NHS
South East Essex

SUMMARY CARE RECORDS
Briefing for Essex and Southend Overview and Scrutiny Committees

1.0 Introduction

1.1 This is a briefing paper for the Health Overview and Scrutiny Committees for Essex and Southend to advise members of NHS South East Essex's plans to implement the roll out of Summary Care Records.

1.2 This is part of a bigger national plan, called the NHS Care Records Service, a secure service that will link patient information from different parts of the NHS electronically so that health care staff and patients have it when they need it to make care decisions. Summary Care Records are being rolled out in East of England during 2010 as part of the national implementation plan.

1.3 NHS South West Essex was one of the early pioneer sites for Summary Care Record, and to date has successfully deployed to approximately 60% of its GP Practices. The remaining PCTs in East of England have all been required to design a trajectory to deploy SCRs throughout 2010.

1.4 We plan to write to patients in a series of waves, starting in January. Each wave will consist of a number of GP Practices, comprising approximately 30,000 registered patients.

1.5 The purpose of this briefing is to inform and advise you of our plans.

2.0 For More Detailed Information

2.1 The Summary Care Record Implementation Team would be happy to attend an Overview and Scrutiny Committee meeting if required to give members more information about Summary Care Records and our plan for implementation.

2.2 A list of Frequently Asked Questions (FAQs) is attached. More information is available at www.nhscarerecords.nhs.uk.

3.0 What is a Summary Care Record?

3.1 The way clinicians are able to access health records is changing. One of these changes is secure electronic Summary Care Records (SCRs) which will allow faster and easier access to patients' vital health information.

3.2 SCRs represent an important leap forward in the way every patient's key health information can be accessed by authorised health care professionals, regardless of where that patient is treated by the NHS in England.

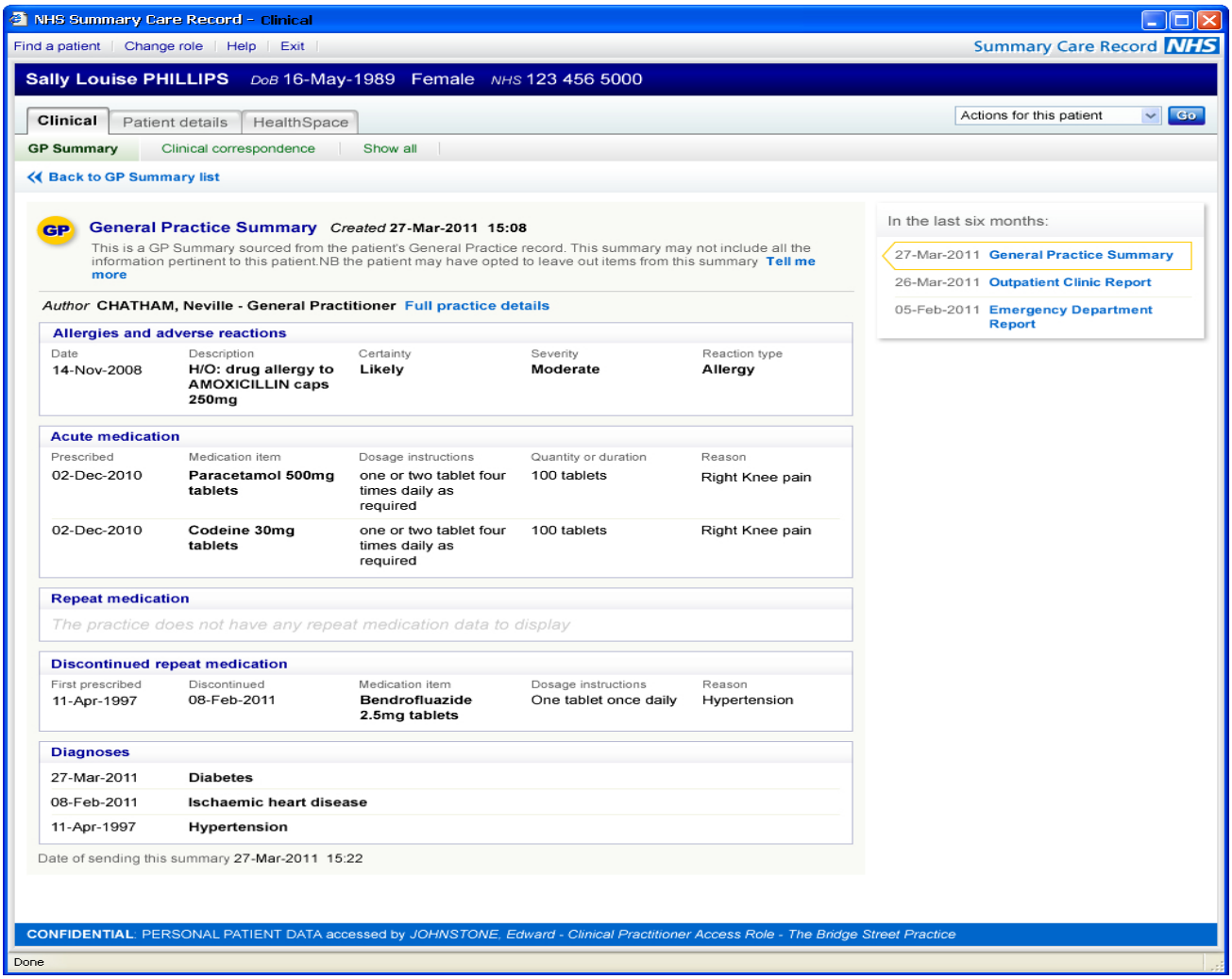
3.3 At the moment, many health care professionals treating patients either do not have their health records to hand or have to rely on faxes, paper copies and internal couriers. Unfortunately, this can result in lost paperwork and is not a very secure way of handling patients' care records.

