	SCR enhancements to GP IT systems - Guidance for GP Practices			
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SCR enhancements to GP IT systems Guidance for GP Practices

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Glossary of Terms:

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1 Purpose of this guide

This guide is aimed at GP Practices who are currently live with the Summary Care Record (SCR). It describes at a high level the SCR enhancements and functionality that will be coming in GP IT systems.

Some sections of this guide will be relevant to all practice staff, some to only clinical staff, and some only to system administrators or staff with specific roles or responsibilities in your practice.

It is assumed that you will already be familiar with the SCR and understand the concepts behind the use and management of the SCR. A prerequisite level of understanding can be found in 'NHS Summary Care Record Guide for GP Practice Staff.'¹

2 Introducing the enhancements

Enhancements are now being introduced in SCR GP IT systems to improve the way they interact with and send information to the SCR. Many of the enhancements are improvements in the usability of the SCR functions within your GP IT system which will provide greater support and improve your GP Practice experience of SCR.

Some of the improvements have been made as a result of feedback from staff in GP Practices. Some have been made based on feedback from clinical staff who are using the SCR to support patients who present for urgent and emergency care. Others have been made following collaborative work between NHS Connecting for Health, the BMA and RCGP.

The significant changes are the activation of the new SCR Consent Preferences to help GP Practices manage SCR consent for their patients, the introduction of the ability for practices to view the SCR to support care of temporary residents and the inclusion of the date of last issue for current repeat medication.

The enhancements are described in the following sections:

- Managing Patients' SCR Consent Preferences
- SCR content
- Maintaining and updating the SCR
- New patient registration
- Viewing the SCR of temporary residents
- SCR GP IT system administration

Whilst this document outlines the enhancements at a high level, the detail of how each GP IT system implements these improvements will be made available as GP IT system providers develop these improvements. The enhancements may be introduced in your GP IT system in a phased manner, i.e. some may appear before others. **Your GP IT system supplier will let you know when they are being introduced in your system.** They will provide more detailed guidance and training material specific to your GP IT system which will be supported by NHS CFH communiqués.

3 Managing Patients' SCR Consent Preferences

Following close collaboration between NHS Connecting for Health, the BMA and RCGP, four new SCR Patient Consent Preferences were introduced in April 2011ⁱⁱ. These support GP Practices to more accurately reflect patients' wishes and provide clearer information to GP Practices on the effect of each preference on the content of the SCR. They support patients who wish to change their preference including those who have previously opted out but subsequently decide that they wish to have an SCR containing only core information

The SCR Consent Preferences are:

- Implied consent for medication, allergies, and adverse reactions only
- Express consent for medication, allergies, and adverse reactions only
- Express consent for medication, allergies, adverse reactions AND additional information
- Express dissent (opted out) - Patient does not want a Summary Care Record

This section explains how these consent preferences will function in the new systems and how the historic consent preferences will be managed.

3.1 Activation of SCR Consent Preferences

Each SCR Consent Preference is associated with a Read or CTV3 code. Whilst the codes are available now, they will only be activated, i.e. recognised and used to control the flow of information to the SCR, when the improvements to your GP IT system have been introduced.

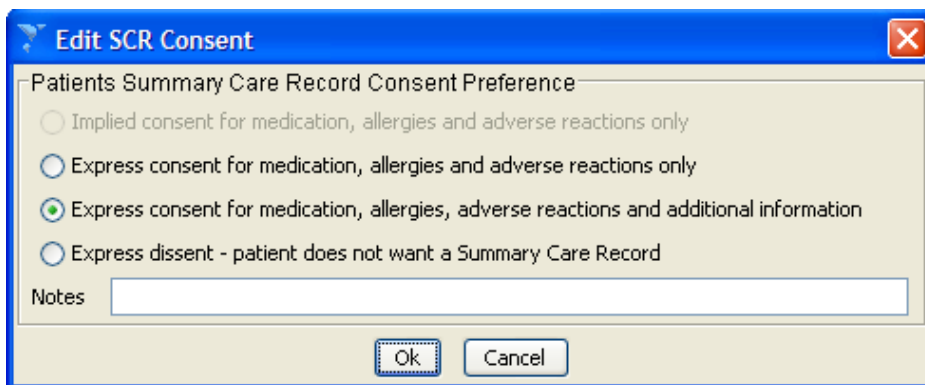
The following table shows the SCR Consent Preferences with their associated codes and terms; and the effect each preference will have on the content of a patient's SCR. The most recent consent preference will be the preference that determines the content of the SCR.

