Professional Record Standards Body

Better records for better care

IMPLEMENTATION GUIDANCE FOR ALL PRSB STANDARDS

Document Management

Revision History

Version	Date	Summary of Changes
0.1	25-08-21	First draft as general “Guidance for all PRSB standards”
1.0	02.02.2022	First version after incorporating reviewer comments
1.1	25/05/2022	Updated for changes to how provenance data is held in PRSB information models
1.2	31/01/2023	Minor updates
1.3	27/03/2023	Minor update to Section 1.1
1.4	15/08/2023	Update to include new version numbering scheme
1.5	17/11/2025	Added information on displaying SNOMED CT codes, handling legacy codes and data types. Updated information on version control and conformance.

Reviewers

Reviewer name	Title / Responsibility	Date	Version
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Name	Date	Version
PRSB Task and Finish Group	May-2022	1.1

Glossary of Terms

Term / Abbreviation	What it stands for
dm+d	Dictionary of medicines and devices
EPR	Electronic Patient Record
FHIR	Fast Healthcare Interoperability Resources
GP	General Practitioner
HL7	Health Level 7
IPS	International Patient Summary
Metadata	A set of data that describes and gives information about other data
NICE	The National Institute for Health and Care Excellence
NHS	National Health Service
NHSDD	NHS Data Dictionary
NHSE/ NHSEI	NHS England/ now NHS England Improvement
NRLS	National Record Locator Service
ODS	Organisation Data Service
PDS	Personal Demographic Service
PRSB	Professional Record Standards Body
DAPB / DCB / SCCI	Data Alliance Partnership Board, formerly Data Co-ordination Board and Standardisation Committee for Care Information. Acts on behalf of SoS health to approve health and care data and information standards
SNOMED CT	Systematized Nomenclature of Medicine - Clinical Terms

Contents

1. Introduction

1.1 Purpose of document

This document provides general guidance to support the implementation and use of all PRSB standards.

Standard specific implementation guidance at section and element level is included in the information model for that standard.

In addition, each standard will have a safety case and hazard log developed and approved in accordance with the DCB0129: Clinical Risk Management standard. This guidance should be used in conjunction with section 2.5 Risk mitigation.

1.2 Audience

This guidance is intended for anyone implementing and using PRSB standards. This will include health and social care professionals, IT system suppliers, developers, and implementers.

2. Guidance

2.1 Structure of the PRSB standards explained

PRSB standards use compositions of clinical information models (CIMs), which are reusable and modular components, to define the clinical content for a given use case as set out in BS EN ISO 13972 Clinical Information Models (CIMs).

These CIMs range from smaller to larger and are generally structured in a way aligning to the BS EN ISO 13606-1:2019 Health informatics – Electronic Health Record Communication Part 1: Reference model (elements -> cluster -> entry -> section). CIMs can be combined together to create a composition e.g. a diabetes care plan or discharge summary or personalised care and support plan.

The ISO 13606 reference model defines the hierarchical generic structure of an electronic health record (EHR), specifying the fundamental building blocks that every EHR system must have. PRSB generally aligns to its fundamental components across its standards agnostic of any particular use case. For example, the Diabetes Record Information Standard uses the reference model of ISO 13606 for self-reported data even though this data is not necessarily coming from an EHR (e.g. it might be from a Continuous Glucose Monitor or insulin delivery device or data aggregator platform), but it helpfully provides an organised and stable (tree like) structure. In that particular example, we're interested in getting the data from devices into EHRs (rather than information from EHRs).

The ISO 13606 reference model has universality and stability.

Universality: It is independent of specific clinical content, meaning it can be applied universally across different healthcare settings.

Stability: The reference model changes very rarely, ensuring that the technical foundation of the EHR system remains stable over time.

The ISO 13972: Health Informatics - Clinical Information Models (CIMs) standard for CIMs sets out that "CIMs are used to capture functional, semantic (non-technical) agreements for the standardisation of information used in the care process."

CIMs use a formal structure to represent clinical concepts, often as archetypes or templates (e.g. an archetype for ‘family history’, which specifies the clinical concepts and the value constraints allowed for that use case). They are designed to be reusable across different systems and contexts and can range from high-level models (e.g. a patient summary) to detailed models (e.g. a specific pathology result).

