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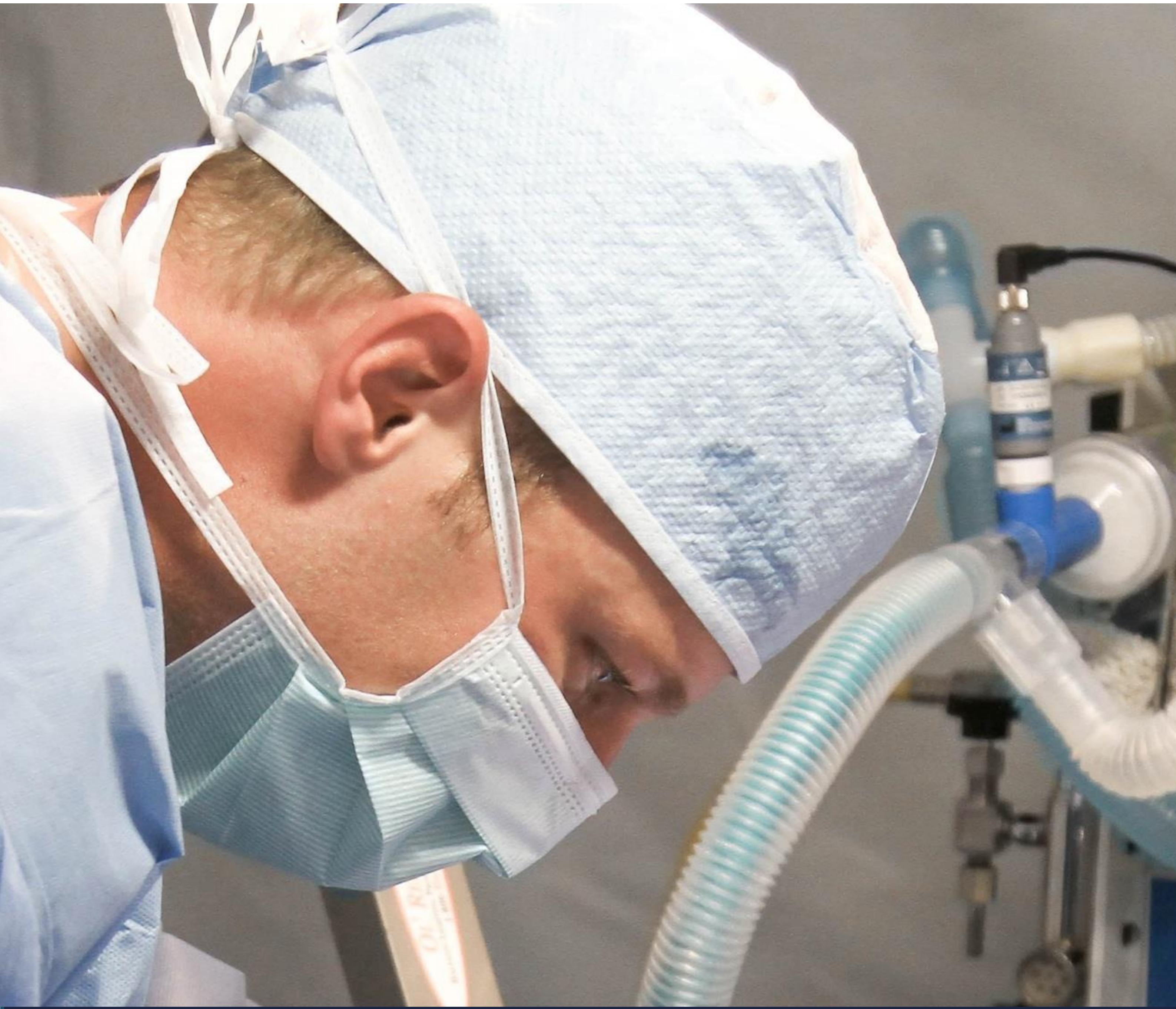

CLINICAL REFERRAL INFORMATION STANDARD:
FINAL REPORT

MAY 2018

Document Management

Revision History

Version	Date	Summary of Changes
0.1	14.05.2018	First draft version.
0.2	20.07.2018	Project Board review

Reviewers

This document must be reviewed by the following people:

Reviewer name	Title / Responsibility
Martin Orton	Professional Record Standards Body, Director of Delivery and Development
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Approved by

This document must be approved by the following people:

