hscic Health & Social Care Information Centre

The Summary Care Record Programme in England

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Clinical Ambassador – National Implementation

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What is the Summary Care Record?

- Each Summary Care Record (SCR) is a **summary** of key health information relating to an individual.
- The summary is sent electronically from a patient's **GP record** and is **stored securely** on the national NHS 'spine'.
- The vast majority of SCRs simply hold '**core**' data of:
  - **Medications** (acute, repeat and discontinued)
  - **Allergies**
  - **Adverse reactions**
- **Additional information** can be included at the request of and with the express consent of the patient.

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The SCR – key clinical information

24 hours a day, 7 days a week

- 60% - 70% of patients presenting for urgent or emergency care are not able to provide an accurate medication history.
- Contacting the GP surgery to obtain that information is time consuming and depends on the GP surgery being open. This cannot be undertaken out of hours, at weekends or bank holidays, but has to wait until the next working day, sometimes three or four days away.

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SCR is instantly available 24/7

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National roll-out of the SCR

- **45.9 million** patients have been contacted by mail across all 211 NHS CCGs.
- **45 million** people in England now have an SCR – that's >78% of the population.
- An SCR is being viewed by a member of healthcare staff **every 28 seconds** – that's over **1 million a year**
- The opt-out rate is **1.4%**

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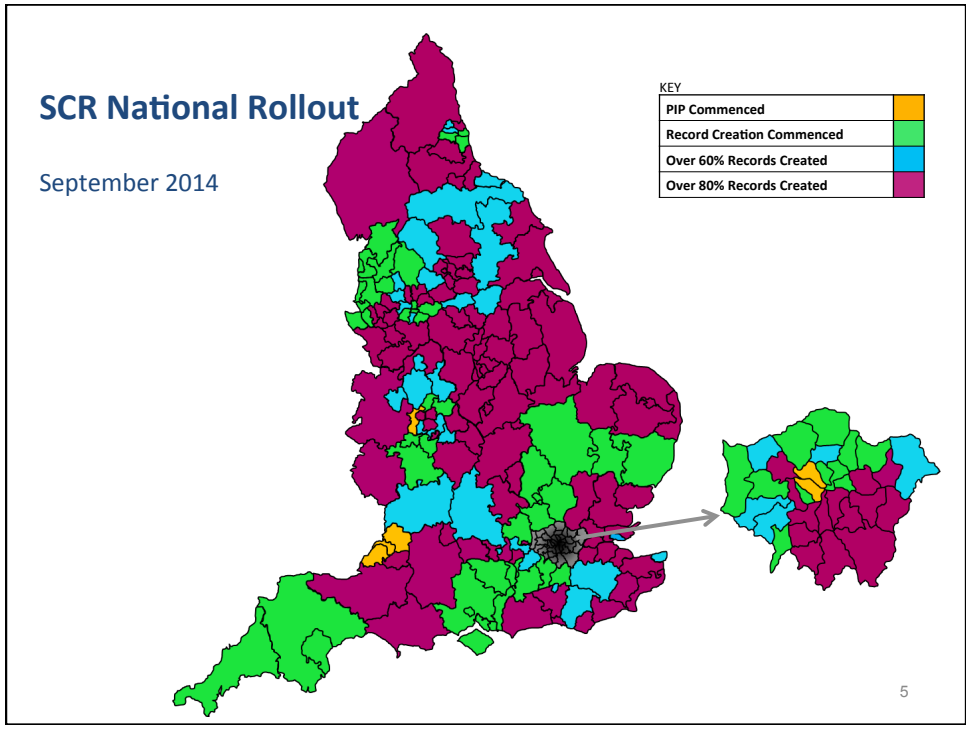

National roll-out of the SCR

- By the end of 2014 over 80% of patients will have an SCR
- By April 2015 over 85% of GP practices will have the improved capability to add additional information
- By the end of 2015 over 95% of patients will have an SCR
- By April 2016… Limit of the current business case

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Benefits

Supporting safer and more informed prescribing by providing timely access to accurate information

Supporting the delivery of appropriate care to patients

Reducing the time, effort and resources required to obtain this information from the patient's GP surgery

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Reducing the requirement on the patient to recall / repeat their medication information and supporting people with difficulties communicating

