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# Summary Care Records Permission to View Guidelines

# Document management

## Revision History

Version	Date	Summary of Changes
0.1	21/09/2015	Initial draft created
0.2	25/09/2015	Incorporating comments from Libby Pink (HSCIC SCR South/London Delivery Lead).
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.
0.4	15/11/2015	Following suggestions and comments from Dr Emyr Wyn Jones (HSCIC SCR Clinical Ambassador)
0.5	20/11/2015	Incorporating suggestions and comments from Dr Alan Hassey (HSCIC IG Clinical Lead & Deputy Caldicott Guardian), Phil Walker (Information Governance Alliance) and further comments from Dr Emyr Wyn Jones (HSCIC SCR Clinical Ambassador)
0.6	07/01/2016	Minor changes prior to sending to SCR Programme Board for approval. Version 0.5 circulated to Joint GP IT Committee - no comments received.
1.0	05/02/2016	Feedback from a number of SCR Programme Board members and comments received from the Information Commissioners Office as part of final review and sign off.
1.1	19/11/2021	Incorporating feedback from Expert Advisory Committee regarding clarifying permission to view guidance for pre-operative assessment and reflecting accessibility needs. Incorporating feedback from RCGP Health Informatics Group regarding the management of patients waiting for call back from GP Out of Hours services.

## Reviewers

This document must be reviewed by the following people:

Reviewer name	Title / Responsibility	Date	Version
Robert Jordan	SCR Product Manager	19/11/2021	1.1
Dr Robert Jeeves	SCR Clinical Lead / Clinical Safety Officer	19/11/2021	1.1
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Name	Signature	Title	Date	Version
Jillian Sharples		SCR Product Owner	19/11/2021	1.1
Robert Marsh		Head of Live Services (ai)	19/11/2021	1.1

## Glossary of Terms

Term / Abbreviation	What it stands for
NHSD	NHS Digital
HSCIC	Health and Social Care Information Centre
PIP	Public Information Programme
SCR	Summary Care Record

### Document Control:

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# 1. Introduction

## 1.1. Purpose of Document

The purpose of this document is to provide guidelines for implementing the 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 SCRs should define the scope of the permission being sought i.e. who is being given permission and for how long.**

- Organisations viewing SCRs 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 SCRs) 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. NHS Digital 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 NHS Digital SCR website (<https://digital.nhs.uk/services/summary-care-records-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 settings 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 NHS Digital SCR website: <https://digital.nhs.uk/services/summary-care-records-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.
- Organisations should regularly review their patient care pathways and procedures, and are encouraged to consider the patient's journey and care from the patient's perspective. Organisations should work with their partners across organisational boundaries to identify the opportunities where patients can consistently and appropriately be asked for their permission to view. Where possible and relevant, patients should be asked for their permission to view early in their care pathway and this information should be passed from one organisation to the next (e.g. from a 111 provider to a GP Out of Hours organisation) to support care by the receiving organisation.

## 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'). 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.

- Organisations are reminded about Guidelines 1 and 3: Organisations should regularly review their patient care pathways and procedures, and are encouraged to consider the patient's journey and care from the patient's perspective. Organisations should work with their partners across organisational boundaries to identify the opportunities where patients can consistently and appropriately be asked for their permission to view. Where possible and relevant, patients should be asked for their permission to view early in their care pathway and this information should be passed from one organisation to the next (e.g. from a 111 provider to a GP Out of Hours organisation) to support care by the receiving organisation.
    - However, where this has not occurred, in the situation where a patient has reported an urgent medical need, clinicians are responsible for the triage of multiple patients and the patient is waiting prior to initiation of treatment by the service (such as GP Out of Hours services or NHS 111), then it is considered appropriate for clinicians managing triaging for these services to access the patient's SCR using the 'Emergency Access' function, to inform their clinical assessments and to support the prioritisation of treatment. It is important for organisations to maintain transparency when using SCR in this way. Where organisations have established standardised messages provided to patients who are waiting for assessment, then including information about how their organisation uses SCR in these messages should be considered. Where information is not provided to the patient in this way, patients should subsequently be informed that their SCR has been used to support their care. Organisations using SCR in this way are required to ensure that their communications are effective, reliable, accessible and make sure that all patients consistently understand what their SCR is, how the organisation will be using their SCR to support their care and the choices available to patients.
    - For pre-planned patient pathways such as those occurring in pre-operative assessment, organisations should plan to use the opportunities provided by earlier contacts with patients in their pathway to seek patient's permission to view for the whole episode of care. If this is not possible and care professionals need access to the patient's SCR prior to the patient attending their appointment, the organisation is required to ensure that their communications are effective, reliable and make sure that all patients consistently understand what their SCR is, how the organisation will be using their SCR to support their care and the choices available to patients. Patients need to be provided with sufficient information to make an informed choice and supported to make a choice. The communications need to deal effectively with patient's individual communication and language needs and meet the accessibility needs of patients. The communications need to clearly let patients know who to contact to decline to provide their permission to view, how to do this and patients need to be supported if they make this choice.
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### 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 the 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 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. An organisation wishes to implement SCR viewing to support patient care in pre-operative assessment clinics. To maximise the benefits, they want care professionals to have access to the patient's SCR prior to the patient attending their appointment.

The organisation is best placed to decide how to communicate with their patients, but they need to ensure that their communications are effective, reliable and make sure that patients consistently understand what their SCR is, how the organisation will be using their SCR to support their care and the choices available to patients.

The communications need to deal effectively with patient's individual communication and language needs and meet the accessibility needs of patients. The communications need to clearly let patients know who to contact to decline to provide their permission to view, how to do this and patients need to be supported if they make this choice.

To facilitate this, they include the following information in pre-operative assessment clinic communications as a part of their wider communications plan:

*'Prior to your appointment, your NHS Summary Care Record (SCR) will be available to view by the 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 current medications, allergies and details of any previous bad reactions to medicines that you have had in the past. Further information such as significant medical history (past and present) may also be included. If you do not want pre-operative assessment staff to access your SCR, please contact XX on XX at least XX before your appointment date.'*

*(This text is provided as an example from which organisations can develop their own tailored messages).*

For any patients that contact the organisation and notify staff that they do not wish for their SCR to be viewed, the organisation has in place robust processes to ensure that this information is shared with the relevant people, and the patient's request is consistently fulfilled.

The organisation is required to ensure that they have effectively communicated with all patients about this, provided them with sufficient information to make an informed choice, supported patients to make a choice and supported those who wish to decline to provide their permission to view.

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.

If organisations would like to seek further clarity on any of the above guidelines, please contact [enquiries@nhsdigital.nhs.uk](mailto:enquiries@nhsdigital.nhs.uk) for the attention of the Summary Care Record Team.