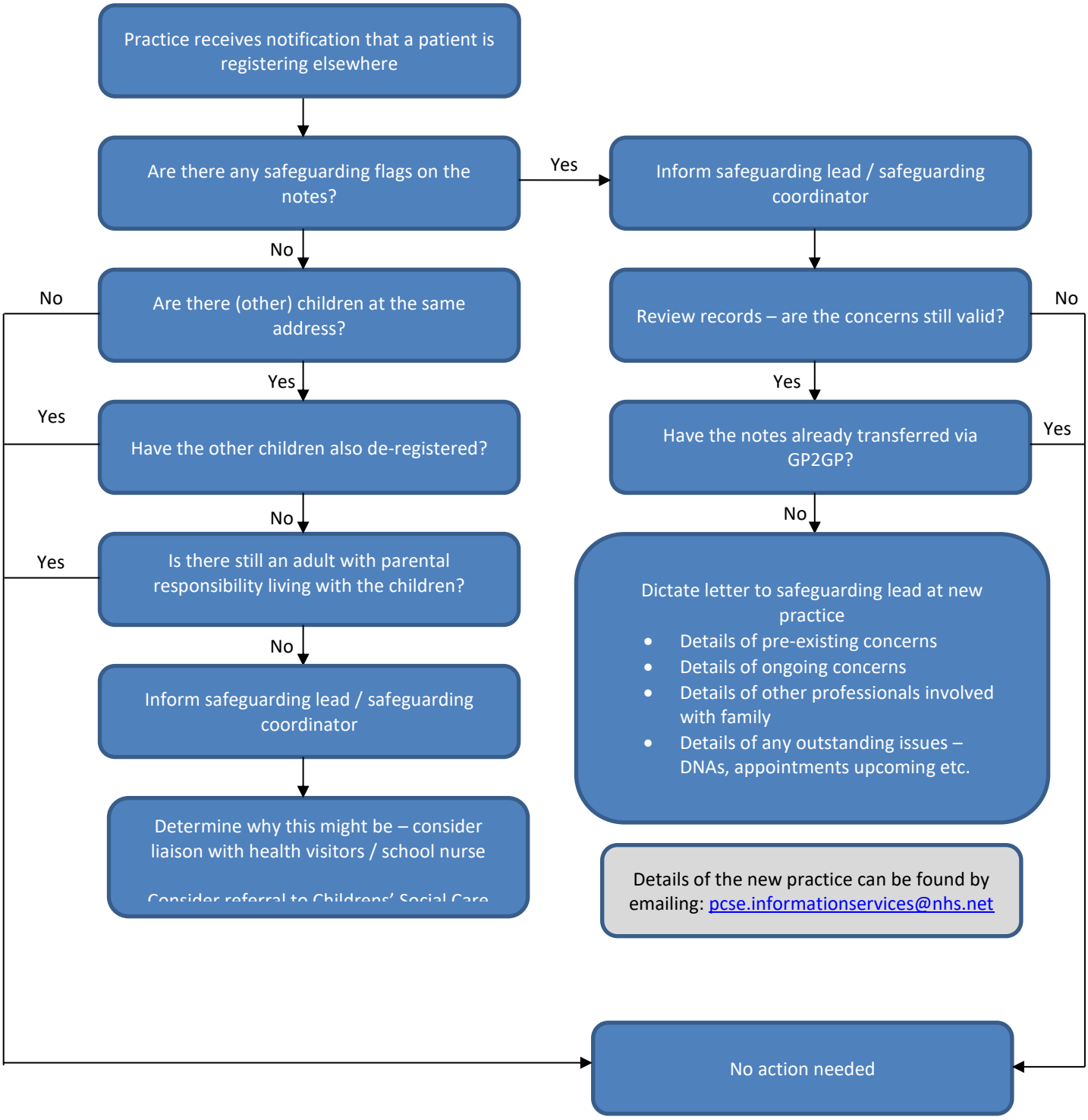


Who has Parental Responsibility?

