Shared Care Record Feasibility Study

December 2023

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Distribution and Action List

Name	Organisation	Job Title	Action *
Kirsty Parker	NHS England	H&J Commissioner	Action
Emma- Charlotte Giles	NHS England	H&J Commissioning Officer	Action
Ivan Trethewey	NHS England	National Police & Courts Healthcare and L&D Team H&J Specialised Commissioning	Inform
James Ward	Rocket Science	Assistant Director	Inform

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Executive Summary

The purpose of this feasibility study is to ascertain the appetite for one joint care record and to assess the ability for care records to share seamlessly. For simplicity this concept has been referred to as a 'Shared Care Record'. The study does not attempt to specify the content or design of the solution, but it does draw out from stakeholders their concerns and expectations.

Undertaking an effective investigation has been possible thanks to the good working relationship between the East of England Health and Justice team, Police, Prisons and healthcare providers. The survey itself covers 32 responses and has captured the key organisations involved.

Avoidable deaths in detention, or shortly afterwards, will always be too many. They can be the most tragic outcomes arising from failings in joined up care, often in extreme circumstances, despite the best intentions of many involved. They can include shortcomings in healthcare itself, or in healthcare information, as have been recounted during some interviews. The survey also points to more commonly encountered situations that result in unnecessary and prolonged discomfort, suffering or distress. Situations that have been exacerbated by systemic failures: in communication, or incomplete information, or missing input from unavailable staff, or insufficient specific training/procedural awareness.

Situations where a well-managed, always available, integrated care record would have the potential to consistently inform clinicians and detention staff sufficiently to deliver a safer, calmer, healthier criminal justice pathway, to the benefit of recipients and staff involved.

Firstly, and foremost; the level of commitment of the staff that took part in the survey and their compassion for people within the justice system was clear and a credit to NHS England. Some excellent examples were cited of what good looks like, demonstrating the great care and numerous safeguards that are provided on the back of good practice and lessons learned. The potential to repeat this kind of best practice on a wider scale leads us to the second insight: the level of frustration and wasted effort that a lack of information engenders on an almost daily basis. Many of the participants observed that efforts to rapidly access information are thwarted and are sometimes only resolved through email and direct contact with specific individuals where a personal rapport has been developed, but this relies on the availability of individuals.

A number of participants recognised that a shared care record alone would not provide a panacea, or silver bullet, citing that staff shortages, training and budgets also need to be addressed. The common theme was the sense that they as professionals could do much better, could reduce misery, could improve care and keep people safer with more consistent access to better information, particularly concerning Mental Health and Substance Misuse.

There is a simple question in which participants are invited to indicate their agreement/disagreement with the statement:

"Is a shared care record a good idea"

It came as no surprise that there was resounding agreement that it is indeed a good idea, with

78% Strongly Agree and 22% Agree

Undoubtedly, with more time and effort, and participation from more stakeholders, agencies and charities, even more support could be demonstrated

1. Background and Context

Background

Avoidable deaths in detention, or shortly afterwards, will always be too many. They are the most tragic outcomes arising from failings in joined up care, often in extreme circumstances, despite the best efforts of many involved. They can include shortcomings in healthcare, or in healthcare information, as have been encountered during some interviews.

The survey also points to more common situations that can also cause unnecessary and prolonged discomfort, suffering or distress. Situations that may have been exacerbated by systemic failures: in communication, or incomplete information, or missing input from unavailable staff, or insufficient specific training/procedural awareness. Situations where a well-managed, always available, integrated care record would have the potential to consistently inform clinicians and detention staff sufficiently well to deliver a safer, calmer, healthier criminal justice pathway, to the benefit of recipients and staff involved.

Reports and Pathways

Research to understand the background of healthcare in the Justice pathway, and to further support the need for one joint care record, or the ability for care records to share seamlessly, includes examination of several recent reports as well as updates from relevant bodies. It confirms the concerns surrounding the health needs of some of the most vulnerable members of society, outlining where failures occur in their healthcare, and the progress currently being made to address them.

Key documents reviewed, and that indicate support for better integration across all sectors have been:

- Rt. Hon. Dame Elish Angiolini DBE QC – Report of the Independent Review of Deaths and Serious Incidents in Police Custody 2017.
- IOPC Deaths during or following Police Contact (in Custody) 2017 – 2023
- Deaths in Police Custody; Progress Update 2022/23

IOPC Reports Summary of Deaths during or following police contact (In Custody) 2017-2023

Key statistics that are reported annually of deaths in or following police custody, and also suicides that occur following release from police custody are shown below for the periods 2017 to April 2023.

Years	Death in or following Police Custody	Drugs/Alcohol link		MH Concerns		Mental Health Act		Force Involved		Unwell in Cell		Apparent Suicides following Police Custody	Total Deaths and Apparent Suicides in or following Police Custody
		Number	%	Number	%	Number	%	Number	%	Number	%		
2017/2018	23	18	78%	12	52%	4	17%	11	48%	8	35%	57	80
2018/2019	16	13	81%	10	63%	1	6%	6	38%	6	38%	63	79
2019/2020	18	14	78%	11	61%	2	11%	8	44%	7	39%	54	72
2020/2021	19	14	74%	12	63%	2	11%	12	63%	7	37%	55	74
2021/2022*	11	9	82%	6	55%	2	18%	4	36%	5	45%	57	68
2022/2023	23	21	91%	13	57%	⬩0	⬩0	11	48%	8	35%	52	75

* From the 2021/22 Report: *For a large portion of 2020/21, England and Wales were in lockdown owing to the coronavirus pandemic. At this stage it is not possible to say with certainty what impact this had on the number or types of interactions that members of the public had with the police. Caution should be taken when comparing data from 2021/22 with previous and subsequent years.*

⬩ Figures not found in this report

The reports do not show a significant or consistent change in numbers or percentages of people dying, with the exception of the year 2021/2022, which may have been influenced favourably by the coronavirus pandemic. Concrete inferences cannot be drawn from these figures. It may indicate that as much as possible is being done in current circumstances, with the current tools processes, training and resources.

What is clear is the extent to which Drugs and Alcohol, Mental Health, and Physical Deterioration appear in these figures. It may suggest that better information, more widely available on a 24/7 basis, to all in the pathway, together with better training, could play an active role both in preventing further deaths in custody or in preventing suicides thereafter.

Deaths in Police Custody: Progress Update 2021

This update in the light of the Independent Review of Deaths in Custody and Serious Incidents in Police Custody references the significant progress being made and creation of the Ministerial Board on Deaths in Custody (MBDC), which brings together Ministers, senior officials, experts and the Independent Advisory Panel on Deaths in Custody (IAPDC). It further states:

Custody Environment

> 2.7 "… Detainees in police custody are often the most vulnerable individuals in our society and the state owes them a significant duty of care." and
>
> 2.12 "NHS England continues to provide national support and oversight to healthcare delivered in police custody suites and maintains the Police Custodial Healthcare Service Specification. This is used by all forces when tendering for new custodial services and is regularly reviewed by key stakeholders, including medical experts and police custody leads, in order to ensure that any policy or legislative changes are reflected. *This delivers equity of care to everyone detained in police settings*. Additionally, internal NHS health and justice leads, supported by NHS subject matter experts and a broad range of non-NHS clinicians provide clinical oversight to the healthcare available in custody settings."

This, therefore, may provide the vehicle through which changes might be made…. so that (in the absence of 24/7 L&D staffing in custody) better information can be made available, enabling police and healthcare professionals to provide improved levels of care and deliver on the state's "significant duty of care".

While the roll-out of NHS England and NHS Improvement commissioned Liaison and Diversion services, referred to in Deaths in police custody: progress update 2021, has placed clinical staff at police stations and courts across England to provide assessments and referrals to treatment and support, this is not a 24/7 service, and it does not cover all locations. However, clinicians *are* available on a 24/7 basis as part of the healthcare delivered in police custody suites, as required in the Police Custodial Healthcare Service Specification. It is possible that a Shared Care Record could greatly assist in providing *as soon as possible* the response most appropriate to the needs of those suffering from mental health-related crises. This would particularly be the case when assessing and treating chaotic people who may be in crisis, or whose presentation gives cause for concern, outside of the normal working hours of Liaison and Diversion.

Following on from Dame Elish's Review and "the cross-agency work programme for preventing deaths in custody …" it is good to note that the co-chairs of the government's Ministerial Board on Deaths in Custody (MBDC) "…remains committed to sustaining momentum to prevent further deaths in all forms of state custody."

A shared care record would significantly improve the chances of delivering on the Progress Update 2021 'Next Steps', and specifically relevant are:

> 3.2.1 Mental Health. "It is crucial that those suffering from mental health-related crises receive the response most appropriate to their needs *as soon as possible* and that appropriate health and social services are available. The Mental Health Act White Paper commits to removing police stations as a place of safety when there are sufficient alternatives in place, for those in mental health crisis to be taken to a health-based place of safety. The white paper additionally accepts the need to improve ambulance provision for urgent mental health cases, which will significantly reduce incidences of conveyancing by police vehicle."

In the current climate of resource shortages, timely information, shared more widely might be the least costly and most effective means of avoiding crises through early interventions

> 3.2.4 post-custody suicides "There were 54 apparent suicides following police custody in 2019/20, a figure significantly higher than the recorded number of deaths in or following police custody. We consider that there may be opportunities to understand more about those individuals who pose the highest risk to post-release suicide and how pre-release assessments may further identify early warning signs of behaviour linked to risk of suicide."

Here again, access to information, shared more widely to the healthcare staff could enable faster interventions from the relevant experts.

2. The Survey

The survey encompassed the Home Office, NHS England, Ministry of Justice, Private Sector and NHS Foundation Trusts, providing responses representing viewpoints from:

- Police
- Custody Healthcare
- Liaison and Diversion
- Prison Healthcare
- HMPPS
- Commissioners

The survey, developed using MS-Teams, has 15 parts in 3 main sections as detailed below:

- Section 1 - Organisations, Roles and Systems
- Section 2 - Systems & Sharing Issues
- Section 3 - Shared Care Record – Risks, Benefits and Expectations

2.1 Organisations Involved and Their Roles

The following Police Forces were engaged and the role of the participate detailed:

Organisation	Services	Roles
Norfolk & Suffolk Constabularies	Police Services	Head of Custody CD Liaison Officer & Coordinator
Metropolitan Police	Police Services	Acting Superintendent – Intelligence Healthcare Director (Retd) Police IT Systems Consultant

The following NHS organisations were engaged:

Organisation	Services	Roles
Luton & Beds NHS Foundation Trust	Liaison & Diversion	Deputy Service Manager
Hertfordshire Partnership NHS Foundation Trust	Liaison & Diversion	Operational Lead
Essex Partnership University Trust	Liaison & Diversion	Operational Lead
NHS England (GP role)	Prison Healthcare	Clinical Lead HJIS (answering as GP)
Northamptonshire Healthcare NHS Foundation Trust	Prison Healthcare	Service Manager
NHS England	Commissioning	Commissioner Health & Justice Commissioning Officer Regional Head of Health and Justice Senior Commissioning Manager Senior Commissioning Manager

The following private healthcare providers were engaged:

Organisation	Services	Roles
CRG Medical Services	Police Custody Healthcare	Clinical Lead Clinical Lead Clinical Lead Corporate Services Director Healthcare Professional Healthcare Professional Healthcare Professional Healthcare Professional Head of Clinical Operations Senior Healthcare Professional Senior Healthcare Professional
CRG Medical Services	Prison Healthcare	Head of Healthcare, HMP Chelmsford Head of Primary Care, HMP Chelmsford Primary Care Team Lead, HMP Chelmsford

The following HMPPS sites were engaged:

Organisation	Services	Roles
HMPPS Norwich	Prison Services	Healthcare Officer (Retd) - HMP Norwich
HMPPS Chelmsford	Prison Services	Custodial Manager - HMP Chelmsford Safer Custody Hub Manager - HMP Chelmsford
HMP Bedford	Prison Services	Secured Services Clinical Director, Chair RCGP SEG, Lead GP HMP Bedford

2.2 Carer, Manager or Executive

To keep the survey shorter and relevant to their role, participants were invited to choose how they wanted to take part in the survey:

- **Carers** – predominantly face-to-face interaction
- **Management/Executive** Roles – some or no face-to-face interaction
- **Basic**, reduced input – skipping the survey but taking account of opinions

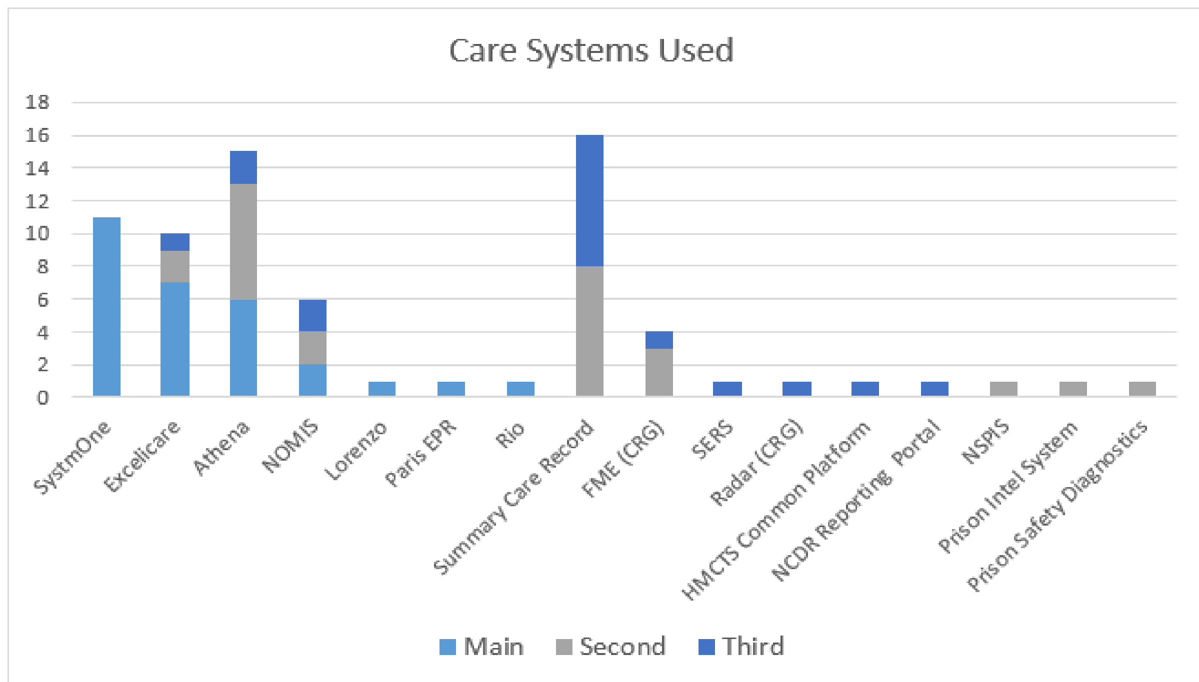
21 participants took the Management/ Executive branch of the survey. Nine participants selected the Carer route, which asks more detailed questions around problems, interventions and good practice. Only one person chose basic, reduced input route.

There were enough views to determine the overwhelmingly positive support for the shared care record, but we recognise that there is much to glean from more face-to-face staff working directly with people progressing through the justice system. Specifically, Substance Misuse Services, Mental Health Staff and Prison Reception Staff, as well as Community-based services.

3. Systems and Sharing Issues

3.1 Current Systems in Use

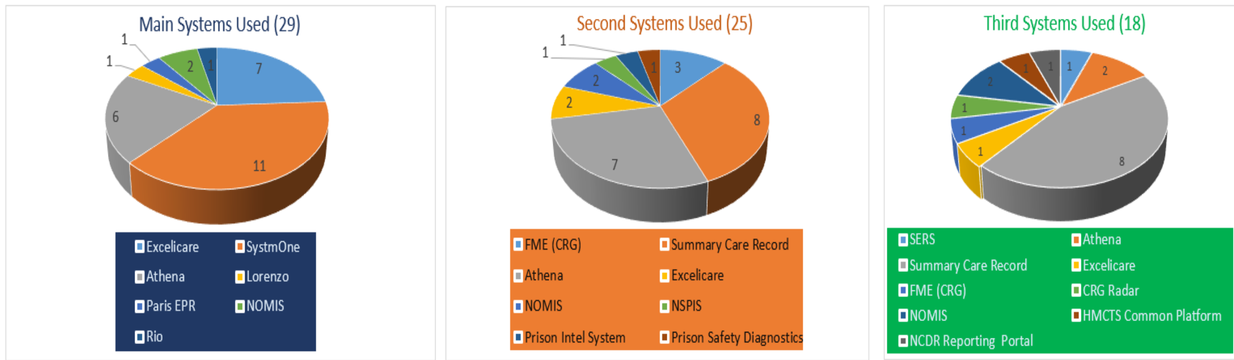
A total of 16 systems were identified either as main systems or systems used for consultation and/or support for safe detention and onward referral. They covered the persons journey through police custody, including physical healthcare and liaison and diversion services, courts and onward to their stay in prison, where they encountered prison healthcare and other systems relating to care.



These charts show that key systems for the sample interviewed are:

- Athena – Police Custody
- ExceliCare – Custody Healthcare
- Nomis – HM Prisons
- SystmOne – Prison Healthcare
- NHS Summary Care Record – all healthcare

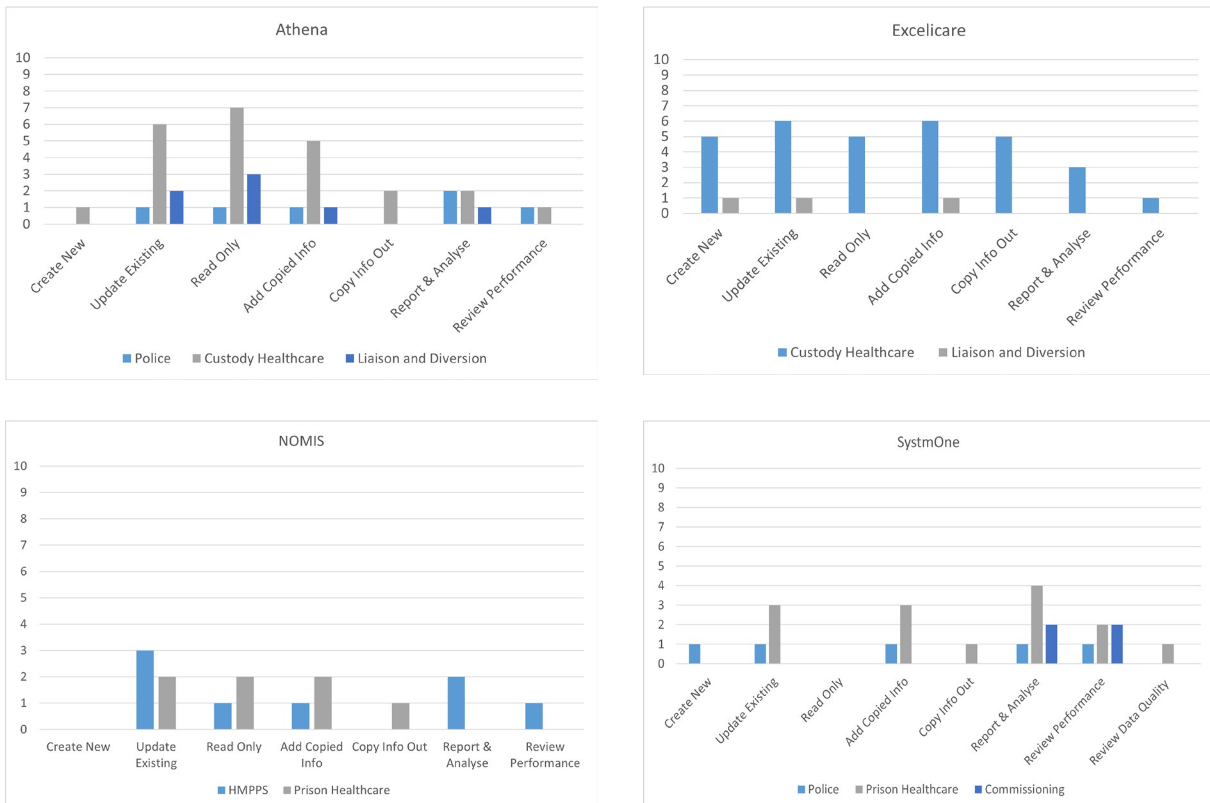
In second and third place are the following systems:

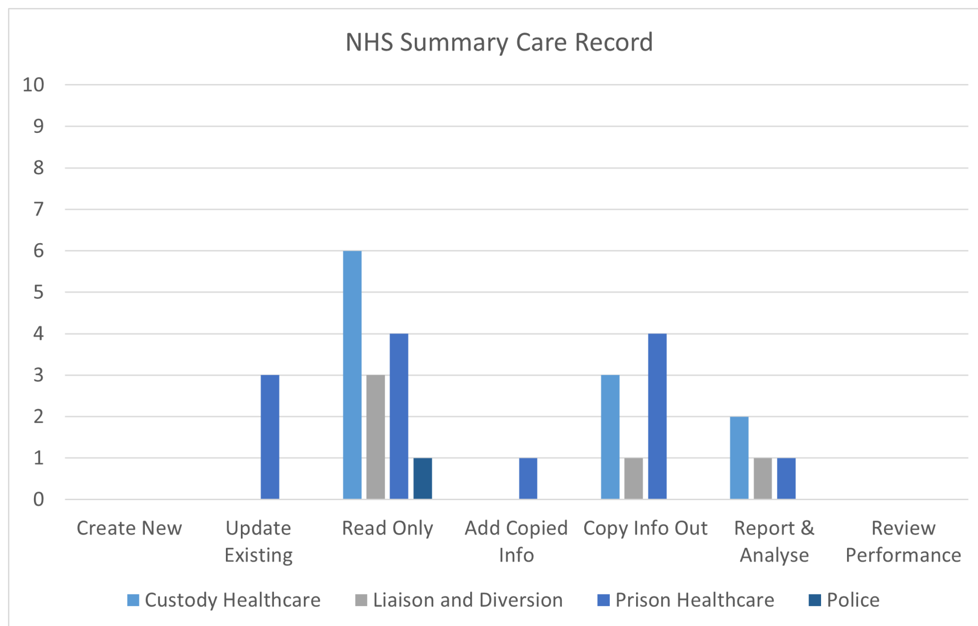


Various respondents observed that access to, or awareness of, Mental Health and Substance Misuse records and past interventions, was missing in many cases and would be advantageous in contextualising some people's presentations. Some gave examples that could lead to improvements in care and improve patient safety.

