**Summarising Policy**

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# Introduction

## Policy statement

The purpose of summarising patient records is to ensure that the patient’s individual electronic healthcare record is an accurate, coded, structured record of important and significant clinical information. At Sheerwater Health Centre, patient e-records are held on the EMIS system and all records are retained as per the Data Protection Act 2018 and GDPR.

## Principles

Patient safety is of paramount importance. It is therefore essential that patient records are maintained to the highest of standards. An accurate summary will support Sheerwater Health Centre in the effective management of all patients.

## Status

The organisation aims to design and implement policies and procedures that meet the diverse needs of our service and workforce, ensuring that none are placed at a disadvantage over others, in accordance with the Equality Act 2010. Consideration has been given to the impact this policy might have with regard to the individual protected characteristics of those to whom it applies.

This document and any procedures contained within it are non-contractual and may be modified or withdrawn at any time. For the avoidance of doubt, it does not form part of your contract of employment.

## Training and support

This organisation will provide guidance and support to help those to whom it applies to understand their rights and responsibilities under this policy. Additional support will be provided to managers and supervisors to enable them to deal more effectively with matters arising from this policy.

# Scope

## Who it applies to

This document applies to all employees, partners and directors of the organisation. Other individuals performing functions in relation to the organisation, such as agency workers, locums and contractors, are encouraged to use it.

## Why and how it applies to them

It is the responsibility of all staff to ensure that they contribute to the effectiveness of the patient’s individual healthcare record. The Good Practice Guidelines for GP electronic patient records v4 (GPGv4 2011)[[1]](#footnote-1) should act as a reference for all those involved in developing, deploying and using general practice IT systems.

# Definition of terms

## Coding

The process of assigning codes to a record

## SNOMED CT codes

SNOMED CT codes[[2]](#footnote-2) are, as of 1st April 2020, the method that has been adopted to code throughout the NHS. These have replaced Read codes which should no longer be used.

## GDPR

A legal framework which sets guidelines for the collection and processing of personal information of individuals within the EU, the GDPR came into effect on the 25th May 2018.

## Data Protection Act 2018

The UK data protection laws which complements the European Union's General Data Protection Regulation (GDPR)[[3]](#footnote-3)

# Summarising

## Aim

The aim of summarising a patient’s record is to establish an accurate summary. This is achieved by:

* Documenting the patient’s significant past medical history
* Ensuring all entries are given an appropriate SNOMED code
* Examining the healthcare record for any errors, incorrectly filed data or omissions of significant conditions or information

## Summarisers

At Sheerwater Health Centre, personnel tasked with summarizing are appropriately trained, competent individuals who have a clear understanding of medical terminology and will adhere to the guidance detailed in this policy. Summarising will be undertaken by doctors, nurses and trained administrative staff.

It is recommended that summarisers do not work in excess of six hours per day (when summarising) as the role requires significant concentration and attention to detail. The responsibility for the overall quality and accuracy of summarising at Sheerwater Health Centre rests with Dr Munira Mohamed. Such is the significance of this essential administrative role that clinicians should regularly endorse the work undertaken by non-clinical summarisers. Furthermore, non-clinical summarisers should have access to a clinician who is able to provide guidance and answer any queries they may have.

## Data capturing

At Sheerwater Health Centre, the Correspondence Management Policy explains the systems that are in place to ensure that all new data relating to patients is processed effectively and recorded onto EMIS system using the appropriate SNOMED CT code.

## Paper records

Upon receipt of the Lloyd George record enter this in the patient record:

Lloyd George Records Received - SNOMED Code: 14361000000109

There is a requirement to retain test results, letters, medico-legal reports and GP notes in separate bundles within the Lloyd-George envelope.

All information within the file should be in chronological order and held together with treasury tags. Summarisers should:

* Arrange letters, test results, medico-legal reports and written GP notes into separate bundles which are held together with treasury tags
* Sift hospital letters to ensure that only those which are relevant are retained
* Review previous summaries and, if there are any obvious omissions or gaps in the patient’s history, take the time to review the records to ensure that all pertinent information is recorded

