Vision 3

DLM 235

including

Referral Message Digest (C&B)

Patient preferences for National Summary Care Record

Organ Donor Consent (Scotland)

Childhood Immunisations

SCI Gateway Referrals

GP2GP v1.1

INPS

Table of Editions and Contents

Date	Version	Contents	Output
10.01.07	DLM 235	Referral Message Digest	
22.03.07	DLM 235-1274		
04.04.07	DLM 235-1292	ESTUB edit Nat Summ.	draft pdf to pre-release DLM site
18.04.07	DLM 235-1303	Allergy warnings not given in some cases	
10.05.07	DLM 235-1339	Pat Preferences for Nat Summary Organ donor turned off GP2GP v1.1	pdf
31.05.07	DLM 235-1372	Auto-selection options for RMD and National Summary	pdf
13.06.07	DLM 235-1384	Preview of Nat Summ only if SDS entry in Vision	pdf
27.06.07	DLM 235-1411	RMD needs to be switched on. Preferences for Nat Summ also include spine consent	pdf

Contents

DLM 235

Summary of changes

Consultation Manager

- **Allergy warnings** are not given when drugs are prescribed which are in similar *action groups* to which an allergy has been recorded, unless they are NSAIDs, penicillins and cephalosporins, in which case a warning is given - see page 3
- **Immunisation Schedule for children** - In September 2006, pneumococcal conjugate vaccine (PCV) was introduced to the routine childhood immunisation programme and the schedule for meningitis C (MenC) and Haemophilus influenzae type b (Hib) vaccines was modified. See page 3.
- **Patient's middle name** can now be displayed on Consultation Manager title bar. See page 5.
- **Repeat masters** - wording changed on Journal entry - see page 6
- **Mailbox in Consultation Manager** now has two new filters - Unfiled messages and Archived messages. See page 7
- **National Summary Patient Preferences** - In Patient Details, Consultation Manager, a record can be made of a patient's preference of either consent or dissent to the National Summary (also called the SCR, Summary Care Record, or sometimes GP Summary) being uploaded and stored on the spine. Several Vision practices will pilot the upload of National Summary data to the spine but the general release will be later. See page 19. The National Summary User Guide will soon be posted on the INPS website under Downloads - CfH. However, there are likely to be changes to the interface and functions in the near future.

Choose and Book

- **Referral Message Digest** - The Choose & Book (CaB) referral message has been streamlined and no longer relies on problems. It will now be much easier to maintain and update the referral data using the new Referral Message Digest. New Auto-selection Options. See page 8. Note that Referral Message Digest will be switched on practice by practice in due course.

Scotland

- In Scotland, **organ donor consent** can be recorded in Registration for all new patients. This function will first need to be "switched on" for participating practices. See page 28.
- **SCI Gateway - Referrals** for Scotland - integration with Consultation Manager. See page 32

DocMan

- Extraction of **DocMan** documents can now be sent in clinical messages, Choose and Book, GP2GP.

PDS

- Selecting patient using **Advance Trace** from PDS no longer allows selection by address. See page 25
- If on-line, new patient registration no longer defaults to surname if "existing" or "selected" is chosen first. See page 26
- If adding a carer as a patient, can choose to add carer details or not to registration, if you are working off-line. If working on-line, no fields are populated by default so that PDS is not overwritten. See page 26.

GP2GP

- **GP2GP v1.1** is incorporated in DLM 235 but will need to be "switched on". This allows transfer of a patient's electronic record between Vision and EMIS practices when the patient registers. Pilots have been carried out in the Isle of Wight and Croydon and general release is planned over the next few months. When registering a new patient, a request is made electronically to the patient's "old" practice and if participating in the GP2GP scheme, the notes are relayed automatically to the "new" practice. Some transferred records, such as repeat therapy and allergies, will need the attention of a clinician at the "new" practice. The full user guide for GP2GP v1.1 can be downloaded from the INPS website www.inps.co.uk under Downloads - CfH.

Consultation Manager

Allergy Warnings

A clinical safety issue has been raised of which you should be aware.

The Vision Drug Dictionary is not able to give allergy warnings when drugs are prescribed which are in similar *action groups* to which an allergy has been recorded.

For example, both Atenolol tablets and beta-cardone are members of the supra-adrenoceptor blocking drugs action group; but if a patient had a recorded allergy to Atenolol, it will not flag a warning if the prescriber tries to prescribe Beta-Cardone.

Allergy warnings will only be given when prescribing the *same* drug to which there is an allergy, or when prescribing a drug *with matching ingredients* to which there is an allergy.

The few exceptions to this rule are NSAIDs, penicillins and cephalosporins which **are** groups that are currently checked against action groups.

> **Tip** - In order for drug checks to be made, in **Consultation - Options - Setup**, on the **Drug Check** tab, set **Contraindications, Precautions** and **Prescribed warnings** to Display All or Patient Specific; **Drug to Drug** to level 1 and **Doubling** to Same Action Group.

Immunisations

In September 2006, the Department of Health introduced new guidance on the childhood immunisation programme. Pneumococcal conjugate vaccine (PCV) is introduced to the routine childhood immunisation programme and the schedule for meningitis C (MenC) and Haemophilus influenzae type b (Hib) vaccines is modified:

- The addition of a PCV at 2, 4 and 13 months of age;
- one dose of MenC vaccine at 3 and 4 months;
- a booster dose of Hib and MenC vaccine (given as combined Hib/MenC vaccine) at 12 months of age.

In the October Read dictionary, the following Read codes for immunisations were included:

657L.00 1st pneumococcal conjug vaccin (First pneumococcal conjugated vaccination)

657M.00 2nd pneumococcal conjug vaccin (Second pneumococcal conjugated vaccination)

657N.00 3rd pneumococcal conjug vaccin (Third pneumococcal conjugated vaccination)

65b..00 Hib/meningitis C vaccination (Haemophilus influenzae type B and meningitis C vaccination

When to immunise	What is given	Protects against
Two months old	**DTaP/IPV/Hib Stage 1** One injection Pediacel **Pneumococcal Conjugate vaccine** (PCV) One injection Prevenar	Diphtheria, tetanus, pertussis (whooping cough), polio and *Haemophilus influenzae* type b (Hib) Pneumococcal
Three months old	**DTaP/IPV/Hib Stage 2** One injection Pediacel **Men C** One injection (Manjugate, Neisvac C or Meningitec)	Diphtheria, tetanus, pertussis, polio and Hib Meningitis C
Four months old	**DTaP/IPV/Hib Stage 3** One injection Pediacel **Pneumococcal conjugate vaccine** (PCV) One injection Prevenar **Men C** One injection (Manjugate, Neisvac C or Meningitec)	Diphtheria, tetanus, pertussis (whooping cough), polio and Hib Pneumococcal Meningitis C
Around 12 months	**Hib/MenC** One injection Menitorix	Hib and Meningitis C
Around 13 months	**MMR** One injection Priorix or MMR II **Pneumococcal conjugate vaccine** (PCV) One injection Prevenar	Measles, Mumps and Rubella Pneumococcal
Between 3 years and four months and five years old. Pre-school booster	dTaP / IPV or DTaP/IPV One injection Repevax (dTaP/IPV) or Infanrix-IPV (DTaP/IPV)	Diphtheria, tetanus, pertussis and polio
	MMR booster One injection Priorix or MMR II (check first dose has been given)	Measles, Mumps and Rubella
13 to 18 years old	Td/IPV booster One injection Revaxis and check MMR status	Tetanus, low dose diphtheria and polio

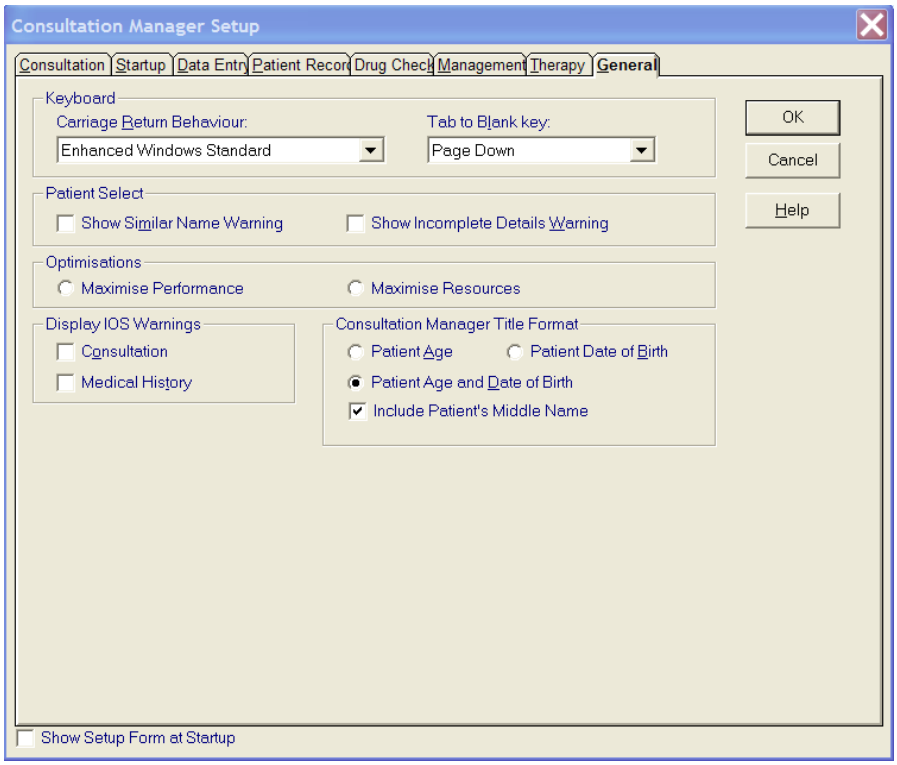
All patient's forenames on title bar

You can now choose to display patient's second as well as the first forename on the Consultation Manager title bar. This depends on the second forename having been entered in the patient's Registration details.

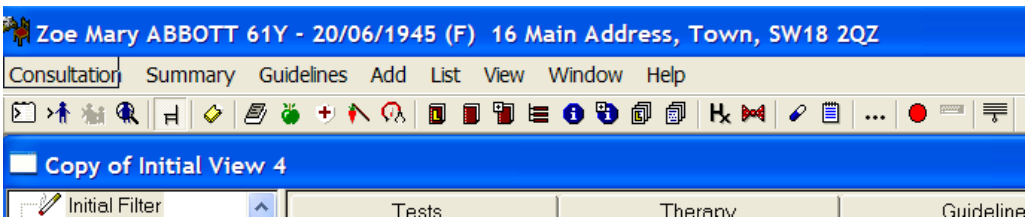
> **Note,** however, that switching on the display of the second forename has implications for practices using Correspondence Manager. The Mail Viewer in Correspondence Manager stops working if a second forename is set up to be displayed. Please consider the consequence of implementing the second forename feature before switching it on.

To implement the second forename

Go into **Consultation - Options - Setup** and select the **General** tab. Tick the box **Include patient's Middle Name**, and click OK.

