



**Professional
Record
Standards
Body**

**Better records
for better care**

DOCUMENT NAMING STANDARD

FINAL REPORT

NOVEMBER 2018

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Glossary of terms

Term / Abbreviation	What it stands for
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AoMRC	Academy of Medical Royal Colleges
CCIO	Chief Clinical Information Officer
CIO	Chief Information Officer
EDMS	Electronic Document Management System
EHR	Electronic health record
FHIR	Fast Healthcare Interoperability Resources
HIG	Health Informatics Group (of the RCGP)
HIU	Health Informatics Unit
IHE-UK	Integrating the Healthcare Enterprise
IHRIM	Institute of Health Records and Information Management
NHSD	NHS Digital
PHR	Personal health record
PID	Project Initiation Document
PRSB	Professional Record Standards Body for health and social care
RCGP	Royal College of General Practitioners
RCN	Royal College of Nursing
RCP	Royal College of Physicians
SNOMED-CT	Systematized Nomenclature of Medicine - Clinical Terms

Planned Review Date and Route for User Feedback

The next maintenance review of this document is planned for November 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.

1. Introduction and background

1.1. Background

'Personalised Health and Care 2020 Using Data and Technology to Transform Outcomes for Patients and Citizens: A Framework for Action'¹, proposes a progressive implementation of digital data standards and an end to paper records in all NHS-funded care contexts within six years, supported by a series of core national standards and incentives.

Over the coming years, the NHS will see an increasingly comprehensive record of digital data (clinical and administrative). This data may be held on a number of clinical and non-clinical systems, brought together as a patient's digital record, or electronic patient record (EPR). The digital data will include documents, e.g. 'legacy' case-notes and contemporaneous (aka 'day-forward') documents generated during or after an episode of care.

There is a need to ensure that documents that form part of a digital record are appropriately indexed to ensure the safe and effective retrieval of documents within a care setting and transfer of these documents across care settings. Therefore, there is a need for national guidance on the naming of digital documents.

As an interim step to full digital patient records, some trusts are bulk scanning paper case notes. An agreed process for the bulk-scanning of paper case-notes is also needed to prevent the current situation in some trusts where, it has been reported, all the paper case-notes are being scanned into a single PDF file which is impossible to navigate safely and quickly.*

National guidance needs to be endorsed as 'fit for purpose' by the end users, e.g. clinicians, patients and document managers in the NHS.

There are different document naming standards in use within the NHS in the UK, for example, the clinical document indexing standard used in Scotland^{2,3} and the standard implemented in radiology. There are also international standards^{4,5} for document metadata, including document names.

1.1.1. NHS Scotland Clinical Document Indexing Standard

The Scottish Clinical Document Indexing Standard (EH4001) (CDIS)^{2,3} was created for the purpose of facilitating finding documents in a document management system and providing a standard set of metadata associated with a document to facilitate transfer of documents across systems and care boundaries. That system was produced in 2007 from a collaboration of Scottish health boards and has been adopted throughout Scotland.

* The latest capture, classification and document management technology, however, does allow for identification and 'tagging' of form names at document level, accessible as high level metadata, even in cases where the whole case note has been scanned as a single, multipage TIFF or PDF file. It is, therefore, possible to filter metadata held in a database and retrieve the exact document desired within a large bulk scanned PDF file.

There are two documents which comprise the CDIS: The Clinical Document Index Guidance³, which details the metadata requirements, and the Clinical Document Indexing Standard (EH4001)² which contains document type definitions and associated codes.

In recent years the Scottish CDIS has been mapped to SNOMED CT codes in addition to the Scottish Document Standard Type. It is important to note that the document type is only a part of the metadata required to adequately describe a document. Other important elements such as patient identifiers, date, author, author role, specialty, subspecialty, location, service, sensitivity and so on are described in the CDIS Guidance document³ and are graded as either 'essential' or 'desirable'. An important principle of the CDIS is to avoid creating document types that include a specialty name in the definition since that information is carried in another piece of metadata attached to the document. Speciality is an essential requirement, and it must always be included in the document metadata. The CDIS is designed to grow and accommodate new document types.

Initially the CDIS was managed by National Services Scotland (NSS) on behalf of the Scottish health boards. It became clear that a governance model that included a large portion of clinical input is required to maintain the CDIS as dynamic and responsive. To support the CDIS the Clinical Change Leadership Group (CCLG) took on ownership of the document and performed an extensive review in 2011. A subset of the CCLG formed the Clinical Document Indexing Virtual Reference Group (VRG). The task of that group is to respond to requests for assistance with the CDIS and for new document types and to provide a solution with a reasonably short turn-around time. The VRG operates through digital communication and consensus. The VRG enables the CDIS to evolve as a living standard responsive to the needs of health care and patients.

