



## Improving Mental Health Information Programme



Workshops with service users and care providers to explore perspectives on information sharing and shared care record systems

Four workshops were held between Oct 2002 and July 2003 in Dundee, Edinburgh, Motherwell and Aberdeen. The workshops were held in partnership with Little Wing, CAPS, Lanarkshire Links and the Aberdeen Mental Health Service Users Network, respectively. The full reports of each meeting are available at <http://www.isdscotland.org/isd/collect2.jsp?pContentID=1584>.

### Prerequisites

- Sufficient money needs to be spent to make systems reliable but not at the expense of employing more care staff. Good information technology can aid good care delivery by enhancing decision-making but is no replacement for trained and sensitive staff.
- Information sharing can only work where people feel they are part of a team working to the same goal. Communication among staff and with service users is key; the computer system is only a small part.

### How would a shared care record help?

- By preventing service users from having to endlessly re-tell their personal story.
- By improving the work of locums and other staff who are not familiar with the care recipient. A shared care record should: assist the delivery of out-of-hours care; reduce the chance of crisis turning to tragedy; and signpost who is delivering which intervention to whom.
- By aiding information sharing among healthcare professionals and between health and social work.

### What should be in a shared care record?

- Items in the shared care record fall into two classes. Some are facts and others are specialist professional opinions. It is especially important that errors be corrected.
- A shared care record should contain a free text component to allow a service user to input the information that they believe is most important.
- Definitions of presenting problems should not only be about medical factors and medicines but should include social and lifestyle factors and what psychosocial/recovery approaches are being adopted.
- Records should also include information on: who is involved in providing care; how to contact the client; early warning signs of a crisis; what needs to be done to support people in, or approaching crisis; their independent advocate; and a person's 'advance statement', if they have one.

### Confidentiality and access

- There should be a balance between complete privacy, and accessibility to allow totally joined up care. Electronic shared care record systems will provide an audit trail so it can be established who accessed what and when.
- It is important to control who can see what in the shared record and who can write in it. Nosiness and 'fishing' expeditions shouldn't be allowed. There should be different levels of controlled access to different parts of the record. Access to individual fields within a record is an alluring option but system administration resources are limited so this might be hard to deliver.
- GPs should have access to all parts of the record.
- Service users should have access to their own records to be able to check who was supposed to be doing what, and what was being said, 'unless the doctor felt it would be particularly harmful'.

### Factors affecting the design of systems

- Systems should share information to support a patient-centred service rather than collect information for information's sake.
- Any system should be as simple as possible, secure and designed for compatibility.
- Shared care record systems should prompt care providers when action is required.
- Systems should provide a link for social workers to health information and vice versa.

### Conclusions and further work

- Users and carers should be involved in discussions about proposed shared care record systems.
- It is important to understand where the voluntary sector fits into shared care records.
- The option of not having an electronic shared care record would be worse.