

**GUIDANCE FOR PRIMARY CARE ON SAFEGUARDING ALERTS, CODING AND UPLOADING OF SAFEGUARDING DOCUMENTS**

|  |  |
| --- | --- |
| Version: | 1 |
| Name of Originator/Author: | Dawn Sherry, Named Professional for Safeguarding in Primary CareKerry Male, Deputy Designated Nurse for safeguarding ChildrenLouise Smailes, Deputy Designated Nurse for safeguarding adults |
| Date issued: | 3 March 2025 |
| Review date: |  |
| Target audience: | Primary Care  |
|  |  |

**GUIDANCE FOR PRIMARY CARE ON SAFEGUARDING ALERTS, CODING**

**AND UPLOADING OF SAFEGUARDING DOCUMENTS**

**CONTENTS**

|  |  |  |
| --- | --- | --- |
| **Section** |  | **Page** |
|  | VERSION CONTROL | i |
| SECTION 1 | purpose | 1 |
| SECTION 2 | legal duty | 1 |
| SECTION 3 | general principles of processing and sotring information on the gp records | 2 |
| SECTION 4 | organisation alerts / warnings | 3 |
| SECTION 5 | redaction | 4 |
| SECTION 6 | transfer of records between gp practices (GP2GP | 4 |
| SECTION 7 | refusing online record access for safeguarding reasons | 5 |
| SECTION 8 | online visibility of safeguarding information  | 5 |
| SECTION 9 | managing safeguarding information  | 6 |
| SECTION 10 | ssafeguarding children  | 7 |
| SECTION 11 | children looked after coding  | 9 |
| SECTION 12 | managing health records of adopted children | 10 |
| SECTION 13 | recording of domestic abuse information  | 11 |
|  |
| APPENDIX 1 | SNOMED CODES |
| APPENDIX 2 | CASE STUDY |

**GUIDANCE FOR PRIMARY CARE ON SAFEGUARDING ALERTS, CODING AND UPLOADING OF SAFEGUARDING DOCUMENTS**

**VERSION CONTROL**

|  |  |
| --- | --- |
| **Document Status**: | Final Version |
| **Version:** | 1 |

|  |
| --- |
| **DOCUMENT CHANGE HISTORY** |
| **Version** | **Date** | **Comments** |
| 1 | 3 March 2025 |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| **Author(s):** | Dawn Sherry, Named Professional for Safeguarding in Primary CareKerry Male, Deputy Designated Nurse for safeguarding ChildrenLouise Smailes, Deputy Designated Nurse for safeguarding adults |
| **Document Reference:** |  |

**GUIDANCE FOR PRIMARY CARE ON SAFEGUARDING ALERTS, CODING**

**AND UPLOADING OF SAFEGUARDING DOCUMENTS**

|  |  |
| --- | --- |
| **1** | **PURPOSE** |
|  |  |
| 1.1 | The purpose of this guidance is to clarify:* which safeguarding SNOMED codes and alerts should be used in primary care when there are safeguarding concerns
* what safeguarding documentation can be uploaded onto EMIS records
* what safeguarding information should be hidden from patient view
 |
|  |  |
| 1.2 | This guidance should be used in conjunction with the ICB Safeguarding Children, Adults and Domestic Abuse Policies. If you have specific safeguarding concerns regarding a child or adult at risk, please follow these policies for advice/support.  |
|  |  |
| **2** | **LEGAL DUTY** |
|  |  |
| 2.1 | All providers and local authorities have a (legal) duty under the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 to ensure that any personal data they process is handled and stored securely. Further information on data storage and security is available from the Information Commissioner’s Office. |
|  |  |
| 2.2 | Where personal data is not properly safeguarded, it could compromise the safety of individuals and damage individual and organisational reputations. Concerns and information about vulnerable children must be recorded in the child’s records, and where appropriate the notes of siblings / other children in the same household, and parents / carers / significant adults. |
|  |  |
| 2.3 | The GMC guidance ‘Protecting children and young people’ came into effect in 2012. It was updated in 2018 to reflect the requirements of the GDPR and Data Protection Act 2018, and updated on 13 December 2024 when regulation of physician associates and anaesthesia associates by the GMC came into effect. |
|  |  |

