Professional Record Standards Body

Better records for better care

LOCAL AUTHORITY INFORMATION (FOR SHARED HEALTH AND CARE RECORDS)

IMPLEMENTATION GUIDANCE v 1.0

OCTOBER 2020

Professional Record Standards Body
7 - 145 Great Dover Street, London,
SE1 4YR
www.theprsb.org

Community Interest Company No 8540834

Acknowledgements

NHS Digital

NHS Digital is the trusted national provider of high-quality information, data and IT systems for health and social care. NHS Digital collects, analyses and publishes national data and statistical information as well as delivering national IT systems and services to support the health and care system. The information services and products are used extensively by a range of organisations to support the commissioning and delivery of health and care services, and to provide information and statistics that are used to inform decision-making and choice.

The Professional Record Standards Body

The independent Professional Record Standards Body (PRSB) was registered as a community interest company in May 2013 to oversee the further development and sustainability of professional record standards. Its stated purpose in its Articles of Association is: “to ensure that the requirements of those who provide and receive care can be fully expressed in the structure and content of health and social care records”. Establishment of the PRSB was recommended in a Department of Health Information Directorate working group report in 2012

Document Management

This implementation guidance is the deliverable that provides guidance to support the implementation of the digital social care information standards for people involved in developing, deploying and using systems which exchange information pertaining to health and care. This document provides general guidance as well as guidance for each specific part of the standards.

Revision History

Version	Date	Summary of Changes
1.0	20/10/20	1st version for publication

Reviewers

This document must be reviewed by the following people:

Reviewer name	Title / Responsibility
Professor Adam Gordon	PRSB Clinical Advisor, Clinical Associate Professor of Medicine of Older People – University of Nottingham, Consultant Geriatrician – Derby Teaching Hospitals NHS Trust, Vice President for Academic Affairs – British Geriatric Society
Beverley Latania	PRSB Social Care Advisor for Digital Social Care Information Project, Head of Mental Health Social Work – Islington Council
Katie Thorn	PRSB Social Care Advisor for Digital Social Care Information Project, Digital Engagement Manager – Registered Nursing Home Association, Project Lead – Digital Social Care
Samantha Goncalves	PRSB Citizen Lead for Digital Social Care Information Project
Dr John Robinson	PRSB Clinical Advisor for Digital Social Care Information Project, PRSB Clinical Safety Officer, Retired General Practitioner and Clinical Informatician

Approved by

This document was approved by the following:

Name	Title	Date	Version
Project Board	Project Board	28/9/20	0.5
Assurance Committee	Assurance	28/9/20	0.5

	Committee		

Glossary of Terms

Term / Abbreviation	What it stands for
ADL	Activities of Daily Living
CHI	Community Health Index
CIS	Core Information Standard
CSP	Care and support plan. Used interchangeably with DCSP
DCSP	Digital care and support plan. Used interchangeably with CSP
DHSC	Department of Health and Social Care
DoLS	Deprivation of Liberty Safeguards
EQ-CL	Equalities and Classifications Framework
GP	General Practitioner
IMCA	Independent Mental Capacity Advocate
IT	Information Technology
LA	Local Authority
LGA	Local Government Association
LHCR	Local Health and Care Record
LPA	Lasting Power of Attorney
LPS	Liberty Protection Safeguards
NHS	National Health Service
NHSD	NHS Digital
NI	Northern Ireland

MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Assessment
MHA	Mental Health Act
ODS	Organisation Data Service
PDS	Personal Demographics Service
PRSB	Professional Record Standards Body
RBAC	Role Based Access Control
SALT	Short and Long Term Services
SCDIP	Social Care Digital Innovation Programme
SCP	Social Care Programme

Contents

a

1 Purpose of this document

This section describes:

- the purpose of the implementation guidance
- how it was developed
- how it will be updated in the future
- the intended audience

1.1 Purpose and use of this document

This document provides guidance to support the implementation of the PRSB Local Authority Information (For Shared Health and Care Records) standard.

It provides:

- general guidance
- guidance by section
- guidance by element

This implementation guidance should be used in conjunction with the following described documents. PRSB has carried out a clinical safety case review of the above products in accordance with DCB0129, which is detailed in the updated Core Information Standard Clinical Safety Case (Core Information Standard Clinical Safety Case Report v (update in progress)) and accompanying Hazard Log (Core Information Standard Hazard Log v (update in progress). The hazard log provides guidance for system developers and implementers. Mitigation of the identified hazards (and those arising during the process of implementation) is an absolute requirement of implementation.

