North East London Health & Care Partnership

North-East London Integrated Care Board (NEL ICB)

Primary Care Safeguarding Handbook

"Improving Standards and Promoting Welfare for Children, Young People and Adults"

> ***"All children deserve the opportunity to achieve their full potential"***
>
> *Working together to Safeguard Children DoH, 2010/2015/2018.*

> ***"Safeguarding the rights of others is the most noble and beautiful end of a human being"***
>
> *Khalil Gibran*

September 2025
Version 9.7.2

INTRODUCTION

The North-East London Integrated Care Board's Primary Care (General Practitioner's) Safeguarding Handbook has been produced to provide support and information for all General Practitioners and their associated Primary Care staff (clinical and non-clinical) working with children, families, and vulnerable adults.

Guidance and legislative requirements on providing best practice with regards to clinical and administrative safeguarding procedures have been provided, in line with the most recent or updated published evidence.

This includes guidance from local and national sources with linked references, including local Child Practice Safeguarding Reviews (CPSR) findings, references to the latest statutory publications and locally agreed protocols and documents to ensure effective 'Working Together' practises.

"All GPs have a duty to maintain their skills in the recognition of abuse and neglect, and to be familiar with the procedures to be followed if abuse or neglect is suspected."

"GPs should take part in training about safeguarding and promoting the welfare of children, and have regular updates as part of their post-graduate education / CPD"

Working together to Safeguard Children
DoH, 2010/2015/2018

ACKNOWLEDGEMENTS

This handbook has been developed from on-going collaborative working from local, London based, and National Safeguarding Leads, individuals and organisations who have given their permission to share their own resources and information for the benefit of all who will find this handbook of use. Special gratitude and acknowledgements go to

- Named Primary Care professionals for Safeguarding Children and Adults from NEL ICB
- Designated and Named NEL ICB clinicians and professionals
- Members of the NHS England's London Network of Named GPs
- The NEL ICB Safeguarding and Quality Assurance Directorate
- Members of the Primary Care Safeguarding Forum (PCSF)
- Members of the National Network of Named GPs (NNNGP)

Dr. Richard Burack
Named GP for Children's Safeguarding
Havering and Barking & Dagenham, NEL ICB

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THE CONTEXT

AI - SAFEGUARDING CYP

"Protecting Children and Young People (CYP) remains the responsibility of ALL doctors & their associated staff"

Child Safeguarding is any activity that promotes:

- *Protection of children from maltreatment*
- *Prevention of any impairment of children's health or development*
- *Children growing up in circumstances consistent with the provision of safe & effective care.*
- *Actions taken to enable all children to have the best outcomes* [1]

Child Protection is part of safeguarding and promoting welfare. This refers to the activity / process that is undertaken to protect specific children who are suffering or are likely to suffer significant harm.

This handbook aims to help clinical staff working in Primary Care keep children and young people (CYP) and adults safe. The 'at place localities' covered by North-East London Integrated Care System (NEL ICS) have collectively seen within its growing CYP population additional challenges that appear connected with higher than national prevalence of safeguarding issues / abusive practices including: -

- *Domestic Violence & Abuse (DVA)*
- *Child Trafficking, modern day slavery and abuse linked to faith and belief or gang culture*
- *Child Sexual Exploitation (CSE) (including peer on peer abuse)*
- *Radicalisation of young people and vulnerable adults*
- *Complex Presentations / Fabricated Induced Illness (FII)*
- *Increased vulnerability of Children who are Looked After (CLA)*
- *Elder abuse*

"Investing in children and young people's health and well-being is a cost-effective way of improving long term health outcomes and reducing pressure on health services as these children grow up"

[1] Working Together to Safeguard Children (2023), HM Government

AII – CYP EQUITABLE ACCESS

> ***"The health of children is the foundation of a healthy society. Denying them access to care is denying them a future"***
>
> *UNICEF Romania, Sept 2024*

Equitable CYP Access [2]

- Children and young people (CYP) in the UK have a legal and moral right to access GP services that are equitable, inclusive, and respectful of their needs. [3]
- Ensuring access is not only a safeguarding duty but also a key part of delivering high-quality Primary Care. [4]
- CYP can register with a GP of their choosing, book and attend appointments alone, where deemed competent.
- Receive care in line with individual needs and without unnecessary barriers. [5]

Challenges to Access

Barrier	Example	Impact
Age-based booking restrictions	Reception policy only allows 18+ to book	***Excludes competent younger patients***
Stigma or judgment	Staff attitudes toward unaccompanied minors	***Discourages help-seeking***
Digital exclusion	Lack of devices or internet	***Blocks use of online appointment systems***
Lack of youth-specific provision	Adult-focused waiting areas	***Makes young people feel unwelcome***
Inadequate training	Staff unsure how to handle young people's autonomy	***Inconsistent responses***

Solutions and Good Practice in GP Practices

- **Staff Training**: Train front-desk and clinical staff on children's rights and Gillick competence.
- **Youth-Friendly Environments**: Display visible information welcoming young people; provide age-relevant leaflets.
- **Flexible Appointment Options**: Offer phone, online, or in-person booking for young people.
- **Feedback Mechanisms**: Include young people in surveys or advisory groups to understand access barriers.
- **Outreach Links**: Partner with schools, youth workers, or social services to support hidden or vulnerable groups.
- Do not set age cut-offs for appointment booking unless legally required.
- Avoid requiring parental presence unless safeguarding dictates otherwise.
- Use accessible language when communicating rights to young patients.
- Consider having a practice children's lead or a named staff member as a youth access champion.

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[2] Children Act 1989 & 2004
[3] NHS Constitution for England, January 2009, latest version January 2023.
[4] GMC Guidance: 0-18 years
[5] UN Convention on the Rights of the Child. (UNCRC), Article 12 (right to be heard) & 24 (right to health)

AIII – CYP PRIVACY & CONFIDENTIALTY

"Confidentiality is the cornerstone of trust between young people and healthcare providers. Without this trust, there may be hesitation to seek care, leading to preventable harm"

Sir Alan Craft, RCPCH, 2005

Confidential and Private CYP Services [6]

- Children and young people (CYP) have the same right to confidentiality as adults when accessing healthcare. [7] [8]
- Respecting their privacy is essential for building trust, promoting engagement, and upholding legal and ethical standards—while always balancing this with safeguarding responsibilities.
- Age is not a barrier: Confidentiality applies regardless of age, provided the child is competent.
- CYP have the right to talk privately to a GP.
- Information must not be shared with parents or carers without consent, unless there is a significant risk of harm.
- Safeguarding does not automatically override confidentiality: Each case must be assessed individually. [9]

Common Misunderstandings and Challenges

Issue	Impact
Belief that all under-16s need parental consent to be seen alone	Can prevent young people from accessing care
Staff uncertainty about when to share information	Leads to over- or under-sharing
Fear from young people that confidentiality won't be kept	Deters honest disclosure about sensitive issues
Parents demanding access to records	Breaches of confidentiality if not carefully managed

Solutions and Good Practice in GP Practices

- Regular staff training on confidentiality and safeguarding.
- Clear protocols for handling requests for information from parents.
- Use of chaperones or safeguarding leads to support complex or sensitive cases.
- Involve youth voice in practice policy design to ensure young people feel safe and heard.
- Display posters or leaflets stating: "You have the right to speak to a doctor or nurse alone. What you say is confidential unless you're at risk."
- Make confidentiality policies accessible on your website, with versions for younger readers.
- Use electronic health record settings to restrict access when appropriate.
- Always explain the limits of confidentiality clearly at the start of the consultation.
- Assess Gillick competence before discussing sensitive matters alone.
- Document carefully: include assessments of competence and reasons for any disclosures.
- Offer private consultations to young people even if they attend with parents.
- Respect the right to confidentiality in all settings, including front-desk interactions.

[6] UNCRC Article 16, a child's right to privacy
[7] GMC 0-18 Years Guidance
[8] NHS Confidentiality Code of Practice
[9] Data Protection Act 2018 / UK GDPR

AIV – CYP COMPETENCY

"… a child is capable of giving consent when he or she has sufficient understanding and intelligence to be capable of making up his or her own mind on the matter."

Lord Fraser, 1985

Assessing Competency: Gillick Competence [10] [11] [12]

- Children and young people under 16 can consent to medical treatment—including booking and attending appointments alone—if they are assessed as Gillick competent. This means they must understand the treatment, its purpose, and potential consequences.
- To determine whether a young person is Gillick competent, consider if they can:
  - *Understand the information provided.*
  - *Retain that information long enough to make a decision.*
  - *Weigh the benefits and risks.*
  - *Communicate their decision clearly and freely.*
- Use open questions, age-appropriate explanations, and seek clarification to ensure understanding.
- Balancing a young person's autonomy with safeguarding is critical. Even if a child is competent, concerns about abuse, exploitation, or significant harm must prompt appropriate action. However, confidentiality should not be breached unnecessarily.

Common Challenges in practice

Challenge	Description	Impact
Inconsistent assessments	Some GPs unsure when/how to apply Gillick test	Risk of denying or incorrectly granting acess
Parental pressure or presence	Young person unable to speak freely	Can lead to incomplete histories or disengagement
Time pressure	Rushed consultations affect assessment quality	Increases likelihood of errors
Lack of youth-friendly systems	E.g. adult-centric policies, environments	Makes young people feel unsafe or unwelcome

Solutions and Good Practice in GP Practices

- Always assess capacity in context, not just by age.
- Promote autonomy while remaining alert to safeguarding risks.
- Provide a safe space for young people to be heard, respected, and understood.
- Empower the whole practice team with clear protocols and training
- **Use templates** to document Gillick assessments clearly and consistently in the records.
- **Youth Participation**. Invite feedback from young people on how services can feel more safe, inclusive, and accessible.
- **Multi-agency Working.** Build links with schools, social workers, and youth services to support those with additional vulnerabilities.
- **Confidentiality Scripts for Staff**. Equip reception and clinical staff with short, clear scripts explaining young people's rights (e.g. "You can talk to the doctor alone and what you say will stay private unless you're at risk.")

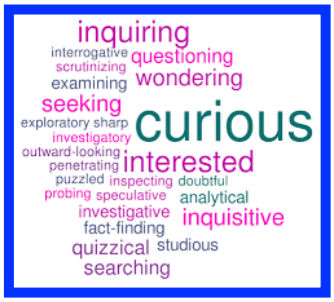
[10] Gillick v West Norfolk and Wisbech AHA, 1985
[11] Fraser Guidelines, 1985
[12] RCGP Safeguarding Toolkit

AV - PROFESSIONAL CURIOSITY

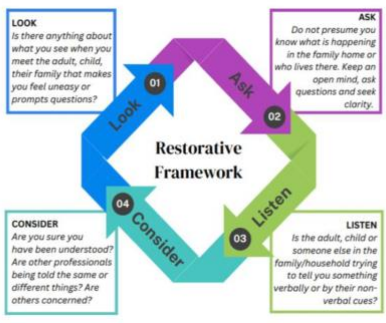
> ***"I have no special talent; I am only passionately curious"***
>
> *Albert Einstein*

Why do we need to be curious in safeguarding?

- *To understand the full picture*
- *To ensure nothing is missed*
- *To improve practice outcomes*
- *To do our best to safeguard children and adults*
- *To identify 'disguised compliance'*
- *To support other professionals working with the family*



- As front-line clinicians, we often encounter a child, young person, or their family when the child is vulnerable to harm. These interactions present opportunities for protection that should not be missed.
- Professional curiosity is the capacity and communication skill to explore and understand what is happening within a family rather than make assumptions or accepting things at face value.
- Children will rarely disclose abuse directly to adults working with them and, if they do, it will often be through unusual behaviour or comments. This makes identifying abuse and neglect difficult for professionals across all agencies.
- All agencies and professionals working with children and families need to work together, the first step is to be professionally curious.
- Curious professionals will spend time engaging with families using their skills to observe and interact. Don't presume you know what is happening in the family home. Ask questions and seek clarity if you are not certain.
- Do not be afraid to ask questions of families and do so in an open way so they know that you are asking to keep the children safe, not to judge or criticise.
- Child Practice Safeguarding Review reports have consistently emphasised the need for clinicians to use and act on their 'Professional Curiosity'. This is best achieved by
  - ***LOOKING***
  - ***ASKING***
  - ***LISTENING***
  - ***CONSIDERING*** [13]
    - *Asking ended and non-leading questions*
    - *Challenging ideas and opinions*
    - *Gently exploring identified inconsistencies*
    - *Being mindful of situations, detail, and background*
    - *Take seriously responses with thoughtful reflection*



- Professional curiosity is an emerging theme in adult safeguarding reviews (ASRs) too including domestic homicide reviews (DHRs).
- Once the index of suspicion is triggered, the formal process and pathways (including sharing information, making a referral and supporting the needs and wellbeing of the CYP or adult) become a statutory obligation that need to be followed diligently and carefully, with good documentation and timely communication with all relevant other agencies.

[13] Multiagency Practice Guidance, Task & Finish Group, Devon Safeguarding Children's Partnership. June 2025

AVI - DISGUISED COMPLIANCE

"Involves parents or carers giving the appearance of operating with agencies to avoid raising suspicions and allay concerns"

- Professional curiosity or respectful uncertainty is needed when working with families who are displaying 'disguised compliance'.
- There is a continuum of behaviours from parents or carers on a sliding scale, with full co-operation at one end and planned and effective resistance at the other.
- Showing your best side or 'saving face' may be viewed as normal behaviours and therefore we can expect a degree of disguised compliance in all families emerging theme in Safeguarding adult reviews (SRAs), Child practice safeguarding reviews (CPSRs), domestic homicide reviews (DHRs) and other reviews at local and national level.
- At its worst, superficial co-operation may be to conceal deliberate abuse.
- Many case reviews highlight that professionals can sometimes delay or avoid interventions due to parental disguised compliance. [14]

AVII – PARENTAL RESPONSBILITY (PR)

What is parental responsibility?

Parental responsibility is where an adult, by law,[15] has the rights, duties, powers and responsibilities for the care and well-being of their child and can make important decisions about the following points for example:

- *Food; Clothing; Education; Home and Medical treatment*

Who has parental responsibility?

- A married couple that have children together both automatically have parental responsibility.
- Parental responsibility continues after divorce.
- Mothers automatically have parental responsibility.
- Where the parents are not married, the unmarried father has parental responsibility if:
  - *His name is registered on the birth certificate - this is the case for births registered after 1 December 2003. Fathers can re-register if their names have not been placed on the birth certificate before this date.*
  - *He later marries the mother.*
  - *Both parents have signed an authorised parental responsibility agreement.*
  - *He obtains a parental responsibility order from the court.*
  - *He obtains a residence order from the court.*
  - *He becomes the child's guardian.*

[14] Disguised compliance: learning from case reviews, NSPCC. 2019
[15] The Children Act, 1989, Section 2

Acquiring parental responsibility

- Others, such as grandparents and stepparents, do not have parental responsibility. They can acquire it by:
  - Being appointed as a guardian to care for a child if their parent dies.
  - Obtaining a residence order from the court for a child to live with them.
  - Adopting the child.

Other facts about Parental Responsibility

- More than one person may have parental responsibility for the same child at the same time.
- A person who has parental responsibility for a child at any time shall not cease to have that responsibility solely because some other person subsequently acquires parental responsibility for the child.
- Where more than one person has parental responsibility for a child, each of them may act alone and without the other (or others) in meeting that responsibility; but nothing in this Part shall be taken to affect the operation of any enactment which requires the consent of more than one person in a matter affecting the child.
- The fact that a person has parental responsibility for a child shall not entitle him to act in any way that would be incompatible with any order made with respect to the child under this Act.
- A person who has parental responsibility for a child may not surrender or transfer any part of that responsibility to another but may arrange for some or all of it to be met by one or more persons acting on his behalf.

Parental Responsibility with Children in Care [16]

- If a child is under a Care Order, PR is shared between the Local Authority (LA) and the birth parents, however the LA can limit the parents' ability to exercise their PR if necessary for the child's welfare
- If the child is under a Section 20 (Voluntary accommodation), the LA does not have PR. Birth parents retain full PR and must be fully consulted (unless PR has been restricted by a court order)

Parental Responsibility with an Adopted Child [17]

- Adoptive parents gain full and exclusive PR once the Adoption Order has been granted
- Birth parents lose all PR permanently

Parental Responsibility with a Child from a Surrogacy Arrangement [18]

- At birth, the surrogate mother (and her spouse/civil partner if applicable) automatically hold PR
- Intended parents do not have PR at birth
- To transfer PR, intended parents must apply for a parental order which if granted would give them full PR permanently and removes PR from the surrogate (and her partner if applicable)
- This process is the same even if the surrogate mother used sperm of one intended father or sperm form both (same sex couple) who intend to be the parents.

[16] The Children Act, 1989, Sections 31 and 20
[17] The Adoption and Children Act 2002, Section 46
[18] The Human Fertilisation and Embryology Act 2008, Section 54

THE ESSENTIALS

BI - GP PRACTICE SAFEGUARDING LEADS
"Competencies & Skills"

"Good Medical Practice places a duty of care on all doctors to protect and promote the health and well-being of CYP"

Protecting Children & Young People
The General Medical Council, 2012

- All GP practices are required to have a Practice Lead for Safeguarding Children
- It is expected that to be able to fulfil their role, GP practice safeguarding leads should have more in depth knowledge {but still only are required to achieve L3 ICD competency}
- The role of a GP practice safeguarding lead is to support their practice colleagues [19] and ensure there is an agreed standard of practice safeguarding processes.
- Good practice in Safeguarding will involve development of robust administrative and clinical procedures and routines [20] and will often require a nominated Deputy safeguarding lead and dedicated administrative support.

Competences

- Leads/oversees the development of strong and updated safeguarding policies, guidelines and protocols within their practice that satisfy current legislative, contractual, local and national safeguarding requirements
- Be able to align national guidance to local practice.
- Facilitates and contributes to own practices audits, multi-agency audits and statutory inspections, establishing a governance structure, annual reporting monitoring and review.
- Undertakes regular documented reviews of their practices safeguarding practice, in various ways, such as through audit, case discussion, peer review, reflective practice, Practice /PCN safeguarding significant event meetings, supervision and as a component of refresher training.
- Can challenge poor safeguarding practice.
- Applies the lessons learnt from audit, serious case reviews, domestic homicide reviews and case management reviews to improve practice.
- Leads/oversees safeguarding quality assurance and improvement processes.
- Facilitates and contributes to the safeguarding training needs of practice staff
- Provides safeguarding supervision and leads or ensures appropriate reflective practice.

Knowledge

- Aware of best practice in safeguarding legislation, information sharing, information governance, confidentiality and consent including guidance from professional bodies.
- Understands own organisational structures/arrangement to be able to challenge and advocate within safeguarding policies, procedures and practice.

Skills

- Able to provide safeguarding advice to their practice team and signpost to more expert advice if needed.
- Able to signpost their practice team to local safeguarding resources.
- Able to provide advice to others in their practice on appropriate information sharing according to Caldicott principles.
- Able to give advice about safeguarding policy and legal frameworks.
- Able to support colleagues in the escalation process and in challenging views offered by other professionals, as appropriate.
- Able to establish safeguarding quality assurance measures and processes.

[19] RCGP Children's safeguarding toolkit, RCGP publications. 2021
[20] Laming Report, Protection of Children, Recommendation No 34: (paragraph 5.24), 2009

BII - PRIMARY HEALTHCARE PRACTICE STAFF
"Responsibilities of all staff"

"Safeguarding is everybody's business"

"Everyone in the practice team has a responsibility for safeguarding. Each practice staff member plays an important and crucial role and should …."

- Understand the principles of adult and child safeguarding that should also form part of core knowledge around safeguarding.
- Ensure all the safeguarding principles described within this handbook and all relevant policies are embedded within their daily functions and service areas.
- Understand the indicators of child and adults abuse and neglect and know how to raise a safeguarding concern.
- Know when and how to share this information with the Local Authority (LA) as a safeguarding referral.
- Ensure information sharing is always done in a timely and expeditious way, and where relevant, includes household members, in compliance with data sharing permissions as per the GMC, NMC and legal guidance.
- Ensure information sharing is provided in an appropriate and proportionate way.
- Participate in relevant training and maintain appropriate knowledge and skills in the identification and response to concerns of abuse against children or adults.
- Act in a timely manner on any concern or suspicion that a child or an adult is being or is at risk of being abused, neglected, or exploited and ensure that the situation is reported to the relevant authorities.
- Ensure that the practice team completes all relevant forms (e.g., Incident, Multi-agency referral form {MARF}; MASH forms; Child Protection conference; core group reporting; Looked after children (CLA) form; Child Death; Domestic Homicide reports; and analysis of significant events.
- Ensure they are aware of the essential supportive safeguarding guidance including:-
  - *GMC Guidance: Protecting children and young people: The responsibility of all doctors* [21]
  - *GMC Guidance: Adult safeguarding ethical hub 2024* [22]
  - *GMC Guidance: Good medical Practice 2024* [23]
  - *Information Commissioner's office (ICO): A 10 step guide to sharing information to safeguard children* [24]

[21] Protecting children and young people: The responsibility of all doctors: GMC, Jan 2018
[22] Adult safeguarding ethical hub, GMC, Jan 2024
[23] Good medical Practice: GMC, Jan 2024
[24] 10 step guide to sharing information to safeguard children, ICO, Jan 2023

BIII - SAFEGUARDING ARRANGEMENTS

"When it comes to safeguarding, it makes sense for the three boroughs to work closely in this way when we have knowledge and expertise that we can share to ensure that immediate steps are taken to protect and safeguard the young people and families at greatest risk".

Councillor Robert Benham,
Havering Cabinet member for Education, Children &n Families

- Following the Wood Report (2016) [25] and Under Working Together 2023 [26] guidance and the Children and Social Work Act 2017 [27] the local safeguarding arrangements have moved from Local Safeguarding Children Boards (LSCB) (as defined and set up through the Children Act 2004) to Local Safeguarding Partnerships (LSP) covering a range of safeguarding arrangements.

- From April 2020, revised safeguarding arrangements [28] established at Place Safeguarding Children Partnerships across NEL with an agreement between the three statutory agencies {the Local Authority; the NHS and the Metropolitan Police} to work together in exercising their functions for the purpose of safeguarding and promoting the welfare of children.

- From April 2022, each Local Authority area will hold direct responsibility for managing the way they approach their statutory safeguarding responsibilities through their LSP structures and processes. They will continue to work collaboratively across the NEL ICB footprint when it makes sense to do so.

- Local Child Safeguarding Practice Reviews (LCSPR) have replaced Serious Case Reviews (SCR) where some of the key differences will include the following: -
  - *15 Day rapid review form initial referral*
  - *Active GP participation in the process*
  - *Introduction of a national panel who will inform of all decisions following a rapid review and - commission national reviews from themes and trends identified.*
  - *Opportunity to undertake across the entire NEL footprint.*

[25] The Wood Report, Review of role & functions of local safeguarding boards, March 2016
[26] Working Together to Safeguard Children, HM Government, December 2023
[27] Children and Social Work Act, April 2017
[28] BHR Safeguarding Partnership, Multi-agency safeguarding arrangements 2019-20

SAFER STAFF RECRUITMENT & TRAINING

CI – EMPLOYMENT & SAFER RECRUITMENT

"GPs have an important role to play as employers in ensuring staff whom they employ are trained in safeguarding and promoting the welfare of children"

- Practices should have robust recruitment and vetting procedures in place for all staff working with children or who handle information about children, in line with the *NHS Employment Check Standards* [29] and other national and local guidance. The NHS Employment Check Standards cover the following areas:
  - *Verification of identity checks*
  - *Right to work checks*
  - *Registration and qualification checks*
  - *Employment history and reference checks*
  - *Criminal record checks*
  - *Occupational health checks*

- Recruitment and vetting procedures should apply to all staff working at practices whether permanent staff, staff on fixed-term contracts, temporary staff, volunteers, students, trainees, contractors, and highly mobile staff employed through an agency (locums). The recommended minimum for clinical and administrative staff includes: -
  - *Appropriate level of Disclosure & Barring Service (DBS) screen as outlined in the NHS Employers publication on Criminal Record Checks July 2010.*
  - *Two references (followed up).*
  - *Proof of identity- primary identification requires photographic identification e.g. current UK, EU and other nationalities passport (UK or overseas), UK Birth Certificate, marriage and civil partnership certificate if there has been a name change.*
  - *For clinical staff, proof of registration and where appropriate, indemnity cover.*

- It is the responsibility of the Practice to ensure that patients and their medical records are safe. The Care Quality Commission (CQC) requirements will likely identify standards related to employment.

- For those working consistently with children and young people it is considered ***good practice to recheck every 3 years***. This remains an organisational decision. [30]

- Employment checks also apply to GP locums who should also have up to date Enhanced DBS disclosure. This can be confirmed with the registered Performers' List.

- It is the responsibility of external contractors to perform DBS checks of their staff. It is advisable to seek confirmation of this with the contractor.

[29] NHS Employment Check Standards, 2015
[30] Ibid

CII – STAFF COMPETENCY FRAMEWORK

"Safeguarding competencies are the required set of abilities that enable staff to effectively safeguard, protect and promote the welfare of children and young people. They are a combination of skills, knowledge, attitudes and values that are required for safe and effective practice."

- All doctors and other practice staff working with children, parents, and other adults in contact with children should be able to recognise, and know how to act upon, signs that a child may be at risk of abuse or neglect, in a home environment, residential and other institutions. [31]
- Different staff groups require different levels of competence and in response to the Laming Report [32] and other evidence; there has been recognition of the importance of the level of competence of some practitioner groups, e.g., GPs and paediatricians.
- Competences should be reviewed annually as part of staff appraisal in conjunction with individual learning and development plan [33]

LEVEL	STAFF GROUPS
Level 1	Applies to the following staff (and equivalent roles): • Receptionists, administrative and secretarial staff (with the exception of manager/lead roles of these groups who will need Level 2) • Volunteer staff
Level 2	Applies to the following staff (and equivalent roles): • Practice managers (including deputy managers) and equivalent leadership roles [ALSO SEE ADDITIONAL REQUIREMENTS FOR THIS GROUP] • Care navigators • Reception managers • Safeguarding administrators • Managers/leads of administrative/secretarial teams • Health Care Assistants, Pharmacy technicians
Level 3	Applies to the following staff (and equivalent roles): • GPs, practice nurses, physician associates, pharmacists, paramedics, Advance Care Practitioners, Advance Nurse Practitioners, social prescribers, mental health workers, physiotherapists, podiatrists, dieticians, all ARRS (Additional Roles Reimbursement Scheme) roles • Primary Care Network (PCN) safeguarding roles in England such as PCN safeguarding co-ordinators • GP Trainees [who should refer to the specific safeguarding training requirements for the WBPA part of the MRCGP exams]

Level 4	**Named Professionals**
Level 5	**Designated Professionals**

[31] The Intercollegiate Document on Safeguarding Children and Young People: Roles and Competences for Healthcare Staff: January 2019 (4th Edition)
[32] Laming Report, Protection of Children, Progress report: 2009
[33] The RCGP Safeguarding Standards, October 2024

CIII – STAFF TRAINING & DEVELOPMENT

"GPs have an important role to play as employees in ensuring staff whom they employ are trained in safeguarding and promoting the welfare of children".

The updated Royal College of General Practitioner's (RCGP) safeguarding training guidance primarily focuses on Level 3 safeguarding training — which is the required level for GPs, Practice nurses and all other clinicians involved in assessing or managing safeguarding concerns.[34] The biggest change is from a time committed learning to a competency-based learning structure including structured reflection and real-world relevance. This is being encouraged across all levels, including Level 1 and Level 2, to improve overall safeguarding culture in healthcare.

Level 1 & 2 training can still be completed through e-learning or annual updates. The recommendation to incorporate competency-based elements may be incorporated gradually but are not yet mandatory.

