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CONSULTING

Use of the Core Information Standard in community settings: pharmacy, dentistry, optometry, ambulance and community services

Document Management

Revision History

Version	Date	Summary of Changes
0.1	26 June 2022	Drafting initial report (Mark O'Connor) prior to distribution to professional leads
0.2	04 July 2022	Final draft issued for PRSB approval
0.3	19 July 2022	Revised Final draft issued for PRSB approval pre release
0.4	22 July 2022	Revised Final draft issued for PODAC review group
0.5	25 July 2022	Revised Final draft issued for NHS England / NHS Digital approval and issued for PRSB Assurance review
0.6	5 August 2022	Revised Final draft post NHS England / NHS Digital milestone and PRSB Assurance feedback
1.0	9 August 2022	Issued following PRSB Assurance approval

Reviewers

Reviewer name	Title / Responsibility	Date	Version
Project Team	Project Team	25 July 2022	0.4

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Martin Tennant	Channel 3 Sponsor	09 August 2022	1.0
PRSB Assurance Committee	PRSB Internal Assurance	09 August 2022	1.0
Project Board	Chaired by NHS England	Issued for final acceptance	1.0

Glossary of Terms

Term / Abbreviation	What it stands for
AEG	Architectural Editorial Group
API	Application Programming Interface
CIS / PRSB CIS	The PRSB Core Information Standard
IDD	NHS Interoperability Data Design Collaborative
MIG	Medical Interoperability Gateway ¹
PODAC	Pharmacy, Optometry, Dental, Ambulance, Community
PRSB	Professional Record Standards Body
RBAC	Role Based Access Control

¹ <https://healthcaregateway.co.uk/>

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1 Executive Summary

The problem PRSB is trying to address

PRSB was commissioned by the NHS to define information standards for each of the five care settings, Pharmacy, Optometry, Dentistry, Ambulance and Community services (collectively referred to as PODAC), with the objective of improving care to individuals through better access to shared care records.

PRSB engaged Channel 3 Consulting to support the process, working with an identified group of leading health care professionals and patient representatives a “*PODAC Standards for Shared Care Records*” project was established to define the information standard for each care setting that answers the question “*As a care professional, in this care setting, what do I need to see from a shared care record?*”

The original objectives of this project were therefore to:

- Review the applicability of the existing PRSB Core Information Standard (CIS) for each care setting of PODAC
- Develop new standards where the PRSB CIS was not the appropriate standard
- Correlate the standards with the contents of the GP record to quantify immediate opportunities for implementation of the standards based solely on the GP record

NHS Digital has been involved throughout the project. It is responsible for the design, development and operation of the national IT and data services that support clinicians at work and help patients to get the best care, as well as using data to improve health and care.

Value this will add to patients and care professionals

If a core information standard can be identified this will improve clinical, organisational, and personal effectiveness across the NHS in line with national programmes and initiatives being developed and delivered incorporated within the national strategy, and most recently incorporated within the “2022/23 priorities and operational planning guidance”, released on 24th December 2021. The priorities include “accelerating partnership working through integrated care systems to make the most effective use of the resources available”.

Access to a shared health record will make a significant difference to NHS care standards, saving patients' lives, reducing operational costs, and increasing the effectiveness of leadership. These benefits can be quickly and easily attained and should be prioritised for urgent deployment.

Summary of project activities

A delivery group consisting of PRSB stakeholders, nominated PODAC leads and service user representatives, supported by Channel 3 Consulting experts and analysts undertook a survey of end user needs, followed by online multidisciplinary workshops which challenged the use of the PRSB CIS in each of the five care settings.

In addition to the service focussed workshops an additional safeguarding and children's safety session was held, involving delivery group members and an NHS Safeguarding lead, which helped establish what actions each service may need to consider going forward to ensure the best possible signposting of issues and concerns across the health community.

All members agreed that safeguarding for both children and adults is the most important and fundamental consideration in any decision making for all care settings. It was also noted that

implementation projects (pilots or otherwise) must include review of processes, training and governance to maintain and ensure the safe, effective and authorised use of shared data.

A public survey, conducted before a full examination of the CIS had been done with each service, indicated a significant level of support for its use. The formal workshops, which were attended by a large number of PODAC related clinicians, managers and user representatives, addressed some of the perceived knowledge gaps and tested how benefits might be attained.

