Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
SYSTMONE ENHANCED DATA SHARING MODULE (EDSM)

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Author/Lead Job Title	Karen Robinson, Information Governance Officer
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VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
V2.0	*Sept 2020*	*GDPR legal basis for sharing added. Consent reports to the IG Group added. Guidance added on the verifications/ restrictions now in place for units to record a "share in". Temporary lack of capacity updated to incorporate current organisational settings. LAC children section updated to allow a default setting implied consent. Child health reporting requirements removed as this is no longer required. Section added to include GP practices, with organisations settings the same as Trust units and explicit consent captured as part of the patient registration process or verbally by health professionals. The patient privacy notice updated to include information on SystmOne sharing. A section on EMIS integration added. Default setting updated to detail that ERP is implied to "share in" only. Patient leaflet reviewed and YHCR incorporated.*
V2.1	*Nov 2020*	*Further section added for the Summary Care Record. Approved virtually by the IG Group.*
V2.2	*July 2022*	*Removed consent override section as this functionality has been removed. Approved at July 2022 IG Group.*
V3.0	*September 2023*	*Full review. 2.5 updated to latest MCA forms. 2.9 updated to allow consent to be taken at any contact with the patient. 2.12 updated to reflect the latest patient registration form. 2.15 updated as consent override is no longer available. 2.16 updated for changes to SCR following the removal of COPI regulations. All links updated. Reference to CCG updated to ICB. Approved at Information Governance Group (4 October 2023).*
V3.1	*July 2024*	*Section 3.1 and 3.14 to detail the initial settings applied for the Mental Health SystmOne Unit and to establish the units within a sharing group. Approved at Information Governance Group (17 July 2024).*

Contents

1. INTRODUCTION

This is a procedure to support the sharing of electronic health records with other SystmOne units providing care to the patient.

2. SCOPE

This procedure applies to all employees of the Trust, including all staff who are seconded to the Trust, contract, voluntary, temporary and agency staff and other people working on Trust premises. This includes members of staff with an honorary contract or paid an honorarium.

The procedure applies to those services using SystmOne.

3. PROCEDURES

3.1. Lawful basis for sharing

The lawful basis for the sharing of electronic records within SystmOne under the General Data Protection Regulation will be:

Article 6 (1)(e) – the processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority.

Article 9(1)(h) – the processing is necessary for the provision of health or social care or treatment or the management of health or social care systems and services.

Under the Common Law Duty of Confidentiality the sharing of detailed medical records will be with the explicit consent of the patient.

The Enhanced Data Sharing Model (eDSM) gives patients greater control over their own records and requires two different consents to be obtained from the patient.

The patient's explicit consent will be obtained to share the electronic health record with other SystmOne units providing care to the patient – "Share out".

The patient's explicit consent will also be obtained to access the electronic health records from other SystmOne units providing care to the patient "Share in"

The patient will be required to make these two decisions at each SystmOne unit where they receive care.

To ensure that health professionals have the most up to date information available to them, the system has been set to an initial implied consent. This must be followed up at the next face to face contact with the explicit consent of the patient.

The exception to this is the East Riding Partnership Unit and Humber Mental Health SystmOne units which have been set to implied "share in" only initially.

All Humber Mental Health units have been placed in a shared group with "Always share all patient data between group members" option set as authorised by the Caldicott Guardian. This will ensure that information is available between Humber mental health units for the safe delivery of health care, regardless of the sharing preference set by patients. For information sharing with other S1 units (both internal and external) the patient's preference will be applied.

Explicit consent will be monitored on a quarterly basis and reported to the IG Group as part of the IG Monitoring report.

It is important to note that the presence of a share does not mean another health professional has read that information. Information sharing that normally takes place to support care, must still continue.

3.2. Obtaining Consent

At first contact the patient will be provided with two patient information leaflets:-

- Trust Privacy Notice (short version) - describing how the Trust uses patient data
- Your Electronic Health Record - describing the Enhanced Data Sharing Model. (An Easy Read Leaflet is also available)

The health professional will ask the patient for their verbal consent for both "sharing in" and "sharing out" and mark the decision on Record Sharing page. This will automatically create an entry in the New Journal detailing when consent was obtained and by whom. A signed consent form will not be obtained from the patient.

