GP Summary Requirements

Document Management

Revision History

|  |  |  |
| --- | --- | --- |
| Version | Date | Summary of Changes |
| 1.6 (Approved) | 22/02/2011 | Major release for CCN.099. |
| 2.0 (Approved) | 20/12/2011 | See embedded Change History document below. |
| 3.0 (Approved) | 24/04/2013 | See embedded Change History document below.Approved for release. |



Reviewers

This document must be reviewed by the following people:

|  |  |  |  |
| --- | --- | --- | --- |
| Reviewer name | Title / Responsibility | Date | Version |
| James Spirit | SCR Senior Project Manager |  | 2.1b |
| Ashley Raines | SCR Release Manager |  | 2.1b |
| Peter Short | SCR Clinical Lead |  | 2.1b |
| Leo Fogarty | SCR Clinical Lead |  | 2.1b |
| Rob Jeeves | SCR Clinical Lead |  | 2.1b |
| Emyr Jones | SCR Clinical Lead |  | 2.1b |
| Adrian Richardson | SCR Clinical Lead |  | 2.1b |
| Andy Carr | SCR Clinical Lead |  | 2.1b |

Approved by

This document must be approved by the following people:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Signature | Title | Date  | Version |
| James Spirit | James Spirit | SCR Senior Project Manager | 24/04/2013 | 3.0 |

Glossary of Terms

|  |  |
| --- | --- |
| Term / Abbreviation | What it stands for |
| Summary Care Record | The Summary Care Record is an electronic record which will provide healthcare staff working in urgent and emergency care settings with faster, easier access to essential information about a patient. |
| GP Summary | The GP summary is a component of the Summary Care Record and aims to provide a summary of the information held in a patient's general practice record and make it available to staff treating patients in urgent and emergency care settings. |

Document Control:

The controlled copy of this document is maintained in the HSCIC corporate network. Any copies of this document held outside of that area, in whatever format (e.g. paper, email attachment), are considered to have passed out of control and should be checked for currency and validity.

Contents

SCR Viewing Requirements 4

1.0 Introduction 4

1.1 Purpose 4

1.2 Requirements Types and Priorities 4

2.0 Overview 4

2.1 The Summary Care Record 4

2.2 The SCR Consent Preference 5

3.0 Requirements 5

3.1 Viewing Summary Care Records 5

CPR.077 SCR Viewing Switch 5

CPR.078 Check Whether Patient Has Viewable SCR Content 6

CPR.079 Check Whether Patient Has Additional Information 6

CPR.066 Indicate Whether a Patient Has SCR Content 7

CPR.047 Record Patient Details Before Viewing Their SCR 7

CPR.073 Only View GP Summaries with Status ‘Normal’ 7

CPR.060 Patients With Verified Demographic Details 7

CPR.057 Only GP Summary Content in SCRs 8

CPR.058 Display GP Summary For Multiple Presentation Text Versions 8

CPR.059 Importing Coded Information 8

CPR.070 Store Copy of SCR Content Locally 9

CPR.074 Store Cache of SCR Content Locally 9

CPR.076 Printing a Patient's SCR 10

3.2 Querying Summary Care Records 10

CPR.041 Querying a Patient's SCR 10

CPR.028 System-Initiated Queries 10

CPR.075 Refresh View of Patient's SCR 11

3.3 Permission to View Process 11

CPR.064 Principles for Implementing Permission to View 11

CPR.063 Viewing a Patient’s SCR (Permission Not Required) 11

CPR.068 Viewing a Patient's SCR (Ask Every Time) 12

CPR.067 Applicability of Permission to View 13

CPR.069 Duration of Permission to View 13

CPR.036 Viewing a Patient's SCR - Emergency Access 14

CPR.037 Viewing a Patient's SCR - Legal Access 14

CPR.050 Viewing a Patient's SCR (Has Opted Out) 14

CPR.051 Viewing a Patient's SCR (Don’t Ask) 15

CPR.072 Don’t Ask Again for this Organisation 15

3.4 Management of Permission to View 15

CPR.065 Permission to View History 15

CPR.056 Report on SCR Accesses 16

CPR.071 Report on Outcomes of Alert Investigations 17

3.5 Handling Error Situations 17

CPR.055 Malformed Clinical Documents 17

CPR.052 Acting on PSIS Error and Response Codes 18

CPR.053 System Should Not Keep Users Waiting 18

CPR.054 User Interaction in Error Situations 18

3.6 Information Governance and Spine Compliance 18

CPR.062 Self-Claim and Self-Referral Legitimate Relationships 18

CPR.024 Consent Alert Types 19

CPR.043 Alerts for Privacy Officers When Viewing 19

CPR.042 Alerts for Privacy Officers When Querying 20

CPR.011 Stop Using the PDS Consent to Share Flag for SCR 20

CPR.048 Only GP Summary Systems Update ACS 20

CPR.014 Smartcard Authentication 20

CPR.015 Recording Information on Local System for Audit Purposes 20

CPR.016 Role Based Access Control 21

4.0 Process Flows 21

4.1 Viewing a Patient's SCR 21

### 1.0 Introduction

#### 1.1 Purpose

This document contains business requirements for viewing Summary Care Records (SCRs), and applies to all suppliers who are including functionality in their products for **viewing** Summary Care Records. This includes GP system suppliers who are including functionality in their products for viewing the Summary Care Records of non-GMS registered patients, and/or will be supporting other care settings such as Walk-In Centres and Out of Hours.

