Professional Record Standards Body

Better records for better care

EMERGENCY CARE DISCHARGE SUMMARY

FINAL REPORT

JUNE 2017

Acknowledgements

NHS Digital
This project was funded by NHS Digital. NHS Digital is the trusted national provider of high-quality information, data and IT systems for health and social care. NHS Digital collects, analyses and publishes national data and statistical information as well as delivering national IT systems and services to support the health and care system. The information services and products are used extensively by a range of organisations to support the commissioning and delivery of health and care services, and to provide information and statistics that are used to inform decision-making and choice.

The Professional Record Standards Body
The independent 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.

Professional Record Standards Body
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www.theprsb.org
Community Interest Company No 8540834

Document Management

Revision History

Version	Date	Summary of Changes
1.0	04.04.2017	Inclusion of Route for User Feedback and planned review dates.
1.1	06.06.17	Update to replace ‘National Care Association’ and ‘Registered Nursing Home Association’ with ‘Care Providers Alliance’, as members of the latter.
1.2	26.06.17	Cover Page added to report and formatting updated. Embedded items removed to be published separately; caveat for examples updated.

Approved by

This document must be approved by the following people:

Name	Signed off?	Date	Version
Project board	Yes	04.01.17	1.0

Glossary of Terms

Term / Abbreviation	What it stands for
AMP	Actual Medicinal Product
AMPP	Actual Medicinal Product Pack
AoMRC	Academy of Medical Royal Colleges
CDA	Clinical Document Architecture
CDGRS	Clinical Documentation and Generic Record Standards
CHI	Community Health Index
CKM	Clinical Knowledge Manager
DM+D	NHS dictionary of medicines and medical devices
EC	Emergency Care
ECDS	Emergency Care Data Set

ED	Emergency Department
EDIS	Emergency Department Information System
EHR	Electronic Health Record
EM	Emergency Medicine
EPR	Electronic Patient Record
GMC	General Medical Council
HCPC	Health and Care Professions Council
HIU	Health Informatics Unit
HL7	Health Level 7
IM	Intramuscular
IV	Intravenous
NG	Nasogastric tube
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
RCEM	Royal College of Emergency Medicine
RCP	Royal College of Physicians
SCCI	Standardisation Committee for Care Information
SNOMED CT	Systematized Nomenclature of Medicine Clinical Terms
VMP	Virtual Medicinal Product
VMPP	Virtual Medicinal Product Pack

VTM	Virtual Therapeutic Moiety

Related Documents

These documents will provide additional information.

Ref no	Title
[1]	Emergency Care Data Set https://www.england.nhs.uk/ourwork/tsd/ec-data-set/
[2]	Standards for the Clinical Structure and Content of Patient Records. http://theprsb.org/publications/bible-sets-out-the-latest-agreed-standards
[3]	Hospital Discharge Summary Standard and Phase 2 information models http://theprsb.org/publications/hospital-to-gp-discharge-summary
[4]	HL7 Emergency Care Domain Analysis http://www.hl7.org/implement/standards/product_brief.cfm?product_id=421
[5]	Jansen JO, Grant IC. Communication with general practitioners after accident and emergency attendance: computer generated letters are often deficient. Emergency Medicine Journal 2003;20:256–257.
[6]	Taylor DM, Cameron PA. Discharge instructions for emergency department patients: what should we provide? Journal of Accident and Emergency Medicine 2000;17:86-90.
[7]	Ramasubbu BM, Yap L, El-Gammal A, Kennedy U. Improvement of Communication with Primary Care Practitioners with the Use of Emergency Department Discharge Summaries. The Journal of Academic Emergency Medicine 2014;13:22-25.
[8]	Johns Hopkins University, Armstrong Institute for Patient Safety and Quality. Improving the Emergency Department Discharge Process: Environmental Scan Report. Agency for Healthcare Research and Quality 2014.
[9]	Royal College of Emergency Medicine: Emergency Department Discharge Data Governance Survey 2009
[10]	Health informatics - Electronic health record communication - Part 1: Reference model (ISO 13606-1:2008)
[11]	Emergency care discharge summary project: Clinical safety case report

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.

Contents

1. Introduction

Purpose of the project

In order for information to be shared and re-used safely in an electronic environment, a standardised structure is required. Standards must meet the needs of patients and the healthcare professionals involved in their care and reflect the ways in which those professionals work.

The goal of the emergency care (EC) discharge summary project is to improve patient safety and continuity of care by developing standards for electronic emergency care discharge summaries which will enable interoperability between EC and GP practice systems. The outputs from the project will be used by NHS Digital to develop technical specifications [1] (These are available, currently at experimental stage (June 2017) which should not be used for implementation. See https://nhsconnect.github.io/NHS-FHIR-Doc-eDischarge/Generated/Chapter.1.About/index.html, follow the link for 'FHIR Documents' at the top), which can be used by suppliers to develop electronic EC discharge summaries. Following message specification development, NHS Digital will run first of type testing, and piloting of the standard is expected through global digital exemplar sites and their associated GP practices.