This was done through open dialogue, supported by the PODAC leads, where issues and challenges were discussed and addressed. At the end of the process, it was confirmed that *“the Core Information Standard with relevant Role Based Access Control (RBAC) and filtering is the appropriate standard for all five PODAC care settings”*.

During the review process it was noted that the correlation of the PRSB CIS with a generic GP record has demonstrated there is merit in considering initial implementation options based on the GP record alone as opposed to a shared care record. Much of the Core Information Standard is theoretically already available in current, and widely shared, GP systems which, across England, uses a single access method. Accessing such information may accelerate the adoption of data sharing across the different care settings. There is existing national infrastructure for accessing GP records in a consistent manner which could be explored through implementation pilots outside the scope of this project, which has focussed on whether the Core Information Standard could be adopted for PODAC, not on how this might be achieved.

There was also regular reference to the proportion of non-NHS patient care delivered across the spectrum of PODAC care settings which, whilst outside the scope of this project, will need to be addressed by each professional service with its relevant commissioner as the benefits of shared care record access are accrued over time.

The use of a national common core information standard across all services will complement the introduction and expansion of local ICS shared care record developments, building upon the early Local Health Care Record initiatives of 2019 onward, some of which have been delayed due to Covid restrictions in the intervening period. Those developments are outside the scope of this project. Where any ICS has a mature shared healthcare record solution in place it would be a local responsibility to ensure that ongoing development and expansion reflected the introduction of national PODAC standards going forward.

As a result of the workshop discussions no additional data items were identified or requested for any PODAC care setting. It was therefore clear that no changes to the existing PRSB CIS Version 2.0 would be required to enable pilot implementations to begin.

Recommendations

The key recommendations from the project to date are as follows:

Recommendation: Transparency is essential to maintain the trust of people about whom data is being shared which will require each care setting having clear communications with their service users about the benefits in terms of care and service user safety that wider, but appropriate, access to the record can bring.

Recommendation: Implementation pilots must explore the ethical, liability, safeguarding and contractual (for example the dentistry contract) challenges of making a wider dataset available at point of care

Recommendation: Information Governance guidance is required, ideally at a national level, for how non-NHS organisations can establish valid, ethical and transparent sharing of data (access to shared care records)

Recommendation: To align and incorporate existing innovative processes such as electronic prescribing into dentistry to maximise opportunities for an efficient and effective shared care record

Recommendation: Upon implementation, access to historic as well as current data will need to be considered. GP and Shared Care Record access may give different insights to history especially for long term conditions where things change over time.

Recommendation: When considering implementation in an IT system it is unlikely to be helpful to have a single screen with all the data over all time displayed – the usability of the data needs to be considered (and explored through pilots).

Recommendation: It was recognised that the [Gillick competency and Fraser guidelines](#) should be adopted for children under the age of 16 with the NHS.

Recommendation: Explicit alignment should be maintained between PRSB CIS and the International Patient Summary (IPS) standard.

Recommendation: Clear and expanded explanations of terms should be a pre-requisite going forward.

Recommendation: Each section of the PRSB CIS should be checked to ensure broad applicability across all care settings for example “equipment” to be any equipment from any provider not just a specific care setting.

Recommendation: The sections of the PRSB CIS should be reordered to a meaningful order. Tight correlation between the sections of the implementation guide, the information model, and the actual model of the standard in the modelling tool should continue to be ensured.

Conclusions

The key finding of the project to date is that *“the Core Information Standard with relevant Role Based Access Control (RBAC) and filtering is the appropriate standard for all five PODAC care settings”*.

With that established, extensive consultation, evidence gathering and comparative research identified a wide range of recommendations and concluded that no additional data items were identified or requested for any PODAC care setting. It was therefore clear that no changes to the existing PRSB CIS Version 2.0 would be required to enable pilot implementations to begin.

Whilst there are significant challenges to overcome and debates to be had to implement the PRSB CIS across the diverse PODAC care settings, there is overwhelming support from those who participated in the delivery groups and workshops for its introduction, with widespread agreement that doing so is important for the benefit of both care professionals and those accessing care. For individuals, this may be particularly relevant to the themes in the *Data Saves Lives* strategy (Department of Health and Social Care, 15th June 2022), which was published during the workshop planning and implementation stage.

