Defining the Electronic Social Care Record

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Defining the Electronic Social Care Record: information management in social care

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What did an Electronic Social Care record ever do for a service user?

This summary provides a non-technical introduction to the concept of the electronic social care record. It attempts to answer:

• Why such a record is needed,
• What it is,
• Who should have access to it, and finally
• How it should be managed.

Service users expect a good consistent service from all government organisations. To achieve this each organisation has to keep records of what it is doing and how it is doing it. This is necessary to ensure:

1. **consistency** in service delivery over time, as staff change or move on
2. **continuity** of service delivery when regular members of staff are not available because of leave, sickness or other absences
3. **quality** of service delivery through monitoring by managers, inspectors, complaints mechanisms or other means.

Having a record in electronic format enhances the responsiveness of services in a number of ways:

- It makes managing the volume of material to be recorded easier
- Records can be available 24 hours a day, 7 days a week
- Records can be accessed from remote locations (i.e. you do not have to be in the office to get hold of the record)
- Several people within an organisation may access and update records at the same time, for example an occupational therapist and social worker may work together to support a service user; a fostering specialist worker may work with a child’s social worker, this can only be achieved with sharable electronic records
- Selected material from records may be shared more easily with partner agencies where services are delivered by a number of organisations.
- Service users can more easily be provided with access to their own record.
- Records can be transferred between local authorities when service users move, enabling a more consistent continuous service to be maintained.
- Establishing common standards of recording should enable staff moving between jobs or covering for colleagues to more easily familiarise themselves with the record they are working on, and so provide a better service.
- Additional security can be provided, with backups, rather than just one file.
What constitutes an electronic social care record?

The Electronic Social Care Record

The electronic social care record brings together all the relevant information for a service user into one place, as in the diagram above.

There will be 3 types of information held on the ESCR:

- **Structured information**
  This will typically be information recorded on forms, including:
  - nationally used forms (such as those for children’s recording)
  - local forms
  - forms completed by service users, such as self-referral or financial assessment forms.

  On many of the forms there will be coded data alongside the other recording. For example, most forms have at least the name, address and date of birth of the service user.

- **Unstructured information**
  This covers all other recording, including that originating outside the agency.
  This will include:
  - letters
  - emails
  - records of phone calls (both written or taped)
  - notes of meetings
  - video clips.

- **Coded data**
This is at least the information as defined in the core information requirements. This is mainly for management and statistical reporting purposes.

Who should have access to it?

A common misconception is that electronic records are less secure and more open to abuse than paper based records. However, with appropriate security and access controls, electronic records are probably more secure than paper records.

With a paper record the security and access to a record is fairly simple to manage, in that it can only be in one place and is normally held in a physically secure environment (a secure building, locked filing cabinets etc). However risks are increased when all the people involved in providing support, even within one organisation, each keep their own records.

The electronic record solves the problem of multiple records but security has to be built in to the way the records are managed. In principle, two things define who has access to a record:

- Who needs to know
- Who the service user agrees should have access.

The underlying principle is that access rights should be defined for each record and agreed with the person to whom the record relates. This is the principle adopted by colleagues in the National Health Service and elsewhere. There will be some exceptions to this to reflect the legal requirement to share information, sometimes against the wishes of the service user (for example in cases of child protection and mental health).

In general it is agreed that the people closely associated with providing support to a service user should have shared access to that person's record, unless the service user objects. For example a care plan for an elderly person being supported in the community, which details the support they receive, when it is delivered and by whom. It would typically be accessed by:

- the social worker responsible for the care (and their manager and administrative support),
- the providers of the support (home care organisation, district nursing service)
- and probably the GP.

This group of people all have what has been called a legitimate relationship with the service user, and form a team to provide support. At times others will need to have access, for example a GP covering a holiday/weekend, or an out of hours social worker.
How it should be managed?
The definition of the electronic social care record (ESCR) lays down the standards for managing records that should be adhered to throughout England.

Records fall into one of three categories:
1. Documents that are either locally created or received from outside the organisation. These may be generated from merging information from a database or be entirely generated outside the organisation.
2. Screens or views of computer information, normally held on a database.
3. Other forms of records, such as images, video and audio material.

The National Archives, formerly the Public Record Office, have established standards for managing records for all government agencies. The Electronic Records Management Standards (ERMS) should be applied to all the records. The ERMS identifies ‘document type’ as a key bit of information.

The main paper outlines common standards that should be applied to all categories of record content. For example there will be a class of records that relate to a service user’s care plan, under which all the records, correspondence, reports relating to the care plan should be ‘filed’.

Associated with each document type are sets of access rights to documents or views. The access rights record the group of people allowed access, normally defined by the role they play (e.g. social worker, GP etc), or are individually named people.

Why use ERMS when we already have a database?

- **Easier to train** – most workers can easily handle documents as forms to be completed, training in a database is generally difficult, especially difficult where agency staff are employed
- **Costs** – It is cheaper to develop a template with some data items on it than a complete data driven system. Similarly changes and modifications should generally be easier, and hence cheaper and quicker to introduce.
- **Correct information** – a document is a statement of information known or believed at a point in time, accuracy is more clearly defined.
- **Information sharing** – The technology to share documents is already in place with virtually all organisations, including private and voluntary sectors in that email can transfer it, or the internet provide access to it. The technical protocols for exchange are all in place, the security layer in terms of encryption is fairly easy to introduce.

In summary the document approach keeps it simple, accessible to users and affordable, while providing security controls.
Summary:

The development of electronic records will provide a wide range of improved services for citizens, by making them available whenever and wherever they are needed. It will enable partner organisations to work together more easily to provide responsive services.

Confidentiality has to be safeguarded with access only allowed to those who have a need to know. This can be achieved by applying nationally defined standards for records management to both documents and views of databases.

These standards provide a flexible, secure and relatively easy to use approach to managing records, and provide better access for managers to ensure good quality work. They support the essential person centred skills that underlie all good social care as delivered by staff in many disciplines throughout the country.
Technical Foreword:

Information for Social Care, [http://www.doh.gov.uk/ipu/socialcare/information.htm](http://www.doh.gov.uk/ipu/socialcare/information.htm), established a set of principles of good practice in managing information within social care. This paper takes the next step and seeks to establish common standards that should be used when developing electronic social care records in England.

This paper ties together the requirements for managing information in an electronic environment, and examines the need to meet the information governance standards required under Caldicott, Data Protection and Freedom of Information. It does this in the light of e-government standards and targets for local government, as well as links with the key partner, the NHS. It has been substantially revised in light of responses to the consultation process carried out in the summer of 2003. This version has substantially grown to reflect inputs from the consultation, thanks are due to the many people who have helped to develop this version.

The contents of this paper may be of interest to the general public. However it is primarily aimed at information management specialists in social care, including colleagues throughout local government and the NHS, as well as the many suppliers of systems to this market. The summary foreword has been produced for a more general readership.
1 Introduction:
1.1 Information for Social Care established a framework of good practice for handling information to improve social care. Since then, in many Councils and through a series of demonstrator projects, some of the key themes have been developed. (http://www.doh.gov.uk/pdfs/informationmain.pdf)

1.2 This paper takes this work further and draws together many developments into a set of standards to enable Councils to develop more clearly their recording practice, and in particular the Electronic Social Care Record (ESCR). This is done in the light of the 2005 e-government targets that apply to local government and developments in the NHS, especially the NHS Care Records Service (NHS CRS). Further background on the government targets for electronic records management is given in Appendix 1.

1.3 Inevitably, as a standard setting proposal, this paper will tend to veer towards the technical issues of information management. It is worth noting these are minimum common standards being developed here, this should not prevent the introduction of additional functionality in managing the care record, for example through workflow. The broader picture and case for the ESCR remains in Information for Social Care. In this key implementation issues, such as the need to address cultural change, were addressed. They remain as critical as ever. An explanation of terms, abbreviations and links to other published material is in the glossary at the end of this document.
1.4 The diagram above illustrates the completeness of the ESCR concept; key aspects of the record were then defined:

There will be 3 types of information held on the ESCR:

- **Structured recording**, such as defined in the Children’s Assessment Framework and Looked after Children recording framework.
- **Unstructured recording**, covering all other recording, including that originating outside the agency.
- **Coded data**, as defined in the minimum datasets (core information requirements)

The boundaries between these are likely to vary over time. The current trend is for a greater degree of structure on the basis of improving standards of recording, and a common practice expected for all staff, including those changing jobs. Coded data may form part of the structured recording and in any event is part of the overall record.

1.5 The complete ESCR will be made up from two types of information. The Core Information requirements, [http://www.doh.gov.uk/ipu/socialcare/coreinforequirements.htm](http://www.doh.gov.uk/ipu/socialcare/coreinforequirements.htm), plus any local additions, and the documents and others materials held in electronic format. The ERMS records management model, explored below applies to both how forms/screens/views of databases are managed as well as how each document is managed. On a computer database each screen/form/view has linked to it who can access it, either in carrying out a role or as a specific person. Similarly in a document management system each document has linked to it who can access it.

1.6 The development of the ESCR in summary should:

- Provide the record that can be shared and accessed by service users or someone acting on their behalf
- Enable the social care record to be used as a comprehensive individual record within social services
- Be the basis of the record that is shared with partner agencies, and in particular form the social care element of the electronic health record
- Have encryption standards built in to protect confidential information
- Comply with Caldicott and BS7799 standards
- Be the means of managing information at the level of the individual case record
- Define the target for electronic records
- Form the basis for management information to be produced
- Form the basis from which workflow can be applied to improve the way processes are carried out.

1.7 To this may be added the need to relate to health systems, specifically in the rapidly developing NHS CRS developments in the NHS national programme for IT. These are dealt with in some detail in section 7. Links are also needed
with the proposed identification, referral and tracking of children systems, as well as local developments such as citizen indices often used in call centre environments. Additionally there is the need to be able to transfer records between local authorities with social services responsibilities, as highlighted in the Climbie inquiry. Additional national standards have emerged such as BS7666, covering addresses. Throughout the assumption has been that all developments are carried forward within the e-GIF framework to provide interoperability, not only between health and social care, but also central and other local government departments. The FAME projects, sponsored by the Office of the Deputy Prime Minister also develop information sharing and exchange.

1.8 These standards are especially critical in a period of organisational change. The standard adopted by the NHS in the section on document management in NHS CRS is the same as proposed here.

2 Existing social care material available:

2.1 The creation of the ESCR is not starting from a blank sheet. Over the past years, latterly through the Information Policy Unit - Social Care, information management has been increasingly systematically developed. Key areas already in place include:

1) Integrated Children System (ICS) – a comprehensive set of exemplars for recording about children in receipt of social care. This pilot system is due to be rolled out throughout England by December 2005. A total of 20+ structured forms for recording are proposed.
2) Single assessment for older people (SAP) – this provides a common model of assessment for older people. It is manifested in a range of formats.
3) Identification, Referral and Tracking for children (IRT) – a multi-agency local approach to supporting children, with possible national implications
4) Care programme approach – an increasingly structured set of documentation for managing mental health cases.
5) Core information requirements for children – in effect a minimum data set for children, relates closely to the recording practice in ICS above.
6) Core information requirements for adults – similar to the children’s material, again a minimum dataset.
7) Common process model – the datasets and the more extensive recording models above all take as their basis a common high level model of:
   Referral > assessment > Care plan > review(s).

2.2 The need for information sharing, one of the key outcomes of enabling electronic records in social care, does bring with it the need to control information sharing. Realistically this has to be done within the information management systems themselves. The rules around information sharing, in the forms of
protocols have been developed in many places, notably in the Information Policy Unit - Social Care at the Department of Health and the eCare project in Scotland. [http://www.doh.gov.uk/ipu/socialcare/caldicott.htm](http://www.doh.gov.uk/ipu/socialcare/caldicott.htm) and [http://www.ecare-scotland.gov.uk/programmes/information_sharing/information_sharing_home.htm](http://www.ecare-scotland.gov.uk/programmes/information_sharing/information_sharing_home.htm) respectively.

2.3 In addition a number of local authorities have started development on the ESCR themselves. Case studies of work in a number of Councils with social services responsibilities and work through the IfSC demonstrator programme has explored key aspects of what constitutes the ESCR and how it might be handled. See appendix 2.

3 Data and text:

3.1 At the individual case level, as an examination of any case record shows, the prime recording is carried out in the form of text. There will be data items, not just basic demographic information, but also key data items for both local and national management information returns, the latter being defined in the core information requirements. For a more detailed discussion of document and data approaches see appendix 8.

3.2 One of the key issues in social care recording is what information was known at a specific point in time that informed the decisions that were made then, and to record those decisions and service provisions. Frequently decisions will be endorsed through the management hierarchy with signatures from supervisors, or panels agreeing to expenditure. It is these documents that will generally be shared with service users and/or carers.

3.3 The key entity that makes up the ESCR is a ‘document’, rather than a data item. Within each document there will generally be data items. The document may be defined as the entity that summarises at a point in time an aspect of the work with a service user. This may be a formal document, such as an assessment summary or closure summary, or a less formal record of work in progress such as the record of a statutory visit or audio record of a telephone call.

3.4 A ‘document’ may be created in a number of ways, including a view from a database. Typically this would be a form or screen in a database application, as well where key parts of a database system are made available as shared information. For example the JET project and CPR online (see [http://www.jetweb.org.uk](http://www.jetweb.org.uk) and [http://www.cpr.nhs.uk/](http://www.cpr.nhs.uk/)) both make available views of selected records in an extranet environment. This view, or set of views, is posted on a routine basis. In order to trace what information has been viewed the audit trail is relied upon, although it can be a complex task to reconstruct precisely what was known when. For the rest of this paper the term ‘document’ is taken to include such views of databases.
3.5 This paper does not define a delivery mechanism for the ESCR, although the case studies in appendix 2 do offer some examples of how different authorities have approached their development, and how they dealt with issues such as the infrastructure. However where national systems, such as the proposed NHS spine, CPR online, and IRT systems are in place each local system will need to produce a suitable output that goes into this national system. It is expected that the interfaces with such national systems (albeit that some are implemented locally, such as IRT) will have common formats, through XML exchange engines. The content of the XML messages will probably be nationally defined. Standards will also need to be defined around the nature of the exchanges, whether these are all real-time or carried out on batch updates. For messages passed between health and social care HL7 will probably be the schema used; - section 7 covers in more detail the relationships with NHS developments.

3.6 One important impact of using the ‘document’ as the key entity is that this becomes necessarily the most detailed level of granularity for record sharing. Potentially this means a service user could withhold consent from a specific assessment or care plan being shared. This will still be difficult to manage, but does appear to be achievable at this level. Managing consent at the data level would introduce an unacceptable degree of complexity. The comparison is with the episode as the level of granularity for the ‘sealed envelope’ in the NHS developments.

