

# Kettering Format Messages in Vision



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# Kettering Format Messages in Vision

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## Introduction

The 'Kettering' Discharge XML message was developed towards the end of the 1990's for use as a Discharge message. It is a fairly simple XML file that has the ability to contain binary data along with 'header' information identifying the sender, receiver and patient. Due to the XML format it is not possible to use embedded images in Kettering messages.

The Kettering message is not designed to carry other information flows and as such the possible service event types used to indicate message type are limited to ones normally associated with Discharge letters. However a number of organisations are using it for other data.

 **England**,  **Wales** and **Northern Ireland** - Currently receive a variety of information in Kettering messages eg:

- **Discharge reports**
- **A&E reports**
- **Out of Hours reports**
- **Hospital Letters**
- **Special clinic letters**

 **Scotland** - Vision does not currently support Kettering messages in Scotland because, although the message once in GP Communicator (GPC) would work in Scotland, it would require a transport mechanism to deliver the messages and modification to GPC to cater for this, eg an E-Links queue for the Kettering message type.

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## Configuring Vision to Receive Kettering Messages

Setting up Vision to allow receipt of Kettering messages is simply a matter of configuring an appropriate trading partner in GPC. Refer to on-screen help [Adding a New Clinical Address](#)


[http://www.inpshep.co.uk/DLM480/GP\\_Communicator/index.htm#20513](http://www.inpshep.co.uk/DLM480/GP_Communicator/index.htm#20513) and [Kettering Format XML Messages](#)

[http://www.inpshep.co.uk/DLM480/GP\\_Communicator/index.htm#58912](http://www.inpshep.co.uk/DLM480/GP_Communicator/index.htm#58912) for details.

The following details are required:

- **Sender and Recipient link codes**
-  England and  Wales - **Trading partner's DTS address**
- Northern Ireland - **Trading partner's e-mail address**
- **Receipt Reports** - Decision as to whether to generate or not.

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 **Note** -If hospital messages are to be sent using the same system as the laboratory uses for Pathology results, and the same link codes are used, the address will already be present and the trading partner will just need the Receipt reports turned off for Kettering messages if these are not to be used.

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## Kettering Message Content

Kettering messages are filed into Vision as attachments, therefore the data is not filed into the patient record in a searchable format.

Message Type or Content is identified by the ServiceEventType value within the Kettering Message and is displayed in Mail Manager and then filed into Consultation Manager using the Vision document type corresponding to the ServiceEventType received, eg a ServiceEventType of IP would mean the document was filed into Consultation Manager as a Discharge Summary. In addition to the original list we added AE as a valid value ServiceEventType.

Service Event Type from the Kettering Message	Displayed in Mail Manager	Filed into Consultation Manager as:
IP	DTY001 - In Patient Report/Discharge Report	MMT012 – Discharge Summary
DC	DTY002 - Out Patient Report/Day Case Report	MMT014 – Out Patient Report
DH	DTY002 - Out Patient Report/Day Hospital Attendance	MMT014 – Out Patient Report
WR	DTY002 - Out Patient Report/Ward Attendance Report	MMT014 – Out Patient Report
FF	DTY002 - Out Patient Report/First Follow-Up Report	MMT014 – Out Patient Report
SF	DTY002 - Out Patient Report/Subsequent Follow-Up Report	MMT014 – Out Patient Report
FV	DTY002 - Out Patient Report/First Visit Report	MMT014 – Out Patient Report
SV	DTY002 - Out Patient Report/Subsequent Visit Report	MMT014 – Out Patient Report
MV	DTY002 - Out Patient Report/Visit Report	MMT014 – Out Patient Report
DI	DTY003 - Investigation Report/Test Result	MMT015 - Diagnostic Test Report
VO	DTY002 - Out Patient Report/Home Visit Report	MMT016 – Out Of Hours Report
VP	DTY002 - Out Patient Report/Home Visit + Procedure	MMT016 – Out Of Hours Report
NC	DTY019 - Hospital Report/No Patient Contact	MMT011 – Other Attachment
RC	DTY019 - Hospital Report/Hospital Report	MMT011 – Other Attachment
TR	DTY019 - Hospital Report/Tertiary Report	MMT011 – Other Attachment
UN	DTY005 - Out of Hours Report/Third Party Contact	MMT016 – Out Of Hours Report
AE	DTY042 - Emergency Department Report	MMT037 Emergency Department Report

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 **Note** - As the Kettering specification is no longer active INPS cannot request additional ServiceEventTypes be created.

