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Summary Care Record Permission to View Guidelines

Document Management

Revision History

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0.3	19/10/2015	Following presentation and feedback at the SCR Expert Advisory Committee and subsequent suggestions from Committee members and community pharmacy stakeholders.
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Reviewers

This document must be reviewed by the following people:

Reviewer name	Title / Responsibility	Date	Version
Dr Emyr Wyn Jones	HSCIC SCR Clinical Ambassador	15/11/2015	0.4 & 0.5
Dr Rob Jeeves	HSCIC SCR Primary Care Clinical Lead	28/01/2016	0.6
Dr Alan Hassey	HSCIC IG Clinical Lead & Deputy Caldicott Guardian	20/11/2015	0.5
Phil Walker	Information Governance Alliance	20/11/2015	0.5

Approved by

This document must be approved by the following people/bodies:

Name	Signature	Title	Date	Version
HSCIC SCR Programme Board	n/a	n/a	25/01/2016	1.0

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1 Introduction

1.1 Purpose

The purpose of this document is to provide guidelines for implementing permission to view element of the Summary Care Record (SCR) consent model. Asking a patient's permission before their SCR is viewed must be part of the process for organisations using the SCR.

Information contained in the SCR is subject to the legal and professional rules governing patient confidentiality. Patient-identifiable confidential information can only be used for purposes that a patient has consented to unless exceptional circumstances apply.

Permission to view for direct care provision is designed to ensure that a patient has been informed how their personal information is being used. It also allows the patient to determine who can view this information in the context of the care being provided.

The ways in which health and social care operates are diverse and therefore the approach to implementing permission to view will vary. This document considers the circumstances in which there may be uncertainty about how to implement permission to view, and provides guidelines that should be applied. Existing procedures must apply where applicable and care professionals should continue to follow their professional guidance.

1.2 Definition of Scope

This document relates to the clinical content recorded in a patient's SCR which requires the patient's permission before authorised staff in a range of care settings can view the information. As part of the SCR Public Information Programme (PIP), citizens aged 15 $\frac{3}{4}$ and over received information packs and were informed that an SCR would be created for them unless they chose to opt out. In addition to the PIP, GP practices should include information about SCR in their new patient process. Currently SCRs contain details of medications, allergies and adverse reactions sourced from the patient's GP record. Patients can provide explicit consent to have a 'richer' SCR with additional information by discussing this with their GP practice.

Excluded from the scope of permission to view are the following:

- Occasions when it is not possible to ask permission and care professionals act in the patient's best interests
- For patients newly registered at a GP practice with the status of 'applied for GMS', this is prior to the patient becoming fully registered at the GP practice.
- Access in legally defined situations (i.e. public interest, statute and court order).

2 SCR permission to view guidelines

There are five areas covered by the SCR permission to view guidelines:

1. Organisations viewing SCRs should define the scope of the permission being sought i.e. who is being given permission and for how long
2. The explanation to a patient, as part of seeking permission to view, should be simple, straightforward, honest and appropriately communicated
3. A patient's permission to view should be sought at the most appropriate point in the patient's care pathway
4. The scope of permission obtained should be appropriately recorded
5. On those occasions when it is not possible to ask for permission to view care professionals may act in the patient's best interests.

1**Organisations viewing SCR should define the scope of the permission being sought i.e. who is being given permission and for how long**

- Organisations viewing SCR must determine the scope of the permission being sought in terms of:
 - Whether this is for an individual, team or wider range of staff as part of a pathway of care
 - The length of time this permission will last which is likely to vary considerably depending on the nature of the care setting
- The systems that allow access to SCR must display a dialogue screen which alerts users to the need to capture permission to view and provides the ability to either proceed with permission, use the 'emergency access' override option, or note that permission was declined. Organisations should not see this dialogue box as restricting the ability to create local processes. For example, if permission is asked by a member of staff on behalf of a team, then it is expected that this can be clearly recorded allowing other appropriate members of the team (with access to view SCR) to confirm permission on the dialogue screen without asking the patient again.
- For care settings where it is beneficial to both the patient and care professionals that permission to view lasts for a prolonged period of time, it is recommended that the decision is reviewed at appropriate regular intervals with the patient. Patients should also be made aware that they can change this decision at any time.
- It is acknowledged that there are pathways of care which involve different care providers and services (e.g. NHS 111 and GP Out of Hours). Permission to view can be transferred with the patient through a pathway of care if the following criteria can be met:
 - There is a robust process for transferring permission to view between organisations. This is likely to be where the technology allows permission to view to be transferred electronically between systems. HSCIC can offer advice about systems that have, or are developing, this functionality.
 - Other relevant guidelines outlined in this document can be met, i.e. there must be 'no surprises' for patients in relation to how their information is being used.
 - If staff are uncertain about the status of a patient's permission it is recommended that that this is checked with the patient.