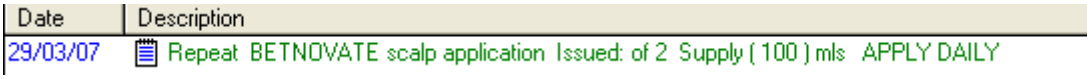


When you select a patient, the second forename, if entered in Registration, should be displayed on the title bar.



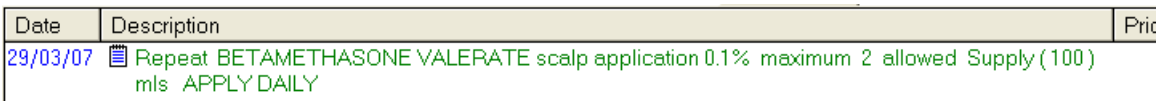
Repeat Masters journal entry changed

Prior to DLM 235, the wording on the Journal of a repeat master record was ambiguous and if added but not yet issued, could be interpreted as having been issued with the words "Issued: of 2 Supply (100) mls...":



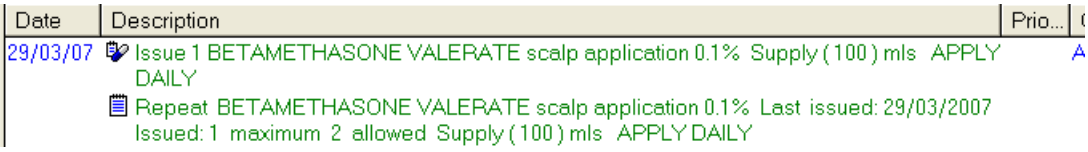
Pre-DLM 235

A similar entry made post DLM 235 will word it as "maximum 2 allowed Supply (100) mls ..."



Post-DLM 235

Once issued, the Journal entry looks like this - note that the Repeat line now has added the Last Issued date and instead of "Issued 1 of 2", it now says "Issued: 1 maximum 2 allowed".



Extra Type of attachment options

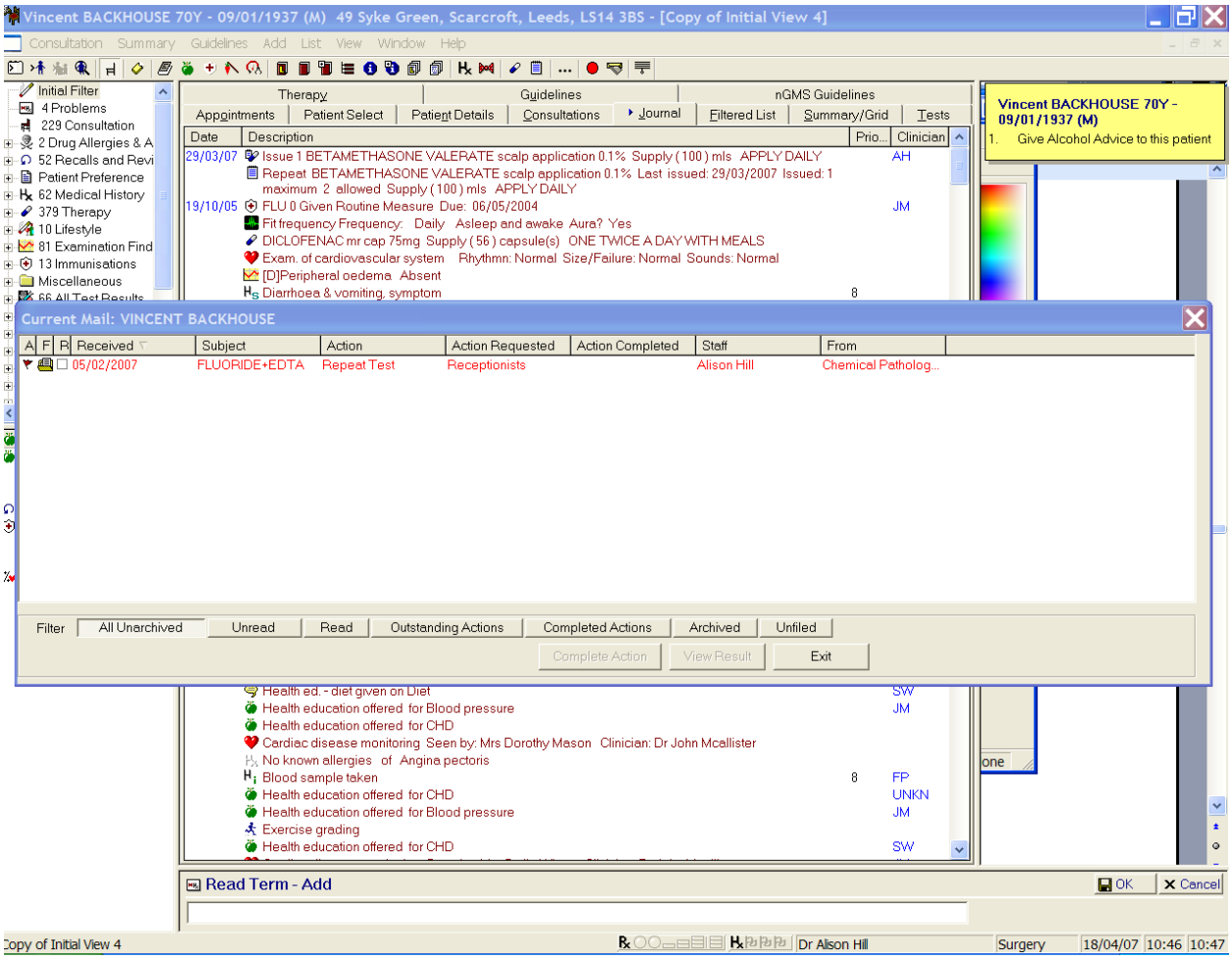
In Attachment - Add, there is a new option in Type of Attachment of Questionnaire. This is anticipating future functionality for those practice participating in THIN data collection.

For Scottish practices embarking on SCI Gateway Referrals, there are also two relevant options in Type of Attachment: SCI Referral Letter (see page 32) and SCI Discharge Notification.

Mailbox filters

There are new filter tabs on the patient's mailbox which lists Current Mail (accessed from  or **Summary - Mail for Patient**).

Unfiled lists only unfiled messages, and **Archived** those that have been archived. The first tab has been renamed **All Unarchived**. These filters have been introduced as part of the GP2GP project.



Choose and Book - Referral Message Digest

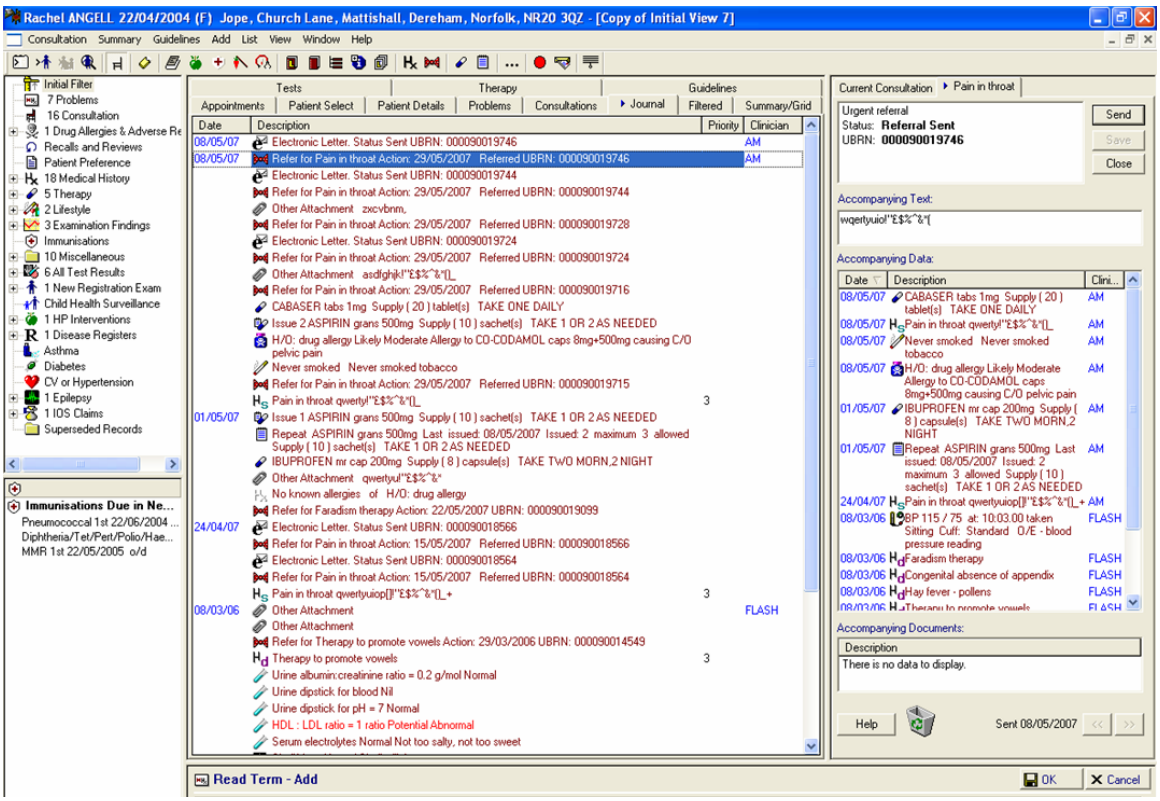
The current workflow surrounding a Choose & Book (CaB) referral message has been much improved with the introduction of the **Referral Message Digest** (RMD). This no longer relies on the use of problems. It will now be much easier to maintain and update a referral message for Choose and Book referrals.

> **Note** that Referral Message Digest will need switching on and each practice will be advised how to do this in due course.

The Referral Message Digest appears in the 'consultation pane' of the Vision 3 framework allowing it to be viewed side by side with other Vision 3 views and allowing easier drag and drop and data.

The structure of the RMD is such that it easily allows you to choose what information is sent in the referral message, including Free text, Accompanying Data from Structured data areas, and Accompanying documents (eg referral letter)

You can choose whether or not to pre-populate the structured data area (using right click within a RMD and selecting Management Options), and adding or removing data from this area is easier.



The Referral Message Digest screen

Start a Choose & Book Referral in the usual way. Check Online Booking, enter the Urgency and click the eBooking button.

On accepting a CaB referral, the Referral Message Digest (RMD) will automatically appear as a tab in the consultation pane. If the consultation pane is not already visible on this initial view of the Patient Record, then it will be made visible.

You can resize the vertical and horizontal boundaries of the RMD.

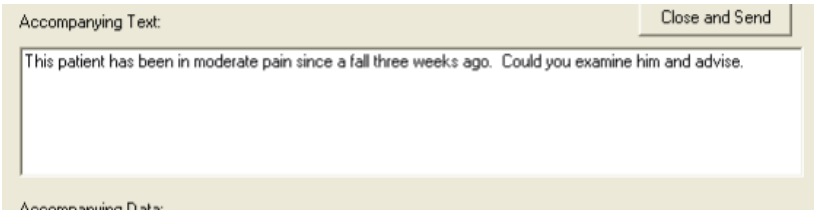
The RMD screen has four major areas: Status/Control Area, Accompanying (free) Text, Accompanying Data and Attachments.