The patient can change their consent at any time by informing their health professional of this decision. The health professional should update the Record Sharing page with the patient's current decision.

If a patient later declines consent, information previously shared will be removed from the record (though this information will still be available within the originating unit).

3.3. Further information required

Some patients may require more information before making this decision. Further information can be found in the Frequently Asked Questions for Patients document available on the internet.

If the patient would like more time to make this decision, this must be respected and the decision must be reviewed at the next contact with the patient.

3.4. Restrictions on consent

If a patient does not give their consent, this must be respected.

Patients may agree to share their records with some SystmOne units but not others. In such circumstances, the "share out" consent should be set to "yes" and the patient should be advised to set the "share in" consent to "no" at the unit they don't want to access the record.

Patient may agree to the service having access to some units but not others. In such circumstances, the "share in" consent should be set to "yes" and the patient should be advised to set the "share out" consent to "no" at the units which they don't want you to access.

Example

You are a physiotherapist treating a patient who is also receiving care from a GP and a District Nurse who use SystmOne. You discuss record sharing with the patient and the patient is happy for you to have access to the district nursing notes but does not want you to see their GP record.

The "Sharing In" consent should be set to "Yes" and the patient should be advised to contact their GP to set their "Sharing Out" to "No".

A patient's decision to dissent from sharing their electronic health record or to mark a particular entry as "private" does not prevent information sharing that would normally take place to support patient care e.g. discharge letters nor does it prevent the sharing of specific information in the

public interest e.g. serious risk of harm/abuse. This should be explained to the patient. Please see Confidentiality Code of Conduct for further information about overriding in the public interest.

3.4.1. Marking an event as private

Events must only be marked as private at the request of the patient. A patient may agree to have their record "Shared in" and "Shared out" but may wish to have certain events marked as private. This is the patient's decision and must be respected. The event should be marked as private and this will be excluded from the shared record. See the Help Guide within SystmOne.

Such information must still be shared using other methods if it is required in the public interest e.g. safeguarding children. Please see Confidentiality Code of Conduct for further information about overriding in the public interest.

3.4.2. Safeguarding Children

The Safeguarding Child Information node and Safeguarding Child Relevant Events must not be used at present. Guidance will be circulated at a later date.

3.4.3. Restrictions on recording a "share-in"

GP practices and patients can restrict other Systmone units from recording a "share-in" for the patient. This restriction is set within the GP practice SystmOne unit and will prevent the shared record from being viewed, unless the unit is on the practice "allowed list". Trust SystmOne Units have been included in all local ICB "allowed" lists. Clinical Systems will ensure that Trust units are updated as necessary e.g. for new SystmOne units.

There are two types of restriction:

Verification –verification needs to take place before the "share-in" is set. If the patient is with you, you can generate a PIN code to the patient's mobile phone or email account. Alternatively, the patient can approve access via their GP SystmOnline account. You will not be able to see the shared record until this is complete.

Prohibited – in these circumstances you will not be able the set the "share in" preference and will not be able to see the shared record. The patient can remove the organisation from the Prohibited list using SystmOnline.

With both restrictions, services can contact the GP practice directly to ask that the Trust is put on the "Allowed" list. This may occur if the patient has an out of area GP practice and the Trust is not part of their allowed list.

3.5. Lack of capacity to consent

If you suspect a person lacks capacity to provide consent, please refer to the Mental Capacity Act 2005 Policy, Procedure and Guidance. This is available on the Intranet under Mental Capacity Act and Best Interest Decision Making Policy

The assessment of capacity must be recorded on the Mental Capacity Assessment Form and the best interest decision clearly documented on the patient record.

Once a decision has been made the electronic record should be marked accordingly. The record should be marked "Consent not asked" and either "Yes" or "No" depending on the decision made. The health professional will then detail "Mental Capacity" and in the text box detail "Please see Best Interest Decision recorded on XX/XX/XXXX for further information". See the Record Sharing.pdf (humber.nhs.uk) on the Intranet

Any elements of the record that would not be in the patient's best interests to share must be marked as "private".

