REVIEW OF INFORMATION SHARING ACROSS LANARKSHIRE

AND THE eCARE FRAMEWORK

April 2012

INTRODUCTION

1. Lanarkshire's initiative to share patient/client information between agencies is a success.

2. That's the conclusion drawn from this exercise based on interviews with staff at all levels from key partner agencies, written submissions, a small number of scenarios/case studies and statistics.

3. Why? See below for more details, but for six simple findings on what has underpinned their success:

A. Realised that this is not about IT. It's about improving their services

B. On that basis, secured senior management commitment to advancing a far from easy cause

C. On that basis, inspired the operational managers and practitioners to make difficult changes

D. On that basis, invested continually in staff support, from fresh mindsets through revised working procedures to using technology often for the first time (and in that order)

E. On that basis, clear acknowledgement that IT has limitations. At the heart of joined-up care are trusted professional relationships. Don't even consider communicating complex patient/client contexts by electronic means. Pick up the phone to the colleague you know, or wait till the next team meeting

F. On that basis, ensured that IT developments are focused on adding value to delivery of services and business led, with practitioner at the heart of developments and re-design

4. And two other important things are increasingly evident:

- If information sharing is in the interests of patient/clients and improved services, there has to be a good reason <u>not</u> to share. Which is a somewhat different mindset to security threats, confidentiality obstacles, silo ownership and sanctions.

- While tackling variability between working practices and procedures is key, you need to be pragmatic about such things. Don't let the best be the enemy of the good

5. Things are however not perfect, and neither would Lanarkshire claim that. Nevertheless they have solid foundations upon which to build and eCare is increasingly becoming business as usual.

Issues for Consideration Going Forward

6. The purpose of this exercise was to describe Lanarkshire achievements, however in carrying out the work we have identified a small number of issues which the Partnership may which to consider going forward. They are:

- Extending the Partnership to include Fire and Rescue Services and the Third Sector

- Cross border electronic information sharing with neighbouring agencies

- Whether or not this is right model for Lanarkshire for the long term?

- Access to information about the DSP and the eCare IT

BACKGROUND

7. Over many years partnership working in Lanarkshire has been a key strength across the partner agencies leading to substantial investment and resource allocation. From the outset the eCare developments have been driven by improving outcomes for patients/clients with the focus being the policy context and the business requirements as opposed to being IT led. This has been accompanied by an overarching vision, innovation, trust, a small number of visionary people and commitment from all the key partners to develop a robust and safe information sharing infrastructure: the eCare Framework.

Lanarkshire Data Sharing Partnership

8. Lanarkshire Data Sharing Partnership (LDSP) was established in 2006 and tasked with Single Shared Assessment and Child Protection messaging. It replaced the Joint Working Across Care Agencies Group established in 2002. This group was responsible for the sharing of older people and adult information i.e. Joint future Agenda and Community Care Act requirements, sharing demographics, assessments/plans, contact and service provision details and service requests for homecare and aids and adaptations. The Children's eCare Project was established in 2004. Its remit was sharing children's information and creating and implementing the child protection messaging, linked child protection children and linked child protection adult messages. Annex 1 contains a summary of the Lanarkshire eCare journey (so far) 2002 to 2012.

9. The population of NHS Lanarkshire is around 557,000 and it is estimated that the Board has around 10% cross border traffic. The Board has 3 main hospital sites (Wishaw, Hairmyres and Monklands) with three A&Es and the full range of adult and children's services. The Board also has around 100 GP Practices, and delivers services at Stonehouse Hospital, the David Matthew Centre and Coathill, Wester Moffat, Udston, and other associated Hospitals and Centres. The combined population of South and North Lanarkshire is around 629,700.

10. The Data Sharing Partnership (DSP) is committed to developing the Lanarkshire eCare Framework. The partnership comprises:

- North Lanarkshire Council – Housing &Social Work, and Leisure and Learning (nurseries and schools)
- South Lanarkshire Council – Social Work, Education and Housing
- NHS Lanarkshire – Primary Care, Acute Care (including A&E), GPs[1] and Out of Hours
- Strathclyde Police – N & Q Divisions
- The Scottish Children's Reporter Administration

[1] Currently piloting access to messaging in INPS Vision

11. North and South Lanarkshire Councils (Social Work/Government and Service Departments) and NHS Lanarkshire provide the funding for the DSP. Funding for 2012 is some £225K and covers the costs of the LDSP Manager, the LDSP Secretary, two permanent eCare Framework posts, the annual support and maintenance costs of the eCare IT and new eCare development work (agreed and contained in the LDSP's Work Plan – see Annex 1 and 2 for details). It excludes what the two Councils and the Health Board spend on funding developments to their host IT systems and what all the partners spend on Information Sharing Protocol and eCare training and practice change/development.

12. North and South Lanarkshire Councils have had the in-house IT applications and capabilities to undertake substantial incremental developments to their IT systems to meet their business requirements. NHS Lanarkshire has also been able to implement IT solutions that have enabled its existing and new IT systems to deliver the DSP's priorities over the years and connect to the eCare Framework.

13. The partnership is accredited as being most mature DSP in Scotland and was the first to:

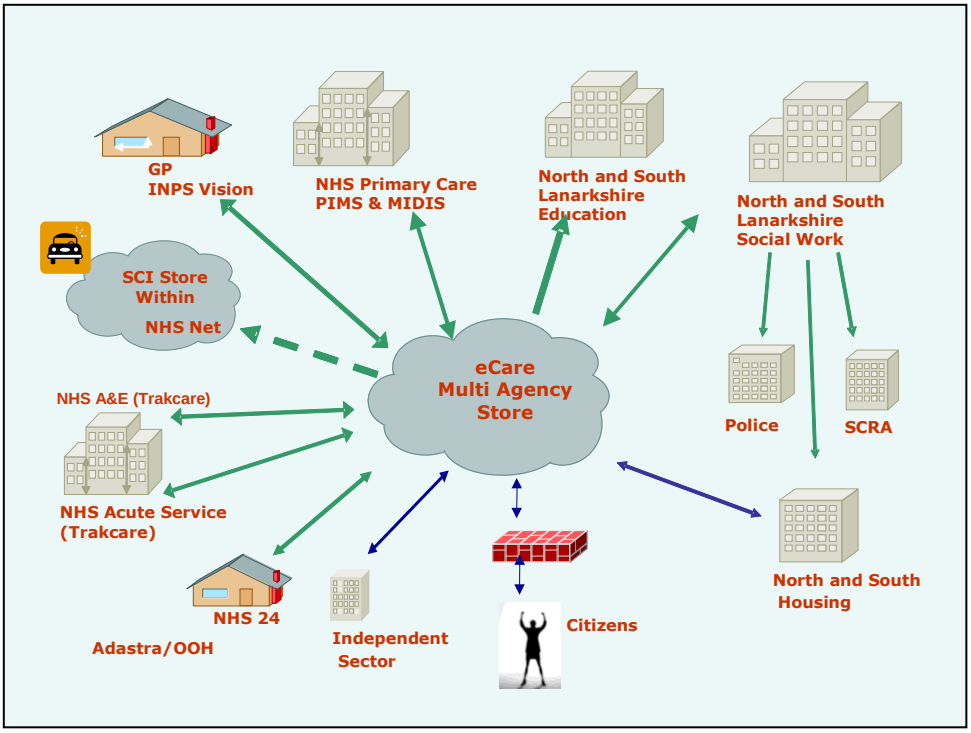
- have an operational eCare Framework
- share Single Shared Assessment (SSA) & Ordering service
- Child Protection, Adult Protection and Pre birth Concern Messaging
- have eCare supporting GIRFEC components

14. The DSP reports to and receives the business requirements from the Children's, Adults' and Older People's Partnership Boards, the Children's Service Strategy Groups, the Child Protection and Adult Protection Committees, and the GIRFEC Programme Executive.

eCare Framework

15. The eCare Framework encompasses the IT infrastructure, systems, linkages, policies, procedures and policies which deliver safe information sharing across Lanarkshire. It has grown pragmatically and incrementally, and will continue to evolve over the coming years.