Status/Control Area

The **Status** area appears at the top of the screen and relates back to the Vision referral record. The referral may have one of the following states:

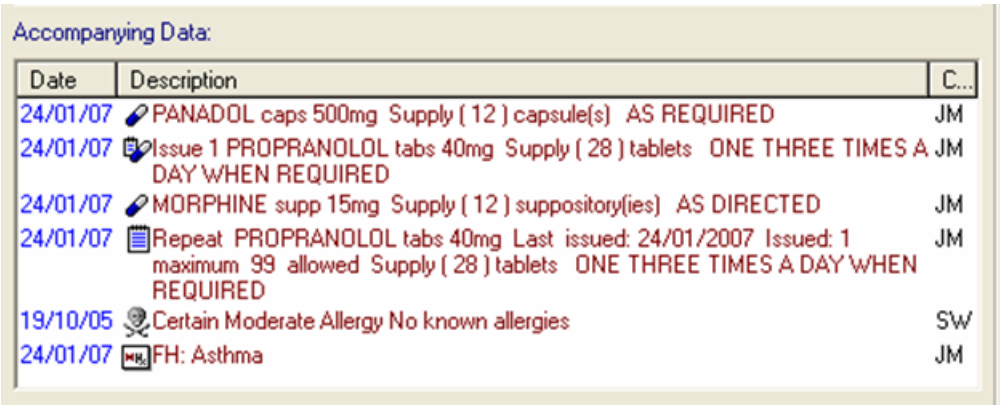
- **Referral Pending -** This is the initial state after saving the referral and indicates that the referral message is yet to be sent.
- **Referral Sent -** The referral message has been sent. Any changes to the RMD will change the status to **Referral Pending** indicating that the changes have yet to be sent.
- **Awaiting Send -** This indicates that a request has been made to send the message but the messaging engine has not yet processed it.

Accompanying Text



The minimum amount of data that can be sent with a referral is simply some free text accompanying it. The free text is optional and not populated by default.

Accompanying Data



The Accompanying Data area contains all the structured data to be sent with the referral (not including the referral record itself and certain patient demographics, including the UBRN, which are always sent). The initial population of the structured data area can be modified by changing the selected items on the Management Options screen which is accessed through the right click menu (see page 11).

To include additional information, drag it from the Journal or other list.

Use the auto populate option - right click within the RMD, select Management Options and tick the criteria you want (see page 11)

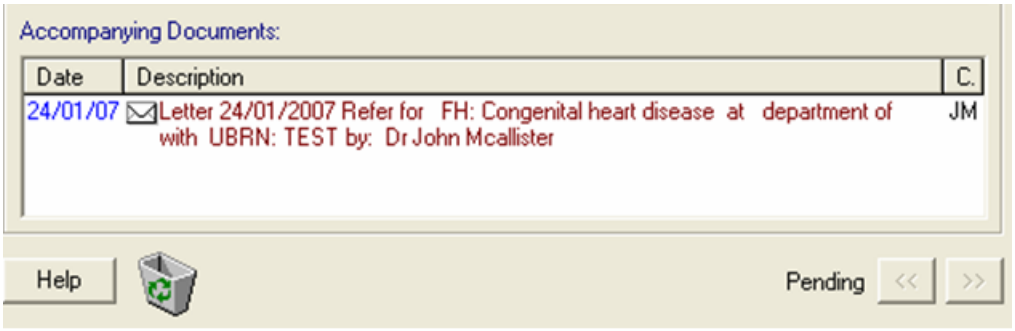
To remove information, do one of the following:

use the right mouse option **Remove selected Items**,

drag the item to a 'waste-bin' area,

select the item and press the **Delete** key.

Accompanying Documents



Letters and attachments occupy a separate screen area in order to emphasise that they are treated separately within CaB but the functionality is much the same as for any other structured data. Any letters or attachments dropped on the structured data area will be directed automatically to the Accompanying Documents area and vice versa.

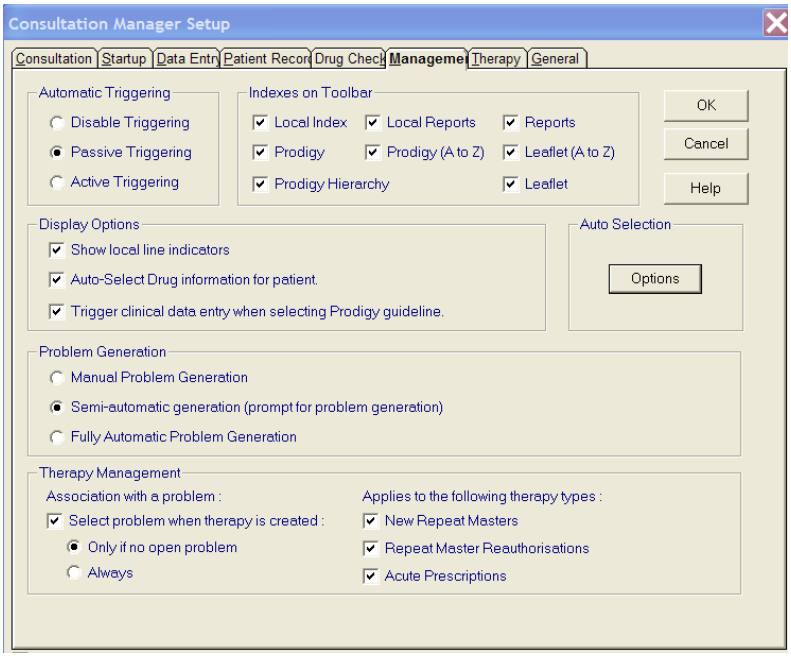
A maximum of four attachments can be added to an RMD and each attachment is limited to 745 kilobytes. If you try to add attachments that exceed these limits, an error message is displayed, stating which attachments could not be added and why.

Auto Selection Options defining the population of the RMD

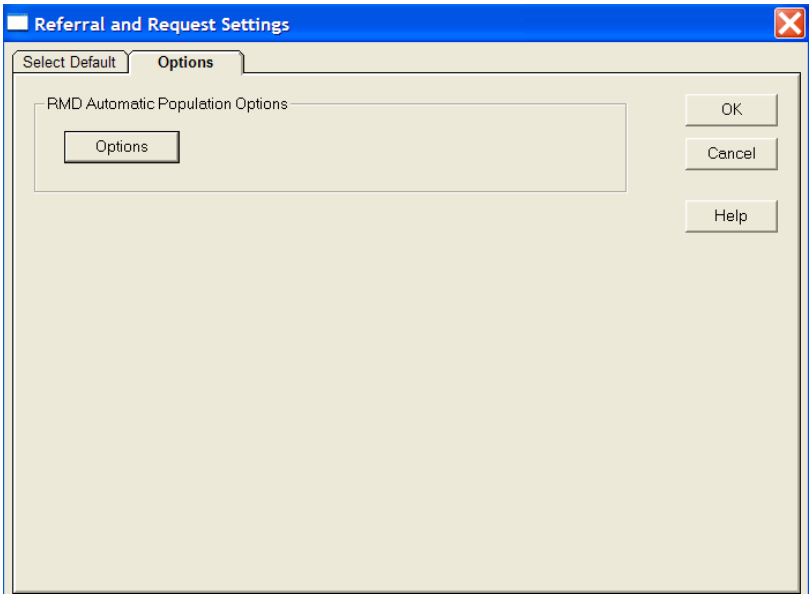
You can decide what data to include automatically in the Referral Message Digest. Note that this is on a login basis and does not apply globally.

There are three ways to access the Auto Selection Options - the first two do not require a patient record to be open:

- From **Consultation - Options - Setup - Management** tab, new **Options** button under **Auto Selection**.



- From **List - Default Referrals/Requests**, click on the **Options** tab, then under RMD Automatic Population Options, click on the **Options** button.



- If you have a patient record open displaying the Referral Message Digest screen, you can right click within the RMD and select **Management Options** for **Auto Selection Options**. Note that any change to Auto Selection via this option during a consultation will not take effect until the consultation is closed.

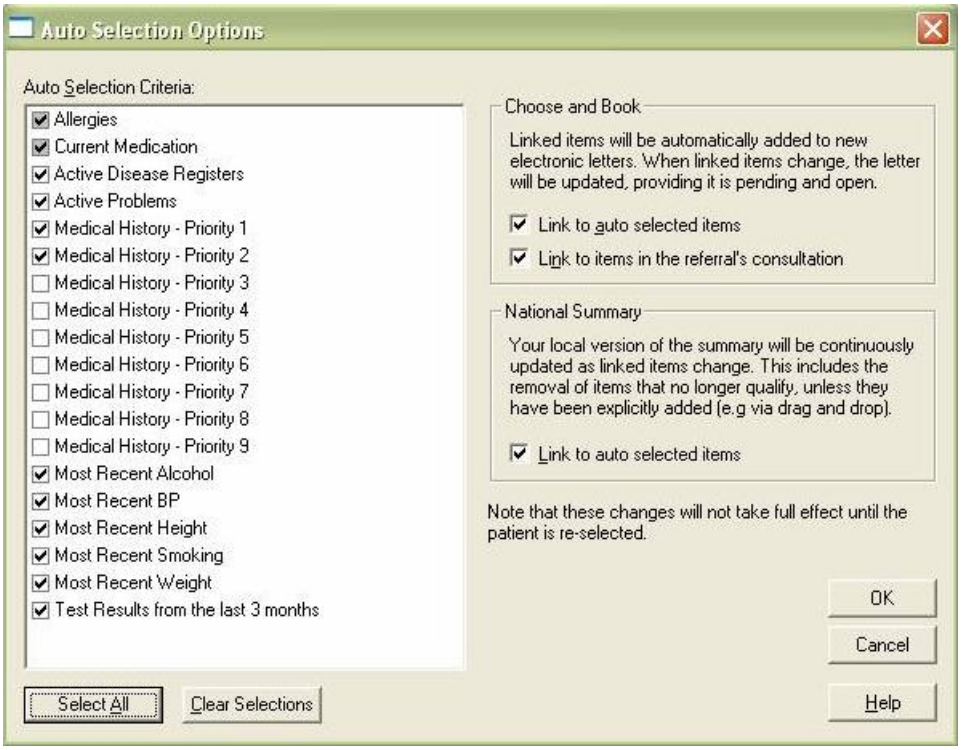
The Auto Selection Options screen

On the **Auto Selection Options** screen, select which data you want to be automatically included in the Referral Message Digest (or electronic letter as it is termed on this screen).

The top right pane relates to **Choose & Book** and the Referral Message Digest. The bottom right pane relates to the forthcoming National Summary, which is about to be piloted.

- **Link to auto selected items** - If this is checked, the RMD screen will be populated with data selected from the left-hand Auto Selection Criteria list. If you want to use this option, then tick those criteria you want included in the left-hand pane, or you can use **Select All** to check all the options (and then uncheck those you do not want). **Clear Selections** removes all ticks. If all items are unchecked, then the RMD will be blank.
- **Link to items in the referral's consultation** - This will populate the RMD with the current consultation data as well as, or instead of, those selected in Auto Selection Criteria.

Click **OK** to finish.