#### 1.2 Requirements Types and Priorities

Requirements are one of three types; Functional, Non-Functional, or a Business Rule.

Each requirement has a priority, which is stated using the keywords MUST, MAY, and SHOULD as described in RFC2119:

- MUST: This word, or the terms "REQUIRED" or "SHALL", means that the definition is an absolute requirement of the specification.

- SHOULD: This word, or the adjective "RECOMMENDED", means that there may exist valid reasons in particular circumstances to ignore a particular item, but the full implications must be understood and carefully weighed before choosing a different course.

- MAY: This word, or the adjective "OPTIONAL", mean that an item is truly optional.  One implementer may choose to include the item because a particular implementation requires it or because the implementer feels that it enhances the implementation while another implementer may omit the same item.  An implementation which does not include a particular option MUST be prepared to interoperate with another implementation which does include the option, though perhaps with reduced functionality.  In the same vein an implementation which does include a particular option MUST be prepared to interoperate with another implementation which does not include the option (except, of course, for the feature the option provides.

### 2.0 Overview

#### 2.1 The Summary Care Record

The Summary Care Record is an electronic record which will give healthcare staff working in urgent and emergency care settings faster, easier access to essential information about a patient.

#### 2.2 The SCR Consent Preference

A patient's SCR Consent Preference can only be recorded by the GP practice at which the patient is fully GMS registered, or by using the SCR Application.

For patients wishing to express an SCR Consent Preference, each patient is given the following choice: *"Do you want to have a Summary Care Record?".* The patient's answer is recorded against the patient on ACS on the Spine. The two phrases and corresponding ACS values for the SCR Consent Preference are:

**1.** *"The patient does not have a Summary Care Record (has opted out)"* - Has an ACS value of *"No"*.

**2.** *"The patient must be asked every time for permission to view their Summary Care Record"* - Value is unset on ACS.

Historically, there was a third SCR Consent Preference phrase and corresponding ACS value, which is no longer available. However, there may be instances where a patient has been set to this value, and systems therefore need to be able to handle this value by not asking the user if they have the patient's permission to view their SCR, and allowing the user to go straight into the patient's SCR and view it. The value is:

**3.** *"The Patient need not be asked for permission to view their Summary Care Record"* - Has an ACS value of *"Yes"*.

The only record affected by a patient's SCR Consent Preference is the patient's SCR; other national and local records for the patient being introduced as part of NHS Connecting for Health are unaffected.

Throughout this requirements document, the term "SCR Consent Preference" is solely referring to the SCR consent value stored on ACS on the Spine. For clarity, "SCR Consent Preference code" and "SCR Consent code", although terms not used in this document, are referring to local codes stored on systems which send GP summaries to patient SCRs on the Spine.

### 3.0 Requirements

#### 3.1 Viewing Summary Care Records

##### CPR.077 SCR Viewing Switch

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

The system MUST use a per-organisation software configuration setting acting as an SCR viewing switch which can be set to "ON" or "OFF", which controls whether organisations can view the SCRs of patients.

"Per-organisation" MUST be sufficiently low-level to allow switching of SCR viewing at individual GP practices, hospitals, clinics, etc.

The system MUST only allow the SCR viewing switch to be set to "ON" or "OFF" by system administrators with appropriate permissions.

When the system is installed, the switch MUST be set to "ON".

For systems which send GP summaries, the SCR viewing switch MUST be independent of the GP summary switch (see GPS.221 in the GP Summary Requirements, which is part of the GP Summary Sending baseline).

##### CPR.078 Check Whether Patient Has Viewable SCR Content

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

(This requirement is called upon by other requirements when needed)

To check whether viewable SCR content exists for a patient, the system MUST perform the following steps, in order:

1. If the patient's SCR Consent Preference on ACS is:

*- "The patient does not have a Summary Care Record (has opted out)"*

then the patient does not have an SCR and therefore **there is no viewable content.**

2. If the patient's SCR Consent Preference on ACS is:

*- "The patient must be asked every time for permission to view their Summary Care Record", or*

*- "The Patient need not be asked for permission to view their Summary Care Record"*

and the patient's SCR contains a GP summary with the status *"normal"* which contains one of the four phrases below:

*- "Following discussion with a member of the practice staff this patient has chosen not to store their clinical information"*

*- "After discussions with a member of the practice staff this patient has chosen not to have a Summary Care Record"*