The openEHR archetypes and HL7 FHIR resources are other practical implementations aligned with ISO 13972 principles.

The set of rules and instructions governing the type of information expected within a section, record entry, cluster and element and how it is communicated, is defined in the PRSB information model under Description, Conformance, Cardinality, Implementation Guidance, Data Type, Value Sets and Information Type.

The PRSB information model structure and rules are explained in table 1 and in there is an example in figure 1 below.

Information Components	Model Description
Section	A section groups together all the information related to a specific topic e.g. ‘Medications and medical devices’ and ‘Person demographics’. It is the highest level to logically group data elements that may be independent or related. For example: - ‘Person demographics’ includes a set of independent elements or data items, grouped in a logical section. - ‘Medications and medical devices’ includes sets of related elements with dependencies between the elements. Sections may contain other 'sub-sections'.
Record entry	Record entries contain data items (as clusters or elements), and a record entry would be the information recorded as values for these data items at a point in time. The default context of a record entry is that it is about the subject of record. A record entry should have contextual information associated with it (provenance data). The type of contextual information is determined by the Information Type of the record entry. There are two information types used: ‘Record’ and ‘Event.Record’. Where the Information Type is defined as ‘Record’, the provenance data should include the person or device recording the data and the date and time it was recorded. Where the ‘Information Type’ is defined as ‘Event.Record’ the provenance data should also include the performer of the activity (person or device), the location, and the date and time the event took place.

Cluster	Clusters are a logical grouping of elements (hierarchical/nested), for example, 'medication course details cluster' which is the set of elements describing the course of the medication.
Element	Elements have a single associated data value. An element can appear in one or more sections e.g. 'Name', 'Role'.
Information model rules and instructions	**Explanations**
Description	This is the description of the section, record entry, cluster or element. For an element, it describes the information that the data value should contain in as plain English as possible.
Conformance	Conformance defines whether information is 'Mandatory', 'Required' or 'Optional' and applies to sections, record entries, clusters and elements. The clinical IT system should be developed to handle all the information elements that are defined in the standard, but not all the information is required for every individual record or information transfer. The rules for conformance (Mandatory, Required or Optional) may differ for different PRSB standards for a particular data item depending on the context of use of the standard. For example, standards that are for data entry (recording) may have different conformance rules from standards that are for data sharing. The following set of rules apply for data entry: • **Mandatory** – the information must be recorded. • **Required** – if the information is known and it is clinically relevant, it should be recorded. • **Optional** – a local clinical decision should be made as to whether the information is recorded. The following set of rules apply for data sharing: • **Mandatory** – the information must be shared, therefore must be recorded. • **Required** – if the information is recorded, it should be shared. • **Optional** – a local clinical decision should be made as to whether the information is shared. These rules apply at all levels in the information model and give the flexibility to allow local clinical or professional decisions on some information that is recorded or shared, while being clear on what is important information. For example, a person referred for treatment may have had many assessments, but it may be that not all of the assessments are relevant

	for the referral. The conformance can be used to indicate that relevant assessments only should be included in the referral and shared. Assessments section – Required – i.e. it is important information and should be included in the referral if there are relevant assessments. Record entry level – Optional – allows a local clinical decision on what assessments are included in the referral, so only relevant ones are included based on clinical or professional needs. Assessment elements – Conformance set on the normal basis of which elements for an assessment are Mandatory, Required or Optional. Note: It is permitted to upgrade a conformance rule but not to down grade one. For instance, a section that is classed as Optional in the standard can be upgraded to Required or Mandatory in local implementations. However, one that is classed Mandatory or Required cannot be downgraded to Required or Optional.
Cardinality	Each section, record entry, cluster and element will have a statement of cardinality. Cardinality defines how many instances of one entity are related to instances of another entity. This clarifies how many sections, records or values are expected or allowed i.e. zero, one or many. The number of sections, records or values expected and allowed are displayed as: • 0…* = zero to many sections, records or values are allowed. • 0…1 = zero to one section, record or value is allowed. • 1…1 = one section, record or value is expected. • 1…* = one to many sections, records or values are expected.
Implementation Guidance	Implementation guidance specific to the section or element is included in the information model. This is additional detailed information to support implementers of the standard.
Data Type	The data type defines the structural format of the data carried in an element. Every element has a data type. Data types define the meaning (semantics) of data values that can be assigned to an element. Meaningful exchange of data requires that the definition of values is known so that they can be exchanged. PRSB standards use a combination of the data types used in the International Patient Summary (IPS) (BS EN ISO 27269:2025) and PRSB defined data types, which are generally constraints on the IPS data types (for example 'Code no text', which is a constraint on 'Coded Element'). Data types are discussed in more detail in section 2.2 of this document.
Value Sets	Value sets describe the allowable or example values for the element where values can, and should, be constrained. If the values are expected to be in the form of coded data, they can be constrained to codes or predefined code sets within code systems.

