Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
COMMUNITY ADOPTION RECORD KEEPING

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VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*17/03/2015*	*Procedure agreed by the IG Committee*
1.1	*June 2015*	*Confirmation received that sealed records will move with the child. Add memos in Appendix E and F. Added clarification as to which record is being referred to.*
2.0	*June 2019*	*Add into notify the IT Service desk if a record shared from another SystmOne unit contains the child's old identity. Add in clarification re legal adoption. SOP updated to complete process electronically rather than printing. Update all references from Health Visitor/School Nurse to Public Health Registered Nurse. Include reference to Child, Family, Health and Social History Template. Only upload documents from the previous electronic record that are necessary to the child's care using previous naming conventions. Add that other Trust SystmOne units providing care to the patient will be notified of the adoption. Section on children adopted out of areas updated in line with current LAC process.*
2.1	*April 2020*	*Redacting the names of health centres/GP practices where treatment has occurred in the transfer of information to the new record to further protect the child's previous identity. ISPHN to check the pre-adopted record to make sure no further information has been added since the record was extracted by Child Health. To advise staff not to include the term adopted in the summary or future letters unless it is relevant to their care. Add clarity that all groups and relationships should be ended including the birth parents. Update the section for children who move out of area to check with the new area if they want the pre-adoption records. Add in that records will be sent following the Safe Haven Procedures.*
2.2	*May 2023*	*Scope and procedure updated to include the Hull 0-19 Service. The term Looked After Children (LAC) updated to Children Looked After (CLA) in keeping with the views of children and young people. Approved at IG Group (24 May 2023).*

Contents

1. INTRODUCTION

This procedure details how health records will be handled when a child is adopted.

The aim of this procedure is to ensure:

- There is no link in the post adoptive health records to the pre-adoptive identity.
- That a summary of relevant health information is transferred into the post adoptive record.
- That there is a system in place to retrieve all pre-adoption health records should that be necessary.

It is expected that legislation will be passed regarding the issuing of new NHS numbers, with the preferred option being not to issue a new NHS number unless the child is deemed 'at risk'. This procedure will be updated once the national policy is published.

Until a time when the legal adoption order occurs, the child must continue to be registered as their birth name.

If staff become aware of any information being shared from another SystmOne unit (including external units) containing the child's old identity in the new record, please contact the IT Service Desk.

2. SCOPE

This procedure applies to electronic health records held within the Child Health SystmOne unit for both Hull and East Yorkshire children. It also covers the electronic records held in the Trust's Integrated Specialist Public Health Nursing (ISPHN) SystmOne unit, the Hull Children and Young People Community Services unit. and paper/scanned records for Hull and East Riding children.

This procedure does not apply to Lorenzo records.

3. PROCEDURE

The following procedure will be followed once a new NHS number has been allocated and the legal adoption has been confirmed. This will be a confirmation email from the East Riding of Yorkshire Council or Hull City Council to Child Health detailing that an adoption has taken place.

If confirmation of legal adoption has not been received, Child Health will task the practitioner from the pre-adoptive record to establish with the adoptive parents that the child has been legally adopted.

Child Health will:

In the **pre-adoptive (old)** record:

- Complete a SAR extract of the full record from the Child Health Unit and save in a restricted folder on the Corporate Servers called "Adoptions – Caldicott Guardian authorisation required". Only the Child Health supervisors will have access to this folder.
- Add a high priority reminder to the record stating "Do not use this record. The record is closed and must not be re-activated under any circumstances".

- Add a high priority reminder to the record stating “Confidential data – take care on disclosure”.
- Cancel any scheduled recalls and confirm these have been automatically rebooked in the new record.
- Ensure all tasks and notifications are completed and any outstanding actions transferred to the new record.
- Remove the child’s new name from the “known as” field, if recorded.
- The pre-adoptive record may contain information relating to the new identity of the child. This will remain in the record unless the practitioner notifies child health that there is a risk to the child.
- Task the Public Health registered nurse from the old record and advise the practitioner:

  “Following a change of NHS number, a new SystmOne record has been created for this child and this record is no longer in use.”

- End care at the unit and deduct the patient, giving the reason as “Adopted child”.