- 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

Pa

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

Oxfordshire CCG

Safeguarding team

SAMPLE POLICY

SAFEGUARDING POLICY FOR VULNERABLE ADULTS AND CHILDREN WHO DO NOT ATTEND APPOINTMENTS ('WAS NOT BROUGHT')

(adapted from a policy written by Dr Nina Feghali, Stanmore House Surgery, with permission)

Staff at this practice are committed to ensure the safety and wellbeing of children and vulnerable adults who are registered with us.

This includes adherence to this policy for ensuring follow up of children and vulnerable adults who do not attend for appointments, routine immunisations, chronic health condition reviews and for appointment in secondary care settings.

Around seven million hospital appointments in England are missed annually. Whilst causing inconvenience and a waste of resources, more importantly, focus should be given to ensuring that these individuals do not face subsequent harm as a result of this.

Whilst competent adults can make decisions for themselves regarding their attendance, children and vulnerable adults rely upon parents/carers/guardians to ensure that they arrive for their planned appointment or test. The safeguarding implications of non-attendance have been identified as important and NHS organisations are required to have policies in place as part of their safeguarding arrangements. It is estimated that around 1/3rd of paediatric non-attendances in hospital settings involve children and families known to social services.

This policy outlines the actions to be taken when: -

1. The practice receives notification of a non-attendance in an outpatient setting (test or appointment)
2. There is non-attendance for routine immunisations by a child
3. There is non-attendance for chronic condition review – adults and children
4. A patient does not attend for a booked appointment at GP practice (adults and children)
5. Action to be taken if a patient arrives late for an appointment (policy applies to all healthcare professionals employed by GP practice on a permanent or temporary basis).

Non-attendance of outpatient appointment

Flowchart 1 outlines the actions that should be taken by staff when notification is received of a non-attendance at a healthcare setting outside of the surgery.

Non-attendance for chronic condition review (including asthma in children)

Flowchart 2 outlines the actions which should be taken by the surgery when a patient fails to come for review of their chronic condition despite being sent invitations from the practice.

Non-attendance for childhood immunisations

Flowchart 3 outlines the actions which should be taken if a child fails to attend a pre-booked appointment for childhood immunisations.

DNA appointment in surgery (adults and children)

Flowchart 4 outlines the actions which should be taken when an adult/child does not attend an appointment at Stanmore House Surgery.