Diagram 2: The Lanarkshire eCare Framework Model (May 2011)



- Social Work South Lanarkshire **SWIS plus** and North Lanarkshire: **MySWIS -** are both two way connections. Further development to share and view children's GIRFEC components and the new consent model.

- NHS Lanarkshire Community Health Nurses and other identified staff: **PIMS** system - two way connection replaced with **MIDIS.** Further development to MIDIS to share and view children's GIRFEC components and the new consent model **MIDIS**

- Education (North and South Lanarkshire): **SEEMIS** - Viewing Child Protection Messaging and further development to share and view children's GIRFEC components and the new consent model.

- NHS Lanarkshire: A&E and Acute Services: **Trakcare** (March 2011) **-** to view Child Protection Messaging, Adult Protection, Pre birth Messaging and shared care information

- GPs: **INPS Vision** - pilot of Child Protection, Adult Protection and Pre birth messaging and shared care information is near completion. Roll out April 2012

- Out of Hours: Adastra (April 2011) – delivers Child Protection Messaging to Out of Hours. Further development for Adult Protection and Pre birth concern Messaging

- Strathclyde Police N & Q Divisions and Housing in North and South Lanarkshire – interim solution to provide Child Protection, Adult Protection and Pre birth messaging and agreed data sets via direct line, and role maintained access to social work applications

- NHS Lanarkshire – Assessment server and forms creator creation of SSA or other forms used by NHS Lanarkshire.

16. The eCare Framework currently includes: all alert messaging, community care older people and adults information sharing and children's information sharing. It also allows the

sharing of individuals' demographic information from social work, health and leisure and learning. Professionals are able to view any difference (e.g. first name) and who is the GP, what professionals are involved, who are the carers etc.

The eCare Index

17. The eCare Index automatically matches all people in partners' host systems (using name, date of birth, address and gender) against the Community Health Index (CHI). The index is a series of numbers: CHI, social work, mySWIS identifying number, Leisure and Learning/Education SEEMIS identifier and NHS Lanarkshire identifier. The index is automatically updated when new patients/clients are entered on a partner's host IT system (Automated Matching Application). Some manual intervention is undertaken (using the Management Application) for the most vulnerable individuals and children, which accounts for some 4%. This ensures that all individuals in the eCare system have a single shared identity which in turn ensures that the right information is shared with the right person. It was the requirement locally for a robust indexing system that enabled Lanarkshire to develop the original eCare solution which led to eCare developments nationally.

eCare Messaging

18. In Lanarkshire, **Child Protection Messages** are generated by social work and are shared via the MAS. There are six types of message:

- Investigation
- Investigation and on the CP Register
- Registration
- Past activity
- Linked child
- Linked adult

19. These messages are viewed by all Social Work staff, NHS Lanarkshire, Education and Leisure and Learning schools and nurseries, Strathclyde Police, by Out of Hours staff, identified housing staff in South and North Lanarkshire and Q & A staff in South Lanarkshire. Child Protection messages persist until a child's 17th birthday and are then removed from the MAS. The messages are an aid and prompt to Practitioners/Agencies to sharing information and they are embedded in and support Child Protection procedures. The acknowledgement on the message has to be clicked to close and move past this message, this creates an audit trail. A protocol is in place for each service/organisation that has access permission.

20. An alert is written to and persists as part of the child's record on each host system. This alert is viewable by any user of the system who may encounter the child. The alert is presented in the form of an icon or a banner. A notification is also generated and delivered to all appropriately involved professionals to inform them that new or additional information is available that may require action on their part.

21. The shared message is viewed from the host application by clicking on the alert icon or the eCare link. The user must acknowledge viewing the message and this creates an audit trail. On viewing any child protection message (or linked adult/child, or an adult protection or pre-birth concern message) the practitioner uses their professional judgement and their knowledge of the child, family or adult to take one of the following actions and record them in their own system/records:

- Action – contact and share information with Social Work

- No further action e.g. staff may be fully update with status and circumstances, or have attended a recent case conference and have no new information or concerns to share with social work

Quote from a paediatrics nurse: All children are checked on admission to Children's Wards and this alerts is immediately of any child protection issues. This information is invaluable as many of the children have a short stay in the ward.

22. **Linked Child/Adult Messages** are generated when a child or adult has a defined relationship and or living arrangement i.e. living at the same or at a different address. Adult's relationships: Parent, Parent's Co-habitee, Partner, Step parent and all child relationships. The linked message will indicate:

- The name of the child they are linked to
- The relationship with the child
- Lives at the Same Address
- If the Child Protection Activity is current or past

23. Additional information is also provided by North Lanarkshire Council, i.e. Primary Carer, Carer, Legal Responsibility.

24. To illustrate the use that is made of alerts/messaging across Lanarkshire and the use that is made of the MAS, the table below contains details of the number of children/adults in Lanarkshire with Child Protection alert messaging in 2011. The number of Child Protection Messages generated and shared to date is 19,0572[3].

Persons (Children/Adults) with CPM from Social Work (North and South Lanarkshire) to MAS Jan to Dec 2011	
Child Protection Messages	**People**
Past Activity ceased on	1091
Registration	439
Investigation (Message 1a)	965
Investigation with Registration (Message 1b)	119
Linked Adults (aged 17+)	3902
Linked Children (aged 16 or under)	2654
TOTAL	***9170***

Scenario 1: A family case study
Tommy and his former partner have a daughter Susan (Age 13) from their previous relationship. Susan lives at another address with her mother and her mother's new partner. She has had previous Social Work contact and past child protection activity**.** Tommy's new partner, Jane, has two children from a previous relationship (Peter age 5 years and Brian age 1).

While changing for P.E. bruising is observed on Peter's arm and back. Peter's Primary School makes a Child Protection Referral to Social Work. Following initial enquiries by Social Work, including enquiries about Tommy's previous relationship and his daughter, the decision to instigate a Child Protection Investigation is made by the Senior Social Worker and is recorded immediately in the Social Work electronic system. The start date of the Child Protection Investigation generates the **Child Protection Investigation Messages** for Peter (subject to a child protection investigation) and Brian (a sibling of Peter subject to a child protection investigation). It also generates all linked child and linked adult

[3] Number of messages and updates to messages e.g. a new address update for a person with a message counts as generating a new message for this person.

messages. The Health visitor for Brian receives the **Child Protection Investigation Message** for Brian followed by a **linked child message** linking Brian to his sibling Peter and to Susan. The Social Worker based in the Justice Section, receives the **Linked Adult Message** in respect of Peter and Brian. The worker was unaware that Tommy had changed address and moved in with a new partner (Jane) and her children (Peter and Brian). In addition to the past child protection message already in place for Susan, the High School Nurse for Susan receives a new **linked child message**. At the Initial Child Protection Case Conference both Peter and Brian's names are placed on the Child Protection Register. Social Work input the date of registration. The message status for Peter and Brian is updated to **Child Protection Registration**. The Primary School and the Nursery authorised staff for Peter and Brian receive the **Child Protection Registration** message. They also receive a text message on their mobile phones notifying them that a Child Protection Message awaits them. Eight months later a Review Child Protection Case Conference concludes that the risk to the Children has diminished. Tommy has moved out of the household he and Jane have separated. The Children's names are removed from the register.
The message status for Peter and Brian is updated to **Past Child Protection Activity** i.e. Child Protection Activity ceased on (date).

