

Summary Care Record Inclusion Dataset Overview

Patients can choose to have a Summary Care Record (SCR) that contains additional information, over and above the core content of medications, allergies and adverse reactions. NHS Digital has worked with GP system suppliers to develop a simple and efficient mechanism for GP practices to populate SCRs with a set of additional information from a patient's GP record. Additional information is only added to the record with the patient's explicit consent, which is enduring - so the SCR is kept up to date in real time. Associated supporting free text is added to the SCR alongside the coded items.

Additional information automatically included in the SCR is selected in one of three ways:

1. It is identified as significant medical history within the GP record. For EMIS Web this is 'Active Problems' and 'Significant Past Problems'. For TPP SystmOne this is the 'Local Summary' and 'Active Problems'. For Vision this is 'Priority 1 Items' and 'Active Problems'.
2. It is part of the NHS Digital SCR inclusion dataset.
3. It is a manually added item from the GP record. Any code within the GP record may be 'manually added' to the SCR.

This document specifically addresses item 2 above and provides an overview of the NHS Digital SCR inclusion dataset. The dataset has been formed from existing datasets created nationally and by GP system suppliers and through input and feedback from SCR users and other stakeholders. The dataset will continue to be revised and updates will be made on a six monthly basis in line with the bi-annual code releases for SNOMED CT (in March and October). The latest version of the SCR inclusion dataset is available for [download from the TRUD](#) (Technology Reference data Update Distribution site).

For further information regarding SCRs with additional information please see <https://digital.nhs.uk/services/summary-care-records-scr/additional-information-in-scr>

Questions, comments or suggested enhancements to the SCR inclusion dataset can be sent to the NHS Digital SCR team at liveservices.operations@nhs.net

As of March 2018, the SCR inclusion dataset contains:

Functional Area	For full details of all codes please see the Summary Care Record Website or the latest release is available for download from the TRUD. The spreadsheet allows the user to filter the code by creation date to view new codes added in the latest release.
SCCI1580 Palliative Care Coordination	A significant number of codes in the SCR inclusion set reflect the SCCI1580 standard (Palliative Care Coordination) content - see Appendix A . Also see details in relevant sections below e.g. Advance statements... Preferred place of care...Carer ... Medications, Equipment, Devices...

<p>Key workers and care services</p>	<p> Arrange care attender Arrange care by neighbour Arrange care by relative Arrange home help Arrange meals on wheels Arrange other care Care Programme Approach key worker Child: social services Chiropody Community specialist palliative care not required Discharge by district nurse Discharge by practice nurse Discharge from cancer primary health care multidisciplinary team Discharge from heart failure nurse service Discharged from care of dyspepsia specialist nurse Discharged from community specialist palliative care team Discharge from palliative care service District nurse attends Domiciliary chiropody Domiciliary O.T. Domiciliary service need Domiciliary service NOS Domiciliary services Full care by hospice Has lead professional (Getting It Right For Every Child) Has named person (Getting It Right For Every Child) Has social care assessor Has Social Services care manager Has healthcare support worker Has cancer key worker Has direct care worker Has end of life care key general practitioner Has end of life care key nurse Has end of life care key worker Has end of life care pathway key general practitioner Has end of life care pathway key nurse Has end of life care pathway key worker Health visitor involv.stopped Health visitor visits Home help Home help attends Home help needed Home help organised Home help requested Integrated care coordinator identified Meals on wheels Medical social worker involved Nursing care NOS Provider of encounter Provider of encounter NOS Referral to community palliative care team declined Referral to respiratory nurse specialist Referral to palliative care service Referral to Social Services Referral to voluntary service Referral to epilepsy clinic Referral to learning disability team Referral to neurologist Referral to optometrist Referral to speech and language therapist Referred to community specialist palliative care team Requires assistance with all activities of daily living Seen by clinical nurse specialist Seen by community heart failure nurse Seen by diabetic liaison nurse Seen in epilepsy clinic Seen in neurology clinic Shared care - hospice/GP Shared care - specialist/GP Social worker involved Specialist palliative care treatment - daycare Specialist palliative care treatment - inpatient </p>
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	<p>Specialist palliative care treatment - outpatient</p> <p>Under care of adult care service</p> <p>Under care of allied health professional</p> <p>Under care of asthma specialist nurse</p> <p>Under care of autism assessment service Under care of cardiologist</p> <p>Under care of care of the elderly physician</p> <p>Under care of clinical nurse specialist</p> <p>Under care of community learning disability team</p> <p>Under care of community matron</p> <p>Under care of community psychiatric nurse</p> <p>Under care of community respiratory team</p> <p>Under care of community-based diabetes specialist nurse</p> <p>Under care of community-based nurse</p> <p>Under care of dermatologist</p> <p>Under care of diabetes specialist nurse Under care of diabetic foot screener</p> <p>Under care of diabetologist</p> <p>Under care of nephrologist</p> <p>Under care of neurologist</p> <p>Under care of nurse</p> <p>Under care of occupational therapist</p> <p>Under care of oncologist</p> <p>Under care of ophthalmologist</p> <p>Under care of paediatric dietitian</p> <p>Under care of paediatric specialist nurse</p> <p>Under care of paediatrician</p> <p>Under care of pain management specialist</p> <p>Under care of palliative care physician</p> <p>Under care of palliative care service</p> <p>Under care of palliative care specialist nurse</p> <p>Under care of rheumatologist</p> <p>Under care of school nurse</p> <p>Under care of school nursing service</p> <p>Under care of school nursing service – Universal</p> <p>Under care of school nursing service - Universal partnership plus Under care of school nursing service - Universal plus</p> <p>Under care of social services</p> <p>Under care of social worker</p> <p>Under care of speech and language therapist</p> <p>Under care of surgeon</p> <p>Under care of team</p> <p>Under care of Youth Justice Service</p> <p>Under multi-agency care</p> <p>Under the care of cancer primary health care multidisciplinary team</p> <p>Under the care of community palliative care team</p> <p>Under the care of psychologist</p> <p>Voluntary worker</p>
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<p>Carer details – Has a Carer</p> <p><i>Supporting the importance of carers</i></p>	<p>Details of the patient's carer:</p> <p>Carer's details - home telephone number / mobile telephone number / work telephone number</p> <p>Name of informal carer / Details of informal carer</p> <p>Home telephone number of informal carer/ Mobile telephone number of ... /Work telephone number of</p> <p>...</p> <p>No carers, though not alone / No longer has a carer</p> <p>Parent is informal carer / Partner is informal carer / Child is informal carer / Relative is informal carer Requires contact via carer</p> <p>[V]Carer unable to cope</p> <p>[V]No able carer in household</p> <p>Lives with carer</p> <p>Has kinship carer</p> <p>Legal guardian details</p> <p>Legal guardian - email address / [home / mobile / work] telephone number</p> <p>Nearest relative of patient as defined by Mental Health Act legislation</p> <p>Carer difficulty interpreting non-verbal communication</p> <p>Carer difficulty interpreting verbal communication</p>
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<p>Carer – Is a Carer</p>	<p>Details for when the patient is a Carer:</p> <p>Carer / Is a carer / Not a carer Carer of a person with a terminal illness Carer of a person with alcohol misuse Carer of a person with chronic disease Carer of a person with mental health problem Carer of a person with physical disability Carer of a person with sensory impairment Carer of a person with substance misuse Carer of person with dementia</p> <p>Referral for general practice carer's assessment Referral for social services carer's assessment Referral to Princess Royal Trust carers centre Referral to voluntary support service for carers</p>
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<p>Communication (including DCB1605)</p>	<p>Ability to communicate about self Communication aid Difficulty communicating Does use hearing aid Hands-on signing interpreter needed Illiteracy / Literacy problems [V]Illiteracy and low-level literacy Interpreter needed - British Sign Language Interpreter needed - Makaton Sign Language Needs an advocate Preferred method of communication: British Sign Language Preferred method of communication: speech Preferred method of communication: written Requires audible alert Requires communication partner Requires contact by email Requires contact by letter Requires contact by short message service text message Requires contact by telephone Requires contact by text relay Requires deafblind block alphabet interpreter Requires deafblind communicator guide Requires deafblind haptic communication interpreter Requires deafblind manual alphabet interpreter Requires healthcare information recording on personal audio recording device Requires information by email Requires information in contracted (Grade 2) Braille Requires information in Easyread Requires information in electronic audio format Requires information in electronic downloadable format Requires information in Makaton Requires information in Moon alphabet Requires information in uncontracted (Grade 1) Braille Requires information on audio cassette tape Requires information on compact disc Requires information on digital versatile disc Requires information on USB (universal serial bus) mass storage device Requires information verbally Requires lipspeaker Requires manual note taker Requires sighted guide Requires speech to text reporter Requires tactile alert Requires third party to read out written information Requires visual alert Requires written information in at least 20 point sans serif font Requires written information in at least 24 point sans serif font Requires written information in at least 28 point sans serif font Sign Supported English interpreter needed Uses a citizen advocate Uses a legal advocate Uses alternative communication skill Uses communication device Uses cued speech transliterator Uses deafblind intervener Uses Deafblind Manual Alphabet Uses electronic note taker Uses lipspeaker</p>
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	<p>Uses manual note taker Uses personal audio recording device to record information Uses Personal Communication Passport Uses sign language Uses speech to text reporter Uses symbols for communication Uses Tadoma method for communication Uses textphone Using British sign language Using lip-reading Using Makaton sign language Using symbols to communicate with client Visual frame sign language interpreter needed</p> <p>Also Includes Main spoken language, Additional main spoken language, Supplemental main language and interpreter requirements. For further information on these specific codes see Appendix B and Appendix C below.</p>
<p>Disability (including Physical, neurological and sensory disability)</p>	<p>Disability Disability - slight/ moderate / severe, Disability NOS Physical disability / Chronic physical disability No known disability/ Patient reports no current disability</p> <p>Neurodisability</p> <p>Registers: Care Programme Approach supervision register Children disability register On depression register, Removed from depression register On national service framework mental health register On severe mental illness register, Removed from severe mental illness register Patient on regional cancer register Registered deaf/ disabled /hearing impaired /sight impaired / [partially sighted] or [partially blind] Special needs register</p> <p>See also Functional Status below</p>
<p>Frailty</p>	<p>Frailty - Mild frailty / Moderate frailty / Severe frailty FI - Frailty Index Frail elderly assessment Canadian Study of Health and Aging clinical frailty scale Edmonton frail scale Electronic Frailty Index score Frailty assessment</p> <p>See also Functional Status and Disability</p>