Send, Save and Cancel

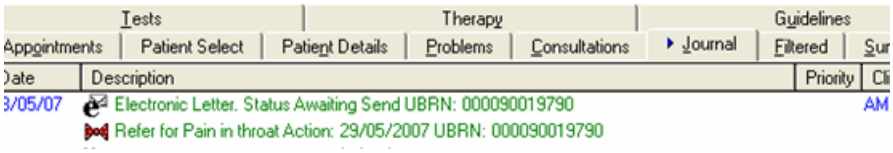
Send

In order to enable the **Send** button:

- You must be online.
- The patient must be synchronised or mismatched.
- The data must be different from the currently saved data.
- You must have rights to edit a C&B referral.
- There must be an open consultation.

The **Send** button is enabled only if the status is **Pending**.

Pressing Send will set the status to **Referral Awaiting Send** and close the RMD dialog.



Note If you change a 'Sent' message and press Save or Send, this will set the message back to Referral Pending or Referral Awaiting Send and activate the Previous button to allow you to view the last message.

Save

In order to enable the **Save** button, the RMD must contain at least one item in any of the areas: Free text, Accompanying Data, Accompanying Documents. In addition:

- The data must be different from the currently saved data.
- You must have rights to edit a C&B referral.
- There must be an open consultation.

Pressing the **Save** button will save the data, but *not* close the dialog. The button will then become disabled (see below for more details on this).

An "Electronic Letter" line is created in the Journal with a status of Referral Pending.

Cancel / Close

Pressing the **Cancel** button will discard any changes from this session, leave the status unchanged and close the RMD. If there are any unsaved changes then a dialog will be shown at this point:

> *Do you wish to save changes to the RMD?" <Yes> <No><Cancel>*
>
> If the data in the list does not differ from the saved selections, then the cancel button will be renamed **Close**.

If this is the only tab in the consultation pane, then closing this will result in the consultation pane being hidden.

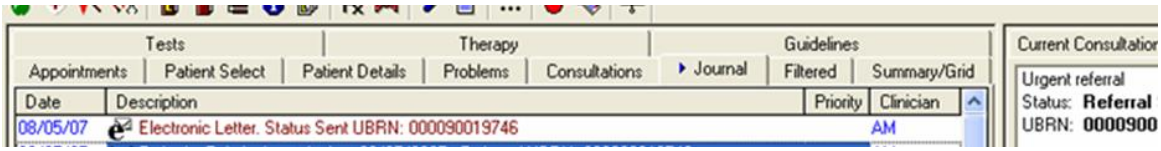
If the consultation is closed without taking either action on the RMD, then it will be saved in its current state with no further prompts.

Closing the consultation and sending the message

Closing a consultation sends the message if it is at 'Referral Awaiting Send' status. Reopening the consultation will show the 'Electronic Letter' with a status of 'Sent'

Journal entry

On the Journal entry, the RMD is called an Electronic Letter. Single click on this to re-display the RMD in order to edit it.

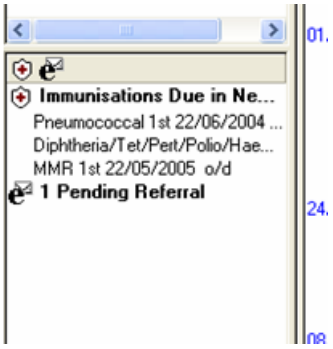


Note that both the referral and the electronic letter show the UBRN so it is easy to relate the two.

Subsequent Actions on RMDs

Having closed an RMD, it can be edited in the normal way by right clicking on the Journal line and selecting Edit. In addition:

- All pending RMDs will appear in the Alerts pane under the navigation pane on the left-hand side
- On opening a consultation for a patient with pending RMDs, these will be automatically opened.



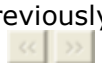
A pending referral is shown on the Alerts pane under navigation pane

Editing an RMD

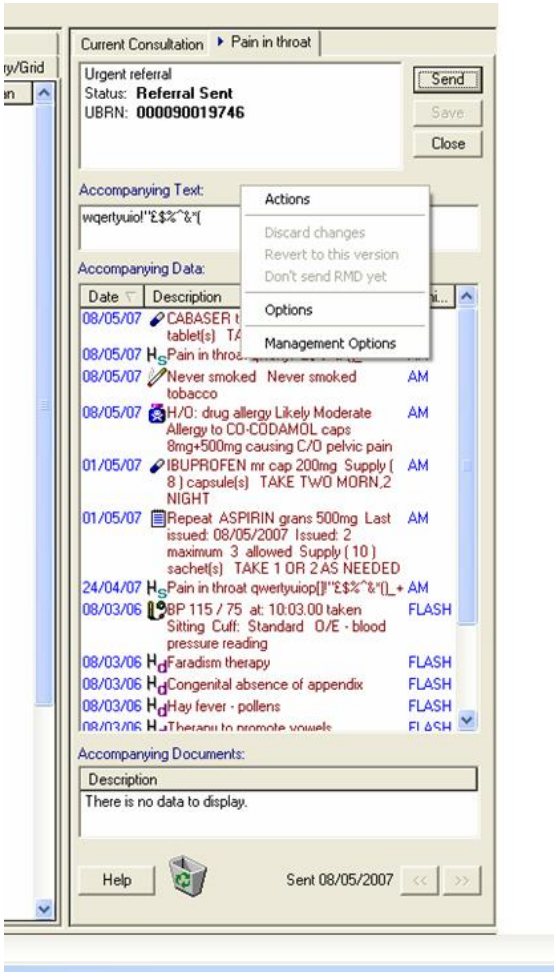
Any changes to an RMD will automatically change the status to **Pending** (if it is not already pending) and enable the **Send** option. It is possible to send multiple RMDs for a single referral; each one will replace the previous instance on CaB.

Right clicking on the RMD background displays the following menu options:

Discard changes - this button is available on the Pending version of an RMD. It will reverse all changes made in this session, restoring the referral status if appropriate.

Revert to this version - Available on Sent versions of the RMD. All previously sent versions of an RMD are stored within an audit trail on the record (though in practice it would be unusual to send more than one). You can review the contents of the previously sent RMDs using the buttons  at the bottom, editing as necessary and then send.

Don't Send RMD yet - Available when the status of the RMD is Awaiting Send. It resets the status to Pending.

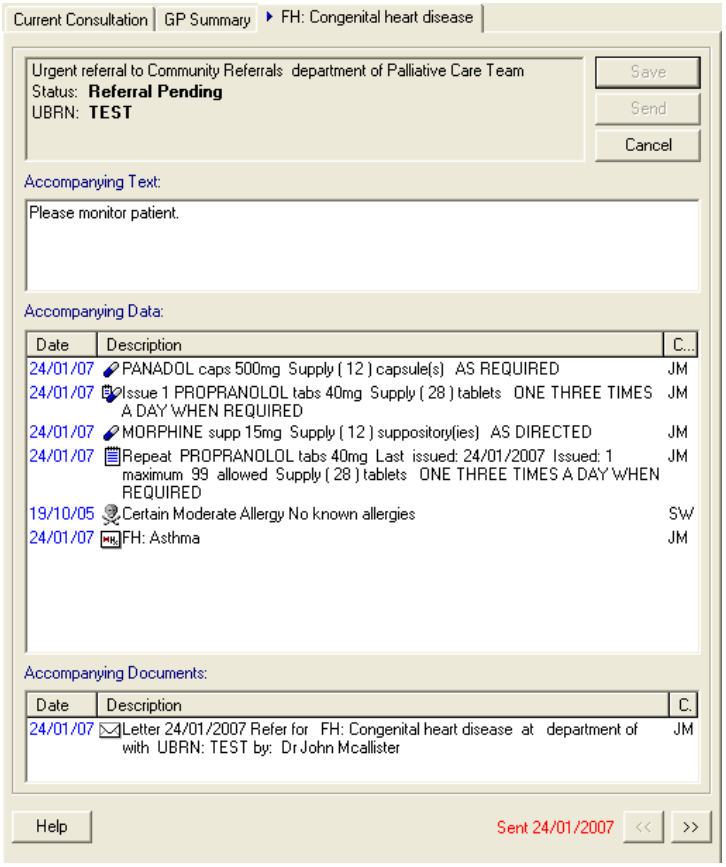


Previously sent versions

You can review the contents of the previously sent RMDs using the buttons at the bottom of the screen  . These arrows are not enabled until you have one sent version and have generated a further RMD. The left arrows show the previous sent version to the current one, and the right arrows the next version.

This allows you to edit the current Pending version and then Send.

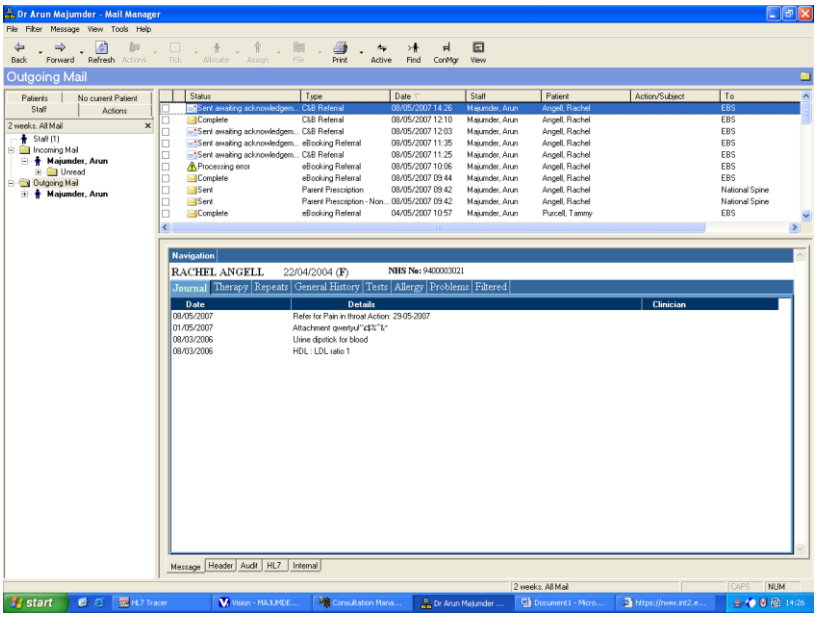
You can also display a previously sent version and right click and select **Revert to this version** before pressing Send.



In Mail Manager

In Mail Manager, you will see a new referral with a status of Sent Awaiting Acknowledgement which changes subsequently to Complete.

Note that the message is now called a C&B Referral (previously it was eBooking Referral).



Recording patient consent and dissent

It is important that patients, doctors and their staff understand for what patients can and cannot express their consent for record sharing.