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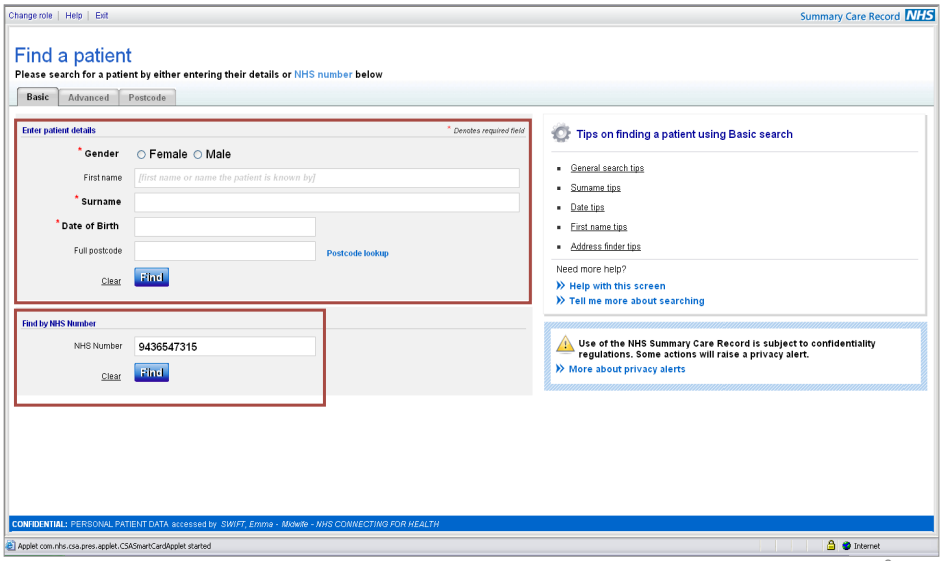
Searching for a Patient



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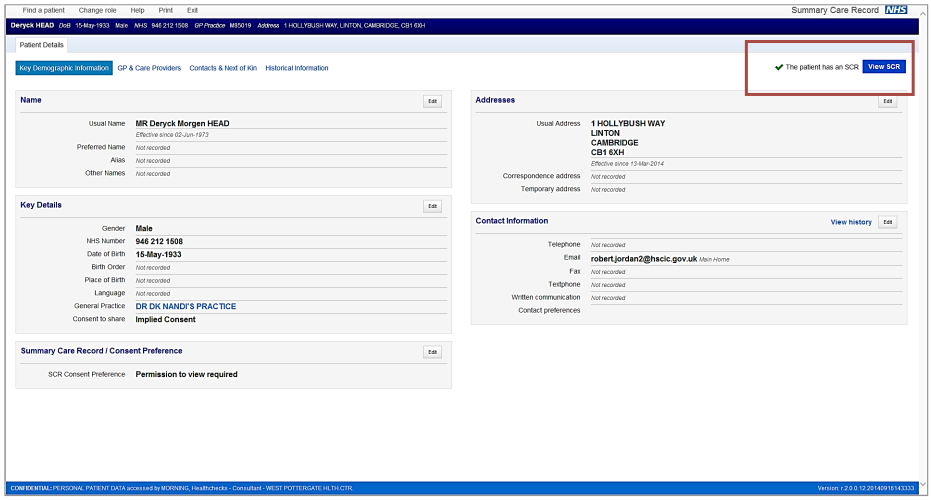
Patient Demographics



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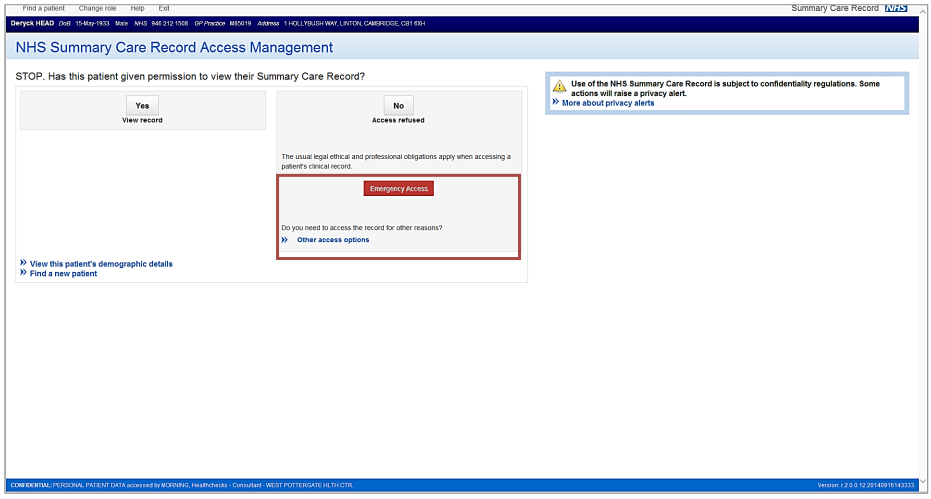
Permission to View