In the **post-adoptive (new)** record:

- Re-register the patient under the child’s new name.
- Transfer information from the child health unit to the new record. Namely: Public Health registered nurse, GP, treatment centres, birth details, completed and scheduled immunisations, new born bloodspot screening, health results and scheduling, visual screening, school.
- Upload any Child Health documents in to the new record at the relevant unit, ensuring that any reference to the previous name, address, NHS number, names of health centres/GP practices where treatment has occurred is redacted and the new identity, including new NHS Number, is detailed on each page.
- Add a reminder to the record that previous records exist for this child and are held within Child Health.
- A redacted extract of the pre-adoptive record in the Child Health unit will not be uploaded into the new record as there is no further information recorded.
- Send an electronic referral to the Public Health registered nurse from the new record.
- Obtain the paper record from Restore (if applicable) and scan to the restricted folder on the corporate server. If the original records are on a disc, these will be saved into the restricted folder. The SystmOne extract and any additional records will be emailed to the Public Health registered nurse with the memo in Appendix 5. If the files are too large, these will be saved to the relevant team’s folder on the network and the health professional will be notified by email.

Children and Young People Unit

The named practitioner will carry out the following:

- At the Removal In visit ask the adoptive parent to inform the practitioner once the legal adoption has taken place.
- Contact Child Health if they come across a record with an NHS number that has been declared invalid, who will then task the practitioner from the new record.
- Provide confirmation of the legal adoption to Child Health.

In the **pre-adoptive (old)** record:

- Add a high priority reminder to the record stating “Do not use this record. The record is closed and must not be reactivated under any circumstances”.
- Add a high priority reminder to the record stating “Confidential data – take care on disclosure”.

- End all groups and relationships in the record including birth parents.
- Confirm whether there are any risks to the child/adopted family if their new location is known and document in the pre-adoptive record. If there are risks, the practitioner will review the record and mark for permanent removal any entries, documents, addresses, group and relationships that relate to the new identity. These will be submitted to the Caldicott Guardian for approval. The practitioner will also notify Child Health to complete the same review of the record.
- End care in the pre-adoptive record and deduct the patient, marking the record as "Adopted child".
- Check the pre-adopted ISPHN record to confirm no further information has been added since the record was extracted by Child Health. Any additional entries should be reviewed for the summary. A copy of the additional entries should be provided to Child Health for inclusion in the sealed envelope.

In the **post adoptive (new)** record:

- Accept the electronic referral from the Child Health unit for the child's new identity.
- Ensure all tasks and notifications are completed and any outstanding actions transferred to the new record.
- Recreate any recalls that existed in the old record.
- Recreate relevant groups and relationships. Adoptive parents should be known as parents once the new record is created.
- The Public Health registered nurse will review the documented history in the electronic and paper record and input a summary of relevant information using the Child, Family, Health and Social History template.

  It is impossible to know today what information will be useful in the future, particularly with medicine advancing so rapidly. Any health information that is available within the child's previous record that would influence their future health needs should be summarised (without identifiable information being included) into the new record. This must include a summary of the birth notification, including APGAR scores, any known allergies and any relevant parental/family history. See Appendix 1 for further information.

  Child Health will ensure that other information such as immunisations and health surveillance are detailed in the new record.

  The term 'adopted child' should not be used within the summary or any future letters unless this is relevant to their diagnosis and/or treatment.

- Review all SystmOne scanned documents for any that are relevant to the child's care. For documents that are relevant, highlight any references to the previous identity (e.g.name, address, NHS number, names of health centres/GP practices where treatment has occurred). This process should be done electronically using a highlight tool in your viewing software. The reviewed documents and Appendix 6 memo must then be emailed to Child Health for redaction and uploading on to the new record on the ISPHN SystmOne unit. If not physically signed, the completed memo should be sent from the reviewing health professional's email address.
- Documentation from the paper record does not need to be uploaded to the new record as any relevant information should form part of the summary input into the new record. If there is a paper document you consider to be essential for the child's care, this can be reviewed (as described above) and emailed to the Child Health for redaction and uploading on to the new record on the ISPHN SystmOne unit.
- Ensure that no previous groups and relationships are recorded in the new record that relate to their previous identity.

- Notify the relevant CAMHS team of the adoption if the record details that CAMHS has been involved in the care of the child.
- Notify the practitioner of the adoption if there are any other Humber SystmOne units that are or have been involved in the care of the child (e.g. SLT, dietician). The teams will then register the child on their unit using the new NHS number and transfer all information relevant to the continued care of the child. Child Health will assist with the redacting of previous documentation, if required.
- An extract of the pre-adoptive (old) S1 record will not be uploaded into the ISPHN unit as all necessary health data has been transferred or summarised.

