



**Professional
Record
Standards
Body**

**Better records
for better care**



OUTPATIENT LETTER STANDARDS

**FINAL REPORT ACCOMPANYING FINAL VERSION OF
INFORMATION MODELS AND IMPLEMENTATION
GUIDANCE**

JULY 2017

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NHS Digital

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The Professional Record Standards Body

The Professional Record Standards Body (PRSB) was registered as a community interest company in May 2013, to oversee the further development and sustainability of professional record standards. Its stated purpose in its Articles of Association is: “to ensure that the requirements of those who provide and receive care can be fully expressed in the structure and content of health and social care records”. Establishment of the PRSB was recommended in a Department of Health Information Directorate working group report in 2012.

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Related Documents

Ref no	Title
[1]	Standards for the Clinical Structure and Content of Patient Records. http://theprsb.org/publications/bible-sets-out-the-latest-agreed-standards
[2]	Hospital Discharge Summary Standard and Phase 2 information models http://theprsb.org/publications/e-discharge-summary-standard
[4]	HL7 Emergency Care Domain Analysis http://www.hl7.org/implement/standards/product_brief.cfm?product_id=421

Glossary of Terms

Term / Abbreviation	What it stands for
AHP	Allied health professional
Academy	Academy of Medical Royal Colleges
CDGRS	Clinical Documentation and Generic Record Standards
CKM	Clinical Knowledge Manager
DM+D	NHS dictionary of medicines and medical devices
ED	Emergency department
EHR	Electronic Health Record
EPR	Electronic Patient Record
GMC	General Medical Council
HCPC	Health and Care Professions Council
HIU	Health Informatics Unit
HL7	Health Level 7
NHSD	NHS Digital
NIB	National Information Board
NICE	National Institute for Health and Care Excellence

ODS	Organisation Data Services
PAS	Patient Administration System
PDS	Patient Demographics Service
PID	Project Initiation Document
PRSB	Professional Record Standards Body for Health and Social Care
RCGP	Royal College of General Practitioners
RCP	Royal College of Physicians
SCCI	Standardisation Committee for Care Information
SNOMED CT	Systematized Nomenclature of Medicine Clinical Terms
ToC	Transfer of care

Planned Review Date and Route for User Feedback

The next maintenance review of this document is planned for June 2020, 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.

1 Introduction

1.1 Purpose of this document

This document is a summary report of the outpatient letter standards project. It presents:

- Evidence and consensus based standard headings and content definitions for outpatient letters with supporting information models and implementation guidance.
- The methodology adopted to develop the standard headings, content definitions, information models and implementation guidance for outpatient letters.

NHS Digital commissioned the Professional Record Standards Body (PRSB) to undertake this project. This report has been prepared by the Royal College of Physicians' health informatics unit, which was subcontracted by the Professional Record Standards Body to facilitate development of the standard headings, content definitions and accompanying documentation, to the point where formal endorsement is sought from the Professional Record Standards Body members.

1.2 Background

1.2.1 Project summary

This project seeks to improve patient care by developing standards for digital outpatient letters to allow clinical information to be recorded, exchanged and accessed consistently across care settings.

Outpatient letters in this project are those sent following an outpatient encounter to a GP practice, and copied to a patient. The outpatient attendance may have taken place as a face-to-face encounter in a hospital building, a community hospital, health centre or other community premises, or via other means, for example over the telephone or via Skype.

Increasingly letters are being sent to the patient and copied to the GP practice. It is anticipated that the standard headings and content definitions, information models and implementation guidance will also be applicable to those letters.

The aims of this work are:

- To improve continuity of care by communicating relevant information more quickly.
- To improve patient safety by reducing transcription errors through enabling re-use of key data in the GP system.
- To improve patient experience by communicating more quickly with patients and their carers.
- To support the delivery of a more effective and efficient health care service through producing better information for secondary purposes (such as clinical audit and research) by carrying information in coded format, where appropriate.

The project is built on the outputs of previous PRSB projects, including discharge summary and other transfer of care standards (emergency care, mental health and ambulance to ED) and crisis care documentation.

The information models produced by this project will be used by NHS Digital to develop technical specifications. The implementation will be managed by NHS Digital, working in collaboration with the PRSB, industry and implementation sites. The ongoing maintenance of the standard will be managed through a separate maintenance contract with the PRSB.

1.2.2 Policy context

The development of standards in digital outpatient letters is grounded in the desire to improve the quality of patient care and underpinned by national policy.

