POLICY DOCUMENT

Burton Hospitals
NHS Foundation Trust

VIEWING SUMMARY CARE RECORDS POLICY

Approved by:	**Trust Executive Committee**
On:	**29 March 2017**
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Department Responsible for Review:	**Medical Directors Office**
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• Essential Reading for:	**Medical Staff** **Pharmacy Staff**
• Information for:	**Registration Authority Team**
Policy Number:	**333**
Version Number:	**1**
Signature:	
	Chief Executive
Date:	30 March 2017

Burton Hospitals NHS Foundation Trust

POLICY INDEX

Title:	**Viewing Summary Care Records Policy**
Original Issue Date:	**February 2017**
Date of Last Review:	**New Policy**
Responsibility:	**Caldicott Function**
Stored:	**Trust Intranet**
Linked Trust Policies:	**Registration Authority Policy** **Information Governance Policy** **Information Security policy** **User Access Policy** **Confidentiality Policy**
E & D Impact Assessed	**EIA 396**
Responsible Committee / Group	**Trust Executive Committee**
Consulted:	**Information Governance Steering Group** **Pharmacy Leads** **Divisional Directors / Divisional Medical Directors / Divisional Nurse Directors** **Clinical Directors** **All Operational Managers**

REVIEW AND AMENDMENT LOG

Version	Type of change	Date	Description of Change
1		February 2017	New Policy

VIEWING SUMMARY CARE RECORDS POLICY

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Burton Hospitals NHS Foundation Trust

VIEWING SUMMARY CARE RECORDS POLICY

1. SCOPE

This Policy is intended for use by Burton Hospitals NHS Foundation Trust (the Trust) and sets the processes and procedures for effectively co-ordinating and managing the viewing of Summary Care Records (SCR). The Trust is moving towards rolling out the viewing of SCR Trust-wide and this Policy is to ensure that the processes are understood and followed. The whole process will be covered from the initial decisions of who should view, the responsibilities of individual staff members, through to the duties of the Privacy Officer within the Trust and the expectation of spot check auditing to ensure the viewing of SCR within the Trust is transparent and the resource is being used in an effective way.

2. INTRODUCTION

The NHS has introduced Summary Care Records (SCR) to enable clinicians access to important information about the patients who use our service, this being; medication, allergies and adverse reactions to medicines that a patient may have had. It is envisaged that the introduction of SCRs will improve healthcare provision across the Trust and be an invaluable resource to clinicians who need to access key patient information quickly.

The access to SCR is controlled by ensuring the appropriate codes are included within the staff member's smartcard; this will occur through the Registration Authority process. The Trust will be rolling the viewing of SCR out Trust-wide as the benefits of this resource are easily realised without cost implications.

In order for any organisation to be able to move forward when viewing SCR they must have an appointed Privacy Officer; the Privacy Officer must undergo training and be able to effectively carry out the duties. The Trust has an identified individual who has undergone the correct training and accepts the role of the Privacy Officer:

Privacy Officer: Claire Tubey
Role: System Support Manager
Contact: (01283) 511511 Ext 5214
Claire.Tubey@burtonft.nhs.uk

3. STATEMENT OF INTENT

This Policy aims to:

- Enable staff members to understand more about SCRs, Privacy Officers and Viewing

- Detail the Trust's position and actions in terms of SCRs
- Detail processes that have been put in place and need to be followed within this area

4. DUTIES

The duties set out below detail the responsibilities of Trust staff for managing evidence and information in relation to SCRs and Privacy Officer requirements.

Chief Executive

The Trust's Accountable Officer is the Chief Executive who has overall accountability for ensuring that information risks are assessed and mitigated to an acceptable level. Information risk is handled in a similar manner to other risks such as financial, legal and reputational risks. Reference to the management of information risks and associated information governance practice is now required in the Statement of Internal Control which the Accounting Officer is required to sign annually.

SIRO (Senior Information Risk Owner)

The role of the SIRO:

- Is accountable
- Fosters a culture for protecting and using data
- Provides a focal point for managing information risk and incidents
- Is concerned with the management of all information assets

The SIRO is an executive Board member with allocated lead responsibility for the Trust's information risks and provides a focus for the management of information risk at Board level. The SIRO is briefed on all Information Governance issues via Finance and Performance Committee.

Privacy Officers

Privacy officers have a responsibility to understand all guidance that has been issued to them and to uphold their responsibilities in terms of managing the viewing of SCRs within their organisations. The Privacy Officer is required to undertake mandatory training and must be aware of what is required within the role.

EPR and Clinical Systems Teams

The Information Governance Team are responsible for ensuring information relating to SCRs and Privacy Officer training is effectively logged and reviewed in line with national standards.

