

Adults Electronic Care File Recording and Record Audit Policy

Version 5.00

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# Version Control

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# Introduction

The Director of Adult Services as the Caldicott Guardian has a particular responsibility for protecting our residents with care and support needs, and their carers interests regarding the use of personally identifiable information, ensuring it is only shared confidentially in an appropriate and secure manner in accordance with Trafford’s Information Sharing Protocol (See Appendix 2). The case file recording policy is ***mandatory*** for all staff in the Adult Directorate who have a responsibility for recording personally identifiable information relating to our residents, their carers, and information obtained from third party sources. All care record is completed electronically using Liquid Logic, which is the primary electronic recording system for Trafford Council Adult Services.

Social care records are Trafford’s “corporate memory” providing evidence of actions and decisions and the rationale for these. Accurate and factual recording plays a crucial part in supporting the rights of individuals, carers, and their families. They are also a critical component in the effective operation of the organisation. Records are important for accountability purposes and need to provide a true account of a person’s journey through the social care system. Care records support current and future operations which demonstrate meeting the requirements of the Care Act and other legal responsibilities and are used as evidence in court proceedings, safeguarding enquires, Safeguarding Adult Reviews, and public enquiries. Additionally, they are used for measuring equality, activity standards, and performance within the directorate.

Care records are monitored and are used by managers and supervisors to evaluate team and individual performance. Line managers are responsible for the quality of recording in their service area and ensuring that care records are up to date, accurate and recording is carried out in accordance with this policy. The electronic recording system provides the directorate with reports that are used to inform national and local monitoring to meet Governmental requirements and provide data for statutory and local reports. These reports also help to evaluate the current level of needs and assist the organisations to forecast future demand that informs Trafford’s commissioning and operational strategies.

The statutory framework governing this policy includes:

* Crime and Disorder Act 1998
* Human Rights Act 1998
* General Data Protection Regulation (UK GDPR tailored by the Data Protection Act 2018)
* The Care Act 2014
* Civil Partnership Act 2004
* Freedom of Information Act 2000
* The Equality Act 2010
* Mental Capacity Act 2005
* Autism Act 2009
* Health & Care Act 2022

Further information can be found In Appendix 1

# Definition

1. **This policy is applicable to information recorded and received in the following formats**

* Electronic or hard copy information of our residents, carers and relevant others.
* CD-ROMS, DVDS, USB disc drives, removable memory sticks, cloud-based recording systems.
* Microsoft Teams and associated platforms.
* Digital records received from other agencies including other stand-alone systems, such as financial information
* Social Media
* Email, text and other message types
* Handwritten records
* Telephone messages
* Complaints and enquiry records
  1. The policy covers all interactions with our residents and or their families, the public and other agencies.

1. **General Principles and Purpose of Care File Recording**

Social Work England (SWE) professional standards sets out the legal requirements for registered social workers, paragraph 3.11 states

*“Maintain clear, accurate, legible and up to date records, documenting how I arrive at my decisions”.*

Additionally, the knowledge and skills statements produced by Department of Health (March 2015) is designed to strengthen and enhance the Professional Capabilities Framework by setting out what is expected of newly qualified social workers working in adult social care, confirming that all workers should be able to demonstrate knowledge of all aspects of the statements which are relevant to their service setting. The statements should be used by social workers and their employers to build a wider framework for induction, supervision and the continuing professional development of social workers and the social work profession. **These standards are applicable to all staff and managers In Adult Services irrespective of whether, or not they hold a Social Work qualification**

2.1 The Adults and Wellbeing Directorate workforce will ensure that all care records held about individuals adhere to these principles and all actions undertaken by staff in relation to our residents must all be recorded on or uploaded to Liquid Logic care records.

2.2 Records must show a fair and accurate description of the nature of Adult Services involvement with our residents, what decisions have been made, why, by whom, when and where, and the outcomes for our residents. All pages of documents that are signed by our residents or their legal representatives, carers or other professionals, must be uploaded into the personal Liquid Logic record, and identified by a relevant case note.

