

GP Online Services Guidance

*Safeguarding and automatic record access*

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Introduction

This guidance is concerned with safeguarding patients who are, have been or will become victims of abuse and who may be put at risk by online access to their GP record. Accurate and detailed GP records are an important tool in supporting longitudinal care of victims and survivors of abuse, but the same information can present a risk to victims if it becomes available to someone who is abusing them.

It is important that practice team members are always vigilant to identify and act on evidence of safeguarding risks and ensure that any potentially harmful information in the record is hidden from the patient’s online view of the record, a process called redaction.

A patient's experience and risk of abuse can fluctuate over a lifetime so practices will always need to be alert to historical, current and emerging safeguarding concerns. Vulnerable groups of patients who are likely to be at increased risk of coercion to allow access to their online record are listed in Box 1 below.

The automation of the process for patients to obtain online access to their future GP record removes the opportunity that practices had to assess patients individually when they have to apply for record access. While considering the application, there was time for practices to investigate whether the applicant might be at risk of being coerced to share their record with an abuser, and to screen the record for evidence of safeguarding risk that may be exacerbated by online record access, or the presence of potentially harmful information that should be redacted.

This document focuses on safeguarding risk and provides guidance about how practices manage records appropriately by heightened vigilance for evidence of safeguarding risk and extra care of the content and safety of patient records.

Ref: This guidance should be read in with the guidance on how to address these issues in “Managing Potentially Harmful Information” “Patient Information Themes for GP Online Services “Safeguarding and Vulnerable Groups” in the Toolkit.

**Box 1: Vulnerable groups at risk of controlling coercion**

Vulnerable groups who are likely to be at increased risk of coercion to allow access to their online record include, but may not be restricted to the following:

* 16 to 17 year olds including Looked After Children, Care Leavers and children on Child Protection Plans
* Victims of any type of abuse, but especially Domestic Abuse, Modern Slavery, Trafficking and exploitation of any kind
* Adults with safeguarding information coded on their record such as ‘Adult Safeguarding Concern’
* Known perpetrators of abuse
* Those with learning disabilities
* Those with autism
* Those with dementia
* Asylum Seekers and those whose immigration status is uncertain
* Those with serious mental health conditions
* Those with post-traumatic stress disorder
* Other vulnerable groups including those who are homeless and those with substance misuse issues
* Prisoners, including those who are about to/have just gone into prison, and those who have come out of prison.
* Patients who are blind/visually impaired, who have poor literacy, who use different languages other than English, who communicate in different ways, who have other accessibility issues such as dyslexia and attention deficit hyperactivity disorder

Safeguarding information

In England, primary care records hold a vast, and increasing, amount of safeguarding information. This information comes from personal disclosures by patients of their own experience of abuse and from organisations and sectors such as the police, social care and education. Records contain information about mental health, contraception, sexual health (including HIV), pregnancy, termination, and gender identity, which could be dangerous in the hands of an abuser. There can also be significant amounts of confidential third-party information related to safeguarding issues, e.g. perpetrators’ records.

If patient information is accessed by an abuser, it could lead to serious harm to the patient and others, such as children in the same family. The perpetrator may gain access to their victim’s NHS Login details, or coerce them to share their phone, tablet, or digital device, etc. and access the patient’s health record.

**Box 2: Prevalence of domestic abuse**

These are the latest figures available for England and Wales in August 2022.

The police recorded a total of 909,504 domestic abuse-related incidents and crimes in England and Wales in the year ending March 2022. This represents an 8% increase from the previous year and a 12% increase from the year ending March 2022.

Of these, 845,734 were recorded as domestic abuse-related crimes, an increase of 6% from the previous year, representing 18% of all offences recorded by the police in the year ending March 2021.

Estimates from our most recent Crime Survey for England and Wales year ending March 2022 show 5.7% of adults aged 16 to 59 years (2.3 million) experienced domestic abuse in the 12 months prior.

https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2021 (accessed 23 August 2022)

In 2020, 10,613 potential victims of modern slavery were identified in the UK.

https://www.gov.uk/government/publications/2021-uk-annual-report-on-modern-slavery (accessed 23 August 2022)

Year ending March 2021, there were 2,725 Honour Based Abuse-related offences recorded by Police in England and Wales. This was an increase of 18% compared with the year ending March 2020.

https://www.gov.uk/government/statistics/statistics-on-so-called-honour-based-abuse-offences-england-and-wales-2020-to-2021/statistics-on-so-called-honour-based-abuse-offences-england-and-wales-2020-to-2021 (accessed 23 August 2022)

A patient may fall into a coercive relationship at any time, between intimate partners, family members, friends, peer groups, or in the context of trafficking, modern slavery, criminal and sexual exploitation. In these situations, patients could struggle to keep their online record secure and private.