3.2 Typical Usage

Participants identified their top three uses of each system to help inform future needs. Alongside input from other L&D and Substance Misuse respondents to provide better detail, this could be useful in prioritising development interfaces for a shared care record. The main systems are identified below.





Other systems identified may be found in Section 2 within a bar chart, and in the base data provided in the Excel spreadsheet.

3.3 Systems and Sharing Issues

This part of the survey was aimed at identifying current capabilities of systems, how they operate, and any issues encountered. It provides insight into identifying areas of risk, what should be kept and what needs to change. Aspects considered cover:

- Current Sharing Capability
- Barriers to Sharing
- Missing Information
- When to Share Information
- When Risks become Issues

3.4 Current Sharing Capability

The charts above show each service depends on 2-3 systems to inform, investigate, treat and communicate issues to others in the health and justice environments. When asked about the sharing capabilities of existing systems,

15 users agreed: Some systems share information with/enable access to other provider's systems

15 users agreed: None of our systems share information with/enable access to other provider's systems

1 user said: I don't use them for sharing / accessing other provider's systems

In most cases 'some' translated into the ability to access the NHS Summary Care Record (from within ExceliCare) or, with SystmOne in Prisons, the recent ability to use GP2GP connectivity. Other instances included the capability for NOMIS to communicate with a Prison Security Database and for this system to then inform a Safer Custody database. What was consistently observed as missing was access to Mental Health and Substance Misuse information systems.

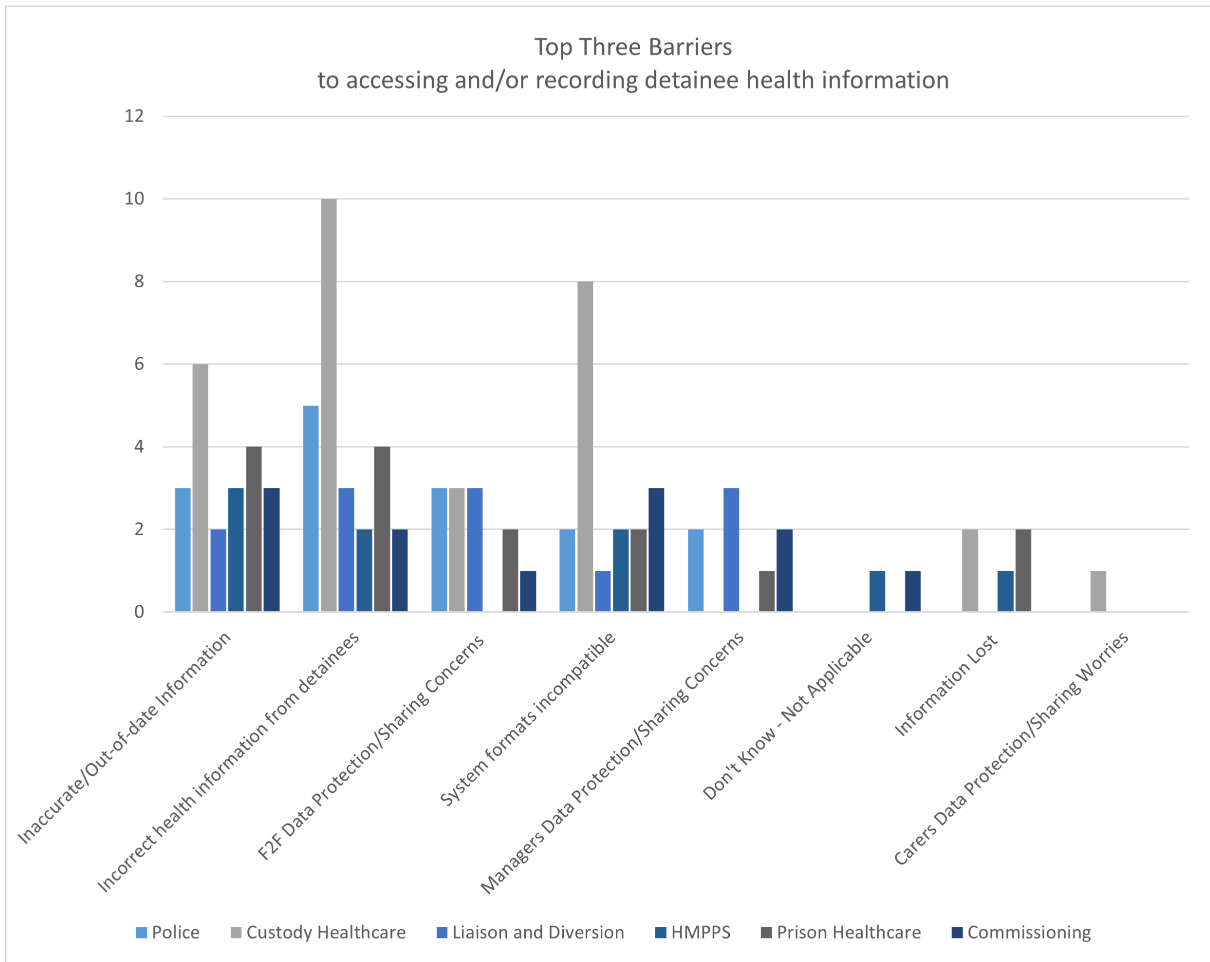
3.5 Barriers to Sharing

Barriers to sharing were explored by reproducing a question from a survey that has been run by Rocket Science in other areas of England. We used similar examples to those used in their survey[1] asking participants to prioritise potential barriers into a 'top three' from the following:

- *Information is not recorded accurately or not kept up to date*
- *Detainees do not disclose their correct health information*
- *Face-to-Face Carers worry about how much information they are allowed to share (because of data protection)*
- *Our systems do not allow recording or access to the information in the right format*
- *We have concerns about how much information should be shared (because of data protection)*
- *Don't know / not applicable*
- *Information is lost at different stages in the process*
- *I worry about how much information I am allowed to share (because of data protection)*

The results are shown below:

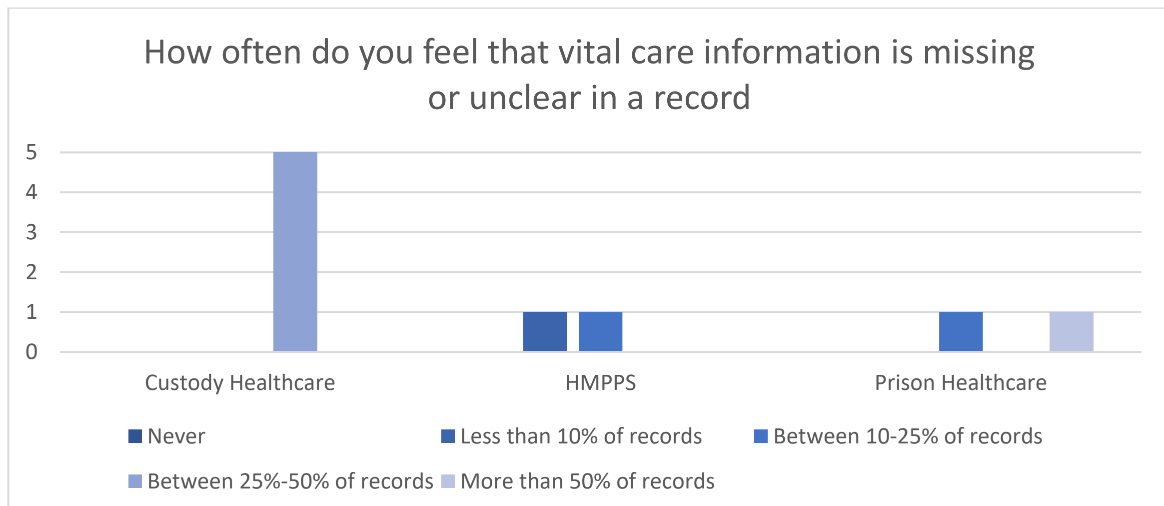
[1] Potentially this will enable their findings and ours to be (traceably) merged – to the benefit of both surveys.

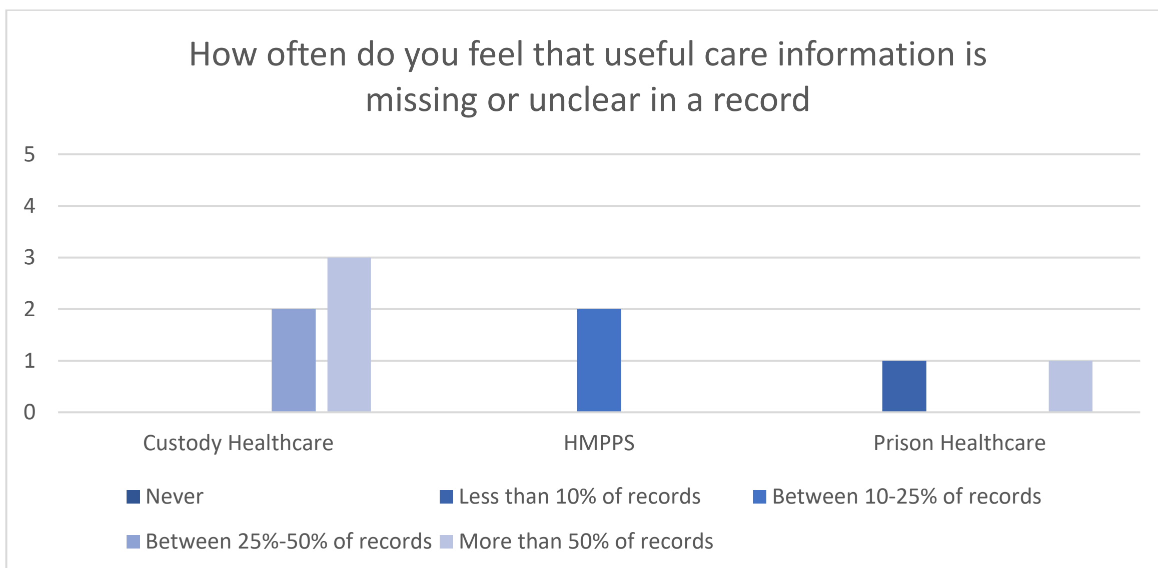


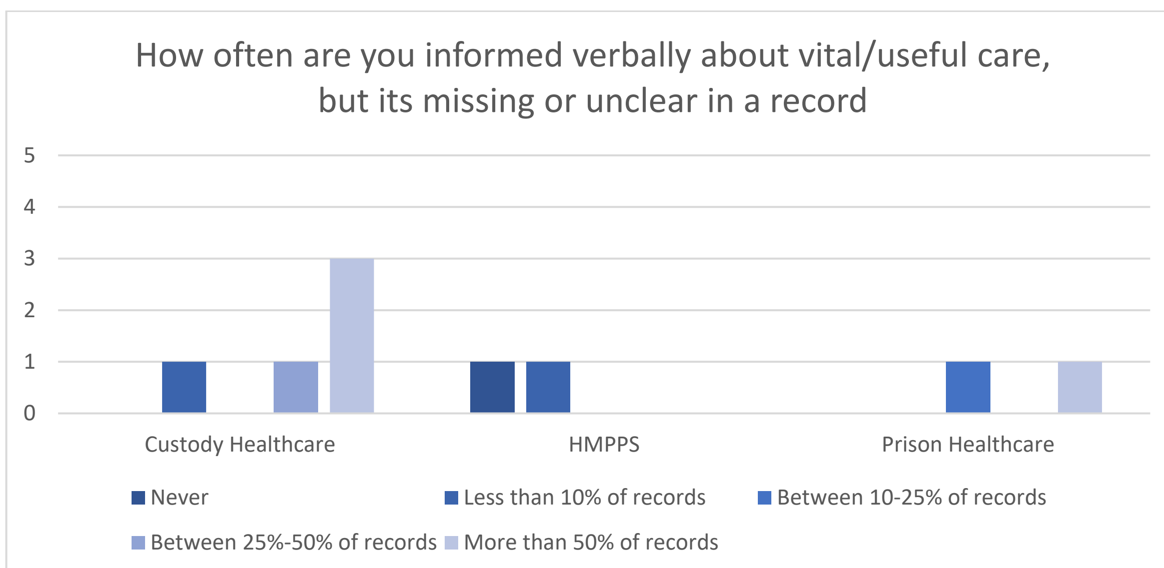
A consistent response from all sectors of the Health and Justice identified the same top three barriers.

- *Information is not recorded accurately or not kept up to date*
- *Detainees do not disclose their correct health information*
- *Our systems do not allow recording or access to the information in the right format*

While the survey could not predict exactly how participants would respond, we included some further follow-up questions that explored inaccurate/incomplete records. We asked them to estimate of how many records were affected by missing information, and how this was overcome. The answers, shown by service, indicates the scale of the issues encountered currently.





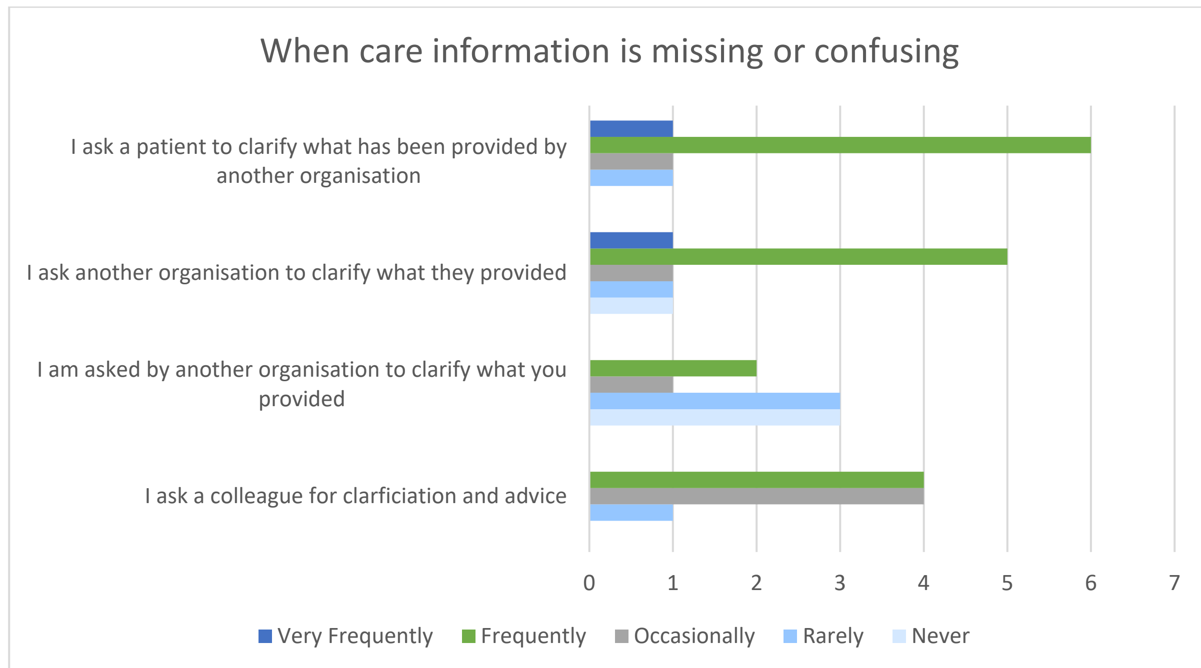


The charts show the extent to which healthcare staff estimate they work with incomplete information.

Later findings will reveal numerous situations when information has existed and, in the view of clinicians, could have improved outcomes and even saved lives.

3.6 Missing Information

A follow-up question set asks clinicians how they go about tracking down missing information to help assure the safety of people needing assessment and treatment, and that, in custody, police enquiries and subsequent treatment of suspects remains PACE-compliant.



Respondents were quick to point out that efforts to investigate and cross check information are very much harder out-of-hours, so risks to patients can increase.

The chart shows that asking a patient to clarify care information is a fairly regular practice, yet it seems to contradict one of the 'top three' barriers to accessing or recording health information: *detainees do not disclose their correct health information.* Potentially this could perpetuate inaccuracies (examples are noted later), although where doubts exist other remedies are available. These include consulting a colleague or contacting the provider of the information if they are at hand when the need arises.

3.7 Information Security

Important considerations for a shared care record are:

- A person's rights to privacy and control over their medical needs,
- Security of information stored and subsequently released to people delivering care
- The requirements for obtaining informed consent to share information.

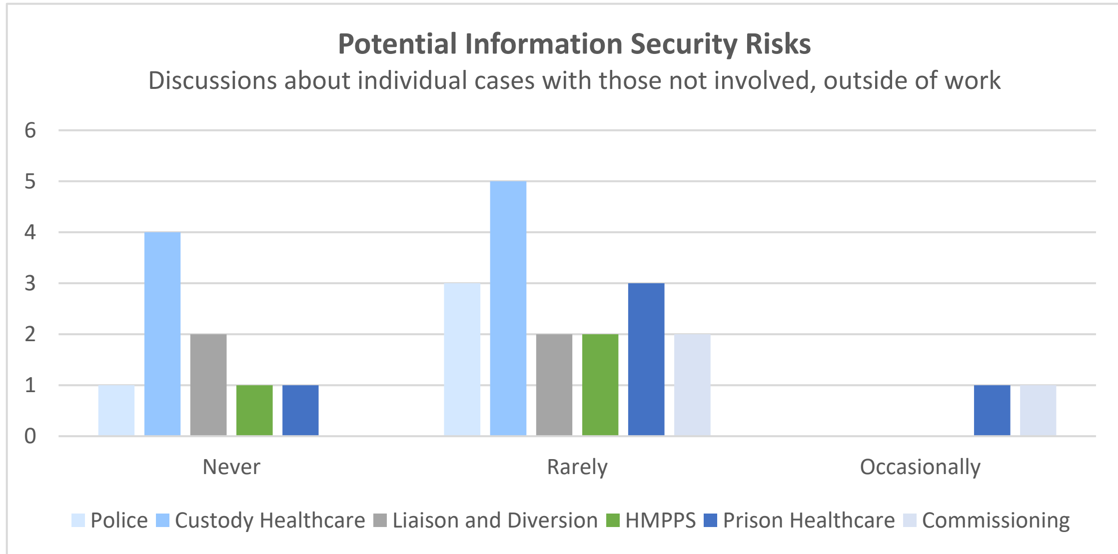
These would all need to be resolved, at least to the satisfaction of the Commissioner.