2.3 Discussions with line managers or senior managers about a resident, must be recorded in care notes using **“Case discussion with Line Manager**” as a case note type and case note alert sent to the manager who provided advice.

2.4 Good care records are central to good practice, and all recording should be:

* Non-discriminatory
* Non-judgemental
* Accurate and factual
* Retrievable
* Secure
* Comprehensive
* Timely within 24 hours
* Differentiation between professional opinion, and fact, must be clearly recorded

2.5 Residents and carers should, wherever possible, contribute towards and be kept informed about decisions. and outcomes of requests for assessment or services. It is a requirement of the Care Act for residents to be provided with copies of their assessment and support plans.

2.7 Quality assurance systems are in place to ensure that practitioners meet good professional standards and adhere to the Directorate’s policies and guidance. Managers will regularly monitor the quality-of-care recording as required by the Care Record Audit policy and procedure.

2.8 Care records will be kept in accordance with this Policy, the Department of Health guidance, and legal requirements.

1. **Equality in Recording Practices**

3.1 The directorate actively promotes good practice in equality. Care records must reflect anti-discriminatory practice and demonstrate sensitivity to the person-centred needs of the resident, carers, and the community.

3.2 Care recording should identify any specific needs arising from a resident’s protected characteristics as outlined in the Equality Act 2010, namely, ethnicity, race, culture, sex, gender identity, age, religion, language, communication, sensory impairment, disability, and sexual orientation. ASC records need to demonstrate how we are promoting and providing personalised support in response to people’s unique needs and outcomes whether these needs are a result of a protected characteristic or not.

**4 Care Record Standards**

4.1 Each person will have a separate care record, and information contained in the care record must be factually accurate and evidence Adults Services involvement in the person life.

4.2 Essential, key components of every care record will ensure that any decisions taken are clearly evidenced, recorded, and inform of actions agreed, when and with whom.

4.3 Care notes should be relevant to the date they are recorded. A new care note should be created for each day and / or date, though where relevant, care notes can be updated throughout the same day.

4.4 The evidence on which decisions are based will be clearly shown indicating who was involved and what information was considered.

4.5 Records must show how and when the person and if appropriate, their carer/ relevant other have been informed of options and included in all choices, plans and decisions

4.6 There should be clear evidence on the record showing when copies of key documents are supplied to the person or their nominated person and when information has been given e.g., info on community services

4.7 The opinions, feelings and views of the person and their families must be clearly recorded. Social care records must be written in a professional manner which is always respectful of the services user’s rights and dignity

4.8 Discussions around finance must be accurately and factually recorded. Specific conversations around financial status and top up procedures will need to clearly evidence where the person’s needs can be met in an alternative option. Records must also show that discussions with the person and their family have taken place, and be recorded by date, time and be person specific.

4.9 The person must be informed about their rights to confidentiality and how, if they choose to do so, to access their own care records

4.10 Recording must be clear, concise, and easily understood, providing sufficient information for any approved reader who has no knowledge of the situation. Records should include any concerns, perceived risk factors, an account of actions taken, and plans made to progress or mitigate.

4.11 The social care record should be updated as soon as possible following an event and recorded within 48 hours. If critical information cannot be added immediately, because of a non-planned urgent situation, the responsible person must relay the information to another member of staff, or their line manager, so that the key points within the case note record can be updated

4.12 Any disagreement between the worker and manager relating to a decision, or an opinion on internal process or workload, should never be recorded in the case file. The issues should be actioned and discussed within informal or formal supervision, and the agreed outcome recorded within supervision notes

4.13 Any person referred to in care notes should be recorded using their full name and have their designated role and or relationship recorded.

4.14 Any/all acronyms must be written in full. This is to ensure that recording is clear to all readers.

4.15 Emails should not be copied and pasted into care notes. Practitioners should make a record of the email having been received and salient points the email should be uploaded into the documents section of the case record if necessary.

4.16 Where a Care Records Audit has occurred; a care note must be recorded by the person completing the audit to show the care records have has been appraised. The outcome of the audit should not be included in the care note, this is recoded on the audit form.

