Professional Record Standards Body

Better records for better care

DOCUMENTATION STANDARDS FOR DISCHARGE SUMMARY TO GP FOR MENTAL HEALTH ADULT PATIENTS

FINAL REPORT V1.3

MARCH 2017

Acknowledgements

This project was funded by NHS Digital (previously known as the Health and Social Care Information Centre). NHS Digital is the trusted national provider of high-quality information, data and IT systems for health and social care. It 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.

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www.theprsb.org

Community Interest Company No 8540834

Document Management

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Revision History

Version	Date	Summary of Changes
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0.3	02.08.2016	Third draft signed off by project board
1.0	05.08.2016	Final created by Annette Gilmore incorporating updates from project board
1.1	02.09.2016	Updated by Annette Gilmore following review by PRSB Advisory Board
1.2	23.10. 2016	Updated by Tom Hobbs following corrections from IHRIM
1.3	13.03.2017	Updated by Annette Gilmore following an amendment requested by BPS; typographical errors

Glossary of Terms

Term / Abbreviation	What it stands for
AHSN	Academic Health Science Network
AoMRC	Academy of Medical Royal Colleges
BPS	British Psychological Society

CCG	Clinical Commissioning Group
CCIO	Chief Clinical Information Officer
CDA	Clinical Document Architecture
CDGRS	Clinical Documentation and Generic Record Standards
EHR	Electronic Health Records
FHIR	Fast Healthcare Interoperability Resources
HIU	Health Informatics Unit
HSCIC	Health and Social Care Information Centre
IHRIM	Institute of Health Records & Information Management
MHDS	Mental Health Discharge Summary
NIB	National Information Board
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
RCPsych	Royal College of Psychiatrists
TCC	Technical Coordination Committee
ToC	Transfer of Care

Reviewers

This document must be reviewed by the following people:

Reviewer name	Title / Responsibility	Date
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This document must be approved by the following:

Name	**Signature**	**Date**	**Version**
Project board	Signed off	02.08.2016	0.3
PRSB Advisory Board	Signed off	02.09.2016	1.1
PRSB Project Board	Signed off	24.01.2017	1.3

Related Documents

These documents will provide additional information.

Ref no	**Title**	**Version**
[1]	Mental Health Discharge Summary, Royal College of Psychiatrists, 2012	1.0
[2]	12 x PRSB produced Information models for a subset of the CDGRS core discharge summary headings in March 2015 (http://systems.hscic.gov.uk/interop/tci/standards).	1.0
[3]	Standards for the Clinical Structure and Content of Patient Records. http://www.rcplondon.ac.uk/resources/standards-clinical-structure-and-content-patient-records	2.1
[4]	Editorial principles for the development of record standards https://www.rcplondon.ac.uk/projects/outputs/editorial-principles-development-record-standards	
[5]	AoMRC headings Implementation guidance (http://systems.hscic.gov.uk/interop/tci/edischarge	
[6]	Professional Records Standards Body Service Specification 2014/15	1.1

[7]	PRSB work programme 2015 Lessons Learned Report	1.0
[8]	PRSB assurance criteria	0.7
[9]	Clinical Documentation and Generic Record Standards Lessons Learned Report	1.0
[10]	PRSB Ambulance transfer of care to emergency departments documentation standards	2.0
[11]	PRSB Crisis care documentation project	2.0
[12]	PRSB e-discharge summary final report V1	1.0
[13]	PRSB Discharge summary phase 2: summary report accompanying final draft version of information models and implementation guidance	0.2
{14}	Professional guidance on the structure and content of ambulance records, December 2014 Professional guidance on the structure and content of ambulance .. https://www.england.nhs.uk/wp-content/uploads/2014/12/amblnce-rec-guid.pdf	

Contents

1. Introduction

1.1. Purpose

In January 2016 the Health and Social Care Information Centre HSCIC (now known as NHS Digital) commissioned the Professional Record Standards Body (PRSB) (www.theprsb.org) to develop care-record information standard headings and content descriptions, with supporting high level information models, for structured content of the mental health discharge summary (MHDS). These care-record standards provide the structured content for the information communicated in the electronic health record (EHR) discharge summary to GPs. In order for healthcare information to be shared and re-used safely in an electronic environment a standardised structure is required which incorporates the information needs of the care professionals, patients and carers and supports current workflows and ways of working.

This project supports the NHS Digital and NHS England interoperability work programme; the context is summarised in section 1.2. This documentation standard was developed by the collaborative efforts of the PRSB and the Royal College of Psychiatrists (RCPsych) using PRSB proven methodology, described under section 3 and see https://www.rcplondon.ac.uk/projects/outputs/editorial-principles-development-record-standards).

This document reports the rationale, methods used in the project, the stakeholders with whom the project team engaged the mental health discharge summary headings and implementation guidance developed as part of the project. The MHDS spreadsheet and select information models are included as embedded documents.

1.2. Background

Clinical documentation for generic record standards

In order for healthcare information to be shared and re-used safely in an electronic environment a standardised structure is required which incorporates the information needs of the care professionals, patients and carers and supports current workflows and ways of working. Documentation standards for the clinical structure and content of patient records were last published in July 2013 by the Royal College of Physicians (RCP). These were endorsed for use by the Academy of Medical Royal College (AoMRC), the PRSB and nationally endorsed and approved by 50 professional bodies and patient organisations. They are henceforth referred to as the 2013 AoMRC/PRSB headings throughout this report. These standards provide the generic structure and content of electronic health records and communications. Specifically they articulate the clinical structure and content, in the form of documentation headings with associated descriptions, of patient care records used during typical patient care scenarios. The standards include documentation structure and content for patient admission, handover, discharge, referral, outpatient and a set of core headings. They are deemed suitable and intelligible if used for all patients and any condition. The standards were adopted as the basis for all developments and enhancements of EHRs by the PRSB and the National Information Board published *Framework for Action* (November 2014) states all organisations and clinical systems should implement the standards following consultation and impact assessment (http://systems.hscic.gov.uk/interop/tci/standards).