It is important that when patients are discharged from EC that vital information is transferred quickly to their GP and made available to the patient. This information is required for the on-going treatment of patients. The information must be both relevant and useful to GPs and their clinical teams, and it must be practicable for EC professionals to record the information.

Electronic EC discharge summaries will enable:

- Key information to be transferred into the GP record, following review by a clinician, which will reduce transcription errors and improve the quality and completeness of information held in the GP system
- Information on the EC attendance to be available more quickly to the GP practice
- Patient safety and patient experience to be improved
- Key information in EC discharge summaries to be standardised, which will also mean that high quality coded data is available for secondary purposes, such as clinical audit, research and stratified medicine.

Background

NHS Digital commissioned the Professional Record Standards Body (PRSB) to develop standards for electronic EC discharge summaries. The project was managed by the Royal College of Physicians (RCP) Health Informatics Unit (HIU), under subcontract from the PRSB and following PRSB processes and methodology. Clinical leadership was provided by a clinical lead from the Royal College of Emergency Medicine (RCEM) and a clinical advisor from the Royal College of General Practitioners (RCGP).

The scope of the project as specified in the Project Initiation Document (PID) was to:

- Develop EC discharge summary headings and content definitions (description of a section name and content within a clinical record in a way which is meaningful for patients, carers, service users and clinicians)
- Develop an EC discharge summary information model (structured representation of the information content including rules and value sets which can be used to develop a detailed message specification)

[1] Clinical validation of human readable renderings of the technical specifications produced by NHS Digital is not within the scope of this project.

- Develop initial implementation guidance based on consultation during the project (it is expected that the guidance will be developed further following implementation by early implementers following project closure)
- Consult with EC professionals, GPs, patients, carers, service users, suppliers and other stakeholders.

The standards will have applicability to UK urgent and emergency care services including:

- **Type 1** – Emergency departments are a consultant led 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.
- **Type 2** – Consultant led mono specialty accident and emergency service (e.g. ophthalmology, dental) with designated accommodation for the reception of patients.
- **Type 3** – Other type of A&E/minor injury activity with designated accommodation for the reception of accident and emergency patients. The department may be doctor led or nurse led and treats at least minor injuries and illnesses and can be routinely accessed without appointment. A service mainly or entirely appointment based (for example a GP Practice or Out-Patient Clinic) is excluded even though it may treat a number of patients with minor illness or injury. Excludes NHS walk-in centres.
- **Type 4** – NHS walk in centres.

The project is aligned with, and builds upon, the following existing work:

1. The Emergency Care Data Set

The Emergency Care Data Set (ECDS) project [see related documents 1], is a new data set for urgent and emergency care. The ECDS has been developed collaboratively between the Department for Health, RCEM, NHS England, NHS Digital, Monitor, NHS Providers and Public Health England. It will be implemented across all type 1 and 2 emergency departments (EDs) in 2017 and types 3 and 4 in 2018 in England. Emergency Department Information System (EDIS) suppliers are being encouraged to update their systems so that they are able to collect data using the ECDS. The aim of the project is that implementation of the ECDS will lead to improved ED data quality to support patient care and provide better information for commissioners and other secondary purposes (e.g. for research, audit and service improvement), whilst minimising the impact on ED staff.

2. The Academy of Medical Royal Colleges (AoMRC)/PRSB) clinical record standards

These standards [see related documents 2] were published in 2013 during the Clinical Documentation and Generic Record Standards (CDGRS) work programme. They provide clinically-approved professional record standards required by the National Information Board (NIB) framework for action, 'Personalised Health and Care 2020' (https://www.gov.uk/government/publications/personalised-health-and-care-2020).

3. eDischarge Summary Standard

The emergency care discharge summary project is closely aligned with the interoperable eDischarge Summary Standard, which includes information models for key structured and coded data on diagnoses, procedures, allergies and medications [see related documents 3]

The emergency care discharge summary projects also supports the Urgent and Emergency Care Review (http://www.nhs.uk/NHSEngland/keogh-review/Pages/urgent-and-emergency-care-review.aspx) route map, by supporting improved discharge from hospital EC departments. The project is included in the NIB plans in the Transfer of Care programme, which aims to implement national standard electronic communications at transfer of care to improve the

quality and speed of communication and hence improve continuity of care and patient experience. Furthermore, the NHS Standard Contract 2017/18-2018/19 (https://www.england.nhs.uk/nhs-standard-contract/17-18/) stipulates that 'discharges from A&E Services must, from 1 October 2018, be a structured message capable of carrying both human readable narrative and coded (SNOMED CT) information, using or consistent with the Academy of Medical Colleges endorsed clinical headings once published.

This report sets out the methods used in the project, including a summary of the consultation outputs and the stakeholders with whom the project team engaged, together with the detailed information models and implementation guidance produced.

