# Supporting Guidance for promoting Enriched Summary Care Records for patients with frailty

## Resource Pack for GP Practices

### New for GMS Contract Changes 2017/18

Information and technology
for better health and care

# Contents

# Introduction

From 1 July 2017, the General Medical Services (GMS) Contract will require GP practices to routinely identify moderate and severe frailty in patients aged 65 years and over. Practices are required to seek informed patient consent to activate the enriched Summary Care Record (SCR), for patients identified with severe frailty. Patients with mild and moderate frailty can also gain significant benefit from an enriched SCR and GP practices should consider offering those patients the same opportunity.

The purpose of this guide is to provide information to practices about the enriched SCR and signpost to supporting resources.

## GMS Contract Amendments 2017/18

The GMS Contract requires routine frailty identification for patients who are 65 and over. The first paragraph of the Five Year Forward View notes that support for older people living with frailty, along with mental health and cancer, is one of the three areas in which the NHS faces 'particular challenges'.

The introduction of routine identification of frailty can help to address this and provide an opportunity to target and improve care and support for older people with the greatest need. Moving from opportunistic to systematic population based identification of frailty can help reduce inequalities, improve access to care and enable the needs of individuals to be met through early, proactive targeted and appropriate interventions.

## Supporting routine frailty identification & frailty care through the GP Contract 17/18

### GP Contract requirement: Identification and management of patients with frailty:

From 1 July 2017, practices will use an appropriate tool e.g. **Electronic Frailty Index (eFI)** to identify patients over 65 who are living with moderate or severe frailty. For those patients identified as living with **severe frailty**, the practice will deliver:

- An **annual medication review**, discuss any **falls** in the last 12 months and any other clinically **relevant interventions**.

- In addition, where a patient does **not** already have an **enriched Summary Care Record (SCR)** the practice **will promote** this, seeking informed patient consent to activate the enriched SCR.

The 2017/18 GP contract aims to help meet the challenge of providing support for older people living with frailty by:

- Proactively identifying older people (aged 65 and older) who are living with frailty and stratify populations by severity using an evidenced based tool (such as the electronic Frailty Index eFI[1,2]) supplemented by clinical judgement.

- Focusing on a small number of key evidence-based interventions (falls risk identification and annual medication review) to reduce the likelihood and/or impact of adverse events such as hospital or nursing home admissions.

- Promoting use of additional information in the Summary Care Record (with explicit patient consent) to share key healthcare information across different care settings thereby supporting more integrated and appropriate care for people living with frailty. For example, by helping ambulance staff and hospitals to more easily identify people living with frailty at the onset of an admission, expediting acute frailty interventions linked to best practice and avoiding interventions or care approaches which may be inappropriate for acutely unwell people living with varying degrees of frailty.

## Why the Summary Care Record?

Having access to appropriate patient information is vital and SCRs enriched with additional information offer an opportunity to consistently share relevant information for this group of patients. The SCR is created automatically through clinical systems in GP practices and is available to other clinicians via the Spine when required. It is automatically updated when further changes are made to the GP record. Additional information can be added to the SCR, with explicit patient consent, by the GP practice. The information is included automatically by changing the patient's SCR consent status.

The purpose of this guide is to provide further information to GP practices about the enriched Summary Care Record.

## Further Information

Further information and supporting guidance about the frailty requirements of the GP contract is provided in the NHS England Guidance: https://www.england.nhs.uk/publication/supporting-routine-frailty-identification-and-frailty-through-the-gp-contract-20172018/.

NHS England's Older People's webpage contains information, support and resources on improving care for older people: https://www.england.nhs.uk/ourwork/ltc-op-eolc/older-people/frailty/.

[1] eFI has been tested with over 900,000 patient records and uses existing coded data from the electronic primary care record to identify frailty in people aged 65 years or over. It is the winner of the Healthcare IT Product Innovation category at the EHI 2016 Awards and Innovation Category at the Royal College of Physicians' (RCP) Excellence in Patient Care Awards 2017.