4.17  **Recording should take place in the following circumstances:**

4.18  **Face to Face visits/meetings (examples are not exhaustive):**

* Date, time and place of the visit or meeting
* The date of the entry onto Liquid Logic – if different
* Who was present
* Clear reasons and purpose for the visit or meeting
* What information is to be/ be gathered during the visit or meeting
* Whether the person was seen (and if not, why not?) and whether seen alone or not.
* Update on any changes, risks or need
* The person’s views and those of carers or identified significant others if appropriate
* Action required by whom and by when – with agreed timescales for follow up
* A summary of any discussion or agreements
* Any use of interpretation service or decision made not to, where English is not the service user’s preferred language should be recorded to inform how communication was assisted or supported.
* 4.19 **Telephone and virtual contacts (MS Teams, Zoom, Face Time, WhatsApp) with people, carer, family member or other professional (examples are not exhaustive):**
* Date of Contact
* If the call was received or made
* Who the contact was with and their role / relationship
* A summary of the discussion
* Agreements discussed
* Action to be taken, by whom and by when - with agreed timescales for follow up

4.20  **Emails, Faxes and Letters (examples are not exhaustive):**

* Where the email is a response from Legal, this should be uploaded into Liquid Logic as a “Confidential Legal Advice” document and case noted with same heading, to exempt the information from subject access requests.
* All emails containing personal, sensitive, and identifiable information should be sent securely or password protected, and the password sent in a separate email or via a telephone conversation with the receiver. Staff must be certain they are giving the email password to the correct person, before disclosing the information.
* Email content must be professional in nature and relate specifically to the person
* Faxes both sent and received should be scanned and uploaded to the relevant person’s Liquid Logic file and case noted accordingly
* It is the social care staff’s responsibility to ensure that all contact details on a person’s records are checked for accuracy and are up to date, any relationship / carer links have been identified, and that any documents printed for posting are sent to the correct address.
* Should a data breach be identified, this should be escalated to your line manager at the first available opportunity.

4.21 **Meetings and Recording of Decisions - All meetings held with or relating to a person (examples are not exhaustive):**

* Where a discussion, reassessment or an evaluation of services delivered is arranged, the recording should include
* Date of the meeting
* Persons present and their relationship/ role in relation to the service user
* People’s opinion or desired outcome and if this can be achieved
* Purpose of the meeting
* A summary of the discussion
* Rationale for decision/s
* Any dissent
* A list of actions
* An agreed timescale for completion
* Who is responsible for carrying out the action(s)
* Evidence that the action plan etc. has been circulated to all present or if appropriate, to those with a responsibility for carrying out the actions
* A specified timescale for reviewing the agreed actions
* Any formal or informal consultations with Legal Services should be uploaded or recorded into Liquid Logic, flagged as confidential and referenced in a case note entitled “Confidential Legal Advice”

All decisions ***must*** be recorded clearly, including who has made the decision. This must include information on all the information considered to facilitate the decision-making, that is evidence-based and legally defensible.

**Evidencing application of statute**

Records should clearly state how the application of relevant statute has been applied for this resident. Where the decision relates to an adult who has substantial difficulty or is assessed as lacking the mental capacity to engage fully in the process, all actions undertaken must be captured to demonstrate compliance with the requirements of the Care Act 2014 and Mental Capacity Act 2005.

Where an adult has the mental capacity to make decisions, and workers are concerned about the impact of unwise decision making on their safety or health and well-being, it will be necessary to record the considerations and observations that led to the assumption of capacity. All the actions and discussions they held in respect of their concerns must include escalation and discussion with their line manager.

Records should reference any significant Best Interest Decisions made, and clearly list all those consulted, their views, and demonstrate how these views informed the final decision.

**Direct payments**

It is a requirement under the Care act to offer a Direct Payment. A record of the discussion with the adult, or their representative, in relation to Direct Payments must be made, clearly noting the views and wishes of the adult. The local authority ***must*** make direct payments if the conditions set out in the Care Act and its [direct payments regulations](http://www.legislation.gov.uk/uksi/2014/2871/contents/made) are met. Where a Direct Payment is refused the adult must be given a written explanation of why and this should be referenced clearly in the care records.