The NHS Care Record Service has a number of components:

1. **PDS** (the Personal Demographics Service) stores names, ages, addresses and registered GP of all NHS patients. This data has been held by the NHS for many years in central computer systems and there is no option to opt-out of this service.
2. **PSIS** (the Personal Spine Information Service) will store details of patients' clinical records and medication. This data has only previously been held on local GP and hospital systems, not centrally. It is allowable for patients to opt out of this service, but they need to understand that this information will then not be available to other healthcare professionals when they are seen, for instance, in an Accident and Emergency department. If they refuse consent for their records to be shared, then a blank record will be created on PSIS to demonstrate that they have opted out. See National Summary - Recording Patient Preferences on page 19.
3. **EPS** (the Electronic Prescription Service) receives details of prescriptions from GPs for pharmacists to draw down and dispense medication items. It is not currently possible to withhold consent for this data to be shared, but it is only shared with the pharmacist who will dispense the medication and the Prescription Pricing Division of the NHS Business Services Authority. If patients do not want their prescriptions transmitted electronically, then GPs can continue to print them on paper.
4. **CAB** (Choose and Book) Choose and Book manages all aspects of GP referral letters and appointments electronically. Patient consent for CAB is now a separate consent area in its own right. This allows the patient to opt out of sharing of clinical information on PSIS but still allows for Choose and Book referrals to be sent electronically.
5. **Summary Care Record (SCR) / National Summary / GP Summary** - If the patient refuses consent for their records to be shared and opts not to have a SCR, then a blank record will be created on PSIS to demonstrate that they have opted out. Although, if required, the patient can refuse consent for their records to be shared but still have a SCR on PSIS which will only be accessible to their GP practice.

Vision supports patients refusing consent for their records to be shared on PSIS. There is an explicit flag that can be set, that will be transmitted to PDS to mark their records as refused consent to share the clinical record. In addition we are aware that GPs have been receiving advice to record a read code (93C3.00 "Refused consent for upload to national shared electronic record") in patients' records. If either condition is true before the Initial Upload, then Vision will transmit a blank National Summary record to PSIS.

National Summary - Recording Patient Preferences (England)

DLM 235 delivers a means of recording patients preferences to allowing their National Summary record to be stored on the spine. General release of this product is not planned yet but a number of pilot sites will be involved this year.

This section below explains what the National Summary is, and how to record the consent or dissent of a patient. It does not cover how the patient data is uploaded to the spine but this is explained in the full National Summary user guide which will be posted soon on the INPS website in the Downloads section under CfH.

What is the National Summary

Connecting for Health is planning for every patient in England to have a complete electronic Summary Care Record (SCR) by the end of 2008. This is also called the National Summary and sometimes, the GP Summary or NHS Care Record.

An individual is likely to be treated by a variety of care professionals in a range of locations throughout their life. The National Summary is a means of ensuring that the details of all their care and treatment are held in a single, easily accessible, electronic record.

Wave 1 of the National Summary rollout process includes:

- 16 weeks before the Initial Upload of patient summaries onto the Spine, there will be a public information campaign informing patients of what will happen and the choices they have. The period between the publicity campaign and the initial upload will initially be eight weeks, but extended to 16 weeks for later sites.
- Patients can contact their surgery to dissent or limit their participation if they wish to do so during this initial period.
- The National Summary software in Vision does not need to be "switched on" for patients' preferences to be recorded.
- Patients can also see a "preview" of what data is included in their National Summary, if the user has used their smartcard at least once in the past.
- The "preview" cannot at this stage be edited and only contains medication and allergy/adverse reaction data.
- On the day of the Initial Upload, a one-off upload of summaries will be automatically compiled and sent to the Spine for all non-dissenting permanent patients. This includes the current medication and allergies/adverse reactions.
- Dissenting patients will have a blank summary uploaded.
- After the Initial Upload has completed, patient summaries can be further updated and sent to the Spine from Consultation Manager. Data can be dragged and dropped into the summary, withheld or removed. There are options (on a per login basis) for automatic population of the National Summary (eg all History priority 1).

- Dissent and patient preference can be recorded and changed at any stage prior to and after the Initial Upload.

The initial upload for a consenting patient includes:

- Repeat medication in the last 6 months which have not been discontinued and are not more than 6 months past their review date. This also includes items which are recorded in Vision but which are prescribed elsewhere (eg hospital or special clinic) or OTC drugs taken by the patients and recorded in Vision.
- All repeat medications which have been discontinued in the last 6 months, including medication prescribed elsewhere and OTC drugs.
- All acute medication issued in the last 6 months, including medication prescribed elsewhere and OTC drugs.
- Suspected adverse and allergic reactions including allergies to drugs, foods and any other substances; recorded either in the Allergies and Intolerances SDA or Read coded allergies.

The initial upload for a dissenting patient includes:

- A blank summary which holds no clinical information but states tha the patient has dissented along with the date of dissent.

Note that the National Summary cannot be used on the Classic Framework of Consultation Manager. You must use a Vision 3 Framework.

Patient Consent or dissent for National Summary

Consent is assumed

It is assumed that all patients consent to having a Summary Care Record (SCR) on the Spine. Initially this will consist only of allergies and current medication. Before the introduction of an electronic SCR, there will be national and local information campaigns to inform the patient about consensual choices and the details of the scheme.

Patient preferences can be recorded in Vision without the National Summary software being "switched on".

What consent and dissent means for the National Summary contents

If a patient would like to opt-out, they can inform the practice of their dissent before the Initial Upload of the National Summary is carried out. At this stage they are not able to 'tailor' the summary which consists of current medication and allergies. If the patient decides to opt-out after the initial upload, the initial summary will be replaced with a blank summary. If patients choose to opt-out from data sharing, their SCR will only be visible to the authorised user.

If patients do not opt-out, an initial text based summary of their medications, allergies and adverse reactions will be uploaded to the Spine as part of the Initial Upload.

Two ways to record consent/dissent

You can record consent or dissent either by Read code or in Patient Details - Preferences. A record in Preferences takes precedence over a Read coded entry.

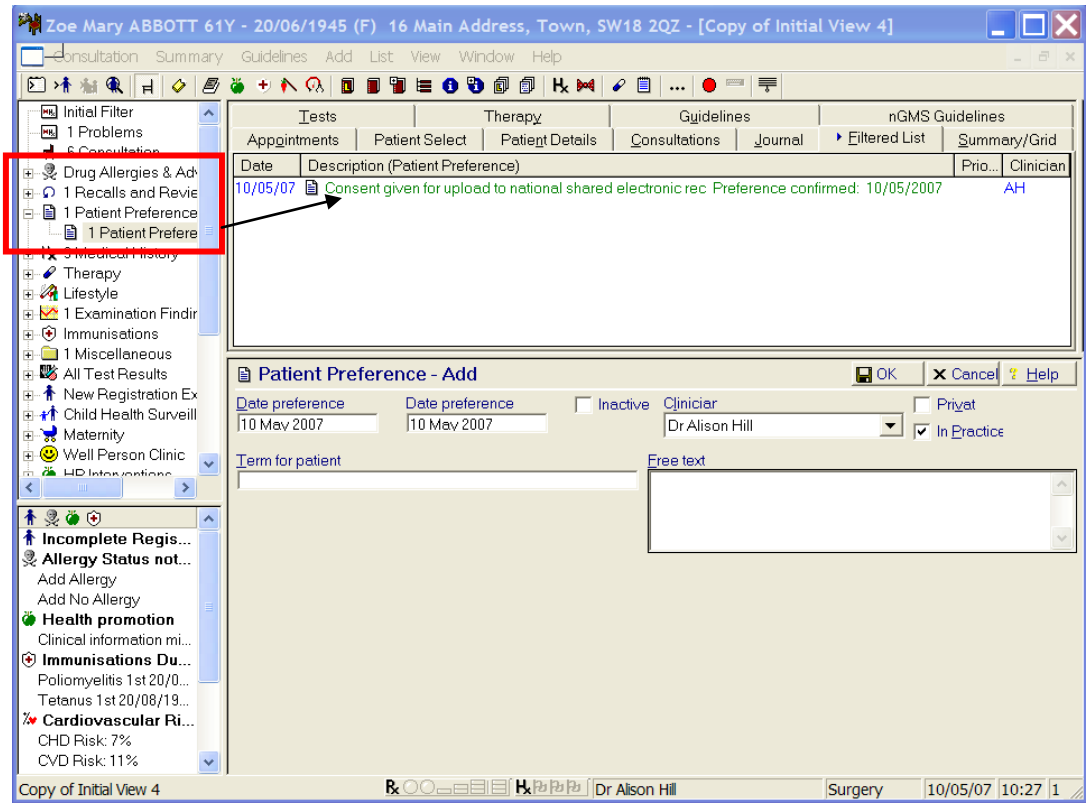
Recording consent/dissent by Read code

A Read code of **93C2 Consent given for upload to national shared electronic record** indicates implies the patient's consent.

The Read code **93C3 Refused consent for upload to national shared electronic record** indicates dissent and the SCR will not be generated as long as there is no subsequent Read code of **93C2 Consent given for upload to national shared electronic record**.

> **Note** The National Summary Patient Preferences take precedence over any Read code entry. Read codes will only be checked for consent if no patient preference record exists.

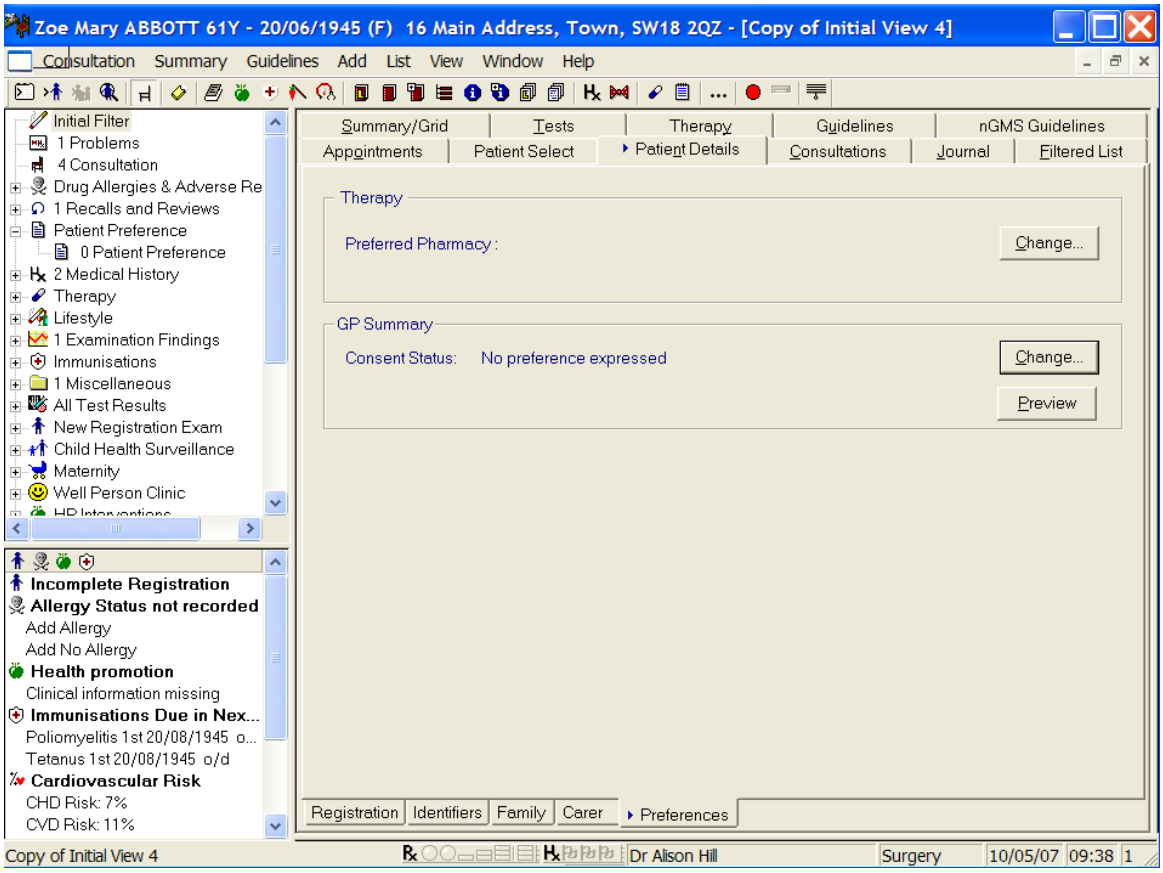
If you click on **Patient Preference** on the navigation pane, a **Patient Preference - Add** screen is displayed. Enter either #93C2 (consent) or #93C3 (dissent) and OK. The record can be filtered through Patient Preference.