1.2 Guidance development

The guidance in this document was developed on the basis of an extensive consultation process as described in the final project report (Digital Social Care Information Final Report v1.0).

1.3 Updating process

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

1.4 Audience – who is this document for?

This guidance is intended for anyone implementing and using the Local Authority Information (For Shared Health and Care Records) standard. This will include health and social care professionals, IT system suppliers, developers, and implementors.

2 Background

This section describes the following about the standard:

- why it was developed
- its position within the social care digital landscape
- its purpose and definition
- how it is intended to be used

2.1 Background to the standard

NHS Digital (NHSD) commissioned the Professional Record Standards Body (PRSB) to support the Social Care Programme (SCP); by development of (new and existing) national information products to support sharing of an individual's care information between health and social care. The Local Authority Information (For Shared Health and Care Records) standard is one of these products.

2.2 The Social Care Programme

The SCP[1] is an NHSD programme, commissioned and sponsored by the Department of Health and Social Care (DHSC), that aims to 'improv[e] digital maturity in the adult social care provider sector' and facilitate IT interoperability with the health sector. As part of SCP the Digital Social Care Pathfinders Programme (DSCPP)[2] has funded 16 local authorities to extend their successfully piloted digital solutions in health and social care to a national scale. From these, PRSB identified five use cases for consultation that were developed into the following national products:

Two new transfer of care standards:

- *Urgent Referral from Care Home to Hospital*
- *Hospital Referral for Assessment for Community Care and Support*

A new standard for local authority data and update of relevant sections of the PRSB Core Information Standard (CIS):

- ***Local Authority Information (For Shared Health and Care Records)***

A view of the PRSB Core Information Standard specifically for care home staff:

- *Care Homes View (Of Shared Health and Care Records)*

An update to the *About Me* section of the following standards:

- Core Information Standard, Urgent Referral from Care Home to Hospital, Care Homes View (Of Shared Health and Care Records), Digital Care and Support Plan (DCSP)

[1] https://digital.nhs.uk/services/social-care-programme
[2] https://digital.nhs.uk/services/social-care-programme/digital-social-care-pathfinders-programme-2019-21

Key implementation drivers include the integrated care agenda[3] that 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.[4] The Social Care Digital Innovation Programme (SCDIP)[5] and more recently the Social Care Digital Innovation Accelerator projects (SCDIA)[6] have further hastened the pace of digital integration of services. In addition, the local authority information (for shared health and care records) standard was informed by the findings of the Local Government Association (LGA) Discovery Project.[7]

2.3 Sharing local authority data

Local authorities have access to data about a person that could be shared with other entities in health and social care to support the individual's direct care needs. A limited number of exemplars exist on a local level only. For example, social care data held by Nottinghamshire County Council, including packages of care, safeguarding concerns and person demographics can be shared in real time with local secondary care organisations.

2.4 Definition and scope of the Local Authority Information (For Shared Health and Care Records) standard

This standard is to define a set of information that is held by local authorities that should be made available to health and care services in a shared care record.

2.4.1 What it is:

- a core set of information that is held by local authorities and relevant for direct care (across a variety of settings)
- both an update of the PRSB Core Information Standard and a standard in its own right for use in shared care records
- a definition of the information held by the local authority that professionals and people who use services have told us they want to see in a shared care record
- a blueprint for individual local authorities to use as a minimum data set and add to if necessary, to meet local requirements

[3] https://digital.nhs.uk/about-nhs-digital/our-work/transforming-health-and-care-through-technology/integrated-care-domain-d
[4] https://www.england.nhs.uk/publication/local-health-and-care-record-exemplars/
[5] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/informatics/local-investment-programme
[6] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/informatics/local-investment-programme/accelerator
[7] https://www.local.gov.uk/local-government-social-care-data-standards-and-interoperability

- a set of information that is held by local authorities that could potentially be shared with professionals depending on their role and circumstances

- a thoroughly researched and validated definition of the core local authority information for shared health and care records that has been tested with citizens, patients, carers, and health and social care professionals

- to reduce the need for persons receiving care to repeat information to a health or care professional that is already held in local authority records

2.4.2 What it is not:

- all information about a person that could be found in a shared care record
- an exhaustive definition of all the items recorded by local authorities in the UK relating to health and social care
- an information set containing data not held by local authorities
- a logical or physical data model. A logical data model will be developed by NHS Digital. FHIR profiles to support interoperability of the data between systems will be commissioned by NHS England.
- a definition of what information professionals should be able to see or change. A Role-Based Access Control (RBAC) proposal was out of scope for this project.

