NHS Summary Care Record

User Guide for Patient Facing Staff

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Introduction to the Summary Care Record

The Summary Care Record (SCR)

The NHS wants to improve the safety and quality of patient care. The availability of the SCR can provide benefits to both staff and patients, by giving healthcare staff faster, easier access to reliable information so they can provide more effective treatment to patients.

Patients can, over the next few years, have a SCR which can be available to authorised health care professionals treating them anywhere in the NHS in England.

PCTs will be undertaking a PIP (PIP) which will inform patients and the public about linking electronic medical records, what it means to them and the choices they have. The PIP will precede the uploading of clinical data, to allow patients to express their preferences - the patient can choose not to have a SCR.

At first a patient's SCR will contain key health information such as details of allergies, current prescriptions and bad reactions to medicines. After that, each time the patient uses any NHS health services, details about any current health problems, summaries of their care and details of the healthcare staff treating them may be added to their SCR.

The story so far...

NHS CFH invited Primary Care Trusts (PCTs) to participate in early stage implementations of the SCR. This was referred to as the Early Adopter phase. Live use of the SCR began in the first quarter of 2007.

An in-depth evaluation of the Early Adopter Phase was conducted by University College London, following which Permission to View consent model (patients are asked by health-care staff for their permission to look at the record before it is accessed) was adopted.

The end of 2008 marked the start of the national implementation of the SCR.

Further information can be found on the SCR website at
http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff

Introduction to this User Guide

This guide is intended to provide patient facing staff with an awareness of what the SCR is, how it will benefit patients and how to assist patients following a PIP.

This guide will refer throughout to the SCR website where more information can be found and relevant documentation or guidance can be obtained.

Different SHAs and PCTs will make different arrangements for staff to have training on the SCR, so this guide is intended to act as either a useful addition to face to face engagements or as a minimum that a staff member would need to know prior to implementing the SCR.

Section 2
The Benefits of Sharing Patient's Clinical Information

- What are the benefits?
- Real Life Benefits Experience
- Predicted Benefits

The Benefits of Sharing Patient's Clinical Information

One of the most important factors in being able to discuss the introduction of the Summary Care Record (SCR) is understanding what benefits sharing patient's clinical information can bring.

What are the benefits of the SCR?

- To improve the safety and quality of patient care and give patients more control
- NHS staff 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 do the benefits really mean?

For the first time, information about patients will be accessible when and where needed rather than remaining in static filing stores.

This means, for example, that if someone from Bolton is seriously injured while on holiday in Dorset, they can be treated by a local health-care staff member who will be able to gain immediate access to the patient's SCR.

An authorised health-care staff member could therefore access information such as the patient's current or previous medications, allergies, adverse reactions and potentially previous treatments. This type of access would mean that they know that they have enough accurate information to support an informed clinical decision and improve the quality of care delivered to the patient.

Real Life Benefits Experience

The ability to access a patient's information, regardless of where they originate from, is key to healthcare staff delivering the high quality care that they and their patients expect. Frequently the patient is the primary source of information about their health conditions, medications and allergies. In some instances, this can be successful. However, sometimes patients are unable to tell healthcare staff important information e.g. if they are confused, unconscious or cannot communicate in the same language. This introduces risk, e.g. the potential to give an antibiotic to which the patient is allergic. The SCR gives this key information when an authorised healthcare staff member needs it.

'Urgent health-care staff are already using Summary Care Records in Bury. GPs have the opportunity to help their colleagues by providing them with this vital information and so ensure that their patients receive optimal care at a difficult time.'

Dr Rob Jeeves
Clinical Lead for SCR, NHS Bury

Predicted Benefits

Once the SCR has need fully implemented into the NHS and becomes part of business as usual, the Benefits that the implementation will achieve can be realised, but until that time they are classed as Predicted Benefits.