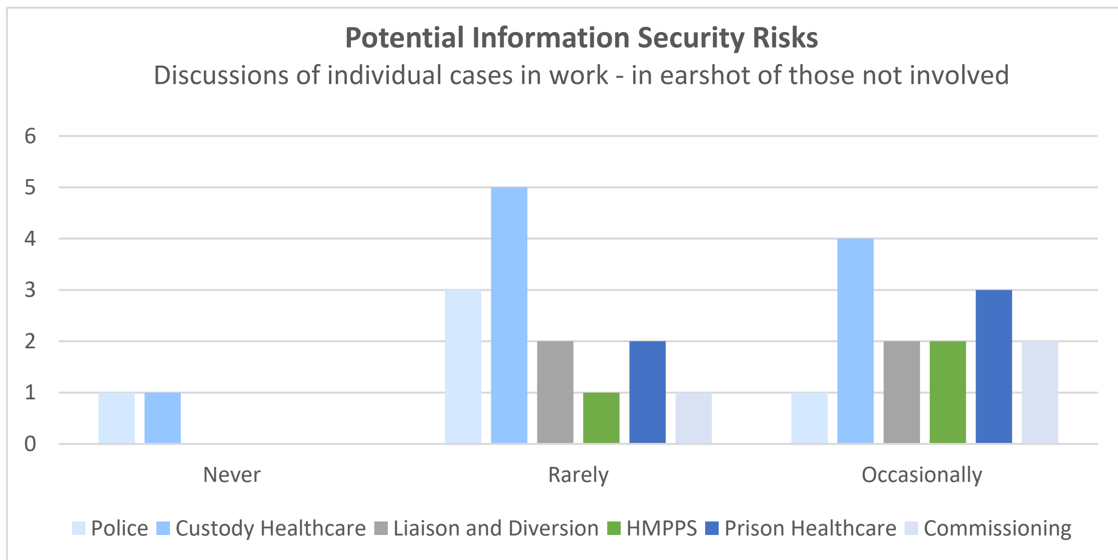
Information Security can be a tricky subject to conceptualise, so to understand how much information security and data-sharing concerns affect systems currently, we asked participants to classify how often different kinds of Information Security breaches occurred, choosing from:

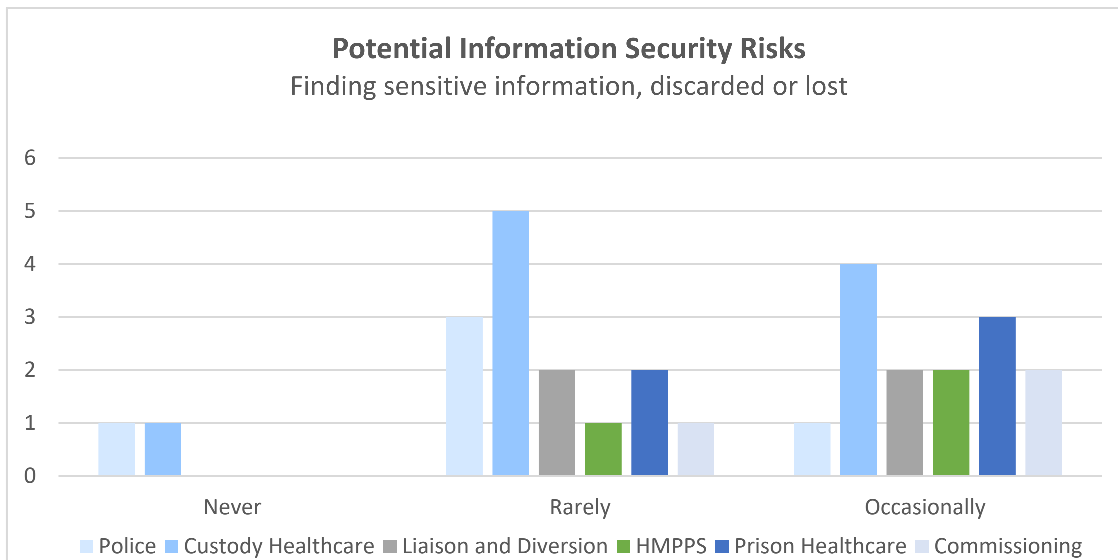
- Never
- Rarely
- Occasionally

- Frequently
- Very Frequently

Six security breach statements were provided. Full details are here. None of the scenarios elicited a response of Frequently or Very Frequently. Three provided responses comprising Never or Rarely, the remaining three are shown below.







Regarding '**Discussions about individual cases…** ', some commented that they may occasionally discuss particularly difficult encounters outside of work with a confidante or partner, as part of their own self-management, but emphasised that person identifiable information was kept out of the conversation.

Others mentioned that at work, in confined areas, it would be inevitable that some staff might overhear discussions about particular people, '**in earshot of those not involved'** but that as professionals they were usually comfortable about the levels of disclosure in such circumstances. There are also occasions when sensitive aspects have, consciously, been discussed more privately.

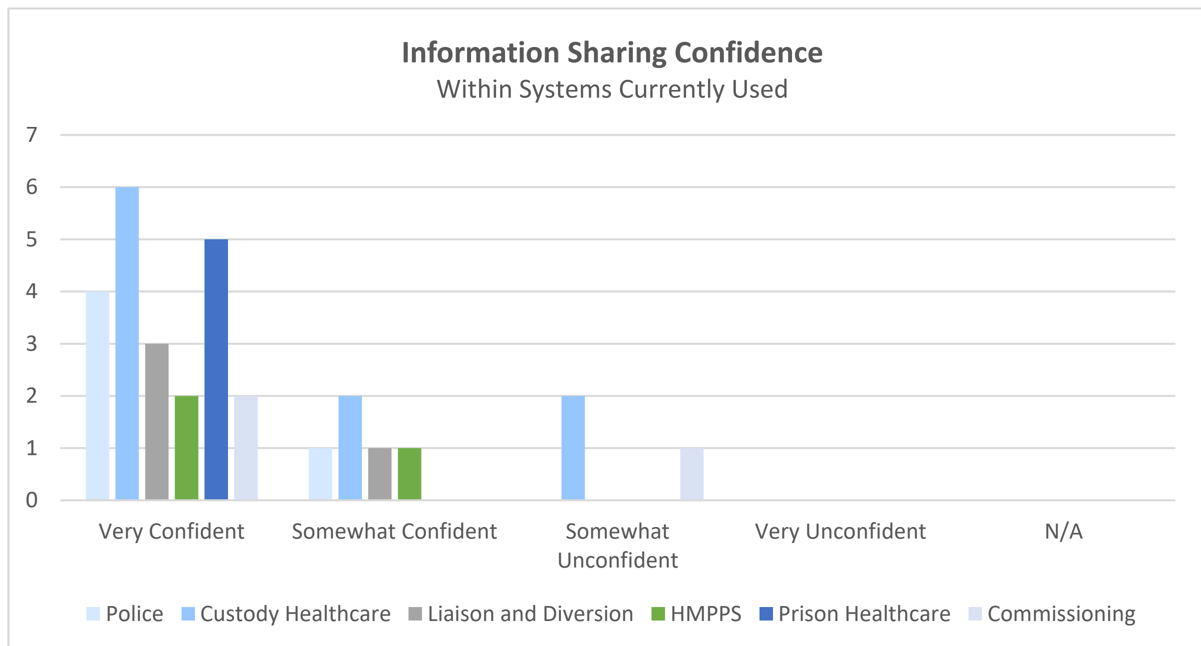
With regard to '**Finding sensitive information, discarded or lost'**, some respondents volunteered that this might reduce if more information was held online, with more reliable systems and less reliance on paper records.

After completing this section several of participants commented that they thought risks to Information Security would not be seriously jeopardised through a Shared Care Record, provided there was adequate training for everyone who sees sensitive information.

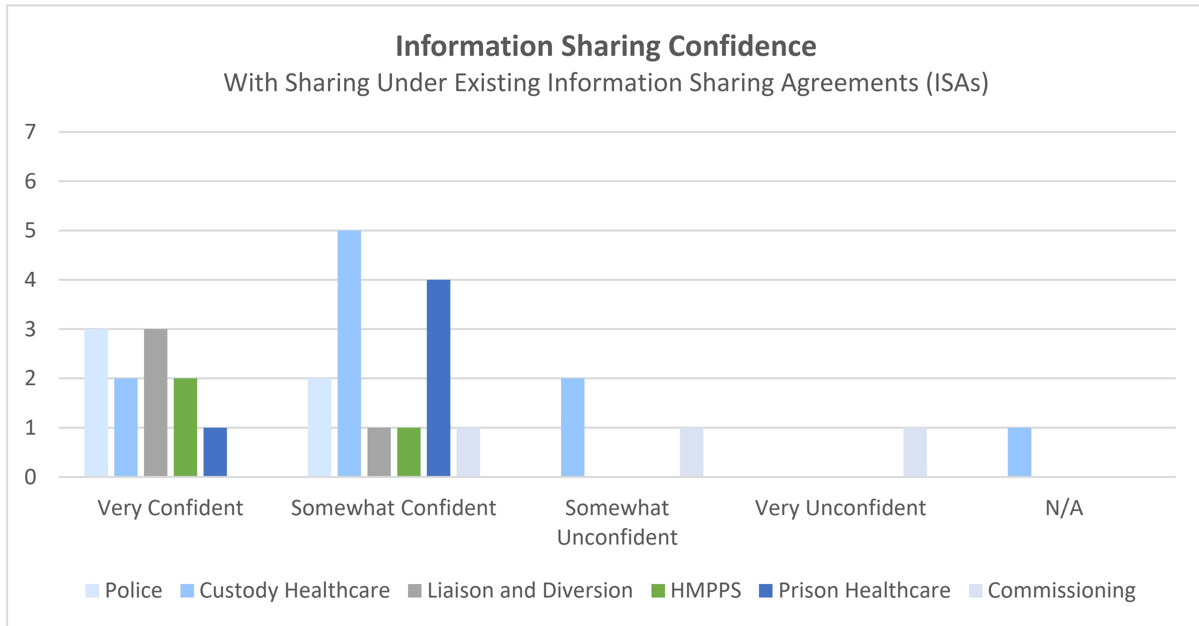
3.8 When to Share

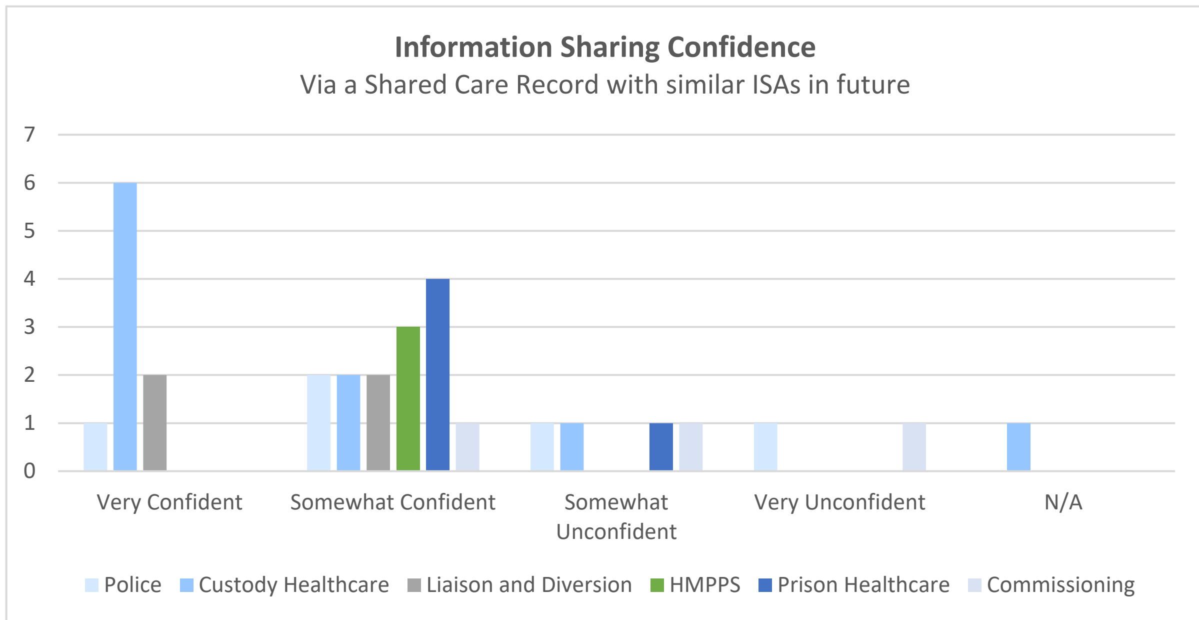
> The National Data Guardian's Eight Caldicott Principles "*apply to the use of confidential information within health and social care organisations and when such information is shared with other organisations and between individuals, both for individual care and for other purposes.*[2]"

The success of a shared care record depends on upholding these principles, alongside compliance with the Data Protection Act (DPA) and the General Data Protection Regulation (GDPR). To understand how well data-sharing issues are currently understood and may in future affect the operation of a shared care record, we asked participants to rate their levels of confidence with three cases. The outcomes are shown here, with further information provided in Annex A:



In the case of the Shared Care Record, many respondents downgraded their confidence rating by one level, because they did not know precisely who else might be involved, so were naturally cautious. Others remained confident and were more trusting of the process and additional professional involvement.





The Custody Healthcare environment projected an increased level of confidence in Information Sharing if there were to be a Shared Care Record, compared to current ISAs. This was explained by an expectation of a more standardised set of ISAs and further training, so that all parties would be ‘on the same page’, with a consequent increased willingness to share information.

4. Risks, Benefits and Expectations

4.1 When Risks Become Issues

Respondents were asked to describe situations where missing information has increased risks to patients. We asked questions to distinguish between first hand experiences, known actual experiences and anecdotal experiences. 22 responses were provided. For brevity we focus on only six here, to indicate a range of issues. The full list is provided in Annex A.

Have you experienced situations where you have heard that information existed elsewhere, but at the time it was not known, resulting in negative outcomes to people in the justice system? ("If only I had known…") **What were the impacts?**
Yes - this has happened to me A DIC happened fairly recently. At 1:00am when the detainee was brought in, we didn't have access to sufficient information. The person had been discharged from hospital, following an overdose, as fit and well. They were subsequently arrested, and they were later found dead in custody. With more background information their risks might have been assessed differently.
Yes - this has happened to our staff We have nighttime issues where we have mentally unwell patients and would need to know the background to their issues. This is difficult without access to MH records. Similarly, Summary Care Records are not always up to date so it is difficult to confirm medication or medical diagnosis of a patient. Also, Summary Care Record would never show if a person were on an Opiate Replacement Therapy... if it had been prescribed by the Drug Worker. At night we cannot access that kind of information, we would need to speak to the Pharmacy, so we wait until normal working hours. This could delay the drug withdrawal treatment.
Yes - this has happened to our staff Lack of information that could affect the care for a detainee whilst in custody. Potentially putting the police or our staff at risk of releasing detainees who haven't seen the correct healthcare professional which could endanger someone when leaving custody. Or they could become clinically unwell. Or the police could be deemed as not managing the detention appropriately - perhaps weakening their case by contravening PACE 'fit-for' guidance or putting the detainee through potentially unlawful processes.
Yes - this has happened to our staff Mental Health - a breakdown in communication between LADS - they would write their notes with a verbal handover, but not written up onto our system until midnight, meaning things like suicidal ideation would not be known until the following day or early hours of the morning, potentially after the person had been released.
Yes - this has happened to our staff Detrimental Healthcare i.e. L&D health trusts working siloed MH systems. HCPs were missing out on crucial information due to them being uncoordinated. (Jade, SystmOne, Care Notes, RIO, GP Practices)
Yes - this has happened to our staff In a coroner’s court with a DIC there were IRs on Quantum which holds all the prisoner information in the country... however we did not have access (which has to be granted by the prison superuser to give individual access to healthcare staff). This meant that medication diversion was not picked up and was a contributory factor to the overdose by the prisoner.

4.2 What Good Has Looked Like

Respondents in the 'Face-to-Face Carer' sector were asked to describe situations that worked well in terms of sharing information. Key factors that determined what was a good in day-to-day interventions were time, and timing. More precisely, that is the extent of availability of information holders for consultation or to provide promptly missing information.

When Rapid Information Sharing Works

Examples of when information was shared rapidly between multiple partners to enable positive interventions are described here:

Can you briefly describe one or two occasions when information, shared quickly across multiple providers, brought about positive intervention.
Getting a member of the healthcare team in place to ring the GP to get the Hospital letter or relevant entries to do with particular treatment and future appointments. Working with the community substance misuse service via an in-reach SMS nurse to share information about the patient's presentation and future treatment in the prison and the community.
Being able to talk to MH or D&A workers, giving full information to determine the right way forward for the person, informing FTD, FTI, FTR - this means the safety of people is more assured.
Someone from EPUT (L&D) may come to tell me about a detainee's situation which might positively influence my investigations, leading to a more realistic, accurate and beneficial outcome.
When I found out about a detainee who said they required Diazepam and had been given it previously in custody, however, checks with the GP surgery showed they were not permitted to be administered this, due to addiction. Also, a detainee with a complex medical history. Getting information through 111 was essential and quickly provided so that he could be diverted to hospital.
This is much better these days with the right person as head of healthcare. When men come in, they are seen by Safer Custody, Mental Health, Physical Health much quicker during reception so that risks are identified much quicker. The correct intervention of all parties means better support at reception and at release are in place meaning that the yoyo effect of return visits to the prison are eliminated or reduced.
We get alerts from court if any prisoner is showing any mental health concerns particularly around self-harm. We can pick this up quickly and do the relevant referrals - EPUT provide the information by phone and email with a Prisoner Warning Notice, we can share with the officers and scan onto SystmOne.
Working with L&D in Custody when we can we do joint assessments and so share information to develop an on-the-spot treatment or management plan.

When Information Shared in Slower Time works

Can you briefly describe one or two occasions when information shared in slower time across multiple agencies have brought about positive interventions
Sharing information can lead to better outcomes, such as the Buvidal (a 30-day depot treatment) trial. Also care for complex patients, by working with the hospitals to ensure the patient has access to their appointments and that we know how to care for them.
With frequent users coming into custody, one gets to understand more about their issues to give context to their presenting information and are then able to make a better decision in respect of the presenting behaviour. This could involve the FME and to propose a recommended course of action or to sanction a proposed solution. The information from different sources available based on previous events can suggest a better solution in the longer term.
Sometimes GP surgeries will get the GP to call us back, and similarly when 111 are required to call back. This can be problematic when busy with someone else to assure continuity of care.
Where there are multiple needs, it can take longer to get relevant information and multidisciplinary teams' meetings for very troubled individuals. It's about getting the right interventions in place while the information is gathered that is also important to minimise distress in the individual.
Yes, having worked in substance misuse I have in the past advised a substance misuse provider that the person being treated are using illicit substances on top of their prescribed medication. (*described as a 'best interests' intervention*)

These examples show the strengths of team working, when staff and information are available, to bring about positive outcomes for individuals in the justice system.

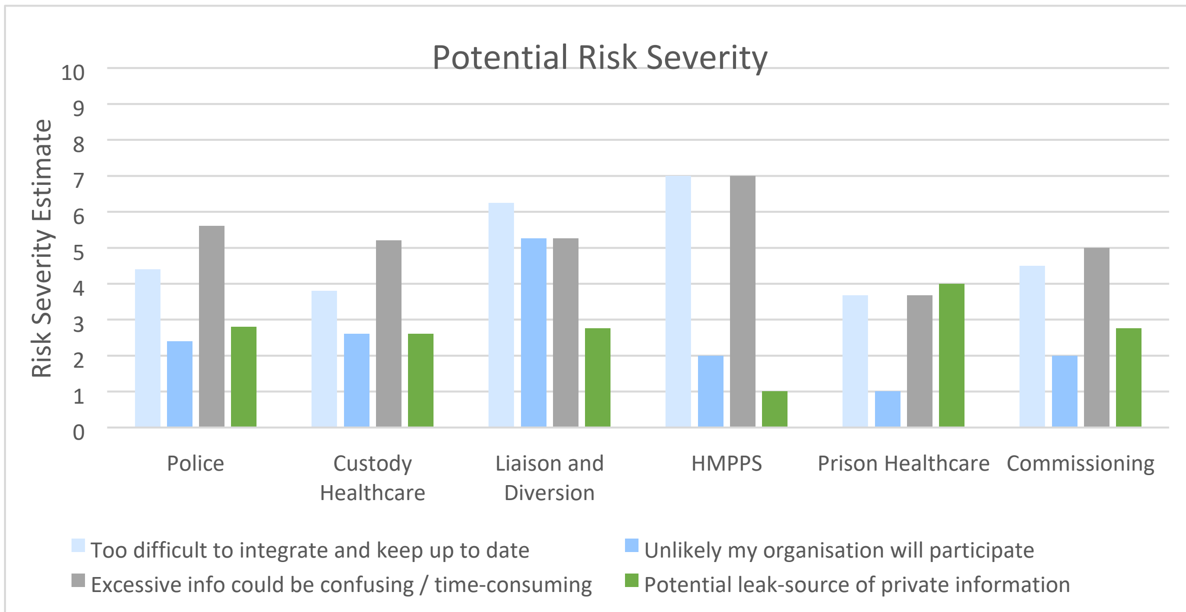
4.3 Risks, Benefits and Expectations

Risks & Benefits

The management participants were invited to rate some high-level Shared Care Record risks and estimate their severity, out of 10, where:

- 10 reflects an imminent risk with very serious impacts that is highly likely to occur.
- 1 reflects a low impact and low likelihood that could happen eventually.
- Severity scores should be apportioned accordingly to correspond to their order of magnitude using the other numbers on the scale provided.

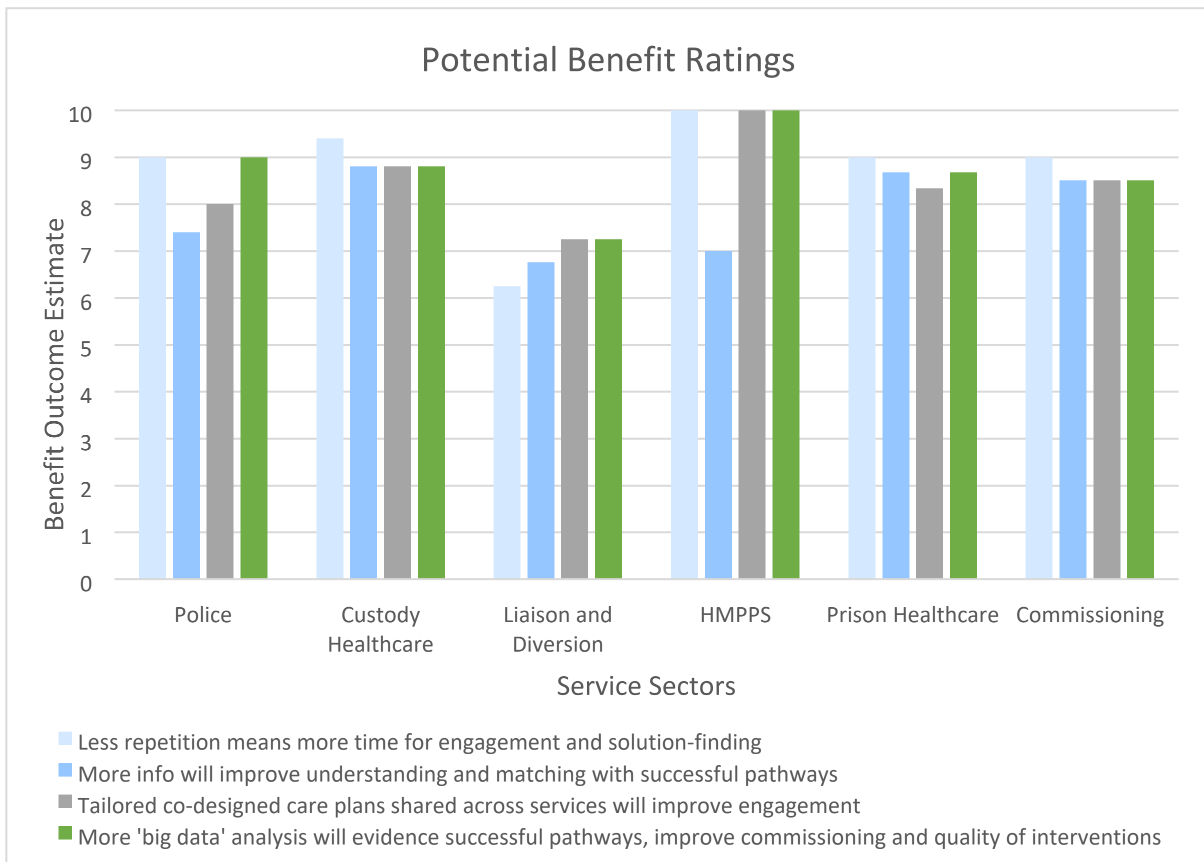
Their averaged answers are shown below for each service sector.