*- "Refused consent for upload to national shared electronic record"*

*- "Following discussion with a member of the practice staff this patient has chosen not to store their clinical information"*

then the patient does not have an SCR and therefore **there is no viewable content:**

3. If the patient's SCR contains a GP summary with the status *"normal"* which does not contain one of the four phrases above, then the patient has an SCR and **there is viewable content.**

##### CPR.079 Check Whether Patient Has Additional Information

Requirement Type: «Functional» Requirement

Requirement Priority: MAY

**Description:**

(This requirement is called upon by other requirements when needed)

If the patient's latest GP summary with the status *"normal"* only contains the following CRE (Care Record Element) headings for core data items:

   - Allergies and Adverse Reactions

   - Acute Medications

   - Current Repeat Medications

   - Discontinued Repeat Medications

then the patient does not have any non-core data items (i.e. additional information) in their GP summary.

If the patient's latest GP summary with the status *"normal"* contains CRE headings in addition to those listed above for core data items, then the patient has non-core data items (i.e. additional information) in their GP summary.

##### CPR.066 Indicate Whether a Patient Has SCR Content

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

The system MUST indicate to the user whether there is viewable clinical information in the patient's SCR (see CPR.078).

This indication MUST be visible to users on all SCR-related screens, and on any patient confirmation screens following a PDS trace.

The indication SHOULD also be visible to users immediately upon opening a local patient record.

The indication MAY also be visible on non-SCR related screens such as clinic patient list screens, appointment list screens, and patient case summary screens.

This indication MUST only be visible to users whose current smartcard role allows them to view SCRs and/or ask for a patient's permission to view their SCR.

##### CPR.047 Record Patient Details Before Viewing Their SCR

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

The system MUST provide functionality to view a patient's SCR, but only for patients whose details are recorded on the system. As a minimum, the following details SHOULD be recorded on the system: NHS number, Surname, Gender, Date of Birth, and either Forename or Postcode.

##### CPR.073 Only View GP Summaries with Status ‘Normal’

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

The system MUST only allow users to view initial GP summaries and GP summary updates which have a status of 'normal'.

If a patient has multiple 'normal' GP summaries, then the system MUST display a list to the user and allow the user to choose which one to view.

**Note:** It is not possible to view a patient's latest GP summary if it has a status of "replaced" or "withdrawn", or if it has a DQ (Data Quality) status of "DQ Nullified". PSIS will not return these GP summaries.

##### CPR.060 Patients With Verified Demographic Details

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

Before viewing a patient's SCR, the system MUST check the patient's identity by verifying the patient's demographic details held on the local system with the patient's demographic details held on the Personal Demographics Service (PDS) by checking that one of the following rules applies:

Either:

- The locally-held Serial Change Number (SCN) matches the SCN on PDS.

Or:

- There is an exact match of all of the following: NHS Number, Surname, Gender, Date of Birth, and Date of Death, and an exact match of at least one of: Forename or Postcode. This is irrespective of any locally-held SCN values.

If a patient fails this check, then the user MUST have the opportunity to resolve the patient's demographic record as described in the PDS Foundation Module. Once the patient passes this check, the patient's SCR can be viewed.

##### CPR.057 Only GP Summary Content in SCRs

Requirement Type: «Functional» Requirement

Requirement Priority: SHOULD

**Description:**

The system SHOULD only be able to view the GP summary content of a patient's SCR, i.e. CSMP documents (GP summary messages). The system SHOULD query PSIS for all documents and post-process the results from PSIS to exclude non-GP Summary Content.

##### CPR.058 Display GP Summary For Multiple Presentation Text Versions

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

The system MUST correctly display the presentation text from GP summaries created with multiple versions of the GP Summary Presentation Text Specification and the Source to Target Map that are listed in the baseline document.

The system MUST adhere to the formatting stated in the multiple versions of the GP Summary Presentation Text Specification and the Source to Target Map that are listed in the baseline document.

Due to differences in implementation of the multiple versions of the GP Summary Presentation Text Specification and the Source to Target Map by different GP system suppliers, the system MUST be able to correctly display initial GP summaries and GP summary updates generated by the systems of each GP system supplier. Example GP summaries for each GP system supplier will be provided by NHS CFH for this purpose.

**Note:** The GP Summary Presentation Text Specification determines the structure of the presentation text portion of the GP summary by a GP system. It is also part of the GP Summary Sending Baseline and was previously called the Source to Target Map.

##### CPR.059 Importing Coded Information

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

The system MUST not automatically import coded information from a patient's SCR (for example: the coded element of a GP summary update message) into the patient's local record, except by agreement with the SCR Programme.

The system MAY import coded information from a patient's SCR into the patient's local record if the coded information is presented to the user and approved for importing by the user.

All imported coded information MUST retain its original date and time, and not be given the date and time that the import took place.