1.2. Purpose

The goal of this project was to ensure that documents that form part of a digital record are appropriately named to ensure the safe and effective retrieval of documents within health and social care settings and transfer of these documents across care settings. The aim of the project was to develop a single national standard and guidance for the naming of digital health and social care documents, which recognises the existing Scottish and international standards already in use.

The name of a document is often not presented to the user when an Electronic Document Management System (EDMS) is used. Instead, the metadata held in the database are presented. A naming convention is most relevant where a system not initially meant to hold documents is used, and documents are uploaded to it by various users across the organisations.

The Professional Record Standards Body PRSB worked with the Royal College of Physicians (RCP) Health Informatics Unit (HIU) and other professional bodies to deliver this work, including the Institute of Health Records and Information Management (IHRIM), The Royal College of Radiologists and the Royal College of Nursing.

1.2.1. Key Definitions

For the purpose of this project, a **document** is defined as ‘a single set of coherent identifiable, self-contained information that is a statement of health and care information and can only be updated by total replacement’.

It is important that the following distinctions are recognised:

- **Document title:** refers to the local name for the document as displayed on the document and not searchable, e.g. St Elsewhere Hospital Discharge Notification.
- **Document name:** refers to a specific item of metadata linked to a document, that is human readable and is searchable.

In this report, where the term ‘**patient**’ is referred to, it should be assumed that this could refer to patient, client, citizen, family or carer, depending on the context within health or social care.

1.2.2. Use cases

The following use cases were identified during the project initiation and this report aims to provide recommendations that are relevant to each of these.

1. Clinicians navigating health and care documents and wishing to quickly and easily identify the particular documents they need in order to support patient care.
2. Clinicians navigating health and care documents that have been transferred from a different care provider and wishing to quickly and easily identify the particular documents they need to support patient care.
3. Patients and their carers navigating personal health records (PHRs) and wishing to easily understand and identify the different documents by their document name.

In each of these use cases, it is likely that the user will apply filters based on other metadata, such as date, author, patient name, but the definition of such metadata is outside the scope of this recommendation, which focuses solely on the human readable form in which the resulting document titles are shown to the user.

2. Methodology

This section describes the approach taken to consult with health and care professionals and patients and carers on the document naming standard.

2.1. First draft naming model

A steering group was established with key stakeholders and interested parties from the field, as determined during stakeholder mapping. The project steering group reviewed existing working and draft document naming models in use in the NHS and internationally. These included:

- NHS Scotland Document Indexing Standard², which includes a list of 165 terms, some include the specialty, e.g. Immunology Report, Cardiac Investigation, but others do not, e.g. Discharge Letter. It is used in the national document indexing service in Scotland.
- United States document ontology^{3,4}, which includes a list of 6400 items which include specialty/service/subject matter, where relevant, together with the kind of document. It is a single list. It uses US terms and so is not applicable to the UK.
- Fast Healthcare Interoperability Resource (FHIR) composition resource, which references the US model as the preferred value set.
- Pre-standard draft, developed by NHS Digital, including two elements in each document title: correspondence care setting and correspondence document type.

The document naming models were considered by the project steering group and their combined knowledge and experience helped to develop principles for and content of a draft model for the naming of digital documents and scanned paper records.

The document naming standards considered in defining the first draft made use of similar constructs: a) the kind of document and b) the document source, being a specialty, service or care setting.

In selecting an appropriate standard as a first draft, the following criteria were used:

- Human readable document name.
- Applicable to documents from all health and care settings.
- Applicable across the four home nations.

2.2. Online survey consultations

An online survey was designed by the HIU, and reviewed by the project steering group, to obtain the views of health and care professionals, patients and carers and suppliers.

The survey was distributed widely amongst stakeholders. A list of targeted stakeholders is provided in 'Appendix B – Target stakeholders'.

Some of the survey respondents (see 'Appendix A – Survey results' for a breakdown of the respondents) agreed to have follow-up conversations with the project team to further discuss the requirements for a document naming standard and, in some cases, the experience of these individuals in their efforts to index documents.

Quantitative and qualitative analysis of the survey results were conducted and reviewed with the project steering group (a summary of the online survey results and analysis are provided in 'Appendix A – Survey results'). The analysis was used, in conjunction with the expertise and experience of the project steering group, to inform the recommendations provided in the 'Recommendations' section below.

There were 31 responses from patients/carers. Of these, 30 responded 'Yes' to the question 'Do you agree that there should be a national standard for document naming?', with one response of 'don't know'. This represents a 97% positive response, compared to a 89% positive response overall. 90% of respondents answered 'Yes' to the question 'Do you feel this naming model is fit for the purpose of naming digital documents in the NHS?', compared to 71% positive response for all respondents.