2**The explanation to a patient, as part of seeking permission to view, should be simple, straightforward, honest and appropriately communicated**

- Where possible the patient's permission to view should be captured explicitly, this may be face to face or over the phone depending on the nature of the care setting. Organisations may choose to make a record of the means and outcome of the request for the patient's permission to view.
- It is acknowledged that there are scenarios where there is a clear benefit to viewing the SCR prior to the patient presenting in person. In such cases, which are likely to be for scheduled (planned) care encounters, it is permissible to view the SCR prior to any appointment providing the patient is aware that this may happen and has not objected. An appointment letter provides a good opportunity to ensure the patient is clearly informed and supporting materials available from the HSCIC website (www.hscic.gov.uk/scr) may also be of use. Suggested wording for appointment letters is included in the 'Scenarios' section of this document. Patients should have sufficient opportunity to decline permission and understand the time frame in which to do this.
- There should be 'no surprises' for patients regarding how their information is being used. Any explanation (either verbal or written) should be straightforward and honest, and should in layman's terms explain the elements from the first guideline, i.e. who is being given permission and for how long. It is not expected that this will require exhaustive explanations, although it is acknowledged that in some cases patients may seek clarification.
- It will be for individual care settings to decide which is the most appropriate method to gain permission and how best to describe this to the patient. The form of words will be slightly different depending on the scope of the permission as detailed in the first guideline, i.e. who is being given permission and for how long.
- In explaining permission to view, various options can be used such as leaflets, conversation, appropriate content in relevant patient communication, posters within care setting or in treatment rooms or a range of accessible information. A combination of these may be used depending on the individual care setting and the needs of the local population. Materials can be found on the HSCIC SCR website: www.hscic.gov.uk/scr.
- In determining the right approach to communication - materials and methods should be used which take account of any communication difficulties e.g. sensory impairment, first language not being English.

3**A patient's permission to view should be sought at the most appropriate point in the patient's care pathway**

- It is acknowledged that the point at which the patient's permission to view is sought will vary depending on the nature of the care setting and local processes. The decision to define the most appropriate point in the care pathway should be taken by the organisation/s or team/s implementing SCR viewing, ensuring that the other guidelines in this document can be met.

4**The scope of permission obtained should be appropriately recorded**

- An audit trail records when an SCR was accessed and by whom, and so for care professionals who access SCRs solely for themselves and not as part of a wider team the audit trail alone is a sufficient record. However, some organisations and individuals may choose to also record this separately either on a local system or on paper records. This may be documented in an existing or new organisational policy.
- Where permission is to be sought for a team or for a wider team as part of a care pathway it is important that a separate record is made in accordance with any organisational documented policy. The key here is to ensure that staff involved in the patient's care are aware that permission to view has already been asked and understand if the patient has granted or declined permission. This avoids patients being asked unnecessarily to provide their permission again, and ensures that those patients who have declined permission have their wishes upheld.
- In recording permission to view, it is also important to be mindful that a patient has a right to seek and receive confirmation of this in their record at any time.

5**Permission to view does not apply where the patient is unable to give permission and care professionals act in the patient's best interests**

