



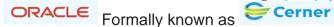
Hertfordshire and West Essex

Shared Care Record

Hertfordshire and West Essex Shared Care Record User Guide from 22 January 2025

Overview:

The technology used to create the Hertfordshire and West Essex Shared Care Record is called the Health Information Exchange (HIE), provided by:



The HIE creates an up-to-date summary view of an individual's health and care record from multiple record systems. As the system is read-only, you cannot change or record information while using the HIE.

Accessing the HIE: The HIE is opened from within the patient/service user record in your local system. The name displayed on the link/button to open the HIE will differ depending on your local system.

Examples include:

- Cerner HIE (Alex Health)
- Portal Cerner new HI (EMIS)
- Shared Care Record (PARIS)
- HIE (Cerner Millennium)
- hweuk.cernerhie.org... (SystmOne)

1. DEMOGRAPHICS AND TOOLBAR

Basic demographic information is viewable at the top of the screen.

Click 'Menu' and tick 'Show partners status' to see the status of each external data feed providing data to the HIE.



New - The demographic bar will now always be viewable to improve safety.



Please note this will not include local partner organisations who are directly connected to the HIE.

OK means the available data has loaded N/D means patient found but no data available N/F means patient not found F stands for failed – data has not loaded

Click **Source MRNs** (Mated Relay Node) to launch a list of source records and their respective patient identifiers (for example hospital number), that have been matched to form the HIE record.

News Feed: The loudspeaker icon will show local messages which can be marked as read/unread by the user. Please look here for important messages about updates and events such as planned downtime or the availability of information.



Disclaimer: A reminder that the HIE is not the full patient record and will not contain all information about a patient/service user. It should therefore be used appropriately as an additional tool to support decision making.

Disclaimer

This is an aggregated view of information obtained from participating health and care providers. It is intended to support optimal care through more informed decision making. It is not intended to replace the person's health or care record(s) nor is it guaranteed to encompass all current or historical information. The data is not manipulated, its validity is determined by the accuracy/quality of original documentation and it may be subject to exclusions as per national guidelines on sensitive data.

Page Search: Use this field to search the HIE record for specific words or items. If the search term is found, it will be highlighted in yellow in the sections below once filtering is complete.

Note the option to include reports (documents) in the search. To clear the search, click 'x'. PLEASE NOTE: Using the search function will filter the data in the HIE to just the search results, therefore remember to clear the search afterwards to restore all other data.

Filters: You can adjust the view of the data available by timeframe, partners ('Results'), source, or encounter. Filtering by **source** is an effective way to find information from one provider. For example, from a specific hospital.

PLEASE NOTE: Filters are stored for the next time you access the HIE so make sure to reset them using the **Reset** button.

The layout drop-down allows you to change the number of columns used to present the information from one column to three.

User preferences



Widgets It is possible to personalise your view by using drag and drop to re-arrange the layout of the sections as well as choosing the number of columns shown in screen from 1-3 using the **Layout** filter.

The HIE will retain these preferences each time it is opened.

2. SECTIONS



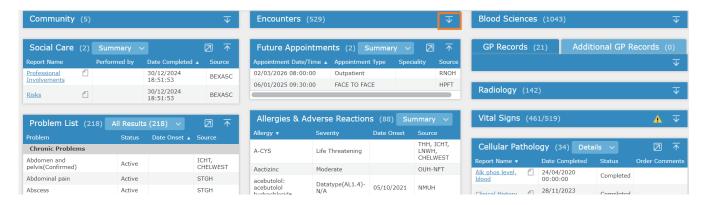
Information is displayed in sections (also known as widgets).

New – Widgets are now all expanded and visible by default. Preferences can still be retained to suit the user.



Darker blue sections contain information and can be expanded or collapsed by using the up/down arrow in the top right-hand corner.

Sections can be maximised by clicking the diagonal expand button in the top right corner.



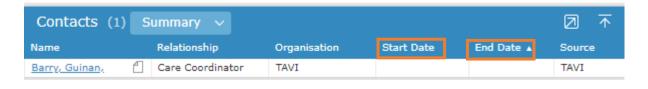
The view can be changed using the drop-down box at the top of the section. For example, from **Summary** view to **Detail** view.



New – Encounter types' and **'Future Appointments'** now have a **'Specialty'** column added with readable text.



New – **SD** (Start Date) and **ED** (End Date) have now been added detailing the date where the relationship between the prescribed person/service users began and ceased.



Press the page numbers at the bottom of the section for more results.

All sections are ordered chronologically by default with the most recent data item first and always display the source of the information. However, clicking on column headers can alter the display. Clicking on a line of information will open more detail or hovering over items will trigger a tooltip to display with the additional information.

Types of section and information provided

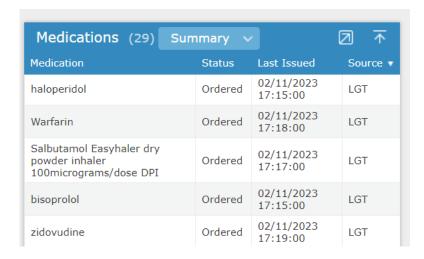
The HIE creates a read-only view of information from multiple host record systems that send different information to the HIE in different ways.