3.7 There are specific areas where this will pose problems. Partial access to key shared documents is likely to be needed, e.g. where a care plan includes services for people with AIDS/HIV. This could be worked round:

- With alternative views of the care plan, perhaps a complete one which includes services for people with HIV, and a cut down version for wider dissemination,
- Or by assembling a Care Plan from a number of component documents, each of which can have variable consent restrictions applied.
- Or by simply editing a document to provide a version without the offending material (as some material is released in access to records excises names and other information). The ERMS standard, metadata element 9, caters for the requirement to have extracts of records.
- Some database applications enable access security to be set up on a data dependent basis, otherwise additional screens will be needed to reflect differing access views.

3.8 Another key impact of using the document as the unit of record management is that data will not be readily aggregatable outside the local authority, for example via the NHS spine. However it does facilitate the use by different CSSRs of different documents for recording, and local branding (if only with Council logos).
3.9 If the structure of recording in specific areas of work, for example the single assessment for older people, develops a common lexicon of descriptions or codes then these may be shared and employed at a cross-organisational level. These would require a much more structured recording practice to be defined, see section 5 for more proposals in this respect.

3.10 So for example does a care plan include?
- services, days/dates
- times
- support provided by other agencies
- carers
- just the social care inputs

Such a minimum content definition will need to be agreed via the Standards Boards where national standards are required.

3.11 This may leave some unresolved issues such as what terminology is used on the care plan, and what is included. However this becomes a separate piece of work that may be delivered via a reworking of recording practice, as has been undertaken to produce ICS.

3.12 There will be a continuing tension between the need to define and standardise, while facilitating service development, innovation and continua of care. However the document classification framework outlined in the next section should be sufficiently robust to handle such developments.

3.13 This requirement for standardisation in key areas where information is exchanged has a number of implications:
- The impact on professional practice, this is being explored in developing common understanding in single assessment process and IRT communities.
- The impact on professional training, to ensure that there is a common widely understood set of meanings available.
- The development of definitional standards, possibly through the work of the NHS Information Standards Board, which has already started to examine social care terms, or the new Local Government Standards Board.
- The need for social care professionals to be closely involved in these developments is noted.

3.14 The need for databases as a core part of the ESCR is critical to manage the data items on a record, for management, financial, data sharing purposes. There may be an additional need for complementary systems to manage documents, whether structured or unstructured alongside the data. The national data as defined in the Core Information requirements do not preclude additional data being held locally where needed.

http://www.doh.gov.uk/ipu/socialcare/coreinforequirements.htm
3.15 There will be requirements for information recorded on documents to be amended or updated on the databases, to ensure the core information requirements can still be delivered. A wide range of possible technologies or processes might be used to avoid as far as possible the necessity for double keying of data. These include:

- Using tablets or similar mobile devices, from which data may be driven into the databases
- Using electronic forms to populate the databases
- Using standardised forms with checkboxes or uniform data recording to enable data to be extracted and written into the database via scanning devices

However manual entry of the extracted data will probably still be required in a number of cases, if only where new information is received by a letter/email.

3.16 The critical issue is to ensure that data quality is maintained. This will to a large measure depend on the technology/systems used, as well as the processes employed where information may arrive in many formats. A number of projects around the country looking at data accuracy are being monitored, and details will be posted on the Information Policy Unit – Social Care website.

4 How to manage documents?

4.1 Having accepted that the key entity that needs to be managed is the document the next stage is to decide how this can be carried out.

4.2 The section that follows looks at how documents can be handled using the standards developed as part of the e-government developments, applying these standards through an accredited ERMS compliant system. In the course of the consultation an alternate approach to managing documents was suggested. Rather than using an ERMS system it extends the use of an existing social services system. For further details of this approach see appendix 6. At this stage it is not possible to fully evaluate the practical implementation of either option, but both support the basic approach proposed in this set of standards.

4.3 The natural starting point is the material already published as government standard at http://www.govtalk.gov.uk/documents/Records_management_metadata_standard_2002.pdf. This is specifically designed to deliver the electronic record management standards for government. The set of documents includes a metadata standard, i.e. records about records, which should be used to define exactly what information needs to be held about each record. The National Archive (formerly the Public Record Office) developed these standards. The current metadata standard was issued as version 2 in October 2002.
4.4 The key metadata elements held are as follows, within which a number of sub-elements may be recorded, for further information and detail refer to the documentation:

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<td>1.</td>
<td>IDENTIFIER</td>
<td>Unique identifier at both object and fileplan (service user) levels.</td>
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<tr>
<td>2.</td>
<td>TITLE</td>
<td>Title given to record, folder or class</td>
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<tr>
<td>3.</td>
<td>SUBJECT</td>
<td>Keywords describing the subject</td>
</tr>
<tr>
<td>4.</td>
<td>DESCRIPTION</td>
<td>Freetext description of the resource</td>
</tr>
<tr>
<td>5.</td>
<td>CREATOR</td>
<td>The person responsible for the content of the resource, normally derived from login information.</td>
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<td>6.</td>
<td>DATE</td>
<td>A number of dates in the life cycle of the record, including creation, when acquired, declared, opened and closed. This needs to cover the access trail, see comments below.</td>
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<td>7.</td>
<td>ADDRESSEE</td>
<td>The person to whom a record may have been addressed. Optional</td>
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<td>8.</td>
<td>TYPE</td>
<td>The type of record, this is the level at which the management policy for that record type can be defined. This will include the default record sharing rights.</td>
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<td>9.</td>
<td>RELATION</td>
<td>Identifies relationships between records. Typically where one record needs to be related to another record. Or one record relates to a number of identifiers (service users) This caters for extracts, relating the extract back to the original.</td>
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<td>10.</td>
<td>AGGREGATION</td>
<td>Used to define where records management is carried out in the information hierarchy.</td>
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<td>11.</td>
<td>LANGUAGE</td>
<td>The language in which the record is held.</td>
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<td>12.</td>
<td>LOCATION</td>
<td>The physical location of hard copies, artefacts etc</td>
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<tr>
<td>13.</td>
<td>RIGHTS</td>
<td>The restrictions and permissions on access to view the record. See notes below.</td>
</tr>
<tr>
<td>14.</td>
<td>DISPOSAL</td>
<td>What will happen to record when disposed.</td>
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<tr>
<td>15.</td>
<td>DIGITAL SIGNATURE</td>
<td>Definition still under development by the National Archives.</td>
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<tr>
<td>16.</td>
<td>PRESERVATION</td>
<td>How the record has been preserved through its life cycle.</td>
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<tr>
<td>17.</td>
<td>MANDATE</td>
<td>The purpose for which the record is held.</td>
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Note – see guidance notes for which elements are mandatory in which circumstances, and for the detail of the sub-elements that lie beneath these major headings [http://www.pro.gov.uk/recordsmanagement/erecords/2002reqs/default.htm](http://www.pro.gov.uk/recordsmanagement/erecords/2002reqs/default.htm).

4.5 On initial examination the metadata set appears to meet most, but not all needs in social care. The key areas to be developed fully are:

- Section 6 – may need development to deliver full audit trails when records have been accessed for viewing, especially when a 'sealed envelope' has been opened. This will need to cover who accessed the record, when it was accessed, record the justification for the access, and possibly where the record was accessed.
• Section 13 – covering rights of access. Appendix 3 on Consent and Confidentiality outlines how the access rights could be maintained from the records of legitimate relationships for a service user that are part of the normal record. Further work to verify this model is proposed.

4.6 Key in the implementation of security is the need for full audit trails. The need for systems to deliver these is now even more critical. The impact on storage space and permanent backup regimes needs to be assessed by each Council with Social Services Responsibilities.

4.7 The ERMS material covers issues of how draft material is handled, however a more detailed working through of this is proposed.

4.8 Case law and British Standards now address issues of legal admissibility, for further information see http://www.bsi-global.com/Portfolio++of+Products+and+Services/IT+Information/Doc+Management/Overview.xalter.

4.9 Similarly work is needed to identify what, if any, information should be maintained about records that have been permanently disposed of. The Records Management Society of Great Britain has published comprehensive guidance on disposal policies in local government, which may provide a useful basis for local implementation, see http://www.rms-gb.org.uk/Retention%20Guidelines%20for%20Local%20Authorities%20version%201.pdf. Also guidance on local authority records appears at http://www.odpm.gov.uk/stellent/groups/odpm_localgov/documents/page/odpm_locator_605680.hcsp.

5 The documents in the record:

5.1 The metadata standard requires that the organisation defines the types of document that it is handling. Some of this is nationally defined as in the Integrated Children’s System that defines the key document types for children’s recording, but other recording is not so formally defined. (http://www.doh.gov.uk/integratedchildrenssystem/exemplarsdocs.htm).

5.2 Records will need to be accessed in a number of ways, including combinations of these ways:

• By service user. Covered in the subject of the record. This may need to be a repeatable item as one document may need to be referenced in a number of individual records. For example a letter from a parent about his/her 4 children.
• By date. So that a chronological catalogue of documents could be seen.
• By source of the record, i.e. who created the record. This would enable identification of all record elements produced by specific workers, agencies etc.
• By access/consent type, see section on service user direct access.
• By record type, this is detailed below with a proposed structure within which records should be maintained.
• By media type, e.g. video, audio etc

5.3 It may be useful to order these for convenience into a record type hierarchy, for example so that the various assessments, care plans, reviews etc are grouped. This is to make it easy to navigate around a case record.

5.4 Documents will be classified at the top level by the key processes they support:
• enquiry/contact
• referral, inc. material related to each referral
• assessment, inc. material related to each assessment
• care plan, inc. material related to each care plan
• service provision, inc. contract material
• review, inc. material related to each review and
• archived un-indexed documents (if indexed they should adhere to the classifications above)

and then by document type.

5.5 Within document types 3 categories of documents will be used:
Agreed national documents, as defined in existing national practice. At present these would include the LACS document set, soon to be replaced by the ICS exemplars, http://www.doh.gov.uk/integratedchildrenssystem/about.htm.

Possible national documents, these are commonly used documents or templates already in wide use, but not in any way currently mandated. This category will include standard national documents as well as local versions of a national requirement. Examples include:

<table>
<thead>
<tr>
<th>National standard forms/templates</th>
<th>National requirements, in their local versions</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAAF forms</td>
<td>Financial assessment forms for Fairer Charges</td>
</tr>
<tr>
<td>Court Reports</td>
<td>Single assessment summary as agreed in each health community</td>
</tr>
<tr>
<td>Care plans</td>
<td></td>
</tr>
</tbody>
</table>

It is proposed that the Information Policy Unit - Social Care at Dept of Health should consult and in agreement with ADSS Information Management Groups define which of these should be adopted as national document types.

Local documents, these allow, enable and where useful encourage local recording practice to develop to meet local needs. These may be local variations of possible national record types, and may, by agreement, be pilots for revised national document types.
5.6 Within the document classification, outlined in 5.4, all the documents associated with that part of the process need to be linked. For example a set of minutes of a meeting may relate to an assessment and would need to be filed in the assessment classification. Some documents may need to be linked to more than one classification, technical solutions may vary.

5.7 This paper does not seek to define the processes that may be associated with any specific document, however the utility of some standardisation in document terminology, and the ability to get this to start workflow processes is clear.

5.8 The ICS exemplars appear to fit into this model with some ease, for example:

+ enquiry/contact, inc. material related to each contact
  - Contact Record

+ referral, inc. material related to each referral
  - Referral and Information Record

+ assessment, inc. material related to each assessment
  - Initial Assessment Record
  - Core Assessment Record - Prebirth to Child Aged 12 Months
  - Core Assessment Record - Child Aged 1 - 2 years
  - Core Assessment Record - Child aged 3 - 4 years
  - Core Assessment Record - Child aged 5-10 years
  - Core Assessment Record - Young person aged 11-15 years
  - Core Assessment Record - Young person aged 16 years and over
  - Chronology
  - Assessment and Progress Record for looked after children - 1 and 2 years (12 months to, and including, 35 months)
  - Assessment and Progress Record for looked after children - 3 and 4 years (36 months to, and including, 59 months)
  - Assessment and Progress record for looked after children - 5 to 10 years
  - Assessment and Progress record for looked after children and young people - 11 to 15 years
  - Closure Record
  - CP1 Strategy- Record of Strategy Discussion
  - CP2 - Record of Outcome of s47 enquiries
  - CP3 - Initial Child Protection Conference Report

+ care plan, inc. material related to each care plan
  - Child/Young Person's Plan
  - Placement Information Record
  - Child/Young Person's Care Plan
  - Child/Young Person's Adoption Plan
  - Pathway Plan

+ service provision, inc. contract material

+ review, inc. material related to each review
  - Child/Young Person in Need Review
  - Child/Young Person's Child Protection Review
  - Child/Young Person's Looked After Review

+ archive material
5.9 Court Reports, registers, complaints/complements, visits and contacts, outgoing correspondence, inc. email, incoming correspondence, inc. email, financial info and risk/health & safety material would be ‘filed’ within the heading to which they relate.

5.10 For each document type there are likely to be a number of documents at differing stages of development. Typically these would be historical versions, a current version, and perhaps a draft version in preparation. There might be abandoned drafts (perhaps a service user dies while the assessment is being undertaken) etc. The full range of document control would need to apply. It is likely that different document rules would apply to drafts, so for example a draft joint care plan might just be shared between the agencies putting together the package of care, but once it is agreed it is available to a wider audience.

5.11 For older records, especially for children where they may date back many years, the ‘archive material’ group is proposed. It is expected that where these are digitised they would probably be held in scanning order for practical reasons. But if they are to be classified they should adhere to the classification structure outlined above.

5.12 This hierarchical framework appears to be robust enough to manage all current record types in social care, however the role for Information Policy Unit – Social Care and the ADSS IMG outlined above should provide for changes to be agreed over time.

6 Document rules:

6.1 The metadata standards crucially work on document types (called record types in the standard, but the terminology is not used here to avoid confusion with record as in ESCR). Associated with each document type should be rules. These will be default rules that can be amended for exceptions.

6.2 Typically these rules will cover security levels, retention and disposal, as well as access rights.

6.3 Access rights in the metadata standard are definable at the individual user as well as the group access level. In effect what would be included in the default access rights would be the information flows as defined for Caldicott. So for example if the care plan were to be shared, it would be with the people who have a legitimate relationship with the service user, typically GPs, health visitors and district nurses. However the service user may withhold consent from any of those even though they are directly involved in the care. This may have some impact on the ability of the service to deliver suitable care. The details of how this could work are outlined in appendix 3.
6.4 The assumption has been made for this proposal that the NHS model that was the subject of consultation in early 2003 will go ahead, as the principles have been incorporated in the NHS CRS material.

