

## **A. Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions**

### **Capability group**

Records, assessments and plans

### **Aims (in terms of take-up and optimisation)**

- Information accessed for every patient presenting in an A&E, ambulance or 111 setting where this information may inform clinical decisions (including for out-of-area patients)
- Information accessed in community pharmacy and acute pharmacy where it could inform clinical decisions

### **Examples of opportunities to go further**

- Usage further extended into other settings (for example, MH Crisis Care, OOH services, UCCs and WICs, scheduled care)
- Mobile access to information

### **Case studies / storyboards**

- [Safer Prescribing Out of Hours - Integrated Care 24, Ashford, Kent](#)
- [Improved Safety for Holidaymakers – Cromer Group Practice, Norfolk](#)
- [Junior Doctor Support for Safer Patient Care – Leeds Teaching Hospitals NHS Trust, Leeds](#)

### **National metrics**

Information regarding the deployment of SCR capability and the number of records viewed is available from HSCIC across all care settings at provider level.

Information regarding access to GP information via SCR and non SCR solutions is available from HSCIC for NHS 111, ambulance and A&E at provider level.

The usage dataset is also used in the 2016/17 CCG Improvement and Assessment Framework to contribute to a composite indicator on 'digital interactions between primary and secondary care.

Mapping needs to be done to CCG and footprint level and this is happening as part of the CCG Improvement and Assessment Framework

### **Digital Maturity Self-assessment (relevant questions)**

- Healthcare professionals can access digital records (or relevant components of them) from wherever they need to as part of their regular day-to-day routine
- When using digital records, healthcare professionals can find what they need quickly and easily; they rarely have to navigate multiple systems / user interfaces and/or sift large volumes of irrelevant data

- Healthcare professionals in your organisation have digital access to the information they need from other local healthcare providers
- Healthcare professionals have access to a consolidated view of their patients' local health and care records

### **National services / infrastructure / standards**

#### **Utilising Summary Care Record**

The Summary Care Record (SCR) is a secure, electronic patient record that contains key information for use in urgent and emergency care. It is a nationwide solution, available across England and contains medications, allergies and adverse reactions as a minimum.

The SCR can be accessed through a web portal (SCRa) using the existing NHS national infrastructure, utilising the secure NHS network, smartcards and role based access. This makes it a straightforward and cost effective solution for health communities to accelerate local record sharing. SCR complements local detailed record sharing by providing key clinical information for temporary patients or patients coming in from out of area, often when no other information is available.

The SCR is also available through integration with core systems used across the NHS. Commercially available spine mini-services make it straightforward to provide access to SCRs in clinical systems. These have been used to provide access to SCR within ambulances and on mobile devices. Mobile device authentication is currently being developed and will be subsequently piloted.

## **B. Clinicians in U&EC settings can access key GP-held information for patients previously identified by GPs as most likely to present (in U&EC)**

### **Capability group**

Records, assessments and plans

### **Aims (in terms of take-up and optimisation)**

- Information available for all patients identified by GPs as most likely to present, subject to patient consent, encompassing reason for medication, significant medical history, anticipatory care information and immunisations
- Information accessed for every applicable patient presenting in an A&E, ambulance or 111 setting (including for out-of-area patients)

### **Examples of opportunities to go further**

- Usage further extended into other settings (for example, MH Crisis Care, OOH services, UCCs and WICs)

### **Case studies / storyboards**

- [Creating SCRs with additional information - Sandford Surgery, Dorset](#)

### **National metrics**

National metrics not currently available

### **Digital Maturity Self-assessment (relevant questions)**

- Healthcare professionals can access digital records (or relevant components of them) from wherever they need to as part of their regular day-to-day routine
- When using digital records, healthcare professionals can find what they need quickly and easily; they rarely have to navigate multiple systems / user interfaces and/or sift large volumes of irrelevant data
- Healthcare professionals in your organisation have digital access to the information they need from other local healthcare providers
- Healthcare professionals have access to a consolidated view of their patients' local health and care records

### **National services / infrastructure / standards**

#### **Enriching SCRs with additional information**

The SCR is available across England and is being used in a wide number of care settings, primarily urgent and emergency care. 98% of GP practices have the capability to simply and consistently create 'richer' SCRs including: significant medical history (past and present); anticipatory care information (e.g. information about the management of long term conditions); patient preferences (e.g. communication and end of life care as per the national datasets); and immunisations.