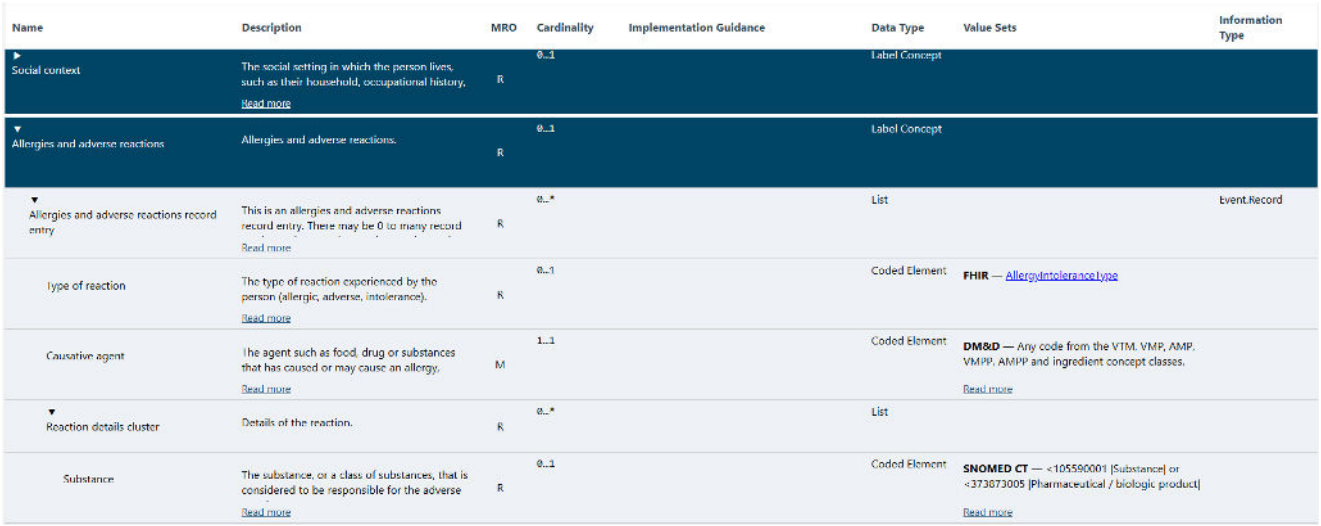
	Value sets have attributes that are used to describe it. 1. **Prefix:** This indicates the code system and could be one of the following: • DICOM — Digital Imaging and Communications in Medicine • DM&D — NHS Dictionary of Medicines and Devices • FHIR — Fast Healthcare Interoperability Resources • HSE_DD — HSE Data Dictionary (Northern Ireland) • IANA Media Types — Internet Assigned Numbers Authority Media Types • ICD — International Classification of Diseases • ISO — International Organization for Standardization • LOINC — Logical Observation Identifiers Names and Codes • NHSWALES_DD — NHS Wales Data Dictionary • NHS_DD — NHS Data Dictionary • NICIP — National Interim Clinical Imaging Procedure code set • OPCS — OPCS Classification of Interventions and Procedures • PHS_DD — Public Health Scotland Data Dictionary • PPPP — PLACEHOLDER • SNOMED_CT — SNOMED CT (Systematized Nomenclature of Medicine Clinical Terms) • UCUM — Unified Code for Units of Measure • UPRN — Unique Property Reference Number 2. **Text:** This is the code or reference to a predefined code set. (For SNOMED CT this could be a concept, refset or expression.) 3. **Use:** This is the status and expected use of the value set and can be: • Mandatory - the value must be one of the values in the value set. • Example – the values in the value set are examples of the type of value expected. • Recommended – it is recommended that the value is one of the values in the value set. • Draft - the value set is subject to review and may be incomplete or contain placeholders. 4. **URL:** This is included where there is a valid link. There would not be a URL for SNOMED CT expressions. In some cases, for larger refsets or expressions, PRSB will provide a link to a downloadable set of codes. The value sets defined in the standards are appropriate for the context of use of the standard. For example: • if the standard is for data entry it might have a small value set of appropriate SNOMED CT concepts for recording the information. • if it is for displaying information it might have a wider value set including inactive or retired SNOMED CT concepts. • if it is for secondary uses, it might have a wider value set depending on what data is being collected.