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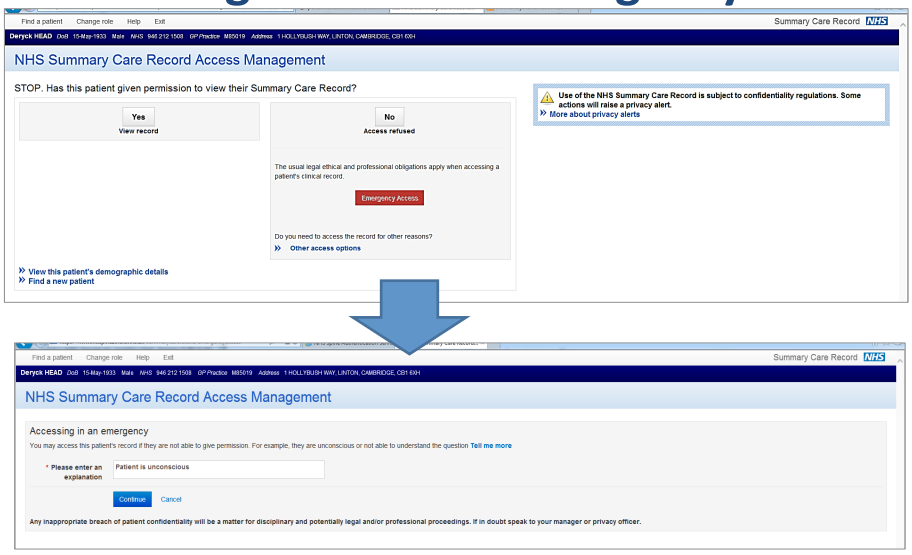
Accessing SCRs in an Emergency



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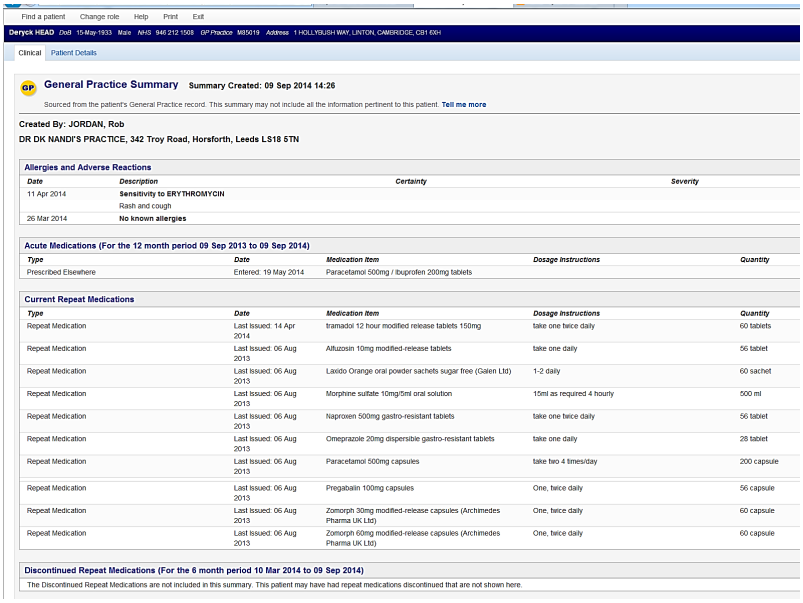
Viewing / Printing the SCR



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Implementing SCRa and Alert Viewer: Pre-requisites

- Identify and agree '**Scope of Use**'
- **Secure network** - N3, IGSoC and relevant ODS set-up
- NHS **smartcard** provision and maintenance (Registration Authority)
  - Identification of appropriate **roles** and **level of access** e.g. Privacy Officers, Legal Access etc.
- **Hardware** / **software** configured (Warranted Environment Spec.)
- **Training** delivery and **business process** design
  - Train the Trainer
  - Reconciling alerts
  - Etc.