A number of local health communities have already recognised the potential of SCRs with additional information and are encouraging GP practices to identify key patient groups and have a process to seek consent to create enriched SCRs. Exploiting opportunities such as the creation of avoiding unplanned admissions care plans, flu clinics, or during routine contact with appropriate patients have been cited. Patient groups identified include vulnerable groups and those more likely to present in urgent and emergency care; such as those with long term or multiple complex conditions, the 'frailest 2%', those with dementia or other communication difficulties or patients requiring reasonable adjustments due to disabilities. For further information see [www.hscic.gov.uk/scr/addinfo](http://www.hscic.gov.uk/scr/addinfo).

## **C. Patients can access their GP record**

### **Capability group**

Records, assessments and plans

### **Aims (in terms of take-up and optimisation)**

- Access to detailed coded GP records actively offered to patients who would benefit the most and where it supports their active management of a long term or complex condition
- Patients who request it are given access to their detailed coded GP record

### **Examples of opportunities to go further**

- Access to clinical correspondence

### **Case studies / storyboards**

- [Safe Access to Online Records – Hulme Hall Medical Group, Manchester](#)
- [Benefits of Online Access to Records – Street Lane Practice, Leeds](#)
- [Providing Patients with Online Access to their Record – Cropredy Surgery, Oxfordshire](#)

### **National metrics**

Data is available from the Patient Online Management Information (POMI) dataset. The following data is available at a GP practice level and on a monthly basis:

- Percentage of patients registered for accessing their GP record, viewing letters and test results
- Number of times that the service has been used

### **Digital Maturity Self-assessment (relevant questions)**

- N/A

### **National services / infrastructure / standards**

#### **Patient Online**

Patient Online is an NHS England programme designed to support GP practices with the provision and promotion of online services to patients. Information on support and resources is published at <https://www.england.nhs.uk/ourwork/pe/patient-online/support/>.

EMIS, INPS, Microtest and TPP are all able to provide the necessary technology to support the implementation of Patient Online services.

#### **Open interfaces**

The open interfaces work aims to define a set of common interfaces which can be used to access clinical content from across different systems and care

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settings. The project will output a set of standards based specifications based on FHIR, SNOMED CT, dm+d and NHS data dictionary to provide a consistent format and content to the shared information.

The GP Connect project is working with the principal GP system suppliers and the HSCIC to develop the interfaces and make them available for use later this year. Further information is at <http://systems.hscic.gov.uk/gpsoc/interface>. The draft interfaces are published at <http://developer.nhs.uk/downloads-data/fhir-resource-definitions-library/>.

## **D. GPs can refer electronically to secondary care**

### **Capability group**

Transfers of care

### **Aims (in terms of take-up and optimisation)**

- Every referral created and transferred electronically
- Every patient presented with information to support their choice of provider
- Every initial outpatient appointment booked for a date and time of the patient's choosing (subject to availability)
- [By Sep 17 – 80% of first outpatient elective referrals made electronically]

### **Examples of opportunities to go further**

- Referrers accessing specialist advice, increased decision support, advice and capacity alerts from commissioners
- Booking of follow-up appointments
- Any to any referrals

### **Case studies / storyboards**

- None yet

### **National metrics**

Data is available from the ERS service, including:

- Number of appointments booked through ERS against the total number of appointments

This data is available on a monthly basis, and by provider, GP practice and by CCG.

Where locally procured solutions are used rather than ERS – which is more prevalent for community and mental health providers – then this will not feature within the national dataset.

This dataset is also used in the 2016/17 CCG Improvement and Assessment Framework to contribute to a composite indicator on 'digital interactions between primary and secondary care'.


### **Digital Maturity Self-assessment (relevant questions)**

- What proportion of referrals received for outpatient or non-urgent assessment are automatically integrated into digital workflows to enable viewing, triaging and scheduling of appointments and investigations?