We were not asking participants to technically evaluate the risks, but more to give their views, having already tackled the key components of Information Security and Data Sharing. Their evaluations of risks were generally low, and this might be construed as participants having a reasonable belief in, and enthusiasm for, achieving a shared care record.

A similar approach was used in the evaluation of potential benefits, as detailed below, where:

- 10 represents the likelihood of positive impacts bringing the greatest benefits to the most people in the justice system, or to the organisations and staff.
- Lower scores reflect only marginal benefits that may affect fewer people, with a score of 0 assigned where there are no perceived benefits.



Effects of the Shared Care Record

The survey included canvassing the participants reaction to how the Shared Care Record might affect future work by asking what the potential impact might be:

- on people passing through the justice system,
- on professionals making use of it •
- on supervision/management
- on systems of work.

The full text of the feedback is captured in tables and fully detailed in Annex A. As each person explains their perspective, it becomes clear that there is a lot of support for the benefits of a shared care record, as well as some drawbacks. Training is raised as a concern, as is Information Security and Sharing of Information, but as concerns to get these aspects right, rather than obstacles to prevent its roll-out and implementation.

What Good Could Look Like

More Information

To discover where gaps occur and what is missing when working with people in the justice system Face-to-Face Carers were asked to describe what additional information is needed to give context to patient presentations and to understand better what they see, so they can provide prompt appropriate treatment. These were their responses:

Are there particular circumstances you can think of where you wish you had more information about a person you are caring for? If so, can you briefly describe below what would be helpful to know?
More information for every patient and access to their records in the community, and an immediate copy of a discharge letter and care from the hospitals, and also in police custody
Mental Health! The only way currently is by word of mouth with L&D MH Services themselves - Fit to Release assessments are done using a threshold system used by MH. If asked at 1:00am, there is rarely anyone around. Can delay the appropriate treatment - Athena sometimes has no information to support a FTR so there is a lot of investigation to be done out of hours, also delaying treatment of others. L&D may also do more by way of help for people such as housing. No direct access means trying to make decisions without sufficient information.
Between Police, previous information recorded, hospital discharge information and detainee narrative I generally have enough information to work with.
We need to know people's medical history, their medications currently prescribed, also any recent visits to A&E - 72 hours i.e.: periods of loss of consciousness. Detainees may be unable to explain, and likewise A&E can be reluctant to share information. No discharge or very brief poorly detailed explanations may be provided. Avoiding giving details because need-to-know is not properly understood by the ED department.
Sometimes GP's do not keep the Summary Care Record up to date and it gives very little information. We also do not have access to DP's mental health records, also information is spread across multiple platforms.
A man in our care was disruptive and we weren't getting any information about the individual, and it turned out he had a quite serious mental illness, leading to assault on staff. After chasing down the right people to give information, improvements were made with better support in place. This took a while to recognise this but now with a better care plan in place it is much easier to manage. If we knew earlier, the right steps to manage the risk would have been taken.
When we get prisoners transferred in and there is no SystmOne information from the sending prison, we have to just rely on what they are telling us with no way to back it up. We really need the medical information from the sending prison. If they are using SystmOne then we can see everything.
When an individual is presenting in crisis, due to medical, physiological, or mental health I always want more information. I want to know what medication they are on, any acute medical care they are receiving, hospital admissions, and up to date treatment plans.
We always need to know more, but difficult to say what we would like to know. Different people have different needs. Timing is important as sometimes information isn't available at the time of admission. This occurred on prison transfers of people where the records were not available on admission.

Time and timing appear again in the narratives, where a lack of one or both of these key factors are highlighted, as well as the wide range of information sources that needed to be accessed. This user

information helps to identify the potential scope/extent of a Shared Care Record. More face-to-face Carer input may give further detail or reinforce the content and priority in the development of a comprehensive and useful Shared Care Record.

What a Shared Care Record Looks Like

To capture individual preferences, we asked for participants' views on what a shared care record might include, asking them to separately rate 32 potential attributes on a 0 (not useful) - 10 (essential) scale. Some questions were paired, to distinguish between the importance of recent behaviours and more historic aspects, enabling alternative values to be assigned accordingly.

This enabled the shape/content of a shared care record to be explored, recognising different needs for different sectors and the need to limit visibility/access so that users are neither overwhelmed by irrelevant information, nor exposed to more private details that should be restricted or redacted. This led to discussions about usability, making sure a Shared Care Record worked *for the user*, and *not against them* progressing swiftly and safely to critical issues that needed to be resolved and keep people safe.

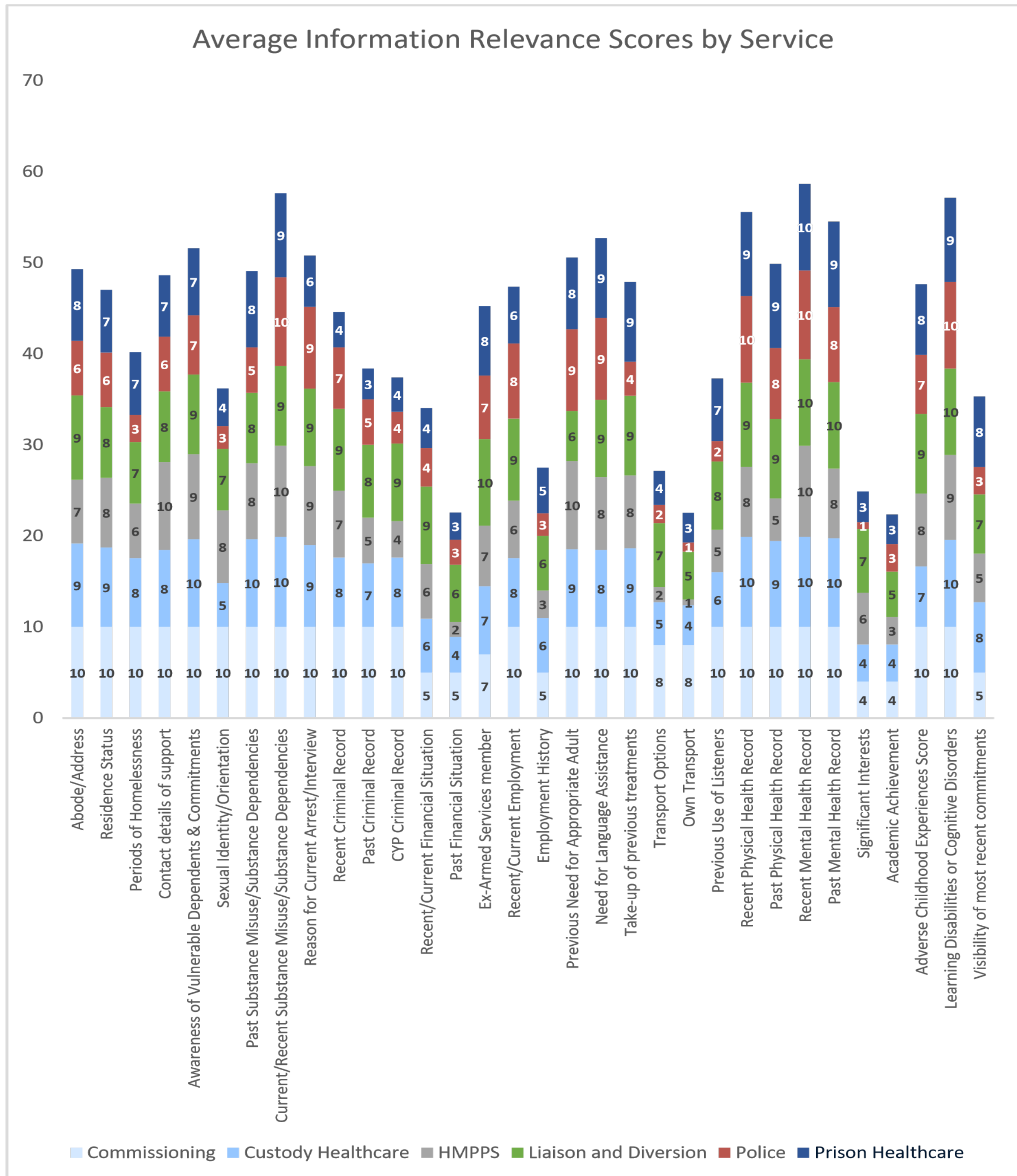
While the outcomes of the ratings exercise do highlight some differences, as shown by the bar chart on the next page, of greater significance is that all services recognise the same essential key requirements, as shown in the ordered table below.

Concern	Commissioner	Custody Healthcare	HMPPS	Liaison and Diversion	Police	Prison Healthcare	Total (60)
Recent Mental Health Record	10.00	9.91	10.00	9.50	9.75	9.50	59
Current/Recent Substance Misuse/Substance Dependencies	10.00	9.91	10.00	8.75	9.75	9.25	58
Learning Disabilities or Cognitive Disorders	10.00	9.55	9.33	9.50	9.50	9.25	57
Recent Physical Health Record	10.00	9.91	7.67	9.25	9.50	9.25	56
Past Mental Health Record	10.00	9.73	7.67	9.50	8.25	9.38	55
Need for Language Assistance	10.00	8.45	8.00	8.50	9.00	8.75	53
Awareness of Vulnerable Dependents & Commitments	10.00	9.64	9.33	8.75	6.50	7.38	52
Reason for Current Arrest/Interview	10.00	9.00	8.67	8.50	9.00	5.63	51
Previous Need for Appropriate Adult	10.00	8.55	9.67	5.50	9.00	7.88	51
Past Physical Health Record	10.00	9.45	4.67	8.75	7.75	9.25	50

This table demonstrates overwhelmingly that ***all participants rate visibility of recent Mental Healthcare information as being absolutely essential*** within a Shared Care Record. Similarly, it clearly shows that ***Substance Misuse information is absolutely essential*** as the second priority across all the services, ***also, awareness of Learning Disabilities and Cognitive Disorders.*** Currently there is no guarantee that any this information can be accessed on a 24/7 basis where it exists. The relevance of these aspects is further recognised in reports into deaths in Police Custody, detailed in Reports and Pathways. There is more certainty that Physical Health, which comes in as fourth in priority, would be

available via the Healthcare Provider and connectivity to the Summary Care Record. It would probably be fair to say that in future a shared care record should….

…. facilitate complete and accurate record keeping by reliably providing the latest information in suitable formats for all services systems, so that awareness of mental health and substance misuse risks are better understood and that users can readily appreciate the range of vulnerabilities present, while enabling swift, easy verification of health information from detainees.



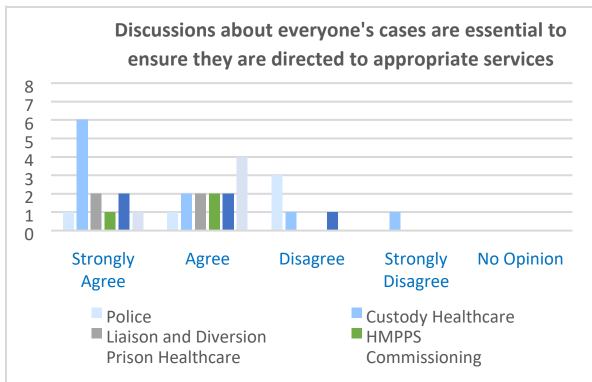
Shared Care Record: Expectations and Appetite

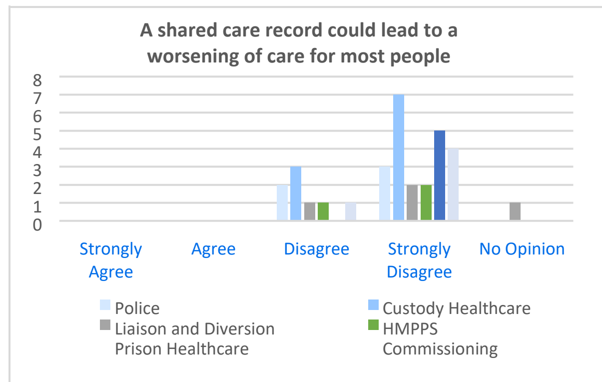
The final three opportunities to feed back regarding the Shared Care Record were in the form of:

- Questions, inviting participants could give their Agreement/Disagreement/No Opinion responses to Shared Care Record statements
- Commentary, to support the final statement, *'A shared care record sounds like a good idea'*.
- Further perspectives, in relation to the Shared Care Record or the Survey itself

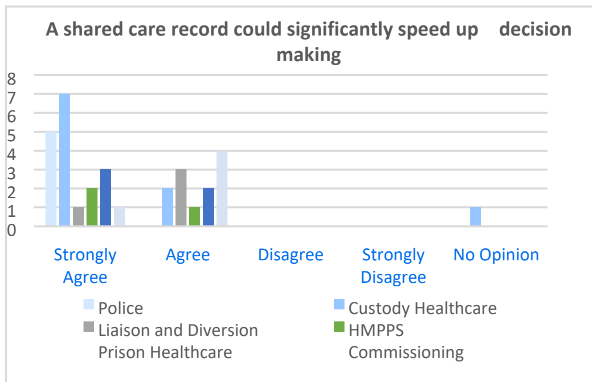
As will be seen, the commentaries were entirely supportive and majority were also enthusiastic, which leads us to conclude there is a genuine appetite for the Shared Care Record.

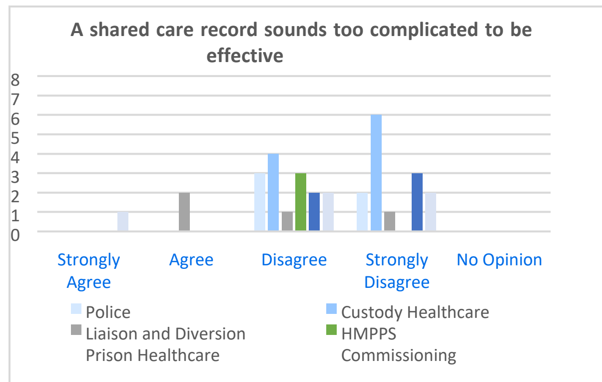
Shared Care Record Question Responses

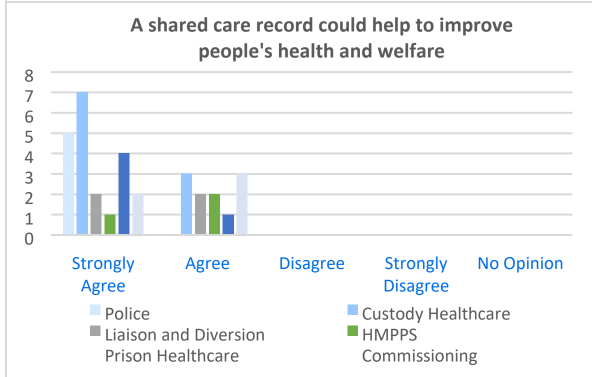


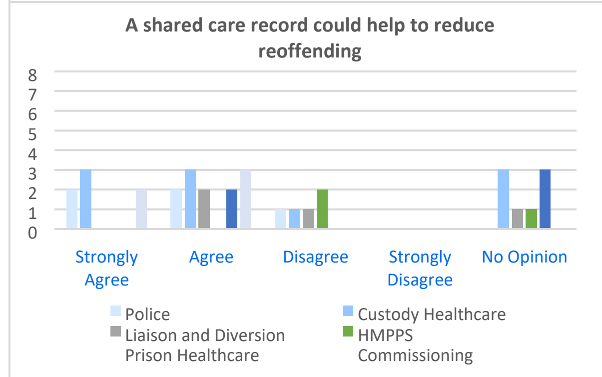


Note that for "*Discussions about everyone's cases…*"; those on the 'disagree' side observed that outwardly well and mentally stable custody detainees or prison occupants may not require discussions about their cases.



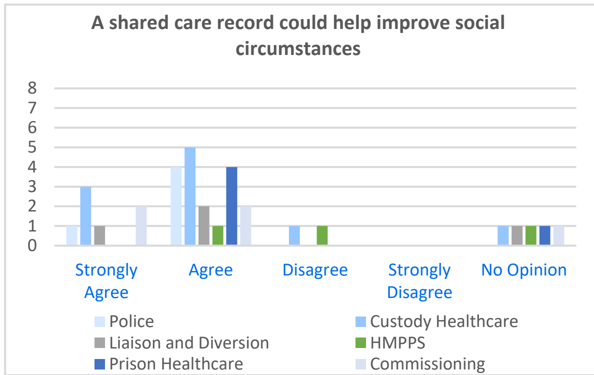


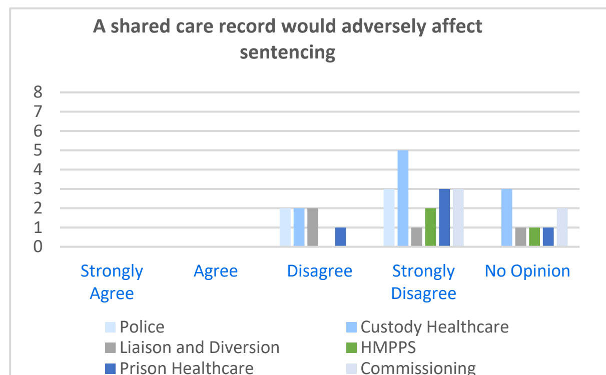


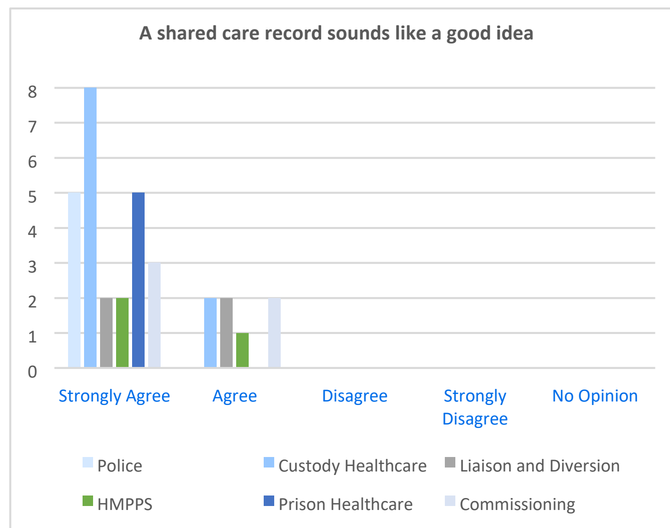


As the chart above shows, there were mixed views about how helpful a shared care record could be in terms of reducing reoffending. Several observed this needs a change in the attitude by the offender

and the shared care record would not bring this about. At the same time, it was acknowledged that it would help keep professionals aware of causal issues that could then be tackled.







When participants were asked to expand, below, on their choice for *'A shared care record sounds like a good idea'* it was clear that they consider it to be very much needed and welcome the idea, indicating an appetite and in many cases, a real enthusiasm for the concept.

Service	Could you add a few words to expand on your response to "A shared care record sounds like a good idea"
Commissioning	There are significant barriers to care at present due to a lack of easy information sharing, it would be positive for both staff and patients to be able to share important information easily as the patient moves through the criminal justice system.
	There are strong and clear connections between someone's mental and physical health, past and present, substance misuse and mental health, so information should be shared, and staff should be expected to know and understand and act on shared information.
	We need to consider more widely the impact on the judicial side of the system. The judiciary should need to know more about the status of the person ... We could get much of what is already in a presentencing report in a semi-automated way from a shared care record.
	Having a single point of access of information enables our providers to identify the right healthcare support required to meet the needs of clients.
	Health professionals should always have immediate access to a patient record, wherever that patient is in the pathway.

