Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Health Information and Standards

Recommendations on the Implementation of a National Electronic Patient Summary in Ireland

Statement of Outcomes on Public Engagement

December 2020

Safer Better Care

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent statutory authority established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

HIQA's mandate to date extends across a wide range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children, Equality, Disability, Integration and Youth, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.

- **Regulating social care services** — The Chief Inspector within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.

- **Regulating health services —** Regulating medical exposure to ionising radiation.

- **Monitoring services** — Monitoring the safety and quality of health services and children's social services, and investigating as necessary serious concerns about the health and welfare of people who use these services.

- **Health technology assessment** — Evaluating the clinical and cost-effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.

- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.

- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health services, in conjunction with the Department of Health and the HSE.

Overview of the health information function of HIQA

Healthcare is information-intensive, generating huge volumes of data every day. Health and social care workers spend a significant amount of their time handling information, collecting it, looking for it and storing it. Therefore, it is imperative that information is managed in the most effective way possible in order to ensure a high-quality, safe service.

Safe, reliable healthcare depends on access to, and the use of, information that is accurate, valid, reliable, timely, relevant, legible and complete. For example, when giving a patient medicine, a nurse needs to be sure that they are administering the appropriate dose of the correct medicine to the right patient and that the patient is not allergic to it. Similarly, a lack of up-to-date information can lead to the unnecessary duplication of tests, if critical diagnostic results are missing or overlooked, tests have to be repeated unnecessarily and, at best, appropriate treatment is delayed or at worst, not given.

In addition, health information has a key role to play in healthcare planning decisions, where to locate a new service, whether or not to introduce a new national screening programme and decisions on best value for money in health and social care provision.

Under section 8(1)(j), HIQA is charged with evaluating the quality of the information available on health and social care and making recommendations in relation to improving the quality and filling in gaps where information is needed, but is not currently available.

Information and communications technology (ICT) has a critical role to play in ensuring that information to drive quality and safety in health and social care

settings is available when and where it is required. For example, it can generate alerts in the event that a patient is prescribed medication to which they are allergic. Further to this, it can support a much faster, more reliable and safer referral system between the patient's GP and hospital.

Although there are a number of examples of good practice, the current ICT infrastructure in Ireland's health and social care sector is highly fragmented with major gaps and silos of information, which prevents the safe and effective transfer of information. This results in people who use the service being asked to provide the same information on multiple occasions.

In Ireland, information can be lost, documentation quality varies, and there is over-reliance on memory. Equally, those responsible for planning our services experience great difficulty in bringing together information in order to make informed decisions. Variability in practice leads to variability in outcomes and the cost of care. Furthermore, we are all being encouraged to take more responsibility for our own health and wellbeing, yet it can be very difficult to find consistent, understandable and trustworthy information on which to base our decisions.

As a result of these deficiencies, there is a clear and pressing need to develop a coherent and integrated approach to health information, based on the standards and international best practice. A robust health information environment will allow all stakeholders (the general public, patients and service users, health professionals and policy makers) to make choices or decisions based on the best available information. This is a fundamental requirement for a high reliability healthcare system.

Through its health information function, HIQA is addressing these issues and working to ensure that high quality health and social care information is available to support the delivery, planning and monitoring of services. One of the areas currently being addressed through this work programme is the area of summary care records, sometimes called patient summaries.

HIQA has developed Draft Recommendations on the Implementation of a National Electronic Patient Summary in Ireland in conjunction with a specially convened Advisory Group. The Recommendations were informed by the findings of the *Best Practice Review of Summary Care Records* and the *As Is Review of the Irish eHealth Landscape,* along with submissions during our public engagement via a pubic consultation and focus groups with patient and public representatives, general practitioners and community pharmacists.

This document gives an overview of the feedback received during the focus groups and submissions received during the public consultation, as well as the impact on the Draft Recommendations in response to those submissions.

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Chapter 1 Introduction

A national electronic patient summary is a succinct summary of the clinical information needed to deliver safe and quality care to patients during episodes of unscheduled care, such as when attending an out-of-hours GP clinic.(1)

The introduction of summary care records—that is, national electronic patient summaries, is a crucial element of national eHealth policy, outlined in the *Sláintecare Implementation Plan (2018)*.(2) The plan identified summary care records (patient summaries) as one of the community-based ICT services that will improve the lives of patients and as an immediate priority for implementation.(2)

International research identifies some of the benefits for patients and for health and social care providers and organisations, in terms of improving medication safety and patient care in out-of-hours and emergency care settings. The benefits identified for patients include:

- improved efficiency of care by reducing the time, effort and the resources required to share a patient's information across different organisations
- improved quality of patient care through more timely and informed clinical decisions in emergency and out-of-hours care
- improved patient safety by reducing the risk of prescribing errors and adverse reactions to prescribed medication
- better patient care by giving healthcare staff relevant information to make appropriate decisions about patient care
- improved patient experience as patients do not need to organise or remember a list of their medications
- reduced number of times that a patient has to repeat his or her clinical information to healthcare staff.

To date, the Health Information and Quality Authority (HIQA) has focused significant research on a national electronic patient summary, including the publication of clinical datasets for diagnosis, allergies, and procedures and the publication of the National Standard on Information Requirements* for a National Electronic Patient Summary in Ireland (2018).[3,4,5,6] The National Standard defined the six categories of information to be included in a national electronic patient summary for Ireland: the subject of care (demographics), health conditions, procedures, current medication, vaccinations, and allergies.

In 2019, HIQA began the development of a set of Recommendations on the implementation of a national electronic patient summary in Ireland, compliant with the National Standard which had been published in 2018. The HIQA Recommendations development process began with the collection of evidence and these Recommendations were informed by two bodies of evidence:

- the Best Practice Review, which outlines findings on best practices from national implementations in nine jurisdictions,
- the As Is Review of the Irish eHealth landscape, which outlines the programmes, projects, and services that would be influenced by, or have an impact on, the national implementation of a national electronic patient summary.

Expert advice was also provided at three meetings of the specially convened Advisory Group, with members from a number of specialist areas providing input. A full list of Advisory Group members can be found in Appendix C. The Draft Recommendations for Consultation cover six strategic areas for national implementation: policy and legislation, programme governance, stakeholder engagement, national health identifiers, potential sources of information, and phased implementation.

* Information requirements are a minimum set of data items that should be implemented in information systems that create and transfer information to support the delivery of safe and quality care to patients.

