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AN ROINN

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

MÁNNYSTRIE O

**Poustie, Resydènter Heisin
an Fowk Siccar**

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Administrative Systems Recording Policy, Standards, and Criteria

Regional Policy for Northern Ireland Health and Social Care Trusts

February 2008

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The original document was written by NSPCC Consultants Richard Green and Jenny Myers on behalf of the Reform Implementation Team (RIT) as a follow up to the Child Protection Inspection published by the Social Services Inspectorate in January 2007.

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Martin McGrath

Mary Logan

FOREWORD

This policy is applicable to all staff working in children's services in Health and Social Care Trusts. However, it may have wider applicability and should be considered by all staff who have contact with children.

The policy reflects the required management of records at a particular point in time. However, it is acknowledged that this is a changing environment and that Health and Social Care Trusts will gradually move from a paper based administrative system to an electronically based system as a result of new investment and IT systems development.

Interpretation of the policy should acknowledge these changes and these will be overseen by the Reform Implementation Team. A formal review of the policy will be undertaken 12 months after the date of issue.

Equality

This report can be made available on request, on disk, in large print, via email, in Braille, on audiocassette or in minority languages for anyone not fluent in English.

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ADMINISTRATIVE SYSTEMS, RECORDING POLICY AND STANDARDS

1. RECORDING POLICY

1.1 Introduction

This policy sets the framework and minimum standards for Health and Social Care Trusts to implement an effective and consistent approach to administrative systems with particular reference to the recording of information in child care cases.

The legislative framework governing this policy is given in Appendix 1.

Quality recording is central to good practice within children's services. It promotes good practice, assists with continuity when workers are unavailable or change and is an essential monitoring tool for managers. It also provides evidence for investigations and enquiries.

This policy applies specifically to all children's services staff within the five Health and Social Care Trusts [Refer to 1.3 - Scope]. However, the principles and standards within it may be equally applicable to staff who fall outside of these parameters (e.g. specialist teams, health, mental health, adult care etc) but who come into contact with children.

There are two elements to this document: a recording policy based on best practice and a set of standards to ensure high quality administrative systems.

1.2 Aims

The aims of this policy are to define:

- A framework for consistent, coherent and compatible records management.
- A single format for case records.
- A common approach to the keeping of records which enables effective information retrieval.
- The minimum standards of recording practice.
- A mechanism by which management can monitor and quality assure recording practice.

1.3 Scope

This is a mandatory policy; which incorporates the following significant key legislative documents:

- *Public Records Act [Northern Ireland] 1923*
- *Freedom of Information Act 2000*
- *Data Protection Act 1998*

It applies to all children's services and administrative staff within the five Health and Social Care Trusts including:

- All social work staff (including social workers, family support workers, other multi-disciplinary members of child care teams) who work directly with children and families.
- Administrative staff whose responsibilities include the filing of records as well as the storage and retrieval of case files.
- Senior practitioners/ team managers whose responsibilities include ensuring adherence to the policy and standards.
- Senior managers who are responsible for monitoring practice.

1.4 Context

This policy has also taken account of the recommendations from a range of reports such as:

- *Good Management; Good Records (DHSSPS, 2002)*
- *Inspection of Child Protection Services in Northern Ireland – Overview Report (SSI, 2006).*
- *Internal Trust audits and case management reviews.*
- *Southern Health and Social Services Board draft recording policy.*
- *Write Enough (DH, 2003).*

The *Inspection Overview Report* (SSI, 2006) stated that records should:

- Contain a range of significant information required for effective planning.
- Identify the relevance and source of information.
- Have a clear plan for each child which:
 - Addresses the child's developmental needs, parental capacity to meet needs and the impact of family and environmental factors.
 - Specifies the service to be provided and the rationale.
 - Specifies desired outcomes and how progress towards these is to be monitored.
- Contain summaries, histories, chronologies and clear analyses of interventions.
- Be an important measure of accountability and effectiveness.

Write Enough (DH, 2003) identified a number of common pitfalls in recording for both practitioners and managers, as follows:

Pitfalls for Practitioners

- Case records are out of date.
- The child is 'missing' from the record.
- Facts and judgements are not distinguished.
- The size of the record makes it difficult to manage.
- There is no assessment on file.
- The record is not written for sharing, it is not used as a tool for analysis. and it is disrespectful to the service user.