<p>Functional Status</p>	<p>Australia-modified Karnofsky Performance Status scale</p> <p>Housebound / Temporarily housebound Bed-ridden Immobile Mobile in home Mobility poor / very poor Mobility aids, Does mobilise using aids, Able to mobilise using mobility aids / wheelchair [V]Dependence on wheelchair Walking aid use Confined to chair Impaired mobility Mobile outside with aid Mobility fair Fully mobile [D] Poor mobility General difficulty in moving</p> <p>Hearing impairment / hearing loss Hearing difficulty / problem Able to use hearing aid Hearing aid worn Does not use hearing aid Difficulty using hearing aid, Unable to use hearing aid Cochlear implant Hearing normal Deafness NOS Hearing symptom NOS O/E – deaf</p> <p>Visual impairment / Impaired vision Poor visual acuity Vision problem Blind left eye, Blind right eye Blindness - both eyes Low vision, both eyes unspecified Low vision, one eye, unspecified Wears contact lenses, Wears glasses Should wear glasses but does not Normal vision Better eye: moderate visual impairment, Lesser eye: low vision unspecified Better eye: near total visual impairment, Lesser eye: unspecified Better eye: profound visual impairment, Lesser eye: unspecified Better eye: severe visual impairment, Lesser eye: low vision unspecified Lesser eye: moderate visual impairment, Better eye: unspecified Lesser eye: severe visual impairment, Better eye: unspecified Low vision, both eyes Blindness both eyes NOS Both eyes total visual impairment Low vision, both eyes NOS Low vision, one eye Low vision, one eye NOS Partial sight Unspecified blindness both eyes Weak vision Speech impairment Has difficulty with speech Difficulty using verbal communication, Unable to use verbal communication Does not use self-expression Has a stammer or stutter Speech limited, Speech problem (& symptom) Requires communication partner Uses symbols for communication Using symbols to communicate with client Ability to comprehend Ability to communicate about self</p>
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Able to use self-expression
 Able to use verbal communication
 Able to read, Able to write
 Non-verbal communication observations
 No speech problem
 [X] Speech disturbances, not elsewhere classified
 O/E - stammer/stutter
 Speech problem
 Speech problem NOS

Cognitive impairment/ Impaired cognition
 Memory impairment
 X]Specific developmental disorders of scholastic skills
 Language-related cognitive disorder
 Mental health disorder
 Mild cognitive disorder
 Able to perform personal care activity
 Difficulty performing personal care activity Difficulty washing self
 Needs assistance with shaving
 Unable to perform dressing activity
 Unable to perform personal care activity
 Unable to wash self
 Impaired ability to recognise safety risks
 Unable to summon help in an emergency

Uses assistance dog
 Uses guide dog for the blind

Patient condition resolved
 Patient cured
 Patient in early remission
 Patient in full remission
 Patient in partial remission
 Patient in remission
 Patient's condition deteriorating
 Patient's condition improved
 Patient's condition poor
 Patient's condition satisfactory
 Patient's condition the same
 Patient's condition unstable
 Patient's condition worsened
 Patient's condition: [worsened] or [deteriorating]

For specific relevant codes related to Palliative Care Coordination – see [Appendix A](#) below.

<p>Learning Disability</p>	<p>On learning disability register</p> <p>Learning disabilities annual health assessment Learning disabilities health assessment</p> <p>Assessment of mental capacity in accordance with Mental Capacity Act 2005 Independent mental capacity advocate instructed Lacks capacity to give consent (Mental Capacity Act 2005) Unable to consent to information sharing</p> <p>Referral to epilepsy clinic Referral to learning disability team Referral to neurologist Referral to optometrist Referral to speech and language therapist Seen in epilepsy clinic Seen in learning disabilities clinic Seen in neurology clinic</p> <p>Learning disabilities health action plan completed Learning disabilities health action plan reviewed Preferred place of care - learning disability unit Preferred place of death: learning disability unit</p> <p>Carer of a person with learning disability</p> <p>All QOF learning disability diagnosis codes are included.</p> <p>Relevant codes concerning mobility, hearing, sight, speech and communication have been included – see Functional Status and Communication above. Other relevant codes will be included if marked appropriately in the GP system (as problems or part of the GP summary) or may be manually included.</p>
<p>Supporting patients with dementia and their carers</p>	<p>Significant codes with respect to the dementia diagnosis and co-morbidities (as a problem or summary item) and other areas such as functional status, advance statements/ directives/ preferences, Power of Attorney, social context, next of kin / carers details are included in the SCR. In addition the following codes are included:</p> <p>Memory impairment Dementia advance care plan Dementia advance care plan agreed Dementia care plan Dementia care plan agreed Dementia care plan reviewed Review of dementia advance care plan</p> <p>Carer of person with dementia No longer carer of patient with dementia</p> <p>The following codes are not automatically included in the SCR, but may be manually included if required:</p> <p>At risk of dementia Initial questioning for memory concern Initial questioning for memory concern- declined</p>