Quote from a Housing Officer: '' A woman fleeing violence placed in temporary accommodation over the weekend presented at the Housing Office on Monday. I immediately received child protection and linked adult messages when I checked the system. I contacted Social Work and a quick response and support was initiated''

Quote from an A&E team member: "A woman who arrived in A&E with a heroin overdose was immediately identified as the primary carer for a child with current child protection activity. This critical information would not otherwise have been known"

25. The **Pre Birth Alert Message** is generated by Social Work when pre birth concerns have been identified and a decision has been made to hold a pre birth case discussion as per the Child Protection Procedures. It is attached to the Mother's identity. Pre birth alert messages remain viewable via the MAS on the pregnant woman's record until either:

- The Senior Social Worker/Social Work Team Leader along with other agencies agrees the alert is no longer required
- The child is born: the pre birth message is removed from the mother's identity and child protection procedures are instigated for the child
- The child is born: no further actions are to be taken under the Child Protection Procedures for the child.

26. Messaging in Lanarkshire was evidenced in a recent HMIE Joint Inspection of North Lanarkshire as one of the factors that was contributing to improved services for the protection of children and young people. A copy of the report can be accessed at http://www.hmie.gov.uk/ViewEstablishment.aspx?id=11858&type=12

27. **Adult Protection Messages** have been developed to support the Adult Support and Protection (Scotland) Act 2007. There are 3 types of message:

- The person is subject to an investigation
- The person is subject to an adult support and protection plan (see example below)
- Adult protection activity for this person ceased on (date).

28. To illustrate the numbers involved and use that is made of the MAS in any one year, the table below contains details of the total number of Adult Protection Messages generated and shared in 2011[4].

[4] Number of messages and updates to messages e.g. a new address update for a person with a message counts as generating a new message for this person.

Persons with APM from Social Work (North and South Lanarkshire) to MAS 10th Jan to Dec 2011	
Messages	**People**
DATA TAKE ON 10/01/11 AP activity ceased on date	90
DATA TAKE ON 10/01/11 Subject to adult protection plan	26
DATA TAKE ON 10/01/11 Investigation	128
DATA TAKE ON 10/01/11 Investigation with Protection Plan	7
LIVE FROM 11/01/11 AP activity ceased on date	268
LIVE FROM 11/01/11 Subject to adult protection plan	77
LIVE FROM 11/01/11 Investigation	287
LIVE FROM 11/01/11 Investigation with Protection Plan	4
TOTAL	***887***

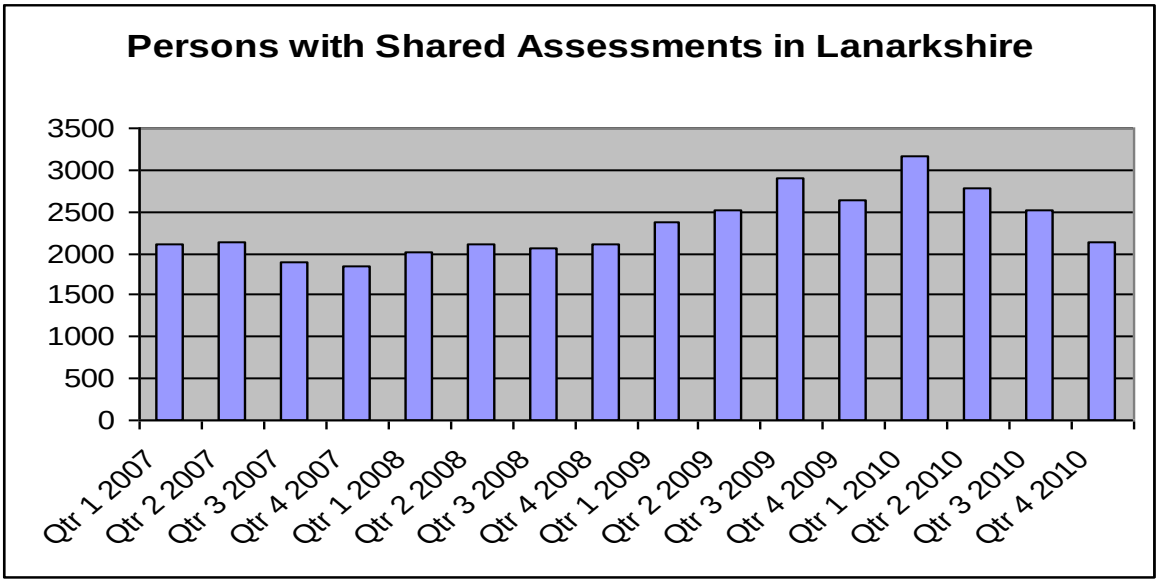
29. These messages prompt practitioners to share information. The messages persist for 3 years from the AP activity ceased date and are then removed from the MAS.

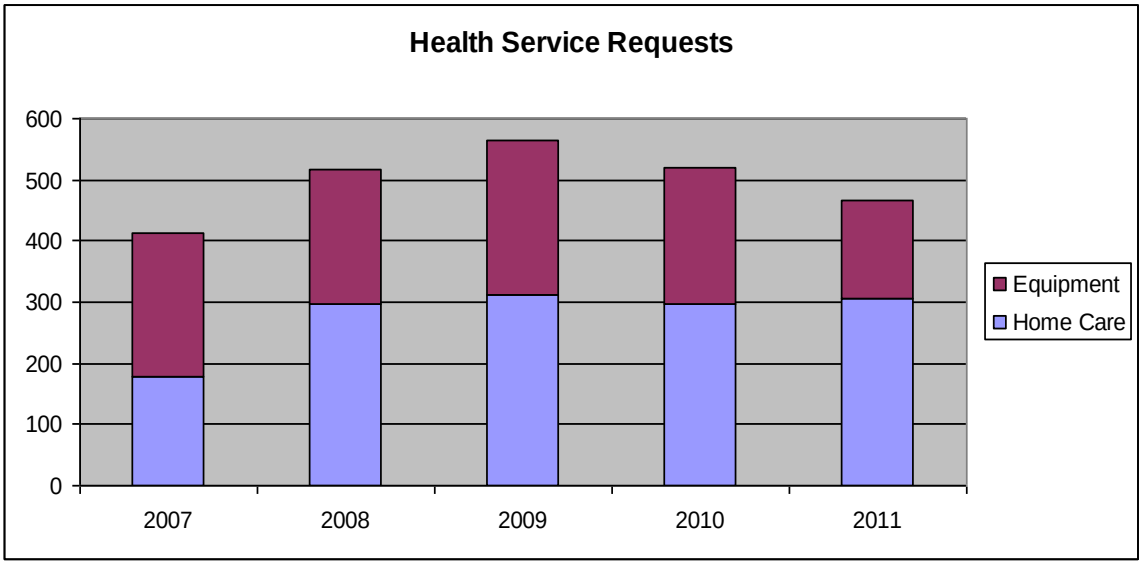
Scenario 2: A man was taken to A&E in police custody, he was unable to speak or give a personal history. When the A&E nurse clicked on the eCare icon in Trakcare and viewed the adult protection alert message, A&E staff were able to establish through sharing information with social work that the man had a significant package of care and support. The police withdrew and the patient was treated and assistance as per his plan was initiated and he was discharged. This outcome would not have been possible before eCare adult messaging.