Level 3 training now needs to include:-

- **Competency-based**, not hour-counting. This approach ensures that learning is relevant, role-specific, and focused on practical application in general practice settings.
- **Structured Reflection and Documentation**. Practitioners are encouraged to engage in structured reflective practice using tools like the RCGP Safeguarding Reflective Practice Template and the Safeguarding Case Review Template which both support ongoing learning and can be utilized for appraisal and revalidation purposes.
- **Annual Safeguarding Updates**
  - Requires documented reflection, learning logs, and demonstration of applied knowledge (e.g. safeguarding case discussions).
  - Encourages multi-agency, case-based, or in-practice learning.
  - Should include both children and adult safeguarding content.
  - A minimum of 3-yearly substantive training and annual updates.
  - Use of RCGP reflection templates or similar for appraisal evidence.
  - Role-specific training, covering a broad range of topics including child and adult safeguarding, transitional safeguarding, domestic abuse and lessons from local and national safeguarding reviews and cover emerging issues (e.g. online harms, contextual safeguarding)
  - Updates can be delivered through various formats, such as face-to-face sessions, virtual meetings, or recorded materials.
- **Enhanced Documentation Practices**
  - Emphasis is placed on the safe and accurate documentation of safeguarding concerns within patient records.
  - Practitioners should be aware of the challenges related to patient online access and implement strategies to mitigate risks, such as coercion to access records.
  - Understanding when and how to redact information in compliance with data protection legislation is crucial.

[34] The RCGP Safeguarding Standards, October 2024

- **Integration of Safeguarding into Daily Practice**
  - Safeguarding should be an integral part of daily practice, with regular discussions during team meetings and case reviews.
  - Engaging in multi-agency and multi-disciplinary learning enhances the effectiveness of safeguarding efforts.
- **Recording & reflection on Safeguarding Learning**
  - To align with the updated guidelines, practitioners should:
    - ❖ Utilize structured templates for documenting learning and reflections.
    - ❖ Maintain a log of safeguarding training activities, including dates, content covered, and reflections on learning outcomes.
    - ❖ Regularly review and update personal development plans to address identified safeguarding competencies.
- **Practice Safeguarding Team Meetings**
  - At least one multidisciplinary safeguarding meeting per year should be documented and reflected on. **It should ideally include:**
    - ❖ Named safeguarding lead for the practice (Clinical & Non-clinical)
    - ❖ GPs and nursing staff
    - ❖ ARRS staff connected / working for the practice
    - ❖ Practice manager and admin representatives (if appropriate)
    - ❖ Out of practice invitees (E.g. Health Visitors)
  - **The meeting should:**
    - ❖ Review recent safeguarding cases and significant events and reflect on lessons learned
    - ❖ Discuss any concerns about individuals or trends
    - ❖ Update on training needs or changes to protocols
    - ❖ Ensure all staff members know who to speak to if they are concerned a patient is at risk from significant harm, is being abused or neglected.
    - ❖ Ensure staff are aware of any updates to the practice policy as well as how to access it for reference
    - ❖ Look to discuss and record at least one clinical incident involving safeguarding children. [35] Staff should be encouraged to keep a log for their appraisal / personal development.
    - ❖ Enable Practice Safeguarding Leads to cascade any information received about Safeguarding Children to all relevant practice staff.

Why it Matters for Accreditation (RCGP & CQC):

- Demonstrates a whole-practice approach to safeguarding.
- Supports continuing professional development for Level 3 staff.
- Reinforces a culture of shared responsibility and early intervention.
- Can form part of Level 3 safeguarding training evidence, especially when combined with reflection.

Recording the Meeting:

- Maintain minutes or notes (stored securely and appropriately).
- Include an anonymised summary for reflection in CPD portfolios.
- Use the RCGP safeguarding reflection template or an in-house format.

The NHS Safeguarding App

- Free mobile application for healthcare professionals (also for the public too)
- Gives updated comprehensive safeguarding information, access to resources
- Local contact directory ***{Appendix C1}***

[35] Information Sharing. HM Government, May 2024

REGISTRATION

DI - SAFER REGISTRATION OF CHILDREN

"When children join the practice".

" All new practice child registrations should NOT be completed without seeing / meeting the child "

- All children that are registered with the practice should ideally have an adult with parental responsibility registered with them.
- When registering a family, the address of the household should ideally match exactly. This will allow all household members to appear together when electronically searched. (Consider linking each family member together)
- Child registration should NOT be declined even if there is no one with parental responsibility who can register. It is generally safer to register first and then seek advice from the Practice Safeguarding Lead / Practice Manager. This situation may alert you to a safeguarding issue e.g., private fostering arrangement, Looked after child. (CLA)
- There is no requirement to confirm the identity of people wanting to register with a practice. Practices should not turn people away if they do not have sufficient ID evidence available, for purposes of safeguarding children, it is important that every effort is made to confirm the identity of those registering the child and their relationship to that child. [36,37,38,39]
- As much information as possible about the child's household should be collected at registration. (Consider using genograms and especially enquire about father figures, 'missing men' from the family) Adults and older adolescents living with the child have an impact on the care of the child. [40]
- Document where the child attends school (or if home schooled) and any significant attendance issues.
- Past or current social care involvement for the child / family should be documented.
- Consider a separate 'New Patient Questionnaire' for children that cover all the above points. Consider scanning it onto the record once registered. ***{Appendix D1}***
- The Health Visitor should be informed of all newly registered children (all 5 years and below but potentially any children). Upon de-registration, Health Visitors should also be informed of any 'vulnerable children' leaving the practice. ***{Appendix D2}, {Appendix D3}***
- When children or adults de-register, it is advisable to check whether there are children at this address who remain registered. If so, this information should be flagged and passed to the attention of the Practice Safeguarding Lead.
- Consider a video / visual virtual consultation to see the children being registered when a F2F consultation is unlikely or not possible. No child should be formally registered without obtaining the assurance that they exist and live at the registered address.,
- Ensure any children who have been adopted have their records clearly updated using the agreed local processes and universally used Snomed codes. [41]

[36] General Medical Council (GMC) Guidance, Protecting children and Young People (0-18): Updated December 2024
[37] NCL ICB Safeguarding children policy & procedures. September 2022
[38] Serious Case Review J and L Executive Summary, London Borough of Lewisham, 2009: recommendation no.4.3.27
[39] NHS Lewisham Safeguarding Children Standards in General Practice. Dr. Chen
[40] Ibid
[41] Adopted children health record principles, NEL ICB, 2024

DII - REGISTRATION OF ADOPTED CHILDREN
"Health record principles"

- When a child is adopted, they are given a NEW NHS number. Their medical records should be merged to the new post adoptive details where possible across all health records [42]

- Merging records creates a continuous health record for the child, protecting their health and well-being, giving them the same rights to their medical history as all children, supporting better efficiency in the health system

Key principles for ensuring continuous health records of adopted children

- The child's clinical health records may remain intact and continuous after the adoption order has been granted
- Only accurate current demographics can be viewed or used by the administration personnel or medical professionals or patients or carers
- Any information relating to the identity or whereabouts of the birth parents should not be included in the new record.
- Information governance and data principles must be enhanced to prevent any accidental disclosure or addresses of authored party information contained in the record
- A Reminder should be used on the record to highlight the sensitivity of the record
- The GP remains the data controller with regards to the child's medical record and as such the process of merging records relies on good communication between primary care the local looked after health/ adoption team and other stakeholders including the local child health information service team
- Subject access requests must be handled by NHS provider medico-legal teams with advice from the Designated Looked After Child professional and or adoption medical staff.
- Use the Universal Standard SNOMED CT codes including
    - Record contains third party information (finding), SCTID
    - 888931000000108; Adopted child (person), SCTID: 392547004

[42] Adopted children health record principles, NEL ICB, 2024

DIII – NAME / GENDER CHANGE REQUESTS IN A TRANS YOUNG PERSON

1. Respect and Affirm the Young Person's Identity

- Use the name and pronouns they request, regardless of legal status.
- Ensure all team members do the same, including reception staff.

2. Name Change on Medical Records

- A patient (or their parent/guardian if under 16 and not Gillick competent) can request a name change without legal documentation.
- Practices should update the patient's "preferred name" field in their record (EMIS/SystemOne) and use it in all non-legal correspondence.

3. Changing Gender Marker (Sex Field)

- This is a legal change in NHS records that requires a formal request.
- NHS Digital allows a gender marker change without a Gender Recognition Certificate if:
  - The patient (or their guardian) submits a written request, including:
    - New name, affirmed gender (Male/Female) & confirmation of intent to live in that gender
  - Often accompanied by a deed poll or letter from a clinician (not strictly required but helpful).

4. NHS Number and Record Splitting

- Changing the gender marker in the NHS Spine automatically generates a new NHS number.
- A new GP medical record is created, and the old record is archived but not deleted.
- This can result in:
  - Loss of continuity in medical history (e.g. immunisations, safeguarding flags).
  - Risk of duplicate records or missed clinical alerts.

5. Risks and Safeguards

- GP should inform the young person (and their guardian, if appropriate) of the implications:
  - Historical records won't transfer automatically (manual reconciliation may be needed).
  - Important safeguarding, allergy, or risk data must be manually copied over.
- Practices should code and document the identity history carefully and confidentially.
- Maintain confidentiality around gender history—this is sensitive personal data under GDPR.

6. Clinical Systems Action [43]

- Flag for the admin team to:
  - Inform NHS Spine (via PCSE or CCG if needed)
  - Update EMIS/SystemOne demographics
  - Create safe alerts to re-link safeguarding info
  - Ensure repeat prescriptions and alerts are correctly re-entered

7. Age and Competence [44]

- Young people aged 16 and over are presumed competent to request name and gender changes.
- Under 16s can do so if Gillick competent; otherwise, parents or guardians must request it.

8. Legal & Ethical Frameworks

- Equality Act 2010: Gender reassignment is a protected characteristic.
- GMC Guidance: Respecting patients' wishes around identity is part of good care. [45]
- NHS Digital Guidelines: Manage gender changes securely and sensitively.

[43] NHS Digital, Changing Gender in the NHS
[44] RCGP Trans Care eLearning
[45] GMC - Trans Healthcare Guidance

DIV – SURROGACY, LEGAL PARENTHOOD & NEWBORN CARE

1. Legal Registration and Parenthood in Surrogacy

- At birth, the surrogate mother is always the legal mother.
- If she is married or in a civil partnership, her spouse or civil partner is also considered a legal parent unless it is proven they did not consent to the surrogacy.
- To transfer legal parenthood to the intended parents, a Parental Order must be obtained through the Family Court.
- This application should be made within 6 months of the child's birth, though late applications may be considered.
- Once granted, a new birth certificate is issued naming the intended parents as the legal parents.

Legal Parent Status at Each Stage

Stage	Legal Parents	Key Action
At Birth	Surrogate (and possibly spouse)	Registered by surrogate
Post-Birth, Pre-Order	Surrogate remains legal parent	Consent cannot be given by intended parents
After Parental Order	Intended parents	New birth certificate issued
No Parental Order	Surrogate remains legal parent	Consider adoption process

2. Newborn Vaccinations and Consent

- Until a Parental Order is granted, only the surrogate (and her spouse, if applicable) can legally provide consent for medical procedures, including routine immunisations.
- Intended parents do not automatically hold parental responsibility.
- If the surrogate is unavailable, practices may accept a written delegation of authority, provided it clearly names the intended parents and the procedures consented to.
- In urgent medical cases, practitioners should act in the best interests of the child and document decisions carefully.

Consent Scenarios for Newborn Vaccinations

Scenario	Who Can Consent	Recommended Action
Surrogate present	Surrogate (legal mother)	Seek written/verbal consent
Surrogate absent, no court order	No legal PR by intended parents	Seek written delegation from surrogate
Parental Order granted	Intended parents	Consent as usual
Urgent care required	Clinician (best interests)	Proceed with treatment, document, and follow up

3. Safeguarding and Clinical Best Practice

- Clearly flag the legal status of the child in clinical systems.
- Document who holds parental responsibility and how consent has been obtained.
- Consult your Named GP for Safeguarding Children for advice in complex cases.
- Ensure a Parental Order is followed up within 6 months to secure legal clarity.
- Coordinate with CAFCASS or legal representatives where applicable.

DV – DE-REGISTRATION

"of Children, Young People (CYP) & Vulnerable Adults"

Whilst there are valid operational reasons for removing a patient from a GP list, vulnerable adults must not be removed using standard deregistration pathways without additional safeguards. This includes those who have not attended the practice for a significant period.

1: Common Grounds for Deregistration

Patients may be removed from a GP list in several circumstances:

- Patient-Initiated: A patient voluntarily registers with a different GP
- Practice-Initiated: Typically for:
    - Irretrievable breakdown in the doctor–patient relationship
    - Immediate risk (e.g., violence) triggering referral to the Special Allocation Scheme (SAS)
    - List maintenance, where patients are removed due to:
        - Prolonged non-attendance
        - Returned mail (e.g., "no longer at this address")
        - Lack of response to contact attempts.
- In most cases, NHS rules require that the patient be notified in writing and given 8–14 days' notice, unless immediate removal is justified.

2: Specific Safeguarding Concerns

Standard deregistration protocols are inadequate for some groups.

- Children, particularly those who are vulnerable or have safeguarding concerns, must not be removed from a GP list using standard deregistration protocols without careful consideration.
- Several Local Child Safeguarding Practice Reviews (LCSPRs) have identified risks where vulnerable children were deregistered before appropriate re-registration or follow-up was confirmed.
- Where a child has not attended or where mail is returned, it should not be assumed that they have moved or no longer require care.
- Practices must make proactive efforts to confirm the child's status and maintain safe continuity of care.
- Vulnerable adults, those with mental health needs, cognitive impairment, substance misuse, or social exclusion may not:
    - Understand or open formal correspondence
    - Be aware that they have been removed
    - Know how to re-register elsewhere
    - Have capacity or support to seek medical care independently.

This is particularly dangerous where removal is triggered by lack of attendance, as absence from services may reflect deeper safeguarding concerns including and self-neglect, abuse, coercion, or social isolation.

There are risks associated with the consequences of deregistration without safeguarding consideration—resulting in a prolonged period without medical oversight.

3: Safeguarding Pathway for Children

- Do not deregister a child until confirmed they have registered with another GP.
- If unable to reach the family, contact the Health Visitor for children under 5 years of age. ***{Appendix D3}***
- Check for vulnerability codes, child protection plans, or looked-after child status.
- Contact other known professionals involved (e.g., social workers, school nurses).
- Escalate to the safeguarding lead GP for advice before any list maintenance removal.
- Document all actions and discussions clearly.

4: Safeguarding Pathway for vulnerable adults

Before initiating removal for non-attendance or returned post, practices should:

A. Check for vulnerability indicators

- Review patient notes for safeguarding codes, alerts, social care involvement, or mental health conditions
- Consider whether removal must occur – flag to your safeguarding lead GP.

B. Attempt direct contact using alternative methods

- Phone call, text message, or home visit (if appropriate)
- Contact next of kin, carers, or key workers
- Inform the relevant social worker or adult social care team.

C. Multi-agency communication

- If the patient is under care of a community or mental health team , social care or health visitor / school health liaise with them prior to removal

D. Avoid removal until re-registration is confirmed

- If the patient is genuinely relocating, assist with transition.
- If vulnerable and not engaging, consider whether this is a safeguarding issue that requires escalation.
- Non engagement with health could be a sign of neglect or self-neglect and a referral to social care may be required.

E. Document all efforts and decisions clearly

- Record contact attempts, discussions with professionals, and rationale for decisions.

5: Policy Recommendations

Practices should have clear internal procedures that:

- Flag patients for review before removal if the reason is non-attendance or returned mail
- Include safeguarding leads in the decision-making process for all patients with known or suspected vulnerabilities.
- Require confirmation of successful re-registration or alternative care arrangements prior to removal.
- Promote staff awareness of the risk of inadvertently leaving a child / vulnerable adult without healthcare access.

RECORD KEEPING

EI – SAFEGUARDING KEY PRINCIPLES

"Concerns about a child's welfare should always be recorded whether or not further action is taken".

- Clinicians should be aware of their responsibility to keep legible, comprehensive, accurate and, where possible, contemporaneous record-keeping. [46] [47]
- Consider documenting any concern (whether taken further or not) using appropriate coding. All relevant practice staff should be aware of the recommended list of Safeguarding Children codes and use it consistently.
- Many Children Safeguarding Practice Reviews (CSPRs) (previously Serious Case Reviews) recommend better record keeping in Primary Care
- When dealing with safeguarding issues, clear, accurate, comprehensive, and contemporaneous notes are essential. Where action is required, one should include a plan of care identifying who has responsibility.
- A comprehensive and accurate record will help practitioners when the patient's care is scrutinised for whatever reason. Any discussions about a child's welfare should be recorded including telephone conversations, any decisions that are made, and the reasons behind the decisions.
- Notes should clearly show the difference between information given by the child or carers, clinical observations, and any subsequent interpretation or assessment of the situation.
- When an A&E letter about a child is received (particularly if it is about an injury), an untoward event; A child 'DNA from a medical appointment ***{Appendix D1}*** ***{Appendix E2}***; a notification/disclosure of DVA within the family, it is good practice to record the incident and review the child's record for safeguarding issues.[48]
- Information should be included in the medical records about any adult in contact with a child with a risk factor for child abuse. For example, the presence of severe long-term mental illness, drug and alcohol dependence, domestic violence or a forensic history should alert the clinician to enquire about dependent children in the household.
- Recording any shared information within the Primary Health Care team (PHCT) is also advisable e.g., Health Visitors for Under 5-year-olds.
- The Practice Safeguarding Lead should review all records with Safeguarding Children coding on a regular / systematic basis to review safeguarding issues.
- The relationship and identity of any accompanying person with the child in a consultation should be recorded. [49] ***(e.g., "Attended with father / mother / parents / on own etc....")***
- Any adult with parental responsibility giving consent for immunisations, procedures or intimate examinations in a consultation should be recorded, to include their name and relationship to the child. [50] [51]

[46] Laming Report, Protection of Children, 2009. Updated summary May 2025
[47] General Medical Council (GMC) Guidance, Protecting children and Young People (0-18): Updated December 2024
[48] Documenting Safeguarding concerns, Oxfordshire CCG. Feb 2019
[49] GMC, Good Medical Practice, Updated 2024
[50] Ibid
[51] Serious Case Review J and L Executive Summary, London Borough of Lewisham, 2009: recommendation no.4.3.27

EII – CYP PATHWAY & PROCESSES

"Concerns about a child's welfare should always be recorded whether or not further action is taken".

- The full set of child protection conference reports should be scanned into <u>all affected children's records and parents' or carers' records</u>, under appropriate coding.
- These reports should be printed out from the e-record and included in the paper record when notes are transferred to the new practice. [52]
- The Practice should have a method of identifying records in which there are child protection conference reports as there will be third party information present which will need to be removed if the record is requested by the patient. Using recommended Safeguarding READ codes should help this process.
- It is a CQC requirement that GP practices should have and operate a children's 'was not brought' (WNB) or 'Did not arrive' (DNA) policy. A North-East London wide policy [53] has been formulated for consideration and sets out a method of highlighting communications which indicate a child has not attended practice or hospital based, specialist review, immunisations or other follow-up and have a system of follow-up. [54,55]
- The Practice should have a method of reviewing communications from A&E / Urgent Care Centres (UCC) from a safeguarding perspective.

Recording Case Conference Minutes in General Practice Records [56]				
	Scan in full minutes [a]	Scan in a summary (if available)	Code significant details	Date of destruction of entered information [b]
Child(ren)	**Yes**	**Yes**	**Yes**	*Full minutes and summary at age 26, but read coding to remain in medical record*
Other children *('Connected' but not subject of conference)*	**No** [c]	**Yes**	**Yes**	
Adults named in report	**No** [c]	**Yes**	**Yes**	*Full minutes and summary when 'index' child reaches 26, but read coding to remain in medical record*
[a] *destroy the hard copy once it has been scanned in – do not store separately*				
[b] *in line with* Records Management: NHS Code of Practice Part 2 *Annex D1 p11*				
[c] *note sufficient social care case number and contact details in the electronic record, so that original full report could be requested from sender if required*				

N.B. The guidance on destroying scanned child protection conference notes is a <u>recommendation</u>.

[52] Ibid
[53] NEL-ICB Was not Brought Policy, 2023
[54] Section 19.3, All London Safeguarding Procedures, 6th Edition, 2020
[55] Children Act 1989 / 2004, HM Government
[56] Ibid

EIII – "WAS NOT BROUGHT"
"in Vulnerable adults"

"The pathway to protection begins when someone chooses not to look away".

In paediatrics, a missed appointment is framed as the child having been 'was not brought', recognising that children depend on adults to access care. A similar principle should apply to vulnerable adults who may face significant barriers in attending appointments and managing their healthcare independently. These risks are often best realised by reception teams and they should be trained to recognize and escalate concerns.

Understanding the Risks

- When a vulnerable adult does not attend a GP appointment, this may reflect more than disengagement.
- It can be an indicator of self-neglect, cognitive decline, mental health deterioration, or drug or alcohol dependency
- Unlike in children's safeguarding, adult services may not routinely escalate or investigate missed appointments, leaving at-risk individuals without support.

Recommended Practice for GP Surgeries

- Administrative staff should check for safeguarding or vulnerability flags on record when an adult fails to attend an appointment or reply to screening or text messages requesting to call for an appointment etc.
- If this is a pattern this should be highlighted to the safeguarding lead.
- Avoid assuming non-attendance is a patient choice; consider capacity, access, and safeguarding issues.
- Review patterns of non-attendance and triangulate with social care, community, or mental health involvement.
- Do not rely solely on text message reminders – consider phone calls or known points of contact.
- Reach out to a patient's wider support network where appropriate, such as:
    - *Next of kin*
    - *Carers or advocates*
    - *Social worker or mental health team*
    - *Supported living providers or care agencies*
- Consider if a safeguarding referral or welfare check is indicated after persistent non-attendance.

Reasonable Adjustments to Support Access

- It is prudent to record reasonable adjustments on their health record to help ensure practice messages get through.
- This cohort tend not to be able to engage with batch text messaging for example. Digital exclusion should also be considered.

Summary

- Missed appointments by vulnerable adults should trigger reflection rather than routine discharge or inaction.
- Health services should actively identify barriers, make reasonable adjustments, and involve wider support systems.
- This approach reduces the risk of harm through unmet health needs, undetected self-neglect, or safeguarding concerns.
- ***{Appendix E1}*** ***{Appendix E2}*** provide algorithms for managing missed GP and hospital appointments and ***{Appendix E3}*** provides a checklist for managing vulnerable adults who were not brought to an appoinbtment

INFORMATION SHARING

FI – SHARING CONCERNS / COMMUNICATION

" Some children have come to harm due to a lack of information sharing whilst NONE have been harmed because of it "

Sharing Concerns & Communication

One of the most difficult dilemmas for any doctor who thinks a child may be neglected or abused is whether to disclose confidential information and to whom.

GPs have a duty of care to act on any concerns they have that a child is at risk.

- Sharing information is vital to build up a picture of a child and family and this is necessary to support a family as well as safeguard the child.
- Get support from local colleagues to discuss a concern, such as"
    - *Practice Safeguarding Leads*
    - *Senior Partner / Trainer in the practice*
    - *Named GP for Children's Safeguarding*
    - *PCN Safeguarding Co-ordinator*
    - *Caldicott Guardian*
    - *Local Medical Defence Organisation*
- Verbal communication is as important as written communication, but all conversations should be recorded carefully and contemporaneously in the medical records afterwards.
- GPs are often concerned that they are raising valid concerns to the appropriate agency. GMC guidance acknowledges and assures doctors that acting upon concerns will be justified 'even if it turns out that the child isn't being neglected or abused' if the concerns were honestly held and reasonable and that they acted through official channels. [57]
- GPs have a **statutory duty** to co-operate with other agencies if there are concerns about a child's safety or welfare. Many serious case reviews recommend improved communication between and within agencies. [58, 59]
- All clinical staff should be aware of how and when to refer to the LA Children's Social Care and when to expect feedback from their referral. [60]
- Use appropriate channels to raise concerns, e.g., the local safeguarding designated or named staff and children's social care pathways.
- **Follow the 'Seven Rules Of Information Sharing' *{Appendix F1}* and the 8 Caldicott Principles *{Appendix F2}* consider using a flowchart to support your decision making {Appendix F3}. All designed to support responsible and lawful information sharing.**

[57] General Medical Council (GMC) Guidance, Protecting children and Young People (0-18): Updated December 2024
[58] Ibid
[59] Beyond Blame: Child abuse tragedies revisited. Reder, Duncan, and Gray, 1993. Routledge
[60] London Child Protection procedures, 6th Edition, 2020, Section 2.1.2

FII – PUBLIC INTEREST

"Disclosing confidential information may be justified in the public interest if failure to do so may expose others to a risk of death or serious harm"

GMC (2023)

Public Interest

In Health and Safeguarding, Public Interest overrides consent only when the benefit of sharing clearly outweighs the individual's right to confidentiality. In practical terms, this means sharing confidential information without consent would be justified when it:-

- Protects an individual from serious harm or abuse
  - *E.g. Child Abuse, Domestic Violence and Abuse, Suicide isk*
- Protects others from harm
  - *E.g. Disclosing risk posed by a dangerous parent to another child*
- Prevents or detects serious crime
  - *E.g. Sexual Exploitation, Grooming, Human Trafficking*
- Promotes safeguarding and welfare of vulnerable individuals
  - *E.g. a child or adult at risk*
- Maintains public confidence in services
  - *E.g. Responding to systemic failings or CSPR findings / recommendations*

Public Interest has legal and professional backing through

- **Data Protection Act 2018** (allows sharing without consent where it is necessary for reasons of substantial public interest) [61]
- **GMC Guidance** (Doctors may disclose information without consent if the benefits to an individual or society outweigh the public and the patient's interest in keeping the information confidential) [62]
- **Caldicott Principle 8** (The duty to share information can be as important as the duty to protect patient confidentiality). ***{Appendix F2}*** [63]

Practical Examples	Is it in the Public Interest to share without consent ?
A child discloses sexual abuse but begs the GP not to tell anyone	Yes, to protect the child from ongoing harm
A concern that a child with bruising maybe experiencing physical abuse at home	Yes, to protect the child from ongoing harm
A parent refuses to consent to share records during a formal Sx 47 SG enquiry	Yes, if the child is at risk
A patient threatens serious harm to another person	Yes, to prevent a crime and protect the victim
A patient discloses a minor theft with no harm involved	Likely No – not serious enough to override consent

[61] Data Protection Act, 2018
[62] General Medical Council (GMC) Guidance, Protecting children and Young People (0-18): Updated December 2024
[63] Manual for Caldicott Guardians. HM Gov, 2017

FIII - CONSENT

"Consent is Fundamental but NOT absolute"

Consent

In General Practice, consent issues can be complex especially when you are asked to share information about a child for a safeguarding enquiry. Several factors need to be considered including the GPs duty of confidentiality, legal considerations, the level of evidenced risk / potential harm and the expected prompt and timely response back to the requesting agency.

Is consent always required?

- **No – not always**. However there maybe compelling reasons not to get consent, or consent may not be possible and the potential harm of not gaining consent will need to be evaluated and weighed up. [64]
- Whilst consent should ideally be sought to share information, you do **NOT** need consent to share information if:
  - ***There is a child protection concern (e.g. a risk of significant harm)***
  - ***It is required by Law / Statute / Court Order***
  - ***It is in the public interest to protect the child***
- This applies even if the parent or the child refuses to give consent.
- The child's interests should always take precedence over the parents or carers (even if this discloses information without consent being sought) [65]
- The following requests do NOT require consent

Enquiry / Request	Public Interest	Legal Basis
MASH Enquiry	Yes	Working Together 2018
Child Protection, Section 47	Yes	Children Act 1989, Section 47
Rapid Review Information Request	Yes	Children & Social Work Act 2017
Death Overview Panel Requests	Yes	Children Act 2004, Section 16Q
Court Order (Family or Criminal)		Children Act, Section 31

When should you seek consent?

- If it is safe to do so and will not place the child at further risk
- There is no immediate child protection concern
- The enquiry is more =general or for early help purposes
  - E.g. A Section 17, 'Child in Need' enquiry
  - E.g. A single health assessment enquiry (even if marked 'urgent')
- Always make legible, contemporaneous notes including if consent was obtained, and if not, why not.

