

GP Summary Component of the NHS Summary Care Record



1. Introduction

- 1.1 This report for the RCGP sets out the recommended interim content and standards for the GP summary component of the Summary Care Record (SCR) in accordance with Recommendation 4 made in the Ministerial Taskforce on the NHS Summary Care Record (December 2006) and represents the output from Phase 1 of the outline business plan submitted by HISG to the RCGP Chairman of Council on 12th July 2007
- 1.2 **Definition of GP summary:** An extract of information from the GP clinical record for a specific purpose.
- 1.3 **Purpose of GP summary:** To provide a GP summary dataset for use by other clinicians in unscheduled care settings. The GP summary will provide the clinician who is seeing the patient with an extract of events in the patient's medical record that may have a bearing on the current consultation. (In particular the draft summary should support the work of the SCR Early Adopter Communities).
- 1.4 **Content of GP summary:** Drugs (prescribed items), allergies & adverse drug reactions, plus additional information agreed by the patient and GP.
- 1.5 **Contributors & stakeholders for this work:** The RCGP, The Joint GP IT Committee (GPC & RCGP), Connecting for Health, the Care Record Development Board, the SCR Early Adopter communities, local/national GP system user groups, patient representative groups, the EA evaluation team and the wider NHS in the four Home Nations.
- 1.6 For clinicians and patients to have confidence in the GP summary (and the SCR) the data contained in the summary must have the following attributes:
- Accuracy
 - Completeness
 - Timeliness (up to date)
 - Safety (requires all of the above plus understanding of issues relating to meaning and context)
 - Relevance (includes context)
 - Consistency (information in the record should be internally consistent i.e. medication lists and clinical problems/diagnoses should be compatible)
 - Appropriateness. Any information (especially relating to 3rd parties or family members) should not contain any personal data that could breach the Caldicott Guidelines

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1.7 To ensure that a GP summary fulfils these essential attributes places certain constraints on those producing it:

- The content of the GP summary should represent a minimum dataset that fits the defined purpose
- The processes for producing and updating the GP summary should be simple (for GP, patient & clinical information system)
- That as far as is practicable and safe, these processes should be automated
- The content of the GP summary will require active management and ongoing maintenance by the responsible GP/practice and some input/direction from patients

1.8 There are however, a number of other constraints that will limit the ability of the “system” to generate meaningful GP summaries:

- Any summary is dependent on the record structure, this varies from GP system to GP system
- In the current GP clinical systems, summaries are completely different from each other with no shared “standard” concept of a summary content or structure
- The content of the clinical summary depends on the context of the patient, the author and the reader
- Therefore patients have a crucial role to play in deciding what constitutes a meaningful medical summary for them

2. **Proposed GP summary content**

2.1 Items to be included in the GP summary:

- Drugs, allergies and adverse drug reactions: *automated process*
- GP summary from local system: *semi-automated process*
 - Should include significant current and past medical problems, procedures and treatments (see below)
 - Should be agreed with the patient
- Patient preferences (limited set): *manual process*
 - Ensures preferences are available in an emergency (see below)

2.2 Items for possible future inclusion in the GP summary:

- Repeat prescription items prescribed elsewhere (e.g. “amber list” drugs prescribed in secondary care)

2.3 We believe it is essential that coded entries to the GP summary can have free text associated with them. Defining what information should be extracted is complex, and it is imperative to include freetext, to enable the appropriate level of communication for these patients.

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However, we have identified several hazards from our experience in the GP2GP and Data Migration projects with the ways different systems handle text. These include; problems with line breaks, line wrapping, different capacities of different information structures to hold text and danger of truncation (and even of excess text turning up in completely unacceptable places), loss of formatting, handling of 'odd' characters like the tilde, different ways of locating text (e.g. in a 'box' as part of a form or as local system coded 'free text entry' with problem linkage to a heading).

Therefore, while we endorse the use of free text in the GP summary, we also need to highlight the potential safety hazards associated with the way text is handled in different systems. We recommend that the experience of the GP2GP and Data Migration projects in England and the ECS project in Scotland be formally integrated into the development of standards for the GP summary component of the SCR.