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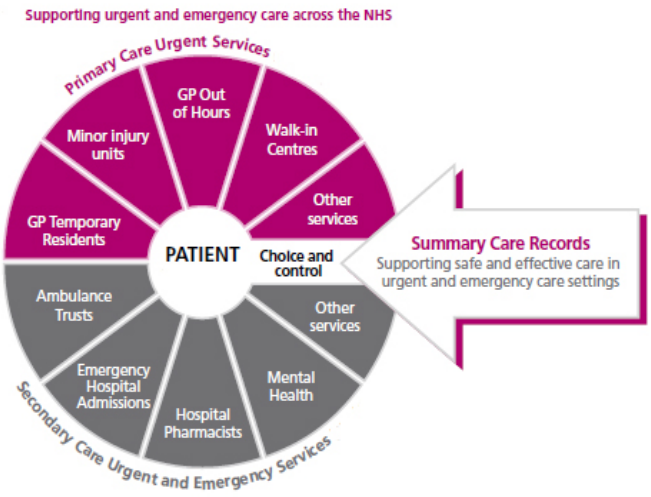
SCR: where can it help?



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Benefits to patients

The SCR benefits patients:

- **Improving Patient Safety** - improving safety by providing timely access to accurate information, for example when prescribing medicines and assessing patients.
- ***Empowering the Patient*** - putting patients in control of their records by requiring clinicians to ask for permission to view the SCR. Patients can decide whether or not to have additional information and change their mind at any time.
- ***Patient centred care - "What is important to this patient?"*** Patients may have specific care preferences or relevant information for use in an emergency e.g. living wills or religious preferences concerning blood transfusion etc. Individual preferences can be included to improve quality of care.
- ***Improved patient experience*** **-** SCRs can reduce the burden on patients to remember, recall and repeat their clinical information.
- ***Support for vulnerable patient groups*** **-** Using SCRs can benefit vulnerable patient groups including: patients that struggle to recall or communicate their health information; dementia patients; patients that take multiple medications; transient or homeless populations; patients whose first language is not English and patients with learning disabilities.

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SCR History and Scope

Dr Emyr Wyn Jones, Clinical Ambassador – SCR National Implementation

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Information for Health

Prime Minister Tony Blair – 1997

- 'If you live in Birmingham and have an accident while you are, for example, in Bradford, it should be possible for your records to be instantly available to the doctors treating you'

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A brief history…

- 2006 Ministerial Taskforce report on how to implement SCR.
- 2007-2008: Early Adopter PCTs were the first in England to create SCRs for patients.
- Public and professional concerns about security of data, breaches of confidentiality, government or others using the information for purposes other than the provision of health to the individual led to much media activity and campaigns such as the big Optout…
- 2009 National rollout starts – creating / viewing SCRs
- 2010: The Ministerial Review into SCR…

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A brief history…

The ministerial review of SCR in 2010 concluded:

'The Summary Care Record is the minimal information required to support safe care in urgent or emergency situations. Both review groups agreed that any further information added to the Summary Care Record should require explicit consent from the patient. Patients must not only be clear about the information contained in the Record but they must play a key role in deciding the evolution of the Record. This means that new arrangements should be introduced to define responsibility for decisions about the introduction of any new content to the Record. As a principle, any change to the scope of the Record must be driven by citizens and patients, with appropriate advice from professional bodies and tempered by knowledge of the Information Technology capability. This is important for building trust in the system.'

The SCR Expert Advisory Committee has been created to support this requirement.

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SCR: What does it include?

- Originally the scope of the SCR was medication, adverse reactions and allergies plus any significant medical history from a patient's GP record, with additional content added over time from other organisations delivering care to the patient e.g. discharge summaries.

Following the Ministerial Review in 2010 the content was limited to just the GP contribution. Anything beyond medication, adverse reactions and allergies required the GP to obtain the patient's explicit consent.

Consideration of scope of content from new care settings falls within the remit of the Expert Advisory Committee.

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SCR: Scope

- Defined in the SCR Scope document (circulated)
- Two distinct components of scope:

1. **Content:** describes the information contained within the SCR and from where that information is derived.
2. **Use or purpose:** describes how, by whom and in what care settings the SCR is used.

- Consideration for expanding the scope of SCR usage is one of the papers submitted to the committee.