It was noted that implementation projects (pilots or otherwise) must include review of processes, training and governance to maintain and ensure safe, effective and authorised use of shared data. Further work to document the lessons and benefits from existing integrations (such as community pharmacy and ambulance services) should be carried out and shared to support implementation in the other PODAC settings, optometry and dentistry in particular.

2 Introduction

The aim of this “PODAC Standards for Shared Care Records” project was to define the information standard for each care setting that answers the question *“as a health care professional, in this care setting, what data do I need to see from a shared care record to ensure that the service being provided is high quality, safe, appropriate and where applicable delivers complementary continuity of care for any individual”*.

The heart of the project was the objective of improving care to individuals through better access to shared care records in each of the five-care settings Pharmacy, Optometry, Dentistry, Ambulance and Community services (collectively referred to as PODAC).

The objectives of this project were to:

- Review the applicability of the existing PRSB Core Information Standard (CIS) for each care setting of PODAC
- Develop new standards where the PRSB CIS was not the appropriate standard
- Correlate the standards with the contents of the GP record to quantify immediate opportunities for implementation of the standards based solely on the GP record

If a core set of information can be identified and standardised this will improve clinical, organisational and personal effectiveness across the NHS in line with national programmes and initiatives being developed and delivered incorporated within the national strategy, and most recently incorporated within the “2022/23 priorities and operational planning guidance”, released on 24th December 2021. The priorities include “accelerating partnership working through integrated care systems to make the most effective use of the resources available”.

Access to a shared health record will make a significant difference to NHS care standards, saving patients' lives, reducing operational costs and increasing the effectiveness of leadership. These benefits can be quickly and easily attained and should be prioritised for urgent deployment.

2.1 Background to the project

NHS Digital is responsible for the design, development and operation of the national IT and data services that support clinicians at work and help patients get the best care and use data to improve health and care.

The PRSB was commissioned by NHS Digital to define information standards for each of the five care settings, Pharmacy, Optometry, Dentistry, Ambulance and Community services (collectively referred to as PODAC), with the objective of improving care to individuals through better access to shared care records.

A preceding project had provided evidence that the PRSB CIS could be applied across the PODAC services. This project was required to provide evidence of demonstrable engagement with stakeholders for the development of standards.

PRSB engaged Channel 3 Consulting to support the process, working with an identified group of leading PODAC health care professionals and patient representatives as well as engaging with a wider range of professionals and individuals through both a survey and open workshops

Future projects will look at implementation of the standards in the individual PODAC care settings. This project was focussed on what data would be beneficial in each care setting, from a shared care record, and not on how access would be achieved.

The core project delivery team included professional leads with expertise or experience of each of the five PODAC care settings and two people with lived experience representing those who access services. PRSB representatives attended all group meetings and workshops, providing detailed input and clarification in respect of the standards being considered. Channel 3 Consulting provided subject matter experts, facilitators, administrative support and advice.

PRSB has already published their Core Information Standard (PRSB CIS) to define what data should be in the shared care record. It is currently at version 2.0, published August 2021

The 'exam question' for the Project delivery group was to consider if the PRSB CIS 2.0 met the needs of each PODAC care setting or if a new standard specific to that care setting would be required (which this project would then develop).

The PRSB CIS consists of 38 sections containing details such as personal health care history. A table showing all sections of the PRSB CIS is shown in Appendix C: The PRSB CIS on page 58.

2.1.1 Objectives and milestones of the project

The original objectives of this project are detailed above.

The original project scope was to undertake the research and development of up to five potential information standards for PODAC or to demonstrate the applicability of the PRSB CIS in each care setting when viewing a shared care record. This represents Milestone 3 of the overall PRSB PODAC project.

Milestone 1 was the approval of the Project Initiation Document and the generation of an outline communications plan. Milestone 2 was the initial determination that the PRSB CIS was the correct standard to use in each care setting. This report evidences the steps taken with each PODAC setting including analysis and validation from the survey and all workshops.

Formal PRSB assurance of this report will achieve Milestone 4, ahead of the final stage of the project, Milestone 5. which will be the sharing of the PRBS CIS with all CIS endorsers.

See Figure 9: Project Milestones on page 33 for details of all milestones.

