Improving lives **together**
Norfolk and Waveney Integrated Care System

Norfolk and Waveney Shared Care Record (ShCR) – FAQ's

What is the Norfolk and Waveney Shared Care Record?

The Shared Care Record is a way of bringing together your most important records from the different organisations involved in your health and social care. These are then visible to frontline health and social care professionals, at the point of care, in a read-only view. This will allow them to see relevant information about the care and treatment you have had across all services so that they can make a more informed decision and support you to tell your story once.

Who does this affect?

Anyone registered with a Norfolk and Waveney Health and Social Care organisation.

Who will see my information?

Only health and social care professionals that are directly involved in your care will see your most important records. We set a very high bar for information security compliance within Norfolk and Waveney ICS. We will ensure that any organisation accessing your records has met the required data protection, confidentiality, and information security standards, before gaining access to your records. Access to your records is governed by role-based permissions and checked to make sure that a *legitimate relationship* exists between you and the health and care professional, so that we can ensure only those providing care access your record. Your details will be kept safe and only used for providing direct care.

Which organisations are involved?

The Norfolk and Waveney Integrated Care System brings together NHS organisations, councils, and wider partners in a defined geographical area to deliver more joined up approaches to improving health and care outcomes.

- Norfolk and Waveney GP practices
- NHS Norfolk & Norwich University Hospital
- NHS James Paget University Hospital
- NHS Queen Elizabeth Hospital
- Norfolk Community Health and Care
- East Coast Community Healthcare
- Norfolk County Council
- Norfolk and Suffolk NHS Foundation Trust
- Cambridgeshire Community Services (who provide our health visiting services)
- Integrated Care 24 (our 111 and out of hours provider)

What information will be seen?

Only information that is appropriate for health and social care professionals to access for the purposes of direct care:

- Dates and outcomes of hospital visits
- Upcoming appointments
- Referrals
- Prescribed Medications
- Allergies
- Investigations & Diagnoses (e.g., blood tests & scan results)
- Care and Support Plans
- Reviews and review dates
- Correspondence exchanged between health and care organisations

How will my records stay secure?

Your records will only be visible to frontline health and social care professionals, at the point of care, in a read-only view. They will not be made public, used for marketing, sold, or shared with any third party.

The Shared Care Record will not alter your information rights under the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018 (DPA); therefore, you can still request access to all information that organisations hold about you and details of the organisations accessing your data. To facilitate this each health and care professional will use their own unique log in credentials to access the Shared Care Record, and we will keep a record of those that have accessed your information, the time and date when it has been accessed and be ready for regular audit.

What benefit will this have?

- **Improved experience for you:** from knowing that any health and care professional you see has the information they need to provide you with the best treatment and care or make the most informed decision for your wellbeing.
- **Reduced waiting times and repetition:** because having readily available information means less time contacting different settings and departments and less time repeatedly telling your story or sensitive, sometimes uncomfortable information.
- **More efficient diagnostic testing:** by avoiding duplication through better communication
- **More holistic care:** by taking a wider scope of information into account, health and care professionals can communicate easily and proactively, considering your overall health, care, and social circumstance where we are aware and not just considering your immediate condition - doing what is right by you.

- **Increased satisfaction:** and confidence that no matter how complex your condition, that you're in the right place, at the right time, and whomever you see for your direct treatment and care is more informed.

How does it work?

With the Norfolk and Waveney Shared Care Record, all your important information will be available to your care team, in most cases through the main computer system they already use. This will eliminate the administrative burden of chasing for your information from colleagues elsewhere and allow those providing care to see the most up-to-date details and progress on your health and care journey.

At present, health and care professionals do not have access to the same set of information about your health and care, they rely on the information they hold within their own records but can make requests for further information by requesting copies of letters, or email or holding peer to peer conversations. Sometimes they have access to a basic online summary of data from your GP, but use of this is not widespread. These methods can be slow and can delay the provision of care.

Information for particularly sensitive patients (e.g. those in the witness protection programme, celebrities etc) will be handled using increased security controls and audit. There will also be restrictions on sharing particularly sensitive clinical information in line with national guidance (e.g. the adoption status of minors, sexual health conditions, HIV etc).

What if I need treatment outside of Norfolk and Waveney?

The new way of sharing information is currently only accessible by Norfolk and Waveney ICS health and care professionals. If you need treatment or care in a different organisation outside of Norfolk and Waveney ICS, those organisations will continue to share your most important information in the traditional ways, adhering to all best practice guidelines.

After we have launched in Norfolk and Waveney, we will work to link our Shared Care Records to those from other Integrated Care Systems, allowing care professionals to see your information if you receive care outside our geographical area (e.g. in Addenbrooke's Hospital Cambridge, or London).

When will my information start to be shared?

This journey has already started with the appointment of Intersystems Corporation as our Technology partner in bringing the Shared Care Record to fruition. We are hoping that our organisations described above will be able to contribute data and view the Shared Care Records in the next few months.

What if I do not want my information shared?

To receive the most timely and appropriate care possible, we recommend that you allow our health and care partners to view information through the Norfolk and Waveney Shared

Care Record which will make information sharing quicker, easier, and more complete. This helps to get you the right treatment at the right time, especially in an emergency situation. If you do not wish for your information to be accessed for the purpose of your direct care in this way, you may opt out by emailing NWICB.ShCR.OptOut@nhs.net with your Full Name, Date of Birth and NHS number. Please be aware that this may create clinical risks as health and care professionals will not see your records as easily. Information will continue to be shared as it is currently.

What does a shared care record mean in real terms?

Use case: Betty, aged 82, has had a fall.

Betty is brought to the Emergency Department (ED) by a neighbour who witnessed her fall in the garden one Sunday afternoon, The fall resulted in a minor head injury. She has a history of dementia. She speaks to the triage nurse and then is seen by the doctor and must repeat the information again. She can remember some of the drugs she is on but not all of them. She remembers having a Social Care Referral in place – But cannot remember the discussion. Betty feels overwhelmed spending her time being asked repeatedly for details she can't remember, by a long series of people. Betty feels ignored when she is talking about her family and grandchildren.

At present:

The triage nurse first assesses Betty with the little information provided. She requests the ED Clerk to contact Betty's GP to locate recent medical history and medication list. The ED receptionist has also been tasked to contact Local Government to find the Social Care worker who has recently assessed Betty.

Betty is seen by the ED Consultant who cleaned and dressed Betty's wound. Unfortunately, as the above information cannot be located as it is late on a Sunday afternoon. Betty has been unnecessarily admitted because the care team are unsure what social care package she has in place.

Betty was discharged early Monday morning after an uncomfortable night on Medical Assessment Unit (MAU) for a social admission she did not need.

With a Shared Care Record:

Following the introduction of the Shared Care Record, the hospital will be able to view the medication lists / recent GP visit. This will save Betty having to remember her medication and will save her having to repeat her story.

With this information available, in addition to healing Betty's wound – the ED consultant would have been able to do a medication review and ask her GP to change the medication that was causing the falls.

The Shared Care Record will also show the Social Care history – so the Hospital will be able to review what social care Betty receives. With this information, the Hospital could feel confident in discharging her as they could see that Betty has carers visit 3 times a day.

Once Discharged, the Social Care team will be able to access the Shared Care Record and see the discharge letter, without the needing to chase for the information – this will enable them to plan the care needed from the start of the intervention and liaise with Therapy colleagues about what equipment / adjustments could support Betty at home. This will save Betty having to repeat what happened (potentially struggling to remember the events of the fall).