##### CPR.070 Store Copy of SCR Content Locally

Requirement Type: «Functional» Requirement

Requirement Priority: SHOULD

**Description:**

The system SHOULD provide functionality for users to take a copy of the patient's SCR content that they are currently viewing (for example: the presentation text element of a GP summary update message) and store it as part of the patient's local clinical record.

Any SCR content stored as part of a patient's local clinical record MUST be labelled with the following text: *"Imported from the patient's Summary Care Record HH:MM DD/MM/YYYY"*.

Any SCR content stored as part of a patient's local clinical record MUST retain the original document title, creation date/time stamp (effectiveTime), author, author's organisation, and author's role, and MUST make this information available to users.

Once SCR content is stored as part of a patient's local clinical record, the system MUST manage that information as being local information from that point onwards.

When a patient changes their SCR Consent Preference to *"The patient does not have a Summary Care Record (has opted out)",* the system MUST not delete any of the patient's SCR content that has been stored as part of the patient's local clinical record.

##### CPR.074 Store Cache of SCR Content Locally

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

If the system stores a cache of a patient's SCR locally for technical reasons (for example: to minimise the retrieval of data from the Spine), then the system MUST ensure that the cache is kept up to date by querying the patient's SCR on the Spine to check for any changes at the same points it would have queried the patient's SCR had it not been storing a cache.

The system does not need to retrieve any clinical information from a patient's SCR on the Spine that is cached locally if it has not changed since it was cached.

When a patient whose SCR on the Spine is cached locally changes their SCR Consent Preference to *"The patient does not have a Summary Care Record (has opted out)",* the system MUST delete the cache of the patient's SCR.

##### CPR.076 Printing a Patient's SCR

Requirement Type: «Functional» Requirement

Requirement Priority: MAY

**Description:**

The system MAY provide functionality for a user to print a patient's SCR.

The print functionality MUST allow users to:

- Print a patient's whole SCR.

- Print part of a patient's SCR only. For example: A user only wants to print a patient's GP summary.

- Print a preview of information that the system is about to send to a patient's SCR.

On all of the above, the system MUST ensure that the patient's full name and NHS number appear on each page.

#### 3.2 Querying Summary Care Records

##### CPR.041 Querying a Patient's SCR

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

The system MUST always check a patient's SCR Consent Preference on ACS on the Spine before viewing a patient's SCR.

For a patient whose SCR Consent Preference is:

*- "The patient does not have a Summary Care Record (has opted out)"*

the system MUST not view the patient's SCR.

For a patient whose SCR Consent Preference is:

*- "The patient must be asked every time for permission to view their Summary Care Record", or*

*- "The Patient need not be asked for permission to view their Summary Care Record"*

the system MUST view the patient's SCR.

If the patient's SCR Consent Preference cannot be determined (ie. due to a network error, local system error, ACS offline, etc), then the system SHOULD still attempt to view the patient's SCR and handle any errors. The system MUST assume that the patient needs to be asked for their permission to view their SCR.

##### CPR.028 System-Initiated Queries

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

For system-initiated queries for viewing where the user is not going to be shown any SCR content for a patient, then for patients whose SCR Consent Preference is *"The patient must be asked every time for permission to view their Summary Care Record*", the system MUST query PSIS in the background without users going through the permission to view process (see CPR.068).

If at any point the system needs to show any SCR content from the system-initiated query to the user, and the user currently does not have valid permission to view (or other outcome such as using one of the legal or clinical override reasons), then the system MUST go through the permission to view process (see CPR.068).

##### CPR.075 Refresh View of Patient's SCR

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

When the system is showing SCR content to a user, the system MUST display the following text: *"Last refreshed HH:MM DD/MM/YYYY"* and MUST provide functionality for the user to choose to refresh the content.

#### 3.3 Permission to View Process

If a patient's SCR Consent Preference is *"The patient must be asked every time for permission to view their Summary Care Record"*, then in normal circumstances the patient must be asked every time for permission to view their SCR. However, in certain circumstances the patient's SCR can be viewed without the patient's permission. These circumstances are:

Clinical reasons:

- Emergency Access (e.g. patient unconscious or confused).

Legal reasons:

- Access made in the public interest.

- Access required by statute, including subject access requests made under the Data Protection Act 1998.

- Access required by Court Order.

##### CPR.064 Principles for Implementing Permission to View

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

In addition to the requirements stated in this document, the system implementation of the permission to view process MUST adhere to the document "NPFIT-SCR-SCRDOCS- 0003.01 Principles for Implementing Permission to View for the Summary Care Record to support the diversity of care settings in the NHS v2.0 (Approved)".

##### CPR.063 Viewing a Patient’s SCR (Permission Not Required)

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

If a user chooses to view the SCR of a patient whose SCR Consent Preference is *"The patient must be asked every time for permission to view their Summary Care Record"*, then the patient's permission to view their SCR is not required if one of the following applies, and the system MUST allow the user to view the patient's SCR without going through the permission to view process in CPR.068:

- The user is attempting to view the patient's SCR from within the organisation at which the patient is fully GMS registered (i.e. the user's organisation code in their current role matches the patient's GP Practice Code on PDS).

