Coding & Scanning Sensitive Information

(Including Safeguarding Children & Adults, Domestic Violence/Abuse Incidents)

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Revision History

South West Commissioning Support Unit		
Document status: Draft		
Version	Date	Comments
Version Control – Scanning Sensitive Information		
1.0	August 2010	Following review of previous document and MARAC Information Sharing on Domestic Violence, this document is a draft combination of the two items
1.1	October 2010	Final draft for stakeholder review
1.2	November 2010	Issued following review
1.3	June 2012	Update on Sexual violence MARAC (now not included)
1.4	December 2012	Further clarity on recording DV documents (not issued)
1.5	February 2012	Addition of the HARKS template link
2.0	September 2014	Updated in relation to Caldicott 2 and sharing information on domestic violence/abuse perpetrators and safeguarding adults information.
2.1	October 2014	Added codes on FGM and clarity on MARAC letters
3.0	April 2018	Revised codes across the whole document, updated MARAC advice as per new guidance, included scanning of MAAPA Data
3.2	10th April 2018	Draft signed off by Director of Nursing, quality and safeguarding BNSSG CCG

1 Purpose

This document sets out guidance for coding and storage of sensitive documents such as safeguarding children case conference minutes, domestic violence and abuse information (including MARAC – Multi-Agency Risk Assessment Conference information), Children in Care, Adult Safeguarding, attendance of children and young people at Emergency Departments and information on sex offenders in general practice.

It provides guidance on the coding and storage of relevant information in electronic health records and measures to avoid paper records being stored separately. The information has the status of guidance for local adaption setting out the key points of consideration.
It should be noted the GP coding is changing on 1st April form READ codes to SNOMED. There will be a transition period after 1st April 2018 and dual coding with SNOMED/READ will continue until 2020 when READ codes will no longer be visible.

2 Background

In 2003 the information governance team looked at the issues of scanning child protection information, such as child protection case conference minutes into the child's record which is stored on the clinical system. Following a lengthy review, the recommendation given at the time was that system controls were not deemed secure enough.

Since then there have been developments both in terms of systems and organisational structures and approaches to handling child protection cases. This guidance has been updated to reflect this. There have been concerns that case conference records stored in paper or electronic files may not follow the child when they register at a new practice, and there have been concerns about records being sent to the wrong departments/organisations. There is recognition that child protection procedures are often an important aspect of a child's health and as such pertinent information should be readily available for health professionals to access.

As there are many similarities of issues with regard to MARAC/Domestic Violence and Abuse information, adult safeguarding and information on sex offenders these items have been brought together into one document.

It is also worthy of note that different document formats with regard to safeguarding children and adults are in use within different local authorities. It is not possible for this guidance to include details of all such items, but it should be seen as key principles to start from.

It is important that all safeguarding information is coded as Major Active Problems so that all health professionals can be immediately aware when they access notes that this child/family/adult has particular vulnerabilities.

3 Risks

Whilst all patient information carries a duty of confidentiality, from a social confidentiality aspect information such as child protection documentation is offered a higher level of protection. Even within a small organisation, there will be staff who do not need to know details to undertake their role and given the 'social sensitivity' of the information within a local community it is not appropriate for them to come across such information whilst undertaking day to day tasks.

On this basis it is critical that such information is:

- Restricted to just those who need to know to care for the patient.

- Not kept for longer than necessary, and therefore not accessed or transferred if no longer required.
- Reasonably accessible to those that need it.
- Stored and processed in ways that are 'adequate, relevant but not excessive' in relation to the purpose.

This guidance is based on endeavouring to adhere to the above principles (derived from the Data Protection Act 1998) and taking account of guidance provided by the Royal College of General Practitioners and the NSPCC.

4 Coding & Scanning of Safeguarding Children Documents

Safeguarding children documents come in many different formats, including Case Conference notes & summaries, reports to conferences, requests for service, strategy discussions and assessment information. Different items are used in varying formats by local authorities and there is limited consistency of approach. It is difficult to create specific guidance to cover all eventualities, so this section should be seen as core principles and minimum requirements, not rules to be rigidly applied.