Information Type	Information Type is used to describe where it is important (from a professional perspective) to know who undertook an activity and/or who recorded the information in the person's healthcare record. This information is known as provenance data. Information Type is held at record entry level in the information model and can hold the value of either Event.Record' or 'Record'. If the Information Type is 'Event.Record', this means the performer of the activity, the location the activity took place and event date should be recorded as well as the author of the record and date the record was authored. If the Information Type is 'Record', this means that the author of the record and date the record was authored should be recorded. The provenance information model is published on the PRSB website.

Table 1: PRSB standard data structure

An example is shown in figure 1 below for 'Allergies and adverse reactions'.

- In this standard the section for 'Allergies and adverse reactions' has a conformance of 'Required', which means it should be included if there is a record of an allergy or adverse reaction and the cardinality is zero or one (or 0...1) i.e. there can be zero or one 'Allergies and adverse reactions' section.
- The section has a record entry to allow for multiple allergies or adverse reactions, which is also 'Required' with a cardinality of zero to many (or 0...*). The record entry contains a set of elements, i.e. the set of information for each allergy or adverse reaction record.
- The record entry has an information type of 'Event.Record' which means that the performer, author, location and date should all be recorded. The record entry also includes a cluster (reaction details cluster), which groups the reaction details together.
- Each element has a description, conformance, cardinality, data type, and may have value sets and implementation guidance. For example, 'Causative agent', is Mandatory, has a cardinality of one only (or 1…1) and a value set from the Dictionary of Medicines and Devices.



Name	Description	MRO	Cardinality	Implementation Guidance	Data Type	Value Sets	Information Type
▶ Social context	The social setting in which the person lives, such as their household, occupational history, Read more	R	0..1		Label Concept		
▼ Allergies and adverse reactions	Allergies and adverse reactions.	R	0..1		Label Concept		
▼ Allergies and adverse reactions record entry	This is an allergies and adverse reactions record entry. There may be 0 to many record Read more	R	0..*		List		Event.Record
Type of reaction	The type of reaction experienced by the person (allergic, adverse, intolerance). Read more	R	0..1		Coded Element	**FHIR** — AllergyIntolerance.type	
Causative agent	The agent such as food, drug or substances that has caused or may cause an allergy. Read more	M	1..1		Coded Element	**DM&D** — Any code from the VTM, VMP, AMP, VMPP, AMPP and ingredient concept classes. Read more	
▼ Reaction details cluster	Details of the reaction.	R	0..*		List		
Substance	The substance, or a class of substances, that is considered to be responsible for the adverse Read more	R	0..1		Coded Element	**SNOMED CT** — <105590001 |Substance| or <373873005 |Pharmaceutical / biologic product| Read more	

Figure 1: Example of the ‘Allergies and adverse reactions’ section within a PRSB standard

2.2 Data types

PRSB standards use a combination of the data types used in the International Patient Summary (IPS) (BS EN ISO 27269:2025) and PRSB defined data types. PRSB has used the following IPS data types in its standards.