Child Health will:

- Redact any information highlighted by the practitioner on the scanned documents and detail the new name and NHS number on each page. These will be uploaded on to the ISPHN SystmOne unit as separate documents using the same naming convention used in the previous record.
- Seal any original paper records/CD in an envelope. The attached form in Appendix 2 will be attached securely to the envelope and filed under their current name within the Child Health department. The records will be stored in Child Health for a minimum of five years and then archived in off-site storage for the required retention period. The location of all records will be held and maintained by Child Health.
- All electronic information, redactions, completed memos will be retained electronically in the restricted folder in Child Health. Once the adoption process is complete, Child health will maintain a log of any access requests for the electronic records, detailing the requestor, job title, reason for access, Caldicott Guardian approval and date of access.
- If the child moves out of area, Child Health will email the new authority to check if they want the pre-adoption records. If required, the pre-adoptive sealed record and an encrypted CD of any electronic information will follow the child with the covering letter detailed in Appendix 3. The post-adoptive record will be transferred electronically to the new area. The SystmOne reminder will be updated to state the new location of the record. Records will be sent following the Trust safe haven procedures. Manual records will be sent special delivery. Encrypted discs will be sent via recorded mail. Electronic will be sent via NHSmail or use the [secure] encryption feature.

Children Looked After (CLA) Team

The CLA team will end care at the unit and deduct the patient, giving the reason as “Adopted child”.

A new record will not be created in this unit and there is no requirement to transfer any information.

Hull/East Riding children who are adopted out of area

The Public Health registered nurse will hand over to the health visitor/school nurse in the new area when tasked by the CLA team about the move. The nurse will email the health record to the new area with the covering email in Appendix 4.

The CLA team will continue to be involved until formal adoption take places. At this point the CLA team will email any further records to the CLA Team in the new area.

Out of area children who are adopted into the Hull/East Riding Area

The pre-adoptive records will managed in accordance with this procedure.

4. IMPLEMENTATION

A list of records with invalid NHS numbers has been maintained by Child Health in readiness for a written procedure.

In cases where an adoption has been confirmed, Child Health and the practitioner will review the electronic and any scanned paper records to ensure the requirements of this procedure have been carried out.

In cases where an adoption has not been confirmed, Child Health will contact the practitioner/ Children Looked After team for further enquiries. This procedure will be followed once confirmation has been received.

If any information in the adopted name is recorded in the pre-adoptive electronic record after the child has been legally adopted, the practitioner must mark the entry in error and re-record the information into the new record. A note should be added to the new entry stating that it is non-contemporaneous.

If letters arrive with the old NHS number/patient details after the child has been adopted, a redacted copy will be stored in the new record and the original letter will be filed in the sealed envelope.

If any information is recorded in the post-adoptive (new) electronic record under the old NHS number/patient details, the practitioner will be requested to mark the entry for permanent removal and will re-record the information in a redacted format in the new record. An un-redacted copy will be placed in the sealed envelope.

If there is only an electronic record, the procedure will be followed omitting any of the steps relating to the paper record.

5. RETENTION

Pre-adoption records will be retained for the same period of time as all records for children and young people. Genetic information should be transferred across to the post-adoption record.

Retain until the patient's 25th birthday or 26th if young person was 17 at conclusion of treatment, or eight years after death. If the illness or death could have potential relevance to adult conditions or have genetic implications for the family of the deceased, the advice of clinicians should be sought as to whether to retain the records for a longer period.

6. FURTHER QUESTIONS

If you have any further questions regarding the above process, please contact the Information Governance Team on 01482 477856.

If you any further questions about whether information is clinically relevant, please contact your team leader in the first instance.

Appendix 1: Suggested Transfer of Information

It is impossible to know today what information will be useful in the future, particularly with medicine advancing so rapidly. Any health information that is available within the child's previous record, that would influence their future health needs should be summarised (without identifiable information being included) into the new record.

As a minimum the following must be included. Please note – this list is not exhaustive and may be added to in the future. The Child, Family, Health and Social History template should be used.

Birth Details
Information from the birth notification including APGAR scores.
Summary of immediate care following birth including any admission to the Neonatal unit, any investigations and treatments required.
Ensure Newborn Bloodspot screening information is present.

Family Characteristics
Record details of (new adoptive) mother, father and any siblings in Groups and Relationships

Health
Allergies, risks, disabilities, statuses.
Parental/family history (clearly indicating the origin: birth/adopted family).
Summarise current developmental status and surveillance completed as per the Healthy Child Programme.
Any previous referrals or involvement from consultant, specialist, therapist including relevant investigations and treatments to date.
Any active clinical problems and ongoing treatments or therapies including current medications.
List of current professionals involved (may be appropriate to record in Groups and Relationships)
What needs to be done – action plan including when and by whom.

Record a Reminder
Previous records exist for this child and are stored in the Child Health Department.

Appendix 2: Confidential Records

Humber Teaching NHS Foundation Trust

CONFIDENTIAL RECORDS

Current Forename ……

Current Surname …….

