Professional Record Standards Body

Better records for better care

# HOSPITAL REFERRAL FOR ASSESSMENT FOR COMMUNITY CARE AND SUPPORT

## IMPLEMENTATION GUIDANCE v 1.0

OCTOBER 2020

## Acknowledgements

**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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## Revision History

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| Project Board | Project Board | 28/9/20 | 0.5 |
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## Glossary of Terms

| Term / Abbreviation | What it stands for |
|---|---|
| AADW notices | Admission, Assessment, Discharge and Withdrawal notices |
| ADRT | Advanced Decision to Refuse Treatment |
| ADW notices | Assessment, Discharge and Withdrawal notices |
| ADASS | Association of Directors of Adult Social Care |
| ASCOF | Adult Social Care Outcomes Framework |
| BIA | Best Interest Assessor |
| CHC | Continuing Healthcare (checklist) |
| CHI | Community Health Index |
| COVID - 19 | Corona virus disease – 2019 |
| CSP | Care and support plan. Used interchangeably with DCSP |
| DCB | Data Coordination Board |
| DCSP | Digital care and support plan. Used interchangeably with CSP |
| DHSC | Department of Health and Social Care |
| dm+d | Dictionary of medicines and devices |
| DoLS | Deprivation of Liberty Safeguard |
| DPIA | Data Privacy Impact Assessment |
| D2A | Discharge to Assess |
| ECT | Electroconvulsive Therapy |
| EHR | Electronic Health Record |
| EoLC | End of Life Care |
| EPR | Electronic Patient Record |

| | |
|---|---|
| FHIR | Fast Healthcare Interoperability Resources |
| GDPR | General Data Protection Regulation |
| GP | General Practitioner |
| HL7 | Health Level 7 |
| ICR | Integrated care record. Used interchangeably with IDCR |
| IDCR | Integrated digital care record. Used interchangeably with ICR |
| ISCE | Information Standards, Collections and Extractions |
| LGA | Local Government Association |
| LHCR | Local Health and Care Record |
| LPA | Legal Power of Attorney |
| MCA | Mental Capacity Assessment |
| Metadata | A set of data that describes and gives information about other data |
| MHA | Mental Health Act |
| NIB | National Information Board |
| NICE | The National Institute for Health and Care Excellence |
| NHS | National Health Service |
| NHSD | NHS Digital |
| 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 |

| | |
|---|---|
| SALT | Short and Long Term support |
| SCCI | Standardisation Committee for Care Information |
| SCDIA | Social Care Digital Innovation Accelerator |
| SCDIP | Social Care Digital Innovation Programme |
| SCP | Social Care Programme |
| SNOMED-CT | Systematized Nomenclature of Medicine - Clinical Terms |
| SPA | Single Point of Access |

## Contents

# 1 Purpose of this document

This section describes the purpose of the implementation guidance and how it was developed and will be updated in the future.

## 1.1 Purpose of the document and how it should be used

This document provides guidance to support the implementation of the Hospital Referral for Assessment for Community Care and Support information standard. It provides general guidance as well as guidance for each specific part of the standard.

This guidance should be used in conjunction with the Hospital Referral for Assessment for Community Care and Support  Standard (which sets out the requirements), the Digital Social Care Information Transfers of Care Hazard Log and Clinical Safety Case report. The Transfers of Care Hazard Log provides guidance for system developers and implementers. It is important that this guidance in relation to those hazards, regarded as system issues, become requirements for implementation.

## 1.2 Implementation guidance development and updating process

The guidance was developed from the evidence gathering and consultation process described in the Digital Social Care Information Project Final Report. The approach to the development of this information standard is set out in the Final Report.

The guidance in this document will be refined and updated regularly as it is anticipated that there will be further findings and feedback as the standard is actually implemented.

# 2 Background

This section describes why this standard was developed including the main national and local programmes and drivers influencing this work; how it relates to and supports other national initiatives including the Assessment, Discharge and Withdrawal Notices Information Standard (also known as the ADW standard) and Discharge to Assess (D2A); purpose and definition of the standard and how it is meant to be used. Section 2.4 describes ADW and points the reader to additional ADW resources that must be reviewed when implementing this standard.

## 2.1 Background to the information standard

NHS Digital Social Care Programme (SCP) commissioned the Professional Record Standards Body (PRSB) to develop a set of nationally agreed information standards and a guidance product to support sharing of an individual’s care information between health and social care. The Hospital Referral for Assessment for Community Care and Support is one of these standards.

### 2.1.1 The social care digital landscape

The SCP is a National Health Service (NHS) Digital (NHSD) programme that was commissioned and sponsored by the Department of Health and Social Care (DHSC); established to support more efficient and person-centred transfers of care between health and social care settings and to drive forward the health and social care integration agenda.

A key driver for this work includes requirements for health and social care to comply with the Care Act 2014[1] (and care and support statutory guidance) and Community Care Act 2003[2] information requirements and processes to ensure the safe, effective and timely discharge from hospital for adults back to the community.

Key implementation drivers include the integrated care agenda, which enables a model of national decentralisation and local integration so local health and social care organisations can develop a range of integrated care systems to best serve their local population. These are underpinned by the sharing of a person's health and care records across their local health and social care organisations e.g. the local health and care record (LHCR) initiatives. The Social Care Digital Innovation Programme (SCDIP) and more recently the Social Care Digital Innovation Accelerator Programmes (SCDIA) have further hastened the pace of digital integration of services.

### 2.1.2 Social care digital maturity and implications for the discharge pathway

The Care Act 2014 and supporting legislation and guidance defines what health and care organisations must comply with but it does not stipulate how organisations should achieve compliance. This has resulted in local variation in the discharge pathway processes and procedures for persons with complex needs requiring community support following discharge - and also, in the progress with which they are being implemented. The emergence of COVID - 19 has accelerated local integrated care programs and rapidly led to new insights into what care and information systems are needed and work at a local level.

If hospital staff believe a person needs continuing care or support after discharge from hospital, then a social care assessment is required.[3] They must notify their local authority's social services team to conduct the assessment. The Assessment, Discharge and Withdrawal Notices Information Standard (SCCI 2016) was introduced mandating the legal minimum information that the treating hospital must send to the social care team to comply with the 2014 Care Act.

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[1] https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

[2] https://www.legislation.gov.uk/ukpga/2003/5/contents

[3] *NB*: At the time of publication assessment and discharge notices are not being sent due to the UK response to COVID-19, see **here** for more information.

The Discharge to Assess (D2A) initiative was introduced and supported by NHS England (NHSE) as a novel means of developing timely and effective discharges from hospital to community. Its introduction has been variable but again accelerated due to COVID - 19 needs. In August 2020, the Department of Health and Social Care issued revised policy on the hospital discharge process developed in response to COVID-19 (See also Care Act easements). Acute hospitals are required to discharge patients as soon as it is clinically safe to do so. As a consequence of the policy social care needs assessments under the Care Act and NHS Continuing Healthcare (NHS CHC) assessments of eligibility should be made in a community setting, during a period of funded recovery lasting up to six weeks; and should not take place during the acute hospital inpatient stay. This means that the context of the "Hospital Referral for Assessment for Community Care and Support" has changed as the assessment for support now takes place after discharge from hospital in the majority of cases. The information defined in the standard will still be required to assess the care and support needs of an individual after discharge, however it may be that some of the information required for assessment is not obtained from hospital records. For example, 'social context' information should have been collected at the point of admission and be held in hospital records[4] whereas 'NHS CHC assessment' will not be held in hospital records as the consideration as to whether a person needs this assessment will not have been conducted / recorded before discharge. This reinforces the need to move to shared records where much of the information needed could more easily be made accessible to professionals within multi-disciplinary teams from multiple organisations at the same time. The D2A process can be seen in diagram form in figure 1. The acute hospital remains responsible for 'pathway 0' – simple discharge home (~ 50% of patients). Patients not for simple discharge home are referred to a Single Point of Access (SPA) 'Community Hub' and are allocated to one of pathways 1 – 3 ('pathway 1' – Home recovery with up to six weeks funded support from health and/or social services (~ 45% of patients); 'pathway 2' – rehabilitation or short term care in a 24-hour bed based setting (~ 4% of patients); 'pathway 3' – ongoing 24-hour nursing care (~ 1% of patients). A proportion of the patients requiring an ongoing package of care will have a 'Care Act' assessment and/or NHS CHC assessment, with the responsible bodies being the local authority and CCG respectively. Regardless of the processes involved, it remains mandatory that the outcome of an NHS CHC assessment is sent to the local authority.

### 2.1.3 How the Hospital Referral for Assessment for Community Care and Support supports this framework

The above described national programmes and incentives has resulted in a continuum of digital maturity within localities across England with a similar picture across the four UK countries. This national standard is introduced as a mechanism to ensure the person's relevant health and care information can be appropriately

[4] Hospital Discharge Service: policy and operating model, August 2020, UK Government

shared within this environment. It is a generic standard with the flexibility to support local systems whatever their levels of digital maturity – from advanced availability of shared care records where minimal information needs to be communicated with the referral to situations where all the information pertaining to the referral needs to be communicated in the messaging.

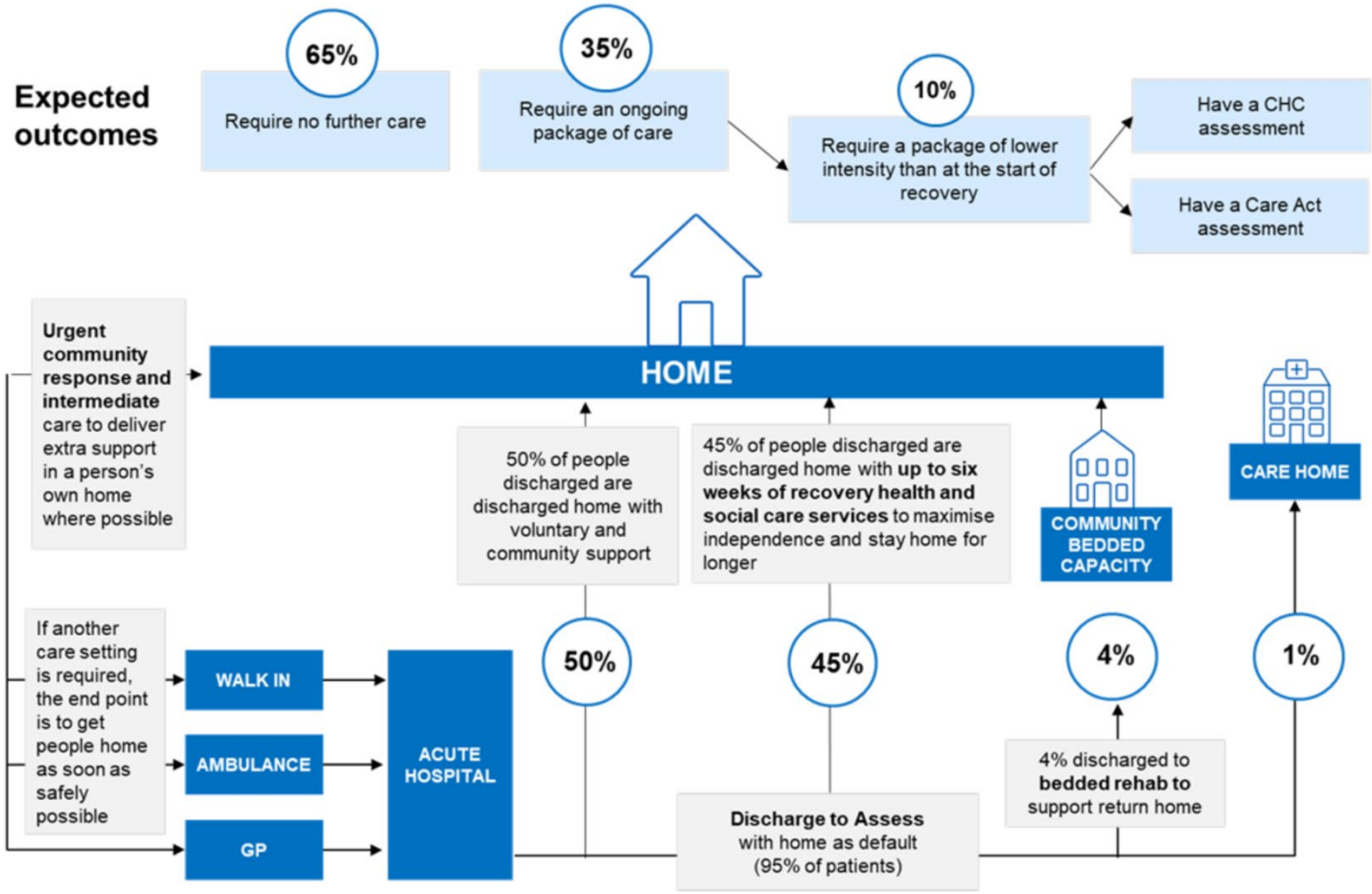
## 2.2 Purpose of the Hospital Referral for Assessment for Community Care and Support Standard

Hospitals must determine when it is safe to discharge a person and implement a discharge plan. Part of that decision-making process requires hospital staff to determine whether the person needs to be referred for an assessment to establish ongoing care and support in the community after discharge.

Example scenarios:

- older people who were previously independent but subsequently require ongoing care; either at home or in a care home after their hospital stay
- adults requiring respite care
- adults requiring reablement
- adults with end of life care needs
- adults with a learning disability or long-term conditions whose community care and support needs have changed following the admission.

Note that the discharge processes themselves are out of scope of the standard. It is intended that the standard, although containing sections facilitating information sharing via processes such as the ADW and D2A, is in fact transfer process agnostic. It simply contains the information that health and social care professionals have told us they need to know about a patient. The ADW is currently a legal statutory requirement and the D2A is due to be fully implemented across England. However, whilst the processes via which information transfer occurs may change over time, it is anticipated that the general information requirements for health and social care professionals assessing the needs of patients around the time of discharge from hospital have been and will remain relatively stable over time. It is intended that the standard be used across the UK.




- **Figure 1: Discharge to Assess Pathway (From *Hospital Discharge Service: policy and operating model, August 2020, UK Government*)**

## 2.3 Definition and scope of the Hospital Referral for Assessment for Community Care and Support Standard

The Hospital Referral for Assessment for Community Care and Support standard defines the information requirements in respect of an adult person being referred from hospital to health and social care for possible ongoing social and health care support following discharge from hospital.

The standard includes the minimum information that currently must be sent to the person's local authority as part of the Assessment, Discharge and Withdrawal Standard notice(s) information (SCCI 2016) as well as the clinical information that health and social care professionals in the community have told us they require following discharge from hospital. ADW notices are explained further in section 2.4, including guidance on use during the COVID-19 pandemic.