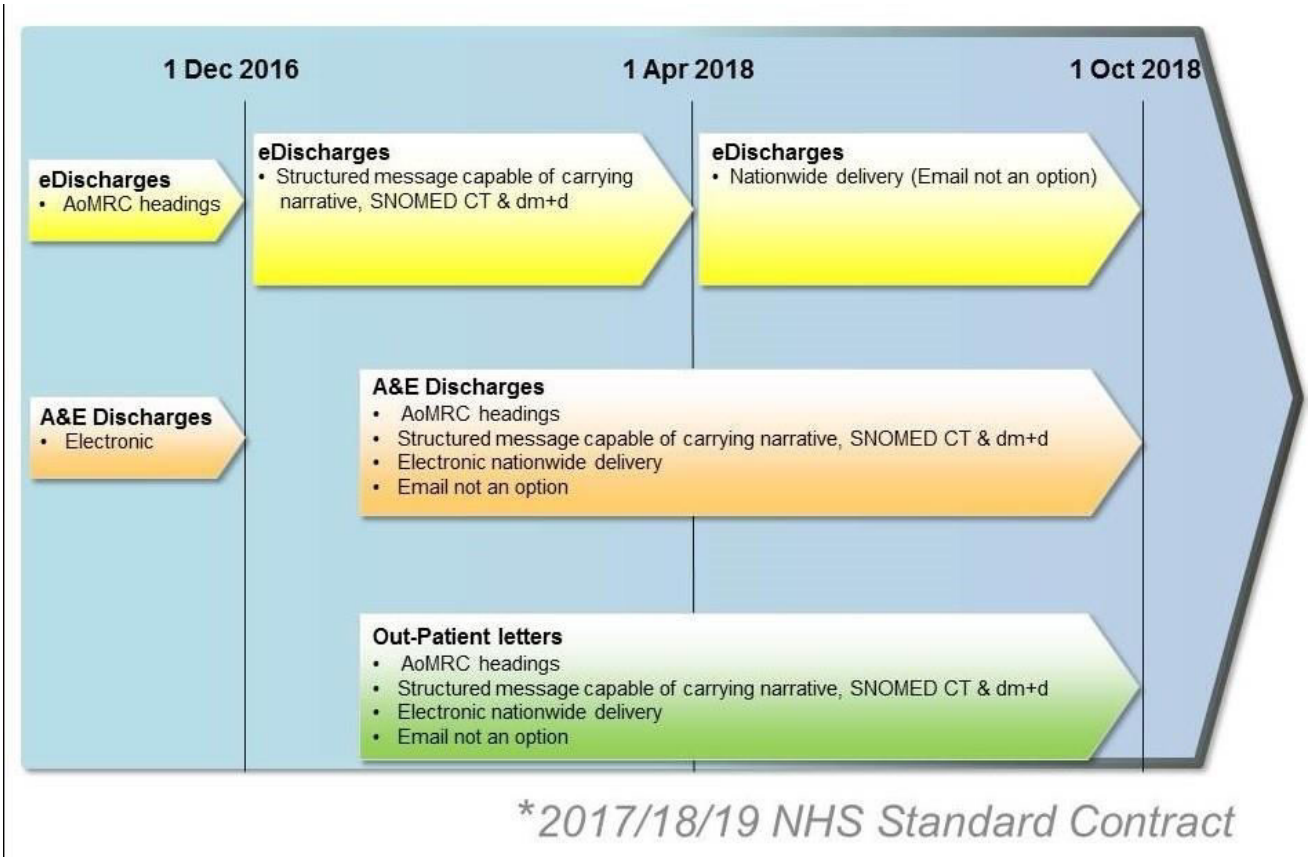
National drivers: Transfer of Care initiative

The Transfer of Care (ToC) initiative is part of a wider interoperability programme run collaboratively by NHS England and NHS Digital. Its primary purpose is the establishment and uptake of consistent professional and technical data standards across the health and care sector and in particular the patient documentation which accompanies a patient's transfer of care between care provider organisations such as discharge from hospital to GP services. The initial priority is to establish and implement patient-care document standards for the electronic transmission of discharge summaries between acute and mental health providers and GPs and patients/carers (http://systems.hscic.gov.uk/interop/tci/edischarge).

The 2015/16 NHS Standard Contract Service Condition 11.6 required Acute and Mental Health NHS trusts to send inpatient and day-case patient electronic discharge summaries to GP practices by 1st October 2015 with the recommendation that they use the 2013 AoMRC/PRSB approved generic documentation standards headings. The NHS Standard Contract for 2016/17 mandates the use of these headings in electronic discharge summaries, with a strong recommendation to use structured messages. There will be requirements in future NHS Standard Contracts to send coded diagnoses, procedures, allergies and medications. In addition, the GP Systems of Choice contract requires the GP IT system suppliers to deliver the capability to receive CDA (clinical document architecture) message-based discharge summaries directly into the primary care systems.

Therefore, the mental health discharge summary must be brought fully in line with the current AoMRC/PRSB approved documentation standard headings and technical requirements for data interoperability.

The road map for e-discharge summary implementation, including related parallel projects is set out in diagram 1.



2. Scope, dependencies and expectations for using the standard

2.1 Scope

The MHDS is for an adult patient discharged from a mental health secondary care service (e.g. hospital) to the care of their GP practice. The purpose of the discharge summary is to communicate to the GP relevant information about the patient and their recent admission to hospital, to support the patient's continued safe and optimal care in the community.

In 2012 the Royal College of Psychiatrists (RCPsych) produced a set of MHDS headings based on the 2008 'Standards for the clinical structure and content of patient records'. This project updates this 2012 mental health discharge summary, aligning it to the 2013 AoMRC/PRSB approved discharge summary headings and conducted the assurance for this updated version. These documentation standards (for this transfer-of-care encounter) form the basis of detailed information models enabling the electronic communications, which are based on the model, to be implementable in the NHS. The design models will be constructed by the NHS Digital messaging team.

The scope of this project was set out in the Project Initiation Document (PID) to include:

- Production of updated mental health discharge summary headings (adult) with descriptions for use when the patient's care is being transferred/ discharged from secondary care to their GP.

- Supporting high-level information models in the form of Excel spreadsheets and/or mind maps.

- Obtain PRSB assurance and endorsement of the headings by professional and patient bodies.

- Development of implementation guidance iteratively throughout the project lifecycle which will form the basis of design models expressed as “openEHR archetypes”, constructed by the NHS Digital messaging team. “OpenEHR archetypes” are defined as a detailed information model using ISO (International Organization for Standardization) 13606 concepts and expressed using openEHR tooling such as the Clinical Knowledge Manager (CKM).

2.2 Dependencies

PRSB has updated the approved documentation standards for specific transfer-of-care-use cases (scenarios where a patient’s care is handed over from one group of care professionals to another) over the last 18 months. This previous and current work has resulted in updates to the generic headings and sub-headings, clinical descriptions, information models and implementation guidance. These updates were incorporated in this project, where appropriate. Additionally, there is new material in the form of headings and associated descriptions which are specific to the MHDS, and updates to existing heading descriptions (where they are deemed to improve those descriptions). Specific project dependencies are as follows:

i. The MHDS headings align with existing professional and technical record standards. The work package will complement and align with, where possible, the current PRSB phase 2 discharge summary project, due for completion in June 2016. This work package reviewed the core discharge summary headings and developed detailed information models, particularly for medications, allergies, diagnoses and procedures.
ii. This project will utilise the latest assured updated headings, sub-headings, descriptions and information models produced by recent PRSB projects including: the e-discharge summary, phase 1 (2015); crisis care documentation project (May 2016); and ambulance transfer of care to emergency departments documentation standards (May 2016).
iii. High-level draft information models (in the form of spreadsheets and/ or mind maps) produced from the MHDS headings. These information models will be further developed, by NHS Digital technical teams, into a message specification for deployment in NHS IT systems.

