



Search and Reports

Predefined Reports User Guide

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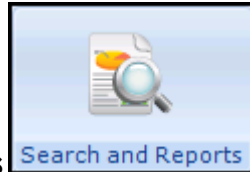
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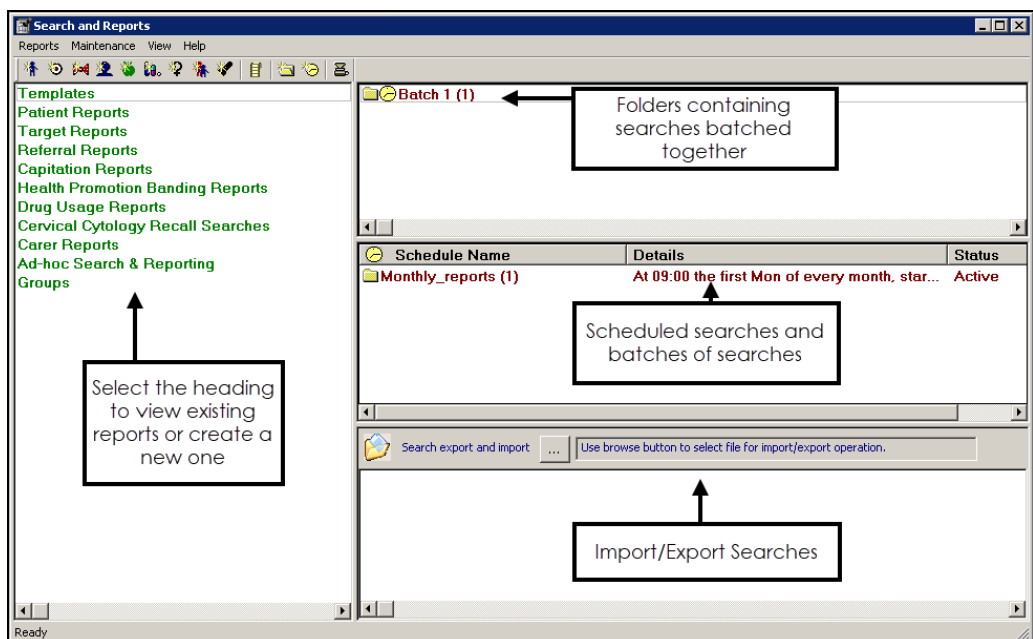
Navigating Search and Reports

To access **Search and Reports**:

1. From the Vision 3 front screen, select the **Reporting** tab.

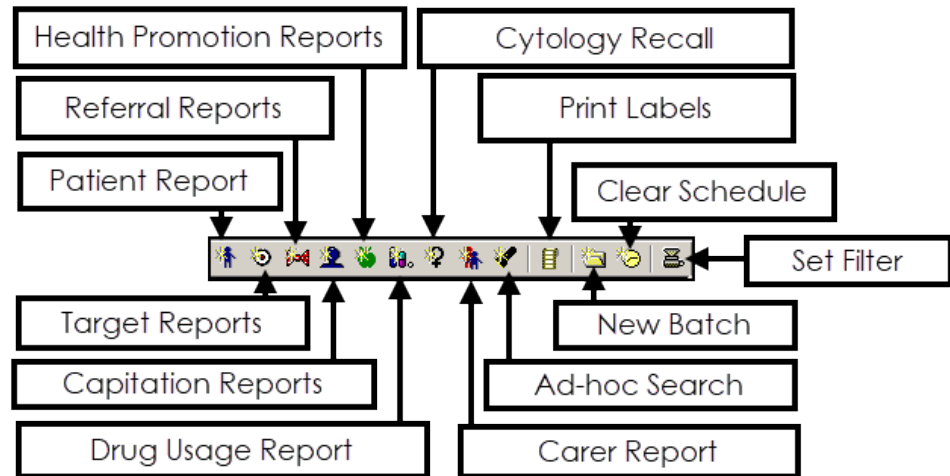


2. Select **Search and Reports** and the **Search and Reports** screen displays:

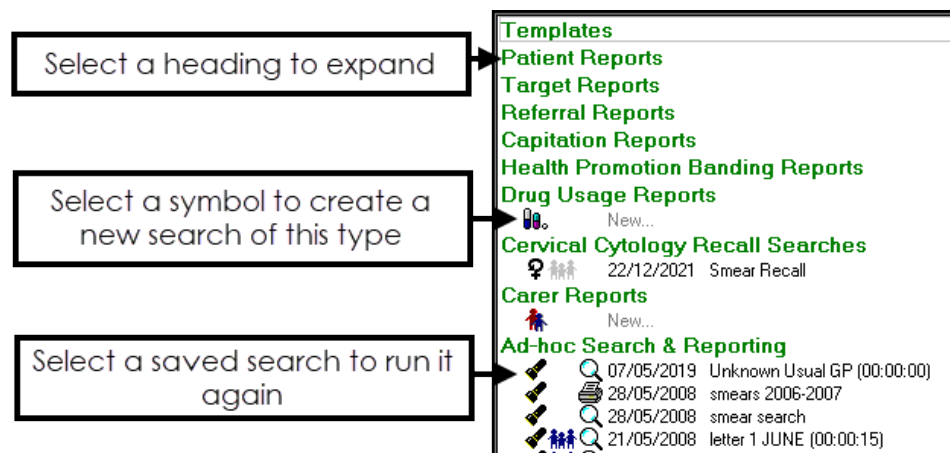



The **Search and Reports** screen consists of the following sections:

- **Toolbar** - Select from the available options to create new searches and reports:



- **Left-hand pane** - Lists the reports types available:



- Select a green header to expand the options.
- Select a symbol to create a new search of the selected type, for example  to create a new **Carer** report.
- If any searches or reports of this type have been saved, they display. Select the symbol alongside it to run again.

- Right-hand panes:
 - **Search Batches** - A batch is a group of searches brought together to make them easier to find and/or to schedule to run, usually on a regular basis, for example monthly reports. You can view, add and maintain batches from here.

 See [Creating Search Folders / Batches](#) for details.

- **Scheduled Searches** - You can view, add and maintain scheduled batches from here.

 See [Scheduling a Batch of Reports](#) for details.

- **Import and Export** - You can import and export searches from here. Searches can be imported from [Predefined Searches](#), your **ICS / Health Board** or other Vision 3 practices.

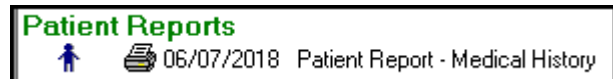
 See [Download Searches](#) for details.


 See [Creating a Search](#), [Example Basic Ad-Hoc Search](#) and [Example Recall Search](#) for more details.

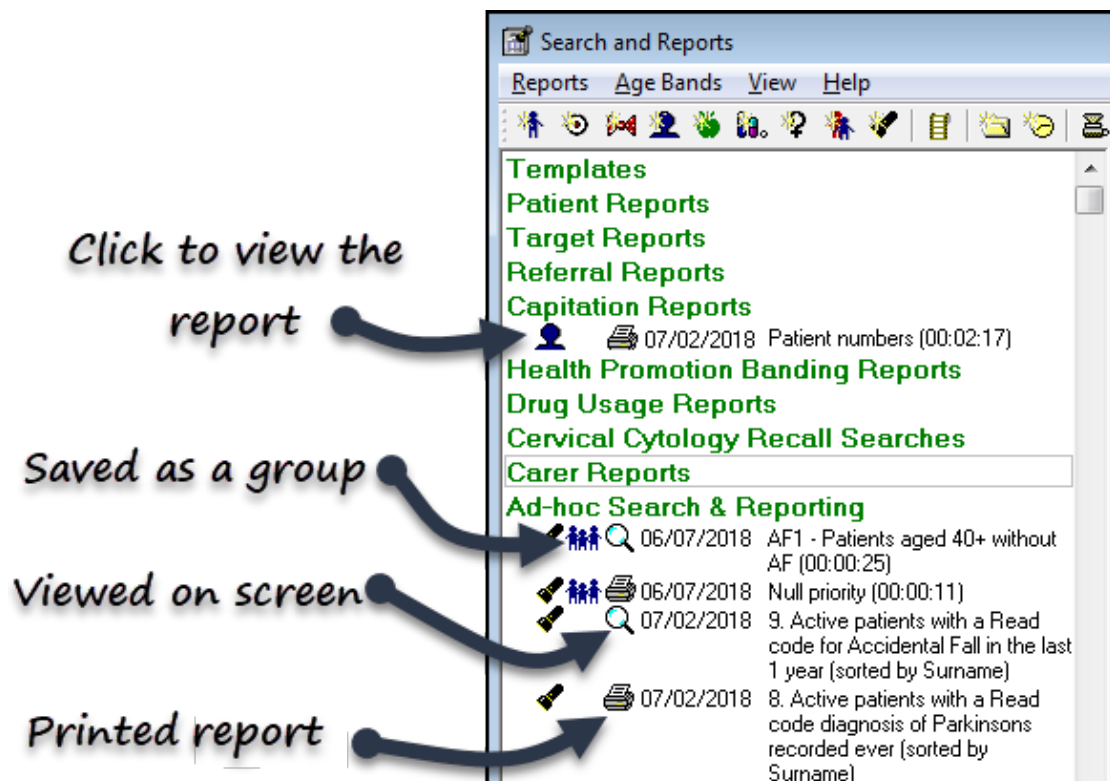
View Existing Searches and Reports



To view reports that have previously been run, click on the appropriate green heading to expand the list. If the list shows **New**, then a report has not been run.

A printer symbol and date show when the report was last printed.



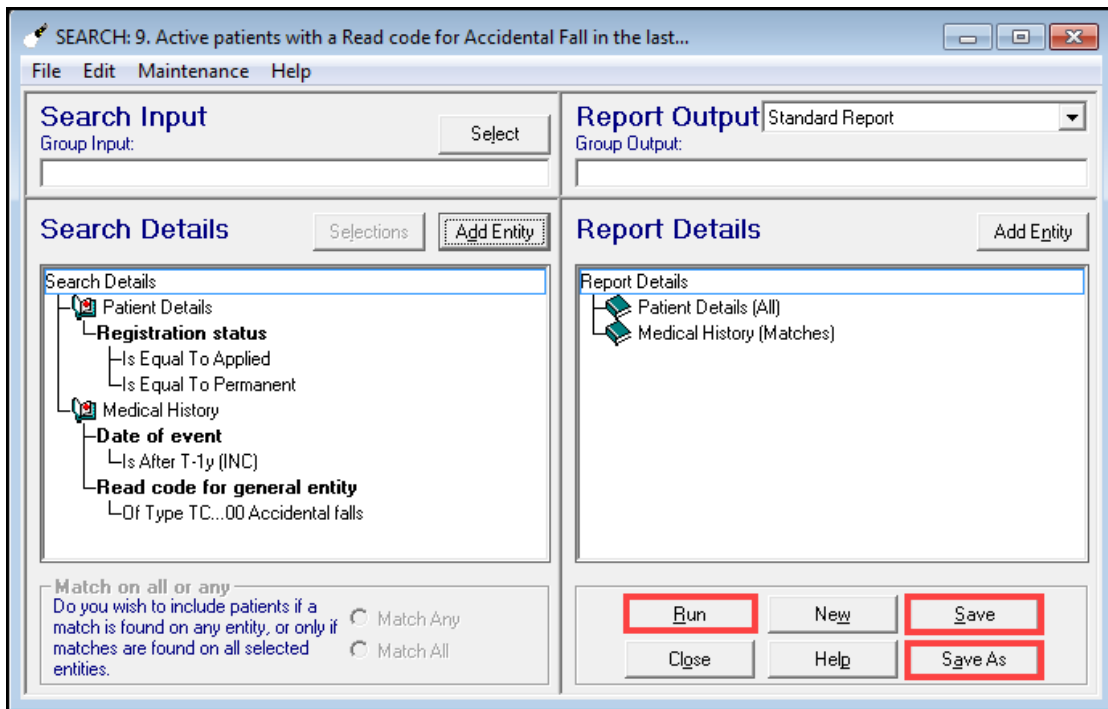
If the report was viewed on-screen, the magnifying glass  displays.



To view a report, select the option to the far left of the name, this varies slightly by category, for example, **Search**  displays **Ad-hoc Searches**, and **Patient**  displays **Patient Reports**.

From the **Search** screen you have the following options:

- Select **Run / Print** (this varies by category) to re-run the search with the existing criteria.
- Amend the search criteria, and **Save** to update the search.
- Amend the criteria, and choose **Save As**, to keep the updated search along with the original search.




➔ See - [Menu Options](#) and [Creating a Search](#).

Generate a New Report

There are different report categories but the process of running a report is the same.


1. Select the appropriate report from the toolbar, or right click on the green heading and select **New**.



 **Note** - Hover over the symbols to access the report names.

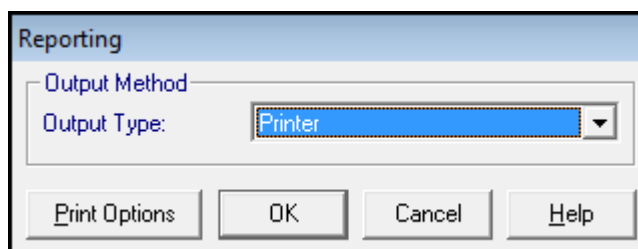
 See [Menu options](#).

2. At the reports criteria selection screen, update as required, for example, all GPs or a single GP.
3. Optionally, you can save the report for future use.
 - **Save** - Update the default criteria.
 - **Save As** - Save the report under a new name.
4. Select **Print** and the **Report Output** - it is often useful to select the default of **Window** and then **Print** from the display.
You can also export the report in various formats.
5. Select **OK** or **Run** to produce the report.
6. Select **Exit** to close.

 See - [Report Output on the next page](#), [View Report on page 19](#) and [Creating a Search](#).

Report Output

At the **Reports** screen, after defining the criteria, select **Print** to generate the report. For some reports, the **Reporting Output Method** options displays:



Select from the following **Output Type** options:

- **Window** (default) - Select to view the report, this includes further options to print, see [View Report on page 19](#) for details.
- **Print** - Select to send your report straight to a printer, see [Print Options on page 18](#) for details.
- **File** - Select to create a file, see [Export to File on page 16](#) for details.
- For the **Referral Report**, **Target Report**, **Capitation Report** or **Health Promotion Banding Report**, you can export in various formats, see [Export Data on page 14](#) for details.

Select **OK** to continue.


➔ See [View Report on page 19](#), [Export Data on page 14](#), [Export to File on page 16](#) and [Print Options on page 18](#) for details.

Output of CMS Reports - Scotland only

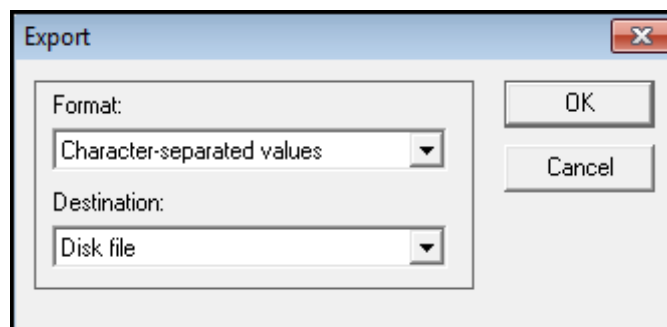
For multi-patient **CMS** reports, there is a **Group** option for report output which allows you to save the results of the search to a patient group. This is particularly useful if used in conjunction with the suitability report, as you can use the group to generate a bulk letter or add a reminder flag.

Export Data

The **Referral Report**, **Target Report** and **Capitation Report** include the options to export the results.

1. Open the report and make your selections.
2. Select **Print**, then select **Window** as the **Output Type** for a report.
3. Select **OK** to generate the report.
The report displays on screen.
4. Select **Export** .

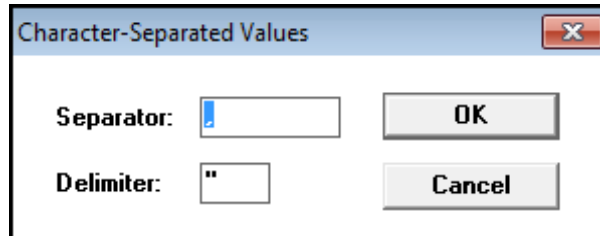
The **Export** dialogue displays.



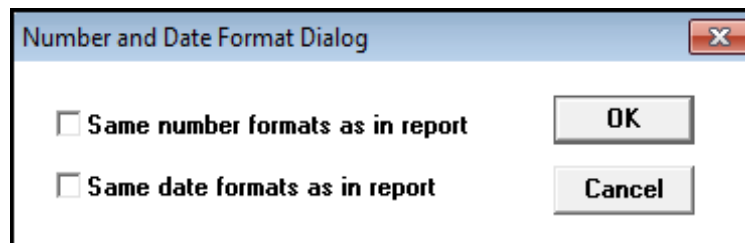
5. From the drop down list select the **Format**:
 - Character-separated values
 - Comma-separated values (CSV) - This is the most commonly used option.
 - Crystal Reports (RPT)
 - Data Interchange Format (DIF)
 - Excel 2.1 (XLS)
6. Select the **Destination** from the drop down list:
 - Disk file
 - Exchange folder

- Lotus Notes Database
- Microsoft Mail MAPI

7. Depending on the format selected in step 5, you may be prompted for further options, such as separator options.



If you want the same format as the report, check the boxes **Same number formats as in report** and **Same date formats as in report**. Select **OK**.



8. If you chose the **Export Data** option, the **Choose Export File** screen displays.

Select **OK** to save in your default directory, or select another directory.

A progress bar displays.