- The user (or another user on the user's behalf) has already been through the permission to view process for the patient, and the permission to view that was obtained still persists (see CPR.069).

##### CPR.068 Viewing a Patient's SCR (Ask Every Time)

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

If a user chooses to view the SCR of a patient whose SCR Consent Preference is *"The patient must be asked every time for permission to view their Summary Care Record"* and none of the conditions in CPR.063 apply, then the patient's permission is required to view their SCR and the system MUST follow this permission to view process. There are no restrictions on how many times a user can go through the permission to view process for a given patient, regardless of previous outcomes. The permission to view process is as follows:

- If there is not any viewable SCR content for the patient as defined in CPR.078, then the system MUST inform the user that *"This patient does not currently have a Summary Care Record"*.

- If there is viewable SCR content for the patient as defined in CPR.078, then the system MUST display to the user *"Has this patient given permission to view their Summary Care Record?"* and "*The usual legal, ethical and professional obligations apply when accessing a patient's clinical record".*

*-* The system MUST make available to the user whichever of the following four options and sub-options the user has the correct RBAC activities for in their current role, and MUST not make available any of the following options or sub-options for which the user does not have the correct RBAC activity in their current role:

**1. Yes (View Record)**

        **Obtain permission for:**

**1a. Yourself only**

**1b. Your workgroup or team**

**2. No (Access Refused)**

**3. Emergency Access**

**4. Access for Legal Reasons**

For all options, the system MUST allow the user to record optional additional information as free-text.

Options **1a** and **1b** MUST only be available to users whose current smartcard role belongs to a workgroup or team. If the user is a member of more than one workgroup or team, then permission to view MAY apply to all workgroups if option **1b** is selected.

Choosing option **1**, **1a** or **1b** MUST take the user straight to the patient's SCR, unless the user does not have the correct RBAC role to view SCRs (for example: Admin staff obtaining permission to view on behalf of clinicians in their workgroup or team), in which case, choosing option **1**, **1a** or **1b** MUST take the user back to the screen they came from prior to choosing to view the patient's SCR.

Choosing option **2** MUST take the user back to the screen they came from prior to choosing to view the patient's SCR.

For options **3** and **4**, refer toCPR.036 and CPR.037 respectively.

Suppliers MAY include additional options to the four options above to accommodate additional clinical or organisational needs for their users. For example: A **"Patient not asked"** option for call handlers, or a **"Don't Ask Again for this Organisation"** option (see CPR.072).

##### CPR.067 Applicability of Permission to View

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

If the outcome of the permission to view process in CPR.068 is **Yes (View Record)**, then the permission to view MUST apply to one of the following:

- The individual user only, and in the user's current smartcard role only. This is option **1a** in CPR.068. If another user, or the same user in a different smartcard role, wishes to view the patient's SCR, then the permission to view process in CPR.068 MUST still be followed.

- The individual user and all other users in the user's workgroup or team in the user's current smartcard role. This is option **1b** in CPR.068.

If the outcome of the permission to view process in CPR.068 is **Emergency Access** or **Access for Legal Reasons** then the permission to view applies only to the individual user, and only in their current smartcard role. If another user, or the same user in a different smartcard role, wishes to view the patient's SCR, then the permission to view process in CPR.068 MUST still be followed.

**Note:** It is required that the option(s) available in the system and chosen by the user for applicability will reflect the questions that will be asked of the patient in the particular care setting. For example: "Is it okay if myself and my colleagues can view your SCR for the duration of your stay in this hospital?", or "Is it okay if I can view your SCR until the end of today?". See CPR.064.

##### CPR.069 Duration of Permission to View

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

If the outcome of the permission to view process in CPR.068 is **Yes (View Record)**, then the permission to view MUST last for one or more of the following:

- For the remainder of the current episode of patient care.

- For a fixed duration (such as 24 hours, a week, etc.)

- For a duration specified by the user (from a list of pre-determined periods).

- For the remainder of the user's current login session.

- Until the patient's record is closed on the local system.

- Indefinitely for the organisation (see CPR.072).

- Some other duration, in agreement with the NHS CFH SCR Team.

If the outcome of the permission to view process in CPR.068 is **Emergency Access** or **Access for Legal Reasons**, then the permission to view override MUST last for one or more of the following:

- For the remainder of the user's current login session.

- Until the patient's record is closed on the local system.

- Some other duration, in agreement with the NHS CFH SCR Team.

**Note 1:** Suppliers should choose the one or more duration options which best suit the care setting that their system is used in, and in consultation with organisations and their users. For suppliers whose products are used in multiple care settings, a different set of options may be used for each care setting.