**Advocacy**

Where a requirement for independent advocate is identified, care records need to include the name of who has been appointed, why, and how their views have informed/influenced decision making. In addition, there should be a record confirming the discussion with that advocate and them agreeing they are happy to take on the role.

1. **Safeguarding - Minimum Standards for Recording**

5.1 When recording contacts, referrals, and care notes in relation to Safeguarding of Adults activity, there are minimum requirements for the information that is recorded. This is to ensure consistency in approach and decision making. All necessary information should be gathered, recorded, and considered, to make clear, logical, structured, evaluated, and accountable decisions.

5.2 All records should be accurate, factual, ethical, relevant, timely and dated, and in the case of uploaded handwritten records, signed where appropriate and legible. It is important to remember that records are evidence and may be called for in legal proceedings, professional misconduct hearings or for Safeguarding Adult Reviews. Also, the Data Protection Act 2018 gives individuals the right to access their Health and Social Care records held manually or on computer.

5.3 **All safeguarding care recording should include the following as a minimum:**

* Name, designation, and team
* Date and time of receipt of information
* Who the information is from, their contact details and what their relationship to the adult at risk (e.g., husband, wife, son, daughter, neighbour, nurse)
* What format the information is in (i.e., letter, fax, telephone call, discussion during home visit)
* What is the information? What are the facts? “Opinions” should be clearly marked as such
* What has happened
* Where has it happened?
* When did it happen?
* Who was involved?
* How has it impacted/affected the adult at risk of harm or abuse, are they safe and well? (E.g., risk, injury, distress, harm etc.)
* Does the adult have capacity to make specific decisions?
* How does the person meet the Care Act S42 criteria or definition of an Adult at Risk, recording information about any current or previous care needs.
* What action was taken at the time? (i.e., police or ambulance called, staff member suspended, family notified, GP attended etc.)
* Is the person aware and agreeing to the referral? Do they have capacity to make the decision?
* Are there any reasons to override lack of consent? (i.e., risks to self or others, child safety concerns, public safety, etc.)
* What does the adult want to happen?
* Is there possibly any intimidation, undue influence, stresses, or pressures which are affecting the response being given by the adult?
* What risks have been identified for the adult, carers, family or friends or any professionals or others involved?
* Are the risks past, present or future (or a combination?)
* What action has been taken in relation to the risks?
* What is the decision about how to proceed and why?
* Is further information needed in the form of an enquiry?
* Who has been consulted or given advice on this decision?
* What factors have been considered?
* Have you signposted or provided information/advice to anyone?
* What actions need to be taken, by whom and by what time?
* What feedback have you given to the referrer (with the agreement of the Service User)?
* Meeting and conversation records, as a minimum, must detail who was in attendance, discussions held, options considered, and outcomes agreed with timescales.
* Records should be clear and based on the facts available, evidencing safeguarding procedures have been followed and that reliable assessment, documents, and records evidence outcomes, reviewing timescales, all actions taken, and when they are completed.
* Practitioners are required to demonstrate when and how intervention has been made and by whom. Decisions should detail a rationale explaining why that decision has been made, if it’s through consultation, with whom, and evidence that it is reasonable and proportionate.
* Decisions not to follow safeguarding procedures should be recorded, detailing how that decision was reached.
* Always consider the following – are your actions:

**JAPAN: (J)** Justifiable**, (A)** Authorised **(P)** Proportionate **(A)** Accountable **(N)** Necessary

1. **Facts and Opinion**

6.1 When recording, it is important to distinguish between:

6.2 Variable fact and evidenced or observed information, for example what has happened, who informed, who witnessed, or if it was described as a probability, when and by whom.

6.3 Your own and other reported but unsubstantiated opinions, and the evidence these opinions are based upon.

6.4 Unsubstantiated and un-attributable information should be identified as such, and only be recorded on the case record if it is of current or future significance.

1. **Confidentiality**

7.1 Local Authorities have a duty under common law to safeguard the confidentiality of personal information which is held in relation to the delivery of social care.