[2] Clegg et al: Age and Ageing 2016; 45: 353–360

Further information about the GP Contact Technical requirements and coding is detailed in Appendix 1.

# Overview of SCR

Summary Care Records (SCRs) are an electronic record of key information from a patient's GP practice and as a minimum contain the 'core' dataset of medication, allergies and adverse reactions. They can be accessed and viewed by authorised staff in other areas of the health and care system involved in providing direct care to the patient.

The SCR is created automatically through clinical systems in GP practices and uploaded to the Spine. It will then be updated when further changes are made to the GP record.

Over 96% of people registered with a GP practice in England (55 million people) now have a Summary Care Record. The benefits include improvements in patient safety and experience and in the efficiency and effectiveness of patient care.

SCRs are viewed in a wide variety of care settings including:

- Acute Trusts (both unscheduled and scheduled care)
- GP Practices
- GP Out of Hours services
- Walk in Centres
- Urgent Treatment Centres
- Minor Injury Units
- Mental Health
- Community Pharmacy
- Custody Suites
- Prisons
- Hospices
- Community Care

The SCR viewing figures steadily increase and currently over 125,000 SCRs are viewed each week (November 2017). View our SCR dashboard.

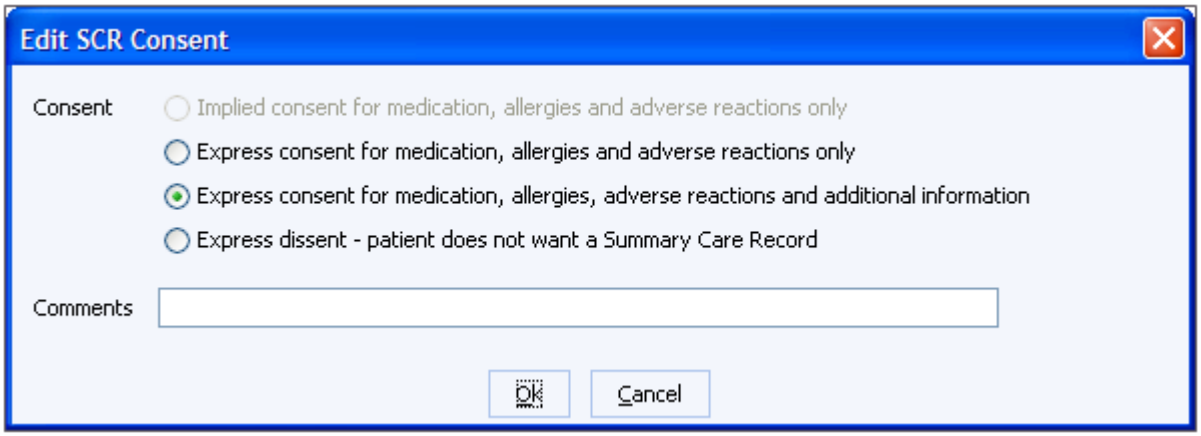
# SCR Consent Model and Best Interests Decisions

SCRs are optional. A patient can choose whether or not to have an SCR and they can change their mind at any time by contacting their GP practice. Patients can also choose whether they wish to share the core data only or whether they wish to have an enriched SCR i.e. include important additional information from their GP record.

For patients identified with frailty, who have previously opted out of having an SCR, the practice could consider discussing the benefits of information sharing with them, so that these patients are given an opportunity to reconsider their previous decision.

The GP practice must update the patient's consent preference in the patient's record within their clinical system either by updating the consent dialogue box as shown below or by coding the patient's choice.

Additional information can only be added with patient consent. To record consent for additional information select "***Express consent for medication, allergies, adverse reactions, AND additional information***" from the consent dialogue box or add Read code **9Ndn.** or CTV3 code **XaXbZ** to the patient record.