2.1.2 Guiding principle

Throughout the project, the guiding principle of "*the right data, in the right place at the right time*" was established. This project was focussed on what information would best serve qualified care professionals in providing the best service to individuals to improve the quality and safety of care. There was, however, a clear recognition that 'the right data' did not mean all data, always, for any user. The "what data" question will be the balance between the duty of care (best care/best practice) and the duty of confidentiality (respecting privacy), which will be established in any future projects governing the deployment of the standard in each care setting. In Information Governance terminology "what data" is referred to as "proportional access."

A critical success factor of communicating any errors and changes noted on an accessed record in a timely fashion and having them quickly executed was identified during the

workshops and will again be an aspect for ongoing projects in respect of enhanced data sharing.

2.1.3 Approach to delivery of the original objectives

This project followed the PRSB standards and development methodologies.

This report represents the attainment of Milestone 3 from the originally approved plan, as amended at the Project Board on 6th April 2022, which signed off Milestone 2 see Figure 9: Project Milestones on page 33. This confirmed the following objectives:

- To establish clear guidance and a related safety case for the use of the PRSB Core Information Standard to accelerate the use and sharing of NHS data in all care settings of PODAC
- Through continued consultation with professional representatives, identify opportunities to enhance the Core information Standard and supporting materials to promote the NHS interoperability agenda across the wider health and social care economy through shared care records
- Correlate the standards with the contents of the GP record to quantify opportunities for implementation of the standards based solely on the GP record
- The project will also identify opportunities to explore the inclusion of further data items in the core information standard if identified as being required for one or more care settings

A project team, supported by Channel 3 Consulting experts and analysts undertook a survey of end user needs, followed by online multidisciplinary workshops which challenged the use of the PRSB CIS in each of the five care settings.

Engagement events were held through open workshops (advertised on Eventbrite and promoted by stakeholders and related PRSB networks) and a public survey was undertaken to discuss the suitability and use of the standards for the improvement of care and safety of individuals accessing those services,

Following the service specific workshops, a session focussed on children's care and safeguarding was held with an NHS subject matter expert. This session concluded that whilst there was agreement with the use of the CIS in sharing records there was specific emphasis on the impact of safeguarding (for both children and adults) and Information governance implications across the PODAC environment that would require tailored training so that the standard could be deployed effectively to best protect the well-being of at-risk individuals.

All members agreed that safeguarding of children and adults is the most important and fundamental consideration in any decision making for all care settings. It was also noted that implementation projects (pilots or otherwise) must include review of processes, training and governance to maintain and ensure the safe, effective and authorised use of shared data.

The following details those who participated in the process of validating the PRSB CIS by assessing (and where appropriate challenging) data sharing aspirations, consulting with:

- Care Professionals (staff) from relevant care services
- Suppliers (of IT systems)
- People who benefit from health and social care, for example those with lived experience (people who access care, their carers and their families)

-
- Stakeholder groups including:
 - the NHS Architecture Editorial Group (AEG) which brings together stakeholders in shared care records and interoperability
 - the NHS Interoperability Data Design Collaborative (IDD) which is wider than the AEG in scope and looks at all aspects of data and interoperability
 - Company Chemists Association (CCA) representing community pharmacist multiples (that is, those with multiple pharmacies rather than independent pharmacies)
 - PODAC Delivery Groups (chaired by NHS England)
 - NHS England Safeguarding & Child Safety

(Greater detail can be found in Section 7.2 Consultation approach.)

Details of those who contributed to the consultation events can be found in Appendix B: Stakeholders.

The survey, conducted before a full examination of the CIS had been done with each service, indicated a significant level of support for its use. The formal workshops, which were attended by a large number of PODAC related clinicians, managers and user representatives, addressed some of the perceived knowledge gaps and tested how benefits might be attained.

This was done through open dialogue, supported by the PODAC leads, where issues and challenges were discussed and addressed. At the end of the process, it was confirmed that *“the Core Information Standard with relevant Role Based Access Control (RBAC) and filtering is the appropriate standard for all five PODAC care settings”*.

It was further determined that no new data items were identified at this time as being outside the existing CIS. As there were no proposed changes to the CIS it was felt that no benefit would be gained in further reviewing the agreed safety case prior to service specific implementation, where such review would be a key factor in the roll-out programmes.