What to scan on to records of child(ren):

The key principle is to scan all documents on to the records of all affected children in the family, not just the child(ren). Systems such as EMIS can be used to scan the item once and attach to multiple records. This principle is set to avoid/reduce risk of information being lost when families transfer between practices.

What to scan on to records of adults:

The link between the adults and the child(ren) should be by the NHS number - scan all documents onto the records of adults named in the report. Domestic Violence and Abuse reports are covered in section 5 below.

Other actions:

Practices need to ensure appropriate read coding of the records and circulation to the named/usual GP for the family, who will determine if further cascade to other Healthcare Professionals is required.

Access to records on the system:

Practices are reminded to restrict access where possible and appropriate i.e. where individuals may be known to staff. Where practices are able to use their system functions to reduce access to a smaller group of staff, ideally only those that need to know, then they should take such action. It is noted that staff are also contractually bound to act professionally in terms of accessing and using data.

Recording Safeguarding Children documents in General Practice records

The Royal College of General Practitioners provide a comprehensive list of codes, this can be accessed online[1] and can be found in Appendix One. It is recommended access it online to ensure the most recent version is being used.

Please ensure there is a distinction coded between did not attend and was not brought; it Is recommended that when a child does not attend an appointment this is coded as:

Child not brought to appointment (9Nz1) and that you have a protocol for reviewing the child's record and arranging appropriate follow-up.

[1] http://www.rcgp.org.uk/clinical-and-research/toolkits/~/media/54D5AE22B3A14BAF9A92DB25D125DBAF.ashx

If a child in your practice is looked after or in care please code as appropriate – child in care.

Disposal of paper records:

If you have a 'hosted' system such as EMIS Web, then records are backed up centrally and continually so paper can be securely destroyed after a short time.

Following either the scanning or entry of pertinent information, the paper copy should be securely disposed of (i.e. secure shredding). If concerned about disposal methods seek advice from Information Governance support.

Retention of electronic records:

The Information Governance Alliance Guidance: Records Management Code of Practice for Health and Social Care 2016 states:

Children's Records: Basic health and social care retention requirement is to retain until 25th birthday or if the patient was 17 at the conclusion of the treatment, until their 26th birthday. Check for any other involvements that could extend the retention. All must be reviewed prior to destruction taking into account any serious incident retentions.[2]

Patients who leave the practice before their 26th Birthday:

The entire record is generally transferred to the new practice who become responsible for adhering to retention guidelines. However electronic systems currently do not delete the data from the previous practice. If the system has the functionality, the record should be 'electronically archived'. This is where it is not generally accessible to all users, but specific users with relevant access can retrieve the record.

Patients who remain with the practice after their 26th Birthday:

The IGA guidance indicates that such information can be removed after their 25th/26th birthday. However, these are guidelines and minimum retention periods, not maximum. Final decision resides with the practice, however, if data is to be kept for longer, then it needs to be justified to meet Data Protection Act principles, for example where information is required as part of ongoing investigations, or where the information is *necessary* to inform future care. If data is to be deleted or removed, a record of the action taken must be made.

4.1 Existing case files

There is no expectation for practices to apply this guidance retrospectively. Previous files must be retained for the relevant period. If safeguarding records have been retained at the practice after the patient has left these should be securely destroyed or passed on.

4.2 When a child is no longer subject to safeguarding arrangements

Practices should be informed when a child is no longer subject to safeguarding arrangements. This should then be illustrated by Read coding as above, with entry of relevant details if appropriate. The parent records should also be amended to reflect the updated status.

[2] https://digital.nhs.uk/information-governance-alliance

4.3 Requests for access to records and GP to GP record transfers

Where an individual requests access to their record, these should be processed as normal, **noting the potential for exempting information that can identify third parties or where disclosure could cause significant harm or distress to any individual.**

Concerns have been raised about 'labelling' individuals and effect there may be on them in the future. For example: where a very young child is subject to safeguarding for a relatively short period, but later in life as a young person or an adult requests access to their records. They may not know about the previous events and may have been too young to know at the time. It is this sort of situation where information can be 'redacted' from the disclosed record, on the basis it could '**cause significant harm or distress to any individual'.**

Where a record is transferred between practices (via any means: electronically, GP to GP, disc) the full record including any paper records must be transferred.