SCR Consent Preference			Effect on the content of a patient's SCR	
Wording on SCR Patient Consent Preference management screen	Code ¹			
	Read 2	CTV3	Code Term	
Implied consent for medication, allergies, and adverse reactions only	9Ndl.	XaXbX	Implied consent for core SCR dataset upload	The SCR will only contain medication, allergies and adverse reactions.
Express consent for medication, allergies, and adverse reactions only	9Ndm.	XaXbY	Express consent for core SCR dataset upload	The SCR will only contain medication, allergies and adverse reactions.
Express consent for medication, allergies, adverse reactions and additional information	9Ndn.	XaXbZ	Express consent for core and additional SCR dataset upload	The SCR will contain medication, allergies and adverse reactions and any additional information the patient has given explicit consent to be included..
Express dissent (opted out) - Patient does not want a Summary Care Record	9Ndo.	XaXj6	Express dissent for SCR dataset upload	No SCR will be available as the patient has opted out

¹ EMIS LV, INPS Vision and iSOFT Synergy use Read codes. TPP SystemOne use CTV3 codes

An enhanced SCR Consent Preference management screen will support GP Practices to understand and change the patient's SCR Consent Preference. When notified by their GP IT system supplier that their system is ready to recognise these preferences, the GP Practice will be able to use the enhanced SCR Consent Preference management screen to manage patient consent.

An example of a screenshot showing the new SCR Consent Preferences:



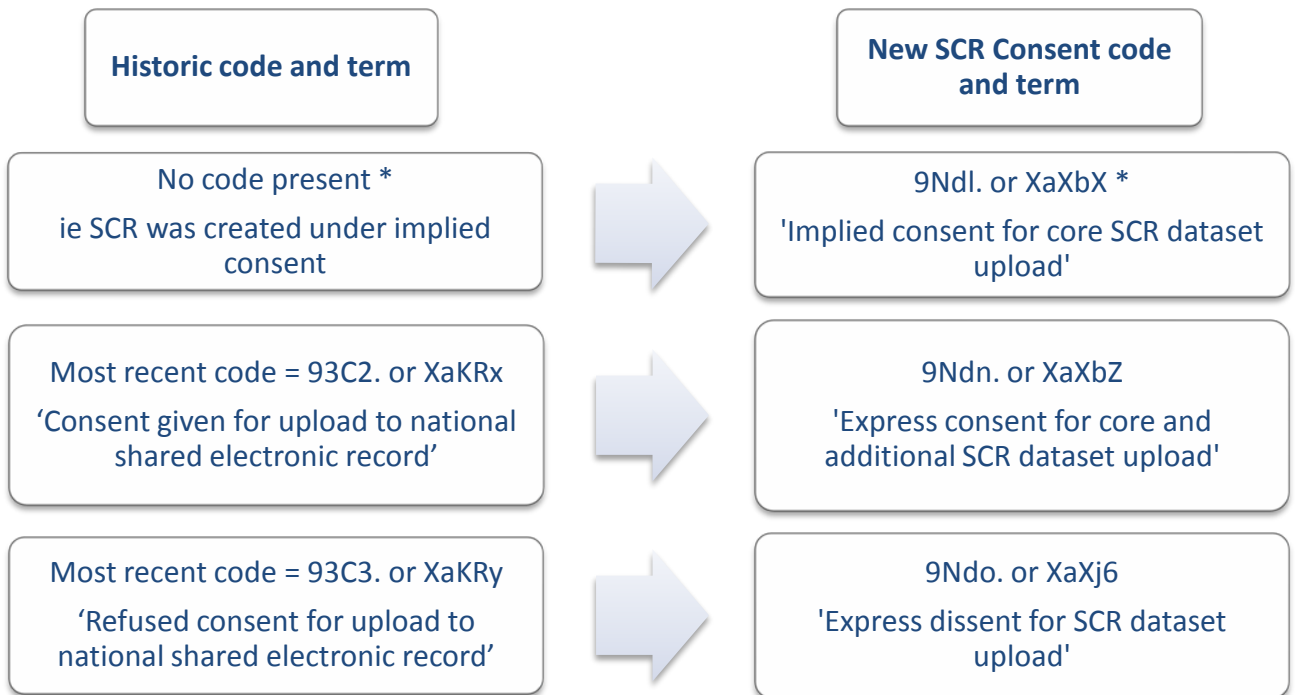
Once a patient has expressed a preference it is not possible to revert the patient to 'implied consent' in the SCR Consent Preference management screen