Using standards in digital health care records allows clinical information to be recorded, exchanged and accessed consistently across care settings in order to deliver high-quality care to patients.

The National Information Board framework for action (2014)

This project is fundamental to delivering the clinically-approved interoperability standards required by the NIB framework for action. This document states:

“The NIB will support key standards that help clinicians ensure that patients are safely transferred between episodes of care. We propose the adoption of the Academy of Royal Medical Colleges’ publication ‘Standards for the clinical structure and content of patient records’, with a requirement that all organisations and clinical systems should implement the standards, following consultation and completion of impact and assessment.”

The scope of the Academy of Medical Royal Colleges (Academy) standards includes headings for admission, discharge summaries, handover, referral letters and outpatient letters.

NHS Five Year Forward View

The NHS five year forward view published by NHS England states:

“In future we intend to take a different approach. Nationally we will focus on the key systems that provide the ‘electronic glue’ which enables different parts of the health service to work together. Other systems will be for the local NHS to decide upon and procure, provided they meet nationally specified interoperability and data standards.”

The project will lead the development of ‘nationally specified interoperability and data standards’. Without this work the status quo will remain as stated in the five year forward view as:

“Systems that don’t talk to each other, and a failure to harness the shared benefits that come from interoperable systems”.

Transfer of Care programme & NHS standard contract requirements

The Transfer of Care (ToC) initiative within NHSD has been established with the primary purpose of driving the establishment and uptake of consistent professional and technical data standards across the health and care sector, with particular focus on the documents that support the transfer of care between organisations and care providers. The Transfer of Care Initiative is part of programme 13: Integration Projects, which sits under the National Information Board Domain D.

To support care integration, as specified in the published 2016/17 NHS standard contract, requirements have been tightened for the production and transmission to GPs of letters (where clinically required) following outpatient clinic attendance. The current timescale for production (within 14 days of attendance) will reduce progressively to 10 days (from 1 April 2017) and 7 days (from 1 April 2018). The deadline for a structured message capable of carrying both human readable narrative and coded (SNOMED CT) information using, or consistent with, the PRSB/Academy of Medical Royal Colleges headings is 1 October 2018.

Changes in outpatient services and quality of current outpatient communication

Outpatient department services are diverse and are changing rapidly. An ageing population, increase in comorbidity and a shift from inpatient care to outpatient care in the UK has resulted in an increase in referrals and attendances at outpatient department clinics, and a growing importance within the NHS of outpatient services. These outpatient services involve a multitude

of medical specialties, nurses and allied health professionals, and serve a diverse population with differing conditions and clinical needs.

The communication created from an outpatient service encounter, known as the outpatient letter, serves a number of purposes. It is the main method of communication between hospital staff and general practitioners. In addition, it communicates to the patient a record of the consultations and decisions. In many cases it is the sole record of the consultation held by the outpatient clinicians and allied health professionals. Outpatient letters can also be communications between one hospital and another, for example tertiary care to secondary care. The scope of this project is the communication following an outpatient appointment to the GP, which is also copied to the patient.

While the above highlights why outpatient letters should be clear, concise and contain sufficient information for the GP involved in the patient's care to ensure uninterrupted patient care and management, the quality of such letters is variable. Research on communication in relation to outpatient clinics shows that these letters contain errors. As a result, communication with general practitioners is less effective than it should be, which could impact negatively on patient safety and quality of care.

The outpatient letter standards project is required to ensure better quality outpatient letters and meet the requirements for digital transfer of outpatient letters using the PRSB/Academy Headings and structured coded messages by October 2018.

1.2.3 Project scope

The project scope was set out in the project initiation document. It included:

- Letters produced by a consultant's team, nurses, nurse practitioners and AHPs following an outpatient episode and communicated to GP practices and patients.
- Letters produced following multi-disciplinary team outpatient consultations.
- Letters produced following outpatient consultations that occur face-to-face, by telephone or by video conferencing.
- Letters produced during initial outpatient consultations, follow-up consultations and annual review outpatient consultations.
- Standard headings and content definitions that align, where practicable, with the PRSB/Academy headings and definitions.
- The focus will be on producing a standard generic outpatient letter, applicable across specialties and disciplines.

