

# **GP Support Unit**

**Standard Operating Procedure**

## **Scanning and Coding**

**Version 1.0**

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## 1. Background

Providing an accessible service that meets the needs of the registered population is essential. Effective and innovative ways of using the skills of practice administrative staff will reduce the administrative workload for GPs and other clinical staff, enabling them to see more patients, thereby reducing the waiting times for appointments. It also expands and builds on administrative staff's skills to give them further opportunities for career development.

This SOP will illustrate the commitment of the GPSU to an advanced approach to correspondence management including scanning and clinical coding. The patient record coordinator team will support clinicians by processing all incoming correspondence and, through continuous improvement, strive to manage 90% of all correspondence, significantly reducing the administrative tasks of the clinical team whilst building their own skill set.

## 2. Purpose

This SOP is the process to be followed when scanning clinical documents for inclusion in patients' records, and for non-clinically related documentation. The purpose of this SOP is to;

- Ensure an accurate depiction of the original document is obtained in a standardised and consistent way
- Ensure the security, ease-of-storage, and accessibility of the information in the future
- Ensure any correspondence requiring action is completed in a timely manner (24-48 hours)

The process of scanning and batching post should take place daily.

## 3. Scope

This document predominantly applies to the patient record coordinator team working within the GPSU. Other individuals performing functions in relation to the organisation, such as agency workers, locums, and contractors, are encouraged to review this policy and use it accordingly.

This SOP will only address GPSU administrative activity and any clinical actions or follow up will be found in each practice's clinical processes.

## 4. Training

All staff who are expected to carry out scanning and clinical coding must be trained appropriately. Training will ensure that individuals understand their additional responsibilities and the requirement to adhere to guidance and protocol and who to seek guidance from if needed.

## 5. Clinical Coding

The purpose of clinical coding, using SNOMED CT, is to ensure that all information in the patient's health record is given a concept ID. Using SNOMED CT enables consistent recording of clinical content in health records. Having consistent records helps us better understand our patient demographics (and how we can best tailor treatment to specific patient groups) as well as enable accurate recording of activity for commissioners, who fund services.

Clinical coding is carried out by the patient record coordinator team at the GPSU.

Staff will be expected to code the following types of correspondence and it is essential that all types of correspondence are coded accurately:

- Discharge summaries
- Clinical letters
- Test results
- Imaging results

## 6. Scanning of Documents

The patient record coordinator team is responsible for ensuring that the correct procedures are adhered to when processing original documents, thereby ensuring that the scanned copy is a true representation of the original document and the process complies with the guidance detailed in the [NHSX Records Management Code of Practice 2021](#).

Scanned documents must be able to perform the same function as the original document whilst also retaining their authenticity, integrity, and usability as records. The patient record coordinator team should ensure that:

- Original documents are scanned straight, with all page content visible and in the original size
- All pages of the original document are scanned
- In the case of numbered pages, all pages of the original document must be scanned, even if one page is blank
- In the case of multiple pages, pages must be scanned in order
- Originals are scanned to a format that is not editable (PDF)
- The scanned document is legible.

### 6.1 Scanning Process

- Correspondence must be opened, and date stamped on the day of receipt (Date stamp only required for paper correspondence) by the patient records co-ordinator team
- Scan the document into the acquired documents area of Systmone –
  - In Systmone select the Scanning logo on the home screen
  - This will open acquired documents – Select ‘Scan Images’ and a box will appear with options for scanning. Select the appropriate option for the document you are scanning.
  - For any downloads from emails the attached document should be dragged and dropped into acquired documents section

## 7. Batching

Once scanned all post must be read and sorted into batches. Urgent items must be batched within 24hours to ensure actions can be picked up by the GPs in a timely manner.

- Patient record coordinator should read the scanned correspondence on the day of receipt
- If there an urgent action the correspondence should be moved to a priority batch which is highlighted as urgent e.g. Actions for GP – URGENT and marked with a red flag within Systmone when sent as an action to the clinician

Documents are batched within the acquired documents tab of Systmone, and you can view the batches by selecting “Batch” drop down at the top of the page. Examples of batches include:

- **Admin action** – Complete action and then file the letter e.g. letters that can be actioned by patient coordinator team including requests for copies of blood tests etc.
- **Send to GP** – Actions requiring an action from the GP should be sent as an action to the GP within Systmone.
- **Send to Practice Pharmacist** – Letters requiring medication changes / issues. Workflow to the pharmacist and add to their appointment list by following your local appointment allocation guide.
- **Send to Practice Pharmacist and GP** – Requires action from both GP and Pharmacist i.e. blood test and medication change. The tasks for both GP and pharmacist should be work flowed to the GP and a separate appointment booked with the pharmacist with a comment to advise the letter has been sent to the GP who will action the letter.