### 2.3.1 What it is

The Hospital Referral for Assessment for Community Care and Support standard **is**:

- a definition of the information to be shared with the responsible body (local authority social care team and community health) when referring an adult for assessment for care and support by social services and/ or NHS services after discharge from an acute hospital
- the information set that should be communicated / available to the responsible body (local authority) to enable them to decide if the person needs to be assessed under the Care Act and what care and support is likely to be needed.
- applicable to individuals who require care and support, after discharge, in their own home or if placed in an accommodation setting such as a care home.
- Supportive of and is an integral part of the discharge planning and process for these individuals.
- for adults only
- supportive of the information elements that are needed to extract ADW notices to the local authority.
- IT system and discharge pathway agnostic.
- compliant with Care Act 2014 discharge pathway information requirements.
- compatible with the Discharge to Assess process

### 2.3.2 What it is not

The Hospital Referral for Assessment for Community Care and Support standard **is not**:

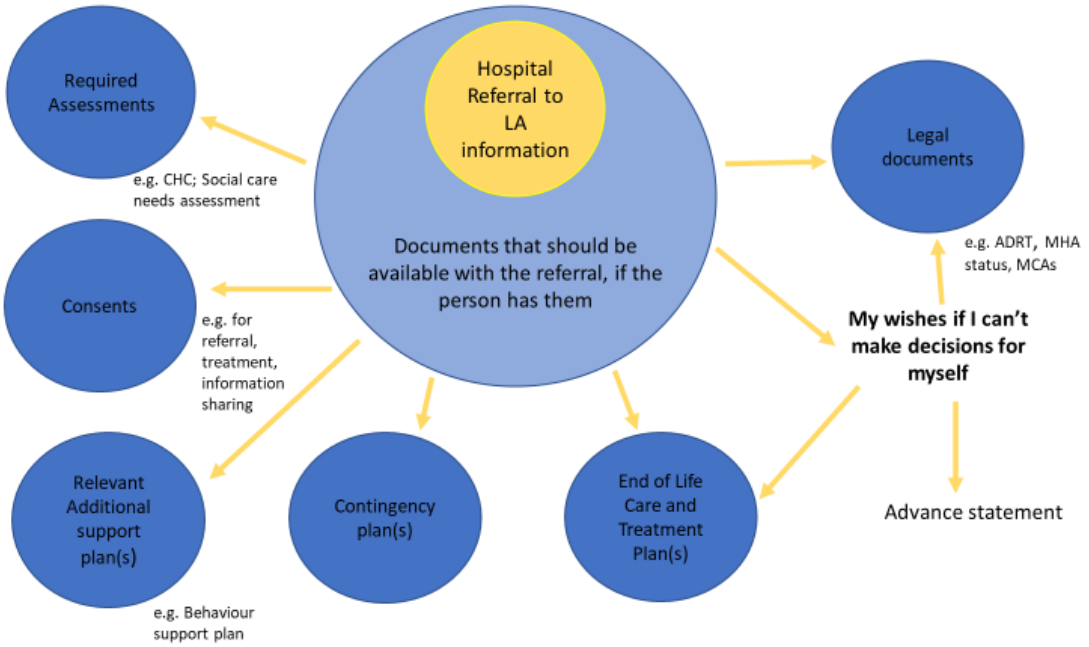
- defining the discharge planning, process or pathway that takes place locally

- guaranteed to include all the referral information required for a person discharged from a mental health service because it is developed for a person who has received care in an acute hospital
- for adults who do not need care and support after discharge from hospital
- for people who wish to make private arrangements for care and support without the involvement of the local authority (it is recognised the local authority may still become involved for self-funded persons)
- a definition of how information should be presented to professionals

### 2.3.3 How it works

The standard includes a core set of information that is communicated in the referral and references other important documents pertaining to the person that should be accessible. These additional documents may be communicated as attachments or be available from shared care records. For example, if an end of life care plan exists it is important that this is communicated in the referral and the recipient is sent the document or knows where to access it. It is recognised and expected that under D2A pathways 1 – 3 (patients who require 'reablement, rehabilitation, and/ or some care followed by further assessment after recovery'[5]) the integrated discharge team or equivalent will be responsible for identifying the information and documents that are required to be sent to the single point of access for the purposes of establishing the person's immediate needs.

Figure 2 on outlines the referral information and relationship with any additional documentation that may be needed.




[5] Hospital Discharge Service: policy and operating model, August 2020, UK Government

**Figure 2: Hospital Referral for Assessment for Community Care and Support Information standard - communication structure**

## 2.4 Assessment, Discharge and Withdrawal Notices information standard

### 2.4.1 Purpose of ADW notices

The information requirements of the ADW notices are set out in the Assessment, Discharge and Withdrawal Notices Information Standard (SCCI 2075, 2016).

The purpose of the Notices is to ensure a timely care and support assessment is triggered, and that information required by the social services team is received to facilitate this. The local authority must send an acknowledgement of receipt of the notices back to the sender.

### 2.4.2 ADW Notices implementation guidance

All those involved in the implementation and use of the ADW notices must refer to specific NHS Digital ADW implementation guidance on how to implement and use these Notices. It should be read in conjunction with the ADW Requirements Specification document.

### 2.4.3 COVID – 19 pandemic effects on ADW standard notices

It is recommended to check NHS Digital current guidance on the use of information standards, collections, and extractions (ISCEs) because some of these have been suspended in response to the current COVID-19 pandemic. *NB*: The ADW is at the time of publication of this document still a statutory requirement even though these are not currently recommended as policy.

# 3 Audience – who is this document for?

The guidance in this document is intended for anyone implementing and using the Hospital Referral for Assessment for Community Care and Support information standard. This will include health and social care professionals, IT system suppliers, developers, and implementors.

# 4 General guidance

This section describes general principles and rules covering this standard in its entirety:

- Section 4.1 outlines how the standard is organised and the rules governing how the information is entered and utilised
- Section 4.2 considers external dependencies affecting implementations
- Sections 4.3 to 4.11 cover general implementation principles and topics

## 4.1 Structure of the standard explained

An information standard is organised into sections made up of several data (information) elements, with record entries and clusters (subsections) to support repeated sets of information and grouping of related items.

The set of rules and instructions governing the type of information expected within a section, cluster, record entry and element and how it is communicated is defined in the information model under the headings Description, Cardinality and Conformance.

The PRSB information model structure and rules are explained in Table 1 and the annotated example below.

| Information model components | Description |
|---|---|
| Section | A section groups together all the information related to a specific topic e.g. 'Medications and medical devices' and 'Person demographics'.<br><br>It is the highest level to logically group data elements that may be independent or related. For example:<br><br>- 'Legal information', includes a set of independent elements or information items, grouped in a logical section.<br>- 'Medications and medical devices' includes sets of related elements with dependencies between the elements. |
| Record entry | A record entry within a section is used where a set of information is repeated for a particular item, and there can be multiple items; for example, for each medication there is a set of information associated with that medication Other examples are Allergies or adverse reactions and Procedures. |
| Cluster | This is a set of elements put together as a group and which relate to each other; e.g. medication course details cluster which is the set of elements describing the course of the medication. |
| Element | The data item.<br><br>An element can appear in one or more sections e.g. name, date. |
| **Information model rules and instructions** | **Explanations** |

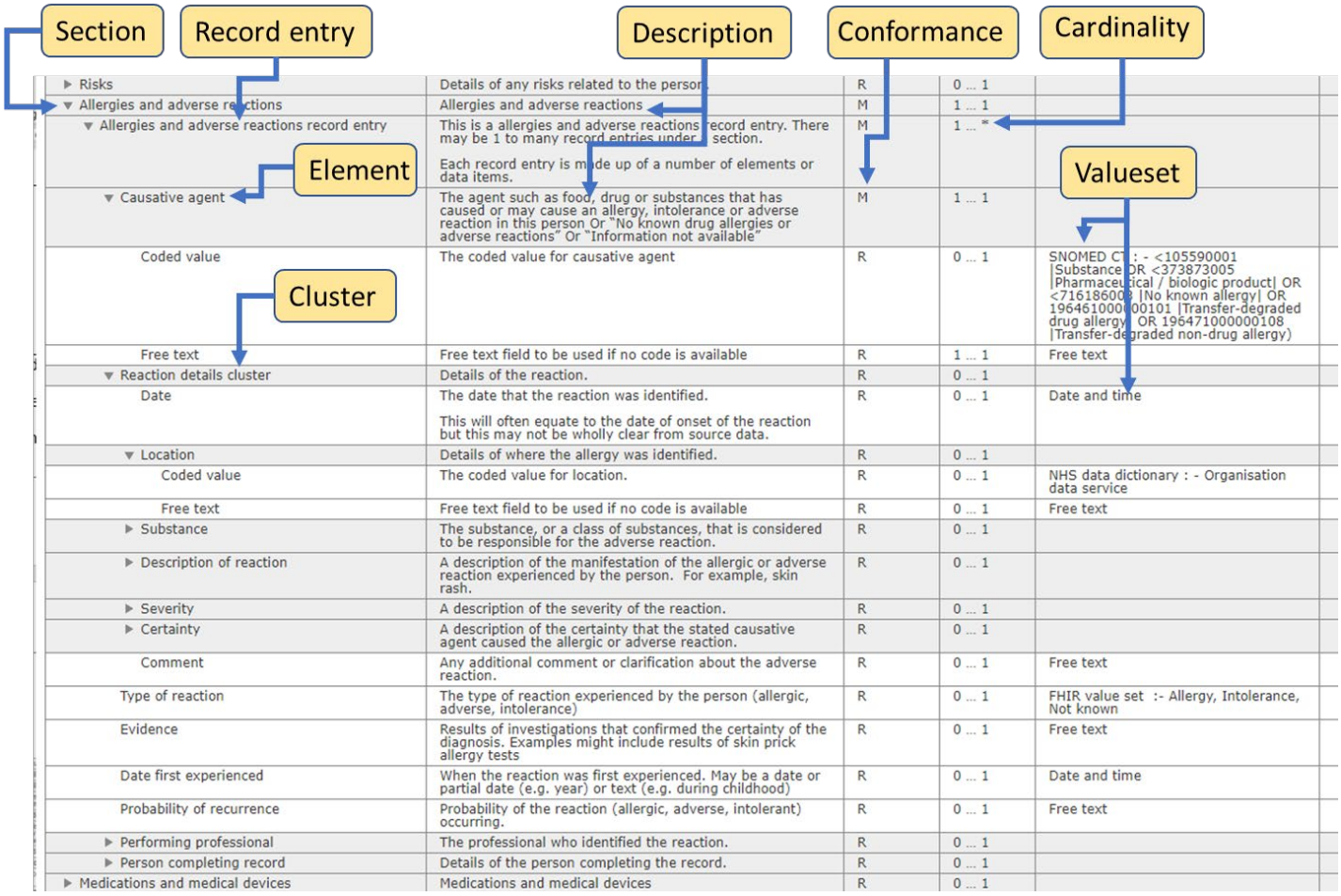
| | |
|---|---|
| Description | This is the description of the section, record entry, cluster or element. For an element it describes the information that the element should contain in as plain English as possible. |
| Cardinality | Each section, record entry, cluster and element will have a statement of cardinality. This clarifies how many entries can be made i.e. zero, one or many entries. The number of records expected and allowed are displayed as:<br>0……* = zero to many record entries are allowed<br>0……1 = zero to one record entry is allowed<br>1……1 = one record is expected<br>1……* = one to many records are expected<br>For example, the 'Medications and medical devices' section may have zero to many medication item records in it and is displayed as 0…… *. |
| Conformance | Conformance defines what information is 'mandatory', 'required' or 'optional' and applies to sections, record entries, clusters and elements.<br>The IT system must be developed to be 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.<br>The following set of rules apply to enable implementers to cater for the end users (senders and receivers) requirements:<br>• Mandatory – the information must be included<br>• Required – if it exists, the information must be included<br>• Optional – a local decision is made as to whether the information is included<br>These rules apply at all levels and give the flexibility to allow local clinical or professional decisions on some information that is included, while being clear on what is important information to include.<br>For example, a person subject to a referral may have many assessments, but not all of these will be relevant to the referral. The conformance can be used to allow just relevant assessments to be included.<br>Assessment Section – Required – i.e. its important information you must include if you have it.<br>Record entry level – Optional – allows a local decision on what assessments are included, 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.<br><br>**NB:** 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. |
| Valuesets | Valuesets describe precisely how the information is recorded in the system and communicated between systems. This is required for interoperability (for information to flow between one IT system and another).<br><br>The information can be text, multi-media or in a coded format. If coded it can be constrained to SNOMED CT and specific SNOMED CT reference sets, NHS Data Dictionary values or other code sets. |

**Table 1: PRSB information standard data structure**

In the annotated example shown below for Allergies:

- The standard has a section for 'Allergies and adverse reactions', it's conformance is 'mandatory' and the cardinality is '1 only' (or 1...1) i.e. there must be just one allergies section
- It has a record entry to allow for multiple allergies, which is also 'mandatory' but with a cardinality of 1 to many (or 1...*). The record entry contains a set of elements, i.e. the set of information for each allergy and there must be at least 1 record entry.
- The record entry also includes a cluster (reaction details cluster), which groups the reaction details together.
- Each element has a description, conformance, cardinality and valueset. e.g. Causative agent, which is mandatory with a cardinality of 1 only (or 1…1) and a valueset with two options, coded value with a constrained set of SNOMED codes (including an option for "No known allergy") or free text if coded values are not available. Other elements are required in this example. i.e. the set of information for each allergy or adverse reaction must have a causative agent, and where available should have the other information such as reaction details, substance, severity etc.




| | | | | |
|---|---|---|---|---|
| ▶ Risks | Details of any risks related to the person | R | 0 … 1 | |
| ▼ Allergies and adverse reactions | Allergies and adverse reactions | M | 1 … 1 | |
| ▼ Allergies and adverse reactions record entry | This is a allergies and adverse reactions record entry. There may be 1 to many record entries under this section.<br><br>Each record entry is made up of a number of elements or data items. | M | 1 … * | |
| ▼ Causative agent | The agent such as food, drug or substances that has caused or may cause an allergy, intolerance or adverse reaction in this person Or "No known drug allergies or adverse reactions" Or "Information not available" | M | 1 … 1 | |
| Coded value | The coded value for causative agent | R | 0 … 1 | SNOMED CT : - <105590001 \|Substance OR <37873005 \|Pharmaceutical / biologic product\| OR <716186003 \|No known allergy\| OR 1964610000000101 \|Transfer-degraded drug allergy\| OR 1964710000000108 \|Transfer-degraded non-drug allergy\) |
| Free text | Free text field to be used if no code is available | R | 1 … 1 | Free text |
| ▼ Reaction details cluster | Details of the reaction. | R | 0 … 1 | |
| Date | The date that the reaction was identified.<br><br>This will often equate to the date of onset of the reaction but this may not be wholly clear from source data. | R | 0 … 1 | Date and time |
| ▼ Location | Details of where the allergy was identified. | R | 0 … 1 | |
| Coded value | The coded value for location. | R | 0 … 1 | NHS data dictionary : - Organisation data service |
| Free text | Free text field to be used if no code is available | R | 0 … 1 | Free text |
| ▶ Substance | The substance, or a class of substances, that is considered to be responsible for the adverse reaction. | R | 0 … 1 | |
| ▶ Description of reaction | A description of the manifestation of the allergic or adverse reaction experienced by the person. For example, skin rash. | R | 0 … 1 | |
| ▶ Severity | A description of the severity of the reaction. | R | 0 … 1 | |
| ▶ Certainty | A description of the certainty that the stated causative agent caused the allergic or adverse reaction. | R | 0 … 1 | |
| Comment | Any additional comment or clarification about the adverse reaction. | R | 0 … 1 | Free text |
| Type of reaction | The type of reaction experienced by the person (allergic, adverse, intolerance) | R | 0 … 1 | FHIR value set :- Allergy, Intolerance, Not known |
| Evidence | Results of investigations that confirmed the certainty of the diagnosis. Examples might include results of skin prick allergy tests | R | 0 … 1 | Free text |
| Date first experienced | When the reaction was first experienced. May be a date or partial date (e.g. year) or text (e.g. during childhood) | R | 0 … 1 | Date and time |
| Probability of recurrence | Probability of the reaction (allergic, adverse, intolerant) occurring. | R | 0 … 1 | Free text |
| ▶ Performing professional | The professional who identified the reaction. | R | 0 … 1 | |
| ▶ Person completing record | Details of the person completing the record. | R | 0 … 1 | |
| ▶ Medications and medical devices | Medications and medical devices | R | 0 … 1 | |

## 4.2 Dependencies

The implementation of the referral information standard is dependent on the following:

- Information sharing agreements between organisations
- The technical messaging standards FHIR profiles (to support the transfer of information between local health and care systems).
- The availability of other sources to access some of the person's care information such as the national record locator service (NRLS) and shared care records.
- Alignment of local discharge pathways, planning and processes with the referral standard and ADW standard for the hospital to be able to send the information and the local authority to receive it. *NB*: It is recognised that in situations where patients are referred to the discharge to assess (D2A) pathway that certain components of the Hospital Referral for Assessment for

Community Care and Support Record that may previously have been identified in hospital that that may now occur in the community. In future, it is expected that this may form part of a shared care record.