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Vision uses several data items during message processing and these must contain specific data or be of the expected format to enable the message to be identified and processed correctly

- **<MsgId>615897-Discharge</MsgId>** Any format is allowed but each must be unique to avoid Duplicate message warnings, therefore ids based on date\time only are not recommended as there is a high risk of messages sent at the same time being marked as duplicates.
- **<MsgIssueDate>200107201522</MsgIssueDate>** Format CCYYDDMM or CCYYDDMMHHMM.
- **<MsgSender>140000123400001</MsgSender>** The suggested value is NACS code or local ID code or DTS name of sender. For a lab this is often a 15 digit code used as the Lab ID for pathology results.
- **<MsgRecipient>140007048300002</MsgRecipient>** The suggested value is the NACS code, local ID or DTS name of sender of the recipient practice. For messages received from a lab system this is often a 15 digit code as the practice ID for the pathology results.

**MsgSender** and **MsgRecipient** values in the message are matched to the **Sender** and **Recipient Link codes** in GPC to identify the sender of the message and allow Receipt reports to be generated and returned. If there is no match then the message is placed in the attention folder, with an unknown sender status, for the practice to manually process.

- **<IdType>Nhs</IdType>** **<IdValue>1234567890</IdValue>** where the NHS number is expected to be 10 numerics
- **<FamilyName>abalunam</FamilyName>** Patient Surname
- **<GivenName>Ghjk</GivenName>** Patients Forename(s)

Patient names are expected to follow the local Registration Links guidelines used by the practice as agreed with the HA. This may mean that any punctuation is either not present in the Vision record or is replaced by a space. This also impacts capitalisation as only the first letter of each name is capitalised. for example:

- O'Keefe is entered as Okeefe or O Keefe
- Wilson-Jones is entered as Wilson Jones

Forenames should be entered in full. Matching of forenames is done as text strings and must be identical to produce a positive match. Where NHS numbers are not used, differences in the format of patient names accounts for a large number of matching failures leaving the practice to manually assign the message to the correct patient.

- **<BirthDate>19962501</BirthDate>** Expected format CCYYMMDD

Other formats are not invalid but will not allow a match to the DOB stored in the patients medical record stored in Vision.



- GMP Code
- <AgentId>
- <IdType>GP</IdType>
- <IdValue>G9405611</IdValue>
- </AgentId>

Messages are assigned to GP's using their General Medical Practitioner (GMP) code which is in the format Gnnnnnnn This must match the GMP codes of one of the GP's set up in Vision to allow messages to be automatically routed to a specific GP. If this is not present, or does not match a GMP code stored in Vision, the message has to be manually allocated to a GP.

- <ServiceEventType>IP</ServiceEventType>

The Service Event type must be one of the 2 character codes listed in the ServiceEventType table. It is used to identify the content of the message and dictates how the message is identified within Vision.

## Filing Dates

Vision users can select to file by:

- Date of the event reported in the message
- Date the message was generated
- Date they received and filed the message (Default).

Although practices normally use the system date at the time of filing, some practices may decide to use the Clinical Event date eg Date of Discharge. This can be configured within Vision, see [Kettering Messages \(OOH and Discharge Summaries\) on-screen help](#) [http://www.inpshelp.co.uk/DLM480/Mail\\_Manager/index.htm#20099](http://www.inpshelp.co.uk/DLM480/Mail_Manager/index.htm#20099) for details. To enable the practice to file by event date it is essential it is present and identifiable in the Kettering message. The clinic event date is picked up from the RELDATE field with a Code of 82.

 **Note** - RELDATE with any other codes will not be used for filing.

- <RelDate><Date>201301211302</Date>
- <RelDateRole>
- <Code>82</Code>
- </RelDateRole>
- </RelDate>

It is possible within Vision to file by the Message Issue Date, only a couple of the early pilot sites have requested this and we haven't widely advertised this option. Normally the message issue date would be either the same day or the day before anything filing by filing date so makes little difference.