### 8. Attaching letter to patient record

The patient record coordinator team should work through the batches starting with the priority batches, match the record to the correct patient and attach to the patient record.

- Select the letter to action
- Right click on the letter and click ‘Process patient document’
- Check that the patient’s details i.e. NHS number, D.O.B, address and name all match with the details on the letter
- Click ‘Next’, keep this as Incoming mail and put the clinic date (Only where there is not a clinic date should you use the letter’s date.)
- Always leave the location box as “Surgery”
- Change the letter type to whatever department or clinic the letter is from
- Click ‘Next’
- In the ‘Sender Address’ look for the hospital / department the letter has been sent from and double click on it and this will go into the address box. If the address is not there, click the icon ‘address book’ and search for it, once found double click and this will go into the address box
- Click ‘Next’ and the surgery address should come up into the ‘Recipient box’ if this does not appear then click the ‘House icon’ and the address will then go into the box
- Click ‘Next’
- Click ‘Confirm’

Once confirmed the details and the letter will be saved to the ‘Communications and Letters’ tab of the patient record within Systmone.

#### 8.1 If the patient has been deducted or is not registered at this surgery

- Print the letter then select to ‘delete it’ from the workflow.
- Place the letter into an envelope and attach a compliments slip, write that you are returning the letter as the patient is either not registered or no longer registered with the surgery
- Place the letter in the correct postage location, either hospital courier or Royal Mail post.

## 9. Coding

The patient record coordinator who attaches the letter to the patient record will also complete any required coding before forwarding any actions.

- Select the read code option at the top of the screen
- The read coding should include any:
  - QOF Codes
  - New diagnosis (the patient record coordinator should also promote this detail to a 'problem' when entering patient notes and add under appropriate heading i.e. minor / major)
  - New medication started
  - Antibiotic therapy
  - Blood pressure
  - Weight
  - Height
  - Procedure's patient may have had
  - Surgical procedures (the patient record coordinator should also promote to this detail to the patient summary under the heading of minor / major)
  - Any other relevant information

If the patient coordinator is unsure on the required coding an action should be sent to the GP to check.

If a request is for a specific GP or there is a request for information from a specific GP then the letter action should be work flowed directly to them

- To workflow the associated action to the GP select forward from the workflow tab dropdown to assign a task to the GP. The patient record coordinator should note if the specified GP is absent that the task should be directed to another GP if required.

## 10. Out of Hours

Out of Hours notifications are received when a registered patient visits an Out of Hours service. Notifications will be received via SystmOne and will includes notes regarding the visit and the outcome, for the doctor to complete any follow up as required.

Out of Hours letters must be read on the day of receipt or the day after if received overnight.

Out of hours notifications are received as an assigned task within Systmone to the patient coordinator team.

- The patient coordinator team must forward on the correspondence to the patient records coordinator team which will automatically create the below batches:
  - Hospital Correspondence
  - NHS 111
  - Systmone Hospital letters

The patient records coordinator team should manage the actioning of the above batches by following sections 7 and 8 above.

## **11. Review**

This policy will be subject to review every three years, or, in light of any changes to National Standards or Trust Policy.



## Appendix 1:

### Letter types and associated actions:

Letters which do not require any follow up action are coded by the patient records co-ordinator team.

Letter Type	Action / Comments
<b>Letters with no required follow up action from patient co-ordinator team</b>	
Summarising	
Notes	
DNA letters	
Declined referrals	
Sooner	
INRs	Code and file accordingly
Discharge letters	Check for actions and workflow appropriately
Xrays	Check if already in pathology, no need to scan onto system if result is already in journal, within Systmone. Tick and put in for shredding.
<b>Letters requiring to be scanned onto the system urgently but with no associated action</b>	
ECG's carried out by the surgery	
Consent Forms	
Maternity discharge summaries	
<b>Letters for reception team</b>	
A&E Reports	
Ophthalmology Letters	
NHS 111	

Note: If unsure on the correct coding to be used for a letter consult with a clinician for support.