- If the patient is not able to provide their permission to view then care professionals, for the purposes of direct care, should act in the patient's best interest and use the option to override permission (called 'emergency access'¹). Organisations are encouraged to use existing procedures where applicable and care professionals should continue to follow their professional guidance. Examples of when this option may be deemed appropriate are:
 - For patients who lack the capacity to provide permission (e.g. patients with dementia and those unconscious or confused)
 - For patients with communication difficulties and where reasonable efforts have been made to overcome these
 - For children when permission cannot be sought from a parent/guardian
- If an individual has Lasting Power of Attorney for health and welfare for the patient then their permission to view the record should be sought.
- The decision as to which staff should be granted the ability to use the 'emergency access' option and view the SCR without permission should be taken at an organisation level based on the need of specific care settings. Organisations may decide to only provide this to registered care professionals accountable to their professional bodies.
- When permission to view is overridden an alert will be generated. Organisations should have a privacy officer/s responsible for regularly viewing and managing these alerts.
- When permission to view is overridden it must be accompanied by supporting information which will be visible to the privacy officer managing alerts and can support the organisation should there be a challenge from a patient. Depending on the system used to view SCRs the supporting information may be system generated, a multiple choice selection, or a free text description.
- If appropriate, good practice would be to inform the patient about the decision to access the SCR whilst they lacked capacity if they have regained the capacity to understand. If capacity is not regained good practice would be to inform the next of kin or a carer.
- The ability to override permission for legal reasons (public interest, statute and court order) should only be granted to appropriate staff by those organisations viewing SCRs. These will be very rare occurrences and advice should always be sought from a Caldicott Guardian or information governance lead. Patients should be informed unless organisations are instructed not to by a court of law or equivalent authority.

¹ HSCIC are currently considering whether 'emergency access' is the most appropriate terminology. Appropriate expert and user input will be sought before any decision is taken to change the terminology.

3 Scenarios

The scenarios below are designed to demonstrate how the guidelines could be implemented in practice across different care settings and circumstances.

1. As part of SCR implementation a hospital trust implements a process that will allow permission to view to be captured by the care professional who first needs to view the record. This permission will be for the duration of the patient's stay in hospital and be applicable to all care professionals with access to view SCR involved in the patient's care for that duration. This scope is explained to patients by the care professional at the point where SCR access is first required – making the patient aware that permission is not just for the individual asking on that single occasion. Once the question has been asked, and in line with local hospital policy, the patient's notes are annotated so the patient's response is clear to all staff and the permission to view question does not need to be repeated. This allows other care professionals who require access to proceed past the permission to view dialogue screen on the system they use without asking the patient again.
2. NHS 111 and GP Out of Hours service providers work together in a local area and agree an approach where NHS 111 call handlers will capture permission to view for all patients who contact the 111 service. As the providers all use systems that can communicate electronically with each other the permission to view will be recorded and transferred if the patient needs the involvement of GP Out of Hours following their 111 call. This avoids the question being repeatedly asked and ensures that clinicians in any of the services involved in the patient's care can view the SCR prior to visiting or re-contacting the patient. Recognising the time pressures for NHS 111 call handlers, the explanation to patients is kept straightforward with patients asked if they are happy that the clinicians involved in their care have access to important information from their GP record.
3. A community pharmacy implements SCR and determines that for regular patients who may benefit from frequent SCR access permission to view will be asked once for the duration of the time they are under the pharmacy's care. The pharmacy start to have conversations with their regular patients, explaining that access to the SCR is for the registered professionals working in the pharmacy. The patient is offered the opportunity not to be repeatedly asked for their permission to view while they are under the care of pharmacy, but that they can change this decision at any time. The pharmacy staff put a note referring to the discussion and what was agreed in their Patient Medication Record (PMR) system. The Pharmacy implements a process to review the decision with the patient every 6-12 months.
4. An NHS Walk in Centre implements SCR and adopts a simple approach with the clinicians asking patients if they are happy to allow them access to view their SCR during the consultation.
5. A hospital trust wishes to implement SCR viewing to support pre-operative assessment clinics. To maximise the benefits of SCR viewing they want care professionals to have access prior to the patient attending their appointment. To facilitate this they include the following information in pre-operative assessment clinic letters: *'Prior to your appointment your NHS Summary Care Record (SCR) will be available to view by the hospital staff involved in your care, unless you have previously opted out of having an SCR. Your SCR contains important information from your GP record including*

medications, allergies and any bad reactions to medicines. If you do not want our staff to access your SCR please contact XX on XX at least XX before your appointment date. For any patients that contact the hospital and notify staff that they do not wish for their SCR to be viewed a note is prominently recorded on the hospital system and relevant paper records to ensure this request is fulfilled.

6. A community provider is implementing SCR viewing for a district nursing team. They agree on an approach to seek permission to view for the district nursing team for the duration of the time the patient remains under their care. As patients are added to the caseload permission is sought either over the phone prior to the first visit or during the first visit. It is explained to the patient that this will allow other nurses as part of the wider team to also have access but only if they are involved in the patient's care. A note is made on the clinical system to make other nurses aware if permission to view has been declined, or if granted to make clear the scope of the permission in terms of the duration.