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Guidance

Coding & Scanning Sensitive information.

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

If you need further copies of this document please telephone Adam Tuckett on 0117 900 2410

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Scanning Sensitive Information	
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Revision History

South West Commissioning Support Unit		
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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

1 Purpose

This document sets out guidance for coding and storage of sensitive documents such as safeguarding children case conference minutes, domestic violence information (MARAC – Multi Agency Risk Assessment Conference) and information on sex offenders in general practice. In particular 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.

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 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 handle child protection cases. This guidance has been updated to reflect this.

There have been concerns that case conference records stored in paper files may not follow the child when they register at a new practice, and there have been concerns about paper 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 issue with regard to MARAC/Domestic Violence information and information on sex offenders these items have been brought together within one document.

It is also worthy of note that different document formats with regard to safeguarding children 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.

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 Document Management can be used to scan the item once and attach to multiple records. If unsure check with your system supplier how to do this. 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 or the computer number of the child, scan all documents onto the records of adults named in the report.

What if documents are exceedingly large:

If your system supports scanning items once and attaching to multiple records, then even large documents should be scanned. If however your system does not support this then the following are the key items that should be entered onto the records of the child(ren) & adults:

- Case number/Social Care index number
- Status
- Category (neglect/sexual/physical/emotional abuse)
- Other family members
- Specific actions for the practice
- Date of next review to plan report

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:

It should be noted that at present information systems in general practice do not necessarily have detailed access control levels or functions and it is not always possible to restrict access to just those users who need to know. 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:

	Read code significant details (1)	Scan documents
Child (subject of case conference)	**Yes**	**Yes**
Other Children (not subject of conference but living in same household/ same carers)	**Yes**	**Yes**
Adults named in report	**Yes**	**Yes**

(1) – suggested Read codes include

For the child/children named in Case Conference Reports:
Subject to CPP (13lv) and No longer subject to CPP (13lw)

For the Parent/Carer:
Family member subject to (13ly) and No longer subject to (13lz)

Child in need (13IS) and Child no longer in need (13IT) and Child in Need plan (8CM5) Vulnerable child (13IF), Child no longer vulnerable (13IW) and Vulnerable child in family (13IQ)

EMIS – Code with the above info for both child and family members

Disposal of paper records:
Provided the practice has been approved to maintain paperless records then the scanned paper copies can be destroyed. Practices should refer to their processes agreed as part of the 'Good Practice Guidelines for Electronic Records' to determine the time lapse between scanning and destruction. Core guidance is that at least two full backups must have been taken before paper information that has been scanned is destroyed. If you have a 'hosted' system such as EMIS Web, then that is backed up centrally and continually so paper can be destroyed after a short time.

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

Retention of electronic records:
The Department of Health Guidance states:
Child Protection register (records relating to): Retain until the patient's 26th Birthday or 8 years after the patient's death if patient died while in the care of the organisation.

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 DOH 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 DOH guidance indicates that such information can be removed after their 26th birthday or 8 years after their death, if earlier. 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. 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. Practices can adopt this guidance at a point in time that is appropriate to them. Previous files must be retained for the relevant period.

Records of patients no longer at the practice must be securely destroyed. They should not be passed on to the CCG or Area Team. There have been issues of old records being sent in with no indication where they have come from and they could easily have been lost in transit.

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. The last report should state the case is closed. 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.

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 affect 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 record, on the basis it could 'cause significant harm or distress to any individual', given the affect it may have on relations with parents or others. Whilst such future concerns are valid, they should have very limited impact on current actions if any as such situations can be handled as and when they arise.

Where a record is transferred between practices a full printout of documents must be sent and a check for any previous paper records carried out. It is important to ensure all documents are printed from the system and any other scanned document stores and contents of the Lloyd George envelope located.