2.3. Further analysis

The following issues arose during the project:

- The scope being restricted to the document name was too narrow, as other information about a document needs to be used to locate specific documents.
- There is no PRSB national standard for the set of information about a document. Given the lack of a standard, with clear clinical definitions, situations arose where very similar pieces of information that are needed to identify a document were used in subtly different ways, e.g. the difference between the specialty/profession of the author and the specialty/service in which the document was produced. Both are necessary pieces of information to record about a document.
- There are shortcomings in all of the existing document metadata models. For example, in the Scottish model², the inclusion of upper GI or lower GI with endoscopy report was identified as an example where procedures have been inappropriately included in the document 'subtype'.
- Concerns from NHS Digital terminologists and other technical experts about combining a document name (e.g. outpatient letter) with a specialty (e.g. cardiology) in a single term, as this would lead to a proliferation of document names.
- Concerns from non-technical steering group members that not including specialty as part of the document name could make it difficult to locate specific documents; in particular, should specialty/service be an optional item (as it is in the FHIR profiles)? For example, trying to find radiology or endoscopy reports where 'report' was recorded as the document name.

There were differences of opinion between project steering group members which resulted in further definitions of two alternate models by two of the steering group members and in consultation being carried out via the INTEROPen Ryver platform. This allowed wider engagement with clinical informaticians and industry. Further details conversations were also held with a systems supplier. This report was updated in response to the wider feedback received through this platform.

3. Results and recommendations

This section provides the project's recommendations to the PRSB Advisory Board following the consultation with health and care professionals, patients and carers.

3.1. Information about documents

The 'document name' is only one piece of information recorded about a document and only one way of searching for and identifying a document. It should be viewed as part of a much wider set of details used to describe a document. Other information needs to be held about a document to enable it to be easily located. This information includes:

- **Document**-related information, including document name, the organization where the document was created, date/time document produced, version.
- **Patient**-related information, such as name, date of birth, NHS or other national identifier.
- **Author**-related information, such as name, job role and specialty or service in the employing organisation.
- **Service or setting (context)**-related information, such as the care setting (e.g. inpatient, outpatient), service or specialty context (e.g. a cardiologist may report on some procedures done in the radiology department: the setting would be radiology but the author specialty is cardiology).
- **Procedure**-related information, where relevant the type of procedure (e.g. laboratory, operations, radiology, endoscopy procedures).

The above is not a comprehensive list and there will also be other pieces of information that need to be recorded – the exact definitions of these additional data items is out of the scope of this project.

3.2. Naming model and key principles

The 'document name' should provide a concise yet unambiguous, human-readable name to the people who see it.

The document **name** should not be confused with the document **title**, which is the local name for the document, as displayed on the document and not searchable, e.g. St Elsewhere Hospital Discharge Notification. The document title could be generated from the document name, but this would be a local choice.

3.2.1. Document name

The document **name** should be a single item of metadata that is coded (with a SNOMED CT code) and searchable. It should include information about the kind of document and may, in relevant cases (e.g. radiology report, endoscopy report) also include information about the specialty/service in which a patient encounter happened.

There is a pre-existing list that should be used to select the document name, published by NHS Scotland and available online.² The list of names is categorised into document 'types' and 'subtypes'. Definitions for these 'subtypes' are also included. In the majority of cases the document name will be made from the 'subtype' but in some cases, the document 'type' must also be included to provide sufficient information, for the type, 'report', subtype, 'radiology'.

Recommendations for the required development and maintenance of this list are described in sections 3.3 and 3.4 below.

The document name should be supplemented with other metadata to enable patients and clinicians to find documents easily. The speciality or service context in which the document was created will be particularly important in locating specific documents. This information should always be included with the document name in the document metadata.

3.2.2. Specialty or service

The specialty or service context should always be recorded to enable documents to be easily found.

Published lists include:

- Main specialty in the NHS Data Dictionary.⁶
- Treatment function code in the NHS Data Dictionary.⁷
- Correspondence Care setting type subset in SNOMED CT.⁸
- The ISD national specialty list is to be used in document indexing, this is available as a reference file from ISD.⁹
- Directory of Services from the NHS e-Referral Service (e-RS).¹⁰ These are locally defined services and so should not be used for a national standard.

We recommend that the treatment functions codes⁷ are used, which incorporate the main specialty list, but also approved sub-specialties and treatment specialties. Given the move to SNOMED CT as a national coding standard, we recommend that these items should be mapped to the correspondence care setting type subset in SNOMED CT⁸; and, if there are gaps not covered by SNOMED CT, then terms would need to be authored.

3.2.3. Other information about the document

To efficiently locate specific documents it will be essential to have more information about the document than just the name and the specialty/service. There is a need to define a standard set of information, but this is out of scope of this project.

The following models of metadata should be considered in developing such a standard:

- Scottish model²
- US document ontology^{4,5}
- FHIR composition profile.

3.3. Implementation recommendations

1. In the case of referral documents, a rule should be applied to specify that the 'specialty/service' should relate to the **destination**, not the source of the document.

