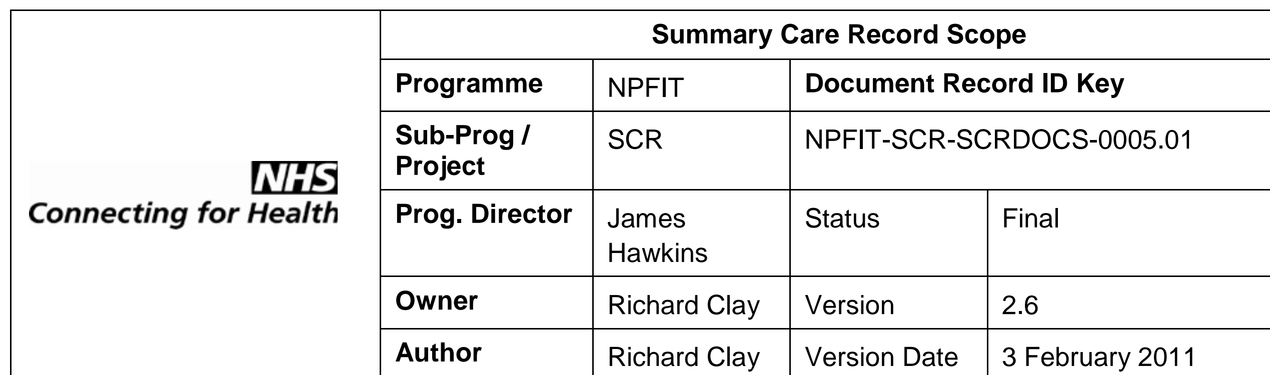

Summary Care Record Scope			
Programme	NPFIT	**Document Record ID Key**	
Sub-Prog / Project	SCR	NPFIT-SCR-SCRDOCS-0005.01	
Prog. Director	James Hawkins	Status	Final
Owner	Richard Clay	Version	2.6
Author	Richard Clay	Version Date	3 February 2011

Summary Care Record Scope

© Crown Copyright 2011

Contents

1 Introduction 3
1.1 Purpose 3
1.2 Definition of Scope 3
1.3 The Summary Care Record in England 3
2 Scope of the SCR 4
2.1 Content of the SCR 4
2.2 Use of the SCR 5
3 Summary Care Record Content Governance 7

© Crown Copyright 2011

1 Introduction

1.1 Purpose

The purpose of this document is to communicate a clear definition of the scope of the Summary Care Record (SCR). This document has been reviewed by the SCR Programme Board, the SCR National Clinical Reference Panel and the SCR Advisory Group which includes membership from NHS organisations, patient groups, British Medical Association, Royal College of GPs, Royal College of Nursing and College of Emergency Medicine.

The scope of the SCR needs to be clearly defined in order to avoid scope creep, which has the potential to lead to unexpected consequences, clinical safety issues or additional costs. It is also required to avoid the perception of scope creep arising from ambiguity and potential misunderstandings.

This document is not intended to provide a detailed view of how the SCR will be implemented or delivered, nor the benefits to be delivered, as this is covered by other more specific documents. It is intended to provide the reader with a clear understanding of the intended use and content of the Summary Care Record at a high level.

The intended audience of this document is for individuals and governance arrangements within organisations that have responsibility for the management and control of SCR usage.

1.2 Definition of Scope

In defining the scope of the SCR, there are two distinct components that should be considered: content and use:

Content: describes the information contained within the SCR and from where that information is derived.

Use or purpose: describes how, by whom and in what care settings the SCR is used.

1.3 The Summary Care Record in England

In October 2010, a review commissioned by the Minister of State for Health into aspects of the Summary Care Record concluded that in an advanced health care system it is reasonable for citizens to expect that when they arrive in an Accident and Emergency department or require treatment out of hours, clinicians have access to the essential medical information they need to support safe treatment and reduce the risk of inadvertent harm.

The SCR includes a defined set of key patient data for every patient in England except those who choose not to have one.

© Crown Copyright 2011

2 Scope of the SCR

2.1 Content of the SCR

The SCR is designed to provide a summary of clinical information which would be deemed useful in the event of urgent or emergency care for a patient, particularly when other sources of information may not be readily available. The over arching aim is that the SCR will contain only significant aspects of a person's care, those deemed to deliver benefit to a patient when receiving urgent and emergency care.

When a patient's SCR is first created it will contain details of:

- Medications;
- Adverse reactions; and,
- Allergies.