The details of the key findings and recommendations are detailed in Section 3 below.

2.1.4 Future stages of the project

This report is produced at Milestone 3 of the project.

The next stages of the project are:

- Project Milestone 4: PRSB assurance prior to circulation to PRSB stakeholders who participated in the PODAC assessment especially those who formally endorsed the standard.
- Project Milestone 5: Share the use of the PRSB CIS with the PRSB member organisations especially those who endorsed the PRSB CIS (through the PRSB endorsement process). Note that as there is no change to the PRSB CIS there is no requirement for new endorsement.

See Figure 9: Project Milestones on page 33 for details of all milestones.

2.2 Critical success factors for the project

The critical success factors for this project have been updated over the course of the project. At Milestone 2 it was determined by the Project Board that, subject to further evaluation, the PRSB Core Information Standard was believed to be the applicable standard for each PODAC care setting. Therefore the critical success factors of the project are now:

1. State the applicability of the PRSB Core Information Standard for each of the PODAC care settings, specifically identifying any sections of the standard which have been identified as not relevant to that care setting.
2. Ensure that the PRSB members and the organisations that endorsed the PRSB Core Information Standard at version 2.0 are aware of the outcomes of this project.
3. Publication of the outcomes of the project on the PRSB Web site alongside the PRSB Core Information standard.

2.3 User Protocols and deployment

Standardising on the PRSB CIS Version 2.0 for shared care record access will better enable PODAC IT system suppliers to understand what data their system should be making available, and for them to implement a Role Based Access Control (RBAC) approach in line with their system architecture. RBAC is a way of ensuring that users (people registered to access the data system) are suitably authorised to access appropriate parts of the shared care record system. Illustrative RBAC use cases include:

- A Dental receptionist may be limited to demographic data about people accessing care, though this may extend to an awareness of currently prescribed medications
- A frontline Ambulance paramedic may access the full detail of a patient's history including care packages, known allergies, currently prescribed medications, hospital admissions
- An assistant optician may have a part time role as an Ambulance Community First Responder – their level of access will be specific to the role that they are performing and not to their personal situation
- Within each PODAC discipline Information Governance experts working with professional leads, will need to determine the correct parts of a record that each user (of relevant IT systems should have access to. In Information Governance terms how much data a user should see is referred to as “proportional access.”
- Transformation leads will use the standard as part of communications (what can be done) and transformation plans (planning when things can be done).

The standards arising from this project form part of, and are required by, the enterprise architecture in each care setting. There will be a requirement for each individual PODAC service to engage with their Information Governance leads to ensure that RBAC standards are appropriate for each discipline and level of engagement within the service. Future developments and deployment will require the full co-operation and engagement of organisation transformation and ICT leads who will be involved in planning rollouts and ensuring the system architectural issues reflect the wider access to a shared care record, and the use of such data within the organisation. Each organisation will also be responsible for the ongoing communication of developments with those who are accessing their services to promote the benefits for better and safer care, and for any associated training needs around use of a shared care record platform.

3 Key findings and recommendations

Following the workshop sessions and related discussion it was agreed across all PODAC settings “...that the Core Information Standard with relevant Role Based Access Control (RBAC) and filtering is the appropriate standard for all five PODAC care settings.” Details specific to each service are presented in sections 3.2.1 - 3.2.5

During the review process it was noted that the correlation of the PRSB CIS with a generic GP record has demonstrated there is merit in considering initial implementation options based on the GP record alone as opposed to a shared care record. Much of the Core Information Standard is theoretically already available in current, and widely shared, GP systems which, across England, uses a single access method ([GP Connect](#)). Accessing such information may accelerate the adoption of data sharing across the different care settings. There is existing national infrastructure for accessing GP records in a consistent manner which could be explored through implementation pilots outside the scope of this project, which has focussed on whether the Core Information Standard could be adopted for PODAC, not on how this might be achieved.

To meet the PRSB CIS standard fully requires use of shared care records, the associated challenge is that there are multiple shared care records. The GP record does not meet (and is not supposed to meet) the PRSB CIS standard, however, a first step of implementation could be to begin with the GP record.

No immediate change to the PRSB CIS version 2.0 is required to begin pilot implementation.