HMPPS	*It enables people to gain a far quicker understanding and provide a better intervention and care plan, the care plan will be there and can make a big difference... taken to the extreme it could mean the difference between living or dying. Better interventions quicker could prevent the worst outcomes.*
	With information you can make the right decisions if it isn't shared its difficult to make the right decisions.
	Making information sharing more effective would be useful for everyone.
Prison Healthcare	I'd like all the information needed to treat the patient effectively and keep them safe at the time the information is needed.
	See above. Already described the benefits
	I think it is a good idea because of our experience of GP2GP sharing which has sped up a lot of processes such as prescriptions, referrals, and hospital care. Adding information from the court's perspective for parole or offender management allows us to get more of a full picture and better risk assessments.
	I think it makes sense and would improve continuity of care and it is seamless this way. Whenever there is an issue there is always a section of it that comes down to communication... always!
	More efficient care and better outcomes
Liaison and Diversion	*Integrating communication with partner agencies is an interesting pathway to improve outcomes but the devil will be in the detail. I'm largely optimistic but aware of the risks as well of overwhelming the system.*
	There is the potential for a Shared Care Record to be useful so that information is not lost, however i do have some concerns. They are about duplication of work, if it reduces duplication, fantastic, but if it reduces the level of detail then it's not such a good idea. My view is that if you have something shared then it goes to the lowest common denominator (of what is safe to share). Having access to a nationwide system would be really useful, if not then it could lead to more work, more duplication and resources.
	This will speed up decision making and help improve peoples' outcomes
	Will enable current risks, history of risks, whether a person is currently under services and what help/support is in place. Current medication and any adverse effects or non-concordance. Ability to audit staff's records and assessments to ensure efficient record keeping.
Custody Healthcare	*Its a good idea for all the reasons I've 'strongly agreed' with listed above.*
	Its difficult to get people all in a room to have a meeting so the next best thing is to be able to access the information through a shared care record. It means we can act promptly having the full facts and make the right decisions.
	Already covered in the first few questions. Covered in depth already.
	Give it to me now! Nothing I've not already said. It would improve the patient's health and outcomes and provide opportunities for collaborative working and positive patient outcomes
	It is similar to a Multidisciplinary team so the effect of it would be it helps to pave a more positive pathway for detainees. It allows us to see who they are under and what they are diagnosed with, while they are detained in Police Custody. It would allow us to make appropriate referrals to other specialities that are not all in the Mental Health capacity, i.e.: in the medical sector.
	There is a potential to expose the clinician to more historical information about the detainee and also has the potential therefore to provide more satisfactory conclusion for the overall future welfare of the detainee.

	Because everyone is in a need-to-know basis only would have access to update the record, review the record they would be able to provide continuity in care and would benefit the patient for signposting to secondary services, where past and current history would be up to date.
	As mentioned, a greater understanding of patients so with greater awareness of their medications and past conditions we can act to provide treatment in their best interests. It would also prevent errors and serious incidents from occurring. I also think it would help with morale in custody, it can be difficult if you don't know what someone else has done. There is no annoyance or frustration among professionals if we can be confident everyone has communicated effectively through this system. It would help police so that the level of care and observations would be better assigned to those with real needs and not incorrectly assigned to craftier detainees. It will improve the rapport between the patient and HCPs.
	SAVING TIME LOOKING AT MULTPLE RECORDS ETC CAN ONLY BE A GOOD THING
	Sharing information enables clinicians to make informed clinical decisions for effective therapeutic management whilst in custody.
Police	*If you take the opinions and information from a wide variety of sources, it helps you to make a more informed decision to plan the best care for the person involved.*
	Its informed decision making, its medical intelligence, it empowers better care, and it would enable a collaborative process of higher level of care.
	The answers are: As a public body I feel we all have an obligation to provide the best care to an individual and to ensure that they get the right care at the earliest opportunity. So, if everybody who has any involvement with an individual's care shares their information there will be a much richer picture available to the individual, thereby meaning we can best support the individual and we can divert them away from criminality and substance misuse etc.
	Minimise risk, assist in decision making, help plan treatment
	It would support a consistent approach of supporting the offender through their criminal justice journey and support the offender in breaking their reoffending cycle.

Our last question, asking for any further perspectives in relation to the Shared Care Record, and the survey itself, yielded more positive support and, for the first time, some misgivings (conspicuous by their absence in almost all other commentary).

These comments add balance and caution that it should not be regarded as a panacea. In closing the Survey Section of this report therefore, it seems only right to leave the last words to those who kindly provided their responses.

Service	Thanks again for your time and effort, please feel free to provide any further feedback concerning the Shared Care Record, or the survey itself, here.
Commissioning	Key to the success of the RECONNECT services (both prison and community based) is timely sharing of expected prisoner release date and the location they are being released to
HMPPS	I think it will be a really good idea and has opened my mind to what could be... I've enjoyed the survey.
	If it's going to roll out, 100% we need loads of focus groups please, if you don't have focus groups including police, prisons staff and healthcare within the prison, you will get a system that doesn't work inside a prison. Predominantly things go wrong in a prison, and it must work inside this environment (it's got the worst environment) so it will probably work in the community effectively. Time and resources mean that it must present information properly. You need no qualifications to be a prison officer - systems must be simple and easy to understand and not pages of written information. It must be easy to understand. Bullet point form... and accessible in detail behind the headline/summary information. People in reception need an easy system.
Prison Healthcare	The survey might be quicker to send with them have it in advance and go through with them if needed.
	I look forward to seeing the first of type!
	Nothing further except - when can we have it!
	I like that it's done over teams, if not you could go through it too quickly and not take stuff in.
Liaison and Diversion	It's been interesting to focus my mind. I have said I agree with the Shared Care Record but not convinced that I do. Sometimes too much faith is put into systems and one system might not be the answer. At the centre of all this has to be about the client and their welfare, it has to be helpful to them and I am not convinced a shared care record necessarily would be. It's about how the individual services communicate and share information and giving the same information to every service may not be most beneficial to the client. The shared care record may have an adverse impact on some clients, and they tend to be the clients that are hardest to reach and most marginalised and that causes concerns for me.
	This was a very interesting survey which allowed me to think about the sharing of information and whilst sharing information is vital, it also depends on the information entered onto the systems and how much relevant information is applicable.
Custody Healthcare	Survey was good to take part in, it shows there is an interest in trying to make HCPs lives a bit easier and better.

	Hurry up and do it!! I felt this was focussed to the L&D aspects more than medical. So, if we're going to share records we need more medical representation, i.e.: District Nurse, or Diabetic Nurse for example... Our role is also Medical so to me if we have these shared care records, we should be able to do things like book in appointments for GP or community and district nurses - also in hospital environments, so that we are looking after those with serious conditions and those non-attending can be brought back into the system and encouraged to continue their treatment. This will help to complete the bigger picture. Prisons also need to be included in this.
	Nothing much to add it's been enjoyable to provide the information and enjoyed doing it. A good discussion.
	It good to have some input into what potentially may come to fruition in the near future hopefully!
	The Shared Care record is something we are desperately needing and essential for our patients to benefit them and be able to look after them in custody. In fact, in this day and age I'm surprised we don't have one already.
	It's been very nice meeting you I'm glad it's being looked into, and I hope there is a positive outcome.
Custody Healthcare	Yes, Mike was very helpful and covered in depth around the Shared Care Record and was very enjoyable to spend time on the appointment.
Police	My ongoing concern is about detainees being able to give specific consent rather than generic consent. It's a big thing about sharing with GPs and staff in the surgeries having access to records due to the worry about the wrong people knowing about their detention. There is a real concern about non-registered healthcare professionals being given access to records with no accountability (as given to some non-registered L&D records) This is likely to be a serious barrier to registered professionals sharing with un-registered staff without the professional qualifications in other organisations. The 'need to know' principles need to be deployed to preserve boundaries and access should be prevented, and the patient's privacy and best interests must be preserved at all times. If we are to depend on just one system, it MUST be reliable and not crash! People would be really let down if it becomes the norm.
	This is an aspiration many people have had for a long time and is long overdue. If used correctly and ethically will no doubt offer a greater standard of care and support, especially to those most vulnerable.
	I just hope it comes to fruition.

5. Next Steps

We recognise that the survey sometimes asks searching questions, (for example, regarding information sharing and security). This is partly to refresh participants in these principles and also as a means of focussing their thinking specifically on data risks and the sharing information generally.

Our hope was to tease out their tacit knowledge and experience to provide examples of good information exchanges and where improvements are required. We were not disappointed in that respect, and the responses have overwhelmingly been both enlightening and positive overall, and certainly worthy of pursuit with more respondents.

We also wanted participants to remain involved if they so wished. Towards the end of the survey, we invited them to leave their email details, to help us and the Commissioner further with ongoing Shared Care Record investigations. This could include providing updates on progress or potentially opportunities to join a focus group to further the shared care record concept. We are pleased to say that 88% of respondents agreed to provide their email addresses for these purposes.

Annex A - Findings in more detail

Survey Introduction

The survey opening page introduces participants to its purpose and intentions, along with a limited set of instructions. Subsequent sections provide further guidance, right up to completion.

H&J Shared Care Record Feasibility Survey

This is a multi-section survey intended to learn from the wide range of staff responsible for the health and wellbeing of people as they pass through the justice system. It is quite detailed but should take no more than 40 minutes to complete (although it could increase depending on how detailed you wish to be). While it provides opportunities to cut answers down, we would really appreciate you providing as much information as possible to help us complete the study effectively. Your views as users/supervisors and managers are essential to making this a success.

Its purpose is to help understand the appetite for, and benefits of, a shared health, wellbeing & social care record. One that provides professionals greater visibility and understanding of the many different interventions that people undergo as they progress through the justice system, so that their decisions are better informed regarding next steps for each individual. It is suggested that a shared care record has the potential to improve the way care is provided, by helping to create coherent pathways that are easier for people to follow to a successful conclusion, and for professionals to support and to report their progress. Such benefits could go a long way to achieving the joint Health and Justice aims of improving people's health and welfare, preventing or reducing offending, and reducing health inequalities. The information it gathers can also be analysed to aide effective commissioning and enhance the judicial process.

You can remain anonymous or you can provide your contact details if you want to continue helping to inform future developments.

Please Note:
Please be aware this is an online MS-Forms based survey, and it does not enable participants to save content and return later. It will need to be completed in one go (about 40 minutes). It will not be stored until you press Submit at the end.
To move through the survey every question needs to be answered. If there is nothing to add, please use the 'other' options, and/or insert N/A or other comment where necessary so that you can progress to the next section.

...

* Required

Your Role within Health and Justice

This will help us understand where you fit within the Health & Justice system, how much care you provide, and the other organisations you interact with.

1. **Please tell us which organisation you work for**
*

Enter your answer

2. **Please tell us your job role**
*

Enter your answer

Carer, Manager or Executive?

To keep the survey relatively short and relevant to their role, participants were invited to choose how they wanted to take part in the survey. The sorting process was based initially on the amount of face-to-face time they spent with people on their justice pathway and supplementary questions thereafter.

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* Required

How You Work

Your responses here help us to tailor the survey to reduce unnecessary questions and focus on aspects related to your role.

13. **Please pick a statement that best describes how much your role involves face-to-face work with people in the justice system** *

Select your answer

- 75% or more (face-to-face work with people in the justice system is the main focus of my role)
- 50-75% (face to face work with people in the justice system is the majority of my role)
- 25-50% (face to face work with people in the justice system is sometimes part of my role)
- 10-25% (face to face work with people in the justice system is occasionally part of my role)

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The options shown in the survey screenshot also included the opportunity to select 0-10% Face-to Face time, and 0% Face-to-Face. These enabled more senior health and justice roles, police and prison teams fulfilling their duty of care, and commissioners to be included in the survey. Those with between 10-50% involvement was asked to provide further role definition and could then choose for themselves whether to take the Carer or Management/Executive route.

14. **Since you selected a response of between 10-50% face-to-face work with people in the justice system please choose one of the following reasons and role descriptors that best describes what you do.**

*

- My role also involves face to face work with other people who are not in the justice system
- My work includes time spent in supervisory/management roles in addition to face-to-face work
- I support people providing face-to-face care, which means i sometimes see people in the justice system too
- There are other reasons

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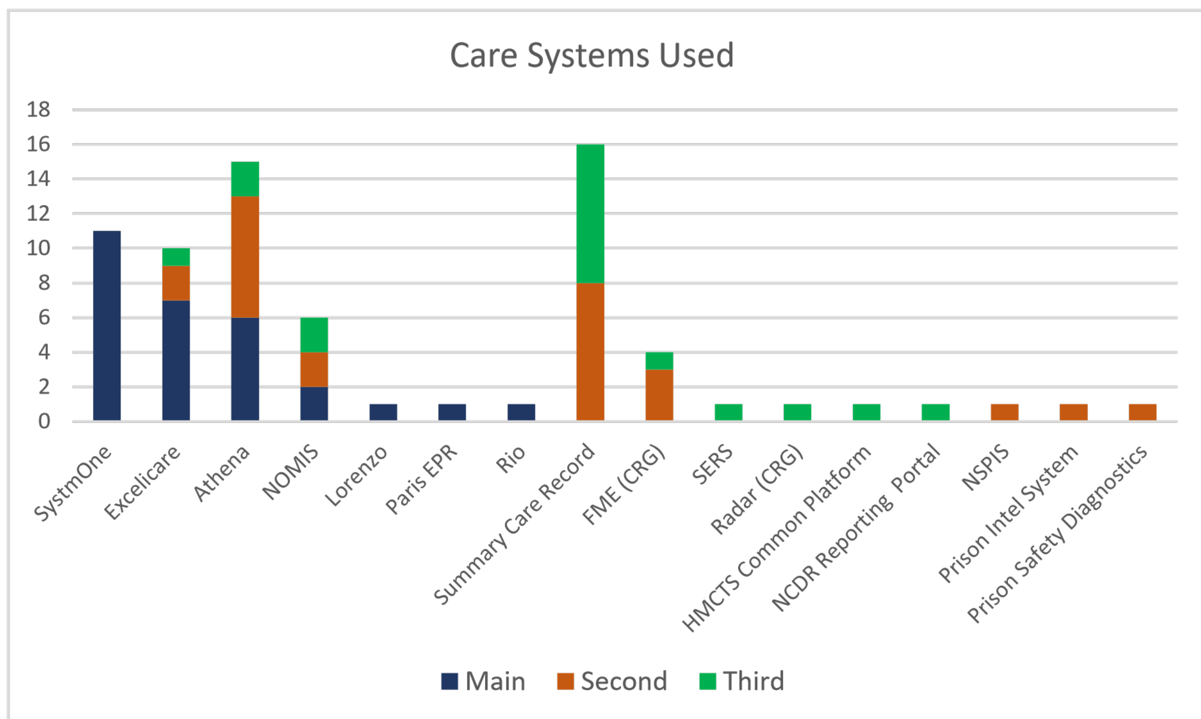
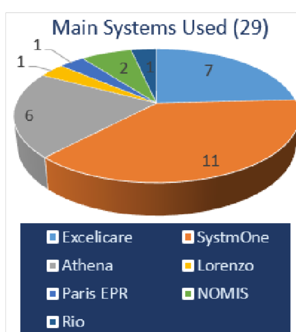
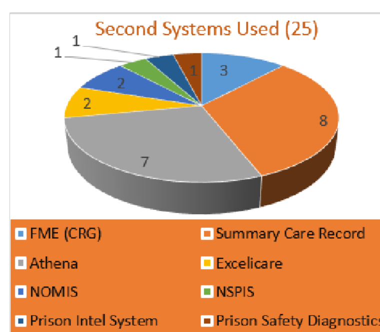
Systems Involved

The survey requested respondents to identify the systems used to undertake their normal roles, asking for Main, Second and Third systems as applicable. In the sample surveyed a total of 16 systems were identified either as main systems or systems used for consultation and/or to support safe detention and onward referral. They covered the persons journey through police custody, including physical healthcare and liaison and diversion services, courts and onward to their stay in prison, where they encountered prison healthcare and other systems relating to care.







The above graphs shows that key systems for the sample interviewed are:

- Athena – Police Custody
- Excelicare – Custody Healthcare
- Nomis – HM Prisons
- SystmOne – Prison Healthcare
- NHS Summary Care Record

During discussions with respondents many recognised that direct access to, or awareness of, Mental Health and Substance Misuse records and past interventions, was missing in many cases and would be advantageous in contextualising some people's presentations. Some gave examples that could lead to improvements in care and improve patient safety. Our expectation is that potentially a further 10

systems could be added to the list shown in the charts, particularly with more input from L&D providers and Substance Misuse respondents when approached. The study survey can be adapted to include these if required.

Systems Sharing Capabilities

The charts provided under Systems Involved and Typical Usage, above, show that each of the Services use at least two, and frequently three or more, systems to inform, investigate, treat and communicate issues to others in the health and justice environments. To understand current capacity to share their data electronically, participants were also asked about the capabilities of existing systems.

Do the systems you use to record care information share information with, or enable access to, other systems/providers?

Selectable Responses	Quantity
Yes, they all either share information with, or enable access to, other provider's systems	0
Some systems share information with/enable access to other provider's systems	**15**
None of our systems share information with/enable access to other provider's systems	**15**
I don't use them for sharing / accessing other provider's systems	1
I don't know if they share information with/enable access to other provider's systems	0

Evidently roughly half considered that none of their systems enabled sharing or access to other systems and half considered that some of their systems did. In most cases 'some' translated into the ability to access the NHS Summary Care Record, or, with SystmOne in Prisons, the ability to use GP2GP connectivity was identified, and was very much appreciated as a recent breakthrough for healthcare in Prison.

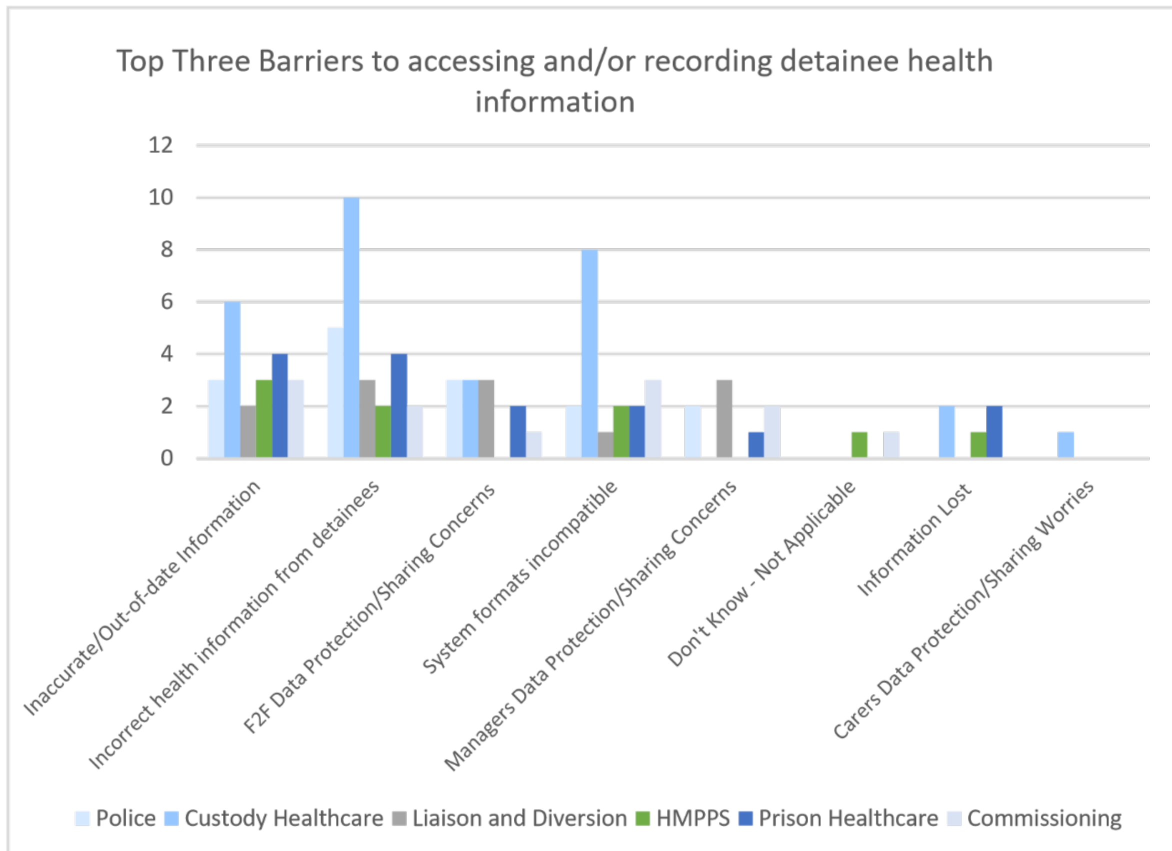
Other instances included the capability for NOMIS to communicate with a Prison Security Database and for this system to then inform a Safer Custody database.

Barriers to Sharing

Barriers to sharing were explored in some detail, initially by reproducing a question that formed part of a similar survey that has been run by Rocket Science – using examples of barriers used in their survey.[2] In our survey we asked users to prioritise potential barriers to form a 'top three' from the following:

- *Information is not recorded accurately or not kept up to date*
- *Detainees do not disclose their correct health information*
- *Face-to-Face Carers worry about how much information they are allowed to share (because of data protection)*
- *Our systems do not allow recording or access to the information in the right format*
- *We have concerns about how much information should be shared (because of data protection)*
- *Don't know / not applicable*
- *Information is lost at different stages in the process*
- *I worry about how much information I am allowed to share (because of data protection)*

The results are shown below:



As previously noted, the survey was split so that role-based insights could be obtained. We noted that those in management roles placed '*Face-to-Face Carers worry about how much information they are allowed to share (because of data protection)*' as a top three concern, however only one Carer recognised this as a top three barrier themselves: *'I worry about how much information I am allowed to share (because of data protection)'.*

[2] Potentially this will enable their findings and ours to be (traceably) merged – to the benefit of both surveys.