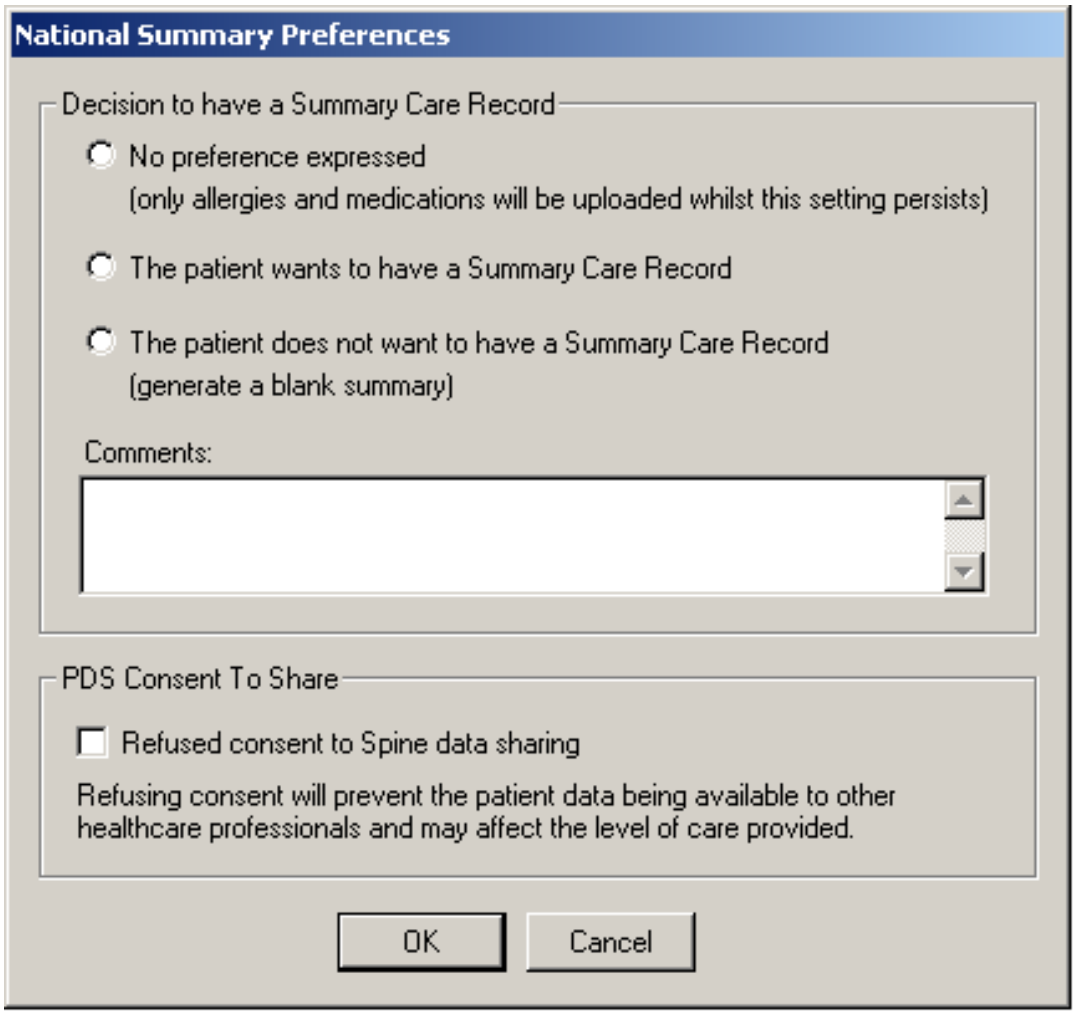
> **Training Tip** You might want to add a reminder to patients who are dissenting

Recording consent/dissent on Preferences

From DLM 235, you can record patient preference from **Patient Details** on the **Preferences** tab. Preferences recorded here take precedence over any previous Read coded entry for consent or dissent.



Click on the **Change** button by **GP Summary - Consent Status**.



There are three consent options on the **National Summary Preferences** screen from which to select:

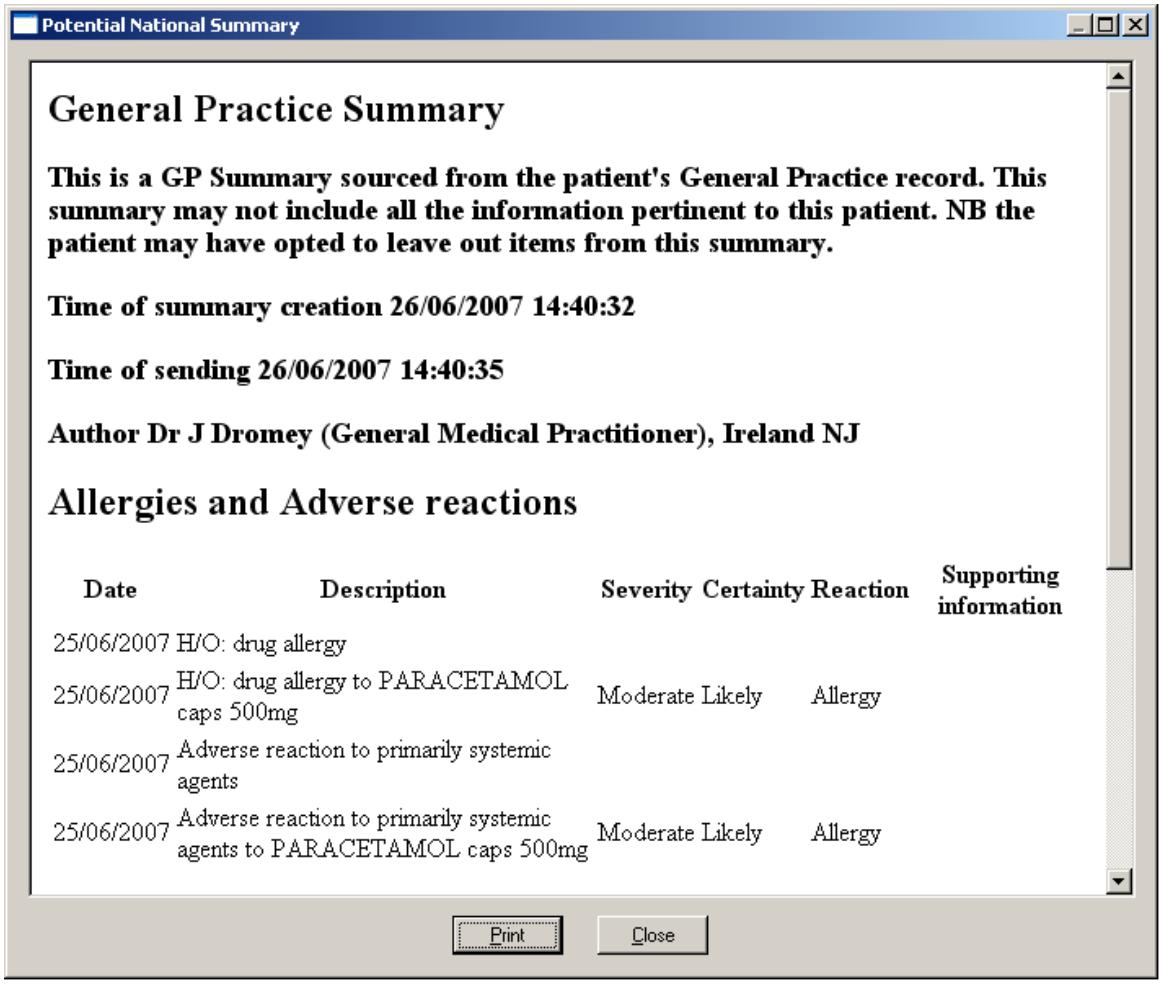
- **No preference expressed** is the default if a patient preference has not yet been recorded. Consent is assumed. When the one-off Initial Upload of patients' data is made to the spine, this will consist of current medication and allergies.
- **The patient wants to have a Summary Care Record.** The Initial Upload will consist of current medication and allergies and a clinician can subsequently update the summary with extra clinical data which is then sent to the spine.
- **The patient does not want a Summary Care Record (generate a blank summary).** When the Initial Upload is made to the spine, a blank summary will be sent under this patient's name. No other data will be sent to the spine unless the patient changes their preference to consent.

Enter any free text Comments and OK.

The bottom part of the National Summary Preferences screen is the same as the Consent dialog in Registration - Consent - **PDS consent to Share**. A tick in this box **Refused consent to Spine data sharing** means that patient details will not be available on the spine.

The **Preview** button on the **Patient Details - Preferences** is enabled if the user has at least once in the past used their smartcard, ie they have an SDS entry in Vision.

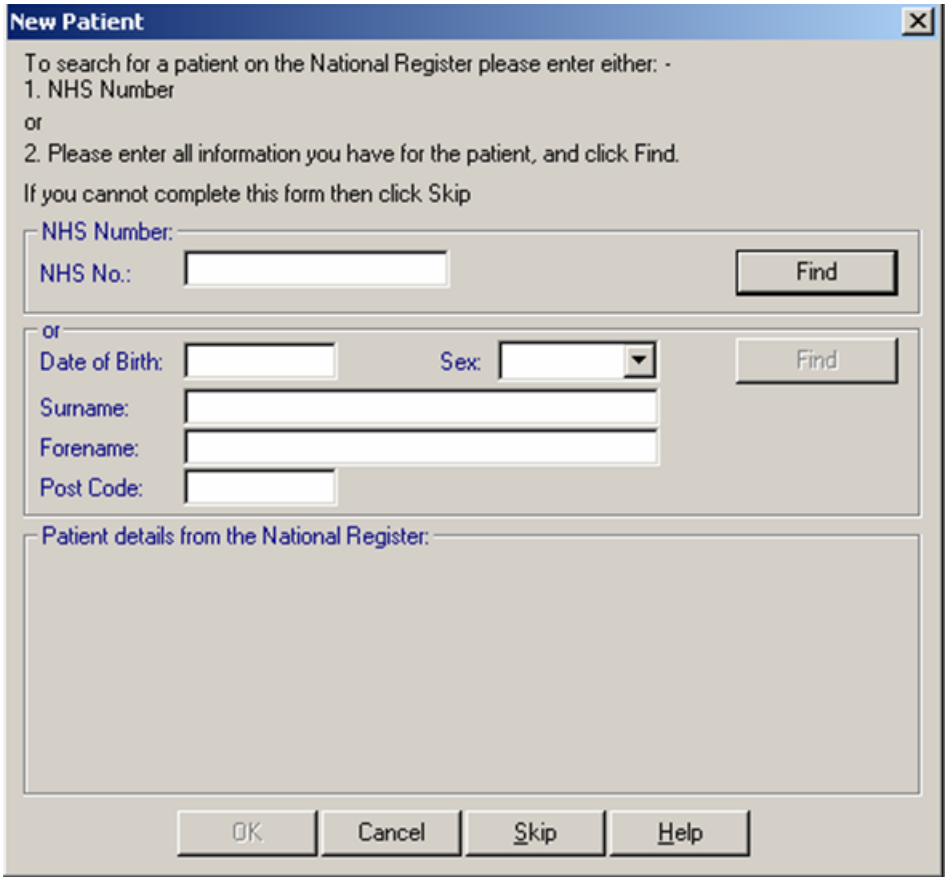
Preview lets the patient view the information that will be sent in the initial upload, ie current medication and allergies. Use **Print** to print this summary. Before an initial upload, there is no way to tailor this information. A blank summary will be sent if the patient dissents. After the initial upload, data can be added or withheld and the SCR re-sent. The patient's preference can also be changed.