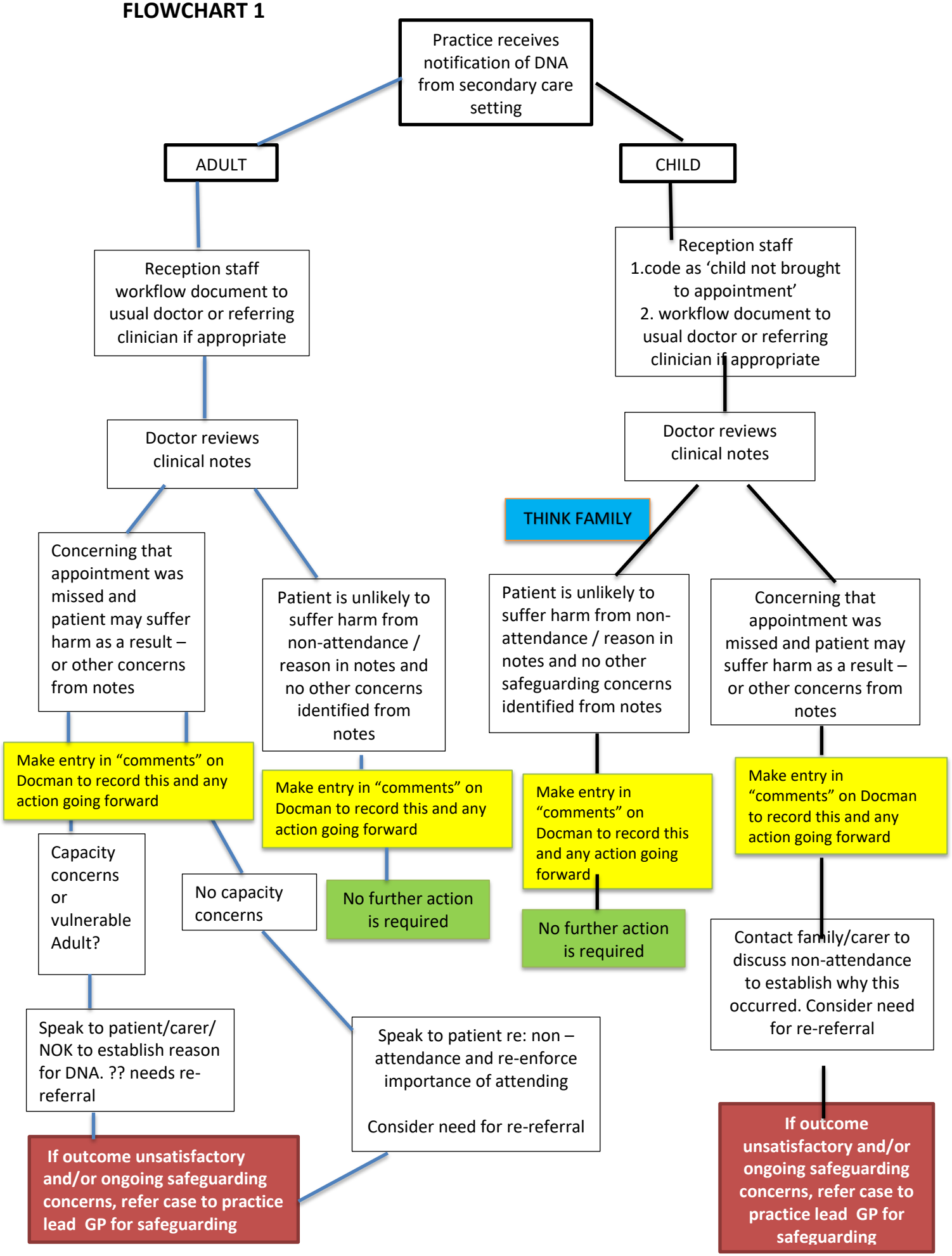
Late arrivals for clinic appointments

- **Children will never be turned away from being seen by any member of staff if they arrive late for an appointment. This includes appointments for routine immunisations.**