**Note 2:** It is required that the option(s) available in the system and chosen by the user for duration will reflect the questions that will be asked of the patient in the particular care setting. For example: "Is it okay if myself and my colleagues can view your SCR for the duration of your stay in this hospital?", or "Is it okay if I can view your SCR until the end of today?".

##### CPR.036 Viewing a Patient's SCR - Emergency Access

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

Following on from CPR.068:

If the user chooses **3. Emergency Access**, then the system MUST display to the user *"You may access this patient's record in the best interests of the patient if they are not able to give permission themselves, e.g. the patient is unconscious or confused. This action will be audited by the system and an alert will be sent to your privacy officer for monitoring purposes. Any breaches of patient confidentiality will be investigated and may be a matter for disciplinary proceedings. If in doubt, speak to your manager or privacy officer"*.

The system MUST allow the user to either continue and view the patient's SCR, or cancel the permission to view process and return to the screen they came from prior to choosing to view the patient's SCR.

##### CPR.037 Viewing a Patient's SCR - Legal Access

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

Following on from CPR.068:

If the user chooses **4. Access for Legal Reasons**, then the system MUST display to the user *"In exceptional circumstances you may be justified in accessing this patient's record without their permission"* and *"Any inappropriate breach of patient confidentiality will be a matter for disciplinary and potentially legal and/or professional proceedings. If in doubt speak to your manager or privacy officer"*.

The system MUST ask the user to select one of three legal reasons for viewing the patient's SCR without the patient's permission (the reason selected is used in *"CPR.043 Alerts for Privacy Officers When Viewing)*:

        **Access made in the public interest**

        **Access required by statute**

        **Access required by court order.**

The system MUST allow the user to either continue and view the patient's SCR, or cancel the permission to view process and return to the screen they came from prior to choosing to view the patient's SCR.

##### CPR.050 Viewing a Patient's SCR (Has Opted Out)

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

It is not possible to override a patient's SCR Consent Preference of *"The patient does not have a Summary Care Record (has opted out)"* and view their SCR. The system MUST not attempt to do so. This is enforced by the Spine, and attempting to view the patient's SCR would result in an error being returned from PSIS.

The system MUST display to the user *"The patient has opted out of having a Summary Care Record, therefore there is no Summary Care Record to display for this patient"***.**

##### CPR.051 Viewing a Patient's SCR (Don’t Ask)

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

If a user chooses to view the SCR of a patient whose SCR Consent Preference is *"The Patient need not be asked for permission to view their Summary Care Record",* then the system MUST allow the user to view the patient's SCR without going through the steps in CPR.068.

##### CPR.072 Don’t Ask Again for this Organisation

Requirement Type: «Functional» Requirement

Requirement Priority: MAY

**Description:**

In the permission to view process in CPR.068, when a user chooses "**1. Yes (View Record)"** the system MAY provide users with a sub-option of **"Don't Ask Again for this Organisation"**, to record that a patient doesn't want to be asked every time for permission to view their SCR by the organisation that the user's current smartcard role belongs to.

If the system provides this sub-option, then the system MUST apply the following rules:

- For patients whose SCR Consent Preference on ACS on the Spine is *"The patient must be asked every time for permission to view their Summary Care Record"*, this is over-ridden by **"Don't Ask Again for this Organisation"** recorded in the patient's local record.

- For patients whose SCR Consent Preference on ACS on the Spine is *"The patient does not have a Summary Care Record (has opted out)"*, this is not over-ridden by **"Don't Ask Again for this Organisation"** recorded in the patient's local record.

If a user chooses to view the SCR of a patient whose SCR Consent Preference is *"The patient must be asked every time for permission to view their Summary Care Record"* and who has **"Don't Ask Again for this Organisation"** recorded in their local patient record, then the system MUST allow the user to view the patient's SCR without going through the steps in CPR.068.

The system MUST provide functionality to remove **"Don't Ask Again for this Organisation"** from a patient's local record.

#### 3.4 Management of Permission to View

##### CPR.065 Permission to View History

Requirement Type: «Functional» Requirement

Requirement Priority: SHOULD

**Description:**

The system SHOULD make a patient's permission to view history easily accessible to users, including during the permission to view process in CPR.068, but MUST only display the data for the organisation that the user's current smartcard role belongs to. The period for which the history is viewed each time MUST be user configurable.

The history MUST show: Date and Time, Outcome ("Permission Given", "Permission Refused", "Emergency Access", or "Legal Access"), User, Organisation, Expiry Date and Time, and Notes (ie. any optional information that was entered as free text). The history MUST make it clear to the user that they are only viewing the patient's permission to view history for the organisation that the user belongs to in their current smartcard role. The history MUST be sorted in reverse chronological order.

For "Legal Access", the history MUST also show the type of legal access: "Access made in the public interest", "Access required by statute", and "Access required by Court Order".