- 2.4 The GP2GP and ECS projects have also demonstrated the difficulties and potential clinical safety implications of trying to make various types of information available across IT platforms (inter-operability). For this reason and *to maximise the chances of success in a short time-frame*, we recommend excluding the items of information listed below from the GP summary:

- GP Alert notes
- Laboratory test results
- Lifestyle information
- Screening information (including call/recall/alert messages)
- Documents (file attachments)

However, where items from this list can be safely and reliably coded and usefully added to the problem/priority list (e.g. Hb value in anaemia) then it is a matter for clinical judgement and discussion with the patient to include items that are significant for that patient.

- 2.5 **The GP summary from the local system:** should have the following types of content, including significant current and past medical problems, procedures and treatments:

- Major diagnoses
- Conditions that may have a chronic or relapsing course
- Conditions for which the patient receives repeat medications
- Conditions that are persistent and serious contraindications for classes of medication
- Major operations
- Significant therapies & treatment plans
- Significant investigations
- Fractures
- Immunisations
- Other

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- 2.6 This list is not intended to be comprehensive: it merely illustrates the range of entries that should be made. Some conditions or events will fulfil more than one category. In the detailed GP record and if the clinical system permits it is helpful to group related entries, so that an entry of “ischaemic heart disease” would have subheadings of the dates of positive angiography, symptoms (angina pectoris), treatments (angioplasty, CABG) ongoing and past problems (MI and LVF).
- 2.7 It should be sufficient to record a subset of these in the GP summary that highlight relevant history, ongoing problems and treatments including prescription items (e.g. ischaemic heart disease, myocardial infarction, angioplasty & medication list). We suggest that it may be appropriate to upload the “problem/priority” list from the detailed GP record as a default summary. This has the advantage that those conditions listed in the problem list are clearly visible to the GP at each consultation and can be relatively easily checked with the patient.
- 2.8 Examples under the headings listed earlier are given below:
- Major diagnoses: life threatening conditions, conditions with significant complications, malignancies. Examples will include significant acute events such as pneumonia, meningitis and MI; ongoing problems such as diabetes, hypertension, Crohn’s disease and rheumatoid arthritis; terminal illness, and shared care pathways
 - Conditions that may have a chronic or relapsing course: exacerbations of asthma or COPD, gout etc. This might also include conditions that are not serious but cause recurrent symptoms (e.g. irritable bowel syndrome)
 - Conditions for which the patient receives repeat medications: each prescription item should have matching problem list entry (where available) or indication for prescription. This is particularly important when drugs might be prescribed for a range of different conditions (e.g. beta blockers, NSAIDs, ACE inhibitors)
 - Conditions that are persistent and serious contraindications for types of medication: examples include dyspepsia, migraine and asthma
 - Major operations: hysterectomy, cardiac surgery, joint replacements etc.
 - Significant therapies: radio- or chemo- therapy, helicobacter eradication etc. Indication that a treatment plan exists and is important to the patient/carers (e.g. asthma, anaphylaxis and terminal care pathways)
 - Significant investigations: key investigations that underpin a diagnosis (e.g. echo cardiogram in LVF, CT scan in TIA/stroke)
 - Fractures: where these have a significant impact on quality of life (e.g. fractured femur), pathological fractures, and those that may be associated with non-accidental injury
 - Immunisations: all immunisations given in general practice should be included and clearly specified (date, type, components & batch numbers)
 - Other: as agreed by the GP and patient to include items that are significant for that patient (e.g. bereavement, recent childbirth)
- 2.9 In general, where these conditions are present in the GP summary and a preferred code set already exists (e.g. the *Quality and Outcomes framework*

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codes & *SCIMP* codeset), we recommend they should be used in the GP summary.

