

Connected Care

# OneLondon – Shared Care Record User Guide

# Introduction/Overview

Shared Care Record enables care homes within 5 of the London HIEs access to the London Shared Care records via an InContext link from within the PCS digital care platform.

The NHS engaged with Person Centred Software to enable staff in homes to access the service through DCS.

## Who can use this service?

- Care Homes within 5 of London HIEs that are regulated by the CQC
- All Users can access information held on the Shared Care Record.

## Pre-requisites

Before you can enable the Shared Care Record there are some pre-requisites needed, which will require support from your ICB. These steps will be shared with you prior to contacting us to assist with the final stages of the setup:

## Managed by ICB

The following steps will be communicated to you by the ICB and must be done before PCS can assist with setting up the Shared Care Record in mCare:

- Check that you have met the necessary requirements to be standards met for the DSPT
- Your ICB will then do the required checks to proceed
- The ICB lead will send out a comms pack, which will include a link to an online form to request activation and set up of your ODS code.
- The care home manager to complete the training sent by the ICB and fill out the online shared care record form to request access to London Care Record.

## Supported by PCS

- The ICB will send PCS your ODS code for us to configure - PCS will add the ODS code to mCare
- Once Configured, you will need to ensure your regulatory body is set to CQC.
- The One London Data Sharing Agreement will then need to be signed in the Community dashboard.
- Once signed, you will be able to configure your workers to have access to the Shared Care Record

### Step 1 – Setting your regulatory body

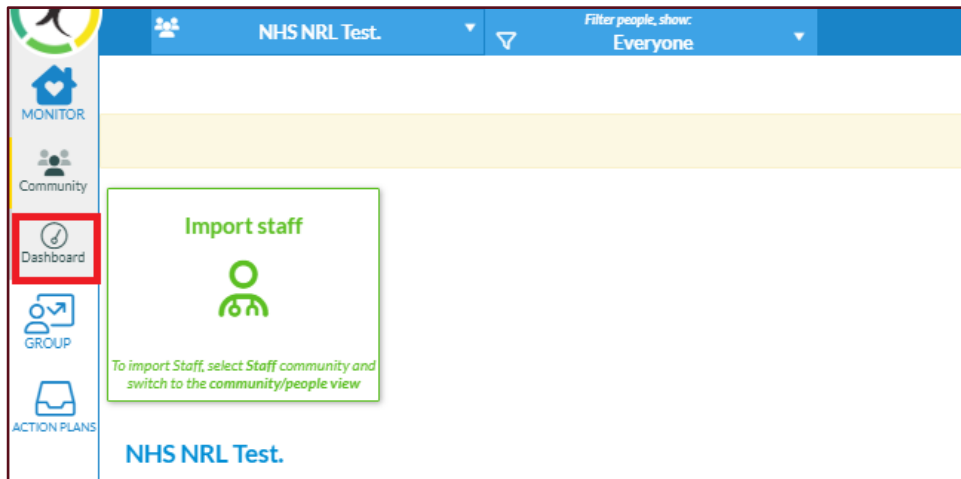
To ensure you can view the Data Sharing Agreement, first check the regulatory body in mCare is set to CQC. To do this, go to the **Admin** menu – click **Organisation Details** – Select the care site you wish to configure (the care home name with a blue background) – in the **Regulatory body** drop-down menu, select **CQC – England**

Community settings:	Care home / Agency office settings:
Community name <u>Doherty Home</u>	Hospital Pack version <u>Version 2 (Full)</u> ▾
Currently used for training <input type="checkbox"/>	Disable Relatives Gateway <input type="checkbox"/>
Allow staff <input type="checkbox"/>	Disable Action Plans <input type="checkbox"/>
Allow service users <input type="checkbox"/>	Gather Group reporting data <input checked="" type="checkbox"/>
Use day of month for care plan review cycles <input checked="" type="checkbox"/>	Analysis group 1 <u>South</u>
Care plan review cycle period <u>Monthly</u> ▾	Analysis group 2 _____
Maximum number of days between reviews <u>180</u>	Last attempt to collect group reporting data <u>2024/05/31 12:00</u>
Using Third Party Incident / Accident system <input type="checkbox"/>	<b>Regulatory body <u>CQC - England</u></b>

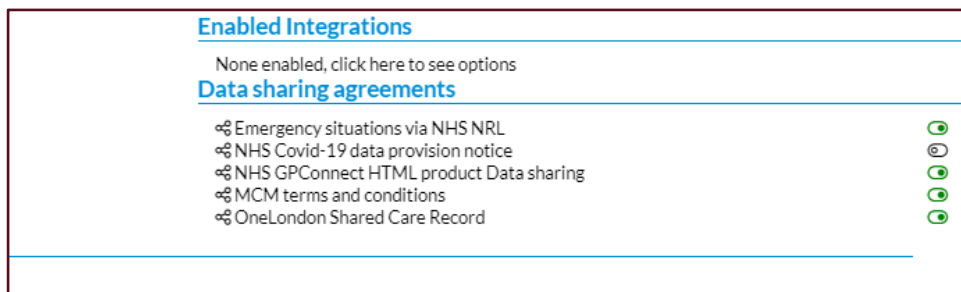
## Step 2 – Signing the Data Sharing Agreement

Once the home configuration has been completed, you will now be able to sign the Data Sharing Agreement. To enable the OneLondon Shared Care Record someone with the correct authority will need to sign the agreement.