|  |  |
| --- | --- |
| **3** | **General Principles of Processing and Storing Information in the GP Electronic medical records** |
|  |  |
| 3.1 | All primary care staff have a role in ensuring safeguarding information is stored correctly and in accordance with RCGP guidance[[1]](#footnote-1), all safeguarding information should be stored within medical records, not separate to it. It is important that all primary care staff are aware of the following basic principles regarding how safeguarding information is recorded, processed, and securely stored on the General Practice electronic medical record: |
|  |  |
| 3.2 | **High quality documentation of safeguarding information is fundamental to safeguarding children and adults.** |
|  |  |
| 3.4 | * **When applying coding to safeguarding problems they should be marked as significant.**
 |
|  |  |
| 3.5 | * **Accurate coding and documentation** of safeguarding information is as important as coding any other significant medical issue. Records should be clear, accurate and readable. Where possible try and record what the patient or informant says verbatim in the notes. Request consent from the individual or their parent / carer to share safeguarding concerns when needed, and document whether consent has been provided or not in the records.
 |
|  |  |
| 3.6 | * **It is important to document safeguarding concerns** in records no matter how minor the concern appears. The notes should reflect the details of any actions taken, information shared, (and with whom) and all decisions made.
 |
|  |  |
| 3.7 | * **Coding and documentation of safeguarding concerns should be the same quality as for any other medical conditions**, allowing GP electronic medical records to highlight patients who are vulnerable or at risk and enable the offer of appropriate support.
 |
|  |  |
| 3.8 | * **Professional discussions regarding safeguarding concerns need to be transparent, complete**, and not inhibited by the concern that a patient may see the record online. These professional discussions or concerns need to be recorded accurately in the electronic medical record to ensure information is available to all and any clinician when needed. When necessary, records can be redacted, (obscured from the document), before being shared with the patient, family or any other party.
 |
|  |  |
| 3.9 | **Online access by the patient to their own record should not be a barrier** to the recording of the safeguarding information by a clinician for fear that information may be seen. The relevant information should be redacted appropriately.   |
|  |  |
| 3.10 | The RCGP safeguarding toolkit covers the key principles of documenting safeguarding concerns and information in the patient electronic medical record as well as a list of essential safeguarding codes to ensure a common safeguarding language and understanding across general **practice.** |
|  |  |
| **4** | **ORGANISATIONAL ALERTS/WARNINGS** |
|  |  |
| 4.1 | Alerts are routinely applied to primary care electronic medical records to highlight important issues such as allergies, ownership of weapons, or whether the individual is subject to community treatment orders. Adding alerts for safeguarding concerns highlight that the individual is at risk of abuse or neglect, or that they pose a risk to others or themselves |
|  |  |
| 4.2 | Please be aware that some alerts will be automatically added when certain codes are applied (e.g. CLA – Children Looked After). Please add additional alerts as required to highlight safeguarding concerns. |
|  |  |
| 4.3 | There are no statutory guidelines for applying and managing alerts and this can pose challenges and risks in ensuring the delivery of safe clinical care. There are a number of issues related to alerts staff need to be aware of: |
|  |  |
| 4.4 | **Triggering an alert**: Safeguarding Alerts can be used alongside coding, to highlight risk. The threshold for applying a safeguarding alert is subjective. NHS England Guidance is clear that *if there is consideration of a safeguarding concern that suggests all users are aware, then this would likely meet that threshold*. |
|  |  |
| 4.5 | * **Consent**: As detailed in the UK GDPR and Data Protection Act 2018 consent is not required to store safeguarding information or apply an alert on electronic medical records if there is a safeguarding concern or public interest.
 |
|  |  |
| 4.6 | * **Responsibility**: GP practices may adopt different approaches to managing alerts. It is important to ensure that the responsible person has the expertise and knowledge of the individual while balancing the need to involve many professionals.
 |
|  |  |
| 4.7 | * **Duration and review**: Safeguarding alerts should remain active as long as the risk persists to that patient. Alerts maybe left active longer than intended and should be reviewed as often as practicable and appropriately removed.
 |
|  |  |
| 4.8 | **Access to alerts**: GP practice staff involved in the care of a patient must have access to safeguarding alerts. There is, however, a need to ensure that this information is shared and understood beyond the practice boundary as required). |
|  |  |
| **5** | **REDACTION** |
|  |  |
| 5.1 | Redaction is a key component in reducing the safeguarding risks associated with online access.  Redaction is the process of restricting access or ‘hiding’ information in the online viewer from the patient and anyone they have granted proxy access to. It does not remove the information from the patient’s record. There is further guidance on redacting information for online record access here: <https://www.england.nhs.uk/long-read/redacting-information-for-online-record-access/>   |
|  |  |
| 5.2 | All staff entering information into the clinical record need to be aware of what, when how and why to redact information.   Staff should add a note to highlight where documents may contain third party information. |
|  |  |
| 5.3 | When printing of records is required consider the need to redact third party information and any sensitive safeguarding information too. Do not include any information that did not originate in primary care. For example Child Protection Conference Reports, Domestic Abuse notifications and MARAC information.  |
|  |  |
| **6** | **TRANSFER OF RECORDS BETWEEN GP PRACTICES (GP2GP)** |
|  |  |
| 6.1 | The [General Medical Services (GMS) GP Contract](https://www.england.nhs.uk/long-read/gp-contract/) requires practices to use the GP2GP facility for the transfer of patient records between practices. Online visibility settings and markers of redacted content are currently not part of a [GP2GP](https://www.england.nhs.uk/long-read/gp2gp-transferred-in-records-processing/) transfer.  If a patient has some entries restricted for online viewing and leaves the practice, the current guidance is to only allow online access to the prospective records from the date they move to the new practice.   This avoids the need to ensure the patient’s historic record does not include information that should be redacted and the associated workload implications.  This doesn’t, however, remove all the risks, so it is recommended that an individual assessment of the appropriateness of record access is considered for all new patients, or reviewing of records to redact safeguarding information again prior to patient online access. |
|  |  |
| 6.2 | There is ongoing work by the GP IT providers to transfer visibility and redaction settings during the GP2GP transfer.  |
|  |  |