Adopting the PRSB CIS across PODAC offers great opportunities to address some of the significant challenges that previous integration/sharing projects have faced within the NHS. The overwhelming support and agreement of the professional representatives involved in the project reflects their understanding that doing so is important for the benefit and safety of both care professionals and those accessing care.

3.1 Key findings

The project has previously found that:

- i. The PRSB CIS with relevant Role Based Access Control (RBAC) and filtering is the appropriate standard for all five PODAC care settings²
 - a. The initial literature review did not find any early indications that there were competing standards to be considered as an alternative to PRSB CIS.
 - b. The initial literature review showed that PRSB CIS has been embraced by the shared care records, as was its purpose, therefore confirming it as an appropriate starting point for consideration.
 - c. What the initial literature review did not evidence was how much of the PRSB CIS would be appropriate for each PODAC care setting which became the focus of Milestone 2.
- ii. There is a viable option to begin implementation using the GP record and that, subject to implementation and piloting outside the scope of this project, this could leverage national infrastructure as opposed to the various current shared care records

During the present phase the following has been found, that:

² <https://theprsb.org/core-information-standard-v2-0/>

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- iii. There is overwhelming support and agreement that implementing PSRB CIS 2.0 across all PODAC settings is important for the benefit of both care professionals and those accessing care.
 - a. Challenges such as change to professional practice to use the shared care record, checking use of shared care record is covered by the contracts that cover those services, challenges of information governance and challenges of professional indemnity should be explored through implementation pilots.
 - b. The PSRB CIS defines the data that should be made available to the end user (the person using the IT system). Pilot projects should look at how the information is best displayed and navigated within IT systems to make the newly available data (as defined by the standard) useable and useful to the end user. Each care setting will need a different display of data and different ways of navigating that data.
 - c. Pilot projects should ensure that all aspects of safeguarding are reviewed in respect of access to the enhanced care record, and that training should be provided at all levels to ensure that best practice is maintained to ensure that patient safety is not compromised
 - iv. No immediate change to the PSRB CIS version 2.0 is required to begin pilot implementation
 - v. When PSRB CIS goes through its next planned maintenance release there are improvements to the presentation of the standard which could aid interpretation of the standard. The delivery team would highlight:
 - a. Expanded explanation of terms especially for readers who are unfamiliar with why a specific phrase or word has been used. For example, where a term, such as a section, is used to maintain (essential) alignment with the International Patient Summary (IPS) standard that reference should be explicit and an explanation for all care settings be added (such as explaining a term from Mental Health for non-Mental Health practitioners).
 - b. Ensure that each section of the PSRB CIS is checked to ensure broad applicability across all care settings for example “equipment” to be any equipment from any provider not just a specific care setting.
 - c. Rearrange the sections of the PSRB CIS to a more meaningful order. It is noted and appreciated that the ordering of the sections in the standard is driven by the current version of the modelling tool used and future versions will allow the sections of the standard to be re-ordered
 - d. Ensure that the tight correlation between the sections of the implementation guide, the information model, and the actual model of the standard in the modelling tool continues.
 - e. It is noted that the PSRB are developing new presentation formats and the PSRB refresh cycle will embrace those enhancements.
 - vi. Pharmacy has already established the use of NHS Services such as electronic prescriptions, summary care record and the associated assurance of connecting to national NHS services. Therefore, there is the opportunity for care settings that have not begun that journey (Optometry and Dentistry) to learn from the experiences of Pharmacy.
 - vii. Ambulance Trusts have always had the challenge of integrating with multiple IT systems covering the population that they serve; therefore, they will have valuable lessons to share for any care setting considering accessing multiple shared care records.

3.2 Detailed findings by care setting

The following sections outline the findings for each care setting. Further information and comments provided by healthcare professionals and patient representatives in response to the workshop sessions and survey are found in Appendix A: Detailed findings.

3.2.1 Pharmacy

"I think... I agree with the previous point about assessments and findings it is important prior to arrival into the community pharmacy that we know what's happened in that current episode of care, because that might have some influence. ... social care contacts are important. ... that's certainly the driver in Scotland ...one last point to make is that the direction of travel is to have every pharmacist being an independent prescriber. (so) we really need to reflect on the information that they will need." - Pharmacist

Due to the nature and complexity of pharmacists' involvement in care and treatment, it was determined that there would be no limits to the access that a fully qualified pharmacist could appropriately justify in determining the correct course of action for any patient they can individually identify.