Shared Assessments

30. Shared care information in the eCare MAS for all Adult Care Groups and Older People includes assessments, plans, contacts, service provision and service requests. Within hospitals, the ability to access shared information reduces the need for staff to contact Social Work in the first instance to established Allied Health Professional (AHP) input, home and environmental assessments, aids and care packages. It also significantly reduces the time taken to gather information from families on GP, Care Manager and Social Worker contact details and to gather a full picture of patients' circumstances. This has led to reductions in hospital stays for a number of cases.

31. Demographics, associated professionals, carers, SSAs, outcome plans, service orders, contacts and service provision are shared and viewed by community based Social Workers and health professionals working together or in integrated teams e.g. Integrated Day Services in Coatbridge. The practice of one agency completing assessments, plans and ordering services etc. on behalf of both agencies is supported by the Lead Professional Protocol. Staff receive notifications of new shared information to view via the MAS. The graphs below shows the total number of Persons with electronic Assessments shared by social work (North and South Lanarkshire) and health from 2007 and the number of electronic requests for homecare equipment made by health practitioners in North Lanarkshire. The latter has been a tremendous benefit to both patients and staff, and has incentivised health practitioners to use the electronic system.





Scenario 3: Mrs. B, a 67 year old lady, presented at A&E following a fall and was transferred to the ACE Unit. Although unharmed and physically well, the lady appeared confused and initial assessment revealed cognitive impairment, resulting in concerns regarding discharge. Using eCare the Doctor responsible for her care was able to access a recent and ongoing Social Work assessment, contact her allocated worker and prevent an unnecessary admission, while facilitating the ladies return to her own home.

Previously, this would have necessitated admission while information was gathered and had the potential of increasing Mrs. B's level of confusion due to the unfamiliar environment and the stress associated with hospital admission.

Scenario 4: Mr. C was admitted to COE after being found wandering in the street at 2am by the police. His daughter was visibly distressed and stated that she was no longer able to cope with her father and would need nursing home care for him. Having accessed eCare the multidisciplinary team were aware that when diagnosed with Alzheimer's 5 years previously an assessment had been carried out and the daughter had not required home care services at that time, as Mr. C was coping well. The team were therefore aware of the reasons for Mr. C's daughter's distress and were able to supply information to allow them to make an informed choice regarding future care more speedily.

This reassured his daughter, reduced her anxiety and facilitated Mr. C's return home with the appropriate services to support them both.

Previously, a social work referral would have been made and the patient would have been seen by an allocated Social Worker, followed by feedback to those responsible for Mr. C's care. This would have caused a delay in the above outcome while adding to the distress of his daughter.

Lanarkshire's Information Sharing Protocol

32. Lanarkshire's revised (and current) Information Sharing Protocol (ISP) was published in 2007 with additional partners and supporting materials (The Obtaining Consent – Good Practice Guidance, consent form, adult and young people's leaflets, training DVD and manual). A new parent and carer's leaflet and the revised consent form are being published. The ISP multi agency training programme is based in localities across Lanarkshire. Copies of these publications can be found at:
http://www.northlanarkshire.gov.uk/index.aspx?articleid=11712 and
http://www.southlanarkshire.gov.uk/downloads/download/427/the_lanarkshire_information_sharing_protocol

GIRFEC

33. Lanarkshire is a Learning Partner with the Scottish Government, and the Lanarkshire Getting It Right Programme Executive is leading on this. The cultural, system and practice change programme and the paper testing and evaluation (2009-10) captured the pathways and business requirements and the DSP secured funding in July 2010 to develop the GIRFEC components on agencies' host IT systems and to share between Health, Social Work and Education. The IT work commenced in 2011 and continues in 2012 to complete the first phase, the GIRFEC Consent Model, Single Agency Chronologies and the Integrated Chronology these developments will be followed by the Child's Single Agency Wellbeing and My World Triangle Assessments and Plan, the Integrated Assessment and Plan and the Request for Assistance.

EHEALTH EXERCISE: FEBRUARY 2012

Methodology

34. The eHealth Strategy & Policy Branch in the Scottish Government's eHealth Division undertook a brief study of LDSP and its eCare IT during February 2012. Information was gathered on both the DSP and the Framework, and interviews were conducted with 16 staff over two weeks from the key partner agencies, with a further three individuals submitting written submissions to the interview questions. See annex 3 for a list of people who were interviewed and/or submitted written responses. A summary of the conversations which took place is provided in Annex 4.

Discussion

35. Other parts of Scotland don't have the 'luxury' of 10 years starting from now to get to where Lanarkshire is today. So, what can others learn from Lanarkshire and its eCare journey and how can that learning inform others, accelerate the pace of eCare developments elsewhere and drive greater support for information sharing and enable greater health and social care integration?

36. And, what of Lanarkshire's 10 year eCare 'journey'? The majority of practitioners we spoke to thought that the journey itself had been valuable and had they had 'their time over again' they wouldn't have changed a lot. The journey was a 'learning experience' and going

through the journey together fostered improved multi-agency working and embedded collaborative working practices.

Lanarkshire realised that this is not about IT, but improving services

37. Lanarkshire acknowledges that IT has limitations. At the heart of its eCare IT are numerous trusted professional relationships, and it is clear from our work that practitioners across the agencies value these relationships and could not, would not, function effectively without them. Interviewees stressed the importance of telephone conversations and regular meetings, and were extremely sceptical that this activity could be replaced by electronic communication without losing its 'richness' and putting vulnerable people at risk. Based on this exercise, our advice would be, don't even consider communicating complex patient/client contexts by electronic means. Pick up the phone to the colleague you know, or wait till the next team or inter-agency meeting. The role of IT (the alert/message) is to trigger that discussion and/or notify practitioners that something has changed. Within Lanarkshire, eCare is the tool that enables the partner agencies to protect its most vulnerable people.

2. eCare was driven by the business requirements

38. eCare developments in Lanarkshire have been driven by improving outcomes for patients/clients with the focus being the policy context and the business requirements of the key partners. This has ensured that IT developments are focused on adding value to the delivery of services with practitioners at the heart of developments and re-design. This is important. As a consequence, Lanarkshire's own CPM evaluation, of the three A & E sites and the Children's Wards at Wishaw General over a 10 month period and some 500 cases in 2008/2009 found that of the range of practitioners using eCare, 83% used it daily (itself a tribute to usefulness) and 97% found it easy to use[5].