Pitfalls for Managers

- There is no management action to support policy.
- Policy is insufficiently detailed to support practitioners.
- Recording is not an integral part of performance monitoring.
- Policies and tools are developed without practitioner input.
- Recording forms overlap.

A number of these themes were re-iterated in the *Inspection Overview Report* (SSI, 2006) which was critical of:

- A lack of accurate family information sheets or summaries of key developments (a particular problem with files containing a lot of information).
- Too much detail - where succinct summaries would have been better.
- The absence of professional judgement – a possible reflection of a misplaced concern regarding user access to records.
- A lack of direction by managers as to the actions and outcomes required in assessments.
- Little evidence of the monitoring of case records.
- A lack of supervision records on file.

The *Inspection Overview Report* (SSI, 2006) was also critical of assessment practice. This is relevant to recording policy and standards as recording is the principal means for practitioners to demonstrate the quality of their assessment practice and for managers to audit this.

1.5 Principles

Good Management/Good Records (DHSSPS, 2002) indicates that records are created, received and used in the conduct of business activities. All Health & Social Care Trusts must ensure they have a comprehensive records management programme which includes issues such as:

- a. Determining what records should be created in each business process, and what information needs to be included in the records.
- b. Determining requirements for retrieving, using and transmitting records between business processes and other users and how long they need to be kept to satisfy legal and regulatory requirements.
- c. Deciding how to organise records so as to support requirements for use [Refer to 1.7 File Format and Contents]

These are the **principles** underpinning recording practice:

- The explicit outcomes for children are integrated into plans and progress against these is monitored.
- The records are child-centred.
- Key information is made readily available via e.g. chronologies, summaries, genograms.
- The UNOCINI Assessment Framework is used appropriately; using all 12 domains to conduct initial & pathway assessments.
- More information does not necessarily make for better recording. As a general rule succinct analytical summaries are better than extended narratives. However, there are occasions e.g. child protection investigations, records of key meetings where legal proceedings are being considered when the recording of detail is crucial.
- There is a discernible link between information, analysis and planning.
- *The Freedom of Information Act* does not prevent practitioners from recording their judgements, provided these are distinguished from fact.
- Assessments are multi-agency i.e. the contributions of disciplines other than social work are considered, accessed and integrated into plans.
- Fact, opinion, judgement and hypotheses are clearly distinguished.
- Records are duly respectful of service users.
- There is a presumption that records will be shared in an appropriate manner with service users (unless there are clearly stated reasons to the contrary).
- There is also the presumption that they will be read (and readily understood) by colleagues e.g. a practitioner needing to grasp key information at short notice in the practitioner's absence, a manager wishing to audit the quality of practice.
- All records are typed (though it is acknowledged that this is a longer term goal).
- Staff are trained and supported to record according to this policy and standards.
- Supervision records relating to case discussions are placed on case files.
- Case records are monitored regularly by management.
- All Trusts will seek to utilise technology to support the administrative task.

1.6 Achieving a balance of quality and quantity

Best practice in recording is based on the above key principles, in particular partnership with parents, children, colleagues, openness and accuracy. Effective recording is part of the total service to children and families and all records should be recorded with this in mind. The balance between quantity (how much to record) and quality (is it useful, relevant, and accurate?) is crucial to the successful recording process. When a practitioner responsible for the case is absent from the office colleagues may need to access and understand key information quickly, succinct summary and analysis is always better than lengthy narrative.

However, it is important to acknowledge that different types of records may have different functions. A daily record on a child in need is not the same as a record of a suspicious injury to an infant (where the detail of who said what may prove paramount) or a court report on a contested application for care proceedings. It therefore follows that how much detail is recorded will hinge to some extent on context and purpose. For instance, recording verbatim what a service user says is generally poor practice. However, it may be absolutely crucial where e.g. a parental explanation for a suspicious injury is being provided or a child is expressing his/her wishes and feelings.

How much to record is a matter of professional judgement. Supervision is obviously important as a 'check and balance'.