##### CPR.056 Report on SCR Accesses

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

The system MUST provide the following report to system administrators with appropriate permissions, which can be run by system administrators on an ad-hoc basis, and MUST provide functionality for exporting the report to a spreadsheet:

Users MUST have the ability to specify the following parameters:

**- Date and Time Period** (mandatory): The date and time period to be reported on.

**- NHS Number** (optional): The NHS number of the patient for whom accesses to their SCR need to reported. Will otherwise report on all NHS numbers.

**- Organisation** (mandatory if NHS number not specified, otherwise optional): The code and name of the organisation to be reported on. Will otherwise report on all organisations

**- User** (optional): The UID and name of the user to be reported on. Will otherwise report on all users.

The output of the report MUST contain one line per access to each NHS number. Each line MUST include the columns detailed below. It MUST be possible to sort the report by any of the columns.

**- Organisation:** The code and name of the organisation that the user who accessed the patient's SCR belongs to.

**- User's Name:** The name of the user who accessed the patient's SCR.

**- User UID:** The unique identifier of the user who accessed the patient's SCR.

**- Date and Time:** The date and time that the patient's SCR was accessed.

- **Additional Information:** Any optional additional information recorded as free-text by the user.

**- Outcome:** The outcome of the permission to view process for each access. Will either be:

        **"Yes (View Record)"**

**"No (Access Refused)"**

**"Emergency Access"**

**"Access for Legal Reasons - Access made in the public interest"**

**"Access for Legal Reasons - Access required by statute"**

**"Access for Legal Reasons - Access required by court order"**

        Any other options added by suppliers to accommodate specific clinical scenarios (see CPR.068).

        **Has Opted Out** (i.e. patient's SCR Consent Preference is *"The patient does not have a Summary Care Record (has opted out)"*)

        **Don't Ask** (i.e. patient's SCR Consent Preference is *"The Patient need not be asked for permission to view their Summary Care Record"*)

      **Don't Ask Again for this Organisation** (only if implemented by the system, see CPR.072)

For the specified parameters, the reports MUST also contain:

- The total number of SCR accesses.

- Totals for each of the PTV outcomes.

- The total number of patient records accessed locally for which SCRs exist for the patient but were not accessed by the user.

##### CPR.071 Report on Outcomes of Alert Investigations

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

For systems which implement local alerting only:

The system MUST provide the following report to system administrators with appropriate permissions, which can be run by system administrators on an ad-hoc basis, and MUST provide functionality for exporting the report to a spreadsheet:

Users should have the ability to specify the following parameters:

**- Alert Type** (optional): One or more of the following:

**- Emergency Access**

**- Access for Legal Reasons - Access made in the public interest**

**- Access for Legal Reasons - Access required by statute**

**- Access for Legal Reasons - Access required by court order**

**- Self-Claim LR - Best Interests of the Patient**

**- Self-Claim LR - Public Interest**

**- Self-Claim LR - Required by Statute**

**- Self-Claim LR - Court Order**

**- Date and Time Period** (mandatory): The date and time period to be reported on.

**- NHS Number** (optional): The NHS number of the patient for whom accesses to their SCR need to reported. Will otherwise report on all NHS numbers.

**- Organisation** (mandatory if NHS number not specified, otherwise optional): The code and name of the organisation to be reported on. Will otherwise report on all organisations

**- User** (optional): The UID and name of the user to be reported on. Will otherwise report on all users.

The output of the report must contain one line per alert investigation outcome. Each line must include the columns detailed below. It must be possible to sort the report by any of the columns.

**- Alert Type:** Will either be:

**- Emergency Access**

**- Access for Legal Reasons - Access made in the public interest**

**- Access for Legal Reasons - Access required by statute**

**- Access for Legal Reasons - Access required by court order**

**- Self-Claim LR - Best Interests of the Patient**

**- Self-Claim LR - Public Interest**

**- Self-Claim LR - Required by Statute**

**- Self-Claim LR - Court Order**

**- Organisation:** The code and name of the organisation that the user who triggered the alert belongs to.

**- User's Name:** The name of the user who triggered the alert.

**- User UID:** The unique identifier of the user who triggered the alert.

**- Date and Time:** The date and time that the alert was triggered.

- **Additional Information:** Any optional additional information recorded as free-text by the user who triggered the alert.

- **Investigation Outcome:** The outcome of the privacy officer's investigation into the alert.

#### 3.5 Handling Error Situations

##### CPR.055 Malformed Clinical Documents

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

If the system encounters a malformed clinical document on PSIS, the system MUST still render the clinical document.

If a clinical document is malformed to such an extent that it cannot be rendered, then the system MUST inform the user that *"The clinical document is corrupt and cannot be viewed".*

##### CPR.052 Acting on PSIS Error and Response Codes

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

The system MUST identify and act accordingly on PSIS error and response codes, as contained in the document NPFIT-FNT-TO-TIN-1228 "PSIS Compliance Specification Clinical Message Handling Addendum", which is part of the GP Summary Viewing Baseline.