PLEASE NOTE: The same type of information sent by different organisations may be presented in different ways and appear in different sections. Information from some organisations will only be available from the date that their record system connected to the HIE. There will be no information about care provided before this point.

Section type 1 – Structured data

Some sections contain structured data which shows directly as a list of items mapped to a relevant section. Examples include **Visits**, **Appointments**, **Problems**, **Allergies** and **Procedures**. The majority of structured data come from acute providers.





PLEASE NOTE: Individual sections are not a complete list of information from all providers. Additional data may be found within reports or documents (particularly within GP Records), that is not displayed within these sections.

For example, the **Medications** section may contain the medication data provided by one or more acute provider. However, the most current medications for an individual are likely to be found within the **GP Records** section. Additional medications may also be found in other documents such as hospital discharge summaries found in the **Clinical Correspondence** section.

Prescribed vaccinations and allergies are other examples of important information that is likely to be found within **GP Records** as well as within structured data sections.

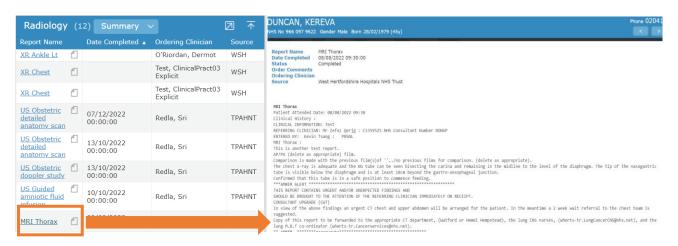
Section type 2 - HTML format/unstructured: The

data is presented as it is sent by the source system as a single report, with sections. Click

the document and navigate through the content which may be stored in tabs and on more than one page. Commonly **GP Records, Community Health and Mental Health** sections exist in this way.



Section type 3 - Documents: These sections contain documents which must be clicked to open. Once opened, navigate to the next document in the list by clicking the right arrow. Typical sections that function this way are **Clinical Correspondence and Radiology**.



PLEASE NOTE: Some reports or documents that can't be mapped to an appropriate section/widget may be found in the **Miscellaneous Reports** section.

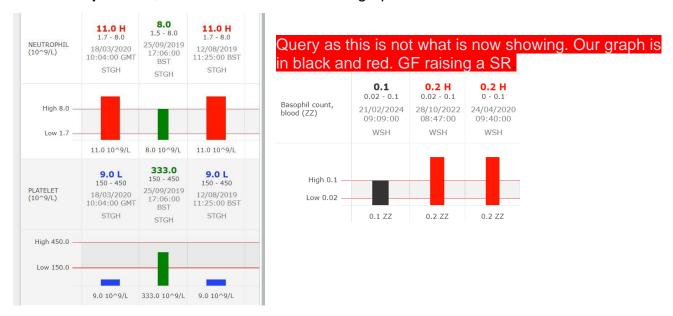
1. Results data

Some sections which contain results data have additional options to display the results in different ways:

Result Sets/Orders displays results grouped by the tests that were ordered as a set.



Within 'Graph view', click on an item to create a graph of the results over time.



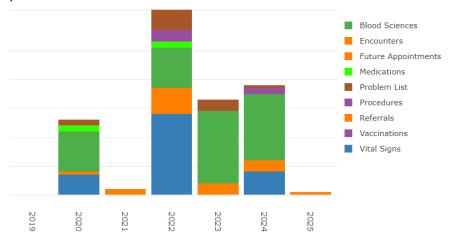
Results information may be shown with the following colour-coding:

Red = higher or lower than the normal range Black/Green = within the normal range

PLEASE NOTE: The units of measurement and normal ranges will be set by the organisation providing the data.

2. Timeline section

This provides a visual overview of the patient/service user's interactions with those healthcare partners that have loaded. Clicking one of the bars in the timeline zooms in and filters the data according to the timeline. Click 'Reset filters' to reload all data for the patient/service user.



3. Printing and recording information

PLEASE NOTE: There is no print facility within the Shared Care Record. Users should not print or take screen shots of the information within the Shared Care Record as this creates risks around data security, record duplication and out-of-date information being used.

When recording information in your own record system, please consider other users. For example, by not using abbreviations that would not be understood by colleagues in other services.

4. How the HIE matches records

The HIE works by searching multiple record systems (from each connected partner organisation) for matching records and presenting the available data to the user. Name, date of birth, address, NHS number and other pieces of demographic information are used to match records.

PLEASE NOTE: When a record in a partner organisation's system has incomplete or incorrect demographic data, for example no NHS number, there is a very small risk of an incorrect match being made. This would result in incorrect data being displayed within the Shared Care Record. Users should be aware of this risk and check information with the patient/service user where possible.