Professional Record Standards Body

Better records for better care

CLINICAL REFERRAL INFORMATION STANDARD
IMPLEMENTATION GUIDANCE

APRIL 2018

Document Management

Revision History

Version	Date	Summary of Changes
0.1	14.05.2018	First draft version.

Reviewers

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1. Purpose

The purpose of this document is to provide guidance for the implementation of the clinical referral communication sent from primary to secondary care.

2. Background

An aging population, increase in comorbidity and a shift from inpatient care to outpatient care in the UK has resulted in an increase in referrals and attendances at OP clinics. Providing appropriate high quality information can help reduce the number of inappropriate referrals.

In 2014 the National Information Board (NIB) framework for action stated:

> "we propose the adoption of the Academy of Royal Medical Colleges' (AoMRC) publication 'Standards for the clinical structure and content of patient records', with a requirement that all organisations and clinical systems should implement the standards, following consultation and completion of impact and assessment". The scope of the AoMRC standards includes headings for admission, discharge summaries, handover, referral letters and outpatient letters.

This standard builds on the AoMRC standards to develop evidence and consensus based standard headings and content definitions. Currently there are differences between GP systems and GP practices in the clinical content of referrals, with multiple templates in use. Although appointments can be booked online through the NHS Digital e-referrals service (NHS e-RS), many referral letters are still paper or PDF -based.

The NHS e-RS handles electronic bookings and associated clinical referral information sent between primary care and secondary care providers. There is also a development programme which aims to improve the service on an on-going basis. The e-referrals programme is developing open source Clinical Referral Information (CRI) APIs, which will allow authorised users the ability to search, review and download CRI, including clinical content in a PDF which can be pulled into a hospital electronic document management system. However, this does not enable data to be re-used in the hospital, nor does it guarantee that a referral letter containing relevant information will be received in the hospital.

The clinical referral information standards project is required to ensure clarity on information required for referrals so that improved and interoperable electronic referrals can be implemented across the full patient pathway.

3. Audience

This document provides professional guidance and so is primarily aimed at healthcare professionals, Chief Clinical Information Officers and primary care staff responsible for referrals. It may also be of interest to suppliers, commissioners and hospital and primary care ICT services which are implementing the standard on their information systems.

4. General guidance

The scope of the clinical referral standard is the referral made from primary care to secondary care. The following general principles apply:

1. It is not anticipated that all headings will need to be used in all circumstances, only where they are relevant to a specific patient, ie headings should not be included in the message where there is no data recorded/available.

2. The order in which headings appear can be agreed locally

3. Data quality and accuracy of coded data entry needs to be monitored and implementers will need to ensure sufficient training and monitoring of record keeping. The system must include the facility to review the output before being sent. It is recommended that clinicians must review the referral content before sending in order to ensure that the content is accurate, complete and does not mislead or contain information the patient does not want to be shared.

4. The section headings are intended to support navigation around the record and are clinical groupings of related subheadings, rather than having any semantic meaning.

5. The information can be displayed in any format as designed by the end user and supplier. The standards provide a common structure to the record, not a style guide. Different IT systems can display the same information in different ways, but the meaning will remain the same.

6. Where there is a heading and a subheading with the same name, there is no need to display the heading as well as the subheading.

7. Each record entry must have the date and time recorded and the identity of the person making the record. This information should be recorded in an electronic record automatically, by date and time stamping each record and associating it with the personal identification of the individual recording it. It is not necessary to communicate this information in the referral letter.

8. Information should be auto-populated from GP practice Electronic Patient Records (EPRs) where appropriate, with the expectation that, in time, auto-population will include supply of appropriate SNOMED CT codes.

9. User interfaces should not restrict the order in which clinicians enter data, so that clinicians can navigate forwards and backwards to complete or partially-complete sections as information becomes available. This does not negate the rule which stipulates that a communication cannot be sent unless all MANDATORY sections are completed.

10. Clinicians should always use professional judgment to determine what information should be communicated. Just because the system records information does not always mean that it would be relevant to send to others. Systems should support this by enabling editing of communications by clinicians prior to them being sent.

11. Communications should be brief, where possible, containing only pertinent information, rather than duplicating information which the recipients already have access to in their own records.

12. The extent to which information can be taken into the recipient system in structured/coded format will depend on the capabilities of the recipient system. Local decisions need to be made about what information is ingested into recipient systems in a structured coded format and what information is ingested as text.

13. Patients (or their designated carer or guardian where applicable) should generally get a copy of communications and so, as far as possible without affecting its efficacy as a clinical communication, it should be written in a way that is understandable to the general public. This may be difficult where technical information needs to be communicated, and in such circumstances, providing

explanatory information in easy to read leaflets to patients should be considered. Providing the documentation in alternative formats and face to face communication should also be considered to meet individual requirements (see the NHS accessible information standard.) Local implementation of the standards should involve patients and carers throughout to ensure that the content is expressed in a way which is person-centred and that support is provided to help patients and carers to understand the contents.

14. There may be circumstances where it is not appropriate to provide the patient with a copy of the communication, eg safeguarding issues. This may be handled in various ways, suppliers should consider providing the ability to enable information to be excluded where there is a need to communicate something privately.