### 4.3 End user requirements and user interface principles

The following requirements apply to ensure the referral standard is used effectively to support the care of the person being referred to the local authority and all those involved in their care:

- All the information in the referral standard should be available to the receiver. How this is achieved will depend on the maturity of local systems that share the information.
- It is anticipated that all sections will not need to be used in all circumstances, only where they are relevant to the specific person, i.e. sections should not be included in the message where there is no information recorded / available or in instances where the information can be easily accessed elsewhere such as a local shared care record or the summary care record.
- Local agreements will need to be drawn up between organisations, including details of the information to be communicated, including which optional sections will be utilised; and the order in which sections appear for example.
- The sections are intended to support navigation around the record and in some cases are clinical groupings of related topics, rather than having any semantic meaning.
- The information can be displayed in any format as designed by the end user and supplier. The standard provides a common structure to the record, not a style guide.
- Communications should be brief, where possible, containing only pertinent information.

### 4.4 Information governance

Sound principles of information governance and respecting the privacy of people and their information is paramount. NHS England is developing a national Information Governance framework that, when complete, should be considered alongside this standard for planning implementation.

### 4.5 Data quality

Data quality and accuracy of coded data entry should be managed in local ‘source’ systems that will feed the referral information.

### 4.6 Context of the information

It is vital for use of the data that all contextual information must be maintained and should not be lost on exchange or import of information. For example, where a

needs assessment was undertaken during the current admission episode, the assessment will be linked to that current episode of care using the contextual elements listed below.

The principle, for PRSB standards, is that for clinical safety and efficacy of communications, the following key contextual data should be shared where instructed in the standard:

- **Performing Professional** – is the person who performed the activity for example conducted the procedure, assessment etc. It has various attributes that are expected to be completed, name, role, specialty, organisation of the professional. If the professional is not known but the organisation and specialty are known they should be included as contextual information.

- **Location** - the place in which the activity took place e.g. a procedure was performed.

- **Date** - the date which the activity took place e.g. the assessment was performed. In some instances, this would be start and end dates e.g. of child protection plans.

- **Person completing record** - is the person that recorded the information and has various attributes; name, role, speciality and organisation and the date the record was completed. This could be implemented as an automatic process (see section 4.7 below).

- **Speciality** - it is recognised that this only applies to some professionals, so it only needs to be included where relevant.

### 4.7 Time stamp and audit trail

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

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

### 4.8 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 in shared care records such as an end of life care plan. The National Record Locator Service will, in due course, hold the links to the person's records that reside in multiple different systems. This information standard does not define all these

possible links. It is expected that the local areas will define the requirements for accessing other records or documents, where applicable and provide access through the shared care record for authorised professionals.

### 4.9 Use of terms

The term ‘role’ has been consistently used rather than ‘designation’ throughout the standard 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.

### 4.10 Coding

The *Personalised Health and Care 2020 framework for action* (https://www.gov.uk/government/publications/personalised-health-and-care-2020) recommends the use of SNOMED CT and the dictionary of medicines and devices (dm+d). Local decisions need to be made about when these codes are to be used, depending on local system functionality and plans. The current ambition is for SNOMED CT and dm+d to be the only clinical coding schemes in use in the NHS.

### 4.11 Accessibility

The design of user interface, for viewing the referral information (by the person or their carer), should comply with the NHS England Accessible Information Standard (https://www.england.nhs.uk/ourwork/accessibleinfo/). This sets out the rules for accessible patient information in patient literature and clinical systems.

## 5 PRSB Support

The PRSB support service is available for any help, enquiries or issues with using or implementing the standards. Any feedback on the standard (including proposed changes) resulting from putting the standard into practice would also be welcome.

Contact is via support@theprsb.org or Tel: 02079227976

## 6 Guidance for specific sections and subsections

Specific instructions relating to the individual sections, subsections and data elements, where relevant, are outlined under this section (see tables 2 and 3 below)