##### CPR.053 System Should Not Keep Users Waiting

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

The system MUST not keep users waiting for responses from TMS or PSIS for unreasonable times. Where responses are delayed, suppliers MUST allow the user to continue using the system.

##### CPR.054 User Interaction in Error Situations

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

Unless explicitly stated otherwise in a requirement, the system MUST not prompt users with information or decisions relating to system or technical errors (For example: PSIS not being available, network failures, system time-outs, PSIS acknowledgements not received for previous messages, etc.). Such errors MUST be resolved by the system in the background without user interaction.

#### 3.6 Information Governance and Spine Compliance

##### CPR.062 Self-Claim and Self-Referral Legitimate Relationships

Requirement Type: «Display» Requirement

Requirement Priority: MUST

**Description:**

**Overview**

In most cases, a user viewing a patient's SCR will not be the same user that recorded the patient's details (see CPR.047) or retrieved the patient's details at the beginning of the episode of care, i.e. there is role separation. This is a self-referral LR.

In cases where the same user records the patient's details on the system or retrieves the patient's pre-existing details, and then views their SCR, there is no role separation. This is a self-claim LR.

**Requirement**

The system MUST support LRs through existing system behaviour, or by implementing Spine LRs.

The system MUST only view or update a patient's SCR if an LR exists between the user and the patient.

The system MUST allow users to create a self-claim LR if an LR does not already exist.

Self-claim LRs MUST be alerted, either using Spine Alerts or equivalent local system functionality. Alerts are not required for self-referral LRs:

If a user who does not already have an LR with a patient chooses **1**, **1a, 1b,** or **"3. Emergency Access"** in CPR.068, and there is no role separation, then a **self-claim LR** with a legitimate relationship justification of *"Best Interests of the Patient*" MUST be automatically created by the system.

If a user who does not already have an LR with a patient chooses **"4. Access for Legal Reasons"** in CPR.068, and there is no role separation, then a **self-claim LR** with a legitimate relationship justification of *"Public Interest"*, "*Required by Statute*", or "*Court Order*" MUST be automatically created by the system.

##### CPR.024 Consent Alert Types

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

The system MUST use the following Consent Alert Types:

CodeSystem: 2.16.840.1.113883.2.1.3.2.4.17.201

AlertType Code: 1

Display Name: **SCR access without permission**

**Note:** Applicable when the patient's SCR Consent Preference is *"The patient must be asked every time for permission to view their Summary Care Record".*

CodeSystem: 2.16.840.1.113883.2.1.3.2.4.17.201

AlertType Code: 1

Display Name: **Access for legal reason**

**Note:** Applicable when the patient's SCR Consent Preference is *"The patient must be asked every time for permission to view their Summary Care Record".*

**Note:** The same AlertType Code is sent for different display names to allow for future flexibility of introducing further AlertType codes.

##### CPR.043 Alerts for Privacy Officers When Viewing

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

For each duration (see CPR.069), the system MUST send one information governance alert to a Privacy Officer in the user's organisation for each unique user who views the patient's SCR without their permission (either Emergency Access or Access for Legal Reasons, see CPR.068).

##### CPR.042 Alerts for Privacy Officers When Querying

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

The system MUST not send an alert when the system is executing a system-initiated query of a patient's SCR (see CPR.028).

##### CPR.011 Stop Using the PDS Consent to Share Flag for SCR

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

The system MUST not use the Consent to Share flag in PDS on the Spine for the purpose of the SCR. This is not used for the SCR Consent Preference.

##### CPR.048 Only GP Summary Systems Update ACS

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

The system MUST not update a patient's SCR Consent Preference on ACS unless it is the system which sends GP summaries for the patient.

##### CPR.014 Smartcard Authentication

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

Users MUST be authenticated using the standard NHS smartcard and comply with Spine authentication requirements applicable to Smartcards (see Information Governance Requirements for ESP Systems or LSP systems, as appropriate) to view a patient's SCR.

##### CPR.015 Recording Information on Local System for Audit Purposes

Requirement Type: «Functional» Requirement

Requirement Priority: MUST

**Description:**

For audit purposes, the system MUST record all user and system initiated interactions with Spine services, in accordance with the IG v3 Foundation Module. The system MUST also record all local user and system initiated interactions with the local system that are related to SCR activity. For each interaction, the system MUST record the interaction type, date, time, user (if not system generated), organisation, patient(s), and any other parameters to the interaction.

The system MUST allow users to access SCR-related audit information (for example: Privacy Officers), and control access using RBAC.

##### CPR.016 Role Based Access Control

Requirement Type: «Non Funct...» Requirement

Requirement Priority: MUST

**Description:**

The system MUST use Role Based Access Control (RBAC) to control which Spine-authenticated users are able to view a patient's SCR (CPR.068).

Refer to NPFIT-SI-SIGOV-0073 Guidance on Implementing RBAC for PSIS and PDS.

### 4.0 Process Flows

#### 4.1 Viewing a Patient's SCR