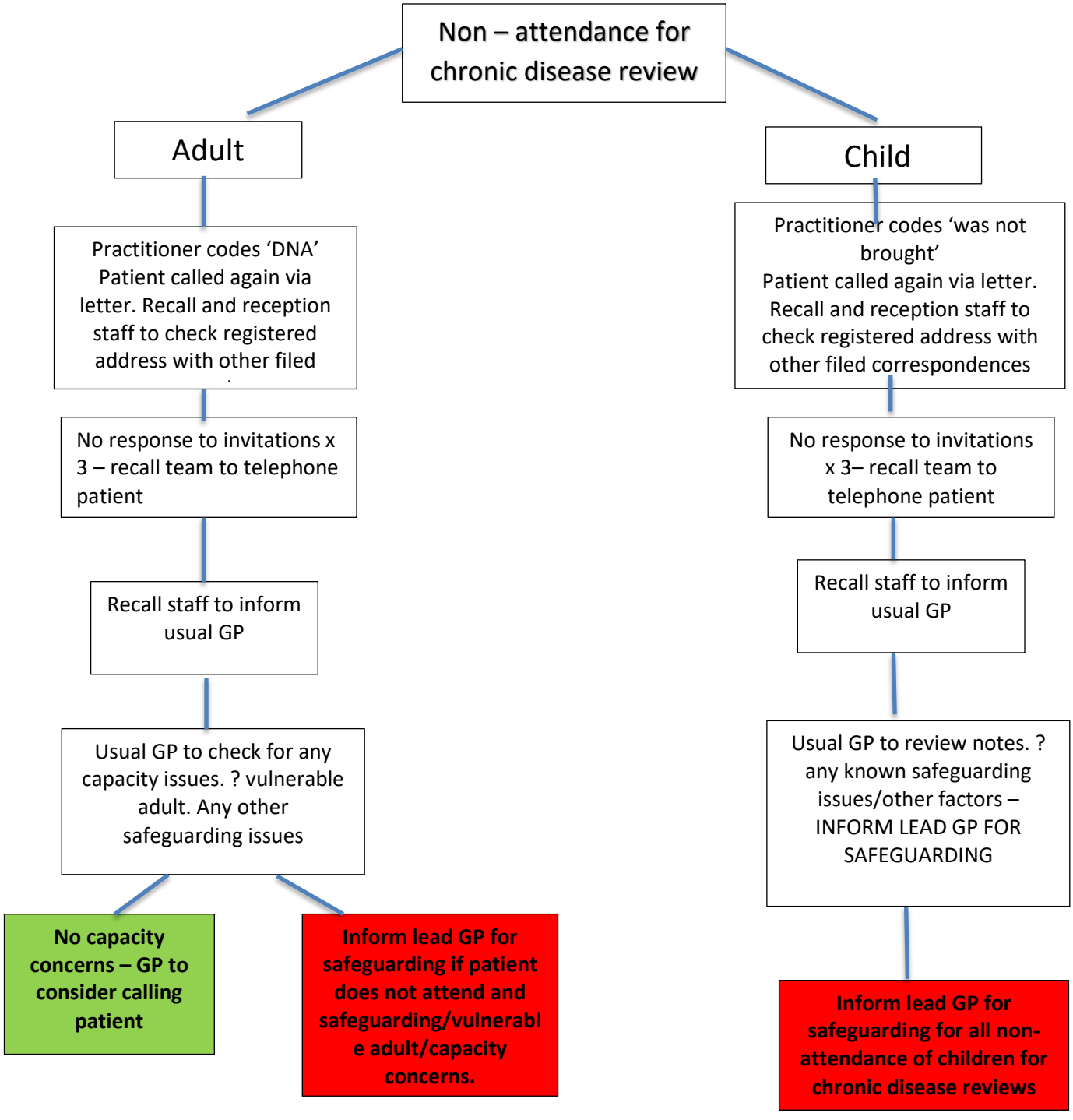
- Adults who arrive late for an appointment will be seen if the clinician is still on the premises but will be asked to wait and they may be seen at the end of surgery. They will be given the opportunity to rebook if they prefer.

- Patients who frequently arrive late for their appointments will receive a letter from the practice stating that this has been noted and that late arrivals are disruptive to the running of the clinics and results in further pressure on clinical staff.

