

# Briefing: 052/17: Local electronic and shared care records: pharmacy access checklist

This Community Pharmacy England Briefing provides a list of issues to be considered by Local Pharmaceutical Committees ([LPCs](#)) and community pharmacy owners when pharmacy access to local health and shared care record systems is being planned and obtained. The experience of LPCs and owners that have been involved in such local developments have informed the development of this list of issues.



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## Introduction

Community pharmacy staff like other primary care staff, have been creating electronic records of their interactions with patients for many years, but these records had not usually been integrated. Community pharmacy teams will frequently be able to provide better care to their patients and will be able to better support the work of other health and care professionals, where they have appropriate access to patients' Electronic Health Records (EHRs) and the ability to record and share healthcare records. The terminology may vary as these may be referred to as [Shared Care Records \(ShCRs\)](#), connected care records, and formerly Local health and care records (LHCR). [Integrated Care Systems \(ICS\)](#) have been [tasked with progressing shared record projects within their areas](#).

The [Community Pharmacy IT vision](#) and [template local digital priority papers](#) also list records access as one of the major digital priorities. Pharmacies within some areas of England have been accessing LHCRs since 2020.

In the past, there have been attempts to create central patient record systems for use by all healthcare professionals, but the focus is now on ensuring interoperability between individual health record systems and across organisational boundaries. EHRs and record-sharing initiatives



have been developed nationally, such as the NHS [National Care Record Service \(NCRS\)](#) / [Summary Care Record \(SCR\)](#) and locally more detailed shared record systems are being developed in many areas, e.g. the Leeds Care Record. Community Pharmacy England maintains a [list of local and national Electronic Health Records initiatives](#).

The [National Data Guardian \(NDG\)](#), said that whilst [data security](#) standards need to continually be strengthened, an additional key principle is the duty to share information, which could be as important as the duty to protect patient confidentiality: *“Health and social care professionals should have the confidence to share information in the best interests of their patients.”*

Seven areas to work through when community pharmacy access to local EHR systems is being planned are set out below:

## 1. Explore shared EHR access with the wider local health and care community

- **Work with local health and care providers and service commissioners to decide what information from patient records could be shared and how, or which EHR is used locally**

This work could be started by mapping the local range of EHR systems. If needed the work could also look at the record content, how this content is used by local health and care providers and assessing which records and elements of records could support pharmacy teams to provide better care to their patients or deliver services. Also consider how information from pharmacy records could be shared or written to local EHR systems. Where information is being written into a shared care record, consider how data will initially be merged from the various sources and how data will be synchronised and updated in the future.

- **Local Pharmaceutical Committees (LPCs) and Local Medical Committees (LPCs) can work together**

They are particularly well placed to consider the advantages of sharing records.

- **Consider the development of formal data sharing agreements, if required**

These may be agreed between different healthcare organisations or there could be a local or national agreement covering all health and care providers. The agreement could detail the systems and practices which will be used to govern access to information within patients’ EHRs. Existing data sharing agreements may provide a useful starting if such an agreement is to be drafted.

## 2. Demonstrate that shared access to EHRs will be appropriate

- **Ensure information viewed will be relevant to the care setting**

Pharmacy team members, like other healthcare professionals, should only seek to actually view the information relevant to their care setting, unless the patient has given their explicit consent for their full record to be viewed.

- **Ensure information will only be accessed if there is a 'legitimate relationship'**

Information viewed must relate to a patient being cared for by the pharmacy or healthcare organisation.

- **Ensure appropriate role-based access controls and audit trails will be in place**

For example, Smartcards or login/authentication credentials can be used to control access to patient data. Audit trails of record access should be maintained which will allow patients to see who has accessed and edited their records and when. If a record is accessed without the appropriate consent of the patient, there must be a mechanism to notify a trusted third party such as an EHR governance person at the appropriate health and care provider.

- **Ensure all health and care providers review their Information Governance (IG) arrangements at least once each year and after any IG incidents**

This would include the NHS Data Security and Protection Toolkit (DSPTK) being done within the period.

- **Clarify that information from the EHR will only be used for direct patient care**

The [Review of data security, consent and opt-outs](#) reported that patients surveyed were content with their information being securely available for those healthcare workers caring for them, but that there would be concerns if the information was to be used for marketing or insurance purposes. Patients should be reassured that information from the EHR will not be used for marketing or insurance purposes.