3.4 Summary Care Records will provide secure access to patients' key health information. SCRs will prove particularly useful when, for example, a patient needs to be seen by a health care professional in out-of-hours, in A&E or away from home.

3.5 Allowing authorised staff to access patients' core clinical information electronically will reduce the chance of misdiagnosis, poor prescribing or suffering an allergic reaction – especially in emergency situations.

3.6 Initially, SCRs will consist of information about medications, allergies and reactions derived from the patient's GP record. They can be added to in time, with the consent of the patient.

4.0 What a Summary Care Record will look like



5.0 Benefits for Patients

5.1 Improved information flow between patient and staff:
The SCR will contain details of key health information including medications and allergies, providing a medical history at a glance

5.2 Better treatment in emergencies, out-of-hours and away from home.
The SCR will be available to health care staff treating patients anywhere in the NHS in England. This will be particularly useful in emergencies or when the patient's detailed health care record is not available

5.3 Faster access
Patients will no longer be delayed by the sending of records from one location to another, and patients will not be required to repeat information to different health care staff.

5.4 Improvements to your care
The reliance on paper records, and their transference from one location to another can be slow and sometimes information can get lost along the way. One central, electronically held SCR for each patients will reduce this possibility

5.5 More tailored care
Information about how a patient would like to be treated, if they need access to information in Braille or wheelchair access, for example, can be added to the record - in time.

5.6 Confidentiality and security of your record
Information in the SCR is safe and secure and is protected by the strongest security measures available for handling data. Only authorised health care staff will be able to see the parts of the record that are relevant to them, improving the quality of treatment and care.

6.0 Benefits for Clinicians

6.1 Quicker access to information
Patient SCRs will be available 24 hours a day. This is particularly useful to health care staff dealing with emergencies and caring for patients in out-of-hours settings.

6.2 Ease of communication
The record will show who has been providing care for a patient and at which stage, easing communication between health care staff.

6.3 Better treatment
With patients not having to rely on verbally telling their history to health care staff, it will increase the quality of care, especially in cases where the patient has trouble explaining their condition.