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Citizens' expectations

- Most citizens assume that basic information known to their GP is available throughout the NHS in any care setting where they are seeking urgent or emergency care.
- *"In an advanced National Health Service care system it is reasonable for citizens to expect that when they arrive in Accident & Emergency or require treatment out of hours that clinicians treating them have access to enough basic medical information to prevent anyone making wrong or even dangerous decisions"* Sir Bruce Keogh (11/10/2012)
- *"Eighty-five percent of the British public want any healthcare professional treating them to have secure electronic access to data from the GP record"*
  YouGov poll, June 2014

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A brief history…

- Today:
- Over 44 million patients have a SCR (over 78%)
- Over 20,000 SCRs being viewed per week
- GP suppliers are providing enhanced functionality to support GPs in adding additional information to benefit patients. By April 2015, over 85% of GP practices will have this improved capability.
- During 2015 - Most patients will have an SCR

The future – maximising opportunities for use of the SCR?

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NHS

Thank you

We'd be happy to take questions

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"The Summary Care Record is a vital tool to make care provided to patients safer, timelier and more effective. Ensuring that the Summary Care Record is used more widely will improve patient experience of services where urgent care is provided and improve some of the joins between different services, where experience is often worst for the patient."

Neil Churchill, Director Improving Patient Experience

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"Stroke is a medical emergency, time lost is brain lost. It is essential that people are given the appropriate treatment as quickly as possible. Summary Care Records offer great potential to assist health professionals deliver more effective care to patients in emergency settings. When stroke happens your ability to communicate is often affected, a service like this may give doctors information that helps them make better decisions when time is of the essence."

Joe Korner, Director of Communications

"There are real dangers for people having a severe asthma attack. Asthma still kills three people a day, so it's vital that someone who is having an asthma attack receives prompt care. And yet it's at that point, when they are struggling to breathe, that many people with Asthma have told us of being asked to repeat their entire medical history.

Summary Care Records have the potential to help healthcare professionals assess and treat people with Asthma quickly and safely, by giving them instant access to vital basic information about each patient – such as their allergies and medication.

Getting these records used consistently across the NHS could make a real difference to people with asthma using emergency care or out of hours services, especially for those who choose to include more information about their treatments and care plans."

Emily Humphreys, Head of Policy and Public Affairs

"Having Muscular Dystrophy or another neuromuscular condition may completely alter the type of treatment that is suitable for a patient. In an emergency, the records allow people to pass on vital information on their health.

The take up of the Summary Care Record across England and the Individual Health Record across Wales is encouraging. We advise people with rare conditions to speak with their GP about the records and to discuss how best theirs can be used as a tool to support any emergency healthcare.

Nic Bungay, Director of Campaigns

DIABETES UK
CARE. CONNECT. CAMPAIGN.

"Summary Care Records could prove vital in emergency situations for people with diabetes as they have been demonstrated to improve patient safety by reducing the risk of prescribing errors, and reducing the average time for medicine reconciliation by almost two hours."

Bridget Turner, Director of Policy and Care Improvement

"The Summary Care Record has clear benefits for patients with a learning disability in helping individuals communicate key health information. In addition, the Summary Care Record has the scope to allow individuals to include additional information about their needs that they may want to make healthcare professionals aware of when accessing treatment. This could include important information about how they communicate, for example, how they show they are in pain. The record could also include contact details for their carer or advocate.

Since 2002, Mencap has had over 85 deaths of people with a learning disability reported to us where families feel their loved ones have died of avoidable causes. These causes have repeatedly shown evidence of discrimination within the health system, which had ultimately cost people their lives.

Summary Care Records provide health professionals with vital information. This is especially true in cases where patients are unable to communicate verbally and are therefore reliant on health professionals having the right knowledge and understanding of their needs to provide them with high quality and safe healthcare. Put simply, Summary Care Records could save people's lives."

Clare Lucas, Campaigns and Policy Officer

"Summary Care Records have the potential to be a real asset in helping health and care services meet the needs of people with dementia and supporting them to work together. We know people with dementia often access a range of health and care services and having a Summary Care Record could prevent a person with dementia or their carer having to explain repeatedly what treatment they are on and any medicine allergies they have. Supporting people with dementia, their carers and healthcare professionals to use the record to store other information, such as care plans, advanced decisions or personal preferences, could make the record even more valuable. Similarly, expanding access to Summary Care Records to social care professionals and those working in the voluntary sector could also have significant benefits to people affected by dementia, so long as proper safeguards are in place to protect sensitive data.

Jeremy Hughes, Chief Executive

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Useful links

SCR website:
www.hscic.gov.uk/scr
www.nhscarerecords.nhs.uk

SCR case studies:
http://systems.hscic.gov.uk/scr/staff/aboutscr/comms/case

SCR deployment map:
http://systems.hscic.gov.uk/scr/staff/impguidpm/deploy

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