2. A single list of specialty/service/care settings should be developed by mapping the NHS data dictionary treatment functions⁷ to the correspondence care setting subset in SNOMED CT.⁸
3. It should be mandatory to include both the document name and the specialty/service in the document metadata to ensure that specific documents can be easily located.
4. The list used to select the document name needs to be extensible, meaning that additional names can be added if required (for example, if a new type of document is identified).
5. A maintenance function is required to ensure that additional items can be added and redundant items removed or updated. This maintenance function should be arranged in collaboration with the NHS National Services Scotland Clinical Document Indexing Virtual Reference Group.
6. The list of document names should be listed and maintained as a SNOMED CT subset for use across the NHS.
7. Clear, unambiguous definitions for each document name should be provided (some definitions are provided for the document subtypes in the NHS Scotland Indexing standard²).
8. Some document subtypes in the Scottish indexing standard² have a procedure in the name, e.g. 'endoscopy report upper GI'. There is a need to develop an approach for including procedure either in the metadata for the document or by adding reports of procedures into the document name list.
9. The recipient system may need to bring in other items of metadata to the document name in order to make it unique – the document date is recommended for this purpose. This recommendation is based on feedback from system suppliers.

3.4. General recommendations

1. The workflows that lead to a user selecting a document name must be clearly defined and tightly controlled via appropriate technological means to ensure appropriate and consistent naming.
2. Suppliers will need to consider the user interface. For example, providing drop-down list(s) to present options for the document name, making most frequently used names appear at the top of the lists, etc.
3. The document naming model should be used in interoperability standards such as FHIR profiles, to ensure appropriate interoperability of documents.
4. When patients are accessing their PHRs they should be able to easily view the document titles and document names.
5. This project has considered the naming of digital documents, to create a clear, concise, human readable name. Additional standards are needed to describe the additional metadata for digital documents (e.g. date, author, organisation, etc.) This work should be taken forward by NHS Digital and the PRSB.
6. Synonyms should be used where the same document is known by different names, e.g. discharge summary and transfer of care document, so that the

underlying coded concept is the same. Preferred terms should be used and the creation of multiple names for a single document must be avoided.

7. Document name elements that accurately represent the specified document should be used wherever possible. For example, the document name 'report' should be avoided where possible, in favour of specifying the type of report, e.g. Pulmonary Investigation Report. Although not encouraged, it should also be possible to use a document name of 'Miscellaneous' if it is not defined elsewhere. See also, recommendations 3 and 4 in section 3.3 Implementation recommendations, above.
8. For documents that originate from patients, the document name may be 'Letter from patient'. Consideration needs to be given, however, to the kinds of documents that patients generate, as additional document names may also need to be added. The patient can be cited as the author of such documents in the additional document metadata.
9. Some NHS organisations will already have a naming model in operation and may need to map this to the proposed standard where sharing documents. The recommendations stated in this report should be followed to ensure consistency of document naming across the NHS.
10. To ensure that the document naming model outlined in this report is fit for purpose in all settings within the NHS, it is recommended that a small study is carried out to test its usage and ability to successfully name a number of real NHS documents. Details of the proposed methodology for this study are outlined in 'Appendix C – Trialling of the naming model'.

3.5. Recommendations for the indexing of scanned paper records

There are several methods being utilised across the NHS in the bulk scanning of paper case-notes, including the following:

- Scanning case-notes of all patients.
OR
- Scanning case-notes of patients who are being treated.
- Scanning all documents within a paper case-note file individually into separate files.
- Scanning all documents of the same kind within a paper case-note file into separate files (e.g. all the letters, all the charts, etc).
- Adding physical dividers to a paper case-note file to mark different sections before scanning, either into different files, as indicated by the dividers, or into a single file.
- Scanning all paper case-notes into a single file.

Recommendations:

1. When scanning paper case-notes, the reason for scanning should be carefully considered in order to choose the best methodology for scanning.

2. It is good practice to avoid scanning complete case notes into a single PDF file, especially if there is a likelihood of them being used operationally. If this is done, however, the resulting document should be named 'legacy bulk scanned record'.
3. When selecting a scanning method, the organisation should take into account their local requirements and capabilities based on available funding, administrative availability and expertise of scanning administrators.
4. Where possible, the naming model described in section 3.2, above, should be used for the indexing of scanned paper records.
5. Where multiple documents of the same kind are scanned into a single file, the resulting document can use the pre-fix term 'bulk scanned', followed by the relevant document name, e.g. 'bulk scanned care plans'.
6. Where multiple documents of varying kinds are scanned into a single file, the resulting document can use the pre-fix term 'bulk scanned', followed by the term 'miscellaneous' to form the document name.
7. Companies able to provide scanning services should be contacted before deciding on a scanning methodology, to ensure they are aware of the specific requirements for the scanning of health and care documents, compared with documents outside of this sector.