Name	**Signature**	**Date**
Project Board		
PRSB Assurance Committee		19.06.2018

Glossary of Terms

Term / Abbreviation	**What it stands for**
BMA	British Medical Association
e-RS	e-Referral Service
HIG	Health Informatics Group (of the RCGP)
HIU	Health Informatics Unit (of the RCP)
PID	Project initiation Document
PRSB	Professional Record Standards Body
RCGP	Royal College of General Practitioners
RCP	Royal College of Physicians

Related Documents

Ref no	**Title**
[1]	Standards for the Structure and Content of Patient Records (https://theprsb.org/patient-records-structure-and-content/)
[2]	NHS e-Referral Service https://digital.nhs.uk/services/nhs-e-referral-service/
[3]	Outpatients Letter Record Standard https://theprsb.org/standards/outpatientletterstandard/

Planned Review Date and Route for User Feedback

The next maintenance review of this document is planned for August 2021, subject to agreement with NHS Digital as the commissioning body.

Please direct any comments or enquiries related to the project report and implementation of the standard to support@theprsb.org.

Table of Contents

1. Introduction and background

1.1 Purpose

This document is the final report of the clinical referral information standard project. The project has developed evidence and consensus based standard headings and content definitions, detailed information models and implementation guidance for digital referrals from GP practices to hospitals.

The Professional Record Standards Body (PRSB) was commissioned by NHS Digital to consult with patients, healthcare professionals and suppliers to ensure that the standard meets their needs. Clinical leadership was provided by the Royal College of Physicians (RCP) and the Royal College of General Practitioners (RCGP). The work has been conducted in partnership with the Royal College of Physicians (RCP) Health Informatics Unit (HIU).

The project has built on the information models developed in the previous PRSB transfer of care projects (which include diagnoses, procedures, allergies and medications) and is aligned with the referral headings in the Standards for the Structure and Content of Patient Records [1], published in 2013. The project was carried out in collaboration with the e-Referrals Service [2] to build on the work already undertaken by the e-RS on requirements for a minimum data set for GP clinical referral information.

The objectives of the project as specified in the project initiation document (PID) were to:

1. Agree evidence and consensus based standard headings and content definitions with supporting information models and implementation guidance for clinical referral information.
2. Agree standards that are practical and feasible to implement, provide hospital clinicians with the information that they need, are useful to patients, and enable GPs to communicate what they regard as clinically necessary.
3. Develop implementation guidance for suppliers and implementers, including business requirements for the way in which information provided in clinical referral letters will be used in hospital systems.
4. Achieve consensus of professional and patient organisations to establish the product as a national standard. The final product is to be endorsed by appropriate professional and patient representative bodies and the PRSB. For a list of the main PRSB member organisations: http://www.theprsb.org/members/
5. Map PRSB referral information models against the current clinical referral information set to identify the differences, to provide a basis for NHS Digital to produce a case and plan for implementation.

2. Methodology

This section describes the approach taken to develop the project deliverables.

2.1. First Draft Information Models

First drafts were based on existing information models published by the Academy of Royal Medical Colleges' (AoMRC) publication 'standards for the clinical structure and content of patient records'. The PRSB project team reviewed the documents and provided feedback on the items at meetings with NHS Digital. This informed a set of draft headings and questions to consult on at the multi-professional workshops.

2.2. Consultation workshop

The first draft information models were converted into a form in which they could be understood by a general audience, including patients and clinicians. A consultation workshop was held on 9 January 2018, including patient representation, health/care professionals, suppliers and other stakeholders (attendees are listed in Appendix A). Following the workshop the outcomes were discussed with the project clinical leads to update the draft deliverables and to identify issues to be explored further in the online survey.

2.3. Online survey consultation

The PRSB project team designed an online survey, to obtain the views of healthcare professionals, patients and suppliers (see Appendix A for a breakdown of the respondents). The survey ran from 05 February – 12 March 2018.

Quantitative and qualitative analysis of the survey results was conducted and reviewed with the project clinical leads (a summary of the online survey results and analysis are provided in Appendix B). The analysis was used in conjunction with the workshop outputs to update the draft information models and to inform the agenda for the expert panel meeting.

2.4. Expert panel meeting

An expert panel meeting was held on 24 April 2018 to inform decisions on several outstanding issues identified in the earlier stages of the consultation (attendees are listed in Appendix A). A summary of the outputs from the meeting are detailed in Appendix C.