	<p>Assessment for dementia Assessment for dementia – declined Referral to memory clinic Referral to memory clinic declined</p>
<p>Acute Kidney Injury (formerly Acute Renal Failure or acute renal impairment)</p>	<p>At risk of acute kidney injury Acute kidney injury stage 1 Acute kidney injury stage 2 Acute kidney injury stage 3 Acute kidney injury warning stage Acute renal failure Provision of written information about acute kidney injury H/O: acute kidney injury Acute renal failure NOS Other acute renal failure</p>
<p>Medication, Equipment, Devices</p>	<p>Advance supply of antibiotic medication Advance supply of steroid medication Home oxygen supply Home oxygen supply - concentrator Home oxygen supply - cylinder Home oxygen supply - liquid oxygen Home oxygen support Issue of palliative care anticipatory medication box Needs domiciliary care worker to administer medication Prescription of palliative care anticipatory medication Supply of medication available at home Syringe driver commenced Syringe driver discontinued</p> <p>Provision of mobility device Support equipment</p> <p>Implantable cardiac electronic device in situ [V]Cardiac pacemaker in situ Patient with internal cardiac defibrillator pacemaker Adjustment of cardiac device Management of cardiac device Deactivation of automatic implantable cardioverter defibrillator</p> <p>Provision of equipment Advice about equipment Advice about types of equipment available Advice about use of equipment Provision of assistive equipment Nebulizer care advice</p>
<p>Resuscitation</p>	<p>The single most recent instance of the four resuscitation codes* below is included in SCR: For attempted cardiopulmonary resuscitation For resuscitation Not for attempted CPR (cardiopulmonary resuscitation) Not for resuscitation</p> <p>Other codes related to resuscitation are also included: Carer informed of cardiopulmonary resuscitation clinical decision Discussion about DNACPR (do not attempt cardiopulmonary resuscitation) clinical decision Family member informed of cardiopulmonary resuscitation clinical decision Not aware of do not attempt cardiopulmonary resuscitation clinical decision Resuscitation discussed with carer Resuscitation discussed with patient</p> <p>* Resuscitation status in the SCR is only to be treated as a signpost to information that is fully recorded elsewhere and viewers and clinicians are</p>

	<p>advised to continue to follow their existing processes according to local and national standards.</p>
<p>Advance Care planning</p> <p>Advance decisions (living wills)</p> <p>Advance statements and preferred priorities for care (PPC) and other preferences and wishes</p> <p>Supporting person centred care</p> <p>see also Care planning and Resuscitation</p>	<p>Has made a living will Has advance decision to refuse life sustaining treatment (Mental Capacity Act 2005) Has ADRT (advance decision to refuse treatment) (Mental Capacity Act 2005) Has Advance Decision to Refuse Treatment (Mental Capacity Act 2005) - Refuses all blood transfusion and administration of primary blood components and minor fractions Has involved healthcare professional in discussion about ADRT (advance decision to refuse treatment) (Mental Capacity Act 2005) Subject to deprivation of liberty under the Mental Capacity Act 2005 Deprivation of Liberty Safeguards</p> <p>Standard authorisation for deprivation of liberty under Mental Capacity Act 2005 given No longer subject to deprivation of liberty under Mental Capacity Act 2005 Advance decision to refuse treatment retracted</p> <p>[Advanced directive* discussed with patient Advanced directive* discussed with relative Advanced directive* signed / Advanced directive* signed (copy in notes)]</p> <p>Has advance statement (Mental Capacity Act 2005) Preferred priorities for care document completed</p> <p>Preferred place of care - community hospital / home / hospice / hospital / learning disability unit / mental health unit / nursing home / residential home Preferred place of care - discussed with family/ discussed with patient Preferred place of care - patient declined to participate Preferred place of care - patient unable to express preference</p> <p>Preferred place of death: care home / community hospital / home / hospice / hospice community lodge / hospital / learning disability unit / mental health unit / nursing home / residential home / usual place of residence Preferred place of death: no preference Preferred place of death discussed with patient Preferred place of death: discussed with family Preferred place of death: discussion not appropriate Preferred place of death: patient declined discussion Preferred place of death: patient unable to express preference Preferred place of death: patient undecided Last days of life discussed Does not have current Last Will and Testament Has current Last Will and Testament</p> <p>Has spiritual and cultural support Procedure refused – religion [V]Refusal of treatment for reasons of religion or conscience</p> <p>Decision making Discussion about preferences</p>

Declined consent for treatment
Preference for female health care professional
Preference for health professional
Preference for male health care professional Preference
for NHS care provider

Advance care planning
Discussion about advance care plan
Discussion about advance care planning with carer
Discussion about advance care planning with family member Has
end of life advance care plan
Has involved health care professional in discussion about advance care planning Sharing
advance care planning decisions with out of hours service

Best interest decision made on behalf of patient (Mental Capacity Act 2005)

Willing to be donor
Eligible for NHS continuing health care Decision Support Tool assessment
Eligible for NHS continuing health care Decision Support Tool assessment
NHS continuing health care checklist completed NHS
continuing health care checklist received
NHS continuing health care checklist returned for further information
NHS continuing health care fast track funding applied for NHS
continuing health care fast track funding granted
NHS continuing health care fast track funding refused NHS
continuing health care fast track funding required
NHS continuing health care fast track funding withdrawn
NHS continuing health care Fast Track Pathway Tool returned for further information NHS
continuing health care funding applied for
NHS continuing health care funding granted NHS
continuing health care funding refused
NHS continuing health care funding required
BD8 completion
Documented agreement for verification of expected death by competent clinician Requires
referral to coroner at time of death

Advice and Information

Signposting to Macmillan Cancer Support Cancer
information offered to patient
Cancer information offered to significant other
Discussion about writing Last Will and Testament
Provision of written information about domiciliary end of life care services Provision of
written information about end of life care services
Provision of written information about hospice services
Provision of written information about writing Last Will and Testament

Admission avoidance care

Patient allocated named accountable general practitioner
Integrated care coordinator identified
Name of care coordinator
Admission avoidance care plan agreed
Review of admission avoidance care plan

Other relevant codes included in SCR are those falling under other functional
areas such as residential status and social history, next of kin / carers details
and care preferences including preferred place of care.

The following codes are not automatically included in SCR, but may be
manually included if required:

Admission avoidance care started
Admission avoidance care ended

*An advanced directive is the (non-legally binding) Scottish equivalent of an advanced decision.

<p>Lasting Power of Attorney</p>	<p>Has appointed person with personal welfare lasting power of attorney (Mental Capacity Act 2005) Lasting power of attorney personal welfare Has appointed person with personal welfare lasting power of attorney with authority for life sustaining decisions (Mental Capacity Act 2005) Unable to provide accommodation detailsprov Consent given by appointed person with lasting power of attorney for personal welfare (Mental Capacity Act 2005) for sharing end of life care coordination record</p> <p>Lasting power of attorney property and affairs</p> <p>Enduring power of attorney Power of attorney applied for Power of attorney held</p>
<p>Care planning</p> <p>Supporting integrated, joined up care</p>	<p>All affirmative codes related to care planning (agreeing, discussed, given, review, commenced, completed) and care pathways have now been included. Examples include:</p> <p>Care plan Admission avoidance care plan agreed Advance care planning Ambulance service notified of patient on end of life care register Cancer care plan / Cancer care plan discussed with patient / Cancer care review CHAT (Comprehensive Health Assessment Tool) discharge plan sent to general practitioner Has CHAT (Comprehensive Health Assessment Tool) care plan Has CHAT (Comprehensive Health Assessment Tool) discharge plan Has CHAT (Comprehensive Health Assessment Tool) immediate care plan Review of CHAT (Comprehensive Health Assessment Tool) care plan Completion of mental health crisis plan Coordinated support plan Coronary heart disease care plan / Coronary heart disease risk clinical management plan Dementia advance care plan / Dementia care plan Dementia care plan agreed / Dementia care plan reviewed Diabetes care plan agreed / Diabetes clinical management plan / Diabetes management plan given Discussion about advance care plan Discussion about advance care planning with carer Discussion about advance care planning with family member Discussion about out of hours care management plan EHCP (emergency health care plan) agreed Emergency health care plan Review of emergency health care plan Epilepsy management plan given Falls care pathway / Falls prevention plan General practitioner out of hours service notified of chronic obstructive pulmonary disease care plan GP out of hours service notified GP out of hours service notified of cancer care plan Has anticipatory care plan Has chronic obstructive pulmonary disease care plan End of life advance care plan End of life care plan offered Has end of life care plan Has end of life advance care plan Not suitable for end of life advance care plan Palliative care not currently clinically indicated Has involved healthcare professional in discussion about advance care planning Learning disabilities health action plan completed Learning disabilities health action plan reviewed Leg ulcer care pathway Management plan for shared care Mental health care plan status Mental health care programme approach contingency plan Mental health care programme approach crisis plan Mental health crisis plan Mental health personal health plan Multidisciplinary review Multiple sclerosis care plan agreed Notification to primary care out of hours service of anticipated death</p>