1.7 File Format and Contents

This is the prescribed generic format for files for all child care teams. It is acknowledged that some sections will be less applicable to specialist teams and that such teams may require additional sections.

Please note the following:

- All records in all sections should be filed in chronological reverse-book order.
- A contents index should be included in every section (other than section 4 – Recording) to be completed by administration staff.
- When submitting a document for filing the social worker/ manager should indicate in which section it is to be filed.
- The social worker should cross-reference accurately within the text e.g. a record such as '*I visited the family in response to a written referral from the school*' needs to be supplemented by a note specifying where precisely this letter is to be found along with distinguishing features (date, name of school, name of referrer).
- It may be helpful to **colour code files** to distinguish each one from the other as well as ease of access; for example Looked After files may be **red**, Family Support may be **green** and Child Protection **blue**.
- All family & child care files should have the office name and timeframe applicable printed on the outside and contents section printed on the inside of the front cover.

The **sections** are:

- 1 Family Information and Professional Contacts.
- 2 Summary and Chronology of significant events.
- 3 Referral and Initial Assessment.
- 4 Recording.
- 5 Child Protection and Case Planning.
- 6 Looked After Child (if colour coded files are not utilised).
- 7 Legal.
- 8 Correspondence.
- 9 Child Specific Documents.
- 10 Restricted (3rd party information).

The **contents** of each section are:

1.7.1 Family Information and Professional Contacts

Every file should have a fronting sheet which is updated immediately as any information changes.

The fronting sheet should be the first document on a file and immediately visible on opening the cover.

A new fronting sheet should be completed for each continuation file.

It is essential that key information i.e. addresses, contact telephone numbers, are up to date for any staff member who may need to access it.

The fronting sheet also records known risk factors, e.g. violence or potential for violence towards staff, risk of self harm etc. It is vital this section is completed so that any staff member reading a file is immediately aware of the risk factors.

The most recent assessment (UNOCINI) should be available in this section at the front of the file as it should represent the best available synopsis of the child and family's circumstances.

Summary and Chronology of Significant Events

A summary should be written in respect of any case which has significant Trust involvement. It should be written at 6-monthly intervals (or sooner if there is a lot of complex information). It provides a concise summary of the history and progress of a case plan / child protection plan which is readily accessible.

The chronology of significant events provides a brief reference to key events and refers the reader to the relevant file section if further details are required.

Any case which has been subject to a transfer between teams/ offices should have a case transfer summary placed in this section.

Any case which has been closed should have a case closure summary placed in this section.

Referral and Initial Assessment

To include:

- All referrals. (including those with a full Preliminary Assessment by the referring agency)
- All UNOCINI initial assessments.

Recording

To include:

- All contacts with or about a child, recorded on the agreed daily record (see below) with the location of key documents e.g. referrals, letters clearly indicated.
- Reports of significant / untoward events - these to be colour coded.
- Case transfer summary sheets.

- Case supervision records and case consultation records – these to be colour coded.
- Record of visit to a Looked After Child – CLA II.
- Record of visit to child on the child protection register.
- Statutory visit records.

Regarding the daily record:

- Every daily record needs to state succinctly who contacted whom, the purpose, content and outcome of the contact.
- Ideally, all such records should be typed. Where records are hand-written, this must be legible with each record written in **black ink**, signed and dated (not initialled). In the transition from paper to electronic records, care should be taken to ensure that all paper based files have been updated with copies and then sorted electronically.
- This should be a 2 sided document to maximise recording opportunity and the page should be punched on the right hand side as opposed to the left to facilitate reverse book filing.
- Impromptu discussions or decisions/actions agreed outside of formal supervision should be carefully recorded in the daily log. It should be clear which manager contributed to the discussion and what was agreed.

Child Protection and Case Planning

To include:

- All case plans and associated documents e.g. UNOCINI Pathway Assessment, other professional assessments and reports.
- All case plan minutes.
- Joint Protocol for Investigation Forms (1 to 7).
- Requests for case conferences.
- All case conference reports, both social worker and other professionals.
- All case conference minutes & child protection plan.
- All parental / child contribution forms for case conferences.
- All child protection forms i.e. CPR 1,2,3.
- Records of core group meetings.
- Contracts with parents/ children/ others.
- All formal assessments, whether conducted by children's services or others where permission has been given to share this information (where not, such assessments belong in the restricted section).
- All pathway assessments or specialist assessment reports.
- Minutes of strategy meetings and any associated reports.
- Protocol for Joint Investigation forms.
- Child Protection Medicals.