There is also a responsibility to effectively communicate information in relation to SCR and Privacy Officer Information to the correct parties within relevant organisations and manage the overall process of SCR within the Trust to ensure compliance with legislative and regulatory requirements.

All Trust Employees

All Trust employees and anyone else working for the organisation (including agency staff, bank staff etc.) who use and have access to Trust information and/or ICT Systems must understand their personal responsibilities for Information Governance and compliance with UK Law.

If a staff member chooses to view a SCR they must understand the implications of doing so and the potential repercussions if the access is not legitimate. It is the duty of the staff member to ensure they understand what is required of them before they view a SCR.

5. SUMMARY CARE RECORDS INFORMATION AND PROCESSES

Introduction to Summary Care Records

A SCR is an electronic record which contains information about the medicines a patient is prescribed, allergies, and any adverse reactions to medicines. SCR also contains demographic information, GP visit history, diagnosis, treatments and resuscitation status. Having this information stored in one place makes it easier for healthcare staff to treat patients in an emergency, or when their GP practice is closed. Only healthcare staff involved in a patient's care can see their SCR.

Those who look at a SCR need to:

- Be directly involved in the patient's care
- Have a Smartcard with a chip and pass code

Healthcare staff are trained to know that the SCR is an information resource to help guide the clinical care they provide (in the same way doctor referral letters or lists of medication are sources of information).

The decision has been made that this resource will be used within the Trust in the hope that this has a positive impact on the efficacy of healthcare treatment for patients, by facilitating medicines reconciliation in line with NICE guidance NG5 2015.

Access

SCR access will be given as Position Based Access Control (PBAC) added as a baseline to selected staff groups job role. PBAC links the job to the access rights that it requires. PBAC provides a simple and effective mechanism for providing users with the access that they need in the course of their work, whilst also ensuring that these access rights are properly managed and appropriate for the job that they are doing.

Guidance & Training

All staff members given the functionality to view SCRs will be required to undertake training via an information leaflet (**Appendix 2**) and have the option to undertake an e-learning module.

The e-learning module has been developed using an adapted e-learning training package that has been provided to the Trust by NHS Digital. The training has been adapted to ensure it meets the requirements of staff members working for the Trust and provides them with the information they need to confidently and competently use the SCR viewing functionality.

Registration Authority (RA)

The RA team also allow users access to the 'Summary Care Record Admin' role. This role contains codes that only allow users to access patient demographics. You do not need patient consent to access these records.

The SCR access role is known locally as 'Pharmacist Summary Care Record'. This role contains the relevant codes required as set nationally, provided by NHS Digital.

If further job roles are identified within the Trust that requires SCR access the RA would work with HR to ensure that the correct roles receive the additional access.

Viewing Summary Care Records

A SCR should only be viewed if the user is involved in the patient's care. This is called a 'legitimate relationship'. Healthcare staff will only see the information they need to do their job, and they will ask permission to look at a SCR. This is called 'permission to view'.

If they can't ask, for example if a patient is unconscious, they may look at a SCR without permission, but only if looking at the patient's SCR would be in the patient's best interest. If they do this, they will make a note on the patient's record, on the SCR screen to say why they have done this.

Before viewing the SCR the user is asked if the patient has given their permission to view and can indicate 'yes', 'no' or that 'emergency access is required'. Self-claiming a legitimate relationship, or selecting emergency access, will generate an alert. These alerts will be audited by the Trust's Privacy Officer to make sure there was a valid reason for the view.

The key thing to note about legitimate relationships and alerts is that as long as there is a legitimate reason for you to be accessing the SCR then, even if an alert is raised, there is nothing to worry about. The Privacy Officer will simply match up your alert with a corresponding entry on your patient administration system and close the alert.

If it is found that there is no legitimate reason for a record to be accessed you will be asked to explain your actions.

Permission to view Summary Care Records

The patient (or their parent or guardian if a child) must have given explicit consent for their SCR to be viewed.

Patients are asked to give their permission for any healthcare professional directly involved in their care to view their GP records for the purposes of ensuring the treatment we will provide is safe and effective.

When the patient has been asked, the response needs to be recorded on Meditech on either the 'Clinical Data Screen' or on the 'Admission'. This grants access for others as required without the patient being repeatedly asked on subsequent visits (**Appendix 1**).

The response can be updated if the patient changes their mind or, for example, becomes able to give permission having been unable when first asked. Changes to the data field are auditable.

The response is available to view as part of the patient's hospital record from then on.

NHS Digital and the Trust advocate using the 'consent model'; at its most basic this is promoting the use of consent by asking an individual if you can view their SCR, explain what this means and why this would assist you in their healthcare.