New NHS Number ……...

Contents of the envelope (please list the records)

This envelope may only be opened and the contents viewed with the authority of the Caldicott Guardian or the Senior Information Risk Owner.

The contents contain information of a sensitive and confidential nature and relate to information about the individual and third parties.

Name of person opening the envelope	Designation	Reason for opening the envelope	Caldicott Guardian Approval	Date

Appendix 3: Letter/Email to Accompany Sealed Envelopes for Adopted Children who Move Out of the Area

Humber Teaching NHS Foundation Trust

Dear

Name:
DOB:
Parents:
Address:

This child has recently moved to your area. In order that his/her health care can be co-ordinated locally I attach his/her community child health record.

The record contains a sealed envelope containing details of the child's birth family and other third party information, it is therefore **highly confidential.**

I am sending the information to your service, as it is in the best interests of the child for local health care professionals to be able to access his/her past medical history, if required. This record, however, should only be seen on a "need to know" basis by the professionals who are directly responsible for his/her care and should be handled in accordance with your local protocol for adoption records.

Yours sincerely

XXXXX

Enc. Highly confidential file

Appendix 4: Email to Accompany Health Records sent by Safeguarding for Children who are Adopted Out of Area

Humber Teaching NHS Foundation Trust

Dear

Name:
DOB:
Adoptive parents:
Address:

This child was recently placed with adoptive parents in your district. In order that his/her health care can be co-ordinated locally I attach his/her community child health record.

This record has not been anonymised. It contains details of the child's birth family and other third party information. It is therefore **highly confidential.**

I am sending the information to your service, as it is in the best interests of the child for local health care professionals to be aware of his/her past medical history. This record, however, should only be seen on a "need to know" basis by the professionals who are directly responsible for his/her care.

Despite greater openness in adoption practice, it remains a matter of principle for a child's adoptive family to decide how widely they wish to share the information about their child's adoptive status. It is therefore good practice to discuss with the adoptive family the fact this information has been transferred and that the adoptive family be given an opportunity to express a wish about this confidential material should be handled.

X however has not yet been legally adopted. Until his/her adoption is finalised by a court order, his/her legal status remains that of a looked after child, with XXX Social Services holding parental responsibility.

Please do not hesitate to contact me if you wish to discuss this issue further.

Yours sincerely

XXXXX

Enc. Highly confidential file

Appendix 5: Email to Public Health Registered Nurse

SUBJECT: Adopted Child

Please find attached records for [name of child]. Please could you review the scanned paper record (if applicable) and SystmOne record in line with the Standard Operating Procedure – Community Adoption Record Keeping Procedure.

Once the review is complete, please complete the enclosed memo and email it to Child Health with any documents that need redacting and uploading into the new record.

Kind regards

Name
Child Health Supervisor

Appendix 6: Email to Child Health

Humber Teaching NHS Foundation Trust

SUBJECT: Adopted Child

In line with Standard Operating Procedure – Community Adoption Record Keeping Procedure, I can confirm I have:

☐ updated the pre-adoptive/post adoptive SystmOne record in line with the procedure.

☐ added a health summary to the post adoptive record.

I attach : -

…….. pages of relevant documents for redacting and uploading on to the new SystmOne record..

Signed: ……..

Job Title: ……..

Date: ……..

Appendix 7: Equality Impact Assessment (EIA)

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: Community Adoption Record Keeping SOP

2. EIA Reviewer (name, job title, base and contact details): Karen Robinson

3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? SOP

Main Aims of the Document, Process or Service This details how health records will be handled when a child is adopted.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people, Young people, Children, Early years	Low	The procedure is specifically for children's records
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory, Physical, Learning, Mental health (including cancer, HIV, multiple sclerosis)	Low	This procedure is written to ensure that all relevant information is transferred appropriately to ensure continuity of care.
Sex	Men/Male Women/Female	Low	
Marriage/Civil Partnership		N/A	
Pregnancy/ Maternity		N/A	
Race	Colour Nationality Ethnic/national origins	Low	
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	
Sexual Orientation	Lesbian Gay men Bisexual	Low	
Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	The protection of this information will be required in addition to the adoption information

Summary

Please describe the main points/actions arising from your assessment that supports your decision. The procedure has been reviewed and it would not result in any adverse impact on individuals or groups based on the above protected characteristics. This procedure aims to ensure that the management of health record for adopted children complies with all legal obligations and guidance such as the Department of Health Records Management Code of Practice for Health and Social Care 2016. Accordingly it aims to have a positive impact on everyone who comes into contact with our services.
EIA Reviewer: Karen Robinson

Date completed: 4 May 2023	Signature: K. Robinson