



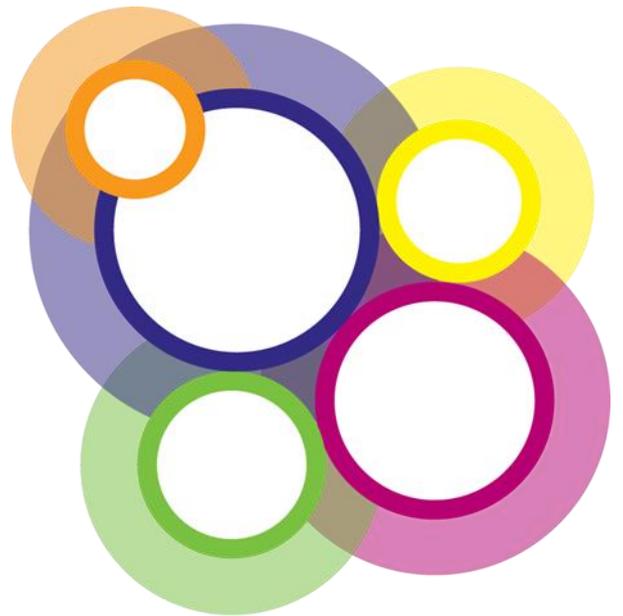
North of England
Commissioning Support

Partners in improving local health

NECS Clinical Systems Specialist Team

SystemOne - Summary Care Record Guide

Author: NECS Clinical Systems Specialists Team





Partners in improving local health



North of England
Commissioning Support

Table of Contents

Contents

What are the SCR Core Data Items?	3
Amending Patient Consent	4
Adding/Removing Individual Items from a Summary Care Record	7
PDS Synchronisation	9



Summary Care Record

What are the SCR Core Data Items?

The Initial GP Summary and GP Summary Update messages contain a number of core data items about key health information, where it exists, for every patient. These items are a group of data fields that cannot be amended.

The data fields include allergies and adverse reactions, acute medications prescribed within the last 6 months, current repeat medications which have not been discontinued and are not more than 6 months past their review date, and repeat medications that have been discontinued within the last 6 months

If a repeat item does not have a review date, the system shall not include repeat items more than 18 months past their last issue date or last authorisation date where there is no issue date.

Practices should be encouraged to review processes if necessary so that repeat medication is not issued beyond a review date as this medication may not show on the SCR.

Amending Patient Consent

This can be recorded in different ways:

1. Retrieve the patient record
2. Select the **Spine Details - SCR Details** node from the Clinical tree
3. Click the Spine icon  in the toolbar at the top of the view
4. Select one of the following options:
 - Express consent for medication, allergies and adverse reactions only – the SCR will consist of only core items (allergies, adverse reactions and medications).
 - Express consent for medication, allergies, adverse reactions and additional – the SCR will consist of core items plus any additional items the patient has requested to be added.
 - Express dissent – an SCR will not exist for the patient.
5. **Save** the patient record