4. Next steps

Publish the document naming standard, using this document, as a draft while seeking endorsement from the professional bodies who are members of the PRSB and others involved in this work. As documents are produced by all health and care organisations, endorsement should be sought as widely as possible (Appendix B – target stakeholders).

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Appendices

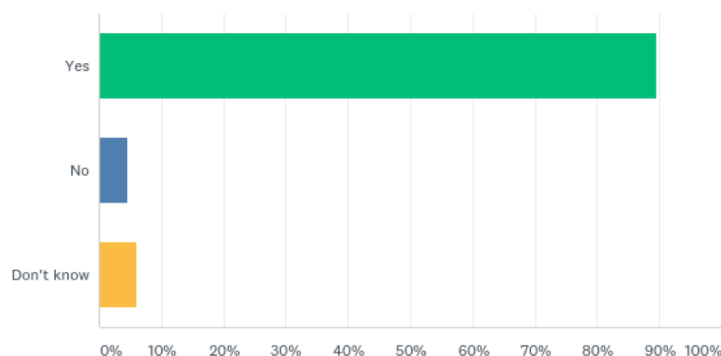
Appendix A – Survey results

A total of 281 people responded to the survey. Below is a summary of the results. For the qualitative responses, a thematic analysis was conducted to identify common themes.

Q1 Respondent roles

Answer choices	Responses as percentage of total (total number)
Patient / carer	11.74% (33)
Paediatrician	2.85% (8)
General practitioner	6.05% (17)
Psychiatrist	6.76% (19)
Other doctor	11.74% (33)
Public health professional	1.07% (3)
Social care worker	0.36% (1)
Pharmacist	2.14% (6)
Midwife	0.71% (2)
Nurse	5.69% (16)
Allied health professional	9.96% (28)
IT system supplier	8.19% (23)
Informatician	8.54% (24)
Manager	4.98% (14)
Record manager	4.63% (13)
Commissioner	0.71% (2)
Other (please specify)	13.88% (39)
TOTAL	281

Q2 Do you agree that there should be a national standard for document naming?



Yes: 89.47% (n=238)

No: 4.51% (n=12)

Don't know: 6.02% (n=16)

Respondents were asked to identify any additional benefits of a national standard. A thematic analysis of the qualitative results identified the following common themes and some illustrative quotes have been provided.

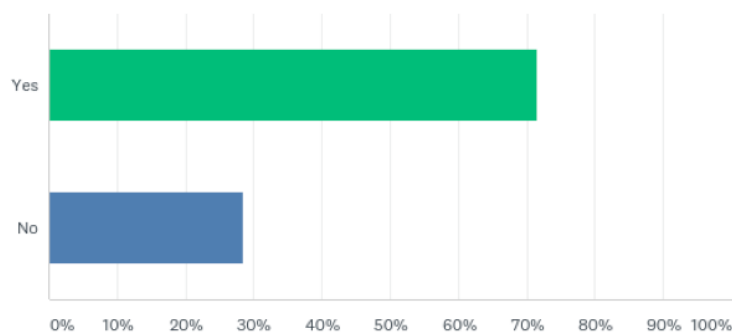
Themes	Illustrative quote
Will provide interoperability	"All clinicians, whichever hospital working in, would know what documents to use. Patients would know what documents are available to them."
Will assist data analysis	"Ability to readily analyse data should be improved."
Patient safety	"Reassure patients that this limits the potential for mistakes."
Will provide consistency	"Uniformity and clarity"
Should use existing standards	"Use the international standards that already exist."
Needs to be easy to use	"Ensure that, where appropriate, they can be navigated and easily identified by the patients/carers".

Q3 The naming model

The model consists of document names in two parts.

- A **document type**, e.g. 'report', 'note', 'result' or 'letter'.
- A **specialty or care setting**, e.g. 'radiotherapy', 'family planning' or 'community nursing'.

Q3 Do you feel this naming model is fit for the purpose of naming digital documents in the NHS?



Yes: 71.53% (n=98)

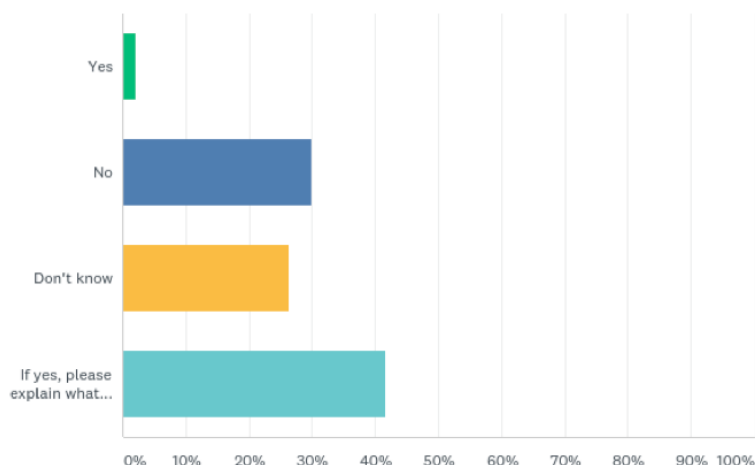
No: 28.47% (n=39)