- 2.10** Patients should also be consulted to review and update the content of the GP summary to make sure it is meaningful in the context of their health needs.
- 2.11 Patient preferences:** should be recorded where they can be safely and reliably coded and may have a bearing on the consultation. We have produced an interim list of preferred terms under this heading below, together with their associated Read codes:
- Advance directive administration: Read code = 9X...
 - Advance directive signed: Read code = 9X2 (preferred)
 - Living Will: Read code = 13VH
 - Refusal of treatment for reasons of religion or conscience: Read code = ZV626 (preferred)
 - Jehovah's Witness: Read code = 1357
 - (Patient) is a carer: Read code = 918G (preferred)
 - Carer Read code = 918A
 - Carer Read code = 9d46

This brief list will need to be developed in Phase 2 of this project, after consultation with patients, GP system suppliers and other interested parties to ensure the codes can be safely and reliably interpreted by users accessing the GP summary via the SCR Clinical Spine Application (CSA).

- 2.12** We believe that it is vital that the Summary Care Record should be subject to a clear and explicit clinical safety assurance process. This is an essential pre-requisite for professional endorsement. The RCGP would be happy to provide support and expertise to Connecting for Health in this area.

3. **Draft standards**

- 3.1** We have developed five draft standards for the GP summary from this work stream.
1. The content of the GP summary should represent a minimum dataset that fits a defined purpose.
 2. The content of the GP summary will include; current and recently prescribed items, allergies & adverse drug reactions, additional information agreed by the patient and GP and patient preferences where they can be safely and reliably coded and may have a bearing on the consultation.
 3. The data contained in the GP summary must have the following attributes: accuracy, completeness, timeliness, safety, relevance, consistency and appropriateness.

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4. The GP summary from the local system should have the following types of content, including significant current and past medical problems, procedures and treatments: major diagnoses, conditions that may have a chronic or relapsing course, conditions for which the patient receives repeat medications, conditions that are contraindications for types of medication, major operations, significant therapies and treatment plans, significant investigations, fractures and other entries as agreed by the GP and patient to include items that are significant for that patient.
5. As circumstances change over time these attributes and content will require that the summary is revised and maintained. Systems for the initial inclusion of new or incoming information and also for revising and editing the existing summary in the light of new circumstances, with an associated audit trail, will be needed by practices. These systems will include interpretation of information by clinicians and patients and should themselves be the subject of standards.

4. Discussion

- 4.1 This document has been developed iteratively by discussion on the HISG list server and discussions with the CfH Early Adopter team. Four things emerged from this process. The first is that each contribution suggested additions to the list: there is a clear risk that the wish to be inclusive may damage the brevity that is required of a useful summary. Second to emerge was the concept of the need for the summary to be regularly reviewed: the salience of some entries (for example “patient pregnant”) is time limited. This is really a development of the first point: the tension between inclusiveness and salience. Third is the notion that “relevance and importance to patient” is an important determinant of what should be included: HealthSpace may facilitate this. Fourth, system design has an important role to play. For internal use, within a clinical system, the crucial thing is that all important relevant information is available quickly to the clinician, without prolonged manual searching. Different clinical systems vary in the extent to which there is a “summary” screen (e.g. EMIS LV/Vision) as opposed to a quick navigation around problem orientated notes (e.g. Synergy). For this reason we have listed *types of content* that should be included in the GP summary component of the SCR and avoided defining any kind of nomenclature or hierarchy within which that content should be displayed.
- 4.2 The GP summary is dynamic, needs to be actively reviewed and the tension between salience and inclusiveness is not static. The GP requires active management and continuing maintenance to ensure its fitness for purpose. GPs and other primary care health professionals will have to exercise clinical judgment to decide with patients which parts of the detailed GP record should contribute to the GP summary component of the SCR.

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- 4.3 We believe that it is vital that the Summary Care Record should be subject to a clear and explicit clinical safety assurance process
- 4.4 We have produced interim guidelines and defined draft standards for the content of the GP summary component of the SCR to complete Phase 1 of this project and highlighted issues for consideration in Phase 2.
- 4.5 This document will need to be validated and reviewed in the light of the experience of the EA communities and comments from other stakeholders listed at the top of this document.

Alan Hassey FRCGP & Paul Robinson FRCGP
For the RCGP Health Informatics Standing Group
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