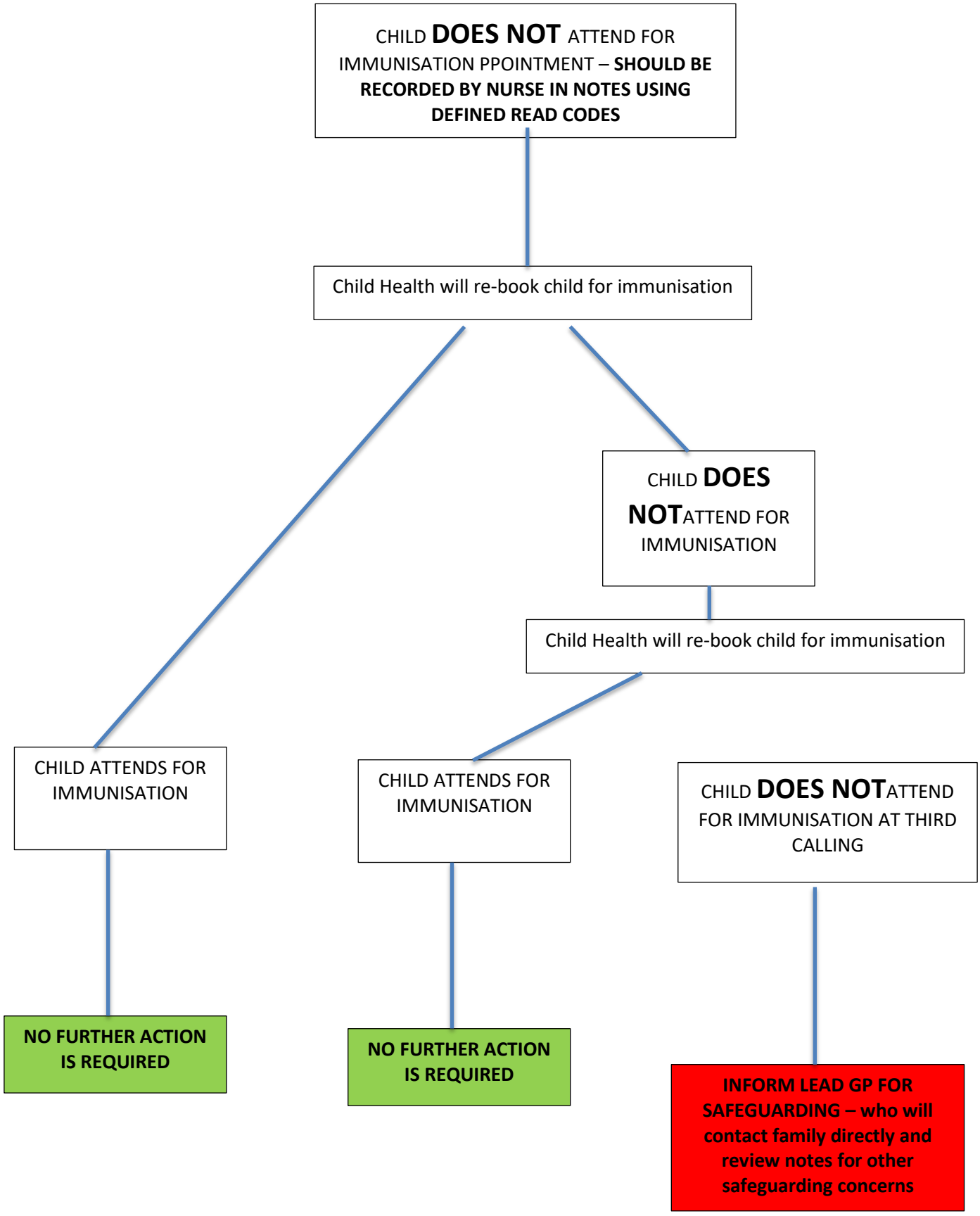
FLOWCHART 1


Practice receives notification of DNA from secondary care setting
ADULT
CHILD
Reception staff workflow document to usual doctor or referring clinician if appropriate
Reception staff 1.code as 'child not brought to appointment' 2. workflow document to usual doctor or referring clinician if appropriate
Doctor reviews clinical notes
Doctor reviews clinical notes
THINK FAMILY
Concerning that appointment was missed and patient may suffer harm as a result – or other concerns from notes
Patient is unlikely to suffer harm from non-attendance / reason in notes and no other concerns identified from notes
Patient is unlikely to suffer harm from non-attendance / reason in notes and no other safeguarding concerns identified from notes
Concerning that appointment was missed and patient may suffer harm as a result – or other concerns from notes
Make entry in "comments" on Docman to record this and any action going forward
Make entry in "comments" on Docman to record this and any action going forward
Make entry in "comments" on Docman to record this and any action going forward
Make entry in "comments" on Docman to record this and any action going forward
Capacity concerns or vulnerable Adult?
No capacity concerns
No further action is required
No further action is required
Contact family/carer to discuss non-attendance to establish why this occurred. Consider need for re-referral
Speak to patient/carer/ NOK to establish reason for DNA. ?? needs re-referral
Speak to patient re: non – attendance and re-enforce importance of attending
Consider need for re-referral
If outcome unsatisfactory and/or ongoing safeguarding concerns, refer case to practice lead GP for safeguarding
If outcome unsatisfactory and/or ongoing safeguarding concerns, refer case to practice lead GP for safeguarding

