Summary Care Records (SCR) use in Care Planning for Patients in LLR

What is the Summary Care Record?

The SCR is an electronic record of important patient information, created from GP medical records. It can be seen and used by authorised staff in other areas of the health and care system involved in the patient's direct care.

- National database of core patient data (Version 1):
  - ➢ Current medication,
  - ➢ Allergies and details of any previous bad reactions to medicines
  - ➢ The name, address, date of birth and NHS number of the patient
- Patients can opt out of sharing core patient data, if they do not opt out it is automatically uploaded to the national database
- Information is secure and the patient is asked for consent by the healthcare professional prior to being accessed

How is it used?

- 100% of all GP practices are currently using SCR

- All providers in LLR have access to SCR

- SCR can be accessed outside of the LLR boundaries

- 82% Community Pharmacies technically live with SCR

- Actively used in UHL pharmacy to support cross referencing of medications and understanding allergies prior to dispensing medicine

- It can be integrated with existing clinical systems or accessed via a stand alone web browser

- Professionals need a smartcard to access the SCR

Summary Care Records Version 2.1

Summary Care Records Version 2.1 is an enhancement to Version 1 and is currently optional for organisations to enable. The benefits of Version 2.1 is that it allows additional datasets to be added to SCR Version 1.

- Version 2.1 can help to create a digital patient **Care Plan**
- Version 2.1 data is not automatically uploaded to the national database so it requires patients to consent to share at the GP practice
- Will be enabled in GP practices by March 2017

What are we planning to do?

- Project manage and implement SCR Version 2.1

- Define the dataset that will be used for sharing in SCR Version 2.1 working with Better Care Together Workstream Leads

- Work with GP practices to gain consent to share additional information on SCR Version 2.1 for defined groups of patients

- Ensure that providers view and use information on Version 2.1 at point of care

Current Limitations

- SCR is currently not available in Social Care

- Data can only be updated at the GP practice

- Patients have to opt in to share their record at the GP practice prior to it being available to other services

- Not all health and care professionals currently use SCR

Mitigation

To address the limitations LLR will do the following:

- Maximise the use of MIG technology
- Maximise the use of TPP SystmOne

These are other data sharing methods that will use the same data sets as the SCR but have less limitations

Interoperability

Interoperability is the ability of different IT systems and software applications to communicate, exchange data, and use the information that has been exchanged.

- Currently limited between current suppliers within LLR
- NHS England have defined FHIR (Fast Healthcare Interoperability Resources) as a common set of standards for software companies to use
- MIG provides some interoperability in LLR
- Rollout of data sharing between TPP and EMIS to start in 2017

What will it mean for Patients and Professionals

Patients

- Core data can be seen by various care professionals
- Reduces to need to remember what medication you are on
- Reduce the need to have paper copies of the care plan

Improves quality of care

Professionals

- Have electronic access to core patient data to help patient care
- Remove the need to ask the patient what medication they are on or specific questions regarding their care plan

Next Steps

- Ensure that Care Planning remains a core part of the Local Digital Roadmap

- Review implementation in Social Care

- Ensure healthcare providers actively use the Summary Care Records as part of care planning

- Review future options for dynamic care planning where all healthcare professionals and patients can add information to their plan