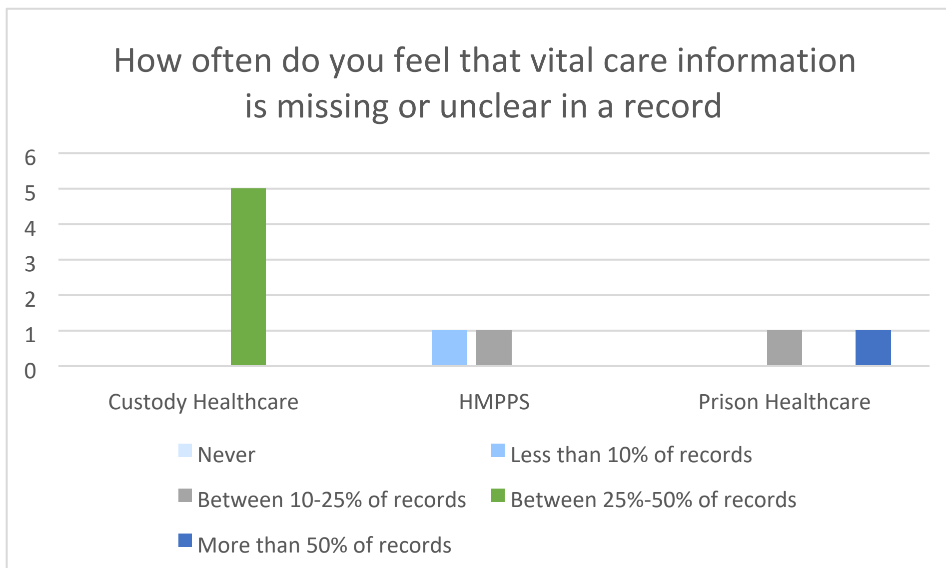
This did not mean that carers had no data sharing concerns, but that the more immediate issues in the Face-to Face role absorbed much more time and effort, more frequently and it was these that were prioritised as higher. The results indicate a consistent response from all sectors of the Health and Justice, with the same top three barriers being identified in all of the services surveyed.

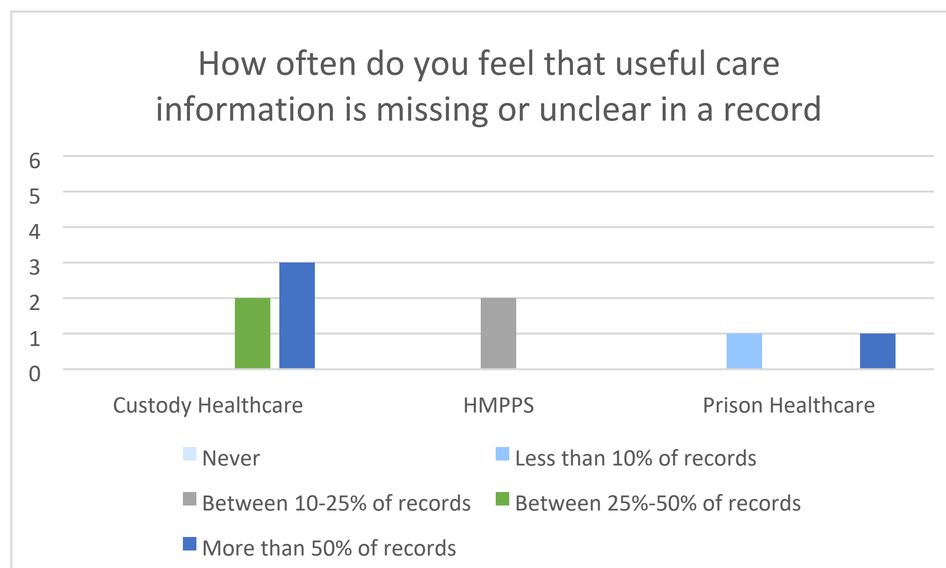
- *Information is not recorded accurately or not kept up to date*
- *Detainees do not disclose their correct health information*
- *Our systems do not allow recording or access to the information in the right format*

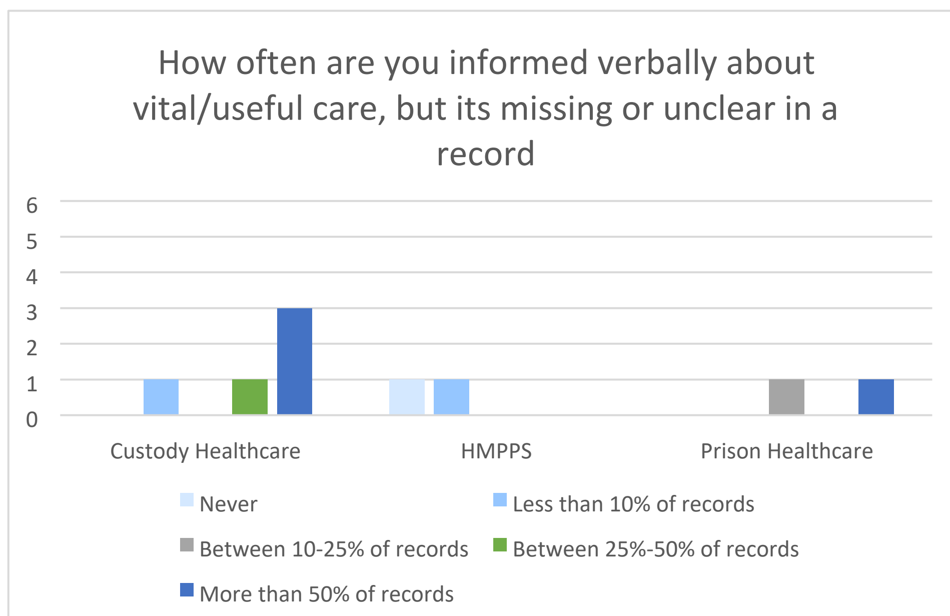
The survey was unable to predict the outcome of the question that were posed, but we did have some insight into reasonable follow-up questions based on the parallel Rocket Science (Annex B). The nearest equivalent to the first statement regarding inaccurate records is shown below with a question regarding Missing Care Information. The answers, shown by service, help to identify the scale of the issues that are encountered.

73. **Missing care information**
*

	Never	Less than 10% of records	Between 10-25% of records	Between 25%-50% of records	More than 50% of records
How often do you feel that **vital care information** is missing or unclear in a record	○	○	○	○	○
How often do you feel that **useful care information** is missing or unclear in a record	○	○	○	○	○
How often are you informed verbally about vital/useful care, **but its missing or unclear in a record**	○	○	○	○	○





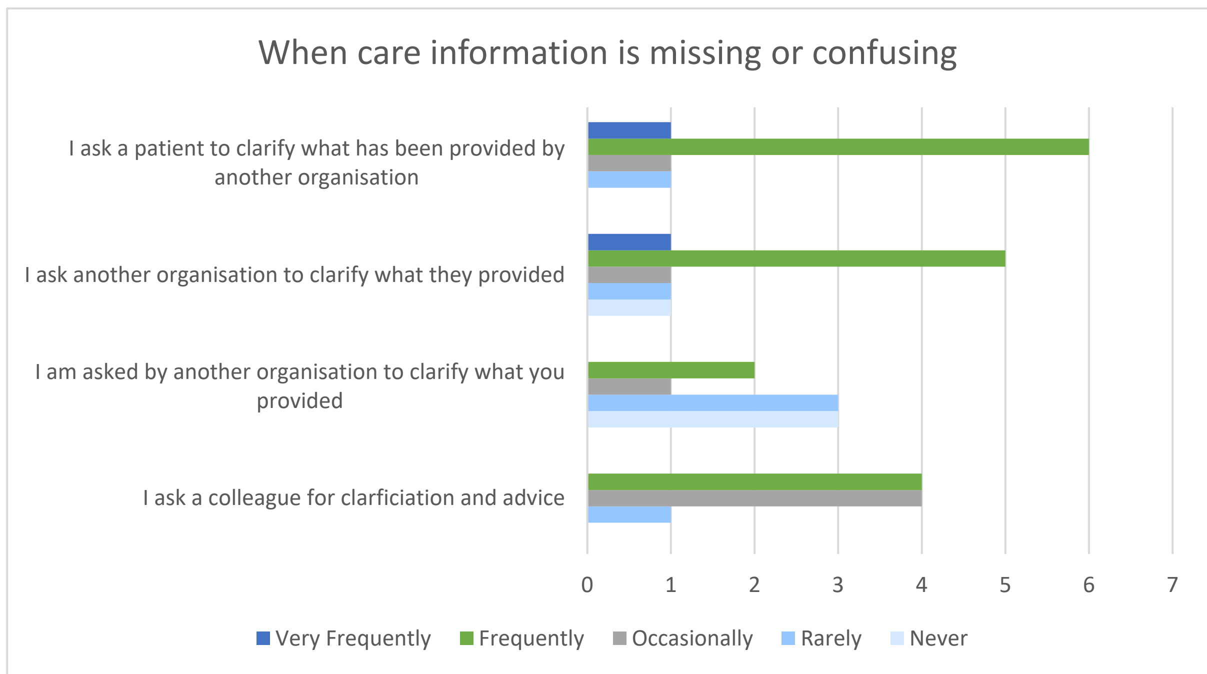


These charts show the extent to which healthcare staff feel they have to work with incomplete information. Of course, having access to other sources of information, such as mental health or substance misuse EPR systems, does not mean that the person examined actually has a record. However later findings do reveal that there are numerous situations when information has existed and, in their view, could have improved outcomes.

A follow-up question concerning actions taken to overcome shortcomings in information gives further insight into the efforts undertaken to assure safety of the people that clinicians are assessing and treating.

74. **When care information is missing or confusing**
*

	Never	Rarely	Occasionally	Frequently	Very Frequently
Do you ask a patient to clarify what has been provided by another organisation?	○	○	○	○	○
Do you ask another organisation to clarify what they provided	○	○	○	○	○
Are you asked by another organisation to clarify what you provided	○	○	○	○	○
Do you ask a colleague for clarficiation and advice?	○	○	○	○	○



Information Security

To gain an understanding of the extent that Information Security and Data Sharing concerns affect systems currently, and how they are overcome now, and potentially in future, we asked participants to give their views via the following question-sets, followed by their responses.

92. **Information Security is seen as a risk in many situations. In your experience/opinion how often do the following potential breaches of security occur:**
*

	Very Frequently	Frequently	Occasionally	Rarely	Never
Discussions about individual cases with those not involved, outside of work	○	○	○	○	○
Discussions of individual cases inside work - within earshot of those not involved	○	○	○	○	○
Illicit checks on individuals by cleared staff	○	○	○	○	○
Illicit checks on individuals by other staff	○	○	○	○	○
Data theft or attempted theft from within an organisation	○	○	○	○	○
Data theft or attempted theft from outside an organisation. (Hacking)	○	○	○	○	○
Opportunisitic copying or photographing of sensitive information	○	○	○	○	○
Finding sensitive information, discarded or lost	○	○	○	○	○

A large proportion of respondents who were interviewed were inclined to check the 'never' box for the majority of responses[4], but in fact clicked on 'rarely', since 'never' was too definite. Many suggested a 'very rarely' or 'extremely rarely' category would have been more appropriate. The remaining situations are represented here, with high confidence that Police and Prison internal systems were very secure.

When to Share

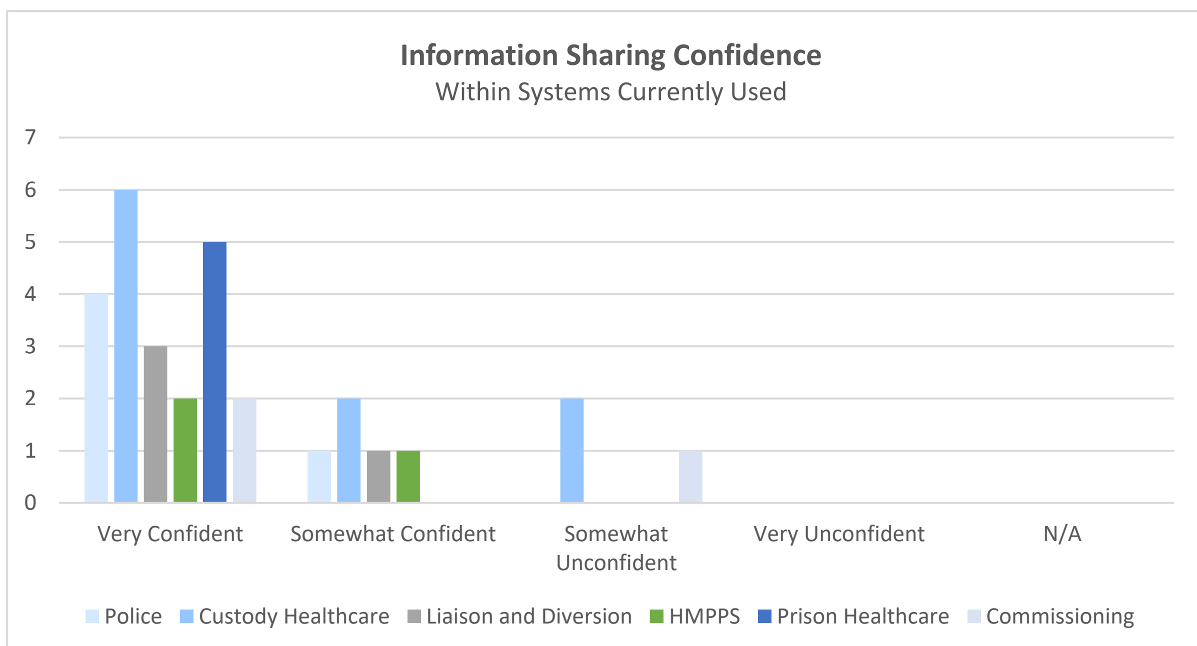
The extent to which data-sharing issues are currently understood and may affect a future shared care record were also assessed via this question.

79. **Sharing information is sometimes seen as problematic. Thinking about GDPR legislation and compliance, how do you, or would you feel about how, when, and what information can and should be shared, and who with?**
*

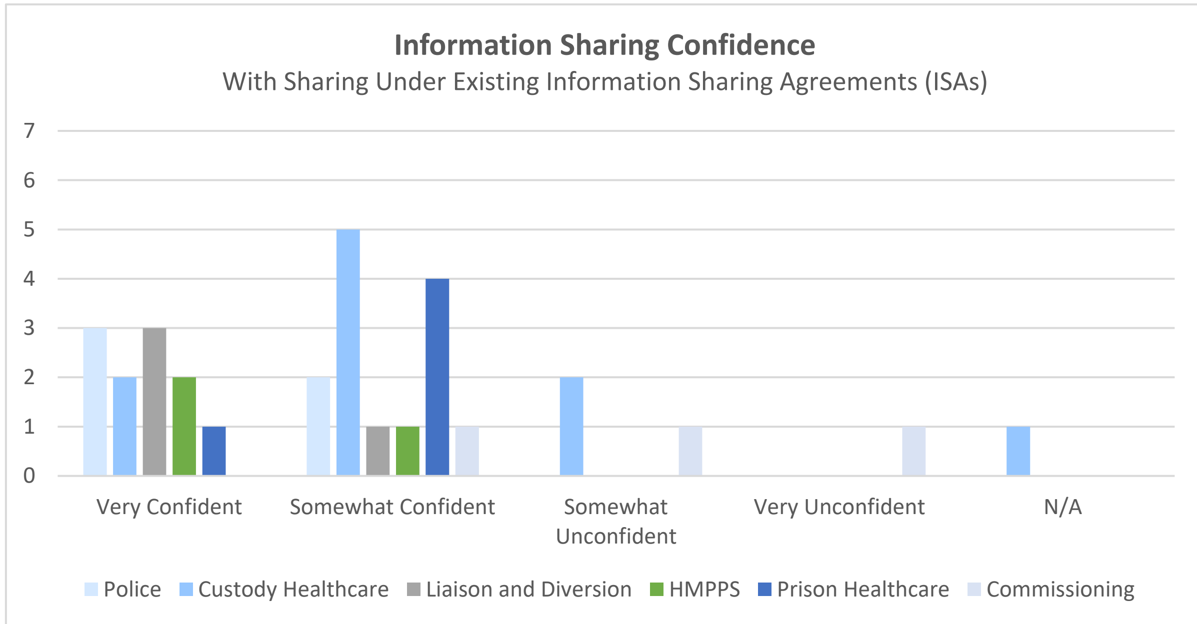
	Very Confident	Somewhat Confident	Somewhat Unconfident	Very Unconfident	N/A
Within the systems I use currently	○	○	○	○	○
With those I share information with under ISAs now	○	○	○	○	○
Via a Shared Care Record with similar ISAs in future	○	○	○	○	○

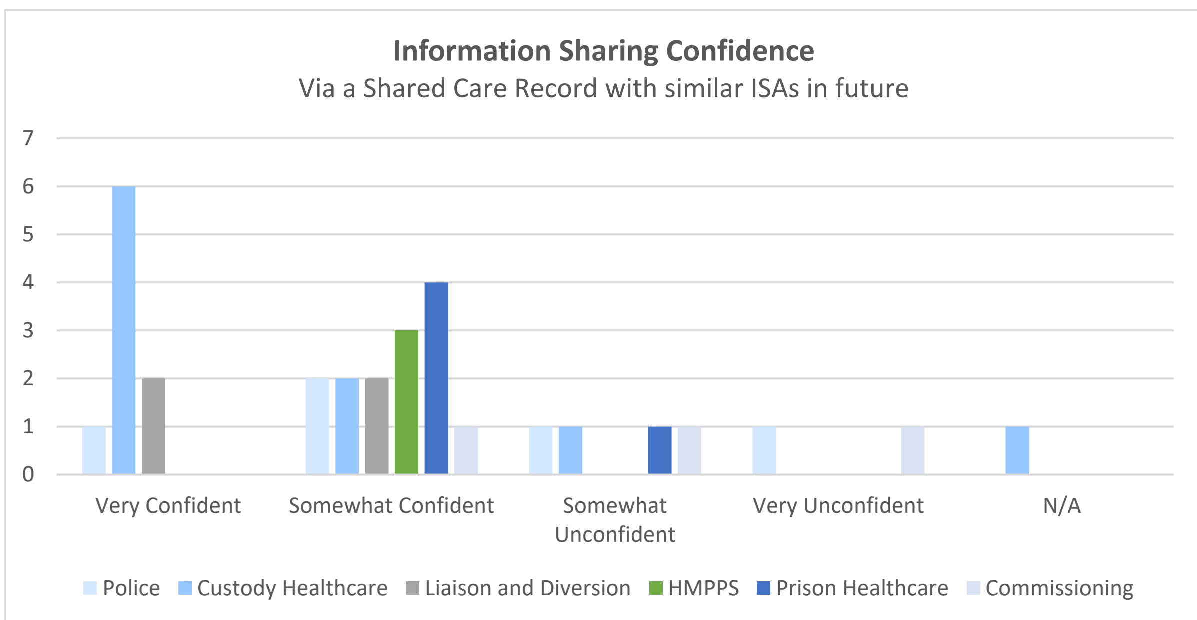
The three questions were provided to understand current levels of confidence around sharing information and to see if there would be any additional issues regarding sharing of information across a greater number of systems and organisations involved in the health and justice pathways.

There were several instances were, in the case of the Shared Care Record, respondents downgraded their confidence rating by one level. For many in this category their explanation was that because they did not know precisely who else might be involved, they were being naturally cautious. Others remained confident and were more trusting of the process and additional professional involvement.



Rather unexpectedly, those in the Custody Healthcare environment projected an increased level of confidence in Information Sharing if there were to be a Shared Care Record, compared to their confidence with current ISAs. This was based on an expectation of more standardised set of ISAs and further training was anticipated, so that all parties involved are on the same page, rather than different arrangements for each organisation, and that this would increase the willingness to share between organisations.





Managing Information Shortcomings

In this section of the survey, we have attempted to give voice to participants to identify shortcomings and their effects on themselves and on the care of people as they pass through the judicial process.

That a person needs to retell their story multiple times is a well-documented issue, but in many cases not having enough reliable information about an individual is at least as distressing for them and can be unsafe in several respects. What goes wrong, where and when is not the main aim of this study, but avoiding such situations does help inform what a good, shared care record could be capable of. It also helps participants to articulate their hopes and expectations – if only to say, "*I don't want this*" or

"we need to avoid that". In this section we have deliberately focused on sets of questions to help unpick the reasons for what goes wrong. In subsequent sections we explore the outcomes when communications are optimal and information flows in a timely manner - what good *can* look like.

Risks & Benefits

To gain insight into the collective attitudes to the concept of a shared care record, the management participants were invited to consider some high-level risks, shown below, that could affect its creation and to give their (non-technical) estimations of the levels, or severity, of those risks out of 10, as shown below. Their answers shown above were averaged from respondents in each service sector.

Considering the potential impact and likelihood of the following risks*, please assign a severity score, where:* •
10 reflects an imminent risk with very serious impacts that is highly likely to occur.