15. Recipients should be able to read all of the content (ie any coded data should be carried with the associated text).

16. The record standards provide a logical information model that identifies the information to be shared from a patient/citizen and health care professional perspective. NHS Digital and INTEROPen, working with the PRSB will produce technical specifications, based on the record standards. It is anticipated that primary and secondary care and other health and care systems suppliers will develop solutions which enable mapping to/from their system headings and content to those in the technical specification. They will also develop new functionality to support the processes for sending and receiving referrals in their systems. These should be done once nationally by each supplier.

17. Trading agreements will need to be drawn up between organisations, including:
    - Details of the information to be communicated, including which optional sections will be utilised.
    - The sequence of the sections.
    - Which fields will be coded and which textual.
    - Mapping from local headings/fields to those in the standard. The mapping should be owned by a clinician in each organisation.
    - Requirements for receipt of the communication, e.g. use of a generic mailbox.
    - New work processes for producing and receiving the communication.

The aim of this standard is not to add to the GP workload but to facilitate the sharing of information when transferring care from the primary care setting to secondary care, ensuring that the relevant information is available when it is needed.

5. Mandatory Required and Optional

A small number of the sections are **MANDATORY** and this means that they must be included in all clinical referrals made by the GP practice. Other sections are **REQUIRED** or **OPTIONAL**.

The **MANDATORY** headings are:
GP Practice
Patient Demographics
Referral Details
Reason for referral
Allergies and adverse reactions

Person completing the record

A distinction has been made between sections which are **REQUIRED** or **OPTIONAL**. The definition of each is given below:

a) **REQUIRED**: this data must be supported and populated into the relevant data sets if the data is available.

b) **OPTIONAL**: a local decision as to whether information is sent to the recipient.

Required	**Optional**
Individual requirements	Family history
Medications and medical devices	Social context
Legal information	Patient concerns, expectations and wishes
Information and advice given	Examination findings
Participation in research	Assessment scales
	Relevant clinical risk factors
	Investigations and results
	Distribution list

6. Guidance on specific sub-headings

6.1. Referral details

Referrer name is a required field. This information allows the secondary care clinician to contact the individual making the referral if there is a need for additional information.

The role of the referrer can be used to identify where a locum or trainee or other member of the practice team is referring the patient, rather than the usual GP. This will tell the secondary care clinician who to contact for more information.

The specialty/service will usually be recorded where known.

6.2. Return response field

This can be used where the outcome of a referral needs to be directed to a specific individual or team or 'in-box' within the practice. Systems should allow the field to be automatically completed and default to the usual GP. Systems should also allow for it to be potentially turned off. A decision should be made locally about how it is used.

6.3. Reason for referral

Any speculative or working diagnosis should not be coded but included as narrative.

6.4. Referral criteria

Systems should allow for the specific criteria to be auto-generated for each service to which the referral is being made. The system should also allow for it to be switched off if a local decision is made that it is not required.

There is a potential patient safety risk if not meeting criteria is used to reject referrals and so it is vital that criteria are not a barrier to referrals being made. Clinical judgement should override the

criteria where appropriate. The rationale for any deviation from the referral criterial should be included in the referral narrative.

6.5. Details of other referrals

Systems should allow the date range for other referrals to be set locally. It is recommended the date range be set at 12 months as a default, however clinicians should be able to override this and choose to include any other referrals which are relevant to the referral that is being made. This will enable clinicians to identify other co-morbidities and support the administration of scheduling appointments. The process should be seamless and not add burden to the clinician. Having access to the Unique Booking Reference Number (UBRN) would support this.

6.6. Expectation of referral

The expectations recorded should be the clinician's expectations formulated in consultation with the patient. Patient specific expectations and wishes can be included under **patient concerns, expectations and wishes**.

6.7. Medications and medical devices

Timeframes for including medication information can be decided locally. Systems should allow for the agreed timeframe to be set.

Systems should allow the facility to add additional medications and medical devices, which are not part of the default list where they are relevant, for example therapeutic failures. If these are required they should be added into the medications section if needed.

Where medication is linked to coded indications, for example from the problem list, the linked codes should be included in the referral with the medication.

6.8. Acute medication

It is advised that the Acute medication extraction period should be 12 months. Clinicians should use their judgement if they think it is relevant to include older medications and systems should support the addition of other medications by the user.

6.9. Repeat medications

It is advised that all current repeat medications are included in the referral.

6.10. Discontinued medications

Clinicians should use their discretion to decide whether discontinued medications should be included, if relevant to the referral.

6.11. Observations

The referrer should include relevant observations using their clinical judgement. Where possible it is suggested the observations should be structured and coded.

6.12. Family history

Family history should only be included if the referrer deems it pertinent to the referral.

6.13. Participation in research

This section should include details of research the patient is actively involved in. It is not used to record a personal preference to participate in research.

6.14. Safety alerts

It is advised that caution is used when adding coded information. Physicians should use their judgement to decide if the information is still valid and relevant to the referral.

6.15. Relevant clinical risk factors

Systems should allow for coded information from GP systems to map correctly into the receiving systems, for example SNOMED CT for heart disease is entered into diagnosis rather than family history.