	<p>Notification to primary care out of hours service of palliative care plan in place On end of life care register</p> <p>Out of hours care management plan discussed with carer</p> <p>Psychiatry care plan</p> <p>Review of admission avoidance care plan</p> <p>Review of anticipatory care plan Review of care plan</p> <p>Review of dementia advance care plan</p> <p>Review of integrated care plan</p> <p>Review of mental health care plan</p> <p>Review of personal care plan</p> <p>Review of supportive care plan</p> <p>Sharing advance care planning decisions with out of hours service</p> <p>Single Assessment Process / Single assessment process summary care plan completed</p> <p>Special patient note (see below)</p> <p>Treatment Escalation Plan Treatment plan given</p> <p>Vulnerable adult care plan</p> <p>Diabetes clinical pathway</p> <p>On chronic obstructive pulmonary disease supportive care pathway</p> <p>On community cardiac care pathway</p> <p>End of life care pathway</p> <p>On deep vein thrombosis care pathway On urinary tract infection care pathway</p> <p>Chronic obstructive pulmonary disease monitoring</p> <p>Diabetic monitoring</p> <p>Diabetic monitoring NOS</p> <p>Rheumatology disorder monitoring NOS</p> <p>Rheumatology disorder monitoring Provision of proactive care</p> <p>Long term condition summary sent to patient</p> <p>On pressure ulcer primary prevention pathway</p> <p>On pressure ulcer secondary prevention and treatment pathway</p> <p>The information above is included as a coded item and supporting free text from the GP system. System specific guidance is available on the Summary Care Record Website</p>
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<p>Special Patient Note</p>	<p>The code:</p> <p>Special patient note</p> <p>is included for users to record further information over and above that which is already in the SCR with additional information.</p>
<p>Social History</p>	<p>Lives alone</p> <p>Lives alone - help available / needs housekeeper / no help available Independent housing, lives alone</p> <p>Lives with biological parent and step parent</p> <p>Lives with biological parents</p> <p>Lives with grandfather / Lives with grandmother</p> <p>Lives with immunocompromised person</p> <p>Lives with partner / Lives with relatives / Lives with spouse</p> <p>Elderly relative lives with family</p> <p>Homeless single person</p> <p>Patient's next of kin / No next of kin</p> <p>Nearest relative of patient as defined by Mental Health Act legislation</p> <p>Legal guardian details</p> <p>Legal guardian - email address / [home / mobile / work] telephone number</p>

	<p>Emergency contact details Child lives with another relative Child lives with father Child lives with grandparents Child lives with mother Child lives with parent Child lives with partner Child living with unrelated adult Divorced couple sharing house Lives as companion Lives as paid companion Lives as unpaid companion Lives in a commune Lives in a community Lives in a school community Lives in boarding school Lives with children Lives with companion Lives with daughter Lives with family Lives with father Lives with friend Lives with friends Lives with grandparents Lives with lodger Lives with mother Lives with parents Lives with son Number in household Unable to provide accommodation details</p> <p>See also Carer details. Codes related to adoptive parents are <u>not</u> part of the SCR inclusion dataset, but may be manually included if required.</p>
Residential Information	<p>Details of where the patient lives: Lives in a nursing home / Lives in a residential home Lives in an old peoples home / Lives in care home / Lives in supported home Lives on council site / Lives on private site / Lives on unofficial site Living in bedsitter / Lives in squat Lives in a childrens home / Lives in a children's unit [V]Institution resident Homeless single person</p> <p>Key Holder or Patient door access key codes are <u>not</u> part of the SCR inclusion dataset. If required, details of the key holder can be manually included in the SCR.</p>

For further information or support: liveservices.operations@nhs.net

Appendix A – SCR inclusion dataset alignment with [Palliative Care Coordination content](#)

The items below comprise those clinical codes aligned with the Palliative Care Coordination SCCI1580 standard (formerly ISB-1580) and other related palliative care codes included in SCR.

Items from SCCI 1580 that are not included in SCR are explicitly stated* and may be manually included. Some items are standard parts of the Spine Personal Demographics Service and available through the SCR application (SCRa). See [here for further information on the elements of the Personal Demographics Service](#) (PDS).

Electronic Palliative Care Coordination Systems (EPaCCS) enable the recording and sharing of people's care preferences and key details about their care at the end of life (in line with SCCI1580) and were previously known as locality registers. SCR is not an EPaCCS system, but can be used to support palliative care coordination in conjunction with a GP system which records the relevant information and makes it available via the SCR. Key benefits of using SCR include:

1. GPs record the information once in their clinical system and the SCR is updated automatically
2. The availability of the SCR to relevant staff across the NHS in England, means that palliative care coordination information can be made available beyond the existing footprint of the EPaCCS system and core user group, wherever the patient is treated and where the EPaCCS system is not accessible. This applies to palliative care coordination information recorded in the GP system (or shared to a GP practice within a shared record system).

For further information on implementing EPaCCS; see the [endoflifecare-intelligence EPaCCS implementation guidance](#).

*Items omitted from the SCR inclusion dataset include such items as actual place of death, Reason for variance between actual and preferred place of death and sexual orientation. These can be recorded and reported on in the source GP system and may be manually added to the SCR if required, if the patient consents to this.

SCCI1580 data item	Notes: Codes in the SCR Inclusion dataset
1. Consent status	<p>Consent given by appointed person with lasting power of attorney for personal welfare (Mental Capacity Act 2005) for sharing end of life care coordination record Consent given to discuss preferred priorities for care with carer Consent given for electronic record sharing Express consent for core and additional Summary Care Record dataset upload</p> <p>The following are not automatically included in SCR but may be manually included: Consent given for sharing end of life care coordination record Withdrawal of consent for sharing end of life care coordination record Best interests decision taken (Mental Capacity Act 2005) for sharing end of life care coordination record</p>
2. Record creation date	This is a standard data element of the SCR.
3. Planned review date	There is no specific code for this in Readv2/ CTV3 or the SCR inclusion dataset. However the information may be recorded against a related code such as a care plan review code.
4. Date and time of last amendment	This is a standard data element of the SCR.
5. Person family name	This is a standard data element of the PDS available in the SCRa.
6. Person forename	This is a standard data element of the PDS available in the SCRa.
7. Person preferred name	This is a standard data element of the PDS available in the SCRa.
8. Person Date of Birth	This is a standard data element of the PDS available in the SCRa.
9. NHS number	This is a standard data element of the PDS available in the SCRa.
10. NHS number status indicator code	The status of the NHS number is managed by the source GP system and is not an element of the SCR.
11. Person gender	This is a standard data element of the PDS available in the SCRa.

12. Person address	This is a standard data element of the PDS available in the SCRa.
13. Person telephone numbers	This is a standard data element of the PDS available in the SCRa.
14. Need for an interpreter	For details of the codes in this section see Appendix B below.
15. Preferred spoken language	For details of the codes in this section see Appendix C below.
16. Main carer name	SCR includes a significant number of relevant carer codes:
17. Main carer telephone numbers	<p>Has a carer Does not have a carer [V]No able carer in household Carer's details Carer - home telephone number Carer - mobile telephone number Carer - work telephone number Lives with carer Has an informal carer Name of informal carer Parent is informal carer Partner is informal carer Relative is informal carer Child is informal carer Details of informal carer Home telephone number of informal carer Mobile telephone number of informal carer Work telephone number of informal carer Does not have an informal carer Has a paid carer Has a parent carer Has an older carer Has voluntary carer No carers, though not alone No longer has a carer</p> <p>While there is no specific code for the carer's telephone number, then the telephone number could be entered as free text against the carer's details(16)</p>
18. Is main carer aware of person's prognosis?	Carer aware of prognosis Carer unaware of prognosis Relative aware of prognosis Relative unaware of prognosis
19. Usual GP name	There is no specific code for this in Readv2/ CTV3 or the SCR inclusion dataset. However, see (20) below and the following codes are in the SCR inclusion dataset: Patient allocated named accountable general practitioner Has end of life care key general practitioner Has end of life care pathway key general practitioner Under care of GP
20. Practice details including phone number	This is a standard data element of the PDS available in SCRa.