|  |  |
| --- | --- |
| **7** | **REFUSING ONLINE RECORD ACCESS FOR SAFEGUARDING REASONS** |
|  |  |
| 7.1 | The UK General Data Protection Regulations (GDPR) and Data Protection Act 2018 provide a number of exemptions in respect of information falling within the scope of a Subject Access Request.  The same exemptions also apply to providing information through patient access to the online electronic medical record.  Once again these are mainly due to the risk of serious physical or mental harm, safeguarding risks and third-party disclosures.  Full details of exemptions are described in the [BMA Access to health records guidance](https://www.bma.org.uk/advice-and-support/ethics/confidentiality-and-health-records/access-to-health-records)[[2]](#footnote-2). |
|  |  |
| 7.2 | The circumstances in which records need to be withheld on safeguarding grounds should be rare.  A patient’s access to their electronic medical records should not be withheld on the grounds that the patient may find information upsetting.  There must be a reasonable case that it would cause harm.  If there are doubts about whether disclosure would cause serious harm, the health professional should discuss with an experienced colleague, your Caldicott Guardian, or a medical defence/professional body. You can also discuss this with the NHS Somerset ICB Information Governance Team (somicb.igteam@nhs.net) or Safeguarding Team (somicb.safeguardingandcla@nhs.net) for further advice and support. |
|  |  |
| 7.3 | Health professionals need to be reassured, however, that both the UK GDPR and Data Protection Act 2018 offer considerable protection, not only to patient data, but also to the health professional themselves when redacting or declining access if there is a safeguarding risk. [NHS England » Redaction](https://www.england.nhs.uk/long-read/redacting-information-for-online-record-access/) [NHS England » Subject access requests (SAR)](https://www.england.nhs.uk/long-read/subject-access-requests-sar/) |
|  |  |
| **8** | **ONLINE VISIBILITY OF SAFEGUARDING INFORMATION** |
|  |  |
| 8.1 | In EMIS, entries become visible as soon as they are saved, if not hidden. If you think that an entry needs to be ‘hidden’, it is better to do this whilst creating the entry to prevent temporary visibility of the entry between saving it and retrospectively ‘hiding’ it. Please note: Hiding information from online visibility WILL NOT redact records when printed. |
|  |  |
| 8.2 | Safely managing domestic abuse information is extremely important. Where there is patient online access, make sure all entries about domestic abuse are marked not for online access. The challenges of managing and recording domestic abuse (DA) information in the electronic medical record (EMR) of people experiencing or perpetrating abuse and how to do this without increasing risk of harm to victims (adult and child) is addressed in the RCGP Guidance on recording domestic abuse in the EMR 2021[[3]](#footnote-3).  |
| **9** | **MANAGING SAFEGUARDING INFORMATION** |
|  |  |
| 9.1 | Safeguarding concerns and information from other agencies such as social care; education; the police, or other health colleagues, including Public Health Nurses and Midwives, should be recorded in the notes under the most appropriate SNOMED codes. |
|  |  |
| 9.2 | All contacts with any parties regarding any safeguarding children issues/concerns should be recorded on the patient’s medical records and any necessary action taken immediately. This includes:* Contact with staff from partner agencies as part of Child Protection / Section 47 investigations and Adult Safeguarding/Section 42 investigations
* Attendance at multi-agency meetings i.e. Strategy meetings, Child Protection Conferences (CPC), Child In Need (CIN) meetings, Core Groups and Team Around the Family (TAF) meetings, Adults at Risk meetings, Multi-Agency Risk Management (MARM), Multi-Agency Safeguarding Hub (MASH)
 |
|  |  |
| 9.2 | Discussions held with staff from partner agencies at the Practice’s Safeguarding meetings. The record for each family member must highlight any agreed actions to be taken as a result of the discussion if appropriate (please consider whether it is appropriate to add information to the record of the person causing harm). |
|  |  |
| 9.3 | Safeguarding information received by the practice should be reviewed by the relevant GP and must be scanned and stored within the records of all people named within the documents. This can include but is not limited to the following:* Child Protection Conference invites and minutes.
* MARAC referrals and information (on ALL named person’s records - see section 10.7 **Recording of domestic abuse information** below)
* Police Domestic Abuse Incident Notifications (on all named persons records – see section 10.7 Recording of domestic abuse information below)
* Child Looked After health reviews
* Team Around the Family (TAF) invites and minutes
* A&E / MIU / Out of Hours reports
* Maternity Social update Form
* Adult Safeguarding Meetings (e.g. Multi agency risk meetings, Adult at Risk Meetings)
* SWAST Reports/NHS 111
 |
|  |  |
| 9.4 | These records are as important as those for serious physical illness and should be recorded in the same way, with the same degree of permanence and never kept separately from the main electronic medical record. Consideration must always be given as to how safeguarding information is stored within a patient’s electronic record as it may need to be saved in such a way that it cannot be seen online by the patient, particularly if to do so would increase the risks to the child(ren) and other adults in the household. Safeguarding information within a patient’s electronic medical record may also need to be redacted if patients ask for a copy of their file. |
|  |  |
| **10** | **SAFEGUARDING CHILDREN AND ADULTS** |
|  |  |
|  | **Safeguarding Adults** |
|  |  |
| 10.1 | Safeguarding adults coding needs to be applied when an adult is identified as being at risk due to safeguarding concerns. This information could be from the patient themselves or via a third party such as family members and other practitioners. 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. |
|  |  |
| 10.2 | 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.
 |
|  |  |
| 10.3 | Safeguarding Adults information will take various forms: section 42 enquiries, multi-agency risk meeting minutes, Adult at risk meeting minutes other professionals/multi-agency meeting minutes. These documents need to be scanned as they, should form part of the patient’s records. |
|  |  |
|  | **Safeguarding unborn babies** |
|  |  |
| 10.4 | * As referenced in the Maternity Communication Standard Operating Procedure use coding when uploading the following documents onto the mothers’ record:
* Maternity booking forms
* Maternity Social Updates
 |
|  |  |