3. Final draft information models

The final draft information models developed during the project are now available on the PRSB website, following the patient and healthcare professional consultation.

4. Next steps

This report contains background to the project, the approach taken, the final draft information models and outputs from the consultation.

This report will be shared with the PRSB assurance committee and the project board for review and sign off.

The report will then be sent to relevant professional bodies to seek their endorsement before being released as a PRSB endorsed standard.

5. Appendix A – stakeholders

This appendix describes the stakeholders who participated in the workshop, the online survey and the expert panel meeting.

Workshop attendees (09 January 2018)

Organisation	Name
King's College Hospital NHS Foundation Trust	Thomas Coats
Retired	Ruth Caudwell
British Medical Association GP Committee	Tom Yerburgh
Cambio Healthcare	Martin Hanlon
Cerner	Pooja Saha
Docman	Rory Dennis
Docman	Rebecca Ryan
East Lancashire Hospitals NHS Trust	Alistair Gray
ESP IT Consultancy Ltd	Zabeda Ali-Fogarty
Healthy London Partnership	Sara Nelson
Londonwide Local Medical Committee Representative	Emma Rowley-Conwy
NHS Digital	Silvia Lillie
NHS Digital	Pete Davies
NHS Digital	Luvjit Kandula
NHS Digital	Chris Dickson
NHS Digital	Catherine Baker
NHS Digital	Adnan Azfar
NHS e-Referral Service	Paul Denton
NHS e-Referral Service	Liz Barfield
NHS Fife	Grant Forrest
NHS Scotland	Iain Hammerton
NHS Wales Informatics Service	Rebecca Cook
Oxfordshire Clinical Commissioning Group	Tom Nichols
Patient Representative	Sabin Qureshi
Position Systems Limited	Dick Wallis
Professional Record Standards Body	Lorraine Foley
Professional Record Standards Body	Helene Feger
Royal College of General Practitioners	Neill Jones
Royal College of General Practitioners	Julian Costello
Royal College of Speech and	Kathryn Moyse

Language Therapists	
Royal Free London NHS Foundation Trust	Tim Yates
Royal Pharmaceutical Society	Stephen Goundrey-Smith
Salford Royal NHS Foundation Trust	Matthew Atkinson
Salford Royal NHS Foundation Trust	Gareth Thomas
South, Central and West Commissioning Support Unit	Jane Thurlow
Southend University Hospital NHS Foundation Trust	Stephanie Carey
Southend University Hospital NHS Foundation Trust	Kathy Murphy
St Georges Foundation NHS Trust	Anthony Hemeson
University Hospitals of Leicester NHS Trust	Steve Jackson

Survey respondents (by role)

This table provides a breakdown of the roles of the 365 survey respondents (*please note respondents were able to choose more than one role*).

Role	Number	%
Secondary care doctor	133	36.44%
General practitioner	59	16.16%
NHS administration/ management	41	11.23%
Allied health professional	36	9.86%
Nurse	29	7.95%
Informatician	27	7.40%
Patient/carer/service user	23	6.30%
Health/care system vendor or developer	11	3.01%
Pharmacist	8	2.19%
Health visitor	1	0.27%
Other	56	15.34%

Expert panel meeting attendees (24 April 2018)

Organisation	Name
Royal College of General Practitioners	John Robinson
Cerner	Andrea Dantas
Civica	Stephen Hawkins
eReferral Service	Paul Denton
NHS Digital	Gerry Firkins
NHS Digital	Andrew Perry

Professional Record Standards Body	Phil Koczan
Royal College of General Practitioners	Neill Jones
Royal College of General Practitioners	Julian Costello
Royal College of General Practitioners	Ralph Sullivan
Royal College of Physicians, Health Informatics Unit	Darren Wooldridge
Royal College of Physicians, Health Informatics Unit	Malvina Rossi
Royal Liverpool and Broadgreen University Hospitals NHS Trust	Michael Fisher
Salford Royal Group	Gareth Thomas
Servelec	Daniel Smillie
Servelec	Vicki Mudd
University College London	Anoop Shah

6. Appendix B – survey results and analysis

This appendix provides a summary of the online survey results and the quantitative and qualitative analyses:

Please visit the PRSB website to view the survey results and analysis.

7. Appendix C – Expert Panel Meeting Outputs

This appendix provides a summary of the outputs from the expert panel meeting.