[64] General Medical Council (GMC) Guidance, Protecting children and Young People (0-18): Updated December 2024
[65] Ibid

FIV – POLICY & PROCESS

> ***"The most important consideration is whether sharing information is likely to support the safeguarding and protection of a child"***
>
> HM Government Information Sharing, 2018

Policy & Process

- The practice should have a current safeguarding policy and procedures in place and ensure all staff has access to it. [66, 67, 68, 69]
- The practice should have a clear policy on handling requests to share information on vulnerable children from external agencies. All requests for information should be treated as a priority with the aim to respond **within 48 hours if possible**.
- The practice should inform their practice population of their Information Sharing policy with regards to Safeguarding Children *(e.g., via practice leaflet, posters, website, at registration).*
- Information shared needs to be factual and not based on opinion.
- Information sharing needs to be shared securely where at all possible. (No faxes)
- You would need a very good reason NOT to information share when so requested.
- Primary Care should have systems in place for sharing information about vulnerable children with others (e.g., Health Visitors, Children's Social Care, school, or LAC nurses). This should include a process for managing children who are 'not brought to appointments.'
  {Appendices D2, D3, E1 & E2}
- The practice should also consider sharing appropriate and relevant information to GP OOH / 111 services including other local providers of unscheduled care such as hubs, extended hours providers to triangulate robust information sharing.
- BHR and the Local Authorities are assisting the process by sending templated letters to practices setting out clear reasons and circumstances for the request to share information and also clarifying issues concerning consent.
- The principles of information sharing with relation to the GDPR and Data Protection Act [70] will aid practitioners in deciding when and how to share relevant information. [71]
- Always consider using the **'Seven Golden Rules'** ***{Appendix F1}*** and the **'Eight Caldicot Principle'** guidelines ***{Appendix F2}*** to assist appropriate, proportionate, adequate, accurate and relevant information sharing. [72]

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66 GDPR & Data Protection Act 2018
67 Information Sharing. HM Government, May 2024
68 BMA Child Protection Toolkit, April 2009
69 Safeguarding Children & Young People in General Practice: A Toolkit; RCGP, 2024
70 GDPR & Data Protection Act 2018
71 Information Sharing. HM Government, May 2024
72 Manual for Caldicott Guardians. HM Gov, 2017

FV – TIMELINESS, MEETINGS & RENUMERATION

"You would need a very good reason NOT to share information when requested to do so".

Timeliness

- Nationally, practices remain slow at responding to such requests, many not responding at all.
- Information should be shared in a timely fashion to reduce the risk of missed opportunities to support and protect children. (Ideally within 1-2 working days)
- Timeliness is key in emergencies, and it may not be appropriate to seek consent for information sharing if it causes delays and places a child or young person at increased risk of harm.
- Any delay in sharing information with an appropriate agency where a child or young person is at risk of, or is suffering, abuse or neglect needs to be justified and duly recorded. [73]

Safeguarding meetings

- It remains good practice for GPs to convene 'in-house' Safeguarding meetings to ensure that all relevant staff get the opportunity to 'information share' and / or raise concerns as felt appropriate on families / children of concern / increasing vulnerability.
- Extended members of the Primary Health Care Team (e.g., Health Visitors, Midwives, School Nurses) should be involved and invited to attend these meetings.
- Guidance is available to support the setting up and ongoing running of MDT in-house meetings. [74]

Renumeration

- The British Medical Association {BMA} and the General Practitioner Committee {GPC} recognise these requests in the same way as other third-party information requests, lying outside of core General Medical Services {GMS} provision, and therefore eligible for a fee.
- NEL ICB have a Safeguarding reporting Local incentive Scheme (LIS) to support timely and quality reporting by practices.
- Payments to the value of £90 an hour (pro rata) can be claimed for quality and timely report provision to CSC for any safeguarding related report request (including MASH enquiries, single health assessment enquiries, child in need (Section 17) and child protection pathways (Section 47).
- Practice sign-up and engagement with the LIS remains optional.
- Failure to receive a payment is not considered a defensible reason by the General Medical Council to either delay or not share information requested or provide a report. [75]

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[73] Children and Social Work Act, April 2017
[74] Guidelines for Vulnerable child MDT Meetings, Newham CCG Safeguarding Team, v4, Jan 2022
[75] Laming Report, Protection of Children, 2009. Updated summary May 2025

FVI – REPORTING TO OTHER AGENCIES

"GPs have key roles in appropriate information sharing with children's social care when enquiries are being made about a child "

The request

Step	***Verification / Comments***
1. Confirm Authenticity	*Needs to be in writing.* *Clear reasons given to be able to information share.* *{Local Authority Template being developed to assist this}*
2. Confirm Information	*Do you hold any relevant information?* *Check Lloyd George notes and IT record*
3. Consider Caldicott Principles of Information Sharing **{Appendix F}**	*Open & Honest* *Data Protection Act is no barrier.* *Proportionality* *Seek advice if unsure.* *Consider consent.* *Consider safety and wellbeing.* *Document*
4. Act seriously & quickly	*Delays could increase harm and undermine efforts to protect* [76] *Aim to appropriately provide / share within 1-2 working days*
5. Co-operate for other formal requests	*e.g., for SCR requests; e-CDOP forms; MAPPA requests; SG Audit*

Preparing the report

- When preparing a report, check the notes of the patient and any associated and known members of the family.
- Consider other patients currently registered at the same address.
- A local template (also being used in other areas nationally) is being piloted to help GPs produce a time efficient, IT/PC friendly and information appropriate report for safeguarding requests. ***{Appendix F4}*** **&** ***{Appendix F5}***

Feedback / outcome

- Ideally children's social care (CSC) would feedback outcomes from information sharing within days of the initial contact. Nationally, this rarely happens.
- Good practice would suggest practices diarise a contact with CSC within 2-4 weeks after sending the original report to get formal (written) feedback (or take to any MDT meetings with the Health Visitors, if so held).
- Any feedback needs to be noted and documented accordingly.
- This can be done by administrative practice support if so organised.

[76] General Medical Council (GMC) Guidance, Protecting children and Young People (0-18): Updated December 2024: P14, 39-41

FVII – GDPR AND INFORMATION SHARING

- The principles of information sharing with relation to the Data Protection Act and GDPR assist practitioners in deciding when and how to share relevant information.
- They are NOT barriers to share safeguarding information.
- The GDPR and Data Protection Act 2018 replace the Data Protection Act 1998 with an updated and strengthened data protection framework. However, the key principles of the original Act remain unchanged.

Key changes for GPs under GDPR

Compliance must be actively demonstrated, for example it will be necessary to:

- *keep and maintain up-to-date records of the data flows from the practice and the legal basis for these flows; and*
- *have data protection policies and procedures in place.*
- *provide more information required in 'privacy notices' for patients.*
- *follow a legal requirement to report certain data breaches.*
- *be aware of significantly increased financial penalties for breaches as well as non-compliance.*
- *practices will not be able to charge patients for access to medical records (save in exceptional / repeat request circumstances).*
- *have Data Protection Officers*
- *have 'GPs as data controllers under the General Data Protection Regulation' (useful further summary information published in 2018 by BMA)* [77]

[77] GPs as data controllers under GDPR, BMA. Sept 2024.

FVIII – ONLINE ACCESS TO RECORDS

Benefits of Online Access to patients

"Patients now have access to their full online record".

- *Improved transparency of records, including factual robustness*
- *Increased patients' involvement in their own health / treatment plans, sharing responsibility.*
- *Patients being better informed of health conditions and more timely access to health information.*
- *Potential reduction of clinical appointments to gain information.*

Accelerated Online Access to patients

From November 2022, patients with online accounts such as through the NHS App are able to read new entries in their health records. This applies to patients whose practices use the TPP and EMIS systems. Arrangements with practices which use Vision as the clinical system are under discussion. This is an NHS England programme supported by NHSX and NHS Digital.

Will patients automatically see all new information about them?

Patients will only see their information once it has been checked and entered, or filed, onto the GP practice clinical system. This means general practice staff will continue to be able to prevent patients from seeing any sensitive information before patients can see it. General practice will also be able to remove access for the very small number of exceptional circumstances where access is inappropriate, considered harmful or where there may be safeguarding concerns. These changes only apply to a patient's general practice record. Other health services records will not be visible to patients. Even if other services use the same clinical system, information will not be viewable by the patient, unless it has been filed into the general practice record.

Impact on general practice

GPs / practices will need to consider the impact of each entry made in the electronic medical record (EMR), including scanned documents and test results, as and when they are added. Patients will not see personal information – such as positive test results – until they have been checked and filed, giving GPs the chance to contact and speak to patients first.

What general practice staff should know?

General practice staff should:

- be aware that patients will be able to see their future records.
- know how to manage this as a change to your workflow - ensuring sensitive information is redacted as it is entered onto the clinical system, or in rare circumstances know when it may be inappropriate to give a patient access to their record.

General practice as the sole data controller

These changes will not change the status of general practice as a data controller. General practice decides on what information is made available to patients, either as it is being entered onto the clinical system, or by reviewing and responding to digital requests for historic coded data. No data is made automatically available without being entered by general practice.

Updates to the general practice Data Protection Impact Assessment

For the provision of access to future information, patients will access the same personal information as they do under current arrangements, via the NHS App and other existing record access apps. There is no change to the category of personal information being processed, the organisations involved or how that information is being processed and secured. As data controllers, each general practice should make an individual assessment of whether their Data Protection Impact Assessment (DPIA) needs to be reviewed and updated.

Patients understanding their medical records

There is an existing professional responsibility to ensure that records are legible, and patients understand and are informed about the care that is being provided. Clinicians need to write notes bearing in mind that patients may see them. Within the NHS App there is currently a 'help with abbreviations section' that supports users with abbreviations commonly found in medical records.

Traditionally, patient encounters with primary care have been face-to-face and over the telephone. Online access to medical records gives patients an avenue to further manage their health. Systems currently allow patients to book appointments, order repeat medications and review their summary medical information and Read coded information online. This provides a convenient and responsive service for patients, families and their carers.

Patients will have access to prospective online records

- ***"All patients will have online access to their prospective record**, including the ability to add their own information, as the default position **from April 2022**, this remains subject to existing safeguards for vulnerable groups and 3rd party confidentiality and system functionality."*

- *Access to their full record will be for prospective information only. It will be a default opt-in position. Practically this means:* ***Online appointments, prescriptions, all consultation notes including Read Codes (or SNOWMED codes), pathology results, referrals, letters, communications, and attachments.***

- *It is important to note that there is provision within the contract for the practice to not offer online services if inappropriate for the patient. Also, regardless of what is enabled at a system level it is still possible and appropriate to tailor access to individual patients.*

Patient access to past or historic records

Patient access to their historic information is not included in the accelerating patient access. Patients who already have access to their historic, or past, health records will maintain this access - nothing will change for them. Patients wishing to view historic records need to apply to their practices and decisions made on a case-by-case basis.

FIX – ACCESSING RECORDS: PITFALLS

Online Access - Potential Pitfalls

- Such access for a minority of patients does pose a potential safeguarding risk.
- RCGP and NHSE have highlighted that practices need to be mindful when granting online access to patients of potential areas of risk which include:

a. *Mistaken Patient Identification (ID)*

- GPs are responsible for data protection & Patient ID verification. Prior to granting online access practices can verify a patient's ID in 3 ways
    - *By an authorised member of staff if patient is well known to the practice.*
    - *By an authorized member of staff with reference questions i.e. DOB, patients address*
    - *Verification with 2 documents i.e., passport, bank statement, driving license. Practices are recommended not to scan into the record, just note that staff has seen it.*
- It is recommended that practices have a Patient IT lead (i.e. Caldicott Guardian) and a verification protocol / guideline to follow.

b. *Coercion*

- Practices need to be mindful that vulnerable patients may be at risk of allowing online access to their medical records/ information to a third party through coercion. If clinicians consider that it is in the patients' best interest to restrict online access to information, they have the right to refuse access / restricted access settings. It is recommended that this should be explained by a GP during an appointment and reasons evidenced within the record.
- Potential patient groups vulnerable to coercion include:
    - *Victims of Domestic Violence and Abuse (DVA)*
    - *Patients with learning disabilities / reduced mental capacity.*
    - *Children*

c. *Proxy Access*

- This is when individual/s acting on behalf of a patient is given access to their online medical record E.g. through the NHS App or a GP Practice portal. Proxy Access may include the ability to:-
    - *View appointments, test results and medical history*
    - *Order repeat prescriptions*
    - *Message the surgery*
- **In the case of a child, the proxy is usually the parent, guardian or a carer**
    - *Younger children (aged 0-10): Parents typically have full access*
    - *Older children (aged 11-15): Access becomes more restricted as the child generally gains rights to confidentiality (assessed via Gillick Competence)*
    - *Teenagers (16+) are assumed to have full rights to their records; proxy access requires their consent*
- Formal access through surgery: The individual who is granted proxy access has their own login details; they do not have to be a registered patient at the surgery.
- Informal access: Patient shares their log in details with another – this is not recommended.
- Proxy access should not inhibit proper and full recording within the medical record.

d. *Data Breaches*

- With all the pitfalls and nuances of providing access, accepting proxy access etc, t is inevitable that errors and data breaches will occur in the access and sharing of otherwise confidential medical / sensitive information. Use the following link to report such data breaches especially when they have safeguarding implications: Data Access Breach

FX – SAFEGUARDING ACCESS CONSIDERATIONS

Contextual relevance

- In cases where a parent may pose a risk to the child or if the child needs to discuss sensitive issues, (E.g. abuse, mental health, contraception) proxy access can compromise their safety and privacy if not carefully managed.
- Children from age of 11 can have capacity.
- NHSE and RCGP recommend any proxy access is routinely removed for children between the ages of 11 and 16 years (can be set at 'practice level') and only reinstated on a case-by-case basis.
- The identity of parent requesting / gaining electronic access (for all children) should be recorded within the child's record.
- Delegated authority may state that foster carers can have electronic access to their foster children's records – this would need to be confirmed with the Looked After Child's allocated Social Worker.
- Caution should be exercised if the child's record details history of abuse or coercion of the child or 3rd party information. Practices should consider refusing online access as access to this information could be damaging to both children/ adults.

Age Based Access

- ***0-10 years****: Parents/carers with parental responsibility typically have full access*
- ***11-15 years****: Access Gillick Competence; gradually restrict proxy access to allow for confidentiality*
- ***16+****: Default to direct patient access; proxy access only with explicit consent from the YP*

Safeguarding -sensitive protocols

- ***Flag safeguarding concerns****: Any safeguarding issue should trigger review of proxy access. Access can be limited or suspended if it poses a risk.*
- *In cases of complexity, often including domestic abuse or custody disputes, ensure the practice safeguarding leads are involved and support reviews.*

Consent and competency assessments

- ***Assess regularly****: Competence should be assessed at least annually from the age of 11 or sooner if issues arise. Code and flag the record prior to giving access.*
- ***Document decisions clearly****: include reasons for granting, limiting, or revoking access in the patient record.*

System Design and Technical controls

- ***Segmented Access****: Use systems that allow partial or tiered access (E.g. access to appointment bookings but not to the full records)*
- ***Automatic Review Flags***: Implement automated system prompt to review access are key age milestones *(E.g. at age 11, 13, 16)*

Staff Training and Guidance

- *Provide regular training on Gillick Competence, Consent and Confidentiality and handling proxy access in safeguarding scenarios.*
- *Ensure all staff know how to escalate concerns to the safeguarding team*

Clear communication with families

- *Develop standardised patient communication that explains proxy access policies, describes the transition to direct access and outlines how safeguarding concerns would affect access.*
- *Provide regular training on Gillick Competence, Consent and Confidentiality and handling proxy access in safeguarding scenarios.*
- *Ensure all staff know how to escalate concerns to the safeguarding team*

FXI – HANDLING 3RD PARTY DATA & REDACTION

3rd Party Data & Redaction

- The RCGP and NHSE recommend that practices review a record prior to granting full record access or detailed coded record access online to redact information which is 'sensitive' or relates to 3rd party information.
- There might sometimes be a need to remove or redact information from medical records when sending them to patients (including provision from patient access requests) or to third parties.[78]
- Redaction should be considered for information that relates to 3rd parties, or which could cause serious harm to the patient or others if it was disclosed.
- Recorded data in patient's notes might be from a 3rd party about the index patient. This could have been collected in confidence.
- If the data is provided by the index patient, then it is not considered 3rd party.
- Redaction is recommended unless consent been given to share by the index patient.
- Information that refers to a 3rd party, redaction is recommended.

Loss of redaction for all GP2GP notes received.

Please be aware that a new patient's electronic record, received via GP2GP by a practice will arrive with any previously redacted information fully visible. It remains the practices responsibility, as the new data controller to consider whether any of the notes require redacting (again) or not.

RCGP online toolkit for 3rd Party Data & Redaction

The RCGP have produced a useful patient online toolkit with specific information on records access. The following subsections on potential pitfalls and specific areas of risk and vulnerability are listed for GPs / practices to consider: [79]

- *Getting started with online record access (325 KB PDF)*
- *Coercion (435 KB PDF)*
- *Proxy Access (178 KB PDF)*
- *Children and Young People (154 KB PDF)*
- *Applications for Record Access (168 KB PDF)*
- *Data Quality (193 KB PDF)*
- *Information Governance (259 KB PDF)*
- *Safe Patient Online Record Access (463 KB PDF)*

Further useful support resources on patient access can be found as follows.

- *Patient online record access for Primary Care by Dr Tamsin Robinson, Dr Neera Dholakia and Dr Shimona Gayle, December 2020* [80]
- *Detailed coded record access (DCRA), Action Plan for EMIS Practices, NHS England* [81]
- *Practice guidance, offering patients prospective record access, Nov 19, Primary Care Digital Transformation, NHSX* [82]
- *Redacting 3rd party information from notes, MDU, 15 May 2019* [83]

78 Redacting third party information from notes. MDU, Feb 2025
79 RCGP online toolkit, https://elearning.rcgp.org.uk/mod/book/view.php?id=12893
80 Patient online record access for Primary Care by Dr Tamsin Robinson, Dr Neera Dholakia and Dr Shimona Gayle, Dec 2020
81 Detailed coded record access (DCRA), Action Plan for EMIS Practices, NHS England
82 Practice guidance, offering patients prospective record access, Nov 19, Primary Care Digital Transformation, NHSX
83 Redacting third party information from notes. MDU, Feb 2025

FXII – CHILD PROTECTION CONFERENCES

"GPs should make available to child protection conferences relevant information about a child and family whether or not they are able to attend".

- The contribution of GPs to safeguarding children is important, particularly relating to child protection conferences where the need for the conference chair to get the professional views and opinions of the GP is often vital.
- If asked or invited, GPs need to co-operate fully and attempt to attend, despite the often-short notice or inconvenient times being asked. [84, 85]
- Dissemination of information regarding the case should be a priority whether attendance is possible or not.
- A report should be submitted which needs to be expeditiously. Any report should only share information relevant to the request, should include family risk factors (such as drug and alcohol misuse. [86]
- It is not considered appropriate to share the complete records. [87]
- The practice ideally should be represented at child protection conferences concerning children registered with them.
- If unable to attend, the GP should send a report and should be open to other possible ways of contributing to the conference, on the day if possible (e.g. Telephone conference call, discussion previously with the Conference chair, discussion with the HV who might be attending and to represent PC views).
- For a consistent / standardised approach to providing good quality and meaningful reports, consider using a template to complete the report, E.g. from
    - *Ardens*
    - *EMIS*
    - *CEG*
    - *CSC defined*

[84] Laming Report, Protection of Children, 2009
[85] General Medical Council (GMC) Guidance, Protecting children and Young People (0-18): Updated December 2024
[86] Ibid
[87] Ibid

FXIII – CHILD DEATH NOTIFICATION & REVIEWS

1. Context of a child's death notification and review process

- All child deaths (0 to18 year olds), irrespective of the cause or expectancy are fully reviewed by locally appointed Child Death Review (CDR) Hubs/Boards.
- If GPs are informed by any other agency / individual of a confirmed child death of one of their patients (wherever the death occurs, including abroad), it remains the GPs responsibility to inform the Child Death Review (CDR) Hub are informed. (Formerly known as the CDOP)
- GPs will be one of many involved agencies asked and required to provide all the relevant and held information on the child surrounding the circumstances of what was always a timely and sometimes tragic event.
- Any request for information, requested by the local CDR Hub needs to be managed in the same way as any other formal Safeguarding request, i.e. efficiently and expeditiously. [88]
- This may include being asked to attend a child death review meeting (CDRM) and / or provide a report for a meeting.

2. Primary Care notification of a child's death

This may come from:

✓ **Formal sources** – you *can* proceed to mark the child as deceased:

- Death certificate / official NHS Demographics update
- Notification from the Registrar
- Coroner's Office
- Hospital or other healthcare provider
- Overseas death confirmed by Foreign Office or equivalent body
- The Child Death Review (CDR) Hub directly

✕ **Informal sources** – *do not* mark as deceased yet:

- Verbal information from family or friend
- Non-confirmed third-party contact
- Overseas death with no formal confirmation yet
- Document the information in the clinical record
- Await formal confirmation
- Notify the CDR Hub

3. Notifying the Child Death Review (CDR) Hub

- It is the GP's responsibility to notify the local CDR Hub of all child deaths (Exception is when the practice has already been contacted by the CDR Hub via email or via the child death reporting form {formerly Form B}
- Once notified of a death the CDR hub will communicate to partners within 24 hours.
- Notification of a child death is done electronically using the child death reporting form (formerly known as 'Form B')
  - Inner NEL at place practices: ***INEL eCDOP FORM***
  - Outer NEL at place practices: ***ONEL eCDOP FORM***
- You will need to provide:
  - *Child's name, DOB & NHS number*
  - *Date, location of death (if known) & brief note on any known circumstances*
  - *Summary of the child's primary care history / recent contacts*
  - *Any relevant vulnerability or safeguarding context*
- All information shared supports the statutory Child Death Review process and may be discussed at a Child Death Review Meeting (CDRM)

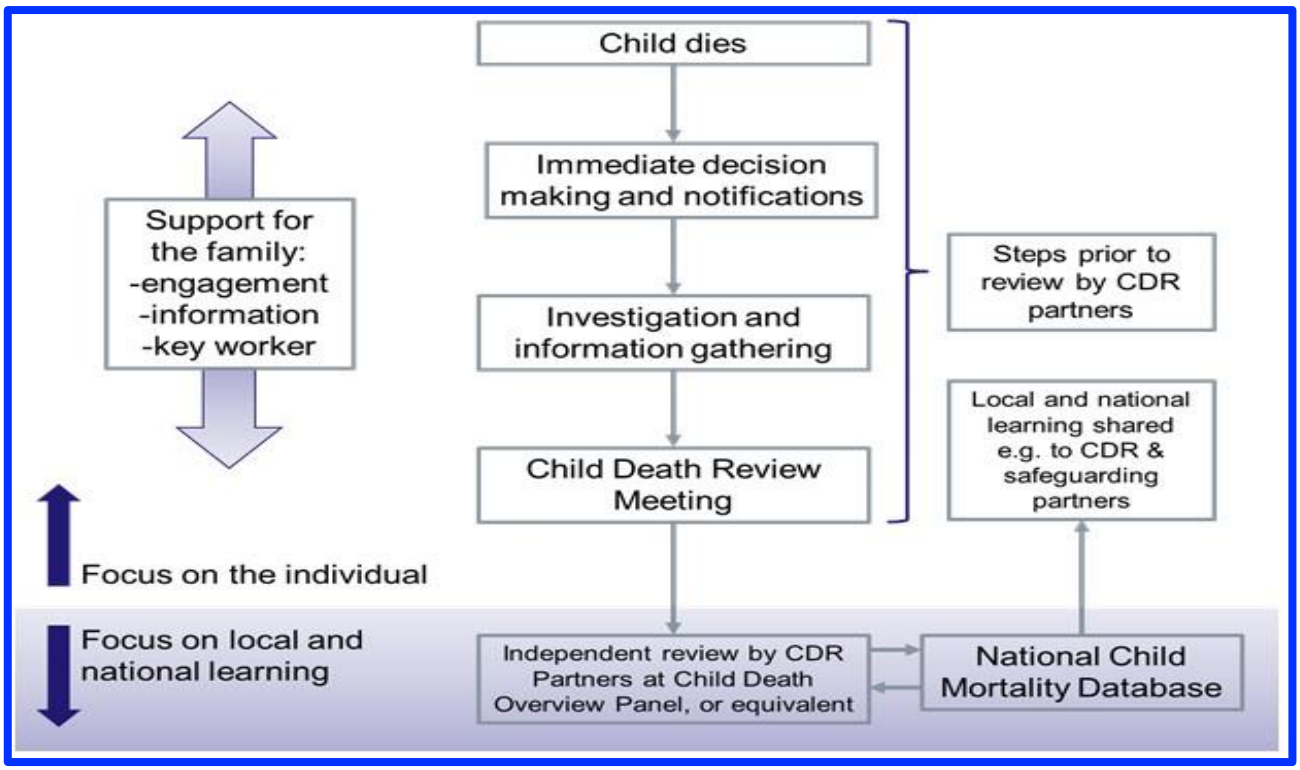
[88] Child Death Reviews, Statutory and Operational Guidance (England), October 2018. HM Government

4. Mark the Patient as Deceased (When formal confirmation received)

- In EMIS Web:
  - Open the patient's record
  - Select the 'Patient Status' icon (top toolbar)
  - Click 'Deceased'
  - Enter date of death and source of confirmation
  - Save
- This updates the NHS Spine, which in turn:
  - Notifies all linked NHS care providers
  - Cancels future appointments and communications
  - Halts screening and recall services
  - Prevents any further automated contact with the family

⚠ ⚠ **Never mark as deceased without formal confirmation** ⚠ ⚠

5. Pathway Summary / Algorithm



FXIV – RAPID REVIEW MEETINGS

What is a Rapid Review?

- Rapid Reviews are an initial statutory response to serious child safeguarding incidents
- They are conducted by the local safeguarding children partnership (LSCP).
- They aim to promptly gather and analyse information about a child's death or serious harm to identify whether there are immediate lessons to be learned
- They determine whether a Child Safeguarding Practice Review (CSPR) is required.

Statutory Nature of Rapid Reviews

- According to *Working Together to Safeguard Children (2018/2023)*, rapid reviews are statutory processes mandated by the *Children and Social Work Act 2017*.
- These reviews are required whenever a serious child safeguarding incident occurs
- GPs will often be asked to either attend a Rapid Review meeting or to provide information on the child and or immediate family members involved.
- Consent is not required from the family before sharing information

Rationale for Sharing Information Without Consent

In the context of a rapid review, sharing information without consent is crucial for several reasons:

Child's Welfare is Paramount:

- The overarching principle in safeguarding is that the welfare of the child is the paramount concern. In situations where a child's safety is at risk, the need to protect the child outweighs the requirement to obtain consent.

Legal and Ethical Justification:

- The *Data Protection Act 2018* and UK GDPR provide legal grounds for sharing information without consent when it is necessary for safeguarding purposes. The statutory nature of rapid reviews, as outlined in the *Children and Social Work Act 2017*, reinforces this obligation.
- **Key Point:** "Professionals are legally permitted to share information without consent when it is necessary for the purposes of safeguarding and preventing harm. The legal framework supports this in the context of rapid reviews, where the primary goal is to protect children."

Preventing Further Harm:

- One of the key objectives of a rapid review is to identify lessons that can prevent similar incidents in the future. Sharing information without consent is often necessary to ensure that all relevant facts are considered, enabling effective measures to be put in place to protect other children.
- **Key Point:** "Information shared during a rapid review can be vital in preventing further harm to other children. The protective function of the review justifies sharing information without consent."

Multi-Agency Collaboration:

- Effective multi-agency collaboration is essential in safeguarding, particularly during a rapid review. All relevant agencies must share information, even without consent, to build a comprehensive understanding of the case and ensure that any risks to children are addressed.
- **Key Point:** "Rapid reviews rely on the collaboration of multiple agencies. For this collaboration to be effective, information must be shared freely and promptly, even if consent has not been obtained."

Primary Care Role in Rapid Reviews

As part of this process, GP practices may be contacted by the Designated Dr or Named GP for Safeguarding Children to provide either an agency feedback form or to gain access to the medical records of the child and their family.

Confidentiality and Access

- Medical records provided for the purpose of a Rapid Review are accessed only by a specialist GP from the safeguarding team.
- This GP identifies and extracts only information that is relevant and proportionate to the Rapid Review.
- The safeguarding partnership does not have unrestricted or full access to medical records.