39. eCare is about much more than the IT and its use has required significant investment at practitioner level across all the partners. This has been achieved by demonstrating its benefits to those practitioners. Benefits for clients/patients in terms of better outcomes and benefits for the organisation and crucially the practitioner in terms of efficiency, more robust processes, peace of mind etc. See table below for a summary of the key benefits

Benefits for Practitioners	**Benefits for Patients/clients**	**Benefits for Organisations**
Immediate information sharing 24/7	Reduce the replication /volume of questions asked	Improved date integrity – outcome of the eCare matching process
Use existing IT systems	Reduce duplication	More consistent and improved recording practices
Reduce duplication	Services are provided quicker – new and enhanced	Information sharing 24/7
Ability to order services electronically	Vulnerable children and adults are identified to practitioners	Reduction in duplication across the partner agencies
Child Protection awareness raising	A more comprehensive and integrated assessment can be done more easily, and the patient/client has a copy	Improved report and planning
Adult Support & Protection awareness raising	Deal one lead practitioner, named person or Care Manager	A toolkit to enable the agencies achieve Joint Future rand NMIS requirements
Reduce the possibility of crucial information not being	Children receive the most appropriate intervention, care	CP messaging supports Child Protection Procedures and

[5] Evaluation carried out by LogicaCMG

shared	and protection	raises practitioners' awareness of their responsibilities
Linked Adult and Children's Information systems	Better protection and Safeguarding of Children and Vulnerable Adults	Child Protection messaging links adult and child information systems and assist agencies meet the recommendations of inquiry reports into child deaths
A more comprehensive assessment of risk	Information leaflets on the ISP are available	Adult Protection messaging supports the Adult Support and Protection Procedures and arises practitioners awareness of their responsibilities
Development of assessment skills	Are asked to given written consent to information being shared, recorded and reviewed, and have an immediate hard copy	Development of an ISP and a comprehensive package of supporting materials and a training programme
Obtaining consent formalised	In future, opportunities for information to accessed electronically	Will provide a tool kit to support GIRFEC and integrated services for children and adults (the health and social care integration agenda)
ISP training and guidance		

40. If information sharing can be demonstrated of being in the interests of patients/clients and improved services, as has been the case in Lanarkshire, then there has to be a good reason why not to share. This is a somewhat different mindset to what exists elsewhere, where security fears, confidentiality obstacles, silo ownership and sanctions are frequently all used as reasons not to share. Lanarkshire is clearly working towards a presumption to share.

41. It is also significant that eCare in Lanarkshire didn't require any radical transformation in working practices. There was no requirement for practitioners to learn new systems and changes were rolled out incrementally to existing systems and processes, usually after extensive paper testing and piloting.

42. While tackling variability between partners' working practices and procedures is key, it is clear from our work in Lanarkshire that you need to be pragmatic about such things. Don't let the best be the enemy of the good.

Lanarkshire had senior management support and inspiring individuals

43. As with all major change processes, eCare requires the commitment of senior managers to advancing this far from easy cause. Lanarkshire has had this commitment throughout its 10 year journey alongside a small team of inspirational and dedicated people in the DSP. They have combined to inspire operational managers and practitioners to make the necessary difficult changes.

eCare in Lanarkshire grew pragmatically and incrementally

44. eCare in Lanarkshire has grown pragmatically and incrementally, and will continue to do so. Development has been responsive to the needs of practitioners and IT problems/glitches have been quickly rectified by the DSP. Crucial if practitioners are to change working practices and make eCare 'business as usual'. The consequences of not

addressing problems quickly can't be overestimated and can do untold damage to changing 'hearts and minds'.

45. Incremental development has worked in Lanarkshire. It has enabled the DSP to pilot developments, and to learn, adjust and reflect from phased deployments. Incremental deployments have also enabled Lanarkshire to be responsive to business needs and provided agility.

Lanarkshire recognised the importance of organisational development and invested in multi agency training

46. Lanarkshire recognised the importance of organisational development from the outset and has invested considerably in multi agency training and resources. The multi-agency training appears to have been a success and is highly valued by staff. It has been used for ISP training and to effectively foster a culture of partnership working across the key partners. However, concerns have been raised that going forward multi agency training may be a victim of financial pressures and replaced with more conventional 'on the job' training by the partner organisations.

47. Things are however not perfect, and neither would Lanarkshire claim that they are. Nevertheless they have solid foundations upon which to build and eCare is increasingly becoming business as usual.

ISSUES FOR CONSIDERATION GOING FORWARD

1. Extending the Partnership to include Fire and Rescue Services and the Third Sector

48. We know from elsewhere in Scotland that some of the most vulnerable people in society are for lifestyle and/or health issues some of the most likely to be seriously injured or die in house fires. We also know from our conversations elsewhere that at least one local authority is effectively sharing information about their most vulnerable patents/clients with their Fire and Rescue Service and that this enabling vulnerable people to be prioritised for home safety checks and other potentially life saving interventions. We would encourage the DSP to look at this (and other) examples to see if there are any transferrable processes and practices that could be used in Lanarkshire with a view to information being shared electronically and supported by the eCare Framework.

49. Another obvious omission from the Lanarkshire partnership is the Third Sector. However, we understand that some meetings have taken place with Lanarkshire Meridan and Barnardos with a view to them becoming signatories to the ISP. The Third Sector is delivering social care throughout Lanarkshire through a mix of formal and informal contracts and contacts with partner agencies. We would encourage Lanarkshire to actively consider ways of representing the diversity of the Third Sector on its DSP and how information might be shared electronically with the key players (and supported by the eCare Framework) to improve business processes and bring benefits to practitioners, organisations and patients/clients.

2. Extending alerts/messaging to neighbouring authorities/agencies

50. Some of Lanarkshire's most vulnerable people live on its boundaries and we know that mobility within this group is relatively high. It is also relatively easy for people living in Lanarkshire to travel to Glasgow for NHS treatment and care. But because Lanarkshire'

alerts and messages don't extend beyond its boundaries and its partners' own IT systems, this valuable information is not available to practitioners outwith Lanarkshire. Social workers, A&E team members, paediatric nurses and education workers all highlighted cross boundary movements as an area of concern, particularly in relation to child protection. All voiced concerns that vulnerable individuals as 'slipping through net'. Within education there was additional frustration as the vast majority of local authorities in Scotland use SEEMIS and information (Pastoral Notes) can be transferred between education authorities, but alerts/messages cannot be shared outwith Lanarkshire, even if the DSP knows which education authority a child has moved to.

51. We would encourage the Lanarkshire to investigate the options for cross boundary electronic information sharing. In the first instance the LDSP might wish to consider opportunities for electronic sharing with its nearest neighbours - West Lothian, Renfrewshire and parts of NHS Greater Glasgow and Clyde. The cross border agencies will have a mix of shared and agency specific IT systems however Lanarkshire has the experience and the building blocks in place to initiate discussion and drawn on the expertise of others who are using and/or piloting different types of electronic sharing technologies (e.g. portals or electronic windows to information).

3. Has Lanarkshire the right eCare model for the long term?

52. There is no doubt that eCare in Lanarkshire is a success, but going forward we would pose the following questions:

1. Is the eCare model that Lanarkshire has developed over the last 10 years or so sustainable going forward?

2. Can the key partners (NHS Lanarkshire and North and South Lanarkshire) sustain the costs going forward? In the short term they can't afford not to, as eCare enables the key partners to protect the most vulnerable individuals in Lanarkshire, but what about the longer term?

3. Work is already in hand to deploy tablets for community based health and social care practitioners and pilots are underway (my SWIS mobile assessment tool) and planned (for MIDAS)[6]. But, is Lanarkshire's eCare model vulnerable to the pace of technological change and practitioners' demands for increasingly sophisticated functionality and tools?

4. Making information on the Partnership and the eCare Framework available to others

53. A far less strategic issue, but nevertheless evident from this piece of the work – is the difficulty we have experienced in obtaining comprehensive online information on the work of the DSP. Comprehensive information is available on the Data Managers SharePoint site and Lanarkshire has for some time proactively shared material with other DSPs and numerous local authorities. The DSP has also over the years given many demonstrations (eCare/alerts/messaging) to meetings of Data Sharing Managers, and at events and conferences. However, here is very little material available online for a wider audience and what material there is (ISP and related guidance, leaflets etc) is available to a greater or

[6] BBC News Site - Mobile MySWIS http://www.governmenttechnology.co.uk/supplier-focus/item/832-north-lanarkshire-council-goes-mobile

lesser extent on North and South Lanarkshire Councils' websites. The Partnership should consider supplementing this activity by putting material online and perhaps developing its own website.