### **National services / infrastructure / standards**

The new NHS e-Referral Service (ERS) was launched in June 2015 as a successor to Choose and Book.

Recent developments to ERS include the availability of time to treatment information.

The NHS e-Referral Service  [delivery roadmap](#) shows current high priority projects that are planned to be delivered between March and September 2016. These projects include:

**System Alert** -Allows messages to be communicated directly to users of the NHS e-Referral Service from within the application.

**Enhanced Service Selection** - Changes to the way information is presented on the service selection screen.

**Capacity Alerts and Commissioner Advice** - These two new areas of functionality will allow commissioners to provide referrers with additional service information.

**Any to Any** - Any to Any functionality will allow patients to be referred to appropriate services by any professional user of the NHS e-Referral Service (subject to appropriate accreditation and smartcard credentials).

**Enhanced System Integration** - The progressive development of Application Programming Interfaces (APIs) will enhance integration between the NHS e-Referral Service and other compliant systems.

**Archiving** - The NHS e-Referral Service archiving capability will ensure that the system's performance is unaffected as the volume of historical referrals increases over time. Historical referrals will be archived in a safe archive storage area to reduce processing and operating costs.

The latest information on ERS is published at <http://www.hscic.gov.uk/referrals>.



## **E. GPs receive timely electronic discharge summaries from secondary care**

### **Capability group**

Transfers of care

### **Aims (in terms of take-up and optimisation)**

- All discharge summaries sent electronically from all acute providers to the GP within 24 hours
- All discharge summaries shared in the form of structured electronic documents
- All discharge documentation aligned with Academy of Medical Royal Colleges headings

### **Examples of opportunities to go further**

- Electronic discharges from other secondary care providers beyond acute
- Fully structured document automatically uploaded into GP core clinical systems and integrated into workflows
- Document encoded with SNOMED-CT and dm+d content

### **Case studies / storyboards**

- None yet

### **National metrics**

National metrics not currently available

### **Digital Maturity Self-assessment (relevant questions)**

- At patient discharge, what proportion of care summaries are shared digitally with GPs?

### **National services / infrastructure / standards**

#### **Transfer of Care Programme**

The Transfer of Care Programme is driving the development and implementation of standards to support transfers of care. Initially the project is working with discharge summaries from inpatient stays to general practice but expanding to cover mental health and A&E attendances. Further information on the initiative is published at <http://systems.hscic.gov.uk/interop/tci>.

The transfer of care content makes use of a number of standards including:

**AoMRC headings** – a set of headings developed in conjunction with the Academy of Medical Royal Colleges via the Professional Records Standards Body. These headings give consistency to the content of the report by standardising the headings which are required as part of a discharge summary. More information can be found at <http://systems.hscic.gov.uk/interop/tci/standards>. Guidance for implementing

the AoMRC headings in eDischarge summaries is available at <http://systems.hscic.gov.uk/interop/tci/edischarge>.

**MeSH** – MeSH is the replacement for the DTS which acts as a method of transporting information. More information on the MeSH programme can be found at <http://systems.hscic.gov.uk/ddc/mesh>.

The transfer of care team are always keen to hear from those involved in implementation or who are considering an implementation in the future. They can be contacted via [information.standards@hscic.gov.uk](mailto:information.standards@hscic.gov.uk).

## **F. Social care receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care**

### **Capability group**

Transfers of care

### **Aims (in terms of take-up and optimisation)**

- All Care Act 2014 compliant Assessment, Discharge and associated Withdrawal Notices sent electronically from the acute provider to local authority social care within the timescales specified in the Act

### **Examples of opportunities to go further**

- Sending the Notices as structured data
- Automatic extraction and uploading into social care systems
- Integration of Notices into social care workflows
- Extending receipt of notices beyond local authorities to other care settings (e.g. care homes)
- Ensuring patients receive relevant information from the Electronic Discharge Notice e.g. adding contact details of services set up by the hospital and contact details of services set up by the local authorities where the patient is resident

### **Case studies / storyboards**

- None yet

### **National metrics**

National metrics not currently available

### **Digital Maturity Self-assessment (relevant questions)**

- Local social care providers have digital access to information from your organisation
- Digital systems support the patient discharge process, including production of section 2 and 5 notifications and multidisciplinary discharge planning

### **National services / infrastructure / standards**

#### **Secure Email Standard and Secure Email Options**

Work is now underway to refresh the ISB 1596 secure email standard to reflect changes in central guidance from the Cabinet Office. This includes the strategic direction set out in the 'secure email blueprint' by Government Digital Service which was developed by Government Digital Service after the ISB 1596 secure email standard was published

<https://www.gov.uk/guidance/common-technology-services-cts-secure-email-blueprint>.