Predicted Healthcare Staff Benefits

- Improved appropriateness of clinical care
- Faster recognition of critical clinical need
- Increased clinical confidence - with access to medical history for confused or non-verbalising patients

General feedback from staff who have used the SCR as part of the Early Adopters:

- *"like it"*
- *"more information beyond medications, allergies and adverse reactions would be useful"*
- *"find it helpful"*
- *"feel more confident when treating patients"*

Predicted Patient Benefits

- Faster treatment in the most convenient and appropriate setting i.e. patient may not necessarily be passed from an out of ours GP service to an Emergency Department if information from the SCR enables the out of hours to treat them appropriately
- Care can be provided closer to home as a result of increased access to information enabling mobile healthcare staff to avoid referrals in some instances e.g. District Nurses
- Reduced need to repeat clinical history to every clinician that treats the patient. This is especially relevant to those patients with long term or multiple conditions
- Reduced inequalities in treatment for patients unable to communicate their needs e.g. non English speakers
- More joined up care across a variety of care settings when SCRs are enriched with additional information e.g. Palliative Care Plans

Patient feedback:

"I thought you were doing this anyway."

"Patients and information are the two most under-used resources in the NHS. The future is about people accessing their own health records safely and effectively whenever they need to make health decisions. Summary Care Records will hasten that day."

Marlene Winfield OBE
Director for Patients and Public

Predicted Service Benefits:

- More appropriate use of resources and care through greater information sharing e.g. better telephone triage by out of hours services
- Reduction in Emergency Department attendances as a result of fewer referrals
- Faster decisions to treat/admit/discharge patients in unscheduled care settings as a result of access to more information

Predicted NHS Benefits:

- Improved patient/health-care staff communication and interaction
- More efficient use of health-care staff time, enabling them to do more
- Information in advance of appointments results in more effective use of consultation time
- Reduced pharmacological risks and improved speed of medicines reconciliation

Section 3
Patient Choice and the SCR

- Assisting patients in deciding whether or not they wish to have a SCR
- Discussing Patient Choices
- Creating Summary Care Records

Assisting Patient in deciding whether they wish to have a SCR

Patients are able to choose whether or not they have a SCR. The introduction of the SCR and the high level of media interest in this area may raise a number of questions from patients, for example, about the security of their data, see section 5.

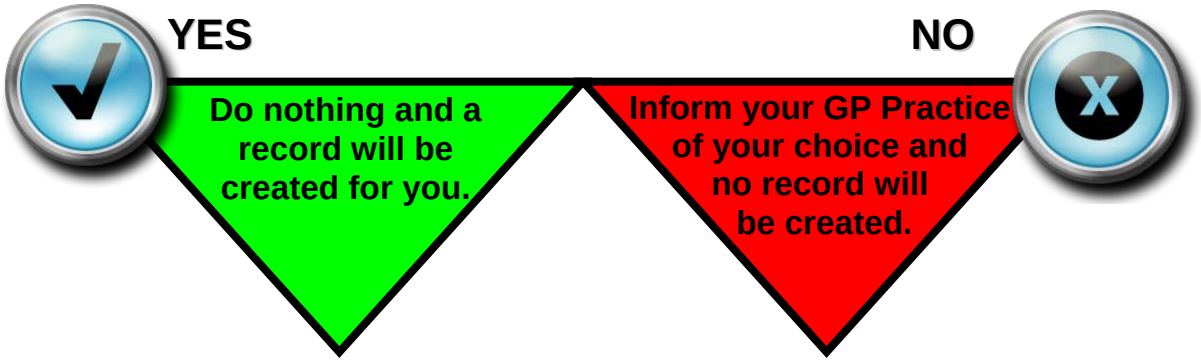
In order to inform patients about the introduction of the SCR, a PIP will be taking place.

As each GP Practice begins to prepare for the implementation of the SCR, the patients registered at the Practice[1] will be sent a personally addressed letter from the PCT or GP Practice along with a leaflet detailing what is happening and what their choices are. They will be told that they have a period of time to decide whether they wish to have a SCR stored for them.