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| **6.1 Person demographics** | The person's details and contact information. | | This section contains the person's demographic and contact details including key identifiers e.g. name, date of birth, NHS number, address etc.<br>The PDS (Personal Demographics Service) should be used as the source of this information.<br>It is recognised that some of the elements in this section are currently shared in a more granular way than currently defined in this information model. PRSB intends to address this in a later release of the information model.<br>Some of this demographics information will be shared with the LA as part of the ADW notices. | M |
| Person name | The full name of the person. | The legal name of the person from the Personal Demographics Service (PDS), or the name volunteered by the person.<br>NHS data dictionary code:<br>PERSON FULL NAME | | M |
| 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. | | R |
| Title | Person's title | Free text | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Date of birth | The date of birth of the person. | NHS data dictionary code:<br>PERSON BIRTH DATE | | M |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| 6.1.1 **Gender** | The person's stated gender. | NHS data dictionary code:<br>PERSON STATED GENDER CODE<br>or<br>PERSON PHENOTYPIC SEX CLASSIFICATION | Displaying ‘sex’ and ‘gender’ data items, in the demographic model, may cause accidental disclosure of gender reassignment of the person, during use of the referral standard. Having both fields on display may show a difference and therefore disclose gender reassignment without consent. It is unlawful to disclose, without consent, a person’s gender reassignment with or without a gender reassignment certificate. Please refer to current national guidance.<br>This risk can be mitigated by appropriate implementation; refer to the clinical safety case report and hazard log. Two options are proposed, either “Sex” can be left out or ensure the design of the standard, including its Information Governance model, reduce this risk to an acceptable level. For example, move ‘sex’ from the demographics to under clinical as it is classed as clinical concept. | R |
| Ethnicity | The ethnicity of the person as specified by the person. | NHS data dictionary code:<br>ETHNIC CATEGORY CODE 2001 | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Religion | The religious affiliation as specified by the person. | SNOMED CT:<br>999000531000000100 \|Religious or other belief system affiliation simple reference set (foundation metadata concept)\| | | R |
| Sex | The person's phenotypic sex. Determines how the person will be treated clinically. | NHS data dictionary code:<br>PERSON PHENOTYPIC SEX CLASSIFICATION | Displaying 'sex' and 'gender' data items, in the demographic model, may cause accidental disclosure of gender reassignment of the person, during use of the referral standard. Having both fields on display may show a difference and therefore disclose gender reassignment without consent. It is unlawful to disclose, without consent, a person's gender reassignment with or without a gender reassignment certificate. Please refer to current national guidance.<br>This risk can be mitigated by appropriate implementation; refer to the clinical safety case report and hazard log. Two options are proposed, either "Sex" can be left out or ensure the design of the standard, including its Information Governance model, reduce this risk to an acceptable level. For example, move 'sex' from the demographics to under clinical as it is classed as clinical concept. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| 6.1.2 **NHS number** | The unique identifier for a person within the NHS in England and Wales. | NHS data dictionary code:<br>NHS NUMBER<br>Traced and verified NHS numbers only should be used i.e. NHS number status indicator code: value 01. If there is no NHS number, then this data item should be reported as null and other unique identifiers will need to flow. | NHS number (or equivalent, e.g. CHI number in Scotland), is the primary person unique identifier however existing national guidance should be followed, including how to handle patients without an NHS number, for example, overseas visitors. Verification of the NHS number is required. | R |
| NHS number status indicator | Provides an indication of the reliability of an NHS number | NHS data dictionary code:<br>NHS NUMBER STATUS INDICATOR CODE | | R |
| Other identifier | Country specific or local identifier, e.g. Community Health Index (CHI) in Scotland.<br>There may be 0 to many record entries for this element. | Recorded as per NHS Data Dictionary:<br>LOCAL PATIENT IDENTIFIER<br>HEALTH AND CARE NUMBER (NI only)<br>COMMUNITY HEALTH INDEX NUMBER (Scotland only) | | R |
| Person's address | Person's usual place of residence, and | | The person's correct address can be a potential source of error. Include the person's current | M |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | where relevant temporary and correspondence addresses. | | place of residence as the primary address. There can be multiple addresses associated with a person including temporary and correspondence addresses. | |
| Address line 1 | Person's first line of address. | NHS data dictionary code: ADDRESS LINE 1 | | R |
| Address line 2 | Person's second line of address. | NHS data dictionary code: ADDRESS LINE 2 | | R |
| Address line 3 | Person's third line of address 3. | NHS data dictionary code: ADDRESS LINE 3 | | R |
| Address line 4 | Person's fourth line of address. | NHS data dictionary code: ADDRESS LINE 4 | | R |
| Address line 5 | Person's fifth line of address. | NHS data dictionary code: ADDRESS LINE 5 | | R |
| Postcode | The person's postcode. | NHS data dictionary code: ADDRESS ASSOCIATION TYPE | | R |
| Person's email address | Email address of the person. | NHS data dictionary code: | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | CONTACT EMAIL ADDRESS (PATIENT OR LEAD CONTACT) | | |
| Person's telephone number | Telephone contact details of the person. To include, e.g. mobile, work and home number if available. There may be 0 to many record entries for this element. | NHS data dictionary code:<br>COMMUNICATION CONTACT STRING | | R |
| Preferred contact method | Preferred contact method, e.g. email, letter, phone, text message etc. | NHS data dictionary code:<br>COMMUNICATION CONTACT METHOD | | R |
| Immigration status | Include details of the immigration status of the person, their permissions to live and receive care and support in the UK e.g. asylum seeker, indefinite leave to remain in the UK. | | Immigration status is required, where available, for the sole purpose of assisting the local authority in deciding if the person is eligible for funded social care. Utilise the national codes.<br>Details of the immigration status of the person to be included (e.g. asylum seeker, indefinite leave to remain in the UK). Include start date, end date and any comments. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | Include start date, end date and any comments. | | | |
| Immigration status | The immigration status of the person, their permissions to live and receive care and support in the UK e.g. asylum seeker, indefinite leave to remain in the UK. | Code:<br>1. Asylum Seeker<br>2. Exceptional leave to remain in UK<br>3. Indefinite leave to remain in UK<br>4. Limited leave to remain in UK<br>5. No Recourse to Public Funds (NRPF)<br>6. Other nationals<br>7. Refugee<br>8. Unaccompanied Asylum Seeker<br>9. EU pre-settled status<br>10. EU settled status | | R |
| Start date | Start date of immigration status | Date | | R |
| End date | End date of immigration status | Date | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Comment | Relevant comments about the person's immigration status | Free text. | | |
| **6.2 About me** | About me | | This section supports sharing of information **that the person** thinks it is important to share with professionals. This could include information about their needs, preferences, concerns and wishes. For example, it could include that a person's requests about how they are communicated with for example 'Please look at me when speaking to assist me with my lipreading.'<br><br>'About me' should be prominently displayed in the record as it is important information about the person relevant to all care and support providers. This information may be available in multimedia formats e.g. jpeg, mp3 etc. These documents are likely to follow a variety of formats but should be transferred in their entirety.<br><br>Care will need to be taken in local implementations to differentiate between 'About me' and things like 'Advance Directives' and preferences and wishes expressed in other care plans such as end of life plans. | R |
| About me | This is a record of the things that a | | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | person feels it is important to communicate about their needs, strengths, values, concerns and preferences to others providing support and care. | | | |
| What is most important to me | A description of what is most important to you.<br>**Emergency Information:**<br>Include any essential information that any professional in health and social care should know about the you in any situation, including emergencies.<br>Other Information:<br>**This could include:**<br>Values | Free text or multimedia file | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | Spirituality/religion<br>Ethnicity<br>Culture<br>Pets<br>Goals and aspirations<br>Meaningful activities including leisure activities, visiting places, sport and exercise, listening to music, employment, education, volunteering. | | | |
| People who are important to me | Details of who is important to you and why. They could be family members, carers, friends, members of staff etc.<br>Include how you want the people important to you to be engaged and involved in your care | Free text or multimedia file | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | and support in both emergency and normal situations.<br>Who should not be contacted or consulted about your care and support and why, if you wish to say. | | | |
| How I communicate and how to communicate with me | A description of how you communicate normally including any communication aids you use, for example a hearing aid.<br>Include your preferred language of communication, if your first language is not English.<br>Include how you would communicate when you are in pain or distress. | Free text or multimedia file | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | Include how you communicate choices.<br>Include how you give feedback or raise a concern.<br>Describe how you would like others to engage and communicate with you , including how you would like to be addressed. | | | |
| Please do and please don't | A description of things you want someone supporting you to do or not to do.<br>For example, this might include:<br>Talk to me not to my carer<br>Remind me to take my medication | Free text or multimedia file | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | Encourage me to wash my hands regularly<br>Explain to me what is happening and why<br>Respond to my communication<br>A description of things you do not want someone supporting for you to do. For example, this might include:<br>Asking questions about certain topics<br>Making assumptions about something<br>Providing support when it is not wanted<br>Talking to you in a certain way | | | |
| My wellness (0.3) | A description covering what you are able to do, how | Free text or multimedia file | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | you engage with others and how you feel on a typical day through to on a day when you are unwell.<br><br>Include any causes that might result in you becoming unwell and strategies for avoiding or addressing the causes. For example, not drinking enough water could cause constipation.<br><br>Include any signs that indicate you might be becoming unwell.<br><br>On a bad day describe what is different about what you are able to do, how you engage with others and how you feel. | | | |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | Include any medical conditions e.g. dementia and any symptoms e.g. itchiness, cough, pain that you are living with and that that affect your everyday life and how you manage those conditions.<br><br>Include past health issues or experiences that need to be considered. | | | |
| How and when to support me | A description of how and when you want someone caring for you to support you.<br><br>This could include support needs in an emergency situation (for example taking blood). | Free text or multimedia file | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | This could include support you need to maintain important routines or to carry out particular activities, for example:<br>Personal care routines<br>Eating and drinking<br>Bedtime routines<br>Taking medications<br>Moving and transitioning<br>This could also include support needed with:<br>wearing glasses/hearing aids/false teeth etc.<br>making informed choices or understanding dangers and risks. | | | |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | managing your emotions, moods and behaviours.<br><br>memory or confusion.<br><br>Include how your support needs change in different environments.<br><br>Include any triggers that might result in you needing further support and strategies for avoiding or addressing the triggers.<br><br>Include how you want the support to be provided. | | | |
| Also worth knowing about me | A description of what is also worth knowing about you for people caring or supporting you. | Free text or multimedia file | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | This could include a short history of your life (where you have worked, where you lived, important events in your life, important people in your past life).<br>This could include a short profile of your current life:<br>your work / study<br>your aspirations<br>your skills<br>your networks<br>things you like e.g. particular foods, places, a football team and things you like to talk about.<br>things you dislike<br>This could also include any care and support preferences | | | |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | that have not been included elsewhere. | | | |
| Date | This is a record of the date that this information was last updated. | Date and Time | | R |
| Supported to write this by | Where relevant, this is a record of name, relationship/role and contact details of the individual who supported the person to write this section e.g. carer, family member, advocate, professional. | Free text | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| **6.3 Individual requirements** | The individual requirements of the person. | | This section allows for the sharing of any individual requirements the person may have, such as to support cognitive impairment or mobility issues. This may relate to special needs and would extend to include a record of reasonable adjustments which would be included in 'Other individual requirements'.<br><br>Specific disabilities would be included in the 'Problem list' section however the requirements to support the disabilities (e.g. needs wheelchair access, needs large print etc.) would be included in this section.<br><br>The accessible information requirements information would be the most recent requirement rather than a history of requirements. | R |
| 6.3.1 **Reasonable adjustment** | A record of reasonable adjustments that must be provided by the service to comply with the Equality Act 2010. | | | R |
| Reasonable adjustment record entry | This is an impairment record entry. There may be 0 to many record | | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | entries under a section. Each record entry is made up of a number of elements or data items. | | | |
| Location | The location where the reasonable adjustment was identified | | | |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Reasonable adjustment | The reasonable adjustment required e.g. requires specific contact method, requires communication professional. | | | R |
| Coded value | The coded value for the reasonable adjustment. | SNOMED CT | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Reasonable adjustment additional detail | Further detail about the support required and the consequence of not providing it. | Free text | | R |
| Date | The date the reasonable adjustment was created. | Date and time | | R |
| Performing professional | The professional who confirmed the need for the reasonable adjustment. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | A record of the details of the person that entered the reasonable adjustment and the date on which it was entered. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| 6.3.2 **Impairment** | A record of any impairments for the person relating to reasonable adjustments. | | | R |
| Impairment record entry | This is an impairment record entry. There may be 0 to many record entries under a section. Each record entry is made up of a number of elements or data items. | | | R |
| Location | The location where the impairment was identified | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Impairment category | The category of the impairment e.g.<br>Autism<br>Dementia<br>Physical disability<br>Sensory disability - such as sight or hearing<br>Long-term condition | | | R |
| Coded value | The coded value for the impairment | SNOMED CT | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Impairment additional detail | Description of what the person can do with the impairment, what they want to be able to do and how they should be supported to do it and what the consequences are of | Free text | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | not providing the support.<br><br>Where there is a sensory disability include sensory processing difficulties (e.g. affects to balance and movement, oversensitive, under-sensitive). | | | |
| Date | The date the impairment was recorded. | Date and time | | R |
| Performing professional | The professional who confirmed the impairment. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | A record of the details of the person that entered the impairment and the date on which it was entered. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| 6.3.3 **Mobility needs** | The mobility needs of the person that allows movement between two spaces and achieves participation and a degree of independence. | SNOMED CT or free text | | R |
| Date | The date when the mobility needs were identified. | Date and time | | R |
| Location | The location where the mobility needs were identified. | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Mobility | The mobility needs of the person that allows movement between two spaces and achieves | | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | participation and a degree of independence. | | | |
| Coded value | The coded value for mobility needs | 999002551000000108 \|Mobility findings simple reference set (foundation metadata concept)\| | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Performing professional | The professional who identified the mobility needs. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| 6.3.4 **Other individual requirements** | Other individual requirements that a person may have. | Free text | | R |
| Date | The date when the other individual | Date and time | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | requirements were identified. | | | |
| Location | The location where the other individual requirements were identified. | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Other individual requirement | Other individual requirements that a person may have | Free text | | R |
| Performing professional | The professional who identified the other individual requirements. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| **6.4 GP practice** | Details of the person's GP practice. | | This section contains details of the GP practice where the person is registered. This information would be sourced from PDS. This will include the GP practice identifier code. In situations where a person is not registered with a GP practice, the GP practice identifier would contain the appropriate code to indicate this.<br>This section would also need to accommodate details for temporary GP where the patient is registered away from their usual place of residence. | M |
| GP practice record entry | This is an GP practice record entry. There may be 0 to many record entries under a section. Each record entry is made up of a number of elements or data items. | | | R |
| GP name | The name of the person's GP. | Free text. If the person is registered with a GP practice, their usual GP name will be something volunteered by the person or their representative. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| GP practice details | Name and address of the person's registered GP practice. | Registered GP practice details are available from the Patient Demographics Service (PDS) or volunteered from the person or their representative. Include details of the practice name and address. | | R |
| GP practice identifier | The identifier of the registered GP practice. | NHS data dictionary code or free text.<br>ORGANISATION CODE<br>This includes codes to use where there is no registered GP practice. | | M |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| **6.5 Alerts** | Details of alerts. | | This section allows for the sharing of alerts, where required.<br>The alerts that are shared should be determined locally. They might, for example, include the presence of a medical implant or COVID -19 diagnosis, the fact that the person has a dangerous dog or that a person requires reasonable adjustments.<br>It is important that alerts are managed and removed when no longer relevant – e.g. “the dangerous dog” alert if the person is moving to a care home (without the dog).<br>The alerts displayed may vary by recipient / user’s role. | O |
| Alerts record entry | This is an alerts record entry. There may be 0 to many record entries under a section. Each record entry is made up of a number of elements or data items. | | | O |
| Alert | Any significant information meriting | Free text | Cardinality = 1…1 | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | a specific and highly visible warning to any user (e.g. metallic implant, potentially dangerous pet). | | | |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| **6.6 Legal information** | The legal information relating to the person. | | This section identifies where there is legal or formal documentation relating to the care of the person. This includes Lasting Power of Attorney (LPA), Deprivation of Liberty Safeguards (DoLS, Advance Decision to Refuse Treatment (ADRT), Mental Capacity Assessments (MCAs) and Mental Health Act (MHA) status.<br><br>The documentation may be available centrally as part of shared care records or held locally as part of the persons health and care records.<br><br>**NB:** Advance statement element is found in the End of life care section. | R |
| Consent for treatment record | Details of the person's consent for treatment. | | | R |
| Date | The date the consent was taken. | Date | | R |
| Location | The location of where consent was taken. | | Key contextual information. | R |
| Coded value | The coded value for location | NHS data dictionary code:<br><br>ORGANISATION CODE | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Consent for treatment record | Whether consent has been obtained for the treatment. May contain where record of consent is located or record of consent. | Free text. A statement about the patient's consent to treatment. | | R |
| Performing professional | The professional who took the consent for treatment. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Consent for information sharing | Details of the person's consent for information sharing. | | | R |
| Date | The date the consent was taken. | Date | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Location | The location of where consent was taken. | | Key contextual information. | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Consent for information sharing | This is a record of consent for information sharing under the common law duty of confidentiality. Where consent has not been obtained or sought, the reason why should be provided. Include best interests decision where person lacks capacity. This is a placeholder until the | Free text. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | national guidance is published. | | | |
| Performing professional | The professional who took the consent for treatment. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Mental capacity assessment | Details of the person's mental capacity assessment. | | Mental capacity needs to be assessed at each instance where treatment decisions need to be made. Hence there should be provisions for more than one mental capacity assessment to be shared. If sharing the outcome of a mental capacity assessment it is important to record to which decision it relates.<br>The mental capacity assessment is based on one of the following Acts:<br>Mental Capacity Act 2005 (England and Wales)<br>Adults with Incapacity Act 2000 (Scotland)<br>Mental Capacity Act 2016 (Northern Ireland) | R |
| Date | The date when the mental capacity | Date and time. | Key contextual information. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | assessment was made. | | | |
| Location | The location where the mental capacity assessment was made. | | Key contextual information. | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Mental capacity assessment | Whether an assessment of the mental capacity of the (adult) person has been undertaken, if so, what capacity the decision relates to and the outcome of the assessment.<br><br>Also record best interests decision if a | Free text. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | person lacks capacity. | | | |
| Location of document | The location of the mental capacity assessment information. | Free text or URL | | R |
| Performing professional | The professional who made the mental capacity assessment. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Lasting power of attorney for personal welfare or court-appointed deputy (or equivalent) | Details of the person's LPA record or equivalent. | | | R |
| Date | The date the LPA was recorded | Date and time | Key contextual information. | R |
| Location | The location the LPA was recorded | | Key contextual information. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Lasting power of attorney for personal welfare or court-appointed deputy (or equivalent) | Record of one or more people who have been given power (LPA) by the person when they had capacity to make decisions about their health and welfare should they lose capacity to make those decisions. To be valid, an LPA must have been registered with the Court of Protection. If life-sustaining treatment is being considered the LPA document must state specifically that the | | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | attorney has been given power to consent to or refuse life-sustaining treatment. Details of any person (deputy) appointed by the court to make decisions about the person's health and welfare. A deputy does not have the power to refuse life-sustaining treatment. | | | |
| Coded value | The coded value for the LPA | SNOMED CT:<br>999001951000000107 \|Personal welfare lasting power of attorney findings simple reference set (foundation metadata concept)\| | | R |
| Location of document | The location of the lasting power of attorney information. | Free text or URL | | R |
| Name of LPA | The name of any appointed people or deputies. | Free text | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Contact details | The contact details of the LPA | Free text | | R |
| Performing professional | The professional who made the decision to detain the person under the mental health act. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Deprivation of Liberty Safeguards or equivalent | Details of the person's Deprivation of Liberty Safeguards (DoLS) or equivalent. | Free text. | | R |
| Application date | The date the application was made. | Date and time. | Key contextual information. | R |
| Application status | The status of the DoLS application. | Requested or authorised. | Key contextual information. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Deprivation of Liberty Safeguards or equivalent | Record of the person's Deprivation of Liberty Safeguards (DoLS) or equivalent, including the reason for this. | Free text | | R |
| Start date of authorisation | The date the DoLS was authorised. | Date and time. | | R |
| Planned or actual end date of authorisation | The planned or actual end date of authorisation. | Date and time. | | R |
| Performing professional | The professional who applied for the DoLS. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Mental Health Act or equivalent status | Details of the persons mental health act record | | There can be more than one record of 'Mental health act status' (a record of a decision to detain the person diagnosed with a mental disorder under the Mental Health Act or equivalent. | R |
| Section start date | The date the person was detained. | Date and time. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Section end date | The date the person was no longer detained. | Date and time. | | R |
| Location | The location where the decision to detain the person was made under the mental health act. | | Key contextual information. | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| 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. If person subject to Community Treatment Order or | | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | Conditional Discharge (or equivalent) record here. | | | |
| Coded value | The coded value for the mental health act | NHS data dictionary:<br>MENTAL HEALTH ACT CLASSIFICATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text | | R |
| Supporting information | If person subject to Community Treatment Order or Conditional Discharge (or equivalent) record here. | NHS data dictionary:<br>Community Treatment Order | | R |
| Performing professional | The professional who made the decision to detain the person under the mental health act. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Advance decision to refuse treatment (ADRT) | Details of the person's ADRT status | | | R |
| Date | The date the ADRT was recorded | Date and time | Key contextual information. | R |
| Location | The location the ADRT was recorded | | Key contextual information. | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Advance decision to refuse treatment (ADRT) | A record of an advance decision to refuse one or more specific types of future treatment, made by a person | | SNOMED CT codes (see National Information Standard (SCCI1580) and associated text). Where available a copy of the ADRT may be appended to the record. Where there has been a change in the ADRT this should be noted in the record in free text. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | who had capacity at the time of recording the decision.<br>The decision only applies when the person no longer has the capacity to consent to or refuse the specific treatment being considered.<br>An ADRT must be in writing, signed and witnessed.<br>If the ADRT is refusing life-sustaining treatment it must state specifically that the treatment is refused even if the person's life is at risk. | | | |
| Coded value | The coded value for advance decision to refuse treatment. | SNOMED CT code:<br>999002181000000105 \|Advance decision to refuse treatment preference findings simple | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | reference set (foundation metadata concept)\| | | |
| Free text | Free text field to be used if no code is available | Free text | | R |
| **6.7 Safeguarding** | The safeguarding details of the person. | | This section includes any concerns in relation to safeguarding. Appropriate policies and technical solutions need to be in place to insure there is appropriate and timely access to this information. | R |
| Safeguarding concerns | Details of safeguarding concerns. There may be 0 to many record entries under a section. | | | R |
| Safeguarding concerns start date | The date the safeguarding concerns were identified. | Date and time. | Key contextual information. | R |
| Safeguarding concerns end date | The date safeguarding concerns ended. | Date and time. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Location | The location where the safeguarding concerns were identified. | | Key contextual information. | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Safeguarding concerns | Identified safeguarding concerns. | | | R |
| Coded value | The coded value for safeguarding concerns | SNOMED CT | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Safeguarding indicator | Indicates whether or not the hospital considers that there are safeguarding | Flag:<br>No = N: yes = Y | | M |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | issues associated with the patient. | | | |
| Performing professional | The professional who identified the safeguarding concerns. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| **6.8 Local authority** | The details of the Local Authority that is responsible for providing care and support to the person. | | This is the local authority where that person is ordinarily resident (or if not known, the authority in which the hospital is based).<br>It is mandatory to complete the contact details of the person at the local authority who is responsible for liaising with the hospital in relation to the person's discharge. | M |
| Organisation code | The ODS (Organisation Data Service) code of the local authority that is responsible for providing care and | NHS data dictionary code:<br>ORGANISATION CODE | Key contextual information. | O |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | support to the person. | | | |
| Local authority name | The name of the local authority that is responsible for providing care and support to the person. | Free text. | Key contextual information. | M |
| Social services team | The name of the local authority social services team or department that is responsible for undertaking the care and support assessment for the person. | Free text. | Key contextual information. | O |
| Local authority contact name | The name of the person at the local authority who is responsible for liaising with the hospital in relation to the person's discharge. | Free text. | | M |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Local authority contact details | The contact details of the person at the local authority who is responsible for liaising with the hospital in relation to the person's discharge. | Free text. | | M |
| **6.9 Professional contacts** | The details of the person's professional contacts. | | This section includes current and historic details of health and care professionals, teams or organisations involved in the care of the person. Third sector organisations can be included.<br>For example, the name and contact details of the person's current care coordinator, key worker, local authority liaison, care home manager, community learning disability team, the local authority's Best Interest Assessor (BIA) should be included here.<br>Some of this information will be sent to the local authority as part of the ADW notices. | R |
| Professional contacts record entry | This is a professional contacts record entry. There may be 0 to many record entries under a | | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | section. Each record entry is made up of a number of elements or data items. | | | |
| Name | The name of the professional with responsibility for the care of the person. | Free text. | | R |
| Role | The role the professional has in relation to the person e.g. GP, physiotherapist, community nurse, social worker, key worker, care home manager, care coordinator, LA hospital liaison person, care home contact, hospital clinician, Independent Mental Capacity Advocate (IMCA) etc. | NHS data dictionary code or free text if code is not available.<br>CARE PROFESSIONAL TYPE | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Speciality | The specialty of the professional e.g. physiotherapy, oncology, mental health etc. | NHS data dictionary code: MAIN SPECIALTY CODE | | R |
| Team | The name of the team. | Free text. | | R |
| Organisation | The name of the organisation. | | | R |
| Coded value | The coded value for location | NHS data dictionary code: ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Contact details | Contact details of the professional (e.g. telephone number, email address etc.). | Free text. | | M |
| Start date | The start date of the professional relationship with the person. | Date and time. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| End date | The end date of the professional relationship with the person. | Date and time. | | R |
| **6.10 Personal contacts** | The details of the individual's personal contacts. | | This section includes the personal contacts (e.g. family, friends, relatives etc.) including informal carers. Comments should be used to share information such as if a particular contact should be called in an emergency etc.<br>Some of this information will be sent to the LA as part of the ADW notices. | R |
| Personal contacts record entry | This is personal contacts record entry. There may be 0 to many record entries under a section. Each record entry is made up of a number of elements or data items. | | | R |
| Name | The name of the personal contact. | Free text. | | M |
| Relationship | The relationship the personal contact has | FHIR value set recommended. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | to the person, e.g. father, grandmother, family friend etc. | | | |
| Relationship type | Additional roles the person performs on behalf of the other (e.g. Carer, Next of Kin, Emergency Contact, Dependent, etc.).<br>There may be 0 to many record entries for this element. | | NB: The term 'next of kin' has no legal basis. See here for further information. | R |
| Contact details | Contact details of the personal contact (e.g. telephone number, email address etc.). | Free Text. | | M |
| Comments | Notes on the significance of the personal contact to the person. | Free text. | | O |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| **6.11 Referral details** | The details of the referral. | | This section includes a record of the current referral to the local authority.<br><br>Referral details includes the service a person is being referred from and to (LA social care), details of the referrer, details of the referral and who the local authority should contact as the liaison person to coordinate the person's referral and discharge. If the service is known, and a code is available, it should be included otherwise the service should be described in free text.<br><br>The names, roles and contact details of the referrer and who the referral is being made to are mandatory fields.<br><br>Some of the referral information is required to populate the ADW notices. | M |
| Referral details record entry | This is the referral details record entry. There may be 0 to many record entries under a section. Each record entry is made up of a number of elements or data items. | | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Date | The date of referral. | Date and time. | Key contextual information. | R |
| Referrer details | The details of the referrer. This could be the person, GP surgery, department, specialty, sub-specialty, educational institution, mental health team etc. | | | M |
| Name | The name of the referrer. | Free text. | This is a required field. This information allows the local authority social care team to contact the individual making the referral if there is a need for additional information. | R |
| Role | Role of the referrer. | NHS data dictionary code or free text.<br>CARE PROFESSIONAL TYPE | Key contextual information. | R |
| Grade | The grade of the referrer. | Free text. | Key contextual information. | R |
| Team | The team or department of the referrer. | Free text. | Key contextual information. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Specialty | The specialty of the referrer. | NHS data dictionary code:<br>MAIN SPECIALTY CODE | | R |
| Service | The service of the referrer. | | Key contextual information. | R |
| Coded value | The coded value for service | SNOMED CT:<br>999000191000000106 \|Care planning patient outgoing referral simple reference set (foundation metadata concept)\| | | R |
| Free text | Free text field to be used if no code is available | Free text | | R |
| Organisation | The organisation of the referrer. | | Key contextual information. | R |
| Coded value | The code value for the organisation | NHS data dictionary code or free text.<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Contact details | The contact details of the referrer. | Free text. | | M |
| Referral type | An indication of the type of referral (e.g. 'Hospital Discharge Notification to Social Care', 'GP Referral', etc.). | | | R |
| Referral method | The method in which a referral is sent and received. This may be a letter, email, transcript of a telephone conversation, Choose and Book, in person (self-referral) etc. | Allow National Codes only:<br>1. Fax<br>2. Phone<br>3. Secure Messaging<br>4. Secure Email<br>5. Letter<br>6. NHS E-Referral Service<br>7. Self Referral | | R |
| Reason for referral | The reason for the referral, e.g. diagnosis, treatment, transfer of care due to relocation, investigation, second opinion, management of the | | A clear statement of the purpose by the person making the referral.<br>Any speculative or working diagnosis / primary care reason should not be coded but included as narrative. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | patient (e.g. palliative care), or carer's concerns. | | | |
| Coded value | The coded value for reason for referral | SNOMED CT:<br>1127581000000103 \|Health issues simple reference set (foundation metadata concept)\| | | R |
| Free text | Free text field to be used if no code is available | Free text | | R |
| Referral to | Details of where the referral is to be sent. If not an individual, this could be a service, e.g. GP surgery, department, specialty, subspecialty, educational institution, mental health etc. | | | R |
| Name | Name of person the referral is to be sent to. | Free text. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Role | Role of person where the referral is to be sent to. | NHS data dictionary code or free text.<br>CARE PROFESSIONAL TYPE | Key contextual information. | R |
| Grade | The grade of the person where the referral is sent to. | Free text. | Key contextual information. | R |
| Team | The team or department of the person where the referral is being sent to. | Free text. | Key contextual information. | R |
| Specialty | The specialty the referral is being sent to e.g. physiotherapy, oncology, mental health etc. | NHS data dictionary code:<br>MAIN SPECIALTY CODE | | R |
| Service | The service of where the referral is sent to. | Free text. | Key contextual information. | R |
| Coded value | The coded value for service | SNOMED CT:<br>999000191000000106 \|Care planning patient outgoing | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | referral simple reference set (foundation metadata concept)\| | | |
| Free text | Free text field to be used if no code is available | Free text | | R |
| Organisation | The organisation of where the referral is to be sent. | | Key contextual information. | R |
| Coded value | The code value for the organisation | NHS data dictionary code or free text.<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text | | R |
| Contact details | The contact details of where the referral is to be sent. | Free text. | | R |
| Return response to | Name of professional to be communicated with, if not the referrer | Free text. | 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 referrer organisation. Systems should allow this field to be automatically completed and default to the person's local authority. Systems should also | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | | allow for it to be potentially turned off. A decision should be made locally about how it is used. | |
| **6.12 Admission details** | Admission details | | This section is for the essential administrative information relating to this admission. Include the relevant site code according to the Organisation Data Service (ODS) codes.<br>Some of this information will be sent to the person's local authority as part of the ADW notices. | R |
| Admission details record entry | This is the admission details record entry. There may be 0 to many record entries under a section. Each record entry is made up of a number of elements or data items. | | | R |
| Date of admission | Date and time the person was admitted to hospital. | The date and time of admission as recorded on the Patient Administration System (PAS) | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Admitted to | The hospital the person was admitted to. | | | R |
| Coded value | The code value for the organisation | NHS data dictionary code or free text.<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text | | R |
| Responsible consultant | The consultant who has overall responsibility for the person (may not actually see the person) | | | R |
| Name | The name of the responsible consultant. | Free text. | | R |
| Role | The role of the responsible consultant. | NHS data dictionary code or free text.<br>CARE PROFESSIONAL TYPE | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Reason for admission | The health problems and issues experienced by the person 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 |
| Coded value | The code value for reason for admission | SNOMED CT:<br>1127581000000103 \|Health issues simple reference set (foundation metadata concept)\| | | R |
| Free text | Free text field to be used if no code is available | Free text | | R |
| Admission method | How the person was admitted to hospital e.g. elective, | | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | emergency, maternity, transfer etc. | | | |
| Coded value | The coded value for admission method | NHS data dictionary code:<br>ADMISSION METHOD | | R |
| Free text | Free text field to be used if no code is available | Free text | | R |
| Source of admission | Where the person was immediately prior to admission, e.g. usual place of residence, temporary place of residence, penal establishment. | | | R |
| Coded value | The code value for source of admission | NHS data dictionary code or free text.<br>SOURCE OF ADMISSION | | R |
| Free text | Free text field to be used if no code is available | Free text | | R |
| Patient location | This is the physical location of the | Free text. | | O |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | patient. For inpatient, e.g. hospital ward, bed, theatre. For ambulatory care, e.g. health centre, clinic, resources centre, patient's home. | | | |
| **6.13 Discharge details** | Discharge details | | This section is for the essential administrative details of the person's discharge, but not the actual discharge content which is shared in the relevant sections such as problem list or procedures or care needs summary.<br>Some of this information will be sent to the local authority as part of the ADW notices. | R |
| Discharge details record entry | This is the discharge details record entry. There may be 0 to many record entries under a section. Each record entry is made up of a number of elements or data items. | | | R |
| Expected date of discharge | The expected / proposed date the | SNOMED CT code: | | O |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | person will be discharged | 861031000000101 \|Expected date of discharge from service (observable entity)\| | | |
| Date of discharge | The date and time of discharge | The date and time of discharge as recorded by the PAS or discharging system. | | R |
| Discharge location | The hospital the person was discharged from. | NHS data dictionary code or free text.<br>ORGANISATION CODE | | R |
| Discharging consultant | The consultant responsible for the person at time of discharge. | | | R |
| Name | The name of the discharging consultant | Free text | | R |
| Role | The role of the discharging consultant | NHS data dictionary code or free text.<br>CARE PROFESSIONAL TYPE | | R |
| Discharge status | Patient status on discharge from emergency care. | Sent as per the ECDS Emergency Care Discharge Status code set (SNOMED CT): | | |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | 999003021000000104 \|Emergency care discharge status simple reference set (foundation metadata concept)\| | | |
| Discharge method | The method of discharge from hospital e.g. person discharged on clinical advice or with clinical consent; person discharged him/herself or was discharged by a relative or advocate. | | | R |
| Coded value | The code value for discharge method. | NHS data dictionary code or free text.<br>DISCHARGE METHOD | | R |
| Free text | Free text field to be used if no code is available | Free text | | R |
| Discharging specialty | The specialty of the consultant responsible for the | NHS data dictionary code or free text:<br>MAIN SPECIALTY CODE | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | person at the time of discharge. | | | |
| Coded value | The code value for discharging speciality. | NHS data dictionary code or free text:<br>MAIN SPECIALTY CODE | | R |
| Free text | Free text field to be used if no code is available | Free text | | R |
| Discharging department | The department from which the person is discharged. | Free text | | R |
| Discharge destination | | | | R |
| Discharge destination | The destination of the person on discharge from hospital e.g. usual place of residence, NHS run care home. | NHS data dictionary code:<br>DISCHARGE DESTINATION | | R |
| Discharge address | Address to which the person is discharged if not the usual place of residence. | Free text. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Discharge date informed status | A statement confirming that the person or carer has been informed of the date on which it is proposed that the person be discharged. | | | M |
| Discharge date person informed indicator | Indicates whether or not the patient has been informed of the proposed discharge date. | Flag:<br>-yes or no. | | M |
| Discharge date carer informed indicator | Indicates whether or not the carer (if applicable) has been informed of the proposed discharge date. | N: No<br>Y: Yes<br>NKC: No Known Carer | | M |