A further Mental Capacity Assessment Form must be completed and a Best Interests Decision recorded for all decisions made in the future e.g. a decision to mark an entry as private. The form must be uploaded into the record.

If the lack of capacity is temporary, the record will remain on the organisation default settings.

Patients who lack capacity may have an Independent Mental Capacity Advocate (IMCA). In such cases, the advocate should review the proposed information decision. This should be detailed on the Best Interest Decision Form.

3.6. Lasting Power of Attorney and Deputies appointed by the Court of Protection

Patients who lack capacity may have a Lasting Power of Attorney or a Deputy appointed by the Court of Protection. They will be the person responsible for the welfare of that service user, subject to the contents of their legal brief. In such cases, the health professional will obtain a copy of the Lasting Power of Attorney and will scan this into the record. The health professional will then obtain the sharing decisions from the Lasting Power of Attorney or the Deputy. The record should be marked "Consent not asked" and either "Yes" or "No" depending on the decision made. The health professional will then detail "Mental Capacity" and in the text box detail "Decision made by the Lasting Power of Attorney" or "Decision made by Deputy Appointed by the Court of Protection".

3.7. CRS Sharing Mismatch

If staff receive a notification that the SystmOne consent and the CRS flag conflicts, this must be investigated further with the patient.

In the first instance, staff should select "Do not change" the consent settings. Organisational Policy should be selected as the reason, with the added explanation of "Investigating further with the patient". The health professional should ask the patient which settings they would like to keep and then update the record accordingly. Further guidance about this issue can be sought from the Information Governance Team and the CRS Mismatch Procedure.pdf (humber.nhs.uk)

3.8. Children's Records

The information sharing decision for children's record will be made by a person with parental responsibility for the child, until the child becomes capable of making that decision themselves. Once they have capacity, consent will be revisited at the earliest face to face contact.

A parent/child's decision to dissent from sharing their electronic health record does not prevent information sharing that would normally take place to support patient care nor does it prevent the sharing of information in the public interest e.g. for safeguarding purposes. This should be explained to the patient. Please see Confidentiality Code of Conduct N-061.pdf (humber.nhs.uk) for further information about overriding in the public interest.

3.9. Services that do not have face to face contact with patients

Some services within the Trust are provided over the telephone. Such services will provide the leaflets detailed in Section 3.2 and then obtain explicit consent at their next contact with the patient.

3.10. Looked After Children Team

The LAC Team have limited contact with the child or their parents in order to obtain their information sharing preferences. Looked after children are some of the country's most vulnerable children and it is essential that information is shared in a timely manner. As such, the LAC team will continue to rely on the organisation-wide sharing rule of implied consent to "share in" and "share out". The default positions will not be followed up with explicit consent.

The team will ensure that the BAAF consent form for the obtaining and sharing of health information has been completed by a person with parental responsibility for the child and the

child/young person if they have capacity to consent. This is completed at the time the child/young person becomes look after by the local authority. Whilst this allows the local authority to gather and share information with those involved in the child's care, it is an indication of the parents/child's information sharing preferences. A copy of the consent will be scanned into the SystmOne record. This will only be available when the LAC Team are completing Health Assessments for the child.

3.11. Child Health Information Service

The Child Health Information Service does not have any contact with parents or children in order to obtain their information sharing preferences and will follow the Implied Consent model.

As a default position, the Child Health "Share Out" option will be set to "Yes". This will allow everyone involved in the care of the child to see Child Health data and enable the Health Visitor and School Nurse to view screening information held on the child's record.

As a default position the "Share In" option will be set to "Yes" - although Child Health do not routinely need access to detailed clinical information, they do require access to core screening/contact data, changes made to professional relationships, transfers of paper records by other staffs, changes made to demographics in other units. Information will only be "shared in" if the consent to "share out" has been gained by the unit holding the data.

The "Share in" option is also necessary for children who move into the area from an area also using SystmOne; the record is referred electronically between units. Without the Share in, all information other than immunisations would not transfer across.

The default positions will not be followed up with explicit consent.