GP Practices can enter free text notes in the SCR Consent Preference management screen to record supporting information e.g. if the patient has changed their consent preference then the GP Practice may wish to record extra information about that decision.

3.2 Managing historic SCR Consent Preferences

In order to support patients and GP Practices who have used the historic SCR Consent Preferences, a process will occur that will ensure that the most recently entered historic SCR consent code and preference in the patients' electronic record will be mapped to a new SCR Consent Preferences. This will occur once for the whole practice as part of the upgrade to the GP IT system. The historic SCR consent codes will remain in patients' records as part of their medical record.

Patients fully registered at the practice will have their SCR Consent Preferences mapped as shown below:



* The migration of 'no code present' to the new implied consent code will only occur if the patient already has an SCR. Reports can be run on the GP IT system to identify whether any fully registered patients do not have an SCR so that an SCR can be created for them.

Some GP IT systems may still allow the historic codes to be entered in the GP IT system and where entered they will affect the content of the SCR as described in the diagram above. However, the use of the historic codes should be avoided as they do not give the accuracy or granularity of patient control that are offered by the new SCR Consent Preferences.

In preparation for the mapping process, GP Practices should be satisfied that the most recently recorded code accurately reflects the patients' choice. Many GP Practices will have already performed this process following the 2010 Ministerial Review using guidance on the SCR websiteⁱⁱⁱ. Practices may prefer to use the new SCR Consent Preferences, once they know they are activated in their system, prior to the mapping exercise in order to accurately record the patient's preference.

3.3 Opt-out preferences updated centrally

Previously, where a patient has decided to opt out from having an SCR, this preference was held only in the local GP IT system. One of the enhancements will be that this preference is held centrally (on the Spine) as well as locally in the GP IT system. This has been introduced so that SCR viewing systems being used by staff in urgent and emergency care settings can recognise immediately that the patient will not have an SCR to view and help ensure that valuable time is not spent looking for an SCR of a patient that has opted out. This will also provide further reassurance for patients moving practices who have expressly stated that they do not want to have an SCR, as the recording of this preference centrally will mean that an SCR cannot be created, accessed or updated by any IT system.

GP Practices will not need to manage this process as it should occur automatically when a patient's SCR Consent Preference is changed to or from "Express dissent (opted out) - Patient does not want a Summary Care Record". However, in rare circumstances they may be a mismatch between what is held locally and what is held centrally. In this situation the GP Practice user will be presented with a message asking them to confirm the consent preference.

3.4 Other improvements supporting the management of SCR Consent Preferences

The following improvements do not require GP Practices to take any action. However, GP Practices may wish to be aware of these improvements and how they will support Practices:

- The history of the patient's SCR Consent Preference will be directly viewable from the SCR Consent Preference Management screen.
- The patient's SCR Consent Preference should be visible in any part of the patient's record. This may be through the use of a unique icon or a message in the patient banner.
- A report showing current SCR Consent Preferences can be easily generated for all patients fully registered with the practice. This will support practices manage SCR Consent Preferences across their practice population.
- When GP Practices perform an initial upload, all patients who have not expressed a preference will have the 'Implied consent for medication, allergies and adverse reactions only' preference added to their GP electronic record.

