

Information Sharing for Direct Care

Governing Body meeting

8 January 2015

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Is your report for Approval / Consideration / Noting	
Approval	
Are there any Resource Implications (including Financial, Staffing etc)?	
Not at this stage	
Audit Requirement	
<u>CCG Objectives</u>	
<i>Which of the CCG's objectives does this paper support?</i>	
1. To improve patient experience and access to care 2. To improve the quality and equality of healthcare in Sheffield	
<u>Equality impact assessment</u>	
<i>Have you carried out an Equality Impact Assessment and is it attached?</i>	
No – this will apply at the next stage	
<u>PPE Activity</u>	
<i>How does your paper support involving patients, carers and the public?</i>	
Patients were actively involved in the earlier Patient Select Committee work - and would be involved in the next stage	

Recommendations

The Governing Body is asked to:

- 1.1. Confirm agreement with the conclusion (section 4)
- 1.2. Recognise that the work regarding integrating out of hospital care under the Integrated Commissioning Programme can only succeed with record sharing along the lines as described in this paper
- 1.3. Agree a CCG position statement regarding the sharing of records for direct care (approve the example in section 7.1, or agree a revision)
- 1.4. Agree the Principles for a good sharing process as arrived at following the Patient Select Committee work (as shown in Appendix B)
- 1.5. Support the encouragement and influencing of practices in making the transition from current arrangements to one where the primary care record is routinely shared in support of holistic person centred care

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2. Aim

The CCG Information Governance Group has said “*We need to identify what we want to achieve with regard to health and care records sharing across the Sheffield system that supports best care from the patient/clients perspective*”. This paper proposes next steps in order to achieve appropriate record sharing and is looking for Governing Body approval.

3. National Context

The call for record sharing is coming from many quarters – this and the following section summarises some of these.

3.1. Caldicott 2

The quotes in this following section are taken from the Government’s response to the Caldicott review.

3.1.1. Caldicott 2 – New Principle 7

“7. The duty to share information can be as important as the duty to protect patient Confidentiality.

Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.”

The report recommended (Recommendation 2) that “*for the purposes of direct care, relevant personal confidential data should be shared among the registered and regulated health and social care professionals who have a legitimate relationship with the individual*”.

3.1.2. Caldicott commitments

All health and care organisations are expected to:

“examine their existing arrangements, and lead by example with their local partners to make it easier to share information” - Page 46

“expect that relevant personal confidential data is shared among the registered and regulated health and social care professionals who have a legitimate relationship with the individual” - Page 46

The CCG is being monitored on its implementation of Caldicott 2 including the above two Caldicott commitments

3.2. New guidance on sharing information for people’s direct care and treatment

The Department of Health wrote to NHS Trust and Local Authority Chief Executives on 7 November 2014 with new guidance on sharing information for people’s direct care and treatment. In the letter it says:

“We have today published a leaflet aimed at frontline staff, which makes it clear that sharing and protecting information are not incompatible. We would like you to make sure that this reaches every person in your organisation who may be making information

sharing decisions, and that they know that they should seek to share information to support the delivery of excellent care.” – see Appendix A for the full leaflet

3.3. National Information Board “Personalised Health and Care 2020 - Using data and Technology to Transform Outcomes for Patients and Citizens - A Framework for Action” Nov 2014

One of the proposals covered in the executive summary is to:

“give care professionals and carers access to all the data, information and knowledge they need” – real-time digital information on a person’s health and care by 2020 for all NHS-funded services, and comprehensive data on the outcomes and value of services to support improvement and sustainability”

4. Local Context

4.1. Sheffield CCG Select Committee Inquiry into Patient Data Sharing

4.1.1. Sheffield CCG set up a Select Committee Inquiry to investigate how the sharing of the primary care record could be enhanced because the CCG wished to improve integrated care and believed the appropriate sharing of information between care providers was essential to support better care. It called many expert witnesses (including patients), examined lots of written evidence, conducted a thorough in depth review, and reported its findings in May 2014. The overall conclusion was that:

“the efficient, effective, secure, ethical and proportionate sharing of clinically relevant primary care information among those responsible for a patient’s care will benefit the patient and the care professionals” (section 6.1)

4.1.2. The follow up draft document ‘Sheffield CCG – Patient Record Sharing Initiative - Blueprint – Draft Vn0.1’ states:

“the benefits of sharing patient data for the purposes of direct care far outweigh the risks of sharing. Furthermore, there was a duty on GPs to share as expressed in guidance from the GMC and recommendations from the Caldicott Reviews. However, GP-input data was not being shared outside the practice for a number of reasons most of which were associated with the processes currently in place for obtaining patient consent and the wider process for sharing the record with other care professionals. There were a number of slightly lesser concerns related to, for example, data quality, security, confidentiality, which exacerbated the situation.”

