How it comes together in practice: two real current projects

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A standard Discharge Summary

The road from clinical record keeping standards to data standards, in England and Wales

A bit of history

- This is by no means the first generation of electronic communication of clinical discharge information
  - Technical feasibility and clinical benefit have been clearly demonstrated
  - Challenge is to make it possible to send and receive an electronic discharge communication to or from anywhere in the ever-changing network of NHS and other providers
- This chapter of the story begins with an NHS-funded project by the Royal College of Physicians and other professional bodies to develop clinical professional standards for record keeping

Step 1: Clinical authority

Document: Standards for the structure and content of medical records and communications when patients are admitted to hospital

"These standards were developed by the Health Informatics Unit, Royal College of Physicians...in collaboration with the other medical Royal Colleges and specialist societies. They were approved by the Academy of Medical Royal Colleges on 17th April 2008."

www.rcplondon.ac.uk/clinical-standards/hiu/medical-records

Step 2: Clarifying requirements

- The clinical record keeping standards were not precise enough to serve as requirements for developing a technical standard
- A consultation group was drawn up within the NHS Logical Record Architecture programme to develop a more exact view of the information required in a discharge summary
  - The group included a range of clinical professionals and health informatics experts
  - At this time, these requirements are in a fairly mature draft state

Step 3: Implementation (Wales)

- The NHS Wales Informatics Service has a development deadline in August 2011 for the discharge letter function in the Welsh Clinical Portal
- Fairly mature requirements are now available, but no technical standard to adopt
- The decision is taken to build to the requirements as they exist now, using a technical standards approach already in use in other projects in Wales (aligned with Scottish work – not HL7)

Step 3: Implementation (England)

- There is already an earlier generation discharge summary standard built in CDA, and published in the ITK
  - It was used in early ITK pilot/demonstration projects
- My expectation is that a new CDA document based on the detailed requirements now nearing completion will replace it, but the timescale is unclear

Points to note

- Clinical authority is essential to enable a standard approach to win over local clinical opinions
- Wales is accepting a divergence from the technical standard that will emerge later in England, but expecting that the common requirements foundation will reduce clinical risk as & when the two may be in use together at a later date
  - For example, displaying both kinds of discharge summary so they look the same (in depth); or converting between the data formats with low risk in the translation

HL7 standards in the NHS Wales E-MPI and LIMS implementation

(separate slides)

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