The ability to deliver high-quality integrated care in Ireland is dependent on the successful implementation of the Shared Record Programme. Currently healthcare records in Ireland are fragmented within organisational siloes this is a barrier to effective self-management and clinical decision-making across different care settings.

The Shared Record will be a single patient-centric health and social care record available to clinicians, patients and carers. It will support integrated care plans, care pathways and multi-disciplinary assessments to enable the delivery of safe, efficient and coordinated care for the entire population of Ireland. The Shared Record Programme’s vision is to create a clinically led Shared Record which clinicians, patients and carers value and use to improve and coordinate care.

The Programme will deliver this solution nationally over a five year period, with a strong focus on the complex clinical change required to implement and realise benefits from the technology solution. The aims of the Shared Record Programme are to:

Facilitate the integration of care

The capability to communicate, collaborate and coordinate care will bridge the gap between health and social care. It will also allow for the management of resources in a way that delivers best health outcomes, improves people’s experiences of using the service and demonstrates value for money. The Shared Record has the potential to provide a seamless care experience for the patient as they navigate services throughout the health system.

Enable better clinical decision-making across all care settings

Information technology plays a critical role enabling health and social care systems to become integrated. Aggregating patient data from disparate organisations’ ICT systems into a national structured Shared Record will ensure that clinicians are better informed to make efficient clinical decisions.

Enable self-care and improved collaboration with patients and carers

The lack of integration within the Irish healthcare system is a major frustration for patients and carers. Making the Shared Record appropriately available to patients and carers will engage and empower patients to manage and make informed decisions about their health and well-being.
Improve the working lives of clinicians

Improving access to patient health records and enabling collaboration with colleagues, patients and carers will improve the working lives of clinicians by allowing them access to the information that they need preventing duplication of work, delays and mistakes.

To support the integration of care, functional capabilities will be deployed incrementally to allow clinicians to communicate securely about individual patients in order to support the case management of patients with chronic conditions, frail and elderly persons and other similarly complex patient groups.

The Shared Record will benefit clinicians, patients and carers. It will also include community teams and clinicians working in unscheduled care settings, such as GP out-of-hours services and Emergency Departments, who typically lack adequate access to patient records to inform clinical decision-making.

The Shared Record will initially leverage hospital IT systems and the national messaging service, Healthlink to create an aggregated view of patient data and make it available across the care continuum. Further data sources, including GP, GP out of hours, community and ambulance systems, will be added to the Shared Record. Patient data from private providers, Defence Forces Medical Services and Prison Medical Services may be added in the future but are not within the scope of this business case. Appropriate access to the Shared Record will be granted to patients, carers, parents and guardians.

The data will be made available for Business Intelligence analysis to support population health management.

Keywords: integrated care; shared care record; patient; clinician; empowerment