1.1 Description of the public consultation

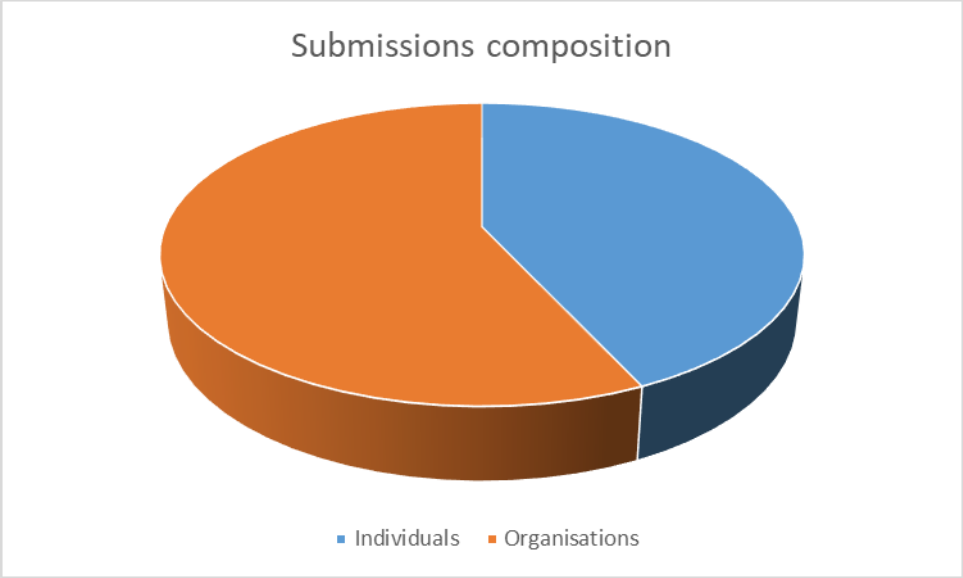
Each Recommendations project also includes a public consultation to seek and incorporate feedback from external stakeholders. A full public consultation on the Draft Recommendations for Consultation was then undertaken, running from Tuesday August 4 to Friday September 11 2020. The public consultation form is available in Appendix A.

The Public Consultation survey posed the following questions through an online survey and PDF feedback form:

1. Do you wish to add any comments regarding Recommendation 1 – Legislation?
2. Do you wish to add any comments regarding Recommendation 2 – Governance?
3. Do you wish to add any comments regarding Recommendation 3 – Stakeholder Engagement?
4. Do you wish to add any comments regarding Recommendation 4 – National Health Identifiers?
5. Do you wish to add any comments regarding Recommendation 5 – Sources of Information?
6. Do you wish to add any comments regarding Recommendation 6 – Phased Implementation?
7. Do you wish to add any general comments regarding the Recommendations?

More than 400 invitations to the Public Consultation were sent to stakeholders including policy and legislative organisations, Health Service Executive (HSE) programmes, standards organisations, professional representative bodies, such as for general practice and pharmacy, academic representatives, patient/public organisations, public and private hospitals, the vendor community, service providers, service users, the general public and other key stakeholders. All late submissions were also accepted.

59 submissions were received, with 26 submissions made by individuals and 33 submissions made by organisations listed in Appendix B.



Each submission was read in its entirety and broken down into individual comments. A total of 406 comments were received, each of which was reviewed and its relevance assessed:

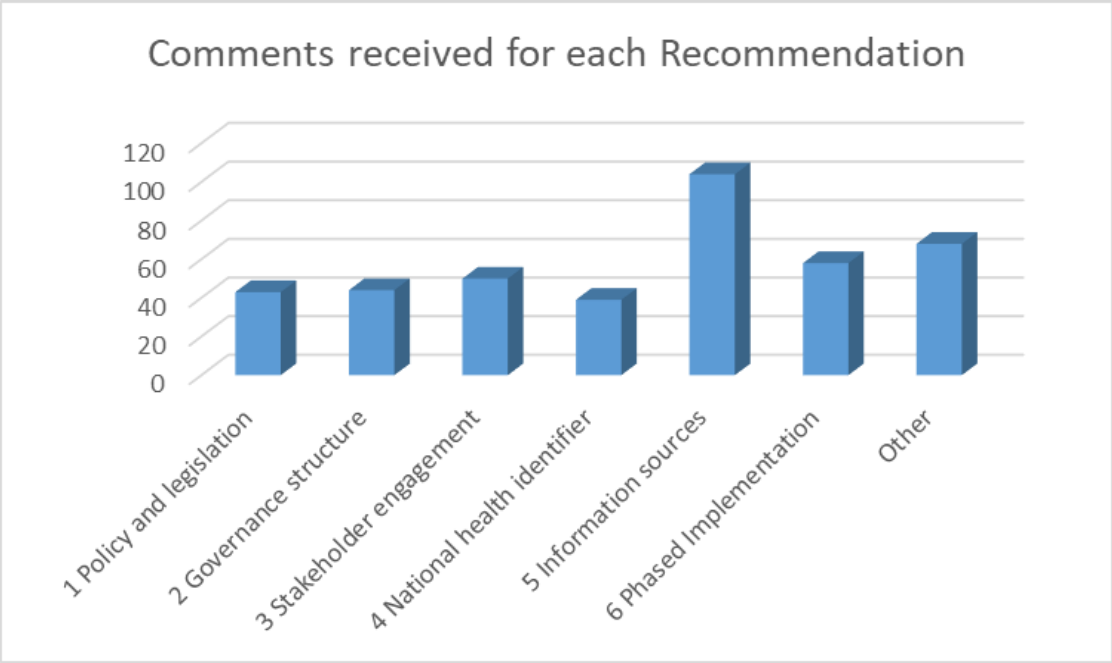


Figure 1 - Comments received for each Recommendation

Overall, consultation feedback was very supportive of the introduction of a national electronic patient summary, both as a means of ensuring better, safer care during an episode of unscheduled care and as a potential first step towards a national shared care record and a national electronic health record.

1.2 Description of the focus groups and interviews

Online focus groups and individual interviews were also undertaken concurrently with the public consultation, to understand the views and opinions of two stakeholder groups that international research identified as critical to the success of such a national implementation: a) GPs and community pharmacists, and b) representatives of patients and the public.

Following a brief presentation on the national electronic patient summary, the patient-public focus groups were asked the following questions:

- *What role should patients and the public play in implementation of the project?*
- *How should patients and the public be engaged as stakeholders – for example, how should they be included in decision-making over the course of the implementation? Should they have a role in communications and developing communication materials? Or in pilot projects?*
- *What advantages and disadvantages do you see from the patient summary?*

Again, following a brief presentation on the national electronic patient summary, the GP-community pharmacist focus group and interviewees were asked the following questions:

- *What are you initial thoughts?*
- *What is your view of the quality of data in your system i) of the demographics, medicines prescribed, and allergies information? ii) of the other information?*
- *What is your view on creating a national electronic patient summary from your system? If part of that process could be done automatically? What kind of clinical review would the information need and how often?*
- *What advantages and disadvantages do you see from the patient summary?*

The overall response from each focus group and interview was positive and supportive, recognising the benefits both as a means of ensuring better, safer care during an episode of unscheduled care and as a potential first step towards a national shared care record and a national electronic health record. It was expected to save time during appointments and reduce the number of times that patients had to repeat their story.

"*This is a brilliant initiative…an excellent idea…You could be safer in the emergency department because of this*." (Comment from a patient-public focus group.)

This statement of outcomes report gives an overview of the feedback received during the focus groups and submissions received during the public consultation, as well as impact on the draft recommendations in response to those submissions.