2.3 Explanation of key standard documentation terms and relationships

PRSB, as described in point (iii) above, will produce abstract information models in the form of spreadsheet and/or mind maps which will form the basis of design models. These information models describe the high-level section hierarchy and descriptions of data elements, optionality and cardinality. Please see the Excel spreadsheet accompanying this report. The following description of key concepts and terms used will aid understanding of the documentation:

“High-level section hierarchy**”** means a clear statement of which are main headings and which are sub-headings, and which sub-headings go under which main headings (and whether this varies according to the document/message).

"Definitions of data elements" will give a precise and unambiguous description of what each item means. These are the descriptions that accompany the headings and sub-headings in the MHDS spreadsheet.

"Optionality" indicates the rules for communicating information under the heading and sub-heading. The options available are: optional, required or mandatory. The meanings are explained as follows:

a) ***Optional (O)*** means that it is optional (written as 'MAY be included') to include that particular piece of information in the patient's health record for this scenario (e.g. discharge summary). Including or excluding 'optional' information items in this patient record scenario will be determined by the local site/hospital policy.
b) ***Required*** **(R)** means that if patient information exists to populate this heading or sub-heading this information SHOULD be included in the patient health record for this scenario/ transfer of care as a matter of good practice. If no information exists for a 'required' heading or sub-heading the heading/ sub-heading is omitted from the record to avoid making the record unduly lengthy.
c) ***Mandatory (M)*** means that information MUST be entered under this type of heading/ sub-heading. If no information exists then there must be an information item to explain this. For example in the absence of drug allergies record 'no known drug allergies…' or where the patient does not have a GP record 'no GP'. Mandatory data fields are kept to a minimum so that the EHR is not unduly lengthy and difficult to read.

"Cardinality" in data-modelling terms, is how one table of data relates to another; this is a critical aspect in database design. It indicates whether data items are related to each other in a one-to-one, one-to-many or many-to-many relationship. The information models developed for the PRSB Discharge Summary project phase 2 incorporate this information.[1] Cardinality was omitted from the final Excel spreadsheet as it is not relevant for clinical and patient review of the documentation standard and may cause confusion.

[1] Where this information was available for MHDS headings (these were identified through review of existing data sets, in particular discharge summary phase 2) they were included in the penultimate review of the documentation standard.

2.4 Using the standard

The mental health discharge summary electronic health record should include all the headings, which will be displayed for information recording, reviewing and communicating. In clinical practice, it is not anticipated that information will be recorded under all headings in all circumstances (i.e. if it is not relevant to that patient, nothing will be recorded). Please refer to the explanation of 'optionality' of headings in the previous section. In addition, some information will be auto-populated from the hospitals' IT systems as these systems mature including patient demographics, investigation results etc. The headings are identified as mandatory, required or optional as described under section 2.3 above. Local agreements will be required between hospitals discharging the patient and the receiving organisations regarding the inclusion or exclusion of each optional heading/subheading in the discharge communication. The implementation guidance, in section 6, will help inform these issues.

The order and sequence in which the headings appear in EHR systems and communications can be agreed locally by system providers and end users.

3. Methodology and project approach

The following approach was taken to develop the documentation standard headings and content descriptions (with supporting information models):

3.1 Mapping existing standards: first draft

The Royal College of Psychiatrists produced a set of MHDS headings based on the 2008 'Standards for the clinical structure and content of patient records' (www.rcpsych.ac.uk/mediacentre/pressreleases2012/dischargesummary.aspx). The project team mapped this dataset to the 2013 discharge summary headings, approved for use by AoMRC and PRSB (see section 1.2). This process identified differences in the two datasets – additional headings which were in the approved standards but not in the MHDS and vice versa. Additionally new headings in the RCPsych dataset did not have descriptions therefore draft descriptions where developed from review of the relevant literature. The project team then reviewed and aligned this initial draft standard headings and content definitions to early PRSB draft discharge summary phase 2 headings and content definitions: this project was conducted concurrently by the RCP Health Informatics Unit team. This ensured the headings and descriptions were updated to the latest versions and resulted in a first draft of MHDS headings, sub-headings and descriptions in an Excel spreadsheet. The main literature sources used are recorded in Appendix A.

3.2 Review by experts: second draft

The Excel spreadsheet with the first draft standard headings and content definitions were circulated by email to expert reviewers including a broad range of mental health care professionals, other care professionals, informaticians and patient representatives. Expert group reviewers are listed in Appendix B. The expert group cascaded the Excel spreadsheet to colleagues and responses were fed back from individual reviewers or as a group response to the project team. Therefore the numbers of reviewers are greater than listed in Appendix B. Feedback from the review by experts informed a second draft of standard headings and content definitions.

3.3 Online consultation survey: third draft

An online consultation survey using SurveyMonkey (www.surveymonkey.co.uk) was carried out between 18 April 2016 and 9th May and reopened between 16th and 18th May 2016. The survey asked 21 questions: four to elicit demographic participant information and the remainder about the draft mental health discharge summary headings and clinical descriptions. The Excel spreadsheet with the draft MHDS documentation standard could also be reviewed from a web link within the survey. The survey questions sought to elicit participant views of the second draft MHDS headings, their descriptions, whether and what additional headings should be included and if any should be removed. They were closed questions requiring yes/no type answers with a comments section to enable free text additional information to be gathered from respondents. The survey link was circulated to a wide range of stakeholders, listed in Appendix B. The length of time available to respond to the survey was extended twice. The first extension was due to a low completion rate which prompted a second reminder email to each stakeholder asking them to recirculate the survey with the completion deadline extended (to 9th May). The survey was subsequently

reopened on 16th May for a further 48 hours (to 18th May), at the request of the RCPsych, to enable more of their members to complete it. The findings from the survey are reported in section 4 and in more detail in Appendix C.

3.4 Expert user group and project board: final draft

Findings from the online consultation survey and any additional feedback from experts, was used by the project team, to update and refine the MHDS headings/ sub-headings, descriptions, information models and implementation guidance. Through an iterative discussion and review process with expert reviewers and the project board a final set of documentation standards and information models were developed and agreed. These were displayed in an Excel spreadsheet and delivered to NHS Digital team.

The implementation guidance, in section 6, is derived from important issues, advice and observations raised by survey responses and from the iterative review by the experts.