4.4 Unborn children

Where an unborn child is subject to safeguarding arrangements, any information can only be recorded on the mother, up to the point the child is born and registered as a patient. At this stage, the practice should record this on the child's records. The Child can be registered on the practice system as soon as it is born without waiting for details from the formal births registrar. Details from a birth certificate can be updated later. The child may be registered at another practice. Where this is known, the basis of concerns and the laws supporting safeguarding mean practices can and should legitimately share information in order to safeguard the child.

4.5 Allegations

Where a third party makes an allegation, it must be decided whether this will be recorded or not. This is a complex area to offer guidance on, but the key factors for consideration are:

- The form, basis and seriousness of the allegation
- The status of the individual making the allegation (are they friend/family, professional)

4.6 Contacts for further advice

CCG Named Doctor for Safeguarding Children –

- North Somerset: Dr Mike Pimm (E: mike.pimm@nhs.net T: 01934 515 878
- Bristol: Dr Helen Mutch (E: helen.mutch@nhs.net T: 0117 964 2211)
- South Gloucestershire: Dr Kate Mansfield (E: katemansfield@nhs.net T: 01454 323 366)

CCG Named Doctor for Safeguarding Adults across BNSSG

Pippa Stable (E: pippastables@nhs.net)

CCG switchboard – 0117 976 6600

Information Governance Support (SCWCSU) scwcsu.westig-enquiries@nhs.net

5 Coding & Scanning of Domestic Violence and Abuse Incidents (Inc. MARAC)

The challenge of recording domestic violence and abuse (DVA) information in the medical records of people experiencing or perpetrating abuse and their children is how to do this without increasing risk of harm to victims and their children. The perpetrator may not know that their ex/partner/ family member has disclosed DVA to a GP or nurse. Nor will they necessarily know if their case is being discussed at MARAC. When the perpetrator is not aware of a disclosure of DVA, an accidental discovery increases the risk to the victim and their children. It is important to be aware of the potential danger of the perpetrator having access to DVA disclosures through the electronic medical record (EMR) of their children or vulnerable adults in the family.

When police attend a DVA incident where there are children in the family (whether present at the incident or not) or if there is a disclosure of pregnancy they will notify the Safeguarding Children Community Health Team of this incident. This notification will include details of the victim, alleged perpetrator and any children in the family. Information about domestic abuse cases is also shared with GP practices from the Multi-Agency Risk Assessment Conferences (MARACs). MARACs are coordinated by the police with the aim of reducing harm in the highest risk cases of DVA. Practices will receive letters from the CCG MARAC team with information about victims and children involved in the MARAC process.

The following are key guidance points for you to consider in managing this information.

5.1 Information on the perpetrator:

DVA Incident forms may contain details of the alleged perpetrator and the MARAC letters may inform you of a perpetrator of DVA.

- If you are **certain*** that the perpetrator is aware that domestic abuse has been disclosed to the police or another agency, relevant information regarding the abuse should be recorded in the perpetrator's EMR and that of the victim and children.

- When you are **not certain*** that the perpetrator is aware of any allegation, do not record. (*This can be ascertained from the details and source of the information received by the practice. The practice safeguarding/domestic violence lead may be best placed to make this judgement).

It is important to remember that the perpetrator may not be aware that the information has been shared with you as this might increase the risks to the victim and children in the family.

5.2 Information on the victim and any children in the family:

Where a perpetrator has a right of access to information on their children, the practice and clinician should redact any reference/read code related to DVA on the basis it might cause an individual harm or distress if this information was disclosed.

Domestic Violence Incident forms when received should be scanned onto the health records.

Practices will also be in receipt of information request from the MARAC Team. These requests explain what information is required and why it can be shared. It is a practice decision as to whether these are scanned into the health record.