Themes of respondents who answered 'No'	Illustrative quote
Care setting needs to be compulsory element	<i>"Care setting or specialty should be required, not optional, otherwise it would be quite difficult to navigate."</i>
Document names will be too long	<i>"File name could get too long and unreadable."</i>
More than one name may be relevant to a document	<i>"The naming model IS sufficient, but only if it will be possible to give the same document two or more labels simultaneously (e.g. a document which is both a 'letter' and a 'report'"</i>
Model needs additional elements*	<i>"A name must have sufficient metadata to allow the reader to know what it is about without opening the document. It should also include a data and a version number and if it is draft or final. This is the standard set by the National Archives. Reliance in inherent metadata has never worked."</i>
Will be too difficult to implement	<i>"Documents will not naturally drop into this model causing confusion, and perhaps danger in key documents being overlooked because incorrectly named."</i>
Need to check British spelling	<i>"need to check British spelling (anesthetics is American)"</i>

Q4 Please comment on the suitability of this naming model for your own purposes. You may wish to consider any of the following:

Common themes in comments				
Ease of creating a document name	Correct level of detail so the document can be identified within a patient record	Understanding of name by all healthcare professionals, patients and carers	Interoperability of names when transferring documents across care settings	Other comments
It will provide interoperability/consistency	Sufficient detail	It will provide interoperability/consistency	It will provide interoperability/consistency	It will be difficult to implement
It's easy	Some names are missing from the lists	Some names are missing from the lists	Not interoperable	Spelling mistakes in name lists
More than one name may be relevant to 1 document	Name needs additional elements	Yes – understandable	Names will be too long for some systems	Use FHIR
Names too long	Care setting should be mandatory	It will be difficult to implement	More than one name may be relevant to 1 document	Attach SNOMED IDs
The lists are too long	Need more sections for mental health	Some technical names for patients/carers. Not understandable by <i>all</i> .	Name lists are too long	“Perhaps a glossary - different groups have different perceptions of meaning”
Need to ensure names are used consistently		Names will be too long	Names may be interpreted differently. Need definitions.	
		A key/list of synonyms needed for patients/lay readers		

Q5 Do you feel there are any critical omissions from the document type and care settings lists attached?



Yes: 2.19% (n=3)
 No: 29.93% (n=41)
 Don't know: 26.28% (n=36)

Common themes in comments
Specific name omissions
Metadata elements (e.g. date, patient name/ID, general)
Check latest NHS Scotland lists
Lists need review – some duplication of terms
Mental health omissions
It can be extended over time

Q6,7 What might be the challenges of implementing a standard for document naming in the NHS? How could these challenges be overcome?

Challenges	How to overcome
Omissions	Piloting the model to identify omissions or duplication
More than one name relevant for one document	
Buy-in	Contracts, CQUINs, communication, training/support, change management, penalties, incentives, benefits, order lists in terms of frequency of use, drop-down lists.
Maintenance function needed/Must be extensible	Ease of access to updates. Define hierarchy of documentation.
Changing from old to new processes/ Mapping existing documents into new system.	Change management
Consistency of use	Use standard coding systems
Fit with FHIR. + Need to agree meanings of each document.	Talk to FHIR team Talk to NHS Data Dictionary team Definitions
File names too long	Shorten names
Over-complication	Get it implemented. Get the standard published. Keep it simple.

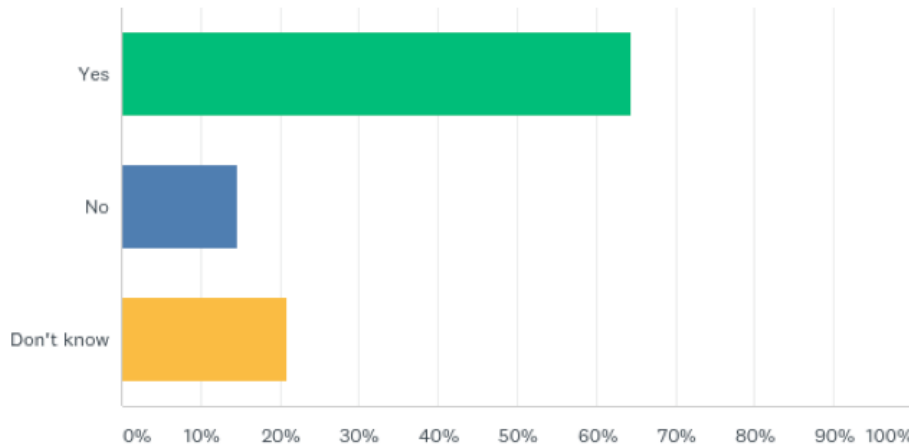
Q8 Bulk scanning

In instances where multiple paper documents must be scanned into a digital record in bulk, a single document naming model will not be compatible. You will see in the document type list that, in these instances, there are several document type names to choose from, also copied below:

