Document Management

COVID-19 SCR Additional Information

Requirements v1.2

Revision History

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| --- | --- | --- |
| **Version** | **Date** | **Summary of Changes** |
| 1.0 | 22/04/2020 | Changes to SCR for Covid-19 |
| 1.1 | 14/07/2020 | Removed “Phased roll-out” requirement and other minor updates |
| 1.2 | 09/05/2022 | Amendments and uplift due to SCR FHIR API work | |

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**Contents**

[Purpose 4](#_Toc102990882)

[Priority of Requirements 4](#_Toc102990883)

[Description 4](#_Toc102990884)

[Background 4](#_Toc102990885)

[Acceptance Criteria 5](#_Toc102990886)

[1. Bulk upload of SCR Additional Information 5](#_Toc102990887)

[2. Latest instance only of COVID-19 risk category codes 5](#_Toc102990888)

[3. Audit trail and reversibility 6](#_Toc102990889)

[4. Use of specified COVID-19 SNOMED CT codes 7](#_Toc102990890)

[5. COVID-19 vaccination data 8](#_Toc102990891)

[6. COVID-19 test results data 8](#_Toc102990892)

[7. Management of COVID-19 test results and vaccinations 8](#_Toc102990893)

[Risks and Issues 9](#_Toc102990894)

# Purpose

This document contains Covid-19 specific business requirements for the GP Summary Sending component of the Summary Care Record and applies to all suppliers who are including GP Summary sending functionality in their products.

# Priority of Requirements

Any requirements in this document take precedence over any corresponding GP Summary requirements until instructed otherwise by NHS England.

For example, in the GP Summary requirements the requirement is for patients with Implied Consent to have an SCR with Medication And Allergy information only, whereas in this document, the requirement is for patients with Implied Consent to have an SCR with Additional Information; therefore the requirement to have an SCR with Additional Information takes precedence.

# Description

As a result of the Covid-19 pandemic, patients’ Summary Care Records were enriched with Additional Information including significant medical history, significant past procedures, and anticipatory care information as well as allergies, adverse reactions, and current medications.

Additionally, Covid-19 related content from the patient’s GP record must be displayed in the Summary Care Record (SCR), including information about suspected or confirmed diagnosis, Covid-19 vaccination event information and risk category for developing complications from Covid-19.

This will assist healthcare professionals making clinical decisions and treating patients.

# Background

It was agreed at the start of the Covid-19 pandemic in 2020 that a centrally managed bulk change would be applied to patient records and GP Summary updates; this was sent for a group of patients who previously had a core only SCR. The purpose of the change was to enrich patients’ SCRs with Additional Information. SCR Additional Information includes significant medical history, significant medical procedures, end of life care information and anticipatory care information.

A change was also introduced to SCR Additional Information in that the SCR inclusion dataset now contains Covid-19 related information including any new relevant codes when there is a SNOMED CT release, currently every one or two months. This change includes Covid-19 risk category information, Covid-19 confirmed and suspected diagnoses, Covid-19 vaccination event information and some Covid-19 test outcomes.

The Additional Information contained in a patient’s SCR as a result of these changes assists healthcare professionals involved in the patient’s direct care. The changes have been directed via the Covid-19 COPI Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002. The change is on-going until instructed otherwise.

This paper contains the requirements, business rules, and the risks and issues associated with these changes.

# Acceptance Criteria

## Bulk upload of SCR Additional Information

### Cohort of patients to apply the change to

All registered patients in the GP supplier estate with implied consent for a core SCR.

### Description

Upload SCR Additional Information to the patients’ SCRs without changing SCR consent preference. This is on-going until advised to revert back or otherwise notified.

This action has the requirement to be completely auditable and reversible, when directed, to maintain the status and reputation of SCR with the profession and patients.