Name	Description	Data Type	Value Sets
Label Concept	The Label Concept IPS data type describes data items that are containers for other data items, as defined in BS EN ISO 27269:2025 section 6.2.2.	Any	
List	The List IPS data type describes an implementation agnostic representation of data items that are containers for lists of other data items (e.g. problem list), as defined in BS EN ISO 27269:2025 section 6.2.3. In PRSB standards lists will usually be represented by record entries with a cardinality of 0 to many or 1 to many. Where there are mandatory data items of the type List in a clinical record, the reason for an empty list must be explicitly stated (e.g. No Known Drug Allergies or Not asked).	Any	
Reference	The Reference IPS data type provides a representation of an implementation independent directional link from a source data item to an internal (i.e. within the clinical record) or external target object (e.g. URL), as defined in BS EN ISO 27269:2025 section 6.2.4. In PRSB standards references are also defined by specific complex data types indicating the target component, which may be an entire information model (e.g. About Me), section or record entry (e.g. Procedures and therapies) or fewer data items such as clusters or individual elements.	Any	
Person Name	The Person Name IPS data type represents the name of a person structured as a sequence of name parts (e.g. first name, family name, title, suffix), as defined in BS EN ISO 27269:2025 section 6.2.5. PRSB recommends use of NHS Data Dictionary elements for name parts (e.g. PERSON GIVEN NAME for first name).	Any	
Person first name	The first name(s) of the person. This includes middle names.	String	NHS Data Dictionary — PERSON GIVEN NAME (Recommended) (https://www.datadictionary.nhs.uk/data_elements/person_given_name.html?hl=person%2Cgiven%2Cname)

Name	Description	Data Type	Value Sets
Person family name	The family name or surname of the person.	String	NHS Data Dictionary — PERSON FAMILY NAME (Recommended) (https://www.datadictionary.nhs.uk/data_elements/person_family_name.html)
Person preferred name	The name by which a person wishes to be addressed. The preferred name volunteered by the person or a preferred name given by PDS that the person has asked to be called by.	String	NHS Data Dictionary — PERSON FULL NAME (Recommended) (https://datadictionary.nhs.uk/data_elements/person_full_name.html?hl=person%2Cname)
Title	Person's title.	String	NHS Data Dictionary — PERSON TITLE (Recommended) (https://www.datadictionary.nhs.uk/data_elements/person_title.html)
Person name suffix	A textual suffix that may be added to the end of a person's name, for example, OBE, MBE, BSc, JP, GM.	String	NHS Data Dictionary — PERSON NAME SUFFIX (Recommended) (https://www.datadictionary.nhs.uk/data_elements/person_name_suffix.html)
Coded Element	The Coded Element IPS data type describes elements holding a single concept from a defined code system (e.g. SNOMED CT) as defined in BS EN ISO 27269:2025 section 6.2.6. PRSB recommends the exceptional use of free text in circumstances where no appropriate coded concept is available.	Any	
Date Time	The Date Time IPS data type supports representation of a full or partial date and/or time as defined in BS EN ISO 27269:2025 section 6.2.7.	Any	
Identifier	The Identifier IPS data type defines a unique name for a thing or object, as defined in BS EN ISO 27269:2025 section 6.2.8. For example, NHS number.	Any	
Address	The Address IPS data type represents the address of a person or organisation structured as a sequence of address parts (e.g. Address line 1, Address line 2, Postcode etc), as defined in BS EN ISO 27269:2025 section 6.2.9. PRSB recommends use of: • NHS Data Dictionary attributes for address parts (e.g. ADDRESS LINE 1) and specific use codes (i.e. ADDRESS ASSOCIATION TYPE). • Unique Property Reference Number (UPRN) identifiers, where available. • Organisation Data Service (ODS) codes to retrieve address details, where available.	Any	