Summary for GP Practices

- Rapid Reviews are statutory safeguarding processes initiated following serious incidents involving children.
- GPs may be asked to complete an agency feedback form or provide medical records of the child and family.
- These requests are legally permitted and do not require patient or parental consent.
- Only the specialist safeguarding GP accesses full medical records.
- Only proportionate and relevant information is shared with the safeguarding partnership.

Child Safeguarding Practice Reviews (CSPRs)

- If a Rapid Review identifies that the criteria are met, the Local Safeguarding Children Partnership (LSCP) may escalate the case to a full Child Safeguarding Practice Review (CSPR).
- These reviews aim to identify systemic learning and improvements following cases where a child has died or been seriously harmed as a result of abuse or neglect.
- GP practices may again be asked to contribute by sharing relevant records or agency feedback.
- This request will be coordinated by the Named GP for Safeguarding Children.
- As with Rapid Reviews, consent is not required to comply, as the sharing of information is supported by statutory guidance under the Children Act 2004 and 'Working Together to Safeguard Children' (2018).
- Only proportionate and relevant information will be extracted and shared, and only by a safeguarding GP.
- The review panel does not receive full access to medical records.

FXV – ADULT & DVA STATUTORY REVIEWS

1. Safeguarding Adults Reviews (SARs)

- Safeguarding Adults Reviews (SARs) are statutory reviews undertaken by the Safeguarding Adults Board (SAB) when an adult with care and support needs dies or suffers serious harm because of abuse or neglect, and there is concern about how agencies worked together.
- GP practices may be asked to provide an agency report or share medical records to support the SAR.
- This is a legal obligation under the Care Act 2014, and consent is not required.
- Medical records are reviewed by a specialist GP in the adult safeguarding team, who will extract and share only information that is relevant and proportionate.
- The SAB does not have direct access to full records.

2. Domestic abuse related death reviews DARDR (Formerly Domestic Homicide Reviews – DHRs)

- Deaths related to domestic abuse (formerly known as Domestic Homicide Reviews) are coordinated by the local Community Safety Partnership when a person dies as a result of domestic abuse.
- These reviews aim to identify learning and improve multi-agency working.
- GPs may be asked to contribute through agency reports or records and are legally permitted to do so without consent under the Domestic Violence, Crime and Victims Act 2004.
- Medical information is reviewed only by safeguarding professionals, who will determine what is relevant to the review. The panel does not have unrestricted access to full records.

3. Summary for GP Practices

- SARs and Domestic Abuse-Related Death Reviews are statutory processes requiring GP input.
- You may be asked for an agency report or medical records relating to the person and family.
- You do not need consent to comply with these requests – legal basis is established in safeguarding law.
- Records are only reviewed by designated safeguarding professionals, not by the review panel.
- Only relevant and proportionate information will be shared externally.

MAKING A REFERRAL

GI - DISCLOSURE OF ABUSE

"Responding to an allegation"

"Doing nothing is never an option".

1: Stay calm

2: Listen carefully to what is being said

3: Reassure the child / person making disclosure that they have done the right thing by telling you

4: Find an appropriate early opportunity to explain that it is likely the information will need to be shared with others **– do not promise to keep secrets.**

5: Allow the child / person making disclosure to continue at their own pace

6: Ask questions for clarification only and always avoid asking questions that are leading or suggest a particular answer

7: Tell them what you will do next and with whom the information will be shared

8: Record in writing what has been said using the child's / person's own words as much as possible – note date, time, any names mentioned, to whom the information was given.

9: Ensure that paper records are signed and dated and / or electronic records are subject to audit trails

10: Discuss your concerns with practice colleagues including the practice safeguarding lead and/or the Named GP for children's safeguarding using the local pathway to pass appropriate information on

11: Make a referral **without delay** to children's social care via a Multi-Agency Referral Form (MARF). This is often done through the Local Authority's website via an online portal. Updated contact numbers and emails to access each Borough's safeguarding hub teams can be found in the contacts section, at Place, across NEL.

12: If the concern relates to or includes an adult or young person > age of 18, then please follow the process of making a referral to the local adult safeguarding team.

"Alone we can do so little;
together we can do so much"

Helen Keller

GII- MAKING A REFERRAL
"When to refer…"

"It is easier to ignore the problem or seek other more comfortable explanations for our observations"

A referral to Children's Social Care should always be made in the following circumstances. [89] [90]

- *Any allegation of sexual abuse (current or historical)*
- *Physical injury caused by assault or neglect, which may or may not require medical attention*
- *Incidents of physical abuse that alone are unlikely to constitute significant harm but taken in consideration with other factors may do so*
- *Children who suffer from persistent neglect*
- *Children who live in an environment that is likely to have an adverse impact on their emotional development*
- *Where parents' own emotional impoverishment affects their ability to meet their child's emotional and / or physical needs regardless of material / financial circumstances and assistance*
- *Where parents' circumstances are affecting their capacity to meet the child's needs because of domestic violence or abuse, drug and / or alcohol misuse, mental health problems, previous convictions for offences against children*
- *A child living in a household with, or having significant contact with, a person at risk of sexual offending*
- *A sexually active child aged 12 years or under (This is statutory rape as the child has no legal capacity to be able to consent to consensual sex)*
- *An abandoned child*
- *Bruising or injury to an immobile baby* [91]
- *Pregnancy where children have been previously removed*
- *Suspicion of Perplexing Presentations (Fabricated or induced illness - FII)*
- *FGM or CSE*
- *Any other serious Safeguarding concerns*

[89] Londo\Safeguarding Children Board, 2007 (paragraph 6.4)
[90] London SG procedures, When to refer a child
[91] Bruising in non-mobile infants, CSPR Panel 2022

GIII - MAKING A REFERRAL
"Key Practice guidance"

"We must put the needs of the child above all others and see the child, not just the parents. Keep the child in focus."

- Practices should have a protocol in place for documenting and notifying concerns. [92]
- The concerns may need to be discussed with a more experienced colleague e.g., Designated or Named Doctor / Nurse to clarify the seriousness and urgency of the situation.
- If, following discussion there are still concerns, consideration should be given to consulting the duty officer at the social care office for advice. (MASH/CSC) This can be done by presenting a 'what if' scenario without necessarily naming the child in question. Both parties, in a retrievable form, should record this discussion.
- In most situations, concerns should be discussed with the child or young person (as appropriate to their age and understanding) and with their parents, whose agreement should be sought prior to a referral being made. **However, agreement should not be sought if doing so would place the child or young person at risk of significant harm.**
- If there are immediate concerns about the safety of a child or young person, a referral should be made by telephone to the local CSC. At the end of any discussion or dialogue about a child or young person, the referrer must record the decision in their records.
- An initial telephone discussion is strongly recommended with the on-call CSC Services Assessment Team [in-hours] or the Emergency Duty Team (EDT) [out of hours] before making the MARF referral.
- All MARF referrals should be submitted within 48 hours of the original telephone contact by the referrer. Each LA will have its own form and can be completed on-line.
- If concerns are not immediate, but it is believed that a child or young person is a child in need, who may also need protection, a referral should be made in writing. [93]
- Where a CAF has been completed by the referring agency this will form the basis of the referral. Where necessary, the assessment should be updated to ensure that the most recent information is passed to Children's Social Care.

[92] Wessex Learning Trust. Child Protection Policy. Aug 2024
[93] Framework for the Assessment of Children in Need and their Families DH, DFEE 2000

SAFEGUARDING PRIMARY CARE VIRTUAL CONSULTATIONS

HI - SAFEGUARDING ISSUES IN VIRTUAL CONSULTATIONS WITH YOUNG PEOPLE

"A revised way of working"

"Can you hear me? …. I think you're on mute".

Privacy & Environment:

- The young person may not be alone or maybe overheard by parents, carers, or potential abusers. There might be a risk of another person directing or listening to responses off camera, especially in cases of domestic abuse or controlling relationships.
- Best practice is to check and ask if they are somewhere private and safe for them where they feel comfortable speaking, use visual cues and body language to assess discomfort or hesitation.

Consent & Confidentiality:

- Best practice is to reaffirm confidentiality and its limits and confirm consent for the consultation, especially if parents are present. Offer an opportunity for 1:1 discussion especially if there is a mental health, sexual health or abuse issue needing to be discussed.

Missed Safeguarding Cues:

- Technical issues may we choose the quality or reliability of the interaction visibly.
- A limited ability to observe nonverbal signs all to see the bigger picture literally may cause issues such as bruising, hygiene, body language and emotional responses to be missed.
- Best practice would be to use open exploratory questions to elicit safeguarding concerns and offer where possible a face to face follow up

Digital inequality & Accessibility:

- Limited access to devices or data can prevent private consultations, especially for vulnerable or disadvantaged young people
- This may lead to missed appointments or reduced engagement with healthcare.
- Best practice is for flexibility with methods E.g. by phone video or in person

Record Keeping and Escalation:

- Best practice is to make robust contemporaneous notes and escalate any safeguarding concerns quickly using the established safeguarding protocols.

National Supportive Guidance: [94] [95] [96] [97] [98] [99]

- Safeguarding GP Virtual Consultations: {**Appendix H1**}
- Safeguarding U18 Virtual Consultations: {**Appendix H2**}
- U18 Consultations involving intimate Imagery: {**Appendix H3**}
- Managing intimate imagery within a virtual U18 consultation: {**Appendix H4**}

[94] Top 10 Tips for successful GP video consultations. RCGP. April 2020.
[95] Using online consultations in Primary Care, Implementation Toolkit, NHS E. January 2020.
[96] Online consultations in general practice: Questions to ask. RCGP. January 2020
[97] Principles for supporting high quality consultations by Video in general practice during COVID-19. RCGP. Aug 2020
[98] COVID-19: video consultations and homeworking, BMA, Nov 2020
[99] Key principles for intimate clinical assessments undertaken remotely in response to COVID-19, NHS E, Aug 2020

LEARNING FROM CHILD SAFEGUARDING PRACTICE REVIEWS (CSPR)

II- LEARNING FROM CHILD SAFEGUARDING PRACTICE REVIEWS

"Key learning points for Primary Care"

- Formerly known as Serious Case Reviews (SCRs), Child Safeguarding Practice Reviews (CPSRs) provide key learning points relating to themes identified as requiring reflection and action from involved organisations, including Primary Care / General Practice.
- In 2024, CSPRs were conducted across North-East London and the following key learning points were identified:-

Key messages for Primary Care

- ***Be professionally curious – ask questions.***
- ***Remember to consider the Voice of the child.***
- ***Don't forget about invisible / missing fathers.***
- ***Consider use of the genogram to identify family links / missing information.***
- ***Don't forget to enquire about private fostering possibilities at a child's new patient registration.***
- ***Trafficking / CSE / Gang involvement are everywhere in the UK.***
- ***Think FII where there are multiple presentations, in and out of hours with complex undefined presentations.***
- ***Practices to consider a lead GP for children with complex health care needs.***
- ***Remember the association between children's safeguarding and parental mental health, drug and alcohol abuse.***
- ***The need to appropriately and expeditiously information share when asked to do so in the correct way.***
- ***To work towards working together efficiently and productively with key other agencies to ensure we safeguard the children in our care.***

- Specific Cases across NEL that highlight how important it is for Primary care to be aware of their recommendations and outcomes have arisen from each at Place locality.
  - *Redbridge.* ***{Appendix I1}***
  - *Havering.* ***{Appendix I2}***
  - *Barking & Dagenham.* ***{Appendix I3}***
  - *City & Hackney.* ***{Appendix I4}***
  - *Newham.* ***{Appendix I5}***
  - *Tower Hamlets.* ***{Appendix I6}***
  - *Waltham Forest.* ***{Appendix I7}***

JI - LEARNING FROM LIVES AND DEATHS - "People with a learning disability and autistic people" (LeDer) [100]

LeDer

- Every health and care professional involved in the care and treatment of people with a learning disability can support people to live happier and healthy lives through ensuring that things like ….
  - ***annual health checks***
  - ***reasonable adjustments***
  - ***stopping over medication of people with a learning disability, autism, or both (STOMP) reviews happen***
  - ***action plans***

  ….. *are acted upon and implemented.*

- Health and care professionals are also supporting LeDer by taking the learning from reviews and making improvements in their services for people with a learning disability [101]

- GPs may be contacted by an LeDer reviewer to assist in the completion of LeDer reviews

[100] Learning from Lives and Deaths-people with a learning disability. Action from Learning 2020/21. Helpful resources. NHS
[101] Capacity and Consent, Red Whale, August 2021

SPECIFIC SAFEGUARDING ISSUES

KI - LOOKED AFTER CHILDREN (CLA/LAC)

"There is a statutory duty to safeguard and promote the welfare of CLA with evidence supporting improved health outcomes for those who have access to specialist health practitioners, including GPs"

- A child who is Looked After (CLA), formerly known as a looked after child (LAC) is a child looked after by a local authority (in care), either following a court granting a care order or a council's children's services department having cared for the child for > 24 hours. The main reasons for being in care are abuse or neglect.
- Two thirds of CLA have been found to have at least one physical health complaint *(e.g. speech and language problems; bedwetting; co-ordination or visual problems).*
- CLA show higher rates of mental health disorders than others (45% -v- 10%), particularly if in residential care (72%). [102]
- Higher levels of pregnancy, drug and alcohol abuse are found in those leaving care
- CLA have a higher chance of not being registered with a GP.

Health reviews / examinations

- CLA require initial health reviews when they enter the care system followed by annual checks / reviews.
- In BHR these are now largely completed by paediatricians but sometimes, the GP will be best placed and asked to complete the assessments.
- It is important for GPs who encounter CLA and their carers to use their competencies [103, 104] to undertake health assessments, contribute to health care planning, ensure clinical governance arrangements to assure the quality of services for CLA, and co-ordinate care for each young person.
- GPs get reimbursed for doing these reviews, but it is important to ensure that **ALL** sections of the health assessment form are completed.
- PART **C** ***{Appendix K1}*** requests a 'Health Care Plan' to be completed. This needs to be completed by the GP if there are any medically relevant issues identified or known about. (The term *'medical adviser'* refers to the GP/clinician completing the review).
  E.g. what follow up is in place for a child with known long term health problems, such as diabetes or asthma?
  E.g. what action is required to support a newly found health problem, e.g. referral to specialist – when and who?

[102] Looked after children: Knowledge, skills and competencies of health care staff, an intercollegiate Framework: RCGP/RCN/RCPCH, March 2025
[103] Ibid
[104] NHS Employment Check Standards, June 2025

KII - PRIVATE FOSTERING

"Children who are in a private fostering arrangement are more vulnerable to abuse"

- Health professionals play an important role in identifying children who may be living in private fostering arrangements.
- In these arrangements, children and young people may not have a responsible adult who is actively ensuring their safety and promoting their welfare.
- It is therefore, essential that health professionals remain vigilant and notify **all** potential private fostering arrangements to the local authority, as required by law, to ensure appropriate assessments and support are provided.
- Children's Services are not involved in arranging private fostering placements.
- However, once notified, they have a legal responsibility for ensuring that such arrangements are safe and suitable for the child.
- Professionals should actively encourage parents, legal guardians and carers to notify the Children's Services about the care arrangement.
- By law, a parent, legal guardian, private foster carer, or other persons involved in making a private fostering arrangement must notify Children's Services at least **six weeks** prior to the arrangement begins **or** as soon as possible; if the arrangement has already begun.
- It is recognised that families and carers may not always be aware of this legal duty.
- Where such arrangements are made without notification to the local authority, this may hinder the local authority's duty to assess and provide appropriate support for the child or young person.

What is Private Fostering?

- Private fostering is the term used when someone who is **not** a parent or a 'close relative' (e.g., like a great aunt, cousin, mum's friend, or a neighbour) is looking after a child or young person under the age of 16 (under 18 if they are disabled) for 28 days or more in their own home.
- It also covers children who stay at a residential school for more than two weeks of the school holidays.

Who are the Close Relatives?

- A 'Close Relative' is defined in the Children Act '1989 as a grandparent, sibling, aunt, uncle, or step-parent (whether by full-blood, half-blood, by marriage or civil partnership).

Who can be a Private Foster Carer?

- A private foster carer can be an extended family member i.e. the child's great aunt, cousin, family friend, neighbour, or someone else known or unknown to the child or young person.
- If a child or young person resides with any of these adults for **28 days** or more, their care and living arrangement is considered to be a private fostering arrangement.

A child or young person is **NOT** privately fostered while they are;

- Looked After by a local authority;
- Placed for adoption;
- In any school in which he /she is receiving full-time education;
- In accommodation provided by a voluntary organisation;
- in any health service hospital or other provision;
- Is privately cared for, for less than 28 days;

- Is cared for by a relative but the parent also lives in the property.

Common situations in which children are privately fostered include:

- Children who have been trafficked ** and are living with non-relatives.
- Children brought into the UK from abroad with a view to adoption.
- Children attending boarding schools who do not return to their parents during school holidays but stay with 'host families' recruited by 'education guardians'.
- Children on holiday exchanges programmes.
- Children attending language schools.
- Children in independent boarding schools who do not return home during school holidays.
- Children who spend more than **2 weeks** in a residential school during the school holidays without returning home.
- Unaccompanied asylum-seeking minors who are living with friends, relatives, or unrelated adults.
- Local children living away from their parents and close relatives.
- A child living with a friend's family because they don't get on with their own family.
- Children whose parents are unable to care for them due to ill health, are hospitalised, in prison, in the army or deceased and is not living with a 'close relative'.
- Children living with a friend's family because of their parents' study or work elsewhere.
- Children staying with another family because their parents have separated or divorced.
- Teenagers living with the family or someone the child describe as their boyfriend or girlfriend.
- Children from abroad who attend a language school, sports academy or mainstream school in the UK and stay with a host family.
- Ukrainian children living with host families remain privately fostered until they are 18.

Safeguarding Privately Fostered Children.

- Children who may have been trafficked into (or within) the UK are recognised as particularly vulnerable and frequently reside in 'informal' private fostering arrangements, often without and adult legally responsible for their care.
- Under UK law, child trafficking constitutes a form of modern slavery and involves the recruitment, transportation, transfer, harbouring or receipt of a child for the purpose of exploitation.
- This may include domestic servitude, sexual exploitation, criminal activity, or benefit fraud.
- In accordance with statutory safeguarding duties, where it is suspected that a child or young person may be a victim of trafficking, an immediate safeguarding referral must be made to the Local Authority Children's Services Multi-Agency Safeguarding Hub (MASH).
- For further guidance, professionals are encouraged to search resources such as ECPAT UK (www.ecpat.org.uk), and statutory safeguarding frameworks.

All clinicians and primary care staff should:

- Be aware of the legal definition of what constitutes a private fostering arrangement;
- Consistently seek to be 'curious' and confirm the relationship of any accompanying adult during consultations (e.g. "child attended with [name/relationship]", if the child is not accompanied by their parent or legal guardian.
- All newly registered children must undergo a face-to-face initial health assessment, during which practitioners should sensitively explore the child's living arrangements to identify any potential private fostering arrangements.
- Where private fostering arrangement is suspected, disclosed, or confirmed, you must notify the Local Authority Children's Services Multi-Agency Safeguarding Hub (MASH) immediately.

KIII – VULNERABLE PARENTS

"Appreciate the increased vulnerability of a child where there is domestic abuse, parental mental health problems, substance or alcohol abuse within the immediate family".

- Research confirms that the environment in which a child lives is crucial to his or her health, safety, and well-being. [105, 106] The term 'Toxic Trio' [107] has been used to describe the issues of domestic abuse, mental ill-health and substance misuse which have been identified as common features of families where harm to children has occurred.
- They are viewed as indicators of increased risk of harm to children and young people.

- Work in this area has shown that there is large overlap between these parental risk factors and cases of child death, serious injury and generally poorer outcomes for children across all ages (Brandon et al, 2008).
- There is a clear co-occurrence between the 'toxic trio' risk factors of domestic abuse, substance misuse (alcohol and/or drugs) and parental mental ill health. Nearly a third of mothers (31%) and of fathers (32%) in these families experiencing domestic abuse also disclosed either mental health problems or substance misuse, or both. [108]
- A review of Serious Case Reviews (2007-2011) found nearly 75% of children lived in families where two or more of these issues were present. [109]

[105] Social work & Adverse Childhood Experiences research, Larkin. Social Work in Public Health, Vol 29. 2014/ 1-16.
[106] Adverse childhood experiences in London report. October 2019.
[107] Ending Domestic abuse, Bickham 2017. Focus on Families. Safelives.
[108] CAADA Research Project, 2014
[109] SCR reviews, Ofsted, 2011

KIV - PERPLEXING PRESENTATIONS {FABRICATED & INDUCED ILLNESS – FII}

"GPs and other Primary Health Care professionals are well placed to recognise FII and may have unique knowledge of uncorroborated, odd or unusual presentations or witness the discrepancy between the child's reported signs and symptoms to those observed".

- Perplexing presentations aka the fabrication or induction of illness in children (FII) is a form of child abuse by a carer and has also been referred to by several different terms, most commonly Munchausen Syndrome by Proxy, [110] Factitious Illness by Proxy [111, 112] or Illness Induction syndrome. [113]
- There are three main ways of the carer fabricating or inducing illness in a child. These are not mutually exclusive and include:
    1. *Fabrication of signs and symptoms, including fabrication of past medical history*
    2. *Fabrication of signs and symptoms and falsification of hospital charts and records, and specimens of bodily fluids (This may also include falsification of letters and documents)*
    3. *Induction of illness by a variety of means.*
- Concerns may arise about possible FII when:
    - *Reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering; or*
    - *Physical examination and results of medical investigations do not explain reported symptoms and signs; or*
    - *There is an inexplicably poor response to prescribed medication and other treatment; or*
    - *New symptoms are reported on resolution of previous ones; or*
    - *Reported symptoms and found signs are not seen to begin in the absence of the carer; or*
    - *Over time the child is repeatedly presented with a range of signs and symptoms; or*
    - *The child's normal, daily life activities are being curtailed, for example school attendance, beyond that which might be expected for any medical disorder from which the child is known to suffer.*
    - *Behaviours of carers appear abnormal and outside of cultural normality (e.g. interfering with treatments by overdosing or not giving; claiming unverifiable symptoms unless directly and closely observed {vomiting, pain, fits} resulting in unnecessary investigations and treatments leading to secondary problems;*
    - *Exaggerating unverifiable symptoms resulting in potentially hazardous or dangerous investigations; obtaining specialist equipment not required; alleging psychological illness in a child)*
- If concerned, discuss with the Practice Lead and with the Named GP or Designated Doctor. Also ensure the child is referred to a paediatrician for an assessment (if not already referred).
- There should be no delay in referring to CSC using a MARF and if not already referred, the GP should initiate this referral and not wait for hospital review or outcome.
- Where possible, it would be considered good practice to prioritise continuity of care for ANY child / family with a 'complex medical history' by ensuring one allocated / usual GP tries to manage all consultations. [114]

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110 Meadow R. Lancet (1977);13;2(8033):343-5. Munchausen syndrome by proxy. The hinterland of child abuse.
111 Bools, C. N. BJ of Psychiatry (1996);169,268-275. Factitious illness by proxy. Munchausen syndrome by proxy
112 Berg & Jones. Arch Dis Child (1999); 81:465-472. Outcome of psychiatric interventions in Factitious illness by proxy
113 Gray et al. Child Abuse & Neglect (1996); 20:8 ,655-673. Illness induction Syndrome
114 RCPCH Guidance, FII. March 2021

KV - DOMESTIC VIOLENCE & ABUSE (DVA)

"Domestic violence and abuse (DVA) can happen to anyone, regardless of their gender, race, ethnic or religious group, sexuality disability or lifestyle."

Domestic violence & abuse (DVA) is any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence, or abuse between those aged 16 or over who are (or have been) intimate partners or family members regardless of their gender or sexuality. This can include, but is not limited to, the following types of abuse:

- ***Psychological***
- ***Physical***
- ***Sexual***
- ***Financial***
- ***Emotional***

Controlling behaviour

A range of acts designed to make a person subordinate and/or dependant by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour

An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. This definition also includes so called 'honour' based violence & forced marriage (p63) and female genital mutilation (FGM) (p51). Victims are not confined to one gender or ethnic group.

Some DVA facts

- *One in four women and one in six men will experience DVA in their lifetime.*
- *a third of DVA against women starts during pregnancy. If the relationship is already abusive, it can get worse.*
- *it is a leading cause of child abuse, present in over 50% of England's SCRs.*
- *There are 2 domestic homicides every week in the UK.*
- *pressuring you to have sex or to have unsafe sex (without a condom) are both forms of sexual abuse.*
- *there is an increased risk of DVA within the LGBT+ community and their relationships.*
- *Anybody can be an abuser.*

For both any victim of abuse, the message is the same:

- *You are not alone.*
- *It is not your fault.*
- *Help is available.*

Recent domestic homicide reviews have identified a need for increased GP / Primary Care awareness and skills in dealing with DVA. [115]

Data entry guidance for recording DVA in victim, child and perpetrator records can be found: ***{Appendix K2}***

[115] DHR Key findings, Sept 21 to Oct 22, Gov UK

KVI – DVA ALTERNATIVE QUESTIONS TO ASK

Asking indirectly

- *How are things going at home?*
- *What about stress levels? How are things going at work? At home?*
- *How do you feel about the relationships in your life?*
- *How does your partner treat you?*
- *Are you having any problems with your partner?*

Framing the question

- *Because unfortunately domestic abuse is so common in our society, I have started asking all of my patients about it.*
- *Because domestic abuse has so many effects on health, I now ask all my patients about it.*
- *From past experience with other patients, I'm concerned that some of your medical problems may be the result of someone hurting you. Is that happening?*
- *I don't know if this is a problem for you, but many of my patients are dealing with abusive relationships. Some are too afraid or uncomfortable to bring it up themselves, so I've started asking about it routinely.*
- *I am sorry if someone has already asked you about this, and I don't want to cause you any offence, but I know 1 in 4 women experience violence and abuse from a partner and I've noticed…[that you have some injuries/house has been damaged]. So I'm just wondering if you need any help?*
- *Violence affects many families. Violence in the home may result in physical and emotional problems for you and your child. We are offering services to anyone who may be concerned about violence in their home.*

Asking directly

- *Are you afraid of your partner? Do you feel you are in danger?*
- *You mentioned your partner's problem with temper/stress/drinking. When that happens, has he ever threatened or hurt you?*
- *Every couple fight at times – what are your fights like at home? Do the fights ever become physical?*
- *Have you been hit or scared since the last time I saw you?*
- *Has anyone at home hit you or tried to injure you in any way?*
- *What kinds of experiences with violence have you had in your life?*
- *Do you feel controlled or isolated by your partner?*
- *Does your partner ever try to control you by threatening to hurt you or your family?*
- *Has anyone close to you ever threatened or hurt you?*
- *Does your partner ever hit, kick, hurt or threaten you?*
- *Have you ever been slapped, pushed or shoved by your partner?*
- *Have you ever been touched in a way that made you feel uncomfortable?*
- *Has anyone ever made you to do something sexual when you did not want to?*
- *Has your partner ever refused to practice safe sex?*
- *I notice you have several bruises/scratches; how did they happen? (if explanation seems improbably continue to probe, e.g. "Did someone do this to you?")*

SAFE Questions

Stress/safety

1. *What stresses do you experience in your relationships?*
2. *Do you feel safe in your relationship?*

Afraid/abused

3. *People in relationships sometimes fight. What happens when you and your partner disagree?*
4. *Have there been situations in your relationship where you have felt afraid?*
5. *Have you been physically hurt or threatened by your partner?*
6. *Has your partner forced you to engage in sexual activities that you didn't want?*

Friends/family

7. *Are your friends and family aware of what is going on?*

Emergency

8. *Do you have a safe place to go in an emergency?*

Acknowledgement and gratitude to Peter Stride, Managing Director of Foundry Risk Management for his permission to reproduce the above set of questions that any clinician can consider using.

KVII – NON-FATAL STRANGULATION (NFS)

"Non-fatal strangulation is a predictor of future homicide, by up to 7 times higher risk in domestic abuse cases"

Non-fatal strangulation (NFS) is a serious safeguarding concern with major implications in primary care, especially when linked to domestic abuse.