2.4.3 Example use cases:

- An **Emergency department** may be able to avoid an unnecessary hospital admission if they can identify that the patient has a care package and liaise with the provider.
- A **community health worker** may be able to see that social care has recently undertaken an occupational therapy assessment, and therefore avoid duplication of activity by discussing the outcome with the appropriate social care team.
- An **hospital discharge team** could use the social care context to help identify the appropriate discharge needs of an individual.

3 General guidance

The local Authority Information (For Shared Health and Care Records) is both a standard its own right and an update of the PRSB Core Information Standard. You can find the original implementation guidance in the PRSB Core Information Standard.

3.1 Structure of the PRSB standards 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'. It is the highest level to logically group data elements that may be independent or related. For example: - 'Legal information', includes a set of independent elements or information items, grouped in a logical section. - '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. An element can appear in one or more sections e.g. name, date.
Information model rules and instructions	**Explanations**

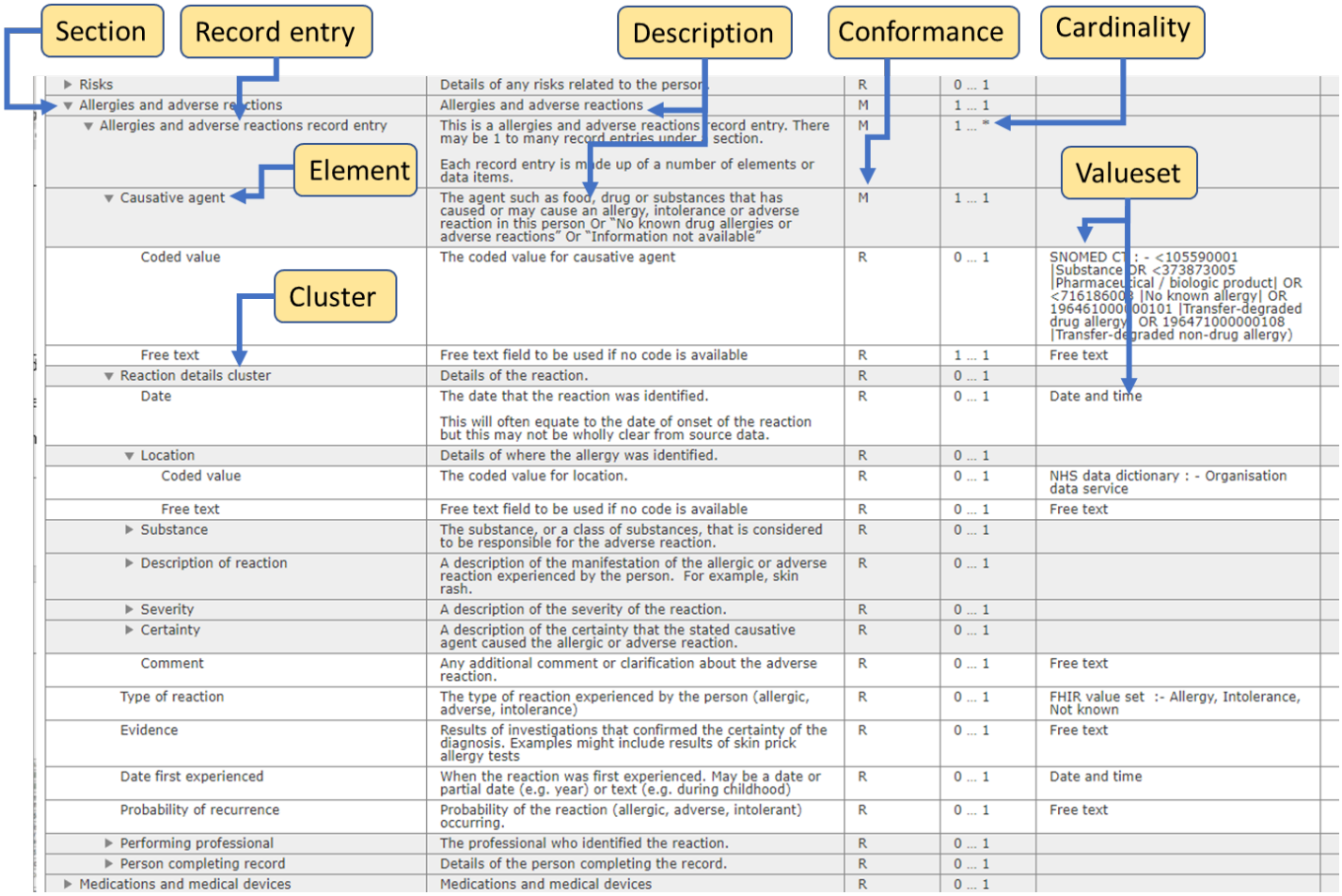
Description	This is the description of the section, record entry, cluster or element. For an element it describes the information that the element should contain in as plain English as possible.
Cardinality	Each section, record entry, cluster and element will have a statement of cardinality. This clarifies how many entries can be made i.e. zero, one or many entries. The number of records expected and allowed are displayed as: 0……* = zero to many record entries are allowed 0……1 = zero to one record entry is allowed 1……1 = one record is expected 1……* = one to many records are expected 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. 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. The following set of rules apply to enable implementers to cater for the end users (senders and receivers) requirements: • Mandatory – the information must be included • Required – if it exists, the information must be included • Optional – a local decision is made as to whether the information is included 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. 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. Assessment Section – Required – i.e. its important information you must include if you have it. 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. **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). 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 PRSB Core Information 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 a section. 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 <373873005 |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. 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	