Implications and how 'consent' works in practice:

- A patient must consent to a staff member viewing their SCR
- If the staff member needs to view SCR but the patient is not in attendance, contact must be made first (i.e. by telephone etc)
- The staff member can explain to the patient that access to their SCR may be required several times. To prevent the patient being contacted several times the staff member on first contact can ask if the consent can be applied to the wider team.
- The consent to view SCR can last as long as the care episode is expected to last; provided this is communicated to the patient and consent to this is obtained and noted in a centralised place viewable by wider team members who may need this information.

Monitoring and Compliance

This monitoring will be used to ensure that in line with statutory requirements staff members only have access to information they require in line with their job role and ensure that risk can be reduced.

Internal Checks for individual viewing notifications:

The Privacy Officer has a duty to ensure SCR viewing is being carried out legitimately. In line with this duty the Trust's Privacy Officer will ensure that all notifications are checked:

- Emergency Override; this is used when a patient cannot give consent to the viewing of their SCR. The Privacy Officer will check each notification of this sort and using the training they have received will assess whether the viewing has been legitimate or requires further clarification

- The Privacy Officer receives an Alert each time SCR is accessed in a certain way. The alert is raised when access is for SCR access made in an Emergency or for a Self-Claimed Legitimate Relationship Alert. The Privacy Officer will complete a full check of all alerts generated at the end of each month.

  Privacy Officer

  Claire Tubey
  System Support Manager
  (01283) 566333 Ext 5214
  Claire.Tubey@burtonft.nhs.uk

The Privacy Officer for the Trust is detailed above. All mandatory training has been completed and the responsibilities for monitoring and compliance as detailed above are understood and accepted.

It is the duty of the Privacy Officer to ensure that any access that is thought to be illegitimate be followed up and an investigation progressed to look into the matter further.

Investigations

As detailed above an investigation would occur if the Privacy Officer identifies inappropriate activity when checking the alerts that are generated for staff members viewing SCR.

This would be an informal investigation at first and involve fact finding to ascertain if the trend and/or access can be appropriately explained. Further investigations will result if the behaviour is inappropriate and the functionality of SCR is being abused. Staff members should be aware that inappropriate use will result in disciplinary action.