7.0 How We Will Roll Out Summary Care Records

7.1 An SCR Implementation Team has been established, reporting in to a project board. This team will consist of a project manager, assistant, communications lead and an IT trainer.

7.2 In January 2010, the team will start writing to patients telling them about the roll-out of SCRs, with full implementation expected in early 2011.

8.0 Detailed Care Records – Local Data Sharing Principle

8.1 In the same letter to patients, the team will be advising of our plans to implement a local data-sharing principle, which will allow authorised local healthcare professionals directly involved in that patient's care to view patients' detailed care records. This will also be with the patient's consent.

8.2 Detailed Care Records are the complete clinical record, incorporating all aspects of health care including medical history, test results, previous illnesses etc etc.

8.3 This data-sharing principle applies to practices using the computer software TPP SystmOne – 80% of our practices.

8.4 The data-sharing principle means that – with patients' consent – health care providers locally, such as GPs, community nurses, podiatrists, health visitors and other community health care staff involved in patient care can access patients' detailed care records.

8.5 The same confidentiality and security aspects will be applied to this local data-sharing principle as is applied to Summary Care Records, and only authorised staff directly involved in that person's care will be permitted to access information.

9.0 Patient Information

9.1 We will write to patients in waves, tackling groups of GP practices in phases, starting with Wave 1 in early January 2010.

9.2 Patients have 12 weeks to consider the information and decide if they want to opt out. If they decide to opt out, they need to get an opt out form and send it to their local GP practice.

9.3 The pack to patients will include:

- A covering letter
- A leaflet explaining Summary Care Records and the data-sharing principle of detailed care records
- A form to order the information in different languages and formats
- A business reply paid envelope – for the order form as above

9.4 In later waves, for patients of practices not on SystmOne, we will reword the leaflet and the letter to omit the information about detailed care records.

10.0 Consent, Security and Confidentiality

10.1 Patients do not need to do anything if they want a Summary Care Record created for themselves. But they can opt out, and will be given

the opportunity to do so if they wish. Early adopters of SCRs have seen less than 0.5% of patients opting out.

10.2 In the vast majority of cases Summary Care Records will only be accessed by clinical professionals with the explicit consent of the patient. However, in an emergency when the patient is not able to provide consent, access can be obtained when it is deemed in the best interests of the patient.

10.3 An electronic and fully auditable record is kept of all individuals who access Summary Care Records, and each instance of access without explicit consent will be investigated thoroughly.

10.4 Patients can request that any sensitive or private information is not disclosed and is kept private and excluded from their Summary Care Records.

10.5 To protect the privacy and best interests of the patient The NHS Care Records Service uses stronger security, encryption and confidentiality measures than internet banking.

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NHS
South East Essex

The NHS Care Records Service – Frequently Asked Questions

What is the NHS Care Records Service (CRS)?

The NHS Care Records Service is a secure service that links patient information from different parts of the NHS electronically so that health-care staff and patients can access it when they need it to make care decisions.

What is the NHS Summary Care Record?

The Summary Care Record is a secure way of allowing authorised staff to access patients' core clinical information electronically regardless of where that patient is treated by the NHS in England. It will reduce the chance of misdiagnosis, poor prescribing or suffering an allergic reaction – especially in emergency situations

How will the NHS Care Records Service work?

At the moment, a lot of information is kept within one NHS organisation and not easily available anywhere else. With the new system, people who are treating you will be able to access those parts of your records that they are allowed to see whenever they need it to provide you with care.

In time, you will be able to see your Summary Care Record whenever you want to on-line via HealthSpace and together with your clinician you will be able to make informed decisions about your care.

You can choose what information is available to those treating you.

Why do we need the NHS Care Records Service?

The NHS Care Records Service will improve the safety and quality of patient care and give patients more control over who sees their records and the ability to view their records.

I have received a letter addressed to someone else/the person on the letter you sent no longer lives at my address/the person on the letter has died/etc/what should I do with it?

You should return the letter to your Primary Care Trust or GP practice. They will then be able to update their records accordingly.

