Health data and scope — what is settled, and what is not

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Pilot scoping file, access log, register of authorisations · fictional document

> **Fictional document — demonstration example**
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> **Fictional document**, produced for the demonstration. **This attachment ALSO says what is not settled. The pilot runs on local inference; nothing is hosted outside the home, and health-data hosting remains a scoping decision to be settled before any go-live.**

What is true today on this pilot — and checkable

Point	Status	How it is checked
Where the agent runs	**A machine in the unit, local inference**	Hardware inventory, machine address, absence of outbound traffic
Dictation	**Processed locally**	**Network log: no outbound traffic during dictation**
Writing up handover notes	**Processed locally**	Network log

Point	Status	How it is checked
Reading incoming prescriptions	**Processed locally**	Network log
Sending requests to prescribers	**The home's secure health messaging**	**Send log, after nurse validation**
External hosting of health data	**None**	**There is nothing to host anywhere else**

What is not settled — and will be settled before, never after

Open question	What would reopen it	When it is settled
HDS requirement for hosting health data	**Any access from outside the home: an on-call nurse from home, access for the coordinating physician, an off-site backup**	**BEFORE the access is opened, at scoping — never after go-live**
Extension to the care assistants' notes	**22 additional users instead of 5**	**Prior review of the access scope, costed in the year-in-review**
Reading hospital discharge summaries	**Documents produced outside the home**	**Prior review of the data scope**

This document does not say the HDS question is settled, because it is not. On this pilot it was dealt with by making it disappear — nothing goes out — and not by answering it. A supplier claiming otherwise would expose you precisely where you believe you are covered.

What holds confidentiality, independently of hosting — art. L1110-4

Guarantee	Actual setting	How it is checked

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Access by role	**A care assistant does not see what a nurse sees; the coordinating physician sees what their role requires**	Register of authorisations, quarterly review
Sharing limited to what is strictly necessary	**A request to a prescriber carries the area concerned, not the record**	Request template, send log
Logging of every access to the record	**Name, time, resident consulted**	Log open to the nurse coordinator
Encryption at rest and in transit	**The unit machine's disk, secure health messaging**	Configuration, operations audit
No pooling	**Environment strictly dedicated to the home**	Inventory, no shared tenant
No measurement of carers by name	**Corrections and set-asides counted by reason**	**It is that counting by reason that produced the 261 carry-overs published**

Why the absence of a per-carer indicator is a setting rather than a nicety: a correction rate per nurse would become a target; the target would push down declared corrections, not errors; and the unit would lose the one signal that made it possible to find the error of the 261 carry-overs. The exception, and it is not one: whoever VALIDATES a note is named, with the date and the time — a validation is not a counter, it is a signature.

Scope and scoping review conducted with management and the nurse coordinator, on:

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