Following MARAC practices will receive a report from the MARAC team which may include details of actions plans and specific actions for the practice. These can be scanned into the victim's health records with a SNOMED/Read code of History of Domestic Abuse. The online visibility function should be used to hide this information from online access.

5.3 Domestic Violence and Abuse Related Read Codes for Current Problems

The recommended code for both victims and perpetrators is History of Domestic Abuse.

Victims:

- Record the disclosure under 'History of domestic abuse'
- The nature of abuse can be coded through the HARK template and/or free text
- Use the *online visibility function* to hide this code from online access
- Use Read code K578 for Female Genital Mutilation (for victim)
- Use Read code 12b for Family history of FGM (for children's records)

Children of victim:

If you are confident of your practice's redaction protocol, record under the History of Domestic Abuse code.

- Use the *online visibility function* to hide this code from online access
- Ensure that any reference to DVA is redacted from the records of children and vulnerable adults if provided to the perpetrator or provided to children or vulnerable adults who are deemed to have capacity to request their information.

Perpetrators:

Ensure that any decision to record the information in the perpetrator's records is made with due regard to the associated risks, and documented. Only code the perpetrator's records if you are **certain** that the perpetrator is aware that domestic abuse has been disclosed to the police or another agency.

The code of History of Domestic Abuse should be used, with further details captured in free text if required.

This guidance is summarised in Appendix Two: Guidance on recording of domestic violence and abuse information in general practice medical records.

6 Coding & Scanning of Safeguarding Adults Information

Adult at Risk Definition:

An adult at risk is defined in the Care Act 2014 as:

An adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs) **and**;
- is experiencing, or at risk of, abuse or neglect; **and**
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

Recording Information for Safeguarding Adults

Suffering abuse or neglect is as threatening to the health and well-being of a patient as other major medical conditions are and therefore should be treated in the same manner. By coding and documenting this in the same way as other medical conditions, patients who are at risk are highlighted which enables the ability to offer appropriate support.

Safeguarding Adults information will take various forms: section 42 enquiries, strategy minutes and actions; case conference minutes and professionals/multi-agency meeting minutes. The storing of this information frequently raises concerns and it should be noted there is no national guidance, however, best practice should be to scan all documentation as it should form part of the patient's records. They should not be stored separately from the medical records because:

- They are unlikely to be accessed unless part of the record
- They are unlikely to be sent on to the new GP should the patient register elsewhere
- They may possibly become mislaid and lead to a potentially serious breach in patient confidentiality.
- Whilst GPs may have concerns about third-party information contained in case conference minutes, part of the solution is to remove this information if copies of medical records are released for any reason, rather than not permitting its entry into the medical record in the first place

Read codes that relate to adults safeguarding issues are listed in Appendix Three (SNOMED codes not available at time of publication of document). These include Safeguarding Adults, MAPPA and FGM. There is no national guidance on Prevent and coding should be considered on a practice by practice basis.

Multi Agency Public Protection Arrangements (MAPPA)

The police who lead on the MAPPA process want to improve links with GPs for further information about MAPPA can be found here:

https://mappa.justice.gov.uk/connect.ti/MAPPA/view?objectId=5681072&exp=e1

If you have any concerns about what should be recorded or any issues related to MAPPA cases you can contact:

ppu@avonandsomerset.pnn.police.uk Tel no. 01278 646358

Appendix 1 – Safeguarding and Young People – The RCGP/NSPCC Safeguarding Children's Toolkit for General Practice – Tool 3 – Recommended Codes

UNIVERSITY OF SURREY

UCL

RC GP Royal College of General Practitioners

Recommendations for recording concerns about Child Maltreatment in Primary Care

Level 1

We recommend that GPs flag whenever maltreatment is considered using the code:

'Child is cause for concern'. (Read version 2 term: 13If Read 3: **XaMzr**)

Level 2

Basic consistent coding of child maltreatment:

We propose the following six codes are used:

Term	Read v2	Read v3
1 Child is cause for concern [1]	13If	XaMzr
2 *Child no longer vulnerable* [2]	13IW	XaLqv
3 Family is cause for concern	13Ip	Ub1Go
4 *Social worker involved*	13G4	13G4.
5 *Child in care*	13IB	13IB.
6 *Health visitor visits*	13G2	13G2.