The options in the SCR consent dialogue box relate to the following Read Version 2 and CTV3 codes.

| **Summary Care Record Consent Preference** | **Read Version 2** | **CTV3** |
|---|---|---|
| The patient wants a core Summary Care Record (Express consent for medication, allergies and adverse reactions only) | 9Ndm. | XaXbY |
| **The patient wants a Summary Care Record with core and additional information (Express consent for medication, allergies, adverse reactions and additional information)** | **9Ndn.** | **XaXbZ** |
| The patient does not want to have a Summary Care Record | 9Ndo. | XaXj6 |

| | | |
|---|---|---|
| (Express dissent for Summary Care Record (opt out) | | |

Where a patient lacks capacity to consent to the inclusion of additional information in their SCR, reasonable attempts should be made to establish whether there is someone who has a legal delegated responsibility on behalf of the individual. Clearly, if someone has a Health and Welfare Lasting Power of Attorney that grants them the necessary powers and is registered with the Office of the Public Guardian, then they can legally give the consent on behalf of a person who lacks capacity - provided they are acting in the patient's best interests.

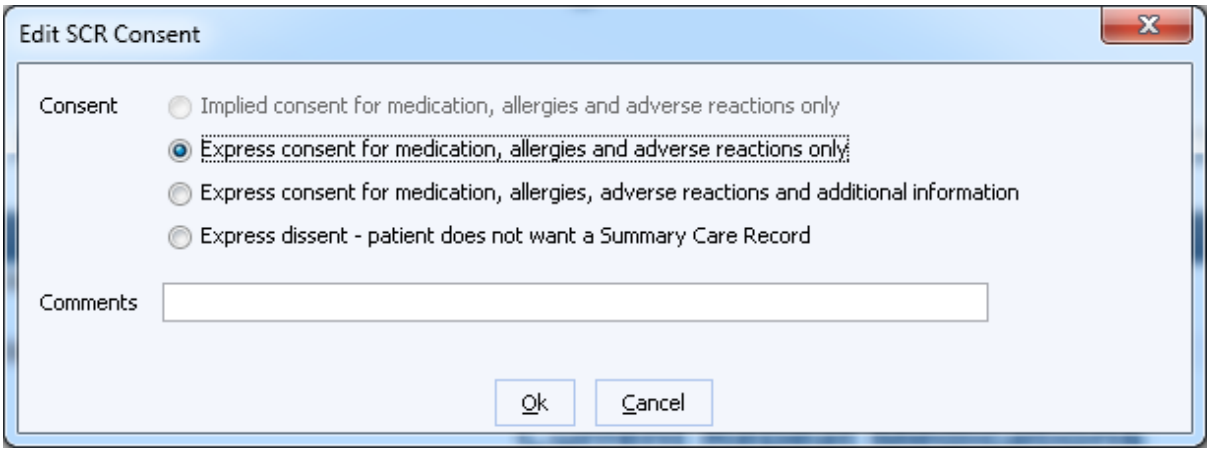
Where a patient lacks capacity to give informed consent and has not previously appointed an Attorney, the GP (or other appropriate clinician) can make a decision in the patient's best interest to create an SCR with additional information. It would be best practice to discuss this with their relatives and carers and to take into account their views and any preference that the patient might have expressed in the past. However, the ultimate decision lies with the clinician who is looking after the patient and they are obliged to consider the patient's best interests in this regard.

If the clinician believes that it would be in the patient's best interest to make additional information available in the SCR, it would be good practice to clearly record how the decision has been made to upload information in the patient's best interest without their consent. This should include recording how the assessment of a lack of mental capacity was arrived at.