4. Results and summary of updates to the MHDS

4.1 Survey respondent demographics

The online survey resulted in 289 individual responses and there were additional responses from clinicians who preferred to submit comments directly onto the Excel spreadsheet and by email. The majority of respondents were mental health care professionals from a broad range of relevant disciplines. Patients, GPs, community physicians and other relevant professionals contributed. The demographics are summarised in table 1, 2 and 3. Please see Appendix C for more detailed information.

Survey respondents were asked to give us their contact details if they wished to take part in future work/ projects. Seventy four (26%) supplied their contact details.

Table 1: What country do you currently live in?

Answer Options	Response Percent	Response Count
England	76.1%	220
Scotland	8.0%	23
Wales	3.1%	9
Northern Ireland	9.0%	26
Ireland	0.7%	2
*Other (please specify)	0.7%	2
answered question		**282**
skipped question		**7**

*Other = Italy and India

Table 2: Survey respondents role

Role	Response Percent	Response Count
Patient	8.4%	24
Carer	0.7%	2
Other lay	1.4%	4
General Practitioner	3.8%	11

Hospital doctor	37.0%	107
Community physician	6.6%	19
Social care	0.7%	2
Pharmacist	4.2%	12
Nurse	11.1%	32
Support worker/Care Assistant	0.7%	2
Allied health professional	16.3%	47
Healthcare system vendor/developer	0.7%	2
Informatician	2.1%	6
Manager	3.1%	9
Commissioner	1.7%	5
Other	1.0%	3
answered question		**287**
skipped question		**2**

Table 3: Respondents specialty*

Specialty	Response Percent	Response Count
Acute medicine	0.9%	2
Emergency medicine	0.9%	2
Care home/residential	0.9%	2
Community	1.4%	3
General practice	1.4%	3
General surgery	0.5%	1
Geriatric medicine	0.5%	1
Learning difficulties	3.3%	7
Mental health	42.3%	91
Obstetrics and Gynaecology	0.5%	1
Psychiatry	41.9%	90
Respiratory medicine	0.5%	1
Social care	0.5%	1
Psychologists	0.9%	2
Other Clinical	2.3%	5
Other (please specify)	1.4%	3
answered question		**215**

skipped question	**74**

*Excludes lay respondents

4.2 Summary of changes in the mental health discharge summary

The analysis of the survey results including thematic analysis of the very large number of comments received and the review of the draft MHDS by expert reviewers ensured a robust evidence-based set of documentation standards were produced. Each survey question allowed participants to include comments. The numbers of participants leaving comments per question ranged from 34 to 114. The implementation guidance in section 6 has been derived from these evidence sources. Headings and subheadings were aligned to Discharge summary phase 2 and descriptions were maintained where possible. However there were differences which are described fully in Appendix D, Table 4. These include the inclusion of additional headings, minor changes to heading descriptions, changes to rules (mandatory, required or optional).

The different nature of mental illness from that of physical illness and disease was stressed, including the very different methods of treatment (i.e. improving psychological, social and physical function) and the crucial role of robust follow-up care in the community. A prominent theme was the requirement to ensure the language and emphasis was appropriate for mental health patients. For instance use ‘treatment and interventions’ as opposed to procedures (except for electroconvulsive therapy); condition and disorder instead of or in conjunction with ‘disease’; use episode, recurrence/ relapse rather than stage of disease (except for dementia diagnosis). These terms have been included in the headings or clinical descriptions where required.

There was a specific debate amongst the expert group about extracting a patient-focused summary from the discharge summary. This was tested in the survey – results are described in Appendix C, page 20. This was out-of-scope for this project but it has been logged as an issue to take forward. It is very important and the experts do not want this topic to be forgotten. A patient-focused summary should be able to be extracted from the EHR system, populated with information agreed locally with patient/carers and care professionals. The project evidence suggests there are areas of good practice where this is already happening. It is included in the implementation guidance.

The evidence to support the changes and updates to the headings were reported in the comments section of the draft MHDS documentation standards circulated to the project board for review and agreement. Appendix C reports pertinent survey responses and why decisions were reached.

5. Discharge Summary for Mental Health to GP information standard

The final standard headings and content definitions developed for the mental health discharge summary for an adult patient discharged from a mental health secondary care/ hospital to the care of their GP are available at **https://theprsb.org/standards**

The phase 2 discharge summary project, running concurrently, has developed detailed information models for medications, allergies, diagnoses and procedures.

6. Implementation Guidance (available at https://theprsb.org/standards)

6.1 Purpose and limitations of the guidance

The purpose of this guidance is to provide additional guidance to implementers and suppliers on how to implement the Mental Health Discharge Summary (MHDS) headings. It is intended to complement the e-discharge summary implementation guidance v1.0 (July 2016), which is attached as an embedded document. Guidance which is additional or different for MHDS is presented here. Therefore this section should be read in conjunction with the attached e-discharge implementation guidance v1.0.

The mental health discharge summary is professional communication between the patient's secondary care providers to their GP. As noted in section 4.2 it is very important to recognise the different nature of mental illness to physical illness and disease including the different methods of treatments (i.e. improving psychological, social and physical function) and imperative follow-up care after discharge. Language used in the headings and in the clinical descriptions has been modified, where necessary, to be more inclusive and sympathetic to the nature of mental illness and processes of care. See Appendix D, Table 4, for a full list of updates to headings and clinical descriptions.

This section sets out topics and issues identified from the online survey and expert reviewers which relate to implementation of the headings in mental health care establishments. They are not intended to be comprehensive, but cover relevant subject matter identified during the project which may or may not be specific to mental health. It is expected that further guidance will be produced from the experience of initial implementations.

6.2 Additional implementation guidance for MHDS

- The scope of this communication is the discharge summary for an adult patient with mental health illness sent by the hospital to the GP. Copies of the communication may be sent by the hospital to others, e.g. community nurses, pharmacists, care home, etc. This will be by local agreement. Other services (e.g. social care) would be notified by other means of the impending discharge.

- There are additional headings in the MHDS which are not in the 2013 AoMRC/PRSB standard headings. These are identified in this guidance.

Patient demographics

- The care coordinator/key worker contact details are vital for follow-up and continuity of care for mental health patients. It should be recorded in professional contacts under the sub-heading 'Relevant Contacts'. This is a REQUIRED field in the MHDS.

Social context

- Drug/ substance use. This heading is not in the 2013 AoMRC/PRSB but a similar heading is in the 2014 Ambulance information standards. Under this sub-heading relevant previous and current drug and substance use should be recorded. This should include all substances that are considered harmful to the patient and misused including illegal drugs, prescription drugs such as methadone, tobacco, caffeine. Alcohol intake is recorded under a separate subheading.

- Alcohol intake. This is a new subheading for MHDS but it is an existing sub-heading in the 2013 AoMRC/PRSB headings.