| | | | | |
|---|---|---|---|---|
| **6.14 Problem list** | A summary of the problems that require investigation or treatment | | This section allows for all relevant diagnoses, symptoms, conditions, problems and issues.<br><br>This would include disabilities, including learning disabilities, and conditions such as autism where they fall into the above categories i.e. are diagnosed, seen as a problem by the person or are considered a condition or similar. Behavioural factors which are not formal diagnoses but could be seen as a problem for the person would also appear under this section.<br><br>'Onset date' should be included where available even if this is estimated in source systems.<br><br>When a diagnosis has not yet been made, the most granular clinical concept with the highest level of certainty should be displayed. This may be a problem, symptom, sign, or test result, and may evolve over time, as a conventional diagnosis is reached. For example, 'dyspepsia' may be the diagnosis when a patient first presents with indigestion, upgraded to 'gastric ulcer' when this is found at endoscopy, and 'gastric cancer' when biopsies reveal this.<br><br>Unconfirmed or excluded diagnoses should not be coded but may be included in free text in the comments field. Thus, in the example above, gastric ulcer and gastric cancer may be in a list of differential diagnoses at presentation, but the symptom, dyspepsia, should be included in the | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | | diagnosis field. The differential diagnoses should only be included in free text in the comments field, and not in a coded diagnosis field until confirmed with confidence.<br><br>Co-morbidities' should be shown as separate diagnoses. For example, dementia may be recorded as a primary diagnosis by a psycho-geriatrician, but as a co- morbidity where a patient is admitted for a hip replacement. Local implementations will need to define what will be prioritised according to each use case.<br><br>In some situations, a diagnosis may need to be qualified by a number of attributes to give further detail e.g. grade; severity; distribution; behaviour; laterality etc. SNOMED CT codes are available for this purpose. | |
| Problem list record entry | This is a problem list record entry. There may be 0 to many record entries under a section. Each record entry is made up of a number of elements or data items. | | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Date | The date the problem was identified. | Date and time | | R |
| Performing professional | Details of the professional identifying the problem. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Location | The location the problem was identified. | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Problem | A condition which needs addressing and so is important for every professional to know about when seeing the person. | | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | Problems may include diagnoses, symptoms, disabilities and social or behavioural issues, and comprise the 'Problem list'. | | | |
| Coded value | The coded value for the problem list | SNOMED CT:<br>1127581000000103 \|Health issues simple reference set (foundation metadata concept)\| | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Onset date | A date or estimated date that the problem began. | Date and time | | R |
| End date | The date or estimated date the problem was resolved. | Date and time | | R |
| Stage of disease | The stage of disease where relevant. | Free text. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Comment | Supporting text may be given covering the problem. | Free text | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| **6.15 Procedures** | The details of any procedures performed | | The section includes details of procedures performed. Which procedures are communicated / visible to viewers of the information should be based on what they are required to know in this referral. Procedures vary significantly between primary and secondary care and therefore different types of procedures are more or less relevant in different use cases/ care scenarios.<br><br>Procedures include diagnostic as well as therapeutic procedures and will need to be clearly defined as such in local implementations.<br><br>Outcomes or results of procedures should be included in comments.<br><br>The record should include what was actually carried out, not the planned procedure as this may have been changed. The detail should be taken from the record of the actual procedure (e.g. operating note).<br><br>The procedure, anatomical site and laterality should be SNOMED CT coded wherever possible, with free text as an option where this is not possible.<br><br>There are specific elements for complications relating to the procedure and anaesthetic issues<br><br>The anaesthesia issues included could be, for example, “short neck, difficult to intubate” and the actual intubation grade or adverse reactions. | O |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Procedure record entry | This is a procedure record entry. There may be 0 to many record entries under a section. Each record entry is made up of a number of elements or data items. | | | O |
| Date | The date the procedure was performed. | Date and time. | | R |
| Location | The location the procedure was performed | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Performing professional | The professional who performed the procedure. | See Table 3 for the additional elements contained within the | See Table 3 for implementation guidance. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | performing professional cluster (this document). | | |
| Procedure | The therapeutic or diagnostic procedure performed. | | | M |
| Coded value | The procedure code. | SNOMED CT:<br>71388002 \|Procedure (procedure)\|<br>OR<br>129125009 \|Procedure with explicit context (situation)\| | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Anatomical site | The body site of the procedure | | | R |
| Coded value | The coded value of the anatomical site. | SNOMED CT:<br>123037004 \|Body structure (body structure)\| | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Laterality | Laterality of the procedure | | | R |
| Coded value | The coded value for laterality | SNOMED CT code or free text:<br>182353008 \|Side (qualifier value)\| | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Complications related to procedure | Details of any intra-operative complications encountered during the procedure, arising during the person's stay in the recovery unit or directly attributable to the procedure. | | | R |
| Coded value | The coded value for complications relating to procedure. | SNOMED CT:<br>404684003 \|Clinical finding (finding)\| | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Specific anaesthesia issues | Details of any adverse reaction to any anaesthetic agents including local anaesthesia. Problematic intubation, transfusion reaction etc. | | | R |
| Coded value | The coded value for specific anaesthesia issues | SNOMED CT | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Comment | Any further textual comment to clarify | Free text. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | such as statement that information is partial or incomplete.<br>Also indicate the outcome of the procedure. | | | |
| **6.16 Clinical summary** | Clinical summary | | Summary of the admission encounter. 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'. | R |
| Date | The date the clinical summary was written. | | | R |
| Location | The location the clinical summary was written. | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Clinical summary | Summary of the encounter. Where possible, very brief. This may include interpretation of findings and results, differential diagnoses, opinions and specific action(s). Planned actions will be recorded under 'plan'. | Free text. | | R |
| Performing professional | The professional who wrote the clinical summary. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | A record of the details of the person that entered the clinical summary and the date on which it was entered. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| **6.17 Treatments and interventions** | Treatments and interventions carried out. | | Include the relevant treatments and interventions which the person received during the inpatient stay that will have an impact on their future care and treatment. Include psychological therapies, drug and alcohol service, smoking cessation interventions.<br>Record as SNOMED CT codes where possible.<br>All medications should be recorded under the medications section. All surgical and medical procedures should be recorded under 'Procedures' e.g. hip replacement, electroconvulsive therapy (ECT). | R |
| Treatments and interventions and changes made to treatments | The treatments and interventions carried out. Where appropriate record the rationale for the decision to treat and the information sources reviewed e.g. end of life care plan etc. All medications should be recorded under the medications section. | | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Coded value | The coded value for treatments and interventions. | SNOMED CT | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| **6.18 Social context** | The social setting in which the person lives, such as their household, occupational history, and lifestyle factors. | | This section includes information about the social setting in which the person lives, such as their household, occupational, and lifestyle factors. Social circumstances include the person's social background, network and personal circumstances, e.g. housing, and should also include if the person is a carer. 'Smoking status' should be shared using SNOMED CT rather than yes or no.<br>It is very important that this information is available to social care for them to be able to assess the person's care and support needs following discharge. | R |
| Household composition | Details of the person's household composition. | | | R |
| Date | The date when the household | Date and time | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | composition was taken. | | | |
| Location | The location where the household composition was taken. | | | R |
| Coded value | The coded value for location | NHS data dictionary code: ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Household composition | Description of the household composition e.g. lives alone, lives with family, lives with partner, etc. | | | R |
| Coded value | The coded value of household composition | SNOMED CT | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Performing professional | The professional who took the household composition. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Lifestyle choices | The lifestyle choices made by the person which are pertinent to his or her health and well-being, e.g. physical activity level, pets, hobbies and sexual habits | | | O |
| Date | The date when the lifestyle choices were taken. | Date and time | | O |
| Location | The location where the lifestyle choices were taken. | | | O |
| Coded value | The coded value for location | NHS data dictionary code: | | O |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | ORGANISATION CODE | | |
| Free text | Free text field to be used if no code is available | Free text. | | O |
| Lifestyle choices | The lifestyle choices made by the person which are pertinent to his or her health and well-being, e.g. physical activity level, pets, hobbies and sexual habits | | | O |
| Coded value | The coded value of the person's lifestyle choice. | SNOMED CT | | O |
| Free text | Free text field to be used if no code is available | Free text. | | O |
| Performing professional | The professional who took the lifestyle choices. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Smoking status | Details of the person's smoking status. | | | R |
| Date | The date the smoking status was taken. | Date and time | | R |
| Location | The location where the smoking status was taken. | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Smoking status | Details of the person's smoking status. | | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Coded value | The smoking status of the person | SNOMED CT code or free text:<br>999000891000000102 \|Smoking simple reference set (foundation metadata concept)\| | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Performing professional | The professional who took the smoking status. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Alcohol intake | Details of the person's alcohol intake. | | | R |
| Date | The date when the alcohol intake was noted. | Date and time | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Location | The location where the alcohol intake was noted. | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Alcohol intake | Latest or current alcohol consumption. | | | R |
| Coded value | The coded value of the person's alcohol intake | SNOMED CT:<br>219006 \|Current drinker of alcohol (finding)\|<br>OR<br>105542008 \|Current non-drinker of alcohol (finding)\|<br>OR<br>228274009 \|Lifetime non-drinker (finding)\|<br>OR | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | 1104551000000109 \|Declined to provide information about alcohol use (situation)\|<br>OR<br>371434005 \|History of alcohol abuse (situation)\| | | |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Performing professional | The professional who noted the alcohol intake. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Drug / substance use cluster | Details of the person's drug and substance use. | | | R |
| Date | The date when the drug / substance use was noted. | Date and time | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Location | The location where the drug / substance use was noted. | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Drug / substance use | Latest or current drug / substance use. | | | R |
| Coded value | The coded value for drug and substance misuse. | SNOMED CT:<br>361055000 \|Misuses drugs (finding)\|<br>OR<br>371422002 \|History of substance abuse (situation)\|<br>OR<br>228368007 \|Has never misused drugs (situation)\|<br>OR | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | 783241000000102 \|Declined to give substance misuse history (finding)\| | | |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Performing professional | The professional who noted the drug / substance use. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Social circumstances | Details of the person's social circumstances. | | | O |
| Date | The date when the social circumstances were taken. | Date and time | | O |
| Location | The location where the social | | | O |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | circumstances were taken | | | |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | O |
| Free text | Free text field to be used if no code is available | Free text. | | O |
| Social circumstances | A person's social background, network and personal circumstances, e.g. housing.<br>This should include whether the person is a carer. | Free text. | | O |
| Performing professional | The professional who took the social circumstances. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Access | Details of access for the person. | | | R |
| Date | The date when the special access requirements were taken. | Date and time | | R |
| Location | The location where the special access requirements were taken. | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Access | Special access requirements e.g. key safe, coded lock, which door to use, stretcher access etc. | Free text. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Performing professional | The professional who took the special access requirements. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Dependents cluster | Details of any responsibility the person has for dependents. | | | R |
| Date | The date when the dependent's details were taken. | Date and time | | R |
| Location | The location where the dependent's details were taken. | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Dependents | Provide details of any responsibility the person has for dependents.<br>In the case of children provide date of birth of the child. | Free text. | | R |
| Performing professional | The professional who took the dependent's details. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Accommodation status | Details of the type of accommodation where the person lives. | | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Date | The date when the accommodation status was taken. | Date and time | | R |
| Location | The location where the accommodation status was taken. | NHS data dictionary code or free text.<br>ORGANISATION CODE | | R |
| Accommodation status | An indication of the type of accommodation where the person lives.<br>This should be based on the main or permanent residence. | | | R |
| Coded value | The coded value for accommodation status. | NHS data dictionary code or free text.<br>ACCOMMODATION STATUS CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Performing professional | The professional who took the accommodation status. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Household environment cluster | Details of the person's household environment. | | | R |
| Date | The date when the household environment details were taken. | Date and time | | R |
| Location | The location where the household environment details were taken. | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Household environment | Factors in the household which impact the person's health and wellbeing, to include smoking in the home, alcohol / substance use etc. | Free text. | Other examples of relevant issues might also include hoarding or access by strangers to the property | R |
| Performing professional | The professional who took the household environment details. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| 6.18.1 **Care needs summary** | A description of the person's current care needs. | | Include a narrative summary of the person's care needs e.g. catheter / continence / stoma care, skin care (wounds, ulcers), tracheostomy, nutrition and fluids, behavioural care and support. Attach additional support plans as required.<br><br>Aids (e.g. needs Zimmer frame) and adjustments required due to needs related to mobility, cognitive impairment, communication and cultural will be recorded under 'Individual Requirements' and Reasonable Adjustments'.<br><br>This is very important information for the local authority social care team to be able to make an assessment and plan the future care and support for the person after discharge from hospital. | M |
| Care needs summary | A narrative summary of the person's nursing and care needs e.g. catheter / continence / stoma care, skin care (wounds, ulcers), tracheostomy, nutrition and fluids, behavioural care and support. Attach | Free text. | | M |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | additional support plans as required. | | | |
| Performing professional | The professional who completed the care needs summary. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Location | The location where the care needs summary was written. | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Date | The date the care needs summary was written. | Date and time | | R |
| Person completing record | A record of the details of the person that entered the care needs summary and | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | the date on which it was entered. | | | |
| **6.19 Assessed level of care** | Record whether enhanced care observation was required during the admission and details of level of enhanced care observation needed and why. | | Record whether enhanced care observation was required during the admission and details of the level of enhanced care observation needed and why. This can be a narrative summary of the level of supervision and care the person needed and should include the grade of care observation e.g. continuous observation within eyesight. | |
| Level of enhanced care observation | Record the level of enhanced care observation the person required during the admission and prior to discharge if different.<br>Record why needed e.g. to reduce risk and protect the person because of high risk of falling and sustaining injury | Levels:<br>A = General level i.e. needed usual inpatient observation<br>B = Intermittent observation i.e. every 30 to 60 minutes<br>C = Continuous observation within eyesight i.e. in a cohort bay<br>D = High level multi professional continuous observation | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | or person very confused. | | | |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| **6.20 Primary support reason** | The primary support reason for social care. | | . | R |
| Primary support reason record entry | This is a primary support reason record entry. There may be 0 to many record entries under a section. Each record entry is made up of a number of elements or data items. | | | R |
| Primary support reason | The Primary Support Reason used to classify a person for National Reporting on Short and Long Term Services | Free text. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | (SALT). e.g. Learning disability support, mental health support, physical support. | | | |
| Active | Flag to indicate whether the primary support reason is currently active. | | | R |
| Start date | The date a primary support reason was authorised as active. | Date. | | R |
| End date | The end date of authorisation. | Date. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| **6.21 Assessments** | Assessment. | | This section includes details of a person's assessments allowing for unstructured, semi structured and structured outputs from the assessment such as the Social Care Needs, Continuing Healthcare Checklist. Some assessment outputs will be narrative and may come with their own sub-sections e.g. psychiatry (Presenting Problem, Personal/Family History, Mental State Examination etc.)<br><br>This section would also accommodate the results of any more structured assessment tools completed (e.g. screening tools / outcomes measures such as PHQ-9 or GAD-7). Numeric results of any assessments completed can also be included. | O |
| Assessments record entry | This is the assessments record entry. There may be 0 to many record entry/entries under a section. Each record entry is made up of a number of elements or data items. | | | O |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Date | The date the assessment was done. | Date and time. | Key contextual information. | R |
| Location | The location where the assessment was done. | | Key contextual information. | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Assessment type | The type of the assessment e.g. social care needs assessment. | Free text. | | R |
| Assessment summary | The summary of the assessment. | Free text. | | R |
| Structured assessment | Details of the structured assessment. | | | R |
| Structured assessment name | Structured assessment name | SNOMED CT or free text. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | e.g. New York Heart Failure, Glasgow Coma scale, Activities of Daily Living (ADL) etc. | | | |
| Assessment score | The structured assessment score. | SNOMED CT or free text. | | R |
| Assessment value | The structured assessment value. | Free text, alphanumeric or SNOMED CT. | | R |
| Global score | The total global score from the assessment. | Free text. | | R |
| Subscale score | The subscale score of the structured assessment. | SNOMED CT or free text. | | R |
| Subscale value | The subscale value of the structured assessment. | Free text, alphanumeric or SNOMED CT. | | R |
| Performing professional | The professional who did the assessment. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Comment | Supporting text may be given regarding the assessment. | Free text. | | R |
| **6.22 Risks** | Details of any risks related to the person. | | Categories of risks are as follows:<br>Risk to self, risk to others, risks from others, risk of infection and other risks to cover anything else.<br>There should be mechanisms in place to validate this information and for it to be reviewed regularly and if applicable ended. The peculiarity of risk factors in mental health needs to be taken into consideration i.e. the most important factor in risk is history so information here should not be archived or filtered without careful consideration. | R |
| Risks to self | Details of the persons risks to self | | | |
| Start date of risk | The start date of the risk. | Date and time | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| End date of risk | The date the risk ended. | Date and time | | R |
| Risks to self | Risks the person poses to themselves, e.g., suicide, overdose, self-harm, self-neglect. | SNOMED CT:<br><br>281694009 \|Finding of at risk (finding)\| | | R |
| Location | The location where the risk was identified. | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br><br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Performing professional | The professional who identified the risk. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the | See Table 3 for implementation guidance. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | person completing record cluster (this document). | | |
| Risks to others | Details of the persons risks to others | | | R |
| Start date of risk | The start date of the risk. | Date and time | | R |
| End date of risk | The date the risk ended. | Date and time | | R |
| Risks to others | Risks to professionals or others | SNOMED CT:<br><br>391155006 \|At risk of harming others (finding)\| | | |
| Location | The location where the risk was identified. | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br><br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Performing professional | The professional who identified the risk. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Risk from others | Details of the persons risks from others | | | R |
| Start date of risk | The start date of the risk. | Date and time | | R |
| End date of risk | The date the risk ended. | Date and time | | R |
| Risk from others | Risks to the person from an identified individual e.g. family member etc. | SMOMED CT:<br>281694009 \|Finding of at risk (finding)\| | | |
| Location | The location where the risk was identified. | | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Performing professional | The professional who identified the risk. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Risk of accidents | Details of the risks the person poses to themselves from accidents. | | | R |
| Start date of risk | The start date of the risk. | Date and time | | R |
| End date of risk | The date the risk ended. | Date and time | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Risk of accidents | Risks the person poses to themselves from accidents. | Free text | | |
| Location | The location where the risk was identified. | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Performing professional | The professional who identified the risk. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Other risks | Details of other risks, factors or behaviours | | 0 to many. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | relating to the person. | | | |
| Start date of risk | The start date of the risk. | Date and time | | R |
| End date of risk | The date the risk ended. | Date and time | | R |
| Other risks | Other risks, factors or behaviours relating to the person. | Free text. | | |
| Location | The location where the risk was identified. | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Performing professional | The professional who identified the risk. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Infection risk | Details of any known infection of the person for which special handling might be required | | | R |
| Start date of risk | The start date of the risk. | Date and time | | R |
| End date of risk | The date the risk ended. | Date and time | | R |
| Infection risk | Any known infection of the person for which special handling might be required | Free text. | | |
| Location | The location where the risk was identified. | | | R |
| Coded value | The coded value for location | NHS data dictionary code: | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | ORGANISATION CODE | | |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Performing professional | The professional who identified the risk. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| **6.23 Allergies and adverse reactions** | Allergies and adverse reactions | | Guidance on good practice recording of allergies and adverse reactions is provided by NICE (https://www.nice.org.uk/guidance/CG183/chapter/1-Recommendations).<br><br>A record should be provided of all allergic and adverse reactions relevant to the person. Coded information on causative agents is important to healthcare professionals to enable safe prescribing of medications.<br><br>When an individual is diagnosed with an allergy related condition (e.g. anaphylactic shock or urticarial skin rash) this will be entered in addition into the diagnosis field in the healthcare system and will need to be cross referenced into the problem list and prominently displayed there.<br><br>Where there is a diagnostic code for an allergy recorded in the system, the system should trigger an allergy entry. There is a significant risk to patient safety if allergies are not explicitly and prominently displayed.<br><br>Adverse reactions need to be treated in a similar manner.<br><br>Information about probability of recurrence may be included in the allergy comments element if this has been identified. | M |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Allergies and adverse reactions record entry | This is a allergies and adverse reactions record entry. There may be 1 to many record entries under a section. Each record entry is made up of a number of elements or data items. | | | M |
| Causative agent | The agent such as food, drug or substances that has caused or may cause an allergy, intolerance or adverse reaction in this person Or “No known drug allergies or adverse reactions” Or “Information not available” | | | M |
| Coded value | The coded value for causative agent | SNOMED CT:<br>105590001 \|Substance (substance)\| | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | OR<br>373873005 \|Pharmaceutical / biologic product (product)\|<br>OR<br>716186003 \|No known allergy (situation)\|<br>OR<br>196461000000101 \|Transfer-degraded drug allergy (record artifact)\|<br>OR<br>196471000000108 \|Transfer-degraded non-drug allergy (record artifact)\|<br>OR<br>alternatively, one of the following statements:<br>"No known drug allergies"<br>OR<br>"Information not available"<br>OR | | |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | a code from the v3 Code System NullFlavor specifying why a valid value is not present<br>OR<br>Choice of• Text• Coded text - constraint: SNOMED CT:Allergy Archetypes Drug Groups | | |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Reaction details cluster | Details of the reaction. | | | R |
| Date | The date that the reaction was identified. This will often equate to the date of onset of the reaction, but this may not be wholly clear from source data. | | | R |
| Location | Details of where the allergy was identified. | | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Substance | The substance, or a class of substances, that is considered to be responsible for the adverse reaction. | | | R |
| Coded value | The coded value for location | SNOMED CT | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Description of reaction | A description of the manifestation of the allergic or adverse reaction experienced by the person. For example, skin rash. | | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Coded value | The coded value for description of reaction. | SNOMED CT:<br>1127581000000103 \|Health issues simple reference set (foundation metadata concept)\| | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Severity | A description of the severity of the reaction | | | R |
| Coded value | The coded value for severity. | SNOMED CT:<br>999004521000000108 \|Health issue severity simple reference set (foundation metadata concept)\| | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Certainty | A description of the certainty that the stated causative agent caused the | | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | allergic or adverse reaction. | | | |
| Coded value | The coded value for certainty. | SNOMED CT:<br>999004531000000105 \|Health issue certainty simple reference set (foundation metadata concept)\| | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Comment | Any additional comment or clarification about the adverse reaction. | Free text. | | R |
| Type of reaction | The type of reaction experienced by the person (allergic, adverse, intolerance) | FHIR value set :<br>Allergy, Intolerance, Not known | | R |
| Evidence | Results of investigations that confirmed the certainty of the diagnosis. Examples might include the | Free text. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | results of skin prick allergy tests. | | | |
| Date first experienced | When the reaction was first experienced. May be a date or partial date (e.g. year) or text (e.g. during childhood). | Date and time. | | R |
| Probability of recurrence | Probability of the reaction (allergic, adverse, intolerance) occurring | Free text. | | R |
| Performing professional | The professional who identified the reaction. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| **6.24 Medications and medical devices** | Medications and medical devices | | *Please refer to the PRSB website to keep informed of the latest developments with the Medication information modelling for interoperability.*<br>This section is for details of the medication the person is taking when discharged from hospital including details of what medication was stopped or changed during the admission and the support a person needs to take the medication. Any medical devices not prescribed should be entered in the medical devices record entry. | R |
| Medication item entry | All medications and devices that can be prescribed to be entered via this Medication item entry.<br>Handles details of continuation / addition / amendment of admission medications. | | The medications section allows for using structured dose and timing information that is machine readable to facilitate the reading and transfer of medications information between systems and providers of care, through the structured dose direction cluster. Technical guidance for implementing the structured dose and timing in Fast Healthcare Interoperable Resource (FHIR) messaging is available from NHS Digital https://developer.nhs.uk/apis/dose-syntax-implementation/.<br>The free text Dose directions description is the form of dosage direction typically used in UK GP Systems. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | | Dose direction duration can be derived from the start and end dates if no other information is available.<br><br>When sharing Dose duration direction, the following examples are provided to clarify definitions for two of the coded text items which appear similar. In both cases, these directions are not an absolute instruction. They are:<br><br>• ‘continue medication indefinitely’ - ongoing treatment planned for example when starting daily aspirin or a statin. There will be circumstances where you would stop them such as a GI bleed.<br><br>• ‘do not discontinue’ refers to medication where suddenly stopping could be dangerous, for example the abrupt withdrawal of long-term steroids.<br><br>This section is 0 to many. | |
| Medication item cluster | Medication item cluster | | | R |
| Date | The date on which the medication or medical device was prescribed. | Date and time | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Location | The location where the medication or the medical device was prescribed. | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Performing professional | The professional who prescribed the medication or medical device. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Medication name | May be generic name or brand name. | | | M |
| Coded value | The coded value for the medication name. | SNOMED CT:<br>999000581000001102 \|National Health Service dictionary of medicines and devices virtual therapeutic moiety simple reference set (foundation metadata concept)\| | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | OR<br><br>999000561000001109 \|National Health Service dictionary of medicines and devices virtual medicinal product simple reference set (foundation metadata concept)\|<br><br>OR<br><br>999000571000001104 \|National Health Service dictionary of medicines and devices virtual medicinal product pack simple reference set (foundation metadata concept)\|<br><br>OR<br><br>999000541000001108 \|National Health Service dictionary of medicines and devices actual medicinal product simple reference set (foundation metadata concept)\|<br><br>OR<br><br>999000551000001106 \|National Health Service dictionary of medicines and devices actual medicinal product pack simple | | |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | reference set (foundation metadata concept)\| | | |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Form | The form of the medication e.g. capsule, drops, tablet, lotion etc. | | | O |
| Coded value | The coded value for form | SNOMED CT:<br>421967003 \|Drug dose form (qualifier value)\| | | O |
| Free text | Free text field to be used if no code is available | Free text. | | O |
| Route | The route by which the medication is administered e.g. oral, IM, IV | | | O |
| Coded value | The coded value for route | SNOMED CT: | | O |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | 999000051000001100 \|ePrescribing route of administration simple reference set (foundation metadata concept)\| | | |
| Free text | Free text field to be used if no code is available | Free text. | | O |
| Site | The anatomical site at which the medication is to be administered. | | | O |
| Coded value | The coded value for site | SNOMED CT | | O |
| Free text | Free text field to be used if no code is available | Free text. | | O |
| Method | The technique or method by which the medication is to be administered. | Free text | | O |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| **6.25 Over the counter medication flag** | Indicates if the medication or device is acquired without prescription i.e. got by the person over the counter. | Flag: - Yes or No. | All over the counter (OTC) medications that the person uses regularly which are not prescribed by a medical professional should be recorded and communicated. These may or may not be required for the treatment and management of their health condition(s). Examples include analgesics for pain relief (Ibuprofen tablets); topical anaesthetics (Voltarol gel); vitamin and mineral supplements (folic acid and calcium); herbal medicines (St Johns Wort). Include details of reason for use, dose amount, frequency, start date and duration of medication. | O |
| Dose directions description | Describes the entire medication dosage and administration directions including dose quantity and medication frequency and optionally duration e.g. “1 tablet at night" or “2mg at 10pm”. | Free text | | O |
| Structured dose direction cluster | A structural representation of the elements carried by the dose syntax in 'parsable dose | | | O |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | strength / timing' i.e. dose strength, dose timing, dose duration and maximum dose. | | | |
| Structured dose amount | A structural representation of dose amount, e.g. 20mg or 2 tablets.<br><br>This element will generally only be used when persisting data within systems with 'parsable dose directions' being used to exchange the same information between systems. | As per: FHIR Dose Syntax Implementation Guidance (NHS Digital) | | O |
| Structured dose timing | A slot containing a structural, computable representation of dose timing and maximum dose. | As per: FHIR Dose Syntax Implementation Guidance (NHS Digital) | | O |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | This element will generally only be used when persisting data within systems with 'parsable dose directions' being used to exchange the same information between systems. | | | |
| Dose direction duration | Recommendation of the time period for which the medication should be continued, including direction not to discontinue. | Choice of Coded Text:<br>Continue indefinitely [The medication should be continued indefinitely.]<br>Do not discontinue [The medication should be continued indefinitely and the prescriber highly recommends that it should never be discontinued. This is an AoMRC Clinical Headings recommendation.]<br>Stop when course complete. [The medication should be stopped when the currently prescribed course has been completed.] | | O |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | Duration: Allowed values: years, months, weeks, days, hours >=0 days | | |
| Additional instructions | Allows for:<br>* requirements for adherence support, e.g. compliance aids, prompts and packaging requirements<br>* additional information about specific medicines e.g. where specific brand required<br>* person requirements, e.g. unable to swallow tablets. | TextRuntime name constraint:Additional instruction [Additional multiple dosage or administration instructions as plain text. This may include guidance to the prescriber, person administering the medication. In some settings, specific Administration Instructions may be re-labelled as "person advice' or 'Dispensing Instruction' to capture these flavours of instruction.]Dispensing instruction [Multiple plain text to record complex dispensing arrangements, particularly for Controlled Drug instalment dispensing. 'Dispensing instructions' may be used as a specific label to overwrite 'Additional instructions' to align with legacy GP system behaviour.]Person advice | This may include guidance to the prescriber, person or person administering the medication including covert medication instructions. For example, include specific instructions such as does the person need a dosset box, do the tablets need crushing and given with food, what covert medicine is given and how etc... Other type of comment includes “Omit morning dose on day of procedure”, "for pain or fever", "Dispense weekly".<br>In some settings, specific Administration Instructions may be re-labelled as "Person advice' or 'Dispensing Instruction' to capture these flavours of instruction. It is important to share this information, so the person’s medicines are administered effectively. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | [Multiple plain text instructions intended for person or carer. 'Person advice' may be used as a specific label to overwrite 'Additional instructions' to align with legacy GP system behaviour.]Monitoring [Special instructions related to monitoring of medication, such as lab tests.] or Free text | | |
| Course details cluster | Details of the overall course of medication. | | | R |
| Course status | The status of this prescription. | Choice of Coded text:<br>Active [This is an active medication.]<br>Discontinued [This is a medication that has been issued. dispensed or administered but has now been discontinued.]<br>Never active [A medication which was ordered or authorised but has been cancelled prior to | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | being issued, dispensed or administered.]<br>Completed [The medication course has been completed.]<br>Obsolete [This medication order has been superseded by another.] | | |
| Indication | Reason for medication being prescribed, where known. | A free text or Coded text term giving the clinical indication or reason for ordering the medication. Coded terms are preferable. | | R |
| Start date/time | The date and/or time that the medication course should begin. | Date and time | | R |
| End date/time | The date and/or time that the medication course should finish. | Date and time | | R |
| Link to indication record | A link to the record which contains the indication for this medication order. | Free text with URL | | R |
| Comment/recommendation | Suggestions about duration and/or | Free text. Additional comment or recommendation about the | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication. | medication course e.g. 'Patient named supply', 'unlicensed medication', 'Foreign brand' or monitoring recommendations | | |
| Medication change summary cluster | Records the changes made to medication. | | The medication changes cluster and medications discontinued cluster are to ensure clarity of what medications have changed or been stopped in hospital. | R |
| Status | The nature of any change made to the medication. | Choice of Coded text:<br>Continued [Medicine present on both admission and discharge with no amendments.]<br>Added [Medicine present on discharge but not on admission]<br>Amended [Medicine present on both admission and discharge but with amendment(s) since admission.]<br>On-hold [Suspended with the intention that they are to be reinstated at some point in the future] | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | Discontinued [The medication is no longer to be taken by the patient] | | |
| Indication | Reason for change in medication, e.g. sub-therapeutic dose, person intolerant. | A free text or coded text term giving the clinical indication or reason for change in medication. | | R |
| Date of change | The date of the change - addition, or amendment | Date and time | | |
| Description of amendment | Where a change is made to the medication i.e. one drug stopped and another started or e.g. dose, frequency or route is changed. | Free text. | | R |
| Total dose daily quantity | The total daily dose of this medication.<br>This is helpful for estimating optimal adherence to dosing guidance. It may be computed from | Free text. | | O |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | product/dose strength and frequency or entered manually. | | | |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Medication discontinued entry | Medication discontinued entry | | The medication changes cluster and medications discontinued cluster are to ensure clarity of what medications have changed or been stopped in hospital. | R |
| Name of discontinued medication | The name of the medication or medical device being discontinued | | | M |
| Coded value | The coded value for medication name | SNOMED CT | See medication name – coded value for appropriate SNOMED CT codes. | O |
| Free text | Free text field to be used if no code is available | Free text. | | O |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Status | The status of any change made to the medication. | Free text | | R |
| Indication | The clinical indication for any changes in medication status | A free text or coded text term giving the clinical indication or reason for change in medication. | | R |
| Date of change | The date of the discontinuation | Date and time | | R |
| Comment | Any additional comment about the discontinuation. | Free text. | | O |
| Medical devices entry | Medical devices | | The Medical devices element is for medical devices that cannot be prescribed and do not have representation in the NHS dictionary of medicines and medical devices (dm+d). Whilst medical devices that can be prescribed in primary care are generally well represented in dm+d, there are other kinds of devices used in hospital care which may not be so this section provides for this. | R |
| Medical device | Any medical device that isn't prescribed. | Free text. | | M |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Comments | Any information regarding the medical device. | Free text. | | O |