4 SCR content

An SCR is made up of the following core patient information from the GP electronic record:

- Medication (acute, current repeat and discontinued repeat medication)
- Allergies
- Adverse Reactions

The SCR is updated whenever there are changes made to medications, allergies or adverse reactions in the GP IT system. Additional clinical information beyond the core data, for example significant diagnoses or care plans, can be added to the SCR by a patient's GP practice where the patient has given explicit consent^{iv}.

Improvements to the content of the SCR e.g. the date of last issue for repeat medications, are being introduced following feedback from clinical staff in a variety of care settings who are using the SCR to support patients who present for urgent and emergency care.

4.1 Changes to 'core' SCR content

No changes are being made to allergies or adverse reactions, however, several changes are being made to the medication content. These changes are described for your information but do not require you to take any action as your GP IT system will manage these in the background.

Medication type

A variety of medication types can be used by GP Practices, for example, repeat dispense medication, post-dated acute medication and medication prescribed elsewhere. Where GP IT systems support the entering of this type of information and GP Practices choose to enter medication in this manner, the upgrade will ensure that the medication type is clearly displayed in the SCR. This is to support healthcare staff viewing the SCR to understand the different types of medication used by GP Practices.

Where a repeat dispense medication is present, the SCR will display the number of repeats authorised by that repeat dispense prescription.

Medication dates

The update to SCR functionality will mean that the dates displayed in the SCR will be more relevant to the type of medication and whether it has been issued by the GP Practice. The table below summarises the date information that will be displayed in the SCR for different types of medication.

Medication type		Date information displayed in the SCR
Repeat medication	Issued by the Practice	Last issued: xx-xx-xxxx
	Not yet issued by the Practice	Authorised (not issued): xx-xx-xxxx
Repeat dispense		Authorised: xx-xx-xxxx
Repeat medication prescribed elsewhere		Entered: xx-xx-xxxx
Acute medication		Prescribed: xx-xx-xxxx
Post-dated acute medication		Post date: xx-xx-xxxx
Acute medication prescribed elsewhere		Entered: xx-xx-xxxx

Discontinued repeat medication will continue to include the date of discontinuation. However, any acute medication that has been cancelled will now also include the date of cancellation.

For improved clarity for healthcare staff viewing the SCR, all acute and discontinued repeat medication tables will now include the date range that applies e.g. "Discontinued Repeat Medications (For the 6 month period 10-Jan-2010 to 09-Jul-2010)"

Medication history

Previously only current repeat medication that was no more than 18 months past its last review date and the last 6 months of acute medication were included in the SCR. Feedback from healthcare staff viewing the SCR indicates that they would prefer more information about the patients' medication. Therefore, the update to SCR functionality will mean that all current repeat medication that has not been discontinued and all acute medication prescribed in the previous 12 months will be included in the SCR. There will be no change to the discontinued repeat medication i.e. the previous 6 months of discontinued repeat medication will continue to be included.

4.2 Changes to 'non-core' SCR content

Information beyond the 'core' SCR content can only be included with the patient's explicit consent. **The additional information will only flow to the SCR if their consent preference is set to 'Express consent for medication, allergies, adverse reactions and additional information' and the information e.g. diagnoses are coded and marked to be included in the SCR.** Therefore, the inclusion of additional information in a patient's SCR requires specific actions by the GP Practice.

A webpage exists that is a resource for GP Practices which brings together key guidance for managing additional information. This webpage contains advice on implementing explicit consent for additional information and a high level overview of adding additional information using GP IT systems ^{iv}.