Primary Care Safeguarding Advice – Non-Fatal Strangulation (NFS)

1: Recognise Non-Fatal Strangulation

- Non-fatal strangulation may be described by the patient or disclosed indirectly (e.g. "he put his hands around my neck"). Watch for:
  - *Voice changes, hoarseness, swallowing difficulties*
  - *Neck pain, bruising, petechiae, ligature marks (often absent)*
  - *Neurological signs: headache, memory loss, dizziness, incontinence*
  - *Psychological signs: fear, trauma, panic, dissociation*
  - *Delayed symptoms: symptoms may emerge over 24–48 hours*
- It often presents with subtle physical signs but carries high risk of fatal escalation and significant neuropsychological and trauma impacts.

2: Ask Safely, Document Clearly

- Use trauma-informed language: *"Has anyone ever held you by the throat or made you feel like you couldn't breathe?"*
- Don't force disclosure, but create safety and trust
- Document what the patient says in their own words, any physical findings (location, shape, colour of marks, emotional state and history
- Be factual. Avoid medical labels unless certain (e.g. "manual strangulation")

3: Clinical Management

- Refer to A&E if:
  - *Loss of consciousness*
  - *Swallowing difficulty*
  - *Neck tenderness, bruising, or swelling*
  - *Neurological symptoms*
- Follow local pathways for immediate safeguarding and risk assessment
  - *Consider MARAC referral (Multi-Agency Risk Assessment Conference)*
  - *IDVA (Independent Domestic Violence Advisor) referral*
- Consider mental health referral for trauma/PTSD risk
- Flag patient record with safeguarding concerns appropriately

4: Safeguarding Duties

- If children are in the household → Immediate referral to Children's Social Care
- If patient is vulnerable → Adult safeguarding team referral
- Report to police if risk is ongoing or with patient's consent (unless overriding duty to report)

5: Legal Context (UK – as of June 2022)

- Non-fatal strangulation is a standalone criminal offence under the Domestic Abuse Act 2021 (came into effect June 2022)
  - *Punishable by up to 5 years in prison*
- Applies even if there are no visible injuries

Resources for GPs and Primary Care:

- IRISi (Identification & Referral to Improve Safety): www.irisi.org
- SafeLives: Domestic abuse training and referral pathways
- RCGP Safeguarding Toolkit
- NICE NG76: Child abuse and neglect (includes adult disclosures with risk to others)

KVIII - FEMALE GENITAL MUTILATION (FGM)

"UK law and context"

"Any type of FGM is illegal in the UK and if performed on children is a recognised form of child abuse"

- Female Genital Mutilation (FGM) involves procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. FGM is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life.

- FGM is known by several names, including 'female genital cutting', 'circumcision' or 'initiation' and has been classified by the World Health Organization into four types based on the extent and severity of surgery performed. UK Prevalence is difficult to estimate because of the hidden nature of the crime. 2001 census data suggests that over 20,000 girls under the age of 15 could be at high risk of FGM in England & Wales (E&W) each year and nearly 66,000 women in E&W are living with the consequences of FGM. [116]

  - *If a girl under 18 tells or a professional see that she has FGM, the professional has to report this to the police, using the 101 non-emergency police number.*
  - *If FGM is identified in anyone under the age of 18, or they are suspected to be at risk of FGM a child protection referral will be made to Havering MASH; there is also a professional duty to report these cases to the police by dialling '101'.*
  - *If FGM is identified in anyone over the age of 18, a case-by-case risk assessment must be undertaken and within this it must be considered if the woman is a vulnerable adult and if she needs a referral to the adult safeguarding team. There is currently NO requirement for automatic referral of adult women with FGM.*

FGM algorithm / pathway: ***{Appendix K3}*** ***Role of the GP:*** ***{Appendix K4}***

- It is now **mandatory** to both record FGM in a patient's healthcare record when known or identified and there are also appropriate onward referrals processes for any health professionals that suspect anyone to have been a victim of FGM. [117, 118]
- Because FGM in under 18-year-old girls is child abuse, any children and vulnerable adults in your care with symptoms or signs of FGM or you have good reason to suspect are at risk of FGM {having considered their family history or other relevant factors} must be referred using standard existing local safeguarding procedures, e.g. to the MASH using a MARF.
- When a patient is identified as being at risk of FGM, this information should be shared with the GP and health visitor as part of safeguarding actions by other agencies (See section 47 of the 1989 Children Act). [119]

[116] FORWARD (2007) A statistical Study to Estimate the prevalence of FGM in England and Wales
[117] Multi-agency statutory practice guidelines for FGM, DoH. July 2020
[118] FGM prevention programme, statement by DoH and NHS E. Dec 2014
[119] Children Act 1989 & 2004

KIX - HONOUR BASED VIOLENCE (HBV) & FORCED MARRIAGE

"Almost always involves the exploitation of vulnerable person"

- 'Honour' based violence (HBV) is a form of domestic abuse which is perpetrated in the name of so called 'honour'. The honour code, which it refers to, is set at the discretion of male relatives. Women who do not abide by the 'rules' are then punished for bringing shame on the family.
- Infringements may include a woman having a boyfriend; rejecting a forced marriage; pregnancy outside of marriage; interfaith relationships; seeking divorce, inappropriate dress or make-up and even kissing in a public place.
- HBV can exist in any culture or community where males are in position to establish and enforce women's conduct, examples include Turkish; Kurdish; Afghani; South Asian; African; Middle Eastern; South and Eastern European; Gypsy and the travelling community (this is not an exhaustive list).
- Males can also be victims, sometimes because of a relationship, which is deemed to be inappropriate; if they are GBT+; have a disability or if they have assisted a victim.
- In addition, the Forced Marriage Unit have issued guidance on Force Marriage and vulnerable adults due to an emerging trend of cases where such marriages involving people with learning difficulties.
- This is not a crime that is perpetrated by men only. Sometimes female relatives will support, incite, or assist. It is also not unusual for younger relatives to be selected to undertake the abuse to protect senior members of the family. Sometimes contract killers and bounty hunters will also be employed.
- In 2016, an estimated 15.4 million people worldwide were forced into marriage.
- This has been taken from recent guidance [120]
  - ***NHS Safeguarding Guide: Domestic Abuse***
- Further resources that can assist in a better understanding of the issues [121,122] include:
  - ***Forced Marriage Guidance***
  - ***Save Lives: Ending Domestic Abuse***

[120] NHS Safeguarding Guide: Domestic Abuse. NHS England.
[121] Forced Marriage Guidance. March 2023. Gov.uk publication.
[122] Safe Lives, ending Domestic Abuse.

KX - CHILD SEXUAL EXPLOITATION (CSE)

"Child sexual exploitation is a form of child sexual abuse often not recognised by the victims"

- Child sexual exploitation (CSE) involves exploitative situations, contexts and relationships where young people (or a third person/s) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities.
- CSE can occur using technology without the child's immediate recognition, for example, being persuaded to post sexual images on the internet / mobile phones without immediate payment or gain. In all cases, those exploiting the child have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources.
- Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice and their social / economic / emotional vulnerabilities.
- 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.
- Perpetrators may be acting as individuals, or as part of a group targeting and sexually exploiting children and young people or as part of a gang. In the gang scenario, sexual exploitation is a by-product of the deviant values held by members, rather than the main purpose of the gang.
- 2010-11 data sources indicate that 16,500 children were at risk of CSE in England; 2,409 children were confirmed as CSE victims of gangs and groups in England and there were 1,875 cases of localised grooming reported by the Child Exploitation and Online Protection Centre (CEOP) [123]
- Children and young people who are sexually exploited can present in a variety of ways *{e.g. poor self-care, injuries, sexually transmitted infections, contraception, pregnancy, termination, drug and alcohol problems, medically unexplained symptoms, mental health problems, self-harming, behaviour or relationship problems}* and to a wide range of health settings. [124] [125]
- All health care professionals need to be aware of the range of presentations and that they know how to respond appropriately. In improving the response by health professionals, the 'SAFEGUARD' mnemonic has been designed to help professionals identify and assess potential risk. [126, 127]
  {Appendix K5}

[123] Berelowitz, S, Firmin, C, Edwards, G and Gulyurtlu, S (2012) 'I thought I was the only one in the world.' The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups. Interim report.

[124] Health Working Group Report on Child Sexual Exploitation. An independent group chaired by the Department of Health focusing on: Improving the outcomes for children by promoting effective engagement of health services and staff (2014)

[125] Signs and indicators, template for identifying and recording CSA concerns, Centre of expertise on CSA, November 2021

[126] Academy of Medical Royal Colleges: (Sept 2014) CSE improving, recognition and response in heath settings

[127] The London CSE Operating protocol, (March 2017)

KXI - CONTEXTUAL SAFEGUARDING

"An approach to understanding and responding to young people's experiences of significant harm beyond their families"

- Recent research developed by Carlene Firmin has started to inform policy and practical approaches to safeguarding adolescents known as 'Contextual Safeguarding.' It recognises that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse. [128]
- Parents and carers have little influence over these contexts, and young people's experiences of extra-familial abuse can undermine parent-child relationships.
- Resulting from this research a different approach is being suggested whereby children's social care practitioners need to engage with individuals and sectors who do have influence over/within extra-familial contexts, and recognise that assessment of, and intervention with, these spaces are a critical part of safeguarding practices.

Contextual Safeguarding expands the objectives of child protection systems in recognition that young people are vulnerable to abuse in a range of social contexts.

KXII - STALKING

"A pattern of unwanted, fixated and obsessive behaviour that is intrusive and causes fear of violence or serious alarm or distress"

- Stalking is one of the most frequently experienced forms of abuse.
- It is insidious and terrifying and can escalate to rape and murder.
- 1 in 6 women and 1 in 12 men have experienced stalking and this is likely to be grossly underestimated.
- 1 in 2 domestic stalkers, if they make a threat, will act on it
- The majority of victims (80%) are female while the majority of perpetrators (71%) are male.
- The Metropolitan Police Service has found that 40% of the victims of domestic homicides had also been stalked. [129, 130]

A National Stalking helpline (run by the Suzy Lamplugh Trust) can offer help and advice.

0808 802 0300

Contact the police if you're being stalked.
You have a right to feel safe in your home and workplace.

999

[128] Contextual Safeguarding, Firmin
[129] Paladin, National Stalking Advocacy Service
[130] Suzy Lamplugh Trust & National Stalking Helpline

KXIII - GANGS, COUNTY LINES & CUCKOOING

"Almost always involves the exploitation of vulnerable persons"

- 'County Lines' is a national issue involving the use of mobile phone 'lines' by groups to extend their drug dealing business into new locations outside of their home areas.
- A 'county lines' enterprise is almost always exploitative (including sexual exploitation) and can involve both children and adults who require safeguarding and are often known to be vulnerable (e.g., mental health issues, broken homes, experienced chaotic / traumatic lives, reported as missing) [131]
- 'Cuckooing' is a form of crime in which drug dealers take over the home of a vulnerable person in order to use it as a base for drug dealing.
- 65% of Police forces reported exploitation of children in 'County Lines'
- Gangs are often involved in running County Lines / Cuckooing. Illegal drug sales are worth around £5 billion a year
- Anyone selling drugs is likely to be carrying a knife too. 60% of deaths from gang or drug related activities are stabbings and 15% from guns
- Fearless.org [132] has further information and tips on how to spot a child who might be involved. This includes identifying signs or risks that may include: -
    - *Are they always going missing from school or their home?*
    - *Are they travelling alone to places far away from home?*
    - *Do they suddenly have lots of money/lots of new clothes/new mobile phones?*
    - *Are they receiving much more calls or texts than usual?*
    - *Are they carrying or selling drugs?*
    - *Are they carrying weapons or know people that have access to weapons?*
    - *Are they in a relationship with or hanging out with someone/people that are older and controlling?*
    - *Do they have unexplained injuries?*
    - *Do they seem very reserved or seem like they have something to hide?*
    - *Do they seem scared?*
    - *Are they self-harming?*

Gangs and Safeguarding further resources

- ***NSPCC: Criminal exploitation & Gangs***
- ***BBC News: Liverpool teenage stabbings***
- ***Crimestoppers: Fearless***

[131] National Crime Agency
[132] Fearless

KXIV - CHILD TRAFFICKING

"Occurs when a child is recruited, moved or transported and then exploited, forced to work or sold"

- Many children are trafficked into the UK from abroad, but children can also be trafficked from one part of the UK to another.
- UNICEF UK Report: 'Identify. Protect. Repeat. How to lead the world in supporting child victims of trafficking.' [133] [134]
    - *In 2016, almost 50 million children globally were on the move, including 10 million child refugees, 1 million child asylum-seekers and an estimated 17 million children displaced within their own countries.*
    - *In 2014, children comprised 28% of all detected victims of trafficking.*
    - *Children, especially children travelling alone, are most vulnerable to trafficking and exploitation.*
    - *The risks of not identifying a child victim of trafficking at the earliest opportunity are significant. As the main purpose of trafficking is exploitation, non-identification results in the exploitation or continued exploitation of children and the trauma and harm that brings.*
    - *Children who are not identified may also be punished or criminalised for illegal activities they have been forced to carry out by their traffickers.*
- Further resources that can assist in a better understanding of the issues include:
    - ***NSPCC: Child trafficking***
    - ***GOV.UK: Modern Slavery Training***
    - ***EPCAT: Useful Tools***
    - ***NHSE elfh: Modern Slavery***

[133] Stop the Traffic, UNICEF, July 2003
[134] NSPCC Child trafficking website

KXV – SEXUAL BEHAVIOUR IN UNDER 16'S

"The fact that a young person is U16 does not automatically mean that sexual activity is a safeguarding issue, but it should always be considered a potential indicator of abuse or exploitation"

Working Together to safeguard Children, HM Government

Sexual Behaviour in Under-16s

- The National Survey of Sexual Attitudes and Lifestyles (NATSAL-3) published in 2013 reported that 31% of young men and 29% of young women had first sex before the age of 16, indicating the normal level of sexual activity amongst under-16s.

- **NATSAL**-4 data is due out later in 2025 following the survey taken again between 2022-2024 but is anticipated to show as many, if not more U16's sexually active.

- The legal age of sexual consent in the UK is 16 years old, this applies regardless of gender or sexual orientation

- Sexual activity with someone under 13 is always treated as statutory rape, as a child under 13 cannot legally consent under any circumstances.

- Sexual activity involving 13-15 year olds is illegal, even if consensual and between peers. However the law does currently distinguish between abuse and experimentation

- **Sexual activity involving 13–15-year-olds is NOT an automatic safeguarding concern or referral.** GPs should use professional judgment and carefully consider factors such as:
    - Maturity and understanding of the young person (Assess Gillick competency and apply Fraser Guidelines)
    - Any coercion or pressure factors present
    - Any risk of exploitation present
    - Any presence of any power imbalances including age differences (especially if there's > 5 years gap between partners)
    - Any presence of drugs / alcohol / gifts / rewards between the partners

- GPs should discuss and share concerns with colleagues, such as the:-
    - GP Practice Safeguarding lead
    - Named Primary Care Health Professional for children's Safeguarding
    - Designated Health Professional for children's safeguarding
    - Community Paediatrician with responsibility for children's safeguarding

KXVI - CRIME & POLICING BILL 2025

"It will be a serious offence to block the reporting of child sexual abuse – punishable by up to seven years in prison"

Jess Phillips, MP on the Crime & Policing Bill

- **The Crime and Policing Bill 2025**: The proposed Crime and Policing Bill is designed to address rising concerns over street crime, antisocial behaviour and safeguarding vulnerable individuals including children. [135]
- **Child Exploitation and Cuckooing:** This will include new offences that criminalise the use of children for criminal activities and exploiting them by taking over homes for illegal purposes.
- **Mandatory Child Sex Abuse reporting:** All health professionals, including GPs, will have a statutory duty to report instances of child sexual abuse.
- Failure to report can result in professional sanctions.
- A "Romeo and Juliet" clause is passing through parliament that exempts consensual sexual relationships between young people (aged 13-15) from mandatory reporting, provided there is no suspicion of abuse or coercion. This aims to avoid criminalising adolescent relationships that lack coercion or significant age gaps.
- If one partner is 13-15 years old, and the other 16-17 years old, sexual activity is illegal. The Romeo & Juliet exemption is not applicable, however mandatory reporting may not apply if the U16 year old is Fraser competent and there is no coercion or abuse of power and the relationship is consensual. The GP would need to make a clear, defensible record of why a safeguarding referral was not made.
- If one partner is 13-15 years old, and the other is an adult (over 18 years of age), then this constitutes a criminal offence irrespective of agreed consensual sexual activity. The Romeo & Juliet exemption is not applicable. Mandatory reporting is currently expected. The GP would need to provide a strong justification NOT to report based on
    - The relationship posing no risk of harm or exploitation
    - The U-16 partner is demonstrably safe, competent and consenting
    - The adult partner is NOT in a position of trust (e.g. teacher, coach, youth worker) whereby the criminal offence of sexual activity includes any U18-year-old partner.
    - Strongly recommend discussing all such cases with a SG colleague either in practice or from the local Named / Designated safeguarding lead network
    - Current representation is being undertaken to bring about an amendment that would not force mandatory reporting in these circumstances

[135] GOV.UK - Crime and Policing Bill: Independent Inquiry into Child Sexual Abuse Recommendations, Gov.UK, Feb 2025

KXVII - RADICALISATION & PREVENT

"Radicalisation is a process by which an individual or group adopts increasingly extreme political, social or religious ideals and aspirations that reject or undermine the status quo or undermine contemporary ideas and expressions of freedom of choice"

- ***PREVENT*** is part of the Government's counter-terrorism strategy **CONTEST** and aims to stop people becoming terrorists or supporting terrorism.
- ***PREVENT*** focuses on all forms of terrorism and operates in a pre-criminal space, providing support and re-direction to vulnerable individuals at risk of being groomed into terrorist activity before any crimes are committed.
- Radicalisation is comparable to other forms of exploitation; it is therefore a safeguarding issue staff working in the health sector must be aware of.
- Staff must be able to recognise signs of radicalisation and be confident in referring individuals who can then receive support in the pre-criminal space. The Prevent Training and Competencies Framework [136] has been developed in conjunction with the 2019 Intercollegiate Document to: -
  - *provide clarity on the level of training required for healthcare workers*
  - *ensure a consistent approach to training and provide parity between the expectations to safeguard both children and adults with care and support needs.*
  - *identify staff groups that require basic Prevent awareness and those who have to attend Workshops to Raise Awareness of Prevent (WRAP).*
- ***CONTEST*** has four key principles:
  - ***Prevent*** *– to stop people becoming terrorists or supporting terrorism (reduce intent)*
  - ***Pursue*** *– stop terrorist attacks happening (reduce capability)*
  - ***Protect*** *– strengthen overall protection against terrorism attack (reduce vulnerability)*
  - ***Prepare*** *– where we cannot stop an attack, mitigate (reduce) its impact*
- The Health Service is a key partner in **PREVENT** and encompasses all parts of the NHS, charitable organisations and private sector bodies that deliver health services to NHS patients
- Three national objectives have been identified for the **PREVENT** strategy:
  - ***Objective 1:*** *Tackle the causes of radicalisation and respond to the ideological challenge of terrorism.*
  - ***Objective 2:*** *Safeguard and support those most at risk of radicalisation through early intervention, identifying them and offering support*
  - ***Objective 3:*** *Enable those who have already engaged in terrorism to disengage and rehabilitate.*
- Prevent focusses on working with vulnerable individuals who may be at risk of being exploited by radicalisers and subsequently drawn into terrorism related activity. In Havering the strategy is managed by the PREVENT Board as part of the safeguarding adults' and children's agenda

[136] The Intercollegiate Document on Safeguarding Children and Young People: Roles and Competences for Healthcare Staff: January 2019 (4th Edition)

- Vulnerability to radicalisation is embedded within safeguarding and should be considered as a part of a holistic assessment when you have concerns about patients' well-being the prevent duty guidance defines radicalization as the process by which a person comes to support terrorism and extremist ideologies associated with terrorist groups.
- the healthcare sector continues to make an important contribution to safeguard those vulnerable to radicalization. In 2019 to 20 healthcare professionals accounted for twelve of all prevent 725 referrals. [137]
- All Primary Care staff can identify a patient at risk of radicalisation and make an appropriate referral [138]

Level 3 (GP) Health professional knowledge requirements:

- *Understand PREVENT in the context of the CONTEST strategy, and the concept of pre-criminal space.*
- *Understand that radicalisation uses normal social processes & the "power of influence" on all.*
- *Recognise influence and understand the concepts of polarisation and the use of narratives and ideology.*
- *Understand the current threat level and that PREVENT can be applied to all forms of terrorism, present or emerging.*
- *Understand the term "vulnerable" in the context of PREVENT and what vulnerabilities are exploited by terrorist groups.*
- *Understand there is no single checklist or profile of a terrorist, and that health staff are a key group and must use their professional judgement in assessing behaviours and risks.*
- *make referrals within their own organisations and with other agencies where appropriate.*
- *Understand Channel multi-agency arrangements to provide support and redirection to individuals at risk of radicalisation.*
- *Be aware of Building Partnerships, Staying Safe: The health sector contribution to HM Government's Prevent strategy: Guidance for healthcare workers and their organisations relevant policies, procedures, and systems for PREVENT.*

Concerned about a patient you feel might be or becoming radicalised?
Anti-Terrorist hotline 0800 789 321
NEL PREVENT officer 07766 227261
….. and /or your local children's social care / MASH office

[137] NHS/DOH Prevent Rapid Read, Issue 2, December 2020
[138] Ibid

KXVIII - MODERN SLAVERY

Slavery is an umbrella term for activities involved when one person obtains or holds another person in compelled service. Someone is in slavery if they are:

"In 2016, at any given time, it is estimated that 40.3 million people worldwide were in modern slavery 70% of these are women / girls and 25% of them are children".

- *Forced to work through mental or physical threat.*
- *Owned or controlled by an 'employer', usually through mental or physical abuse or the threat of abuse.*
- *Dehumanised, treated as a commodity, or bought and sold as 'property'.*
- *physically constrained or have restrictions placed on his/her freedom.*

The following definitions are encompassed within the term 'modern slavery' for the purposes of the Modern Slavery Act 2015. [139] These are:

- *'Slavery' is where ownership is exercised over a person.*
- *'Servitude' involves the obligation to provide services imposed by coercion.*
- *'Forced or compulsory labour' involves work or service extracted from any person under the menace of a penalty and for which the person has not offered himself voluntarily.*
- *'Human trafficking' concerns arranging or facilitating the travel of another with a view to exploiting them.*

The Centre for Social Justice Report (2013) [140] further states that the term 'modern slavery' includes the definitions below:

- *Human Trafficking*
- *Slavery*
- *Servitude*
- *Forced Labour*

There is no typical victim of slavery. Victims are men, women and children of all ages, ethnicities and nationalities and cut across the population. However, it's normally more prevalent among the most vulnerable or within minority or socially excluded groups. In 2018, the UK Modern Slavery Helpline indicated that 3,280 potential victims of modern slavery cases were men, while 1,476 were women.

Child victims are victims of child abuse and should therefore be treated as such using existing child protection procedures and statutory protocols.

[139] The Modern Slavery Act 2015, HM Government
[140] The Centre for Social Justice Report, 2013

KXIX - HUMAN TRAFFICKING

"... is the movement of people by means such as force, fraud, coercion, or deception, with the aim of exploiting them ..."

- Human trafficking is a form of modern slavery.
- Trafficking involves the transportation of people in the UK to exploit them using force, violence, deception, intimidation, or coercion. This exploitation includes commercial, sexual, and bonded labour. Trafficked people have little choice in what happens to them and often suffer abuse due to violence and threats made against them or their families. In effect, they become commodities owned by traffickers, used for profit.
- These three elements form part of trafficking:
    1. ***The act**: recruiting, transportation, transfer, harbouring or receipt of persons.*
    2. ***The means**: force, fraud, coercion, deception*
    3. ***The purpose**: exploitation*
- Human trafficking is a crime.
- It does not always involve international transportation.
- Victims include those transported around the UK into exploitative situations, those born into servitude, or those who escape a trafficker before being exploited.
- It also includes anyone who once consented to work for a trafficker or slave master or participated in a crime as a direct result of being enslaved.

    - **Sexual exploitation / sex trafficking** - *this includes but is not limited to sexual exploitation and sexual abuse, forced prostitution and the abuse of children to produce child abuse images/videos. In 2016, 25% of all reported potential trafficking victims in the UK were victims of sexual exploitation.*

    - **Domestic servitude** - *this involves a victim being forced to work in usually private households, usually performing domestic chores and childcare duties. Their freedom may be restricted, and they may work long hours often for little or no pay, often sleeping where they work. (In 2016, there were an estimated 16 million victims worldwide)*

- **Forced labour** - *victims are forced to work long hours for little or no pay in poor conditions under verbal or physical threats of violence to them or their families. It occurs in various industries including construction, manufacturing, laying driveways, hospitality, food packaging, agriculture, maritime and beauty (nail bars). Often victims are housed together in one dwelling. In 2016, 84% of all reported forced labour victims were male. (An estimated 24.9 million victims worldwide).*

- **Bonded labour** *is where victims are compelled to work to repay a debt and unable to leave until the debt is repaid. It is the most common form of enslavement in the world.*

- **Criminal exploitation** - *the exploitation of a person to commit a crime, such as pickpocketing, shoplifting, cannabis cultivation, drug trafficking and other similar activities that are subject to penalties and imply financial gain for the trafficker. The most prevalent subtype of labour exploitation reported is within the block paving and tarmacking industry.*

- **Other forms of exploitation** – *organ removal; forced begging; forced benefit fraud; forced marriage and illegal adoption.*

- In 2018, nearly 7,000 potential victims were identified and submitted to the UK National Crime Agency's (NCA) National Referral Mechanism, an increase of 36% from 2017 figures. [141, 142]

- Potential victims were reported from 130 different nationalities with UK (25%), Albanian (13%) and Vietnamese (10%) nationals the most reported victims.

- The British people who are trafficked might be homeless people offered jobs that turn out to come with threats and without pay; teenagers groomed into criminal exploitation by gangs; girls and women forced into prostitution by abusive partners or by organised criminals: all of these and more would involve trafficking.

- Thousands of people across the UK are being held in squalor and undertaking forced labour.

- Some may be fleeing war zones, others may have financial problems, but all find dreams turning to nightmares as their life descends into fear, debt and drudgery in exhausting, unpaid, dangerous, and degrading work, with escape impossible, forbidden or punished.

141 Unseen, UK Charity for supporting the eradication of Modern Day Slavery
142 UK National Crime Agency (NCA)

KXX - UNACCOMPANIED ASYLUM SEEKERS

"… in the midst of migrants in search of a better life there are people in need of protection: refugees and asylum-seekers, women and child victims of trafficking…"

Antonio Guterres

- Unaccompanied children and young people are outside their country of origin and are without the care and protection of their parents or legal guardian.

- Their status, age and circumstances may well be uncertain. Sometimes they may have witnessed, or experienced traumatic events and they may be suffering the most extreme forms of loss.

- There are many reasons why children and young people may leave their home country. Some of the reasons include.
    - *fear of persecution, due to their religion, nationality, ethnicity, political opinion, or social group.*
    - *parents having been killed, imprisoned, or disappeared.*
    - *in danger of being forced to fight or become a child soldier.*
    - *war, conflict.*
    - *poverty, deprivation.*
    - *sent abroad by parents/family.*

- The literature suggests that unaccompanied children have significant physical and mental health needs.

- These are influenced by access to basic healthcare in their home country, their experience of hardship, including the witnessing and experiencing of traumatic events, and the duration of and conditions experienced on their journey to the UK.

- Refugee and unaccompanied asylum-seeking children and young people are Children Looked After and have the same rights to care as UK nationals.

- There should be support and expeditious processes in place at surgery level to register UASC and provide Primary Care support [143]

- The Looked after children team will not arrange an Initial Health or Review Health Assessment without a suitable interpreter being available.

[143] Patient Registration, SOP for Primary Care. November 2015. NHS England

- **New Patient Registrations**. Ensure all are seen face to face by the practice clinician, ideally with independent language support. Be alert to private fostering arrangements and ensure health screening includes immunisations, TB, and infectious disease screening. [144]

- **Pregnancy**. Directly refer to antenatal services, do not ask patients to self-refer. Consider whether could be the result of rape or sexual exploitation and consider trauma support.