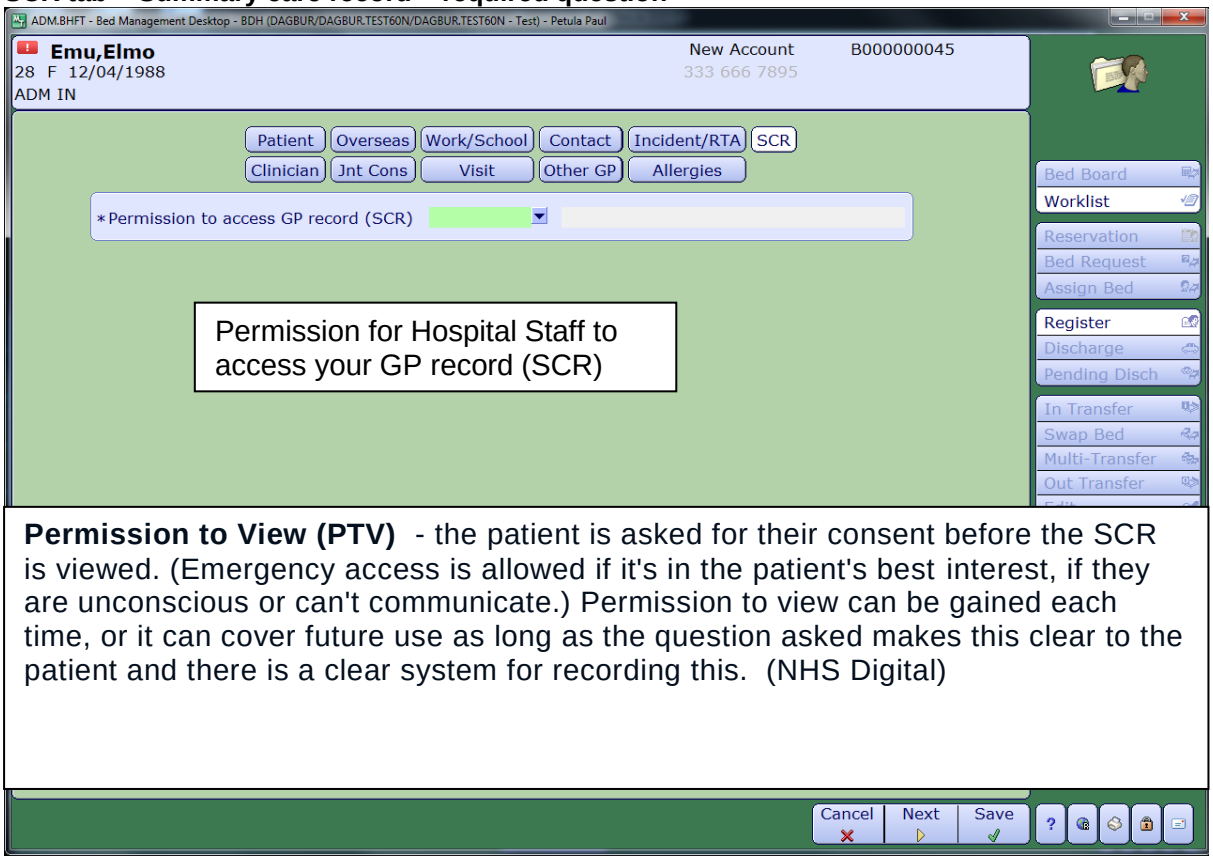
6. PRINTING

It is not expected that the print function is used. However in some complicated instances this may be required. Shredding of the print out after usage is essential.

Appendix 1

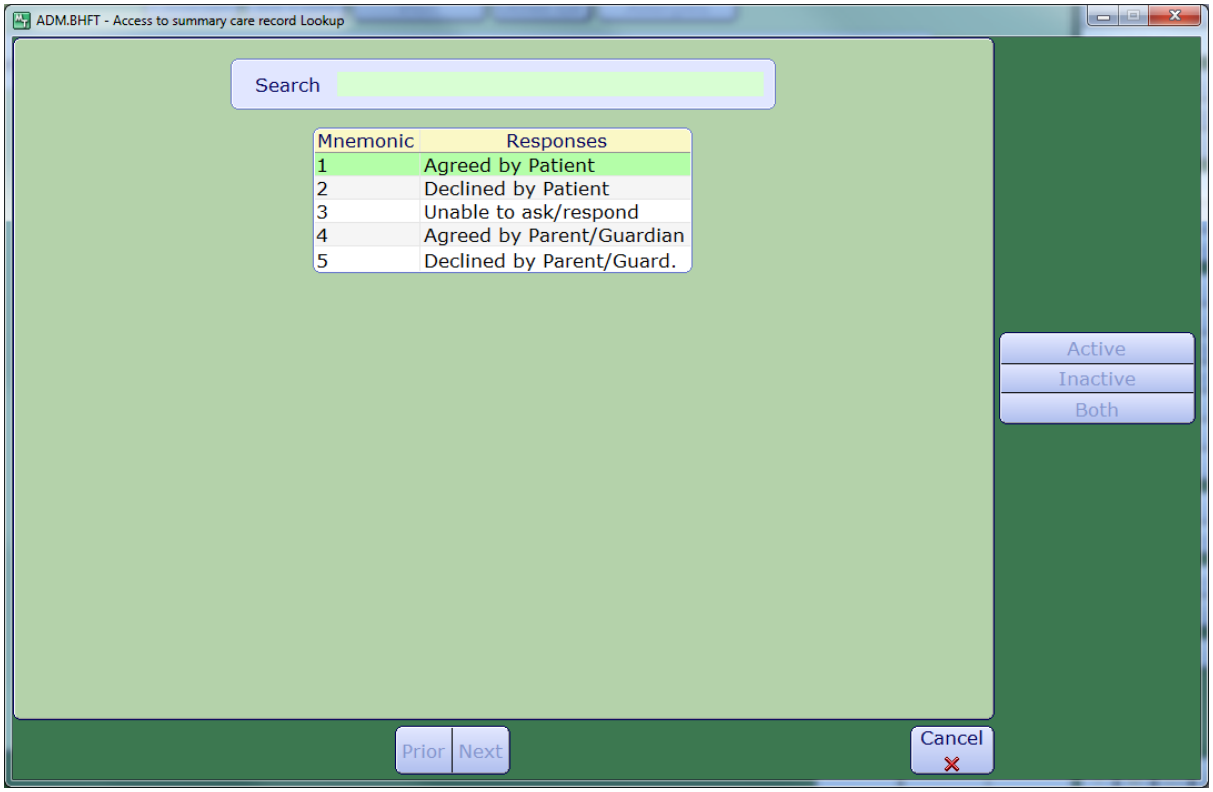
Summary care Record Permission Record V6.0

1. **Registrations screens for Emergency Department and Inpatients plus Registrations edits screen**
   SCR tab = Summary care record – required question