- Bulk scanned correspondence/letters
- Bulk scanned reports
- Bulk Scanned nursing documents
- Bulk scanned clinical notes
- Bulk scanned legals/alerts/living will etc

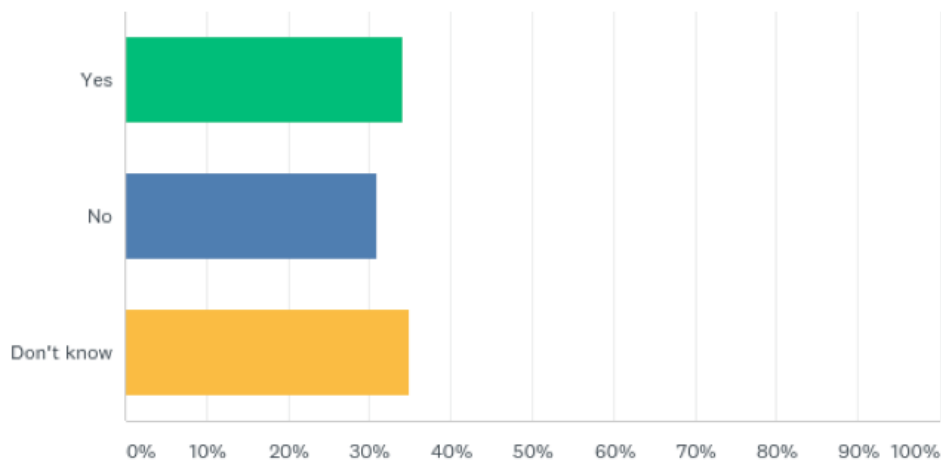
- Bulk scanned charts and forms
- Bulk scanned other

Q8 Do you agree that there should be a standard for naming groups of bulk-scanned documents?



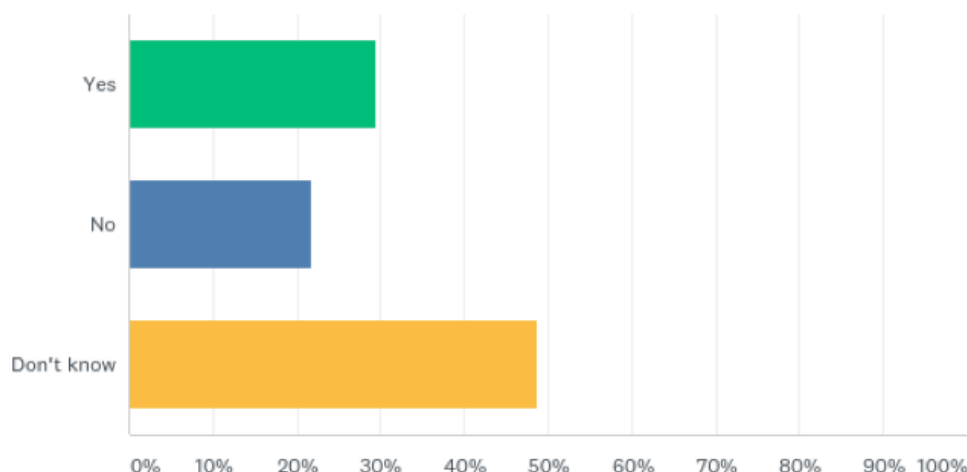
Yes: 64.34% (n=83)
 No: 14.73% (n=19)
 Don't know: 20.93% (n=27)

Q9 Do you feel the above naming model is fit for the purpose of naming bulk-scanned documents in the NHS?



Yes: 34.11% (n=44)
 No: 31.01% (n=40)
 Don't know: 34.88% (n=45)

Q10 Is there anything missing from the bulk-scanning naming model above?