Admission details

- Legal status on Admission: A new sub-heading which is not in the 2013 AoMRC/PRSB headings.

Discharge Details

- Legal status on discharge: This is a new sub-heading not in the 2013 AoMRC /PRSBheadings.

- Time of discharge: This is the time the patient leaves the unit to go to their discharge destination.

Diagnoses

- Stage of disease/ disorder: The word disorder is added to the sub-heading.

Procedure

- Electroconvulsive therapy (ECT): Details of ECT sessions should be recorded under this heading.

Clinical summary

- The discharge summary may have contributions from multi-disciplinary team members, not just an individual clinician.

- Treatment and interventions heading: This is a new sub-heading specific to MHDS. It is not in the 2013 AoMRC/PRSB headings but there is a similar heading in the 2014 Ambulance documentation standards. Relevant therapies given, such as psychological and occupational therapies, should be recorded here. Record information about medications given under the 'Medications' heading.

- Formulation: This is a new sub-heading, specific to MHDS. It is a REQUIRED field therefore if a current Formulation is recorded it should be included in the communication. Formulation is a record of the personal meaning and origins of a person's difficulties, shared by the person and the therapist, in order to identify the most helpful way forward.

Family History

- Family history: This is a new heading. It is a core heading in the 2013 AoMRC/PRSB headings.

Investigations results

- Investigation results is for communicating relevant test results that have been completed, e.g. blood tests, MRI scans and their impact on the patient's treatment and care. Mental health specific functional assessments and outcome measures are recorded under 'Assessment Scales'.

Assessment scales

- Assessment scales: This is for communicating results of relevant **functional** assessments and outcome measures with dates performed and plans for repeats.
- Other test results such as blood tests are recorded under investigation results.

Legal information

- Systems should allow copies of legal documentation to be attached to the record where it would be necessary to see copies of the original documents (e.g. mental health act status, 'lasting power of attorney for personal welfare').

- Mental capacity assessments: There should be provision for more than one MCA assessment to be recorded.

- Deprivation of Liberty Safeguards (DoLS) or equivalent: This is a new sub heading. It is not in the 2013 AoMRC/PRSB headings. It was also included as a new heading in the 2016 Ambulance transfer of care to ED headings.

- The legislation relating to mental capacity in England is set out in the Mental Capacity Act 2005. The legislation in Scotland is set out in the Adults with Incapacity (Scotland) Act 2000 and in Northern Ireland, the Northern Ireland Mental Capacity Bill, was passed by the Northern Ireland Assembly on 15 March 2016.

- The Mental Health Act (MHA) status or equivalent: There is different legislation in the four UK countries. This is a new sub-heading. It is not in the 2013 AoMRC/PRSB headings but it is included in the 2014 Ambulance information standards. The clinical

description has been expanded. Information pertaining to the MHA status of the patient should be recorded here.

- Safeguarding issues: Record which agencies (i.e. social services, police, voluntary sector) have been sent relevant documentation with their contact details and dates e.g. adult safeguarding.

Investigations and procedures requested

- Investigations and procedures requested but not yet undertaken when the patient is discharged. This heading is separated from ‘investigation results’ to ensure they are not overlooked and are followed up. There could be potential confusion between some items recorded under this heading and ‘Planned and requested actions’ heading.

Patient concerns, expectations and wishes

- Person’s concerns, expectations and wishes: The word carer has been removed from the sub-heading and the clinical description has been updated.

Planned and requested actions

- Suggested strategies should identify what actions to be taken if the patient deteriorates e.g. sometimes referred to as “safety net”.

- Care-planning arrangements: This new sub-heading specific to the MHDS. It is not in the 2013 AoMRC/PRSB headings. Care-planning arrangements are covered by country-specific legislation. It is a REQUIRED field. The GP must have access to this information. Record where and how to access this information and/ or provide a link to the documentation or send as an attached document. The name of the patient’s care coordinator or key worker should also be recorded under ‘Relevant contacts’ in the patient demographic section.

Information and advice given

- This is the place to record what information was given to the patient about their diagnosis, treatment, instructions on how to take their treatment etc. For instance if the diagnosis was shared with the patient, whether the patient understands and agreed with the diagnosis, if the patient received instruction and understands how and when to take their medication.

- IT systems should have the ability to generate a patient-specific summary from the discharge summary to give to the patient and/or carer. The contents should be agreed locally with input from patients, carers and the care team.

Person completing record

- ‘Professional identifier’ should be recorded.

- Contact details: Completion is mandatory. The person completing the discharge summary may by a locum and very difficult to contact if further information about the summary or patient is required.

6.3 Mandatory and Optional

There are some important differences between the mental health discharge summary and the e-discharge summary headings in terms of whether they are mandatory, required or optional. Refer to the mental health discharge summary information models to identify which headings are mandatory, required or optional.

The principles are:

1. All mental health e-discharge discharge summary sections must be supported by IT systems, but they may not all be included in every local implementation.

2. Some of the record entries and fields within them will be mandatory, but others will be optional. The information models define which are mandatory and which are optional.

3. A small number of the sections are MANDATORY and this means they must be included in all e-discharge summary communications. They are denoted by ‘M’ and ‘MUST’. If no information is available under a mandatory heading, then this must be conveyed in the summary (e.g. ‘no known drug allergies or adverse reactions’ or ‘no known GP practice’).

4. Sections which are not mandatory are either REQUIRED or OPTIONAL. The definitions are:
a. REQUIRED (R): if there is information recorded under this heading it SHOULD be sent to the recipient.
b. OPTIONAL (O); a local decision is made as to whether this information is recorded and sent to the recipient. The information MAY be included in the communication.

6.4 Coding

- Secondary care/ hospital based professionals tend to use and are familiar with the International Classification of Diseases (ICD) 10th Revision Code (ICD- 10: 2016) coding methods, which is used for coding hospital episodes. GP practices use READ codes which are being replaced by SNOMED-CT. 'Personalised Health and Care 2020: A Framework for Action' specifies SNOMED CT as the single terminology to be used across the health system. SNOMED CT is managed and maintained, in the UK,

by the UK Terminology Centre (UKTC). A license is required to use SNOMED CT. Readers can find more information on the UKTC website Terminology and Classifications - NHS Digital https://digital.nhs.uk/article/290/Terminology-and-Classifications

- National policy expects headings and descriptions to be aligned with NHS data dictionary terms where possible.

- Further guidance regarding ICD-10 codes is available in the NHS Data Model and Dictionary.

- Local implementers and suppliers will need to agree how best to meet the national requirements in the allocated time scale.

Appendix A – Key references

Clinical care

Right here, right now – help, **care** and support during a **mental health crisis**.
People's experiences of help, care and support during a mental health ...
https://www.cqc.org.uk/sites/.../20150630_righthere_mh**crisiscare**_full.p...