6.5 The model of information access associated with each document type is one of a series of filter layers:

<table>
<thead>
<tr>
<th>Layer</th>
<th>Access controls</th>
<th>How managed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Layer 1</td>
<td>Document creation and indexing</td>
<td>Creation and access rights within application.</td>
</tr>
<tr>
<td>Layer 2</td>
<td>Access controls imposed within the CSSR, e.g. people in adult services are unable to view children’s placement information or adoption records are only available within the adoption team.</td>
<td>Normally role defined within CSSR, but defaults may be overridden, e.g. for staff who are also service users. Should be managed within application and metadata.</td>
</tr>
<tr>
<td>Layer 3</td>
<td>Access controls imposed by the CSSR, these may include withholding service user access, typically for 3rd party information or similar reasons.</td>
<td>Defined by information flows as agreed in Caldicott process. Managed within metadata to record changes from the default position.</td>
</tr>
<tr>
<td>Layer 4</td>
<td>Access controls imposed by the service user. These are the consents to information sharing.</td>
<td>Changes made in metadata for each document. Note need only be applied to documents that are subject of information sharing. Service user cannot impose limits on internal CSSR access, but may agree with the CSSR for layer 2 limits to be imposed.</td>
</tr>
<tr>
<td>Layer 5</td>
<td>Access controls of 3rd party organisation, such as GP, hospital et al</td>
<td>Normally defined by user management in 3rd party agency. It is at this layer the ‘sealed envelope’ management would operate. This would both prevent access, audit all access that occurs and prompt for justification for overriding any ‘sealed’ information.</td>
</tr>
</tbody>
</table>

Underlying this structure is the need for both audit trails of who saw what and when, and a reporting mechanism that feeds information to Caldicott Guardians, and well as the service user/data subject. A flowchart showing how this should work is in appendix 5.
6.6 The government has defined a series of standards for authentication, to ensure security of systems and access to them. Level 2 authentication requires essentially a user name and password, while level 3 seeks additionally either a token of some kind, normally a smart card device, or biometrics. For further details see www.govtalk.gov.uk/gateway-partnerlink/resources/reg&auth_v3.doc.

6.7 This is a rapidly developing area of practice and technology. It would appear that within an organisation, especially where BS7799 standards are achieved, level 2 authentication within a secure network is adequate for most transactions. However for any external access level 3 is needed. External access naturally includes any use of encryption such as the developing PKI standards. Discussions are underway between Information Policy Unit - Social Care and the Government Gateway on developing means of authenticating external access to systems.

6.8 Many of the developments proposed here have legal implications in respect of Data Protection and Freedom of Information. It is the intention to develop this work in the light of such requirements.

7 Links with NHS CRS and the rest of the local authority environment:

7.1 NHS CRS, the NHS Care Records Service, is the centrepiece of the NHS programme for IT developments. It is a major multi-billion pound development integrating records systems throughout the country through a number of key national and regional service providers.

7.2 The programme is designed to cover the delivery of all health care information management requirements, including self-care, primary care, secondary and tertiary care (general and specialist hospitals services), in whichever setting it is delivered. This not only covers the obvious health settings of GP surgeries, health centres, hospitals etc, but also private health, prison service, hospices and social services departments.

7.3 The Outline Business Specification for ICRS makes it clear that there needs to be a close linkage between the ESCR and ICRS (Modules 119 – Social Care and 116 – Document Management). This is a rapidly developing area and is likely to be the subject of significant change as contracts for both national and local service providers (NASP & LSP) are concluded. The specification material is available at http://www.doh.gov.uk/ipu/programme/obs_icrs.htm.

7.4 The relationship between the ESCR and NHS CRS might be described as a journey both parties are setting out on, both broadly know where they are going, but expect incidents en route, do expect to meet eventually, but are not sure either who will get there first or when they will meet up. The objective of the
joint work is therefore to keep the two projects in touch, and ensure that neither takes a diversion that prevents the eventual meeting.

7.5 From initial work it seems clear that a series of 4 different models of relationship with the NHS CRS may be employed as most appropriate:

1 - Unified working
   - Direct access to NHS CRS or social care functionality
   - Characteristics:
     - Supports unified working as part of integrated health and social care team
     - Integrated health and social care record
     - Interface supports transfer of information or data from NHS CRS to Social Services system(s), but is this transfer necessary, provided relevant social services personnel have access to NHS CRS.
   - Example – Mental Health CPA

2 - Information Exchange
   - Exchange of data between NHS CRS and ESCR/Social Services systems
   - Characteristics:
     - Uni/bi-directional data interface between NHS CRS and ESCR/Social Services Systems
     - Structured, regular exchange of information to ensure consistent, shared access to common documents
   - Example – Single Assessment Process for older people

3 - Look up access
   - Referential access to data held by Social services (or vice versa)
   - Characteristics:
     - Look up access with no requirement/permission to update
     - Extranet solutions or mutual systems access – may go alongside unified working
   - Examples:
     - Children at Risk Register (health access to social services record)
     - Out of hours access to Mental Health Record (social services access to health record)

4 - Messaging
   - Structured/unstructured messages to communicate information between health and social care services
   - Characteristics:
     - Creation and dispatch of structured/unstructured messages from NHS CRS to Social Services
     - Receipt of structured/unstructured messages from Social Services into NHS CRS
• Must constitute auditable/attributable component of the patient/client record, typically delivered through email and generally within an encryption regime (probably PKI).
• Example - Communication of alerts, actions, reminders or just key information (core group minutes, abuse allegations)

7.6 Whichever of these models is employed in a particular area, we still need to address how the social care element of wider recording is managed, hence the requirement for the ESCR definition.

7.7 The specification of the NHS spine in the NHS CRS includes a requirement for key information to be made accessible. Work is underway to jointly define what information is shared. This is being done in the context of what else is on the spine, through the LSP development in London. It is clear that the information should encompass the key information but not the complete case record, and probably will involve a set of pointers to information. This has been illustrated as a stem and leaves model, see appendix 7.

7.8 What gets posted is subject to the explicit consent of the service user. If no consent is forthcoming then a ‘sealed envelope’ is posted, with the normal rules that surround these. There are some cases, such as child protection and safety issues, where there is an obligation to share information, in which cases no consent is needed, but may be sought as part of good practice.

7.9 Within the framework outlined above the most obvious groups of document for the spine are:
   a) Adults:
      i) Referral
      ii) Assessment, (possibly latest only)
      iii) Care plan
      iv) Review
      v) Safety issues
   b) Children:
      i) Referral
      ii) Assessment
      iii) Care plan
      iv) Review
      v) Pathway plan
      vi) Register information
      vii) Safety issues

7.10 The key issue is that these groups of documents need to be defined at a national level for the spine. So that if assessments for older people are to be made available then this type of document should be available throughout the country. This is especially critical in the large cities where local authority boundaries are routinely crossed by patients visiting their doctors, hospitals,
clinics etc. The differing approaches to information management in the NHS and social care are addressed in appendix 8.

7.11 The specification for NHS CRS contains a number of generic standards covering Information Governance in module 730. This covers a wide range of issues, virtually all of which apply in the ESCR. It is proposed that this specification is adopted wholesale in social care for the ESCR. This will ensure the standards adhered to in social care are the same as those in health. As both are derived from Caldicott guidelines congruence should be maintained. See http://www.doh.gov.uk/ipu/programme/icrs_obs_part3_v2b_august03.pdf pp70-151.

7.12 The NHS CRS is generally a record for life. This has an effect on the disposal policies of most local authorities where frequently records may be disposed after fixed numbers of years of no contact. This poses significant problems, as most CSSRs who responded to the consultation saw their holding records well after they would normally keep them unjustifiable in Data Protection terms. It is proposed that further work in need to clarify this position.

7.13 In addition the interfaces proposed need to fully cater for the proposed document level approach taken in the ESCR. This should link in with the document management module defined in the NHS CRS specification.

7.14 While the NHS CRS defines a ‘service’ and this ESCR paper defines a ‘record’ standard there is nevertheless a commonality of objective underlying both projects. Where necessary this standard should apply within NHS CRS as a delivery service, where the recording is outside the scope of NHS CRS the delivery service will be via the local authority. But in both cases the same standards apply, and the record handling should be as seamless as possible for those working across the organisational or service delivery divide.

7.15 This section so far has focussed on the links with the NHS as a key partner. What is less well defined are the links with the remainder of the local authority. If anything these are set to grow in importance for social care recording with Children’s Trusts.

7.16 The 150 Councils with Social Services Responsibilities in England have developed in many different ways. For example some have developed a citizen-focussed approach with the general public initially contacting corporate customer service staff, using customer relationship management software. This software tends to provide some level of access to many back office systems. This raises a number of questions:

- What social care information does the front desk adviser have access to?
- At what point should they pass a call to specialist assessors?
- Should they have any access to other organisations information to enable them to respond?
7.17 These issues were rightly raised in the consultation process, and do require further work and guidance, based on the good practice that has already started to develop.

8 Service user direct access:

8.1 A key element in the development of self-care models is the ability of the service user and their authorised agent, to access their own record, propose amendments and corrections, and where possible self-manage their own care. This builds on and develops the existing models of Direct Payments for care already in place.

8.2 The model of layered access to records has already defined what the service user can access, catering for a possible set of documents that are not available to the service user.

8.3 The NHS CRS Information Governance module specifies level 3 authentication, i.e. needs a digital certificate and biometrics or tokens. Just password access is insufficient control for information that could lead to substantial damage. The ERDIP patient access project in Oxford explored these issues. Work is underway in Leicestershire to develop this further. Oxford information is at http://www.nhsia.nhs.uk/erdip/pages/demonstrator/demonsites.asp?site=buryk, a summary of the Leicestershire project appears in appendix 2.

8.4 While the issue of authentication of digital access can be handled via the Government Gateway this does raise the issue of authentication of service users as they present to social services. The Department for Work and Pensions has devised a framework for this which may need to be adopted where necessary http://www.dwp.gov.uk/publications/dwp/2001/verframework/index.asp.

8.5 The handling of this for the ESCR could generally be handled via the Government Gateway possibly alongside that for the NHS ‘myhealthspace’. Access would also be available via a local authority website, again with the Government Gateway or similar authentication provider granting access. At present the Gateway does not cater for level 3 authentication, however in proof of concept work this has been included, although no business case for such as extension has yet been made. The requirement for both NHS and social care records for this level should provide such a business case. See appendix 2 for further information on this, as well as http://www.govtalk.gov.uk/schemasstandards/gateway.asp.

8.6 Concerns have been expressed that the complexity of registering for authentication and then using it is likely to put many people off. Smart card technology may open up opportunities to facilitate access, however given the nature of sensitive information that could be accessed it would appear that level 3 will be necessary in all cases.
8.7 This will require three areas of control on the ESCR to be defined, again by document type, and data item. The direct access controls will differ in each area.

<table>
<thead>
<tr>
<th>Control Area</th>
<th>Examples of documents covered -</th>
</tr>
</thead>
</table>
| Service user, full access with amendment rights | • Managing consents, and viewing record accesses made  
• communication area, e.g. for advising required service changes  
• operating any self-service aspects of social care  
• updating information on Direct Payments  
• error correction notification area  
• specific user feedback materials, inc. questionnaires. |
| Service user access, read only rights, but able to comment and identify amendments needed. | The main bulk of the record produced by the organisation. This will include all the data items maintained on the record. |
| Closed part of file, service user access not allowed. * | Specific documents that have restricted access imposed on them, e.g. 3rd party information |

*The Public Record Office metadata standards hold record items to manage subject access in items 13.9 and 13.10 (see para 4.4 above), but Freedom of Information requirements may affect this.

~ The key worker for a case will need to decide what to do with an error notification, options include:
  
  accept the notification and amend the record as requested  
  record a disagreement with the notification on the substantive record  
  or seek further information to corroborate the notification

9 Transferring cases between authorities:

9.1 What actually transfers is a set of documents indexed and wrapped by the metadata standards. At the very simplest level most of the record can be expressed as a series of documents, some of which may be views of the database taken at fixed points in time, and each of these is managed by using the ERMS metadata standards.

9.2 As these standards are nationally defined, as long as both the sending and receiving systems can manage the standard transfers are possible.

9.3 However each receiving system will need to read the relevant data items into its own database, for indexing purposes as a minimum. To establish the core information requirements, additional work will be required locally. This will probably entail a manual entry of the key demographic information on to the file.
9.4 The ELSID project, IfSC demonstrator project, is exploring this further, including the legal and consent issues involved. This section will be developed in the light of their work. A dataset for basic exchange purposes has been developed, for more information see the Jetweb site (http://www.jetweb.org.uk). But it is expected that a full data exchange (for example the full history of a looked after child’s placement history) would probably be manually loaded. Given the volumes of complex case transfer this will probably be adequate for the foreseeable future.

10 Delivering the ESCR:

10.1 In Information for Social Care, published in May 2001 the delivery date for an electronic record was set October 2004 for the creation of new records. In the light of the consultation this has been scaled back, as in the table below. However, it is noted that key service developments, such as self-service, e-government, joint working (notably in SAP and IRT) all need electronic records to be in place to enable partnership working, whether it is with the service user or other agencies.

<table>
<thead>
<tr>
<th>Targets</th>
<th>In operation by these dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic database/index system</td>
<td>October 2004: All CSSRs have such systems in place and operational</td>
</tr>
<tr>
<td>Plans</td>
<td>by April 2004: Realistic delivery plans in place.</td>
</tr>
<tr>
<td>ESCR: all new documents created or received for new cases. To be electronically retrievable (video and audio not included)</td>
<td>October 2004: 20% of CSSRs, expected to be mainly high-performing ones. October 2005: all CSSRs have this recording operational</td>
</tr>
<tr>
<td>ESCR: all new audio, video for new cases</td>
<td>April 2006</td>
</tr>
<tr>
<td>ESCR: all new and pre-existing documents (inc. audio/video) for current cases, and have metadata added</td>
<td>October 2006</td>
</tr>
<tr>
<td>ESCR: all documents for all cases, inc. archives</td>
<td>No specific requirement, each CSSR to make its own business decision.</td>
</tr>
</tbody>
</table>

Note, related targets: Single Assessment for older people (SAP) has its own timetable, see http://www.doh.gov.uk/scg/sap/, as does ICS, due to be fully implemented by December 2005.

10.2 It is proposed to monitor the development of the ESCR in each Council with Social Services Responsibilities through the Development and Improvement Statement process. It is accepted that for some functions Councils with Social
Services responsibilities will employ elements of NHS CRS as in the ‘unified working’ model. The targets outlined above in such cases do not apply, but the NHS CRS delivery and implementation dates should be used. These will also be monitored through the Development and Improvement Statement process.

10.3 The responses to the consultation noted the extent to which CSSRs are dependent on suppliers of systems to the social care market. The Department of Health, in collaboration with Department for Education and Science, will continue to liaise with suppliers and other developers to ensure they are fully aware of the requirements. It does not propose however to undertake a national procurement on behalf of CSSRs in the way that NHS CRS has been undertaken, because of the distinct legal status of local authorities.