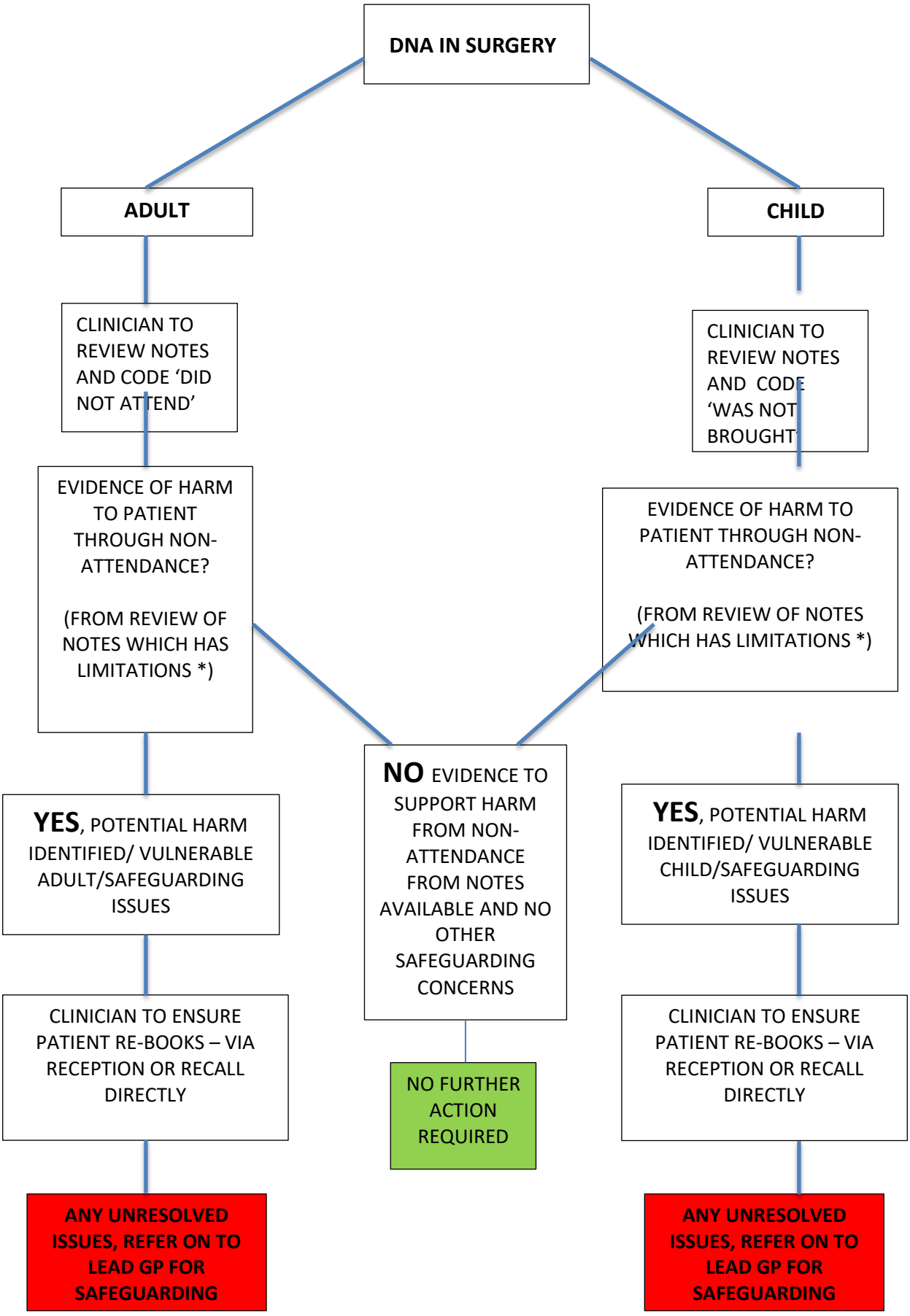
FLOWCHART 2


Non – attendance for chronic disease review
Adult
Child
Practitioner codes 'DNA' Patient called again via letter. Recall and reception staff to check registered address with other filed
No response to invitations x 3 – recall team to telephone patient
Recall staff to inform usual GP
Usual GP to check for any capacity issues. ? vulnerable adult. Any other safeguarding issues
No capacity concerns – GP to consider calling patient
Inform lead GP for safeguarding if patient does not attend and safeguarding/vulnerable adult/capacity concerns.
Practitioner codes 'was not brought' Patient called again via letter. Recall and reception staff to check registered address with other filed correspondences
No response to invitations x 3– recall team to telephone patient
Recall staff to inform usual GP
Usual GP to review notes. ? any known safeguarding issues/other factors – INFORM LEAD GP FOR SAFEGUARDING
Inform lead GP for safeguarding for all non-attendance of children for chronic disease reviews

