Benefits of shared electronic patient records more modest than anticipated

June 16 2010

The benefits of the Summary Care Record (SCR) scheme, introduced as part of the National Programme for IT (NPfIT), appear more modest than anticipated, according to a study published in the British Medical Journal today.

The findings are based on an independent evaluation by researchers at University College London and come as the new coalition government announces a review of the scheme.

The Summary Care Record is an electronic summary of patient medical records accessible over a secure internet connection by authorised NHS staff. In 2008, the English government began to roll out the scheme nationally with the aim of improving the quality, safety and efficiency of care, especially in emergency situations.

But the scheme has proved controversial with a range of alleged benefits and drawbacks, from better clinical care and fewer medical errors to high costs and threats to confidentiality.

Researchers set out to evaluate the scheme over a three-year period (2007-2010). They analysed data across three sites, including over 400,000 encounters in participating primary care out-of-hours and walk-in-centres and 140 interviews with policymakers, managers, clinicians and software suppliers involved in the scheme.

By early 2010, 1.5 million SCRs had been created, but the researchers

found that creating SCRs and supporting their adoption and use was a complex, technically challenging and labour-intensive process which occurred much more slowly than originally planned.

In participating primary care out-of-hours and walk-in centres, they show that an SCR was accessed in 4% of all encounters and in 21% when an SCR was available. These figures were rising in some but not all sites.

Individual clinicians accessed available SCRs between 0 and 84% of the time. This varied considerably depending on setting, the type of clinician and their level of experience.

When accessed, SCRs seemed to support better quality care and increase clinician confidence in some encounters. There was no direct evidence of improved safety, but findings were consistent with a positive impact on preventing medication errors.

The research team found that SCRs sometimes contained incomplete or inaccurate data, but they did not see any cases where this led to harm because clinicians used their judgement when interpreting such data and took account of other sources of information. SCR use was not associated with shorter consultations, nor did it appear to reduce hospital admission - benefits which were anticipated by policymakers.

The evaluation also showed that successful introduction of SCRs required collaboration between stakeholders from different worlds, with different values, priorities, and ways of working. The authors say that these differences may have accounted for many of the misunderstandings and frictions occurring at the operational level. And they suggest that the programme's fortunes will depend on the ability "to bridge the different institutional worlds of different stakeholders, align their conflicting logics, and mobilise implementation effort."

They conclude: "This evaluation has shown that some progress has been made in introducing shared electronic summary records in England and that some benefits have occurred. However, significant social and technical barriers to the widespread adoption and use of such records remain and their benefits to date appear more subtle and contingent than early policy documents predicted."

In two accompanying papers, also published on bmj.com today, experts debate whether summary care records have the potential to do more harm than good. Mark Walport, Director of the Wellcome Trust believes that the national electronic database of patient records will make valuable contributions to better care, but Ross Anderson, Professor of Security Engineering at the University of Cambridge, argues that it is both unnecessary and unlawful.

Provided by British Medical Journal