All records to be filed in chronological reverse book order with all case conference forms, reports, and minutes etc for a specific case conference filed together.

Looked After Child (if colour coded files are not utilised)

To include:

- Essential Information 1 & 2.
- Placement Plan 1 & 2.
- Care Plans.
- Review of Arrangements and minutes.
- Statutory medicals.
- Review contribution forms – parent, carer and child.
- Other professional reports for reviews.
- All CLA forms except CLA II.
- Records of core group meetings.
- Minutes of Professionals' meetings.
- Pathway Plans.

All records to be filed in chronological reverse book order with all documents relating to a specific review filed together.

Legal

To include:

- Reports for care proceedings.
- Court Orders
- Reports for discharge of orders.
- Article 4 reports.
- Court directions.
- Legal correspondence.

This section also contains privileged information i.e. records of telephone consultations, meetings, correspondence to and from legal advisors, printed copies of e-mails between Trust and legal advisors on how to proceed with a specific matter. However, these should be filed in a separate pocket within this section, enabling it to be easily removed from the file if necessary.

Correspondence

To include:

- Copies of all correspondence (other than to/from legal advisors) into and out of the office by letter, memo and printed email.
- Copies of all referrals to other agencies.

Child Specific Documents

To include, as applicable:

- Copy of birth certificate.
- Copy of adoption certificate.
- Passport.
- Photographs.
- Letters from a parent e.g. for indirect contact.

All such records to be inserted into a clear wallet to enable safe storage and ready transfer to a continuation file.

Restricted (3rd party information)

Any information which is restricted for whatever reason. It is anticipated that there will be a minimal amount of information in this section as guidance suggests that information should only be restricted where its disclosure would impact negatively upon a child's welfare.

1.8 Administration of Files – Specific Responsibilities

The purpose of the following stipulations is to define the specific responsibilities of various parties to ensure a consistent approach to:

- Opening a file.
- Closing a file.
- Transfer of cases
- Maintaining the filing system.
- Filing documents

1.8.1 Opening of Files

Upon taking a referral the (duty) Social Worker is responsible for:

- Seeking relevant information and ensuring information is appropriately recorded on manual/computerised record by the end of that working day at the latest. The Line Manager will ensure completion of relevant UNOCINI documentation. completing the referral form by, at the latest, the end of that working day.
- Checking SOSKARE (ensuring CPR check) to establish whether the service user is known and recording this information on UNOCINI documentation.
- Accessing any prior records.
- Making a provisional decision re action and urgency and pass to the (duty) manager for ratification and signature.
- Following ratification, forward the referral to administrative staff.

Administrative staff are then responsible for:

- Entering the referral information on SOSKARE within one working day.
- Opening a new child/ adult file in respect of each family member or accessing an existing file.
- Giving the file an identifiable number.
- Insert the designated sections and removable folders (as outlined in 1.5) and contents indexes.
- Noting different surnames on the file index system and cross-referencing to other files.
- Noting on the new file the number and location of any existing files.
- Attaching to the outside of the front cover the designated pro forma and completing those sections marked with an asterisk*:
 - Name*:
 - File Ref No*:
 - Date of first entry in file*:
 - Date of last entry in file:
 - Volume No*. _____ of _____ (e.g. 1 of 4)
 - Retention period as defined in *Good Management Good Records* (DHSS&PS 2004).

1.8.2 Closing a File

Where a case has been identified for closure the Social Worker is responsible for:

- Completing a case closure form and forwarding to the manager.
- It is the Social Worker's responsibility to complete recording and ensure it is appropriately filed prior to forwarding to manager for authorisation for closure.
- It is the manager's decision to close a case and to sign this off.
- It is the Team Leader's/SSW's responsibility to satisfy him/herself that all recording is complete and correctly filed prior to closure.
- Social Worker will then forward file to administrative staff.