The following changes are being introduced for specific aspects of 'non-core' SCR content:

- Where GP IT systems support the linking of medications to a 'reason', for example a diagnosis, this linked 'reason for medication' will only be added to the SCR if the 'reason' is coded and specifically marked to be included in the SCR.
- Where GP IT systems support 'reasons' for cancellation or discontinuation of a medication, the 'reason' for cancellation or discontinuation will only be added to the SCR in certain circumstances. This will occur if the 'reason' is coded and specifically marked to be included in the SCR or in certain GP IT systems where the user chooses a 'reason' from a predefined list. GP Practices should ensure that allergies and adverse reactions, including those which may be a reason for cancelling or discontinuing a medication, are continued to be recorded in the appropriate manner in their GP IT system to ensure that the allergy or adverse reaction is included in the core information of the SCR.

GP Practices should be aware of the changes being introduced as described above and the guidance available on the additional information webpage.

5 Maintaining and updating the SCR

Improvements in the way that GP IT systems maintain the SCR are being introduced following feedback from GP Practices that are already live with the SCR. These will ensure that the patient and practice remain in control of the content of the SCR, but will minimise the impact on practice staff and help ensure that the SCR is kept up to date in line with local records.

5.1 Prompts

GP Practice feedback has indicated that prompts related to the SCR can appear too frequently or inappropriately. In response to this the upgraded systems will ensure that prompts should only appear where appropriate and necessary e.g. when healthcare staff need to take an action or be alerted.

5.2 Use of Smartcards

The improvements to SCR functionality in GP IT systems will mean that the SCR is updated when a user, who is correctly logged into their system using their smartcard with the appropriate smartcard permissions, saves or closes the patient's record.

If an update needs to be sent but a smartcard is not being used then the user will be prompted to insert their smartcard. If this does not happen then the update will be placed in a queue and sent automatically in the background when the user subsequently authenticates with their smartcard. If the patient's record is updated by another member of staff (who is smartcard authenticated) at the practice before this queued update has been sent then the system will automatically send the most recent update.

If necessary, a user with the appropriate smartcard rights can authorise all queued updates from a practice to be sent together. This has been introduced to support practices manage queued messages and to ensure updates are sent as quickly as possible whilst maintaining the appropriate levels of control for an national electronic patient record.

GP Practices should ensure that all staff use smartcards at all times to ensure that SCRs are kept aligned with local records as quickly as possible.

5.3 Updating the SCR

In order to reduce prompting, introduce consistency across all GP IT systems, and ensure the SCR is updated in line with local records the SCR will be updated automatically by the system when appropriate. There will not be the opportunity to prevent an SCR being updated. Local record restrictions will no longer prevent updates being sent to the SCR. The patient does not have to be present for the SCR to be updated. Updates will be sent in the following circumstances:

- The patient's medication, adverse reactions, or allergies are changed
- A repeat prescription is issued
- Certain changes to the patient's SCR Consent Preference:
 - Changing from express dissent (opted out) to any of the explicit consent preferences
 - Changing from express consent for core information to express consent for core and additional information or vice versa.
- The patient's FP69 status is removed
- Additional information is specifically marked to be included with the patient's consent
- Additional information that was previously marked to be included with the patient's consent is now marked to no longer be included

No updates will be sent when the patient's SCR Consent Preference is changed to express dissent (opted out) as per section 3.3.

GP Practices should be aware that updates will be sent automatically by the system when appropriate without the user having to take any additional action.

6 New patient registration

Functionality is being introduced to better support GP Practices manage the SCR for newly registered patients. This will ensure that an SCR will be created as efficiently and automatically as possible for patients and minimise the need for staff to perform extra manual steps. The activation of the SCR Patient Consent Preferences in the upgraded systems will make this process simpler for practices and easier for patients to understand. Where patients already have an SCR, the system will support practices to manage the existing SCR.

6.1 Supporting new patient registrations

Patients registering at a GP Practice need to be informed about the SCR and have the opportunity to express their preference. Practices should already have this process in place as part of being live with SCR. The activation of the SCR Patient Consent Preferences in the upgraded systems will enable GP Practices to accurately record newly registered patients' wishes.