<p>21. Key worker name if not usual GP</p>	<p>Name of care coordinator Patient allocated named accountable general practitioner Integrated care coordinator identified Care Programme Approach key worker Has cancer key worker Has end of life care key general practitioner Has end of life care key nurse Has end of life care key worker Has end of life care pathway key general practitioner Has end of life care pathway key nurse Has end of life care pathway key worker Has named person (Getting It Right For Every Child)</p>
<p>22. Key worker telephone number</p>	<p>There is no specific relevant code for this in Readv2/ CTV3 or the SCR inclusion dataset. However the telephone number could be entered as free text against the key worker name(21)</p>
<p>23. Care workers involved in care: name</p>	<p>There is no specific relevant code for this in Readv2/ CTV3 or the SCR inclusion dataset. However, the name could be entered as free text against the care workers involved in care: professional group(24)</p>

24. Care workers involved in care: professional group

Arrange care attender
 Arrange care by neighbour
 Arrange care by relative
 Arrange home help
 Arrange meals on wheels
 Arrange other care
 Care Programme Approach key worker
 Child: social services
 Chiropody
 Discharge by district nurse
 Discharge by practice nurse
 Discharge from cancer primary healthcare multidisciplinary team
 Discharge from heart failure nurse service
 Discharged from care of dyspepsia specialist nurse
 Discharged from community specialist palliative care team
 District nurse attends Domiciliary chiropody Domiciliary O.T.
 Domiciliary service need
 Domiciliary service NOS
 Domiciliary services
 Full care by hospice
 Has cancer key worker
 Has direct care worker
 Has end of life care key general practitioner
 Has end of life care key nurse
 Has end of life care key worker
 Has end of life care pathway key general practitioner
 Has end of life care pathway key nurse
 Has end of life care pathway key worker Has healthcare support worker
 Has lead professional (Getting It Right For Every Child)
 Has named person (Getting It Right For Every Child) Has social care assessor
 Has Social Services care manager
 Health visitor involv.stopped
 Health visitor visits
 Home help
 Home help attends
 Home help needed
 Home help organised
 Home help requested
 Integrated care coordinator identified
 Meals on wheels
 Medical social worker involved
 Nursing care NOS
 Provider of encounter
 Referral to respiratory nurse specialist
 Referral to Social Services
 Referral to voluntary service
 Referred to community specialist palliative care team
 Seen by clinical nurse specialist
 Seen by community heart failure nurse
 Seen by diabetic liaison nurse Shared care - hospice / GP
 Shared care - specialist / GP
 Social worker involved
 Specialist palliative care treatment - daycare Specialist palliative care treatment - inpatient
 Specialist palliative care treatment - outpatient
 Under care of adult care service
 Under care of allied health professional
 Under care of asthma specialist nurse
 Under care of autism assessment service Under care of cardiologist
 Under care of care of the elderly physician
 Under care of clinical nurse specialist

Under care of community-based diabetes specialist nurse Under
 care of community learning disability team
 Under care of community matron
 Under care of community psychiatric nurse Under
 care of community respiratory team
 Under care of community-based nurse
 Under care of dermatologist
 Under care of diabetes specialist nurse
 Under care of diabetic foot screener
 Under care of diabetologist
 Under care of dietitian
 Under care of district nurse
 Under care of dyspepsia specialist nurse
 Under care of educational psychologist
 Under care of family nurse partnership team
 Under care of gastroenterologist
 Under care of GP
 Under care of health visiting service
 Under care of health visiting service - Universal
 Under care of health visiting service - Universal partnership plus
 Under care of health visiting service - Universal plus
 Under care of health visitor
 Under care of homeless advocacy service
 Under care of hospital admission prevention service
 Under care of hospital-based diabetes specialist nurse
 Under care of Macmillan nurse
 Under care of nephrologist
 Under care of neurologist
 Under care of nurse
 Under care of occupational therapist
 Under care of oncologist
 Under care of
 ophthalmologist
 Under care of paediatric dietitian
 Under care of paediatric specialist nurse
 Under care of paediatrician
 Under care of pain management specialist
 Under care of palliative care physician
 Under care of palliative care service
 Under care of palliative care specialist nurse
 Under care of physician
 Under care of physiotherapist
 Under care of podiatrist
 Under care of practice nurse
 Under care of Prevention Matters service
 Under care of psychiatrist
 Under care of respiratory physician
 Under care of retinal screener
 Under care of rheumatologist
 Under care of school nurse
 Under care of school nursing service
 Under care of school nursing service - Universal
 Under care of school nursing service - Universal partnership plus
 Under care of school nursing service - Universal plus
 Under care of social services
 Under care of social worker
 Under care of speech and language therapist
 Under care of surgeon
 Under care of team
 Under care of Youth Justice Service
 Under multi-agency care
 Under the care of cancer primary health care multidisciplinary team
 Under the care of community palliative care team
 Under the care of psychologist
 Voluntary worker

25. Telephone numbers for care workers involved in care	There is no specific code for this in Readv2/ CTV3 or the SCR inclusion dataset. However the telephone number could be entered as free text against the Care Worker(s)(23/24)
26. Primary diagnosis: The diagnosis that is main contributing factor to the need for palliative care	There is no specific code for this in Readv2/ CTV3 or the SCR inclusion dataset. However, the relevant diagnosis should be one of the significant diagnoses included in the SCR as additional information and this can be indicated as <i>Primary diagnosis</i> in the supporting free text associated with the diagnosis code.
27. Other relevant diagnoses and clinical problems that need to be taken into account	These are standard components of the SCR with additional information derived from the GP record. These include: <ul style="list-style-type: none"> • Significant past medical history

when making end of life decisions	<ul style="list-style-type: none"> • Reason for medication • Significant previous procedures • Anticipatory care information • Immunisations <p>Other elements include codes related to Acute Kidney Injury (AKI).</p>
28. Disability	<p>The following disability related codes are included in SCR:</p> <p>Disability Disability - slight/ moderate/ severe, Disability NOS Physical disability / Chronic physical disability No known disability/ Patient reports no current disability</p> <p>Neurodisability</p> <p>Registers: Care Programme Approach supervision register Children disability register On depression register, Removed from depression register On national service framework mental health register On severe mental illness register, Removed from severe mental illness register Patient on regional cancer register Registered deaf/ disabled /hearing impaired /sight impaired /[partially sighted] or [partially blind] Special needs register</p> <p>See also Functional Status below</p> <p>Other disability – There is no specific code for this in Readv2/ CTV3 or the SCR inclusion dataset.</p> <p>See also other codes related to SCCI1605 - Accessible information standard and Learning Disability – which are included in the SCR.</p>

29. Functional status	<p>The following functional status codes are a selection of those included in SCR:</p> <p>Australia-modified Karnofsky Performance Status scale</p> <p>Bed-ridden Confined to chair Fully mobile Housebound Impaired mobility Mobile outside with aid Mobility fair Temporarily housebound Difficulty performing personal care activity washing self Needs assistance with shaving Unable to perform dressing activity Unable to perform personal care activity Unable to wash self Able to perform personal care activity</p> <p>For further detail on the range of functional status codes within the SCR inclusion dataset see the Functional Status and Frailty sections above.</p>
30. Allergies/adverse drug reactions	These are standard components of the core SCR.
31. Anticipatory medicines/just in case box issued	<p>Medications prescribed by the GP practice are a standard component of the core SCR. The inclusion dataset also includes the following codes:</p> <p>Prescription of palliative care anticipatory medication Issue of palliative care anticipatory medication box Advance supply of antibiotic medication Advance supply of steroid medication Needs domiciliary care worker to administer medication Supply of medication available at home</p>
32. Location of anticipatory medicines/just in case box	There is no specific code for this in Readv2/ CTV3 or the SCR inclusion dataset. However, the location could be entered as free text against the Anticipatory medicines/just in case box issued (31)
33. EoLC tool in use? (eg GSF, PPC, other)	<p>On gold standards palliative care framework Preferred priorities for care document completed</p>