If patients are not sure whether they wish have a record, they will be encouraged to seek further information and support, to help them make their decision. The information they are sent includes a helpline telephone number and web addresses, where they can receive further information. The letter may also have details of any local events that the PCT may be planning as part of a public awareness campaign.

It is likely that some patients will want to discuss these issues at their GP Practice or during consultation with other healthcare staff, therefore ***it is vital that all frontline healthcare staff understand the choices that are available and what processes are in place to record any decision that the patient makes***.

Patient choice following the PIP - Do you want to have a Summary Care Record?



Recording a patients choice not to have a record

In the period before the GP System is upgraded to include software containing SCR functionality, a Read code can be added to the record if the patient has indicated they do not wish to have a SCR:

NO = Read code 93C3 (XaKRy in CTv3 (TPP SystmOne))

[1] *The letter will be sent to fully registered patients who will be aged 16 or over when Summary Care Records are created.*

Patient choice at the point of care - Can I look at your SCR?

*In an emergency where you are unable to be asked, or certain medical/legal circumstances (such as Court Order) clinicians involved in your care may access the record without asking. All such actions will be recorded for investigation.

Should a clinician need to view a patient's SCR they will be asked if the healthcare staff involved in their care can view their SCR:

- If they say "No" their SCR will not be accessed in that instance
- If they say "Yes" then their SCR will be accessed

Patients can also at this point say that they no longer want to be asked every time they present for care. This choice can also be recorded so that the question is not asked in future. Should a patient change their mind about this or any other SCR related question, they can contact their GP practice to ask for the setting to be altered.

Discussing Patient Choices

Patients need to be made aware of the implications of their choice, therefore it is important that NHS staff make every effort to clarify the choices available with patients who are uncertain about having a SCR.

Note: *During and following the PIP patients may assume that they can seek advice from any healthcare staff or other related professional whether or not they are directly involved in implementing the SCR. It is therefore important that all frontline healthcare staff fully understand and can explain the choices available to the patient.*

The following is one way of explaining the choices to clarify a patient's wishes:

Do you want your SCR to be made available when you attend for care away from your GP Practice? (For example, NHS Out of Hours services or Accident and Emergency care.)

Yes	An initial SCR will be created, with supplementary data enriching it at some point in the future.	*This means the content of your SCR will be available to other authorised health-care Staff outside of this Practice, e.g. in Accident and Emergency, who ask for your permission to view.* *If you do nothing a SCR will be created containing medications, allergies and adverse reactions. Remember you can change your mind about this choice at any time.*
No	No information will be stored on the SCR.	*This means that there may be no clinical information about you available in an urgent or unscheduled encounter.* *If you change your mind, you can instruct us any time in the future to create a record for you.*

***Note:** It is **important** that you remind a patient that they can change their mind about their SCR at <u>any</u> time.*

Creating SCRs

Once a Practice has been approved to send the GP contribution to the SCR, there is an automatic process whereby a SCR for every fully registered[2] patient in the Practice is generated. This process is referred to as 'SCR Creation' or 'Initial Upload'. The batch process to generate a record for every fully registered patient will only happen once.

This process will result in the creation of the patient's SCR containing details of current/dis-continued medication, allergies and adverse reactions. Further detailed or updated information can be added at any time following the initial record creation.

Records cannot be tailored prior to the initial SCR creation. However, if a patient has chosen NOT to have a SCR a blank summary will be generated indicating this choice and ensuring that no information about the patient is held on the SCR.

Any patient record that is marked as FP69 will be excluded for the automatic record generation and these patients will not have a SCR created for them.

Viewing a Record Prior to Initial Record Creation

In order to help a patient make a decision about storing a SCR, some patients may want to see what their record would look like.

Until a Practice has had its internal system upgraded, it will not be possible to show a patient the exact content of their SCR in the correct format.