The OneLondon Shared Care Record can be found on the community dashboard.



The OneLondon Shared Care Record agreement will show in the dashboard:



Click the toggle on the button next to **OneLondon Shared Care Record**. You will be taken to another screen where you can sign the Data Sharing Agreement



### OneLondon Shared Care Record

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Name of Care home manager / DPO / Director:-  
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Date agreed:-  
--/------

Enter your password before pressing the button

Commit for 12 months

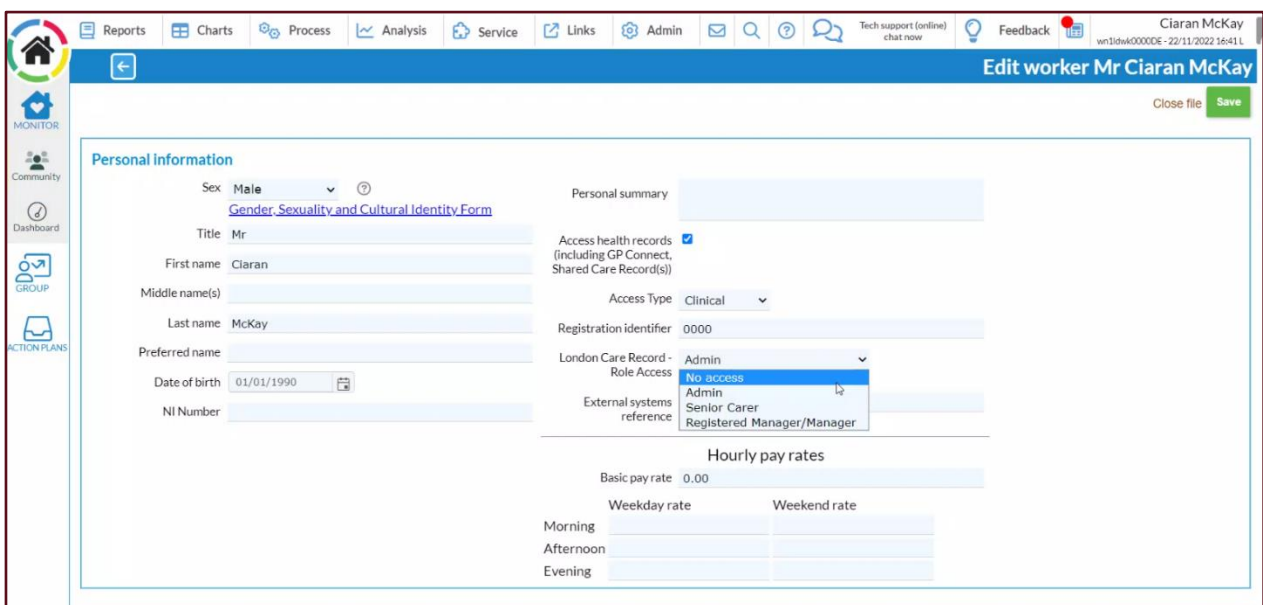
⚠ **WARNING: You should only commit if Doherty Home is known to be DSPT Standards met. You will be in breach of the obligations set out if you 'commit' and are not at DSPT Standards Met.**

To sign the agreement, enter the password you use to login to mCare with and click **Commit for 12 months**. Please note, the Data Sharing Agreement will need to be re-signed every year in order to continue accessing the Shared Care Record.

### Step 3 – Setting up the correct role access

Next, we need to set up the correct permissions for each member of staff who will need to access the Shared Care Record. To do so, select a staff community, click on the relevant staff member and click on **Edit details**.

On this page, there will be a drop-down for **London Care Record – Role Access**.