|  |  |
| --- | --- |
|  | **Safeguarding Children**  |
|  |  |
| 10.5 | Use coding when uploading the following documents to both children and relevant parent / carer records:* Early Help Assessments
* Children and Family Assessments
* Children Social Care documents (case closures, Child in Need Minutes, Strategy Discussion Minutes, Child Protection Conference Reports and Minutes etc)
 |
|  |  |
|  | **Recording Child Protection Case Conferences**  |
|  |  |
| 10.6 | * **A child (born or unborn) in receipt of a Child Protection plan**: A short note should also be added to their record to illustrate the category(ies) of the plan i.e. Emotional Abuse, Sexual Abuse, Physical Abuse, and Neglect. If the child is not yet born, a record should be added to the mother’s notes and then added to the child’s record once born. When a child is no longer subject to Child Protection Plan the appropriate code needs to be added as a Major Active Problem.
 |
|  |  |
| 10.7 | * **Siblings:** It is often the case that all siblings in a family will be subject to the same Child Protection Plan so will have this information coded on their notes. However, if the siblings are not subject to a Child Protection Plan, they also need appropriate codes added to their record as a Major Active Problem. A short note should be added as explain which sibling is subject to a Child Protection Plan (name, D.O.B) and the category of their plan.
 |
|  |  |
| 10.8 | * **Household members of a child subject to a Child Protection Plan:** Parents/Step-parents or any other adult living in the same household will require a Major Active Problem code. Again, a short note should be added to explain who is subject to a Child Protection Plan, their name, date of birth and Plan category.
 |
|  |  |
| 10.9 | * **Child Protection Case Conference invitations and reports:** should generally be scanned into ALL the notes of the family/household members – there will be some exceptions to this which need to be judged on a case-by-case basis. Please contact the ICB Safeguarding Team for further advice or guidance if you are concerned that there is information in a Child Protection Conference Report that should not be made visible or uploaded on to a family members’ records.
 |