4.1.3. The draft principles for a good sharing process from the abovementioned document are shown in Appendix B

4.2. Integrated Commissioning Programme

The aims of the Integrated Commissioning Programme as stated in the Better Care Fund BCF Submission are:

“We believe that through integrated commissioning of health and social care we will:-

- 1. Ensure service users have a seamless, integrated experience of care, recognising that separate commissioning can be a block to providers establishing integrated services.*
- 2. Achieve greater efficiency in the delivery of care by removing duplication in current services.*
- 3. Be able to redesign the health and social care system, reducing reliance on hospital and long term care so that we can continue to provide the support people need within a reduced total budget for health and social care.”*

More specifically it refers to information sharing on page 25 as follows:

“Issue 5: Improve Access & Information Sharing Capability and Customer Service Responsiveness

Will have very clearly reflected in our programme structure the vital role of facilitated exchange of information in the delivery of integrated care with the establishment of a project to deliver these aspects. We are currently urgently defining the scope of the work within those workstreams.

We will be commissioning integrated models and emphasising the role of community access and community assets and hubs in the delivery of equitable care services.

The BCF will allow us to consider new inexpensive pervasive technologies to forcing change in delivery models

It may also offer an opportunity for the Council to further develop self-service and e-access via the introduction of digitally enabled services

In our plans we will aim to ensure the information flows follow the person and show clearly how important this is in delaying deterioration and in delaying the progression of conditions”

And on page 58:

“Information systems will support the ‘single plan’ for a patient\service users across the integrated service, adhering to the following principles:

- The right information available to the right person at the right time, to allow effective care and safeguarding as appropriate.*
- Recognise the patient\service user, supporting family members and friends as users of the information systems that support the single plan”*

4.3. Prime Ministers Challenge Fund Bid

The GP Provider Board is in the process of putting a bid into the Prime Ministers Challenge Fund – the following is the relevant draft extract (as provided by Trefor Roscoe 22/12/14) and represents the intention currently already signed up to by the majority of practices:

“Better utilisation of Technology

- Improvements in information sharing and access to patient clinical information*
- Linking primary care, social services and mental health records.*

The main plank of the IT solutions will be the use of the Medical Interoperability Gateway (MIG) to link up, and allow access to, all GP practices from the hub and satellites. Linking into secondary and community care systems should be possible. Our aspiration is to make as many of the separate medical and social care systems to be able to be viewed from anywhere and eventually exchange data with each other. Most of the information sharing and permissions issues have been solved. There are some technical issues that have been identified which should be able to be solved in the lifetime of the project. Many of these are associated with the way SystemOne handles messaging and we understand these have already been identified by other projects and solutions are being sought. We have the support of the informatics services of the CCG, the Care Trust, STH and the support of the GP practices to make these changes and work to solving the technical and organisational issues.”

4.4. Provider developments

4.4.1. STH new Technology Strategy

Sheffield Teaching Hospital has recently embarked upon a new Technology Strategy (June 2014) geared around clinical requirements – the following extracts give a flavour of some of their intentions

“3.1 Provide single view of all relevant patient information

This theme is focused on providing a single view of a patient record, allowing Clinicians to care for patients with complete and simple access to patient information and their history so that decision making can be better informed and more timely.”

“...There is therefore a requirement to provide a flexible, consistent way of viewing all relevant patient information from any location.”

“... • Work with Primary and Community Services Care Group to deliver streamlined, integrated pathways for patients. An integrated IT solution will be required for a successfully integrated service model”

“3.1.6 Provide access to patient information across healthcare boundaries

As a major tertiary centre we provide care on behalf of both primary and other secondary care providers. A frequent issue raised was the ability for our healthcare partners to be able to view their patients’ information that we hold to inform status and progress.