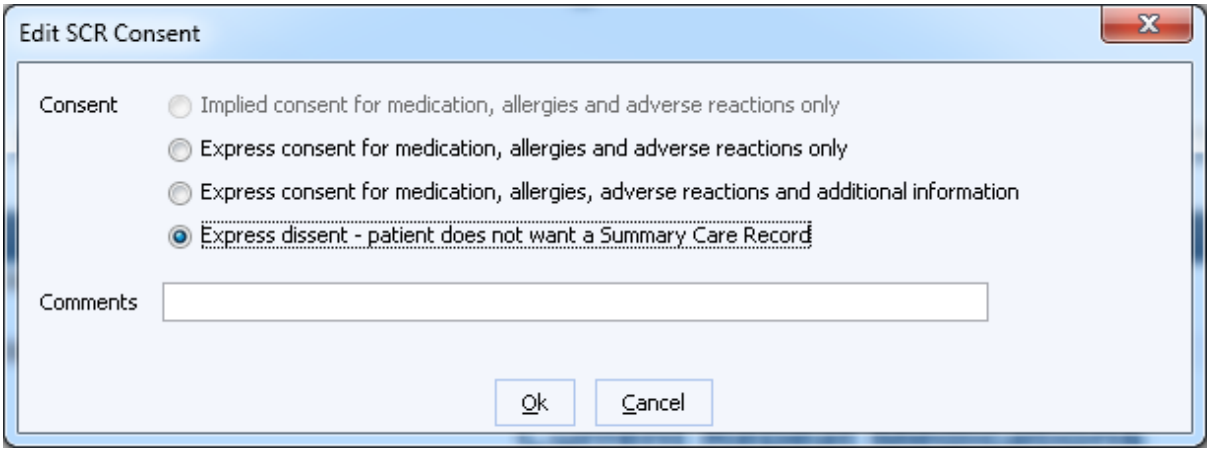
In this scenario, the clinician would record 'Express consent for medication, allergies and adverse reactions and additional information' as shown in the screen shot above and record how the decision was made, including why they decided the patient lacks capacity, in either the free text box when the SCR consent status is updated or elsewhere in their local GP record.

## Patient Choices

If a patient decides not to have additional information, patients can still choose to have a SCR and opt to share medications and allergies only. To record consent for sharing medications and allergies select "***Express consent for medication, allergies and adverse reactions only"*** from the consent dialogue box or Read code **9Ndm.** or CTV3 code **XaXbY**




Alternatively, patients can choose not to have a SCR if they do not wish to use SCR to share any information with other health care professionals. If patients opt out of having an SCR select ***"Express dissent - patient does not want a Summary Care Record"*** from the consent dialogue box or Read code **9Ndo.** or CTV3 code **XaXj6**




## Permission to View

An important part of the process for organisations using the SCR is that they ask for a patient's permission before the SCR is viewed to support their direct care. This is designed to ensure that a patient is informed when, where and how personal information in their SCR is being used.

In situations where the patient is too unwell to give permission (e.g. patient is confused or unconscious) or when permission cannot be obtained from the patient because they lack capacity (and have not previously appointed an Attorney for Health and Welfare), a clinical decision can be made to view the SCR using 'Emergency Access', provided that decision can be shown to be in the patient's best interest. It is good practice to record the reason for having viewed the record without the patient's permission to view. If the patient's condition later improves so that the patient regains full mental capacity, then it is recommended that they should be informed that their SCR has been viewed and why.

In circumstances where the patient is not present to give permission then viewing the SCR without that permission is only allowable if it is clear that to do so is in the patient's best interest and that the patient would not be likely to be surprised when later told that their

SCR had been accessed.

The only other situations where the SCR can be viewed without the patient's permission is where there is a legal justification such as a court order or an over-riding public interest for disclosure.

## Enriched SCRs

The GP Contract 2017/18 requires GP Practices to seek informed patient consent to activate the enriched SCR for patients aged 65 and over with **severe frailty**. It is also recognised that patients with **mild** and **moderate frailty** can gain significant benefit from an enriched SCR and GP practices should consider offering those patients the same opportunity.

Enriched SCRs include both core information (Medications, Allergies and Adverse Reactions) and additional clinical information from a patient's GP record. Additional information can be added to the SCR, with explicit patient consent, by the GP practice. The information is included automatically by changing the patient's SCR consent status.

GP Clinical Systems have been updated to provide a simple and more efficient way to update SCRs with a set of additional information from a patient's GP record.