NHS CFH recommends that each Practice considers how it will deal with patient requests to view their data (possibly in printed format) and how such requests will be processed. Each PCT should issue its own advice on how this process should be administered. Following the record creation it may be possible for the patient to view their own SCR through HealthSpace.

HealthSpace is a national service which will allow people to view their own individual electronic SCR via a secure portal accessed via the internet.

Opting out and deleting records

As explained above, patients can choose not to have a SCR and this is referred to as opting out of the SCR. The patient can choose this option at any time even after the record has been created.

If the patient chooses to opt out of having a record, any record that had previously been created is no longer able to be accessed by healthcare professionals.

In extreme circumstances a patient may request that any previously created record be completely deleted. This can be requested by completing a Record Deletion Request Form.

Once a request is submitted, the SCR programme will perform an investigation to assess if the patient's SCR has been accessed. The outcome of the investigation will determine if the SCR can be deleted.

- If the SCR **has not** been accessed then the SCR **will** be deleted. The Practice or nominated Co-ordinator will be informed by the SCR Programme.

[2] *Patients registered as temporary patients or with an FP69 status will be excluded from the initial Summary Care Record creation.*

- If the SCR **has** been accessed then there may be circumstances (such as where the content has been used to inform clinical decision making) when a SCR **may not** be deleted. In these circumstances the Practice or nominated Co-ordinator will be informed by the SCR Programme.

Full details of the process for processing a deletion request is detailed in the document: NHS SCR Deletion Process, available to download from the SCR Website.

Section 5
Security of Data

- Security of Data
- Sources of Data Security information
- Access Control

Security of Data

The SCR will use the strongest security measures available for handling patient data. These measures will ensure that a patient's information is stored safely and securely.

Patients should be aware that:

- By law, everyone working for, or on behalf of, the NHS must respect patient confidentiality and keep all information about patients secure. This duty of confidentiality applies equally to existing electronic and paper records and SCRs.
- The SCR adheres to the Care Record Guarantee for England and has been designed to fulfil all of the guarantees detailed within. This guarantee explains how the NHS will collect, store and allow access to patients' electronic records, and details a patient's choices regarding taking part in the service.

Sources of Data Security Information:

You can support patients and encourage them to get more information, by:

- Offering patients a copy of the summary leaflet - **'The NHS Care Records Service. Better information for better, safer care.'**
- Offering patients a copy of the leaflet - **'Your health information, confidentiality and the NHS Care Records Service. Answers to your questions.'**
  This has been produced to provide answers for those people who have additional concerns.

Both communications can be found on the SCR website
http://www.connectingforhealth.nhs.uk/systemsandservices/scr

Access Control:

Access by Patients

Patients have a right to see their records or a list of people who have accessed their record, whether they are paper or electronic. In order to do this, they need to apply directly to the NHS organisation where they received treatment, using subject access procedures drawn up to meet the Data Protection Act 1998.

However, patients will have the option to view their SCR at any time using HealthSpace. They will be able to check it for accuracy and record their preferences, for example how they are communicated with.

If a patient believes that there is an inaccuracy in their record, they have the right to ask for it to be changed or, if agreement on the requested change cannot be reached, to ask that a statement be added saying that they disagree with their record. This should be done in accordance with existing guidelines for amending patient records

Access by Authorised Healthcare Staff

Authorised health-care staff can only access patient data after they have satisfied robust access control mechanisms. These include:

- Physical access control – to access a SCR a healthcare professional must have a NHS Smartcard. Rigorous processes are in place around the issuing of smart cards. Staff need to be sponsored and have ID checked before they are issued with a Smartcards.
- Access control to ***whose*** record can be viewed - to access clinical content a clinician must be involved in the patient's care - referred to as a Legitimate Relationship (LR) - before their record can be viewed. For example, a clinician treating a patient at an Emergency Department would be able to claim a Legitimate Relationship with that patient and therefore would be able to view that patient's record.
- Access control of ***what*** content can be viewed - Role Based Access Control (RBAC) limits what functions can be used by a particular user and would be set by the local Registration Authority. For example, RBAC controls whether a user can see demographic information versus clinical information. This restricts non-clinical staff from accessing clinical information.