- Please always note and document the accompanying adult present (beware of CSE, trafficking, history of physical or sexual abuse)

- **Mental Health.** Consider mental health stressors. There is a higher incidence of PTSD, PH of Torture, gender-based violence, domestic abuse.

- **Age Disputes.** There are rules about how a young person's may be determined in the absence of documentation. Liaise with Children's social care if there are concerns. It is NOT the GPs role to investigate or refer to medical services to ascertain / verify age.

- **Human trafficking.** Asylum seekers are at increased risk from modern slavery, forced marriage, radicalisation and being trafficked. Refer on to the and seek help.

[144] Safeguarding Considerations for Asylum Seeking Patients, NWL CCG, PC Support Tool. V2, 2021

KXXI – MANAGING HISTORICAL CSA CHILD SEXUAL ABUSE DISCLOSURES

"… it took me 30 years to speak out, I didn't need judgement, I needed someone to hear me and believe me…"

Survivor testimony, IICSA Truth Project

Prevalence and Presentation

- Around 1 in 6 children experience some form of sexual abuse before age 16 (NSPCC estimates).
- Many survivors delay disclosure until adulthood — often during GP consultations.
    - Presentations are usually non-specific, including:
      Chronic pain (e.g. pelvic, abdominal)
    - Gastrointestinal issues
    - Sexual health concerns
    - Mental health issues (e.g. PTSD, depression, anxiety)
    - Substance misuse
    - Self-harm or suicidal ideation

Responding to Disclosure

- Listen without judgment, offer support and validate their experience.
- You don't need to investigate or ask for explicit details.
- Avoid pressing for a disclosure if the patient is hesitant — your role is to create a safe space.

Safeguarding Duties

- If there's a current risk to a child or vulnerable adult (e.g., perpetrator has access to others), you must escalate under safeguarding procedures.
- If the abuse is entirely historic with no ongoing risk, a referral is not mandatory, but support options should be offered.

Documentation

- Record factually what the patient says in their own words.
- Include the date, time, and relevant context.
- Do not include your own interpretations or labels (e.g., "rape" or "CSA") unless the patient uses those terms.

Referral and Support Options

- Offer referral to:
    - Mental health services (IAPT, trauma-specific therapy)
    - SARCs (Sexual Assault Referral Centres) if recent abuse is involved
    - Third-sector organisations, such as:
        - NAPAC (National Association for People Abused in Childhood)
        - SurvivorsUK
        - Rape Crisis
- Consider whether a safeguarding lead or Named GP for Safeguarding should be consulted.

Professional Guidance

- RCPCH, GMC, NICE, and RCGP all stress the need for trauma-informed care.
- NICE Guideline NG76 on child abuse and neglect includes historic concerns.
- RCGP e-learning modules cover how to manage historic CSA disclosures sensitively and appropriately.

Useful Clinical Tip

"Ask once, listen well, support always."

KXXII – MANAGING AI GENERATED CHILD SEXUAL ABUSE MATERIAL (AI-CSAM)

"… Even when AI-generated CSAM causes real-world harm, it retraumatises survivors and demands the same safeguarding urgency, legal response and trauma informed care as any other form of CVSA …"

Primary Care SG Lead, Home Office & IWF Guidance

Why It Matters

- AI is being misused to create **child sexual abuse material (CSAM)**.
- AI-CSAM includes altered or entirely fake abusive images/videos.
- **All forms of CSAM are illegal** in the UK, including cartoons or illustrations.
- Professionals in primary care settings play a critical role in safeguarding.

What is AI-CSAM?

- **AI-CSAM** is content that depicts abuse of children, created or altered using **generative AI tools**.
- May involve:
  - "Nudify" tools that remove clothing from real images
  - AI-generated fake images of children
  - Synthetic media trained on real abuse images

Legal Framework

- **Protection of Children Act 1978** – criminalises creation, distribution or possession of indecent images.
- **Coroners and Justice Act 2009** – prohibits all indecent images of children, even if not photorealistic.

Key Safeguarding Considerations

- Even when generated by AI, CSAM causes **significant harm**.
- **Young people may also generate AI-CSAM**—whether as a joke, prank or to harm others.
- Always treat any suspicion of AI-CSAM with the **same urgency** as other abuse material.

Your Response Checklist

1. **Do not view, save, download, or share** the material.
2. **Immediately inform your Designated Safeguarding Lead (DSL)**.
3. **Do not investigate or attempt to determine if content is AI-generated**.
4. **Preserve digital evidence** (e.g., URLs, usernames, screenshots of messages).
5. **Report to police** via 101, or 999 if a child is in immediate danger.
6. **Ensure the young person receives support** (refer to wellbeing or mental health services).
7. **Report content** to platforms and the **IWF/Childline Report Remove Tool**.

Further Support

- ***CEOP Education:***
- ***The NSPCC:***
- ***Internet Watch Foundation (IWF):***
- ***UK Government: Sharing Nudes and Semi-Nudes Guidance (March 2024):***

ADULT SAFEGUARDING

LI – DEFINITION & CATEGORIES

An adult at risk

As defined in the Care Act 2014 [145] as a person aged 18 or over who needs care and support (whether those needs are being met), who is experiencing or at risk of abuse or neglect, and because of those needs is unable to protect themselves against the abuse or neglect or the risk of it.

Categories of Adult Abuse

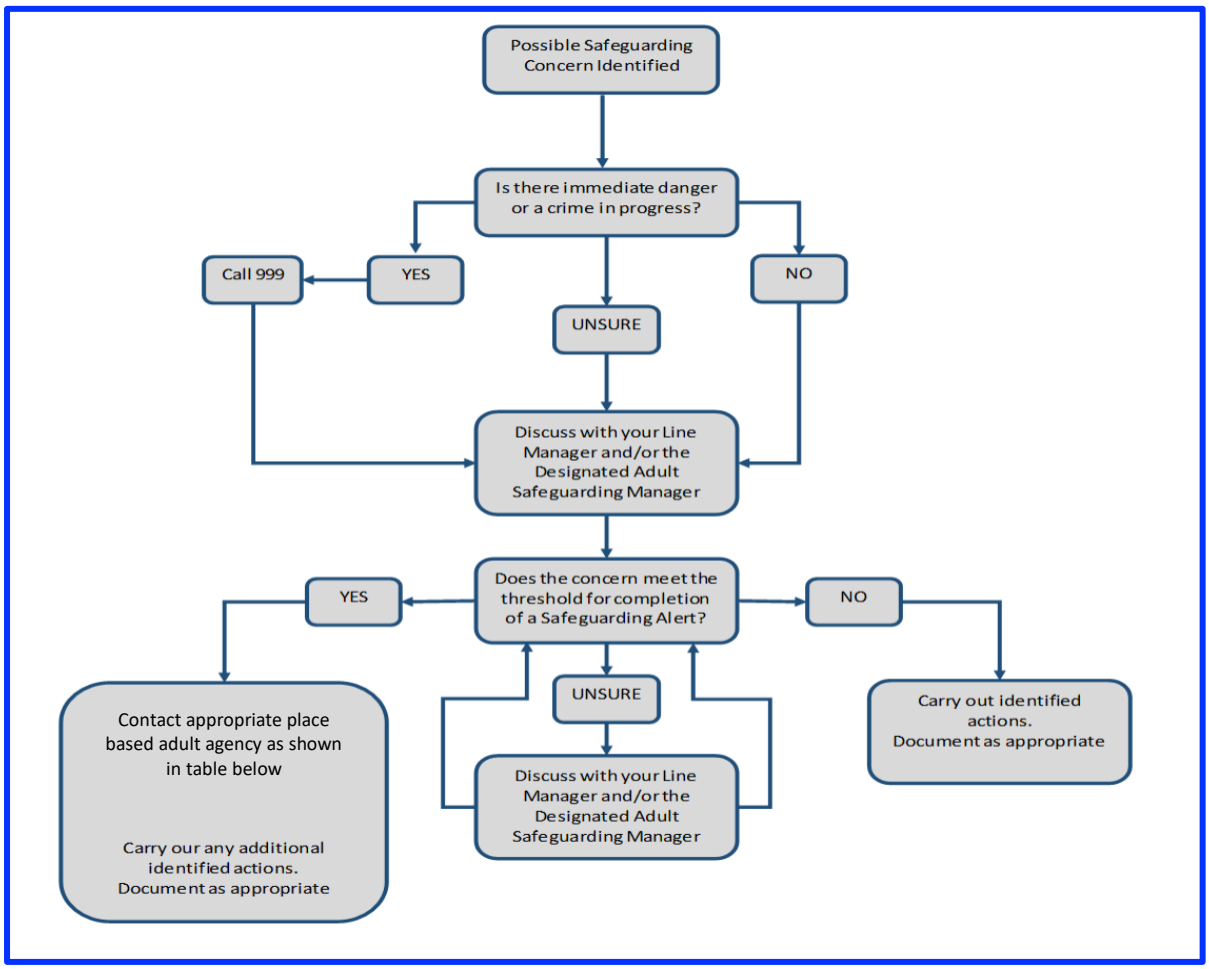
Physical abuse	*including hitting, slapping, pushing, kicking, misuse of medication, inappropriate restraint, or inappropriate sanctions;*
Sexual abuse	*including rape and sexual assault, contact or non- contact sexual acts to which the adult at risk has not consented, or could not consent or was pressurised into consenting; indecent exposure sexual teasing or innuendo subjection to pornography or witnessing sexual acts*
Psychological abuse	*including emotional abuse, threats of harm or abandonment, deprivation of contact or communication, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks;*
Financial or material abuse	*including theft, fraud, exploitation, pressure in connection with Wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits, on-line fraud or theft;*

Neglect or acts of omission	including ignoring medical or emotional/physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating; failure to report abuse or risk of abuse; Self-neglect (wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings (including e.g. hoarding)
Discriminatory abuse	*including that based on a person's ethnic origin, religion, language, age, sexuality, gender, disability, and other forms of harassment, slurs or similar treatment*
Organisational abuse	*including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation*
Domestic Abuse	*As defined by the home office. Any incident or pattern of incidents of controlling, coercive or 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. This can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial and emotional*
Modern Slavery	*encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment*

[145] The Care Act 2014, May 2014. HM Government

LII – REFERRAL / NOTIFYING A CONCERN

If you have concerns for the safety of an adult, please contact the relevant Adult Social Care Safeguarding Teams.



At place agency	Telephone number	Website access	Email
London Borough of Barking & Dagenham	020 8227 2915	https://www.lbbd.gov.uk/safeguarding-adults-at-risk-of-abuse-or-neglect	safeguardingadults@lbbd.gov.uk
London Borough of City & Hackney	020 8356 5782 (H) 020 7332 1224 City	https://hackney.gov.uk/safeguarding-adults-board	
London Borough of Havering	01708 433550	https://www.havering.gov.uk/info/20015/adult_social_care/117/adult_protection_and_safeguarding/1	safeguarding_adults_team@havering.gov.uk
London Borough of Newham	020 3373 0440	https://www.newham.gov.uk/health-adult-social-care/sg-raising-alert/2	
London Borough of Havering	01708 433550	https://www.havering.gov.uk/info/20015/adult_social_care/117/adult_protection_and_safeguarding/1	safeguarding_adults_team@havering.gov.uk
London Borough of Redbridge	020 8708 7333 opt 2	https://mylife.redbridge.gov.uk/pLorotecting-adults-at-risk-of-abuse-or-neglect/	Adults.alert@redbridge.gov.uk
London Borough of Tower Hamlets	0300 303 6070	https://www.towerhamlets.gov.uk/lgnl/health__social_care/ASC/Adults_Health_and_Wellbeing/Staying_safe/Adults_at_risk_of_abuse_or_neglect.aspx	
London Borough of Waltham Forest	020 8496 3000	https://www.walthamforest.gov.uk/families-young-people-and-children/child-protection/multi-agency-safeguarding-hub-mash/how-report-adult-safeguarding-concerns	

LIII – LEGISLATION, THE CARE ACT

"The rights of every man are diminished when the rights of one man are threatened"

John F Kennedy

The Care Act 2014

- The Care Act 2014 [146] brings in the requirement for integrated care and support that is person-centred, tailored to the needs and preferences of those needing care and support.
- The Care Act puts adult safeguarding on a legal footing and requires each Local Authority to set up a Safeguarding Adults Board (SAB).
- In discharging these duties, there are express reciprocal duties to co-operate on local authorities and their "relevant partners" (including NHS England, Primary Care and all CCGs and health trusts) in order to help and support adults in need along with their carers and to protect adults with care and support needs experiencing or at risk of abuse or neglect.
- All NHS organisations need to ensure that there is sufficient capacity in place to fulfil their statutory duties and should regularly review their arrangements to assure themselves that they are working effectively. The Care Act 2014 places a duty on agencies to co-operate to safeguard adults
- There are key sections to this Act regarding statutory duties for Local Authorities and **Other** agencies regarding safeguarding ***{Appendix T}*** with local multi-agency policy and procedures available too.
- The Care Act introduced six principles that underpin adult safeguarding:
    - ***Empowerment*** *– Personalisation and the presumption of person-led decisions and informed consent.*
    - ***Prevention*** *– It is better to act before harm occurs*
    - ***Proportionality*** *– Proportionate and least intrusive response appropriate to the risk presented.*
    - ***Protection*** *– Support and representation for those in greatest need.*
    - ***Partnership*** *– Local solutions through services working with their communities.*
    - ***Accountability*** *– Accountability and transparency in delivering safeguarding.*
- We have a duty to promote these principles through discharging the functions of the CCG and by ensuring providers have these principles embedded within their organisational philosophies and practices as they work with adults and adults at risk of abuse or neglect. ***{Appendix L1}***

[146] The Care Act 2014, May 2014, HM Government

Care Act, Section 42 Enquiry by local authority

- This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)
    - *has needs for care and support (whether the authority is meeting any of those needs),*
    - *is experiencing, or is at risk of, abuse or neglect, and*
    - *because of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.*
- The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.

Care Act, Masking Safeguarding Personal (MSP)

- should always be to ensure the safety and well-being of the adult.
- Making Safeguarding Personal (MSP) is a person-centred approach to adult safeguarding that is led by the individual, not be the process
- Adults are encouraged to make their own decisions and are provided with support and information to empower them to do so.
- It is vital the adult feels they are the focus and they have control over the process
- It is about getting a person to tell us what kind of help they want, listening to them and making sure that what the person wants is understood and is part of any plans

What does MSP mean to practitioners?

- *Always think of prevention of abuse and neglect and not only reacting to specific incidents.*
- *working in partnership with all agencies and individuals involved in the persons life*
- *be flexible and ensure you enable the person to be involved which helps them to express their views.*
- *ensure the persons views and wishes I'll listen to and respected.*
- *recognise the person's right to make choices on how they live their lives.*
- *avoid prioritising process and making assumptions.*
- *All clinicians are required to have an in-depth knowledge of the MCA, to ensure they comply with the both the MCA 2005 and The MCA Code of Practice within the functions of their roles e.g., Continuing Health Care*

LIV – LEGISLATION, MENTAL CAPACITY ACT

The Mental Capacity Act 2005

- The Mental Capacity Act 2005 [147] provides a statutory framework to empower and protect people who may lack capacity to make decisions for themselves; and establishes a framework for making decisions on their behalf. This applies whether the decisions are life-changing events or everyday matters. All decisions taken in the adult safeguarding process must comply with the Act.

The Act clarifies:

- *The process for caring for someone who may, at some time, lack capacity*
- *How decisions should be made for that person*
- *When family, relatives or carers should be consulted about decisions being made for that person*
- *How that person is protected when others are making decisions for them*

- The Mental Capacity Act outlines five statutory principles that underpin the work with adults who may lack mental capacity:
    - *A person must be assumed to have capacity unless it is established that he lacks capacity.*
    - *A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.*
    - *A person is not to be treated as unable to make a decision merely because he makes an unwise decision.*
    - *An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.*
    - *Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.*

- ***Mental capacity is time and decision specific.*** This means that an adult may be able to make some decisions at one point but not at other points in time. Their ability to decide may also fluctuate over time.
- If an adult is subject to coercion or undue influence by another person this may impair their judgement and could impact on their ability to make decisions about their safety.
- Thus, an adult could be put under pressure, for example in domestic abuse situations, that they lack the mental capacity to make the decisions about their safety. Staff must satisfy themselves that the adult has the mental ability to make the decision themselves, if not, it is best to err on the side of caution, identify the risks and consider support or services that will mitigate the risk. Preventing the person from isolation can be a protective factor.
- Involving an advocate could assist in such circumstances. Advocacy support can be invaluable and may be provided by an IMCA or another appropriate advocate.

[147] The Mental Capacity Act 2005, April 2005, HM Government

LV – ADULT SAFEGUARDING & CONSENT

Mental Capacity and Consent

- Most adults that require additional safeguards are likely to lack mental capacity to make decisions about their care and support needs.
- Mental Capacity refers to the ability to decide about a particular matter at the time the decision is needed. It is always important to establish the mental capacity of an adult who is at risk of abuse or neglect, should there be concerns over their ability to give informed consent to:
    - Planned interventions and decisions about their safety.
    - Their safeguarding plan and how risks are to be managed to prevent future harm.
- In those instances where the person lacks the mental capacity to give informed consent, staff should always bear in mind the requirements of the Mental Capacity Act 2005, and whether sharing it will be in the person's best interest.

Safeguarding Adult Reviews (SARs) and Consent

SARs are conducted under the *Care Act 2014*, which mandates local authorities and partners to safeguard adults at risk of abuse or neglect.

- **Care Act 2014 - Section 45:** Authorizes the sharing of information without consent when necessary to safeguard adults, ensuring SARs can be conducted effectively.
- **Duty of Cooperation (Care Act 2014 - Sections 6 & 7):** Requires cooperation between relevant partners, allowing information sharing without consent if it is crucial for protecting adults at risk.
- **Data Protection Act 2018 & UK GDPR:** Permits the processing of personal data without consent when required for public interest tasks, such as safeguarding.

Domestic Homicide Reviews (DHRs) and Consent

DHRs are mandated by the *Domestic Violence, Crime and Victims Act 2004*, with the purpose of learning from domestic homicides to prevent future incidents.

- **Domestic Violence, Crime and Victims Act 2004 - Section 9:** Obligates agencies to share information without consent during DHRs to fully understand the circumstances and prevent future homicides.
- **Crime and Disorder Act 1998 - Section 17:** Supports information sharing without consent as part of the duty to prevent crime and ensure public safety.
- **Data Protection Act 2018 & UK GDPR:** Provides legal grounds for sharing personal data without consent when necessary for public safety in the context of DHRs.

LVI – DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)

"The rights of every man are diminished when the rights of one man are threatened"

John F Kennedy

- The Deprivation of Liberty Safeguards (DoLS) are an amendment to the Mental Capacity Act 2005. They apply in England and Wales only and they came into force in April 2009. [148] They were originally applied to any person who lacks capacity and is currently being cared for in a care home or hospital setting. Hospital and care home managers would need to seek an authorisation from the appropriate BHR Local Authority DoLS teams.

- The Supreme Court extended these arrangements to cover people in other situations following a decision made in 2014 known as the 'Cheshire West case'. [149]

- This means that for those who live in settings such as a supported tenancy or their own home they can still be subject to a deprivation of liberty dependent upon the "acid test" being applied i.e. is the person subject to continuous supervision and control? And are they free to leave? – with the focus being not on whether a person seems to be wanting to leave, but on how those who support them would react if they did want to leave.

- If the answer is yes to these questions and the person lacks capacity to consent to the arrangements, then an application will need to be made to the Court of Protection by those funding the care (either the Council or ICB).

- These safeguards protect people who are unable to make decisions for themselves. This may be because of conditions such as:
  - *Brain injury*
  - *Dementia*
  - *Learning disability*
  - *Mental disorder*

- If you are concerned about somebody and think there should be an Authorisation in place, please make a referral to relevant Council DoLS teams (or speak to the person's nurse or social worker).

- DoLS are applicable for adults only

[148] The Mental Capacity Act Deprivation of Liberty Safeguards, January 2018, HM Government

[149] The Cheshire West Case, Judgement, The Supreme Court of Appeal, March 2014. HM Government

SAFEGUARDING APPENDICES

Appendix C1:

NHS SAFEGUARDING APP

The NHS Safeguarding App continues to support frontline staff and citizens with 24-hour, mobile access to updated safeguarding guidance and local contacts to report safeguarding concerns.

Currently accessed by over 300 users daily and has had over 100,000 downloads. It provides an overview of necessary legislation and guidance covering both children and adults safeguarding as well as an NHS staff guide and contains regional contact information on how to report a safeguarding concern, as well as links to national bodies and for healthcare staff to have a one stop sign posting and safeguarding information.

It can be accessed via Apple IOS and Google Play, or it can be downloaded by visiting your device's appropriate app store and searching for 'NHS Safeguarding'

https://www.england.nhs.uk/safeguarding/nhs-england-safeguarding-app/

Appendix D1:

CYP NEW PATIENT REGISTRATION FORM TEMPLATE

	_____ *Surgery* **New Patient Registration Form (Children: under 16s)** **completing this form on behalf of a Child**		**Today's Date**

1. Complete a separate form for each child to be registered
2. Complete in BLOCK CAPITALS and tick the boxes and fill in each section as appropriate

1	**Full Name:**		**Telephone Number:**
	Title : Master ☐	Miss ☐	**Mobile tel. number:**
	Other. *Please state* **:**		
	NHS number if known:		We will use this to send appointment reminders and health promotion details. Please tick here if you do not wish to receive messages from us: ☐
	Address: **Postcode:**		**E-mail address:**
			Next of Kin:
	How would like us to contact you about your child: Letter ☐ Email ☐ SMS (text) ☐ Phone ☐		**Relationship to child:**
			Next of Kin contact tel. number:
	Date of Birth:	**Gender:** Male ☐ Female ☐	**Mothers name if different:**
	Town* and Country of birth **(*If town is London please state which Borough)**	**Country:** **Town:**	**Borough (*If born in London):**
	Please list other residents of your home who are registered with us:	**Name:**	**Date of Birth:**

2	**Looking after a family member**		
	Is your child looking after someone? Let us know if your child is looking after someone who is ill, frail, disabled or has mental health and/or emotional support needs, or substance misuse problems		Yes ☐ No ☐
	Is someone looking after your child? Let us know if a family member, friend or neighbour looks after your child.		Yes ☐ No ☐
	Carer's name:	**Relationship to your child:**	
	Telephone number of carer:	**Is your child's carer registered with us?**	
	Address of carer:		

3	**Your Child's Religion** (Please tick)	C of E ☐	Catholic ☐	Other Christian (state): ☐	Buddhist ☐	Hindu ☐	Muslim ☐
		Sikh ☐	Jewish ☐	Jehovah's Witness ☐	No religion ☐	Other religion (state) ☐	
	Your Child's Ethnic Origin (Please tick one)	White (UK) ☐		White (Irish) ☐	White (Other) ☐		
	Black Caribbean / British ☐	Indian / British Indian ☐		Arabic ☐	Other Mixed Background ☐		
	Black African / British ☐	Pakistani / British Pakistani ☐		Chinese ☐	Other Asian Background ☐		
	Other Black Background ☐	Bangladeshi / British Bangladeshi ☐		Other ☐	Ethnic Category Refused ☐		
	Does your child need an Interpreter?	Arabic ☐		Hindi ☐	Gujurati ☐		
	Polish ☐	Farsi ☐		French ☐	Portuguese ☐		
	Urdu ☐	Bengali / Sytheti ☐		Punjabi ☐	Other language. ***Please state***: ☐		
	Does your child need help with mobility/hearing/speaking? (tick all that apply)						
	Wheelchair ☐	Walking aid ☐		Hearing aid ☐	British sign language (BSL) ☐	Makaton sign language ☐	
	Lip reading: ☐	Large print: ☐		Braille ☐	Other. ***Please state***: ☐		
	Is your child currently?	Homeless ☐		A Refugee ☐	An Asylum Seeker ☐		
	Is your child housebound?	Yes ☐	No ☐	Comments:			

4	**Medical background**				
	Are there any serious diseases that affect your child's **parents, brothers or sisters**? Tick all that apply ***and*** state **family member**:				
	Diabetes ☐ Who:	**Asthma** ☐ Who:	**Thyroid disorder** ☐ Who:	**Stroke** ☐ Who:	**COPD** ☐ Who:
	Heart Attack under age of 60 ☐ Who:	**Cancer (Specify type)** ☐ Who:	**High Blood pressure** ☐ Who:	**Any other important family illness. *Please state*:** Who:	
	Please state any allergies and sensitivities that your child has to medicines, food & dressings:				
	Please state any mental disabilities your child has:				
	Does your child have any problems taking medicines?	Yes ☐ No ☐	***If yes*** please give details, e.g. swallowing		

Appendix D2:

CHILD REGISTRATION NOTIFICATION TEMPLATE TO HEALTH VISITOR / CSC

Practice letterhead

Date:

Dear Colleague (Health Visitor)

Name:

DOB:

NHS no.

Address:

School (if known).

We would like you to inform you that the above named child, has recently registered at our practice along with an adult who has parental responsibility.

We do not have access to any previous medical records as of yet but felt it appropriate to let you know of their registration with us.

If you are aware of any relevant information about the child / family, especially if it is of a safeguarding nature, we would be grateful if you would consider sharing this with us at this time.

This will enable us to provide appropriate medical care for them with important historical information at hand, until the notes arrive accordingly.

Yours sincerely

Practice Safeguarding (administrative) lead

Telephone number:

e-mail contact:

Appendix D3:

CHILD DE-REGISTRATION NOTIFICATION TEMPLATE TO HEALTH VISITOR / CSC

Practice letterhead

Date:

Dear Colleague

Name:

DOB:

NHS no.

Address:

School (if known).

We would like you to inform you that the above named child, was registered at our practice but has now left the list following an

☐ Internal ☐ External transfer request.

According to our records, they were subject to the following recent / current safeguarding processes affecting them and / or a close member of their family.

☐ Sx 47, Child protection

☐ Sx 17, Child in Need

☐ Other.