| | | | | |
|---|---|---|---|---|
| **6.26 Plan and requested actions** | This is a plan and requested actions record entry. There may be 0 to many record entries under a section. Each record entry is made up of a number of elements or data items. | | This is the treatment plan, following discharge, for the treating teams and clinicians and any actions requested. This plan should make clear who is expected to take responsibility for actions when the person is discharged from hospital for example the person receiving care or their carer; the GP, another health and social care professionals, the care home staff. For example, follow up renal function test to be arranged by the GP within two weeks or actions to continue the care of the person with COVID -19 in the care home.<br><br>Shared decision-making principles should apply to the development of the plan and where the person's opinions differ, this should be included under 'Agreed with the person or their legitimate person representative' which will include both the aspects of the plan the person (or their representative) agree with and the aspects they disagree with.<br><br>The section would allow for the recording of planned investigations, procedures and treatment for the person's identified conditions and priorities.<br><br>This is not a care plan it is a plan for specific actions to be carried out as a result of an encounter (e.g. following the admission to hospital). | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Date | The date on which the plan and requested actions were prepared. | Date and time. | | R |
| Performing professional | The professional who prepared the plan and requested actions. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Location | The location where the plan and requested actions were prepared. | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Actions for professionals | Including planned investigations, procedures and treatment for a person's identified conditions and priorities. | A record of the planned and requested actions. May be structured (table), with actions, names, dates, status, location, strategies, or free text. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | For each action the following should be identified: outcome expectations, including the person's expectations. | | | |
| Actions for person or their carer | For each action the following should be identified: outcome expectations, including person's expectations. | A record of the planned and requested actions. May be structured (table), with actions, names, dates, status, location, strategies, or free text. | | R |
| Agreed with the person or their legitimate representative | Indicates whether the person or their legitimate representative has agreed the entire plan or individual aspects of treatment, expected outcomes, risks and alternative treatments. | A record of the agreement of the decisions made. Free text. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Outcome of plan and requested actions | The details of the outcome of the plan of requested actions. | Free text. | | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| **6.27 Person and carer concerns expectations and wishes** | Patient and carer, 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 obtained peri-discharge. Record who has expressed these (Person or carer/ representative on behalf of the Person). Where the person lacks capacity this may include their representative's concerns, expectations or wishes.<br><br>**NB**: It is recognised that peri-discharge the patient may wish to record an advance statement (a non-legally binding statement for written requests and preferences made by a person with capacity conveying their wishes, beliefs and values for their future care should they lose capacity) – although this statement does not always relate to palliative concerns, this element can be found in the end of life care section of the standard. Likewise, elements regarding preferences relating to preferred place of care and preferred place of death, which may be appropriate to record around the time of discharge can be found under end of life care. | R |
| Date | The date on which the concerns, wishes or goals of the | Date and time | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | person were recorded. | | | |
| Location | The location where the concerns, expectations and wishes were recorded/ | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Patient and carer, 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. Record who has expressed these (patient or carer/ representative on behalf of the patient). Where the person | A record of statements expressed by the person or their carer or representative. Free text. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | lacks capacity, this may include their representative's concerns, expectations or wishes. | | | |
| Person completing record | This is the person recording the concerns, wishes and expectations.<br>Should include their name, role, grade, speciality, organisation, professional identifier, date and time completed, contact details. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| **6.28 Contingency plans** | Contingency plans. | | This section includes contingency / crisis plans for those people who have specific and predictable risks associated with their health and wellbeing. It describes how disruptions to the care and support plan should be addressed.<br>A contingency plan sets out what should be done if the person's condition or other circumstances get worse.<br>Not everyone who has a care and support plan will need a contingency / crisis plan. It is, however, widely used in mental health.<br>Contingency plans may include end of life care planning elements. These may form part of an initial conversation, but a full end of life care plan should also be included where appropriate as an additional supporting plan. | R |
| Agreed with person or legitimate representative | Indicates whether the plan was discussed and agreed with the person or legitimate representative. | Free text. | | R |
| Anticipatory medicines/equipment | Medicines or equipment available that may be required | Free text. A statement regarding the availability or location of the | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | in specific situations and their location. | anticipatory medicines/equipment. | | |
| Contingency plan name | Name of the contingency plan – what condition or circumstances it is addressing. | SNOMED CT or free text. | | R |
| Date this plan was last updated | The date that this contingency plan was last updated. | Date and time | | R |
| Planned review date/interval | This is the date/interval when this contingency plan will next be reviewed. | Date and time or free text. | | R |
| Responsibility for review | This is who has responsibility for arranging review of this information.<br>Should include their name, role and contact details. | Free text. | | R |
| Trigger factors | Signs to watch out for that may indicate | Free text. A statement of trigger factors. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | a significant change in health or other circumstances. | | | |
| What should happen | Guidance on specific actions or interventions that may be required or should be avoided in specific situations.<br>This may include circumstances where action needs to be taken if a carer is unable to care for the person. | Free text. A statement of suggested actions. Usually expressed as: in the event of X do Y. | | R |
| Who should be contacted | Who should be contacted in the event of significant problems or deterioration in health or wellbeing. E.g. name, role and contact details. | Free text. This may be obtained from the record of professional or personal contacts elsewhere in the person's record. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Location | The location where the contingency plan was prepared. | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Performing professional | The professional who prepared the contingency plans. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| **6.29 Additional support plans** | Additional support plans | | This section includes additional supporting plans, which may be linked to the person's care and support plan. Examples of additional supporting plans include: The Asthma UK action plan, a mental health plan (for people that are supported by a Care Programme Approach package), tissue viability plans, nutrition plans, a falls prevention plan, an end of life care plan, a behavioural support plan, a hospital or other service transfer of care plan etc.<br><br>The format of additional supporting plans will vary according to the type of plan. Some may be structured and coded, others may include diagrams or images.<br><br>Additional supporting plans, if relevant to the referral, should be available for others to view, but will only be created, updated and ended by the service creating the plan.<br><br>See the detailed guidance in the Digital Care and Support Plan for further information https://theprsb.org/standards/dcsp/. | R |
| Additional support plan name | The name of the particular additional supporting plan, e.g. dieticians plan, wound management | Free text. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | plan, discharge management plan and behaviour support plan. | | | |
| Additional support plan content | This is the content of any additional care and support plan which the person and/or care professional consider should be shared with others providing care and support. | Free text. May be structured in different ways, e.g. tables, diagrams, images. This is the content of any additional care and support plan which the individual and/or care professional consider should be shared with others providing care and support. It should be structured as recommended for the care and support plan and if contains additional detail, it may be referenced here. | | R |
| Planned review date/interval | This is the date/interval when this information will next be reviewed. | Date and time or free text. | | R |
| Responsibility for review | This is a record of who has responsibility for arranging review of this information. | Free text. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | Should include their name, role and contact details. | | | |
| Date this plan was last updated | This is a record of the date that this information was last updated. | Date and time | | R |
| Location | The location where the additional support plan was prepared. | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Performing professional | The professional who prepared the additional support plan. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the | See Table 3 for implementation guidance. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | person completing record cluster (this document). | | |
| **6.30 End of life care** | Information relating to end of life care.<br>N.B. This is not an end of life care plan but contains information that would be found in an end of life care plan. | | This is not an end of life care plan, but this section contains information that would be expected in an end of life care plan. It provides details of a person's end of life preferences and wishes including cardio-pulmonary resuscitation decision (CPR), estimated prognosis, awareness of prognosis, preferred place of care and preferred place of death.<br>The information included in the standard is consistent with the end of life minimum dataset and SCCI1580. However, PRSB recognises that there is work to do to develop a nationally agreed information standard for an end of life care plan.<br>**NB:** Lasting power of attorney and advance decision to refuse treatment components of the standard are found in the Legal section. | R |
| Cardio-pulmonary resuscitation (CPR) decision | Whether a decision has been made, the decision, who made the decision, the date of decision, date for review and location of documentation. Where the person or | | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | their family member/carer have not been informed of the clinical decision please state the reason why. | | | |
| Date | The date when the cardio-pulmonary resuscitation decision was made. | Date and time. | | R |
| Location | The location where the cardio-pulmonary resuscitation decision was made. | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Cardio-pulmonary resuscitation (CPR) decision | The Cardio-pulmonary resuscitation (CPR) decision. | | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Coded value | The coded value for CPR | SNOMED CT:<br>450475007 \|For cardiopulmonary resuscitation (finding)\|<br>OR<br>450476008 \|Not for cardiopulmonary resuscitation (finding)\| | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Date for review | The date for review of CPR decision. | Date and time | | R |
| Location of document | The location of the CPR decision document. | Free text or URL | | R |
| Performing professional | The professional who made the cardio-pulmonary resuscitation decision. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Estimated prognosis | Details of the person's estimated prognosis. | | | R |
| Date | The date when the estimated prognosis was made. | Date and time. | | R |
| Location | The location where the estimated prognosis was made. | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Estimated prognosis | Where a person is terminally ill this is a clinical judgment indicating the | Free text. | | |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | anticipated period of time until death e.g. last days, weeks, months or year of life. | | | |
| Performing professional | The professional who made the estimated prognosis. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Awareness of prognosis | Details of the person's awareness of prognosis. | | | R |
| Date | The date when the assessment of the level of awareness of the prognosis was made. | Date and time. | | R |
| Location | The location where the assessment of the level of | | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | awareness of the prognosis was made. | | | |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Awareness of prognosis | Description of the level of awareness the person and or their carer/family has regarding their estimated prognosis. | Free text. | | |
| Performing professional | The professional who made the assessment of the level of awareness of the prognosis. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Advance statement | Details of the person's advance statement | | | R |
| Date | The date when the advanced statement was made. | Date and time. | | R |
| Location | The location where the advanced statement was made. | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Advance statement | Written requests and preferences made by a person with capacity conveying their wishes, beliefs and values for their future care should they lose capacity. Include the location | | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | of the document if known. | | | |
| Coded value | The coded value for the advance statement. | SNOMED CT:<br>816281000000101. Has advance statement (Mental Capacity Act 2005). | The content of the advance statement should also be included attached as a document where available. | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Performing professional | The professional who made the advance statement. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Preferred place of death | The preferences that a person has identified as their preferred place to die. | | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Date | The date when the preferred place of death was identified. | Date and time. | | R |
| Location | The location where the preferred place of death was identified. | | | R |
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Preferred place of death 1st | The preferences that a person has identified as their preferred place to die. | SCCI1580 code:<br>10: Hospital (Acute/Community/Other)<br>20: Private residence<br>21: Patient's own home<br>22: Other private residence (e.g. relatives home, carers home)<br>30: Hospice (inpatient specialist palliative care)<br>40: Care Home | | |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | 50: Other (free text e.g. secure and detained settings)<br><br>517111000000103 Preferred place of death: patient unable to express preference<br><br>517131000000106 Preferred place of death: discussion not appropriate<br><br>766391000000108 Preferred place of death: patient declined discussion<br><br>517161000000101 Preferred place of death: patient undecided | | |
| Name of the place | The name of the preferred place of death | Free text. | | |
| Type of place | The type of the preferred place of death. | | | |
| Preferred place of death 2nd | The preferences that a person has identified as their | SCCI1580 code:<br><br>10: Hospital (Acute/Community/Other) | | |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | preferred place to die. | 20: Private residence<br>21: Patient's own home<br>22: Other private residence (e.g. relatives home, carers home)<br>30: Hospice (inpatient specialist palliative care)<br>40: Care Home<br>50: Other (free text e.g. secure and detained settings)<br>517111000000103 Preferred place of death: patient unable to express preference<br>517131000000106 Preferred place of death: discussion not appropriate<br>766391000000108 Preferred place of death: patient declined discussion<br>517161000000101 Preferred place of death: patient undecided | | |
| Name of the place | The name of the preferred place of death | Free text. | | |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Type of place | The type of the preferred place of death. | | | |
| Performing professional | The professional who identified the preferred place of death. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Preferred place of care | The preferences that the person has identified as their preferred place to receive care. | Free text. | | R |
| Date | The date when the preferred place of care was identified. | Date and time. | | R |
| Location | The location where the preferred place of care was identified. | | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Coded value | The coded value for location | NHS data dictionary code:<br>ORGANISATION CODE | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Preferred place of care | The preferences that the person has identified as their preferred place to receive care. | Free text. | | |
| Performing professional | The professional who identified the preferred place of care. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| **6.31 Documents (including correspondence and images)** | Details about documents related to the person. | | This section includes details for documents and images. It includes the metadata that is required for the document or image and a link to the actual document or image. When displayed in a record, documents and images should be organised logically in date order. Local implementations will need to determine the best logical groupings for use here.<br><br>A specific cluster is included for images as these are a special case where there is a document (e.g. a KOS document) with information about the image and often produced by the machine or imaging system, and a specific set of additional information (such as event code list and format code). Note that this document is separate from the investigation report which provides the results or interpretation of the imaging. For images the performing professional will be the person performing the imaging procedure rather than the author. | R |
| Documents | This is the documents record entry. There may be 0 to many record entries under a section. Each record entry is made up of a | | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | number of elements or data items. | | | |
| Date | The date and time the document was created. | Date and time | | R |
| Performing professional | The professional who authored the document. | See Table 3 for the additional elements contained within the performing professional cluster (this document). | See Table 3 for implementation guidance. | R |
| Documentation location | The URL for the document. | Free text. | | R |
| Confidentiality | The code specifying the level of confidentiality of the document. | Free text, recommend the use of the FHIR values set:<br>V3 Value Set Confidentiality Classification | | R |
| Class | The document type e.g. report, summary, images, treatment plan, patient preferences, workflow | SNOMED CT or free text. | | R |
| Document title | The title of the document. | Free text. | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Document name | The name of the document.<br><br>This should align to the PRSB document naming standard.<br><br>Where the document is a KOS document this field (designated typeCode) is used to carry the DICOM Imaging procedure:<br><br>This attribute shall be populated by the XDS-I Imaging Document Source from a code in the Procedure Code Sequence (0008,1032) of the performed procedure with which the document is associated.<br><br>Values may be found in a suitable DICOM browser | | | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Document MIME type | MIME type of the document e.g. application, pdf | Free text. | | R |
| Person completing record | Details of the person completing the record. | See Table 3 for the additional elements contained within the person completing record cluster (this document). | See Table 3 for implementation guidance. | R |
| Service | The high level imaging speciality code e.g. (R-3027B, SRT, “Radiology”) | | | R |
| Coded value | The coded value for service | SNOMED CT:<br>999000381000000107 \|Correspondence care setting type simple reference set (foundation metadata concept)\| | | R |
| Free text | Free text field to be used if no code is available | Free text. | | R |
| Comments | Comments associated with the document. | Free text. | | R |