2. Methodology

The following approach was taken to develop the project deliverables:

Evidence review

An evidence review of documentation related to emergency care discharge summaries to GPs was carried out in June 2016 in order to inform an initial draft set of record headings and associated content definitions. This included:

1. Emergency care discharge letter templates:
    - RCEM: Emergency Department Discharge Summary Example (2009) [see Appendix 1]
    - Airedale NHS Foundation Trust: Emergency Department Discharge Letter Example
    - East Cheshire NHS Trust: Emergency Department Discharge Letter Example

2. Information standards and draft standards:
    - RCEM: ECDS [see related documents 1]
    - AoMRC: Standards for the Structure and Content of Clinical Records [see related documents 2]
    - PRSB: Hospital Discharge Summary Standard and Phase 2 information models (allergies, medications, diagnoses and procedures) [see related documents 3]
    - HL7: Emergency Care Domain Analysis [see related documents 4]

3. Academic papers found on online databases including Pubmed, Medline and Google Scholar [see related documents 5-9]

A mapping exercise was then conducted to identify commonality and divergence between the information content in the evidence sources. A meeting was held with the RCEM clinical lead and the RCGP clinical advisor to review the mapping document. This meeting informed a first draft of EC discharge summary record headings, associated content definitions and identified a number of issues to be raised at the consultation workshop.

Consultation workshop

The initial draft headings and content definitions 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 8 September 2016, including patient representation, health/care professionals, suppliers and other stakeholders. Attendees are listed in Appendix 2. A summary of the key issues raised in the workshop is provided in Appendix 3. The workshop also identified some implementation issues for consideration in the implementation guidance.

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, and the first draft information models and implementation guidance.

First draft emergency care discharge summary information model

An information model, in the form of a Microsoft Excel spreadsheet was drafted by the project team and reviewed with the project clinical lead and clinical advisor. The information model was produced in line with ISO 13606-1:2008 [see related documents 10] international standard which specifies the communication of part or all of the electronic health record (EHR) of a single identified patient between EHR systems. The draft information model was shared with the NHS Digital terminology and messaging leads for their review and feedback. The draft information model was shared with the NHS Digital terminology and messaging leads for their review and feedback.

First draft implementation guidance

An implementation planning meeting was held with NHS Digital, PRSB, the project clinical lead and clinical advisor on 6 September 2016. This meeting discussed general principles about implementation of the EC discharge summary standard and how the implementation should be linked closely with the ECDS to reduce the impact on Trusts and suppliers during implementation.

Following the consultation workshop the project team held a meeting with the clinical lead and clinical advisor to review the implementation guidance produced for the PRSB hospital discharge summary and to develop draft implementation guidance suitable for EC discharge summaries. The draft implementation guidance included issues identified from the evidence review and workshop which related to implementation of the headings.

First draft emergency care discharge summary examples

Illustrative examples of how the EC discharge summary may be presented were developed by the project clinical lead. NHS Digital rendered the draft examples in CDA and populated the examples with dummy data. The examples were provided for illustrative purposes during the online survey consultation.

Online survey consultation

The project team, clinical lead and clinical advisor designed on online survey to obtain the views of health care professionals, patients and suppliers on the acceptability of the draft headings, content definitions and examples. The survey was also used to gain patient and professional consensus on a number of identified issues. The survey was circulated to a wide range of stakeholders (see Appendix 2) using a number of communication channels and ran from 03 – 31 October 2016.

209 individuals responded to the survey including:

- 56 general practitioners
- 39 emergency care physicians
- 37 other hospital physicians
- 14 nurses
- 14 healthcare system suppliers/informaticians
- 11 patients

A summary of the online survey results are provided in Appendix 4.

Quantitative and qualitative analysis of the survey results was reviewed with the project clinical leads. This informed amendments to the draft headings, content definitions, information models and implementation guidance and also identified a number of issues to be discussed further at the expert user group meeting.

Suppliers/clinical informatician review of draft information model and implementation guidance

The draft information model and implementation guidance were circulated to system suppliers and clinical informaticians for review and comment. 18 individuals provided over 100 separate comments on the draft deliverables. Most comments were provided in emails, but a few individuals had recorded comments in the documents themselves. All of the comments were reviewed by the project clinical lead/advisor and this informed:

- Amendments to the headings/content definitions
- Amendments to the information model
- Amendments to the implementation guidance
- Issues to be added to the clinical safety case report [see related documents 11]
- Issues to be discussed further with the expert user group

Mental health workshop

The RCEM held a mental health workshop on 12 October 2016 to ensure that recording of mental health information is adequately covered by the ECDS. Attendees are provided in Appendix 2. Outputs from the meeting informed the latest version of the ECDS and the EC discharge summary.

Expert user group meeting

An expert user group meeting was held on 24 November 2016 with patients, health/care professionals, suppliers and informaticians. Attendees are listed in Appendix 2. The meeting was used to make final decisions on unresolved issues which had been identified during the consultation. A summary of the meeting outputs are provided in Appendix 5.

Following the meeting the outputs were discussed with the project clinical lead and clinical advisor. This informed the final draft headings, content definitions, information models and implementation guidance.