Annex 1: a summary of the Lanarkshire eCare journey (so far) 2002 to 2012.

2002-03	The Lanarkshire Partnership were the first to build and have an operational eCare Framework; index, gateway and a MAS. Following pilots in North and South Lanarkshire, North Lanarkshire social work and NHS Lanarkshire began sharing SSA, referrals, service requests, contact details and order homecare services and equipment from the Joint Equipment Store for older people. This was supported by the launch of the initial Lanarkshire ISP, joint working agreements and lead assessor protocol. This was followed by roll out to South Lanarkshire.
2004-05	Development of and sharing data sets for adult users
2004-05	Development and implementation of child protection messaging, linked children and linked adult messaging
2005	Child protection messaging shared with Health and Education across Lanarkshire
2006	In North Lanarkshire Social Work and Health sharing adult SSAs (including mental health, substance misuse, learning disabilities)) this was completed in South Lanarkshire in 2010
2007	Launch of Lanarkshire's revised ISP with additional partners and supporting material
2008-09	Adult Support and Protection Messaging were developed and went live in the North and South Lanarkshire SWIS systems (and sharing via the MAS began in the North Lanarkshire in 2011 with a rolling programme across Lanarkshire) The initial roll out of Child Protection Messaging to A&E and the Children's Wards, substance misuse, maternity and neo natal, outpatients, day clinics and day surgery, ENT, dietetics, dermatology, othoptics and other identified acute services Development of the Assessment Server and Forms Creator within the eCare Framework to expand the ability of Health professionals (on the many IT systems) to create assessments and other forms and share these via the MAS
2009	Development and implementation of Pre Birth messaging on the North and South Lanarkshire Social Work systems, and sharing via the MAS
2009-10	NHS Lanarkshire and North Lanarkshire Social Work agreed an Outcomes Plan for all adults and older people (Social Work share this and the Board will start sharing via MIDAS in 2012) MIDAS connected and testing of Child Protection messaging completed Child Protection messaging piloted in 3 GPASS GP Practices (INPS Vision pilot is now underway)
2010	NHS Lanarkshire and acute sites can view shared assessments and other shared information via the MAS (available in emergency receiving units, older

people's wards and ACE on 3 main hospital sites and older people's wards at associated hospital sites across Lanarkshire

2011 Out of Hours Adastra system connected to the MAS and receives Child Protection messaging at the Out of Hours base and in mobile cars

Work with NHS Lanarkshire A&E and acute services Trakcare system to view all alert messaging and shared information for older people

Adult Protection messaging shared via the MAS with Health by North and South Lanarkshire Social Work

Pre birth concern messaging shared via the MAS by North and South Lanarkshire Social Work

NHS Lanarkshire MIDAS testing sharing assessments and ordering services directly from MIDAS complete and rolled out across Lanarkshire

2011-12 Obtaining Consent – Good Practice Staff Guidance revised and published, ongoing multi agency training events, information sharing leaflets (for carers and parents) published and revision of the Lanarkshire ISP with the addition of new partners – Strathclyde Fire & Rescue and Meridan Services

Annex 2: LDSP Forward Work plan

2012-13 GIRFEC – the completion of the IT infrastructure in the eCare IT to support sharing and the development of the host IT systems for all the GIRFEC components and the development of staff protocols and training materials

Child Protection, Adult Protection and Pre birth Messaging – the production of protocols and staff briefing materials for all new services and staff groups to support further rollout, and staff training requirements. The completion of the roll out of alert Messaging to Board Acute Services and Allied Health Professionals. The delivery of all types of messaging to GP Practices across Lanarkshire

Community Care Outcomes – the pilot and roll out to the Board of the direct ordering from the Joint Equipment Store in North Lanarkshire. The sharing of Adult and Older People's outcome plan and review document by MIDAS and South Social Work SWISplus system.

Annex 3: List of individuals that were interview and/or submitted written responses to the interview questions

Mary Thomson	Social Work	South Lanarkshire
June Delaney	Ward Sister, Wester Moffat Hospital	NHS Lanarkshire
Audrey Demetriou	District Nurse/Community Practice Teacher	NHS Lanarkshire
Helen Edment	Implementation Manager, Joint Services	NHS Lanarkshire
Elaine Drennan	Management Secondment, Maternity Wishaw General Hospital	NHS Lanarkshire
Trudie Marshall	Practice Development Practitioner - Older Adults	NHS Lanarkshire
Gillian Corbett	Consultant Nurse - Emergency Care Wishaw Hospital	NHS Lanarkshire
George Cruikshank	Team Leader – Mental Health Lanark Health Centre	NHS Lanarkshire
Alan Lawrie	Director, South Lanarkshire CHP	NHS Lanarkshire
Bobby Miller	Manager, Younger Adults, Social Work	North Lanarkshire
Audrey Brogan	Co-ordinator, Integrated Day Services - Older People	NHS Lanarkshire
Lorna Kinsman	Child Protection & Inclusion Officer, Education Resources	South Lanarkshire
Pamela Buddy	Paediatrics, Wishaw General Hospital	NHS Lanarkshire
Bruce Thomson	GP, Uddingston	NHS Lanarkshire
Kathy Shilliday	Manager, LDSP	NHS Lanarkshire
Val McIntyre	ICS Co-ordinator, Education	South Lanarkshire
Anne Donaldson	Education Officer, Leisure & Learning	North Lanarkshire
Allison Hood	Depute Head Teacher, Coatbridge	North Lanarkshire
Susan Kelso	Social Work	North Lanarkshire
Carron O'Bryne	Service Manager, Children and Families	North Lanarkshire

Annex 4: Summary of the conversations that took place with individuals across the key agencies

A. Previous arrangements

1. How did care integration work before the data sharing initiative began?

Care integration and associated information sharing was pretty ad hoc and at times a bit haphazard, or as Mary Thomson (Social Work) put it a bit 'hit and miss'. So for example George Cruickshank (Community Care) remembers the days when he regularly embarked on a round of phone calls to social work, trying to find the right person and never being quite sure what could be disclosed to the unknown person at the other end of the line.

More formal referral arrangements were also rather clunky and lengthy. Helen Edment (Community Care) recalls at least a month between a nurse judging the need for a service or piece of equipment, social work doing their own assessment and, finally, delivery. Mary Thomson (Social Work) recalled using very bad photo copies of photo copied forms and she relied heavily on admin colleagues to find the right ones to use.

Within the acute sector, health professionals frequently lacked the most basic information about their patients and Pamela Buddy (Paediatrics) remembered how they relied heavily on parents/guardians for information and how children were often discharged before the nurses had even spoken to social work. Others including (June Delaney (Ward Sister) spoke about their reliance on the relatives of older patients for information and the time it could take if relatives couldn't assist.

Obviously it made all the difference if there were good individual relationships between health and social work staff (Mary Thomson (Social Work) and Audrey Brogan (Community Care)). **Which is probably the key learning point in this whole paper.**

Audrey Brogan (Community Care) recalled how responsibility for individual patients/clients didn't sit with any person and there was no overall picture. Val McIntyre (Education) recalled duplication in children's' services and delays, particularly if it was unclear who was in the lead.

Equipment and services requesting were particularly burdensome and protracted, and as Susan Kelso (Social Work) recalls not helped by three different equipment stores and slightly different processes depending on which town.

2. What were the biggest challenges?

Within health the challenges were mainly to do with staff adapting to use of IT systems, compounded by the fact that many community nurses had no previous experience with IT at all and 'problems' with PIMS.