Yours sincerely

Practice Safeguarding (administrative) lead

Telephone number:

e-mail contact:

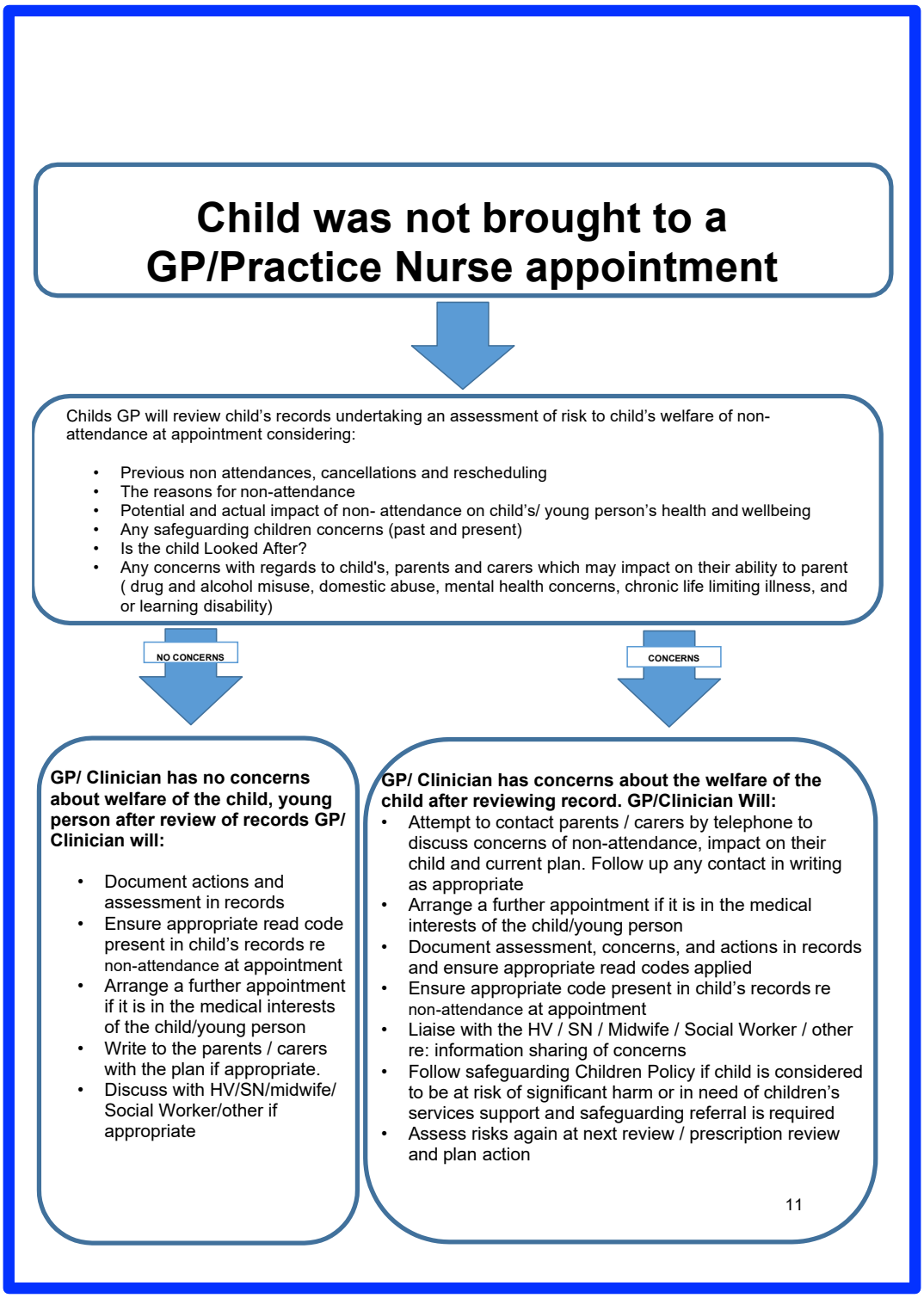
Cc: ☐ Health Visitor

☐ Named social worker

☐ CSC / MASH

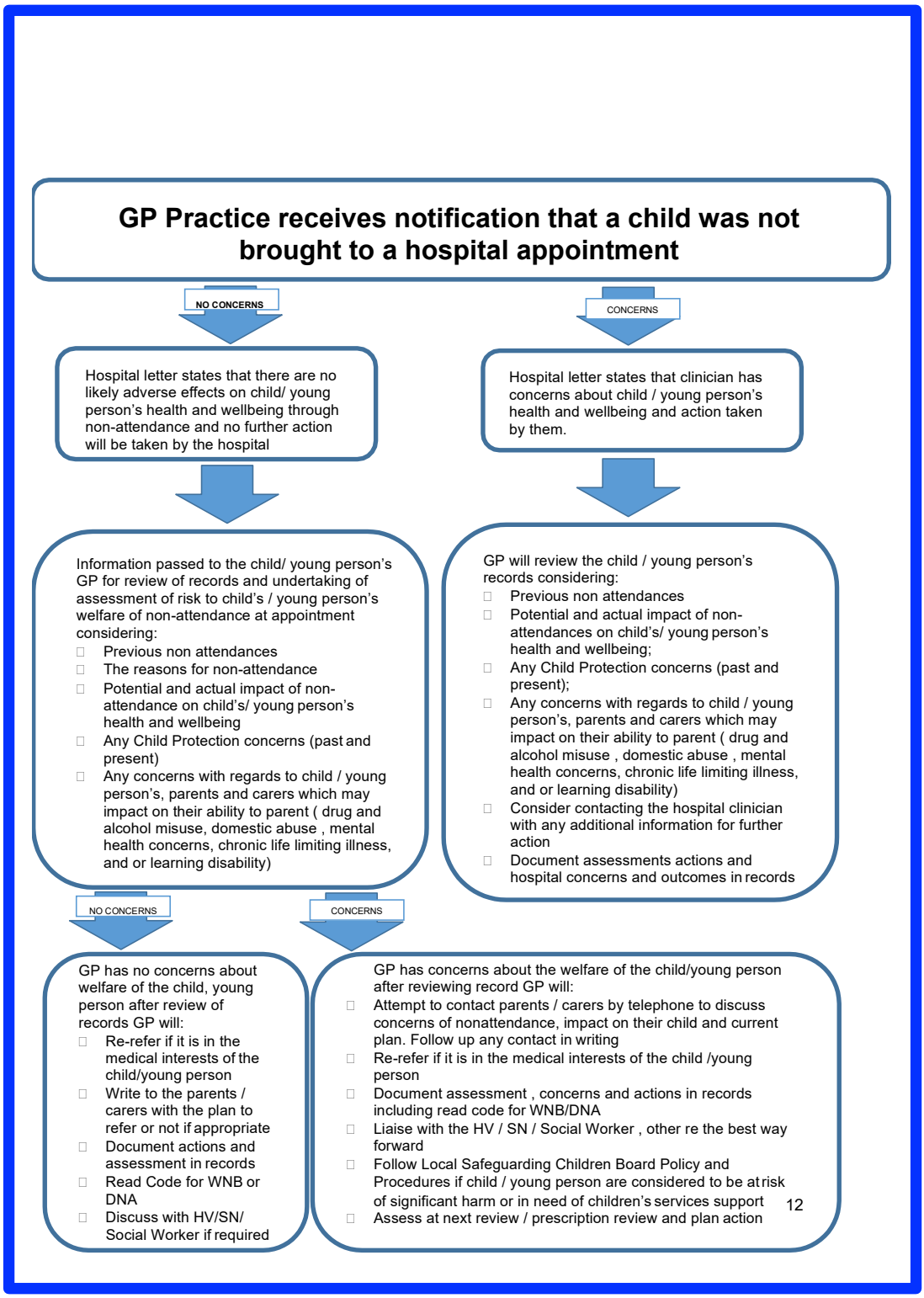
Appendix E1:

'WAS NOT BROUGHT PROCESS FOR CHILDREN' - NOT BROUGHT TO A PRIMARY CARE APPOINTMENT



Appendix E2:

'WAS NOT BROUGHT PROCESS FOR CHILDREN' - NOT BROUGHT TO AN APPOINTMENT OUTSIDE OF PRIMARY CARE



Appendix E3:

VULNERABLE ADULTS
‘Was not brought”

Use this checklist when a vulnerable adult does not attend a scheduled appointment.

Missed contact may indicate self-neglect or wider safeguarding concerns.

Consider the following actions before closing care episodes or discharging.

- 🔍 Check for vulnerability codes, safeguarding alerts or mental health concerns.
- 📞 Attempt contact by phone – don’t rely solely on SMS.
- 📬 Consider alternative methods – letter, email, or in-person if appropriate.
- 👥 Contact next of kin, carer, support worker, or social worker if known.
- 📈 Review attendance history – is there a pattern of non-engagement? If so escalate to the practice safeguarding lead.
- 📋 Consider whether the patient has capacity to make healthcare decisions.
- ⚠️ Assess for potential self-neglect or deterioration.
- 🔄 Consider rescheduling with reasonable adjustments:
    - Flexible timing
    - Support person present
    - Accessible communication
- 👨‍⚕️ Liaise with community, safeguarding or mental health teams if needed.
- 📝 Record all actions, decisions and contacts clearly in the patient record.

🚨 **Missed appointments can be safeguarding indicators – not just disengagement.**

Appendix F1:

7 GOLDEN RULES FOR INFORMATION SHARING

HM Government

Seven golden rules for information sharing

1. **Remember that the Data Protection Act is not a barrier to sharing information** but provides a framework to ensure that personal information about living persons is shared appropriately.
2. **Be open and honest** with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
3. **Seek advice** if you are in any doubt, without disclosing the identity of the person where possible.
4. **Share with consent where appropriate** and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, that lack of consent can be overridden in the public interest. You will need to base your judgement on the facts of the case.
5. **Consider safety and well-being:** Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.
6. **Necessary, proportionate, relevant, accurate, timely and secure:** Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.
7. **Keep a record** of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

Local contacts

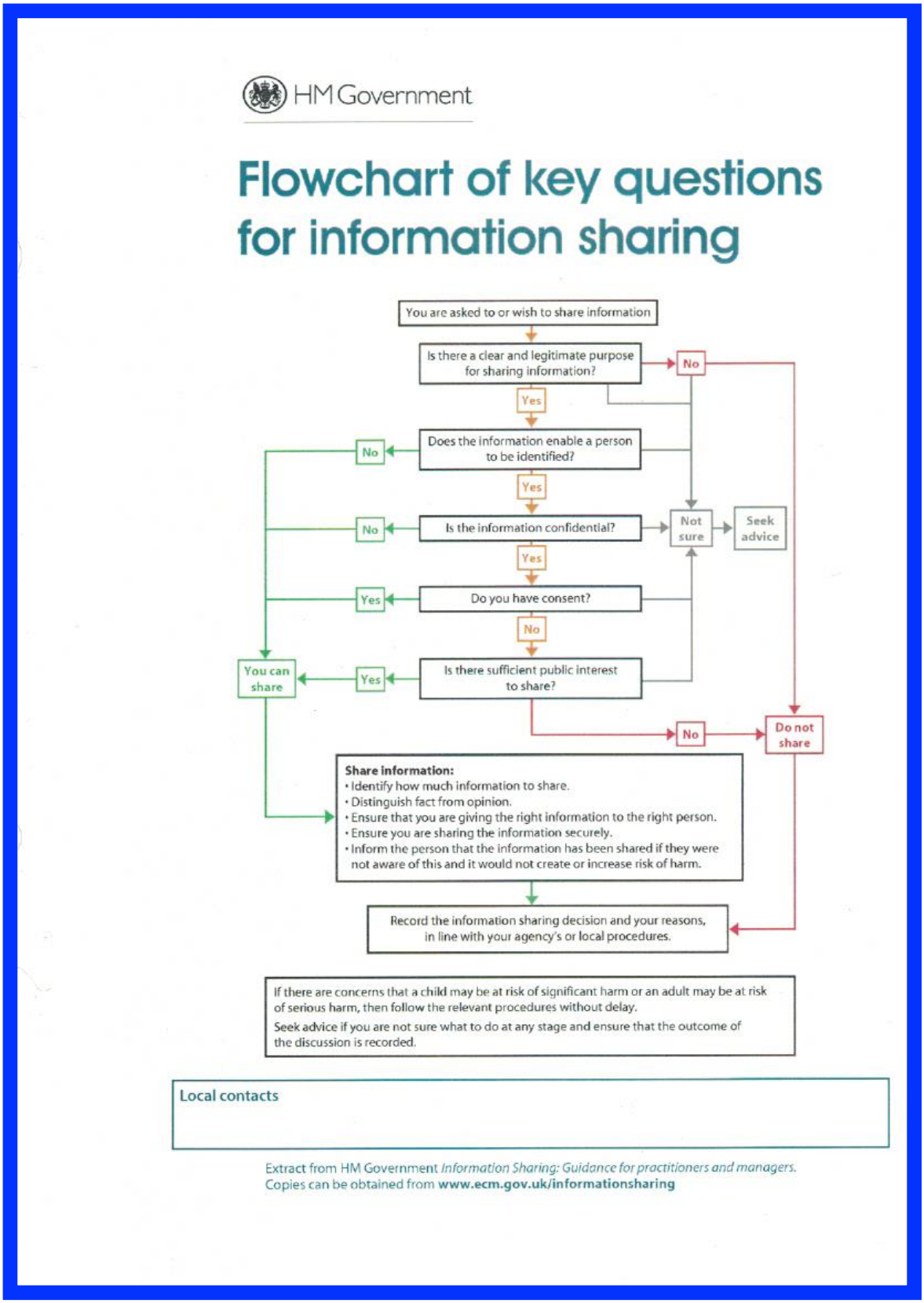
Extract from HM Government *Information Sharing: Guidance for practitioners and managers.*
Copies can be obtained from **www.ecm.gov.uk/informationsharing**

Appendix F2:

CALDICOTT 8 PRINCIPLES

Appendix F3:

FLOWCHART FOR INFORMATION SHARING



Appendix F4:

INFORMATION SHARING TEMPLATE I

A MASH information request form {LB of Havering}

Havering LONDON BOROUGH

Name

(Business Support Officer)

Ruth Grocock and Katharine Norden
(Health Team)

Department: Triage, MASH & Assessment Team, Children, Adults and Housing, London Borough of Havering
Mercury House, 4th Floor, North Wing, Mercury Gardens, Romford, RM1 3DW

***t:* 01708 43 3222**
f: 01708 43 3375
Text relay: 18001 01708 43 3222
Email: tmash@havering.gov.uk
Date:

To:

E-mail:

CHECKS REQUIRED FOR MASH

Reason for Safeguarding / Child Protection concern:

Information required by:
Red = due in 4 hours (Urgent) ☐ **Amber** = due in 24 hours ☒

Date of last MASH:

A referral to children's services has been received relating to the concerns highlighted above. Based on the seriousness of concern we require your co-operation to provide a reponse within the timescale indicated above. Any delay could increase the risk of harm to a child or young person or undermine efforts to protect them.

The General Medical Council's "Protecting Children & Young People" (GMC, 2012) gives clear guidance on how to promptly respond to requests for information (Sections 46-50). Whilst it remains good practice to consider obtaining consent before sharing any requested confidential medical information (Section 34-35), it also highlights the significant risks and potential harm to a child or young person a delay in providing information could have (Section 39-41).

For this request, it is possible to share information, without the need to obtain consent (Section 31, 36-38).

Please note, if we receive another referral for this family after 4 weeks, we may need to contact you again to request an update to this information.

If you have any further queries regarding this request or wish to share this information over the telephone, please contact us on 01708 433222.

Thank you for your timely assistance in this matter.

Please e-mail the completed form back to the MASH team tmash@havering.gov.uk
Kind regards,
Triage, MASH & Assessment Team

Havering MASH complies with the London Child Protection Procedures regarding GDPR and relies upon Legal Obligation / Public Task as the primary basis for processing information to establish whether or not there is a need to safeguard the welfare of a child. Please promote good practice and inform parents/carers when personal data is being shared. For any safeguarding concerns, please contact 01708 433222.

Cleaner, Safer, Prouder Together

Havering LONDON BOROUGH

Information Required on the following Family Members:

Family Member	DOB	Relationship	Addresss	NHS No.

Please respond to the below questions as applicable
(To best comply with GDPR, please only respond to the below questions rather than provide a clinical / computer summary sheet)

1. Confirm that the child/ren and parents are patients at your surgery, that their dates of birth and address are correct (as above). Please confirm ethnicity of the child/ren if you have this on record.
2. Are you aware of any another persons or family members living at the above address? If so, are there any concerns we should be aware of?
3. When was each member of the family last seen?
4. Are there any medical issues that may affect the child/ren's ability to achieve the expected development of a similar age?
5. Are you aware of any issues within the household that may affect the care of the child/ren, for example: substance misuse, mental health problems or domestic violence?
6. Do you have any safeguarding concerns regarding this family?
7. Have you seen the child/ren with any injuries?
8. Has there been any persistent non-attendance?
9. Are the child/ren's immunisations up to date?
10. Is there anything else you wish to add that may help the current safeguarding investigation?

Information provided by:
Position in Practice:
Practice Name:
Signature: **Date:**

Havering MASH complies with the London Child Protection Procedures regarding GDPR and relies upon Legal Obligation / Public Task as the primary basis for processing information to establish whether or not there is a need to safeguard the welfare of a child. Please promote good practice and inform parents/carers when personal data is being shared. For any safeguarding concerns, please contact 01708 433222.

Cleaner, Safer, Prouder Together

Appendix F5:

INFORMATION SHARING TEMPLATE II

Section 47 information request form {LB of Redbridge}

Date:

Urgent GP request for information

in respect of:
{Name & Address}

The London Borough of Redbridge Child Protection Team are currently investigating the above-named child/ren's circumstances under Section 47 of the Children Act 1989. We require medical information that is relevant to the safety and well-being of the child/ren, together with any **relevant** information about the carers' health and ability to parent.

Under the GDPR and Data Protection Act 2018 you may share information without consent if, in your judgement, there is a lawful basis to do so, such as where safety may be at risk. You will need to base your judgement on the facts of the case … Consider safety and well-being: base your information sharing decisions on the safety and well-being of the individual and others who may be affected their actions … ensure that the information you share is necessary for the purpose for which you are sharing it. *HM Government Information Sharing Guidance 2018.*

As this is a S.47 investigation, parental consent is not required and due to the urgent nature of this request for information it is necessary for the information to be provided within 3 working days. Under S11 of the Children Act 1989, GPs are expected to effectively discharge their responsibilities to protect and promote the welfare of children. The ***2012 Ethical Guidance for Doctors*** requires doctors to co-operate fully with all child protection procedures.

The nature of the concern is:

Could you please provide the following information to the best of your knowledge?

1. *Any additional detail of the family members as known to you i.e. full names, dates of birth and National Health Service Numbers.*
2. *Whether there is any indication from their history or meeting with the family that the child may have been abused or whether their vulnerability increases future risk of harm.*
3. *Dates and reasons that the child/ren have been seen over the last 12 months, including dates of DNAs.*
4. *Whether the parent/carers attended arranged appointments and followed medical advice appropriately.*
5. *Any relevant information regarding family dynamics, parenting capacity and any health or behavioural condition of the parents/carers, which may impact on parenting ability (e.g. effects of medication, substance misuse, depression, DV).*
6. *Are the child/ren's immunisations up to date?*

Please securely email your information within **72 hours**

Appendix H1:

SG & GP VIRTUAL CONSULTATIONS

NNNGP PRIMARY CARE SAFEGUARDING

NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group

Safeguarding in Virtual Consultations in Primary Care

Before all consultations:

- Check the medical record for all patients – are there safeguarding flags or alerts recorded?

Safeguarding alerts already on the records:

- Try to organise a face to face assessment wherever possible
- If a face to face consultation is not possible then try to consult via video rather than by phone
- Read through the previous safeguarding notes to understand the context of these concerns.
- Check at the start of the consultation whether it is safe for them to talk
- If there is no alternative but a virtual consultation, have a low threshold of concern.
- The known concerns should be specifically explored during the consultation, including in relation to the impact on the health of the person at risk of abuse.

During consultations:

- Ask and record who is in the room with the patient; but even if the person states that they are alone, be aware that there may be people outside of the video who you cannot see and bear this in mind in your questioning.
- Ask more questions than normal about how the patient is doing generally; normal cues may not be as accessible in virtual consultations, particularly phone calls.
- If the consultation is about a child, try to speak with the child, or if not possible, ask to see the child on the video
- Where relevant, ask what support a person has and whether this has changed due to Covid.

Observations:

- What can you see in the room behind the patient? Is it tidy / messy / clean / dirty?
- Can you see any obvious injuries?
- Is the person looking to someone else before answering?
- Any concerning background noise, e.g. someone else talking as if giving answers?

Clinician has concerns about abuse, or abuse disclosed:

- Consider if the person is safe to stay at home – consider calling 999
- Try and gather as much information as possible.
- If abuse is disclosed, offer validating statements such as "no one deserves to be treated in this way."
- Make a face to face appointment to discuss further that day wherever possible - the person may feel able to discuss abuse if alone in a consultation at the surgery.
- Refer to the appropriate service (Children's or Adult Safeguarding, MARAC, IDVA etc)

After the consultation:

- Record everything carefully in the notes
- If a referral is made, add the read code for this: "**referral to safeguarding adult's team**," "**referral to safeguarding children's team**," or "**referral to MARAC**."
- Use other codes appropriately – see coding guidelines for further details of correct codes.
- Ask your administrator to record any referral on the practice safeguarding register.
- Remember to look after yourself, these consultations can be stressful, so housekeep and take a quick 5 minutes break.
- Remember to prevent online access to the consultation notes by the patient.
- If you feel you need further advice, speak to your safeguarding lead.

Please see "Safeguarding Guidance to health professionals: conducting Non Face-to-Face Health Assessments or Reviews" for more detailed advice on this topic.

Author. Dr M. Sharma *Final. Sept 2020*

Appendix H2:

U18 GP VIRTUAL CONSULATIONS

NNNGP
PRIMARY CARE SAFEGUARDING

Safeguarding Primary Care Virtual Consultations in the U18s

"An A to G guide for safer U18 virtual consulting"

Amend existing policies

- Amend existing SG policies to include remote access and digital imagery handling in U18s
- Provide update / training for all staff

Be vigilant and professionally curious

- Remain aware, vigilant and professionally curious
- Have your safeguarding antennae alert at all times

Consult the same way as you would in a F2F consultation

- Use the same principles to assess capacity (Gillick Competence and Fraser Guidelines) for consulting remotely as you would in a F2F consultation
- Ensure consent is obtained and confidentiality assured
- Provide a quality consultation with written advice and information / guidance
- Offer chaperones when appropriate and necessary to do so
- Pay attention to the tone of your voice, try and smile! These things matter much more remotely

Digital & IT awareness

- Be aware of associated GP IT Futures, IT and digital regulations
- Be aware of IT security and legal regulations regarding remote & intimate consultations
- Be up to date with safeguarding and information governance training

Equality of provision – Voice & Choice

- Ensure that U18s are not disadvantaged by providing full access to the remote offer *(eConsult does not currently allow under 16s direct access)*
- Ensure U18s have a choice and have a voice in their service offer, where possible and appropriate to do so

Face to Face (F2F) where possible

- Many young people would choose F2F over remote, and phone over video
- Retain a low threshold to convert a remote into a F2F consultation especially if there is a known or suspected vulnerability / disability or safeguarding issue
- If seeing them F2F is not an option, 'meeting' by video first just to make introductions and establish some rapport, and then continuing the consultation by phone, in order to discuss their problem may be an option

Good record & house keeping

- Document carefully and contemporaneously
- Check the identity of the patient – by date of birth and their location + 1 or 2 other pieces of information known only to the patient (e.g. date of last consultation, last hospital appointment or prescribed medication)
- This may be important if the call is terminated abruptly and you are concerned about their safety / use of drugs or alcohol / mental wellbeing.
- Establish who has initiated this call – did the young person know that the appointment was being made? {a parent making the appointment can adversely affect the outcome and you should ask the young person if they want to continue}
- Document who else is present in the room, can anyone overhear, do they feel safe?
- Rearrange the call if necessary or bring them in for F2F

NELCA CCG Named GPs for Children's Safeguarding,
Dr E. Tukmachi (Newham, C&H & TH); Dr H. Jones (TH), Dr S. Pheerunggee (WF)
Dr R. Burack (B&D & Havering) and Ruth Rothman (Redbridge)

November 2020, v4

Appendix H3:

U18 GP CONSULTATIONS & INTIMATE IMAGERY

NNNGP
PRIMARY CARE SAFEGUARDING

Safeguarding U18 Virtual Primary Care Consultations involving intimate imagery

THE CONTEXT

- Managing intimate examinations for U18's virtually, either by video or by handling imagery is fraught with risk and should only be conducted in exceptional circumstances.
- Previous studies have confirmed U18 year olds would prefer a F2F consultation over a remote consultation if given the choice
- If at all possible, a F2F appointment should be arranged.
- This document should also be read in conjunction with the A to G guidance of safer remote consulting for U18's and also the latest national guidance issued by the RCGP/NHS I , the MDU and the GMC

THE LEGALITIES

- The UK 1978 Protection of children act has a strict prohibition on the taking, making, circulation, and possession with a view to distribution of any indecent photograph of a child. This is not age specific, i.e. is - applicable for adults and U18s.
- The 'making of an image' includes
  - **Opening** an attachment to an email containing an image
  - **Accessing** a website where images pop up automatically
  - **Downloading** an image from a website onto a computer screen
  - **Storing** an image in a computer's directory / hard drive
- The 1988 UK Criminal Justice Act (Section 160) makes the simple possession of indecent photographs of children an offence.
- The primary legislation around images of children does indicate the ability to hold images that may be considered indecent when there is a legitimate reason to do so.
- One can assume [although can't ever be 100% confident on this] that reviewing images as part of telemedicine would be a legitimate reason.

NECESSITY

- Is a picture absolutely necessary and in the best interests of the patient?
- Is a remote consultation the most appropriate method of arriving at a safe diagnosis and treatment plan in circumstances where you or the patient thinking an image is necessary?
- Will an image be enough, or will you need to undertake a more extensive examination of the patient?

RECEIPT OF INTIMATE IMAGES IN U18

- ***Most GPs working in child safeguarding report that they would not be requesting intimate images of U18s as it is not considered a normal practice***
- If on balance it is felt that this is clinically warranted and the child lacks capacity to make the decision themselves, still consider the 'voice of the child' before making a final decision.
- Advise the parent / carers wherever possible to talk directly to their child and explain why the image is required and ask if it is acceptable first.
- Give clear advice to the parent / U18 about proportionate image sharing. (E.g. crop the image to contain just the concerning pathology, do not include the patient's face etc).
- Use approved online consulting providers
- Record clearly regarding consent & capacity (including name and relationship to the child if a parent is giving consent on behalf of a child who lacks capacity)
- Advise to delete the image from their camera / mobile once it's been sent.

NELCA CCG Named GPs for Children's Safeguarding,
Dr E. Tukmachi (Newham, C&H & TH); Dr H. Jones (TH), Dr S. Pheerunggee (WF),
Dr R. Burack (B&D & Havering) and Ruth Rothman (Redbridge).

November 2020, v4

Appendix H4:

U18 CONSULTATIONS & MANAGING INTIMATE IMAGERY

NEL Guidance intimate / digital images of U18 in primary care

Clinician requesting an image of an U18

- MDU advice suggests it is not desirable to store intimate body images into GP records.
- The MDU further state they cannot see any circumstance in which GPs would sanction the taking by parents or teenage patients photographs of intimate body parts of U18s

- **Clinicians should not be requesting intimate images of children**
- When requesting images of children you must use GPSOC hardware (GP systems – accurx or via online consultation platforms) to manage processes, never your own personal devices.
- All requests for images should include clear guidance that intimate images should not be sent .

Unsolicited Intimate image of an U18 sent to GP

Carefully and contemporaneously document the circumstances.
Contact the parent/ carer/ individual who holds parental responsibility or young person with a standard response (could include..)
1. Mention that the Practice has not requested the image but will be in contact for a consultation.
2. Advise the image is deleted from their device(s).
3. Reiterate the patient facing messages re code of conduct when sharing images of u18s.
Ensure your online consultation platform/text service has clear patient facing messages stating NOT to send in photos of intimate areas: bottom, genitalia etc

Storage of Intimate images of U18's

- The decision to store must be justifiable and transparent and lies with the Clinician
- In most cases it would be appropriate to document findings from photo and delete
- Only store images that you would have done if it was a F2F consult
- Files with stored images should be flagged to aid review at a later date.

NEL ICB Named GPs for Children's Safeguarding,
Dr E. Tukmachi (Newham, C&H & TH); Dr H. Jones (TH), Dr S. Pheerunggee (WF), Dr R. Burack (B&D & Havering) and Ruth Rothman (Redbridge). *Reviewed March 2025*

Appendix I1:

LEARNING FROM LOCAL CSPR REVIEW
Baby T – Redbridge, 2017

👶 Case Summary

- 👶 **Baby T (11 months old)** – died from **head injuries**.
- 🏠 Mother was **temporarily accommodated as an asylum seeker**.
- 🌐 **Interpreter services** limited / unavailable → communication barriers.
- 📉 Lack of information → **poor referrals, incorrect support, misallocation of resources**.
- 😔 **Maternal mental health illness not identified**.
- 🚫 **Unregistered childminders** used and risks not recognised.

💡 Primary Care Recommendations

- 🧾 **Comprehensive history**: obtain full information from **pregnant asylum seekers** at registration to ensure timely support.
- 🤱 **Infant registration**: asylum seekers with infants must have a **thorough assessment at GP registration** so all health needs are addressed promptly.
- 🏥 **System responsibility**: Redbridge Safeguarding Children Partners request NHS England emphasise this duty to **all GP practices nationally**.
- 🧠 **Parental mental health**: GPs should remain alert to evolving parental MH issues that may **impact child safety**.
- 🌍 **Interpreting services**: BHR Safeguarding Children Partners to improve **availability of trained interpreters**.
- 🎓 **Training**: Redbridge SC partners to consider enhanced training on **asylum system complexities** for professionals supporting asylum-seeking families.

⚠️ **Key Takeaway for GPs**: For asylum-seeking families, ensure **comprehensive registration, proactive mental health vigilance, and access to interpreting services**—to prevent missed risks and support child safety.