10.4 The other key dependency noted in the responses was that of cost. This broadly broke down into 3 main elements:

- The purchase/lease costs of the software, hardware required to implement ERMS compliant systems.
- The implementation costs, not just project management but also training, extra staff to back load material etc.
- The impact on existing networks, especially in rural areas. Most document systems use .tif files, in which an A4 page takes c40kb, but audio and video files were seen as likely to have critical effects, as would down loading a large multi-page case file.

It would appear that the purchase costs, dependent on the size of CSSR, would be in the range of £150k - £500k. Other costs are more difficult at this stage to estimate. However a number of studies, including one by the Gartner Group, have identified the costs of maintaining paper records. The precise business case will vary between CSSRs; appendix 4 seeks to outline some of the factors that need to be considered in developing business cases.

10.5 The Information for Social Care grant is included in the 3 year spending programme up to 2005/06, see LASSL(2002)11, http://www.info.doh.gov.uk/doh/coin4.nsf/6b61058ff3b239dc802569b4003cb778/df95ce8c8517b63f80256c8d004af40b/$FILE/11lassl.PDF. All local authorities receive significant funding from the Office of the Deputy Prime Minister for e-government initiatives, a proportion of this should be available for developments covering social care, especially as they contribute towards corporate local authority goals. In addition a range of different project related funding schemes are available for local authorities to bid for, at regional, national and European level.

11 Next Steps, an implementation support programme

11.1 This section identifies the various developments that arise from this definition of standards. In the course of the consultation a large number of responses commented that they would find it helpful for either central direction or guidance. It is the intention of the current Information Policy Unit, Social Care to sponsor, co-ordinate and encourage the necessary developments across the
social care information management community. Local government where social care is situated (even in the new world of Children’s services) should also be prepared to play its part collectively and individually at local level. Note: the role of the Information Policy Unit, Social Care is subject to the Department of Health Change Programme, which may affect how the support programme is delivered.

11.2 It is expected that the developments will manifest themselves in a number of ways, including:

- Identifying good practice throughout the country and disseminating this through the DoH web site. Links with the regional and national information management groups are key to this. With 150 CSSRs each with some capacity there is a large community of involved staff who can deliver much of this agenda.
- Where national negotiations are required the IPU-SC is in a position to develop partnerships on behalf of CSSRs, that can be implemented locally where required.

11.3 A national ESCR Implementation Support Programme will be underpinned by some core values, and these include:

- Implementation being based on a partnership between central and local government – each will be contributing what they are best at as common national interests and local issues are determined
- Opportunities being developed for CSSRs to work together, to develop in concert where it helps
- Benefits and costs should be shared out – ‘investment’ should be as equitable as possible
- As much inclusiveness as possible should be sought – with software and service providers, corporate IM&T interests etc.
- Implementation should be incremental – but within the target dates which accept growth and development over several years in phases both national and local (including convergence with other national records programmes IRT, NHS CRS etc.)
- Implementation needs to be as opportunistic as possible – there are new opportunities developing all the time, and the programme must take account of these

11.4 The Support programme is currently being planned to maximise benefits and be as accessible as possible in 4 ways:

- Building a support infrastructure
- Developing benefits for all involved
- Specifying technical requirements and developing standards
- Programme management
11.5 The issues identified in the consultation process that need to be addressed are listed in appendix 9. This will be very much a developing work programme that will need to be updated on a regular basis. This will be maintained as a separate document on the IfSC website.
Glossary
1. A note on Government targets for electronic records management
2. Experience and links to other material
3. Consent and Confidentiality model
4. Business case development, a suggested checklist
5. Access controls flowchart
6. Implementing ESCR with a social services system rather than just using ERMS standards
7. Stem and leaves model
8. Recording practice in Social Care – documents and databases
9. ESCR implementation Support Programme
10. Methodology of the ESCR project
Glossary
In what is inevitably a technical document a number of abbreviations are used. These links enable the source material to be accessed.

**BS7799** (security), **BS7666** (place) and **BS8666** (people), see BSI, formerly British Standards Institute, website for details [http://www.bsi-global.com/index.xalter](http://www.bsi-global.com/index.xalter)

**Caldicott**, part of the structure for ensuring security and confidentiality of information in Health and Social Care, see [http://www.doh.gov.uk/ipu/socialcare/caldicott.htm](http://www.doh.gov.uk/ipu/socialcare/caldicott.htm)


**Core Information Requirements** the data required to provide statistical returns for external organisations, [http://www.doh.gov.uk/ipu/socialcare/coreinforequirements.htm](http://www.doh.gov.uk/ipu/socialcare/coreinforequirements.htm)

**CPR online** – a system designed to enable child protection registers to be shared across CSSRs and hospitals [http://www.cpr.nhs.uk/](http://www.cpr.nhs.uk/)

**CSSR**, Council with Social Services Responsibility. As not all Councils have Social Services departments in England this term is used to cover how the organisations used by Councils to deliver their social care responsibilities.

**ECDL** – European Computer Driving Licence, an internationally recognised set of attainments in using ICT, [http://www.ecdl.co.uk/](http://www.ecdl.co.uk/)

**eGIF**, government interoperability framework, the technical standards that enable all government systems to work together, see [http://www.govtalk.gov.uk/schemasstandards/egif.asp](http://www.govtalk.gov.uk/schemasstandards/egif.asp)

**ERMS** – electronic records management standards, as developed by the Public Record Office, now the National Archive. [http://www.pro.gov.uk/recordsmanagement/erecords/2002reqs/default.htm](http://www.pro.gov.uk/recordsmanagement/erecords/2002reqs/default.htm)

**Government Gateway** – a centrally developed set of services, among other things providing public authentication to government services. A range of material available via [http://www.govtalk.gov.uk](http://www.govtalk.gov.uk)

**HL7**, an international health interchange and messaging standard, see [http://www.hl7.org/](http://www.hl7.org/)

**ICS**. integrated children system, a co-ordination of recording practice about children in social care, see [http://www.doh.gov.uk/integratedchildrenssystem/briefings.htm](http://www.doh.gov.uk/integratedchildrenssystem/briefings.htm)

**Information for Social Care** – the document published in May 2001 which provides a framework for the use of information management in social care, see [http://www.doh.gov.uk/ipu/socialcare/information.htm](http://www.doh.gov.uk/ipu/socialcare/information.htm)

**Information Policy Unit, Social Care** – see web site for a range material relating to information management issues in social care, including core information requirements. [http://www.doh.gov.uk/ipu/socialcare/index.htm](http://www.doh.gov.uk/ipu/socialcare/index.htm)

**NHS CRS** – The NHS Care Records Service, the centrepiece of the NHS information technology programme. See [http://www.doh.gov.uk/ipu/programme/index.htm](http://www.doh.gov.uk/ipu/programme/index.htm) The main contracts are at the National and Local levels, with service providers for each, NASP and LSP respectively.


**PKI**, public key infrastructure, a means of encrypting email and other material for transmission over the Internet, the NHSIA provide a useful overview documents at [http://www.doh.gov.uk/ipu/strategy/crypto/index.htm](http://www.doh.gov.uk/ipu/strategy/crypto/index.htm).


**SOCITM**, the Society of IT Managers, a group that links together IT managers in the local authority and allied sectors. There is also a commercial consulting arm. [http://www.socitm.gov.uk/Public/default.htm](http://www.socitm.gov.uk/Public/default.htm)
Appendix 1

A note on the Government Targets for electronic records management:

As Information for Social Care, and now this guidance document, takes as its target the 2004 electronic records date set by Government it seemed useful to refer back to the documents that established that target and monitor developments since then.


This outlines in detail why records management is required, and how it should be achieved. Technically it only applies as follows:

‘The 2004 target applies to all central government departments and their agencies, and Non-Departmental Public Bodies (NDPBs). The term ‘government organisation’ is used in this document to denote all organisations which fall within this scope. P3, para 1.2’

Therefore it does exclude local government, which is not normally included as an agency. However all the arguments for records management apply in the local government arena, notably:

- The 2005 transactions target (to deliver records access online the records need to be in a format where this can be delivered)
- Freedom of Information and Data Protection rights of record access
- The need to share information with government organisations that are covered by the mandatory 2004 target.
- In addition this was the basis on which the IfSC grant, £53m over the first 3 years and provisionally continuing to 2006, at least, was made.

Information for Social Care espoused the 2004 target and used it as the date for the full implementation of the electronic social care record.

It is necessary to understand that this target only covers the creation of new records as stated in the Modernising Government paper:

The Public Record Office is leading a strategy across government for managing and accessing archives, using modern IT to support service delivery and accountability. It is our aim that by 2004 all newly created public records will be electronically stored and retrieved. (box in para 9) Source http://www.archive.official-documents.co.uk/document/cm43/4310/4310-05.htm

Nevertheless for a number of business reasons, well argued in the ERM paper quoted above, social care has a requirement to manage a large archive, often going back as far as 70 years. This may mean that the business case for back loading closed cases may be worth examining, especially in the light of ERM systems that need to be installed for new records. This should reduce the marginal costs of extending ERM to old records through scanning. Of course most of the arguments for good ERM apply to old records as much as they do to new ones.

For further information on records management see the Public Record Office (now The National Archive) website section at http://www.pro.gov.uk/recordsmanagement/erecords/default.htm.
Appendix 2 – Experiences:

What follows are examples of good practice that has come to light in the course of the consultation. A lot of other developments are in progress and we hope to publicise developments so that all may benefit. Further information will be published on the IPU social care web site, http://www.doh.gov.uk/ipu/socialcare/.

Links to material published from demonstrators in:
- **Tameside** - [http://www.doh.gov.uk/ipu/socialcare/tamesidepresentation.ppt](http://www.doh.gov.uk/ipu/socialcare/tamesidepresentation.ppt)
- **Stockport** - [http://www.doh.gov.uk/ipu/socialcare/demonstrator/result_stockport_escr_trainingmanual.pdf](http://www.doh.gov.uk/ipu/socialcare/demonstrator/result_stockport_escr_trainingmanual.pdf)

**Barnsley** have developed a web-based approach to linking and aggregating information from various systems across health and social care. This is called the Information Gateway. The result of this is information combined ‘on the fly’ and presented to the user as a web application. Access is via the internet (to avoid social care access to NHS net issues) and all information is encrypted and security protected. The application is accessed via PC or remotely by hand-held devices. Information is shared on the basis of robust confidentiality and information sharing protocols.

**Bradford** have already started work on integrating document management software with their existing social services application and are in the process of implementing this into the Children & Families department.

**Derby** already have a Document Management solution for Revenues and Benefits. Social Services have begun discussions with the corporate supplier about implementing their solution. The integration work has been completed, and we are likely to be a development customer in proving its implementation in a live operational setting. We have commissioned some preparatory work which will mean we will have a Project Board, PID, Project Manager, costing and timescales in place by December 2003. Our expectation is to meet the timescales set out in the draft consultation document, but we will be clearer on this by the end of the year, when funding implications are quantified and the impact of the green paper has been assessed.

**Dorset** have already produced a detailed analysis of requirements among other things quantifying the amount of files they have. Across the Directorate are approximately 81,321 file as and papers for service users. This includes active, inactive and closed cases that have not been destroyed/microfilmed. In terms of space this takes up approximately 260 square metres. The 8 page document outlines all the interfaces needed, including capturing emails about service users.

**East Sussex**, the implementation of the Electronic Social Care Record (ESCR) is crucial to the success of their Information for Social Care program and is vital in helping the Council achieve their e-Government targets. The ESCR aims to be used as a comprehensive individual record within social services that can be accessed by service users and shared with partner agencies. It will also form the basis for management information to be produced. From October 2004, service user records should be held electronically and information that has previously been held in paper form at East Sussex will need to be captured in electronic format by using document-imaging technology.

**Business issues**

Like many other authorities, lack of information sharing is a key issue for East Sussex. The inability to share information between specialist teams can be complex as the areas the teams cover, such as mental health, physical disabilities etc., can often lead to an overlap in the teams
requiring access to the same person’s record, i.e. a client may have a mental health problem and a physical disability. Trying to retrieve all the necessary paperwork from both service areas, which may be in different locations, can prove time consuming as East Sussex covers a large geographic area with a widespread population. Other issues include the inability to share data with external agencies such as health, GPs, and service providers etc.

**Implementing a solution**
East Sussex recognised the significant benefits of choosing an ESCR solution that would seamlessly integrate with existing systems and provide a mechanism for all parties to easily share information. The council took a progressive approach and worked in close partnership with software suppliers on the development of a product a module of an already existing client information system and appointed a Business Analyst to manage the programme. The Council then undertook a pilot programme and identified their client finance files as appropriate for this purpose. During the pilot, over 12,000 files were scanned (equating to 1 million pieces of paper) which are now held in off-site storage awaiting destruction. The system provided users with a ‘hot button’ link enabling quick access via the Council’s relevant existing systems.

**Business benefits**
Following the pilot, the council concluded that the system fulfilled their requirements and found that it was easy to use and provided a seamless integration to the council’s existing systems. Additional benefits included:

- Increased productivity by providing quick access to documents
- Joins up all information held on an individual
- Easy access from any location
- Reduced physical storage space - paper files stored offsite or destroyed
- Successful user acceptance – users can see immediate benefits, e.g. out of hours teams
- Improved quality of information
- Significant time saving in indexing

**Current Issues**
As could be expected there are issues as well as benefits. Most are practical problems that can be dealt with as part of an implementation programme but do require close attention. These can be summarised as follows:

- Security/levels of access
- Staff confidence/culture
- Network implications
- Significant impact on existing business processes
- Legal admissibility/acceptability of scanned documents
- How long to keep paper after being scanned
- How thorough the bureau scanning process is

**Next steps**
The next stage in the Council’s programme is to begin work in Adult Services which will be followed by Children & Families and also complaints files. East Sussex is confident it will meet the requirements of ESCR by October 2004 and have substantially progressed their Information for Social care Agenda.

**Gloucestershire — Experience To-Date**
Overview
As a bespoke developer, Gloucestershire is benefiting from a strategic decision taken in the late 1990’s to use a single database as a repository for a range of specialist modules that then support the specific requirements of Social Service operations. This approach has proved to be an excellent foundation on which to build a comprehensive ESCR system. Prior to core elements of ESCR being incorporated, the system recorded information relating to the dates of all core process outcomes such as assessments, care plans, services and reviews, however there was no mechanism to actually view, say, a series of chronologically presented care plans completed by hand. It is this capability, together with the other new requirements concerning confidentiality, data sharing and recording additional information that is our current focus of development on behalf of both our system and service users.

Core ESCR Elements
To realise the strategic vision of a holistic business solution for social care, our approach to ESCR is one of designing a system that incorporates a full range of adult and child care service requirements, including routine operational management support and national initiatives such as Supporting People, Fairer Charging and Funded Nursing Care. With the addition of “electronic everything” solutions for producing Service User data within an e-GIF environment and several modules already live, confidence is high for a very successful ESCR implementation.