Administrative staff are then responsible for:

- Case closure on SOSKARE.
- Completing the File Closure Form.
- Updating the index card and removing the file sling from the filing cabinet.
- Filing in the appropriate closed records filing system.

When a file reaches 2.5cm's thickness (but the case remains open) a continuation file should be opened and key documents should be transferred to it e.g. Court Orders, Child Specific document folder, legal advice folder, chronology of significant events, contact details.

1.8.3 Transfer of Cases

Where a child is on the Child Protection Register and the child and family move to another Trust:

- a written summary of the family history and the reason for registration must be forwarded within 5 working days to the receiving Trust.
- a record of the transfer of responsibility should be made, signed by the original Director of Social Work, and placed on the child's file.

Reference should be made to Chapter 7 of the Regional Child Protection Policy & Procedures.

In respect of the agreed transfer of a child in need the Trust must ensure a copy file is provided to the new Team.

1.8.4 Maintaining the Filing System

All paper-based files should be maintained in a secure lockable filing cabinet. All electronic files should have appropriate security access levels.

When a file is removed from the cabinet a tracer should be completed to indicate who has taken it and its location.

The tracer should be updated on the file's return.

Filing cabinets should be routinely checked to ensure e.g. files are present, tracers completed and closed files removed. Similarly, there will be a need for regular monitoring of security access levels in relation to the range of files stored electronically.

1.8.5 Filing of Documents

The Social Worker is responsible for:

- Ensuring all documents are signed and dated prior to filing.
- Ensuring that all documents can be readily identified by administrative staff e.g. by name and address of family or file reference number.
- Passing documents promptly to administrative staff.
- Ensuring duplicate copies are not filed – but rather shredded.

The Administrative Staff are then responsible for:

- Filing documents within one working day.
- Filing them in chronological reverse book order.
- Updating the contents index in the relevant section of the file.

1.9 Quality Assurance/ Audit

It is important that a systematic and planned approach to the management of all records is in place within all Trusts. This should ensure that from the moment a record is created until its ultimate disposal, the Trust can control both the quality and the quantity of information it generates; can maintain that information in a manner that effectively serves its needs and those of its stakeholders; and can dispose of the information appropriately when it is no longer required.

There are three different levels of quality assurance:

1. Social workers are responsible for the quality of their own recording.
2. First-line managers are responsible for monitoring the quality of recording. This should be done by sampling files and discussing them in Supervision. First Line Managers also have responsibility to sign off UNOCINI documentation.
3. Senior managers are responsible for auditing a small sample of case files and supervision records at least once every four months. Whereas self-audits and first-line manager monitoring are essentially *operational* in purpose the senior manager audits are equally strategic.

2. RECORDING STANDARDS AND CRITERIA

Standards are used in many different areas of life. They describe the basic level of performance or ability that is required for a product or service to be effective and do the job it was designed to do.

In this case, the standards define what needs to be in place in order that agencies ensure a consistent approach to recording at all levels and across the Trusts. Under each standard are a number of criteria i.e. indicators that will help decide whether this standard has been met.

Standard 1

Files are created and maintained and closed in such a way as to make information readily accessible and retrievable to appropriate personnel.

Criteria:

- Files are structured in adherence to the recording policy.
- All entries are filed in chronological and reverse-book order.
- All entries are typed (see note in the policy about this being a longer term goal).
- Files are opened in adherence to policy.
- Files are closed in adherence to policy.
- Files are maintained in adherence to policy.
- Filing of documents is undertaken in adherence to policy.
- Files are stored in adherence to policy.

Standard 2

Files contain the correct documentation.

Criteria:

- The content of files is as stipulated in the recording policy.
- To enable key information to be readily understood files contain:
 - A contents index which is updated by administrative staff as they file each document.
 - A fronting sheet which is updated immediately upon receipt of new/ amended information.
 - A chronology of significant events, cross-referenced to the relevant file section.
 - A concise summary (see below) completed, at a minimum, at six-monthly intervals.
 - A daily record, recording succinctly all contacts with or information about a child.
 - Any risks to staff caused by e.g. threats or violence by service users.
- Files do **not** contain duplications.