Assurance committee review

The PRSB Assurance Committee raised queries on two of the EC discharge summary sections: ‘safeguarding’ and ‘treatments and interventions’, both of which had not been in the original AoMRC 2013 headings and which had been added for the EC discharge summary. On review by the project clinical advisers, it was decided that both of the new sections could be accommodated in the original AoMRC headings:

- Safeguarding issues were covered by the ‘legal issues’ section, with the ‘safeguarding issues’ element and the ‘safety alerts’ section.
- ‘Treatments and investigations’ were covered by the ‘procedures’ section. Investigation results would be included in the ‘clinical narrative’ section where important. These changes were made to the information models.

Final emergency care discharge summary letter examples

Example EC discharge summary letters, based on the information model, are provided on the PRSB website https://theprsb.org/standards/emergencycaredischarge/. These examples indicate where information may be recorded as part of an EC discharge summary for a patient in a given scenario.

3. Information model

The information model is published separately at:
https://theprsb.org/standards/emergencycaredischarge/

Please refer to the glossary and guidance below alongside the implementation guidance, which can also be found at https://theprsb.org/standards/emergencycaredischarge/ when implementing the standard.

Glossary of terms used in the information model

Term	Definition
Section	This is the equivalent of a main heading in the AoMRC headings, e.g. 'Allergies and adverse reactions', 'Patient demographics', etc.
Entry	A single record, e.g. a medication item or a diagnosis, which will be made up of one or more data items, e.g. name, form, route, site.
Element	This is the equivalent of a sub-heading in the AoMRC headings, e.g. 'GP practice identifier' is an element of the 'GP practice' section.
Mandatory	Mandatory headings should always be included in the electronic communication. Where there is no information then the message will contain appropriate coded text to identify this.
Required	Where information should be recorded (and communicated) if available.
Optional	Where local decisions can be made about whether or not to communicate the information.
Cardinality	The numerical relationship between two parts of an information model. In this document, it refers to the number of times that a sub-component occurs within a 'container' i.e. document, section, sub-section or record entry. E.g. The 'Medications and medical devices' section may have 0 to many medication records in it.
Value	The values that can be recorded within an element e.g. free text, constrained SNOMED CT subset etc. Business values were derived from existing PRSB information models and from the ECDS, where relevant.

Use of the model

Suppliers should be able to support all the headings in the information model. However, it is not anticipated that all headings will need to be used for all patients in all circumstances, only where they are relevant to a specific patient, i.e. the general rule is that headings should not be included in the communication where there is no data recorded/available. The standard headings and content definitions are intentionally generic so that they can be used consistently across different use cases and care settings. The order in which the headings appear in EC discharge summary communications and letters can be agreed by system providers and end users.

Please note that where there is a section which is required/optional, but there is an entry in that section, there will be at least one mandatory element. For example, although the 'attendance details' section is required, where an entry is made there must be a 'date and time of arrival' element recorded.

Appendix 1: Royal College of Emergency Medicine: Emergency Department Discharge Summary Example (2009)

St Elsewhere's Hospital NHS Trust Emergency Department **(01234) 567890**

Discharge Summary **ed@st.elsewheres.nhs.uk**

Patient Details	ED Attendance and GP Details
SURNAME , Forename	Responsible ED Consultant
M / F …… Date of Birth/(Age) / / ( )	Method of Arrival
NHS/ Hosp No.	Time; Date of Arrival
Address	Time: Date of Discharge
Postcode	G.P. Details
Tel/Mobile No.	GP Phone Number

Presenting Complaint(s); Reason for/Context of Attendance

Clinical Narrative

Relevant Investigations and Results *(eg Bloods/ X-ray/ US/ CT/ MRI / Contrast)*

Problem/Diagnosis	Treatments and Procedures	Future Plans, Advice and Recommendations
1		
2		
3		
4		
5		

Medications Stopped/ Change Yes/No If yes please give details

Allergies/ Adverse Reaction/Risks & Warnings

Discharge Medications	Dose	Frequency	Route	Duration	Quantity Supplied (Pharmacy used)

Pharmacy dispensed by Checked by Date

Discharge Destination

Discharging Clinician

Print Name_____Grade-._____ GMC/RCN PIN No. _____

Signature_____ Date _____

Appendix 2: Stakeholders

1. **Individuals who participated in the consultation workshop (8 September 2016)**