Details of the changes can be found here along with the current options for secure email: <http://systems.hscic.gov.uk/nhsmail/secure> and <http://systems.hscic.gov.uk/nhsmail/future>.

### **Structured Messaging: The National Adapter Service**

The Adapter Demonstrator Project was successfully piloted in London for Assessment, Discharge and Withdrawal Notices, using 'middleware' to facilitate the sending of patient identifiable information between health and social care depending on their digital maturity. In this case it was by using secure email (acute trusts) and the use of national structured ITK messages in (social care suppliers).

It has now been confirmed that in 16/17, there will be a new option for localities to consider - the 'National Adapter Service'. It will build on the Adapter Demonstrator Project, have at least the same functionality but with the Spine providing the 'middleware' (N3 will not be required).

The service will not be compulsory but can facilitate interoperability and information sharing - routing interactions between two end points and transforming the input/output to a format that the local organisation can produce/consume. It will be complementary to [MESH](#) (Message Exchange for Social Care and Health).

### **National Standards – Social Care**

The National Adapter will also use the initial national social care standards that are now being developed, starting with Assessment, Discharge and Withdrawal Notices, followed by GP Referral to Social Care. This work is taking place in collaboration with the Standardisation Committee for Care Information (SCCI) and the Professional Record Standards Body (PRSB).

## **G. Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly**

### **Capability group**

Decision support

### **Aims (in terms of take-up and optimisation)**

- Child protection information checked for every child or pregnant mother presenting in an unscheduled care setting with a potential indicator of the child being at risk (including for out-of-area children)
- Indication of child protection plan, looked after child or unborn child protection plan (where they exist) flagged to clinician, along with social care contact details
- The social worker of a child on a child protection plan, looked after or on an unborn child protection plan receives a notification when that child presents at an unscheduled care setting and the clinician accesses the child protection alert in their record

### **Examples of opportunities to go further**

- Child protection alerts flagged within core clinical patient record
- Information accessed directly from clinicians' core system
- Alerts shared with other clinical teams via electronic discharge summary
- Alerts integrated into existing social care workflows

### **Case studies / storyboards**

- [Shared Information Flags Safeguarding Needs – Homerton University Hospital, London](#)

### **National metrics**

Data is available from the CP-IS programme, including:

- Trusts live with CP-IS
- Local authorities live with CP-IS
- Number of children on database flagged for each of child protection plan, looked after child, unborn child protection plan (by Local Safeguarding Children's Board)
- Number of times CP-IS accessed (by Trust)
- Number of alerts sent to social care indicating vulnerable child presented in unscheduled care setting (by Trust)

Data should be considered in the following context:

- The proportion of children who are considered vulnerable may vary across footprints
- Professional judgement may be used over when to check for child protection information, particularly if it resides on a different system

### **Digital Maturity Self-assessment (relevant questions)**

- Healthcare professionals receive digital alerts to specific patient risks

### **National services / infrastructure / standards**

**National Spine Integration.** The CP-IS system will hold the CP-IS dataset and also will create an access history of unscheduled care settings accessing this information. This history will then be sent as notifications to the Local Authority systems where the social workers responsible for the children attending can access it. Further information on CP-IS is published at <http://systems.hscic.gov.uk/cpis>.

**NHS Number Standard.** All interactions between the Local Authority systems and the National Spine use the NHS Number as primary identifier.

**Social Care Systems enhancements.** The CP-IS team has been working closely with Local Authorities to support changes to the Social Care systems so they can send CP-IS information and receive the children's unscheduled care encounter notifications. As of today, supplier systems covering 87% of the Local Authorities in England have developed the CP-IS changes. The Health and Social Care Information Centre, suppliers and Local Authorities are working together to finalise the timescales for rollout of these changes to the Local Authorities.