## 3. Determine the standard consent and opt-out models

- **Consider the standard patient consent model**

The [Review of data security, consent and opt-outs](#) (page 39) proposed an 'eight-point consent model' – a set of eight statements which could be presented to patients to inform them about the use of their information. Consider whether this model could help to inform the locally agreed consent model.

- **Consider the opt-out model**

The [Review of data security, consent and opt-outs](#) also outlined several example opt-out models (pages 38–41), e.g. for any patients who might be concerned about the sharing of their EHR information. The NDG proposed that several sharing settings could be tested with patients:

- *Standard setting* – information about the patient can be used to run the NHS and social care system and to support research to improve treatment and care for everyone.
- *Limited setting* – information about the patient can be used to run the NHS and social care system, but not for research.
- *Restricted setting* – information about the patient can only be used by the people directly providing their care.

Some EHRs may display certain information across healthcare settings only if explicit patient consent has been provided – for example the [‘enriched’ version of the SCR](#) requires explicit consent to become functional.

#### 4. Determine the emergency access and signposting procedures for EHRs

- **Develop an emergency EHR access procedure**

This might be used if a patient is not able to give their consent, e.g. the patient is unconscious, but the healthcare professional believes there is a clinical requirement to view the patient’s EHR. A reason for such accesses should be recorded in the patient’s record, e.g. on the PMR system or another EHR. Such an override might not be possible if a patient has not consented to share access to their record.

- **Develop the procedure for EHR access relating to a patient which has been signposted**

These procedures may outline what EHR information can be viewed or shared if a patient is signposted from one organisation to another (e.g. to or from a pharmacy). Information might be accessible under implied consent where appropriate.



## 5. Support the development of usable and secure EHR platforms

- **Only use secure EHR systems**

Use expert advice from trusted organisations to ensure that only trusted EHR platforms, which meet appropriate security standards, are used.

- **Consider the benefits with EHR systems which use common standards and open source**

EHR platforms which make use of [open source](#) and [common standards solutions](#) are likely to contribute towards longer term interoperability.

- **Provide usability feedback to the system supplier**

Help pharmacy teams to identify suggestions to improve the usability of the system to help inform the future development of the system.

## 6. Develop training for users and help them to plan how they will use the system

- **Help Pharmacy owners to develop or edit standard operating procedures (SOPs) for EHR access**

Pharmacy owners may develop an EHR SOP or adapt one from [a template](#).

- **Help pharmacy teams to determine how EHR access will fit into their usual workflows**

The Royal Pharmaceutical Society (RPS) has published a [one-page factsheet](#) which provides examples of how EHR access can be used in pharmacies. The decision as to when to access an EHR or to make a record into an EHR is a professional one, which should be guided by the [General Pharmaceutical Council's Standards for Pharmacy Professionals](#).

- **Help pharmacy teams to develop a plan for maximising the potential of EHR access and usage, for the benefit of patients**

LPCs may want to monitor the number of EHR accesses and highlight best practice by individual pharmacy teams which could be shared with all pharmacy teams.

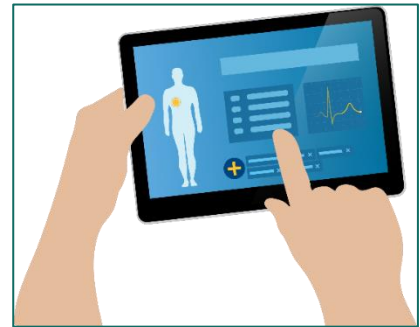
## 7. Decide how patients will be informed about the use of an EHR system

- **Ensure patients are made aware of the changes, before the new system is introduced**

This could involve an agreed organisation communicating with the patient, an information leaflet being sent to patients and being made available in the pharmacy, [social media](#) or other communications with the public. Guidance explains how the [NHS logo can be used appropriately](#) on such communications.

□ **Consider the local communications plan**

This may include posters in the pharmacy, use of the [CPE template pharmacy transparency notice](#) which references records access, information on the pharmacy website, or use of local media to raise awareness. Pharmacies may wish to consult with local patient participation groups and [Healthwatch](#). Pharmacy teams should have confidence that these methods of communication have been effective.



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If you have any queries or require more information, please contact: [it@cpe.org.uk](mailto:it@cpe.org.uk)