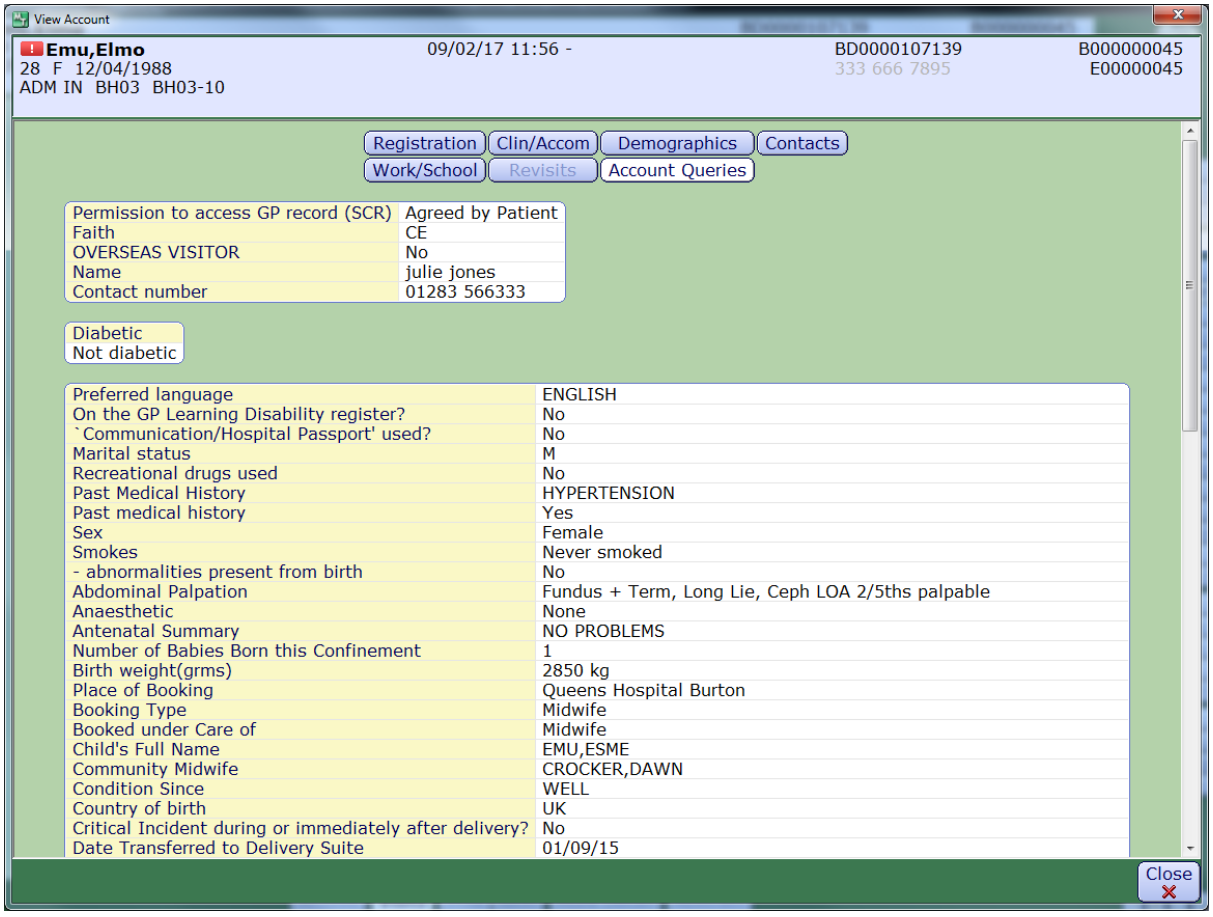


Permission to View (PTV) - the patient is asked for their consent before the SCR is viewed. (Emergency access is allowed if it's in the patient's best interest, if they are unconscious or can't communicate.) Permission to view can be gained each time, or it can cover future use as long as the question asked makes this clear to the patient and there is a clear system for recording this. (NHS Digital)