### Business rules for SCR content

|  |  |  |
| --- | --- | --- |
| **Patient’s most recently recorded SCR consent preference** | **SCR content before the change** | **SCR content after the change** |
| Express dissent for Summary Care Record dataset upload | N/A (No SCR) | N/A (No SCR) |
| Implied consent for core Summary Care Record dataset upload | Core SCR | SCR with Core and Additional Information |
| Express consent for core Summary Care Record dataset upload | Core SCR | No change - Core SCR only |
| Express consent for core and additional Summary Care Record dataset upload | SCR with Core and Additional Information | No change – SCR with Core and Additional Information |

## Latest instance only of COVID-19 risk category codes

### Prerequisite

The most recent version of the SCR inclusion refset must be implemented in the GP system following each release. This will include COVID-19 specific SNOMED CT concepts.

The current release of the UK SNOMED CT Clinical Edition, RF2: Full, Snapshot & Delta pack can be found here: [UK SNOMED CT Clinical Edition, RF2: Full, Snapshot & Delta download](https://isd.hscic.gov.uk/trud3/user/authenticated/group/2/pack/26/subpack/101/releases)

The SCR Inclusion refset and concept ID to be imported is:

* 999004331000000102 |Summary Care Record inclusion simple reference set (foundation metadata concept)

The SCR Inclusion refset includes 3 COVID-19 specific codes related to the risk category for developing complications.

### Description

Only the latest recorded instance (by date/time) of the ‘COVID-19 risk category for developing complications’ code set is to be included in SCR.

**COVID-19 risk category for developing complications code set**

|  |  |  |
| --- | --- | --- |
| **CONCEPTID** | **FULLY SPECIFIED NAME** | **PREFERRED TERM** |
| 1300591000000101 | Low risk category for developing complication from coronavirus disease 19 caused by severe acute respiratory syndrome coronavirus 2 infection (finding) | Low risk category for developing complication from COVID-19 infection |
| 1300571000000100 | Moderate risk category for developing complication from coronavirus disease 19 caused by severe acute respiratory syndrome coronavirus 2 infection (finding) | Moderate risk category for developing complication from COVID-19 infection |
| 1300561000000107 | High risk category for developing complication from coronavirus disease 19 caused by severe acute respiratory syndrome coronavirus 2 infection (finding) | High risk category for developing complication from COVID-19 infection |

The free-text associated with the ‘COVID-19 risk categoryfor developing complications’ code MUST also be included which will include an indication as to whether the patient is considered to be part of the Priority Treatment Group.

## Audit trail and reversibility

Reporting on the bulk change is required at a local practice level via clinical reporting and searches. It must be possible to reverse the process at a future date so that the specified patients can return to having a core SCR, in order to maintain status and reputation of SCR with the profession and patients.

It must also be possible to report at a local practice level on all patients that have had Additional Information added to their SCR and have an SCR consent code of ‘Implied consent for core Summary Care Record dataset upload’. This change may have been applied either during a bulk upload process or subsequently.

## Use of specified COVID-19 SNOMED CT codes

There are five SNOMED CT codes that are used to indicate that a patient has been diagnosed or is suspected of having COVID-19. Four of the codes relate to whether the patient has had a diagnosis of confirmed COVID-19 based on laboratory test results or clinical diagnostic criteria. The fifth code relates to whether the patient has suspected COVID-19, which includes assessments by NHS 111 telephone service.

These five SNOMED CT codes are a subset of the wider group of COVID-19 codes within the SCR inclusion dataset. These five codes are the only codes that will appear in the structured part of the GP Summary message.

Where the SCR information is consumed by a healthcare professional using the Summary Care Record application (SCRa), the presence of these codes will cause a yellow COVID-19 alert to be presented to the user as a signpost to the information. Therefore, the code and the terminology used must be consistent.

### Description

The specified set of SNOMED CT codes MUST be coded into clinical statements as defined in the appropriate Summary Care Record specification.

In addition, the presentation text block of the message MUST be populated with a human-readable rendering of the local code phrase (SNOMED CT Preferred Term) and its associated text only, as defined in the presentation text specification.