HIQA is very grateful to those who participated in the focus groups and those who made submissions to the public consultation for taking the time to contribute to the development of these Recommendations.

Chapter 2 Analysis of feedback

This section provides a high-level summary of the feedback received for each Recommendation. It includes comments from submissions received during the public consultation and comments and themes that arose in focus groups and individual interviews. Then it summarises any changes made to each Recommendation as a result of the feedback.

2.1 Recommendation 1 – Policy and legislation

For this Recommendation, 43 comments were received through public consultation. Consultation feedback concurred with the need for the gap analysis of current legislation and regulations, to identify any need for new legislation or regulations enabling the implementation of national digital solutions—for example, identifying the legal basis for the processing of personal and health data of citizens. Other themes that emerged included compliance with all applicable national and EU legislation and regulations, including the provisions of General Data Protection Regulation. Data protection, information governance, and patient consent also featured and it was also considered imperative that the HSE carry out a Data Privacy Impact Assessment as an early priority.

Examples of comments received:

- *We agree with national legislation for electronic health records.*
- *No further comments. This seems like a sensible approach.*
- *Based on international requirements; the Legislation of an Irish National Patient Summary must analyse and identify the applicable legal basis for processing the personal and health data of citizens, their applicable staff, external service providers and health professionals. This analysis must consider the GDPR provisions, as well as any other applicable national and EU legislation.*

2.1.1 HIQA's response

After analysis of these comments, Recommendation 1.1 was redrafted and three new Recommendations (1.2 to 1.4) were drafted. The new Recommendations covered the need for:

- a consent model to be identified, in line with current legislation and with input from the HIQA recommendations on a consent model for the collection, use and sharing of personal health information in Electronic Health Records in Ireland
- the national electronic patient summary to comply with any and all relevant, existing and future national and EU legislation and regulations, and
- that the Health Service Executive carries out a Data Privacy Impact Assessment as an early priority.

2.2 Recommendation 2 – Programme Governance

44 comments were received through public consultation. They strongly reinforced the need for a comprehensive mapping of stakeholder organisations, with a view to ensuring broad representation on the Project Board. Many stakeholder groups were suggested and organisations also volunteered to join the Project Board or to participate in focus groups, or engage in other ways. Some of the examples of the stakeholder groups mentioned in comments include:

- the Department of Health
- general practitioners and their professional representative organisations such as the Irish Medical Council, the Irish Medical Organisation, and the Irish College of General Practitioners
- hospital doctors and consultants
- pharmacies, including community and hospital representation (for example, the Hospital Pharmacists Association of Ireland or the Irish Medication Safety Network)
- health and social care professionals (HSCPs), nursing and midwifery organisations
- patients and their carers, through patient representative groups, disease-specific advocacy groups, national advocacy groups (such as, the National Advocacy Service for people with disabilities)
- Public health nurses and community intervention teams
- mental health services
- academia
- paediatric patients

Examples of comments received:

- *We would suggest the frequent publication of progress re the project, including updates for board members, stakeholders and the public, where appropriate.*

- *Agree with Project Board and Change Advisory Board set up. At the outset you need to include the clinical stakeholders who will be directly involved in utilising the patient summary and they need to brought in at the start of the project and directly involved in workflows and design.*
- *Patient representatives should be identified via an open and transparent selection process which invites expressions of interest from a broad cross-section of the patient community.*
- *At least two patient representatives should be included in the Project Board composition to ensure responsibility does not rest on a single individual.*
- *Patient representatives should be remunerated for their expenses and for their expertise.*

In the patient public focus groups, participants agreed on the need to ensure effective patient representation on the Project Board, though they differed on whether the patients should only have experience of using the health services, or only have experience of relevant board membership, or have experience of both. Patient representatives on the Project Board were seen as playing a role in monitoring and in setting up channels to communicate patient needs. It was also emphasised that patient representatives should be included at the planning and design stages including the development of key performance indicators and not just in public engagement campaigns.

- *Regarding patients and governance groups - service users have experience and this can be an advantage. Real patients are needed rather than experienced professional patient representatives.*
- *Patients should be involved in the design phase of the programme.*
- *Patient members should be present on the project board for the agreement of the matrixes for success e.g. how they will be measured and shared, proactive benchmarks and check points.*
- *We need to look at advantages, issues, and areas of concern and ensure they are documented and addressed.*

- *It will alleviate problems if we use patients in pilots who use the local service.*

2.2.1 HIQA's response

Comments identified a wide range of possible stakeholder groups for membership of the Project Board, far more than were included in the suggested list. It was considered prudent to remove the list of possible stakeholder groups from Recommendation 2.2, to avoid any misinterpretation that the Project Board membership should be limited to those stakeholder groups listed. The comprehensive list of stakeholder groups that were proposed, or had volunteered, to participate in the programme will be shared appropriately with the HSE so that it can be used at the relevant stage of the programme.

2.3 Recommendation 3 – Stakeholder Engagement

50 comments were received through public consultation and this Recommendation was covered in detail in the focus groups for patients, their carers, and the public.

Many comments received through public consultation echoed the need for a comprehensive stakeholder mapping and for strong engagement with clinical groups and the public in particular as crucial stakeholder groups. Comments also suggested stakeholder groups that should be considered as part of the stakeholder mapping and strongly endorsed the appointment of clinical champions and public champions, providing examples of same. It was also suggested that, while patient representative organisations have a role to play, efforts should also be made to engage the wider group of patients and members of the public.

Patient and public focus groups provided valuable information about how to engage stakeholder groups. Feedback from those focus groups was that it was critical to communicate what patient summaries are, what benefits can be expected from them, and examples of how they will be useful. Comprehensive materials intended for a 'lay' audience were needed. True life patient stories, told from the patient's point of view, were considered particularly effective in building trust and influencing both patients/the public and clinicians. The public engagement campaign needed to have a clear core message, consistent across all channels, but adapted to different media, such as Twitter. It was important to use effective imagery and comparisons. Patients and the public should review the materials prior to publication.

The engagement campaign needs to have broad and sustained engagement with a wider range of stakeholders, involving as much of the public as possible. The campaign needs to support accessibility and inclusivity needs across population groups—considering people with visual and hearing impairments, with technological illiteracy, with specific language requirements, and so on.

Patient advocacy groups, disease support groups, and other patient representative organisations were considered to be important stakeholders. However, it was considered important to get perspectives from outside the national patient forum. Other mechanisms include the Public Participation Network, patient councils, and household leaflet campaigns.

A number of engagement mechanisms were suggested – for example, through community pharmacies, outpatient departments, GP waiting rooms, public health nurses. Carers and care assistants were seen as an important, and often underrepresented, stakeholder group.

Patient champions should have a huge role to play in communicating the implementation of the project to the general public. Concerns were raised that the general public may not buy into the project as easily as patient populations and patient champions have been successful in getting clinicians on board as they help to bring value to the system. Some suggested that young people should be engaged as users, through schools and youth groups. This would promote understanding of the importance among that age group and encourage them to act as champions within their own networks at home, in school, with grandparents and other relations.