|  |  |
| --- | --- |
|  | **Recording Multi-Agency Safeguarding Hub (MASH) Discussions**  |
|  |  |
| 10.10 | * MASH has statutory representatives from the Health System (Somerset NHS Foundation Trust, Public Health Nursing and the ICB representing Primary Care), Somerset Children’s Social Care and Avon and Somerset Police. A MASH discussion is held when multi-agency information needs to be shared to ensure there is a timely and appropriate response to safeguarding concerns regarding children.
 |
|  |  |
| 10.11 | * Please be aware the MASH outcome template and the MASH Discussion minutes may contain third party information regarding individuals that are not under the care of your GP Practice. This information is shared with GP practices to give you the whole picture in the interests of safeguarding all parties involved.
 |
|  |  |
| 10.12 | * MASH information does not need to be redacted in your records, but it should not be shared with any other party and should NOT be visible to the patient through online access.
 |
|  |  |
|  | **Recording non-attendance at appointments** |
| 10.13 |  |
|  | Children and adults with care and support needs, who need to be brought to health appointments by their caregivers/carers. Therefore, they cannot ‘not attend’ an appointment and should be coded as ‘not brought’ rather than ‘did not attend’. This changes how the action of any follow up from these missed appointments. Not being brought to an appointment can be a sign of neglect or that the family/caregivers are struggling in some way. Each practice should have a policy of how these missed appointments are actioned.  |
|  |  |
| **11** | * **CHILDREN LOOKED AFTER CODING**
 |
|  |  |
| 11.1 | The following groups of people need codes added to their notes as Major Active Problems: * Children who are Looked After, (also known as a Child in Care / Fostered child)
* Parents/carers whose child is Looked After
* Siblings of the child who is Looked After but they themselves are not Looked After
* Adults who are foster carers
* Other children/adults in the household of the foster carers where the Looked After Child resides
 |
|  |  |