Name	Organisation	Role
Aaron Haile	Royal College of Emergency Medicine	Emergency Care Data Set Project Manager
Adnan Azfar	NHS Digital	Senior Relationship Manager – Clinical
Ana Miorelli	Royal College of Psychiatrists	Liaison Psychiatry Faculty
Andrew Carr	Royal College of Nursing	Emergency Nurses Practitioner
Anoop Shah	University College London	Clinical Pharmacology and PhD Student
Ashish Sinha	British Society of Gastroenterology	Clinical Informatics Fellow
Carey Bloomer	Care Providers Alliance	Nurse Manager
Darren Wooldridge	Royal College of Physicians	Health Informatics Unit Project Manager
David Barnet	NHS Digital	Interoperability Lead
Deirdre McLellan	Royal College of Physicians Patient and Carer Network	Patient Representative
Grace Charlesworth	Royal College of Physicians	Health Informatics Unit Programme Coordinator
Haidar Samiei	EMIS	Clinical Director
Howard Leicester	Accessible Info	Patient Representative
Ian McNicoll	OpenEHR Foundation	Co-chair
Jan Hoogewerf	Royal College of Physicians	Health Informatics Unit Programme Manager
Jane Lynch	Independent	Legal Advisor
John Williams	Royal College of General Practitioners	Project Clinical Advisor
Jonathan Brown	British Society of Gastroenterology	Joint RCP/British Society of Gastroenterology Informatics Lead
Liz Goodier	Royal College of Physicians Patient and Carer Network	Patient Representative
Manesh Patel	System C	Interoperability Product Manager
Martin Orton	PRSB	Director of Delivery & Development
Monah Shah	Royal College of Physicians Patient and Carer Network	Patient Representative
Nicola Quinn	Royal College of Physicians	Health Informatics Unit Project Manager
Rosa McNamara	Imperial College Healthcare NHS Trust	Emergency Medicine Consultant
Sarah Montgomery	College of Occupational Therapists	Highly Specialist Occupational Therapist (ED and Acute Medicine)
Sarah Pearce	Imperial College Healthcare NHS Trust	Matron
Shamil Haroon	University of Birmingham	Public Health, Epidemiology and Biostatistics Clinical

		Research Fellow
Tom Hughes	Royal College of Emergency Medicine	Project Clinical Lead
Vijaya Rajoo Naidu	University of Hertfordshire	Emergency Care and Advance Nursing Practice

1. **Stakeholders who provided comments on the draft information model and implementation guidance, when they were opened for general review**

Name	Organisation	Role
Afzal Chaudhry	Cambridge University Hospitals	Chief Clinical Information Officer
Andrea Dantas and colleagues	Cerner	Physician Executive
Bernard Fernando	University College London	General Practitioner
Gill Otway and colleagues	South Devon Health Informatics Service	IT Programme Manager
Haidar Samiei and colleagues	EMIS	Clinical Director
Howard Leicester	Accessible Info	Patient Representative
Isabelle Smith	Age UK	Patient Representative
John McCormick	South Devon and Torbay Clinical Commissioning Group	Chief Clinical Information Officer
Kai Sander	NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group	General Practitioner
Laura Sharples and colleagues	TPP	Clinical Systems Analyst
Liz Angier	British Society for Allergy & Clinical Immunology	General Practitioner
Marianne Markowski	University of Greenwich	Research Fellow at the Centre for Positive Ageing
Marie Migale	Kings College Hospital NHS Foundation Trust	Senior Occupational Therapist
Michael Green	Torbay and South Devon NHS Foundation Trust	Chief Clinical Information Officer
Michael Thick	IMS Maxims	Chief Clinical Information Officer
Neelam Dugar	Royal College of Radiologists	Informatics Advisor
Nick Booth	Connected Health Cities	Chief Informatics Officer
Sharon Bishop	St Helens & Knowsley Health Informatics Service	Data Intelligence Analyst

2. **Stakeholders who were invited to participate in the online survey consultation (03 – 31 October 2016)**

Academic Health Science Networks	Accessible Info
Action on Pain	Age UK
All Scripts	Allied Health Professions Federation
Ambulatory Emergency Care Delivery Network	Association of Directors of Adult Social Services
Asthma UK	Atos

British Cardiac Patients Association	British Computer Society
British Heart Foundation	British Liver Trust
British Lung Foundation	British Society of Gastroenterology
Care Providers Alliance	
Care Quality Commission	Carers UK
Cerner	Chief Clinical Information Officers leaders network
Clinical commissioning group lay members	Computer Sciences Corporation
Diabetes UK	EMIS
Epilepsy Society	General Electric
Genetic Alliance	Health Chief Information Officers network
Healthy London Partnership Urgent and Emergency Care Programme	Ideagen
IMS Maxims	Interopen
Intersystems	Mind
Multiple Sclerosis Society	National Voices
National Kidney Federation	NorseCare Ltd
NHS Clinical Commissioners	Quadramed
Nuffield Trust	Resuscitation Council
PRSB advisory board members	Royal College of General Practitioners
Royal College of Emergency Medicine	Royal College of Nursing
Royal College of Midwives	Royal College of Physicians, Health Informatics Unit register (individuals who have expressed an interest in the work of the HIU)
Royal College of Paediatrics and Child Health	Royal College of Psychiatrists
Royal College of Physicians, Patient and Carer Network	Royal Pharmaceutical Society
Royal College of Radiologists	Sickle Cell Society
Servelec Healthcare	Silverlink Software
Siemens	Stroke Association
Society for Acute Medicine	TechUK
System C	
TPP	