The scope did NOT include:

- Bespoke communication to a GP that is used following a procedure at an outpatient attendance (eg endoscopy), where the bespoke communication is the only communication to the GP about the encounter. A procedure report is often generated through a different route to outpatient letters.
- Letters produced following an outpatient contact that are sent to care professionals other than GPs. The scope of the project is defined as communication from outpatient clinic to GP and copied to patient, only. However, it is expected that the headings and content definitions developed will be similar for outpatient communications directed to other care professionals and their use is encouraged. Other care professionals are welcome to use the record headings and definitions, but they will not be devised with their specific needs in mind.
- Discipline and specialty-specific variations to the generic outpatient letter. However, the seven examples will demonstrate how different specialties can use the generic outpatient letter (available at <https://theprsb.org/publications/outpatient-letter-standards>).

1.2.4 Project governance

Oversight of the project was provided by a project board. End user representation at project board level was provided by:

- A pharmacist
- A user of healthcare services
- NHS Digital
- A nurse
- An allied health profession

Clinical leadership and advice at project team level was provided by a general practitioner and a consultant physician.

2 Headings, definitions and information models

Available from the PRSB website at <https://theprsb.org/publications/outpatient-letter-standards>.

3 Implementation guidance

Available from the PRSB website at <https://theprsb.org/publications/outpatient-letter-standards>.

4 Methodology

4.1 Project approach

The project was conducted according to the editorial principles for the development of record standards, developed by the RCP and adopted by the PRSB. The methodology adopted is set out below.

The focus was on:

- Identifying what information GPs and patients require in outpatient letters and what information it would be preferable to have in a coded form.
- Identifying what structured (and coded) information is feasible to include in outpatient letters and how this may change with the implementation of more integrated electronic patient record systems. This will help to inform phasing of implementation in trusts.
- Engaging with specialist societies and relevant royal colleges to ensure that the standard meets their needs, they are engaged and support implementation of electronic outpatient letters, based on the standards.
- Developing case-studies for hospital clinicians and GPs on the implementation of standardised electronic outpatient letters that will provide good practice and lessons learned related to engagement, communication, dissemination and professional leadership.

4.2 Evidence review and developing draft 1

Purposes:

- To develop a first draft of the record headings, content definitions and information models that are evidence based.
- To capture learning from academic literature and current practice.

Literature review:

A literature review was undertaken in relation to outpatient letters. Themes that needed to be covered for the purposes of the outpatient letters project were identified. Search terms were reviewed and refined and used to identify relevant research papers. Key findings were extracted.

Mapping of:

- Standards related to the outpatient letter reviewed. For example, the PRSB hospital discharge summary information models, PRSB/Academy record headings.
- Example outpatient letters from a range of specialties¹.
- Identification of key issues from site visits to Cambridge and Cardiff.

¹ 29 outpatient letters to GP from outpatient clinics were included

Synthesis:

- Identified the similarities and differences in data recorded.
- Drafted the standards reviewed by the clinical advisor and clinical lead.

4.3 Consulting on draft 1 and developing draft 2

Purposes:

- To develop a second draft of the record headings, content definitions and information models, and guidance that are evidence-based, and where the views of key stakeholders on the draft are captured and considered at this early stage.
- To ensure that the project products are consensus-based.

Consultation workshop

Draft 1 of the headings and content definitions were discussed at a consultation workshop held on 19 January 2017. There were 45 attendees, comprising patient and carer representation, health and care professionals, industry and other stakeholders. The workshop identified some implementation issues for consideration in the development of the guidance.

Post consultation workshop

Following the workshop the outcomes were discussed with the project clinical lead and clinical advisor. This informed the second draft of standard headings and content definitions, information models and the first draft implementation guidance.

Information models, in the form of word documents, were drafted by the project team and reviewed with the project clinical lead and clinical advisor. The information models were informed by the evidence review and the consultation workshop. Values were derived from existing PRSB information models, where relevant.

The draft 1 information models were shared with the NHS Digital terminology and messaging leads for their review and feedback. The terminology lead has mapped headings to SNOMED CT and provided additional subsets, where relevant. These have been reviewed by the clinical adviser (GP) and feedback provided on the proposals made.

The information models also categorised headings as either:

- MANDATORY: must be included in all outpatient letters sent by the sending organisation.
- REQUIRED: if there is information recorded it should be sent to the recipient.
- OPTIONAL: a local decision as to whether information is sent to the recipient.