This requirement was expressed as:

- STH staff need to be able to access patient results electronically where the test has been undertaken by other NHS organisations, particularly other local District General Hospitals (DGH)*
- Ability to electronically access patient information held by GP’s in order to reduce emergency admissions*
- Secure electronic communication channels between STH and other providers / primary care”*

5. Conclusion

There is clear alignment between Caldicott 2, national guidance and the conclusions from the Sheffield Patients Select Committee review that *“for the purposes of direct care, relevant personal confidential data should be shared among the registered and regulated health and social care professionals who have a legitimate relationship with the individual”*.

In order to care holistically for individuals across health and social care we need a new approach to record sharing across primary health, secondary health and social care in Sheffield (of, for example, assessments and shared care plans for the frail elderly, or people with long term conditions)

Sheffield CCG has an important role to play in enabling and encouraging the implementation of this via its member practices and through its commissioning arrangements with its providers.

6. What might this mean in practice?

The following is an illustration:

- For SystmOne practices the primary care records are set to ‘shared out’ so the primary care record is available to be shared with other services, and ‘shared in’ so that the practice can view information from elsewhere (we need to check the equivalent for EMIS practices)
- There are approved processes for other services/ health and care professionals to ‘share in’ with appropriate consent
- We look to encourage the implementation of the Medical Interoperability Gateway MIG (or equivalent) to enable sharing with other systems (eg between SystmOne and EMIS practices, with the out of hours service, A&E, LA Social Services, STH clinical portal)

- In time there is an electronic shared record(s) for use by a range of health and care professionals – this could be virtual on-the-fly records created at (and only for) the time of use by pulling together appropriate data from a range of different systems (not an actual permanent separately stored record)
- There is much more engagement with the local population about care record sharing & consent

7. How do we get there?

The CCG needs to agree its expectations of the Sheffield health and social care system with regard to record sharing in order to best meet patients/clients needs

Where appropriate the CCG agrees in contracts with providers (practices, hospital provider trusts, Local authority provider services) to deliver shared records as part of their service delivery – perhaps via the GP Provider Board, and wider Provider Board

8. Implications / Proposals

8.1. CCG position statement re sharing records for direct care

We need to develop a statement which clearly gives the CCG's position that can be shared with other organisations along the lines of:

“Sheffield CCG agrees with the national view that ‘for the purposes of direct care, relevant personal confidential data should be shared among the registered and regulated health and social care professionals who have a legitimate relationship with the individual.’

In order to enable delivery of the best integrated health and social care services to individuals in Sheffield we will share relevant personal health and care data between care professionals involved in their care (this means sharing records across primary care, hospitals and social care organisations). This will be communicated to individuals, and will be facilitated by new technology that ensures the security of data and access by authorised staff only.”

This may need to be re-worded for the version that goes into the Privacy Notice to service users and the public to make it more user friendly

8.2. Citywide endorsement

We need to share our position statement with other Sheffield organisations (practices, hospital providers, City Council) to encourage the adoption of a shared statement that can then be made available to service users and the public at large

8.3. Action for Practices

We will need to encourage practices to adopt the agreed approach

8.4. Information Sharing Protocols

We will need to develop and sign up to appropriate Information Governance protocols / agreements to ensure that services are operating in an appropriate, properly managed way

8.5. Privacy Notice to service users & the public

We will need to develop communications with service users and the public at large. It would be good to have a shared Privacy Notice for the public about the use of

care records across the Sheffield health and social care system (each service could put any additional service specific information below the standard paragraph)

8.6. Technical solutions

We need to explore technical solutions for the short / medium and long term of creating access to records, creating shared records, enabling service user access

9. Recommendations

The Governing Body is asked to:

- 9.1. Confirm agreement with the conclusion (section 4)
- 9.2. Recognise that the work regarding integrating out of hospital care under the Integrated Commissioning Programme can only succeed with record sharing along the lines as described in this paper
- 9.3. Agree a CCG position statement regarding the sharing of records for direct care (approve the example in section 7.1, or agree a revision)
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- 9.5. Support the encouragement and influencing of practices in making the transition from current arrangements to one where the primary care record is routinely shared in support of holistic person centred care