Crisis services | Mind, the mental health charity - help for mental health ...
mind.org.uk/information-support/guides-to-support.../**crisis**-services/
A guide explaining what **mental health crisis** services are available, how they can help and when to access them….

The Triangle of Care - Carers Trust
static.**carer**s.org/files/**caretriangle**-web-5250.pdf
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Good Practice Guidelines on the use of psychological formulation
https://www.canterbury.ac.**uk**/...**psychology**/.../DCP-Guidelines-for-**Formulation**.pdf
Printed and published by the **British Psychological Society**. © The **British Psychological Society**

The ICD-10 Classification of Mental and Behavioural Disorders
www.who.int/classifications/**icd**/en/**bluebook**.pdf

Discharge summary

Data Set: Mental Health Services Data Set
www.datadictionary.nhs.uk › Main Menu › Clinical Data Sets Menu

Mental Health Datasets - National Data Catalogue
www.ndc.scot.nhs.uk/docs/**Mental**%20**Health**%20**Datasets**.pdf

Audit of psychiatric discharge summaries: completing the cycle ...
pb.rcpsych.org/content/28/9/329 by I Crossan - 2004

Psychiatric discharge summaries: what do general practitioners want?
www.ncbi.nlm.nih.gov › NCBI › Literature › PubMed Central (PMC)
by J Serfontein - 2011

Issue 2 - March 2014 - Royal College of Psychiatrists
www.rcpsych.ac.uk/pdf/HTAS%20newsletter%20issue2.pdf
2 Mar 2014 - developing a standardised **discharge summary** letter for ….

National Standard for Patient Discharge Summary Information - Hiqa
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Adherence to UK national guidance for discharge information - NCBI
www.ncbi.nlm.nih.gov/pubmed/25041244 by EA Hammad - 2014

Harms from discharge to primary care: mixed methods analysis ... - NCBI
www.ncbi.nlm.nih.gov/pubmed/26622036 by H Williams - 2015

Hospital Discharge: The Patient, Carer and Doctor Perspective | The ...
www.rcoa.ac.uk/news.../**hospital-discharge-the-patient-carer-and-doctor**
15 Apr 2014 - The BMA *patient* liaison group have produced a checklist to help support *patients* with the *hospital discharge* process.

Legislation

Deprivation of Liberty Safeguards - Age UK
www.ageuk.org.uk/.../FS62_**Deprivation_of_Liberty**_Safeguards_fcs.pd...

Mental Health Act Scotland: information from the Mental Welfare ...
www.mwcscot.org.uk › The Law

Your rights under the Mental Health Act | Care Quality Commission
www.cqc.org.uk/content/your-rights-under-**mental-health-act**
26 Feb 2016...

Welsh Government | Mental health
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Mental health: Legislative update - the Northern Ireland Assembly ...
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About the Mental Capacity Act | Care Quality Commission
www.cqc.org.uk/content/about-**mental-capacity-act**

Related Information Standards and Policy

SNOMED CT Browsers — Health and Social Care Information Centre
systems.hscic.gov.uk/data/uktc/**snomed**/**browser**

Implementing the SCCI Standard: SNOMED CT
https://hscic-**standards**.citizenspace.com/.../Implementing%20the%20**SCC**...

Personalised Health and Care 2020 - Gov.uk
https://www.gov.uk/government/uploads/system/uploads/...data/.../NIB_Report.pdf

Appendix B – Stakeholders

1. Expert reviewers of Excel spreadsheet and MHDS

Name	Organisation
James Reed	RCPsych, Birmingham & Solihull Mental Health Foundation Trust
Jonathan Richardson	RCPsych, Northumberland, Tyne and Wear NHS Foundation Trust
Matt Butler	RCN, Mental Health Nurse
Ken Lunn	Mindfulness Network
Munish Jokhani	NHS Digital
Ronald Newall	RCP Patient and Carer Network
Julian Costello	RCGP HIG, GP
Graham Fawcett	BPS, East London NHS Foundation Trust
Ashimesh Roy Chowdhury	RCPsych, St Andrews Healthcare, Northampton
Anthony Jemmott	Mental Health Nurse, Camden and Islington NHS Foundation Trust
Jane Leigh	GP Advisor; Tees, Esk and Wear Valleys NHS Foundation Trust
Rajesh Moholkar	Specialist advisor to the CQC
Steve Carney	National Deaf Mental Health Service
Dhruba Bagchi	Birmingham & Solihull Mental Health Foundation Trust
Thomas Clark	Birmingham & Solihull Mental Health Foundation Trust
Jayne Greening	Birmingham & Solihull Mental Health Foundation Trust
Tina Irani	Birmingham & Solihull Mental Health Foundation Trust
Alison Reed	Birmingham & Solihull Mental Health Foundation Trust
Suzanna Lingiah Rongpi	Birmingham & Solihull Mental Health Foundation Trust
Mahmoud B Saeed	Birmingham & Solihull Mental Health Foundation Trust

Name	Organisation
Muzaffar Sajid	Birmingham & Solihull Mental Health Foundation Trust
Leo Fogarty	GP, Clinical Lead GP2GP Scotland
Ian McNicoll	GP, Fresh EHR
David Dodwell	Psychiatrist
Annette Gilmore	Professional Record Standards Body, RCN, Nurse
Matthew Whitty	Professional Record Standards Body
Philip Scott	Professional Record Standards Body

2. Stakeholders who were invited to participate in the online consultation survey (18th April 2016 to 9th May 2016)

- Allied Health Professions Federation
- Association of Directors of Adult Social Services
- British Psychological Society
- Care UK
- CCIO Network
- College of Paramedics
- College of Occupational Therapists
- Genetic Alliance
- Health and Social Care Information Centre
- Health Watch
- Institute of Health Records Information Management
- Mindfulness Network
- National Care Alliance
- NHS England
- NHS Northern Ireland
- National Services Scotland
- NHS Wales
- Nursing Home Association
- PRSB members
- PRSB vendor forum
- PRSB website
- RCP Patient and Carer Network
- Registered Nursing Home Association
- Resuscitation Council*
- Royal College of Emergency Medicine
- Royal College of General Practitioners
- Royal College of Midwives
- Royal College of Nursing
- Royal College of Psychiatrists
- Royal Pharmaceutical Society
- TechUK
- Welsh Government Department of Health and Social Services

*The Resuscitation Council (UK) took a pragmatic decision not to circulate this particular survey to its membership as it was not pertinent to the organisation's core purpose. They have a policy to minimise the information sent to its membership to reduce burden.