[1] Use as standard "Red flag" about concerns

[2] Use when concerns cease

Recommendations for recording concerns about Child Maltreatment in Primary Care

Level 3

Consensus coding of child maltreatment
We recommend where more detail is needed the following codes are used:

1. What is the cause for concern?		Read v2	Read v3
Non-specific	Child is cause for concern *1*	13If	XaMzr
	Child no longer vulnerable *2*	13IW	XaLqv
	Suspected child abuse	13Ip	Ub1Go
	History of abuse	13G4	XaEFq
Specific	At risk of neglect	13ZV	XaKbS
	At risk of emotional abuse	13ZR	XaKbP
	History of emotional abuse	14X2	XaEFt
	At risk of physical abuse	13VF	XaKbR
	History of physical abuse	14X0	XaEFr
	At risk of sexual abuse	13ZW	XaKbT
	History of sexual abuse	14X1	XaEFs
	a/n care: social risk *3*	625	6252

2. Is the family a cause for concern?		Read v2	Read v3
Family *Cause for concern?*	Family is cause for concern	13Ip	Ub1Go
	Family member no longer subject of a child protection plan	13Iz	XaPkG
	Paternal drug misuse	12X2	XaPDT
	Maternal drug misuse	63C6	63C6
	Both parents misuse drugs	12X1	XaPDU
	Maternal alcohol abuse	63C7	63C7
	Alcoholic in family	1282	XM1Jq
	At risk violence in the home	13VF	13VF
	History of domestic violence	14X3	XaJhe3

3. Child protection / Children's Social Care Services involved?		Read v2	Read v3
Protection procedures	Child protection procedure	64c	Ub0ex
	No longer on child protection plan	13Iw	XaOtl
	Child protection investigation	Z352	Ub0ez
	Social services case conference	3875	3875
	Child subject of a child protection plan	13Iv	XaOnX
	Family member subject to a child protection plan	13Iy	XaPkF
Contact with social services	Social worker involved	13G4	13G4
	Refer to social worker	8HHB	XaBva
	Report received from social services	9NDA	XE2NS
	Child in Need *4*	13IS	XaEFq
	Child no longer in need *5*	13IT	Xa1087
Looked after	Child in care	13IB	13IB
	Foster care	8GE7	8GE7
	Fostering medical examination	6982	6982
	Child lives with another relative	13Ic	XaMFL
	Child lives with unrelated adult	13Iu	Xa0in4

4. What other professionals are involved?		Read v2	Read v3
Healthcare or other professional involved	Health visitor visits	13G2	13G2
	Under care of paediatrician	9NNG	XaAPa
	Seen by community paediatrician (v2=seen in paed' clinic)	9N1V	XaASU
	Seen by child and adolescent psychiatric services	9No0	XaAXM
	Under care of school nurse	9NNP	XaAQt
	Police record	13JN	XE0pJ

Version 4 021011

Notes

1 ALWAYS CODE to flag concern in all children in whom maltreatment is 'considered' (as defined in NICE guidance). This is the minimum coding we recommend for any child with concerns.

2 Use *'Child is no longer vulnerable'* to indicate the end of a period of professional concern

3. Use *'a/n care social risk'* to indicate any child who was identified as a cause for concern before birth, including maternal drugs/alcohol use, domestic violence or child protection concerns during pregnancy

4. Use for children assessed by CSC as needing extra service to meet full potential and avoid impairment (section 17, Children Act 1989).

5. Use no longer in need when appropriate

Copies available from:
www.clininf.eu/maltreatment/

This coding list is recommended by RCGP, Institute of Child Health & University of Surrey Multisite Audit Group

Appendix Two

Guidance on recording of domestic violence and abuse information in general practice medical records

The challenge of recording domestic violence and abuse (DVA) information in the electronic medical record (EMR) of people experiencing or perpetrating abuse and their children is how to do this without increasing risk of harm to victims and their children. The perpetrator may not know that their ex/partner/ family member has disclosed DVA to a GP or nurse. Nor will they necessarily know if their case is being discussed at the multi-agency risk assessment conference (MARAC). When the perpetrator is not aware of a disclosure of DVA, an accidental discovery increases the risk to the victim and their children.