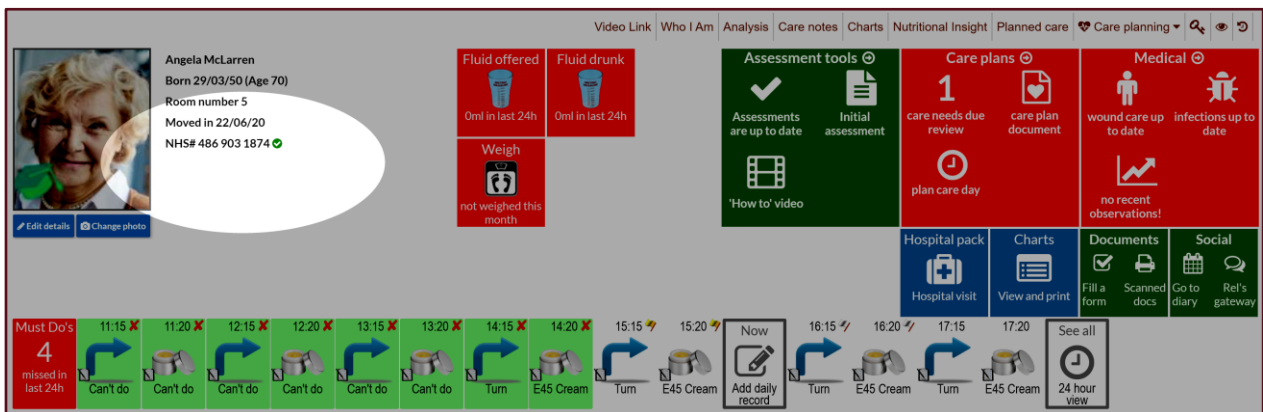
The screenshot shows the 'Edit worker Mr Ciaran McKay' page. The 'Personal Information' section includes fields for Sex (Male), Title (Mr), First name (Claran), Middle name(s), Last name (McKay), Preferred name, Date of birth (01/01/1990), and NI Number. The 'Personal summary' field is empty. The 'Access health records (including GP Connect, Shared Care Record(s))' checkbox is checked. The 'Access Type' is set to 'Clinical'. The 'Registration identifier' is 0000. The 'London Care Record - Role Access' dropdown menu is open, showing options: 'Admin', 'No access', 'Senior Carer', and 'Registered Manager/Manager'. The 'External systems reference' field is empty. The 'Hourly pay rates' section includes a 'Basic pay rate' of 0.00 and a table for 'Weekday rate' and 'Weekend rate' with rows for Morning, Afternoon, and Evening.

The following permissions will grant you different access which is explained below:

- **No access** – the member of staff will not have access to the Shared Care Record
- **Admin** – View encounters and appointments only (Other areas will be greyed out)
- **Senior Carer** – This provides an elevated level of access, but slightly less information than a Registered Manager. The Senior Carer will have access to view encounters, appointments, clinical correspondence, alerts, assessments and care plans.
- **Registered Manager/Manager** - This gives you access to all the information available. (GP records, mental health and community data, clinical correspondence access is exclusive to Registered Manager role only)

#### Step 4 – Ensure all resident’s date of birth are correct and NHS numbers are valid

The resident file will show if the NHS number has not been validated, is valid or invalid. The validation is carried out when editing the details. The Personal Demographic Service (PDS) is currently only available to homes in England and we have input their ASID (accredited system ID) that we obtain from the NHS.



Validation indicator	Meaning	What to do
NHS# 486 903 187 ?	A grey circle with a question mark means that the NHS number has not yet been checked with the PDS	Edit the service user details and save the record. This will use the PDS service to validate the NHS number

NHS# 486 903 187 ❌	A red circle with a cross indicates the NHS number is invalid. It may be that the NHS number has been incorrectly entered or the details (Name, D.O.B) do not match NHS records.	Edit the service user, check the Name and Date of Birth and Save the record to revalidate.
NHS# 486 903 1874 ✅	A green circle with a tick – all good! The NHS number and demographic details match and have been validated.	Nothing to do!
NHS# 486 903 1874	No indicator displayed.	Check that the top-level community for the care site is set to “CQC – England” and that there is an ASID code recorded in the Integrations section of the community edit page. Contact support for further assistance

## Accessing Shared Care Records for your Residents.

You should only access records for residents that are admitted to your home and have a legitimate basis to view records (e.g. that there is a contract in place to provide care). Note that all accesses are logged with an audit record kept. To open the Shared Care Records there is a link within the resident file

If everything is set up correctly, then you will be able to access the page and details are returned. The information that is displayed on this page will change depending on what permission you have.

The screenshot displays the NHS Shared Care Record interface for a patient named DONOTUSE. The interface includes a navigation menu on the left with options like Reports, Charts, Process, Analysis, Service, Links, Admin, and Feedback. The top header shows the patient's name, gender (Female), and age (71y). The main content area features a patient summary with a 'Loading...' status and a 'This patient is deceased' warning. Below this, there are various data categories and filters, including Clinical Correspondence (25), Encounters (314), Lab results (146), GP Records (10), Additional GP Records (15), Future Appointments (0), Vital signs (138), Mental Health (0), Allergies & Adverse Reactions (12), Community (0), Medications (30), Social Care (0), Past Meds (48), Meds Issues (13), Problem List (39), and Vaccinations (13). A disclaimer is also present, stating that the information is aggregated and not guaranteed to be complete or accurate.