The core elements to be contained in Gloucestershire’s release of ESCR are likely to be:

- A Service User’s core data set, as available in the current family of existing system modules.
- Pre-populated, scanned, digitised & indexed care plans, offering instant retrieval and viewing capabilities for care professionals.
- Digitised images of any ad-hoc documentation communicated from Service Users or their interested parties and care professionals, or visa-versa.
- General documentation concerning any specialist piece of work concerning the Service User.
- A suite of flexible reports, focussed to support routine operational management and practitioner decisions along with DoH returns.
- Active support for Joint Agency initiatives such as Delayed Transfers of Care, which is currently under joint development with local Health Trusts.
- A “Consents” facility, for the formal recording of a Service User’s position towards the sharing of information with partner agencies such as Health.
- A “Contacts” facility, which will act as a knowledge base of information, recording every initial information enquiry that results in SSD offering advice to a member of the public.

Document Management
As document management is a foundation element of ESCR, our particular experience in this area to-date is outlined below:

There currently exists a broad mix of computer literacy at practitioner level across the county. Whilst certain staff are at ease with directly inputting information into system generated forms, significant quantities of information is still routinely recorded by hand. The concept of only providing direct input methods for staff was therefore considered culturally unacceptable in the short-term, so our ESCR system has been designed to manage both scanned and directly inputted information within one environment. Due consideration has also been given to minimising the impact of introducing scanning equipment into the current recording process. This has resulted in “auto-scanning”, where the use of bar-coding techniques, pre-populated forms and header sheets combine to limit staff involvement to simply loading paper documents into the hoppers of high-speed scanning equipment installed at locality offices. The system then automatically categorises and indexes document detail before storing the images on a central server at minimal disruption to existing operational practices. This approach means that all Service User information, from an initial referral through to final review, will be viewable throughout the county via our client-centric solution, regardless of whether the original information was generated on paper or directly inputted to the system.

Acceptance. In order to gain acceptance Gloucestershire has developed a PowerPoint presentation, including a video introduction from the Director, outlining what the ESCR will deliver.

Hackney – have a corporate document management system and are seeking to build an interface between it and their main social services system. They estimate that just for the long
term archive they have £3 million pages of case records to be held, in addition to a long established microfilm archive.

**Hammersmith & Fulham** – projects related to ESCR

**JET**
Secure extranet which makes Social Service data available 24/7 over the web. Now in use in Health centres and Charing Cross A&E. Authorised users can view/submit information about a Social Service client. JET contains a client consent process and relies on data encryption for security. Testing will shortly start on the use of NHS IA approved security tokens, using these tokens will add to the current comprehensive security levels.

For further information concerning JET see [www.jetweb.org.uk](http://www.jetweb.org.uk)

**PRISM (Partner Remote Internet Service Mall)**

Hammersmith and Fulham are committed to using the internet to share information with all our partner agencies e.g. other councils, care agencies and NHS colleagues. These agencies would be accessing our information via secure links and each agency would have a number of authorised application users. In opening up our information we were faced with the issue of system administration i.e. who would set all these users up and maintain their details. It was not practical for H&F to maintain the day to day system access of these partner agency staff.

PRISM was our solution to this problem. Basically PRISM is a secure web based system administration application. Each agency has to be accredited by H&F, once this has been done H&F staff set the agency up on PRISM. Each agency has nominated staff who are allowed to set up and amend user details, these staff are responsible for maintaining the staff details of their agency.

Therefore PRISM ensures a secure and audited process for opening up and sharing our information. It also ensures that this process is not dependent on H&F resources.

**WEB-EPAC**

Like many councils H&F relies on private care agencies for some of their Homecare service provision. The ordering of a Homecare service is all on-line at H&F i.e. from Social Worker ordering to care order going out to the relevant agency.

The authorised Care Order is e-mailed to the relevant care agency. To ensure confidentiality no client details are included in the e-mail, instead the agency receives a .html link to a Client's care order. Once the order has been received the agency worker can access the encrypted details (having gone through further security checks).

**Electronically Sharing Client Data (ELSID)**

ELSID is a west London Alliance project to share information across the 6 west London boroughs. ELSID is a 2002/3 DoH Information for Social Care Demonstrator projects and its also an ODPM Pathfinder as well.

ELSID enables the secure transfer of client information between the participating boroughs. The boroughs involved are:

- Hammersmith and Fulham
- Hounslow
- Hillingdon
- Harrow
- Ealing
- Brent

For the pilot ELSID will concentrate on information transfer concerning a client changing address, child protection and schedule 1 offenders. Each borough has a different Social Service system but this does not affect the ELSID project. All partners are conscious that ELSID offers potential for other business areas like IRT and corporate customer care. ELSID has an in-built consent process.
Electronic Social Care Records in Kensington & Chelsea are based on the social work case file and have converted this almost completely to electronic format. We see this file, with its referrals, assessments, care plans, reviews and day-to-day recording as the key to Electronic Social Care Records, since it provides the information on which our care decisions are made and the plans for that care. Our records for this have been in existence for several years now, based on pilots in 1997 and 1998, and full implementation in all children and adult teams between 1999 and 2001. The records accompanied (in some cases implemented) changes to our assessment and care management procedures, and were therefore critically part of a business change, which drove what we did on Information Technology.

They were also based on a strategy in 1997 that agreed to centre all our systems on our current mainframe client index (as the method of ensuring that all workers used a single identity number, and knew whether others were involved), and then use best of breed systems to do the main tasks of social care. To date, we have separate systems for home care scheduling, charging, fostering, travel support (and other minor elements), as well as the central systems that we use for support for our social work practice. But this strategy already built on substantial use of word processing and e-mail within the department, as well as a unifying client index.

The implementations (separate systems in Children and Families and Community Care) were based on a business case, of which the main elements (all achieved) were:

- Typed readable records, shared with users
- Organised files
- Secure files
- Easier transfer and shared work
- Good review procedures
- Management control of assessment process
- Outcomes orientation
- Management information for government returns and internal review

In addition

- Children and families were able to integrate Section 47 assessments (and full child protection processing) with normal children in need processes, and also use the word templates for LAC materials. The system maintains our processing of day nursery applications, and many ad-hoc financial transactions.
- Community Care used the system for electronic communication of home care and meals orders to internal and external suppliers, as well as integrating OT and social work assessment processes.

Because we could not find systems on the market to do this electronic case file work at that time, we wrote our own using Lotus Notes file management capabilities. This proved particularly useful for its replication abilities, which have enabled us to deliver a full 24x7 service, with virtually no downtime. It also enabled us to embed external word documents (letters), e-mails, and any electronic files (e.g. scanned images) within our records. Its textual handling capacity and form orientation also made it most appropriate for our practitioners, meaning that their recording was still very similar to previous practice, making the IT system much less of a major culture shift. A particular emphasis was put on training, hand holding during go-live, and a responsive help desk (with the ability to adjust data, with full audit file, when people made mistakes).

The budget for the whole process was £463,000 (but built on an existing infrastructure), and the system was brought in within this budget (but to an extended timescale). The whole process was under active project management, and in Children & Families, this project management was responsible for all changes to the assessment process. This meant that the changes to practice drove the IT system, and in both divisions, practitioners and their managers were in effective
control of the implementation. Practice support was available as well as IT support, and this also inspected the quality of recording.

A key lesson that we learnt was that breaking the information into fields was only necessary, when the information in those fields was going to be processed electronically or aggregated. Workers used to text could continue to record primarily textually, because it was the communication and storage of the information that was the prime purpose of the record. The other major lesson was keeping things simple – so that people could understand what they were doing and why. This helped create a critical mass of practitioners that could support the system, and lessened the threat to those who found it difficult to engage with ICT.

We now have 5.8 Gb of information on our linked Children & Families databases (5), representing 135,000 documents. In Community Care, which went live slightly later, we have 4 Gb of information (11 linked databases) representing 250,000 documents. Our Joint Review commented that we were at “the national vanguard of harnessing IT to promote good care management practice”. Equally important, our practitioners now have a shared electronic file, which is the centre of their recording, is available in emergency, and is shared (on paper) with the users they serve. We believe this contributes to the quality and effectiveness of care we are able to deliver.

Kirklees Social Services are currently running a small pilot of their document management system. Although the pilot has given us the opportunity to evaluate the software the main focus of the pilot has been to assess the impact of electronic document storage on our internal business processes.

The objectives of the electronic archiving pilot are as follows:

1. Introduce the concept of Electronic Data Management to Social Services staff.
2. Gain practical experience of security privileges and document indexing.
3. Gain an appreciation of realistic scanning throughput and any scanning logistical problems e.g. stapled documents.
4. Identify the current paper documents and associated volumes that will require scanning e.g. letters and contact sheets. Clarity is required about what documents will be created in the system using a module that creates electronic templates e.g. careplans, and what will remain on paper and therefore need to be scanned.
5. Identify the volume of historical paper files and assess the benefits of scanning these files taking into consideration our Retention and Disposal of Information Policy.
6. Investigate the best methodology to continue input of paper files e.g. central scanning centres.
7. Understand and address storage issues e.g. Server, Jukebox, DVD etc.
8. Investigate how split files e.g. information held in assessment and finance teams can be linked to the main file.
9. Prove the concept of accessing files over the network.

An Electronic Document Management Focus Group has also been created that consists of staff from a range of disciplines from each Service Area e.g. Children and Families. Workshops have been arranged to discuss the following topics:

• Identify current business processes
• Create a standardised electronic file structure across all teams and departments
• Scanning of 3rd party documentation
• Define new business processes required for working with electronic documents
• Back scanning of current case files options
• Security and legal requirements
• Network infrastructure and hardware compatibility

Leicestershire CareOnLine is a multi-agency project supported by the Leicester Shire Partnership, consisting of representatives from social services, health, district councils, the voluntary sector and users.
Leicestershire CareOnLine provides information for older and disabled people from a single place. It enables users to find out about Social Services, health, housing, local community services, information for carers and advice about benefits etc.

CareOnLine has been designed especially with the needs of vulnerable adults and older people in mind. Information is presented in a simple, clear and easy to use format. A key part of the CareOnLine approach has been to involve users in the development of the project. A group of volunteers has been recruited, including users who are blind, physically disabled or elderly – most of whom had never used a computer before. The volunteers are able to access CareOnLine either from their own homes, or from a number of sheltered housing locations. Evaluation of the project has shown that CareOnLine provides many benefits, including reducing isolation and social exclusion and helping users to be more independent.

In addition, CareOnLine provides registered users with on-line access to their Social Services Care Plan. Users known to Social Services can register with CareOnLine to receive a secure login and password, which will give access to a selection of their personal information on the Social Services database. This information includes name and address, date of birth, contact details (such as GP, Social Care provider and Social Worker), and full details of their current care services. Sharing of information or access to other areas of the database is prevented. The data displayed is not stored on any intermediate system as it is extracted by interactive enquiry routines which reside on the Oracle database within the County Council's firewall secured zone.

Secure messaging between professionals is also being piloted. This provides a web-mail service which alerts registered users to the fact that mail (which may contain service user personal data) is waiting for them. They can then log on to the secure server, read the mail, reply and download encrypted Word documents.

**Warwickshire: UTOPIA** (Using Technology for Older People: Information and Action. (ISB Round 6 Project)

Exploring ways that service users, their representatives, primary health care professionals and home care providers, can gain access, via the web, to some service user records normally maintained on SSD's client database system. As such we have been trying to take note of other projects and developments to consider how best to deal with issues of consent, authenticating access, and designing roles and privileges to access particular records – and there appears to be a variety of different approaches to each of these matters. In common with other projects we are choosing an approach that fits our circumstances, but are concerned that, in doing so, we are contributing to a situation where older people may find themselves being dealt with differently in different circumstances. We are also concerned that the administration and maintenance needed to provide a high level of security around access might prove prohibitive to individual organisations.

A note from the Government Gateway

The Gateway will be able to support level three transactions in the future - all that is required is for a firm business requirement and deliverable target date to be agreed. This will not be within the next 6 months, but certain from mid next year (2004), the Gateway development cycle to be able to take this on board. In a shorter timeframe - i.e. next spring - the Gateway will be able to handle internal government users, i.e. to manage the authentication (via certificates) of internal staff, i.e. GPs, healthcare workers, etc. This will allow us to start looking at the potential gov-to-gov services that are implied by allowing access to such information as the ECSR.

Looking at the Gateway as being able to authenticate and authorise a GP or healthcare worker will allow the requirements for authorities like Leeds to be progressed into much more detail, dealing with such issues as consent management and how this will be managed at the local systems levels. For the moment I can only see the Gateway authorising such users at a local
organisation level, i.e., they are allowed to access a particular PCT system or type of customer record. How to restrict down to the individual cases will have to be done locally, and I think that this is the best place to manage this.

Note from Peter Middleton eDT
Appendix 3 – Consent and Confidentiality:

A Model for Inter-agency Consent and Confidentiality

1. Introduction:

This model has been generated as part of the definition work on the Electronic Social Care Record (ESCR) undertaken by the Information Policy Unit - Social Care at the Dept of Health. Much of this is now reflected in the ICRS Outline Business Specification, notably the Information Governance module, 730. This is available publicly at http://www.doh.gov.uk/ipu/programme/obs_icrs.htm.

Why review the model upon which we base system support for confidentiality? Three reasons:

• The strong policy drive to centre what we do upon the experience of care of those whom we care for emphasises both parties view of the customer: provider relationship. This broadens the balance of influence on the management of individual privacy, beyond any exclusive reliance upon professional codes of ethics (not that we wouldn’t want the stance to continue to be included there though).

• The traditional Consent and Confidentiality model has been based on a single organisation and the original bi-lateral relationship between the single professional practitioner and her patient or client. The drive for care that is integrated between existing organisational forms blurs their boundaries. Flexible ‘client teams’ are a sensible operational response to this, and build upon plentiful experience.

• Things are going to get more complex from here on in, in inter-agency information-sharing development. Whereas the response so far amongst older people has been relatively straightforward, we are now approaching other client groups where, for example, the relationships between the various users involved may be routinely more complex, or may on occasion involve a refusal to participate. Our system support for confidentiality and information sharing needs to be able to cater for these issues.

The notes below draw very much upon recent research and development– in the main from thinking from colleagues in Scotland, especially Peter Ashe, and the Electronic Health Records work. The level of footnoting in the main text is intended to acknowledge this debt. In seeking to spin some of the concepts into the broader Inter-agency setting, the points touched upon form the beginning of a journey rather than pretend to be a summative statement. In order to test and consolidate the model into practical and pragmatic good practice it is hoped that further work will shortly be commissioned.

Michael Custance
Information Policy Unit - Social Care
Sept 2003
2. **The proposed Model:**

The main features of the Model are

- A ‘Frame of Reference’ that emphasises *Customer Service*;

- Consent to share is embedded within and supports *consent for care*, and is tightly linked with the document driven approach of the ESCR definition, which in effect defines the ‘what’ in information sharing:

- The suggested organisational paradigm is the ‘client team’ within which the management of information sharing is predominantly carried out; this defines the ‘who’ in information sharing.