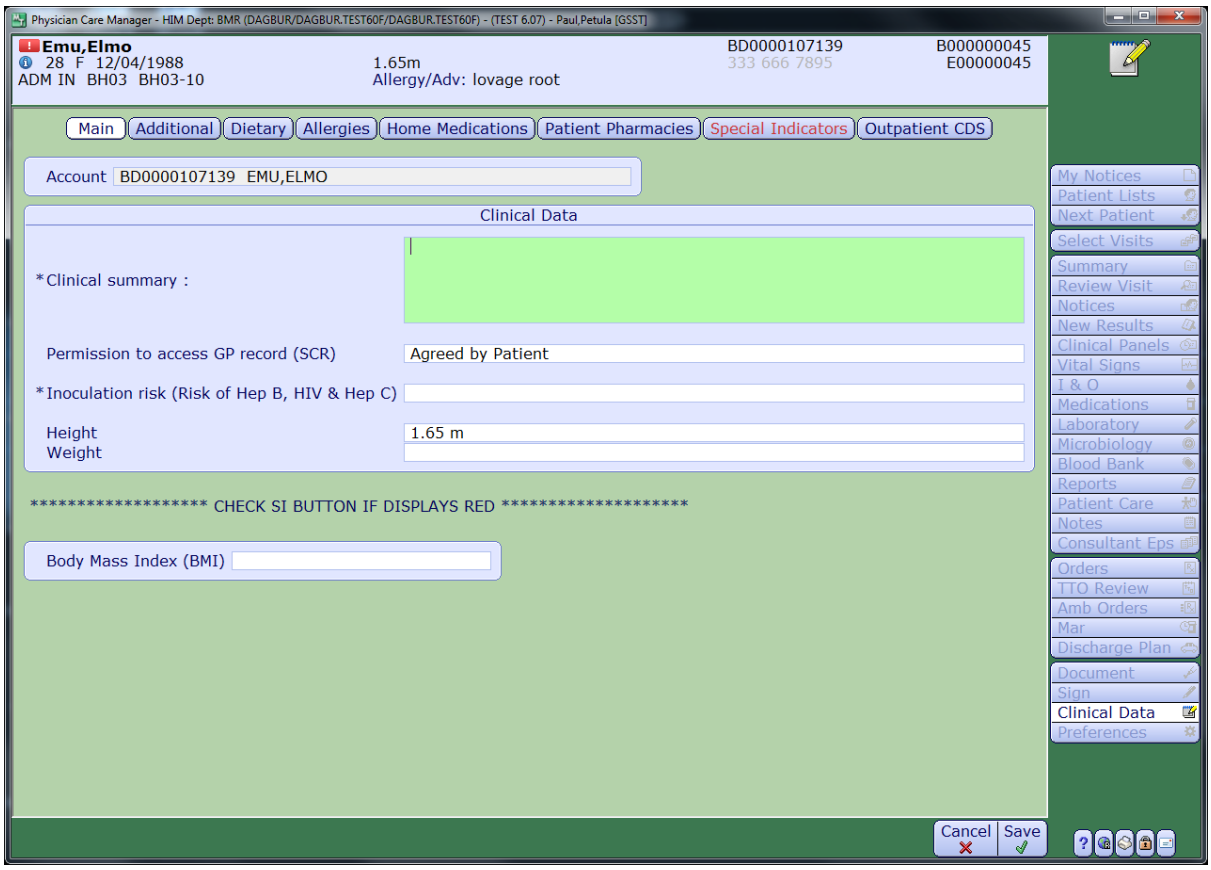
2. **Drop down responses for question `permission to access GP record (SCR)**
   Once recorded the response will default across admissions.



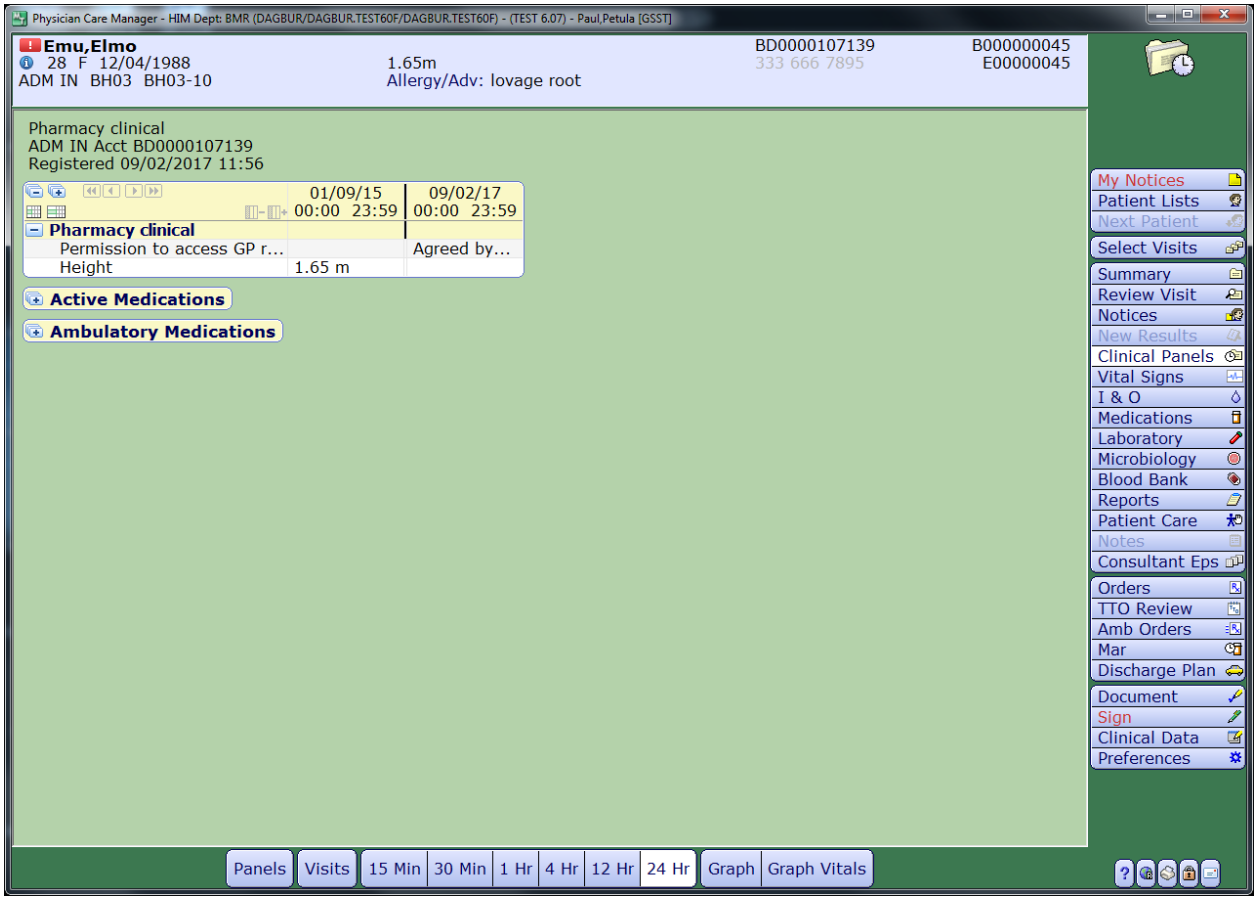
3. **Review Visit button – more detail – Account Queries will display last response.**



