How can PPGs support practices with the uptake of information sharing with patients?

Feedback from PPG members is that they are happy to help practices in reaching out to patients on this topic.

- Suggest the following to the practice:
    - Include "Who can see my health record" form in pack for new patients registering at your practice
    - Pile of forms on reception for handing to patients
    - Displays in waiting room – some PPGs have already assisted practices with a stand and speaking to patients in waiting rooms
    - Flu clinics – PPG members help to hand out forms
    - Learning Disability health checks (an easy-read form is available)
    - Chronic Disease annual check – in fact any review.
    - Load the 'Happy to Share' video onto waiting room screens available from the CCG website.
    - Use Dispensary / Pharmacies – hand out forms with prescriptions
    - Patients with more questions – direct to the website listed on the form
    - Bulgarian, Portugese and Romanian versions of the form have been produced and are available on request.

More information about: Who can see my health record?

Background

- Currently 500,000 of the 650,000 patients in West and East Suffolk have an electronic primary care record on SystmOne.
- West Suffolk Hospital, Ipswich Hospital, mental health, MASH, St Nicholas Hospice, community teams, Allied Health Professionals (AHP), Integrated Diabetes Service, admission avoidance services (Frailty Access Base / Crisis Action Team / Early Intervention Team) can either view or access SystmOne records – there is the potential for these services to reduce their administrative contact and assessment time with patients if all of those records were shared.
- Of the 500,000 patients on SystmOne some 100,000 (20%) of those patients have been asked to make a decision about sharing their record
- Summary Care Record with Additional Information is a national system accessed by all healthcare providers in England, but not social care.
- Explicit consent is required to share the additional information
- The "Who can see my health record" form has been developed to capture both consent for SCRai and the whole patient record, and explains the difference.
- Patients are always asked to make a decision when seen by any other organisation.
- The CCG's are engaging with the public on informing them of their right to make a decision to share their SCRai and their patient record.

Benefits to practice staff, patients and organisations caring for those patients

Time

- GP Administrative Staff, GP+ staff, Community Staff, AHP Staff, Urgent Care Staff, Out of Hours providers, Mental Health Staff:
    - Retaking past medical history – would save between 20 and 90 minutes per patient if the record is shared
    - Negates clinicians other than GPs recording duplicate diagnoses in the record – this causes issues in other healthcare areas, including primary care, such as QOF issues.
    - Other clinicians call practices for information if it is not shared, where time is spent:
        - GP Administrative staff looking for information
        - GP Administrative staff then share this information either by phone, fax or email
        - GP Administrative staff members are sharing the information anyway – but do not have patient consent to do so
- Patients - tell us over and over again they do not like having to repeat themselves over and over again
- Time saved in consultations by other clinicians – more patients could be seen

Safety

- Without sharing the record, all organisations involved in a patient's direct care only have half, or less of the information.
- Reduction in clinical risk
- Improves patient safety

Any further queries

Julie Irving is available to talk to any practice and their staff regarding concerns they may have in promoting the gaining of decisions from patients:

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