The enriched content has been defined and reviewed by clinical groups and GP system suppliers. Enriched SCRs incorporate individual coded items and associated free text and will include:

- Significant medical history (past and present)
- Reason for medication
- Anticipatory care information (such as information about the management of long term conditions)
- Communication preferences (as per the DCB 1605 national dataset - formerly ISB-1605)
- End of life care information (as per the SCCI 1580 national dataset - formerly ISB-1580)
- Immunisations

Additional information is included in the SCR through in one of three ways:

1. It is identified as **significant medical history** within the GP record. For EMIS Web this is 'Active Problems' and 'Significant Past Problems'. For TPP SystmOne this is the 'Local Summary' and 'Active Problems'. For INPS Vision this is 'Priority 1 Items' and 'Active Problems'.
2. It is part of the **NHS Digital SCR inclusion dataset** (see below).
3. It is a **manually added** item from the GP record. Any code within the GP record may be 'manually added' to the SCR, in line with the patient's wishes.

# NHS Digital SCR Inclusion Dataset

The SCR inclusion dataset (PDF, 437.0kB) describes key elements of the dataset presented as functional areas such as carer information, key workers and services, unplanned admissions and alignment with the Palliative Care Coordination dataset – SCCI 1580.

To see the complete list of codes currently in the inclusion set, as utilised by GP suppliers implementing SCR v2.1:

Inclusion dataset.xlsx

# Excluded information

Some potentially sensitive coded items specifically related to fertility treatments, sexually transmitted diseases, terminations and gender re-assignment are automatically excluded from the SCR as per the RCGP sensitive dataset:

RCGP sensitive dataset.xls

If the patient wants these items including in their SCR they must provide consent for their GP to add them.

If any items have been marked as private or confidential in the local record, SCR honours these settings.

Further items not automatically included or sensitive items that the patient would like adding to the SCR can be manually added.

# Creating Enriched SCRs

The key steps for creating an enriched SCR are as follows:

- **Patient consent** sought and provided - either verbally or by signature.
- **SCR consent changed** on GP system (Express consent for medications, allergies and adverse reactions and additional information - 9Ndn/ XaXbZ or via system specific SCR consent screens) to indicate express consent for additional information. The SCR content can be previewed for completeness, data quality, sensitive and confidential items. See clinical system user guides (above) for more information.
- **Additional items** are instantly added to the SCR. These are defined by the agreed **inclusion and exclusion** datasets.
- The **enriched SCR** is then **updated automatically** as the GP record is updated over time.

# Informed Patient Consent

There is no requirement to gain written patient consent. However there is a combined information leaflet and consent form available for practices (and other teams working alongside them in primary care) that wish to use it (Appendix 2).

The information available for new patients has also been updated to explain the choices available to patients about Summary Care Records including providing their express consent for additional information (Appendix 3).

For further guidance on patient consent, see patient consent and considerations for patients who lack the capacity to consent (Appendix 4).

Patient information leaflets and the consent form are available on the SCR additional information webpage: https://digital.nhs.uk/summary-care-records/additional-information.

# Benefits of Enriched SCRs

Enriched SCRs offer the opportunity to:

- Increase patient safety by providing timely access to information such as significant diagnoses.
- Empower patients and increase satisfaction as patients can make their preferences known.
- Empower health professionals by providing consistent, accurate and accessible information.
- Increase efficiency and effectiveness through more integrated care and reduced time/effort.

Enriched SCRs can also flag the existence of important information such as, an advance care plan, resuscitation status and Lasting Power of Attorney. Enriched SCRs compliment other record sharing solutions such as electronic palliative care co-ordination systems (EPaCCS).

Using enriched SCRs in your GP practice can help you to meet the requirements of the new Accessible Information Standard. The codes associated with the four subsets of the Accessible Information Standard have been included as part of the inclusion dataset for SCR.

The enriched SCR information is then available to all healthcare staff that already routinely access SCRs. This provides an immediate, cost effective way to increase the flow of information used for direct care across the healthcare system.

Local health communities are being encouraged to consider how other related patient groups (e.g.patients with long term conditions, patients approaching the end of life and patients with dementia or other communication difficulties) can be targeted to ensure that they are offered the opportunity to have an SCR with additional information.