FLOWCHART 3


CHILD DOES NOT ATTEND FOR IMMUNISATION PPOINTMENT – SHOULD BE RECORDED BY NURSE IN NOTES USING DEFINED READ CODES
Child Health will re-book child for immunisation
CHILD DOES NOTATTEND FOR IMMUNISATION
Child Health will re-book child for immunisation
CHILD ATTENDS FOR IMMUNISATION
CHILD ATTENDS FOR IMMUNISATION
CHILD DOES NOTATTEND FOR IMMUNISATION AT THIRD CALLING
NO FURTHER ACTION IS REQUIRED
NO FURTHER ACTION IS REQUIRED
INFORM LEAD GP FOR SAFEGUARDING – who will contact family directly and review notes for other safeguarding concerns

FLOWCHART 4


DNA IN SURGERY
ADULT
CHILD
CLINICIAN TO REVIEW NOTES AND CODE 'DID NOT ATTEND'
CLINICIAN TO REVIEW NOTES AND CODE 'WAS NOT BROUGHT'
EVIDENCE OF HARM TO PATIENT THROUGH NON-ATTENDANCE?
(FROM REVIEW OF NOTES WHICH HAS LIMITATIONS *)
EVIDENCE OF HARM TO PATIENT THROUGH NON-ATTENDANCE?
(FROM REVIEW OF NOTES WHICH HAS LIMITATIONS *)
YES, POTENTIAL HARM IDENTIFIED/ VULNERABLE ADULT/SAFEGUARDING ISSUES
NO EVIDENCE TO SUPPORT HARM FROM NON-ATTENDANCE FROM NOTES AVAILABLE AND NO OTHER SAFEGUARDING CONCERNS
YES, POTENTIAL HARM IDENTIFIED/ VULNERABLE CHILD/SAFEGUARDING ISSUES
CLINICIAN TO ENSURE PATIENT RE-BOOKS – VIA RECEPTION OR RECALL DIRECTLY
NO FURTHER ACTION REQUIRED
CLINICIAN TO ENSURE PATIENT RE-BOOKS – VIA RECEPTION OR RECALL DIRECTLY
ANY UNRESOLVED ISSUES, REFER ON TO LEAD GP FOR SAFEGUARDING
ANY UNRESOLVED ISSUES, REFER ON TO LEAD GP FOR SAFEGUARDING

Appendix 2

Recommended Read codes (be aware that SNOMED codes will be different)

Read Code	Read Code meaning	Whose notes should this be applied to?	When should this code be applied?
13WX	"Child is Cause for Safeguarding Concern"	Child in question & all relevant family members	All situations where child maltreatment / risk is considered a possibility. This code could feasibly be used for all potential safeguarding issues as it then allows them to be easily linked together, so the free text entries can bring the context. This will likely be the most commonly used safeguarding code. Please note is does not appear as 'significant active problem' and should be changed to appear as this. A CPflag will appear on notes.
9NgB	Child no longer safeguarding concern	All relevant children and family members	When after balancing the information previously coded under the 13WX code it is felt that there is no longer a significant risk to the child / children This is a KILL code, which will remove the previous "Child is cause for safeguarding concern" CP alert & pop-up
13If	"Child is cause for concern"	Child in question	Situations where something might make a child at risk, but not significant enough in isolation to warrant the previous code (for example a first attendance at ED after ingesting washing powder, or wherein a parent has mild-moderate depression not presently affecting parenting capacity) No flag will appear on the notes with this code.
9NZ1	Child not brought to appointment	Child in Question	When a child fails to attend an appointment at the practice or in secondary care.
387A	Initial child protection conference	All relevant children discussed.	Record outcome if not placed on child protection plan
3879	Review child protection conference	All relevant children discussed	
13Iv	Subject to Child Protection Plan	All relevant children made subject to child protection plans	Following a CP case conference whereupon the children were placed onto a child protection plan. A CP flag will appear. Categories: Emotional 12WT1 Physical 13WT2 Sexual 13WT3 Neglect 13WT4
13Iw	Child no longer subject to child protection plan	All relevant children who were previously on child protection plans	When a child is taken off a child protection plan after a case conference This is a KILL code, which will remove the previous "Subject to Child Protection Plan" CP alert & pop-up
13Iy	Family member subject of child protection plan	Parents of children made subject to child protection plans	Following a CP case conference whereupon the children were placed onto a child protection plan