PDS - Selecting patients and new registrations

Advance Trace from PDS

You can no longer search for a patient on the PDS by address if you are doing an Advanced Trace. If you don't know the NHS number, then use surname, forename and sex; and if needs be, the date of birth and postcode.



The address fields have been removed from the PDS patient select screen

New Registrations

Existing family surname only overwritten if off-line

Within Registration if you linked a new patient to an existing family, the surname is changed to the existing family surname. This has caused some problems with GP2GP and PDS as the surname is then updated on the Spine if the user didn't notice the changed name.

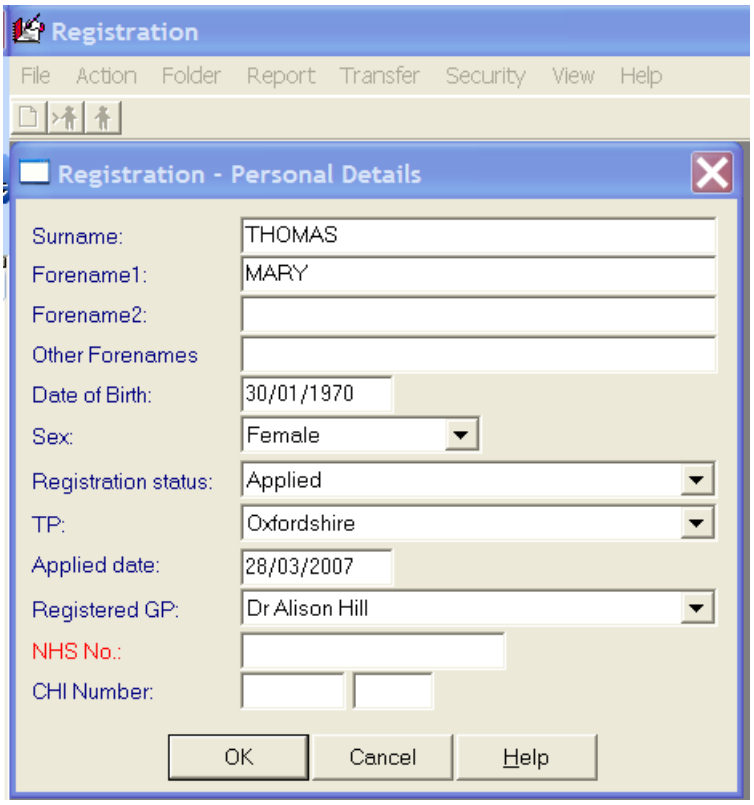
As families and people living together do not always having the same name, a change has been made.

- When on-line, registering a new patient and selecting Existing Family, the patient details will NOT be overwritten with the existing family details.
- When off-line, registering a new patient and selecting Existing Family, the patient details WILL be overwritten with the existing family details.

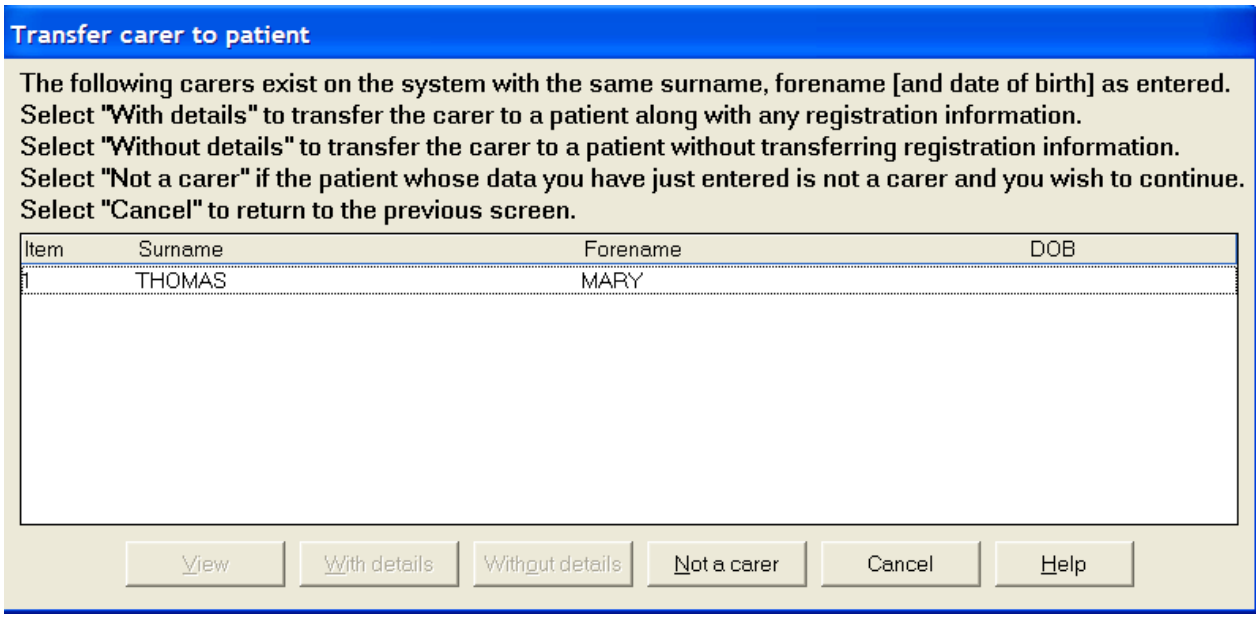
When online and registering a new patient who is a carer

As you know, patients can have carers recorded who are not from your Vision practice. This can be set up from either Consultation Manager - Patient Details - Carers, or from within Registration on the Carers tab.

If the carer then signs on as a new patient, then after completion of the initial Personal screen and clicking OK:



Vision will search the patient database to see if this patient is already registered. If there is a carer who matches the details entered, then a **Transfer carer to patient** screen is displayed:



Click on the patient you are registering to highlight their line. There are several options:

View lets you view the carer details including date of birth, address etc. Exit from this screen with Close.

With details will proceed with the new registration and automatically enter the carer's Title, Address and Comm numbers to be that of the patient. Note that the With details option is disabled if you are working on-line, so that you do not overwrite any details on the PDS.

Without details leaves those fields blank.

Not a carer - select this option if the patient whose data you have just entered is not a carer and you want to go on a register them anyway.

Cancel - returns to the previous screen.

The change is that now, if you are working on-line, the **With Details** button will be disabled. This will prevent you overwriting any existing PDS information about this patient. So whether you select New Patient (Existing/Selected/New Patient) and Without details or Not a Carer, the PDS details will not be overwritten with the carer address details.

Scotland - Organ Donor Consent

Introduction

The Special Health Authority, UK Transplant, maintains the NHS Organ Donor Register for the whole of the UK. This register records the most recently received details of a potential donor's expressed intentions, regardless of source (which may be the DVLA, ODR1 forms, GPRs, etc). Patients under 12 require parental consent. Those over 12 can decide for themselves.

When a patient registers with a GP Practice in Scotland, they are required to complete a GPR form which offers the patient the option to be registered as an organ donor. If this part of the GPR is completed by the patient, the GPR is passed to PSD (Practitioner Services) where the organ donor data is entered on CHI and then sent to UK Transplant for inclusion in the Organ Donor Register. Patients under 12 require parental consent; those over 12 can decide for themselves.

You will now be able to record and send this organ donor consent electronically from the GP practice to PSD as part of the patient registration process. This will facilitate an increase in organ donor registrations, whilst assisting practices in their move towards paper-light working.

What this user guide covers

This section describes the recording and transmission of patient voluntary consent to organ donation at the point of a new registration in Scotland.

Note that consent can only be recorded when registering a new patient in Vision and there is no facility for reviewing or changing consent within the system.

Switching on Organ Donor Consent

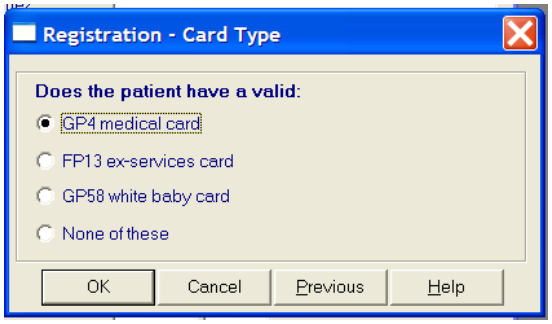
Once you have received DLM 235, your practice has the potential to switch on the Organ Donor Consent screen as part of the Registration process. Once switched on, and if when registering a patient, you don't know if any consent has been given, you can bypass the Organ Donor Consent screen by leaving it blank and clicking OK (see overleaf).

Recording consent in Registration

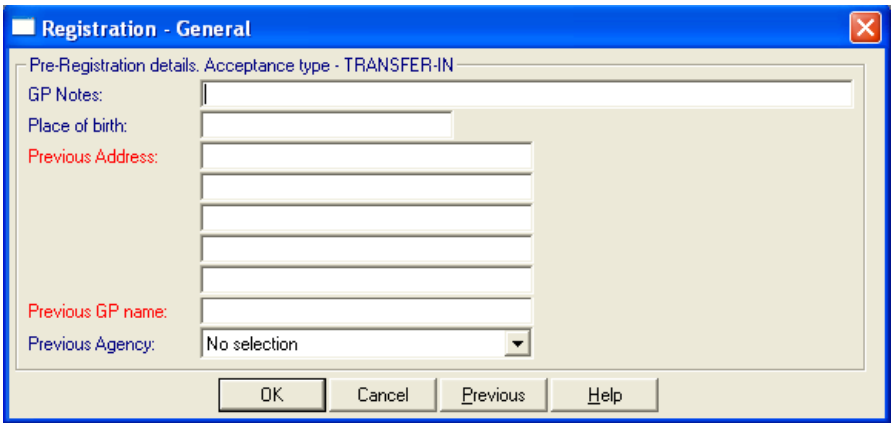
The patient should complete and sign the section marked 'Voluntary consent to organ donation' in the GPR form. The organ donor details can be entered as part of the Registration process.