3. Individuals who participated in the RCEM mental health workshop (12 October 2016)

Name	Organisation
Aaron Haile	Royal College of Emergency Medicine
Anne Hicks	Royal College of Emergency Medicine
Caroline Clements	University of Manchester
Dan Thorpe	Mayor's Office for Policing and Crime
Elena Baker-Glen	Royal College of Psychiatrists
Fani Kontidou	NHS England
Gary Slegg	Public Health England
Helen Barrett	UCL Partners
Holly Dorning	Nuffield Trust
Iain Armstrong	Public Health England
Jo Simpson	NHS Digital
Laura-Louise Arundell	Royal College of Psychiatrists
Lucy Palmer	Royal College of Psychiatrists
Matthew Lees	Department of Health

Michael Partridge	Healthy London Partnership
Michelle Costa	Royal College of Psychiatrists
Mike Brodie	South London and Maudsley NHS Foundation Trust
Tom Hughes	Royal College of Emergency Medicine
Viral Kantaria	NHS England

4. **Stakeholders who attended the expert user group meeting (24.11.16)**

Name	Organisation	Role
Adnan Azfar	NHS Digital	Senior Relationship Manager – Clinical
Andrea Dantas	Cerner	Physician Executive
Andrew Carr	Cambridge University Hospitals Trust	Emergency Nurses Practitioner
Darren Wooldridge	Royal College of Physicians	Health Informatics Unit Project Manager
David Barnet	NHS Digital	Interoperability Lead
Gary Hartnoll	Chelsea and Westminster NHS Trust	Associate Medical Director for Clinical Informatics and Transformation
Jan Hoogewerf	Royal College of Physicians	Health Informatics Unit Programme Manager
John Williams	Royal College of General Practitioners	Project Clinical Advisor
Kirsty Challen	Lancashire Teaching Hospitals NHS Trust	Emergency Department Consultant
Laurie Beed	Royal College of Psychiatrists Informatics Committee	Patient Representative
Marcus Baw	Royal College of General Practitioners	Healthcare IT Adviser
Matthew Barlin	Cerner	Emergency Department Solution Consultant
Michael Bond	NHS Digital	Clinical Terminology Specialist
Mona Shah	Royal College of Physicians Patient and Carer Network	Patient & Carer Representative
Munish Jokhani	NHS Digital	Clinical Engagement Lead
Rhian Morgan	Royal Berkshire NHS Foundation Trust	Clinical Change Lead
Tom Hughes	Royal College of Emergency Medicine	Project Clinical Lead
Victoria Heald	Royal Pharmaceutical Society	Lead Pharmacist (Emergency Care)

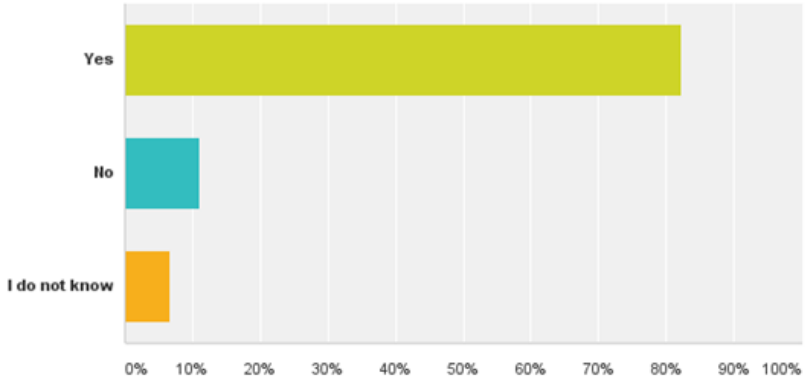
Appendix 3: Summary of issues raised in the consultation workshop (08 September 2016)

- Emergency care discharge summary was felt to be a preferable term to emergency department discharge summary.
- Past medical history was felt to be missing from the discharge summary.
- There was a query whether important patient contacts should be included (e.g. next of kin, carer, interpreter).
- Consistency is required between the use of the terms patient/person.
- Attendance type: Information about previous EC attendances may be required. It was pointed out that if EC departments sent discharge summaries to GP practices this would provide them with this information.
- Presenting complaints or issues: It is important to know the **main** reason for the attendance.
- Assessment type: If included this concept needs to be unambiguous. I.e. a single standardised scale used nationally.
- Investigation: Doesn't cover investigations requested but not yet performed. It is also important to include details of those investigations carried out in EC.
- Investigation results: Only pertinent results should be sent, but if that is not possible, then all results would be better than no results.
- Diagnoses: Working diagnosis may not be the best term to describe unconfirmed diagnoses as it is not used in GP systems.
- Medications: Query whether existing medication should be included. The GP will already be aware what medications the patient is on.
- Medication route: There need to be separate headings for route and site. These exist in the hospital discharge summary, and should be used in EC discharge summary too.
- Allergies - Causative agent: Only newly identified allergies should be communicated. It is important that allergies are recorded as allergies and not as diagnoses as this way they can be included in the patient's allergy information in the GP system.
- Safeguarding should be a heading in its own right, not as a subheading of safety alerts.
- Information and advice given: Needs to be concise and the information which the GP needs to know.
- Clinicians involved: Likely to be local rules for person responsible for discharging the patient. This may not be the person writing the record. Other people involved may be covered in the clinical narrative. Person responsible for ensuring the content of the discharge summary is complete and accurate is more important. There may also be a need to record a senior reviewing clinician. It is very important to include details of the person who the GP should contact for further information.

