Staff FAQs

The NHS Care Records Service and Summary Care Records

What is the NHS Care Records Service?
The NHS Care Records Service is a secure service that links patient information from different parts of the NHS electronically so that authorised NHS staff and patients, have it when they need it to make care decisions.
Why do we need the NHS Care Records Service? What are the benefits?
To improve the safety and quality of patient care and give patients more control. You will have fast access to reliable information about patients to help their treatment, especially in emergencies and out of hours. Patients will have access to a summary of their health records. They will also have much more control than now over who sees their records and what they see.
What types of record will patients have?
There are two types of record, the Summary Care Record and detailed records.
What is the Summary Care Record?
It is a summary of a patient's key health information that will be available to anyone treating them in the NHS across England. It will be really useful for out of hours or emergency care.
What information is in the Summary Care Record?
The Summary Care Record will have details of a patient's medications, any allergies and any bad reactions to medicines they have and will build over time to include their main health issues such as diabetes.
What are detailed records?
Over the next few years, as the NHS Care Record Service develops, instead of having separate records in all the different places where a patient receives care, NHS organisations which normally work together in local area - such as hospitals, clinics and GPs - will develop and begin to link and access detailed electronic records for patients.
Where will NHS Care Records be stored?
On secure NHS computers.
How will the NHS Care Records Service work?
At the moment, a lot of information is kept within one NHS organisation and not easily available anywhere else. With the new system, NHS staff will be able to access those parts of a patient's records that they are allowed to see whenever they need it to provide care.Patients will be able to see their Summary Care Record whenever they want to online via HealthSpace and will be able to make informed decisions about their care. Patients will be able to choose what information is available to those treating them.

Information Governance & Data Security

Is the NHS Care Records safe from hackers? How secure is the NHS Care Records Service?
It would be very difficult to hack into it because the system uses the strongest national and international security measures available. It uses stronger safeguards than Internet banking.
Could records be accidentally deleted or lost?
No there is strong protection to prevent any information being lost or deleted. The information is copied to a separate secure site so there is always a back up.
How will access to records be regulated and controlled?
Staff will have to pass three tests to access a patient's records: - They will have to be appropriately registered as proper staff to be issued with a Smartcard and passcode which works like a chip and PIN bankcard - They have to be recognised by the system as providing care or treatment to a patient (Legitimate Relationship) - They will only be able to see the sorts of information they need to give you that care or treatment (Role Based Access) So, the receptionist may not be able to see the same information as a doctor or nurse, and nothing at all if they are not involved in providing care to a patient. NHS staff will need to ask a patient if they can look at their Summary Care Record every time they need to.
What are patients rights regarding confidentiality and their NHS records?
Patients have rights under the law to confidentiality. They will have options about what is on their record and what is not. A patient's right to confidentiality are made clear in the NHS Care Record Guarantee.
What is the Care Record Guarantee?
The Care Record Guarantee is a document that sets out the commitments that the NHS makes to patients about how it handles their NHS Care Records. It talks about issues such as confidentiality, security and who can access a patient's record.

Consent – Storing, Accessing and Updating Summary Care Records

Will the NHS ask a patient's permission before creating their Summary Care Record?
Patients will be contacted by their GP Surgery or Primary Care Trust before a Summary Care Record is created and will have several weeks to think about their options. An information pack will be sent to them that explains the changes that are taking place and the choices they can make. If they are happy with the changes, then they do not need to do anything and their Summary Care Record will be created. If they have concerns, then they can get more information about the changes. The pack they receive will include details of where they can find more information about the changes. If after reading the information they still have concerns, then they should find out who in their GP Surgery or Primary Care Trust they can speak to about this.
How long will a patient have from receiving the leaflet to making their choice about whether they want a Summary Care Record and what information they want to share?
Patients will have choices for limiting access to their Summary Care Record. - They can ask that their Summary Care Record be created but it will not be accessible by anyone outside the GP Surgery unless they ask for their permission to view. - They can ask not to have a Summary Care Record created. The letter they received from their GP should mention a date, sometime after which their Summary Care Record will be created. There will be a minimum period (currently 16 weeks) from when the information is sent to them before a Summary Care Record is created.
What will happen if a patient chooses not have a Summary Care Record?
The NHS will always endeavour to provide a patient with the best care possible. However, it could mean that there might be times when key health information about a patient is not available. For example, if a patient does not have a Summary Care Record and are taken into A&E, then the staff in A&E may not be able to access their current medications, allergies or bad reactions to medicines if they cannot access the Summary Care Record. The same could apply if a patient needs a doctor outside surgery hours.
Can a patient limit particular items of sensitive information being accessed in various places where they receive care?
Yes, a patient will be able to limit access to all or parts of their Summary Care Record.
Will other people than those delivering NHS care be able to access a patient's records?
People outside of the NHS will not be able to access a patient's record without their permission other than in circumstances where it is allowed by law.
Will people from other government departments be able to see a patient's records?
People from other government departments such as the police or social services will not be able to look at a patient's records directly. As now, they can apply for specific information from a patient's records. There are strict controls on who can apply, what information they can have and the circumstances under which the information is released.

Can a patient stop information being put into their record?
Health care professionals are required to make accurate, relevant records of the care provided. A patient can discuss what is recorded, where it is recorded and how it is expressed but they cannot prevent a healthcare professional from making some record of relevant information.
Can a patient change information on their NHS Care Record?
A patient cannot change information written by others.
Can a patient add information to their NHS Care Records?
Not now, but in the future they will be able to add information such as their treatment preferences.
Can a patient access their own records?
Yes, they can already ask to see their records where they are treated, at their GP, hospital or clinic. To access their records patients will need to follow the procedures laid out by the Data Protection Act - i.e. make an application in writing or, if that's not possible, by some alternative method. Patients can also ask to see a copy of the GP Summary contribution to their Summary Care Record before it is created. When a Summary Care Record has been created a patient will be able to see it through HealthSpace, a secure Internet site, free of charge, at any time they like, by using their computer.
Can a patient find out who has looked at their Summary Care Record?
A record is kept of everyone who looks at a Summary Care Record and an alert will be sent to a nominated member of staff where access occurs in an unexpected setting, for example, if a clinician who doesn't usually treat a patient accesses their information. If it is found that the access was unreasonable, the the patient is informed. Patients can request information about who has accessed their record. They can apply to the 'Caldicott Guardian' for their Primary Care Trust who will let them know who has looked at their record. The Caldicott Guardian will investigate every incident of inappropriate access to a patient's record and will let them know in the eventuality that there has been inappropriate access.