Examples of comments received:

- *As proposed, a comprehensive stakeholder engagement plan will be necessary in order to ensure the effective implementation of the system. This will require systematic engagement with all stakeholder groups and with the public. It will also require a targeted dissemination of public information about the initiative and why it is important.*
- *Stakeholder engagement needs to be a continuous assessment with feedback loop at every stage of the process not just during the implementation phase.*
- *In the UK they have patient champions. It is a new concept. The NHS is using patient to change clinicians and practice. It is proved useful for patient to tell*

clinician how patient can help them. This is still new in the NHS - they are not doing it very long but it has worked well.

- *There needs to be representation from patients in the stakeholder groups and patients need to understand the importance of active participation. This is not about having one or two patients, but about putting them at the centre around which everyone else works.*
- *Resources should be provided to ensure appropriate stakeholder engagement. These are currently almost exclusively voluntary.*

2.3.1 HIQA's response

Stakeholder mapping is the responsibility of the Project Board. A comprehensive list of stakeholder groups that were proposed, or had volunteered, to participate in the programme will be shared appropriately with the HSE so that it can be used at the relevant stage of the programme.

After an analysis of all comments, the Recommendations 3.2 and 3.3 were redrafted slightly to reflect the importance of clinical champions and public champions to the success of the programme.

2.4 Recommendation 4 – National Health Identifiers

39 comments were received through public consultation and the theme of health identifiers was also raised in the GP and community pharmacist focus group feedback. Feedback from the focus group participants was indicated that national health identifiers were critical to the successful implementation of a national electronic patient summary:

- *IHI is hugely important. Patients acquire any number of non-unique identifiers across the healthcare system. So the IHI is vital. Strongly recommend universal adoption by all healthcare services and that its use be mandated in public and private healthcare.*
- *Disappointed that there hasn't been a move to more universal adoption of the IHI, it's the starting point for any electronic health record.*
- *Patient identifier number needs to feed into this. Important for patients who move between GPs and would be great to pull information from different sources for patients.*

Examples of comments received through public consultation include:

- *'There is also consideration for healthcare professionals with identifiers, which allows for the recording of patient information to include the health care professional, this should also be included.'*
- *There is no mention of Health Identifiers for Healthcare Professionals/Locations. In the Patient Summary context there is also the need to uniquely and securely identify the Healthcare Professional accessing/creating/updating the Patient Summary and to identify the point of care.*

2.4.1 HIQA's response

After analysis of these comments, Recommendation 4.1 was amended to include both national health identifiers defined in the National Health Identifiers Act 2014. The National Health Identifiers Act 2014 specifies two national health identifiers:

- Individual Health Identifiers.
- Health Services Provider Identifiers.

2.5 Recommendation 5 – Sources of Information

104 comments were received through public consultation, the highest comment count by far, and the Recommendation was discussed in depth by participants in the GP and community pharmacist focus group and interviews.

2.5.1 Feedback from public consultation

Public consultation submissions were generally very supportive of the implementation of a patient summary, recognising the potential benefits for patients and for healthcare professionals. Submissions also identified possible gaps and limitations in the medications list in the national electronic patient summary, if the list were to be generated from GP practice management systems or community pharmacy dispensing systems only. Feedback highlighted that the following medications may not be recorded on either GP practice management systems or in community pharmacy records:

- Information on medications for patients treated for a number of **rare diseases.**
- **Drugs administered in the community** may not be on GP lists as they are administered in outpatient or in other community setting and not dispensed by community pharmacies e.g. Clozapine.
- **Dialysis** patients may also have medications prescribed that are not known to their general practitioner.
- **Opiate substitution therapy** information will be captured for those who attend community pharmacies through the PCERS schemes but those who attend HSE clinics do not currently have a record of their treatment in community pharmacy/GP practice.
- Items on the **high-tech hub** may not appear on GP summaries but could be highly relevant for e.g. interacting drugs like linezolid, posaconazole, orkambi.
- GP or community pharmacists may not have information on medications prescribed for transplant patients.

Another key consideration regarding potential sources of information for the national electronic patient summary is the frequency with which the information is updated. It was noted that Hospital In-Patient Enquiry (HIPE) Scheme contains some information about administration of particularly high cost medication and potentially could fill some of the gaps about hospital administered medications. However, concerns were raised that HIPE is not a primary data source, rather it is a hospital discharge registry where, with current coding delays, data could be 'months' out of date.

Other comments suggested that the Primary Care Eligibility & Reimbursement Service (PCERS) could provide valuable supplementary information and could be upgraded as needed, for example, to include missing information, as a more practical solution than sourcing information from over 1700 community pharmacy systems. However, objections were noted owing to the update frequency, as PCERS data can be up to two months out of date and medication errors most commonly occur shortly after the commencement of treatment.

Several comments referenced the Maternal Newborn Clinical Management System (MNCMS) as a potential source of information, because it serves as a functioning electronic record for maternity/gynaecology and neonatal patients in four hospitals (including three maternity hospitals). It was further noted that 40% of babies born in Ireland have an electronic record through MNCMS, this could also form the basis of a data source for the paediatric population, in particular those who have spent time in the neonatal units. Likewise some maternal and gynaecological patients will have diagnoses or procedures and medications added through their electronic record and this could also form the basis of the data source.

2.5.2 Feedback from focus groups and interviews

GPs considered that patient information in their practice management system to be current, as it was typically updated after each consultation. They considered that generating a national electronic patient summary automatically from GP practice management data would create a very up-to-date and accurate record. Demographics and prescriptions information could be used as is, while the other categories of information could be coded.

- **Allergies information** – Participants identified the need for a system to differentiate between clinically diagnosed allergies and self-reported allergies.
- **Procedures information** – Suggestion to include a predefined list with a caution that the information might not be complete. GPs did not track procedures, especially routine ones but felt it would be useful to have that information.
- **Conditions information** – Pharmacies can sometimes infer conditions from prescription information, but cannot do so in all cases and so should not. Increasingly, GPs are coding disease, particularly chronic conditions.
- **Vaccinations information** – GPs have a legal obligation and therefore typically record vaccinations given, though many practices record the administration, ('flu vaccinations given' as free text) while others record what vaccine, when administered, and batch number. Questions were raised over how far back to go – and it was stated that GP vaccinations have been recorded for the past 15 years. Pharmacies record vaccinations administered in the pharmacy, such as pneumococcal and flu vaccinations, or shingles vaccinations.

Focus group participants and interviewees saw the automatic update of the patient summary as a means of ensuring data accuracy, as well as reducing the burden that manual clinical review would create for GPs. Interviewees cited the example that when generating referral letters electronically, the prescription record is pulled in automatically and the GP can review, and deselect any discontinued medications.

There was also broad agreement that the data should be uploaded automatically and that the GP should ensure that data in the GP practice management system must be accurate, to ensure that the patient summary is correct and up to date.