The measures being used by the NHS for the protection of patient confidentiality have been scrutinised and approved by the Information Commissioners Office. This provides better levels of control than currently exists for paper records.

Monitoring Access Control

In order to ensure that access to patient records is appropriate, audit trails are created when a patient's record is accessed. Patients can request a copy of this information through a formal 'data protection subject access request'.

Alerts will be triggered automatically if there is a chance that an access may be inappropriate both to deter misuse of access privileges and to report any misuse when it occurs. When access is not justifiable, someone in the NHS organisation responsible for overseeing patient confidentiality – known as the Caldicott Guardian or Privacy Officer – will take action. This may include disciplinary procedures, and informing the patient where appropriate.

Section 6
Data Quality

- Data Quality Standards

Data Quality

Good data quality is fundamental to the success of the SCR. Therefore, as part of the whole process for getting a practice ready for SCR, a GP Practice will need to meet the minimum requirements for using uploading to the SCR. Your PCT will work with you to measure and, where required, assist in improving your data quality in order to meet these required standards.

For more information please see
http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/impguidpm/dq

Section 7
PCT Responsibilities & Practice Readiness

- PCT Responsibilities
- Practice Readiness

PCT Responsibilities and Practice Readiness

In introducing the SCR, NHS CFH, SHAs and PCTs recognise the need to assist and support GP Practices in planning and preparation.

PCT Responsibilities

With the guidance of their SHA, each PCT will be responsible for supporting their Practices and ensuring that every patient receives appropriate information in an appropriate format regarding all aspects of the implementation of the SCR.

PCTs also need to advise local voluntary sector organisations of the changes and potential impact of the SCR implementation and ensure that they are well enough informed to manage any queries and meet the information requirements of their service users.

Practice Support

The level of support provided by the PCT to each GP Practice may vary but can consist of any or all of the following:

- project management for the SCR implementation
- own the supplier relationship on behalf of the PCT
- provision of trainers to attend CFH Train the Trainer sessions and cascade training to all relevant personnel
- assistance from fully trained staff in the implementation of the SCR
- knowledge of and access to all to the information resources and tools available

Patient Information

Each patient must receive as much information as required for them to make an informed decision regarding their SCR.

The PCT may work with their SHA to develop its own strategy for the delivery of communications to patients, but may decide to follow tried and tested methods already in use, such as:

- posting individual patient letters
- publicising information
- by displaying leaflets / posters within the GP Practice
- posting adverts on local radio or in the local press
- providing Information Booths within the Local Health Community
- providing GP Practice question and answer sessions

Practice Readiness

Considerations for the Practice

Each GP Practice will need to consider, and potentially seek advice from their PCT, to make some important decisions regarding internal processes that may be required to implement the SCR. These are examples of some of the decisions that may need to be made:

- What processes do you need for handling patient questions?
- How will you ensure that all patient-facing staff understand all the patient choices?
- Should you have nominated SCR experts?
- Prior to your GP system software upgrade how will you register a patient's choice?
- How will you arrange to provide printed patient summaries if they are required?
- Do all the relevant Practice staff have Smartcards and use them consistently?
- How will the Practice manage processes for locum doctors to access patient records and contribute to the SCR?
- What process will be put in place for informing newly registered patients?
- How will the Practice handle any requests from parents of children under the age of 16 with regard to the child's SCR?
- Following the initial mailing out to patients, there may be an increase in the number of patients contacting a GP practice to record their choice. However, experience to date has shown that this number is low. ("No one so far has opted out of having an SCR since we went live in 2008", Angela Styring, PM at Yardley Wood Medical Centre). Processes to deal with patients enquiring about the SCR and how patient choices will be recorded will need to be in place within the GP practice following patients at the practice having received information about the SCR.

Section 8 of this document provides information on the support available to deal with these considerations.