4. **Clinical Data Screen – response defaults from admissions and can be edited by clinical staff**



5. **If required can be added to Clinical panels e.g Pharmacy**



Burton Hospitals NHS
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Quick guide to using Summary Care Records Application (SCRa2)

What is SCRa2?

The SCRa2 is a web based portal that allows healthcare staff access to view patient data held on the National Spine. The Data available is allergies and medications but more types of data are being added. The data originates from the patient's GP.

ESR e-learning

This leaflet is a quick guide, a comprehensive e-learning module is available on ESR – search courses for "Summary Care Record"

Who can access SCR

Only staff who:

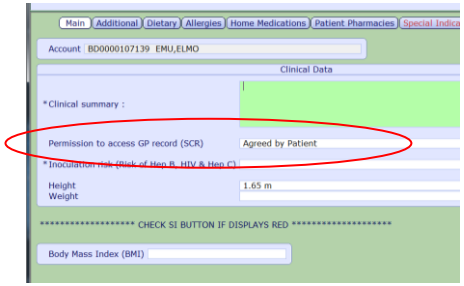
- Have been issued with an ESR card
- Have a job role that the Trust considers would need access to SCR
- Are directly involved in that patients care

can access SCR for the purposes of patient care.

Access is auditable and is monitored by the IG department**Permission to view the SCR**

You have to have the patient's permission to view their SCR unless, in the patients best interest, you claim emergency access and indicate why.

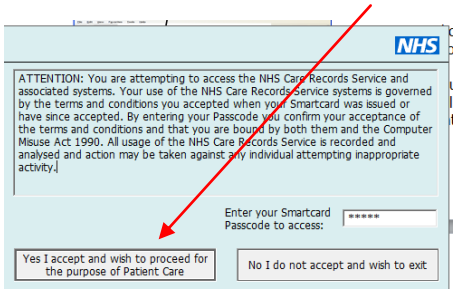
Patient Registration screens include the patients response to being asked if they give their permission for healthcare staff to view their GPs record. This displays, **and can be updated,** in the Clinical Data Screen in EMR.



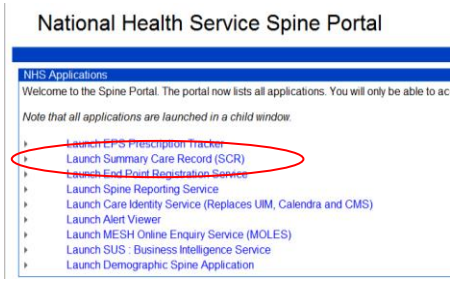
To view the SCR

- Select the Desktop icon for the National Portal or click the web link on the bottom right of the v6 screen or open Internet Explorer and go to: https://portal.national.ncrs.nhs.uk/portal/dt

- Put your ESR card into the reader, enter your pin then click " Yes …patient care"



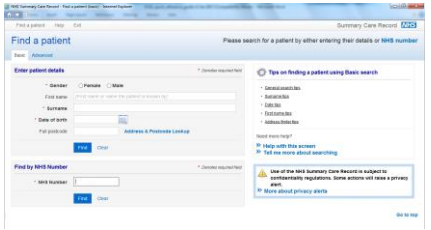
- The Spine Portal menu will appear:



- Click on the 'Launch Summary Care Record' link – you will be taken to the patient demographics search screen.