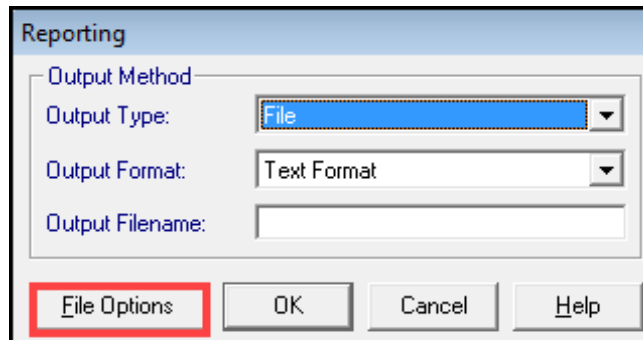
9. Select **Close** to exit.

Your file is located in the chosen directory.

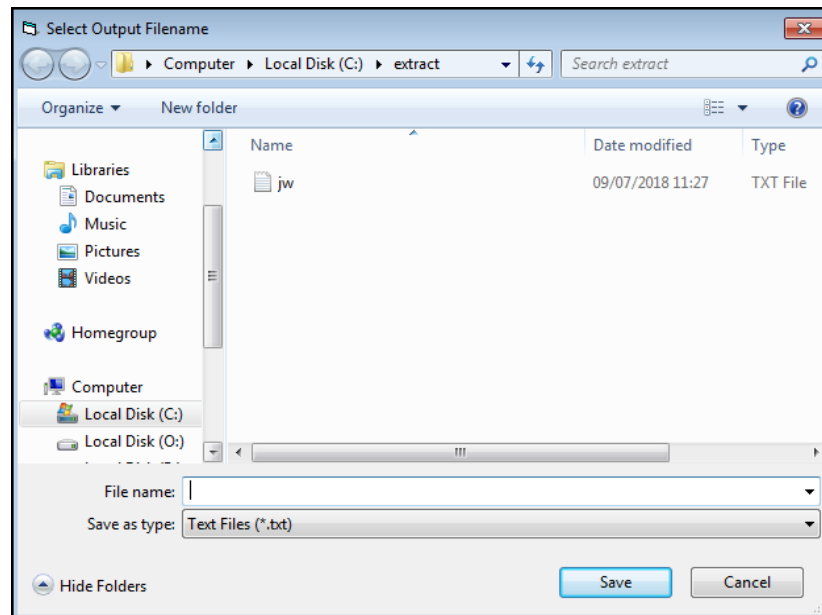
Export to File

Reports can be exported in various formats.

1. Select **Print**, and choose **File** from the drop down list.



2. Select the **Output Format** from the drop down list.
 - Record format
 - Tab separated
 - Text Format (default)
 - DIF Format
 - Comma Separated Value
 - Tab Separated Text
3. To access the **Output Filename** screen, select **File Options**:
 - **Save In** - default directory is your EXTRACT directory
 - **Save File as Type** - default is Text Files (*.txt)
 - **File name** - type in a title



4. Select **Save** to exit.
5. Select **OK** to proceed with the export.

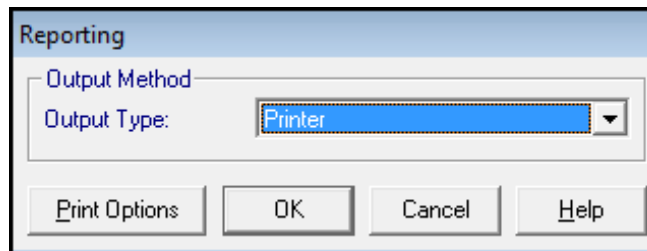
You may be asked to confirm or amend the **Output file** name, this is an opportunity to change the extension, for example, .csv.

6. Select **Exit** to close.

The report can be found in your chosen directory.

Print Options

1. Select **Print** to generate the report.
The **Reporting** screen displays.
2. Select **Printer** as the **Output Type**.

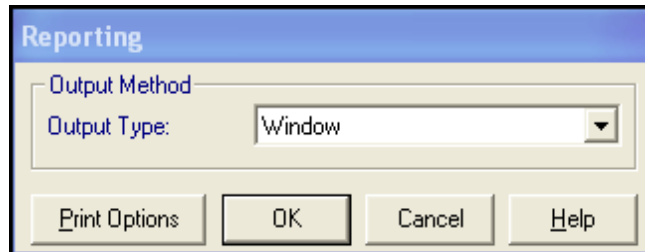


3. Select **OK** to start the report processing using your default printer.
Alternatively, to change printers, select **Print Options**.
Select a new printer, and select **Print** followed by **OK**.

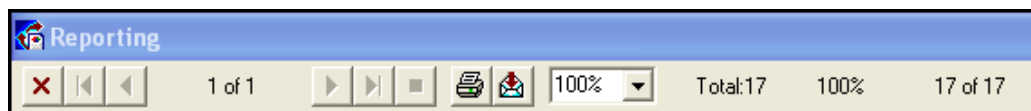
View Report





1. After defining report criteria, select **Print**, then select **Window** (default) as the **Output Type**.

See - [Report Output on page 12](#).



2. Select **OK** to start the report processing.
The report displays.
3. Additional options are available on the tool bar:





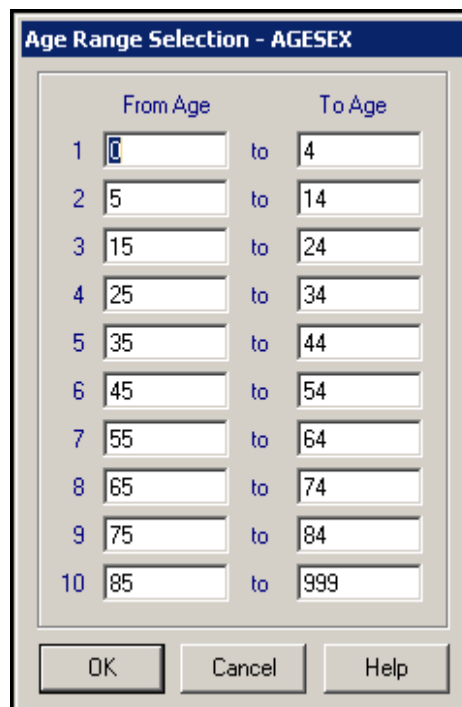
- Use the arrows to navigate forwards or backwards through the pages.
-  - **Rotate views** - Zoom, screen width, and one page at a time. (Not available on all reports).
-  - **Print**
See - [Print Options on the previous page](#).
-  - **Export** - The Referral Report, Target Report, Capitation Report or Health Promotion Banding Report have this additional option.
See - [Export Data on page 14](#).
-  - **Close report**

Setting up Age Bands

The **Age Bands** that are used by the **Capitation Reports**, **Health Promotion Reports** and the **Age / Sex** output option in **Ad-hoc** searches can be updated to match your practice requirements.

To update the **Age Bands**:

1. From the Vision 3 front screen, select **Reporting - Search and Reports**.
2. Select either:
 - **Maintenance - Age Sex**,
 - **Capitation Report**  - **Age Ranges**, or
 - **Health Promotion Report**  - **Select Age Ranges**.
3. The relevant **Age Range Selection** screen displays. Complete as required, remembering not to overlap the ranges:



	From Age		To Age
1	0	to	4
2	5	to	14
3	15	to	24
4	25	to	34
5	35	to	44
6	45	to	54
7	55	to	64
8	65	to	74
9	75	to	84
10	85	to	999

The defaults are:

- **Age Sex** - 0 to 4, 5 to 14, 15 to 24, 35 to 34, 35 to 44, 45 to 54, 55 to 64, 65 to 74, 75 to 84, 85 to 999 years.
- **Capitation Report** - 0 to 4 , 5 to 64, 65 to 74 and 75 to 999 years.
- **Health Promotion** - 15 to 24, 25 to 34, 35 to 44, 45 to 54, 55 to 64, 65 to 74 years.

4. Select **OK** to save.

 See [Age / Sex Report](#), [Running a Capitation Report on page 24](#) and [Creating a Search](#) for details.

Capitation Report Overview

The **Capitation Report** totals the numbers of patients registered per GP, each GP has their own page with totals at the bottom of each page. The last page of the report is a summary page for the whole practice.

Each page displays:

- A report heading, containing:
 - The practice name
 - Trading Partner (TP)
 - Selected GP
 - Type of GP, Registered or Usual
 - The date selected in the criteria
- The registered patients, split by:
 - Registration status
 - Sex
 - Age ranges:

Capitation Summary for		The New INPS Surgery Inps Health Centre, London, SW3 3QJ					dated 13/07/2018
TP:	All	Selected GP :					All
Type of GP :	Registered						
	Total No. Registered	0 - 4	5 - 14	15 - 64	65 - 74	75 - 999	
Applied	Male	0	0	0	0	0	0
	Female	0	0	0	0	0	0
	Total	0	0	0	0	0	0
Child Health Surveillance	Male	0	0	0	0	0	0
	Female	0	0	0	0	0	0
	Total	0	0	0	0	0	0
Contraception	Male	0	0	0	0	0	0
	Female	0	0	0	0	0	0
	Total	0	0	0	0	0	0
Emergency Treatment *	Male	0	0	0	0	0	0
	Female	0	0	0	0	0	0
	Total	0	0	0	0	0	0

The totals also display:

- New registrations, those registered within the last three months.
- Patients for whom an indeterminate sex is recorded.

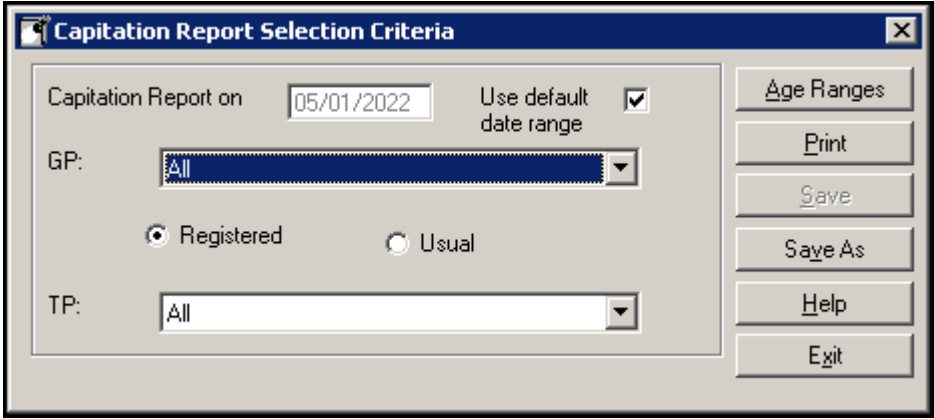
 See [Running a Capitation Report on the next page](#) for details.

Running a Capitation Report

Running the **Capitation Report** creates a report which includes all of your registered patients by GP. They are split into the following age bands, 0 to 4, 5 to 64, 65 to 74, and 75 years onwards, see [Setting up Age Bands on page 20](#) for details on updating these ranges.

To run a **Capitation Report**:

1. From the Vision 3 front screen, select **Reporting - Search and Reports**.
2. Select **New Capitation Report**  and the **Capitation Report Selection Criteria** displays:



3. Complete as required:
 - **Capitation Report on** - The date defaults to today, remove the tick from **Use default date range** to update if required.
 - **GP** - Defaults to All GPs, select from the available GPs if individual GPs are required.
 - **Registered/Usual** - The report defaults to **Registered** GP, select **Usual** to update if required.
 - **TP** - Trading Partner (TP) defaults to **All**, select from the available TPs if individual TPs are required.

4. Optionally, select:

- **Save** to save the criteria, or
- **Save As** to save this **Capitation Report** with a new name. The **Save Search** screen displays, in **Name** enter a short name for this search and in **Description**, enter the details. Select **OK** to save. This search can now be accessed from the left-hand pane under **Capitation Reports**:



- **Age Ranges** - Optionally, select to update the age banding, see [Setting up Age Bands on page 20](#) for details.

5. Select **Print** to run the report.

6. The **Reporting - Output Method** screen displays, select from:

- **Window** - To display the report on your screen.
- **Printer** - To send your report straight to your report printer
- **File** - To save your report as a file. The **Select Output Filename** screen displays, in **File name**, enter a name for your report and select **Save**.

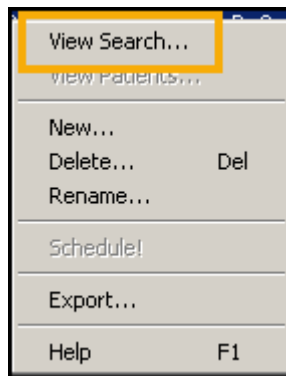
Viewing the Criteria of a Saved Capitation Report

To view the criteria of a **Capitation Report** that has been saved:

1. From the Vision 3 front screen, select **Reporting - Search and Reports**.
2. Select the **Capitation Report** green heading to view saved criteria:



3. Right click on the report you want to view and select **View Search:**



4. The **saved Capitation Report Selection Criteria** screen displays.


 See - [Capitation Report Overview on page 22](#).

Carers Report

The **Carers Report** enables you to list either:


- All patients registered as carers in **Patient Details - Contacts**, or
- A list of patients registered in **Patient Details - Contacts** with a carer.

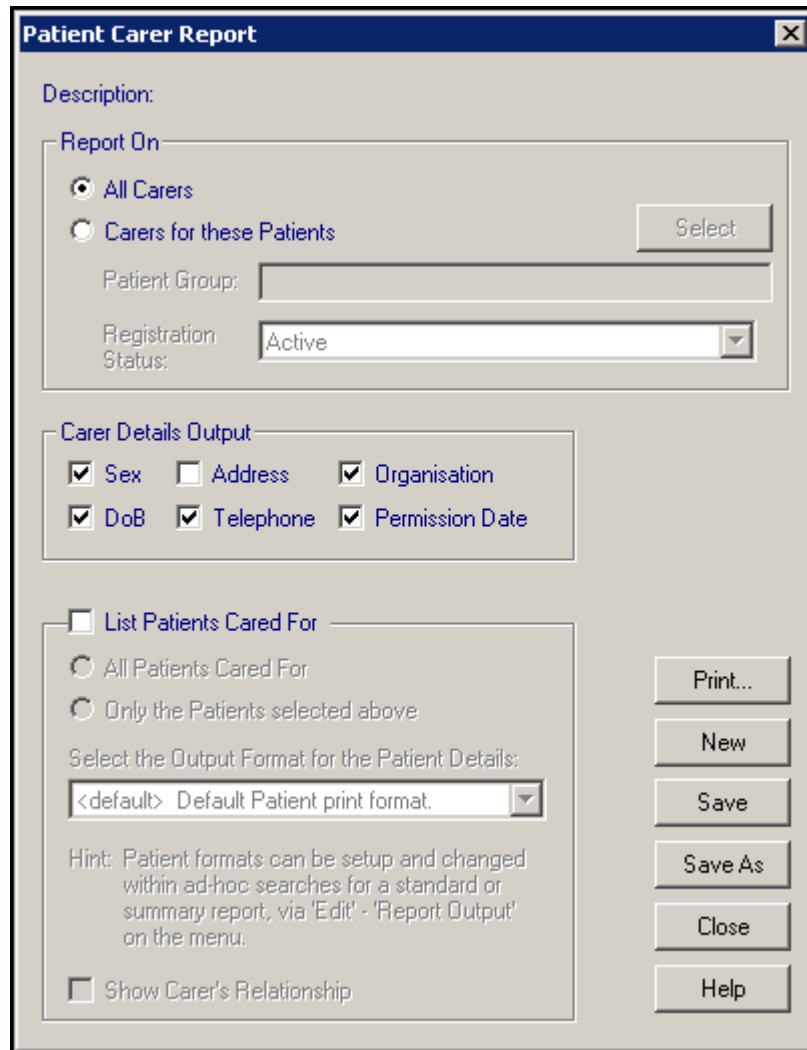
 See [Contacts Overview in the Registration Help Centre](#) for details.

 **Note** - Carers, including non-patient carers, have the right under the Data Protection Act to see what information is held about them.

Running a Report on all Carers

To run the **Carers Report** for all carers:

1. From the Vision 3 front screen, select **Reporting - Search and Reports**.
2. Select **New Carer Report**  and the **Patient Carer Report** screen displays:



Patient Carer Report

Description:

Report On

All Carers

Carers for these Patients Select

Patient Group:

Registration Status:

Carer Details Output

Sex Address Organisation

DoB Telephone Permission Date

List Patients Cared For

All Patients Cared For

Only the Patients selected above

Select the Output Format for the Patient Details:

Hint: Patient formats can be setup and changed within ad-hoc searches for a standard or summary report, via 'Edit' - 'Report Output' on the menu.

Show Carer's Relationship

Print...

New

Save

Save As

Close

Help

3. Complete as required:
 - **Report On - Select All Carers.**



Note - This includes all patients regardless of **Registration Status**.

- **Carer Details Output** - Tick to include the following information on the report as required:
 - **Sex**
 - **Address**
 - **Organisation**
 - **DoB - Date of birth**
 - **Telephone - If recorded**
 - **Permission Date - The date permission for non-patient information to be held on Vision 3 was given.**
- **List Patients Cared For** - Tick to include details of the patient cared for.
 - **All Patients Cared For** - Selected by default, no other option is available for this report.
 - **Select the Output Format for the Patient Details** - Select from the available list as required.
 - **Show Carer's Relationship** - Tick to display the patients relationship to the carer on the report.

4. Optionally, select:

- **New** - To reset the report criteria,
- **Save** to save the criteria, or
- **Save As** - To save this **Carer Report** with a new name. The **Save Search** screen displays, in **Name** enter a short name for this search and in **Description** enter the details. Select **OK** to save. This search can now be accessed from the left-hand pane under **Carer Reports**:



5. Select **Print** to run the report.

6. The **Reporting - Output Method** screen displays, select from:
- **Window** - To display the report on your screen.
 - **Printer** - To send your report straight to your report printer.
 - **File** - To save your report as a file. The **Select Output Filename** screen displays, in **File name**, enter a name for your report and select **Save**.