**N3 and non-N3 access to the National Spine.** The CP-IS system offers at this point both N3 and non-N3 mechanisms to transfer the children dataset to the National Spine. During 2016 the CP-IS system is expected to also provide the MESH capability for transferring data from Local Authorities to the National Spine (<http://systems.hscic.gov.uk/ddc/mesh>)

**National Standard for CP-IS implementation.** In July 2016 the Standardisation Committee for Care Information (SCCI) published standard SCCI1609 which specifies the functional requirements for NHS systems to support the implementation strategy for the Child Protection Information Sharing (CP-IS) Service in England.

## **H. Professionals across care settings made aware of end-of-life preference information**

### **Capability group**

Decision support

### **Aims (in terms of take-up and optimisation)**

- All patients at end-of-life able to express (and change) their preferences to their GP and know that this will be available to those involved in their care
- All professionals from local providers involved in end-of-life care of patients (who are under the direct care of a GP) access recorded preference information where end-of-life status is flagged, known or suspected

### **Examples of opportunities to go further**

- Recording and amending of preferences by other professionals
- Recording and amending of preferences by patients

### **Case studies / storyboards**

- None yet

### **National metrics**

National metrics not currently available

### **Digital Maturity Self-assessment (relevant questions)**

- Patients' end-of-life preferences are recorded in accordance with the Palliative Care Co-ordination: Core Content (SCCI1580) national standard

### **National services / infrastructure / standards**

#### **National Information standard for Palliative Care Coordination (SCCI1580)**

This national information standard specifies the core record content to support the provision of high-quality co-ordinated care at the end of life, was published 20 March 2012 and last revised in September 2015. It provides commissioners, health and social care organisations and IT systems suppliers with the information needed to support implementation of palliative and end of life care. It was developed to support local decision making and also defines the basic core content of palliative care coordination systems.

For further information see [http://www.endoflifecare-intelligence.org.uk/national\\_information\\_standard/end\\_of\\_life\\_care\\_coordination/](http://www.endoflifecare-intelligence.org.uk/national_information_standard/end_of_life_care_coordination/).

## **Electronic Palliative Care Coordination systems (EPaCCS)**

A number of areas in England have developed electronic palliative care coordination systems (EPaCCS) and are using them to:

- improve communication between professionals
- improve access to key information that is not otherwise available e.g. for ambulance staff and out of hours providers
- improve communication of Advance Decision to Refuse Treatment (ADRT), Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) decisions and advance statements of wishes and preferences
- improve communication of the issue and location of anticipatory medication
- provide clarity of people involved in care – informal carer, Lasting Power of Attorney and others to be involved in decision making
- impact on avoiding unwanted/unnecessary treatments and interventions.

For further information on EPaCCS see

<http://www.nhs.uk/improvement-programmes/long-term-conditions-and-integrated-care/end-of-life-care/coordination-of-care.aspx>.

## **Spine and SCR supporting palliative care coordination**

The spine has great potential to support palliative care coordination through ongoing work to develop an EPaCCS record locator. This will provide relevant health professionals with access to EPaCCS information through integrated applications or the SCR application (SCRa).

The SCR can be used to support palliative care coordination by sharing patient preferences and other end of life information from GP records. The main GP systems have the capability to enrich SCRs with a set of additional information including codes from the SCCI1580 standard related to patient preferences, advance care planning, lasting power of attorney and specific preferences such as preferred place of care. For further details of the palliative care coordination information supported by SCR see <http://systems.hscic.gov.uk/scr/additional/inclusiondataset.pdf>

SCR is already being used in a wide number of care settings, primarily urgent and emergency care and provides a cost effective solution for health communities to accelerate local record sharing and an opportunity for settings with lower digital maturity to support palliative care coordination.