34. Likely prognosis	<p>Last months of life Last weeks of life Last days of life</p> <p>Gold standardsframework prognostic indicator stage A (blue) - year plus prognosis Gold standardsframework prognostic indicator stage B (green) - months prognosis Gold standardsframework prognostic indicator stage C (yellow) - weeks prognosis Gold standardsframework prognostic indicator stage D (red) - days prognosis Gold standards framework supportive care stage 1 - advancing disease Gold standardsframework supportive care stage 2 - increasing decline Gold standardsframework supportive care stage 3 - last days: category B - months prognosis Gold standardsframework supportive care stage 3 - last days: category C - weeks prognosis Gold standardsframework supportive care stage 3 - last days: category D - days prognosis</p> <p>Terminal illness, Terminal illness - early stage / late stage</p>
35. Advance statement requests and preferences	<p>Has advance statement (Mental Capacity Act 2005) Has involved healthcare professional in discussion about advance care planning Assessment of mental capacity in accordance with Mental Capacity Act 2005 Lacks capacity to give consent (Mental Capacity Act 2005) Best interest decision made on behalf of patient (Mental Capacity Act 2005) Independent mental capacity advocate instructed</p> <p>Gold standardsframework advance care plan discussion statement Thinking ahead gold standard advanced care plan discussion statement</p> <p>Decision making Discussion about preferences Consent given to discuss preferred priorities for care with carer Preferred priorities for care document completed</p> <p>Procedure refused - religion [V]Refusal of treatment for reasons of religion or conscience</p> <p>See also 49. Person has made an advance decision to refuse treatment</p>
36. Preferred place of death 1st choice	<p>There are no exact match codes for these in Readv2/ CTV3 or the SCR inclusion dataset. However the choice rank, organisation name and address can be recorded as free text against the following codes (in the SCR inclusion dataset):</p>
37. Preferred place of death organisation name (1st choice)	
38. Preferred place of death address (1st choice)	
39. Preferred place of death (1st choice) is usual place of residence	
40. Preferred place of death 2nd choice	
41. Preferred place of death organisation name (2nd choice)	
42. Preferred place of death address (2nd choice)	

43. Preferred place of death (2nd choice) is usual place of residence	Preferred place of death: patient declined discussion Preferred place of death: patient unable to express preference Preferred place of death: patient undecided Preferred place of death: no preference
44. Cardiopulmonary resuscitation decision	The single most recent instance of the four resuscitation codes below is included in the SCR: For attempted cardiopulmonary resuscitation For resuscitation Not for attempted CPR (cardiopulmonary resuscitation) Not for resuscitation See also (48).
45. Date of cardiopulmonary resuscitation decision	The date of the cardiopulmonary resuscitation decision can be recorded with the relevant resuscitation code (44), which is then shown in the SCR.
46. Date for review of cardiopulmonary resuscitation decision	There is no specific code for this in Readv2/ CTV3 or the SCR inclusion dataset. However the date could be entered as free text against the current resuscitation code or other related SCR inclusion code.
47. Location of cardiopulmonary resuscitation documentation	There is no specific code for this in Readv2/ CTV3 or the SCR inclusion dataset. However the location could be entered as free text against the Resuscitation Awareness codes (48). Recording the location against the Resuscitation Awareness codes is recommended, as they are always included in the SCR, unlike the Resuscitation codes (44), of which only the latest single instance is included.
48. Awareness of cardiopulmonary resuscitation decision	Carer informed of cardiopulmonary resuscitation clinical decision Discussion about DNACPR (do not attempt cardiopulmonary resuscitation) clinical decision Family member informed of cardiopulmonary resuscitation clinical decision Not aware of do not attempt cardiopulmonary resuscitation clinical decision Resuscitation discussed with carer Resuscitation discussed with patient
49. Person has made an advance decision to refuse treatment	Has ADRT (advance decision to refuse treatment) (Mental Capacity Act 2005) Has advance decision to refuse life sustaining treatment (Mental Capacity Act 2005) Has Advance Decision to Refuse Treatment (Mental Capacity Act 2005) - Refuses all blood transfusion and administration of primary blood components and minor fractions Has involved healthcare professional in discussion about ADRT (advance decision to refuse treatment) (Mental Capacity Act 2005) Advanced directive discussed with patient Advanced directive discussed with relative Advanced directive signed Advanced directive signed (copy in notes) Has made a living will Advance decision to refuse treatment retracted
50. Location of advance decision to refuse treatment documentation	There is no specific code for this in Readv2/ CTV3 or the SCR inclusion dataset. However the location could be entered as free text against the ADRT codes (49)
51. Name of Lasting Power of Attorney (LPA) for personal welfare	There is no specific code for this in Readv2/ CTV3 or the SCR inclusion dataset. However the name could be entered as free text against the LPA codes (52)

52. Authority of LPA	<p>Has appointed person with personal welfare lasting power of attorney (Mental Capacity Act 2005)</p> <p>Has appointed person with personal welfare lasting power of attorney with authority for life sustaining decisions (Mental Capacity Act 2005)</p> <p>Consent given by appointed person with lasting power of attorney for personal welfare (Mental Capacity Act 2005) for sharing end of life care coordination record</p> <p>Enduring power of attorney</p> <p>Power of attorney applied for</p> <p>Power of attorney held</p> <p>Lasting power of attorney personal welfare</p> <p>Lasting power of attorney property and affairs</p>
53. Telephone number(s) concerning Lasting Power of Attorney	There is no specific code for this in Readv2/ CTV3 or the SCR inclusion dataset. However, the contact details could be entered as free text against the LPA codes (52)
54. Name of additional person to be involved in decisions (1)	<p>There are no specific codes for these in Readv2/ CTV3 or the SCR inclusion dataset. However, relevant detail(s) could be entered as free text against suitable advance statement, carer, care plan or other codes:</p> <p>Consent given to discuss preferred priorities for care with carer Agreeing on care plan with legitimate patient representative</p> <p>Nearest relative of patient as defined by Mental Health Act legislation</p>
55. Telephone number of person (1) to be involved in decisions	
56. Name of additional person to be involved in decisions (2)	
57. Telephone number of person (2) to be involved in decisions	
58. Other relevant issues or preferences about provision of care	<p>[V]Refusal of treatment for reasons of religion or conscience Procedure refused – religion</p> <p>Preferred priorities for care document completed</p> <p>Preference for female healthcare professional Preference for health professional</p> <p>Preference for male healthcare professional</p> <p>Preference for NHS care provider</p> <p>See also 35.</p>
59. Date of death	This information is not automatically included in SCR additional information but will be recorded in the source GP system.
60. Actual place of death	

Other SCCI1580 related codes:

Content heading/subheading	
61. Religious, spiritual and cultural requirements	<p>Has spiritual and cultural support</p> <p>[V]Refusal of treatment for reasons of religion or conscience Procedure refused – religion</p>
62. Current medication	This is a standard component of the core SCR available in SCRa.

<p>63. Next of kin - The name and contact telephone number of next of kin identified by the person.</p>	<p>Patient's next of kin No next of kin</p> <p>Other related codes in the inclusion set are: Has kinship carer Legal guardian - email address Legal guardian - home telephone number Legal guardian - mobile telephone number Legal guardian - work telephone number Legal guardian details Nearest relative of patient as defined by Mental Health Act legislation</p> <p>The following code is not currently included in the SCR inclusion dataset but may be manually added: Emergency contact details</p> <p>Next of kin information is also available on the PDS (in Alternative contacts - The patient's legal guardian, proxy, family/close contact).</p>
<p>64. Person lives alone</p>	<p>Lives alone Lives alone - help available Lives alone needs housekeeper Lives alone -no help available Independent housing, lives alone Homeless single person</p> <p>SCR also includes the following other social history information: Lives with biological parent and step parent Lives with biological parents Lives with grandfather Lives with grandmother Lives with immunocompromised person Lives with partner Lives with relatives Lives with spouse Elderly relative lives with family Child lives with another relative Child lives with father Child lives with grandparents Child lives with mother Child lives with parent Child lives with partner Lives as companion Lives as paid companion Lives as unpaid companion Lives in a commune Lives in a community Lives in a school community Lives in boarding school Lives with children Lives with companion Lives with daughter Lives with family Lives with father Lives with friend Lives with friends Lives with grandparents Lives with lodger Lives with mother Lives with parents Lives with son</p>