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)
- A view on the credibility of the allegation(s)

4.6 Contacts for further advice

CCG Named Doctor for Safeguarding Children –

- North Somerset: Dr Mike Pimm
- Bristol: Dr Helen Mutch (helen.mutch@gp-l81053.nhs.uk, 0117 9642211)
- South Gloucestershire: Dr Kate Mansfield

Contact via relevant CCG switchboard.

Information Governance Support (South West Commissioning Support) – email: confidentiality@aimtc.nhs.uk, phone: 0117 900 2410

5 Coding & Scanning of domestic violence incidents (inc MARAC)

Police notify Health services when they have attended a domestic/sexual violence incident in a family where there are children. This will include details of the victim, alleged perpetrator and any children in the family. Multi-Agency Risk Assessment Conferences are run by the police with the aim of reducing repeat harm in the highest risk cases of domestic/sexual violence. Practices will receive letters with information about individuals involved in a MARAC case. The information may solely be about a perpetrator (where they are a registered patient) or may be about the victim, perpetrator and others (where at least two are registered patients, if not all). Letters should be scanned to the victims and any children's file, but must not be scanned to the perpetrators. More detail is below.

The following are key guidance points for you to consider in managing this information. It is divided into two sections relating to information on the perpetrator and information on the victim(s)/others:

5.1 Information on the perpetrator:

- Domestic/Sexual Violence Incident forms contain details of the alleged perpetrator and MARAC letters may inform you of a perpetrator of Domestic/Sexual Violence.
- Documents about the perpetrator **must not be scanned** into health records, but:
- A perpetrator's health record can be coded as follows:
    - Where the practice are aware that the perpetrator is themselves aware of the allegation(s) and/or convictions, then the record can be coded with the relevant read code (see table in 5.4)
    - If the practice are not aware of the perpetrator's level of knowledge of allegations, then the record can be coded using the read code for 'confidential data NOS' (9R1Z). There should also be a free text entry associated with the code including the NHS number of the victim. DO NOT include the victim's name.

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:

- Practices may be in receipt of an information request form from the MARAC Nurse. These forms 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. The information is generally taken from the record, so is already present.
- Information provided following a MARAC may include details of action plans. These can be scanned into the victim's health records. An appropriate read code such as 'domestic violence in the family' should be added to the health records of children in the family. (see next page for a list)
- Domestic Violence incident forms can be scanned onto the health records. It is practice choice, based on whether they feel access to detailed sensitive information in their system is appropriately controlled and meets their responsibilities to safeguard

access to sensitive information provided by Third parties. If practice choice is not to scan then the DV log number must be recorded an appropriate read code (SEE LIST BELOW) should be added to the health records for the victim and any children in the family

Where a perpetrator has a right of access to information on their children, any reference/read code should be removed from the information provided, on the basis that it might cause an individual harm or distress if this information was disclosed.

5.3 HARKS & IRIS Practices

IRIS (Identification and Referral to Improve Safety) is a programme developed to reduce under recognition and under treatment of domestic violence in primary care. It has developed from a research programme progressed in Bristol in conjunction with a number of practices. A template called 'HARKS' has been established in EMIS and Synergy systems that links to DV codes Practices participating in the IRIS programme are advised to consider continuing to use the HARKS template with its underlying codes.

5.4 Advice & support:

Please use the following contacts for advice & support:

MARAC Liaison Nurse – Rachel Griffiths (0117 9002385)
Information Governance – Adam Tuckett (0117 9002410)

Read codes for use:

Domestic Violence/Abuse related Read Codes for Current Problems

The first codes are the most commonly used codes. It is a practice decision which code to use in any circumstance

Victims:
14XG Victim of domestic abuse
13HM Subject of multi-agency risk assessment conference *(MARAC)*
13Hl Subject of multi-agency public protection arrangements
67IA *(capital i)* Advice about domestic violence
8Hl7 *(lower case L)* Referral to domestic violence advocate
K578 Female genital mutilation (for victim)
12b Family history of FMG (for children's records)

Children of victim: code as 'Child at risk: 131F'

