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How will the new Care Records Service developments impact on patient care?

The Government will guarantee that patients will be able to control and monitor who has access to their electronic health records. But both pharmacists and GPs have concerns about the implications for patient care. **Hannah Pike** investigates the questions that need answering

Last week's publication of the NHS care record guarantee assures patients that their health records will be kept confidential when they are added to the national electronic database that forms part of Connecting for Health, the national programme for IT (*PJ*, 28 May, p637). However, the question remains about exactly what data will be held on the new care record, and how much access different health care providers will have to it.

The NHS Care Records Service (CRS) will digitise over 50 million patient records and will be implemented in stages, with the whole project due to be completed by 2010. The national contract has been awarded to British Telecom with local systems being provided by Accenture, the Capital Care Alliance (led by BT), CSC and Fujitsu Alliance.

The care record will consist of a national database of basic patient information, known as the "spine", which will link to local records holding more detailed information. Under current plans, the spine will contain a summary of patient data, such as the patient's name, date of birth, any allergies and visits to accident and emergency departments. More detailed information, such as scan results and medication lists, will be held locally at the sites where the care is delivered.

What remains to be seen is exactly what data will be stored on the summary record and what will remain in local records, and who will have access to the different parts.

Lindsay McClure, head of information services at the Pharmaceutical Services Negotiating Committee, notes that the profession has been waiting to hear about access to care records since the Department of Health published "A vision for pharmacy in the new NHS" in 2003.

"The Government signalled that it would be consulting on elements of patient information that community pharmacists may need to deliver appropriate health care services as part of the new pharmacy contract," she says. "The PSNC has been involved in initial discussions with the Department of Health on this issue. We anticipate that the Department of Health will consult on this in the future."

David Pruce, director of practice and quality improvement at the Royal Pharmaceutical Society, says: "The average community pharmacist needs fairly wide access to information about patients' conditions, treatment plans and probably some test results. They may not need access to everything for all patients, but you cannot predict the patients for whom it is necessary to delve deeper to get an accurate picture of what is going on."

However, community pharmacist access in particular is likely to be more limited than many pharmacists may hope, since one of the commitments laid out in the care record guarantee states that information will only be shared with other health care providers if it is needed for them to play their part in the patient's care (see Panel).

Harry Cayton, chairman of the NHS Care Record Development Board (CRBD) says that it is therefore unlikely that community pharmacists will have access to much clinical data, since it is not strictly necessary for them to perform their job. However, what is likely to come out of the Department of Health consultation are specifications for role-based access, so that hospital pharmacists, for example, may have access to a wider range of patient data than community pharmacists.

Ms McClure adds: "Different pharmacists will need different levels of access. For

NHS commitments to patients outlined in the guarantee

The NHS care record guarantee promises the following:

- To give patients access to everything recorded about them upon written request (whenever possible this will be free of charge or at a minimum charge, as allowed by law)
- Only to share as much information as health professionals need to know to play their part in patients' health care
- Not to share patient identifiable data outside the NHS without specific permission from the patient, unless the request is a legal requirement or there is good reason to believe that not doing so would put someone else at risk
- To get patients' agreement before sharing information with other bodies, eg, social services, and to discuss the effects of not sharing this information if it will impact on health
- To give patients the right to choose not to have information in their records shared
- To deal fairly and efficiently will questions or complaints
- To ensure that information is accurate (patients can apply to have information amended or deleted if they are suffering distress or harm)
- To make sure all staff understand their duty of confidentiality
- To make sure records are held securely
- To keep a record of who looks at patient records and provide this if requested
- To take action if someone looks at a record without permission or good reason, which may include disciplinary action, terminating a contract or bringing criminal charges

The full guarantee can be accessed via *PJ Online* (www.pjonline.com/links/pj).

example, a pharmacist supplementary prescriber should have access to the same level of information as any other prescriber, but a pharmacist simply carrying out a dispensing role is unlikely to need access to all information held on the patient's record, for example, laboratory results."

Mr Pruce says: "The Society has been in discussions with Department of Health representatives about the access that community pharmacists would need and we look forward to responding to the Department of Health when they decide to consult on the issue."

Another commitment in the care record guarantee is that the patient will be able to choose which care providers have access to their data. Therefore, if they so wished, a patient would be entitled to say that they do not want their pharmacist to have access to their records. This highlights the importance of reinforcing the public understanding of the role of the pharmacist in health care.

Ms McClure says that patients' views on whether or not to opt out of sharing their records with community pharmacists are likely to depend upon the relationship that they have with them and their understanding of pharmacists' need for information about them in order to support their care.

"All community pharmacists will have a role to play in explaining how information about patients will be used responsibly within the community pharmacy setting and in helping to build public confidence in community pharmacy access to the CRS," she says.