The project team held a meeting with the clinical lead and clinical advisor to review the information models and inform development of the draft implementation guidance. The implementation guidance includes issues identified from the evidence review and workshop which relate to implementation of the headings. They are not intended to be comprehensive, but just those issues identified at this stage. It is expected that this guidance will be updated following later stages of the project and will certainly need to be updated once pilot implementations are undertaken, to include the lessons learnt from them.

4.4 Consulting on draft 2 and developing draft 3

Purpose:

To seek feedback from a greater number of stakeholders on draft 2.

Approach:

An online survey using Survey Monkey was developed to seek views from patients, carers, healthcare professionals, and clinical information system suppliers on draft national standards for the structure and content of outpatient letters.

One thousand and eight individuals participated in the survey. After data cleansing, nine hundred and seven responses were deemed suitable for analysis. See appendices for breakdown by area of interest/specialty.

The survey asked for feedback on four main areas, identified during the evidence gathering and consultation workshop phase as needing wider consultation. These areas are:

- What elements of patient history ought to be communicated in an outpatient letter following (a) an initial outpatient appointment; and (b) a follow-up outpatient appointment?
- Should only NEW allergies and adverse reactions be communicated in a letter; and, should allergies and adverse reactions to MEDICATIONS ONLY be communicated in an outpatient letter.
- Should the 'diagnoses' and 'problems and issues' elements be located within a single overall heading called 'condition'.
- Which overall headings should be 'mandatory'. Mandatory headings are headings where information must be communicated in the outpatient letter. If information is not provided, then the letter cannot be sent as it would compromise patient safety.

Participants were given the opportunity to provide additional feedback under an 'any other comments' section.

The survey was sent via personalised emails to over three hundred identified stakeholders from patient and carer groups, royal colleges and specialist

societies with a request to complete and distribute among colleagues using formal and informal networks. The survey and accompanying consultation document were hosted on the Professional Record Standards Body (PRSB) website and promoted via the Royal College of Physicians and PRSB social media channels.

Survey responses were collated and analysed and recommendations from the clinical lead and clinical advisor are outlined. Recommendations are based on the following considerations:

- A greater majority of respondents across all professional and patient cohorts demonstrate a preference for one position or option being offered over an alternative.
- Stronger rationale for an alternative minority position is demonstrated, eg patient safety; or,
- A suggestion is not assessed as practical to implement at this time.

Any outstanding issues from the email review and online survey were discussed at an expert review group meeting held on 6 April, and consensus-based solutions or mitigations identified. Implementation guidance was revised and circulated for additional feedback.

4.5 Development of case studies to support implementation

Producing structured standardised electronic outpatient letters is not common practice in the NHS. It will require clinicians to adapt their working practices, and hence the outpatient letter project includes case studies from leading sites to help others with implementation.

Purpose of case studies

- To gain insight into the models used currently in creating digital outpatient letters, the lessons learned from implementation that could be helpful to other trusts, CCGs and GP practices, and examples of good practice.

Approach: through site visits to communities implementing structured digital outpatient letters.

- An understanding of the different processes involved in pulling a digital outpatient letter together, including use of digital dictation.
- An understanding of the issues implementing electronic or standard outpatient letters present and how they can be mitigated.
- Insight into how changes in producing outpatient letters have been implemented. For example, whether it was phased, including the experience of clinical teams, and any lessons learned.

- Gather data from designers, drivers and recipients of implementation, clinicians (primary and secondary care).
- Analyse and write up. Findings validated through sites reviewing and signing off content.

The case studies will be available via the PRSB website.

4.6 Development of exemplar letters to aid implementation

Purpose of the letters

- To demonstrate how the headings can be structured in different services for different types of appointments.

Audience

- The letters were created primarily for the NHS digital messaging team to use in the creation of outpatient message specifications. As hospitals and GPs have different structures for their EPRs, the project has developed standards for communication of outpatient letters, ie a common standard to which local outpatient letter content can be mapped to enable the meaning to be retained when communicated to the recipient (ie semantic interoperability). The examples provided are not intended as exemplars of the way in which outpatient letters should be structured but simply to provide varied content for the messaging team to use to illustrate mapping to the PRSB standard.

Approach

- Clinicians from different specialties were asked to compose example outpatient letters to represent different types of appointments (initial and follow-up, doctor, and AHP led clinics) to demonstrate how the information might be best structured.
- The letters were quality assured by the PRSB assurance committee.

The letters are available from the PRSB website at <https://theprsb.org/publications/outpatient-letter-standards>.