Patients with a learning disability or cognitive impairment, or those who have poor literacy or who are unable to speak or read English, may be easily coerced to share their online record.

Indirect harm may also be experienced by patients who have a particular fear of authority and how authorities may want to access their online record, such as refugees and those whose immigration status is uncertain. They may be deterred from seeking healthcare when they need it because of a fear that health records are no longer confidential.

Ref: Examples of good practice in identifying, documenting and managing safeguarding risks in Primary Care are available on the SafeLives website at https://safelives.org.uk/GP-pathfinder-profile (accessed 23 August 2022).

To quote the SafeLives GP Pathfinder Profile:

**“*Disclosure and Data recording of Domestic Abuse***

*Disclosures of domestic abuse made to health practitioners are not always recorded - this can be due to inconsistent recording, lack of understanding of abuse, no structural framework requiring such data to be recorded, concerns over GDPR legislation and many others. It is, however, important to collect and record such information, as it will allow practitioners to better understand the driving cause of some of the medical conditions the patients are presenting with and offer better support. Without it, there is little evidence to show the work practitioners already do to support victims/survivors of abuse.*

*Not only is effective data recording useful for practitioners, it is also helpful for victims/survivors themselves. Recording disclosures in case notes means victims/survivors do not have to repeat their story to multiple professionals, which can be traumatising and impair their mental health and wellbeing. Every practitioner who is working with and supporting the victim/survivor should know about their experience of abuse. This means that disclosures of domestic abuse must be clearly recorded in a factual manner on case management systems. Note details of the abuse as told to you by the victim/survivor. A Case Analysis Report produced by Standing Together Against Domestic Violence, a Pathfinder partner, found that consistent and comprehensive record keeping are crucial in ensuring appropriate continuity of care and an integrated response.*

***Practitioners need to be aware of safety implications of this for themselves and the victim/survivor and ensure this is done sensitively - the perpetrator should not be able to gain access or be able to see that this has been recorded.*** *Ensure that case notes are not visible on the front screen during appointments (as often perpetrators will attend appointments with the victim/survivor).*”

**EMPOWER AND ENABLE**

Enabling and empowering victims and survivors of abuse to make their own choices and retain control of their lives is key to supporting them

Coercion to gain access to the online record

Coercive behaviour is a central characteristic of many types of abuse. It is a pattern of behaviour used by perpetrators to exert control and power over their victims, often by inducing fear. It is found in domestic abuse, modern slavery and trafficking, honour-based abuse, criminal and sexual exploitation. Perpetrators will often use any means available to them to control their victims, including controlling their use of technology and their access to healthcare.

Ref: You can learn more about coercion to share online record access in the “Coercion” guidance in the Toolkit.

By gaining access to their victim’s GP Online Services, perpetrators of abuse can

* See what their victim has informed their clinician in a consultation or from evidence in documents from other sources such as psychiatrists, the police or child protection services to see if they have disclosed their abuse.
* See if their victim has accessed healthcare for any reason e.g. if their victim has come to a GP for contraception when their perpetrator has told them they are not to go on contraception.
* Infer that their victim has disclosed abuse if a consultation has clearly been redacted from online view
* Learn through information in consultations or reports in their own record, or in their children's records, that their victim has disclosed abuse or accessed healthcare without their knowledge.

Perpetrators could see this information by a variety of means:

* Coercing the victim into sharing their login details and record
* Sharing the same electronic devices as the victim
* Setting up online access without the victim even being aware, for example if a perpetrator has been inadvertently given access to transactional GP services for appointment booking or requesting prescriptions, with automatic online record access, they will automatically have access to their victim’s prospective record.

This can have the following impact on the victim:

* An increased risk of harm from their perpetrator as 'punishment' for disclosing abuse. In high-risk abuse situations, this could mean an increased risk of severe violence or even death. This risk may also apply to any children in the situation – increased risk to an adult victim can also mean an increased risk to their children.
* No longer being allowed to access healthcare at all, or the perpetrator will always insist on attending with them.
* No longer feeling safe to disclose abuse to a healthcare professional therefore not receiving the help, support and protection they should.
* No longer seeing healthcare settings as safe places therefore not seeking help for any health issue which could result in poorer health outcomes.

Ref: There is more information about redaction in the guidance on “Managing Potentially Harmful Information” in the Toolkit.

Ref: There is guidance on the effects of the relevant SNOMED terms on automatic record access in the guidance on ”SNOMED Terms that Control Automatic Record Access” and in the Toolkit.