"As part of the PSNC's work to raise awareness of the new contract, we have been working with patient groups to increase their understanding of the pharmacist's changing role and the importance of access to information to support patient care. Over the next few months, we will be continuing to work with patient groups on this issue."

A conference hosted by the British Medical Association last week discussed the implications of the care record guarantee. Concerns were raised about how it may impact on patient care. Many of these concerns apply not only to general practice, but also to pharmacy and the other health professions.

For example, in order to be able to see a patient record a health professional must be able to demonstrate that he or she has a professionally "legitimate relationship" with the patient. The conference was concerned about whether there will be an expiry time on this relationship. For example, a locum would need access to the patient records for the period for which he or she was employed, but this access would need to expire once the locum moved on.

The definition of a "legitimate relationship" also needs to be established. Trainee doctors and pharmacists currently use patient notes for training purposes and case studies. Will this access continue to be permitted?

According to an earlier *Which?* report, about two thirds of people would be happy for all of their information to be held on the national database as long as it was secure. About 8 to 10 per cent of people said they would want absolute control over access to their records and 1 to 2 per cent said they would opt out completely. The Department of Health has pledged to explain the possible consequences of opting out of the CRS completely, but professionals are still concerned about what safeguards will be put in place to limit the extent to which these people will be disadvantaged.

How care records will be integrated with the private sector is another issue health professionals would like clarified, since many patients receive treatment from both sectors.

If patients can opt to hide selected information on the record from their health professionals, will health professionals be able to hide information from the patient? One GP mentions that he frequently makes notes not intended for the patient to see, and is concerned that to continue working in this manner he will have to start a separate, private record to hold such information for himself. It has also been questioned whether an incomplete patient record creates safety issues of its own.

It is not yet clear whether pharmacists will be able to upload information onto the record as well as download it. Ms McClure says: "We believe that, where appropriate, pharmacists should have both read and write access to the records. For example, if a pharmacist carries out a medicines use review, it would improve patient care and joint working if the pharmacist could upload a summary of the review to the patient's care record so that other health professionals can access this information at the touch of a button."

A situation could potentially arise in which a pharmacist is in possession of some information that the patient does not want the doctor to see. Will pharmacists have the same right to "hide" information as doctors are likely to?

There are also a number of legal issues that health professionals would like clarified, such as whether consent to upload information onto the spine is implicit if the patient does not actively object.

Since implementation of the CRS is at such an early stage, the majority of these questions do not yet have an answer. So much depends on what the content of the care records will be.

Mr Cayton says that other issues the CRDB is addressing include how the records will cater for people who move across the home countries, those in prison or the armed forces, issues surrounding childrens' records, and those who have additional security needs such as victims of domestic violence.

Pharmacists must now wait for the Department of Health's consultation on role-based access to find out what implications the new databases will have for pharmacy and thus for the care of patients.

Mr Pruce adds: "In the meantime we need to be able to explain to patients why pharmacists may need access and what benefit it can bring them."

Electronic transfer of prescriptions — progress continues

Electronic transfer of prescriptions is progressing, says Lindsay McClure, head of information services at the Pharmaceutical Services Negotiating Committee. She says that the initial implementer sites that have gone live are giving NHS Connecting for Health the opportunity to study the impact that electronic prescriptions have on prescribing and dispensing processes so that changes can be made to the model where necessary before ETP is rolled out nationally. National roll out of ETP is still expected to start over the summer.

"The NHS Connecting for Health ETP team have confirmed that they will be issuing guidance on the compliance status of systems in the near future," says Ms McClure. "We would encourage pharmacy contractors to take time now to learn about the national programme projects that will impact on their practice in the future and investigate different options that may be available to them from different system suppliers. As soon as the necessary information is available on the ETP implementation plan, the PSNC will be able to progress to agreeing the new contract ETP payments with the Department of Health."

According to Ian Cowles, group director of implementation, NHS Care Records Service, Connecting for Health, about 9,700 ETP transactions have taken place to date. Speaking at the BMA conference, Mr Cowles said that elsewhere in the IT programme, electronic booking services are now rolling out into the NHS community, with about 1,000 electronic bookings made so far. There have been about 200 initial implementations of the NHS Care Records Service into trusts, and about 7,000 connections to N3, the national network replacing NHSnet.

Focus should be on patients

Speaking at the BMA conference, Richard Granger, chief executive of Connecting for Health, said that although some of the aspects of Connecting for Health have been delayed, others have been delivered on time, and some have been completed that were not in the plans to start with.

He noted that much of the public interest in the programme now quite rightly surrounds the patient care record guarantee, rather than focusing on the technology itself. "Things will go wrong with the plumbing occasionally," he said. "We need to focus on what we are going to deliver for patients and how it is going to be used by people who work in the NHS."

He added that despite speculation to the contrary, the national programme for IT has not gone over budget. "I have not gone back to ministers or the Treasury for any additional funding," he said. "We are spending exactly what we said we would."