13Iz	Family member no longer subject of child protection plan	Parents of children who have been removed from a child protection plan.	When a child / family are taken off a child protection plan after a case conference
13Iv0	Unborn child subject to child protection plan	Pregnant woman and the father of the child	Following a CP case conference whereupon the unborn child was placed onto a child protection plan
13Id 13IM 8CM6	On child protection register Child protection register Child protection plan		Suggest don't use these as they can confuse
13IO 13IPO	No longer on child protection register Family member no longer on child protection register		'KILL' code for the codes above
13IS	Child in need	Child now subject to child in need plan	Following information from case conference
13IT	Child no longer in need		Following information from case conference/social worker
13IB1	Looked after Child	Child who has become "Looked After"	When you are alerted that a child is now formally "Looked After".
9NgF	No longer subject to looked after child arrangement	Child who was previously 'Looked After'	When a child is no longer formally "Looked After", for example if after investigation they are returned to the care of their parent(s) or if they reach an age whereupon they are no longer the responsibility of the state.
8GE71	Own child has been fostered	Parents of the child who has become formally "Looked After"	When you are alerted that a child is now formally "Looked After".
13I81	Own child has been adopted	Birth parents of the child who has been adopted	When you are alerted that a child has been adopted.
13VX	At risk of Sexual Exploitation	All relevant children	Where it is identified that a child is a risk of CSE, for example if identified as high risk within the practice, or is discussed at a MASE (Multi-Agency at risk of Sexual Exploitation) conference
14XH	Victim of sexual exploitation	Child or adult	When a child or adult is known to have been victim of SE
14XD	History of Domestic Abuse	Victims and children within the household as relevant. Perpetrator when you are CERTAIN that they are aware of the disclosure. (See flowchart)	When you become aware of domestic abuse within a household. Please refer to more detailed flow chart detailing what information should be stored within records & how this can be kept confidential.
13Hm	Subject to Multi-Agency Risk Assessment Conference (MARAC)	Victim and children referred to within the letter	Where you are advised that a family are being discussed at a Multi-Agency Risk Assessment Conference (MARAC) for high level domestic abuse.
8T0B	Referral to MARAC	Victim and children if referral made	
K578	History of FGM		
12b	Family history of FGM		
EMISNQHO50	Elective home education	Child (finishes age 18)	Note this is an EMIS code but will map to Snomed when these are introduced
9Ngj	Adult safeguarding concern	All relevant vulnerable adults or caregivers	When there is reason to suspect that a vulnerable adult might potentially be at

		who give rise to concerns	risk of abuse or neglect, either as a result of something relating to themselves, or potentially as a result of something regarding their carers or environment
9Ngk	Adult no longer safeguarding concern	All relevant vulnerable adults or caregivers	When you feel that they are no longer at a raised level of risk.
9NdL	Lacks capacity to give consent	When consent sought	
2JR	Lacks mental capacity to make decision	When decision to be made	
9NgzG	Standard authorization deprivation of liberty MCA 2005 given	The person subject to a DOLS	When you are informed that a person has been made subject to a Deprivation of Liberty Safeguard (DOLS)
9NgzW	No longer subject to deprivation of liberty under MCA 2005DOLS	The person no longer subject to DOLS	When you are made aware that a person is no longer subject to a Deprivation of Liberty Safeguard (DOLS)
13HI-1	Subject of Multi-Agency public protection arrangements(MAPPA)		
14XL	Victim of modern slavery		
9LL	Record contains third party information	Every relevant consultation	Add this code to every consultation where third party information is mentioned or where you feel that inadvertent disclosure of the contents of the consultation to a third party might pose a risk. This allows the consultations to be easier found & redacted.