|  |  |
| --- | --- |
| 11.3 | In each of the above situations a short note should be added to each relevant record with the code to give details of the Looked After child’s name and DOB. When a child is no longer Looked After, the appropriate code needs to be added to their notes (this can happen when either the child is returned to their parents, is adopted or turns 18 years of age). |
|  |  |
| **12** | **MANAGING HEALTH RECORDS OF ADOPTED CHILDREN** |
|  |  |
| 12.1 | When a child is adopted, they are given a new NHS number. When the new NHS number has been allocated their EMIS records should be merged with the new post-adoptive details. This is set out in Primary Care Support England’s [Medical records for adopted patients practice guide for GPs.](https://pcse.england.nhs.uk/sites/default/files/2023-08/adoption-medical-records-practice-guide.pdf) |
|  |  |
| 12.2 | To ensure an adopted child can continue to benefit from continuous contemporaneous health records, please follow the below key principles: 1. The child’s clinical health records must remain intact and continuous after the adoption order has been granted.
2. Only accurate current demographics can be viewed or used by administration personnel, medical professionals or patients/carers.
 |
|  |  |
| 12.3 | Information governance and data principles must be enhanced to prevent any accidental disclosure of addresses or third-party information contained in the record.  |
| 12.4 |  |
|  | 1. Reminders should be used on the record to highlight the sensitivity of the record.
 |
|  |  |
| 12.5 | 1. 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 Somerset NHS Foundation Trust Looked After Children Health/Adoption team CLAnursesanddoctors@somersetft.nhs.uk and other stakeholders, including your local Child Health Information Service team.
 |
|  |  |
| 12.6 | 1. The use of standard SNOMED CT codes should be universal, in this case:
* Record contains third-party information (finding), SCTID
* 888931000000108; Adopted child (person), SCTID: 393547004
 |
|  |  |
| 12.7 | 1. Subject Access Requests for the records of an adopted child must be handled by NHS provider medico-legal teams with advice from the Designated Nurse for Children Looked After somicb.safeguardingandcla@nhs.net .
 |
|  |  |
| **13** | **RECORDING OF DOMESTIC ABUSE INFORMATION**  |
|  |  |
| 13.1 | ALL domestic abuse information must be recorded in the EMR on all patient records involved (including perpetrator) and MUST be hidden from patient online access. If you are concerned about this, please contact your safeguarding lead or Somerset ICB Safeguarding team for advice. This decision has been made as evidence and learning from local and national reviews indicate more harm has come from not sharing information and recording risks adequately. * Family records should be linked in practices where possible.
* The name of anyone accompanying a patient in a consultation should be documented.
* The name of any alleged perpetrator/s should be included when documenting disclosure of domestic abuse.
* Ensure that any reference to domestic abuse on a patient’s records is not accidently visible during appointments. The computer screen showing the medical record should never be seen by third parties (i.e. family or friends accompanying a patient).
* When providing a summary printout for a hospital admission for example, care should be taken that information about domestic abuse is not inappropriately included when printing out these summaries to give to patients, as the perpetrator may see this. These summaries do display when information has been redacted which may cause patients to question what has been redacted.
* Ensure problem codes are redacted before sending any referrals.
* Never disclose any allegation to the perpetrator or other family members.
 |
|  |  |
| 13.2 | Ensure that any decision to record the information in the perpetrator’s EMR is made with due regard to the associated risks. |
|  |  |
| 13.3 | * Ensure that any reference to DA in a perpetrator’s record is redacted if provided to the perpetrator unless you are certain it is information that the perpetrator already knows. For example, the perpetrator has disclosed this information themselves to you, or there is a relevant conviction which the perpetrator has disclosed or is aware has been disclosed to you such as in Child Protection Conference minutes, when the perpetrator has been present at the conference and is aware this information is being shared.
 |
|  |  |

|  |  |
| --- | --- |
| 13.4 | * Be aware of the potential danger of the perpetrator having access to information about their abuse and to information in children’s EMRs (electronic medical record); this includes via online access to their own information and their children’s information, as well as coercive access to the victim’s EMR.
 |
|  |  |
| 13.5 | * This guidance should be read in conjunction with the domestic abuse project ISA tier 2.
 |

The below table has been developed using the most relevant and frequently used safeguarding codes.

|  |
| --- |
| **Domestic Abuse Coding****All safeguarding coding needs to be marked as significant** |

|  |  |  |
| --- | --- | --- |
| **SNOWMED Code** | **Classification on NHS Digital / SNOMED Wording** | **Rationale for use of code in Primary Care** |
| 886201000000108 | Assessment using Domestic Abuse, Stalking and Harassment and Honour Based Violence (2009) Risk Identification and Assessment and Management Model Checklist (procedure) | Use this code when a DASH RIC checklist has been completed with a patient, due to concerns about domestic abuse. |
| 978091000000105 | Referral to multi-agency risk assessment conference (procedure) | Use this code when referring a patient to MARAC for high-risk domestic abuse |
| 758941000000108 | Family Subject of multi-agency risk assessment conference (finding) | Use this code when receiving notification that a patient has been/or will be discussed at MARAC. |
| 429746005 | History of Domestic Abuse | To be used when there is an identified history of domestic abuse within a household. Could be used to record when child/vulnerable have been identified as living in household where domestic abuse is taken place from MARAC / police notification/disclosure.  |
| 758599003 | Referral to Domestic Abuse agency | When referring to Somerset domestic abuse service.  |
| 206411000000103 | Alleged Perpetrator of Domestic Abuse | Use when disclosure / police report / MARAC info received |
| 879911000000102 | Victim of Domestic Abuse | Use when disclosure/police report/MARAC info received  |
| 895141000000105 | Police domestic incident report received | Police report received (use for children in household or other adult present during incident) |

|  |
| --- |
| **Child Safeguarding Coding****All safeguarding coding needs to be marked as significant** |