- A framework for access to information that is based upon a web of ‘legitimate relationships’ with the service user, with some of these at least in turn based upon practitioner roles.

- Consent (obtaining, re-affirming) is associated with *key Service transactions*, within Care Pathways (a.k.a. ‘the client/patient journey’) which themselves offer a key operating framework for client teams;

These features are unpacked a little, below.

### 2.1 necessary caveat - Keep it simple!

We should be open rather than closed – more (significant to the individual) damage has historically been done through the lack of information rather than its over-supply (though see US surveys & reports of embarrassment caused, referenced in ERDIP N5). The risk otherwise of clinicians and practitioners acting in ignorance, is perhaps eclipsed by the significance of the risk to the individual of their failing to act through ignorance. Recent case law from Australia suggests that the obligation to share information may need to be balanced against the need for confidentiality.

Either way, it’s more beneficial for all, to place adequate emphasis on effective policing of a relatively simple model, rather than devote effort to developing a complex model that is thereafter badly implemented and policed.

Our model is intended to apply when it’s needed, rather than across the board, to every service user. It may be that the majority of service users feel no need to set their access preferences to anything other than ‘open’.

In seeking to connect to concepts, practices, and organisational forms that are part of day-to-day operational life for service users and practitioners, this model attempts to minimise any additional overheads involved in implementation and policing.
2.1 Models are usually felt to need a **diagram**, so here’s a draft up front in case a picture helps explain\(^1\). It deploys various concepts (*italicised* in the vignette) that are subsequently touched on in the text:

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\(^1\) The vignette here relates to health and social care: one of the next steps in validating the model would be to create equivalents involving, say, a Guidance Teacher and a Health Visitor, or a Housing Support Team and the local CRM one-stop-shop staff, or…
3. A Customer Service Frame of Reference:

This crucial choice - of frame of reference (bearing in mind the alternatives such as ‘legal compliance’) - stems originally from the strong policy drive towards improving patients’ and clients’ direct experience of care. As soon as one adopts this policy stance as the starting point, it becomes necessary to look at the issues from her point of view.

So, what is her point of view likely to be? The team involved with the research underpinning the PIU report on Privacy and data-sharing2 uncovered – underneath a welter of “well it depends [on the use you’re going to put the information to]” caveats - a clear picture of a variety of frames of reference all nonetheless based firmly upon the various relationships citizens had with their various service providers.

The individual’s relationship - voluntary/ involuntary, frequent/ occasional - with the service provider is crucial for her perception of information sharing.

Meanwhile, individuals do not ‘inhabit’ a fixed single frame of reference. “…it depends on…” is a very important caveat:

“…A finding of major importance from this research is that almost all of us (had we conducted a group with privacy experts, I should expect that we should have found the same thing) move between frames, according as we direct our attention to different benefits and risks.” [emphasis added]3

Service users may not only shift between frames when they inter-act with different service providers, facing different combinations of risks and benefits for their privacy, but may – naturally - also shift frames within their interaction with any given provider, as the service package is developed, reviewed, or evolved. This is a fundamental point, since it requires a subtle set of responses, rather than one single solution, to the various aspects of consent and confidentiality (the PIU report in the main focused upon the implications for public awareness), as well as the model itself.

For example, the PIU identified some key public agency re-assurances that were needed to respond positively to what they described as ‘privacy pragmatism’ (the set of attitudes with which people approach the mix of trade offs and variable relationships with service providers).

One of these re-assurances is that “…information will be used to draw reliable and valid inferences.”4

If our model were to concentrate solely upon managing access to information, it would fail to support the provision of this important element of re-assurance. On the other hand a more developed response to this need would also emphasise the support of the capability for ‘annotation’ of information with an explanation or ‘gloss’ on it5.

Above all, this web of shifting customer service relationships involves one thing in common: the customer, patient, or service user. If the model is to have multi-agency applicability it needs to be based upon this common element.

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3 ibid.
5 Most document management systems support the capability for electronic ‘Post-it’ notes to be ‘attached’ to a part of a record. This facility could be re-purposed to enable clients to be able to offer an explanation for, say, a social work report of a domestic altercation. This need not explain the incident away, but could offer a useful added interpretation for anyone not in possession of the original context.
4.  ‘Consent to share’ linked with ‘consent for care’:

‘Consent’ has been described as occurring when a person freely agrees that some action should take place – implicit in this is that:

• they understand the situation, the action(s) intended, and the future implications;
• they are not coerced;
• what they agree to will actually happen;
• no more than what they have agreed to will be done.\(^6\)

The key information required to enable consent is an understanding of what is being shared, and with whom.

Meanwhile recent Health Service research highlighted two rather anxiety-provoking points:

• the publics’ low level of understanding of how public service providers use information entrusted to them and
• their suggested lack of preparedness to legitimate any but minimal expenditure on the matter\(^7\).

These perceptions are unlikely to apply universally: when emphasising the 80:20 principle – the model needs to be good enough for the majority rather than super-complex for the minority - the ERDIP N5 Report suggests\(^8\) that

1. “there is a small group of people, probably at most 5%, possibly less than 1%, who are seriously concerned about the use of their medical data (this may reflect specific personal information that they wish to suppress, or simply a personal objection in principle);
2. there is another segment of the population (possibly 20-40%) who are quite unconcerned about the use of their health data, possibly as they have little health data anyway, or it is of a routine nature, or because they are open about their health problems anyway.

This leaves a large chunk of the population who may be apathetic in responding to surveys, or for whom their choice will be more complex depending on the nature of the data, how and with whom it is to be shared, and how the data (and hence their interests) are to be protected.

Clients and patients are likely to be familiar with being involved, having to think about – or at the very least deal with – decisions about their care. This is a very important part of people’s experience of service provision. By contrast, thinking about information sharing in its own right is pretty abstract.

Consent performs the task of managing and confirming and codifying the results of the negotiation over what to do for the service user. For example, if a referral to another professional is at issue, then the necessity to send relevant information across for them to make an informed intervention (such as going to the right address, or not having to ask yet again for personal details) is embedded in the dialogue over whether to refer. Consent for sharing is embedded within consent for caring.

4.1 Documents, letters, and the Record:

Applying the yardstick of “what makes intuitive sense to the service user?” also bears upon ways of thinking about what is shared. The ESCR definition proposes that what is shared are documents. There remains an issue that when a range of documents are shared a wider picture can be painted that conveys more than the parts.


\(^8\) though they don’t quote any source of evidence in support of these proportions.
5. **The concept of the ‘service user team’**

“Team: a small group of people who relate to each other to contribute to a common goal”

The model assumes that the day-to-day management of information-sharing is predominantly carried out within the groups of practitioners more or less directly involved with the patient or service user.

Traditional Guidance has rather tended to assume that practitioners work and think almost exclusively as members of an individual profession or specialist discipline, with a private bi-lateral relationship with the service user. Meanwhile, working in flexible multi-disciplinary groups, whose membership will be tailored to and evolved with the needs of the service user or patient, is an approach that is both familiar and increasing in use. In these circumstances traditional Guidance can have the unfortunate effect of predisposing those practitioners who pay attention to look outwards over their mental shoulders, rather than towards their ‘team’ colleagues.

An important point for the model is that service user teams/networks/associations (the lack of capitalisation is deliberate) are often informal groupings around individuals, rather than of the more formal Community Mental Health/Drugs Action Team variety. These groupings are well outlined in Ovretveit’s work on Community Care.

Though the ‘service user team’ concept of course does not apply everywhere within ‘health proper’, it does apply (to a greater or lesser extent) in some contexts and particularly within some crucial transitions such as hospital discharge.

Here is Ovretveit’s ‘Care Manager’s provider team’ - adapted a little to put the service user at the centre. Each of the blobs on the outer ends of the lines indicates a member of the team. This form of team has no particular existence outside of providing service to the central user. The lengths of the lines may indicate the significance of the relationship between provider and user, which itself could be a product of a number of factors. Meanwhile the concentric rings are intended to indicate a form of ‘gradient of trust’ radiating outwards. [Of course in practice this gradient might be neither radial nor evenly spaced, but might be more like the wavy and uneven contours around a hilltop]. Depending upon the nature of their relationship with the service user, different members of the client team are trusted with different levels of access to information about the user.

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10 A useful recent exemplar of Guidance based upon a workaday ‘service user team’ framework is ‘Getting our Priorities Right: Good Practice Guidance for working with Children and Families affected by Substance Misuse’ - available at http://www.scotland.gov.uk/library5/education/gopr-00.asp
11 By contrast, the recent ‘How Confidentiality Works’ series of information booklets for professionals engaged in sexual health services for 13-15 year olds make it quite clear that practitioners need to talk to one another about their particular perspectives, negotiate a whole-team confidentiality policy etc. These are available at <http://www.healthy-respect.com>
12 Ovretveit identifies two other main types: Network association team; Formal team (various sub-types of this) – but while the varieties may be important for the providers, our user may be indifferent.
13 As in ‘I trust you, and by extension your friend – but I don’t know him well enough to know whether I trust his friend’.
6. **Access control: legitimate relationships, and roles**

It is often suggested that the single most useful set of information within service users’ records is ‘who’s involved’, and facilities exist in most current health or social care systems to record varieties of ‘professional involvement’.

Besides the basic contact details in the MGF1 eCare project example shown here, please note the inclusion of both ‘Involvement Type’ (a synonym for ‘role’?) and ‘Notify’. In the pilot application, this latter field is intended to support a simple system for notifying the client team of key events in the client/patient’s care. Similar records are held in Swift and Carefirst, the 2 English leading products, screens appended.

Taken together, these functions offer some basic infrastructure potential for:
- Information governance work on agreeing the access entitlements of given roles
- Communications development work on patterns of notification appropriate to particular circumstances, for example the Care Pathway milestones mentioned below…

…with the result beginning to support the ‘gradient of trust’ touched upon earlier.

The ICRS specification used the South & West Devon ERDIP Project report on use cases & the EHR sets roles within the helpful context of ‘legitimate relationships’ (with the service user). The Project report described the concept thus:

> “A **legitimate relationship** describes the role a clinician (or other user with access to the personally-identifiable health record) has with a patient when accessing their health record.
> a. There are times when a user might be granted access to only a part of the record (e.g. only those items originating in one organisation or specifically requested by a court). It is anticipated that such restrictions would be determined by the user’s role rather than by making the legitimate relationship applicable to only parts of the record.
> A legitimate relationship can be current (active), suspended or terminated.
> A current relationship grants the user access to the patient’s health record within the constraints of their user role (i.e. on a need to know basis)
> b. A user should continue to have access to records within a suspended relationship, but with a restricted set of permissions (for example read-only access)
> c. When a relationship is terminated the user no longer has any rights of access to the record.
> It is a requirement that users can only gain access to a health record when they hold a current (active) legitimate relationship with the patient\[15\].

This material is now in the specification in the section on legitimate relationships in module 730.

Earlier work (e.g. Tees ERDIP) on roles – tended to equate role with professional persona rather than relate it (as above) to the contribution to the service users’ care. Applied simply, this might mean that a consultant might – via the permissions associated with that status – be able to view the same level of information about relevant patients irrespective of whether any form of active involvement existed. Or a geriatrician would never be able to access details of neo-natal care. However, moving to the other extreme, of allowing access only to a limited list of named individuals trusted by the patient, seems

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\[14\] Forth Valley eCARE Project - to support Single Shared Assessment, working with Occupational Therapists in Hospital, Community Health and Social Care settings as the pilot staff group. Details available at <http://www.show.scot.nhs.uk/ecare/>

equally unrealistic – it makes no allowance for staff holidays or any other sensible reason for having to use a stand-in!

A role-based access framework can act as a backstop for access based upon the nature of actual involvement in the care of the user. This caters for forms of service provision that may need to be available on demand (e.g. out-of-hours cover, A&E etc.) where trust cannot be established in the same way as via a milestone on a Care Pathway.

In summary therefore access may be seen as operating at 4 levels:

<table>
<thead>
<tr>
<th>Level</th>
<th>Access controls</th>
<th>Comments – all access noted in audit trails</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Defined as a named legitimate relationship</td>
<td>Access allowed to the relevant documents/views.</td>
<td>Recorded as an involved person in the record, and no withdrawal of consent.</td>
</tr>
<tr>
<td>2 - Carrying out a defined relationship, but not named, e.g. GP cover, emergency provider.</td>
<td>Access allowed, but reason has to be justified from pre-coded list (defined in 730.48.27 of module 730 OBS)</td>
<td>Assumes that consent has not been withheld. Consent may be granted by the service user at the point of access, included as one of the codes.</td>
</tr>
<tr>
<td>3 – Not a defined relationship, but either over-riding a sealed consent or justifying access.</td>
<td>Access allowed, but reason has to be justified from pre-coded list (defined in 730.48.27 of module 730 OBS). The allowable codes for such access would need to be restricted.</td>
<td>Notification to Caldicott Guardian and service user required.</td>
</tr>
<tr>
<td>4 – Other persons seeking access.</td>
<td>Access prevented.</td>
<td>Access attempts recorded in audit trail.</td>
</tr>
</tbody>
</table>
7. **Consent associated with key ‘service transactions’, within Care Pathways:**

It’s assumed that the Customer Service relationship is mediated (created, reviewed, ended) via particular forms of practitioner/user ‘service transaction’ (e.g. referral, assessment, care plan components).

A service transaction of this sort forms a ‘trade’ (wherein sensitive information offered is exchanged for service) which is increasingly familiar to service users (cookies & web sites etc.) but also starkly so to older users in re chargeable services and financial assessment (you can opt for privacy in your financial circumstances, but then you must pay the full rate without the option).

The adjustment of the service relationship within this sort of service transaction (referral, assessment, care plan, review, hospital discharge) is commonly associated with the output of a form or letter that amongst other things both conveys information about the service user, and should also signify or incorporate consent. Logically the printed Care Plan would include the information that these are the people with whom this Care Plan will be shared, thus combining information for the service user of who will see what information.

The model assumes confidentiality is negotiated within this setting – often implicitly and as a continuation of norms established in the service relationship. But occasionally this is done explicitly at milestones/ breakpoints in the care process such as admission for respite care [see Tees ERDIP project Final Report re milestones\(^1\)] where the membership of the ‘service user team’ may be re-shuffled, as part of re-jigging the package of care or service.

