HEALTH AND WELL-BEING SCRUTINY COMMITTEE 14 MARCH 2012

SUMMARY CARE RECORDS

REPORT OF THE NORTH EAST STRATEGIC HEALTH AUTHORITY

1. Purpose of Report

1.1 To provide the Committee with a briefing on the Summary Care Record (SCR). The SCR is a summary of a patient's key health information that will be available to anyone treating them in the NHS across England.

2. Background

2.1 Summary Care Records are being introduced to improve the safety and quality of patient care. They are being gradually introduced across England.

2.2 The Summary Care Record is an electronic record which will give healthcare staff faster, easier access to essential information about patients, to help provide safe treatment when emergency care is needed or when a patient cannot access a GP.

2.3 The Summary Care Record will primarily be used in provision of out of hours or emergency care and will have details of a patient's medications, any allergies and any bad reactions to medicines they have.

3. Information Governance and Data Security

3.1 Strong protection has been built in to prevent any information being lost or deleted. The information is copied to a separate secure site so there is always a back-up.

3.2 In order to regulate and control access staff will have to pass three tests to access a patient's records:

- They will have to be appropriately registered as genuine staff to be issued with a Smartcard and passcode which works like a chip and PIN bankcard.
- They have to be recognised by the system as providing care or treatment to a patient (this is termed a legitimate relationship).
- They will only be able to see the sorts of information they need to give a patient that care or treatment (Role Based Access). So, a receptionist may not be able to see the same information as a doctor or nurse, and nothing at all if they are not involved in providing care to a patient.

3.3 NHS staff will need to ask a patient if they can look at their Summary Care Record every time they need to.

3.4 Patients have rights under the law to confidentiality and they will have options about what is on their record and what is not. A patient's right to confidentiality is made clear in the NHS Care Record Guarantee. This sets out the commitments that the NHS makes to patients about how it handles their NHS Care Records. It covers issues such as confidentiality, security and who can access a patient's record.

4. Consent – Storing, Accessing and Updating Summary Care Records

4.1 Patients will be contacted by their GP surgery or Primary Care Trust before a Summary Care Record is created and will have at least 12 weeks to think about their options. An information pack will be sent to them on March 30 2012 explaining the changes that are taking place and the choices they can make. If they are happy to have an SCR, then they do not need to do anything and their Summary Care Record will be created. If they have concerns, then they can get more information about the changes. The pack they receive will include details of where they can find more information about the changes.- these include the local Patient Advice and Liaison Service and a national dedicated information line. They can also find out more via their GP practice or Primary Care Trust.

4.2 Patients will have choices about limiting access to their Summary Care Record and they can ask not to have a Summary Care Record created. The letter they receive from their GP sets out a date, sometime after which a Summary Care Record will be created. There will be a minimum period (currently 12 weeks) from when information is sent to the patient and before a Summary Care Record is created.

4.3 Creating SCRs is dependent on individual GP practices joining the initiative. Engagement with practices is done on a rolling basis and as a result it can take up to a year for SCRs to be available for use in local emergency or out of hours services. If practices do not join the initiative, the patients registered with those GPs will not have SCRs made for them, regardless of whether they have opted out.

4.4 If a patient chooses not have a Summary Care Record the NHS will continue to endeavour to provide a patient with the best care possible. However, it could mean that there might be times when key health information about a patient is not available. For example, if a patient does not have a Summary Care Record and is taken into A&E, then the staff in A&E may not be able to access their current medications, allergies or bad reactions to medicines if they cannot access the Summary Care Record. The same could apply if a patient needs a doctor outside surgery hours.

4.5 A patient will be able to limit access to all or parts of their Summary Care Record if, for example, there are items of sensitive information being accessed in various places where they receive care.

4.6 People outside of the NHS will not be able to access a patient's record without their permission other than in circumstances where it is allowed by law. People from other government departments such as the police or social services will not be able to look at a patient's records directly. As now, they can apply for specific information from a patient's records. There are strict controls on who can apply, what information they can have and the circumstances under which the information is released.

4.7 Health care professionals are required to make accurate, relevant records of the care provided. A patient can discuss what is recorded, where it is recorded and how it is expressed but they cannot prevent a healthcare professional from making some record of relevant information. Currently the patient is not able to add information to their records but in the future they will be able to add information such as their treatment preferences.

4.8 Patients are able to ask to see their records in whatever form they are held where they are treated, at their GP, hospital or clinic. To access their records patients will need to follow the procedures laid out by the Data Protection Act - i.e. make an application in writing or, if that's not possible, by some alternative method. When a

Summary Care Record has been created a patient will be able to see it through HealthSpace, a secure Internet site, free of charge, at any time they like, by using their computer.

4.9 A record is kept of everyone who looks at a Summary Care Record and an alert will be sent to a nominated member of staff where access occurs in an unexpected setting, for example, if a clinician who doesn't usually treat a patient accesses their information. If it is found that the access was unreasonable, the patient is informed. Patients can request information about who has accessed their record. They can apply to the 'Caldicott Guardian' for their Primary Care Trust who will let them know who has looked at their record. The Caldicott Guardian will investigate every incident of inappropriate access to a patient's record and will let them know in the eventuality that there has been inappropriate access.

5. Conclusion & Recommendations

5.1 Key messages about the Summary Care Record are:

- Patients can choose to have an SCR or not – opting out is simple to do
- Patients must consent before their SCR can be viewed - unless they are unconscious
- SCRs are only used in emergencies or when GP practices are closed
- SCRs contain only a patient's allergies, medications and poor reactions to medicines

5.2 Members are asked to receive the briefing.

6. Background Papers

NHS Summary Care Records

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