Appendix C – Survey Analysis

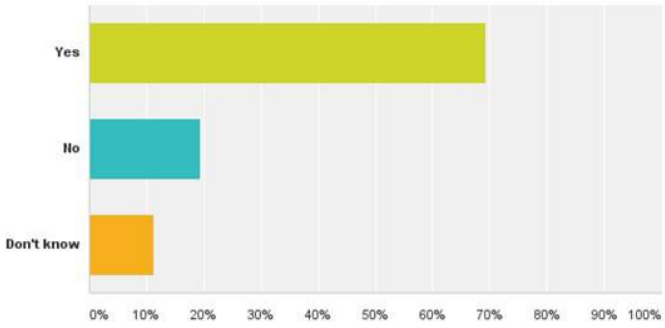
This section provides information about consultation results that require further explanation.

In relation to procedures undertaken during admission, are there any headings or subheadings shown in the above extract from a discharge summary which are not required for adult mental health clients, and which should therefore be deleted?		
Answer Options	**Response Percent**	**Response Count**
Yes	49.7%	95
No	31.9%	61
Don't know	18.3%	35
Comment		**114**
	answered question	**191**
	skipped question	**98**

Note: The survey respondents suggested removing this heading as it was not perceived as relevant in mental health. However, 114 respondents left comments with many contradicting this by stating the heading was needed to record electroconvulsive therapy (ECT) procedures. It was agreed with experts that the heading should be retained.

Q9: Do you agree with the above information about Assessment Scales in the discharge summary in relation to adult mental health clients? If no please add reasons in the comment box

Answered: 186 Skipped: 103

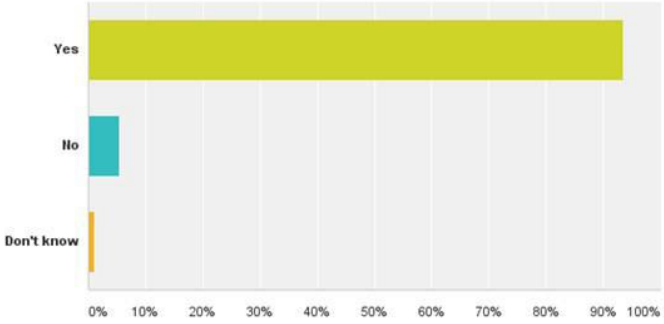


Note: 70% of respondents completing this question stated Assessments scales should be retained. There was an abundance of comments from respondents explaining the nature and purpose of assessment scales in mental health and how inappropriate some of the examples were for these patients. In response to the consultation the heading description was updated and examples removed from the description. There is instruction in the implementation guidance to improve appropriate use.

Note: The vast majority of survey respondents suggested including the legal information headings as outlined below. The Deprivation of Liberty Status (DoLS) sub-heading was added to the MHDS. Survey respondents and expert reviewers indicated that it should be included as a separate heading.

Q11: In relation to adult mental health clients, should admission method include whether admission was voluntary or against the client's wishes?

Answered: 184 Skipped: 105



Q10: In relation to adult mental health clients, which of the following areas of legal information should be recorded in the discharge summary? Please add any explanatory comments in the comments box provided for any areas that you feel should NOT be included

Answered: 183 Skipped: 106

	Include	Don't include	Don't know	Total	Weighted Average
Consent for treatment record	74.44% 134	20.00% 36	5.56% 10	180	1.31
Consent for information sharing	81.11% 146	12.78% 23	6.11% 11	180	1.25
Mental capacity assessment	77.40% 137	15.25% 27	7.34% 13	177	1.30
Mental Health Act or equivalent status	96.15% 175	2.20% 4	1.65% 3	182	1.05
Advance decision to refuse treatment (ADRT)	86.11% 155	6.11% 11	7.78% 14	180	1.22
Lasting power of attorney for personal welfare	82.87% 150	9.39% 17	7.73% 14	181	1.25
Organ and tissue donation	35.63% 62	37.36% 65	27.01% 47	174	1.91
Safeguarding issues	94.48% 171	2.21% 4	3.31% 6	181	1.09

Note: The initial expert review of the Excel spreadsheet with draft MHDS documentation standards sparked a debate about being able to derive a patient-focused discharge summary from the discharge letter. This was further tested in the survey. The quantitative results are as follows.

This is very important but out of scope for this project. It will be logged as an issue to be taken up in the future. The purpose of the Discharge summary to GP is as professional correspondence. It is acknowledged that a patient summary can be extracted from the EHR system. Further work is required, at a local level with the input of patients and carers, to decide what populates the summary and what local initiatives already exist.

Do you think there should be a separate patient/carer summary written in plain English within the discharge summary?

Answer Options	Response Percent	Response Count
Yes	43.3%	77
No	45.5%	81
Don't know	11.2%	20
answered question		**178**
skipped question		**111**

In relation to an adult mental health client, do you think the headings and information already in the discharge summary can include a patient/carer focused summary (e.g. Care Plan Approach, Planned actions)?		
Answer Options	**Response Percent**	**Response Count**
Yes	78.9%	135
No	21.1%	36
	answered question	**171**
	skipped question	**118**

Appendix D – Summary of updates to 2013 AoMRC/PRSB headings

The Royal College of Psychiatrists mental health discharge summary (MHDS) was published in 2012 and the AoMRC/PRSB headings were published in 2013. Since then there have been widespread consultations and feedback, via PRSB projects, suggesting changes to some of the headings and updates to the clinical descriptions. A record of these updates is included in the e-discharge summary implementation guidance document. Additional changes and updates in the MHDS are recorded in Table 4 below.

If the original headings have already been implemented, implementers will need to consider updating their local information models.

Note: In the second column of Table 4 there is text in bold typeface. This is the wording that has been amended or added to the 2013 AoMRC/PRSB clinical descriptions.

Table 4: Summary of updates to 2013 AoMRC/PRSB headings

Heading/ sub heading	Description	Rule*	Summary of change
Relevant contacts	Include the most important contacts including: *Personal contacts e.g. next of kin, in case of emergency contact, **holder of** Lasting Power of Attorney, dependants, informal carers etc. *Health/care professional contacts e.g. social worker, hospital clinician, care coordinator/**Key worker,** Independent Mental Capacity Advocate (IMCA) etc. *Name, relationship, role (if formal role), contact details and availability, e.g. out of hours.	R	Care coordinator is an essential contact for mental health patients. Added key worker to description to aid clarity. Rule changed from 'Optional' to 'Required'.
Alcohol intake	Latest or current alcohol consumption observation.	R	Heading added. This is an existing heading in the 2013 AoMRC/PRSB and is in the 2016 Ambulance transfer of care to ED documentation.
Drug/ substance use	Record of current or previous drug/substance use.	R	Heading added. This is a heading in the 2016 Ambulance transfer of care to ED documentation.
Occupational history	The current and/or previous relevant occupation(s) of the **person**.	O	Updated in the Ambulance transfer of care to ED to exclude Education history, which is now a separate sub-heading.