This will be copied to the Summary Care Record from the patient's GP record, under "informed implied consent".

Following this a patient and their doctor may wish to add additional information to the patient's Summary Care Record. This must only be added with the explicit consent of the patient.

Any additional information will be selected to allow a greater quality of care to be delivered to the patient by other clinicians who may access the patient's SCR whilst providing treatment in an urgent or emergency setting. A specific example of this additional information is the inclusion of End of Life Care Plans for patients undergoing palliative care.

An update will be sent to the SCR as information in a patient's General Practice record is changed, for example, as new medications are prescribed. Each update sent to the SCR is time and date stamped and replaces the information already held. The latest version of the patient's SCR is the only one available for staff giving care to the patient.

© Crown Copyright 2011

2.2 Use of the SCR

2.2.1 Care settings using the SCR

The Ministerial review into the content of the Summary Care Record, which reported in October 2010, concluded that the SCR is the minimal information required to support safe care in urgent and emergency situations.

Care settings that are most likely to treat patients in an urgent or emergency situation are as follows:

1. **General Practice Out of Hours and Primary Care Urgent Services**.
   For example:
   - GP Out of Hours Services
   - Walk in centres
   - Minor injury units

2. **Secondary Care Emergency Services.** For example:
   - Emergency Departments
   - Acute Hospital Assessment and Admissions Units / Wards
   - Hospital Pharmacists supporting urgent and emergency care

3. **Community and Intermediate Care Services.** For example:
   - Rapid Response Teams
   - Mental Health Crisis services

4. **Emergency Ambulance Services**

5. **Single point of access providers**

If the NHS believes that there are other local opportunities to realise additional benefits from accessing the SCR in urgent and emergency situations, this should be managed and controlled by the NHS through local SCR governance arrangements and made transparent to the local health community.

Healthcare professionals with a legitimate patient relationship will access the SCR through either the purposely designed web application known as the SCR application (SCRa) or through their own local systems integrated with the SCR. It is also possible to access the SCR via other methods, such as mobile devices. Patient access will be via an advanced HealthSpace account.

© Crown Copyright 2011

By whichever means the SCR is accessed, a number of security and information governance controls apply. These include access to a patient's Summary Care Record only for those users who have a legitimate relationship with the patient and have sought the patient's permission to view their SCR. All users who access a patient's SCR will have been uniquely issued with a Smartcard and assigned the appropriate Role Based Access Controls. In addition all activity relating to a patient's SCR is audited and alerts on certain activities are generated for Privacy Officers to investigate.

Boards of health organisations have a statutory responsibility to ensure compliance with legal requirements for data protection, Caldicott Principles and Information Governance Toolkit requirements.

2.2.2 Patient access via HealthSpace

Currently patients can access and view their Summary Care Record via HealthSpace and access it from wherever they are being treated, if necessary (subject to access to an Internet connection being available).

By using HealthSpace to access their own SCR, along with other HealthSpace functionality, patients can view key clinical information and be better informed to make decisions about their own health and care.

2.2.3 Use of the SCR Data

Clinicians accessing the SCR must be aware that the record is as accurate as the last professional update and must consider the SCR information as an additional tool to traditional history taking and clinical examination.

All of the content that is viewed through the SCR is secondary and originates from the patient's GP record. For this reason there are no plans to include the SCR as a source feed for the Secondary Uses Service (SUS).

© Crown Copyright 2011

3 Summary Care Record Content Governance

In order to support the NHS Summary Care Record, a National Clinical Reference Panel (NCRP) was established, which amongst its responsibilities provided governance for the scope of the clinical content of the NHS Summary Care Record.

The ministerial review into the Summary Care Record, which reported in October 2010, recommended that new governance arrangements are introduced to oversee the evolution of the record.

These new governance arrangements will:

- assume responsibility for the clinical content of the NHS Summary Care Record;
- be responsible for decisions about the introduction of any new content to the record;
- be driven by patients and citizens in partnership with the professions, tempered by knowledge of the IT capability; and,
- only consider expanding the content of the record when we have built trust in the system and patients request that we do.

It is planned that the chair, membership and Terms of Reference for the new SCR content governance will be in place by early 2011 and this SCR Scope document will be updated to reflect this at this point. This update will include how the new governance arrangements will link to the SCR Programme Board and the detailed process for changing the scope of the record.

© Crown Copyright 2011