3.2 How we expect the Local Authority Information (For Shared Health and Care Records) standard to be used

What is defined is a set of information which should be common to most local authority systems and would aim to approximate an amalgamation of records drawn from different councils nationwide; covering as many of their needs as possible. The expectation is that this information would be read only, at least initially. It sets out a minimum set of information that should be shared between local authorities and organisations in various geographies and could be used to populated shared care records. Local implementations will need to define different 'views' in their shared care record of the information for different professionals (and other users, including people who use services) and local use cases based on the information governance framework which will be published by NHS England in due course. These views should define what information is needed by a professional (or person) in particular circumstances. How the information is presented to professionals and citizens in a shared care record will be dependent on the local systems in place, but it should be presented in such a way as to provide maximum benefit for different users (in different roles) in each given use case. We expect individual local authorities to use

the standard as a blueprint for their records – adding to it from the PRSB Core Information Standard and other validated sources as required.

3.3 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 which needs to be considered alongside this standard when planning implementation.

3.4 Context of the information

Key to the proper reading and comprehension of shared information is some understanding of the *context* in which the data were originally recorded. It is vital for clinical use of the data that all contextual information must be maintained and should not be lost on exchange or import of information. So, for example, where an assessment was made by a local authority it should be possible for the end user to ascertain where, when, by whom, and for what purpose etc and assessment was conducted.

This standard does not define all possible linkages between different components of information. This will be defined in the logical data model, FHIR profiles and in the local shared care records.

However, following consultation and safety case review we arrived at the following key contextual data which need to be shared:

- '**Performing Professional**' which has various attributes, name, role, specialty, organisation of the professional that, for example, performed the assessment. It might be that the actual professional is not known however the organisation and specialty are known and should therefore be included as contextual information.
- '**Person completing record**' - which is the person that actually recorded the information and again has various attributes name, role, speciality and organisation and the date that the record was completed.
- '**Location'** - the place in which the activity took place e.g. an assessment was performed.
- '**Date'** - the date on which the activity took place e.g. then date the activity was performed. In some cases, this would be start and end dates e.g. of safeguarding concerns.

Note that although both 'Performing professional' and 'Person completing record' contain the element 'Speciality' it is recognised that this only applies to some professionals so only needs to be included where relevant.

The principle applied in the information model is that where it is important (from a professional perspective) to know who undertook the activity and who recorded the

activity, ‘Performing professional’ and ‘Person completing record’ will be included in the model. For every item of information shared it is important that an audit trail is recorded (even if not explicitly stated in the information model). This is set out below.

3.5 Time stamp and audit trail

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 which may be viewable by the end user to enhance transparency.

3.6 Data Quality

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

3.7 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 a particular activity. Role is the term used in the NHS data dictionary. We have used the term ‘organisational role’ to mean the role the professional has in the organisation they work for.

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.

3.8 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 ambition is for SNOMED CT and dm+d to be the only clinical coding schemes in use in the NHS by 2020.

3.9 Accessibility

Attention must be paid in the design of user interface for viewing the core information complying 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.

3.10 PRSB Support

The PRSB support service is available for any help, enquiries or issues with the 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

4 Guidance for specific sections and subsections

Specific instructions relating to the individual sections, subsections and data elements, where relevant, are outlined under this section.