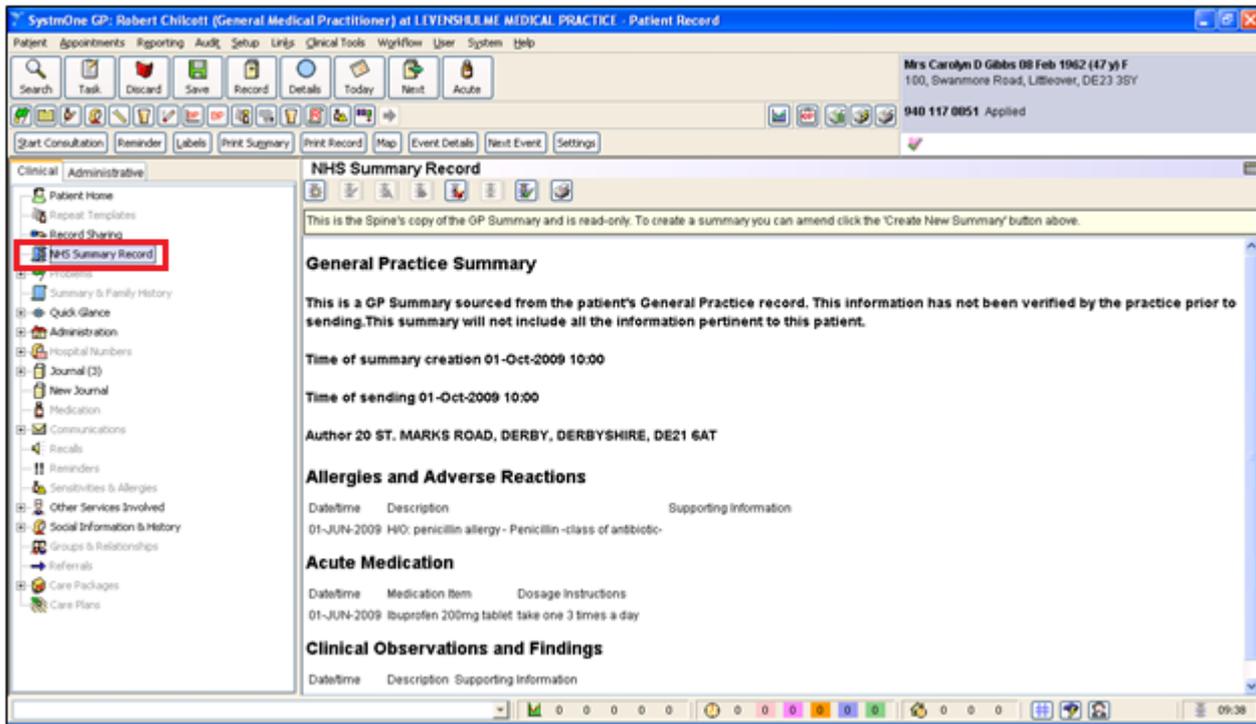
Alternatively, you can record one of the following Read codes to update the patient's SCR consent on Spine:

- | | |
|---|---------|
| a. Express consent for core Summary Care Record | (XaXbY) |
| b. Express consent for core and additional SCR | (XaXbZ) |
| c. Express dissent for Summary Care Record | (XaXj6) |

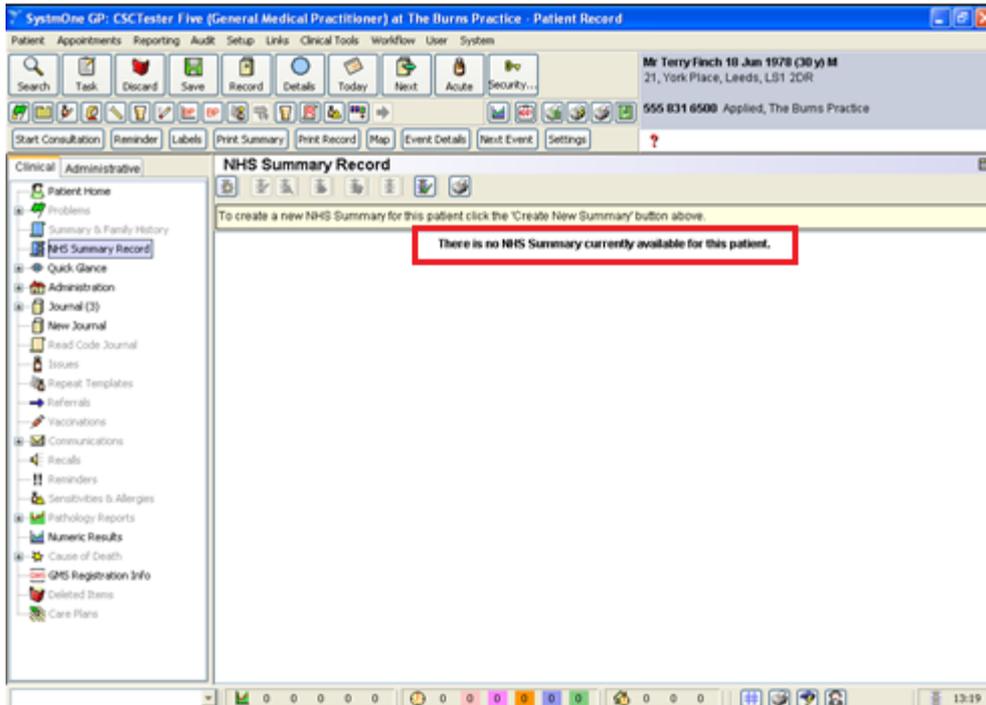
Partners in improving local health

The Practice can add the **NHS Summary Record** icon node to the Clinical Tree if required (Smartcard access rights will be required to view the information).

