Mid and South Essex Integrated Care System

NHS Mid and South Essex

Shared Care Record data visibility guide: 9th March 2026

This information is regularly updated, please refer to the MSE ICS website for the latest version.

Datasets by organisation

GP practices (GP Connect)

- **Datasets live now:**
  - Summary
  - Encounters
  - Problems and issues
  - Allergies and adverse reactions
  - Medications
  - Referrals
  - Observations
  - Immunisations

Please Note: Clinical items and administrative items will not be included in the MVS phase but are expected to be included in the record in a future phase.

Community providers (TPP SystmOne)

Organisations: Provide Community, Essex Partnership University Trust, North East London Foundation Trust, IC24, Farleigh Hospice, Havens Hospices, St Luke's Hospice

- **Datasets live now:**
  - Encounters
  - Immunisations
  - Medications
  - Observations
  - Problems and issues
  - Referrals
  - Summary

Please Note: Clinical items and administrative items will not be included in the MVS phase but are expected to be included in the record in a future phase.

Mid and South Essex NHS Foundation Trust (Medway and Lorenzo systems)

Includes the following data:

- Inpatient discharge summaries (created after 1 April 2024)
- Emergency department discharge summaries (created after 21 October 2024)
- Maternity discharge letters (created after 21 October 2024)
- Inpatient hospital admissions (created after 1 January 2021)
- Emergency department attendances (created after 1 January 2021)
- Outpatient appointments (created after 29 May 2025)
- Radiology reports (created after 1 October 2025)
- Scheduled admissions for treatment or surgery (TCIs)

Please Note: Discharge summaries do not include cardiology or maternity.

Essex Partnership University Trust (Mobius & Paris systems)

Includes the following data:

- Advanced Decision Safeguarding (Paris)
- [illegible]
- MH_Inpatient Discharge (Paris)

Essex County Council (Mosaic system)

Live now:

- **Personal contacts:** name and relationship of next of kin.
- **Professional contacts:** details of any allocated social worker, including team name and contact number (if available).
- **Support reason:** such as physical disability, learning disability, mental health needs, or sensory impairment. Includes a recorded start date and classification.
- **Alerts & Hazards:** including safeguarding concern or enquiry status. These entries show the type of alert and whether it is active but may not include detailed information. Contact the professionals identified in the care network section for further information if required.
- **Events & appointments:** shows any adult social care assessments that have been completed within the previous 365 days on a rolling

basis. Each entry shows the type of assessment, start and end dates, outcome (where recorded), and the team involved. Outcomes may include actions such as referral for occupational therapy or creation of a support plan.

To follow at a later date:

- **Provisions:** care packages or service provisions in place such as day care or home care including provider name and contact details, start and end date and frequency

Southend City Council and Thurrock Council (LiquidLogic system)

Includes the following data from the past 3 years:

- **Demographics:** Person demographics and contact details
- **Personal contacts:** such as next of kin, advocate, emergency contact
- **Professional contacts:** details of any practitioners currently involved, including team name and contact number (if available).
- **Support reason:** information about the person's primary and secondary support needs, such as physical or personal care support. Includes a recorded start date and classification.
- **Referrals:** referral information, indicating whether the referral is active or completed. Key details include the service referred to, referral date, and status.
- **Alerts & Hazards:** critical alerts and hazards that may impact the person's care. These are split into two categories:
    - **Risks**: specific dangers or issues, such as physical or environmental hazards, that may require immediate attention.
    - **Special factors**: conditions or considerations that could influence care, such as access challenges or sensory impairments.
- **Disabilities affecting care:** disabilities declared that may impact the person's care, including the type of disability and date recorded.
- **Events & appointments:** shows any adult social care assessments, safeguarding, hospital admissions and DoLS – Deprivation of Liberty Safeguards that have been completed.
- **Provisions:** council commissioned care provision currently in place, including the type of service, provider name, and status (active or completed).
- **Care and support plan:** indicates whether a care or support plan is in place and its status (active or inactive). While full plans cannot be viewed directly, users can see key details like start and review dates, providing insight into ongoing support arrangements.

Key information about Southend City Council data:

- **Referrals:** To identify the correct social care team the person has been referred to, look at the name stated first in the 'service referred to' field in the description. The wording after the hyphen defines the social care system work tray.
- **Professional network card:** Most professionals are included, but some details, such as those for occupational therapists, are not yet available. These will be added in a future update.
- **Care and support plans card:** Interim and respite care plans, which are temporary and should display an end date, are not currently included in the Shared Care Record due to technical limitations. These plans will be added in a future update.

Please Note: For hospital admissions & discharges there will only be data for those know to Adult Social care and required input to facilitate discharge.

IC24 - NHS 111 (Cleo system)

Includes data created after 26 February 2025:

- Out of hours episodes and events summary details
- NHS 111 report document (post-event message) which includes:
  - Reported condition
  - Pathway disposition (outcome of the NHS Pathways triage process)
  - Consultation summary
  - Pathways assessment
  - Advice given

Types of data in the Shared Care Record

The Shared Care Record contains both structured and unstructured data. Understanding the difference between these types of data will help you navigate and utilise the information effectively.

Structured data

Structured data is highly organised and easily searchable. This information is displayed in the interactive dashboards, such as the Person Summary or events and appointments.

Unstructured data

Unstructured data is more free-form and does not follow a specific format. It often includes text and documents. This type of data is stored in the clinical document viewer tree of the Shared Care Record

Understanding GP connect

Summary:

- Emergency Codes 3
- Last 3 encounters
- Active problems and issues
- Major inactive problems and issues
- Current allergies and adverse reactions
- Acute medication (last 12 months)
- Current repeat medications

Encounters:

- Planned encounters - such as pre-arranged appointments with a GP.
- Unplanned encounters - such as at an out of hours clinic and those unrecorded through appointment module(s).
- Direct encounters - such as a face-to-face session with a GP.
- Indirect encounters - such as a GP reviewing and updating a patient record on receipt of some test results.

Clinical items:

- To allow a clinician to view a history of items relating to the health and wellbeing of a patient. Examples of this type of information include history.

Allergies and adverse reactions:

- To provide the clinician with a list of patient allergies to enable safe prescribing and treatment recommendations for a patient.
- Contains two subsections:
    - Current allergies and adverse reactions, sorted by start date descending.
    - Historical allergies and adverse reactions, sorted by end date descending.

Problems and issues:

- Information about a patient’s significant problems and issues which will inform or may have previously informed the clinically significant to a patient that impacts their health or wellbeing. It includes disease, surgery, and social issues such as bereavement.

Medications:

- Acute medication (last 12 months) 1, sorted by start date descending.
- Current repeat medication 1, sorted by start date descending.
- Discontinued repeat medication 1, sorted by last issued date descending.
- All medication 2, grouped by medication item (for example, Ibuprofen 400mg tablets) and sorted by start date descending.
- All medication issues 2, grouped by medication item (for example, Ibuprofen 400mg tablets) and sorted by issue date descending.

Referrals:

- Details of any request for transfer of care or request to provide assessment/treatment or clinical advice.

Observations:

- To enable the clinician to view and compare chronological data pertaining to a patient's physical condition.

Immunisations:

- To provide the healthcare professional with information about any immunisations that have been administered to the patient. Vaccinations vaccination-related information such as flu vaccine declined.

Administrative Items:

- To provide information for the healthcare teams on the recorded management and administrative processes and activity to support such as scheduling and administering clinical care encounters, clinical communication with other care organisations, administering and monitoring medication administration and call/recall for care.