5 Appendices

5.1 Articles identified in literature search

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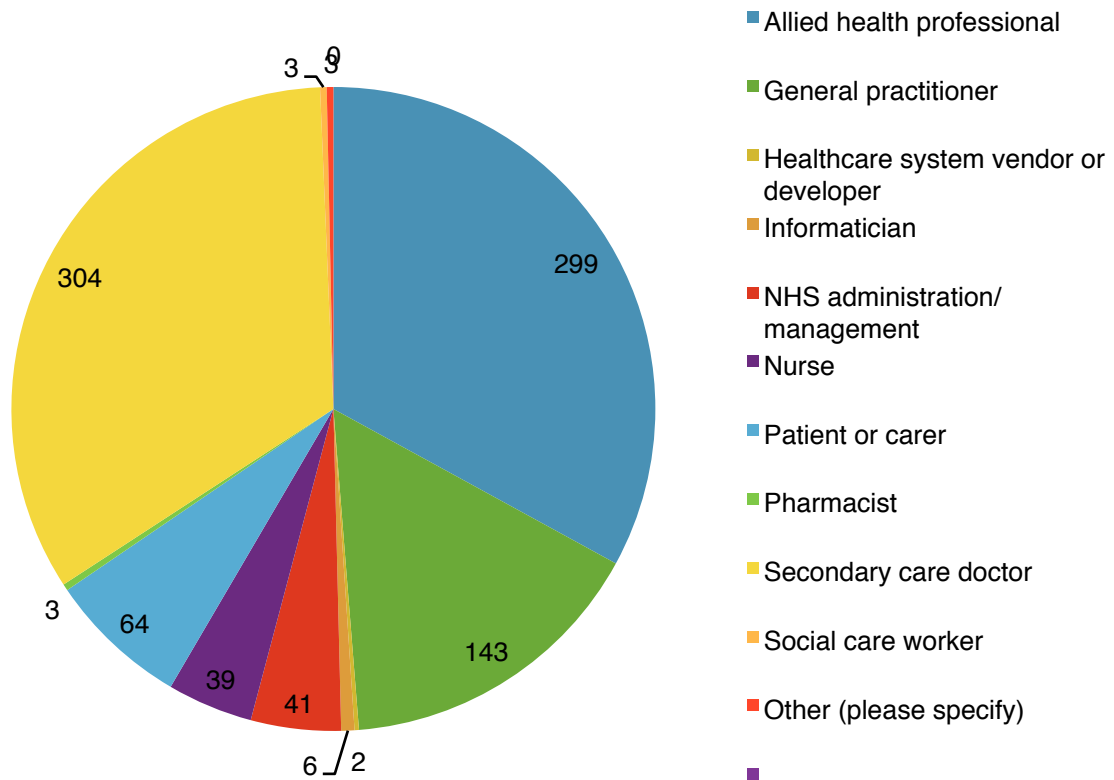
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5.2 Survey participants: breakdown by area of experience or specialty

<i>Profession/patient and carer</i>	No.	%age
Allied health professional	299	33%
General practitioner	143	16%
Healthcare system vendor or developer	2	0%
Informatician	6	1%
NHS administration/ management	41	5%
Nurse	39	4%
Patient or carer	64	7%
Pharmacist	3	0%
Secondary care doctor	304	34%
Social care worker	3	0%
Other (please specify)	3	0%
Total	907	100%

Participation by cohort



Service users/carers and healthcare professional respondents had experience of at least one of the following specialties or service areas.

Acute internal medicine	Haematology	Paediatrics
Anaesthesia and intensive care	HIV	Pain Management
Breast Surgery	Infectious diseases	Palliative care
Cardiology	Intensive care/ anaesthesia	Physiotherapy
Clinical genetics	Learning disabilities	Plastic Surgery
Clinical pharmacology	Mental health/Psychiatry	Podiatry
Colposcopy	Musculoskeletal	Psychiatry
Dermatology	Neonatology	Rehabilitation Medicine
Dietetics	Nephrology	Renal Medicine
Ear, nose and throat	Neurology	Respiratory medicine
Endocrinology	Neurosurgery	Rheumatology

Fertility	Nursing/care home	Social Work
Gastroenterology	Occupational Therapy	Speech and language therapy
General medicine	Oncology	Sport and exercise medicine
General surgery	Ophthalmology	Stroke Medicine
General practice	Orthodontistry	Surgery
Geriatrics	Orthopaedics	Urology
Gynaecology and obstetrics	Orthoptics	