Educational history	The current and/or previous relevant educational history of the **person**.	O	See explanation above
Reason for admission	The specific reason that prompted the decision to admit to hospital e.g., chest pain, **mental health crisis,** blackout, fall, a specific procedure, **intervention,** investigation or treatment, **non-compliance with treatment.**	R	Examples added (bold typeface). These are more appropriate for mental health.
Legal Status on admission	Record if the patient was admitted as Informal or formal/detained. Record the legal status of the patient at discharge.	R	New subheading, 93.5% of survey responses and the expert reviewers agreed this was required. More detailed information will be recorded under Mental Health Act status. Heading specific to MHDS.
Legal Status on discharge	Record if the patient was discharged as Informal or formal/detained.	R	New subheading. More detailed information will be recorded under Mental Health Act status. Heading specific to MHDS. Rationale: legal status may change during the course of the admission.
Stage of Disease/ Disorder	Include stage of disease**/ disorder** where relevant.	O	The word 'disorder' is added to the heading. Mental health conditions are more appropriately described as 'disorders' (see WHO ICD 10 Classification of Mental and Behavioural Disorders). Patient may also have associated physical diseases so both words are required e.g. dementia.
Procedure and all sub headings under Procedure	Under this heading information about all relevant therapeutic and diagnostic procedures should be included, relevance based on clinical decision	O	Survey responses suggest this heading should be omitted. However the majority of comments contradicted this stating it was required to record electroconvulsive therapy (ECT) procedures. Therefore heading

			retained with agreement from experts and Project Board.
Clinical summary	Narrative summary of the episode. Where possible very brief. This may include interpretation of findings and results; differential diagnoses, opinion and specific action(s). Planned actions will be recorded under ‘plan’. In mental health and psychiatry **this is** the place for Formulation.	M	Deleted 'Where possible, very brief' (survey observation that this is unhelpful). Similar feedback from discharge summary phase 2 project. Formulation - changed the word from 'may be' to 'this is’.
Formulation	An account, shared by a therapist and person, of the personal meaning and origins of a person's difficulties. This is viewed in the context of multiple factors including relationships, social circumstances and life events and will indicate the most helpful way forward.	R	Additional sub-heading specific to MHDS. This was in the 2012 RCPsych MHDS.
Treatments and interventions and changes made to treatments.	The relevant treatments **and interventions** which the patient received during the inpatient stay. Include psychological and occupational therapies. All medications should be recorded under the medications section.	R	Agreed to keep this additional heading which was included in the 2012 RCPsych MHDS. Added ‘interventions’ to heading and description to be explicit about inclusion of psychological and other therapies such as occupational therapy. 'Can include medication given whilst an inpatient' removed from the original description in order that all medications are recorded under the medication section. The description is specific to MHDS. There is a similar heading in the Ambulance transfer of care to ED.
Family History	The record of relevant illness in family **members** deemed to be significant to the care or health of the person, including mental illness and suicide, genetic information etc.	O	Agreed to keep this additional heading which was included in the 2012 RCPsych MHDS. This is a core 2013 AoMRC/PRSB approved heading. Replaced ‘relations’ with ‘members’.

Assessment scales	Structured assessment scales used as part of assessment and treatment.	O	Description updated and examples removed as they were seen as unhelpful for mental health. See implementation guidance.
Mental capacity assessment	Whether an assessment of the mental capacity of the (adult) person has been undertaken, if so, **what decision the capacity assessment relates to**, who carried it out and when, and the outcome of the assessment. Also record best-interests decision if person lacks capacity.	R	Rule changed from One record may be present to ONE or MORE records of mental capacity SHOULD be present, if recorded. See implementation guidance. Description updated with text in bold typeface.
Deprivation of Liberty Safeguards or equivalent	Record of Deprivation of Liberty Safeguards (DoLS) or equivalent, including the reason for this.	R	Additional heading. This was a new heading added to 2016 Ambulance transfer of care to ED standards documentation
Mental Health Act or equivalent status	Record where a person diagnosed with a mental disorder is formally detained under the Mental Health Act or equivalent, including the section number **and start date, start time and end date. If person subject to Community Treatment Order or Conditional Discharge (or equivalent) record here.**	R	Additional heading in RCPsych 2012 MHDS and agreement to keep. Heading also added to 2016 Ambulance transfer of care to ED standards documentation. Description has been updated with the text in bold typeface.
Organ and tissue donation	Whether the person has given consent for organ and/or tissue donation or opted out of automatic donation where applicable. The location of the relevant information/documents.	**O**	Heading has been retained. Rule changed from required to optional for MHDS. 37% of survey said to take this heading out, 36% said leave in and rest didn't know. This heading was included in the original 2013 AoMRC/PRSB standards at patients and carers request. See implementation guidance.
Person's concerns, expectations and wishes	Description of the concerns, wishes or goals of the person in relation to their care, as expressed by the person, their representative or carer (if appropriate). **Record who has**	R	The word 'carer' removed from the heading. Text in bold added to description in order to reflect that this is the patient's concerns/ wishes and goals. The

	expressed these (patient or carer/ representative on behalf of the patient). Where the person lacks capacity this may include their representative's concerns, expectations or wishes on behalf of the person.		carer is consulted in situations where person is incapacitated. Survey respondents highlighted the risk if carers/ family members are not acting in the best interests of the patient. This is a legal requirement that the adult person is consulted and only with consent or in capacity issues then carers are consulted.
Actions	Including planned investigations, procedures, **interventions** and treatment for a patient's identified conditions and priorities: A) person/ **team** responsible - name and designation / department / hospital / patient / etc responsible for carrying out the proposed action, and where action should take place B) action - requested, planned or completed C) When action requested for - requested date, time, or period - as relevant D) suggested strategies - suggested strategies for potential problems, e.g. telephone contact for advice.	R	Text in bold added to original description.
Care planning arrangements	Record if Care Programme Approach (CPA) documentation is available and how and where it can be accessed; care and treatment plan in Wales and Scotland. In Wales this is superseded by the Mental Health Measure 2010.	R	Additional heading which was in 2012 RCPsych MHDS. Specific to MHDS. Heading has been updated to reflect the 4 Nations requirements. These care plans are required, by law, for patients with severe mental illness. The categories of patients that must have these care plans differ between countries. The key worker/ care coordinator is a critical contact under these arrangements - this key contact is covered

			under the 'Relevant Contacts' current subheading in the patient demographics.
Contact details	Contact details of the person completing the record. For example a phone number, email address. Contact details are used to resolve queries about the record entry.	M	This is a sub-heading under the ‘Person completing record’ heading. The rule was changed from optional to mandatory (M). Rationale - person may be a locum and very difficult to find if further information about the patient is required.

*Rule: M = mandatory, O = optional and R = required.