However, as noted earlier, the completeness of information for any patient depends on a number of factors, such as how long the patient is with the practice and how much information an individual general practitioner is coding. If the GP is not coding, or if the patient has moved GP practice frequently, the information will be less complete. Automation was also understood to be a means of reducing additional work load on GPs.

- *It was recommended that the patient summary record system would update at times of the day chosen by the service provider and preferably only once a day.*
- *Imperative to make this an automatic upload.*
- *If it was twice a day - would need to see the impact on my systems and if it was necessary to upload twice a day. At the moment our provider uploads our data to their central served nightly.*
- *We can't have anything happening that slows down the systems and slows us down seeing patients.*

Participants note that the implementation should not interfere with day-to-day practice or increase workloads. GPs considered that manually reviewing patient summaries or 'constantly cross-checking' with other sources would be a burden that could significantly undermine the benefits delivered. They held that it should be relatively easy to generate the patient summary automatically from their records. One suggestion was that the national electronic patient summary should be prospective not retrospective, otherwise GPs would have no time to see patients.

There was also an understanding that information might not be complete and that patients expectations should be managed. Triangulation with another source was also seen as a good idea.

- *Regarding clinical review - this information should be automatically pulled as it should be correct as I have responsibility for the quality of my data. I would only check records as patients attend and some of my patients, in particular the private ones only attend once every 3 or 4 years.*
- *We need to manage all expectations including patient's expectations. It should be clear that this record is indicative and the record may not be complete of full.*

Feedback was that a high level of investment may be needed to ensure high-quality, clinically-coded data. Some GPs do not feel obligated to code data and so might need to be incentivised. Some progress is currently being made – for example, coding for chronic conditions, which is incentivized. It was suggested that individuals in other roles – such as clerical staff or practice nurses – could do some coding and that coding also needs to be standardised across systems.

2.5.3 HIQA's response

From this wealth of feedback a few themes emerged strongly. First, the quality of data in the national electronic patient summary is crucial to its successful implementation. Second, another critical factor was the need for any patient summary implementation to fit seamlessly into GP and community pharmacy working practices. Third, the necessity of identifying and addressing any gaps or limitations in the information in source systems was reiterated time and again, with emphasis placed on the protocols needed to address the same. Related to this, the feedback identified a number of medications that are not typically recorded by GP practices or community pharmacies.

After analysis of these comments, the Recommendations were amended as follows:

- Recommendation 5.1 was amended to emphasise the importance of good quality data as a prerequisite for the implementation of a national electronic patient summary.
- Recommendation 5.2 was redrafted to reflect the need for the implementation of a national electronic patient summary to fit in seamlessly with the way GPs and community pharmacists work.
- Recommendation 5.3 was redrafted to include the need to identify any gaps or limitations, such as in the current medication list and to introduce protocols to address same.
- Recommendations 5.4 and 5.5 reflect the text in the original Recommendations.

2.6 Recommendation 6 – Phased Implementation

58 comments were received through public consultation. Consultation feedback emphasised the importance in engaging different groups of stakeholders and the necessity of engaging them appropriately for the pilot. One example, was establishing whether patient summaries for paediatric patients required specific consideration. This follows from the stakeholder engagement plan outlined in previous Recommendations.

Examples of comments received:

- *Strategic roadmap needs to be identified and agreed in an agile manner, allowing for quick wins to be realised/pilots and KPI progress tracked resulting in iterative learning/adaption of roadmap as necessary to be included in subsequent phasing unlike previous health sector capital projects.*
- *Comorbidities including mental health history should be piloted also.*
- *The incorporation of systems, including the National Immunisation Information System and the national ePrescribing service will bring added value to the national electronic patient summary, and create a holistic view of the care and treatment of patients.*
- *The minimum data set as outlined is very minimal, albeit just a starting point. Should this also include medical conditions and procedures as a minimum requirement? The scenario laid out would suggest it should.*
- *A phased trial approach seems sensible.*
- *Grossly over-optimistic scope for Phase 1. A much smaller phase 1 scope stands some chance of getting progressed.*
- *Recommendation 6.2 - We could all add a long list of what we would like to see here depending on our special interest, but as we know setting a minimum dataset needs a starting point and is dependent on what information is already in the system. As this recommendation relates to unscheduled care the criteria above is a good baseline to start with.*

- *Yes during the pilot phase consider including both paediatric and adult patients.*

Discussion at focus groups for patients and the public emphasised that patient representatives should be included at the planning and design stages, not just in public engagement campaigns. Patient and public focus groups also considered it important that pilot projects reflect accessibility and inclusivity needs across population groups and that key patient groups are included, particularly those using local services. It was also suggested that these patient groups complete a survey on their experience at the end of the pilot. Patients should also be involved in the development of the training materials to be used during the pilot and the overall national implementation:

- *Patients should be involved in the design phase of the programme.*
- *We need to look at advantages, issues, and areas of concern and ensure they are documented and addressed.*
- *It will alleviate problems if we use patients in pilots who use the service. They need to ask the user. They also need to know what is working well with the service. Users will need to know how smoothly this was rolled out.*
- *There needs to be diversity within pilot projects and patient stakeholder groups for example reach outside of patient groups.*
- *The patient summary pilot program needs to capture a wide audience to ensure accessibility and inclusivity across all population groups.*

2.6.1 HIQA's response

After analysis of all relevant comments, the Recommendations were amended as follows:

- Recommendation 6.2 was redrafted slightly.
- Recommendation 6.4 was redrafted completely, as there was a lack of clarity around the purpose of the specific examples of key performance indicators included. Instead the original text from Recommendation 6.5 was moved to

6.4 and redrafted slightly to emphasise the inclusion of local users in pilot implementations.

- Recommendation 6.5 was added, describing the role of the eHealth Review programme in assessing compliance with National Standards, reporting on those findings, and making Recommendations on any required improvements to the eHealth service, which may include revision of the Standard.

2.7 Other comments

Sixty-eight comments were received through the public consultation (with one duplicate removed). Many comments raised through public consultation were already covered by the amendments to the six Recommendations.

In the focus groups for patients and the public, the topics raised included where a patient's information was and who could access it. Participants noted that patients need to be aware that they have the right to withdraw at any time and should be able to track who used their records. It was also considered vital that the information in the patient summary be complete and up to date and that patients have a mechanism for rectifying errors. Similar concerns were expressed in the GP pharmacist focus groups and interviews.

In the focus group and interviews for GPs and community pharmacists, themes that were outside the scope of this review included the financing of upgrades to systems for GPs and pharmacists and attendant renegotiations of any contracts. Consent models, in particular 'implied assumed consent' and the opt-out consent model, were also discussed together with data access and where the responsibility for rectifying errors lies. Community sources were considered to contain a lot of useful information for future extension of scope. Hospital discharge summaries were raised a number of times, especially poor population of data and how to use the information.

Chapter 3 Conclusion

Overall, there was significant and substantial engagement from policy and legislative organisations, Health Service Executive (HSE) programmes, standards organisations, professional representative bodies, such as for general practice and pharmacy, patient/public organisations, public and private hospitals, the vendor community, service providers, service users, the general public and other key stakeholders.