- <MsgIssueDate>200107201522</MsgIssueDate>

## Sample Kettering Discharge Message

The items in Bold are used by INPS for:

- Message typing
- Sender/Recipient/Patient matching
- To date to message
- Identify the message type
- Check for duplicate messages

```

<?xml version="1.0" encoding="ISO-8859-1"?>
<!-- edited with XML Spy v4.1 U (http://www.xmlspy.com) by Mark Taylor (In
Practice Systems Ltd) -->
<!DOCTYPE ReportMsg SYSTEM "..\Schemas\ReportMsg03.dtd">
<ReportMsg MsgStatus="Test" MsgUrgency="Normal">
  <MsgId>615897-Discharge</MsgId>
  <MsgIssueDate>200107201522</MsgIssueDate>
  <MsgSender>0080140000123400001</MsgSender>
  <MsgRecipient>Z080140007048300002</MsgRecipient>
  <ServiceRequester>
    <IdValue>1</IdValue>
  </ServiceRequester>
  <ServiceProvider>
    <IdValue>2</IdValue>
  </ServiceProvider>
  <PatientMatchingInfo>
    <PatientId>
      <Id>
        <IdType>Nhs</IdType>
        <IdValue>1234567890</IdValue>
      </Id>
      <Id>
        <IdType>Requester</IdType>
        <IdValue>11720</IdValue>
      </Id>
      <Id>
        <IdType>Provider</IdType>
        <IdValue>20001005</IdValue>
      </Id>
    </PatientId>
    <PersonName_s>
      <PersonNameType>CU</PersonNameType>
      <StructPersonName>
        <FamilyName>abalunam</FamilyName>
        <GivenName>Ghjk</GivenName>
        <Title>Mr</Title>
      </StructPersonName>
    </PersonName_s>
  </PatientMatchingInfo>
</ReportMsg>

```

```

<BirthDate>19962501</BirthDate>
<Sex>1</Sex>
<Address_u>
  <PostCode>LS25 2JP</PostCode>
  <UnstructAddress>
    <UnstructAddressLine>77 Allnew
Road</UnstructAddressLine>
    <UnstructAddressLine>Leeds</UnstructAddressLine>

  <UnstructAddressLine>Yorkshire</UnstructAddressLine>
  </UnstructAddress>
</Address_u>
</PatientMatchingInfo>
<AgentsDirectory>
  <AgentInContext>
    <IdValue>1</IdValue>
    <AgentId>
      <IdType>GP</IdType>
      <IdValue>G9405611</IdValue>
    </AgentId>
    <AgentRel>
      <AgentRelType>3</AgentRelType>
      <AgentId>
        <IdType>PRA</IdType>
        <IdValue>ABBO140442</IdValue>
      </AgentId>
    </AgentRel>
  </AgentInContext>
  <AgentInContext>
    <IdValue>2</IdValue>
    <AgentId>
      <IdType>Specialist</IdType>
      <IdValue>C2709019</IdValue>
    </AgentId>
    <AgentRel>
      <AgentRelType>3</AgentRelType>
      <AgentId>
        <IdType>Provider</IdType>
        <IdValue>RNQ00</IdValue>
      </AgentId>
    </AgentRel>
  </AgentInContext>
</AgentsDirectory>

```

```

        </AgentId>
    </AgentRel>
</AgentInContext>
<AgentInContext>
    <IdValue>3</IdValue>
    <AgentId>
        <IdType>GP</IdType>
        <IdValue>G9405611</IdValue>
    </AgentId>
    <AgentRel>
        <AgentRelType>3</AgentRelType>
        <AgentId>
            <IdType>PRA</IdType>
            <IdValue>K82600</IdValue>
        </AgentId>
    </AgentRel>
</AgentInContext>
</AgentsDirectory>
<MsgRef>
    <MsgIdRef>23</MsgIdRef>
    <MsgIssueDate>199910261007</MsgIssueDate>
    <MsgSenderRef>0080140007048300002</MsgSenderRef>
</MsgRef>
<ReportedService>
    <ReferralNumber>83</ReferralNumber>
    <PaymentCategory>PPI</PaymentCategory>
    <ServiceReportStatus>UN</ServiceReportStatus>
    <ReportedEventItem>
        <Cuid IdScope="Message">1</Cuid>
        <RelDate>
            <Date>200102060000</Date>
            <RelDateRole>
                <Code>82</Code>
            </RelDateRole>
        </RelDate>
        <ServiceEventType>IP</ServiceEventType>
        <AdministrativeOutcome>
            <Code>UN</Code>
        </AdministrativeOutcome>
    </ReportedEventItem>
</ReportedService>