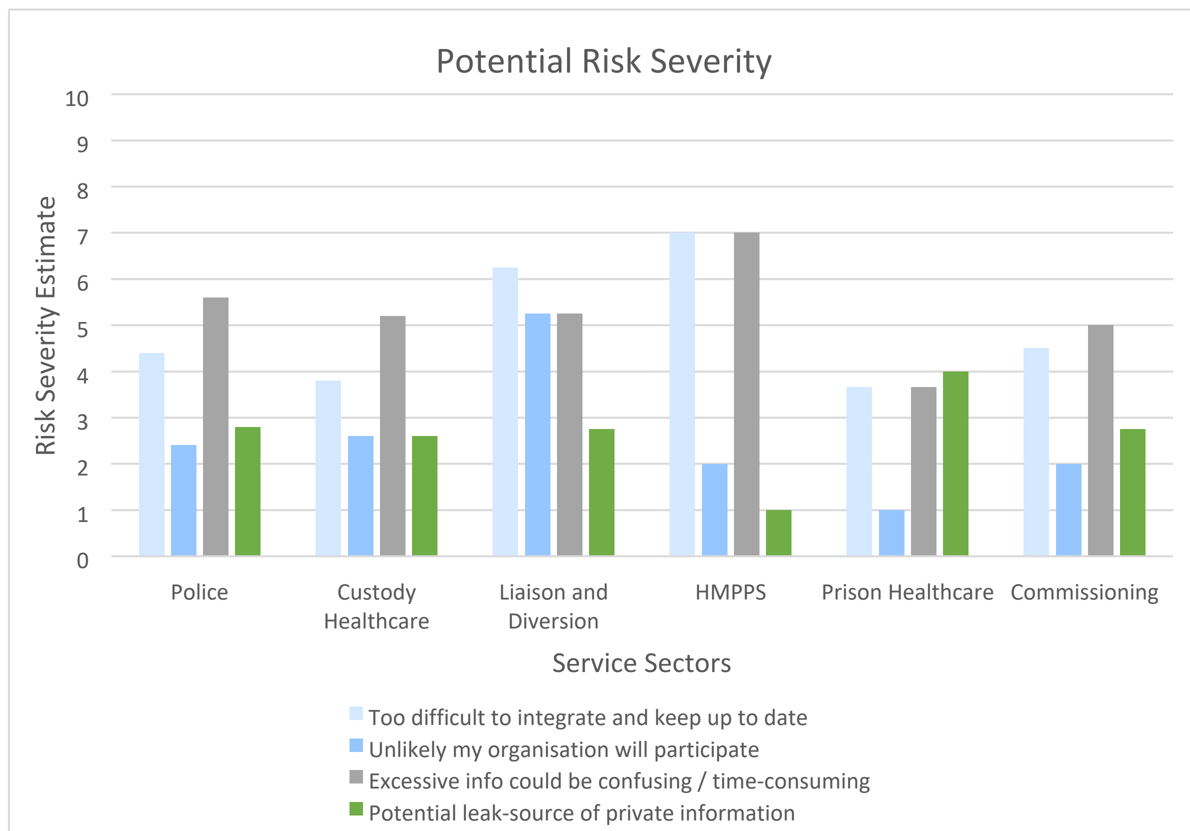
- *1 reflects a low impact and low likelihood that could happen eventually.*
- *Severity scores should be apportioned accordingly to correspond to their order of magnitude using the other numbers on the scale provided.*

RISK: With the number of organisations potentially involved, a Shared Care Record would be too difficult to integrate and keep up to date

RISK: I think my organisation is unlikely to participate in making information available to support a Shared Care Record.

RISK: Access to an excess of information about an individual could be confusing / time-consuming when trying to decide on the next course of action

RISK: A Shared Care Record could become a leak-source of private information and used for nefarious purposes such as shaming, blackmail or extortion.



As with most questions, we were not asking participants to technically evaluate the risks, but more to give their views, having already tackled the key components of Information Security and Data Sharing. The subsequent evaluations of risks were, overall, quite low and this might be construed as participants

having a reasonable belief in, and enthusiasm for, achieving a shared care record. A similar approach was used in the evaluation of potential benefits, as detailed below:

Please assign a score for the potential benefits listed, *where:*

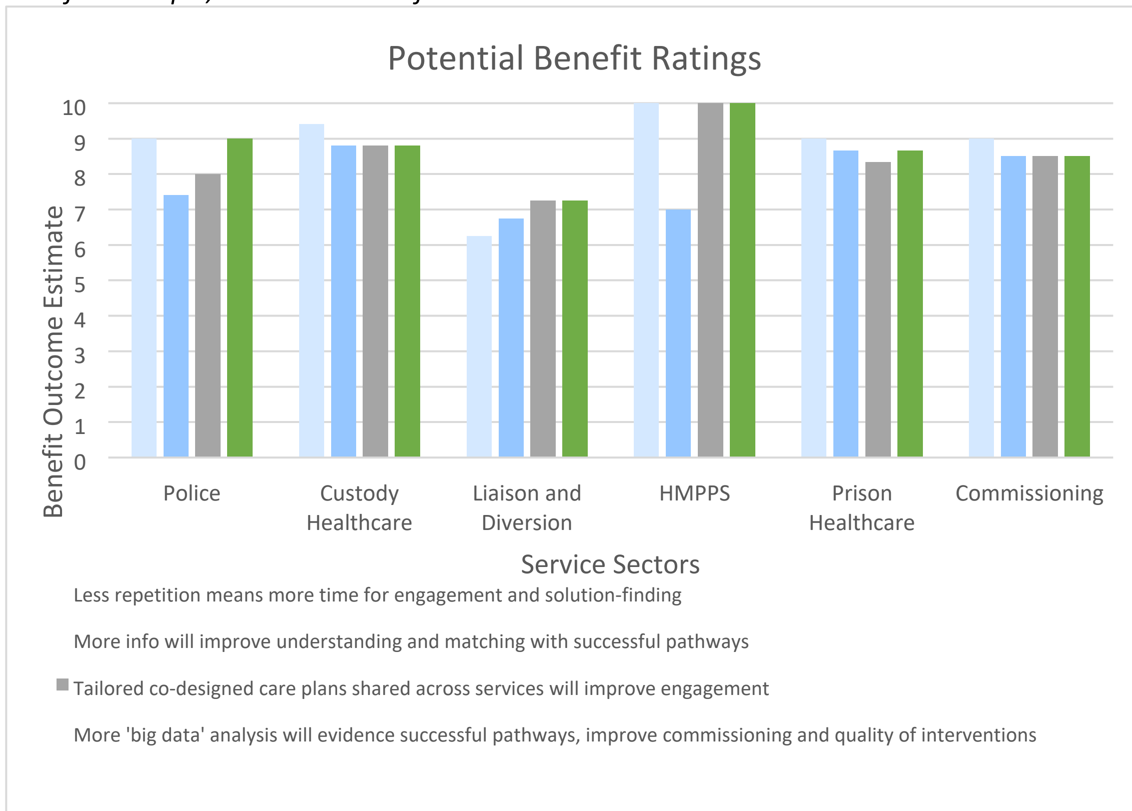
- *10 represents your views of the likelihood of positive impacts occurring bringing the greatest benefits to the most people in the justice system, or to the organisations and staff.*
- *Assign lower scores where only marginal benefits are likely to affect fewer people with a score of 0 reflecting a likelihood of no perceived benefits.*

BENEFIT: With information readily accessible to relevant staff there will be less time spent taking repetitive histories, leading to better engagement and more time to find suitable remedies for current issues/conditions

BENEFIT: Within each shared care record the greater number of attributes accessible for consideration will enable a more informed profile to be developed and used to motivate people and match their needs with successful pathways

BENEFIT: As more is collectively understood via the Shared Care Record about every individual in the justice system, coherent, tailored, strengths-based health and welfare plans can be co-designed with them, and made accessible to other professionals so that people are less isolated and better supported in their efforts to reduce reoffending and avoiding harmful behaviours.

BENEFIT: Analysis of the Shared Care Record data pool could provide evidence required to enable better correlation of referrals with outcomes, and better understanding of the combination of factors affecting why some interventions are more successful than others. Analysis will provide new intelligence to inform commissioning of services and resource justification to improve health and wellbeing and reduce health inequalities and reoffending, for example, with earlier and focused interventions.



Effects of the Shared Care Record

The following feedback has been provided by asking what the potential impact of the shared care record might be:

- on people passing through the justice system,
- on professionals making use of it • on supervision/management
- on systems of work.

As each person explains their perspective it becomes clear that there is a lot of support for the benefits of a shared care record. Naturally training is raised as a concern, as is information security and sharing of information, concerns to get these aspects right, rather than obstacles to prevent its roll-out.

Service	Assuming consent was given, *what do you think would be the effect on people in the justice system* if a wider range of the staff involved in their care had access to a shared care record? (positive and negatives?)
Commissioning	Better support for patients and more consistent provision of care. Quicker access to care they need and less repetition. More positives than negatives!
Commissioning	Staff would support people if they were aware that their behaviour was due to their mental health condition. There is a risk that staff would misinterpret health information or use it against someone.
Commissioning	Sharing the stigma that someone has been in prison, the nature of their detention may be off-putting to some. There is an element of data overload where clinicians and others become overwhelmed with the data being presented to them. Positives are that a more holistic picture will be developed of the needs of the patient, meaning there can be more bespoke services while also reducing risk with the more holistic picture of each person.
HMPPS	I'm not sure but think in the prison services we tell information to our colleagues, if it was information they needed to know. For prisoners the more relevant information available to be shared the better, there is sometimes a reluctance to share information.
HMPPS	Having more knowledge of a person, knowing what worked and what might need to be. The negative issues would be regarding privacy and intrusiveness, with information that a person was not prepared to have shared with a wider group, such as prison staff. Concerning for example: If they had been sectioned previously, also some primary health issues such as HIV. Consent may not be a well understood concept among some prisoners.
HMPPS	A massive positive for me - with a shared care record that could be accessed with the right controls when it comes to reducing self-harm and violence and recognising mental illness. This will help massively since more people can see the relevant information instead of having to chase it down. It would be a brilliant idea and make a lot easier for those in care. People in crisis in custody will be helped more quickly based on information - and not assumptions.
Prison Healthcare	In most cases it would be positive as the more information and history we have would enable more informed risk assessments and the correct level of care required to be identified. A negative might be because we work in the prison environment there might be a danger of more people knowing their background than is necessary and this could risk their safety.

Prison Healthcare	Positives would be continuity and understanding of their care. If there were Head Injuries or LD, the advanced awareness helps with preparations. A negative might be if they had HIV or Hep then we wouldn't tell everyone about their conditions due to dignity preservation/stigma associated with such sensitive issues. The effect on the patient would be to do with the reducing pressure on 'everyone knowing'. A further positive has come about since the GP2GP capability, giving an opportunity for better management of risk and avoiding over-prescribing based on issues being falsely notified by the prisoner - These can be checked with GP systems and better controlled.
Prison Healthcare	More timely access to relevant clinical information to inform prescribing and other treatment, no negatives.
Prison Healthcare	Assuming the right people are provided the information then timely information would improve safety. Negatives could be duplication, if the care is being provided from two or more places, i.e.: duplicate prescriptions, one provided at a time. Appropriate coordination would be needed such as visibility of notes but not necessarily inputting - avoiding inadvertent alteration of plans etc.
Prison Healthcare	I think that things would just get done quicker, if we had all the information about past medical history then we wouldn't need to go back and request it. This would enable quicker and better and more efficient treatment. This will help to give the patient more confidence in the treatment they get.
Liaison and Diversion	It would be a very positive thing if we, police, and probation could share information. They would be reaching into the system rather than relying on us sending it to each other. That said it works well with Athena as we are practiced and trained in how we work. The Shared Care Record will enable people to read only the information relevant to them.
Liaison and Diversion	People in the Justice system might assume that L&D NHS staff work for the police (as can be the case currently) which could prevent them divulging information. People can tend to compartmentalise according to the services they encounter. People's health might be being looked after by the L&D Team. but if the police had access to that information they may wish to intervene and make an arrest, rather than L&D advising the person to attend the police. Institutional barriers might be an issue too. Holistic Care would be more possible.
Liaison and Diversion	Shared information would allow identified risks to be communicated and management plans put in place to keep the individual and others safe
Liaison and Diversion	The positives are the ability to provide an understanding of their mental health condition to others which may prevent the same questions being asked. Up to date information on a person's current situation and mental health state of the individual. The negatives could be if staffs did not update information in a timely way to ensure the information was on the system.
Custody Healthcare	The more knowledge a clinician has, the better. The person in the system would potentially benefit from a clinicians input better if the clinician was informed with the maximum amount of information available to the clinician

Custody Healthcare	They will not have to repeat themselves numerous times to every service they come into contact with, this can be extremely stressful, particularly to those with MH problems. It should enable continuity of care. A history can be built up which is important when dealing with people, so that it gives context to the presenting issues. Shared information from wider sources such as diabetics, epileptic, cardiac history is useful.
Custody Healthcare	More information from specialities (or about specialists) would make it possible to set up care pathways more easily. Detainees displaying physical symptoms of illness could be treated in other ways by HCPs setting up onward care through alerting specialists from the community to visit at home so that treatment can be undertaken more rapidly.
Custody Healthcare	Continuity of care for the patient. It would mean their medication would be verified and given on time.
Custody Healthcare	On the whole a more positive outcome. Because we don't access MH records, we rely on what people tell us themselves. With that information we can treat them differently and with better visibility it could inform better diagnosis and a more effective outcome.
Custody Healthcare	People would be less likely to slip through the net and the Shared Care Record would allow continuation of the care-plan across establishments. The information from the police system would need to be strictly filtered to restrict access to sensitive information, to assure privacy of conditions or treatment (i.e.: medical assessment of a drink-driver). Information should be shared on a need-to-know basis.)
Custody Healthcare	The patient journey would be a more positive one, it would provide a more holistic approach to the care and treatment they would receive. It would allow collaborative working, meaning the goals could be set, met and reached. No negatives... we are all healthcare providers and all working to help patients we should be able to have the whole picture, without it, it becomes a nightmare.
Custody Healthcare	Caldicott principles would have to be followed and staff does not abuse the system, but it would improve the pace and smoothness of care for individuals. So, HCPs aren't spending hours searching or typing on multiple records. Documentation in custody is what takes most of the time. I believe it can only be a positive if all agencies are singing from the same hymn sheet, so to speak.
Custody Healthcare	I don't think giving Sergeants or Detention Officers access would be beneficial to them. Having increased access to their medical conditions would not beneficial, as they are not medically trained. They would still need guidance. With access to better information there would be opportunities for improved assessment treatment and management of the individual.
Custody Healthcare	Better health outcomes, a good potential to reduce offending habits which could then lead to less pressure on third sector and NHS resources. There could be a strain on resources if more people were referred but didn't engage.
Police	More consistent approach to their treatment, reduce the risk to prisoners, less tendency to 'plays the system' and less misleading of the healthcare worker. All contributing to reduced risks.
Police	Ensure it is INFORMED consent; this must be clear. The person would benefit from all relevant information being shared by involved parties. The wider the level of input would be positive because organisations should be able to act for the best interests of the person. This can lead to conflicts in priorities. A

	negative might mean a Drugs/MH/Protection of the person and Public Interest is in even more conflict than currently - a more complex process.
Police	Safer detention or medication and decision making is more likely to be positive and their journey is going to be safer for them
Police	Can't think of negatives - all professionals ultimately interested in the best healthcare for the detained person. Positive: It reduces the number of times individuals are asked about their wellbeing but a lot less repetitive Enables the right information to go to the right people. It means the best possible help could be provided to that individual whether short term or longer term through an appropriate pathway
Police	Reducing risk to individual, be more knowledgeable in dealing with someone, capacity, having to deal with the extra information

Service	Assuming consent was given, what would be the effect on staff involved in the care of people in the justice system of having access to a shared care record? (positives and negatives?)
Commissioning	Better able to support people via an awareness of their medical needs (e.g. supporting people with learning disabilities to understand information being given to them). Non-medical staff do not need access to a detailed medical history, only high-level information.
Commissioning	they would be without defence if they did not act appropriately.
Commissioning	Information overload could be a negative. A way of weeding out what is not pertinent. Each of the roles cover a combination of Healthcare, Key Holder, Judicial Decision
Commissioning	Support continuity of care - and continuation of care wherever the person was in the criminal justice pathway.
HMPPS	It's going to benefit staff as they will be able to recognise information so that planning for the individual would be available and we could make care-plans much quicker. It helps us to look into their needs and addresses the unconscious bias which will lead to a more equal and more positive outcome for the individual.
HMPPS	There may be a reluctance from management to allow information to be shared as there are concerns that sometimes the information might be spread to those who do not need to know. Younger members of staff were less experienced, and less aware of what information needs to be shared and what needs to be kept as confidential. They may be good staff but lack life experience and there are insufficient experienced staff to help them learn this.
HMPPS	It would be good to have everything in the same place to avoid repeating information, currently there is often information in several places but that sharing can be missed. If there was one central place, then that would be a good idea to save repetition and hunting in several places for information.

Prison Healthcare	Staff may well feel relief and empowered by having access to the information needed to treat the patient.
Prison Healthcare	Better use of clinical time as informed decisions can be made in regard to prescribing and other treatments.
Prison Healthcare	Positive, more information means better risk assessment - contributing to better joint working and better communication between prison officers and us and courts and community teams and parole. Negative it might take much more time to find the information required, this might also mean it takes longer to work through a file with information not always relevant to what we need to know.
Prison Healthcare	Safer Prescribing would be enabled, particularly concerning first night prescribing. We can literally look all the way back to birth giving visibility of self-harm, overdosing and mental health, this gives the staff more confidence they are treating the person correctly and giving them the right care. A man came in with 'odd' behaviour, with the community MH team we were able to give them the right treatment - so much more promptly rather than having to learn what their symptoms meant and diagnosing from the start. (similar benefits will be delivered to MH and treatment for HIV, Hep when people return to the community - they can see what has been happening in the prison too)

Prison Healthcare	I think there would be a lot less pressure on staff to try and find out information, a lot of our time is used up with investigative work rather than actually spending time with the patient. Staff would be more confident with treating the patient when they have the right information
Liaison and Diversion	Staff would probably very positive about it provided the system is workable and not as clunky as current systems. It would improve teamworking with the Police and other services. A drawback might be if it did not set up an equivalent record in the NSFT Systems (a task done currently by the L&D team).
Liaison and Diversion	Some information given by the client to our staff which was passed onto the police resulted in a further arrest/charge and involved the staff member in making written statements. The concern would be that information on the shared care record would be accessible to the Police and would negatively affect the client. There would be a tendency for the information to be used in different ways. A police colleague cannot ignore when a person is admitting to a crime - currently the way information is used by health care workers does may have impacts that have not been thought through.
Liaison and Diversion	Time will be saved and plenty of time will be released to care instead of spending hours requesting for information
Liaison and Diversion	The positives would be that staff would have current risk history and potential interventions or agencies already in place. There would be a reduction in time contacting agencies/staff to gain information. The negatives would be the amount of information shared and whether it would be applicable for all staff to require access to all information and the security of the information being shared.

Custody Healthcare	Greater visibility of patient's health and the treatment they have undergone. A reduction in time /increased capacity due to having accurate information to hand rather than relying on writing to a GP or faxing requests. No negatives come to mind immediately.
Custody Healthcare	We would be over the moon as it would save so much time for one person to have the information. We can see 15-20 detainees in a shift and if you need to make all these follow up calls to get missing information it is so time-consuming. If we had the information, it would be so much easier to give care of the right standard to more people.
Custody Healthcare	It would significantly reduce the investigation time because we would not need to access information from several different sources. It would allow safer practice and a higher quality of care.
Custody Healthcare	It will make staff feel safer about the decisions they are making since they would have access to the information available from wider sources. Staff would feel safer and more protected. If it's not documented - it didn't happen. If you don't have access to the information, you don't know what did or didn't happen.
Custody Healthcare	We would be happier to have access to more information... with access to information could improve our treatment of the person in custody.
Custody Healthcare	The clarity of the clinician's decision could potentially be enhanced where there is additional information to guide their thinking.
Custody Healthcare	A Shared Care Record helps verify patients' issues. Access into one system would make investigations far easier. Negatives: Everything is on a need-to-know basis and the records could be read by someone who is not aware of information security precautions. It means that as a manager you would need to check that people, on leaving, have their access to systems also removed.
Custody Healthcare	With regard to giving the clinician greater understanding of the person's medical record and history it would enable them to prevent medication errors from occurring, and better understanding of their needs and to verify their medication more confidently.
Custody Healthcare	Caldicott principles would have to be followed and staff does not abuse the system, but it would improve the pace and smoothness of care for individuals. So, HCPs aren't spending hours searching or typing on multiple records. Documentation in custody is what takes most of the time
Custody Healthcare	It would make them feel more enabled to give better care.
Police	INFORMED consent has to be a priority - CONFIDENTIALITY must be preserved in line with their training and code of conduct. With others not in healthcare roles this is required - but no penalty (known) for breaches and that could be problematic.
Police	Positive: as it helps them keep their registration as they would be less likely to make mistakes, they can have more confidence in what they are doing and giving better protection to them. medication

Police	It enables all staff, police or otherwise, to accurately assess risk and the needs of the individual. Although lengthy risk assessments are done the right information might not be disclosed in their management. This is not nosiness, it's about the best care for the individual.
Police	Capacity, having to action the information, being more professional being aware, not having to rely on others
Police	Improves professionalism and reduces risk, improving decision making - a consistency in approach with better informed staff.