What might be termed 'rivalry' or 'territorialism' was also an issue, where staff became very protective of their roles when it was suggested that they could be done by a different agency. Bobby Miller (Social Work) recalled staff being required to adopt a wider role and acquire 'generic core skills' and Audrey Brogan (Community Care) spoke of professionals having to accept other professionals' decisions.

And, but certainly not least, the scale of the organisational development and change agenda required, including winning over hearts and minds was mentioned by many, including Kathy Shilliday (LDSP and Bobby Miller (Social Work).

3. What were the consequences for members of the public/patients & partner organisations?

The virtual absence of effective information sharing meant duplication of information gathering, as each agency carried out their own assessment of the patient/client's needs (Mary Thomson (Social Work), Audrey Brogan (Community Care) and Audrey Demetriou (Community Care) to name a few of the many who made this point).

For the patient this meant several visits from different organisations, pretty much the same questions being put to them, and inevitable delays. Crucially it was the responsibility of older patients/clients (or their carers) to liaise separately with each of the different professionals involved and to oversee the co-ordination of their home care package.

In the acute sector, delays contributed to delayed discharge. Whilst in the community, care services were disjointed and care packages were frequently not in place or delayed.

4. What was the catalyst (or catalysts) for change?

There have been various Government-led initiatives designed to foster better inter-working by community agencies, with Joint Future probably being the most significant. However of much greater significance were the commitments made by local partners themselves, at senior levels to improve the quality of their services. Audrey Brogan (Community care) recalled 'an appetite' for change and 'to make it much better for people' and Pamela Buddy (Paediatrics) , Audrey Demetriou (Community Care) and Audrey Brogan (Community Care) all spoke of professionals wanting to do a better job for their patients/clients.

High profile children protection case review findings also highlighted the need for improved communication and information sharing, and to join up child and adult services. A point made by all the Social Workers we spoke to.

5. Anything else you would like to add?

Just that it wasn't all bad but there was definitely room for improvement.

B. Current arrangements

6. How does it work now?

While this paper is mainly about information and IT, progress there cannot be considered outwith the continuing organisational changes and improvements. To illustrate, trust in professional relationships makes a big difference to information sharing. Co-location of services fosters that trust, as George Cruickshank (Community Care) recalls when social workers and mental health officers were moved into where CPNs were in Lanarkshire Health Centre.

But co-location is not the whole answer. How is it that CPNs and Social Workers in one health centre can share effectively yet the CPNs have no ready access to the GP medication records in that health centre? And, how Integrated Day Services are sharing offices in Coatbridge, but continue to use separate IT systems (Audrey Brogan (Community Care)).

But looking simply at current IT systems and related processes, and put very simply, what now exists is:

- a shared information store (IT database – the MAS)
- a 'matching' service that allows each agency to interact with that store using their own patient/client identifier scheme (the eCare Index)

- access by authorised practitioners to the store that is embedded in each agency's operational IT systems
- equipment/service requesting
- alerting orchestrated by the MAS, for example child protection
- ongoing investment in IT infrastructure, training and staff development

However many of these features are still developing. For equipment/service requesting for example, the original 'Order' button in PIMS did little other than semi-automate the same request direct to social work (and as Susan Kelso recalls didn't even do that perfectly since due to a limitation of the system only a certain amount of data could be transmitted). While progress has seen further streamlining of the number of steps, along with merging of stores and the improvements that MIDIS will bring, it is only now that procurement is underway for a full end-to-end ordering and stock control system.

Meanwhile a sobering fact is that some 200 to 300 faxed requests a week continue to be received by stores, all the more clunky due to requirement to fax patient/client identity details separately from assessment/request details. This 'security' requirement is seen as pretty daft by practitioners, and an objective assessment of risk would find it hard to disagree. Progress is however being made. Susan Kelso (Social Work) spoke of the East Kilbride electronic ordering pilot that is eliminating the need to send faxes, bringing about efficiencies and streamlining the ordering process. It is hoped that following its evaluation, electronic ordering will be rolled across NHS Lanarkshire. Practitioners have been central to this development e.g. testing with MIDAS to ensure it would work.

7. What has had the greatest effect on the challenges? What are the key things that have made a difference? (also includes critical ingredients to success)

Sharing of information has improved gradually over the years. Why? Because there is now the IT means? Or, as Helen Edment (Community Care) points out, because relationships and common cause between health and social work have also improved over the years? Actually the question is pretty silly. Each needs the other. But if the interviewees were forced to say how they saw the relative importance of 'people stuff versus IT stuff' then the answer would probably be 80:20.

Bobby Miller (Social Work) recalled how the agreement and development of the eCare Indexing system was crucial. In his opinion, its development was vital, not just by ensuring that information was shared about the right person, but its robustness ensured that the original partners (and all subsequent partners) had confidence in the system.

One interesting thing that emerged is that the IT:People pendulum has swung over the years. Roughly speaking there have been three eras. The first was probably too IT-led, but at least resulted in the basis information sharing IT infrastructure being established.

The next era, from about 2006 for three years, began with the DSP noticing that while the IT basics might be in place, beneath that there were various shaky organisational and people foundations. Processes varied between localities, as did care documentation, but perhaps of greatest significance was the need for a sound and unambiguous Information Sharing Protocol along with associated practices and staff understanding. The focus of work over this period therefore switched to addressing these issues, and arguably the journey was more valuable than reaching the destination.

And the final era, continuing beyond today? To continue with incremental improvements in both IT and organisation/people, but in step.

So for the key people things that have made a difference we can identify are:

- leadership and ownership, encouraged at locality level (Bobby Miller (Social Work), Val McIntyre (Eduction), Kathy Shilliday (LDSP) and Carron O'Byrne (Social Work))
- enthusiasm of individuals and the commitment of key individuals - in the DSP and key partners (Bobby Miller (Social Work), Val McIntyre (Education) and Kathy Shilliday (LDSP))
- more efficient and less labour intensive processes in place; and
- a range of measures to foster better collaboration, joint training and development e.g. multi agency ISP training (Val McIntyre (Education), Bobby Miller (Social Work) and Kathy Shilliday (LDSP))

And if a single IT thing had to be identified then it would probably be alerting, i.e. the IT means by which the practitioner's attention is drawn to certain information. See below for more on this.

But how does the more day-to-day communication related to patient/clients between practitioners happen? Does IT have a role, e.g. using simple email? Interestingly, relatively little use is made of email, many staff don't have access to it and some interviewees were quite against it. In part it is due to security concerns, and in part the issues around separation from main records.

However the main reason is yet again the importance of conversations whether by phone of face to face that can so much more effectively convey context, complexity and so on. As Elaine Drennan (Acute Services) points out, if she has a gut feeling about a family then the place to raise it is during her monthly meeting with partner agencies in the locality.

A final aspect that deserves mention is the principle of embedding 'sharing' features within existing IT systems that staff in each agency use, as opposed to something like a separate system that they need to remember to log on to. So for example in SWIS a social worker can copy a piece of information to the shared information store by clicking the Share button, and can see what else is the client's shared record through a split-screen view of their own record alongside the shared record.

8. What were the biggest barriers to be overcome? How were they tackled?

The biggest barriers were not the money needed, not the IT challenges, not the management commitment, and not even the cultural differences, although they were huge!

In fact most interviewees would probably agree that the biggest barriers were at the level of individuals. As Helen Edment (Community Care) observes, fear of IT and fear for role, perhaps manifesting as cynicism and negativity, can be very hard to overcome. While the slightest ambiguity in procedures or whatever can be seized upon as fatal flaws.