3.12. General Practices

The default setting for GP practices will be implied consent to "share in" and "share out" until explicit consent/dissent is given by the patient. This may be gained verbally by health professionals as outlined in Section 3.2. It may also be obtained as part of the patient registration process. All registration forms will include the following question:

Sharing Your Health Record

Do you consent to your GP Practice sharing your health record with other organisations who care for you?

☐ Yes *(recommended option)*
☐ No, never

Do you consent to your GP Practice viewing your health record from other organisations that care for you?

☐ Yes *(recommended option)*
☐ No

For existing patients, information about SystmOne record sharing is included in the patient privacy notice available on the practice websites. Patients will be advised: -

SystmOne Information Sharing
SystmOne allows us to share your medical records with others providing you with care. The practice automatically sets the system to share your medical record to ensure that those treating you have the most up to date information. This may include district nurses, community services, child health, urgent care, out-of-hours services. Please contact the

practice if you would prefer your record not to be shared. You are free to change your mind at any time.

For further information, please see Your Electronic Health Record patient information leaflet.

Practices will set organisation-wide share in rules and will import the "allowed list" of organisations issued by Humber and North Yorkshire ICB. These are organisations which can set sharing in preference without verification. The ICB will re-issue the "allowed list" when updates are required.

Practices will allow other specific units to be added to the "allowed list" if the organisation is directly involved with the patient's care.

3.13. EMIS Integration

Direct sharing is available between EMIS Web and SystmOne as part of the Interoperability Programme. This is subject to the necessary patient consents being recorded in the respective clinical systems. This will enable the Trust to share information with GP practices using EMIS. Organisations will be required to submit the requests to the clinical system supplier providing the details of all organisations involved in the sharing agreement. To view information from an EMIS practice please see Third Party Record Sharing with EMIS.pdf (humber.nhs.uk)

3.14. Default settings

The default setting for all units will be implied consent until explicit consent/dissent has been gained from the patient. This preference will be applied to all new registrations and for those patients whose explicit sharing preferences have not yet been set. The exception to this is the East Riding Partnership unit and Mental Health Systmone units. These have been set to implied "Share in" only.

New units will be set to an initial implied share in/out unless the sensitivity of the unit requires otherwise. Variations will be agreed with the Caldicott Guardian.

All Humber Mental Health units have been placed in a shared group with "Always share all patient data between group members" option set as authorised by the Caldicott Guardian. This will ensure that information is available between Humber mental health units for the safe delivery of health care, regardless of the sharing preference set by patients. For information sharing with other S1 units (both internal and external) the patient's preference will be applied.

3.15. Access and Security

Access to the system is based on Role Based Access Control (RBAC). SystmOne has full audit trails detailing the time, date and user who has looked at a particular record. The Information Governance IT Forensic Investigation and Confidentiality Audit Procedures should be followed to access such audit trails

The Access to Records Policy will be followed for any requests to access health information by the patient or their representative.

3.16. Summary Care Record

Summary Care Records (SCR's) are a short summary of the patient's medical record held by their GP. They include information such as medication, allergies and basic details. They can also include Additional Information such as significant medical history, reason for medication, anticipatory care information, end of life care information and immunisations.

During the height of the pandemic changes were made to the SCR to make additional patient information available to all appropriate clinicians when and where they needed it, to support direct patient care, leading to improvement in both care and outcomes. The changes to the SCR remain in place unless the patient has opted out or declines Additional Information.

Trust GP Practices will check the patient's preference when a new patient registers with the practice using the SCR consent preferences form. The patient can also opt out at any time by contacting the practice and completing the form. The practice will record the patient's SCR consent preference in SystmOne.

Staff with a Legitimate Relationship with the patient are able to access the SCR on a permission to view basis. Staff accessing the SCR under the "Emergency Access" option must put a clear reason as to why this was required.

The Trust patient privacy notices will include information on the Summary Care Record.

4. REFERENCES/DEFINITIONS

TPP – Using the enhanced Data Sharing Model (eDSM)
TPP – Enhancements Data Sharing Model Updated for non-GP Users
TPP – Enhanced Data Sharing Model Updates for GPs