Appendix 4: Summary of online survey results

1. **Are the terms used for the headings appropriate?**

Of the 209 respondents who answered this question 172 (82%) felt the terms used for the headings were appropriate.

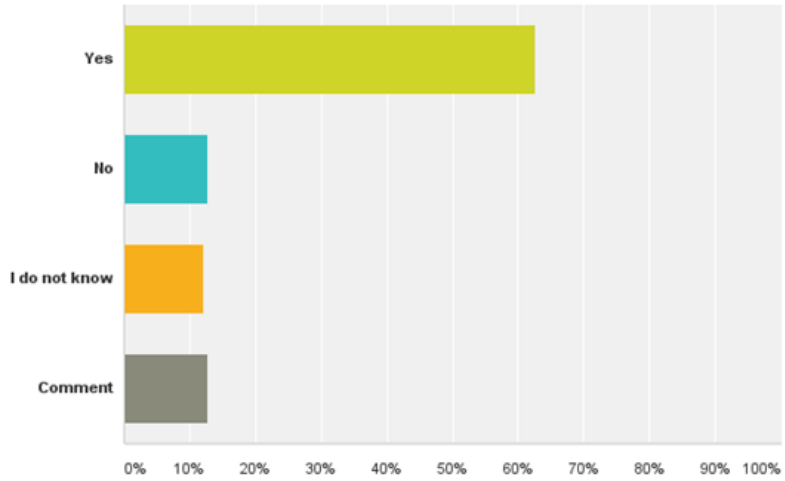


A thematic analysis of the comments provided on the acceptability of the headings identified a number of issues, which are described in the table below , together with the course of action decided upon by the project clinical leads.

Issue	Example comment	Action
'Acuity of care' term not appropriate	'Acuity of care is not a commonly used term and won't be understood'	Changed to 'presenting acuity level' and to be discussed at the expert user group
Safeguarding actions need to be captured	'Safeguarding needs to include actions taken'	Discuss at expert user group if a comments field should be added to the 'safeguarding issues' section. Update implementation guidance
Relevant patient contacts should be included in the discharge summary	'Next of Kin or Preferred contact'	This would be recorded already in the GP record, but could be included in the clinical narrative if required
Follow up actions need to be clearly stated	'As a GP clearer statement of follow up arrangement - including none if appropriate - is critical'	Content definition of 'Plan and requested actions' section updated to make this clearer
Layout of the discharge summary needs to work for end users	'The order of headings need to be re-organised to make it user friendly for the recipient'	The layout of the discharge summary, including sequence of headings, will be a decision for end users

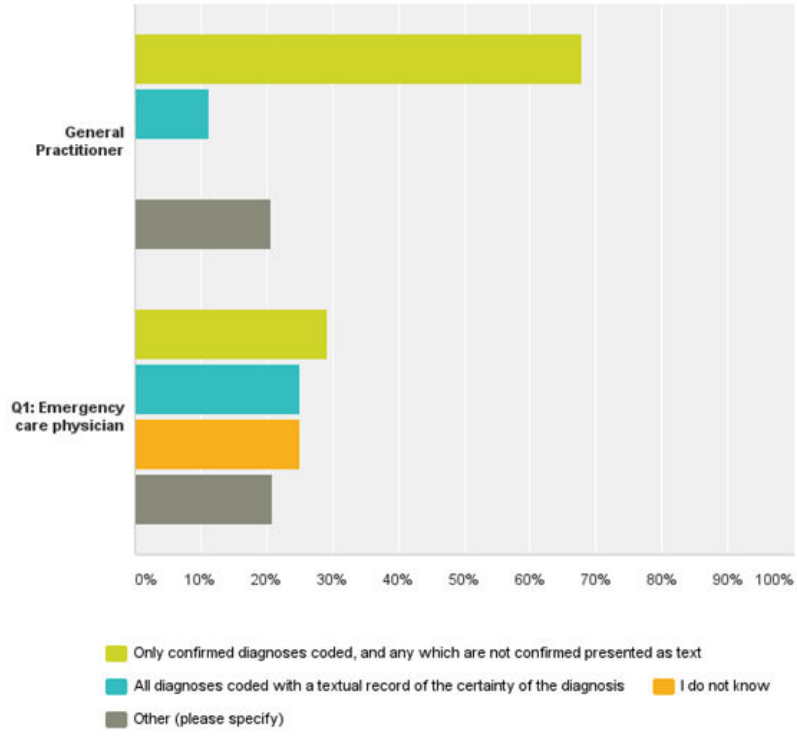
2. **Should tentative (working / possible / probable) diagnoses be displayed in a separate box to definite (established / confirmed) diagnoses on the discharge summary displayed in the GP system?**

Of the 158 respondents who answered this question 99 (63%) felt tentative diagnoses should be displayed separately to definite diagnoses. Due to the high level of consensus it is recommended in the implementation guidance that this is how diagnoses should be displayed in GP systems.