```

```

        </AdministrativeOutcome>
    </ReportedEventItem>
</ReportedService>
<PatientAdminInfo>
    <RelAgent>
        <RelAgentRole>
            <Code>PRG</Code>
        </RelAgentRole>
        <IdValue> 3</IdValue>
    </RelAgent>
</PatientAdminInfo>
<ClinicalReport>
    <TextItem>
        <Cuid IdScope="Message">2</Cuid>
        <TextMarkupIndicator>-//IETF//DTD
HTML//EN</TextMarkupIndicator>
        <TextBlock><![CDATA[<html>
    <head>
        <meta name="generator" content="HTML Tidy, see www.w3.org"/>
        <link rel="Edit-Time-Data"
href="./E6623952-C6BC-45F4-B964-1CFFCE2FA080_files/editdata.mso"/>
        <title></title>
    </head>
    <body>
        <div>
            <table border="0" cellspacing="0" cellpadding="0"
width="655">
                <tr>
                    <td valign="top">
Dr T M Penney<BR>
                    </td>
                </tr>
                <tr>
                    <td valign="top">
24 Linden Avenue<BR>
Kettering<BR>
Northants<BR>

```

NN34 5TH<BR>

</td>

</tr>

<tr>

<td valign="top">

&nbsp;   <BR>

</td>

</tr>

<tr>

<td valign="top">

05 May 2001<BR>

</td>

</tr>

<tr>

<td valign="top">

&nbsp;   <BR>

</td>

</tr>

<tr>

<td valign="top">

Dear Dr Penney<BR>

</td>

</tr>

</table>

<table border="0" cellspacing="0" cellpadding="0"

width="655">

<tr>

<td>

<h4 align="center">Re: <a id="Re" name="Re"></a>Mr Ghjk Albalunam - Date of Birth 25/01/1996</h4>

<div align="center"><b>27 Station Road, Kettering, Northants, NN3 4RT</b></div>

</td>

</tr>

<tr>

<td>

<div align="center">Admission Date 12/12/2000 - Discharge Date 13/12/2000</div>

</td>

```
</tr>
</table>
```

I saw this patient as requested and could not find any evidence of a n injury. I was therefore able to examine Mr Howarth without sedation.<BR>

My conclusion about the cause of his problems are listed below.<BR>

```
<BR><table border="0" cellspacing="0" cellpadding="0"
width="100%">
```

```
<tr width="100%">
  <td valign="top" width="85%">
    <b>Primary Diagnosis:<a
id="Diagnosis" name="Diagnosis"></a></b><BR>
```

```
</td>
```

```
<td valign="top" width="15%">
```

```
<b>Code:</b><BR>
```

```
</td>
```

```
</tr>
```

```
<tr>
```

```
<td valign="top">
```

Multiple Sclerosis<BR>

```
</td>
```

```
<td valign="top">
```

PKY42<BR>

```
</td>
```

```
</tr>
```

```
<tr>
```

```
<td valign="top"></td>
```

```
<td valign="top"></td>
```

```
</tr>
```

```
<tr>
```

```
<td valign="top">
```

```
<b>Secondary Diagnosis:</b><BR>
```

```
</td>
```

```
<td valign="top"></td>
```

```
</tr>
```

```
<tr>
```

```
<td valign="top">
```

Chronic Bronchitis<BR>



```

        </td>
        <td valign="top"></td>
    </tr>
    <tr>
        <td valign="top"></td>
        <td valign="top"></td>
    </tr>
</table>
<BR><BR><table border="0" cellspacing="0"
cellpadding="0" width="100%">
    <tr width="100%">
        <td valign="top" width="35%">
            <b>Discharge Medication: <a
id="DischargeMedication" name="DischargeMedication"></a></b><BR>
        </td>
        <td valign="top" width="30%">
            <b>Dose: </b><BR>
        </td>
        <td valign="top" width="20%">
            <b>Quantity: </b><BR>
        </td>
        <td valign="top" width="15%">
            <b>Code: </b><BR>
        </td>
    </tr>
    <tr>
        <td valign="top">
Paracetamol 600mgs<BR>
        </td>
        <td valign="top">
Two tablets every eight hours if in pain<BR>
        </td>
        <td valign="top">
60x 1 tabs<BR>
        </td>
        <td valign="top">
Reed<BR>
        </td>
    </tr>