| | | | | |
|---|---|---|---|---|
| **6.32 Assessment notice** | Informs the social services team that an assessment will be required, with expected discharge date if known. | | This is an assessment notice that must be sent to the local authority social services team informing them that a care needs assessment will be required for the person.<br><br>If the hospital staff decide the person needs additional care after discharge, this triggers the ADW notices in this section to be sent to the local authority as part of the persons discharge planning. See section 2.4 for further background information.<br><br>All the information required to complete and communicate the ADW notices to the local authority can be extracted from this standard such as the person's demographics, the referring organisation and recipient LA contact details and any other care and clinical information required. The following information elements relate specifically to the ADW notices and are not required for any other communication transaction.<br><br>The LA must send an acknowledgement of receipt of the notices back to the sender as described under section 6.32.1.<br><br>Include here relevant details of discussions held about the person's discharge planning and future care following hospital discharge and what agreements were reached and with whom. Some of this information will populate the ADW notices so please refer to ADW notice information requirements. | O |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | | Record and communicate if the person/ representative and carer, where relevant, have been informed of their expected (predicted) date of discharge and their actual discharge date. It should also be recorded and communicated if the person/ or their representative where relevant, have been informed and consented to the referral to local authority for a social care needs assessment to be conducted. Record what discussions have taken place with the carer and if they have been informed of the local authority referral for a social care needs assessment. | |
| Issued date and time | The date and time on which the Assessment Notice was given. | Date and time | | O |
| Person consultation indicator | Indicates whether or not the patient has been consulted in relation to the Assessment Notice. | Flag:<br>N: No<br>Y: Yes | | O |
| Carer consultation indicator | Indicates whether or not the carer (where applicable) has been consulted in relation | Flag:<br>N: No<br>Y: Yes | | O |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | to the Assessment Notice. | NKC: No Known Carer | | |
| Person consent indicator | Indicates whether or not the patient has consented to the Assessment Notice or lacks the mental capacity to do so. | Code:<br>N: No<br>Y: Yes<br>L: Lacks Mental Capacity | | O |
| Third party person consent source | A coded value specifying the source of consent where the patient lacks mental capacity and consent has been provided by a third party with the appropriate legal status. | Code:<br>C: Legal Representative (Carer)<br>O: Legal Representative (Other)<br>B: Best Interests Decision<br>N/A: Not Applicable | | O |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| **6.33 NHS CHC assessment** | NHS Continuing Healthcare Assessment (checklist) entry. | | This is a statement that the NHS has considered whether or not to provide the person with NHS funded Continuing Health Care (CHC) and the result of that consideration. It is mandatory to send this information to the local authority if it is applicable i.e. a CHC assessment was conducted. Note that from September 1 2020, social care needs assessments and the CHC assessment will recommence. | O |
| Assessment considered indicator | Indicates whether or not the NHS body has considered providing the patient with NHS Continuing Healthcare. | Flag:<br>N: No<br>Y: Yes | | O |
| Assessment considered result | Used to record the result of a consideration to provide the patient with NHS Continuing Care. | Free text. | | O |
| Discharge notice | Confirms discharge date to social services. | | This is a notice that must be sent to the local authority informing them when the patient is being discharged from hospital. | O |
| Issued date and time | The date and time on which the | Date and time | | O |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | discharge notice was given. | | | |
| Withdrawal notice | To withdraw either or both the assessment notice and / or the discharge notice. | | This is a notice the hospital sends to the local authority cancelling an assessment or discharge notice for example if the person's discharge is delayed. | O |
| Issued date and time | The date and time on which the Withdrawal Notice was issued. | Date and time | | O |
| Withdrawal type | The type of notice that has been withdrawn. | 1: Assessment Notice<br>2: Discharge Notice<br>3: Assessment Notice and Discharge Notice | | O |
| Reason for withdrawal | The reason why the notice has been withdrawn. | 01: Patient is safe to discharge without a needs assessment<br>02: Patient is eligible for NHS Continuing Health Care<br>03: Proposed care package is inadequate<br>04: Patient's proposed treatment has been cancelled or postponed | | O |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | 05: Patient has refused a needs assessment<br>06: Patient is resident in another local authority<br>07: Patient's condition has deteriorated<br>08: Patient has died<br>09: Patient has transferred to intermediate care<br>10: Patient has self- discharged<br>11: Patient is making their own arrangements<br>12: Notice sent in error<br>13: Other | | |
| Reason for withdrawal - other | A free format description of why the notice has been withdrawn. To be used when 'Reason for withdrawal' = 'Other'. | Free text. | | O |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| 6.33.1 **Notice receipt** | Notice receipt, from social services, entry. A receipt notice is issued and sent to the referring organisation to acknowledge that a notice has been received e.g. assessment, discharge, withdrawal. | | This is the receipt notice, from the local authority to the hospital acknowledging that they have received the notice pertaining to the person (e.g. assessment, discharge and/ or withdrawal notices). | O |
| Issued date and time | The date and time on which the Notice Receipt was issued. | Date and time | | O |
| Notice type | The type of notice that the Notice Receipt relates to. | 1: Assessment Notice<br>2: Discharge Notice<br>3: Withdrawal Notice (Assessment)<br>4: Withdrawal Notice (Discharge)<br>5: Withdrawal Notice (Assessment and Discharge) | | O |
| Response type | The Notice Receipt response type. | Binary: | | O |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| | | 1: Accept<br>2: Reject | | |
| Response details | Supporting information for the Notice Receipt, for example the reason why a notice was rejected. | Free text. | | O |