7.2 The Council has a clear statement about confidentiality to which staff are required to adhere. Staff are also required to understand and explain the limits of confidentiality, recognising the requirements for professional accountability.

7.3 The consent from our residents must be sought wherever possible to share information about them with other relevant persons; if the person refuses to share the information, then the consequences of not sharing should be explained to the person, and the discussion recorded in the relevant care note.

7.4 When information is received from a third party, it must be made clear to the “provider of this information” that the Council has an information sharing policy and that the information may be disclosed to the person and their family/carer. It must be recorded in the care file when and who this has been agreed with. If this information is not to be divulged, then the “provider of the information” must make this clear and the worker clearly record and highlight this request in the care file. Where there is any doubt staff are advised to discuss the information with their line manager.

7.5 Where third-party information has been obtained and it is not clear if this can be shared then the worker must obtain consent before divulging any information, unless in exceptional circumstances i.e., that the information was crucial to share to safeguard and protect the person / others from harm.

7.6 Information held about people cannot be passed on to others unless we have a legal duty to do so i.e., that public interest overrides the residents right to confidentiality.

7.7 Section 115 of the Crime and Disorder Act 1998 allows all relevant authorities to disclose information between them for the purpose of the Act. (This is between the relevant LA and Police).

**8 Monitoring/ Care Record Audits**

8.1 **Management Arrangements**

8.1 Managers must regularly monitor all electronic care files (including safeguarding activity) by undertaking Care File Audits to ensure accountability and to give feedback to Social Care Practitioners, thereby aiding and supporting professional development, ensuring staff understand the required care recording standards and know how to improve their recording to achieve the required standard. The care worker is responsible for ensuring that the case file is up to date and that it meets with the required principles and standards as set out in this policy, by implementing the support and direction received from their line manager. The Audit can be undertaken with the relevant staff member to support learning and understanding of the required standards of recording.

8.2 Service Managers will each examine one electronic care file from their team area every month, completing the Case File Audit form, uploading the forms to the relevant Microsoft team channels. Service Managers should also record outcomes and actions taken on the Monthly management return information. This will escalate via Senior Leadership Team (SLT) 1:1s to ensure that the Director has an overview of the feedback from Care File Audits. The respective SLT member will moderate to ensure consistency.

8.3 Learning from the audit, and a copy of the outcome should be shared with the appropriate senior practitioner or team manager, to ensure feedback on the quality-of-care recording is given to practitioners during supervision and recorded in the supervision records.

8.4 It is the responsibility of the senior practitioner, team manager or service manager, or covering manager that they read and evaluate all documentation prior to making decisions and electronically authorising records to ensure all recording is delivered to the required standard. Where escalation is required to SLT this should be done so by the SLT escalation process.

8.6 Senior Practitioners, Team Managers, Service Managers will have a role in the auditing of cares and will at 6 monthly intervals or as determined by the SLT, randomly select an agreed number of cares from each team to present thematic to SLT.

8.7 Care file recording should feature monthly on team meeting agendas and any emerging issues, learning or developmental requirements are to be discussed in supervision.

**9**  **Chronologies**

9.1 A chronology is an ordered, dated record and sequential story of significant events in a person’s history, which interweaves information to contribute to an emerging picture, based on fact and interactions of a case. This enables current information to be understood in the context of previous information, informing professional assessment.

9.2 A chronology provides a skeleton of key incidents and events that inform the assessment of complex situations or people who are considered at risk or in need. Chronologies also enable significant historical and current events and dates to be viewed in the order of their occurrence.

9.3 A chronology can inform care discussion, evidence based key decision making and can be crucial to enable professional judgement to be based upon sequenced information. It can also support decision making for working within complex situations, Local Government Ombudsman (LGO) enquiries, Safeguarding Adult Review and Child Safeguarding Practice Review.