65. Sexual orientation	This information is not automatically included in SCR additional information but may be manually included if the patient wishes.
66. Syringe driver at home	Syringe driver commenced Syringe driver discontinued
67. Other equipment at home - To include catheter/ continence products at home.	Provision of mobility device Support equipment Home oxygen supply Home oxygen supply - concentrator Home oxygen supply - cylinder Home oxygen supply - liquid oxygen Home oxygen supply started Home oxygen support Other relevant codes such as the following may be manually included in the SCR: Catheter care equipment available at home Continence care equipment available at home
68. Expressed wish for organ donation	Wishes to be donor
69. Carer's assessment carried out	Referral for general practice carer's assessment Referral for social services carer's assessment Referral to Princess Royal Trust carers centre Referral to voluntary support service for carers
70. Bereavement risk assessment	This information is not automatically included in SCR additional information but a relevant bereavement related code may be manually included in the SCR.
71. Person's wishes of things to be avoided	Has Advance Decision to Refuse Treatment (Mental Capacity Act 2005) - Refuses all blood transfusion and administration of primary blood components and minor fractions Has involved healthcare professional in discussion about advance care planning Further detailed information could be recorded as free text against a suitable care plan code. For the complete list of care plan codes, see the SCR inclusion dataset. See also Treatments that have been refused and circumstances of refusal (74)

72. Preferred place of care - To identify where an individual would prefer to be cared for. (Select from NHS hospice/specialist palliative care unit, voluntary hospice/specialist palliative care unit, person's own home, hospital, care home, other)	There are no exact match codes for these in Readv2/ CTV3 or the SCR inclusion dataset. However the choice rank, organisation name and address can be recorded as free text against the following codes (which are in the SCR inclusion dataset): Preferred place of care - community hospital Preferred place of care - home Preferred place of care - hospice Preferred place of care - hospital Preferred place of care - learning disability unit Preferred place of care - mental health unit Preferred place of care - nursing home Preferred place of care - discussed with family Preferred place of care - discussed with patient Preferred place of care - patient declined to participate Preferred place of care - patient unable to express preference
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<p>73. Plans for verification of death - to include permission/suitability for nurse verification of death.</p>	<p>There are no exact match codes for these in Readv2/ CTV3 or the SCR inclusion dataset. However, information could be recorded as free text against a suitable care plan code, such as: Notification to primary care out of hours service of anticipated death Notification to primary care out of hours service of palliative care plan in place</p> <p>For the complete list of care plan codes, see the SCR inclusion dataset.</p>
<p>74. Treatments that have been refused and circumstances of refusal</p>	<p>[V]Refusal of treatment for reasons of religion or conscience Procedure refused – religion</p>
<p>75. Details of social care plan and location of document</p>	<p>Health and social care plan agreed</p>
<p>76. Completion of form DS1500 - Fast track application for benefits for people that are terminally ill</p>	<p>DS1500 form - attendance allowance claim DS 1500 Disability living allowance (terminal care) completed</p> <p>Other codes in the inclusion set related to benefits include: Benefits counselling Entitled to prescription exemp Has free prescriptions - automatic / low income / unspecified Has prescription season ticket</p>
<p>77. Has person been accepted for Continuing HealthCare funding - a package of continuing care provided outside hospital, arranged for people with on-going healthcare needs.</p>	<p>This information is not automatically included in SCR additional information but a relevant NHS Continuinghealthcare... code may be manually included in the SCR.</p>
<p>78. Reason for variance between actual and preferred place of death</p>	<p>This information is not included in SCR but may be recorded and reported on in the source GP system.</p>
<p>79. Should person's GP be contacted out-of-hours? Telephone numbers</p>	<p>There is no specific code for this in Readv2/ CTV3 or the SCR inclusion dataset. However the information could be recorded as free text against one of the following codes: Under care of GP Patient allocated named accountable general practitioner Has end of life care key general practitioner Has end of life care pathway key general practitioner GP out of hours service notified of cancer care plan</p> <p>Notification to primary care out of hours service of anticipated death Notification to primary care out of hours service of palliative care plan in place Ambulance service notified of patient on end of life care register</p> <p>or against a relevant care plan code automatically included in SCR.</p>
<p>80. Whether the person/family has been given a copy of the record - as a minimum, the individual should be offered a copy of the record or access to it.</p>	<p>This information is not automatically included in SCR additional information but a relevant code such as Copy of clinical record given to patient may be manually included in the SCR.</p>

81. Whether GP will sign death certificate in normal circumstances	There is no specific code for this in Readv2/ CTV3 or the SCR inclusion dataset. However the information could be recorded as free text against a suitable care plan code, included in the SCR.
82. Date person added to Gold Standard Framework register	There is no specific code for this in Readv2/ CTV3 or the SCR inclusion dataset. However the date can be recorded with the code: On gold standards palliative care framework which is included in the SCR.
83. Date of last discharge from hospital/hospice - The date of discharge from the most recent admission to hospital or hospice.	The following codes related to discharge are in the SCR inclusion dataset: Discharge by district nurse Discharge by practice nurse Discharge from cancer primary healthcare multidisciplinary team Discharge from heart failure nurse service Discharged from care of dyspepsia specialist nurse Discharged from community specialist palliative care team Other relevant discharge related codes may be manually included in the SCR.
84. Implanted devices - details of any implanted devices that may require management (includes implantable cardiac defibrillators).	[V]Cardiac pacemaker in situ Implantable cardiac electronic device in situ Patient with internal cardiac defibrillator pacemaker

NON SCCI1580 specific content:

Other SCR inclusion set items that could be potentially related to palliative care coordination and that may be used to contain other information not explicitly matched to existing codes above:

Other SCR inclusion set items	Notes: Codes in the SCR Inclusion dataset
<p>For the complete list of codes see the SCR inclusion dataset https://www.digital.nhs.uk/summarycare-records/additional-information or the latest release on the TRUD.</p>	<p>On end of life care register</p> <p>Advance care planning Agreeing on care plan with legitimate patient representative Agreeing on health professional actions in care plan Agreement of care plan Ambulance service notified of patient on end of life care register Anticipatory palliative care Cancer care review Cancer diagnosis discussed Cancer information offered Care plan Children and young people acute deterioration management form Clinical management plan Clinical management plan agreed Clinical management plan review Discussion about advance care plan Discussion about advance care planning with carer Discussion about advance care planning with family member Discussion about out of hours care management plan EHCP (emergency health care plan) agreed Emergency health care plan / Review of emergency health care plan End of life advance care plan End of life care plan offered End of life care pathway</p>

	<p>Final days pathway GP out of hours service notified Has anticipatory care plan Has children and young people acute deterioration management plan Has end of life advance care plan Has end of life care plan Has involved healthcare professional in discussion about advance care planning Notification to primary care out of hours service of anticipated death Notification to primary care out of hours service of palliative care plan in place Palliative care plan review Review of anticipatory care plan Review of care plan Sharing advance care planning decisions with out of hours service Special patient note Suspended from last days of life pathway Treatment Escalation Plan</p> <p>Benefits counselling Entitled to prescription exemp Has free prescriptions - automatic / low income / unspecified Has prescription season ticket</p>
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Appendix B – Need for an interpreter