New Patient Processes

Patients registering at a GP practice after patients have been contacted via a PIP will need to be informed about the SCR and have the opportunity to opt out should they wish to do so.

Practices are recommended to have processes in place for capturing and dealing with patient preferences from the date that their patients are contacted about the SCR, via a PIP.

Assistance with business processes around this can be found at
http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/impguidpm/buspromaps

Patient opt out forms and guidance is available at
http://www.connectingforhealth.nhs.uk/systemsandservices/scr/documents/gpguide

Additionally, your PCT will be able to provide guidance on how to handle new patients following a PIP, and will be able to provide you with materials to use to inform new patients about the SCR.

Supporting Non-English Speaking Patients

The SCR Patient leaflet that is sent to patients during the PIP is available in a range of other formats , including Braille, Large Print, Easy Read and has been translated into several languages including Farsi, French, Guajarati, Mandarin, Urdu, Polish and Spanish. A form to request copies in other formats is included in the pack that patients receive.

Translated versions can also be from:

http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/aboutscr/comms/otherformats/index_html

Section 8
Support

- The SCR Website
- Training Support for the SCR
- Further Information
- NHS SCR Information Line
- Patient Advisory Bodies
- Business Process Maps and Protocols for Managing Scenarios

SCR Website

To support the whole NHS in implementing and supporting the use of the SCR, a SCR website has been developed which contains implementation guidance, communications materials, training and background to the SCR. Staff are encouraged to visit the website for further information on any of the areas covered in this guide.

The SCR website can be accessed at
http://www.connectingforhealth.nhs.uk/systemsandservices/scr

Additionally, there is a patient facing website that patients can be directed towards to find further information on the SCR. This can be found at
http://www.connectingforhealth.nhs.uk/systemsandservices/scr/patients

Training for the SCR

Practice staff training will be arranged in conjunction with the PCT and will be one the two following types:

1. **Concept Training**:
   to provide general awareness of the SCR. This may be delivered individually to a practice, be communicated through an engagement event or via materials such as this user guide.
2. **GP System Supplier Training:**
   to provide GP Practice staff with up-to-date skills for using their GP System to contribute to the SCR. This will be delivered by the GP system suppliers.

Additionally, for care settings accessing the **SCR Application Training** is available to provide the skills required to understand and access the SCR via the SCR Application.

Training guides, materials and information on how to book training can be found on the SCR website at
http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/impguidpm/training

Further Information

A range of additional information sources are available to provide you with further information and assist you in implementing the SCR and in supporting patients:

- Fact sheet for NHS Staff - http://www.connectingforhealth.nhs.uk/systemsandservices/scr/documents/fact_sheet.pdf
- Patient Choices Consent Model http://www.connectingforhealth.nhs.uk/systemsandservices/scr/documents/patientchoice.pdf/view
- GP Opt out guidance - http://www.connectingforhealth.nhs.uk/systemsandservices/scr/documents/gpguide
- SCR Summary Leaflet - http://www.connectingforhealth.nhs.uk/systemsandservices/scr/documents/summary.pdf
- Patient FAQs - http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/faqs
- Clinician FAQs - http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/faqs/mpsfaqs
- Key Benefits http://www.connectingforhealth.nhs.uk/systemsandservices/scr/documents/key_benefits.pdf
- Opt out form http://www.connectingforhealth.nhs.uk/systemsandservices/scr/documents/optout.pdf

- Opt out guidance http://www.connectingforhealth.nhs.uk/systemsandservices/scr/documents/gpguide
- SCR Scope Document - http://www.connectingforhealth.nhs.uk/systemsandservices/scr/documents/scrscopel.pdf
- Care Record Guarantee - http://www.nigb.nhs.uk/guarantee/2009-nhs-crg.pdf
- Further information is available from the SCR website at - http://www.connectingforhealth.nhs.uk/systemsandservices/scr
- Enriching Records Document - http://www.connectingforhealth.nhs.uk/systemsandservices/scr/documents/screnriching.pdf

NHS SCR Information Line

For patients requiring further information about the SCR, GP Practice staff are able to refer them to the NHS Care Records Service Information Line on **0845 603 8510** (The line is open every day between 07:00 and 19:00, except Bank Holidays).