```

<p>Ibuprofen 100mgs&lt;BR&gt;</p> <p>1-2 tablets to be taken morning and evening for 7 days&lt;BR&gt;</p> <p>24x1 tabs&lt;BR&gt;</p> <p>Reed&lt;BR&gt;</p>	<p>&lt;tr&gt;</p> <p>&lt;td valign="top"&gt;</p> <p>&lt;/td&gt;</p> <p>&lt;td valign="top"&gt;</p> <p>&lt;/td&gt;</p> <p>&lt;td valign="top"&gt;</p> <p>&lt;/td&gt;</p> <p>&lt;td valign="top"&gt;</p> <p>&lt;/td&gt;</p> <p>&lt;/tr&gt;</p> <p>&lt;tr&gt;</p> <p>&lt;td valign="top"&gt;</p> <p>&lt;/td&gt;</p> <p>&lt;td valign="top"&gt;</p> <p>&lt;/td&gt;</p> <p>&lt;td valign="top"&gt;</p> <p>&lt;/td&gt;</p> <p>&lt;td valign="top"&gt;</p> <p>&lt;/td&gt;</p> <p>&lt;tr&gt;&lt;td&gt;&lt;BR&gt;&lt;/td&gt;&lt;/tr&gt;&lt;/tr&gt;</p>
--	---

</table><BR>

Yours sincerely<BR>

Owen Davison FRCS<BR>

Consultant Urologist<BR>

</div>

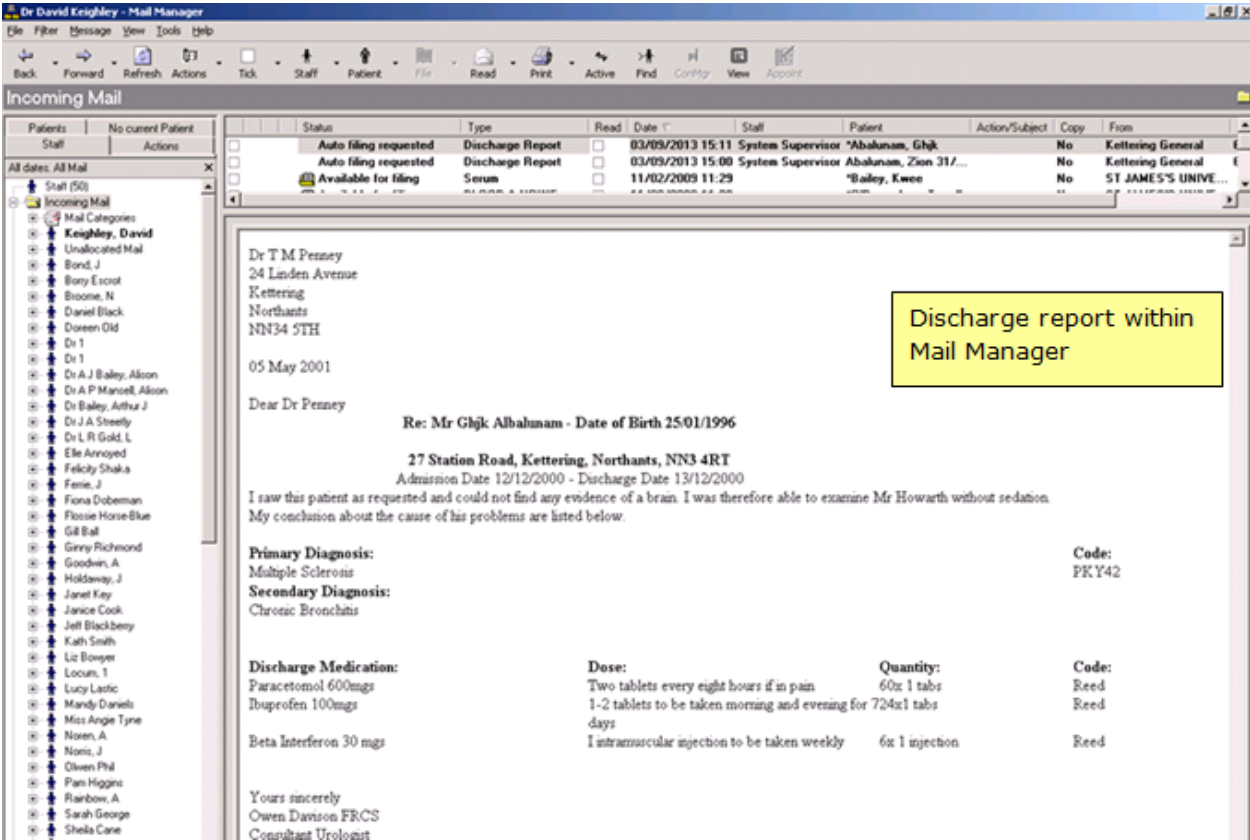
</body>

</html>

```
]]></TextBlock>  
    </TextItem>  
  </ClinicalReport>  
</ReportMsg>
```

# Message in Mail Manager

The following is an example discharge message displayed in Mail Manager:



