White Paper

Digital Shared Care Record: Definition and Benefits

Digital Shared Care Records in Context: The National Strategy

Shared care record systems occupy a central position in today’s vision of a transformed NHS fit for the 21st century. The drive to integrate health and social care, reduce costs and improve services to patients means that hospitals, GPs, mental health trusts, community trusts, councils and other providers all need to work together effectively on joined up care pathways. Integrated record systems are a key tool in facilitating these new ways of delivering care and in driving and managing the process of change.

Nationally, the case for shared care records is increasingly well-documented.

- An influential 2013 report by PriceWaterhouseCoopers, supported by Secretary of State Jeremy Hunt, proposes that the NHS could make an additional £4bn savings from better use of IT including electronic prescribing and shared records
- The Francis report into failures at Mid Staffs backs investment in electronic patient records, recommending the collection and dissemination of real-time information about patients and the care they are receiving
- The NHS Information Strategy and Caldicott2 also promote data sharing, with Caldicott putting particular emphasis on sharing information between agencies
- The Health and Social Care Act (2012) sets the agenda for integrating health and social care and for cutting NHS administration costs by 30% within 4 years
- The £3.8bn Better Care Fund pools health and social care funds to join up services and improve information-sharing
- The £290m ‘Safer Hospitals, Safer Wards’ Technology Fund specifically targets the introduction of integrated care records
- The £240m Integrated Digital Care Fund (‘Tech Fund 2’) is focused on projects that capture and link clinical and care information in digital care records.

Shared care records also dovetail with other significant government policies. They support the use of the NHS number as the key patient identifier, for example, and data matching across...
organisations ensures that a valid NHS number is used throughout healthcare communities. Shared care records also directly support Health Secretary Jeremy Hunt’s target of a paperless NHS by 2018.

**What is a Digital Shared Care Record?**

Over recent years the NHS has moved away from plans to provide national “one size fits all” systems for healthcare organisations. Proven systems and technical advances have shown that it is much better to share records between organisations delivering care in a particular geographic area, perhaps covered by one or more Clinical Commissioning Groups, or across an entire county or local authority area.

One organisation in an area can host a shared care record, which will collect data from the care records systems used by all of the care providers in that area, including GPs, hospitals, community and mental health trusts, and providers of social care. Feeds will include the following:

- **Acute Hospitals:** patient demographics, referrals, attendance (inpatient/outpatient, A&E), waiting list, medications, alerts, allergies, pathology results and radiology reports
- **GP Practices:** patient demographics, diagnoses, treatments, medications, allergies, results, disease register, co-morbidities and family history
- **Community and Mental Health:** patient demographics, care plans, problems, interventions, medical and social alerts, medications, referrals and clinical summaries
- **Social Care:** care teams, keyworkers, contacts and other involvements, assessments, needs and care provision details

The result is a full multi-agency record of key data covering the provision of care from primary to secondary and community care. It supports assessments, care plans and pathways which are multi-agency and multidisciplinary.

The digital shared care record is available to clinicians and care professionals across a health community, whenever and wherever they need it. It should be accessible not only in care provider facilities, but also in patient homes, nursing and care homes, ambulances, treatment centres and hospices. Mobile technologies ensure that the shared record can be accessed anywhere care or treatment is provided.

Shared care records have processes in place to ensure the correct records are matched, that patient consent is addressed, that records can only be viewed by clinicians and care professionals with the right authority to view and that data is secure and safe.
However, shared care systems should also go beyond simple record viewing. They should include the workflow, alerting and data collection facilities required to support the multi-disciplinary and multi-agency care pathways which are essential for the NHS of the future.

What Does a Shared Care Record Do?

A shared care record will have four primary functions:

- It will make the shared patient data available to authorised clinicians and carers where and when it is needed
- It will support assessment and other data collection forms so that users from different care settings can add data to the common record
- It will support workflow so that clinicians and carers can perform tasks and then inform, refer or handover to others
- It will include an automated alerting facility using text messages, emails and in-system messaging so that clinicians and carers can be notified of key events - a patient under their care being admitted to hospital, for example

To be really effective, access to the shared record should be possible from within a clinician or care professional’s usual system, so there is no need to remember passwords and processes to find the right patient or the right information. The easier it is to use, the more information will be entered into it and therefore the richer and more useful the record will become.