Any patient who wants more time to decide whether they wish to have an SCR or not, should have their consent preference set to "Express dissent (opted out) – Patient does not want a Summary Care Record". This will prevent an SCR from being created. A recall should be placed on their patient record to ensure that this preference is reviewed once they have had the opportunity to consider their wishes. Should the patient subsequently decide to have an SCR then their preference should be updated accordingly to either 'Express consent for medication, allergies, and adverse reactions only' or 'Express consent for medication, allergies, adverse reactions, and additional information.'

GP Practices should review their processes to ensure that they manage the SCR Consent Preferences for new patient registrations.

6.2 Registering a new patient who already has an SCR

The upgraded GP IT systems will support practices registering new patients who already have an SCR from their previous GP Practice. When any new patient is registered, the GP IT system will check to see whether they have an SCR. This is to help ensure that the new SCR does not inadvertently overwrite a more comprehensive existing SCR from the patient's previous practice.

If an SCR already exists for the newly registered patient then the following message will be displayed:

"The patient has not yet had a GP summary sent from this practice. The GP summary that is about to be sent will overwrite the last GP summary sent from the patient's previous practice. It is your responsibility to check the content of the patient's current GP summary in their Summary Care Record with the content of the GP summary that is about to be sent. Do you want to continue?"

The user will be presented with the following three options:

- **Send.** This will update the SCR with information from the patient's electronic record in the new GP Practice.
- **Don't Send.** This will mean that the SCR is not updated with information from the patient's electronic record in the new GP Practice. Users will be presented with this message each subsequent time that the patient's record is opened until the "Send" option is chosen and the SCR is updated.
- **Compare.** This will present the user with a view of the content the SCR sent from the patient's previous GP Practice compared with a view of the content that will replace it from the new GP Practice. The user will then have the option to either "Send" or "Don't Send".

GP Practices should consider how they wish to manage the process for newly registered patients with an SCR. Whilst it may be appropriate to use the 'Don't Send' option, this could result in delay in a newly registered patient having their SCR updated by their new GP Practice, for example, if they do not have contact with that GP Practice for a further time period. GP Practices may wish to ensure that as part of their new patient notes summarisation process that the SCR is updated.

7 Viewing the SCR of temporary residents

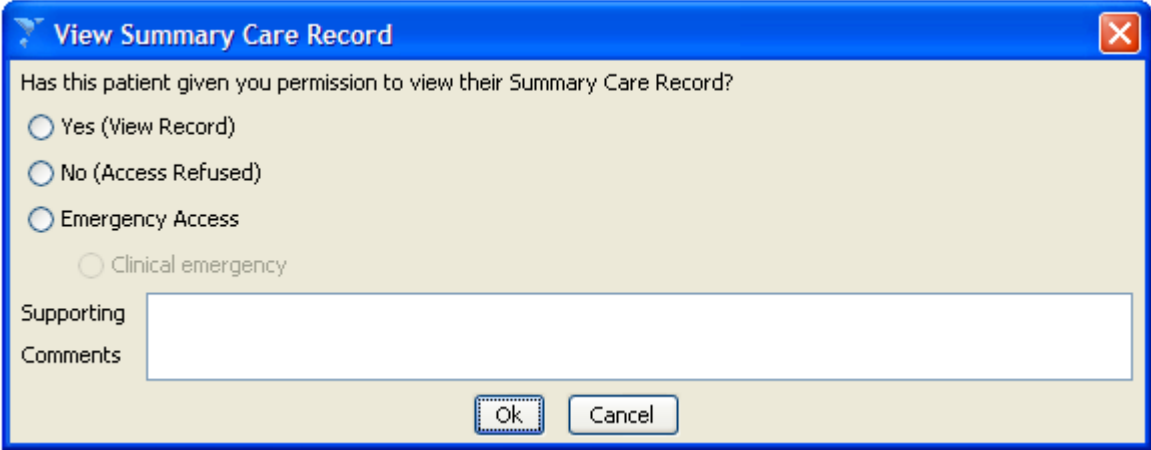
One of the most important benefits to GP Practices of the upgrade is the ability to view the SCR of a patient not fully registered at a practice (e.g. a temporary resident) within their GP IT system. Timely access to the SCR may help inform prescribing decisions, reduce errors and increase a clinicians' confidence to make more informed treatment decisions. In some cases it will make it easier, and in some cases possible, for practice staff to obtain information where language and other communication barriers exist. Detailed information on viewing the SCR is available on the SCR website ^v.