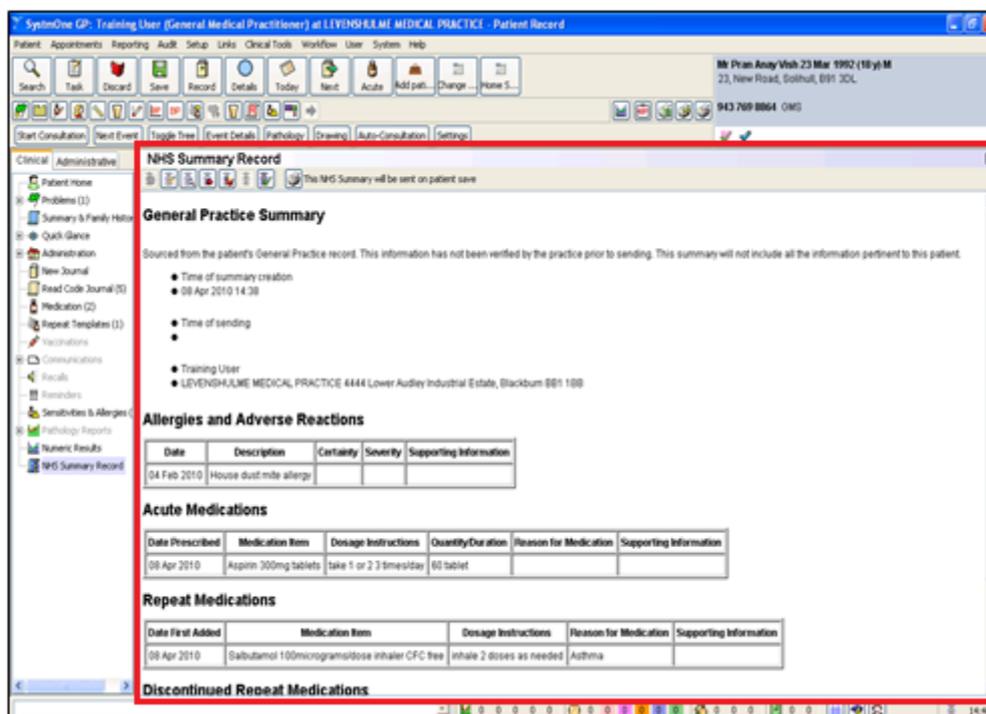
If the patient already has a Summary Care Record, the following screen will show when the NHS Summary Care Node is selected.



If the patient does not have a Summary care Record, the following screen will show



If there is no SCR, a new one will be created when the patient record is saved



Adding/Removing Individual Items from a Summary Care Record

As well as the Core data, additional data can be added to the Summary Care Record as required.

To add an individual item to a patient's Summary Care Record:

1. Locate the data in the patient record, for example on the Summary & Family History, New Journal, or Read Code Journal view
2. Right-click on the item and select **Add to Summary Care Record**

It is also possible to add items to the SCR as you record them

1. Select the relevant Read code on the Record New Coded Entry or Record Family History dialog
2. Select **Add to Summary Care Record**
3. Click **Ok**

To remove an item from the Summary Care Record from a patient record view

1. Locate the item on the patient record view, for example on the Summary & Family History, New Journal, or Read Code Journal view
2. Right-click on the item and select **Remove from Summary Care Record**

To prevent a **core** item from being included in the Summary Care Record, it must be marked as 'private'.

If a patient has specified that they do not want a core item to be included in their Summary Care Record, it is possible to remove it by marking the item as 'private' via the New Journal or Tabbed Journal.