Name	Description	Data Type	Value Sets
Address line 1	First line of the address.	String	NHS Data Dictionary — ADDRESS LINE 1 (Recommended) (https://www.datadictionary.nhs.uk/attributes/address_line_1.html)
Address line 2	Second line of the address.	String	NHS Data Dictionary — ADDRESS LINE 2 (Recommended) (https://www.datadictionary.nhs.uk/attributes/address_line_2.html)
Address line 3	Third line of the address.	String	NHS Data Dictionary — ADDRESS LINE 3 (Recommended) (https://www.datadictionary.nhs.uk/attributes/address_line_3.html)
Address line 4	Fourth line of the address.	String	NHS Data Dictionary — ADDRESS LINE 4 (Recommended) (https://www.datadictionary.nhs.uk/attributes/address_line_4.html)
Address line 5	Fifth line of the address.	String	NHS Data Dictionary — ADDRESS LINE 5 (Recommended) (https://www.datadictionary.nhs.uk/attributes/address_line_5.html)
Postcode	Postcode of the address.	String	NHS Data Dictionary — POSTCODE (Recommended) (https://www.datadictionary.nhs.uk/data_elements/postcode.html) NHS Data Dictionary — POSTCODE OF USUAL ADDRESS (Recommended) (https://www.datadictionary.nhs.uk/data_elements/postcode_of_usual_address.html)
Address type	The type of address e.g. main permanent residence or temporary residence.	Coded Element	NHS Data Dictionary — ADDRESS ASSOCIATION TYPE (Recommended) (https://www.datadictionary.nhs.uk/attributes/address_association_type.html?hl=address%2Cassociation)

Name	Description	Data Type	Value Sets
Address start date	The date when the address became valid for the person or organisation.	Date Time	
Address end date	The date when the address was no longer valid for the person or organisation.	Date Time	
Unique Property Reference Number (UPRN)	Unique Property Reference Number (UPRN) is the unique numeric identifier (up to 12 digits) for every addressable location across the UK.	Identifier	Unique Property Reference Number — https://www.geoplace.co.uk/addresses-streets/location-data/the-uprn (Recommended) (https://www.geoplace.co.uk/addresses-streets/location-data/the-uprn)
Telecom	The Telecom IPS data type provides the telecommunication contact details of a person or organisation (e.g. contact telephone number, email address), as defined in BS EN ISO 27269:2025 section 6.2.10. PRSB recommends use of: • NHS Data Dictionary attributes (i.e. COMMUNICATION CONTACT METHOD and COMMUNICATION CONTACT STRING) and the FHIR value set ContactPointUse for these details. • Organisation Data Service (ODS) codes to retrieve organisation contact telephone numbers, where available.	Any	
Telecom contact method	The telecommunications system or contact method. e.g. phone, email, other.	Coded Element	NHS Data Dictionary — COMMUNICATION CONTACT METHOD (Recommended) (https://www.datadictionary.nhs.uk/attributes/communication_contact_method.html?hl=communication) FHIR — ContactPointSystem (https://simplifier.net/packages/hl7.fhir.r3.core/3.0.2/files/59580)

Name	Description	Data Type	Value Sets
Telecom value	The telecom value e.g. UK telephone number, email address or other communication contact string.	String	NHS Data Dictionary — COMMUNICATION CONTACT STRING (Recommended) (https://www.datadictionary.nhs.uk/attributes/communication_contact_string.html) NHS Data Dictionary — UK TELEPHONE NUMBER (Recommended) (https://www.datadictionary.nhs.uk/data_elements/uk_telephone_number.html) NHS Data Dictionary — CONTACT EMAIL ADDRESS (PATIENT OR LEAD CONTACT) (Recommended) (https://www.datadictionary.nhs.uk/data_elements/contact_email_address__patient_or_lead_contact_.html?hl=contact%2Cemail%2Caddress)
Telecom type	The telecom contact type or use e.g. home, work, mobile etc.	Coded Element	FHIR — ContactPointUse (Recommended) (https://hl7.org/fhir/STU3/valueset-contact-point-use.html)
Preference of telecom value	The preferred order of use for the telecom value.	String	(Recommended)
Organisation Name	This aligns to the IPS data type Organization Name and represents the name for an organisation as a simple string, as defined in BS EN ISO 27269:2025 section 6.2.11. PRSB recommends use of Organisation Data Service (ODS) codes to retrieve organisation names, where available.	Any	
Text	The Text IPS data type supports human readable text (e.g. for clinical narrative or a person's About Me responses), as defined in BS EN ISO 27269:2025 section 6.2.12.	Any	
Any	The Any IPS data type is an abstract data type of which all other data types are concrete specialisations, as defined in BS EN ISO 27269:2025 section 6.2.13. This data type is not generally used for PRSB data items, which must usually use concrete IPS (i.e. Label Concept, List, Reference (PRSB equivalent), Person Name, Coded Element, Date Time, Identifier, Address, Telecom, Organisation Name (PRSB equivalent), Text, Range, Quantity, Period, General Time Specification (abstract type), String, and Ratio) or PRSB		