Carers and their Carers								
Mr Kathleen Jackson	01/08/1978	6 Harehills Avenue, Leeds, LS7 4EU					West Glamorgan TP/HB/CSA	Registe
Miss Gertrude Muntagh	01/08/2003		Female	811 113 8359	Permanent	Carer's Relationship: Mother	West Glamorgan TP/HB/CSA	Registe
Miss Jane Macdonald	01/08/1960	12 Newton Park Drive, Leeds, LS7 4HH					West Glamorgan TP/HB/CSA	Registe
Ms Dorothy Richardson	01/08/1991		Female	811 113 7455	Permanent	Carer's Relationship: Carer	West Glamorgan TP/HB/CSA	Registe
Mr Judith Jones	01/08/1966	19 Hamilton Avenue, Leeds, LS7 4EC					West Glamorgan TP/HB/CSA	Registe
Ms Karen James	01/08/1928		Female	811 116 2391	Transferred Out	Carer's Relationship: daughter	West Glamorgan TP/HB/CSA	Registe
Ms Maxiezia Hannan	01/08/1939	43 Hillcrest Avenue, Leeds, LS7 4ED					West Glamorgan TP/HB/CSA	Registe

Running a Report on the Carer(s) for Specific Patient(s)



Important - This report can be run on an existing patient group or a Clinical Audit group, see [Patient Groups Help Centre](#) for details.

To run a report on the Carer(s) for Specific Patient(s):

1. From the Vision 3 front screen, select **Reporting - Search and Reports**.
2. Select **New Carer Report**  and the **Patient Carer Report** screen displays:

3. Complete as required:
 - **Report On - Select Carers for these Patients.**
 - **Patient Group** - Choose **Select**, highlight the group required and select **OK**.
 - **Registration Status** - Defaults to **Active** which includes patients that are **Applied** and **Permanent**, select from the available list if required.

- **Carer Details Output** - Tick to include the following information on the report as required:
 - **Sex**
 - **Address**
 - **Organisation**
 - **DoB - Date of birth**
 - **Telephone - If recorded**
 - **Permission Date - The date permission for non-patient information to be held on Vision 3 was given.**
- **List Patients Cared For** - Tick to include details of the patient cared for:
 - **All Patients Cared For - Not relevant for this report.**
 - **Only the Patients selected above - Select to run this report.**
 - **Select the Output Format for the Patient Details - Select from the available list as required, see [Alter the Patient Format](#) for details.**
 - **Show Carer's Relationship - Tick to display the patient's relationship to the carer on the report.**

4. Select **Print** to run the report.

5. The **Reporting - Output Method** screen displays, select from:

- **Window** - To display the report on your screen.
- **Printer** - To send your report straight to your report printer.
- **File** - To save your report as a file. The **Select Output Filename** screen displays, in **File name**, enter a name for your report and select **Save**.

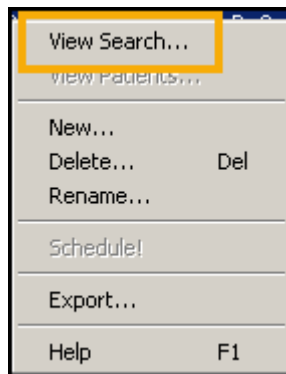
Viewing the Criteria of a Saved Carer Report

To view the criteria of a **Carer Report** that has been saved:

1. From the Vision 3 front screen, select **Reporting - Search and Reports**.
2. Select the **Carer Reports** green heading to view saved criteria:



3. Right click on the report you want to view and select **View Search**:



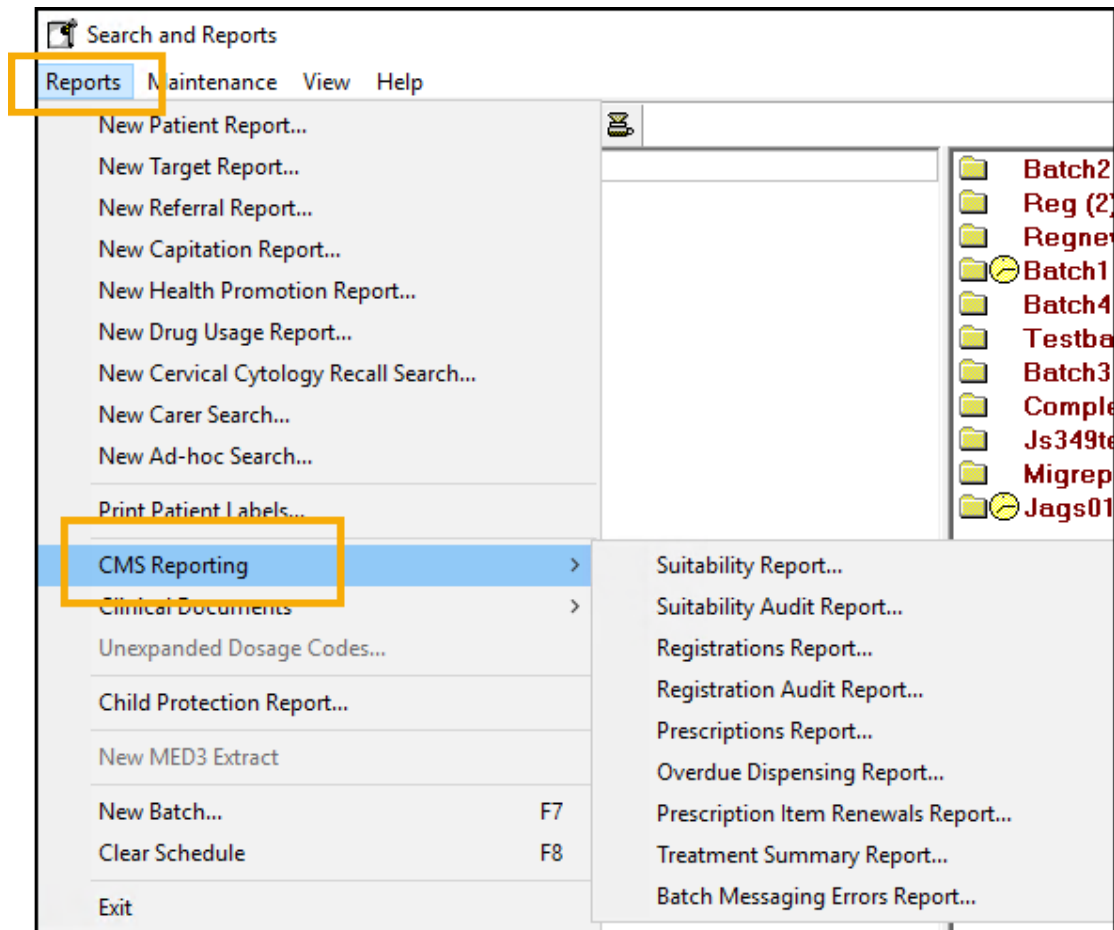
4. The **saved Patient Carer Report** screen displays.

 See [Data Protection Act on page 82](#) for further details.

CMS Reporting - Scotland

There are a selection of reports within **Search and Reports** that can help you to monitor **Chronic Medication Service (CMS)** activity.


To run a **CMS** report, from **Search and Reports**, select **Reports - CMS Reporting** and then select the report you require:



Select from:

- **Suitability Report** - Lists patients with a **Suitability Status** of **CMS Suitable**, see [CMS Suitability Report on page 36](#) for details.
- **Suitability Audit Report** - Lists changes in **Suitability Status** for individual patients, see [CMS Suitability Audit Report on page 39](#) for details.

- **Registrations Report** - Lists all patients currently registered for **CMS** with a Community Pharmacy, see [CMS Registrations Report on page 41](#) for details.
- **Registration Audit Report** - Lists changes in **CMS Registration Status** for individual patients, see [CMS Registration Audit Report on page 44](#) for details.
- **Prescriptions Report** - Lists **CMS** prescription items within a date range, see [CMS Prescriptions Report on page 46](#) for details.
- **Overdue dispensing Report** - Lists **CMS** items that have overdue dispensing information, see [CMS Overdue Dispensing Report on page 48](#) for details.
- **Prescription Item Renewals Report** - Lists **CMS** prescription items that are due to expire within a specified date range but are not yet been reauthorised, see [CMS Prescription Item Renewals Report on page 51](#) for details.
- **Treatment Summary Report** - Lists all **Treatment Summaries** received, but not been marked as **Read** in **Mail Manager**, see [CMS Treatment Summary Report on page 53](#) for details.
- **Batch Messaging Errors Report** - Lists **CMS** messages with errors within a specified date range, see [CMS Batch Messaging Errors Report on page 55](#) for details.

 See [Report Output on page 12](#), [CMS Information in Patient Reports on page 58](#), [CMS Information in Standard Reports on page 59](#), [Searching for CMS Repeat Masters on page 62](#) and [Searching for CMS Dispensed Items on page 60](#) for details

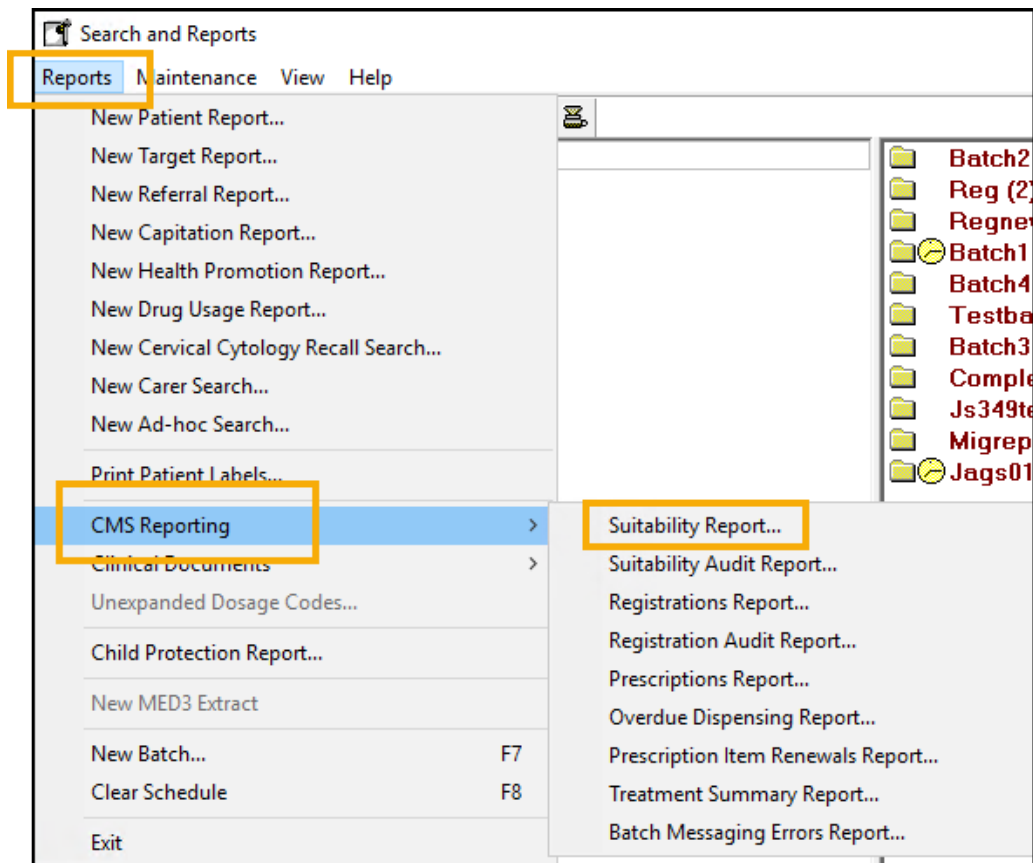
CMS Suitability Report

 **Note** - Only available in Scotland.

The **CMS Suitability Report** lists the patients who are flagged as suitable, unsuitable or unspecified for **Chronic Medication Service (CMS)**.

To run the **CMS Suitability Report**:

1. From the Vision 3 front screen, select **Reporting - Search and Reports**.
2. From **Reports**, select **CMS Reporting - Suitability Report**:



3. The **CMS Suitability Report** screen displays:

Select as required:

- **Include patients who are suitable for CMS.**
- **Include patients who are unsuitable for CMS.**
- **Include patients whose suitability for CMS is not specified.**
- **Date suitability specified from** and **to** - Enter dates if required.
- **CMS Registration** - Select from:
 - **All** - Include all patients
 - **Registered** - Include patient who are registered
 - **Withdrawn** - Include patients who have withdrawn
 - **Not Registered** - Include patients not registered

4. Select **OK**.

5. Select the required output method, see [Report Output on page 12](#) for details.

6. Finally, select **OK** to generate the report.

The results display in surname order, and include:

- Selected report criteria
- Name
- Date of birth (DoB)
- CHI Number
- CMS Registration Status:

CMS Suitability Report					
Include patients who are suitable for CMS:	Yes	Include patients who are registered:	No		
Include patients who are unsuitable for CMS:	No	Include patients who have withdrawn:	Yes		
Include patients whose suitability for CMS is not specified:	No				
Name	DoB	CHI Number	CMS Registration Status	CMS Suitability	Reason for change
Mr Elliot Aaron	15/06/1929	150629 0116		Suitable	
Mr Simon Adrian	23/11/1965	231165 2311		Suitable	

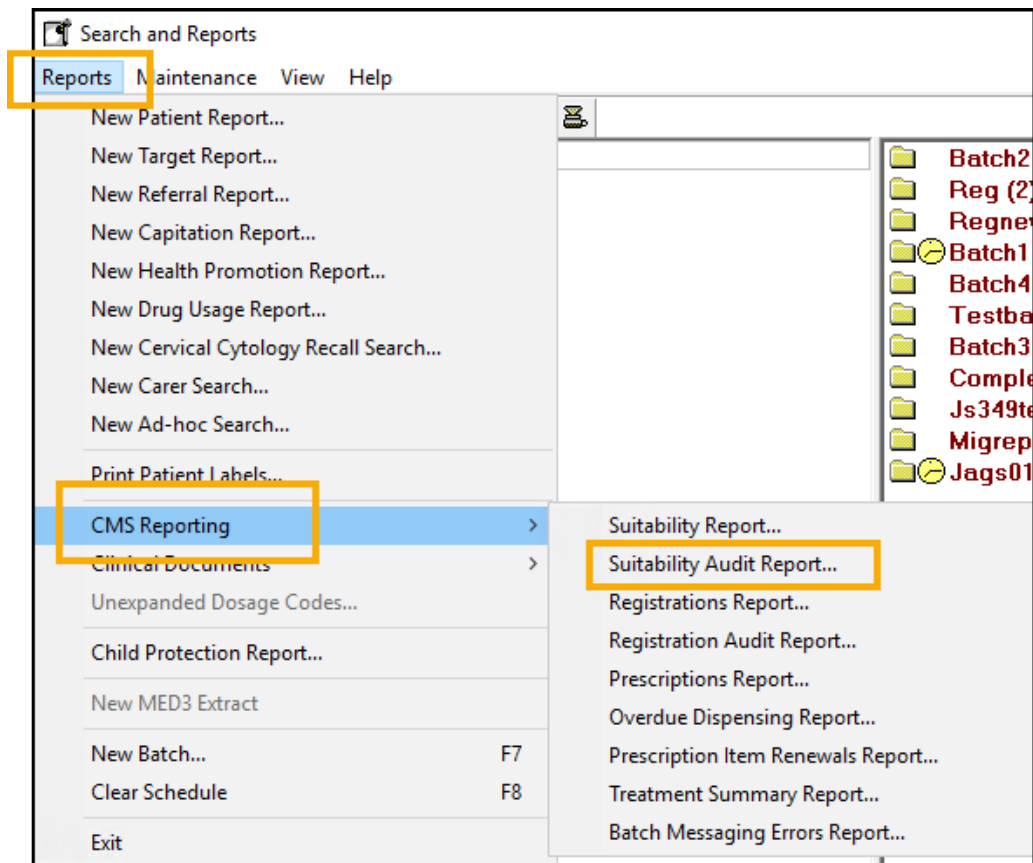
CMS Suitability Audit Report

 **Note** - Only available in Scotland.

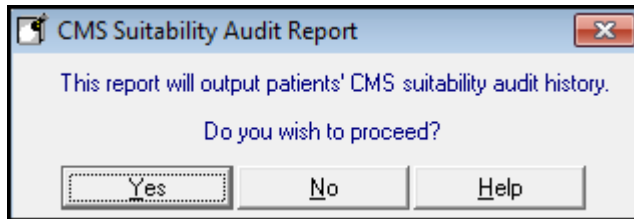
The **CMS Suitability Audit Report** is an individual patient report listing historical changes in **Chronic Medication Service (CMS)** suitability status.

To run the **CMS Suitability Audit Report**:

1. From the Vision 3 front screen, select **Reporting - Search and Reports**.
2. From **Reports**, select **CMSReporting - CMS Suitability Audit Report**:



- The **CMS Suitability Audit Report** screen displays, select **Yes** to proceed:



- Select the required output method, see [Report Output on page 12](#) for details.
- From **Select Patient**, find the patient required in the usual way.
- Select **OK** to run.