Enriched SCRs can complement local data sharing solutions which offer data sharing between care settings, but generally do not offer the national coverage that SCR provides.

## Supporting Resources and Contacts

For guidance on getting started with additional information, including examples of opportunities for engaging with relevant patients, practical considerations and useful resources, see Appendix 5.

Further information can be found via the SCR additional information web page: https://digital.nhs.uk/summary-care-records/additional-information

For help with implementation or further questions please contact the SCR Team at scr.comms@nhs.net

# Appendix 1

## GP Contract Technical Guidance Link

Information on the recommended coding and data collections can be found via NHS Employers Technical requirements for 2017/18 GMS contract changes document: www.nhsemployers.org/GMS201718

### Identification and management of frailty Read codes

| Read Codes for Frailty | Read Version 2 | CTV3 |
|---|---|---|
| **Frailty Index** | **38Ql.** | **XabYS** |
| **Mild frailty** | **2Jd0.** | **XabdY** |
| **Moderate frailty** | **2Jd1.** | **Xabdb** |
| **Severe frailty** | **2Jd2.** | **Xabdd** |
| **Express consent for core and additional Summary Care Record dataset upload** | **9Ndn.** | **XaXbZ** |

### Management Information Counts

CCDCMI18: Quarterly (cumulative) count of the number of registered patients aged 65 years or over, who have a diagnosis of moderate or severe frailty diagnosed using the appropriate tool up to the end of the reporting period, who have given consent to activate their enriched Summary Care Record up to the end of the reporting period.

# Appendix 2

## SCR with additional information leaflet and consent form:

Leaflet and consent form

# Appendix 3

## SCR consent form for new patients

SCRConsentFormDec16.pdf

# Appendix 4

## Patient consent and considerations for patients who lack the capacity to consent

GP practices and clinicians should follow existing guidance (such as that produced by the General Medical Council) and their usual processes for gaining consent and making best interest decisions on behalf of patients.

All patients should be appropriately informed and supported to come to a decision as to whether they would like additional information to be added to their SCR. Information should be provided in a way and format that individual patients can understand, so that patients are appropriately supported to come to their decision and to communicate this. There are resources available to support discussions with patients to seek their informed consent.

Where a patient lacks capacity to consent to the inclusion of additional information in their SCR, reasonable attempts should be made to establish whether there is someone who has a legal delegated responsibility on behalf of the individual. Clearly, if someone has a Health and Welfare Lasting Power of Attorney that grants them the necessary powers and is registered with the Office of the Public Guardian, then they can legally give the consent on behalf of a person who lacks capacity - provided they are acting in the patient's best interests.

Where a patient lacks capacity to give informed consent and has not previously appointed an Attorney, the GP can make a decision in the patient's best interest to create an SCR with additional information. It would be best practice to discuss this with their relatives and carers and to take into account their views and any preference that the patient might have expressed in the past. However, the ultimate decision lies with the GP who is looking after the patient and they are obliged to consider the patient's best interests in this regard.

Therefore, if the GP believes that it would be in the patient's best interest to make additional information available in the SCR, the GP can upload the additional information.
It would be good practice to clearly record how the decision has been made to upload information in the patient's best interest without their consent. This should include recording how the assessment of a lack of mental capacity was arrived at. There is the option to add free text when the SCR consent status is changed in the GP system.

# Appendix 5

## Creating Enriched Summary Care Records

### Background

- All patients have a Summary Care Record (SCR) consisting of medications, allergies and adverse reactions, unless they have previously chosen to opt out.

- With explicit patient consent, additional information from the GP record can be automatically included in the SCR, such as: reason for medication, significant medical history, anticipatory care planning information, communication preferences, immunisations and end of life care information. Other relevant key information can be manually added.

- The additional information is automatically included when the SCR consent preference is set to '**Express consent for medication, allergies, adverse reactions and additional information'** in the GP system.