**Table 2: Implementation guidance by section, subsection and element**.

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| **6.34 Performing professional** | The professional who performed the activity. | | | R |
| Name | The name of the professional. | Free text. | | R |
| Role | The role the professional has in relation to the person e.g. GP, physiotherapist, community nurse, social worker etc. | NHS data dictionary code or free text if code is not available.<br>CARE PROFESSIONAL TYPE | Key contextual information. | R |
| Grade | The grade of the professional. | Free text. | Key contextual information. | R |
| Speciality | The specialty of the professional e.g. physiotherapy, oncology, mental health etc. | NHS data dictionary code:<br>MAIN SPECIALTY CODE | Key contextual information. | R |
| Professional identifier | Professional identifier for the professional e.g. GMC number, HCPC number etc or the personal identifier used by the local organisation. | Free text. | Key contextual information. | R |
| Organisation | The name of the organisation the professional works for. | NHS data dictionary code or free text.<br>ORGANISATION CODE | Key contextual information. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Contact details | Contact details of the professional (e.g. telephone number, email address etc.). | Free text. | Key contextual information. | R |
| **6.35 Person completing record** | Details of the person completing the record. | | | R |
| Name | The name of the person completing the record. | Free text. | | R |
| Organisational role | The organisational role of the person completing record. | NHS data dictionary code or free text if code is not available.<br>CARE PROFESSIONAL TYPE | Key contextual information. | R |
| Grade | The grade of the person completing the record. | Free text. | Key contextual information. | R |
| Specialty | The main specialty of the person completing the record. | NHS data dictionary code:<br>MAIN SPECIALTY CODE | | R |
| Organisation | The organisation the person completing the record works for. | NHS data dictionary code or free text.<br>ORGANISATION CODE | Key contextual information. | R |
| Professional identifier | Professional identifier for the person completing the record e.g. GMC number, HCPC number etc, or the personal identifier used by the local organisation. | Free text. | Key contextual information. | R |

| Name | Description | Values | Implementation guidance | MRO |
|---|---|---|---|---|
| Date completed | The date and time the record was completed. | Date and time. | Key contextual information. | R |
| Contact details | Contact details of the person completing the record (e.g. telephone number, email address etc.). | Free text. | | R |

**Table 3: Implementation guidance by section, subsection and element for performing professional and person completing record vital contextual sub-section**

## 7 Appendix A – References


- *Community Care (Delayed Discharges etc.) Act 2003 Sections 2, 3 and 5* http://www.legislation.gov.uk/ukpga/2003/5/contents
- *The Care Act 2014 www.legislation.gov.uk/ukpga/2014/23/contents/enacted*
- *The Care and Support (Discharge of hospital patients) Regulations 2014* www.legislation.gov.uk/uksi/2014/2823/pdfs/uksi_20142823_en.pdf
- Care and Support Statutory Guidance issued under Care Act 2014 www.gov.uk/guidance/care-and-support-statutory-guidance
- 'National Framework for NHS CHC and NHS- funded nursing care' to decide eligibility. 2018
- NHS Continuing Healthcare Checklist, December 2018, Department of Health & Social Care
- Transition between inpatient hospital settings and communityor care home settings for adults with social care needs NICE guideline published December 2015. www.nice.org.uk/guidance/ng27
- Factsheet 37, *Hospital discharge, August 2019, AGEUK*
- *Hospital Discharge Service: policy and operating model, August 2020, UK Government*