If a patient’s automatic record access is restricted, it is essential to continue to redact potentially harmful information. The record may be unrestricted in the future and unredacted information may be exposed to the perpetrator or another perpetrator. Episodes of abuse may fluctuate or victims may go from one abusive relationship to another. Also, information may need to be redacted temporarily or permanently because of direct harm it may cause to the patient or because it reveals confidential information relating to a third-party.

Ref: For further information on safeguarding vulnerable groups see the “Safeguarding and Vulnerable Groups” Guidance in the Toolkit.

Ref: For more information on when and how to document domestic abuse see the RCGP Adult Safeguarding Toolkit https://elearning.rcgp.org.uk/mod/book/view.php?id=12530 (accessed 23 August 2022)

Ref: There is also an RCGP Child Safeguarding Toolkit https://elearning.rcgp.org.uk/mod/book/view.php?id=12531 (both accessed on 23 August 2022)

**Conversations with patients** – It is helpful to have ongoing conversations with patients about online record access, the choices patients have and how they and the practice can safely manage this.

**Information for patients about record access** – It is important to provide accessible information to patients to explain how the practice provides online record access, how the practice manages safeguarding risks, and when patients should contact the practice if they have any concerns someone else is accessing their records. This could be linked to information on the practice website about where else victims of abuse can get support e.g. domestic abuse agencies.

Ref: There is a list of information that can be helpful to patients about GP online services in the “Patient Information Themes for GP Online Services” guidance in the Toolkit.

**Practice leadership** - Safeguarding Leads, the Caldicott Guardians and Information Governance Leads, should start having discussions with all practice teams about the safeguarding risks of record access and how to mitigate them, particularly the new hazards presented by automatic record access. In particular, discussions about what 'coercion' is and what that might look like to different staff members (clinical and non-clinical).

Ref: There is further information on coercion and how to identify it in the “Coercion” document in the Toolkit

Appendices

1. Actions for those with strategic primary care safeguarding roles

Named GPs and Nurses for safeguarding and Designated Doctors and Professionals for safeguarding within local Primary Care areas should consider:

* Informing their multi-agency safeguarding partnerships about automatic records access and the risks it presents to victims and survivors of abuse. This is particularly relevant for agencies who share information with primary care. They may wish to review and strengthen their information sharing procedures. For example: if an external agency is sharing a document with primary care that contains third-party information or information that may cause significant harm to the patient or others, they could ensure there is a clear written message on the front of the document that it should be hidden from online access.
* Including information about automatic record access, the risks and the mitigations in any safeguarding training given to Primary Care.
* Sharing information and guidance for sectors working for victims and survivors of abuse with their multi-agency partners

Ref: There is a document in the Toolkit written for health and care professionals working outside General Practice: there is a specific document in the toolkit for this purpose: “Online GP Record Access for Other Sectors”.

1. Further information on domestic abuse

Data from SafeLives Pathfinder toolkit and Pathfinder Profile: General Practitioners (links above) helps describe the scale of the interaction between Primary Care and victims of domestic abuse:

* There is extensive contact between women and primary care clinicians with 90% of all female patients consulting their GP over a five-year period.
* Approximately 80% of women in a violent relationship seek help from health services, usually GPs, at least once and this may be their first or only contact with professionals.
* and will visit their GP on average 4.3 times.

The duration of abuse before disclosure is likely to be much longer for some victims/survivors including older victims/survivors, and those who are Black, Asian and Minority Ethnic (BAME) and/or disabled. Disclosure is an opportunity for GPs to recognise domestic abuse and provide more effective care and support for their patients.

1. Data from SafeLives Spotlight resources

Disabled people and domestic abuse

* Disabled women are twice as likely to experience domestic abuse than non-disabled women
* Disabled clients are much more likely to be suffering abuse from a current partner than non-disabled people
* Disabled clients are more likely to be experiencing abuse from an adult family member compared to non-disabled people

Honour-based violence (HBV) and forced marriage

* Approximately 68% of victims of HBV were at high risk of serious harm or homicide
* Victims at risk of HBV were more than 7 times more likely to be experiencing abuse from multiple perpetrators (54% vs 7%) compared to those not identified as at risk of HBV

Older people and domestic abuse

* Victims aged 61+ are much more likely to experience abuse from an adult family member or current intimate partner than those 60 and under
* Older victims are significantly more likely to have a disability – for a third (34%), this is physical

LGBT (lesbian, gay, bisexual, and transgender) + individuals and domestic abuse

* LGBT+ victims of domestic abuse are more likely to be abused by multiple perpetrators

Domestic abuse and mental health

* Victims of domestic abuse with mental health needs were more likely to have visited their GP and Accident and Emergency (A&E) before accessing support for the abuse.