Mail Manager - Incoming Mail - Discharge Report

## Message Filed to Patient Record

The following is an example discharge message displayed in Consultation Manager:



The screenshot displays the Consultation Manager interface for patient Adam ABALUNAM. The main window shows a list of consultations with a 'Discharge Summary' entry highlighted. A yellow callout box points to the 'View' button for this entry, with the text 'Click View to open the attachment'. Below the list, the 'Attachments - Display' section is visible, showing the 'Discharge Summary' attachment details, including the event date (03 September 2013) and clinician (System Supervisor, Mr). The interface also shows a left-hand navigation pane with various patient data categories and a bottom status bar with the text 'Mr System Supervisor Discharge 03/09/13 15:18'.

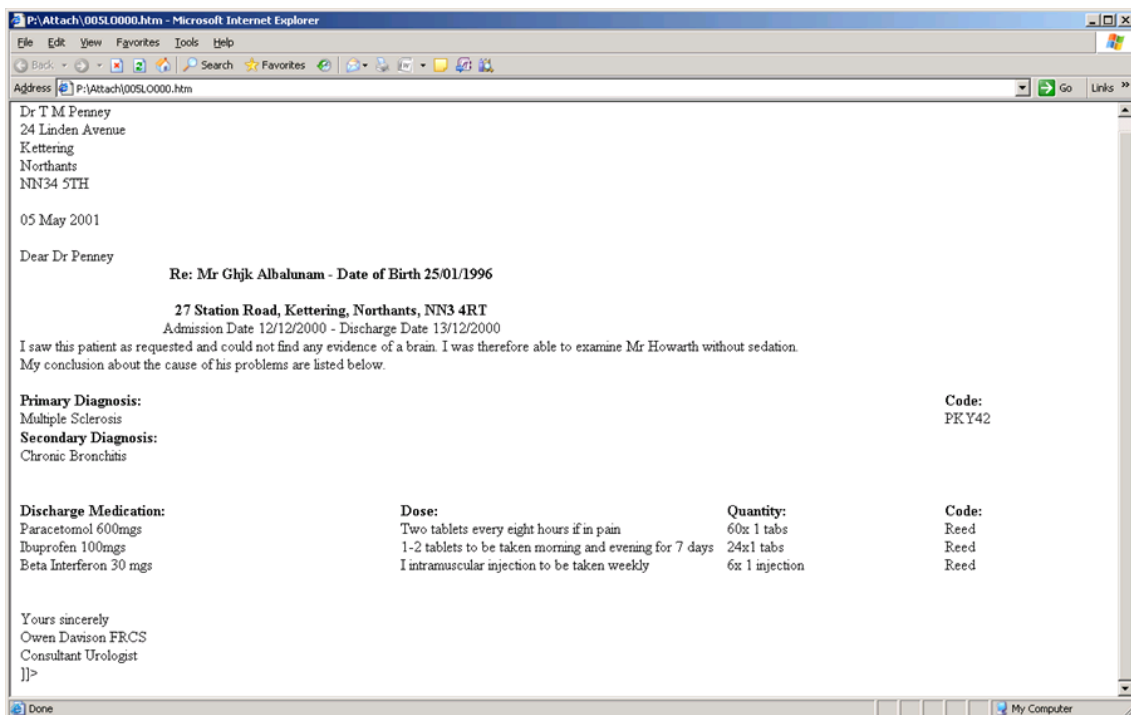
Date	Description	Priority	Clinician
03/09/13	Discharge Summary		SYS
17/04/03	MENC Stage: 1 Given Routine Measure Due: 15/05/2003		DB
20/06/01	MED3 - doctor's statement	8	LS
20/06/01	MST CONTINUS tabs 10mg Supply (60) tablets ONE TWICE A DAY		
20/06/01	DOTHIEPIN tabs 75mg Supply (28) tablets ONE EVERY DAY		LS
09/05/01	Referral for further care		DB
09/04/01	Patient given advice		LS
19/03/01	MED3 - doctor's statement		
	Nursing care	8	SW
	DOTHIEPIN tabs 75mg Supply (56) tablets TWO EVERY DAY		LS

Consultation Manager - Discharge Summary attachment

To view an attachment within Consultation Manager:



1. From **Consultation Manager**, select the patient in the usual way.
2. Select **Miscellaneous** from the left hand column.
3. The **Filtered List** tab is displayed in the main part of the screen.
4. Double click on the  Attachment required.
5. Click  **View**.
6. The attachment is displayed.



*Displayed attachment*

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