7.1 Viewing the SCR in GP IT systems

Where a patient is not fully registered at a GP Practice and they are seeking urgent or emergency care from that GP Practice, then it is possible for the healthcare staff to view their SCR (if the patient has one) to support their care. As part of registering the temporary resident, the patient's home address will need to be entered in the GP IT system to ensure that the SCR is available. The content of the SCR of a temporary patient will not automatically populate any part of the GP IT system and the SCR can only be amended or updated by the patient's fully registered GP Practice.

In order to view the SCR the healthcare staff must use their NHS Smartcard; have a legitimate relationship with that patient – i.e. be involved in their care (in most cases this will be managed in the background by the GP IT system) and obtain the patient's permission to view their SCR. This permission may be given for an individual or for a group of healthcare staff e.g. the doctors and nurses at that GP Practice ^{vi}. If the patient is unable to give permission to view their SCR, for example, if they are unconscious, then the healthcare staff should act in the patient's best interests and use the Emergency Access option. Emergency Access should not be used where a patient with capacity has refused access. Existing processes should be applied to support clinicians and patients where a patient is under 16 or may lack capacity.

An example of an SCR permission to view screen:



View Summary Care Record

Has this patient given you permission to view their Summary Care Record?

Yes (View Record)

No (Access Refused)

Emergency Access

Clinical emergency

Supporting Comments

Ok Cancel

All actions taken will be audited and certain actions e.g. using the Emergency Access option will result in an alert being generated. The alerts will be sent to the organisational Privacy Officer which may be the GP Practice or another local health community organisation. Guidance on audit trails and alert management is available^{vii}.

7.2 Understanding the content of the SCR for temporary residents

The SCR for temporary residents contains the same information as any SCR i.e. the core data set of medication, allergies and adverse reaction plus any additional information the patient has agreed to have included (as discussed in section 4).

In order to understand the content of the SCR, healthcare staff viewing the SCR should be aware that:

- The SCR will contain information at the top of the SCR to support the viewer such as the date and time stamp of when it was sent, details of the GP Practice that created the SCR and may also include other pertinent information e.g. if the patient has deregistered.
- If a medication is in both the repeat and discontinued repeat medication section then the medication is a current repeat medication. This reflects the fact that an earlier version of the medication has been stopped. This could occur in a variety of scenarios and is dependent on the sending GP IT system, but is most likely when there have been changes to the dose, frequency or amount of medication.
- Where the patient's registered GP Practice is not yet live with SCR then no SCR will be available and there will be no message explaining why.
- When a patient's SCR does not contain any core information i.e. no medication, allergies or adverse reactions then they will see a message that advises them that there is no core information available.
- If the patient has chosen to opt out of having an SCR and their GP Practice is live with SCR then the user will see a message explaining that no SCR exists or that the patient has opted out.
- If the SCR was last updated by a GP Practice where the patient is no longer registered and they have not newly registered at an SCR-live GP Practice then the last SCR will still be available, but will contain a message advising that the patient is no longer registered at that GP Practice.
- Where the patient's GP Practice was live with SCR but has since stopped contributing, the last SCR will still be available, but may contain the following message: "Practice updates to SCR ended on <dd-Mmm-yyyy>. GP Summary no longer being updated".