The report displays the patient surname, forename, DOB, CHI Number, the activity and reason for change along with the person who changed it:

CMS Suitability Audit			
Name:	Mr Simon Adrian		
DoB:	23/11/1965	Current Status:	Suitable
CHI Number:	231165 2311	Changed by:	Carol Saturn
Date & Time	Activity	Reason for Change	Changed by
08/06/2018 18:10:47	Suitable		Carol Saturn

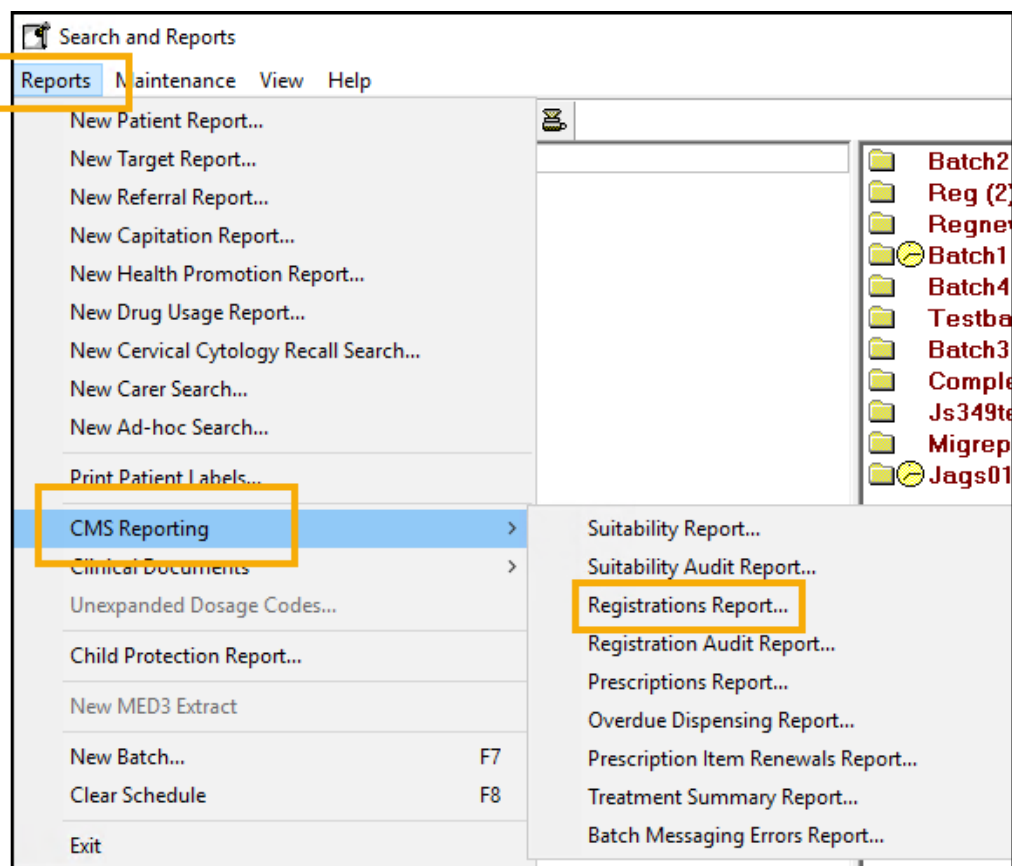
CMS Registrations Report

 **Note** - Only available in Scotland.

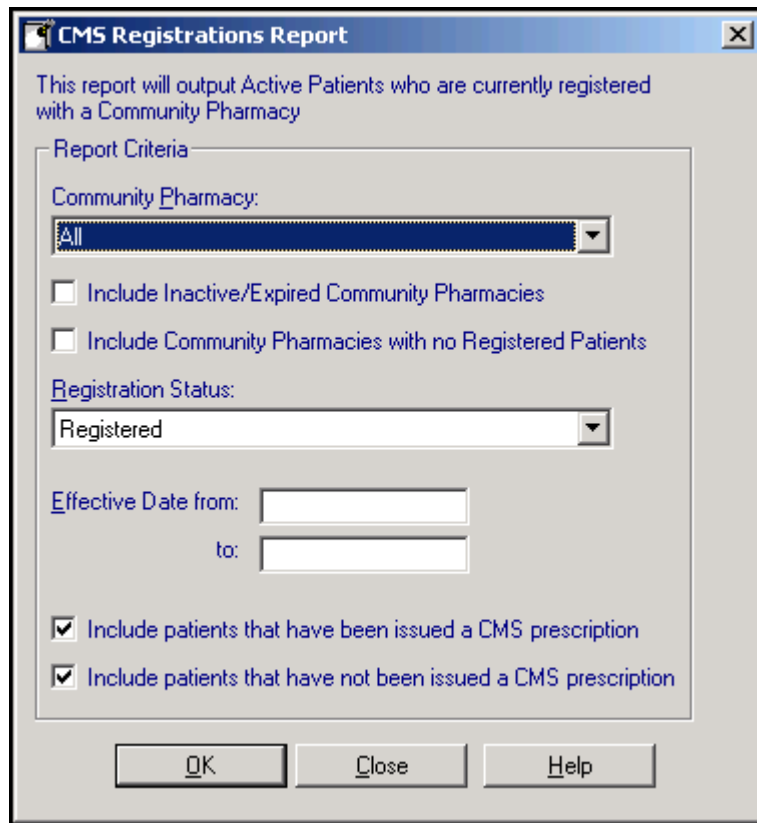
The **Registrations Report** lists all patients who are currently registered for **Chronic Medication Service (CMS)** with a Community Pharmacy.

To run the **CMS Registrations Report**:

1. From the Vision 3 front screen, select **Reporting - Search and Reports**.
2. From **Reports**, select **CMSReporting - Registrations Report**:



3. The **CMS Registration Report** screen displays:



The screenshot shows a dialog box titled "CMS Registrations Report". At the top, it states: "This report will output Active Patients who are currently registered with a Community Pharmacy". Below this is a section labeled "Report Criteria".

Under "Report Criteria", there is a dropdown menu for "Community Pharmacy" with "All" selected. Below this are two unchecked checkboxes: "Include Inactive/Expired Community Pharmacies" and "Include Community Pharmacies with no Registered Patients".

There is a dropdown menu for "Registration Status" with "Registered" selected. Below this are two text input fields for "Effective Date from:" and "to:". At the bottom of the criteria section are two checked checkboxes: "Include patients that have been issued a CMS prescription" and "Include patients that have not been issued a CMS prescription".

At the bottom of the dialog box are three buttons: "OK", "Close", and "Help".

Select as required:

- **Community Pharmacy** - Select either **All** or a specific pharmacy.
- **Include Inactive/Expired Pharmacies**
- **Include Community Pharmacies with no Registered Patients**
- **Registration Status** - Select the CMS registration status from **All**, **Registered** or **Withdrawn**.
- **Effective Date from** and **to** - Enter dates if required.
- **Include patients that have been issued a CMS prescription**
- **Include patients that have not been issued a CMS prescription**

4. Select **OK**.

5. Select the required output method, see [Report Output on page 12](#) for details.

The report displays the patient name, community pharmacy (CP) code and the first line of the address, postcode and telephone number of the registered pharmacy. The results display by pharmacy and are ordered by Patient Surname.

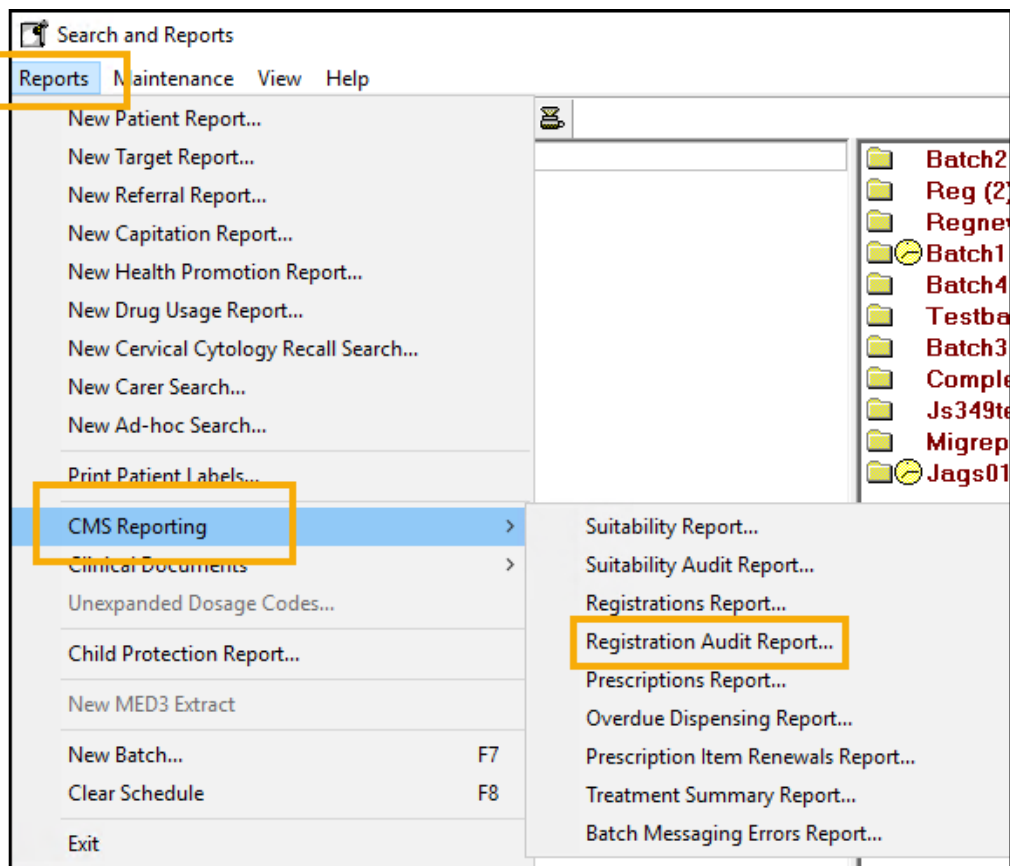
CMS Registration Audit Report

 **Note** - Only available in Scotland.

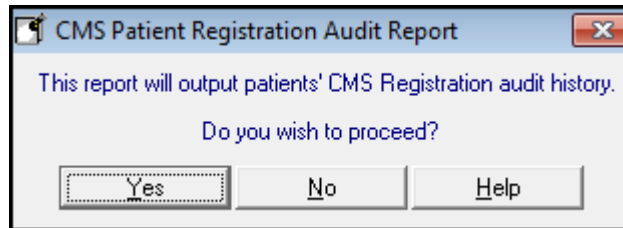
The **Registration Audit Report** is an individual patient report which shows historical changes in **CMS Registration status**.

To run the **CMS Registration Audit Report**:

1. From the Vision 3 front screen, select **Reporting - Search and Reports**.
2. From **Reports**, select **CMSReporting - Registration Audit Report**:



3. The **CMS Patient Registration Audit Report** screen displays, select **Yes** to continue:



4. Select the required output method, see [Report Output on page 12](#) for details.
5. From **Select Patient**, find the patient required in the usual way.
6. Select **OK** to run.

The report displays the patient name, community pharmacy (CP) code, first line of the address, postcode and telephone number of the registered pharmacy and the person who changed the registration. It also lists an audit trail of the previous registration status history.

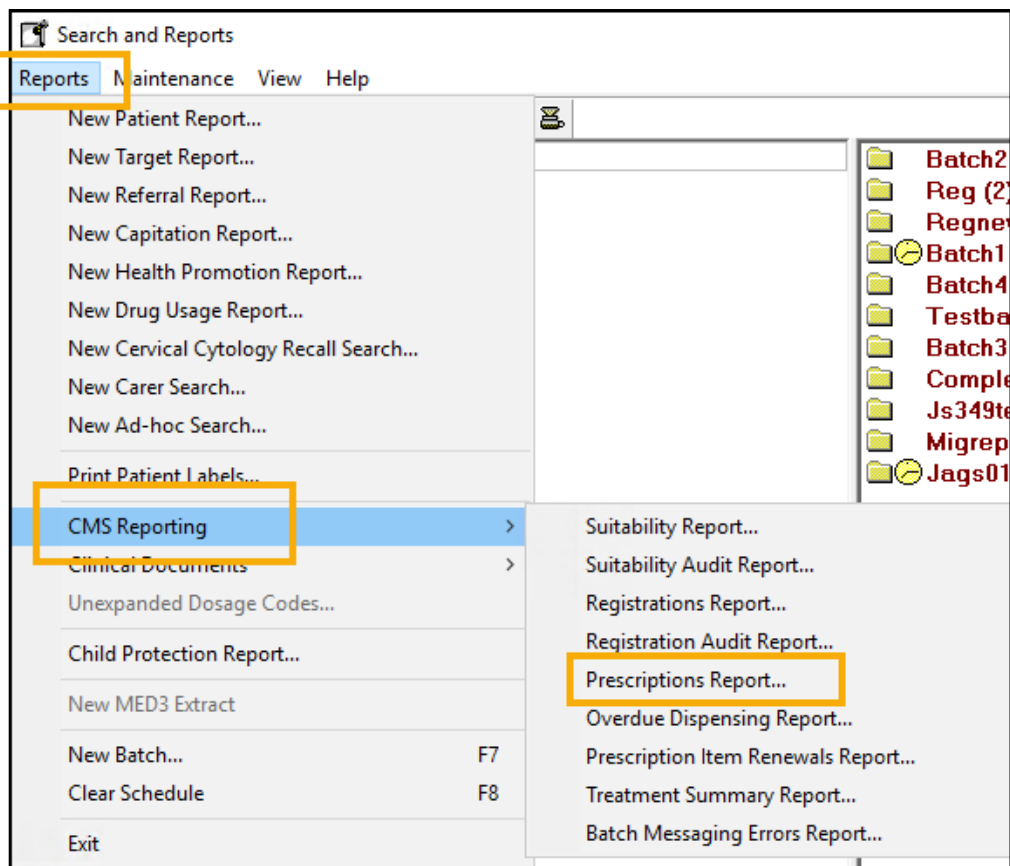
CMS Prescriptions Report

 **Note** - Only available in Scotland.

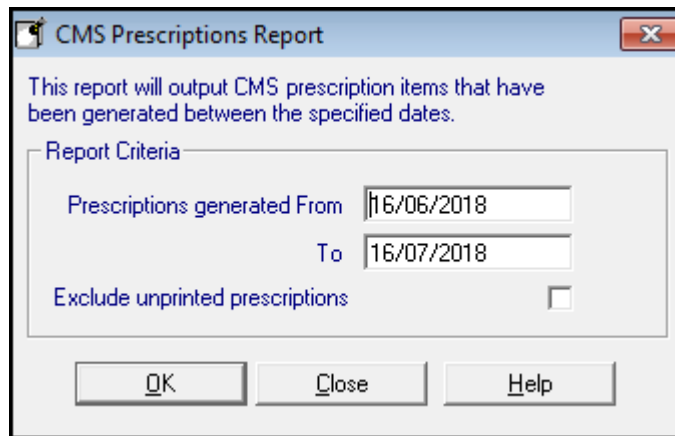
The **CMS Prescriptions Report** lists **CMS** items added within a specific date range.

To run the **CMS Prescriptions Report**:

1. From the Vision 3 front screen, select **Reporting - Search and Reports**.
2. From **Reports**, select **CMSReporting - Prescriptions Report**:



3. The **CMS Prescriptions Report** displays:



- **Prescriptions generated From/To** - The date range defaults to the previous month, update as required.
- **Exclude unprinted prescriptions** - Tick to exclude unprinted prescriptions from the report.

4. Select **OK**.

5. Select the required output method, see [Report Output on page 12](#) for details.

6. Finally, select **OK** to generate the report.

The results display in order of patient surname with the names of the CMS items and the dates prescribed listed underneath:

Name	DoB	CHI Number
Mr Patrick Aaron	21/09/1974	210974 1236
PARACETAMOL + CODEINE PHOSPHATE caps 500mg + 30mg	Date Prescribed:	20/07/2018
LEVOTHYROXINE tabs 25micrograms	Date Prescribed:	04/07/2018

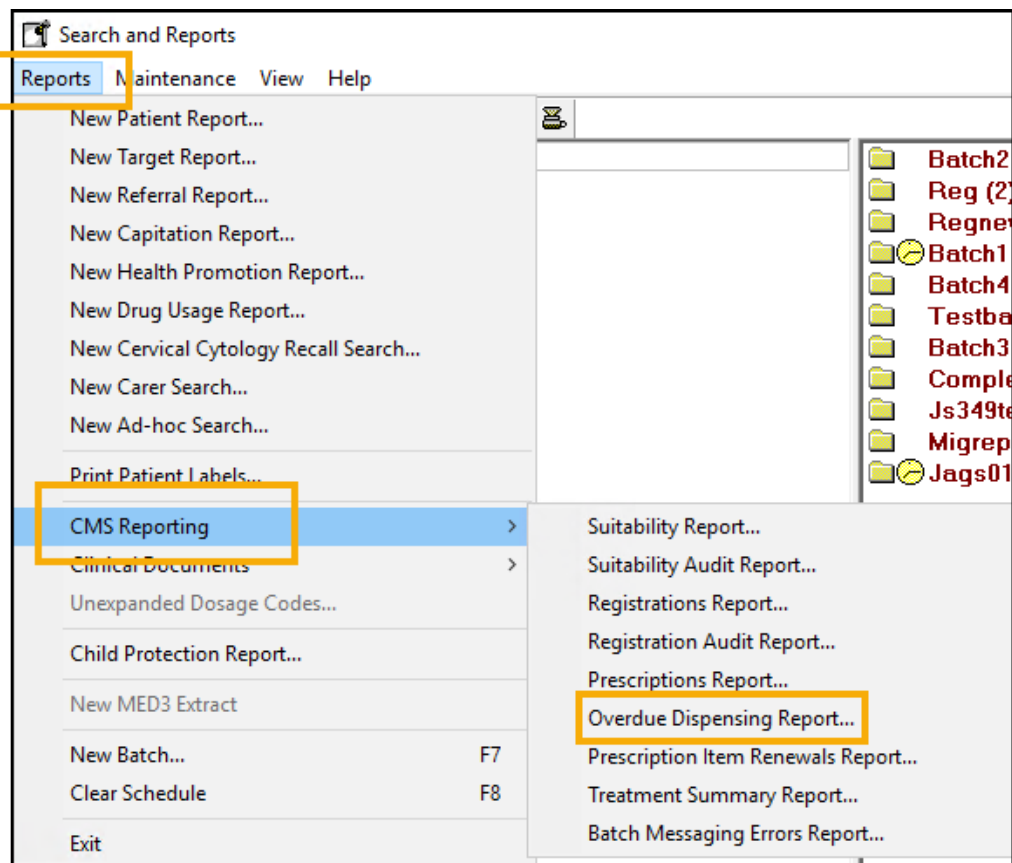
CMS Overdue Dispensing Report

 **Note** - Only available in Scotland.

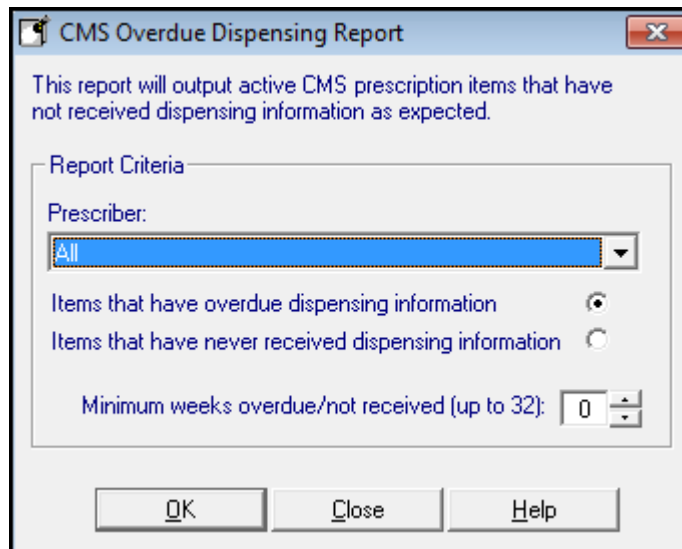
If you set a dispensing alert period when adding a **CMS** item, the **CMS Overdue Dispensing Report** identifies patients who are not collecting their prescriptions from the pharmacy. You can also include items for which dispensing information has yet to be received.