**Specified COVID-19 code set**

|  |  |  |
| --- | --- | --- |
| **CONCEPTID** | **PREFERRED TERM** | **MAPPED CARE RECORD ELEMENT HEADER** |
| 1240751000000100 | COVID-19 | Diagnoses |
| 1300721000000109 | COVID-19 confirmed by laboratory test | Diagnoses |
| 1300731000000106 | COVID-19 confirmed using clinical diagnostic criteria | Diagnoses |
| 1240581000000104 | SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2) RNA (ribonucleic acid) detection result positive | Clinical Observations and Findings[[1]](#footnote-2)  or  Investigation Results |
| 1240761000000102 | Suspected COVID-19 | Diagnoses |

## COVID-19 vaccination data

For each occurrence of COVID-19 vaccination event information the following conditions apply:

* The following supporting information for the COVID-19 vaccination Procedure code MUST be included:
  + Manufacturer (e.g. Pfizer BioNTech)
  + Site (e.g. left arm)
  + Batch Number (e.g. PV46676, 4120Z002)
  + Expiry Date
* The COVID-19 vaccination Product code MAY be included under the Acute Medications Care Record Element heading in the SCR where other criteria for inclusion in this section are met, e.g. code recorded within the preceding 12 months.

## COVID-19 test results data

The COVID-19 test result information will be included under the relevant Care Record Element heading in the SCR, as defined in the Care Record Element mapping table on TRUD. The COVID-19 test result will be an integral part of the SNOMED CT code.

## Management of COVID-19 test results and vaccinations

When COVID-19 test results and/or vaccinations are received into the GP IT system and filed within patient records, then:

* the receipt of either a COVID-19 test result or COVID-19 vaccination event information MUST be recognised as a trigger event for SCR upload
* the GP Summary update (SCR) MUST be triggered without the patient record needing to be opened and closed/saved by an end user
* the resulting GP Summary update (SCR) MUST be queued until a user authenticates with a smartcard, resulting in triggering the upload of pending GP Summary Updates to Spine

# Risks and Issues

### Practice burden

If it becomes necessary to reverse a bulk upload change then suppliers should consider the impact of the reversal on practice burden, namely:

* Patient questions and concerns
* Patients further changing SCR consents after the change is applied
* As the process will take a long time, patients may present or contact GP surgeries before the change has been applied to their SCR
* GP practice system workflow queues would likely increase following any over-night bulk consent activity triggered by the practice following the supplier’s action to change consent. As patients may not have been into practice for a while there may be PDS discrepancies or patients may have left the practice etc. Consider CCG resource and uplifted guidance materials to support GP practices.

### New patient process

Upon migrating the GP record via GP2GP for example, the receiving system would have no awareness of this action being applied to the patient’s record. Therefore, there is a risk that the SCR core status could be reinstated by the receiving practice.

Therefore, consideration should be given to the newly registered patient process to ensure that patients who have an enriched SCR due to the change, still have an enriched SCR at their new practice. The practice should make the patient aware of what choices are available to them regarding their SCR <https://digital.nhs.uk/binaries/content/assets/legacy/pdf/g/c/new_patient_consent_form.pdf>

### Latest recorded instance of the ‘COVID-19 risk category for developing complications’ code set

In separate discussions between NHSD and existing suppliers, a risk was highlighted by clinical leads regarding the requirement to only include the latest recorded instance (by date/time) of the ‘COVID-19 risk category for developing complications’ code set. Below are the main points that were raised:

* If the rule wasn’t introduced, then it would be a dynamic status showing for example that a patient who was flagged, is now no longer flagged. It was pointed out that this could be a true representation of a patient’s risk – they were high risk but now they are low risk. A Pharmacist, for example, would see a status of ‘low’ and understanding what the status has changed from would be useful to them.
* The risk category status will rarely change.
* Practices that have used Low and Medium risk category for other purposes. In some cases earlier in the SPL programme the codes were batch-added to cohorts of patients.

1. This code is required to map to the Clinical Observations and Findings CRE Type but there are legacy mappings that have been sent to Investigation Results. It should be possible to receive either mapping. [↑](#footnote-ref-2)