| **SNOMED Code** | **Classification on NHS Digital / SNOMED Wording** | **Rationale for use of code in Primary Care** |
| --- | --- | --- |
| 514341000000108 | Referral to Child Safeguarding Team | Referral to Children Social Care |
| 762931000000105 | Child Protection Strategy Meeting | Child has been discussed at a StrategyDiscussion meeting |
| 342191000000101 | Subject to Child Protection Plan | Child is on a Child Protection Plan (CPP) |
| 375041000000100 | Family member subject of child protection plan | A family member of the patient is on a ChildProtection Plan |
| 836931000000102 | Subject of Child in Need Plan | Child is on a Child in Need Plan (CIN) |
| 1036511000000100 | Child Protection Conference Report Submitted | Child Protection Conference Report Submitted |
| 1659091000000102 | Child Protection Conference Minutes received | Child Protection Conference Minutes received |
| 901441000000108 | Child was not brought to appointment | Child was not brought to appointment. Inclusive of not answering telephone appointments or not present for home visits.  |
| 747531000000108 | History of Childhood Adverse Experiences | Highlighted historic Childhood Adverse Experiences |
| 1659241000000103 | Abusive head trauma | Traumatic injury to head and/or neck due tophysical abuse / non-accidental injury |
| 150091000000106 | Provision of information about infant crying about ICON (Infant Crying is Normal, Comforting Methods can help, It’s OK to walk away, Never, ever shake a baby) | Information about infant crying and how tomanage this has been given to patient |
| 300731000000106 | Family cause for concern | History taking, or information shared / requested highlights family safeguarding concerns. |
| 836881000000105 | Child is cause for safeguarding concern  | History taking, or information shared / requested highlights child safeguarding concerns. |
| 818901000000100 | Unborn Child Subject to Child Protection Plan | Unborn Child Subject to Child Protection Plan |
| 22451000000100 | Report received from social services | Report received from social services |
| 1188261000000103 | At risk of criminal exploitation  | Identified risk of criminal exploitation |
| 1188271000000105 | Victim of criminal exploitation | Identified as a victim of criminal exploitation |
| 1086791000000109 | Child is cause for concern regarding sexual exploitation | Concerns highlighted that child is at risk of or victim of child sexual exploitation.  |

|  |
| --- |
| **Child Looked After Coding****All safeguarding coding needs to be marked as significant** |

|  |  |  |
| --- | --- | --- |
| **SNOMED Code** | **Classification on NHS Digital / SNOMED Wording** | **Rationale for use of code in Primary Care** |
| 764841000000100 | Looked after child (finding) | Use this code to identify when a child has become looked after |
| 770347003 | Care leaver | Applies to young people aged 16-25 years who have been in care.  |
| 314381008 | Approved Foster Parent | Adult has become an "Approved Foster Parent" |

|  |
| --- |
| **Safeguarding Adults Coding****All safeguarding coding needs to be marked as significant** |

|  |  |  |
| --- | --- | --- |
| **SNOMED Code** | **Classification on NHS Digital / SNOMED Wording** | **Rationale for use of code in Primary Care** |
| 766561000000109 | Adult safeguarding concern | Use when safeguarding concern identified. This could include information received from third parties |
| 514331000000104 | Referral to Safeguarding Adults Team | Use when a safeguarding referral / alert has been made |
| 1659071000000101 | Adult is subject to Section 42 enquiry | When info received that Subject to safeguarding enquiry under section42 of Care Act 2014 |
| 1323481000000100 | Adult was not brought to appointment | For adults with care and support needs who were not brought to appointment |
| 150141000000100  | Referral to social services for care needsassessment | Referral made to adult social services for careneeds assessment |

|  |
| --- |
| **Capacity Decisions****All safeguarding coding needs to be marked as significant** |

|  |  |  |
| --- | --- | --- |
| **SNOMED Code** | **Classification on NHS Digital / SNOMED Wording** | **Rationale for use of code in Primary Care** |
| 1136641000000105 | Has the capacity to make this decision (Mental Capacity Act 2005) | Has the capacity to make this decision |
| 787381000000106 | Lacks the capacity to make this decision (Mental Capacity Act 2005) | Lacks the capacity to make this decision  |
| 816361000000101 | Has appointed person with personal welfare lasting power of attorney (Mental capacity Act 2005) | Power of attorney in place for this patient personal welfare |
| 765141000000105 | Best interest decision made on behalf of patient (Mental Capacity Act 2005) | Best interest decision made on behalf of patient |