Relevant to all DVA information

- Ensure that any reference to DVA on a victim's or their children's records is not accidentally visible to the perpetrator during appointments. The computer screen showing the medical record should never be seen by third parties (i.e. family or friends accompanying a patient)
- Never disclose any allegation to the perpetrator or any other family members
- Ensure that any decision to record the information in the perpetrator's EMR is made with due regard to the associated risks, and documented.
- Ensure that any reference to DVA in a perpetrator's record is redacted if provided to the perpetrator unless you are certain it is information that the perpetrator already knows
- Be aware of the potential danger of the perpetrator having access to information about their abuse and to information in children's EMRs; this includes via online access to their own information and their children's information, as well as via the victim's EMR.
- Ensure that any reference to DVA is redacted from children's records if provided to the perpetrator or provided to children who are deemed to have capacity to request their information.

Information about DVA from police report or MARAC correspondence

When you are **certain*** that the perpetrator is aware that domestic abuse has been disclosed to the police or another agency, relevant information regarding the abuse should be recorded in the perpetrator's EMR and that of the victim and children.

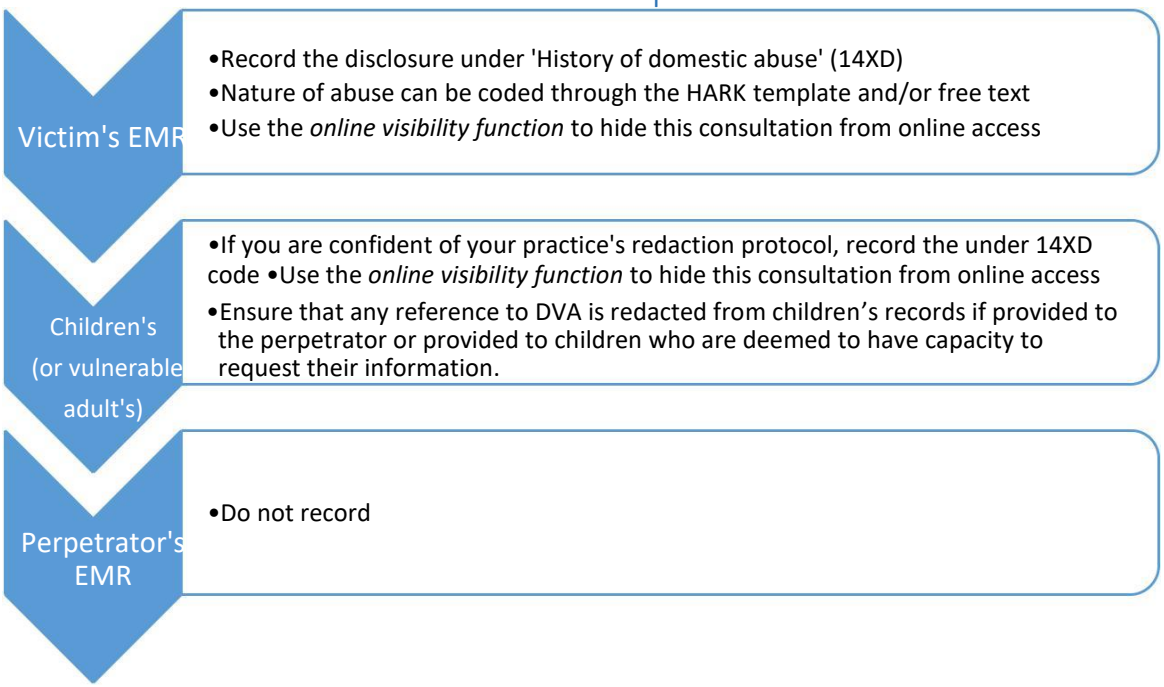
When you are **not certain*** that the perpetrator is aware of any allegation, the guidance is the same as for disclosure from the victim.