However, the shared care record is independent from primary and secondary care system providers – this provides a system which is not viewed as being “owned” by a particular care sector. Instead it is a truly shared record, hosted by one organisation, but available to all, and accessible using familiar systems and processes, with shared passwords, enabling more comprehensive use of shared care plans and pathways across organisational boundaries.

Example uses of a Digital Shared Care Record

The following examples show how shared care records can positively impact the quality of patient care provided and the efficiency of services:

- An A&E department is able to reduce admissions into hospital and the length of time patients are in the department, resulting from the availability of information at the point of care. Some A&E admissions can be avoided because GPs and paramedics are able to make informed decisions using a shared care record; patients admitted can be treated more quickly
in A&E with reduced risk as the shared record is able to provide medication history etc the patient flow through A&E and assessment wards will be improved as a result of faster decision-making.

- Reducing re-admissions. More integrated discharge management and better information availability for community staff means that 30 day re-admissions may be reduced.

- An Out of Hours GP service is able to access details related to a recent hospital discharge and follow-up GP visit, so that they are able to treat a patient appropriately at home rather than either admitting to A&E or asking the patient’s GP to provide a follow-up visit because insufficient patient history is available.

- Reduction in phone calls and record copying - clinicians and support staff in primary and secondary care no longer need to spend time copying records and dealing with telephone enquiries for patients needing treatment elsewhere.

- The shared care record can be used as a driver for coordinated working across disciplines and agencies for anticipatory and end of life care planning – the patient’s wishes, including their chosen place of death, can be made known to all care providers and ambulance staff. The shared care record is ideal for other multi-agency and multi-disciplinary care pathways for long term conditions, such as dementia assessment, diabetes management, asthma, and COPD. Assessment and data collection forms and worklists can be set-up, with alerts and baton passing to ensure that key checks and tasks are not missed.

- Improved medications management, resulting from the availability of medication history across care settings at the point of patient treatment. This supports faster and safer clinical decisions.

- Improved patient safety. This is because decisions are made more quickly, backed up by full supporting information on current or previous medication, tests and treatment provided across all care settings.

- Eradication of paper. The provision of unified information views means that there will be a reduction in printing and paperwork. This in turns leads to reduced time spent printing and sending paper between organisations associated with secondary care admissions and discharges, and a cut in associated telephone costs.
Benefits of using a Digital Share Care Record

Clinical Benefits

A shared care records system across a health and social care community will deliver significant clinical benefits which are summarised below:

- Improved access to patient health and social care information across multiple providers leading to:
  - better and faster clinical decisions based on richer and more timely information
  - fewer steps for patients
  - safety improvements
  - reduced length of stay
  - productivity improvements/reduced pressure
  - improved communication
  - reduced errors
  - improved healthcare outcomes for patients including patient experience
  - reduced risk in relation to care for children and vulnerable adults
  - Improved communication between referrers and service providers
  - Improved continuity of care across provider organisations
  - Patient wishes and preferences available to all care providers
  - Patients are involved and engaged

Cost Savings and Productivity Benefits

A community wide shared care record will also deliver cost savings, for example:

- substantial improvements in efficiency across the board, e.g. fewer repeat tests, less time spent completing forms and chasing results, a massive reduction in paper/stationery costs and printing
- a reduction in unnecessary A&E attendances and inpatient stays resulting from better and faster clinical decisions
- time saved by clinical and support staff requesting and responding to requests for patient records
- savings in call costs between organisations involved
Studies in England have shown that shared care systems which support End of Life care, allowing patients to record their wishes about where and how they wish to die, enable a significant increase in Deaths in the Usual Place of residence (DIUPR), resulting in net saved costs of hospital care of at least £38,900 per 200,000 population.

Other Quantifiable Benefits

Other quantifiable benefits are likely to include the following:

In primary care:
- a reduction in the number of requests for follow-ups from Out of Hours and A&E services
- a reduction in calls requesting information from other care providers and patients
- less time spent searching for information

In secondary care:
- a reduction in A&E attendances via ambulance
- fewer 4 hour breaches
- fewer emergency admissions from GPs, Out of Hours and A&E
- a reduction in calls from other care providers requesting information
- delays in medicines reconciliation eliminated
- Reduction in untoward significant events
- Improved patient satisfaction scores

For Further Information

Tel: +44 (0)1908 500 700
Email: info@graphnethealth.com
Web: www.graphnethealth.com