|  |
| --- |
| **Other safeguarding codes which apply to both adults and children****All safeguarding coding needs to be marked as significant** |

|  |  |  |
| --- | --- | --- |
| **SNOMED Code** | **Classification on NHS Digital / SNOMED Wording** | **Rationale for use of code in Primary Care** |
| 1659101000000105 | Referral to Prevent.  | Patient open to Channel Panel |
| 1659211000000104 | Notification received that subject of record ismissing | Notification received that subject of record isMissing  |
| 1659221000000105  | Safeguarding-relevant information requested by council | Information requested by council for safeguarding purposes |
| 1659231000000107 | Provision of safeguarding-relevant information to council  | Information shared with council for safeguarding purposes  |
| 1290331000000103 | Online access to own health record declined by patient  | Patient declined online record access  |
| 1290311000000106 | Online access to own health record grantedfollowing enhanced health record review | Patient online access granted  |
| 1290301000000109 | Online access to own health record withheldfollowing enhanced health record review | Patient online access withheld  |
| 495021000000105 | Subject of Multi-Agency Public ProtectionArrangements | Use when official information received from probation services.  |

|  |
| --- |
| **Current FGM Terms****All safeguarding coding needs to be marked as significant** |

|  |  |  |
| --- | --- | --- |
| **SNOMED Code** | **Classification on NHS Digital / SNOMED Wording** | **Rationale for use of code in Primary Care** |
| 95041000119101 | Female Genital Mutilation | Use this for when a woman has experienced FGM |
| 902961000000107 | Family History of Female Genital Mutilation | Use this for a child who has family members who have experienced FGM.  |
|  442290007 | Deinfibulation of vulva | Woman has had a procedure to open the vagina following FGM.  |

**CASE STUDY EXAMPLE**

Ella is a 28-year-old who presented to the practice with depressive symptoms and disclosed to you that her husband has been verbally abusing her and very controlling.  She asks the GP not to write anything in her notes as she is worried that her husband will see the record as he has access to her online record.  The GP redacts the consultation so there is no record of the discussion and no record of the coding of depression in the online record.

In this case the GP acknowledges the safeguarding risk and redacts the consultation.  This does, however, expose several risks:

* If the husband was aware that Ella had been to the GP and is unable to see the entry, he could assume the GP had redacted the information even though the consultation may be redacted.
* Ella may be less confident in presenting due to her own concerns over her husband having online access.

This case highlights one of the deficiencies of redaction, i.e. information provided by inference.  In this case the husband may infer that the patient has disclosed information about the abuse as there is no consultation in the online record.

This may have been the first time that the practice had any reason to believe there were any safeguarding issues.  Having identified a potentially coercive relationship, the immediate solution may be to reduce the level of access, but this leads to placing the patient at risk if the husband infers access has been restricted due to the disclosure of abuse.

Although this sort of situation is likely to be rare, it could become more likely as more patients get full record access (which could be both prospective and retrospective).  These situations must be considered on a case-by-case basis, looking at the potential ramifications of each decision and minimising risk.

Communicating with the patient is crucial in order that both parties understand the risks.  It may be useful to discuss concerns with the practice or local safeguarding lead, Caldicott Guardian, or medical defence organisation.  A plan can then be agreed about how to safely limit online access in the future while the safeguarding issues are being addressed.

(NHS England Good Practice Guidelines for GP Electronic Records 2023)

1. https://ico.org.uk/for-organisations/advice-for-small-organisations/frequently-asked-questions/data-storage-sharing-and-security/

 https://www.gmc-uk.org/professional-standards/the-professional-standards/protecting-children-and-young-people

 RCGP Safeguarding Toolkit Part 4: Documenting Safeguarding Concerns and information [↑](#footnote-ref-1)
2. [Access to health records (bma.org.uk)](https://www.bma.org.uk/advice-and-support/ethics/confidentiality-and-health-records/access-to-health-records) [↑](#footnote-ref-2)
3. [RCGP guidance on recording of domestic violence updated Jan 2021.pdf](https://elearning.rcgp.org.uk/pluginfile.php/205139/mod_book/chapter/901/RCGP%20guidance%20on%20recording%20of%20domestic%20violence_updated%20Jan%202021.pdf) [↑](#footnote-ref-3)