*This can be ascertained from the details and source of the information received by the practice. The practice safeguarding/domestic violence lead may be best placed to make this judgement.

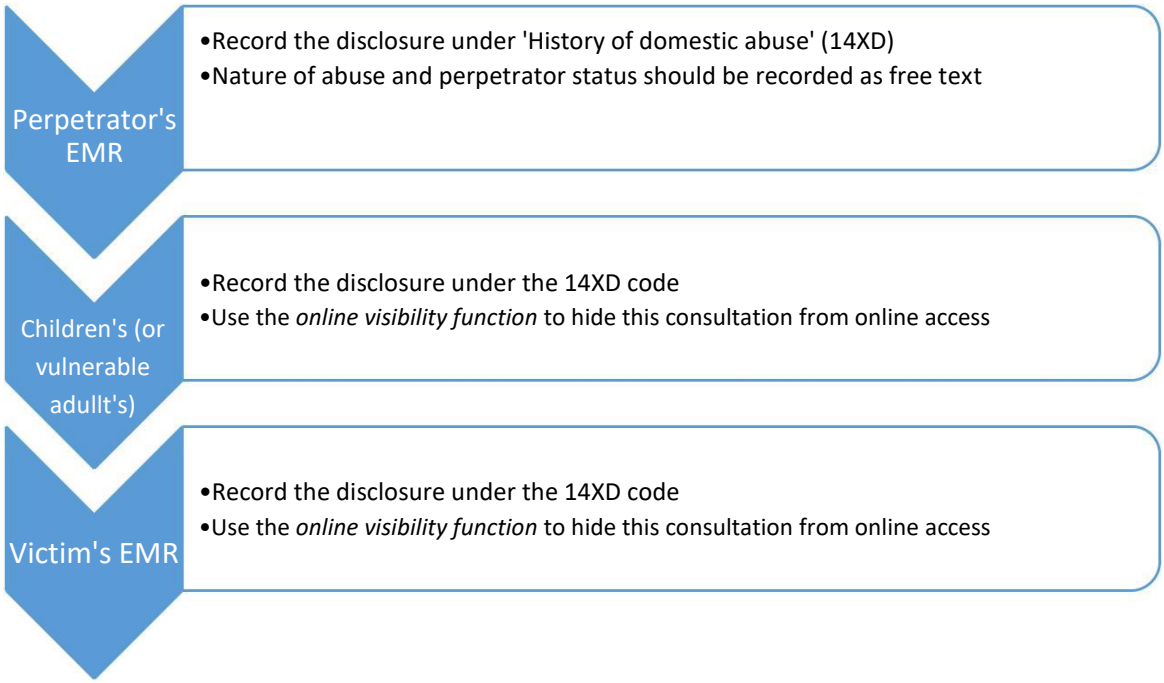
Disclosure by a victim, perpetrator or child living in a household with DVA

Three flowcharts are presented below to summarise what to do in each of these cases. If you are not sure whether someone is a victim or perpetrator of abuse it is probably safest to follow the victim disclosure flowchart. If you do code a consultation or communication as 'History of Domestic Abuse', as we recommend, this should be a *major active problem* until the abuse is resolved or the patient is presenting it as a past problem.