* 1. **An up-to-date Chronology will provide:**
* Relevant information about previous history which may be an indicator of risk
* An immediate view of what has happened over the course of the recording
* Clear information
* A focus on key events so you can understand what is happening in a person’s life
* Information that enables professionals to put pieces of a jigsaw of information together
* Highlights of vulnerabilities, gaps and risk, but also strength and resilience
* Patterns in social history and behaviour
* Events which can appear insignificant in isolation that can together be identified as significant.
* Highlights of the nature of current relationships and wider networks, giving important information about support, strength and risk
* Records of actions taken at that time, but also when there was no action to identify gaps, missing details or inconsistencies that require further assessment and decision
* Lists what interventions or care work has been tried, what worked, what didn’t
* A reflective tool for multi-agency work undertaken and a positive tool to evidence decision making

9.5 **To complete a chronology the practitioner must identify the key events to be recorded, that can include but is not restricted to:**

* Referrals received, including Adult at Risk Referrals
* Actions following the referral
  + Changes in name
  + Date of birth
  + Changes of address
  + Employment /education history
  + Personal history/significant life events, e.g., pregnancy, death of relevant other people
  + Records that reflect the persons opinions and views
  + A record of informal support that they both give or receive with timeline of when it started
  + Things that are important to that person with timeline (key pastimes, hobbies, relationships)
  + Diagnosis of specific condition
  + Hospital admissions/ serious illness
  + Periods where the persons care is closed or held on review
  + Safeguarding enquiry, process or decision
  + Best Interest or DoLS activity
  + Any police involvement/ criminal proceedings & offences
  + Any legal advice requested or given
  + When assessments commenced and were completed
  + Dates of any meetings relating to the person
  + All contacts by phone and visits
  + Changes in Social Care Worker

**10 Care work ending/ moved to review/ Case Transfer to another Team or Service/ Case Closure**

10.1 Prior to ending involvement with a person, the allocated social care worker is responsible for all care recordings, should evaluate all relevant information and ensure data for performance has been recorded. Furthermore, documentation sent for authorisation has been received back and uploaded into the documents section of Liquid Logic, and that all outstanding actions have been completed.

10.2 This check should be recorded in care notes using the heading “Ending Involvement Actions”

10.3 Ending involvement must be communicated with the person and/or their carer/representative. This conversation must be recorded.

10.4 When a care record is closing the completed record should be sent to the Senior Practitioner or Team Manager to authorise the closure on Liquid Logic. It is the workers responsibility to ensure all actions have been competed prior to sending.

The care record should provide a brief closing/transfer summary with any confirmed actions/next steps and start with the words ‘CLOSING/TRANSFER SUMMARY’ to provide clarity and easy reference.

Regardless of whether there is any on-going support/provision, details **must** be given to the person (or their representative) regarding whom to contact (with telephone number) should the situation change and require reassessment/review and the information **must** be recorded in the person’s care records.

Next of kin details and/or emergency contact details **must** be recorded in the appropriate section of Liquid Logic.

Key safe numbers **must** be recorded in Liquid Logic, under the heading factors and risks there is a special category, and you can input key safe numbers and not within a support plan or assessment document.

10.5 Ahead of any care transferring to another team a case notification to authorise the transfer must be sent to the Senior Practitioner, Team Manager or Service Manager before the transfer. Where there are complexities around the transfer a telephone conversation should be had between the respective teams Senior Practitioner, Team Manager or Service Manager. It is the allocated workers responsibility to ensure all the above actions have been completed prior to sending to another team. It is the responsibility of the allocated worker sending the case to ensure outstanding tasks are not transferred to the receiving team, unless these have been agreed between senior Practitioners and authorised at point of transfer.

10.6 Exceptions to 10.5 are cases which are being transferred from the Safeguarding Hub and Urgent Care Teams. This however does not exclude complex cases as conversations are still required between services for these cases.

**11 Review**

This document will be reviewed annually. For any changes to procedure in-between the annual review, a new version will be issued and approved as required.

**Appendix 1**

Relevant legislation

**Equality Act 2010**

The Equality Act 2010 brought together a large range of previous equality legislation.

Section 4 of the Act sets out the ‘protected characteristics’ that qualify for protection under the Act. The legislation maintains protection from discrimination based on:

* age
* disability
* gender reassignment
* marriage and civil partnership
* pregnancy and maternity
* race
* religion or belief
* sex
* sexual orientation

**The Act prohibits**

* direct discrimination
* indirect discrimination
* harassment; and
* victimisation

It also contains special provisions for pregnancy and maternity, which includes the right to breast-feed in a public place.