Appendix I2:

LEARNING FROM LOCAL CSPR REVIEWS
Family D – Havering 2017

👧 Case Summary

- 👨‍👩‍👧‍👦 **Four children seriously harmed**, subjected to repeated and **invasive medical investigations** across primary, secondary, and tertiary care.
- 🏥 **Multiple attendances** with **complex medical illnesses**, often **not easily substantiated**.
- ⚠️ Concerns raised about **multi-agency working** and how effectively services collaborated to safeguard the children.

💡 Primary Care Recommendations

- 📋 **Policy**: ensure Primary Care has a **clear policy for Fabricated or Induced Illness (FII)** management.
- 🎓 **Training**: strengthen GP **Level 3 safeguarding training** to explicitly include FII.
- 📊 **Audit**: consider dip-sample audits of **case transfers** to check safe handover.
- 🤝 **Coordination**: where children have multiple diagnoses or providers, develop systems to ensure **regular and effective communication** across professionals.
- 👩‍⚕️ **Lead clinician**: each organisation should nominate a **lead health professional**; GP practices to appoint a **lead clinician for children with complex needs**.
- 🧭 **Supervision**: practices should implement reflective supervision and discussion processes for children with **complex health needs**.
- 💻 **IT systems**: explore ways to enable **information sharing** across primary care and wider providers.
- 🧠 **Parental mental health**: GPs must remain vigilant, as evolving parental MH problems may **impact child safety at any stage**.

⚠️ **Key Takeaway for GPs**: For children with complex or unexplained medical issues, have **robust FII policies, clear leadership, effective inter-professional communication, and vigilance for parental mental health risks**.

Appendix I3:

LEARNING FROM LOCAL CSPR REVIEWS
Child F – Barking & Dagenham, 2018

👶 Case Summary

- 👶 **Baby F (9 months old)** – died from severe **head injuries** (subdural + retinal haemorrhage).
- 👩 Young mother with vulnerabilities and troubled childhood; **family background insufficiently explored**.
- 🏠 Family moved several times → **gaps & inconsistency in support** from professionals.
- 👤 **Lack of curiosity about father** and **'hidden' new partner** who was unseen by services.
- 😔 Mother had **low mood / postnatal depression** – referred to MH services via GP but did not engage.
- 🤱 Input from early help worker + health visitor suggested mother was coping → **case closed prematurely**.
- 🚑 Baby later admitted to A&E with catastrophic injuries → died 2 days later.

💡 Primary Care Recommendations

- 📖 **Social history**: take a full social history for all newborns. Include a **written genogram** to identify any 'missing men' or hidden family members.
- 📝 **Postnatal checks**: at every **6-week postnatal check**, assess maternal mood and consider using a **validated depression score**.
- 👂 **Voice of the child**: always consider the baby's welfare during consultations. Enquire about their care and wellbeing at **every follow-up**.
- 🔍 **Professional curiosity**: maintain vigilance regarding the child's safety, especially if parental **mental health concerns** are present.

⚠️ **Key Takeaway for GPs**: For infants, ensure **robust social history, vigilant mood assessment, clear focus on the child's welfare, and persistent curiosity**—especially where hidden risks may exist.

Appendix I4:

LEARNING FROM LOCAL CSPR REVIEWS
City & Hackney

Appendix I5:

LEARNING FROM LOCAL CSPR REVIEWS
Newham

Appendix I6:

LEARNING FROM LOCAL CSPR REVIEWS
Tower Hamlets

Appendix I7:

LEARNING FROM LOCAL CSPR REVIEWS
Waltham Forest
Children L – Perplexing Presentation

👩 Case Summary

- 👨‍👩‍👧‍👦 White British sibling group, loved but **basic day-to-day needs unmet**
- ⚕ **Widespread health/developmental concerns**: feeding, constipation, incontinence, mobility, speech & language delay, poor social skills
- 🧩 Parental concerns of **additional learning needs**, but **professional support fragmented**
- 🏥 **Extensive medical input** – diagnoses/specialists, but **didn't match parents' reports**
- 📉 **Irregular attendance** at health and school appointments → "perplexing presentation"
- ⏳ **Delay in recognising cumulative harm** despite statutory interventions
- 🌱 Children now **thriving in foster care**, maintaining parental contact

💡 Learning for Primary Care

- 👂 **See the child's world**: hear the child's voice, don't let parental narratives dominate
- 🚨 **Escalation**: unresolved concerns → escalate to **consultant paediatrician / psychiatrist**
- 📝 **Recording matters**:
  - Document observations of child behaviour and home (what is seen/not seen)
  - Use **chronologies and genograms** to track patterns
  - Convert jargon into **plain language** – seek clarification when unsure
- 🤝 **Relational practice**: balance **empathy, trust, partnership, and authority** to support change
- 🧭 **Supervision**: reflective supervision helps test assumptions and support complex decisions
- 🔍 **Professional curiosity**: be **tenacious, persistent, and questioning**. Trust gut instinct if "something doesn't fit"

⚠️ **Key Takeaway for GPs**: In cases of perplexing presentation, **listen closely to the child**, maintain **curiosity**, **record thoroughly**, and **escalate early** when inconsistencies persist.

Appendix K1:

CLA HEALTH ASSESSMENT FORMS

The following represents the Part C of IHA-YP in order to highlight the importance for GPs to fully complete this part of the form as well. If NO identifiable health concerns are known or identified, then this needs clearly stating within the 'Health Recommendations for YP Care Plan' part of this section.

Part C should be retained in the young person's heath record and a copy sent to the social worker. It is good practice, with appropriate consent, to share this information with the young person's current and future carers. This summary should also be shared with adoption and fostering panels. For adoption only, a copy of this entire form will be sent to the young person's adoption agency.

SUMMARY REPORT FROM AGENCY HEALTH ADVISER

Date completed	

Relevant family history (state source) **and implications for future**			
Mother		**Father**	
Siblings		**Other**	
Relevant factors in young person's own health history and implications for future			
Birth history and past health history			
Present physical and dental health			
Developmental and educational history			
Emotional and behavioural development			
Sexual health and lifestyle issues			
Parenting issues in current placement			
Issues will be reviewed by your social worker at your statutory review with your permission. Personal or sensitive health topics should not be discussed in a group setting. If you need help with these, please ask the help of your carer, social worker, or health professional.			

HEALTH RECOMMENDATIONS FOR YOUNG PERSON CARE PLAN

Personal or sensitive health topics should not be put in this plan or discussed in group settings without the express knowledge and consent of the young person.

Date of next health assessment	

Issues	**Action required**	**By when**	**Named person responsible**

Allergies	Yes/No		
Immunisations up to date?	Yes/No		
Registered with GP?	Yes/No		
Permanently registered with GP?	Yes/No	**Name**	
Registered with dentist?	Yes/No	**Name**	

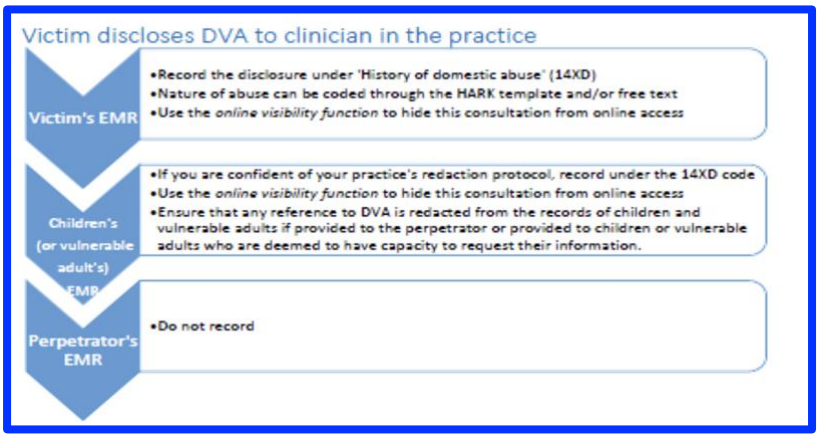
All issues to be reviewed by social worker at Looked After Young Person Reviews

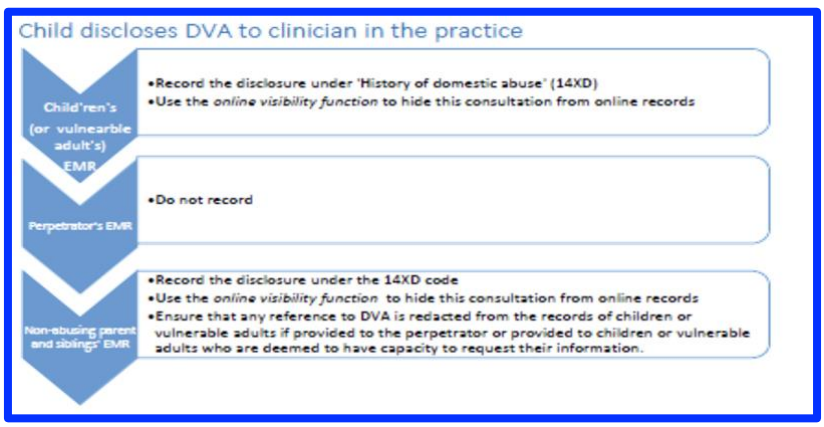
Name of person completing Part C		**Date**	
Designation		**Address**	
Qualifications			
Postcode			
Telephone			
Fax			
Email			
Signature		**Panel**	

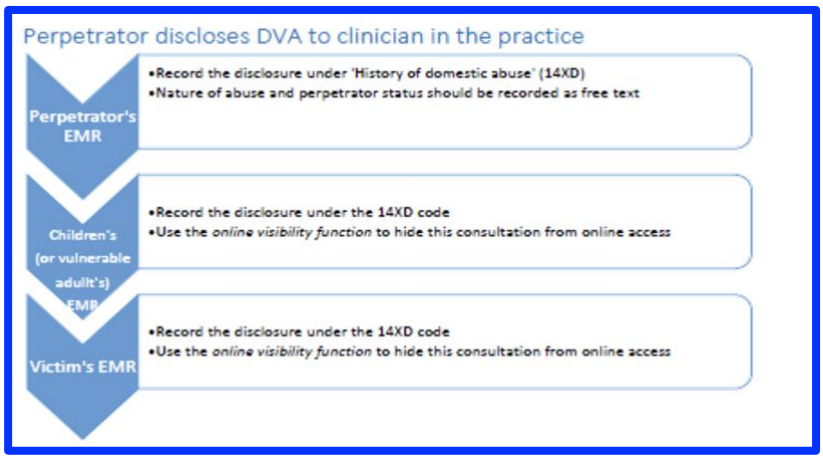
***** If a GP has been asked to complete the LAC Health assessment, then they are the 'Health Advisor' and so should complete <u>both</u> Part B & C as part of the LAC assessment form *****

Appendix K2:

DATA ENTRY FOR DVA IN PC RECORDS (Victim, Child, Perpetrator) [150] [151]



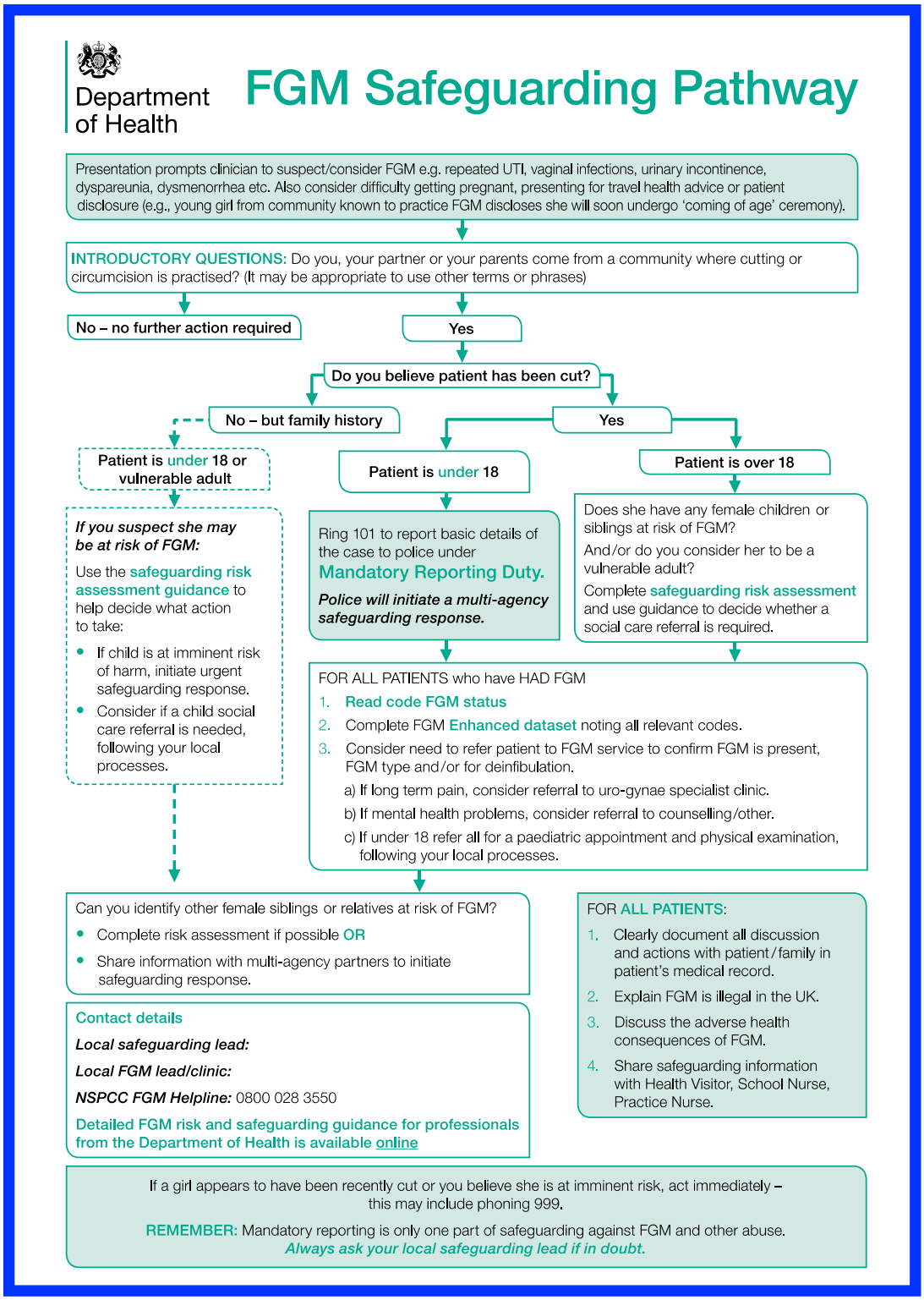




[150] Guidance on recording domestic abuse in the electronic medical record. RCGP. 25 January 2021
[151] 'Ask for ANI': Briefing on DVA codeword scheme for local partners. Home Office. 2021

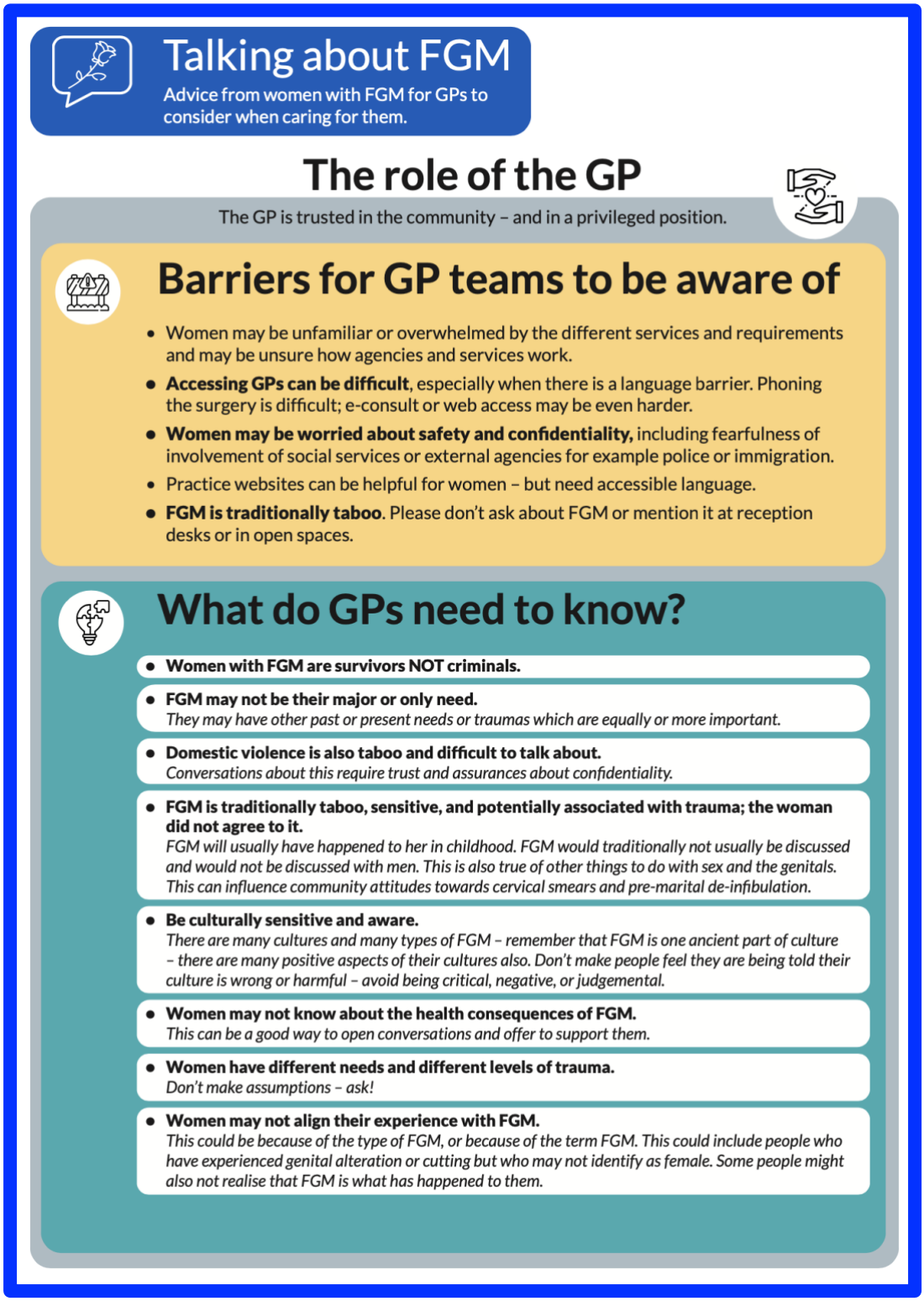
Appendix K3:

FEMALE GENITAL MUTILATION "Pathway"



Appendix K4:

FEMALE GENITAL MUTILATION "Role of the GP"



Appendix K5:

CSE WARING SIGNS

Appendix 3

CSE Warning Signs

Often children and young people who are victims of sexual exploitation do not recognise that they are being abused. There are a number of warning signs that can indicate a child may be being groomed for sexual exploitation and behaviours that can indicate that a child is being sexually exploited. To assist you in remembering and assessing these signs and behaviours we have created the mnemonic **'SAFEGUARD'.**

Sexual health and behaviour
Evidence of sexually transmitted infections, pregnancy and termination; inappropriate sexualised behaviour.

Absent from school or repeatedly running away
Evidence of truancy or periods of being missing from home or care.

Familial abuse and/or problems at home
Familial sexual abuse, physical abuse, emotional abuse, neglect, as well as risk of forced marriage or honour-based violence; domestic violence; substance misuse; parental mental health concerns; parental criminality; experience of homelessness; living in a care home or temporary accommodation.

Emotional and physical condition
Thoughts of, or attempted, suicide or self-harming; low self-esteem or self-confidence; problems relating to sexual orientation; learning difficulties or poor mental health; unexplained injuries or changes in physical appearance identify.

Gangs, older age groups and involvement in crime
Involvement in crime; direct involvement with gang members or living in a gang afflicted Community; involvement with older individuals or lacking friends from the same age group; contact with other individuals who are sexually exploited.

Use of technology and sexual bullying
Evidence of 'sexting', sexualised communication on-line or problematic use of the Internet and social networking sites.

Alcohol and drug misuse
Problematic Substance use.

Receipt of unexplained gifts or money
Unexplained finances, including phone credit, clothes and money

Distrust of authority figures
Resistance to communicating with parents, carers, teachers, social services, health, police and others

Taken from the London Child Sexual Exploitation Operating Protocol (March 2015)

Appendix L1:

Adult Care Act 2014, Key Legislation Points

Section 1: *The Local Authority has an overriding duty to promote individual wellbeing which also covers for neglect;*

Section 2: *Outlines the duty to reduce dependency on state intervention through preventing, delaying and reducing needs for care and support which includes preventing needs that arise from experiencing, or being at risk of abuse and neglect;*

Section 4: *The promotion of independence is supported by the duty to provide information and advice which includes information around staying safe and who to contact if people are concerned about not being able to maintain their own safety;*

Section 6: *Outlines organisations general duties of cooperation, which includes the duty upon all organisations to work together to safeguard adults who are experiencing, or at risk of abuse and neglect;*

Section 11: *The refusal of a needs assessment allows the Local Authority to discharge its duty of assessment if an adult refuses their right to a S9 needs assessment. However, the Local Authority will be under a specific duty to undertake an assessment (when an adult is refusing) if there is reasonable belief that the adult is under coercion, or the adult is experiencing, or at risk of abuse or neglect;*

Section 42: *Duty of enquiry by Local Authority applies when there is a reasonable belief that an adult in its area (a) with care and support needs (b) is experiencing, or at risk of experiencing abuse and neglect (c) and is unable to safeguard themselves as a result of their care and support needs. When these conditions are satisfied the Local Authority must make or cause whatever enquiries it deems necessary to determine what actions (if any) are necessary to safeguard the adult. The Local Authority cannot delegate its duty under S42 and when it causes an enquiry to be made by an external partner, it must satisfy itself that the enquiry has been concluded effectively and determine if it needs to undertake any further enquiries under S42 of the Care Act 2014. NB the eligibility for a safeguarding adult enquiry is determined by the conditions set out in S42 of the Care Act 2014 and it is UNLAWFUL to decline an enquiry on the grounds that someone is not receiving, or eligible for on-going paid support.*

Section 43: *Requires the Local Authority to establish a Safeguarding Adults Board (SAB) whose main objective is to protect adults from experiencing or being at risk of abuse and neglect. The three main duties of the SAB are to produce an annual strategic plan, publish an annual report and undertake a safeguarding adults review under certain circumstances.*

Section 44: *The SAB must commission a safeguarding adults review when an adult with needs for care and support (a) dies and abuse or neglect is suspected (b) is alive but it is believed the adult experienced significant abuse or neglect. All partners must cooperate to ensure lessons can be identified to improve local multi agency safeguarding work.*

Section 45: *Enables the SAB to request specific information from an individual that is necessary to support the Board to meet its primary objectives of protecting adults from abuse or neglect.*

Section 47: *Outlines the circumstances under which a Local Authority is under a duty to safeguard an individual's property when they are being cared for (temporarily or permanently) away from their home.*

Section 68: *Places a duty on the Local Authority to provide an advocate to support an adult who would experience significant difficulties participating in a S42 enquiry, or a safeguarding adults review under S44. This Local Authority is not under a duty to provide an advocate if they believe there is an appropriate independent person to support the adult.*

Section 81: *Places a Duty of Candour on organisations to provide information when the person's safety is affected during the course of being provided a service by their organisation.*

Appendix M1:

SAFEGUARDING GLOSSARY

ACE	*Adverse Childhood Experience*
CAF	*Common Assessment Form*
CDRP	*Child Death Review Panel*
CIN	*Child in Need*
CLA	*Children who are Looked After*
CQC	*Care Quality Commission*
CSA	*Child Sexual Abuse*
CSC	*Children's Social Care services*
CSE	*Child Sexual Exploitation*
CYP	*Children & Young People*
DoL	*Deprivation of Liberty*
DVA	*Domestic Violence & Abuse*
DHR	*Domestic Homicide Review*
FGM	*Female Genital Mutilation*
FII	*Fabricated Induced Illness / Complex Presentations*
GDPR	*General Data Protection Regulation*
ICB/S	*Integrated Care Board / System*
LPS	*Liberty Protection Safeguards*
LSAB	*Local Safeguarding Adult's Board*
LSCB	*Local Safeguarding Children's Board*
LSP	*Local Safeguarding Partnership*
MAPPA	*Mulkti-Agency Public Protection Arrangements*
MARAC	*Multi-agency risk assessment conference*
MARF	*Multi-Agency Referral Form*
MASH	*Multi Agency Safeguarding Hub*
MCA	*Mental Capacity Act*
NEL	*North-east London*
NHSE	*NHS England*
PCN	*Primary Care Network*
RCGP	*Royal College of General Practitioners*
SAR	*Safeguarding Adult Review*
SCR	*Serious Case Review*
SPB	*Safeguarding Partnership Board*
Sx11	*Section 11, Children's Act2004, Duty to co-operate*
Sx17	*Section 47 Children's Act 1989, Children in Need provision*
Sx42	*Section 42, Care Act 214, Enquiry by Local Authority for adults*
Sx47	*Section 47 Children's Act 1989, Duty to investigate*
UN	*United Nations*

Appendix M2:

SAFEGUARDING LEGISLATION

Relevant Legislation:

- The Children Act 1989
- The Children Act 2004
- Sexual Offences Act 2003
- The Adoption and Children Act 2002
- Safeguarding Vulnerable Groups Act 2006
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- The Care Act, 2014
- Children and Social Work Act 2017
- England and Wales: Modern Slavery Act 2015
- Counter Terrorism and Security Act (2015)
- Domestic Violence, Crime and Victims (Amendment) Act 2012
- Female Genital Mutilation Act 2003
- Data Protection Act 1998
- Data Protection Act 2018
- General Data Protection Regulation (GDPR) 2018
- Mental Health Act 1983
- Mental Capacity Act 2005
- The Serious Crime Act 2015
- Health and Social Care Act 2012
- Children and Families Act 2014
- The Criminal Policing Act, 2025

Appendix M3:

SAFEGUARDING GUIDANCE

Relevant Guidance:

- Deprivation of Liberty Safeguards (amendment to MCA 2009) (to be replaced by Liberty Protection Safeguards (LPS)
- Safeguarding Vulnerable People in the NHS -Accountability and Assurance Framework. National Commissioning Board July 2019
- CQC Fundamental Standards; Outcome 13;
- Working Together to safeguarding children 2018: A guide to inter-agency working to safeguard and promote the welfare of children
- Care and Support Statutory Guidance Issued under the Care Act 2014
- Safeguarding Children & Young People: Roles and Competences for Health Care Staff (Intercollegiate Document 2019)
- Safeguarding Adults: Roles and Competencies for Health Care Staff First edition: August 2018
- Mental Capacity Act Code of Practice 2005
- NHSE Prevent: Training and Competencies Framework, October 2017
- Female genital mutilation: resource pack (Home Office 2014);
- FGM Multi-Agency Practice Guidelines (Home Office 2014);
- Female Genital Mutilation Risk and Safeguarding: Guidance for professionals
- (Department of Health 2015); Commissioning services to meet the needs of women and girls with FGM 2018
- Service standards for commissioning Female Genital Mutilation (FGM)
- Framework for the assessment of children in need and their families, Department of Health (2000).
- NICE guidance 'When to suspect child maltreatment' (2009)
- Tackling FGM in the UK, Intercollegiate recommendations for identifying, recording and reporting 2013
- Multi-agency statutory guidance on female genital mutilation 2016
- NICE guidelines for health and social care professional's Domestic violence and abuse: multi-agency working (2014)
- NICE Domestic violence and abuse Quality standard Published: 29 Feb 2016
- The NICE Quality Standards (2016)
- Statutory Guidance on Promoting the Health and Well-being of Looked After children 2015 (DoH,DfE)
- Looked After Children – knowledge, skills and competence of health care staff Intercollegiate Role Framework (RCN, RCPCH) 2015
- NICE public health guidance 28 - Looked-after children and young people Issued: October 2010 last modified: April 2013
- *RCGP Safeguarding standards for General Practice, Updated 2024*
- *RCGP Safeguarding Toolkit, Updated 2024*
- Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework 2015 (Archived)

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