Feedback from public consultation was largely positive with some discussion of gaps in the areas of legislation, stakeholder engagement, and the selection of potential sources of information that resulted in changes to the Recommendations.

Participants in patient-public focus groups was also very positive, with the national electronic patient summary expected to save time during appointments and reduce the number of times that patients had to repeat their story. Other topics arising from these discussions included the collection and use of patient data, as well as the need for inclusive stakeholder engagement. Overall, the discussions verified the themes that arose during public consultation.

GPs and pharmacists was also very supportive of the introduction of a national electronic patient summary, both as a means of ensuring better, safer care during an episode of unscheduled care and as a potential first step towards a national shared care record and national electronic health record. Other topics included the possible (and avoidable) burden that a manual update would create and possible omissions in the patient summary. The discussions similarly supported the themes arising from the public consultation.

The depth of much of the feedback indicates a very high level of interest in, and engagement with, the national implementation programme for a national electronic patient summary as a whole. It also appears to be a recognition of the potential

benefits that a national electronic patient summary could bring and a desire to get the implementation right on many different levels. As noted earlier, this feedback will be shared with the appropriate bodies to inform later stages of the programme and to inform related areas.

Appendix A Public Consultation feedback form

Draft Recommendations on the Implementation of a National, Electronic Patient Summary

Consultation feedback form

July 2020

The Health Information and Quality Authority (HIQA) is developing Draft Recommendations on the Implementation of a National, Electronic Patient Summary in Ireland.

We are holding a public consultation to give people an opportunity to identify the key areas that the standards should address and to provide examples of good practice.

We will carefully assess all feedback received and use it, along with other available evidence, to develop the draft national standards. Before you complete this consultation feedback form, please read the instructions for submitting feedback on the next page accompanying.

You may also wish to read the accompanying evidence on www.hiqa.ie:
Best Practice Review of Summary Care Records
As Is Review of the Irish eHealth Landscape

Closing date for the consultation is Friday 11th September 2020

Instructions for submitting feedback

- If you are commenting on behalf of a service or organisation, please combine all feedback from your organisation into one submission form and include the details of the service or organisation. When completing this form online, please ensure you scroll down the webpage and complete the form in full.
- Do not paste other tables into the boxes already provided — type directly into the box as the box expands.
- Please spell out any abbreviations that you use.

Data Protection and Freedom of Information

HIQA will only collect personal information during this consultation for the purposes of verifying your feedback or where you have indicated that you would like to be contacted to partake in future focus groups. If you have any concerns regarding your data, please contact HIQA's Information Governance and Assurance Manager on infogovernance@hiqa.ie. Please note that HIQA is subject to the Freedom of Information (FOI) Act and the statutory Code of Practice in relation to FOI. Following the consultation, we will publish a statement of outcomes document summarising the responses received, which will include the names and types of organisations that submitted feedback to us. For that reason, it would be helpful if you could explain to us if you regard the information you have provided us as being confidential or commercially sensitive.

If we receive a request for disclosure of the information under FOI, we will take full account of your explanation, but we cannot give you an assurance that confidentiality can be maintained in all circumstances.

1. About you

The feedback in your consultation form will only be used to help develop the Draft Recommendations on the Implementation of a National, Electronic Patient Summary in Ireland. Any information you provide will be held securely and will not be published, subject to legal requirements under Freedom of Information (FOI) legislation.

Please select as appropriate:

Are you providing feedback as:

- **an individual**
- **on behalf of an organisation:**

  (For verification purposes, please provide the name of the organisation and a name and landline number for a contact person within the organisation)

2. Feedback to inform the Draft Recommendations

In this section, we would like to know your views on the implementation of a national, electronic patient summary. Please provide us with feedback on the Draft Recommendations, or alternatively you can provide general comments.

Question 1: **Do you wish to add any comments regarding Recommendation 1 – Legislation?**

Question 2: **Do you wish to add any comments regarding Recommendation 2 – Governance?**

Question 3: **Do you wish to add any comments regarding Recommendation 3 – Stakeholder engagement?**

Question 4: **Do you wish to add any comments regarding Recommendation 4 – National health identifiers?**

Question 5: **Do you wish to add any comments regarding Recommendation 5 – Sources of information?**

Question 6: **Do you wish to add any comments regarding Recommendation 6 – Phased implementation?**

Question 7: **Do you wish to add any general comments regarding the Recommendations?**

3. Register to hear about future engagement opportunities

Would you like to hear about opportunities to engage with us on the development of these draft national standards or on other future projects?

(This may include an invitation to focus groups or to comment during consultation on draft standards)

☐ **Yes** ☐ **No**

Please provide your name and a contact email address

Thank you for taking the time to give us your views on the development of the Draft Recommendations on the Implementation of a National, Electronic Patient Summary in Ireland.

You can **download** a consultation feedback form at www.hiqa.ie

Then **email** the completed form to **technicalstandards@hiqa.ie**

Print the consultation feedback form and **post** the completed form to:

Technical Standards Public Consultation

Health Information and Quality Authority

George's Court

George's Ln

Smithfield

Dublin 7

D07 E98Y.

If you have any questions on this document, you can contact the standards team either by:
phoning: +85 8743527 or
emailing: **technicalstandards@hiqa.ie**

Please ensure that you submit your form online or return it to us either by email or post by 5pm Friday 11th September 2020.

Appendix B Contributing organisations

The following organisations made submissions to the Public Consultation:

- Article Eight Advocacy
- Cantillons Solicitors, Cork
- Caredoc, Carlow
- Citizens Information Board
- Data Protection Commission
- Department of Health
- Digital Rights Ireland
- Enterprise Technical Architecture, HSE Office of the CIO
- GS1 Ireland
- Health Research Board
- HRB Primary Care Research Centre
- HSE Access to Information Programme
- HSE eHealth HSCP Advisory Group
- HSE National Quality Improvement Team
- HSE Primary Care Eligibility Reimbursement Service
- Information Architecture, HSE Office of the CIO
- InterSystems Corp
- Irish College of General Practitioners, GPIT Group
- Irish Lung Fibrosis Association
- Irish Medical Council
- Irish Medical Organisation
- Irish Medication Safety Network
- Irish Platform for Patient Organisations, Science and Industry
- Irish Society of Chartered Physiotherapists
- Mental Health Commission
- National Cancer Control Programme
- National Rare Diseases Office

- National Release Centre for SNOMED CT
- NSAI HISC Committee
- Pre-Hospital Emergency Care Council
- Private Hospitals Association
- St Patrick's Mental Health Services
- Takeda (Shire) Pharmaceuticals