7.1 **Care Pathways and ‘Trust Footprints’ (a.k.a. Confidentiality domains):**

Based on:

- Consent to share being embedded within consent for care;
- An informally constituted ‘service user team’ whose membership evolves alongside the patient/service user’s journey;
- Consent for care and consent to share being obtained, reviewed, and re-affirmed at key decision points or milestones on the patient/service user journey…

The idea of a ‘trust footprint’ becomes clear, sometimes referred to as a ‘confidentiality boundary’ (ERDIP) or ‘domain’ (NHS Lifehouse) – see the figure. (NB. You will need to substitute ‘service user team member’ for at least some of the ‘clinics’ here)

In their references to letters providing information “outside the system” the original authors\(^1\) may have thought that this footprint was static:

> “Ideally the access controls should fit as exactly as possible to the imaginary ‘confidentiality boundary’ so that no-one has access to data that the patient would not wish them to see.

Inevitably there will be some who have the facility to see data when they have no need, and there may be some whom the patient would like to have some access who cannot. Hopefully, these discrepancies can be balanced by obligations of confidentiality (so that people do not use


\(^1\) ERDIP Evaluation Report N5
the facilities when they shouldn’t) or other mechanisms (e.g. referral letters) to provide the appropriate information outside the system.”

To some extent this becomes a maintenance issue for both the service user team as well as the service user. As the circumstances change, so do those who have access to the record.

Where information is processed for purposes that don’t sit within the confidentiality boundary, it should first be anonymised or pseudonymised.

8 Miscellaneous points

8.1 Duration of consent & confidentiality:

The PIU focus groups thought that the principle of ‘forgiveness’ (statute of limitations, wiping the slate clean) was important. This needs to be managed in practice (beyond the obvious statutory timescales attached to certain classes of record) as part of the general records management and archive processes.

The moving trust footprint will mean changes over time, which can be managed through the legitimate relationships records. The access controls noted in section 6 enable involvements to be recorded as ended.

‘Outline Requirements’ for inter-agency C&C support:

The English ICRS development has now produced a worked through Outline Business Specification (OBS) to which various references have been made throughout this document. See http://www.doh.gov.uk/ipu/programme/obs_icrs.htm for more details.

In addition the ESCR definition work at the Department of Health and the ICRS social care module (119) both adopt a common set of ways that social care and health system can work together.

The ESCR definition proposes that the ICRS Information Governance module is adopted in principle in social care organisations.

It is proposed that this becomes the basis from which any further developments are taken across the wider care community.
Involvement/Relationship Information on Carefirst and Swift:

Swift, courtesy of London Borough of Tower Hamlets:
Involvement Tab in Frontdesk, Involvement describes all those with professional responsibility for the health, education, protection and welfare of a child.

Carefirst, courtesy London Borough of Hackney:
Relationship screen caters for roles in a case.
Appendix 4 – Business case development, a suggested starter checklist

Costs:
- Purchase or leasing costs of software and hardware
- Project implementation costs
- Initial training of staff
- Bulk back scanning of old material, optional
- Extra costs of printing (initially staff will want to take paper with them)
- Upgrading VDUs, regular users will need at least 17” screens
- Network impacts

Savings:
- Costs of accessing documents (see Gartner estimates)
- Costs in stationary
- Costs in filing documents
- Costs of storage, could this space be used for staff and other buildings closed
- Reduced duplication of records in different parts of the organisation, consolidation of records (less input time, consistent recording)

Opportunity costs/service improvements:
- Some of the possibilities of service delivery are not possible with manual files (e.g. 24/7 access and cross-organisational record sharing)
- Service user access to records
- Staff access to information from almost anywhere
- Hot desking
- Improved links with providers

Sources of information:
- Apart from other local authority developments, research and consulting groups such as SOCITM and the Gartner Group ([http://www4.gartner.com](http://www4.gartner.com)) can furnish a wealth of information.
Appendix 5 – Access control flowchart

Request for record access

Is there a legitimate relationship recorded for the person logged on?

Do they have a role that is legitimate to have access?

Is record is a 'sealed' envelope?

The reason for access is recorded, priority category 2

Is a professional over-ride of the seal justified?

The reason for over-ride recorded, priority category 1

Access to record is provided

Audit of access written: name/date/ location from which access made/ role/ reason

Notification sent to the person who sealed envelope (clinician or service user)

No access provided, message to system user advising attempt is being logged.

Audit of access written: name/date/ location from which access made/ role/ reason, priority category 3

Produce audit report for Caldicott Guardian, based on priorities noted.
Appendix 6 – IMPLEMENTING ESCR WITH A SOCIAL SERVICES SYSTEM RATHER THAN JUST USING ERMS STANDARDS

Introduction
In the main document, the implementation of ESCR using ERMS standards is detailed. Major parts of these standards (as embedded in the metadata) are to hold, index, retrieve, preserve and delete documents.

An alternative approach could be to use the core Social Services systems for these functions pointing to an external document store (meeting standards for records management). In this model, the Social Services system provides much of the functionality traditionally provided (using the metadata) in the ERMS (much of which is already in built as case views in social services systems).

This model does not detract from the basic document centric concept that underlies both social work practice and this iteration of ESCR. Indeed it builds on a basic concept within the main ESCR material of the ERMS document system working closely with the main core information requirements system.

A potential advantage of the method is that it does not require definition of the file structures and indexing material for the ERMS, since this has already been defined in the social services system.

Essence of the solution
Social Services systems are already designed to retrieve records and bring them together in person centred views. Some solutions have already gone down the route of embedding word processing within their functionality to provide document style creation and retrieval.

Future solutions would need to embed the locator of the document in their functionality. Thus the assessment locator is embedded within the record of the assessment process in the social services system. Since this process already has security built around it, the same security concepts can be extended to the document itself and its content display (possibly with the level set higher for the actual document).

The security status of the document in the ERMS should be set so that it could only be retrieved through an agreed system – at this moment the social services system.

Given the possibility of system error, creating some metadata as well could ensure that a document could always be found if the locator was in some way lost or corrupted. This data would be the same minimum data that was necessary to transfer the document from one system to another – see listing at the end of this appendix.

Common security rules
To create effective joint working health and social care need to adopt common security rules (they already have similar confidentiality standards and requirements), and an agreed document set (document names not precise content specifications). This needs to cross all health communities and local authorities. It could be argued that this is essential anyway, given the need for common information sharing protocols (which will become more critical as the children’s green paper approach to education and residence records is implemented in larger urban conurbations), which define what use will be made of shared information and by whom.

If the rules, the document set and the key elements of security detailed both in this material and the latest proposals for NHS CRS are adopted across the health and social care community, it will be reasonable to transfer documents under such protocols and assume that such rules will be maintained in local systems.

All based on a common lexicon of roles, a common approach to legitimate relationships, a common lexicon of documents and the roles allowed to see them, and active monitoring of breaches and emergency/lesser relationship accesses.

It could be argued under these circumstances, that the only thing that needs to transfer with the document as its security wrapper, is the agreed document name (which defines which roles may access it) and any sealed envelope type rules that bar access to certain individuals (would need a common listing of all potential people) or roles.

Common approach for sharing with Corporate Relationship Management Systems
Where an authority also operates a CRMS, so that it can operate One Stop shop type access to the authority, the CRMS can be extended to access the document store, provided that, it subscribes to the common lexicon of roles and security rules. Information could be embedded in the CRMS in the same way as it is transferred to other systems, but with no requirement to transfer the document, only its locator.

**Long term option**
When all of us are effective at offering web services, it is even possible that long term, no actual document transfer takes place. The locator is transferred to other systems which have appropriate security codes to retrieve the documents, after having checked in their own security the role and legitimate relationship of the requestor, and written that information to their own security log, and provided it for the security log of the document system.

**Potential system diagrams and processes to illustrate the concepts above**

1. The first diagram shows how confidential social care material would be retrieved, in a final system.

   Process 1. The user attempts to retrieve material — the system checks that they have a suitable role to look at social care data at all, and then retrieves and displays the records about information that a user is allowed to see (e.g. allocations, assessments etc.). The user chooses to look at one of the assessments.

   Process 2 + 3. The system checks its file of current associations (allocations) which is typically always maintained in social care or NHS CRS systems. If there is a direct match between the system user and the service user, and the system user has an appropriate role, then the social care system or NHS CRS attempts to retrieve the actual document, writing a record to the audit file (Process 6). For certain roles, or, inherited associations, the system will still retrieve the document, but may write a flag to the audit file, or prompt the system user to enter the emergency reason for access (again recorded in the audit file (Process 6), but not shown here).

   Process 4. To retrieve the document, the social care system or NHS CRS transmits the URL, and agreed security code, and the user identifier to the document management system, and if these are appropriate, the document management system displays the document to the user (Process 5), and writes a record to the system audit file (Process 6).

2. The second diagram shows how material would be filed away in any system.

   Obviously systems may not have records of all transactions as documents. Simple contact records may be filed in any of the systems, but would not then be notified to other involved parties.

   Process 7. The final copy of the document is filed in the document management system.

   Process 8. Retrieval data (including the URL) for this is associated with a pre-existing record, or, recorded in the social care system. If the document type is appropriate, a record of its existence (including the URL) is also sent to NHS CRS and/or CRMS.

   Process 9. Checking current allocations, both the social care system and NHS CRS may send notifications of the final document to relevant users (based on their files of allocations). These notifications include the URL, and drop the user straight into the first process (at process 3).

The underlying assumption that is made in this picture is that the social care system and NHS CRS will maintain details of current allocations, as separate processes.

There is also an assumption that confidential social care documents will only be retrieved using the security of the social care system or NHS CRS — where a common security model based on material in 730 of the OBS is embedded (this is almost a condition for joining up systems).
1. User retrieves record of assessment in system

2. System checks user rights to view assessment - role + legitimate relationship

3. Data of current "allocations", roles and team relationships

4. Document store retrieves assessment document by URL

5. Document store presents document to user

6. Audit record of access written

7. Document filed in document management system

8. Retrieval data (from metadata, or already part of system) filed in or sent to social care system, ICRS and CRMS

9. Notification sent to people with relevant role in current allocations

Social Care system or ICRS

Yes, System transmits URL for retrieval + authorisation code to Document Store

No - user access declined
Mapping the metadata, so that it can be shared

1. IDENTIFIER - Unique identifier at both object and fileplan (patient) levels. May need LA number, System identifier (URL), person no. May also need a web service to translate different unique person numbers.

2. TITLE - Title given to record, folder or class.

3. SUBJECT - Keywords describing the subject. Possibly service user name – in a standard format.

4. DESCRIPTION - Freetext description of the resource.

5. CREATOR - The person responsible for the content of the resource, normally derived from login information. For purposes of transfer = person responsible at date of declaration (e.g. social worker or team manager – not admin.) In a social services system, typically the assessor for an assessment Note that in an ERMS this may not give the result of assessor, which NHS CRS exchange requires.

6. DATE - A number of dates in the life cycle of the record, including creation, when acquired, declared, opened and closed. This needs to cover the access trail, see comments below. Date declared (should not be used for calculating performance indicators if it comes from an ERMS) is the moment for sharing.

7. ADDRESSEE - The person to whom a record may have been addressed.

8. TYPE - The type of record, this is the level at which the management policy for that record type can be defined. This will include the default record sharing rights. Name of document – needs an agreed lexicon – may need to allow some flexibility “e.g. important transferred SAP document”

9. RELATION - Identifies relationships between records. Typically where one record needs to be related to another record or one record relates to a number of identifiers (patients).

10. AGGREGATION - Used to define where records management is carried out in the information hierarchy.

11. LANGUAGE - The language in which the record is held.

12. LOCATION - The physical location of hard copies, artefacts etc.

13. RIGHTS - The restrictions and permissions on access to view the record. See notes below. This may be a list of teams/people allowed to access, or, roles allowed to access, or, may be just people barred from access (outside standard rules) – sealed envelope style.

14. DISPOSAL - What will happen to the record when disposed.

15. DIGITAL SIGNATURE - Definition still under development.

16. PRESERVATION - How the record has been preserved through its life cycle.

17. MANDATE - The purpose for which the record is held.
Appendix 7: The leaves and stem model of information systems, courtesy John Rowlands, DfES.

Some standard information about each child in a population of children is collected together in an IT system that is represented by the stem. It could be called the spine. The standard information is sufficient to be able to be certain about the identity of the child, where there are other records on the child and what are the rules of access that apply. This is called reference data and access rules and is represented by r1, r2 and r3. The IT support to an IRT system would be this sort of information system. So also would be the spine of the NHS Care Record Service that NHS is developing.

Case records on individual children are represented by the leaves. In this diagram each child has three leaves representing health, social care and education records. These are the working records of agencies and practitioners. Access to these full records will be governed by confidentiality protocols (the rules).

The case records from the three agencies will contain the shared reference data that is used to make up the stem or spine. But these records will contain much more detailed information that is appropriate for the function of the agency and should not be part of a record with common access, for example medical details, personal histories of children looked after etc.
Appendix 8 – Recording practice in Social Care – documents and databases

Background:
Over the past few months as major work programmes have been under way to develop NHS CRS in the NHS, the electronic social care record for local authorities, and specific developments such as the Single Assessment Process for older people, it has become clear that the cultural assumptions around recording practice do vary between partner organisations.

To simplify the positions:

<table>
<thead>
<tr>
<th>NHS, specifically the approach proposed by the NHSIA</th>
<th>Social Care, the approach proposed in ‘Electronic Social Care Record’ definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>All recording practice should be highly structured and handled in datasets, sometimes called minimum datasets. In modern systems this is supplemented by “clinical noting”</td>
<td>Most recording can be typified as a document, generally structured in some form on a template. A small number of core information data items need to be maintained.</td>
</tr>
</tbody>
</table>

It is understandable why we have reached this position:
Social Care is attempting to provide customised services that respect the infinite variety of citizens’ social environments; the diagnostic model is holistic. This is rarely solely driven by a few key issues, but rather a range of interrelated issues. There is little history or practical use for epidemiological analysis of information as the variables are great.

Health has a great history of epidemiological analysis and responses. The success of the diagnostic model, with specific interventions works very well. It is also possible to bring such coded datasets together across many systems.

This does leave a set of interface issues where health and social care come into close co-operative working. It is most apparent in the Single Assessment Process for older people and the Care Programme Approach in mental health.

Why the document approach in social care?

The background suggests why we are in differing positions. This is in effect a descriptive statement of why we are where we are. It does not necessarily justify keeping to these differing emphases. There are very good reasons why the document approach should be retained in respect of holistic service delivery, whether this is in fact provided or initiated via health or social care.

They are:

- **Communication with the citizen** – one of the key factors in assessment systems is the involvement of the public with their own care. This itself is likely to need to be done on a document basis. Traditionally social care uses the same document for record and communication. We would not want to have to create a separate document from the standard recording for public use (e.g. in my healthspace), and it is dubious that the public would understand (or like) material based on a coded system.
- **Understanding** – it is important that both practitioners and citizens understand the information held and how it is used to help them. A document based system is much easier to describe and closer to general knowledge and understanding (e.g. filing cabinet analogies).
- **Easier to train** – most workers can easily handle documents as forms to be completed, training in a database is generally difficult, especially difficult where short-term contract staff are employed. It is even possible to resort to low-tech (but cheap and effective) paper forms, which can be scanned. Workers with “people” oriented skills frequently find database style training difficult (and alien) to understand.
- **Practitioner resistance** – for many reasons (but mainly high effort for low returns), it is not easy to get practitioner buy-in to computer systems. The simpler the system, the less likely the failures that litter our past.
• **Costs** – It is cheaper to develop a template with some data items on it than a complete data driven system. Every field costs money and adds to system complexity, which in turn costs even more.