3. **This question is aimed primarily at General Practitioners. How would you prefer diagnoses sent by ED to be presented in the GP system?**

Of the 53 GPs and 24 emergency care physicians who answered this question 36 GPs (68%) and 7 emergency care physicians (29%) felt that confirmed diagnoses should be coded and non-confirmed diagnoses should be presented as text. This was taken to the expert user group meeting for further discussion.



4. **The plan is to implement digital emergency care discharge summaries in NHS systems. This will result in changes in working practices and processes. What challenges do you anticipate and how could these challenges be mitigated?**

A thematic analysis of the comments provided for this question identified a number of challenges and suggested mitigations, which are described in the table below. These comments

informed the implementation guidance and the clinical safety case report [see related documents 11].

Challenge	Example comment
Risk of data burden on those completing and receiving discharge summaries	'Digital overload with a large amount of information of marginal relevance overwhelming what is actually important'
Poor quality data being sent in the discharge summary	'This information is only as good as that being inputted'
Incomplete discharge summaries	'Incomplete completion of forms'
Resistance to change	'There is always resistance to change and new processes'
Lack of interoperability	'Lack of joined up IT systems'
Staff time pressures	'Insufficient time for juniors to create these discharge summaries without setting time aside'

Mitigation	Example comment
Ensure adequate staff resourcing	'Appropriate staffing levels'
Assign sufficient time for completion of discharge summaries	'Adequate time to populate'
Auto-population of data	'Auto-populate where possible'
Engage all stakeholders	'Broad consultation with inclusion of local representatives'
Staff training	'This could be mitigated with adequate training'
Involvement of system suppliers	'Close working with IT suppliers'
Appropriate roll out	'Proper staged roll out, done slowly, with all problems fixed before further roll out'
Pilot test sites	'Pilot first'
Improve system interoperability	'New IT systems which integrate with primary care'

Appendix 5 – Summary of the expert user group meeting outputs (24 November 2016)

Attendance type

Issue	Action
This is administrative rather than clinical information needed for secondary purposes rather than direct patient care	Do not include 'attendance type' in the EC discharge summary

Presenting acuity level

Issue	Action
'Presenting acuity level' is important information to be recorded in EC systems however it does not need to be communicated to GPs in the discharge summary as this can be inferred from other clinical data. Acuity will have changed when patients are discharged and thus could be a false discriminator	Do not include 'presenting acuity level' in the EC discharge summary

Diagnosis

Issue	Action
GPs need to know about both suspected and confirmed diagnoses. EC use diagnosis qualifiers to indicate certainty of diagnoses. It is important that qualifiers are never separated from the diagnosis codes	Do not include 'diagnosis qualifier' in the EC discharge summary. The implementation guidance describes how to handle working diagnoses (section 1.6.5)

Allergies

Issue	Action
In EC allergies are recorded as diagnostic terms but for allergies to be recognised in GP system clinical decision support they need to be recorded as allergies	The implementation guidance states that where an allergy is recorded as a diagnostic term the clinician should be prompted to record an allergy term. The clinical safety case [see related documents 11] includes this as a hazard

Plan and requested actions

Issue	Action
There needs to be consistency with the AoMRC standards for the 'plan and requested actions' section. However it must be clear that individuals responsible for actions may not be named, in which case their role could be included	Content definition has been updated to include the role (e.g. GP) of the person responsible for the action. This section may be structured (table), with actions, names, dates, status, location, strategies, or free text

Safeguarding issues

Issue	Action
There will be circumstances where it will be appropriate to include additional information	A new element for 'comments' has been added to the safeguarding issues section to

about a safeguarding issue. If this was recorded in the clinical narrative it would not be easy to associate this information with the safeguarding code which would pose a patient safety risk	provide further detail on a safeguarding issue

Clinician tier

Issue	Action
Recording a number or the ECDS description for clinician tier would not be of interest to GPs	Do not include 'clinician tier' in the EC discharge summary

Information and advice

Issue	Action
There was discussion about whether there was a need to record anything other than the fact that a copy of the GP letter had been given to the patient. It was felt that it would be useful to continue to use this heading to record information given to the patient e.g. links to patient information pamphlets	Retain 'information and advice given' section as per the AoMRC heading

Appendix 6 – Final emergency care discharge summary letter examples

The examples produced in the project available at https://theprsb.org/standards/emergencycaredischarge/ are to show how patient information should be placed under the headings developed in the EC discharge summary standard for a range of different patient requirements. Please note that the headings cover all possible information needs, and only those headings which are relevant to a given patient's needs are included in the example letter.

The standard does not specify the layout or appearance of the discharge, which is for local determination, and therefore the examples are not intended to be used as templates. For the people creating templates in their organisation, please read the implementation guide.

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