Registering the new patient

The current registration process leads you through a series of pre-registration screens beginning with the **Registration - Card Type**:



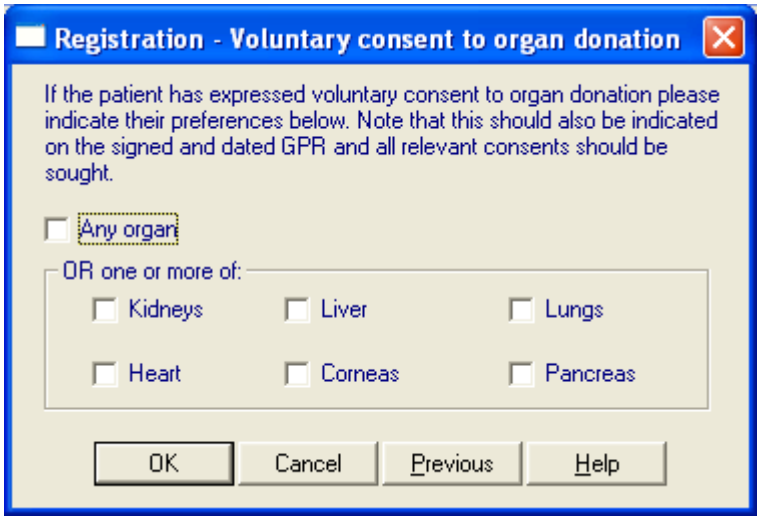
Thereafter, a number of screens appear to collect the required information. The end result of this process is the **Registration – General** dialog.



Registration - Voluntary consent to organ donation

After the **Registration - General** screen, you are prompted for consent to organ donation. This consent will only be sought if all of the following conditions are met:

- The practice is in Scotland
- The practice is participating in the Organ Donor project
- The patient's registration status is Applied



There are three options, one of which bypasses this screen if no consent is to be recorded:

- Checking the **Any organ** box will check and disable all the options in the frame below. The patient consents to any organ being donated.
- Unchecking the **Any organ** box will uncheck and enable all the options in the frame below to be checked as per the patient's wishes (kidneys, liver, lungs, heart, corneas, pancreas).
- Leaving both **Any organ** and the specific boxes for **Kidneys, Liver**, etc unchecked bypasses this screen if you just click OK. This implies either no consent has been given or the patient has not been asked.

On pressing OK, the registration process goes on to the next stage. It will be saved once you click the final OK and until the final acceptance is made, you can go back (using Previous) and review or amend responses.

Patient's signature on GPR

It is recommended that you ask the patient to sign the GPR with the organ consent. It is not possible to print the organ donor consent form from Vision.

Status of Organ Donor record

The status of the Organ Donor record can be:

Incomplete - New Registration has not been completed, i.e. Incomplete Reglinks

Unacknowledged - Awaiting Approval transaction (APF or APH) of new registration before organ donor record is written to Daily Transaction file

Complete - Organ donor record written to Daily Transaction file.

Patient Approval

Note that the Organ Donor transaction is not transmitted until *after* an Approval transaction for that patient has been received by the GP System or a 'manual' approval has been made.

If and when an Approval transaction is received from PARTNERS/Registration Links, and if an Organ Donor Consent record exists, then it can be viewed in the Daily Transaction file with a transaction type of ODR (Organ Donor Record) (see below).

GPC sends the message

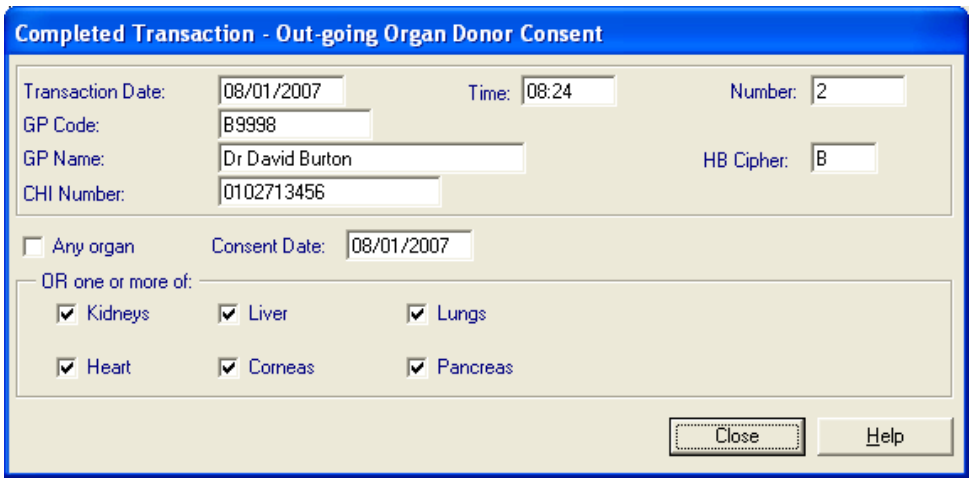
GPC will process these daily transaction records and assign a transaction number. An XML message is compiled and transmitted via a SOAP interface. The message contains the Transaction date and time, the transaction number, the Health Board

cipher, the GP code for the registered GP, the CHI number of the patient in the Approval transaction, the applied (registration) date for the patient, and either Any Organs or the specific organs which have been ticked.

You will not find this message in the Attention or Pending Folder as it is transmitted immediately and there is no acknowledgement. Note that you may be required to Re-Transmit this message (found in the Outgoing Folder) if there has been a message failure. The Quarterly Archive has been amended slightly to include these donor consent messages.

Viewing the consent later

To help determine what transactions are currently held in the Daily Transaction or Completed Transaction file, **Registration Links** has been changed to allow you to view these transactions on screen under **Completed Transactions - Outgoing Organ Donor Consent - View.** You can print a list of Completed Transactions from Action - Reports - Completed Transactions.



Record Read code for consent in Consultation Manager

You may want to record the organ donor consent in the patient's record in Consultation Manager. Relevant Read codes include:

1392. Will donate kidney

1393. Will donate cornea

8922. Consent to donate organs given (and add free text comment on which organs have been consented to)

13V1. Not willing to be a donor

SCI Gateway Referrals

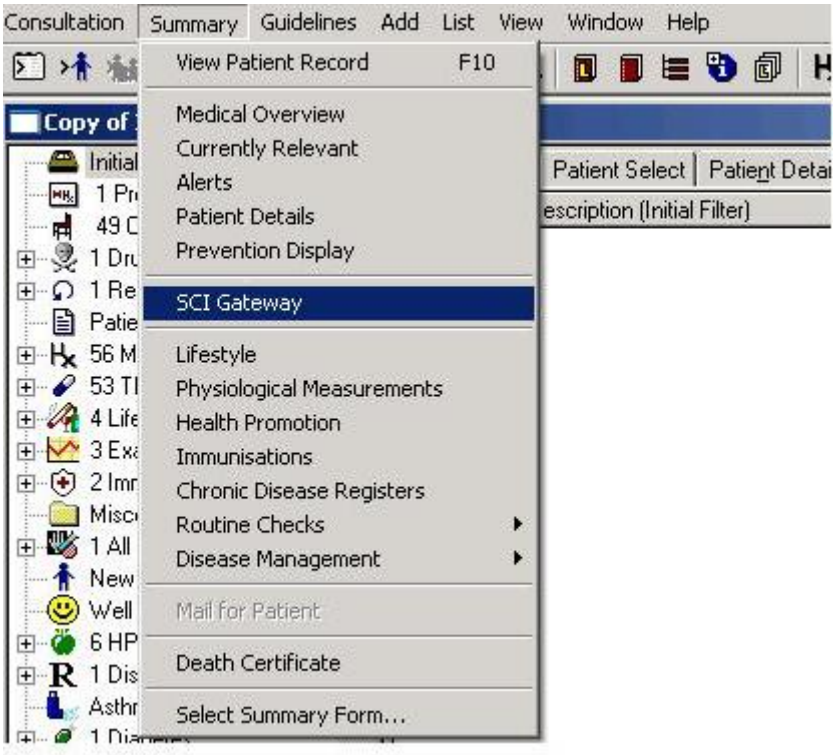
SCI Gateway is the national product in NHSScotland for the electronic exchange of clinical information – such as referral letters and discharge documents – between Primary and Secondary Care. You can use SCI Gateway to send referrals directly to healthcare providers via the NHSNet, and you can monitor the progress of referrals once they have arrived at the hospital.

This section explains the integration of SCI Gateway with Vision Consultation Manager, and how to access and logon to SCI Gateway, in order to create and send a referral. Further user guides from SCI Training can be found at http://www.sci.scot.nhs.uk/training/train_docs.htm

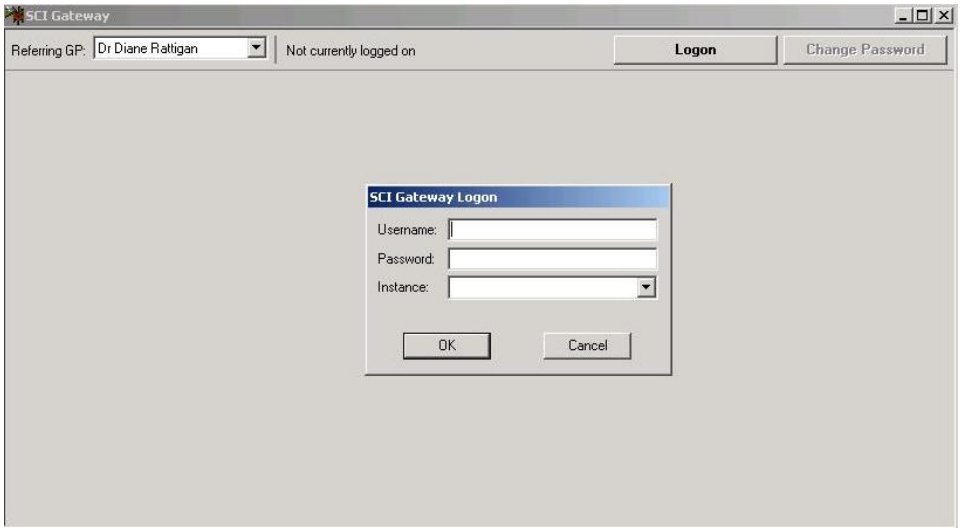
Integration with Vision

SCI Gateway integrates with Vision via Consultation Manager, instead of using the SCI Gateway Icon on the desktop.

1. First select the patient in Consultation Manager.
2. Then select **SCI Gateway** from the **Summary** menu.



3. At the SCI Gateway screen, click on **Logon** to display the login window. Sign into this and click OK. Your local health board issue and maintain user names and passwords and any queries regarding these should be directed there in the first instance.



4. At this point the SCI GATEWAY Referral Screen is displayed.
5. You can use this to complete the referral. Note that in the top left hand corner of the window there is the "Referring GP" drop down menu which allows you to select the referring GP before creating the referral.
6. When the referral has been completed in SCI GATEWAY and submitted, a copy is saved as an attachment in Vision, using Type of Attachment on the Attachment - Add screen of SCI Referral Letter. Note there is also an option under Type of Attachment of SCI Discharge Notification.