- The additional information is then available to all healthcare staff that already routinely access SCRs. This provides an immediate, cost effective way to increase the flow of information used for direct care across the healthcare system.

### Communicating with patients

GP practices may wish to tailor their approach according to local priorities, resources and processes. This may include identifying those patient groups that will benefit most from SCRs enriched with additional information. The following are examples of opportunities that GP practices have highlighted for discussing and seeking consent for additional information:

- ***End of Life care*** - GPs or extended members of the multi-disciplinary palliative care team can discuss with patients during appointments or home visits or when creating and reviewing advance care plans. SCRs can be used to share information about the patient's preferences, Lasting Power of Attorney and advance decisions.

- ***Frail patients -*** Members of the primary care team involved in proactive care planning for patients with frailty can discuss with patients during their review appointments.

- ***Patients with long term conditions -*** Existing regular review processes present an opportunity to obtain consent. Patients can be provided with a leaflet prior to their review (e.g. by post or at the time of a monitoring blood test appointment) and consent can then be discussed at the review appointment.

- ***Flu clinics -*** The seasonal flu campaign provides an opportunity to seek consent for additional information for patients over 65 years of age or with chronic conditions. Leaflets can be provided for the patients to read while they are waiting for their appointment or sent to targeted groups of patients with their invitation letter.

- ***New patient registration -*** Patients can be provided with a leaflet as part of the registration process. They can then be asked for consent at their first appointment or new patient check. Alternatively, a combined information leaflet and consent form can be used:

Consent form.pdf

- ***Dementia and Learning Disabilities reviews -*** Regular health checks for patients with dementia or learning disabilities present an opportunity to discuss with patients (and their carers). This can be used to share key information from a health action plan. For patients who lack capacity to consent to additional information, see Gaining consent for additional information below.

- ***Care Home patients -*** Staff working in care homes can support GP practices by providing information and raising awareness with patients and/or their families.

- ***Patients with physical, sensory or other disabilities -*** The Equality Act, 2010 places a legal duty on all service providers to make 'reasonable adjustments' to support disabled people. This includes service users with communication needs, who often receive inaccessible information or fail to receive the communication support they need. Creating SCRs with additional information for these patients will help health professionals to make reasonable adjustments to support patients with disabilities.

- ***Other considerations -*** A number of other patient groups can gain significant benefit from having additional information added to their SCR, such as: non-English speakers, those with Advance Decisions (Living Wills), Lasting Power of Attorney for Health and Welfare and those with particular care preferences or details of their carers that they want to share.

## Practical steps to consider

- Run reports to identify appropriate patients.

- Add a prompt to patient records to guide staff to seek patient consent.

- To encourage patients to discuss additional information consider: posters, notes on prescriptions, SMS messaging, information on the practice website and included with routine letters to patients.

- An active Patient Participation Group can also help to raise awareness.

- Consider adding the consent code for additional information (Read code **9Ndn.** or CTV3 code **XaXbZ**) to relevant clinical templates such as EPaCCS, annual health check or Long Term Conditions review templates.

- If the extended primary care team (and beyond) are supporting the process of providing information and obtaining consent (such as palliative care nurses and care home staff) consider how this is communicated back to the GP practice.

## Gaining consent for additional information

To support the above activities and help ensure that patients are fully informed about additional information, some supporting resources are available. There is no requirement to gain written consent, however, a combined information leaflet and consent form is available for GP practices that wish to use it (see appendix 2.)

Where a patient lacks capacity to consent to the inclusion of additional information in their SCR, reasonable attempts should be made to establish whether there is someone who has a legal delegated responsibility on behalf of the individual. Where a patient lacks capacity to give informed consent and has not previously appointed a Health and Welfare Lasting Power of Attorney, the GP can make a decision in the patient's best interest to create an enriched SCR . More detail concerning this is available in appendix 4.

## Further Information

Further information can be found via the SCR additional information web page: https://digital.nhs.uk/summary-care-records/additional-information

For help with implementation or further questions please contact: scr.comms@nhs.net