To run the **CMS Overdue Dispensing Report**:

1. From the Vision 3 front screen, select **Reporting - Search and Reports**.
2. From **Reports**, select **CMSReporting - Overdue Dispensing Report**:



3. The **CMS Overdue Dispensing Report** screen displays:



Complete as required:

- **Prescriber** - Select **All**, or a particular prescriber from the available list.
- **Items that have overdue dispensing information** - Tick to search on **CMS** items that have been printed, and dispensing information is overdue/not received within the number of weeks defined in **Minimum weeks overdue/not received**. These items have been previously dispensed but subsequent dispensing information is overdue. This is checked against the non-Dispensing alert set for each **CMS** item.
- **Items that have never received dispensing information** - Tick to search on **CMS** items that are printed, but for which no dispensing information has ever been received, for example, prescription has been given but no items have been dispensed.
- **Minimum weeks overdue/not received** (up to 32) - Select the number of weeks by which the dispensing information is overdue.

4. Select **OK**.

5. Select the required output method, see [Report Output on page 12](#) for details.
6. Finally, select **OK** to generate the report.

The report displays in order of patient name, community pharmacy (CP) code, first line of the address, postcode and telephone number of the registered pharmacy, last dispensed date and days dispensing overdue.



Note - Non-dispensing warnings also display on the individual patient record in the **Alerts** pane in Consultation Manager.

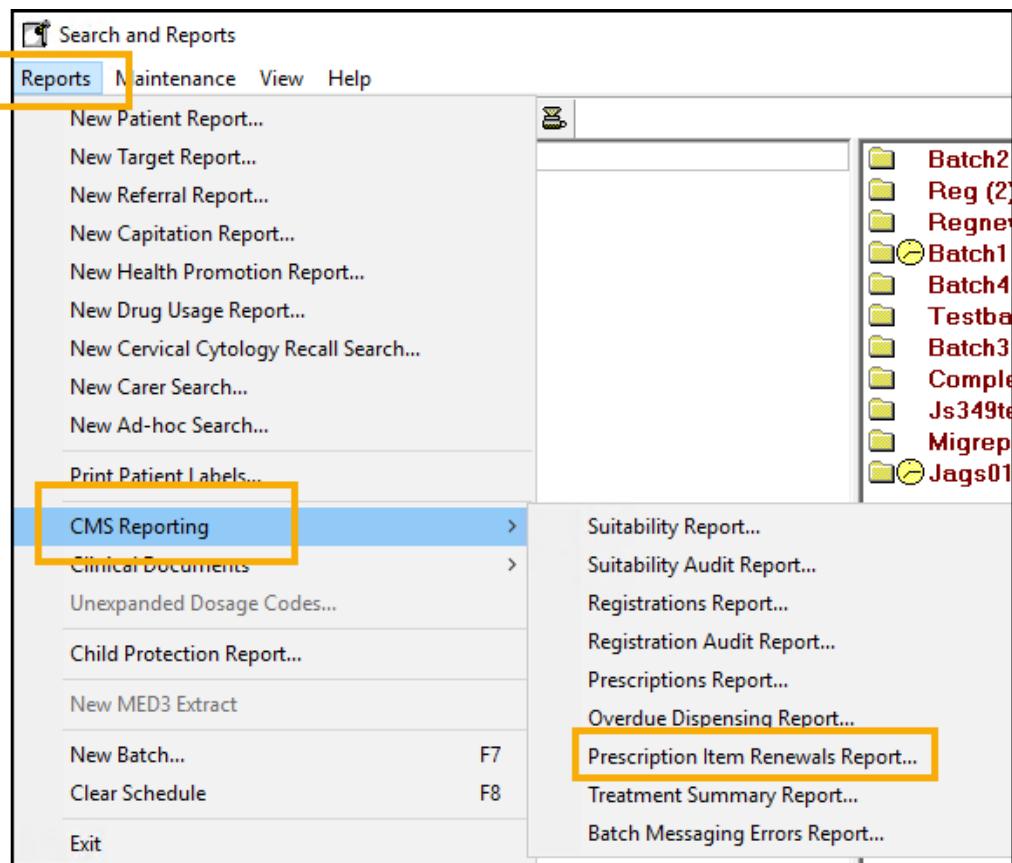
CMS Prescription Item Renewals Report

 **Note** - Only available in Scotland.

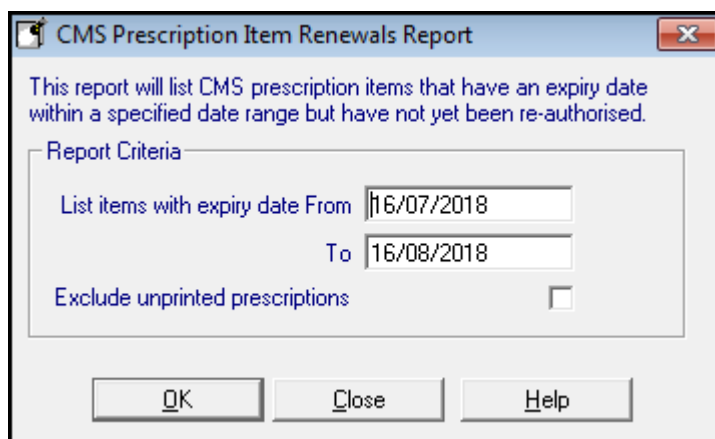
The **CMS Prescription Item Renewals Report** lists **CMS** prescription items that have an expiry date within a specified date range, but have not yet been re-authorised.

To run a **Prescription Item Renewals Report**:

1. From the Vision 3 front screen, select **Reporting - Search and Reports**.
2. From **Reports**, select **CMSReporting - Prescription Item Renewals Report**:



3. The **CMS Prescription Item Renewals Report** screen displays:



Complete as required:

- **List items with expiry date From** and **To** - The date range defaults to the previous month, update as required.
- **Exclude unprinted prescriptions** - Tick to exclude unprinted prescriptions.

4. Select **OK**.
5. Select the required output method, see [Report Output on page 12](#) for details.
6. Finally, select **OK** to generate the report.

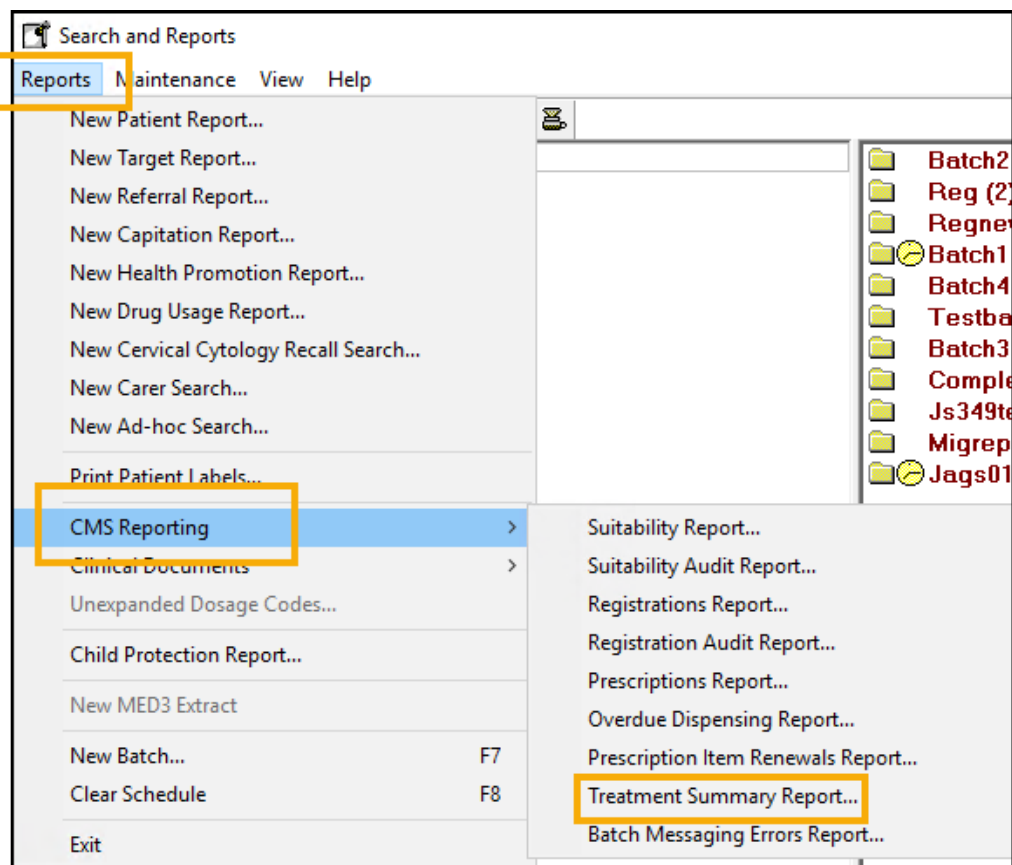
The results display in order of patient name and include community pharmacy name, Community Pharmacy (CP) code, first line of the address, postcode and telephone number of the registered pharmacy with the names and dates of the expiring drugs.

CMS Treatment Summary Report

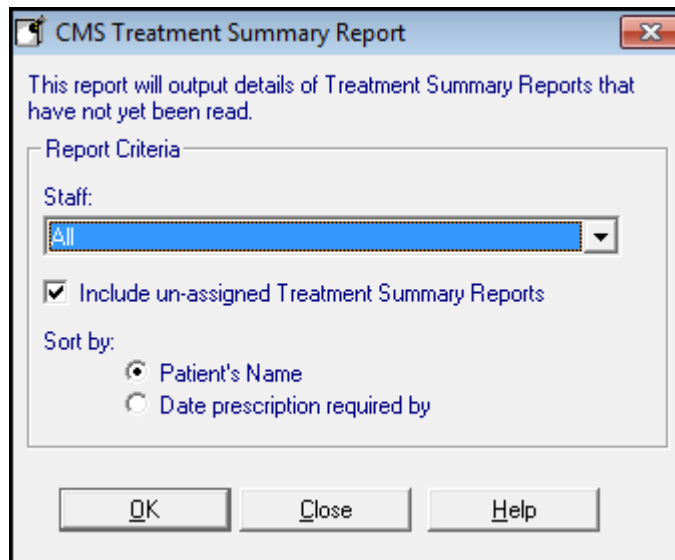
 **Note** - Only available in Scotland.

The **CMS Treatment Summary Report** lists all the **Treatment Summaries** received, but not marked as **Read** in **Mail Manager**.

1. From the Vision 3 front screen, select **Reporting - Search and Reports**.
2. From **Reports**, select **CMS Reporting - Treatment Summary Report**:



3. The **CMS Treatment Summary Report** screen displays:



Complete as required:

- **Staff** - The recipient of the message, select from the available list or leave as **All**.
- **Include un-assigned Treatment Summary Reports** - Tick to include Treatment Summary Reports that are unassigned to a patient.
- **Sort by** - Select from:
 - **Patient's Name**, or
 - **Date Prescription required by**.

4. Select **OK**.

5. Select the required output method, see [Report Output on page 12](#) for details.

6. Finally, select **OK** to generate the report.

 See [Finding Unread Treatment Summaries in Mail Manager on page 57](#) for details.

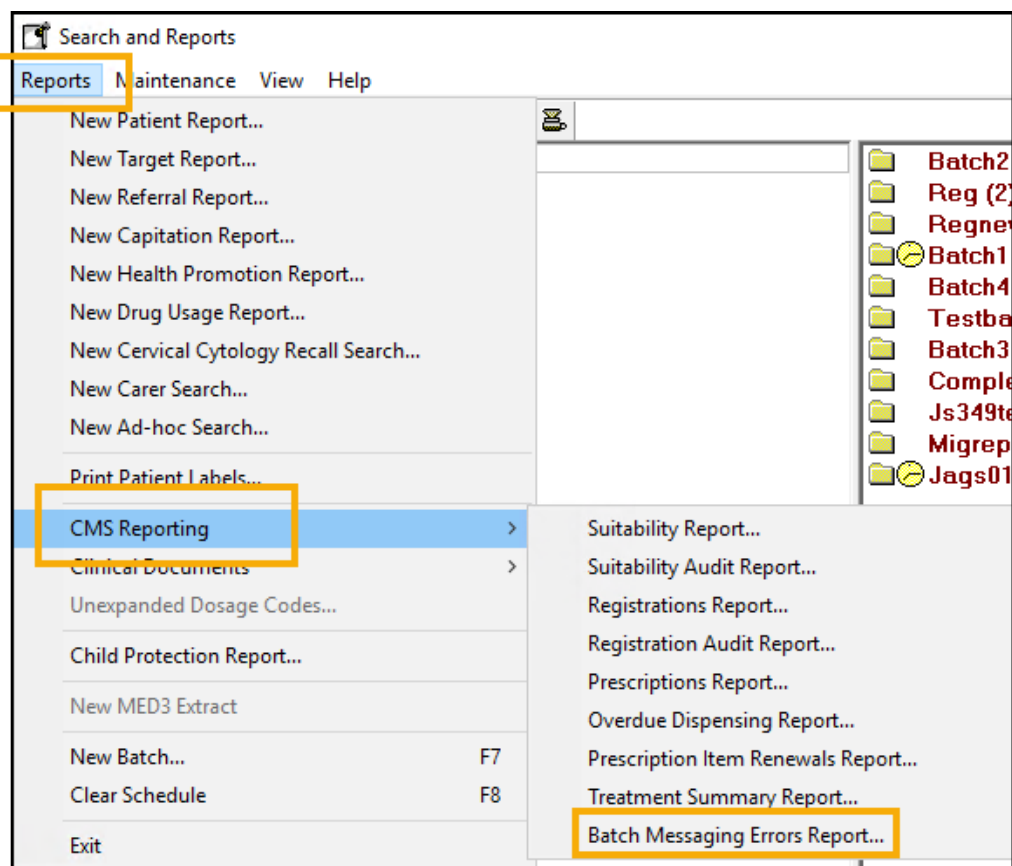
CMS Batch Messaging Errors Report

 **Note** - Only available in Scotland.

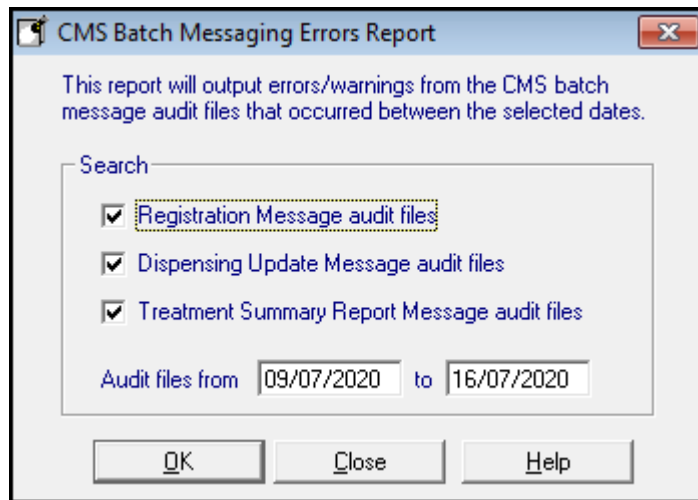
The **CMS Batch Messaging Errors Report** allows you to report on any **CMS** messaging errors.

To run the **CMS Batch Messaging Errors Report**:

1. From the Vision 3 front screen, select **Reporting - Search and Reports**.
2. From **Reports**, select **CMSReporting - Batch Messaging Errors Report**:



3. The **CMS Batch Messaging Errors Report** screen displays:



Select the message types and date range you would like to search on.

4. Select **OK**.
5. Select the required output method, see [Report Output on page 12](#) for details.
6. Finally, select **OK** to generate the report.