Name	Description	Data Type	Value Sets
	(Code No Text, Timestamp, Document, MultiMedia, Lower Limit Range and Upper Limit Range) data types. Occasionally, Any may be used in draft specifications as a placeholder for another data type.		
Range	The Range IPS data type represents an ordered set of quantities usually expressed as lower and upper limit values with units of measure, as defined in BS EN ISO 27269:2025 section 6.2.14. Exceptionally the lower or upper limit value may be omitted (e.g. < 3.0 mmol/ L). PRSB recommends use of UCUM (Unified Code for Units of Measure) for representing units. The PRSB data types Lower Limit Range and Upper Limit Range constrain this data type.	Any	
Quantity	The Quantity IPS data type defines dimensioned quantities that are usually the result of measuring and expressed as values with units of measure (e.g. 120 mmHg), as defined in BS EN ISO 27269:2025 section 6.2.15. PRSB recommends use of UCUM (Unified Code for Units of Measure) for representing units.	Any	
Period	The Period IPS data type defines an ordered set of time stamps for start and end date times (e.g. from 1 Aug 2024 to 31 July 2025) or start date time and width (e.g. from 1 Aug 2024 for one year), as defined in BS EN ISO 27269:2025 section 6.2.16.	Any	
General Timing Specification	This aligns to the IPS data type General Time Specification (GTS) and is an abstract data type that defines an unordered set of distinct values that are time quantities used for specifying the timing of certain events and actions that may be cyclical (e.g. every other Wednesday morning from 1 Aug 2024 to 31 July 2025), as defined in BS EN ISO 27269:2025 section 6.2.17.	Any	
String	The String IPS data type supports machine readable text (i.e. character string), as defined in BS EN ISO 27269:2025 section 6.2.18.	Any	
Ratio	The Ratio IPS data type broadly defines a quotient quantity with a numerator and denominator (e.g. an insulin to carbohydrate ratio (ICR) of 1:10), as defined in BS EN ISO 27269:2025 section 6.2.19.	Any	

The PRSB defined data types are generally constraints on the IPS data types and are as follows:

Name	Description	Data Type

Code No Text	The PRSB data type Code No Text constrains the Coded Element IPS data type so that exceptional use of free text is not allowable.	Coded Element
MultiMedia	Represents the actual multi-media file if it is stored in the system.	Text
Lower Limit Range	The PRSB data type Lower Limit Range constrains the Range IPS data type so that the upper limit value is omitted (e.g. > 13.9 mmol/ L.).	Range
Upper Limit Range	The PRSB data type Upper Limit Range constrains the Range IPS data type so that the lower limit value is omitted (e.g. < 3.0 mmol/ L).	Range

2.3 Version numbering

Latest releases of PRSB standards are published using two-part version numbers, for example Palliative and End of Life Care Standard v1.11. The information model version numbers take the form of major.minor version, e.g., v1.11 where the standard is major version 1 and minor version 11. Major versions are incremented on significant revisions or enhancement of the information model and minor versions are incremented on minor updates such as changes or issue resolutions.

PRSB may also make development versions of the standards available for feedback or consultation and these would have three-part version numbers e.g. 1.11.1.

2.4 Dependencies

The implementation of PRSB standards is often dependent on the following:

- The national and local Information Governance frameworks, which will determine information access and sharing controls and legitimate relationships between health and care provider organisations.
- Technical messaging standards e.g., FHIR (Fast Healthcare Interoperability Resources) profiles (to support the transfer of information between systems).
- The availability of other sources to access some of the person's care information such as the National Record Locator Service (NRLS), GP records and shared care records.

2.5 Risk mitigation

We recommend system suppliers and local implementers apply further risk mitigations when implementing PRSB standards by addressing the risks that have been flagged in the clinical safety case report and hazard log for each standard. Suppliers and implementers should aim to reduce the risk scores to 2, or better, when carrying out clinical risk assessments and developing safety cases for their implementations with respect to DCB0129 and DCB0160.