<p>Codes related to the need for an interpreter: Need for an Interpreter</p>	<p>Interpreter needed Abkhazian language interpreter needed Afar language interpreter needed Afrikaans language interpreter needed Armenian language interpreter needed Assamese language interpreter needed Aymara language interpreter needed Azerbaijani language interpreter needed Basque language interpreter needed Belarusian language interpreter needed Bihari language interpreter needed Bislama language interpreter needed Brawa language interpreter needed Breton language interpreter needed Bulgarian language interpreter needed Burmese language interpreter needed Catalan language interpreter needed Central Khmer language interpreter needed Corsican language interpreter needed Danish language interpreter needed Dzongkha language interpreter needed Esperanto language interpreter needed Estonian language interpreter needed Ethiopian language interpreter needed Faeroese language interpreter needed Fijian language interpreter needed Frisian language interpreter needed Further interpreter needed Galician language interpreter needed Georgian language interpreter needed Guarani language interpreter needed Hungarian language interpreter needed Iban language interpreter needed Icelandic language interpreter needed Indonesian language interpreter needed Interlingue language interpreter needed Interpreter needed - Akan Interpreter needed - Albanian Interpreter needed - Amharic Interpreter needed - Arabic Interpreter needed - Bengali Interpreter needed - Cantonese Interpreter needed - Croatian Interpreter needed - Czech Interpreter needed - Dutch Interpreter needed - Farsi Interpreter needed - French Interpreter needed - French Creole Interpreter needed - Ganda Interpreter needed - German Interpreter needed - Greek Interpreter needed - Gujarati Interpreter needed - Hakka Interpreter needed - Hausa Interpreter needed - Hebrew Interpreter needed - Hindi Interpreter needed - Igbo Interpreter needed - Italian Interpreter needed - Japanese</p>
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	<p> Interpreter needed - Korean Interpreter needed - Kurdish Interpreter needed - Lingala Interpreter needed - Lithuanian Interpreter needed - Malayalam Interpreter needed - Mandarin Interpreter needed - Norwegian Interpreter needed - Panjabi Interpreter needed - Pashto Interpreter needed - Polish Interpreter needed - Portuguese Interpreter needed - Russian Interpreter needed - Serbian Interpreter needed - Shona Interpreter needed - Sinhala Interpreter needed - Somali Interpreter needed - Spanish Interpreter needed - Swahili Interpreter needed - Swedish Interpreter needed - Sylheti Interpreter needed - Tagalog Interpreter needed - Tamil Interpreter needed - Thai Interpreter needed - Tigrinya Interpreter needed - Turkish Interpreter needed - Ukrainian Interpreter needed - Urdu Interpreter needed - Vietnamese Interpreter needed - Welsh Interpreter needed - Yoruba Inuktitut language interpreter needed Inupiaq language interpreter needed Javanese language interpreter needed Kalaallisut language interpreter needed Kannada language interpreter needed Kashmiri language interpreter needed Kazakh language interpreter needed Kinyarwanda language interpreter needed Kirghiz language interpreter needed Lao language interpreter needed Latvian language interpreter needed Luganda language interpreter needed Macedonian language interpreter needed Malagasy language interpreter needed Malay language interpreter needed Maltese language interpreter needed Maori language interpreter needed Marathi language interpreter needed Moldavian language interpreter needed Mongolian language interpreter needed Nauru language interpreter needed Nepali language interpreter needed Occitan language interpreter needed Oriya language interpreter needed Oromo language interpreter needed Quechua language interpreter needed Romanian language interpreter needed Romansh language interpreter needed Romany language interpreter needed Rundi language interpreter needed </p>
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	Samoan language interpreter needed Sango language interpreter needed Sindhi language interpreter needed Slovenian language interpreter needed Southern Sotho language interpreter needed Sundanese language interpreter needed Swati language interpreter needed Tajik language interpreter needed Tatar language interpreter needed Telugu language interpreter needed Tibetan language interpreter needed Tongan language interpreter needed Tsonga language interpreter needed Tswana language interpreter needed Turkmen language interpreter needed Twi language interpreter needed Uighur language interpreter needed Uzbek language interpreter needed Xhosa language interpreter needed Yiddish language interpreter needed Zhuang language interpreter needed Zulu language interpreter needed Hands-on signing interpreter needed Interpreter needed - British Sign Language Interpreter needed - Makaton Sign Language Requires deafblind block alphabet interpreter Requires deafblind haptic communication interpreter Requires deafblind manual alphabet interpreter Sign Supported English interpreter needed Visual frame sign language interpreter needed Other interpreter needed Interpreter not needed
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Appendix C – Preferred Spoken Language
Codes defining the patient’s preferred spoken language

Preferred spoken language	Main spoken language Main spoken language Abkhazian Main spoken language Afar Main spoken language Afrikaans Main spoken language Akan Main spoken language Albanian Main spoken language Amharic Main spoken language Arabic Main spoken language Aragonese Main spoken language Armenian Main spoken language Assamese Main spoken language Aymara Main spoken language Azerbaijani Main spoken language Bamun Main spoken language Bashkir Main spoken language Basque Main spoken language Belarusian Main spoken language Bengali Main spoken language Bihari Main spoken language Bislama Main spoken language Brawa Main spoken language Breton Main spoken language Bulgarian Main spoken language Burmese Main spoken language Cantonese Main spoken language Catalan Main spoken language Central Khmer Main spoken language Corsican Main spoken language Croatian Main spoken language Czech Main spoken language Danish Main spoken language Dari Main spoken language Dutch Main spoken language Dzongkha Main spoken language English Main spoken language Esperanto Main spoken language Estonian Main spoken language Ethiopian Main spoken language Faeroese Main spoken language Farsi Main spoken language Fijian Main spoken language Filipino Main spoken language Finnish Main spoken language Flemish Main spoken language French Main spoken language French Creole Main spoken language Frisian Main spoken language Gaelic Main spoken language Galician Main spoken language Georgian Main spoken language German Main spoken language Greek Main spoken language Guarani Main spoken language Gujerati Main spoken language Hakka Main spoken language Hausa Main spoken language Hebrew Main spoken language Hindi Main spoken language Hindko Main spoken language Hungarian
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Main spoken language Iba
Main spoken language Icelandic
Main spoken language Igbo
Main spoken language Indonesian
Main spoken language Interlingua
Main spoken language Interlingue
Main spoken language Inuktitut
Main spoken language Inupiaq
Main spoken language Irish
Main spoken language Italian
Main spoken language Japanese
Main spoken language Javanese
Main spoken language Kalaallisut
Main spoken language Kannada
Main spoken language Kashmiri
Main spoken language Kazakh
Main spoken language Kinyarwanda
Main spoken language Kirghiz
Main spoken language Konkani
Main spoken language Korean
Main spoken language Kurdish
Main spoken language Kutchi
Main spoken language Lao
Main spoken language Latvian
Main spoken language Lingala
Main spoken language Lithuanian
Main spoken language Luganda
Main spoken language Macedonian
Main spoken language Malagasy
Main spoken language Malay
Main spoken language Malayalam
Main spoken language Maltese
Main spoken language Mandarin
Main spoken language Maori
Main spoken language Marathi
Main spoken language Moldavian
Main spoken language Mongolian
Main spoken language Nauru
Main spoken language Ndebele
Main spoken language Nepali
Main spoken language Norwegian
Main spoken language Occitan
Main spoken language Oriya
Main spoken language Oromo
Main spoken language Pashto
Main spoken language Patois
Main spoken language Polish
Main spoken language Portuguese
Main spoken language Punjabi
Main spoken language Quechua
Main spoken language Romanian
Main spoken language Romansh
Main spoken language Romany
Main spoken language Rundi
Main spoken language Russian
Main spoken language Samoan
Main spoken language Sango
Main spoken language Serbian
Main spoken language Shona
Main spoken language Sindhi
Main spoken language Sinhala
Main spoken language Slovak

	Main spoken language Slovenian Main spoken language Somali Main spoken language Southern Sotho Main spoken language Spanish Main spoken language Sundanese Main spoken language Swahili Main spoken language Swati Main spoken language Swedish Main spoken language Sylheti Main spoken language Tagalog Main spoken language Tajik Main spoken language Tamil Main spoken language Tatar Main spoken language Telugu Main spoken language Tetum Main spoken language Thai Main spoken language Tibetan Main spoken language Tigrinya Main spoken language Tongan Main spoken language Tsonga Main spoken language Tswana Main spoken language Turkish Main spoken language Turkmen Main spoken language Twi Main spoken language Uighur Main spoken language Ukrainian Main spoken language Urdu Main spoken language Uzbek Main spoken language Vietnamese Main spoken language Welsh Main spoken language Wolof Main spoken language Xhosa Main spoken language Yiddish Main spoken language Yoruba Main spoken language Zhuang Main spoken language Zulu Additional main spoken language Supplemental main language spoken
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