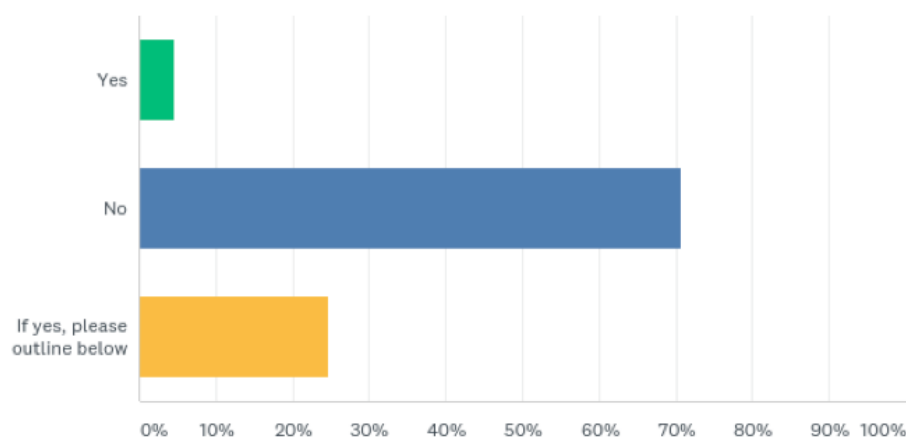
Yes: 29.46% (n=38)

No: 21.71% (n=28)

Don't know: 48.84% (n=63)

It was recognised that there was no clear consensus or agreement with the model proposed for bulk scanning. This was interpreted to mean that different solutions would be relevant in different locations and care settings. Due to this, a set of recommendations were developed for bulk scanning, describing key principles and advice, but a single model has not been specified. See section 3.5.

Q11 Would you recommend an alternative model for bulk-scanning of documents?



Yes: 4.59% (n=5)

No: 70.64% (n=28)

Don't know: 24.77% (n=27)

Appendix B – Target stakeholders

The following stakeholders have been identified during a stakeholder mapping exercise.

The table below lists the target stakeholders and the main route for engaging with them. Those which are highlighted in bold are the main organisations from which endorsement will be sought.

Stakeholder	Main engagement route
Allied Health Professionals	Allied Health Professionals Federation, Royal College of Occupational Therapy and Chartered Society of Physiotherapy - PRSB Advisory Board nominee
Chief Clinical Information Officers	Chief Clinical Information Officers network - via Digital Healthcare run discussion forum and NHS D forum
Chief Information Officers	Chief Information Officers network – via Digital Healthcare run discussion forum
Four nations of the UK	PRSB nominees for Northern Ireland, Scotland and Wales
General Practitioners	Royal College of General Practitioners (RCGP) - PRSB Advisory Board nominee Royal College of General Practitioners Health Informatics Group RCGP – other forums and communications via RCGP communications contact Joint GP/IT Committee to the BMA (and may influence communications to LMCs) liaise with Arjun Dhillon and Paul Cundy. GPSoc – Martin Warden (via Keith Naylor)
NHS Digital	NHS Digital representatives in steering group.
NHS England	
NHS Providers	NHS Providers Informatics Network
Nurses	Royal College of Nursing - PRSB Advisory Board nominee
Midwives	Royal College of Midwives – PRSB Advisory Board nominee
Other clinicians	Royal College of Physicians, Royal College of Paediatrics and Child Health, Royal College of Emergency Medicine, Royal College of Obstetrics and Gynaecology, Royal College of Radiologists, Royal College of Pathologists -PRSB Advisory Board nominee
Patients and Carers	National Voices RCP Patient and Carer Network (PCN) AHSN patient and carer networks Point of Care Foundation
Pharmacists	Royal Pharmaceutical Society - PRSB Advisory Board nominee
Public Health	Public Health England Local Government Association
Mental health	Royal College of Psychiatrists (RCPsych) - PRSB Advisory Board nominee British Psychological Society – PRSB Advisory Board nominee
Social Care	Association of Directors of Adult Social Services - PRSB Advisory Board nominee

Stakeholder	Main engagement route
Information and record managers	IHRIM – via Sean Brennan
Industry	TechUK INTEROPen BCS Health HL7 UK IHE

Appendix C – Trialling of the naming model

A suggested methodology for trialling the naming model was developed by the project steering group and is summarised below. Both the development of a document name, and the ability to retrieve documents, should be tested.

1. Select a number of different units doing different sorts of work – primary care, community care, hospital outpatients, A and E, ambulance, social services etc.
2. Ask each unit to collect copies of a selection of the documents they receive (ideally c.300-400 from each site). Documents should be consecutive, so that there is no bias in selecting particular kinds of document.
3. Ask each site to go through these photostats, deleting all identification aspects, working with the organisation’s Caldicott Guardian.
4. Circulate the de-identified documents among a selected group of testers, asking them to generate names for the documents using the naming model and lists described in section 2. Ask testers to consider the ease of generating names and note any missing items.
 - 5a. Compare the names that are generated by different individuals to determine if they were able to follow the naming model to develop the same names as each other for the same documents. Also compare
 - 5b. Determine whether testers are able to retrieve documents appropriately in the same way across the different units.
 - 6a. If there is a difference in the way that testers name documents, consider refining the lists for the document name, or providing additional guidance, and repeating the process above to see if naming becomes common.
 - 6b. If some testers/units are unable to retrieve some documents, consider whether additional guidance is required.