Standard 3

Files provide evidence of planned and purposeful work with children and families.

Criteria:

- There is evidence that information obtained has been analysed and that the analysis has influenced the plan.
- Literature and research has been integrated into analysis.
- There is a multi-agency plan (based on UNOCINI) in existence in respect of each child subject to children in need or child protection processes
- The social worker develops an individual plan (linked, where appropriate to the multi-agency plan) specifying the aims of each input and progress against these aims.
- The desirable outcomes (for children) of interventions are defined and monitored within the plan.
- Plans are formally reviewed and updated as appropriate in supervision – with amendments to plans recorded in the file.

Standard 4

Recording is conducted promptly.

Criteria:

- All records are dated and signed (full name) prior to submission to the administrator for filing (If the record is electronically an electronic signature will be issued.)
- Records relating to child protection investigations are recorded immediately and with reference to the time of contacts and interventions as well as the date.
- Records of contacts are completed on daily record sheets within one working week.
- Assessments are conducted and recorded within stipulated timeframes.

Standard 5

Recording is consistent with relevant legislation and is duly respectful of service users.

Criteria:

- Records clearly distinguish between fact, opinion, judgement and hypothesis.
- Records should contain evidence of service user contribution.
- Records are written in such a manner as they can be readily understood by the service user – e.g. jargon is avoided, acronyms are explained, job titles are stated etc.
- Records demonstrate that statutory requirements have been met.
- Service users' views are recorded, especially where these differ from the social worker's views.
- Records comply with the requirements of Data Protection/ Human Rights/ Freedom of Information legislation.
- However, concerns about the above legislation do **not** prevent the social worker from analysing material and expressing opinions.
- Service users are informed of the Trust's record-keeping policy and of their rights to access information held about them.
- Service user details are accurately recorded e.g. spellings of names, ethnicity.
- Assessments and reports are fully shared with service users (other than where this poses risk to children).
- Service users are informed of Trust recording policy.
- Service users have given consent for the sharing of information with third parties (other than where consent is not required in order to safeguard a child's welfare).

Standard 6

Recording is child-centred.

Criteria:

- Records indicate that children have been seen and spoken to (where appropriate, on their own) in accordance with the Trust's policy.
- Where it has not been possible to comply with policy (in respect of seeing and speaking to children) recording clearly states why this is so, that this fact has been shared with management and what steps are to be taken to address this.
- Records demonstrate that efforts have been made to obtain and record the wishes and feelings of all children (including e.g. disabled children with communication difficulties and for whom English is not their first language).
- The impact of parental functioning and behaviour on the child's development and well-being is assessed.
- Records describe children's *experiences* i.e. they paint a picture of what life may be like from a child's perspective.

Standard 7

Child protection records contain specific relevant information.

Criteria:

- There is an accurate detailed record of any injuries, signs and indicators and parental behaviours which give rise to concern.
- There is an accurate record of explanations offered by children, parents and others who may hold relevant information.
- Immediate risk to children is evaluated and immediate protective action considered.
- Longer-term risk to children is evaluated with the plan describing how this is to be countered.
- Consultations with managers around child protection matters – and decisions which ensue from these – are recorded.
- Reports are prepared in advance of child protection conferences and sent to the chairperson at least two working days before the conference.
- Relevant assessment/UNOCINI forms should be clearly completed and filed.

Standard 8

Records demonstrate a commitment to multi-agency practice.

As part of its commitment to multi-agency practice, the Health and Social Care Trust standards, procedures and protocols should be shared with partner disciplines to assist their understanding of how the HSCT seeks to ensure highest standards of service.

Criteria:

- All staff should be aware of the Regional Information Sharing policy.
- The rationale for sharing information with another agency is made explicit.
- The rationale for referring a child and/or family to another agency is made explicit in writing – along with the contribution to children's outcomes such an intervention might make.
- Consideration is given to drawing on the specialist expertise of other disciplines and agencies.
- Where specialist assessments are commissioned, the findings of these are considered and integrated into plans.
- Records demonstrate a mutual understanding (intra- and inter-agency) of the nature of shared information and agreed actions.
- All appropriate agencies make a positive contribution to e.g. making referrals, child protection conferences, LAC reviews, core groups and (especially) to the making and implementation of multi-agency plans.