SCR is available wherever the patient is treated across the NHS in England:

- beyond the footprint of EPaCCS
- beyond the EPaCCS core user group
- where an EPaCCS system is not available

For further information on how SCR can be used to support EPaCCS see

[http://www.endoflifecare-intelligence.org.uk/resources/publications/implementation\\_guidance](http://www.endoflifecare-intelligence.org.uk/resources/publications/implementation_guidance)



## I. GPs and community pharmacists can utilise electronic prescriptions

### Capability group

Medicines management and optimisation

### Aims (in terms of take-up and optimisation)

- All permitted prescriptions electronic
- All prescriptions electronic for patients with and without nominations - for the latter, the majority of tokens electronic rather than paper
- Repeat dispensing done electronically for all appropriate patients
- [By end 16/17 – 80% of repeat prescriptions to be transmitted electronically]

### Examples of opportunities to go further

- Electronic prescribing used from other care settings when solutions are available. This may include integrated urgent care services, acute and community settings.

### Case studies / storyboards

- [Safer Dispensing with Electronic Prescription Service – Rohpharm Pharmacy, London](#)
- [Time Savings and Safer Prescribing – Risedale Surgery, Cumbria](#)

### National metrics

The dataset available from HSCIC represents % utilisation of EPS Release 2 – derived from number of prescriptions claimed by electronic prescribing divided by the total number of prescriptions claimed. Data is available at practice, CCG and NHSE sub-region levels.

This data is also used in the 2016/17 CCG Improvement and Assessment Framework to contribute to a composite indicator on ‘digital interactions between primary and secondary care’.

### Digital Maturity Self-assessment (relevant questions)

- N/A

### National services / infrastructure / standards

**Electronic Prescription Service (EPS)** - EPS (Release 2) enables prescribers - such as GPs and practice nurses - to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. Further information is published at <http://systems.hscic.gov.uk/eps/>.

**EPS “Phase 4”** - The next phase of EPS2 (Phase 4) will add the ability for patients that have not chosen (nominated) a pharmacy to utilise the service through the use of paper or electronic tokens for the patient to use to collect

the prescription from the pharmacy of their choice. Additionally, new legislation was recently passed to make it legal for Schedule 2 and 3 Controlled Drugs to be prescribed and dispensed via EPS Release 2. It is anticipated that all dispensing sites will have access to the controlled drug functionality by the end of 2018. Further information, including the latest progress report, is published at <http://systems.hscic.gov.uk/eps/future-eps>.

**Dictionary of Medicines and Devices (dm+d)** - dm+d is a dictionary of descriptions and codes which represent medicines and devices in use across the NHS, and is used within EPS R2. It is delivered through a partnership between Health and Social Care Information Centre and the NHS Business Services Authority and provides the recognised NHS Standard for uniquely identifying medicines and medical devices used in patient care. dm+d enables clear, consistent recording and communication of information relating to medicines and devices used in patient care. It provides consistency in how medicines and medical devices are expressed through a robust published Editorial Policy. Further information is at <http://systems.hscic.gov.uk/eps/dispensing/dmd>.

## **J. Patients can book appointments and order repeat prescriptions from their GP practice**

### **Capability group**

Remote care

### **Aims (in terms of take-up and optimisation)**

- [By end 16/17 – 10% of patients registered for one or more online services (repeat prescriptions, appointment booking or access to record)]
- All patients registered for these online services use them above alternative channels

### **Examples of opportunities to go further**

- More than 10% of patients registered by end 16/17
- Highest registration levels amongst those patients who are the heaviest users of these transactions

### **Case studies / storyboards**

- [Benefits of Online Access to Records – Street Lane Practice, Leeds](#)

### **National metrics**

Data is available from the Patient Online Management Information (POMI) dataset. The following data is available at a GP practice level and on a monthly basis:

- Percentage of patients registered for each of accessing their GP record, booking or cancelling appointments, ordering repeat prescriptions, viewing letters and test results
- Number of times that each service has been used

### **Digital Maturity Self-assessment (relevant questions)**

- N/A

### **National services / infrastructure / standards**

#### **Patient Online**

Patient Online is an NHS England programme designed to support GP practices with the provision and promotion of online services to patients. Information on support and resources is published at <https://www.england.nhs.uk/ourwork/pe/patient-online/support/>.

EMIS, INPS, Microtest and TPP are all able to provide the necessary technology to support the implementation of Patient Online services.