Finding Unread Treatment Summaries in Mail Manager

You can find unread treatment summaries in **Mail Manager** by selecting **Unread - Treatment Summary Reports** within the folder of the prescriber in question:



CMS Information in Patient Reports

Patient reports that include medication display **Chronic Medication Service (CMS)** information:

Encounter Report				
Miss Lynne Cassidy	09/07/2001	Female	809 052 4141	Permanent
Address				
12 Buckstone Wood Edinburgh EH10 6QW			Address Type: Main address	
Problems				
Currently Relevant	Started: 03/09/2018	Ended:		
Repeat Masters				
SALBUTAMOL mr cap 4mg	Until: 03/11/2018	CMS last disp.: 19/05/2018	Num. disp. events:	2 maximum 3
TAKE ONE TWICE DAILY				
ALUPENT sf syrup 10mg/5ml	Until: 03/11/2018	CMS last disp.: 19/05/2018	Num. disp. events:	2 maximum 3
1X5ML SPOON 4 TIMES/DAY				
PANADOL caps 500mg	Until: 03/11/2018	CMS last disp.: 19/05/2018	Num. disp. events:	2 maximum 3
TAKE 1 OR 2 4 TIMES/DAY				
Consultation				
21/05/2018	Other	Mr System Supervisor		
Total patients for report 1				

Full Report				
Miss Julie Broadford	04/03/2006	Female	252 550 2094	Permanent
Address				
5-5 Sheriff Bank Edinburgh Midlothian EH6 6ER			Address Type: Main address	
Problems				
Currently Relevant	Started: 03/09/2008	Ended:		
Asthma register				
Asthma Placed on register: 25/01/2010 Removed from register:				
Medical History				
25/01/2010	Asthma clinical management plan			Dr Christine Green
Repeat Masters				
Frekini energy liq [FRESENIUS]	Until: 03/10/2018	CMS last disp.:	Num. disp. events:	maximum 3
12				
GAVISCON sf liq	Until: 03/10/2018	CMS last disp.: 02/09/2018	Num. disp. events:	maximum 3
20ML 4 TIMES/DAY				
DIPROBASE crm	Until: 03/10/2018	CMS last disp.: 02/09/2018	Num. disp. events:	maximum 3
APPLY AS NEEDED				
RAMIPRIL caps 1.25mg	Until: 03/10/2018	CMS last disp.: 02/09/2018	Num. disp. events:	maximum 3
TAKE ONE DAILY				
HELIXATE NEXGEN pw dr/inj soln 500 iu	Until: 03/10/2018	CMS last disp.:	Num. disp. events:	maximum 3
4TDS CMS Notes: cms notes				
FRADOR tincture	Until:	Last issued: 02/09/2018	Number of issues:	1 maximum 12 allowed
APPLY AS NEEDED				
PANADOL caps 500mg	Until:	Last issued:	Number of issues:	maximum 12 allowed

CMS Information in Standard Reports

Dispensing details for **Chronic Medication Service (CMS)** drugs display when printing therapy on a Standard report:

Therapy History Report			
Mx Bob Blobby	21/10/1980	Female	421 114 3638 Permanent
Acute and Repeat Issue Therapy			
08/02/2019	6 disp.	Paracetamol 500mg capsules	Supply: (90) capsule 1 TDS
09/01/2019	5 disp.	Paracetamol 500mg capsules	Supply: (90) capsule 1 TDS
10/12/2018	4 disp.	Paracetamol 500mg capsules	Supply: (90) capsule 1 TDS
04/12/2018	4 issued	metformin 500mg modified-release tablets	Supply: (56) tablet 1 EVERY DAY AT NIGHT
Notes for dispenser: ensure 2 box of 28 not 1 of 56			
10/11/2018	3 disp.	Paracetamol 500mg capsules	Supply: (90) capsule 1 TDS
06/11/2018	3 issued	Metformin 500mg modified-release tablets	Supply: (56) tablet 1 EVERY DAY AT NIGHT
Notes for dispenser: ensure 2 box of 28 not 1 of 56			
28/10/2018	4 issued	Morphine 10mg modified-release capsules	Supply: (60) capsule 1 CAPSULE TWICE A DAY
11/10/2018	2 disp.	Paracetamol 500mg capsules	Supply: (90) capsule 1 TDS
09/10/2018	2 issued	Metformin 500mg modified-release tablets	Supply: (56) tablet 1 EVERY DAY AT NIGHT

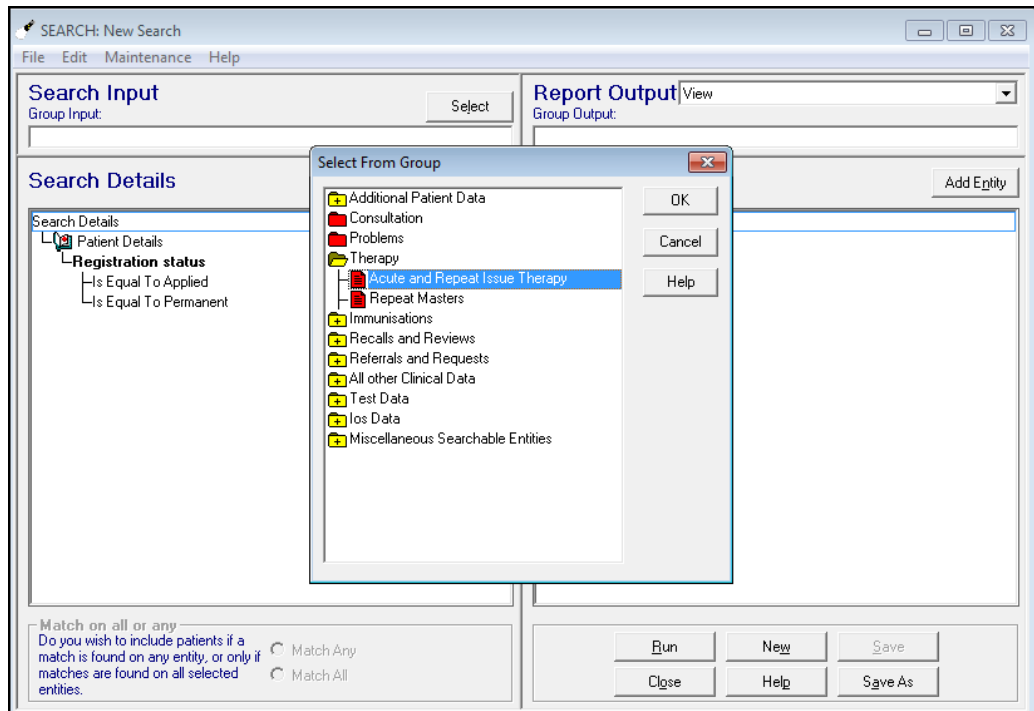


See [CMS Information in Patient Reports on the previous page](#) for details.

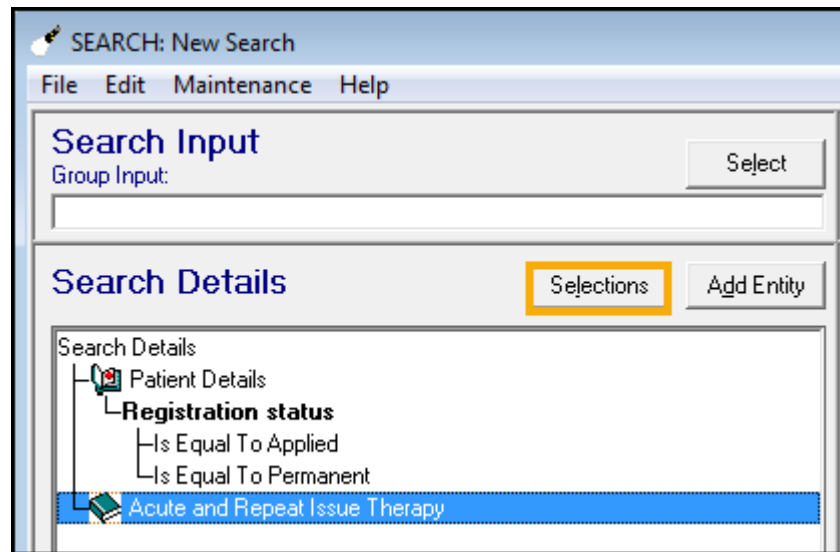
Searching for CMS Dispensed Items

To search for **Chronic Medication Service (CMS)** dispensed items:

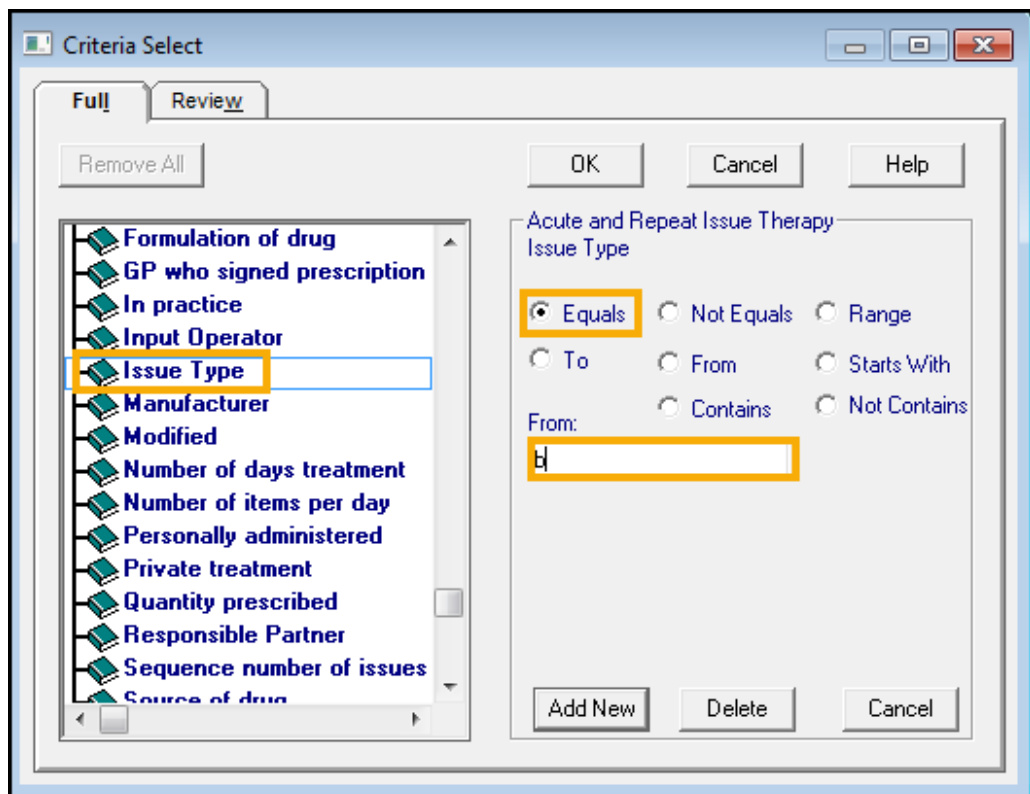
1. From the Vision 3 front screen, select **Reporting - Search and Reports**, open a new **Ad-Hoc** search, select **Add Entity, Therapy** and then **Acute and Repeat Issue Therapy**:



2. Highlight **Acute and Repeat Issue Therapy** and select **Selections**:



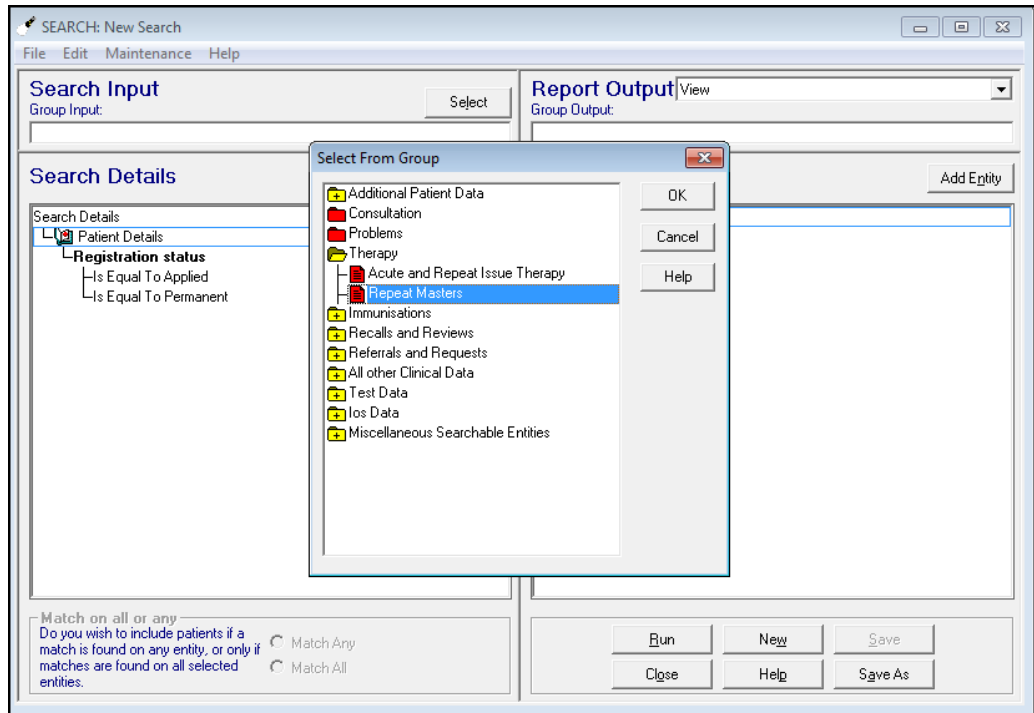
3. Select **Issue Type** from the search criteria screen and select **Add New**. Enter the letter **B** (for Batch/CMS dispensed items) in **From** and select **OK**:



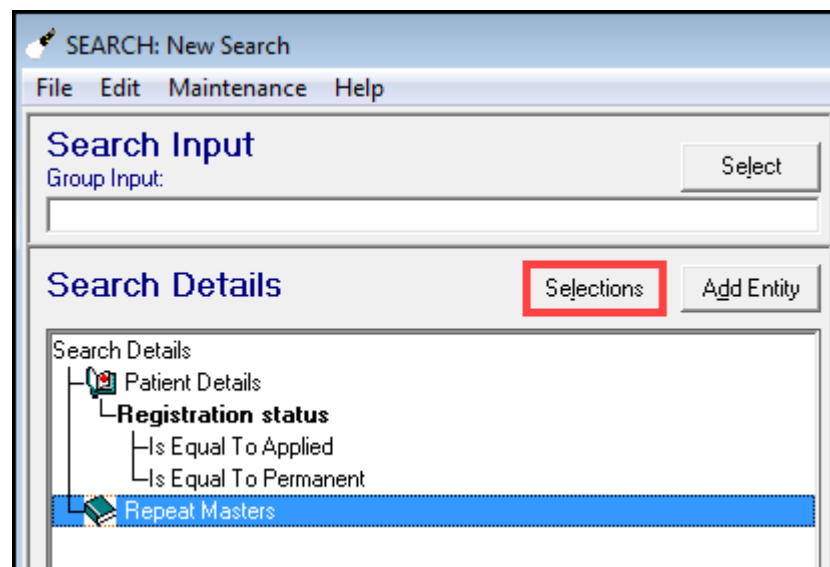
The **View of Patient Details** displays.

Searching for CMS Repeat Masters

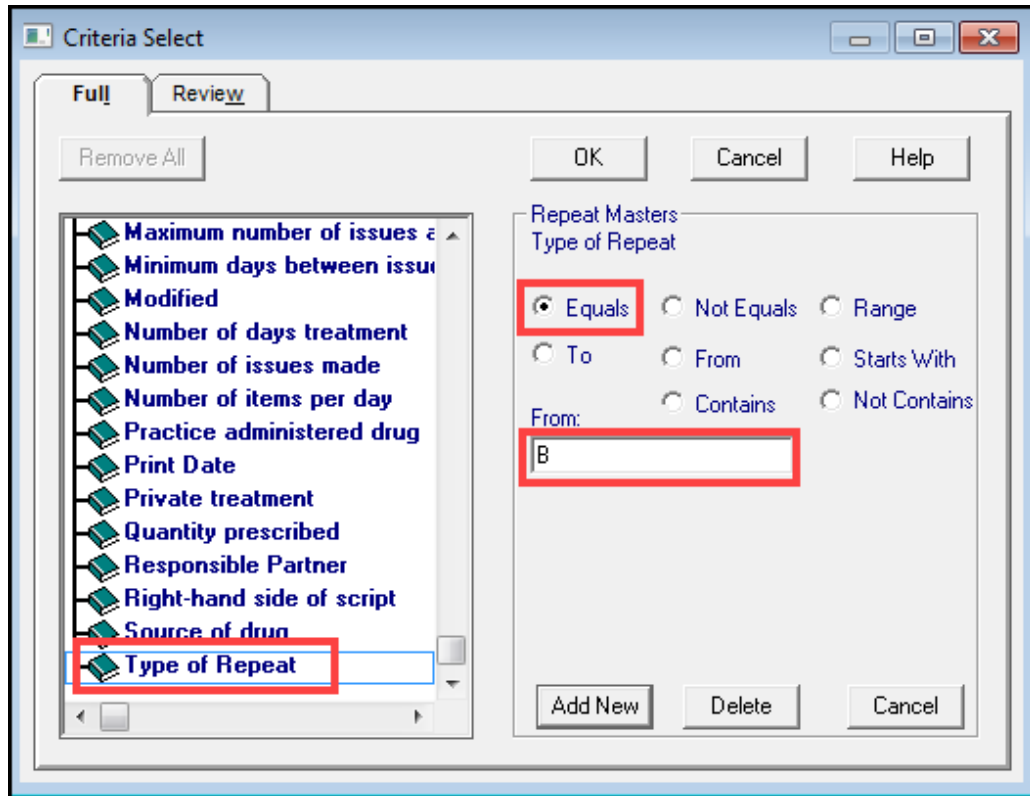
1. To create an ad-hoc search that identifies CMS Repeat masters, open a new **Ad-Hoc Search**, choose **Add Entity**, select **Therapy**, and then **Repeat Masters**.