Appendix C Advisory Group membership

Organisation	Nominee
Department of Health	**Niall Sinnott** Head of eHealth & Information Policy
General Practice Information Technology, Irish College of General Practitioners	**Dr Conor O'Shea** Irish College of General Practitioners
	Dr Johnny Sweeney National ICT Project Manager
Health Service Executive	**Alan Price** Digital Primary Care Programme
	Anne Lawlor National Patient & Service User Forum
	Dr David Hanlon National Clinical Advisor and Group Lead Primary Care
	Fran Thompson Acting Chief Information Officer
	Dr Gerry MCCarthy Emergency Medicine National Clinical Lead
	Dr Gerardine Sayers Public Health Medicine, HSE
	Loretto Grogan National Clinical Information Officer for Nursing & Midwifery
	Noreen Noonan, Deputy Delivery Director, National EHR Programme
	Peter Connolly Head of Enterprise Architecture
	Rosin Doherty Director, Access to Information and Health Identifier Programme
	Yvonne Goff Director of Scheduled Care Transformation Programme and Integrated Information Services

Irish Association of Directors of Nursing and Midwifery	**Karen Greene** Director Of Nursing, Beaumont Hospital
Irish Medical Organisation	**Val Moran** Director of Industrial Relations, General Practice, Public & Community Health
Irish Pharmacy Union	**Jack Shanahan** Pharmacist
National Standards Authority of Ireland	**Dr Damon Berry** Chair Health Informatics Steering Committee National Standards Authority of Ireland
Royal College of Physicians of Ireland	**Dr Emer Kelly** Acute Medicine and Respiratory Medicine Saint Vincent's University Hospital Dublin
Royal College of Surgeons of Ireland	**Gerry Kelliher** Business Intelligence Manager, Royal College of Surgeons of Ireland
Sage Advocacy	**Mervyn Taylor** Executive Director
Irish Platform for Patient Organisations, Science and Industry	**Derick Mitchell** Chief Executive Officer
Cairde	**Iyrna Pokhilo** Patient Representative

Appendix D Draft Recommendations Pre- and Post-Consultation

This table shows Draft Recommendations for Consultation (right side) and post-consultation (left side).

Policy and legislation		
1.1	The Department of Health should undertake a gap analysis of current policy, legislation and regulations and any gaps identified should be addressed with new policy, legislation or regulations enabling the implementation of national digital solutions, including a national electronic patient summary.	Clarity in the form of national policy and legislation is required to support the implementation of large scale digital solutions, as set out in Sláintecare. Specifically, a gap analysis of current legislation and regulations should be undertaken and addressed with new legislation or regulations enabling the implementation of national digital solutions, including a national electronic patient summary.
1.2	A model to support the collection, use and sharing of personal health information is a current gap in Ireland. This is required to support the implementation of large scale digital solutions as set out in Slaintecare, including the National Electronic Patient Summary. This needs to be developed in line with current legislation, input from key stakeholders including the public. (HIQA is currently developing a set of recommendations on a consent model for the collection, use and sharing of personal health information in Electronic Health Records in Ireland.)	N/A
1.3	The Health Service Executive must ensure that a national electronic patient summary, and its implementation, complies fully with any and all relevant, existing and future national and EU legislation and regulations.	
1.4	In order to ensure that individual rights are protected and that any implementation of the national electronic summary is compliant with GDPR, the Health Service Executive should carry out a Data Privacy Impact Assessment (DPIA) as an early priority.	

Programme governance		
2.1	In line with best practice internationally, and cognisant of the Irish eHealth landscape and existing governance structures, the HSE should: ▪ Establish a Patient Summary Programme Board, with responsibility for national delivery.[10,11] ▪ Appoint a Patient Summary Programme Sponsor, to act as the national sponsor for the programme at executive level, ensuring that the programme has appropriate oversight and with overall responsibility for the agreement of the scope and roadmap of the implementation programme. The Chief Clinical Officer should fulfil this role.	In line with best practice internationally, and with knowledge of the Irish eHealth landscape and existing governance structures, the following governance structure be established for the implementation of a national electronic patient summary: ▪ A Patient Summary Project Board with responsibility for national delivery should be established, reporting to the EHR Steering Group, which is currently jointly chaired by the Chief Operating Officer and Chief Clinical Officer. The Project Board should be chaired by the Chief Clinical Information Officer, representing the Chief Clinical Officer. ▪ The Chief Clinical Officer should act as the national sponsor for the programme at the executive level, ensuring that the programme has appropriate executive oversight and with overall responsibility for the agreement of the scope and roadmap of the implementation programme. ▪ The Project Board should also maintain a working relationship with the HSE Digital Oversight Group, within the terms of reference of that group.
2.2	The Patient Summary Programme Board should be chaired independently and have representation from all stakeholders involved in the programme. As potential sources of information for the patient summary, general practice and community pharmacy should be well-represented on the Patient Summary Programme Board	The Project Board should also have representation from all entities involved in the programme such as: ▪ policy and legislative organisations, ▪ Health Service Executive (HSE) programmes ▪ standards organisations ▪ professional representative bodies, such as for general practice

	and in the governance structure. Internationally, clinical groups and patients/the public have been shown to be critical to the success of the programme and should also be well represented at all levels of the governance structure.	and pharmacy ▪ patient/public organisations ▪ public and private hospitals ▪ the vendor community. Internationally, two stakeholder groups were identified as critical to the success of the implementation: clinical groups and patients/the public. Therefore, both groups should be well-represented at all levels of the governance structure, as outlined in Recommendations 3.1, 3.2, 3.3 on Stakeholder Engagement.
2.3	In line with both international best practice and with HSE guidelines, following the launch of the programme, an appropriate ongoing governance mechanism should be established.(13)	In line with both international best practice and with HSE guidelines, following the launch of the programme, an appropriate ongoing governance mechanism should be established—including a Change Advisory Board chaired by the Chief Clinical Information Officer.

Stakeholder engagement		
3.1	Review of international best practice shows that the effective engagement of stakeholder groups is essential to the successful implementation of the programme. Therefore, the Patient Summary Programme Board should develop a comprehensive stakeholder engagement plan, identifying all stakeholder groups and engaging with them consistently and appropriately over the implementation and during the post-implementation phase.	Review of international best practice shows that the effective engagement of stakeholder groups is essential to the successful implementation of the programme. Therefore, the Patient Summary Project Board should develop a comprehensive stakeholder engagement plan, identifying all stakeholder groups and engaging them consistently and appropriately over the implementation and during the post-implementation phase.
3.2	Clinical champions should be identified and supported to engage clinical groups, for example, within each region where a regional structure is devised. Engagement of clinical groups has been shown to be a critical factor in the acceptance and use of a national electronic patient summary, with clinical champions playing a decisive role.	In particular, clinical ownership has been shown to be a critical factor in the acceptance and use of a national electronic patient summary, with clinical champions playing a decisive role. The clinical champions should be identified and supported to engage clinical groups—for example, within each region where a regional structure is devised.
3.3	The Patient Summary Programme Board should ensure that the stakeholder engagement plan includes a broad range of stakeholder groups representing patients, their carers, and the public, as these groups are also considered essential for the success of the programme. Appropriate mechanisms to ensure full participation of these groups should also be developed, including identifying relevant public champions and the most effective communication channels to reach those groups.	Patient and public perceptions of the implementation have also been found to be a key determinant of implementation success. This engagement is essential to the success of both the implementation of a national electronic patient summary and the implementation of other national eHealth solutions for health and social care. Based on expert advice, public champions should be identified and supported to engage patients and the public, to ensuring their full participation in this process.