Please note that this information line is for patients only and that practice staff should speak to their practice manager, PCT or SHA should they require any additional assistance with the SCR.

Patient Advisory Bodies

As well as providing information to a patient on the various sources of information previously mentioned, you may also recommend that they seek advice from any local patient advisory body such as the Patient Advisory Liaison Service (PALS),

Business Process Maps and Protocols for Managing Clinical Scenarios

The introduction of the SCR may result in changes to current processes. A range of suggested Business Process Maps and Protocols have been developed to provide assistance to NHS staff to understand the processes which either support the SCR or are affected by the introduction of SCRs.

The Maps and Protocols cover a number of scenarios, for example, suggestions for how to handle enquiries from patients who wish to see a GP prior to having an SCR created.

A range of suggested Business Process Maps and protocols have been developed to support the introduction of the SCR. These can be accessed at www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/impguidpm/buspromaps.

Appendix A
How it Works

- The Spine
- Personal Demographics Service (PDS)
- Personal Spine Information Service (PSIS)
- SCR Application

How it Works

Before being able to discuss with patients what their options are, it is beneficial to understand where data is coming from, where it is stored and how it is accessed. Whilst it is not necessary to understand all the technical elements, understanding the following background information may be helpful.

The Spine

The Spine is a national, central facility where SCRs will be stored.

A messaging system directs requests for patient details to the various parts of the Spine where the information is held. The messaging system then sends back the details to the individual callers. To use the system these staff must have been issued with a Smartcard and PIN number by their NHS trust.

The Spine also supports other key services being introduced by the National Programme for IT to improve patient care and the working lives of frontline staff – such as Choose and Book and the Electronic Prescription Service.

The Spine contains both the Personal Demographics Service (PDS) and the Personal Spine Information Service (PSIS). These two databases hold distinct sets of data relating to a patient. Each record within these databases is identified and linked using a unique code which is issued to the patient – their NHS number.

Personal Demographics Service (PDS)

The Personal Demographics Service (PDS) is the central and single source for patient demographic information, such as name, address and date of birth. Currently when a patient registers as an NHS patient, their basic demographic details are stored in PDS.

It can also contain a much wider range of information, for example to allow for circumstances such as where a patient may be residing with a relative during recuperation, enabling important correspondence to be sent to the correct address.

Personal Spine Information Service (PSIS)

The Personal Spine Information Service (PSIS) is the central database containing summaries of clinical information for NHS patients. The PSIS record will provide an up-to-date summary of information and key events in a patient's life and care – drug allergies, operations, conditions, medication history – as well as details of contacts with care providers.

As the system develops and current treatment generates essential information for continuing care, such as discharge information or notes of a visit to a walk-in centre, summary information will be added to the PSIS record. In this way, the person-based PSIS record gives information to, and receives it from, many local systems as the patient experiences healthcare.

SCR Application

As systems are developed there will be a range of integrated solutions that allow users to access the SCR from within current systems. Where an integrated solution, the SCR application will provide access to the records.