Search for a patient

- Find patient using either the NHS number or the minimum search criteria (gender, surname, date of birth)
-

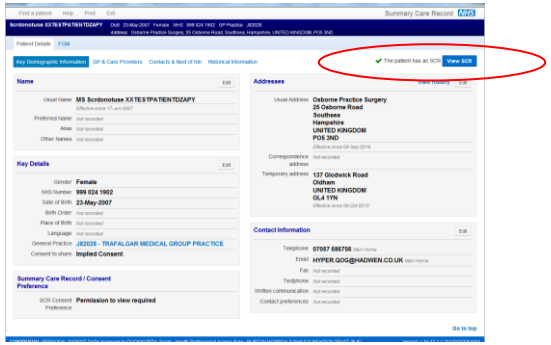


- If patient cannot be found, use more information e.g. first name, postcode or click on the 'Advanced' tab to perform a more detailed search.

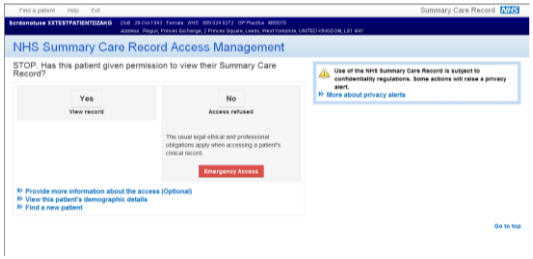
- If using an NHS number the correct patient will appear otherwise select the appropriate patient.

Continued

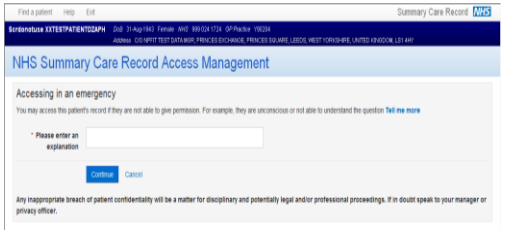
- If the patient has an SCR record a green tick will be displayed in the top right corner, if not a red cross will be present. Click view SCR.



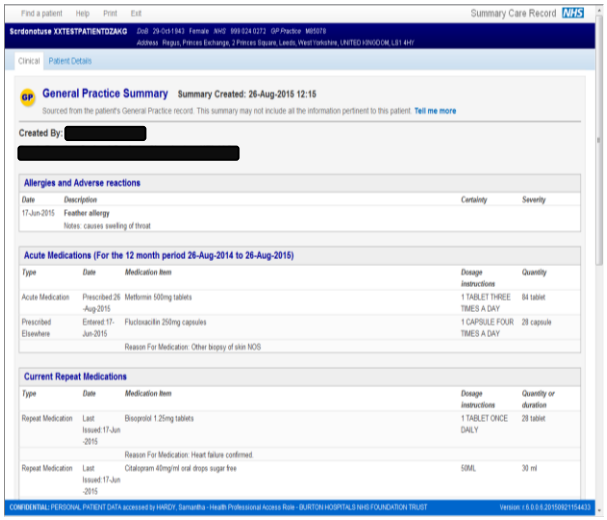
- The permission to view screen will appear. Gain permission, select yes or emergency access as appropriate.



- If you selected emergency access, add in details as to why the patient is not able to give permission then press continue.



A standard summary looks like this;



- There is a print function. The print should be considered a confidential part of the patient record.
- Click 'Find a patient' to continue using SCR for another patient otherwise exit.

Exit the record

Always ensure you exit the record, log out of SCRa2 and remove your smartcard before leaving the PC.

Test Patient NHS numbers

Please feel free to explore the Summary Care Record with the following test patient NHS numbers;

9990241902
9990240272
9990240736
9990243662

IMPORTANT TO NOTE

When viewing the record, remember:

- ✓ Note when the summary was created, it could be old information, especially if the patient has been in hospital in the meantime.
- ✓ the dates - may be 'last issued' or 'first entered'.
- ✓ the patient may not be taking what is prescribed.
- ✓ the patient may be taking meds not prescribed by their GP e.g. OTC or hospital only drugs.
- ✓ 'Acute' could still be regular.
- ✓ 'Discontinued' could be because of dose change, moved to acute or be very recent.
- ✓ If there is no SCR either the Surgery is not uploading or the patient has refused to consent to uploading.