• **Flexibility** - Changes and modifications are generally easier, cheaper and quicker to introduce. Local branding for local authorities is possible. This is particularly valuable in areas of practice that are still experimental (like SAP) and helps practitioners “own” systems.

• **Correct information** – a document is a statement of information known or believed at a point in time, accuracy is more clearly defined. Even seeming facts like gender can change over time, and analyzing such material in a time oriented database for epidemiological reasons can be a nightmare.

• **Information sharing** – The technology to share documents is already in place with virtually all organisations, including private and voluntary sectors in that email can transfer it, or the internet provide access to it. The technical protocols for exchange are all in place; the security layer in terms of encryption is fairly easy to introduce.

• **Systems investments** – NHS CRS accepts that document management, if only to handle external correspondence, is needed. So document systems need to be in place anyway, so we are here looking at exploiting necessary systems, rather than additional investments. It appears that the systems investment for most local authorities would be of the order of £500k at a maximum, thus c£75m of capital investment across England.

• **Lack of adequate codification** – the wide variety of interacting problems in the sphere of combined social and health care has not yet been adequately codified. Some professions even see such codification as diminishing the individual approach. Until agreed codifications have overcome such professional resistance (and can be sold to service users), we would be jumping the gun to implement them. It is difficult to see the business justification for replacing the text with codes, when most of the professionals involved are actually used to textual material for the overlap of health and social care (they send one another letters or talk). Coupled with this lack of codification, the model of social care, where multiple interacting needs are tackled with multiple interacting services for multiple outcomes does not lend itself easily to the epidemiological approach that has justified it in health.

In summary the document approach keeps it simple, accessible to users and most of the public, and affordable.

**What impacts does this have for NHS CRS?**

It is widely accepted that for key services, such as SAP, content, or access to content needs to be posted on the NHS spine. Some modeling has already taken place on the messages that need to flow to and from the spine in respect of SAP. This handles a mix of content formats, some being in a formal minimum (albeit with 300+ data items) dataset as may be produced by health colleagues, while other content is in the form of documents.

The key element to make this work is an agreed lexicon of form names so that all users of the spine broadly know what to expect when they open a document called a ‘Summary Assessment’, or whatever the finalised term is.

It is worth remembering that for a patient/service/citizen centric record no data analysis is needed at all. The record viewed is that for the individual, and would display on a form, image or document. The key issue is that whoever is viewing the record knows what they are looking at, and how up to date it is. We do not even need precise format for this content that can vary according to changing practice, as long as the practitioner and citizen can understand it.

The same models apply for recording that links with other key spines of information, such as the IRT spine for children, and citizen spines that support local authority call centre systems. It may have general applicability to all systems where a lengthy needs or risks driven assessment process is the heart of practice.
Appendix 9 – ESCR implementation Support Programme, initial listing, to be updated as work develops

Note: numbers relate to paragraphs in the main definition document.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Suggestion as to how it might be handled.</th>
<th>CSSRs, organisations, suppliers, People involved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BUILDING AN IMPLEMENTATION INFRASTRUCTURE</strong> <em>(see also Benefits – next section)</em></td>
<td><em>This includes both development of ‘essentials’ within CSSRs in order to implement ESCR when capacity may be low, and also structures between CSSRs, within LG, and between SC/LG and Government which are essential for knowledge and learning to be shared so that as much cost-effectiveness as possible is generated</em></td>
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</tbody>
</table>

Many ways of developing the Implementation Plan rely upon picking up on projects and ‘what works’ through regional IMGs and other sources, and packaging this for local use. This will not be repeated for each strand of work.

**Local ‘essentials’**

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Social care cultural issues, developing a sufficient ‘information culture’</td>
<td>Working with all professional and management communities relevant to CSSRs (ADSS, GSCC, LGA, BASW, SCA etc.) Working with SCIE through Knowledge Management routes</td>
</tr>
<tr>
<td>Developing IM&amp;T skills and competencies</td>
<td>Working with Local Government and NHS agencies Consider options for best investment (e.g. ECDL roll-out)</td>
</tr>
<tr>
<td>Training programmes, what is needed to get the messages across on a continuous basis</td>
<td>IPU-SC to sponsor a series of roadshows for local authorities. Work with education &amp; training groups (SW Review, SCIE,</td>
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<td>TOPSS, NATOPSS etc.)</td>
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<td>----------------------</td>
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<tr>
<td>Data accuracy, developing insights into best practice</td>
<td></td>
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<tr>
<td>Ensuring accuracy when information comes from multiple sources, resolving contradictions</td>
<td></td>
</tr>
<tr>
<td>Linking with national datasets and authentication programmes.</td>
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</tr>
<tr>
<td>Citizen’s systems in local authorities, relationship with ESCR, see para 7.16</td>
<td></td>
</tr>
<tr>
<td>Reviewing business processes</td>
<td></td>
</tr>
<tr>
<td>Develop work from process mapping demonstrator project, MAPSS, and other tools to assist CSSRs</td>
<td></td>
</tr>
</tbody>
</table>

**Intermediary structures**

| Establish and/or service Regional IMGs or other relevant bodies |
| Ensure linkages of IM&T issues locally/regionally to practice and management agendas |
| Discuss with ADSS and LGA how to do this. Also seek participation from professional groups – IM&T (SOCITM, ASSIST etc.) as well as Social Care (BASW, SCA etc.) |
| Set up websites and pages as relevant |
| Regular postings re. Implementation Programme to be made available on selected websites. Making relevant tools available |

**DEVELOPING BENEFITS FOR**

_This is specifically about the ‘people groups’ who will be..._
<table>
<thead>
<tr>
<th>STAKEHOLDERS</th>
<th>users, beneficiaries, developers, managers of electronic social care records and their contributions to good practice and service-delivery.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparing briefings to engage relevant stakeholder groups including</td>
<td>Programme management function, involving sub-project ‘leads’ as required. Bring together and utilise materials already available, e.g.</td>
</tr>
<tr>
<td>• Front line workers and</td>
<td>• Gloucestershire presentation</td>
</tr>
<tr>
<td>• Service Managers (of the various care groups)</td>
<td>• East Sussex work</td>
</tr>
<tr>
<td>• Strategic managers and Directors</td>
<td>• IfSC demonstrators</td>
</tr>
<tr>
<td>• IM&amp;T managers &amp; staff (inc. corporate staff)</td>
<td>• FAME work</td>
</tr>
<tr>
<td>• Information governance staff</td>
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<tr>
<td>Raising awareness of NHS CRS, and getting LA buy-in to a Social Care strategy towards NHS CRS</td>
<td>Briefings and presentations based on London NHS CRS and allied work.</td>
</tr>
</tbody>
</table>

**SPECIFYING TECHNICAL REQUIREMENTS AND DEVELOPING STANDARDS**

- Assumed that this is led by Programme Management, with significant input from CSSR and SC/LG community
- Standards, both technical and operational, for handling messages and alerts. It is expected that this will be the main form of communication between organisations and systems, whether statutory, private or voluntary sector. These flows to
- Links with NHS CRS and IRT projects, and ‘what works’ through regional IMGs
<table>
<thead>
<tr>
<th>Task</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree with NHS CRS a common lexicon or set of roles</td>
<td>Based on work in London through secondment to project, liaison with similar work in other clusters</td>
<td></td>
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<tr>
<td>Date stamping records, impact on service delivery</td>
<td></td>
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<tr>
<td>ERMS fileplan development</td>
<td>Joint work between leading CSSRs and the National Archive</td>
<td></td>
</tr>
<tr>
<td>Consent &amp; Confidentiality model, testing out practical implications, appendix 3</td>
<td></td>
<td>IPU-SC possibly to commission work from Peter Ashe</td>
</tr>
<tr>
<td>Managing withheld consent from specific bits of information, data or text</td>
<td>Inc in above work,</td>
<td>IPU-SC to commission work from Peter Ashe, based on ERMS standards</td>
</tr>
<tr>
<td>Development on ERMS model as they affect access information and audit trail of records accessed and reasons</td>
<td>Joint work between leading CSSRs and the National Archive</td>
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<tr>
<td>Document management options</td>
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<tr>
<td>Scoping volumes of paper for scanning etc.</td>
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<tr>
<td>Determining impact on local infrastructure and equipment requirements</td>
<td></td>
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<tr>
<td>Impact on (and of) mobile working practices</td>
<td></td>
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<tr>
<td>Legal standing of documents</td>
<td></td>
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<tr>
<td>e-gov/corporate fit</td>
<td></td>
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</tr>
<tr>
<td>Develop list of standard documents, 5.5, and</td>
<td>Collate material from IMGs, establish IPU-SC role in defining national document set.</td>
<td>Mike Custance to do an initial submission to both</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Preparation for Information Standards Board (cross-refer to e-Standards Body for local government)</th>
<th>To consider the early submission of the core information requirements.</th>
<th>Standards boards covering LACS, and ICS as its successor; the care plan and assessment as defined in RAP with a view to a follow up with review and referral shortly after.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continued core information requirements development, including agreeing with information standards boards</td>
<td>IPU-SC work with local government and NHS information standards boards</td>
<td></td>
</tr>
<tr>
<td>Data Protection and Freedom of Information implications, 6.8</td>
<td>IPU-SC work with Information Commissioner and NHSIA</td>
<td></td>
</tr>
<tr>
<td>Authentication of citizen access, 6.7</td>
<td>IPU-SC work with Government Gateway and NHSIA</td>
<td></td>
</tr>
<tr>
<td>Authentication of identity, is this really who they say they are</td>
<td>IPU-SC links with DWP model</td>
<td></td>
</tr>
<tr>
<td>Security standards (across all personal local services) advice and development to meet ISO17799/BS7799</td>
<td>Risk assessment (CRAMM) model already available.</td>
<td></td>
</tr>
<tr>
<td>Encryption, developing standards that all partners can use, esp. private and voluntary sector</td>
<td>IPU-SC work with NHSIA, links with UK Information Assurance and Critical National Infrastructure developments.</td>
<td></td>
</tr>
<tr>
<td>Corporate v specialist systems in document management, including building interfaces</td>
<td>Mainly through system user groups, but some IPU-SC input with suppliers</td>
<td></td>
</tr>
<tr>
<td>Rules on audit and length of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time audit trails are retained</td>
<td>Record retention and NHS CRS, harmonising dates and practice, 4.9</td>
<td>Records Management Society</td>
</tr>
<tr>
<td>Disposal policies, and archiving</td>
<td>Picking up on projects and ‘what works’ through regional IMGs</td>
<td></td>
</tr>
<tr>
<td>Transfers of records between CSSRs</td>
<td></td>
<td>Develop outputs from ELSID project at Hammersmith &amp; Fulham</td>
</tr>
<tr>
<td>Information Sharing protocols, continued input, and evolution of standards</td>
<td>Major work stream for Information Governance. IPU-SC work with NHSIA, suppliers and other partners</td>
<td></td>
</tr>
<tr>
<td>Risk assessments around information sharing</td>
<td>Disseminate legal precedence and advice, IPU-SC</td>
<td></td>
</tr>
<tr>
<td>Managing multi-agency shared systems, implication for Data protection</td>
<td>IPU-SC work with Information Commissioner</td>
<td></td>
</tr>
</tbody>
</table>

**PROGRAMME MANAGEMENT**

Considerable network management will be required, as well as sub-project management. Some of this will best be carried out from the IPU-SC – some might best be carried out through ADSS IMG and related networks. But it will all need to be brought together.

Assessing and managing ‘drivers’ for implementation – especially ‘benefit’, but also money and targets

Pull together required resources

Gather working groups as
<table>
<thead>
<tr>
<th>required</th>
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<tbody>
<tr>
<td>Specify requirements for sub-projects, and assign/gain permission for project ‘leads’</td>
<td></td>
</tr>
<tr>
<td>Working with software and services suppliers to CSSRs where national work gains cost-effectiveness and synergy</td>
<td>Liase with system User groups and CSSR specialists</td>
</tr>
<tr>
<td><strong>Ensuring all required linkages</strong></td>
<td></td>
</tr>
<tr>
<td>Clarifying and organising all ‘management involvement’ – e.g. DfES, NpfIT, ODPM</td>
<td></td>
</tr>
<tr>
<td>Links with NHS CRS, notably information governance and information exchange. Section 7</td>
<td>Based on work in London through secondment to project, liaison with similar work in other clusters</td>
</tr>
<tr>
<td>Links with IRT</td>
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<tr>
<td>Links with FAME</td>
<td>Liaison with involved local authorities</td>
</tr>
<tr>
<td>Links with ICS development</td>
<td>Work with DfES on the implementation of the recording practice.</td>
</tr>
<tr>
<td>Links with SAP developments</td>
<td>Work with DoH policy team on the implementation of the recording practice.</td>
</tr>
<tr>
<td>Disseminating best practice</td>
<td>Picking up on projects and ‘what works’ through regional IMGs</td>
</tr>
<tr>
<td>NSF and other NHS developments,</td>
<td>IPU-SC work with NHSIA, supported by input from CSSRs.</td>
</tr>
<tr>
<td>Managing draft materials, develop guidelines, 4.7</td>
<td>Picking up on projects and ‘what works’ through regional IMGs</td>
</tr>
</tbody>
</table>
Appendix 10 - Methodology of the ESCR project

This paper has been developed with the assistance of many colleagues throughout the Information Management Community in Social Care.

The project has been sponsored by the ADSS Information Management Group, chaired by Colin McKinless, Director at Tameside, and the Information Policy Unit - Social Care (SCIPU) at the Department of Health, led by Roger Staton.

A project group comprising, Roger Staton from SCIPU, Lisa Nuttall - Dorset, Peter Coates - Sunderland, Alan Burns - Newcastle upon Tyne, Sally Wilson - Stockport, Tony Ellis – Hammersmith & Fulham, Alan Miles – Gloucestershire, and Michael Custance - Hackney oversaw this work.

Presentations were made to regional information management groups throughout England, as well as major system user groups. Public consultation took place between June and September 2003. During which period all known system suppliers were contacted as well as all English local authority CSSRs plus a number of other key stakeholders. A presentation was made to c40 representatives of system suppliers in September.

About 50 local authorities responded either directly or via regional groups. In addition comments have been received from suppliers, specialist groups and others. Special thanks are given to Scottish and Welsh colleagues for their observations and input. Significant input was also received from the National Archive, the NHS Information Authority and the Design Authority, as well as the London NHS CRS team.

All the comments were reviewed by the project group, and they informed the reworked final draft.