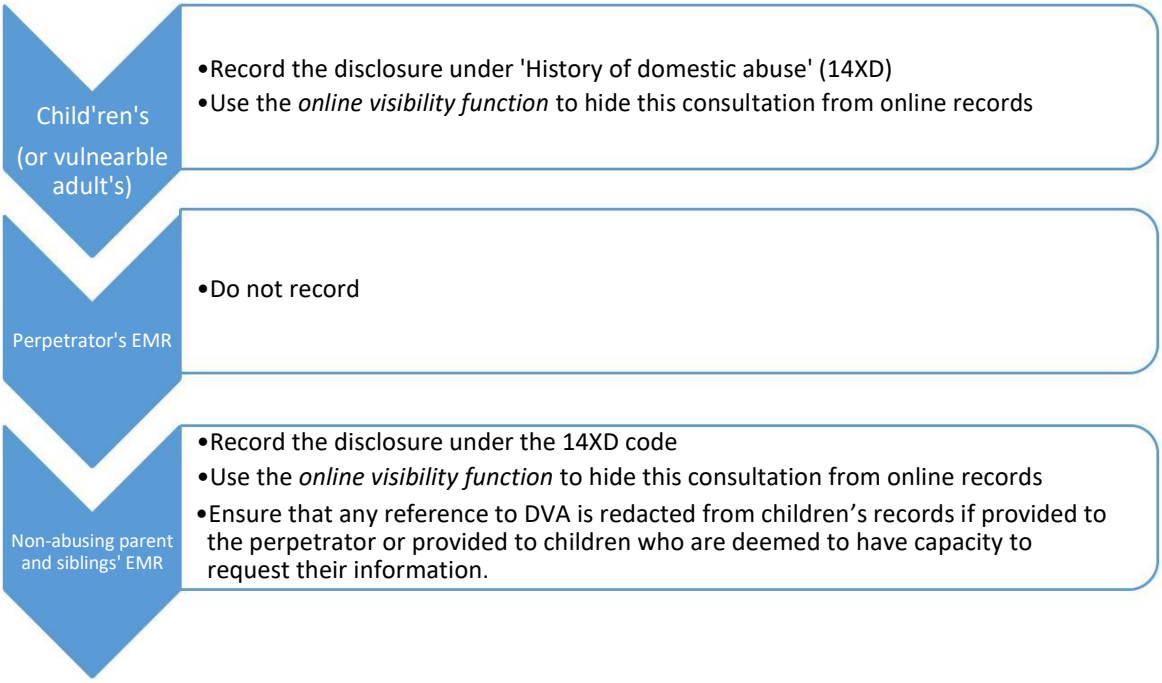
Victim discloses DVA to clinician in the practice



Perpetrator discloses DVA to clinician in the practice



Child discloses DVA to clinician in the practice



This guidance has been written by:

Ø Professor Gene Feder

o Professor of Primary Health Care, Centre for Academic Primary Care, University of Bristol o Chair of Inter-Collegiate and Agency National DVA Forum

o Chair of NICE Programme Development Group for NICE guidance (PH50, February 2014) *Domestic Violence and Abuse: multi-agency working*

Ø Dr Lucy Potter

o GP & Academic Clinical Fellow, Centre for Academic Primary Care, University of Bristol o Clinical Lead for IRISi Bristol

Ø Medina Johnson

o Chief Executive of IRISi

(IRIS intervention, www.irisdomesticviolence.org.uk)

Appendix Three – Read Codes for Safeguarding Adults

ADULTS	EMIS CODE
Adult Safeguarding Concern	9Ngj
Adult no longer Safeguarding Concern	9Ngk
If initial safeguarding meeting attended for adult	387A
Review safeguarding meeting attended	3879
Safeguarding report submitted (when filing the report)	9Ee01
Safeguarding Adults Protection Plan agreed	8CSC
Referral to Safeguarding Adults Team	8Hkc
History of Domestic Abuse	14XD
At risk of Sexual Exploitation	13VX
Victim of Sexual Exploitation	14XH
Lacks capacity to give consent (MCA 2005)	9NdL
Lacks mental capacity to make decision (MCA 2005)	2JR
IMCA instructed	9Ng6
Standard Authorisation DoL given	9NgzG
No longer subject to DoLS	9NgzW
Subject of MAPPA (Multi agency Public Protection Arrangements	13HI-1
Victim of Modern Slavery	14XL
Family history of alcohol misuse	12X0
Family history of substance misuse	1283
Family history of mental disorder	ZV1A
Family history of learning disability	12W1
Carer of a person with learning disability	918W
Carer of a child with learning disability	133E
Homeless	13D-1
Homeless Family	13D1
Subject of MARAC	13Hm
Referral to MARAC	8T0b
Prevent - no specific codes suggest Adult/Child Safeguarding concern	9Ngj/13WX

RCGP-Safeguarding-Coding-Information-J