Referral clinical information standard
Expert Panel Meeting
Meeting notes

Joining by webex: Andrea Dantas (Cerner), Mike Fisher (CCIO, Royal Liverpool Hospital), Kiri Elliott (British Dietetics Association), Paul Denton (NHS Digital), Anoop Shah (Clinical Pharmacologist, University College Hospital), Gerry Firkins (NHS Digital), Ralph Sullivan (RCGP Health Informatics Group)

Referral details: Problem about when locums are making referrals. This would be handled by including locum in the role. There is also a return response to field which would allow responses to be to the regular GP if required. Concern in survey about additional burden but implementation guidance would explain this is a non-mandatory field. Return response to should be defaulted to the regular GP. Grade does not exist on SPINE today, only on GP systems – if it cannot be populated and there is no benefit we could remove it from all. However it could be entered as text. Info model may need to be updated to state this is a text only field.

Referral criteria: would be good if it could be prepopulated and save time. Risk is where it would prevent referrals where the criteria are not met – however implementation guidance should explain that this should not block referrals. Need to distinguish between referral criteria being a safety issue (by blocking people), or putting them into the letter (clinician burden). No need for yes/no answer. It is a very variable mechanism. It is about recognising that there is a detailed pro-forma and is locally determined which would be found under this heading. Important that the criteria are not a barrier to referrals being made. This heading could be used for when the referrer chooses the service, system generates criteria (if they exist) and then GP can choose which are met/not met.

Details of other referrals: this is about active other referrals. However time limit would need to be added if it was auto-populated. 12 months could be the time limit and could edit the ones that are not relevant. Imp guidance needs to be clear this is about clinical information, identifying other comorbidities and administrative (i.e do not clash with other appointments). Having access to a link to the full referral (UBRN for e-referrals only) would be the ideal solution to identify open episodes. Paul Denton to send us something about UBRN and ERS so we can build it into guidance. **Group felt this is a helpful heading. Should be auto-populated but with clinical review. Should be a list of the referrals and where a UBRN exists the ability to get the full referral. User should be able to edit the timescales but default at 12 months (filter should be explicit to the recipient that a filter is in place).**

Reason for referral, expectation and presenting complaints: these are somewhat separate things and should thus be separate. Reason for referral could mostly be narrative e.g. for treatment, for diagnosis etc, however there are some codes within SNOMED CT. The problem list would be separate under presenting complaints and issues.

Information Governance (IG): Important point that working diagnoses, speculative diagnoses should not be coded in case of incorrect propogation through record (same issue as in Emergency Care discharge summary).

Preference for ‘problem list’ rather than ‘medical history’. All major significant problems, active and inactive should be included.

Examinations and findings: Like on EMIS there is system functionality to choose what is relevant. The standards need to have observations and examinations as optional. All of the data items will be date stamped and clinical discretion is required as to which is used. FHIR resources will specify that codes or text can be used. Vital signs is felt to be removed as it just one type of examination finding. No need for 2 headings of examination and examination findings (they should be merged). Observables need to be consistent across whole of PRSB work.

Safety alerts: there is value of having both coded and free text entries but risk of adding coded date about things which are no longer valid (i.e. suicidal thoughts 5 years ago). Therefore clinical judgement and should not be auto-populated – implementation guidance to clarify.

Medications: In SCR default is 12 months for acutes (authorised repeats will be included), in EMIS view is 90 days. Should be consistent with SCR but referrers have option to add in older things where relevant (including stopped meds). Discontinued repeats could be added at discretion.

Other issues: Concern about burden on clinicians – first of type testing should identify issues. System design will be created by suppliers, NHSD, PRSB implementations to identify reducing burden e.g. auto-population, user interface etc. Needs to be very clear that clinician burden will be minimised.

Implementation guidance: May need to update participation in research heading to required and the definition to be updated to make clear that is active research projects only (i.e not interest to take part in a study). Definition of required apparently may need to be tweaked in line with Data Dictionary (however this is a wider PRSB issue and should be consistent in all standards).

Risks – data dump, which overwhelms receiver, or too little information, which poses a clinical safety risk. Where coded info is coming in it needs to be mapped correctly – if it goes into wrong field it changes the meaning (i.e code of heart disease entered in diagnosis rather than family history).

Only relevant information to be extracted – add to IG Investigations, examinations, observations.
Risk is entering the wrong end point – not knew to this work but could add this to log and add in safety check to make sure there is a mitigation.
Change title to referral professional record standards as information standard is something different. Action to find out timescales regarding FHIR profiles and inform ERG.