References

- Government response to Caldicott 2 'To share or not to share' - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251750/9731-2901141-TSO-Caldicott-Government_Response_ACCESSIBLE.PDF
- National Information Board "Personalised Health and Care 2020 - Using data and Technology to Transform Outcomes for Patients and Citizens - A Framework for Action" Nov 2014 <https://www.gov.uk/government/news/introducing-personalised-health-and-care-2020-a-framework-for-action>
- DoH Letter re New guidance on sharing information for people's direct care and treatment – 7 Nov 2014 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/377016/Letter_to_CEs_with_link_7_November_2014.pdf
- Sheffield CCG - Select Committee Inquiry into Patient Data Sharing - Stage 1 - Interim Report 28/5/2014 - <http://www.sheffieldccg.nhs.uk/Downloads/get%20informed/Interim%20Report%20Vn1.0.pdf>
- Sheffield CCG – Patient Record Sharing Initiative - Blueprint – Draft Vn0.1
- Sheffield Health and Wellbeing Board - Better Care Fund Submission: Part 1- September 2014
- Sheffield Teaching Hospitals NHS Foundation Trust Technology Strategy and Roadmap Part 1 - Strategic IT Requirements 14 June 2013

Paper prepared by Mark Wilkinson (Head of Informatics, Deputy SIRO, CCG IG lead)

On behalf of Idris Griffiths (SIRO), Dr Andrew McGinty (Caldicott Guardian)

23 December 2014

If you have questions or need guidance on a particular issue please contact the following:

Local senior manager / information governance lead

Name: _____

Tel: _____

Caldicott Guardian _____

Name: _____

Tel: _____

More detailed guidance on confidentiality and information sharing is available from the Information Governance Alliance (IGA) at www.hscic.gov.uk/iga

The IGA is a group of national health and care organisations that are working together to provide a joined up and consistent approach to information governance. It is being created as a focal point for good practice and guidance for the whole health and care system.

This leaflet has been reviewed and will be endorsed by the IGA once stakeholder engagement is complete.

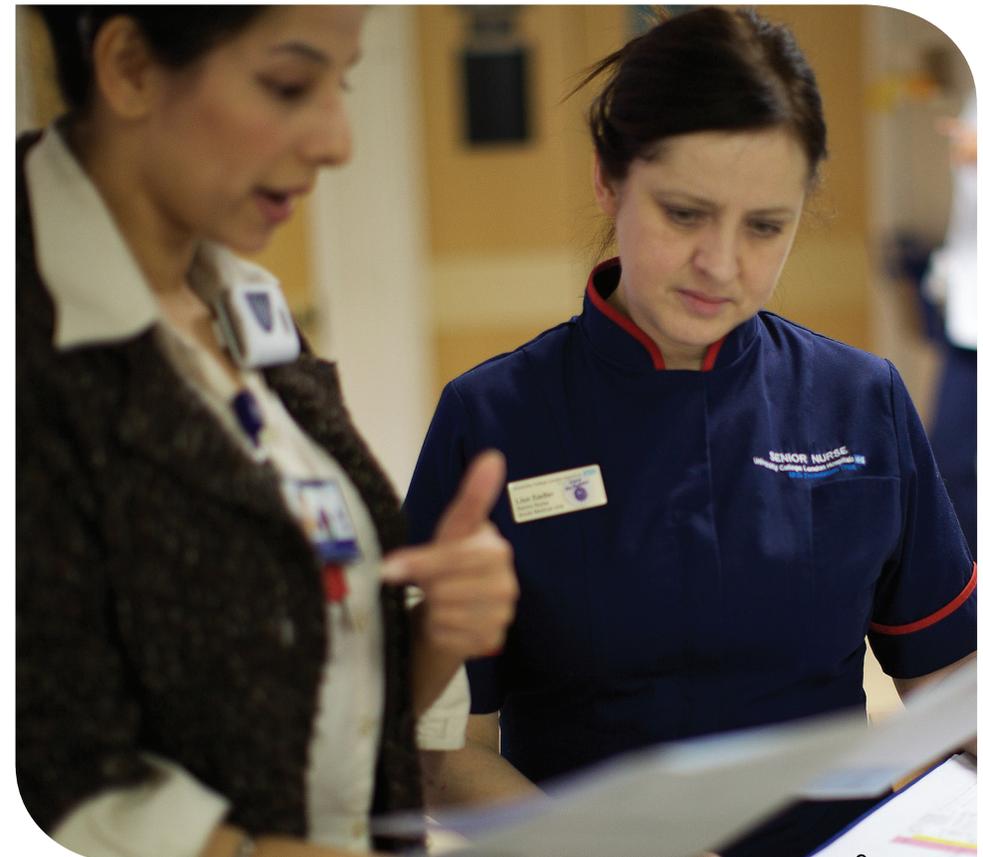
For more information go to: www.hscic.gov.uk/iga



Department
of Health

Confidentiality and Information Sharing for Direct Care

Guidance for health and care professionals



Confidentiality and Information Sharing for Direct Care

This leaflet emphasises the importance of sharing information with professionals and other members of the team who are providing health or care services to an individual. It sets out five clear rules for information sharing as part of a person's direct care.