2. Highlight **Repeat Masters** and choose **Selections**.





3. Select **Type of Repeat** from the search criteria screen and select **Add New**.
4. Type the letter **B** (Batch/CMS prescribing) in the **From** box and select **OK**.




The **View of Patient Details** output displays.

Cervical Cytology Recall Search

 **Note** - Additional Cytology searches are included in Clinical Audit.


The **Cervical Cytology Recall** search  is designed to find patients due for smear recalls, and excludes patients not eligible. Groups are created depending on whether the first, second or third recall letter is required.

- The search finds patients whose most recent smear recall date falls within the date range of the search (by default this is from five years ago to one month ahead). There must be a triggering Read code entered in recalls. The Read codes are pre-defined, these can be updated if required.
- This search looks for a patient's latest cervical smear result and the recall date attached to it, for example, last smear result 10/01/2016, with a recall due in January 2019.
- All ineligible patients are removed from this group and placed in one of four groups - hysterectomy / refusal / not needed / inappropriate.
- The remaining eligible patients are placed in one of four groups - first, second, third or fourth smear recall letter. Group names are automatically given.
- Recall letters can then be generated using the Patient Groups module.

 **Note** - Please see Clinical Audit for country specific cytology reports.

 See - patient groups.

Drug Usage Reports

 **Important** - For practices with a hosted server, for example AEROS, you must watch the videos on your local desktop. To do this copy and paste the url for this web page into your local browser. Local health board restrictions may also affect access.

The **Drug Usage Report** enables you to report on:

- Patients with more than a specified number of current medication items on repeat.
- Patients with more than a specified number of repeat or acute issues within a specified time span.

To run a **Drug Usage Report**:

1. From the **Search and Reports** screen, select **New Drug Usage Report**



and the **Patient Drug Usage Search** screen displays:

Patient Drug Usage Search

Description:

Report On

Active Repeat Masters

Acute and Repeat Issue Prescriptions Use date offset

Count prescriptions from: 22 December 2021 until 22 December 2021

For Each Patient

Count All Items

Count Number of Different Items

Count Number of Different Drug Classes

Run

Includes patients who are on at least 3

Exclude Appliances and Reagents

New

Save

Save As

Close

Help

Output Group

Name: Description:

2. Complete as required:

- **Report On** - Select from:
 - **Active Repeat Masters** - To report on active repeat masters, or
 - **Acute and Repeat Issue Prescriptions** - Selected by default, to report on therapy issues.

Either tick **Use date offset** and in **Count prescriptions from** and **until** enter an offset date range or enter a specific date range in **Count prescriptions from** and **until**.

- **For Each Patient** - Select:
 - **Count All items** - To count the total number of items prescribed.
 - **Count Number of Different Items** - To count the total number of different items prescribed, this option excludes multiple issues of a single drug.
 - **Count Number of Different Drug Classes** - To count the total number of different drug class items prescribed, so those of the same class count as one item.
- **Includes patients who are on at least** - Defaults to 3 as the minimum number of items, update as required.
- **Exclude Appliances and Reagents** - Tick to remove appliances and reagents from the count.
- **Output Group** - Enter a name and description for the group of patients created by the search.

3. To continue, select:

- **Run** to run the search, once finished a *Search complete* message displays. Select **OK**.



Note - The output does not display on screen, it creates a patient group. Please be aware this patient group includes transferred out patients.

- **Save** to save the search criteria.
- **Save As** to save the search criteria with a new name.
- **New** to clear the criteria and start again.




See [Viewing Patient Groups](#) for details.

Viewing a previously run Drug Usage Report:

To view a **Drug Usage Report** that has previously been run:

1. From the **Search and Reports** screen, select the green **Drug Usage Reports** heading to expand the list:



2. Select **Drug Usage Report**  next to the search and the **Patient Drug Usage Search** screen displays.
3. Select **Run** to run the report as it is, or update it and then select **Run**.



Training Tip - If you update the report criteria, select **Save As** to save it under a different name to run again in the future.

Patient Reports

From **Patient Reports** you can produce various pre-defined reports for either a single patient or a group.



Note - Similar reports can be run within Consultation Manager under **Patient Reports**.

- [Running Patient Reports on page 74](#)
 - [Patient Report Criteria on the next page](#)
 - [Modifying Patient Reports on page 72](#)
 - [Exporting a Patient's Report to CSV on page 81](#)
 - [Data Protection Act on page 82](#)
-



Training Tip - If your reports are for home visits, then why not consider using Vision Anywhere mobile? This gives live access to your patient records outside of the practice. Please contact your Account Manager for further information.

Patient Report Criteria

The following table lists each report type and contents. It shows the area that the **Date From** option affects and the entities that are date restricted by default and cannot be changed.



Note - Recalls are included by their Recall Date NOT the Event Date.

Report Type:	Data the Date Option applies to:	Data that is already date restricted and therefore unaffected by new date option:
Encounter	Problems Therapy Allergies - Drug Allergies - Non-Drug Allergies - No History Hypertension Register CHD Register Stroke Register Diabetes Register Asthma	Epilepsy Register Medical History Consultations Blood Pressure Referrals Cervical Cytology Smoking Alcohol Weight Height Contraception Immunisations
		Tests - Within 6 months Recalls - Due by today Repeat Therapy - Within 1 year

	Register		
Home Visit	Problems	Consultations	Repeat Therapy - Within 1 year
Health Check Card	Blood Group Allergies - Drug Allergies - Non-Drug Allergies - No History Problems	Cervical Cyto-logy Contraception Blood Pressure Weight Height	Recalls - Due by today Immunisations - Due by today Repeat Therapy - (Within 1 year)
Medical History	Medical History		
All Clinical	Problems Referrals All Other Clinical	Free text Tests	
Therapy History	Therapy		
Full	Problems All Other Clinical Repeat Therapy Acute Therapy Recalls	Consultations Referrals Immunisations Tests	



See - [Running Patient Reports on page 74.](#)

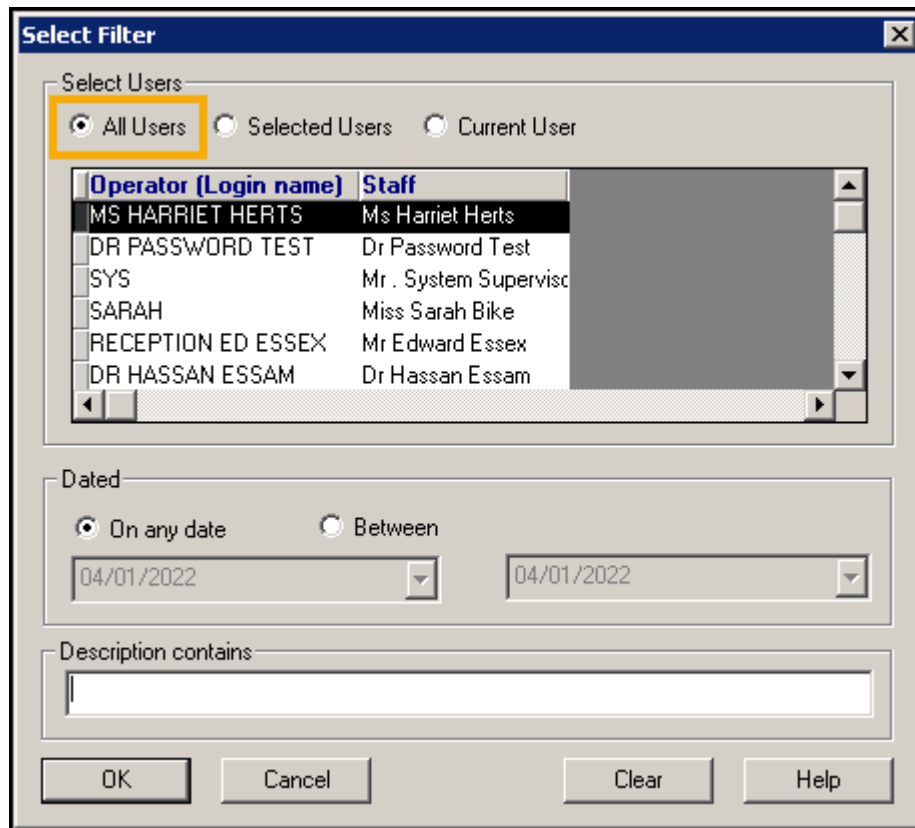
Modifying Patient Reports

Standard patient reports can be customised as required, for example, you may prefer to have Medical History, Acutes and Repeat Issues on the Home Visit report along with the standard criteria of Address, Problems, Repeat Masters and Consultation.

The reports are listed in the **Ad-hoc Searches** section, the reports default to date order so you may have to scroll down to see these:

		04/01/2022	Default Therapy History Report (00:00:07)
		04/01/2022	Default Medical History Report (00:00:02)
		04/01/2022	Default Home Visit Report (00:00:11)
		04/01/2022	Default Health Check Card Report (00:00:05)
		04/01/2022	Default Full Report (00:00:29)
		04/01/2022	Default Encounter Report (00:00:25)
		04/01/2022	Default All Clinical Data Report (00:00:11)
		04/01/2022	Currently Relevant search criteria (00:00:10)

If you have an active filter, you need to clear it or change the filter to **All Users** to see the reports:





Select **Search**  preceding the report to update the criteria.

 See [Creating a Search](#) for details.

Running Patient Reports

To run a patient report:

1. From **Search and Reports**, either:
 - Select the **Patient Report** green heading and select **New Patient Report** ,
 - Right click on the **Patient Report** green heading and select **New**, or
 - Select **New Patient Report** .
2. The **Patient Report** screen displays, select the **Report type** required:

Select a topic below to expand the section:

Encounter

Includes registration details, address, all communication numbers and prints a one line summary of each clinical record in each category including:

- Problems
- Disease registers
- Medical History
- Recalls
- Referrals
- Consultations
- Acute and repeat medication issues
- Prevention data
- Absence of condition

Home Visit

Displays:

- Registration details
- Address
- Problems
- Repeat Masters
- Consultations

Health Check Card

Displays:

- Registration details
- Address
- Problems
- Allergies
- Repeat masters
- Recalls
- BP
- Smears
- Weight
- Height
- Contraception
- Immunisations
- Blood group
- Absence of condition

Medical History

The last ten Medical History records display, the header includes the patient's name, date of birth, sex, NHS / CHI number and registration status.

All Clinical

Displays:

- Patient's name
- Date of birth
- Sex
- NHS / CHI number
- Registration status
- Problems
- BP
- Referrals
- Smears
- Smoking
- Alcohol
- Weight
- Height
- Contraception
- Notepad entries
- Family History
- Allergies
- Repeat masters
- Recalls
- Immunisations
- Blood group
- Absence of condition

Therapy History

The last ten Acute and Repeat Issue records, the header includes patient name, date of birth, sex, NHS / CHI number and registration status.

Full

Displays all their clinical data, includes the patient's name, date of birth, sex, NHS / CHI number and registration status at the top of every page.



Note - The **Encounter, Home Visit** and **Health Check Card** reports print the last main address and all Communication Numbers recorded for the selected patient.


The screenshot shows a 'Patient Report' dialog box with the following elements:

- Report Type:** A list of report types with radio buttons: Encounter (selected), Home Visit, Health Check Card, Medical History, All Clinical, Therapy History, and Full. Each type has associated checkboxes for 'Print All Headers' and 'Search Name', and a text input field for the search name.
- Patient:** A large text area containing the message 'NO PATIENT SELECTED'. A 'Select Patient' button is located at the bottom right of this area.
- Options:** Radio buttons for 'Single Patient' (selected) and 'Group'. Below this is a 'From date:' label with a note '(Blank date to exclude from search)' and a date input field.
- Command:** A vertical stack of buttons: Print, Save, Save As, Help, and Exit.


3. Tick **Print All Headers** against the report required, this displays/prints headings for each category, including where the patient has no record.



Training Tip - This can act as a prompt that the patient has no relevant entry.

4. From **Options**, select either:
 - **Single Patient** - Selected by default, to select an individual patient. Choose **Select Patient**  and select the patient in the usual way, see [Selecting a Patient](#) for details if

required, or

- **Group** - To produce reports for a predefined group of patients. Choose **Select**  and the available lists of **Groups** and **Clinical Audit Searches** display, highlight as required and select **OK**. The view refreshes and the group displays at the bottom of the screen, together with the number of patients in the group.

5. Optionally, enter a **From Date**, for example, T-2m for the last 2 months if required.
6. Tick **Search Name** and enter a name for your report to save the criteria for future use, for example Medical History in the last 12 months:

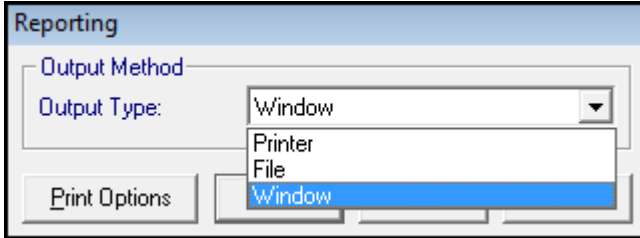


Medical History Print All Headers Search Name



Note - You cannot apply a **From Date** with a **Search Name** selected.

7. Optionally, select:
 - **Save As** - To save a new report or an existing one with a new name, or
 - **Save** to update and existing report with new criteria.
8. Select **Print**.
9. The Reporting screen displays:



Reporting

Output Method

Output Type: Window

Printer

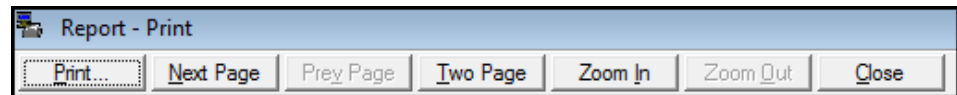
File

Window


Print Options

Select as required:

- **Window** - Selected by default, displays the report on screen. From here you can **Print**, navigate to the **Next** or **Previous** page, select **Two Page** format, **Zoom In** or **Zoom Out** or select **Close** to exit:

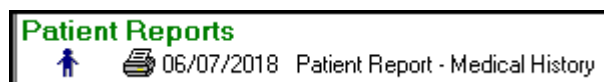



- **Print Options** - To select a printer
- **File** - To select from the drop down menu to save as a .TXT file.

 **Note** - When printing a report for a patient who has more than one page of freetext in their record, the comments section truncates to fit on a single page and the following text displays: "Some data has been truncated to fit page.".

View previously run Patient Reports

1. Select the green **Patient Reports** heading to expand the list of saved reports.




2. Select the **Patient**  next to the report name. The report displays.
3. Amend the **Patient Report Selection Criteria** if required, or select **Print** to run.

 See - [Patient Report Criteria on page 70](#).

Exporting a Patient's Report to CSV

To export a patient's record (excluding correspondence and attachments):

1. Select **New Patient Report** .
2. Tick next to **Full** in the **Report Type**.
3. Select **Patient Select** to choose your patient and select **OK**.
4. Select **Print**.
5. Change the **Output Type** to **File**.
6. In the **Select Output Filename** enter a name, for example, SMITH.
7. Select **Save** (the file SMITH.txt is not used).
8. In the Reporting dialog for the **Output Format**, select Comma Separated Value.
9. Select **OK**.
10. In the **Print to File** dialog type in the file name, and note the location.
11. The document can be opened in Excel.

Note -There are alternative ways to print out patient data in Consultation Manager - select the Reports Index  and All Consultations, then the Encounter Report. The attachments need to be printed separately.

Data Protection Act

The Data Protection Act allows the patient to have access to information held about them on the computer, known as 'right to subject access'. They also have the right to have this information corrected or deleted, where appropriate.

The easiest way to print this out is from **Searches** -  **Patient Report - Full**.

This gives all the patient's registration details and all their clinical data. There are some details the Full Patient report omits which strictly speaking by law the patient should see on the printout - the Previous Surname, Second Forename and Other Forenames.



Note - The report cannot include the carers name, just an entry indicate a carer.

To ensure compliance:

1. Before running the **Patient Report**, find out if the patient has a carer. If so, add a Medical History entry with a Read code **918F Has a carer**.
2. Run and print out the **Full Patient Report**.
3. Open a new **Ad-Hoc search**.
4. In the **Search Details** section, under **Patient Details**, select **Current NHS Number** or **CHI number**.
5. Enter the patient's NHS / CHI number.
6. Then in **Report Output**, select **Detailed**.
7. Select **Run**.

This gives all the patient's registration entries, but no clinical data.



See - [Modifying Patient Reports on page 72](#) and [Creating a Search](#).

Referral Reports Overview

The Referral Report provides the analysis of patient and diagnostic service referral figures and can be generated at any time to monitor practice referrals.

Note - If the referral is done electronically, for example, using eReferral or SCI Gateway, the provider details do not populate automatically.

The report shows the number of referrals made for all patients, or selected patients, by GP, provider unit, speciality, inpatient / outpatient.

The Detailed Report provides a breakdown by GP and ICS / Health Board, the Summary Report just shows a total for all GPs and ICS / Health Boards.

Note - The only referrals that appear on the Referral Report are those marked as either In Patient, Day Case or Outpatient in the Referral Type field on the Referral screen.

Further reports are available from your electronic booking provider.

 See - [Referrals Reports on page 85](#) and [Referral Report Content on the next page](#).

Referral Report Content

The Referral Report heading displays:

- The date range for referrals.
- Selections of Trading Partner(s), GP(s), registration status, and patient criteria.
- The left-hand column shows each provider unit.
- Across the top of the report are specialties.

Surgery, Medical, Orthopaedic, Rheumatology, ENT, Gynaecology, Obstetrics, Paediatrics, Ophthalmology, Psychiatry, Geriatrics, Dermatology, Neurology, Genito-Urinary, X-ray, Pathology, Others and None.

- A total for each specialty displays.

