



Your emergency care summary

Yardley Wood Health Centre describe their Summary Care Record implementation

A Summary Care Record is a secure electronic summary of a patient's key health information that is available to authorised healthcare staff providing care to patients in an emergency.

A patient's Summary Care Record holds their medications, allergies they suffer from, and any adverse reactions to medicines they have had.

NHS healthcare staff will have quicker access to key health information, which means they can provide safer care to patients during an emergency, when a GP practice is closed or when a patient is away from home in another part of England.

Yardley Wood Health Centre has over 9,000 patients in Yardley Wood and the surrounding areas. Angela Styring, Practice Manager, explains how the centre started uploading records in 2008 and has not looked back since.



"When I first found out about Summary Care Records I raised the idea at my patient forum meeting to get some feedback on how this new system would be received. The patient forum was very supportive of the idea."

"Everyone was really excited and impressed with the Summary Care Record demonstration."



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Before any records were made for patients at Yardley Wood Medical Centre, patients were informed about Summary Care Records and their choices by their local NHS, as part of the Public Information Programme.

“Most patients understood what was happening to their records after receiving their letter and information pack. A lot of our patients were under the impression that their records were already shared with other NHS organisations,” explained Angela.

“We made sure all staff at the centre had a good general knowledge about Summary Care Records so that they could help answer patients’ questions.”

“Some patients wanted to opt out because of security concerns. Quite a few came to see me first with their concerns and I was able to talk to them about the process involved in uploading the records, which put a lot of their concerns to rest.”

Healthcare staff need to ask permission every time they need to look at a patient’s Summary Care Record. They will only see the information they need to do their job and will have their actions recorded.

Before a practice can join the Summary Care Record programme, the Data Quality and Information Governance standards within the health centre need to be assessed to ensure that they are appropriate for sharing information on the Summary Care Record.

“The pre-and-post audit checks were the only added work we had to do and they did not cause us too many problems. After the upload the only additional workload implication has been informing new patients that join the centre.

“On registering with the practice, they are given as much information about Summary Care Records as possible and contact details of the practice if they need any further information.

“No one so far has opted out of having a Summary Care Record since the practice went live in 2008.”

To find out more about Summary Care Records, please visit:
www.connectingforhealth.nhs.uk/systemsandservices/scr

NHS Connecting for Health is supporting the NHS to introduce national applications and services such as the Summary Care Record. These will help the NHS deliver better care for patients.