2.6 Information governance

Sound principles of information governance and respecting the privacy of people and their information is paramount. NHS England has published a national Information Governance framework that needs to be considered when planning implementation.

Local agreements should be drawn up between organisations to define information requirements for communication.

2.7 Data quality

Data quality and accuracy of coded data entry should be managed in local 'source' systems.

2.8 Context of the information

It is vital for use of the data that all contextual information is maintained and should not be lost on exchange or import of information. For example, if a frailty assessment was undertaken at a care home two days before an individual was admitted to hospital, it is important that the full context of the information is known (where and when the assessment was done and by whom).

The principle, for PRSB standards, is that for clinical safety and efficacy of communications, the following key contextual data should be shared where specified by the 'Information Type' of the record entry in any PRSB standard:

- **Author -** the professional, person or device that recorded the information.
- **Date and time recorded** - the date and time the information was recorded. This is expected to be automated and linked to audit trail (see section 2.9).
- **Performer** – is the professional, person or device who performed the activity for example carried out the procedure.
    - A professional has various elements including 'Name', 'Role', 'Specialty' and 'Organisation'. If the professional is not known but the 'Organisation' and 'Specialty' are known, they should be included as contextual information.
    - A person has 'Name' and 'Relationship'.
    - A device has 'Device type', 'Device manufacturer', 'Model', 'Software version' and 'Unique identifier'.
- **Activity location** – the place in which the activity took place e.g. where observations were made.
- **Event date and time** - the date and time on which the activity took place e.g. when the assessment was performed. In some instances, this would be start and end dates.

Note that the element 'Speciality' only applies to some professionals so only needs to be included where relevant.

The principle applied in the information model is that where it is important (from a professional perspective) to know who undertook the activity and who recorded the activity, an 'Information Type' of 'Event.Record' or 'Record' is included in the model at the record entry level in the hierarchy. 'Event.Record' means that the performer and author should both be recorded and 'Record' means that the author should be recorded.

The provenance information model sets out how and what contextual information should be recorded.

2.9 Timestamp and audit trail

It is important that an audit trail is recorded for every item of information recorded or shared (even if not explicitly stated in the information model).

Each record entry should be time stamped from the source system with date and time recorded and the identity of the person making the record. This should be viewable in the records themselves where appropriate and via a full audit trail, which may be viewable by the end user to enhance transparency.

2.10 Links to other records and documents

The person may have multiple detailed records or documents held on local systems, e.g. there may be a mental health record for a person at a particular trust or shared care records such as an end of life care plan. PRSB standards do not define all these possible links. It is expected that the local areas will define the requirements for accessing other records or documents, and where applicable and provide access through the shared care record for authorised professionals.

2.11 Use of terms

The term ‘role’ has been consistently used rather than ‘designation’ throughout PRSB standards to apply to the role the professional had in an activity. It is the term used in the NHS data dictionary.

The term ‘organisational role’ means the role the professional has in their employer organisation.

Some clusters such as ‘Referrer details’ have elements for one or more of ‘Specialty’, ‘Team’, ‘Service’ and ‘Department’. This is to allow for all situations across health and care where different terms are required. Where possible ‘Specialty’ and ‘Service’ should be used and coded as detailed in the value set for the element.

2.12 Coding

The Personalised Health and Care 2020 framework for action recommends the use of SNOMED CT and the dictionary of medicines and devices (dm+d). Local decisions should be made about when these codes are used based on local system functionality and plans. The current ambition is for SNOMED CT and dm+d to be the primary clinical coding schemes in use in the NHS. Where SNOMED CT concepts are displayed in systems, the UK SNOMED preferred term should be displayed.

2.13 Legacy data

Information may already be recorded in clinical systems using old inactive codes and using old code systems that do not conform to the coding requirements set out in the PRSB standard.

The standards do not address the issues of migrating historically recorded data and clinical concepts to conform with the coding requirements set out in the standard. Implementers of the standard will need to be mindful of pre-existing data. This data may need to be migrated to the new forms – or left in its original model/concepts and displayed as appropriate.

2.14 Accessibility

The design of user interfaces for health and care record systems should follow guidance for specific PRSB standards and should comply with the NHS England Accessible Information Standard . This sets out the rules for accessible patient information in patient literature and clinical systems.