The public sector equality duty, previously related to race, disability and gender, was extended to the other ‘Protected Characteristics’ (not including marriage and civil partnership).

The duty is to have due regard to the need to:

* eliminate discrimination, harassment, victimization and other conduct that is unlawful under the Act
* advance equality of opportunity between people who share a protected characteristic and those who don’t - this includes the need to:
  + 1. remove or minimize disadvantage suffered by particular groups
    2. take steps to meet different needs of particular groups
    3. encourage participation by particular groups in areas of public life where they are under-represented
    4. foster good relations between persons who share a protected characteristic and those who don’t – this includes the need to tackle prejudice and promote understanding

Civil Partnership Act 2004

The Act creates a new legal relationship of civil partnership, which two people of the same sex can form by signing a registration document. It also provides same-sex couples who form a civil partnership with parity of treatment in a wide range of legal matters with those opposite-sex couples who enter into a civil marriage.

Data Protection Act 2018

The Data protection Act 2018 aims to:

* Facilitate the secure transfer of information within the European Union.
* Prevent people or organisations from holding and using inaccurate information on individuals. This applies to information regarding both private lives and business.
* Give the public confidence about how businesses can use their personal information.
* Provide data subjects with the legal right to check the information businesses hold about them. They can also request for the data controller to destroy it.
* Give data subjects greater control over how data controllers handle their data.
* Place emphasis on accountability. This requires businesses to have processes in place that demonstrate how they’re securely handling data.
* Require firms to keep people’s personal data safe and secure. Data controllers must ensure that it is not misused.
* Require the data user or holder to register with the Information Commissioner.

Freedom of Information Act 2000

The Freedom of Information Act deals with access to official information and gives individuals or organisations the right to request information from any public authority.

Human Rights Act 1998

The Human Rights Act makes part of UK law the following rights contained in the European Convention on Human Rights:

* The right to life (Article 2)
* The right not to be tortured or treated in an inhuman or degrading way (Article 3)
* The right to be free from slavery or forced labour (Article 4)
* The right to liberty (Article 5)
* The right to a fair trial (Article 6)
* The right to no punishment without law (Article 7)
* The right to respect for private and family life, home and correspondence (Article 8)
* The right to freedom of thought, conscience, and religion (Article 9)
* The right to freedom of expression (Article 10)
* The right to freedom of assembly and association (Article 11)
* The right to marry and found a family (Article 12)
* The right not to be discriminated against in relation to any of the rights contained in the European Convention (Article 14)
* The right to peaceful enjoyment of possessions (Article 1 of Protocol 1)
* The right to education (Article 2 of Protocol 1)
* The right to free elections (Article 3 of Protocol 1)

**Mental Capacity Act 2005**

**The five principles of the Mental Capacity Act**

* Presumption of capacity
* Support to make a decision
* Ability to make unwise decisions
* Best interest
* Least restrictive

**Appendix 2**

Caldicott Principles and Caldicott Guardians

The Review of Patient-Identifiable Information, chaired by Dame Fiona Caldicott (the Caldicott Report 1997), made several recommendations for regulating the use and transfer of patient-identifiable information between NHS organisations in England and to non-NHS bodies. The aim was to ensure that patient-identifiable information was shared only for justified purposes and that only the minimum necessary information was shared in each case.

Principles for use or flow of identifiable information

1. Justify the purpose(s) for using confidential information
2. Only use it when absolutely necessary
3. Use the minimum that is required
4. Access should be on a strict need-to-know basis
5. Everyone must understand his or her responsibilities
6. Understand and comply with the law

Caldicott Guardians

Arising from the Caldicott report and subsequent regulations Councils with Adult Social Services Responsibilities are required to appoint a Caldicott Guardian to oversee the arrangements for the use and sharing of personal information. The role Includes responsibility for the Data Protection Act 1998 and the Human Rights Act 1998.

In Trafford the Caldicott Guardian is the Director of Adult Services