At senior management level, addressing these barriers meant being clear about the basic principles that all six partners were committed to, then discussing and seeking to agree implementation issues such as pace and degree of consistency. There were and will continue to be disagreements, but key is to acknowledge the inevitability of that while having a shared determination to find acceptable and pragmatic ways forward. Audrey Brogan spoke about there being a 'no opt out clause' i.e. that her team had to use eCare and had to share, and that without sharing they couldn't do anything. It is this single minded commitment by practitioners to making eCare business as usual that has made possible Lanarkshire achievements.

At a more operational level the measures adopted to addressing the barriers have included:

- Processes have to be worked through and communicated precisely. All leaders have to be saying the same thing so there is no room for confusion (Audrey Brogan (Community Care))
- Robust protocols for joint working help enormously. There can be no ambiguity around what is expected from each staff member e.g. the ISP and good practice guidance (Kathy Shilliday (LDSP) and Bobby Miller (Social Work))
- Making it make sense for staff – trying always to emphasis the improved outcomes for patients/clients e.g. a single point of contact for each client, improved quality of assessments etc (Audrey Brogan (Community Care)and Bobby Miller (Social Work))
- Support for front line staff in implementing the initiative e.g. multi agency training, mentoring and a buddy system (Audrey Brogan (Community Care))
- Robust IT systems that are fit for purpose and an IT department that can solve staff's problems quickly and effectively e.g. providing additional space for text on IT systems, changes to SEEMIS so that messages can no longer be deleted (Lorna Kinsman (Education)) etc
- Training which is short sharp and to the point ticks everyone's boxes in a time when resources are short on the ground and the use of a cascade model
- Performance Framework and ensuring this was reported on at locality reviews and issues addressed there
- And all underpinned by a major and clear communication effort, at all levels. Challenging negativity. Producing FAQ's to help combat ambiguity. Ensuring protocols were robust and IT systems were up to the challenge.

Clearly consent and security have also been addressed. While these are key enablers of information sharing, nevertheless two interesting but unintended effects are becoming evident.

The first is around the requirement to get written consent. In practice this comes after the conversation with the patient where it is agreed that whatever services should be put in place. However it can be a slightly alarming puzzle to patients/clients when they are then taken through a consent to share their information conversation, leading to a multi-part form being signed. As was pointed out, for older people there has only ever been one refusal, but if the individual – particularly relating to a child - did refuse then it rather rings alarm bells.

And if the practitioner then forgets to click the 'OK to share' box in their IT system then of course nothing happens!

The second issue that came up related to security, specifically of community nurse records. There have been various instances of records being lost during home visits, with predictable negative consequences. Nevertheless management response to these incidents have had the effect of some staff becoming reluctant to carry any records whatsoever, with even complex assessments being written up later from memory. It is hoped that the introduction of tablet computers will help address this.

9. What have been the benefits for members of the public/patients & partner organisations?

Faster access to reliable information, quicker and more streamlined access to services, less duplication although this is not totally eradicated. Less form filling required to access another agencies resources.

Identified Lead Assessor/Care Manager who co-ordinates all care for a patient so they only have to contact one person, probably the single biggest improvements for patients/clients (Audrey Brogan, Community Care)

Alerting has clearly been a success, along with tailoring how it works for each agency. To illustrate, there are various levels:

- as Elaine Drennan (Acute Services) explains, as a community midwife when seeing a newly-pregnant women it is now standard procedure to log on to the shared record system to check for any child protection issues in the family
- as Gillian Corbett (A&E) explains, in A&E when a child attends their record within the Trakcare hospital system is opened. If there is child protection activity related to the child then this is clearly indicated by a coloured alert triangle, which can be clicked for more detail including details about adults involved with the child. For GPs it works in much the same way. Meanwhile for Gillian (A&E) "The difference that e-alerts have made is phenomenal. Previously we were working in the dark."
- but as Allison Hood (Education) and Lorna Kinsman (Education) explain, in schools the alerting is even more proactive. Hence whenever a new child protection alert relating to a student is notified to SEEMIS then this results in a text message being sent to the designated manager's phone
- for GP Dr Bruce Thomson , piloting alerts in Vision has seamlessly provided his GP Practice with direct access to information for the first time and a mechanism for sharing this information with the Partners

But to return to the oft-made point, alerting is just a trigger (albeit an important one to help avoid slipping through the net). But what then needs to happen is the conversation at locality meetings, the phone call to social work, the onward referral, the all-important people stuff. And as Anne Donaldson (Education) makes clear, having the policies in place that are agreed with other agencies is vital.

The benefits around equipment requesting has been covered elsewhere, however an interesting new development is to make available requesting direct to the patient/client, as part of self-directed care, this will work through guided self-assessment via the web.

10. What remains to done, what's next (whether planned or not)?

There are still more sectors and professional groups to link in to the arrangements. Hospitals are seen as key, although in care of the elderly units there is now access to the shared care record. On a similar theme there needs to be information support for new initiatives around hospital at home (emergency admission avoidance) and managed discharge.

So far, GPs have been fairly peripheral to the process. The current INPS Vision (alerts) pilot needs to be evaluated and rolled out to all GPs Practice with training. Dr Thomson (GP) also suggested that having all Older People's adult care assessments accessible to GPs via Vision might be something for the future. Older People are a much larger part of GPs case loads, so day to day may be useful, particularly when you consider demographics and the nature of the business.

3rd sector and voluntary organisations is another obvious area for future work, and already there is some work going on to assess the feasibility of compliance by these organisations with the Information Sharing Protocol. No-one underestimates the challenges, however.

For children, there is a lot of support for the IT helping make the GIRFEC principles happen. Those involved in developing the 'chronology' view of a child's needs and service receipt

believe it has considerable potential. Coupled to that and going further, the direction of travel is toward child-centred outcomes and plans based on SHINARI principles as opposed to single agency views and 'silo' records. This 'SSA for children' can both learn from similar experiences with older people, with a start point of having a blank slate so let's make sure we do it consistently for all Lanarkshire.

Nevertheless the concept of chronology is still something of a cultural shift and a phased approach has been mooted, for example for the introduction of police into the process. Perhaps however the biggest challenge around GIRFEC is around the shift to a very simple mindset shift from *My information/ Reasons to keep it that way* to *If in doubt, share, and if not then have a very good reason*. This shift must come about through leadership at all levels of the all organisations.

This in turn refers back to the earlier points about administration around consent. While other than in relation to child protection the requirement for explicit consent remains for sharing between different legal organisations, might there be scope for relaxing some of the administrative aspects and shifting more to a model more based on professional codes of conduct?

However this raises the point made by some interviewees about the world outside Lanarkshire. What about a Lanarkshire child seen in a Glasgow hospital, or vice versa? Many interviewees including Bobby Miller (Social Work), spoke of a desire to share information with their neighbouring authorities, perhaps particularly relevant in Lanarkshire, where patients can (and do) easily travel to a neighbouring Board for treatment.

When a family moves into Lanarkshire from an education authority that also uses SEEMIS then their records including 'Pastoral Notes' move with them. What about their chronologies involving other agencies and alerts/messaging?

One or two specific future IT issues were raised. A regular complaint is the sheer number of separate IT systems that are around, each with own log-ons and look-and-feel. Issues around limitations of PIMS are well known, and there is much optimism around the MIDIS replacement. A number of interviewees also expressed a wish to have clearer messages in SEEMIS and more information in messages more generally, particularly where a message is driven by updates to core data set in SWIS. Equally, there is a lot of anticipation around current work looking at handheld devices such as tablet computers that are actually useful to peripatetic staff.