

FAQs Electronic Record Sharing – Summary Care Record (SCR) 2.1

Q. What is SCR?

A. The Summary Care Record is an electronic record of patient information, created from GP medical records. It can be seen and used by authorised staff in other areas of the health and care system involved directly in the patient's care. Unless they have specifically opted out, all patients have a core SCR, containing basic information.

Q. What is the difference between SCR and SCR 2.1?

A. SCR 2.1 allows for additional information to be added to the core SCR if the patient consents. Within LLR we have an agreed enhanced data set enabling the important elements of a care plan to be summarised clearly and concisely and uploaded to SCR. Patients who do not consent to having an SCR with additional information will retain their core SCR, unless they withdraw their consent.

Q. I keep hearing reference there are different layers of consent - what does that mean?

A. Core SCR is implied consent; SCR 2.1 is express consent and this is because we are sharing more information. Patients can opt in and out of sharing at any time.

Q. Who decides what additional information is included in an SCR?

A. The patient. They can choose to add any information to their SCR that they think will help improve their care. This can be of particular benefit to patients with detailed and complex health problems.

Q. Can they ask for information to be withheld?

A. Yes, they can ask that specific elements of their health record are marked as private and so not uploaded to SCR.

Q. Can patients opt out of having a Summary Care Record?

A. Yes. Patients can choose to opt out at any time, and they should let their GP practice know by filling in an opt-out form (PDF, 245.9kb) which can be downloaded here; <https://digital.nhs.uk/summary-care-records>

Q. What if they change their mind and want to opt in?

A. Patients can opt back in at any time should they change their mind. If so, they should speak with their GP.

Q. Can patients access their own Summary Care Record?

A. Yes. From April 2015 all GPs should give their patients online access to summary information in their records. However, patients wishing to view their own Summary Care Record need to speak with their GP. Patients are not able to access SCR online by themselves.

Q. Who can access or view SCR?

A. Only authorised healthcare professionals directly involved in a patient's care can access SCR. So this means that the person viewing SCR:

- needs to have an NHS Smartcard with a chip and passcode
- will only see the information they need to do their job
- will have their details recorded every time they look at a record

Q. Do healthcare professionals need to seek permission every time they want to view SCR?

A. Yes, the healthcare professional must seek the patient's permission if they need to look at SCR. The only exception is if a patient is unconscious or otherwise unable to communicate, the healthcare professional may decide to look at their record because doing so is in the patient's best interest. This access is recorded and checked by the Privacy Officer of the organisation to ensure it is appropriate.

Q. Will information from SCR be used for any purpose other than direct patient care? (i.e. anonymised for research purposes.)

A. No. As above, SCR will only be accessed by healthcare professionals directly involved in a patient's care.

Q. Is the Summary Care Record available outside of England?

A. No, SCR is currently only accessible in the NHS in England, and not in the other countries in the United Kingdom.

Q. Who is responsible for updating the SCR?

A. As the data source for the SCR is the patient's electronic GP record, the practice Data Controller is ultimately responsible. The content is maintained by the GP practice and updated automatically when it is changed in the GP record.

Q. Will other healthcare providers ever be able to update SCR directly?

A. No, not for the foreseeable future. Providers have SCR as a 'read only' view of the patient's electronic GP record. Information can only be added by the GP practice, via entry onto the GP

practice system. Where a medication has changed, this information should be shared with the patient's practice in order that they can update the GP record accordingly.

Q. Do practices have to duplicate demographic information, such as next of kin and carer details?

A. This depends on whether that information is already coded within the patient record; if it is, then it doesn't need to be added again unless the details have changed. But if the demographic details are not coded in the record, practices will have to duplicate the information for it to pull through to SCR.

Q. If a patient has an existing Care Plan will that information pull through to SCR?

A. For existing care plans created using earlier care planning templates, much of the existing care plan information will pull through to the Summary Care Record, but some codes are not in the Inclusion Dataset, and so will not be added. Please note that the care plan will only be shared if the patient has given **express consent** to have an SCR with additional information. We are developing a pre-care planning document to enable you see where there are gaps in each patient's electronic care plan and so identify what work needs to be carried out. Further information will follow in the next couple of weeks.

Summary Care Record v2.1 – Consent scenarios for GP practices

Background

Most patients in England have a core Summary Care Record (SCR) containing medications, allergies and bad reactions, unless they have expressly opted out.

With explicit consent patients can now enhance their SCR with additional information. This can be of particular benefit to patients with long-term health conditions.

To assist GP practice staff in gaining their patients' explicit consent, three scenarios are described below.

LLR GPs and Practices - Scenarios

Scenario 1 – The Holiday Season: Pam's daughter and family live some distance away and she is going to stay with them over summer. She is looking forward to this, but is concerned about becoming unwell while away.

She asks her GP for advice. He advises Pam to consent to enhancing her Summary Care Record with additional information about her diabetes and treatment history. That way if she were to fall ill, the clinicians treating her would be able to access this information immediately and look after her just as if she were being treated nearer home.

Pam consents to adding additional information to her SCR. The GP ticks the relevant box, and finishes by reminding Pam that she can withdraw her consent at any time.

Scenario 2 – The Carer: Tina is a part-time carer for her son Chet who has a learning disability. She books an appointment with Helen, the nurse practitioner. Helen recommends that Tina consent to an enhanced Summary Care Record (SCR) to include details of her caring responsibilities, as well as her own complex medical history. Helen advises Tina that she can opt out at any time.

If Tina were to fall ill and come under the care of urgent or emergency services, the clinicians treating her could be made aware of Chet's needs via SCR and have quicker access to detailed information about Tina's own health and treatment history. Helen gives Tina an information leaflet to take away and give to Chet so he can make an informed decision about his own Summary Care Record as well.

Scenario 3 – The Pharmacist: Guy has severe asthma. While Becky is dispensing his repeat medications, she notices that Guy hasn't given explicit consent for an enhanced Summary Care Record. Becky hands Guy a leaflet and explains the benefits of consenting.

She recommends that Guy speak with staff at his GP practice about adding additional information concerning his asthma to his summary care record. This would enable clinicians from urgent or emergency services who were treating Guy to quickly access details about his condition, should he fall seriously ill. Quicker access to this information can aid accurate diagnosis more quickly, leading to quicker treatment - whether during the day, at night or on the weekend.

Following this conversation Guy consented to an enhanced Summary Care Record, understanding that he could later change his mind at any time.