Perpetrators:
14XD History of domestic abuse
(For use where alleged perpetrator is aware of allegation or conviction)
Confidential data NOS = 9R1Z
(Where perpetrator may not be aware – include NHS Number of victim as freetext entry

14X4 On sex offenders register
14X9 Alleged perpetrator of physical abuse
14XA Alleged perpetrator of sexual abuse

14XB Alleged perpetrator of emotional abuse
14XC Alleged perpetrator of domestic violence

6 Coding & Scanning of safeguarding adults information

Safeguarding Adults definition

"Abuse is a violation of an individual's human and civil rights by any other person or persons" (No Secrets: Department of Health, 2000)

Abuse includes:

- **Physical abuse**: including hitting, slapping, punching, burning, misuse of medication, inappropriate restraint sexual abuse: including rape, indecent assault, inappropriate touching, exposure to pornographic material

- **Psychological or emotional abuse:** including belittling, name calling threats of harm, intimidation, isolation

- **Financial or material abuse:** including stealing, selling assets, fraudmisuse or misappropriation of property, possessions or benefits

- **Neglect and acts of omission:** including withholding the necessities of life such as medication, food or warmth, ignoring medical or physical care needs

- **Discriminatory abuse:** including racist, sexist, that based on a person's disability and other forms of harassment, slurs or similar treatment

- **Institutional abuse:** including regimented routines and cultures, unsafe practices, lack of person-centred care or treatment

Recording Information

Concerns and information about vulnerable adults should be recorded in the medical records. These should be recorded using recognised computer codes.

Concerns and information from other agencies such as social care, the police or from other members of the primary and secondary health care, should be recorded in the notes under a computer code.

Email should only be used when secure, [e.g. nhs.net to nhs.net] and the email and any response(s) should be copied into the record.

Conversations with and referrals to outside agencies should be recorded under an appropriate computer code.

Safeguarding Adults professionals or strategy meetings notes may be scanned in to electronic patient records as this will usually involve the summary/actions, appropriately annotated by the patient's usual doctor or Practice Adults Safeguarding Lead.

Recording information on records of individuals connected to a vulnerable adult

If there is a need to record information on the record of a vulnerable adult about another individual connected to them, then the following principles should apply:

- Only facts are recorded
- Where possible the name of the individual is not written but the relationship . e.g Mrs X says that her son/husband /daughter or son in-law shouted and pushed her. Mrs X had

visible bruises and does not want anything done about at the moment she aware that this has been entered into her notes
- If the patient in this case the perpetrator is registered with the same practice and or shares the same GP, cross referencing may be difficult unless the individual who is under duress due to carers stress. This can be recorded as such in the both records even if no harm has occurred.
- If abuse occurred and is alcohol and drugs related irrespective of age safeguarding adults principles of recording will be the same for domestic violence and Children
- If scanning information from a case conference, consider redacting names and details of third parties prior to scanning.

Safeguarding Adults Strategy Minutes and Actions
Case conference minutes frequently raise concerns - much of it about information concerning third parties.

Case conference minutes should be stored in the patient's records.
Conference minutes 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

Sharing Information and Confidentiality
GPs will follow GMC guidance on patient confidentiality.

In most situations patient consent must be obtained prior to release of information including making a safeguarding adults alert.

If the patient may lack capacity an assessment of mental capacity should be undertaken. If this assessment indicates that the patient lacks capacity then an alert may be made and information shared under best interest's guidance.

In some circumstances disclosure of confidential information should be made without patient's consent in the public interest. This is most commonly if there is a risk to a third party.

An example would be it children or other vulnerable adults were potentially at risk. The patient should normally be informed that the information will be shared but this should not be done if it will place the patient, yourself or others at increased risk.

References:
Corporate Records Retention & Disposal Schedule & Guidance 2014
GMC guidance on patient confidentiality 2009

Paulette Nuttall Safeguarding Adults Lead Nurse (Contact details?)

Codes to be used:

vulnerable adult:	13Iq
at risk violence in the home :	13vf