Service	Do you think Care Processes would change significantly if there was access to a Shared Care Record?
Commissioning	No, but these would be quicker.
Commissioning	Possibly, it certainly gives opportunities for people to work more flexibly.
Commissioning	The more holistic picture should mean there will be improved care. There will also be potential changes in the judicial system if there is more information, e.g. in terms of learning disabilities and sentencing, such as better use of community drug orders, MH Treatment
HMPPS	I think it would not change significantly but it would improve the speed with putting a care plan in place, whereas if it was there and in place, we could act on it. We would be able to correctly assess and correctly put the care plan in place.
HMPPS	I don't think there would be too much change, there's not enough staff and not enough money which could affect how well this is used.
HMPPS	I don't know if process would change, but information might not be being recorded/shared as effectively as it could be. I think the same processes would be more effective if there was a single place to work from.
Prison Healthcare	It would avoid duplication of effort trying to access information. Currently we rely too much on the patient and also having to contact the hospital directly to find out the information. The pathway/interface would become more efficient with seamless sharing of information. A risk might be in ensuring only those who need to know about appointments are told and are able to access information to avoid potential security breach.
Prison Healthcare	Certainly, some of the administrative aspects of providing care would be altered. For example: rather than having to email a practice, if information is available somewhere else... the Shared Care record would be accessed first. The Shared Care Record method would be far less resource intensive.
Prison Healthcare	It might speed up certain things - if someone comes in and they have a hospital appointment it would be easier to see, and any changes needed could be managed more easily.
Prison Healthcare	Yes, I think it would massively improve. With the shared records we already have I don't have anything bad to say about them. I think the prison would benefit too - as security and the prison do not seem to be sharing information, which can cause anxiety to transferring prisoners who know they won't be safe in the new prison.

Prison Healthcare	Yes, all the above. Faster access to the right information will make the patient receive better care.
Liaison and Diversion	There may be additional Care Record duplication if the services we are referring into were not using the Shared Care Record. May be a bit more resource intensive.
Liaison and Diversion	A difficult question. It depends if it was the only record.... or if there were parallel systems (which contained the detail). There is already duplication which has its justification. The full picture on a shared care record might omit some detail that does not need to be shared with the police.
Liaison and Diversion	Yes- this will enable practitioners to make informed decisions quickly
Liaison and Diversion	There would be a better understanding of the need, risk and any interventions in place as too what has worked for the individual and what has not worked. Staff would have access to in a timely way providing more time spent with the person as opposed to going through the number of services, staff and agencies before an assessment takes place.
Custody Healthcare	There would be more targeted intervention and treatment, potentially treatment could become more effective with appointments generated more rapidly.
Custody Healthcare	The assumption is sometimes that MH and Healthcare have access to each other's records. There is inconsistency between using Athena to bridge the gap in information, for MH and Healthcare but it is inconsistent. Shared Care Record access will keep people better informed 24/7.
Custody Healthcare	Processes would not significantly change but the Shared Care Record would enable better quality of care and save time. The basic processes would be the same.
Custody Healthcare	Yes, I think because we would have access to more information it will allow my staff to make better informed decisions about their care management and how to deal with that person.
Custody Healthcare	Yes, this is outlined in the previous answers. More information could in some cases reduce the time (because we can access it quickly) but for complex cases could increase it. Time penalties need to be reconsidered or eliminated completely as more and more people have more complexity.
Custody Healthcare	It's likely we could expect some beneficial effects for our detainees were this the case.
Custody Healthcare	There would be greater continuity of care, e.g. in substance misuse, mental health, children's services.
Custody Healthcare	Yes, particularly around administration of medication to patients - it allows us to give them their medication with confidence.
Custody Healthcare	Yes. More up to date information, improved assessment, improved treatment plans and hopefully improved outcomes. For example: if substance misuse knew they were using on top of their medication, and this showed on the shared care record, better management could result from understanding these previously unknown risks.

Police	Yes, ideally, they should. In reality lots of the problems of where people need to leave the CJ system and go into Care in Community may not improve; due to lack of beds, lack of money and, potentially, of political will. We tried piloting with some trusts and social care services to improve, but it's a resource issue. The end result of a good care pathway will be quicker, but all the services are so pushed, and lack of beds or assessment prevents them from getting the right access and they end up in Police or CJ detention.
Police	Yes, there would be an improvement. Faster access to key vital medical information Improvement in decision making, and we will do a better job... medical intelligence improving how we work.
Police	Care would be a lot more informed. Sharing of a care record is useful because it would enable the police and involved partners in supporting the patient better. i.e.: supporting a person through their court and forward planning to prison or release. It is not a good use of the tax-payers money to repetitively assess and treat when better consideration could be given to the onward journey of the person being detained could be made.
Police	For the better
Police	Potentially yes, a longer-term treatment plan applied rather than short term fixes that are not necessarily well informed. Result would be a more consistent longer-term support plan.

Service	Do you think the management and supervision of staff would be different if a Shared Care Record was introduced? If so, in what ways? (positives and negatives?)
Commissioning	Yes, greater oversight of the use and access of information - people should only be reviewing information that is relevant and required for their job role.
Commissioning	Yes. See previous answers.
Commissioning	I don't think it would be. Trust must be developed. Ultimately it could reduce the length and time of meetings which are currently lengthy due to their being a lack of information. There will be efficiencies in the system hard to quantify ... not instantaneous...

HMPPS	As a manager it would be easier to quality assure all the information, if I wanted to see the care and support had been entered correctly in one place this would make the management team's role a lot easier, and more effective. Currently looking in several places is very laborious and inefficient.
Prison Healthcare	The positive is in regard to increased provision training and understanding the correct use of shared information and sharing information to improve continuity of care. There is already a level of system-use fatigue - having to know another system, use it, navigate and obtained the information within it... a further issue of whether not using it could lead to criticism at a later point.
Prison Healthcare	No, I don't think you'd need to change the supervision and management except obviously they would need proper training on using the shared care record.

Prison Healthcare	I don't think it would, but I would want the training to identify what is appropriate to share and a back-up audit to ensure that staff understand and implement appropriate controls. I think it wouldn't change much beyond that and the staff would probably find things easier.
Liaison and Diversion	I don't think it would be changed except maybe more monitoring by the police, in which case feedback would be useful in improving our work jointly.
Liaison and Diversion	If there was one record and it decreased the amount of paperwork that would be great, however if there was an increased amount then it would be detrimental. We use information in different ways and therefore the information that we give the police is very much on a need-to-know basis and we only provide background in a basic level of detail, with much of the information left off the 'Police version'. The organisations and family and friends that we phone and share information with may be less forthcoming if they know it is going to incriminate the person, which could adversely affect the outcomes for the individual.
Liaison and Diversion	Clinical Supervision of staff would involve accessing those records to see what decisions have been made
Liaison and Diversion	It would provide management access to the reports and assessments which staffs have completed in order to audit documentation and any learning opportunities. How efficient the shared care record was in accessing just the records and assessments completed in a timely way if all agencies and staff had access.
Custody Healthcare	Probably more targeted supervision. There would be a more focussed and more effective supervision
Custody Healthcare	It would be enhanced as it would include the management of a new sharing system. They would need training on the new system and properly facilitated with booklets and guides created. We would be encouraging people to share concerns and support them. We would need a better understanding and ways of explaining the sharing of information to people in custody to assure them of data security.
Custody Healthcare	Not really. The way staff are managed is not about what access to records they have; it wouldn't make any difference to how I manage my staff.
Custody Healthcare	I don't think it would, except maybe time management, which would need to be looked at. It could take more time reading up on the detainee's information. By having access to the information, it could absorb more time for complex cases... but that might be preferable to be able to give the best care whilst detained. In my opinion target times would therefore need to be reconsidered, because additional time spent understanding a patient's presentation and history could
	improve subsequent treatment. This would conflict with target timescales set by NHS(E) / Police, and we could be penalised for trying to offer the best care and outcomes for the patient.
Custody Healthcare	As a manager you would have to encourage staff to use the system effectively. May be through supervision or training. Technophobes would need to be encouraged, and gain confidence through good support... (not here's a hand-out, go away and work it out)

Police	From my perspective nothing would really be too different because we already share information verbally, with A&E, Referrals to Children's Services. There has to be training and ISAs in place to be clear about when these sharing can, can't and must be done. The specifics would be made clearer, but no substantial changes. Better, faster access to meaningful information would be the main benefit.
Police	There would be differences their performance would be easier to monitor, with relevant information and past record and previous health conditions, this makes it easier to monitor the HCP has used all available tools to improve their health, it could be used for training and encouraging good practice through examples.
Police	From my perspective probably not, but if things went wrong there would be more accountability for those involved and should have been aware of that information. At times we might be held accountable but not necessarily always sighted on the necessary information. This information could help drive better decision making - giving support to staff in their decision. Staff will be able to demonstrate their justified actions more easily.
Police	Probably more challenging from a supervisory point of view
Police	Not so much on the policing side.

Service	As far as you are concerned what do you think are potential issues or risks could affect a shared care record?
HMPPS	The risks are inexperienced people not sharing information appropriately and having to recruit the type of staff into the role.
HMPPS	Only if people talk about it when they know they shouldn't. If it's used professionally and shared with those who need to know the nit will work - which could happen in any situation. As far as I am concerned its a very positive idea.
Prison Healthcare	I think possibly if there are too much information then vital parts could be lost or obscured.
Custody Healthcare	Inappropriate access could be a problem, similar information security issues as there are at present, but with MH there are anecdotally more restrictions about sharing information which might need to be overcome. Leaving desktops open or accessing inappropriately.
Custody Healthcare	Computer data breaches, computer system or program failure could cause the loss of data or unauthorised access to it.
Custody Healthcare	The biggest thing people would be worried about would be GDPR we would need full understanding of GDPR. Making sure that people are medically and mentally fit. IT issues regarding initial access and also if it crashed and access was prevented for the day.
Custody Healthcare	Access would need to be controlled

Custody Healthcare	Misuse of information, misunderstanding of information... a reflection of the level of training of the person using it. If Custody Officers have access to health information, they will still need support and education on what that actually means.

Shared Care Record: Expectations and Appetite

Three final opportunities to provide feedback in respect of a Shared Care Record concept were provided in the form of the following question set, wherein participants were invited to give their views in terms of Agreement/Disagreement and No Opinion, and then provide commentary to support the final statement, *'A shared care record sounds like a good idea'*.

The individual response charts are provided in the next three pages, followed by their responses. As will be seen, the commentaries were entirely supportive and majority were also enthusiastic, which to us confirms a real appetite for the Shared Care Record.

143. **Please indicate your opinion with respect to the following statements regarding people in the justice system**
*

	Strongly Agree	Agree	Disagree	Strongly disagree	No Opinion
Discussions about *everyone's* cases are essential to ensure they are directed to appropriate services					
A shared care record could lead to a worsening of care for most people					
A shared care record could significantly speed up decision making					
A shared care record sounds too complicated to be effective					
A shared care record could help to improve people's health and welfare.					
A shared care record could help to reduce reoffending					
A shared care record could help improve social circumstances					
A shared care record would adversely affect sentencing					
A shared care record sounds like a good idea					

Service	Could you add a few words to expand on your response to "A shared care record sounds like a good idea"
Commissioning	There are significant barriers to care at present due to a lack of easy information sharing, it would be positive for both staff and patients to be able to share important information easily as the patient moves through the criminal justice system.
	There are strong and clear connections between someone's mental and physical health, past and present, substance misuse and mental health, so information should be shared, and staff should be expected to know and understand and act on shared information.
	We need to consider more widely the impact on the judicial side of the system. The judiciary should need to know more about the status of the person ... We could get much of what is already in a presentencing report in a semi-automated way from a shared care record.
	Having a single point of access of information enables our providers to identify the right healthcare support required to meet the needs of clients.
	Health professionals should always have immediate access to a patient record, wherever that patient is in the pathway.
HMPPS	*It enables people to gain a far quicker understanding and provide a better intervention and care plan, the care plan will be there and can make a big difference... taken to the extreme it could mean the difference between living or dying. Better interventions quicker could prevent the worst outcomes.*
	With information you can make the right decisions if it isn't shared its difficult to make the right decisions.
	Making information sharing more effective would be useful for everyone.
Prison Healthcare	I'd like all the information needed to treat the patient effectively and keep them safe at the time the information is needed.
	See above. Already described the benefits
	I think it is a good idea because of our experience of GP2GP sharing which has sped up a lot of processes such as prescriptions, referrals, and hospital care. Adding information from the court's perspective for parole or offender management allows us to get more of a full picture and better risk assessments.
	I think it makes sense and would improve continuity of care and it is seamless this way. Whenever there is an issue there is always a section of it that comes down to communication... always!
	More efficient care and better outcomes
Liaison and Diversion	*Integrating communication with partner agencies is an interesting pathway to improve outcomes but the devil will be in the detail. I'm largely optimistic but aware of the risks as well of overwhelming the system.*
	There is the potential for a Shared Care Record to be useful so that information is not lost, however i do have some concerns. They are about duplication of work, if it reduces duplication, fantastic, but if it reduces the level of detail then it's not such a good idea. My view is that if you have something shared then it goes to the lowest common denominator (of what is safe to share). Having access to a nationwide system would be really useful, if not then it could lead to more work, more duplication and resources.
	This will speed up decision making and help improve peoples' outcomes

Liaison and Diversion	Will enable current risks, history of risks, whether a person is currently under services and what help/support is in place. Current medication and any adverse effects or non-concordance. Ability to audit staff's records and assessments to ensure efficient record keeping.
Custody Healthcare	*Its a good idea for all the reasons I've 'strongly agreed' with listed above.*
	Its difficult to get people all in a room to have a meeting so the next best thing is to be able to access the information through a shared care record. It means we can act promptly having the full facts and make the right decisions.
	Already covered in the first few questions. Covered in depth already.
	Give it to me now! Nothing I've not already said. It would improve the patient's health and outcomes and provide opportunities for collaborative working and positive patient outcomes
	It is similar to a Multidisciplinary team so the effect of it would be it helps to pave a more positive pathway for detainees. It allows us to see who they are under and what they are diagnosed with, while they are detained in Police Custody. It would allow us to make appropriate referrals to other specialities that are not all in the Mental Health capacity, i.e.: in the medical sector.
	There is a potential to expose the clinician to more historical information about the detainee and also has the potential therefore to provide more satisfactory conclusion for the overall future welfare of the detainee.
	Because everyone is in a need-to-know basis only would have access to update the record, review the record they would be able to provide continuity in care and would benefit the patient for signposting to secondary services, where past and current history would be up to date.
	As mentioned, a greater understanding of patients so with greater awareness of their medications and past conditions we can act to provide treatment in their best interests. It would also prevent errors and serious incidents from occurring. I also think it would help with morale in custody, it can be difficult if you don't know what someone else has done. There is no annoyance or frustration among professionals if we can be confident everyone has communicated effectively through this system. It would help police so that the level of care and observations would be better assigned to those with real needs and not incorrectly assigned to craftier detainees. It will improve the rapport between the patient and HCPs.
	SAVING TIME LOOKING AT MULTPLE RECORDS ETC CAN ONLY BE A GOOD THING
	Sharing information enables clinicians to make informed clinical decisions for effective therapeutic management whilst in custody.
Police	*If you take the opinions and information from a wide variety of sources, it helps you to make a more informed decision to plan the best care for the person involved.*
	Its informed decision making, its medical intelligence, it empowers better care, and it would enable a collaborative process of higher level of care.
	The answers are: As a public body i feel we all have an obligation to provide the best care to an individual and to ensure that they get the right care at the earliest opportunity. So, if everybody who has any involvement with an individual's care shares their information there will be a much richer picture available to the individual, thereby meaning we can best support the individual and we can divert them away from criminality and substance misuse etc.

	Minimise risk, assist in decision making, help plan treatment
	It would support a consistent approach of supporting the offender through their criminal justice journey and support the offender in breaking their reoffending cycle.

Our final question asked for any further perspectives in relation to the Shared Care Record, and the survey itself, which yielded further positive support and for the first time some misgivings (conspicuous by its absence in almost all other commentary).

These comments give a good balance and advises that it should not be regarded as a panacea. In closing the Survey Section of this report therefore, it seems only right to leave the last words to those who kindly provided their responses.

Service	**Thanks again for your time and effort, please feel free to provide any further feedback concerning the Shared Care Record, or the survey itself, here.**
Commissioning	Key to the success of the RECONNECT services (both prison and community based) is timely sharing of expected prisoner release date and the location they are being released to
HMPPS	I think it will be a really good idea and has opened my mind to what could be... I've enjoyed the survey.
	If it's going to roll out, 100% we need loads of focus groups please, if you don't have focus groups including police, prisons staff and healthcare within the prison, you will get a system that doesn't work inside a prison. Predominantly things go wrong in a prison, and it must work inside this environment (it's got the worst environment) so it will probably work in the community effectively. Time and resources mean that it must present information properly. You need no qualifications to be a prison officer - systems must be simple and easy to understand and not pages of written information. It must be easy to understand. Bullet point form... and accessible in detail behind the headline/summary information. People in reception need an easy system.
Prison Healthcare	The survey might be quicker to send with them have it in advance and go through with them if needed.
	I look forward to seeing the first of type!
	Nothing further except - when can we have it!
	I like that it's done over teams, if not you could go through it too quickly and not take stuff in.
Liaison and Diversion	It's been interesting to focus my mind. I have said I agree with the Shared Care Record but not convinced that I do. Sometimes too much faith is put into systems and one system might not be the answer. At the centre of all this has to be about the client and their welfare, it has to be helpful to them and I am not convinced a shared care record necessarily would be. It's about how the individual services communicate and share information and giving the same information to every service may not be most beneficial to the client. The shared care record may have an adverse impact on some clients, and they tend to be the clients that are hardest to reach and most marginalised and that causes concerns for me.
	This was a very interesting survey which allowed me to think about the sharing of information and whilst sharing information is vital, it also depends on the information entered onto the systems and how much relevant information is applicable.
	Survey was good to take part in, it shows there is an interest in trying to make HCPs lives a bit easier and better.

Custody Healthcare	Hurry up and do it!! I felt this was focussed to the L&D aspects more than medical. So, if we're going to share records we need more medical representation, i.e.: District Nurse, or Diabetic Nurse for example... Our role is also Medical so to me if we have these shared care records, we should be able to do things like book in appointments for GP or community and district nurses - also in hospital environments, so that we are looking after those with serious conditions and those non-attending can be brought back into the system and encouraged to continue their treatment. This will help to complete the bigger picture. Prisons also need to be included in this.
	Nothing much to add it's been enjoyable to provide the information and enjoyed doing it. A good discussion.
	It good to have some input into what potentially may come to fruition in the near future hopefully!
	The Shared Care record is something we are desperately needing and essential for our patients to benefit them and be able to look after them in custody. In fact, in this day and age I'm surprised we don't have one already.
	It's been very nice meeting you I'm glad it's being looked into, and I hope there is a positive outcome.
Custody Healthcare	Yes, Mike was very helpful and covered in depth around the Shared Care Record and was very enjoyable to spend time on the appointment.
Police	My ongoing concern is about detainees being able to give specific consent rather than generic consent. It's a big thing about sharing with GPs and staff in the surgeries having access to records due to the worry about the wrong people knowing about their detention. There is a real concern about non-registered healthcare professionals being given access to records with no accountability (as given to some non-registered L&D records) This is likely to be a serious barrier to registered professionals sharing with un-registered staff without the professional qualifications in other organisations. The 'need to know' principles need to be deployed to preserve boundaries and access should be prevented, and the patient's privacy and best interests must be preserved at all times. If we are to depend on just one system, it MUST be reliable and not crash! People would be really let down if it becomes the norm.
	This is an aspiration many people have had for a long time and is long overdue. If used correctly and ethically will no doubt offer a greater standard of care and support, especially to those most vulnerable.
	I just hope it comes to fruition.

Annex B - Survey Development

Approach

The survey was developed and refined following a series of discussions within JWPM to ensure that it was as broad, far-reaching, inclusive and objective as possible. We aimed to make sure that a wide range of organisations and respondents could complete it comfortably, to help encourage further involvement by recommendation. To assure engagement it needed to be both non-specific and at the same time relevant

We fully appreciated that we would most likely have only one opportunity to engage with busy healthcare and related professionals, and we wanted to capture as much relevant and meaningful raw data as possible, so that we could provide Commissioners with multiple perspectives

Survey Basics

The survey was developed using MS-Forms and comprised a combination of check boxes, drop-down menus and ratings scorecards to enable easy selection of common standardised answers. Working with consistent data helped subsequent analysis and presentation of findings. We also provided for more individuality by including text boxes, so that unique responses and qualities could be captured, as well as brief descriptive feedback for a number of questions later in the survey. It was also influenced by a similar survey being undertaken by Rocket Science who, with their commissioner's permission, shared their questions and some early responses with us. There was mutual recognition that, by including some of their questions in our survey, we each could benefit from an extended reach into other areas of the country, by pooling responses.

Method

The majority of our surveys were undertaken as guided interviews with our staff, using MS-Teams and a screen-share of the survey. This reduced task-loading for participants and allowed some less experienced participants to be talked through the forms and encouraged to share their thoughts, which we typed into the form response boxes. The benefit of this approach was it enabled us to appreciate the extent of individual frustrations and concerns and a common urge to improve service delivery. It was, without exception, hailed as a positive initiative. A drawback of this method was that it affected completion of the surveys, with some participants needing to postpone or cancel participation altogether. Some surveys were completed, but unfortunately with others, previously agreed opportunities were lost.

Shared Care Record Feasibility Survey Flowchart