National Health Identifiers		
4.1	As a matter of urgency, national health identifiers need to be fully embedded and used in the highest priority potential information sources for a national electronic patient summary: GP practice management systems and community pharmacy dispensing systems. The Health Identifiers Act 2014 defines two national health identifiers: ▪ Individual Health Identifiers ▪ Health Services Provider Identifiers.	The Individual Health Identifier (IHI) and associated demographic dataset should be operationalised in all projects, programmes, and services supporting a national electronic patient summary.

Information sources		
5.1	The success of the national electronic patient summary is dependent on having good quality data available. Essential criteria for inclusion should be developed for the assessment of all potential information sources for the national electronic patient summary. These criteria should include the quality of data and information in the source, such as the accuracy, timeliness, and completeness of the data. HIQA considers at this point in time that the GP practice management systems and community pharmacy management systems are the highest priority information sources for assessment against the essential criteria. Additionally, other existing national systems and other potential (future) information sources, such as the National Immunisation Information System and the national ePrescribing service, should be assessed against the inclusion criteria and brought on board as appropriate.	Essential criteria for inclusion should be developed for the assessment of all potential information sources for the national electronic patient summary. These criteria should include the quality of data and information in the source, such as the accuracy, the completeness, and update frequency[†] of the data. HIQA considers GP practice management systems and community pharmacy management systems as the highest priority information sources for assessment against the essential criteria. Additionally, other existing national systems—such as the Hospital In-Patient Enquiry System and Primary Care Eligibility and Reimbursement Service and the national messaging broker Healthlink —and other potential (future) information sources—such as the National Immunisation Information System and the national ePrescribing service—should be assessed against the inclusion criteria and brought on board as appropriate.
5.2	The national electronic patient summary should be automated and easy to use, to avoid placing an additional burden on GPs and community pharmacists. When designing and implementing the national electronic patient summary solution, the Patient Summary Programme Board should consider the requirements of GPs and community pharmacists, and their respective ways of working, as well as the potential impact on their practices, to	Mechanisms should be put in place with data controllers to work towards the improvement of the quality of data in the information sources identified to provide information to a national electronic patient summary, in the context of the overall Sláintecare Implementation Plan.

[†] Update frequency means how often the data is provided to the national electronic patient summary.

	ensure that the national electronic patient summary fits seamlessly into the way GPs and community pharmacists deliver care.	
5.3	The patient summary should clearly indicate the accuracy, completeness and update frequency[‡] of clinical information and any potential gaps or limitations, such as any potential gaps in the current medications list. Appropriate measures and processes should also be developed to address any such gap limitations, for example, triangulation with another source, where the clinician checks the information in the patient summary with the patient or their carer.	The Project Board ensures that a comprehensive skills and training programme be implemented for the intended user base, to ensure that the content of a national electronic patient summary is well understood. In particular, the accuracy, completeness and update frequency of patient summary information should be clearly communicated to the users and understood by them, with appropriate protocols introduced, for example, triangulation with another source, where the clinician checks the information in the patient summary with the patient or their carer.
5.4	The Patient Summary Programme Board should ensure that a comprehensive skills and training programme be implemented for the intended user base, to ensure that the content of a national electronic patient summary is well understood.	N/A
5.5	The Patient Summary Programme Board should agree and implement mechanisms for data controllers to work towards the improvement of the quality of data in the information sources identified to provide information to a national electronic patient summary, in the context of the overall Sláintecare Implementation Plan.	

[‡] Update frequency means how often data is provided to the national electronic patient summary.

Phased implementation		
6.1	In line with international best practice, the Health Service Executive, and especially the Patient Summary Programme Sponsor and Programme Board, should consider the implementation of a national electronic patient summary as the initial step in the longer term road map. This may, at later stages, address other use cases, such as the treatment of chronic conditions across primary and secondary healthcare settings and the cross-border exchange of patient summaries within the EU. The implementation can also build public trust and provide opportunities for learning that can support the successful implementation of a national shared care record and a national electronic health record in the longer term.	In line with international best practice, the national electronic patient summary be considered as an initial step in the longer term road map, providing opportunities and learnings that can feed into the implementation of the shared care record and other elements of the Sláintecare Implementation Plan.
6.2	The phases of the implementation of a national electronic patient summary should be determined by the outputs of the data quality assessment in Recommendations 5.1 and 5.2. The implementation of a national electronic patient summary is likely to be split into several phases. In order for the national electronic patient summary to yield benefits, Phase 1 needs to have the following information available in the electronic patient summary as a minimum): ▪ demographic information ▪ medication ▪ allergies.	The phases of the implementation should be determined by the outputs of the data quality assessment in Recommendations 5.1 and 5.2. If the implementation of a national electronic patient summary is split into multiple phases, at minimum Phase 1 should include the following information, in line with international best practice: ▪ demographic information ▪ medication ▪ allergies. Subsequent phases can be informed by assessment of other potential sources against essential criteria for inclusion—see

	Without this information, the national electronic patient summary will have little value. Subsequent phases can be informed by assessment of other potential sources against essential criteria for inclusion, see Recommendation 5.1.	Recommendation 5.1.
6.3	The implementation of Phase 1 of the national electronic patient summary should consist of four stages: ▪ A small pilot involving a number of GP practices linked to local out-of-hours clinic(s) and emergency department(s). ▪ Regional pilots managed by the regional steering group, with similar groupings to above, feeding back to the central programme. ▪ National rollout including the minimum information for Phase 1, outlined in Recommendation 6.2. ▪ Post-implementation support.	The implementation of Phase 1 of the national electronic patient summary should consist of four stages: ▪ A small pilot involving a number of GP practices linked to local out-of-hours clinic(s) and emergency department. ▪ Regional pilots managed by the regional steering group, with similar groupings to above, feeding back to the central programme. ▪ National rollout including demographic information and prescribed medicines. ▪ Post-implementation support.
6.4	Service users should be included appropriately at all stages of the programme, but in particular as part of the pilot and subsequent implementation phases.	To encourage uptake by end users and full realisation of expected benefits, appropriate key performance indicators (KPIs) should be developed in line with international best practice and with engagement from end users of the system. Examples of minimum performance criteria from international best practice include: ▪ Complete patient summaries should be present for at least 50% of patients with records in the system, especially patients that access out-of-hours or emergency care on a regular basis.

		▪ It should be possible to retrieve and read a patient summary in less than 30 seconds. The patient summary should be presented through a user-friend system that also supports single sign on and appropriate security measures.
6.5	Once the national electronic patient summary has been implemented nationally, HIQA, through its review programme of eHealth Services, will review the national implementation to assess compliance with the National Standard on Information Requirements for a National Electronic Patient Summary. HIQA will report on the findings and make recommendations on any required improvements to the national implementation and where necessary, will make amendments that need to be made to the National Standard.	

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