Standard 9

Records demonstrate professional accountability.

Criteria:

- Records are concise and written in clear, grammatically-correct English.
- All records are signed and dated (If the record is electronically a electronic signature will be issued.)
- Supervision records are created and filed as stipulated in the supervision policy and standards.
- Formal reports (for meetings and conferences) are drafted, proof read and produced by the social worker in advance of the forum and signed by both the social worker and supervisor.
- Records demonstrate analysis of information and outcomes of work plans.
- Any physical or verbal threats to or intimidating behaviour experienced by the worker should be briefly recorded as an incident on file. However lengthy detail should not be logged in daily records but recorded in significant event reporting process.

Standard 10

Recording demonstrates a commitment to diversity in all aspects of work (i.e. that all children and families are entitled to the same quality of service irrespective of ethnicity, religion, language, gender, age, disability or sexual orientation).

Criteria:

Recording demonstrates that:

- All assessments, plans and interventions address the implications of the child's ethnicity etc (see list above).
- The potential vulnerabilities of specific children e.g. physical/sensory disability are identified and countered.
- Discrimination that children may experience is acknowledged and, in so far as this is possible, countered by service provision.
- There is effective communication with all children (including e.g. disabled children with communication difficulties and for whom English is not their first language).
- All children receive an appropriate level of protection.
- Children and families receive appropriate services irrespective of ethnicity etc (see list above).

Standard 11

The quality of recording is assured by social workers and management.

Criteria:

- The social worker assures the quality of his/her own recording by auditing a small sample of his/her records on at least a three-monthly basis.
- The first line manager samples files of each supervisee on at least a three-monthly basis against the recording standards:
 - Identifying adherence to the recording standards.
 - Identifying strengths and weaknesses (and how the latter are to be remedied).
 - Identifying the social worker's training/ development needs.
 - Signing and dating the records.
- Senior managers audit a small sample of case files and supervision records on at least a six-monthly basis (as outlined in the supervision policy and standards).

3. APPENDIX 1

Legal Requirements

Public Records Act (Northern Ireland) 1923

Document available at

http://www.legislation.gov.uk/RevisedStatutes/Acts/apni/1923/capni_19230020_en_1

It is essential that all HPSS staff understand that all HPSS records are classed as public records under the Public Records Act (Northern Ireland) 1923.

Therefore Chief Executives and Senior Managers are personally accountable for records management within their own organisations

Freedom of Information Act 2000

Document available at http://www.opsi.gov.uk/acts/acts2000/ukpga_20000036_en_1

The Freedom of Information Act 2000 creates a statutory right of access by the public to all records held by public bodies (exceptions apply).

Data Protection Act 1998

Document available at http://www.opsi.gov.uk/acts/acts1998/ukpga_19980029_en_1

All HPSS organisations have a statutory duty under the Data Protection Act to protect the personal data they hold, in relation to records management. All HPSS organisations must ensure that they have a system to:

- Maintain the accuracy of records held ;
- Protect the security of personal data;
- Control access to personal data and ;
- Make arrangements for secure disposal once the record is no longer required. However all HPSS organisations must ensure that they comply with legislative requirements in terms of safe/secure storage of records/files for specified timescales and only dispose of records in keeping with legislation governing disposal/destruction.

The Data Protection Act covers computerised records as well as manual/paper records. The Data Protection Act outlines 8 basic data protection principles to be followed by anyone ``processing`` data.

`` Good Management, Good Records ``DHSSPS 2002

Document available at <http://www.dhsspsni.gov.uk/dhs-goodmanagement.pdf>

Good management and good records states:

``Records management is most effective when it commands commitment from senior managers and all HPSS staff regard it as a professional activity requiring specific expertise and good practice ``.

This document highlights the importance of an effective records management service to ensure information is properly managed and available whenever and wherever there is justifiable request for it.

Equality

This policy/proposal has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998, and it was found that there were no negative impacts on any grouping.

Human Rights

This policy has been considered under the terms of the Humans Rights Act 1998 and was deemed compatible with the European Convention Rights contained within the Act.