Patient Referral Report for The New INPS Surgery											from 01/07/2018 to 13/07/2018										
DHA : All Active		GP : All Active		TP : All Active		GP Type : Registered		Registration Status : Active		Report Type : Summary											
Surname : A to Z		Sex : All		Dates of Birth : to																	
		Sur	Med	Ort	Rhe	Ent	Gyn	Obs	Pae	Oph	Psy	Ger	Der	Neu	Uri	Xra	Pat	Othr	None		
Mount Stuart Hospital	In	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Out	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Total	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Salford Royal Foundation	In	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	
	Out	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	
	Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	
The Exeter Nuffield	In	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Out	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	
	Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	
Total for GP :	All	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1		
Total for TP:	All	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1		
Total for all GPs and TPs		1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1		



See - [Referral Reports Overview on the previous page.](#)

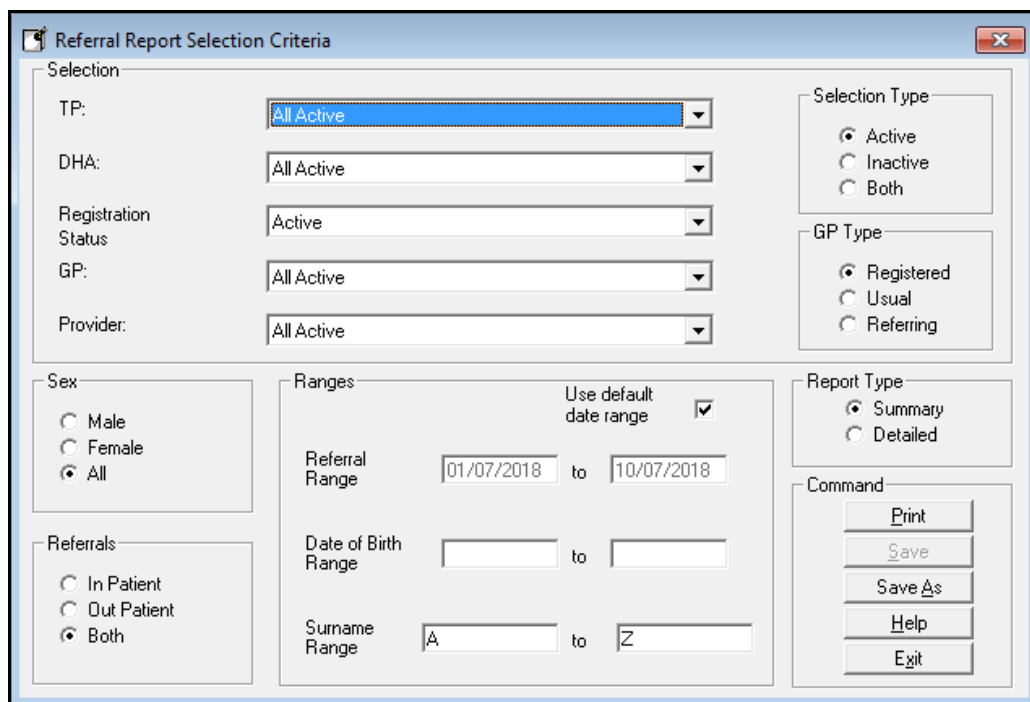
Referrals Reports

Note - If the referral is done electronically, via for example, eReferral or SCI Gateway, the provider details do not populate automatically.

Running a new Referrals report:

1. Select **Referrals Report** .

The **Referral Report Selection Criteria** screen displays.



2. Choose which **TP - Trading Partner** (ICS / Health Board) you wish to search on.

The default is **All Active**. Alternatively select a single ICS / Health Board from the picklist.

3. **DHA** - this field is no longer relevant.

4. Select the **Registration Status** from the drop down list.

The default is **all active patients**, ie permanent or applied, including transferred out patients with a transferred out date later than the

report date, as it is assumed they were permanent / applied when the referral was recorded.


5. The **GP** selection defaults to all GPs.
Alternatively choose a single GP from the drop down list.
6. The **Provider** defaults to **All active providers**, or select a single provider from the drop down list.
7. In the **Selection Type** box, optionally, refine the TPs, GPs and Providers to either **Active** (the default), **Inactive** or **Both**.
8. The **GP Type** section can be used to display the patients by their **Registered GP, Usual GP, or Referring GP**.
9. If needed amend the **Sex** option to either male or female, the default is all.
10. Use the **Referrals** options to refine the report to either inpatient, outpatient or both (default).



Note - The only referrals which appear on the referral report are those marked as either **In Patient, Day Case** or **Outpatient** in the **Referral Type** field on the Referral screen in Consultation Manager.

11. The **Referral Range** dates default to the current quarter up to today.
To alter the dates, uncheck the **Use default date range** box and edit.
12. If left blank the **Date of birth range** includes all ages.
Optionally, enter a range, for example, over 65s.
13. The **Surname Range** defaults to A to Z, update if required.
14. Choose the **Report Type - Summary** (default) or **Detailed**.
15. To save the current criteria select **Save**.
The report is saved under **Referral Reports**.
To modify a saved report and save under a different name use **Save As**.


16. Select **Print** to generate the report.
Or select **Exit** to close.

 **Note** - The specialty breakdown is based on the ICS / Health Board *Specialty* field on the Referral screen and includes all specialties.

To view a previously run Referral Report:

1. Select the **Referral Report** green heading on the front **Search and Reports** screen.
The expanded list displays.



2. Select the **Bow Tie**  next to the report you want to view.
The **Referral Report Selection Criteria** screen displays.
3. Amend the criteria as required and select **Print** to run the report.
4. To update the saved criteria select **Save**, or select **Save As** to save under a different name.

 See - [Referral Report Content on page 84](#)

Target Reports Overview

The Target Reports cover three categories of patients and then determines the percentage of permanent or applied patients that criteria have been achieved within the quarter:

- **Children age two - Immunisations**
- **Children age five - Immunisations**
- **Female patients - Cytology**

Women may be excluded from target reports if they have had a hysterectomy or a vault smear and marked as excluded in Cervical Cytology, Consultation Manager. The smear must have adequate cytology and be within 5.5 years of the report date.

For all three categories, the in-practice or out-of-practice status is relevant.

Reports can be printed either as a one-page summary, or as a detailed listing with patient names.

Available Reports

- [Detailed Immunisation Target Reports on page 96](#)
- [Detailed Cytology Target Reports on page 94](#)



Note - Please see Clinical Audit for additional immunisation and cytology reports.

Target Reports Content

The Target Reports cover three categories of patients and then determines the percentage of permanent or applied patients who meet certain criteria within the quarter.

Target Report Heading

Each report is headed with the criteria selected: Date of report, TP (Trading Partner), DHA and GP.

	Total No.	Under GMS	Not under GMS
Women targeted aged 25 to 64 inclusive:	1,943		
Less exclusions:	5		
Total women eligible:	1,938		
		80% of 1,938:	1,550
		50% of 1,938:	969
Adequate smear	565	557	8
Total	565	557	8
Total of completed %		99.0 %	1.0 %
Current Target percentage is	29 %		



See - [View Report on page 19](#).

Target Summary Report

The summary page shows the numbers eligible within the correct age range, and shows the percentage achieved out of the total target population.

For cervical cytology this is 50% or 80%, and for children's immunisations is 70% or 90%.

Childhood Immunisation Targets for INPS Practice Demo Practice 4

on 01/07/2018

DHA : All
TP : All

Selected GP : All
Type of GP : Registered

Children Targeted : 1

90% of 4 : 4
70% of 4 : 3

	Completed Immunisations	As part of GP	Not part of GP
MenC	0	0	0
MMR	1	1	0
5 in 1	0*	0*	0*
Total	1*	1*	0*
Total of completed %		100.0%	0.0%

Current Target percentage is **25.0 %**

*5 in 1 is doubled to account for 50% weighting




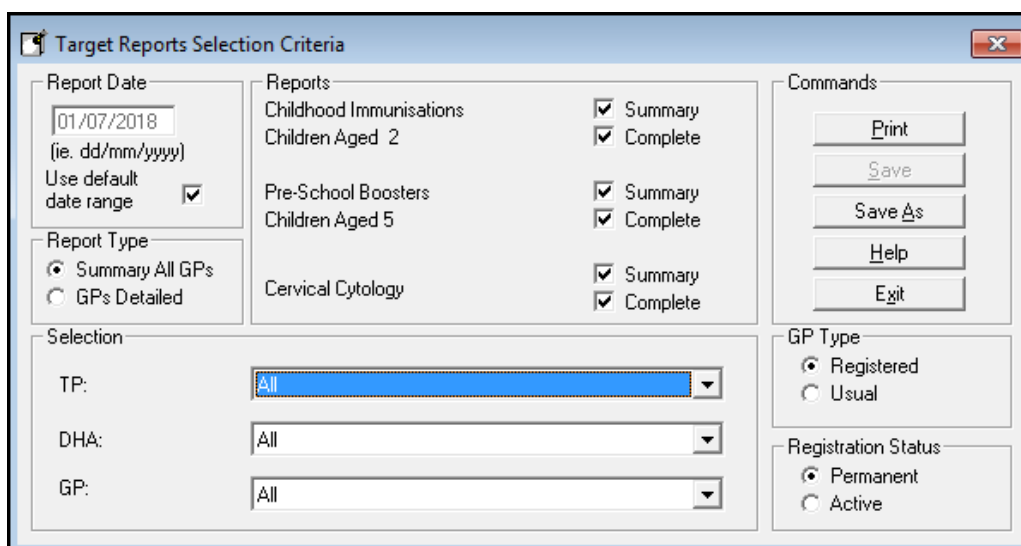
See - [Detailed Immunisation Target Reports on page 96](#) and
[Detailed Cytology Target Reports on page 94](#)

Viewing Target Reports

 **Note** - Please see Clinical Audit for additional immunisation and cytology reports.

Run a New Target Report

1. To run a new report, select **New Target Report** .
The **Target Reports Selection Criteria** screen displays.
2. Select report date and type.



The screenshot shows the 'Target Reports Selection Criteria' dialog box. It is divided into several sections:

- Report Date:** A text box containing '01/07/2018' with a note '(ie. dd/mm/yyyy)'. Below it is a checked checkbox for 'Use default date range'.
- Report Type:** Two radio buttons: 'Summary All GPs' (selected) and 'GPs Detailed'.
- Selection:** Three dropdown menus for 'TP:', 'DHA:', and 'GP:', all currently set to 'All'.
- Reports:** A list of report categories with checkboxes for 'Summary' and 'Complete':
 - Childhood Immunisations: Summary (checked), Complete (checked)
 - Children Aged 2: Summary (checked), Complete (checked)
 - Pre-School Boosters Children Aged 5: Summary (checked), Complete (checked)
 - Cervical Cytology: Summary (checked), Complete (checked)
- Commands:** A vertical stack of buttons: 'Print', 'Save', 'Save As', 'Help', and 'Exit'.
- GP Type:** Two radio buttons: 'Registered' (selected) and 'Usual'.
- Registration Status:** Two radio buttons: 'Permanent' (selected) and 'Active'.

- **Report Date** - The report date defaults to the first day of the current quarter.
To alter the date, uncheck the box **Use default date range** and update.
- **Report Type**
Summary All GPs - one page summary.
GPs detailed - by GP.

3. Choose the report category.

Reports - Select **Summary** and / or **Complete** for one or more of the following targets:

- **Childhood Immunisations Children aged 2** - Children aged two with completed courses for the 5-in-one DTPPolHib, DT and Polio, Pertussis, MMR (measles, mumps and rubella), HiB.
- **Pre-school boosters Children aged 5** - Children aged five, and the pre-school boosters.
- **Cervical Cytology** - Female patients aged between 25 and 64 years (England and Wales) or 20-59 (Scotland) and their cervical smear status.
The age range is automatically determined by your country setting.

A **Summary** report gives a one page summary of the percentages achieved, the **Complete** report provides a detailed listing of patient names and their status.

You can select to run all the target reports or just one or two at a time.

4. Select TP, DHA, GP and output:


- **TP** - The default is **All Trading Partners**. Or
- **DHA** - This field is no longer used.
- **GP** - The default is all GPs as targets are calculated per practice.

To run the report for a single GP, select from the drop down list.

5. **GP Type** - Choose either **Registered** or **Usual**.

6. Choose the **Registration Status**:

- **Registered patients** - Permanent only.
- **Active** - Permanent and Applied, and patients with a transferred out date later than the report date.

7. Select **Save**, enter a name (8 characters) and description.
The report displays on the front **Search and Reports** screen under **Target Reports**.
Or use the **Save As** to save under a different name.
8. Select **Print** and choose the output type.
9. Choose **OK** to process the report.
If you choose Window to display the report on screen, when you click on either **Print** or  to exit, the next report automatically displays until they are all processed. Select **Exit** to finish.

View an Existing Target Report


1. Select the **Target Report** green heading on the **Search and Reports** view.
The list of saved target reports displays.



2. Right click on the report you wish to view.
3. Select **View Search**.
The Target Report Selection Criteria screen re-displays.
You can click **Print** to run, or amend the criteria and choose **Save As**, to create a new report.

 See - [Report Output on page 12](#) and [Target Reports Content on page 89](#).

Detailed Cytology Target Reports

 **Note** - Additional Cytology searches including country specific are covered in Clinical Audit.

The detailed report includes:

- Women who are eligible and have had an adequate smear within 5.5 years under GMS.
- Women who are eligible and have had an adequate smear within 5.5 years not under GMS.
- Women who are eligible and have had no adequate smear within 5.5 years.
- Women who are excluded from the eligible figures.


The final page is a summary of the totals by ICS / Health Board.

Cervical Cytology Targets for The New INPS Surgery				on 01/07/2018	
DHA:	All	Selected GP:	All		
TP:	All	Type of GP:	Registered		
Women targeted aged 25 to 64 inclusive:	1,943				
Less exclusions:	5				
Total women eligible:	1,938	80% of	1,938:	1,550	
		50% of	1,938:	969	
	Total No.	Under GMS	Not under GMS		
Adequate smear	565	557	8		
Total	565	557	8		
Total of completed %		99.0 %	1.0 %		
Current Target percentage is	29 %				

Excluded from Cervical Cytology Targets

In the Cervical Cytology target report the **Excluded from Targets** group is based on the following criteria:

- The **last** cytology entry on Cytology in Consultation Manager **must** have the **Exclude from Targets** field ticked.

-  **Note** - Although exclusions are usually permanent, it is vital that the last cytology entry is flagged as excluded - earlier entries with flags are ignored.

Detailed Immunisation Target Reports

The detailed Immunisation Target report for two year olds lists children by name, date of birth and NHS / CHI Number, who have completed the course of DTPPolHib (named 5 in 1), MMR (measles, mumps and rubella), MenC and whether under GMS.

The five year old Immunisation Target reports shows those with the pre-school boosters.

A summary page details the totals for patients within each ICS / Health Board.



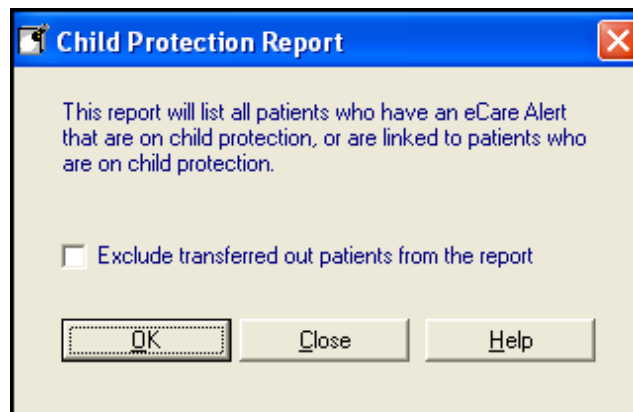
Note - Please see Clinical Audit for additional Immunisation reports.

Child Protection Report - Scotland


A Child Protection Report is available if **Lanarkshire Multi Agency Service eCare** is enabled on your system.

To run the report:

1. From **Search and Reports**, select **Reports - Child Protection Report**.
2. A **Child Protection Report** message displays *'This report will list all patients who have an eCare Alert that are on child protection or are linked to patients who are on child protection.'*:



Select **Exclude transferred out patients from the report** if required.

 **Note** - eCare alerts stay active until the child reaches the age of 17 regardless of registration status.

3. Select **OK** to continue.
4. Select an appropriate output:
 - File
 - Printer
 - Window

5. Select **OK** to run the report.



Note - The report lists all patients who have an eCare alert, it does not distinguish between the two alert types, **Child Protection** or **Linked Person**.

The **Child Protection Report** returns the following data for qualifying patients:

- CHI number
- Surname
- Forename(s)
- Date of birth
- Address
- Postcode
- Telephone number

Unexpanded Dosage Codes

The Unexpanded Dosage Codes report identifies repeat masters that may have an unexpanded dosage code, for example, OD should be expanded to Every day. Once run, a **\$DOSEUNEXP** group is created.

1. From the Vision 3 front screen, select Reporting - **Search and Reports**.
2. Select **Reports - Unexpanded Dosage Codes**.
3. The unexpanded dosage codes report screen displays along with the following message *"This will analyse active Repeat Master records for unexpanded dosage codes in dosage instructions. Unexpanded dosage codes may result in unclear instructions to the pharmacists or patient. A patient group will be created (\$DOSEUNEXP) containing all records with this condition for currently active patients. The group can be used to correct the dosage instructions in Consultation Manager. This option can be run any number of times."*. Select **Run**.
4. If you have previously run the report you are prompted *"Patient group 'DOSEUNEXP' already exists. Do you wish to overwrite it? Yes/No"*, select **Yes** to continue.
5. When the report is complete, the *"Unexpanded dosage codes report has completed"* message displays. Select **OK**.
6. Select **Cancel** to close the report.

You can now either add the group to an ad-hoc search, or use the **Consultation Manager - Select Group Patient** option to view each patient individually and correct any errors.