Other caring organisations, including A&E and Out of Hours services, will not be able to see items marked as 'private' from either the SystemOne patient record or from the Summary Care Record. Marking an item as 'private' must be an informed decision made by the patient in consultation with their Health Care Professional.

If you mark a core item as 'private', the entry will be removed from the Summary Care Record and a message will be displayed on the SCR stating that the patient has deliberately withheld items from the SCR.

To mark a core item as 'private'

1. Retrieve the patient record

2. Select the **New Journal** or **Tabbed Journal** node from the Clinical tree.
3. Select the entry you want to remove from the Summary Care Record
4. Click the privacy icon  on the toolbar.
5. Select **Mark Event as Private**
6. Read the warning message carefully and click **Yes** to confirm that the patient understands that the information will not be visible to other caring organisations.
7. Click **Yes**
8. **Save** the patient record

Entries marked as 'private' will display an  icon beside them in the New Journal and Tabbed Journal to indicate that they are not part of the shared record.

PDS Synchronisation

When a patient record is not PDS matched on retrieval, there will be no SCR functionality available, therefore no updates will be sent to the Spine.

Once PDS matching has occurred, the next time the patient record is retrieved, core data items will be updated and a revised SCR sent on saving the patient record.

Below is a list of demographic details that synchronise with PDS;

System specific

- a. Sensitive Record Indicator
- b. NHAIS posting

Patient Details

- a. NHS Number
- b. Address
- c. Title
- d. First Name, Middle Name and Surname
- e. Known as
- f. Date and time of birth
- g. Date and time of death
- h. Gender
- i. Home/Mobile/Work Telephone
- j. E-mail

Relationship

- a. Type
- b. Next of Kin
- c. Contact Order
- d. Title
- e. First name, Middle Name and Surname
- f. Language
- g. Interpreter Required
- h. Address
- i. Contact Method
- j. Contact Times
- k. Communication format
- l. Telephone
- m. Work Telephone
- n. Call centre call back consent
- o. Copy Correspondence



Spine Consents

- a. NHS CRS information sharing
- b. Call centre call back

Spine Preferences

- a. Preferred contact method
- b. Preferred format
- c. Health Space registration

Updating the Summary Care Record

Where core items have been added to the patient record, the next time the patient record is retrieved in SystemOne a new SCR will be created and sent once the patient record is saved.

Note: that if the patient record is accessed from a SystemOne Unit other than the registered GP, e.g. a Community Unit, and medication prescribed, the SCR will not be updated until the record is once again retrieved and saved by the GP. Also, in order to ensure that a comprehensive SCR is maintained, any core data items such as medication prescribed by non SystemOne locations will need to be added manually by the GP.

To view the SCR Updates screen, select **Workflow** and **SCR Updates**.

The SCR Updates screen allows you to view a list of the patients whose Summary Care Record update has failed to be sent to Spine. Until this is resolved, the Spine version of the SCR will not contain all the details added to the SystemOne version.

The patient will be listed on this screen if their SCR update is not sent to Spine for one of the following reasons:

- a. the user who attempted to send the update was not logged on with a Smartcard
- b. an SCR consent difference was identified and a new consent was not recorded
- c. the patient has unresolved PDS differences
- d. another user had the patient retrieved
- e. the patient's consent on Spine is Express dissent – patient does not want a Summary Care Record but it has been changed to Express consent for medication, allergies and adverse reactions only consent or Express consent for medication, allergies, adverse reactions and additional information on SystemOne
- f. the patient is newly registered and you have chosen not to overwrite their last SCR
- g. Spine rejected the update

The SCR Updates screen should be checked daily to monitor any updates that have not been sent to ensure the most up to date information is visible on the patients' Spine Summary Care Records. You can view the differences for individual patients from the Compare Changes tab of the Amend Summary Care Record window.



To update the Spine Summary Care Records of the patients listed on the SCR Updates screen:

1. Click **Authorise and Send**.

You will be asked to confirm that you want to update the patients' Spine Summary Care Records.

2. Click **Yes**.