What information will you include in my NHS Care Record?

In the future, you can have an electronic NHS Care Record made up of a Summary Care Record and, over time, more detailed records.

Can I access my own records?

Yes, you can already ask to see your records where you are treated, at your GP, hospital or clinic. You will need to follow the procedures laid out by the Data Protection Act - i.e. make an application in writing or, if that's not possible, by some alternative method.

You may have to pay a small charge. You can also ask to see a copy of the GP Summary contribution to your Summary Care Record before it is created.
Your Primary Care Trust or GP Practice can tell you where you can do this.
When your Summary Care Record has been created you will be able to see it through HealthSpace, a secure Internet site, free of charge, any time you like, by using your computer.

Will the NHS ask my permission to create my Summary Care Record?
You will be contacted by your GP Surgery or Primary Care Trust (PCT) before your Summary Care Record is created and you will have several weeks to think about your options.

An information pack will be sent to you that will explain the changes that are taking place and your options.

How long will I have from receiving the leaflet to making my choice about whether I want a Summary Care Record and what information I want to share?
The letter you received from your GP should mention a date, sometime after which your Summary Care Record will be created.

There will be a minimum period (currently 12 weeks) from when the information is sent to you before your Summary Care Record is created.

What will happen if I choose not have a Summary Care Record?
The NHS will always endeavour to provide you with the best care possible, however, it could mean that there might be times when key health information about you is not available.

For example, if you do not have a Summary Care Record and are taken into A&E, then the staff in A&E may not be able to access your current medications, allergies or bad reactions to medicines if they cannot access your Summary Care Record.

The same could apply if you need a doctor outside surgery hours. Please read the NHS leaflet If I do not have a SCR (PDF, 34 Kb).

Can I limit particular items of sensitive information being accessed in various places where I receive care?
Yes, you will be able to limit access to all or parts of your Summary Care Record. If you have concerns and want to limit access to sensitive information in your record, please contact your GP Surgery to find out who, at your local surgery you can discuss your options with.

Will I be asked for permission to view my Summary Care Record?
Yes, you are in control of your record and who can access it - you will be asked at the point of care if those treating you can look at your Summary Care Record.

Will other people than those delivering my NHS care be able to access my

records?

People outside of the NHS will not be able to access your record without your permission other than in circumstances where it is allowed by law.
This is explained in the leaflet NHS Care Record Guarantee: Our Guarantee for NHS Care Records in England (PDF, 92Kb).

Can I stop information being put into my record?

Health care staff are required to make accurate, relevant records of the care provided. You can discuss what is recorded, where it is recorded and how it is expressed but you cannot prevent a health care professional from making some record of relevant information.

Can I change information on my NHS Care Record?

You cannot change information written by others, however if you spot an error you should let your GP know.

Can I add information to my NHS Care Records?

Not now, but in the future you will be able to add information such as your treatment preferences.

Is the NHS Care Records Service safe from hackers?

It would be very difficult to hack into it because the system uses the strongest national and international security measures available. It uses stronger safeguards than Internet banking.

Could my records be accidentally deleted or lost?

No there is strong protection to prevent any information about you being lost or deleted. The information is copied to a separate secure site so there is always a back up.

What are my rights about how you keep my information confidential?

You have the right to expect us to keep your health information private. You also have rights to make sure we keep your details confidential under the Data Protection Act, human rights legislation and the common law. In every place we treat you, there are people who are responsible for making sure your details are kept confidential. They are sometimes known as Information, or Caldicott, Guardians.

Your rights to privacy and our commitment to protect them are set out in the NHS leaflet Your health information, confidentiality and the NHS Care Records Service (PDF, 82Kb).

How do I find out who has looked at my Summary Care Record?

A record is kept of everyone who looks at your Summary Care Record and an alert will be sent to a nominated member of staff where access occurs in an unexpected setting, for example, if a clinician who doesn't usually treat you accesses your information. If it is found that the access was unreasonable, we will let you know.