7.3 Preparation for viewing

In preparation for viewing the SCR for temporary residents, GP Practices upgrading to the new systems should:

- Understand that they can now view the SCR of temporary residents to support urgent or emergency patient care where the patient gives permission
- Ensure that appropriate healthcare staff have the correct role and rights on their smartcard to enable them to view the SCR
- Ensure healthcare staff understand the principles around Permission to View^{vii}
- Ensure that healthcare staff who may be viewing the SCR of temporary residents understand the content of the SCR
- Liaise with their local SCR project manager to ensure that appropriate processes are in place to manage alerts^{vii}.

8 SCR GP IT system administration

The update to SCR functionality will contain improvements to support the administration of SCR within the GP IT system and GP Practices. The contents of this section are primarily aimed at GP Practice IT system administrators. If a GP Practice is on a hosted GP IT system then the following enhancements will be under the control of the GP Practice but the IT system supplier may perform the necessary actions.

8.1 Patient deregistration

When a patient is deducted following deregistration from a GP Practice list a message is added to the most recent SCR explaining that it will no longer be updated by that GP Practice. The enhancements will ensure that this message is more clearly presented to the viewing healthcare staff i.e. "Practice updates to SCR ended on 28-09-2011. GP Summary no longer being updated."

GP Practices do not need to take any action as this process will happen automatically when the patient is deducted.

When the patient re-registers with a GP Practice that is live with the SCR then an SCR will be sent by the new practice which will replace the SCR from the previous GP Practice as discussed in section 6.

8.2 Bulk sending

Certain circumstances can interrupt the sending of SCR for all patients at a Practice. For example, when:

- A practice changes GP IT system supplier
- A practice moves between different products from the same GP IT system supplier.
- A practice moves to a GP IT system that is not SCR compliant
- A practice splits into two or more practices.
- Two or more practices merge into a single practice.

In order to maintain continuity of patients' records, and minimise interruption or Practice disruption in these situations, the new GP systems will allow the bulk sending of SCRs by GP Practices. Where a practice moves to a GP IT system that is not SCR compliant, the bulk sending can include a message in the SCR of all patients saying "Practice updates to SCR ended on 21-Sep-2011. GP Summary no longer being updated".

If a GP Practice is in a situation where this functionality is or may be required, they should discuss their needs with their local SCR team and/or GP IT system supplier.

8.3 Improved reports for system administrators

A range of new reports will be available that will allow system administrators to more easily monitor and manage SCRs. The reports will support managing current SCR Consent Preferences for all patients fully registered with the practice and a variety of circumstances where messages from the GP IT system to the SCR may have not been sent or have failed.

GP Practice system administrators may wish to familiarise themselves with the new reports.

9 Further Support

Further support for GP Practices can be sought through the NHS CFH Implementation team.

Key resources for GP Practices include:

- 1) The SCR GP Practice webpage

<http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/gppracinfo>

- 2) Viewing the SCR webpage:

<http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/impguidpm/scra>

10 References

- ⁱ NHS Summary Care Record Guide for GP Practice Staff:
<http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/gpracinfo>
- ⁱⁱ Introducing the new SCR consent codes:
www.connectingforhealth.nhs.uk/systemsandservices/scr/documents/consentcodes.pdf
- ⁱⁱⁱ Managing consent guidance has now been incorporated into the 'NHS Summary Care Record Guide for GP Practice staff' at:
www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/gpracinfo
- ^{iv} Further guidance about adding additional information (including Patient consent for additional information; Content of additional information; Guidance on how to add additional information; Guidance for NHS staff implementing additional information in their local health community) is available at:
www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/impguidpm/createscrs/additional
- ^v Detailed guidance about viewing the SCR can be found at:
www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/impguidpm/scra
- ^{vi} Principles for implementing permission to view for the SCR can be found at:
www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/aboutscr/documents/principles.pdf
- ^{vii} Guidance on viewing SCR in GP Practices for patients not fully registered can be found at:
www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/impguidpm/ig/nonregpatients