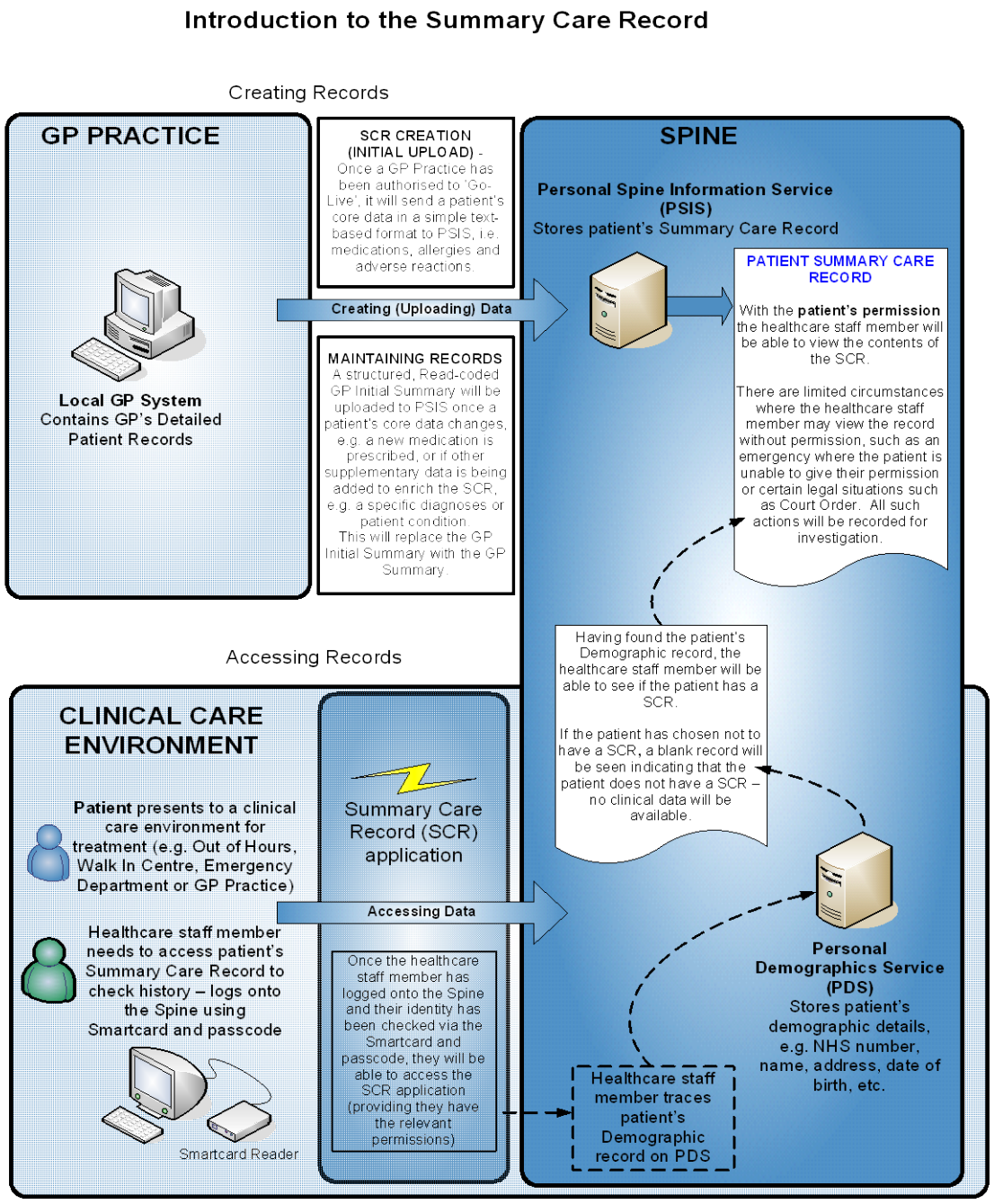
The web-based SCR application will provide authorised healthcare Staff with access to the SCR to gain access to patient information provided by PDS and PSIS.

Currently, the SCR application enables clinicians and other authorised health-care Staff within unscheduled care environments (such as, Out of Hours, Walk in Centres and Emergency Departments) to find and access a patient's SCR, assuming the patient has given permission.

SCR application training will be provided to these users.

Putting it All Together

The following diagram offers a high level overview of how data is transferred to the Spine from the GP Practice and subsequently accessed from an unscheduled care environment.



Note: *Different software solutions may use different local sharing models in addition to this model.*

Important – A patient's SCR will be populated over time and other clinical information will appear from different sources. These summaries are not a primary store of information and as such may not be complete.