It provides an overview of the main things you need to think about when making decisions on information sharing in your day-to-day contact with individuals who use our services. It also explains support you can expect from your organisation on more detailed issues.

Rule 1: You should treat confidential information about individuals confidentially and respectfully.

You must manage the information contained in care records respectfully and confidentially, using secure systems and processes, and share it in accordance with these five rules. You must keep individuals informed about the care you are providing, about the content of the records that you make, and about any proposed sharing of that content with others. If, as is their right, the individual asks for access to their records you must follow your organisation's documented procedures and, if appropriate, those of your regulatory and professional bodies.

Rule 2: You should share confidential information when it is needed for the direct care of an individual.

As someone involved in providing care to an individual, you have a legal duty to keep complete, accurate and up-to-date records about the care you provide. Subject to the other rules, you must share **relevant** information with others involved in providing direct care to that individual, regardless of organisational boundaries. Where this requirement means sharing information with people who are not care professionals (e.g. voluntary sector staff, family members, carers and friends), you should seek the agreement of the individual first. Where an individual lacks capacity, you should make a judgement about whether sharing the information is in their best interests. Confidentiality should **not** be a barrier to safe and effective care.

Rule 3: For purposes beyond direct care, you should not normally share confidential information that might enable individuals to be identified.

For purposes other than direct care (e.g. for research or for service management), you should not normally share information that might enable individuals to be identified. You should follow your organisation's policies and procedures to make sure you are following this rule. There are exceptions to this rule however, so if you are asked to share patient level information you must obtain the approval of a senior clinician, senior social care manager, an information governance expert, or your Caldicott Guardian who will review the legal basis for sharing the information.

Rule 4: You should respect an individual's request that their confidential information is not shared beyond their own care and treatment.

When an individual objects to any proposed information sharing – whether for their direct care or for other purposes - you should respect their wishes. You should carefully explain the consequences of not sharing the information. If an individual has the capacity to make this decision then it is their choice. However, there are exceptions, such as where there is a legal requirement to share information, where the public good served by sharing information outweighs the public good served by protecting patient confidentiality, or where an individual lacks the capacity to decide. Where you cannot respect an individual's wishes, they have the right to be told the reasons. These are complex areas so you should seek advice from your manager or Caldicott Guardian.

Rule 5: Your organisation's policies, procedures and systems should support you to follow this guidance.

Your organisation should support you to follow these rules. All the necessary policies and procedures should be readily available and you should have access to information governance advice when you need it. If you find that you are being prevented from following these rules, particularly if this non-observance may result in worse outcomes for individuals, then you must raise your concerns with your manager or Caldicott Guardian.

Patient Select Committee – Principles for a good sharing process

The select committee work came up with the following principles for a good sharing process.

1. Information should be securely shared between professionals providing direct care for the same patient through a process of implied consent
2. The process is legal and ethical and is in line with Caldicott and GMC guidance.
3. Changes to a new data sharing approach are manageable by GPs and patients/carers
4. The consent process is seen by GPs and patients to be practical and less time-consuming compared to the current approach.
5. Patient data is available at the point of care anywhere on the patient's care pathway
6. Patient information explaining the consent process is as minimal, simple and accessible as possible with an offer of further information if needed
7. The 'sharing out' process is as easy as possible for GPs
8. The Caldicott Guardians are responsible for ensuring that sharing happens and are able to undertake their enhanced role
9. Data quality is 'good enough' and regularly monitored by the practice
10. The process is accepted by as many GPs and patients/carers as possible.
11. Necessary security and confidentiality safeguards are in place and accepted by patients/carers and GPs
12. Information shared is necessary and sufficient for the purposes of direct care
13. Medical data is owned, and accessible, by the patient
14. Publicity should exist in clinical areas and on websites explaining to service users the approach to sharing information, and how to withdraw their permission to share their information between professionals