The following table shows what is to be retained or discarded:

|  |  |  |
| --- | --- | --- |
| **Item** | **Retain** | **Discard** |
| Letters | * Initial and subsequent significant letters of a condition/treatment
* Maternity/postnatal letters
* Hysterectomy and histology
* Chronic diseases
* Letters relating to current conditions
 | * Duplicate letters
* Did not attend letters
* Dental
 |
| Cervical cytology | * All results
 |  |
| Results | * All results, i.e. bloods and urinalysis
 | * Duplicates
 |
| X-rays | * All relevant copies
 | * Duplicates
 |
| Mammography | * All results
 | * Duplicates
 |
| Medico-legal | * Keep relevant records if they supplement what is within the record
 | * Duplicates
* Irrelevant information
 |
| Discharge summaries | * Retain all copies, including A&E summaries
 |  |

All relevant information should be noted and added (if not already present) to the

e-record held on EMIS system. The latest tests, such as mammograms, smears, etc., should be added to the system if they are not already present.

When adding information, it is important to ensure that the correct significance is given (see paragraph 4.6).

## Electronic records

The following information should be recorded (if known):

|  |  |  |
| --- | --- | --- |
| **Social history** | **Clinical history** | **General health overview** |
| * Marital status (married, divorced, separated,

marital difficulties)* Death of a close relative
* If defined as being “at risk”
* History of abuse as a child
* Patient adopted
* Significant family history (CHD, BP, stroke, TIA, diabetes, thyroid, etc.)
 | * Major trauma, injuries and fractures
* Surgery (any history)
* Obs and Gynae
* Chronic or recurring diseases
* Dermatological conditions
* Immunisations and vaccinations
* Allergies
* Results of investigations
* Cytology information
* Mental health
* Malignancy
* Registered deaf
* Registered blind
* Significant childhood illnesses
 | * Blood group
* Alcohol consumption
* Smoking status
* Record of BP
* Lifestyle (advice)
 |

All entries should be appropriately SNOMED CT coded. This will enable accurate searches to be conducted whilst providing an opportunity for the team to review statistical data in relation to QOF.[[4]](#footnote-4)

## Problems and significance

It is essential that the summary clearly differentiates between active and inactive problems as well as significant and minor conditions:

* Active – a current condition that is affecting the patient
* Inactive/past – an event or condition that is no longer active
* Significant – a serious condition, e.g. ischaemic heart disease
* Minor –a minor condition, e.g. migraine
* Significant inactive/past – a condition that has the potential to have an impact on the patient’s health in the future, e.g. myocardial infarction

Summarisers should ensure that they review the summary page in EMIS prior to updating the record as the problem may already exist. For example, if atrial fibrillation is already recorded as an active and significant problem, then it should not be recorded more than once. The active problem should give the date the condition was first diagnosed (not the date of the summarisation).

Some events may be recorded more than once. For example, if the patient has experienced multiple TIAs, each event should be recorded separately.

## Accurate coding

Summarisers should ensure that they use the correct code.

Additionally, summarisers should avoid entering tasks, instead they should enter the problem, for example, lethargy is a problem, blood taken is a task.

A full list of SNOMED CT codes can be found at this [link](https://digital.nhs.uk/services/terminology-and-classifications/snomed-ct).

## Recording the summary

Once the summariser is content that the summary is complete, they should add an admin entry to reflect the fact that the notes have been summarised, using either of the following SNOMED codes:

|  |  |
| --- | --- |
| **SNOMED title** | **SCTID** |
| Notes summary on computer | 184229000 |
| Electronic record notes summary verified | 519211000000103 |

It is also good practice to write the date of the summary on the front of the Lloyd George envelope.

## Omitting information

At Sheerwater Health Centre, it is agreed that the following will not be coded when summarising:

* Minor childhood illnesses
* Minor sprains, strains or other MSK injuries
* Infections of little significance, e.g. conjunctivitis, gastroenteritis, etc.

# Summary

Summarising is an effective way of ensuring that the data held by organisations is accurate and structured. It is a process that requires staff to be given the appropriate level of training, support and time to complete the task in order to ensure that the summarising process is effectual.

1. [Good Practice Guidelines for General Practice Electronic Patient Records v4](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215680/dh_125350.pdf) [↑](#footnote-ref-1)
2. [NHS Digital - SNOMED CT](https://digital.nhs.uk/services/terminology-and-classifications/snomed-ct) [↑](#footnote-ref-2)
3. [Data Protection Act 2018](http://www.legislation.gov.uk/ukpga/2018/12/contents/enacted) [↑](#footnote-ref-3)
4. [Quality and Outcomes Framework](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/quality-and-outcomes-framework-qof) [↑](#footnote-ref-4)