Pharmacy has a broad range of services provided by specific levels of staff. The information needs of those staff groups varies. For instance, a pharmacy assistant may need nothing more than an address, GP and advisory information on immediate care needs or issues, whereas a pharmacist being asked to assess a wound or to provide a quality consultation as part of the Discharge Medicines Service will benefit from having full access to discharge notes, medical history, prescriptions, and allergies.

The purpose of the PRSB CIS assessment was not to map the information needs to specific pharmacy roles, but to determine whether access to the various elements of a shared care record could be justified to improve the care that is provided to individuals accessing care.

Through workshops and consultation exercises (see Appendix A), it was determined that access to a shared care record will allow for better decision making, better signposting and better all-round care provision, reducing service user and carer stress, improving organisational efficiency, and improving overall NHS service provision for every service user. Safety is a key factor to all the PODAC settings.

The appropriate access for Pharmacy is outlined in Figure 1 below

"The message here I suppose is this is the core information standards and there are to be discussions ongoing and in the implementation guidance with regard to the filtering." - Pharmacist/PRSB PODAC pharmacy lead

Pharmacy service appropriate access to the Shared Care Record

PRSB CIS sections:









































Personal demographics 	GP practice 	About me 	Individual requirements 	Alerts 	Legal information 
Safeguarding 	Professional contacts 	Personal contacts 	Participation in research 	Referral details 	Contacts with professionals 
Admission details 	Discharge details 	Future appointments 	Vaccinations 	Problem list 	Procedures and therapies 
Social context 	Services and care 	Primary support reason 	Family history 	Investigation results 	Investigations requested 
Examination findings 	Pregnancy status 	Assessments 	Formulation 	Risks 	Allergies and adverse reactions 
Medications and medical devices 	Equipment and adaptations 	Plan and requested actions 	Care and support plan 	Contingency / safety plans 	Additional support plans 
End of life care 	Documents (including correspondence, audio and images) 	Key:  Data always available to the care professional  Data not required for this PODAC care setting			

Figure 1: Pharmacy use of PRSB CIS

3.2.2 Optometry

“I worked on this project a few years ago. I have access to a bespoke view of our entire Northern Ireland electronic care record, ... we have a substantial number of our primary care workforce now accessing it on a regular basis, not just to look up relevant history and medication, but certainly, as regards all their ophthalmic information that's available in there.”
– Optometrist

Due to the nature and complexity of optometrists' involvement in care and treatment, it was determined that there would be broad access that a fully qualified optometrist could appropriately justify in determining the correct course of action for any patient they can individually identify.











































Optometry has a range of services provided by specific levels of staff. The information needs of those staff groups varies. For instance, a receptionist would only require nothing more than an address, GP and supporting information on a patient's immediate care needs or issues upon visit. An optometrist will benefit from having wider access to discharge notes, medical history, prescriptions, and allergies, if being asked to assess an individual recently discharged from hospital.

The purpose of the PRSB CIS assessment was not to map the information needs to specific optometry roles, but to determine whether access to the various elements of a shared care record could be justified to improve the care that is provided to service users.

Through workshops and consultation exercises (see Appendix A), it was determined that access to a shared care record will allow for better decision making, better signposting and better all-round care provision, reducing service user's stress, improving organisational efficiency, and improving overall NHS service provision for every service user. Safety is a key factor to every PODAC setting

The appropriate access for Optometry is outlined in Figure 2 below

The consensus reached through this project was that Optometry (as a care setting) does not have a reason to access “Admission Details” or “Assessments” from a shared care record therefore these would be excluded by the Optometry IT system and not retrieved from the shared care record. The debates considered that “End of Life care” could also be shown in “Individual Requirements” and the best use of information considered during implementation pilots.

Optometry service appropriate access to Shared Care Record					
 					
PRSB CIS sections:					
Personal demographics 	GP practice 	About me 	Individual requirements 	Alerts 	Legal information 
Safeguarding 	Professional contacts 	Personal contacts 	Participation in research 	Referral details 	Contacts with professionals 
Admission details 	Discharge details 	Future appointments 	Vaccinations 	Problem list 	Procedures and therapies 
Social context 	Services and care 	Primary support reason 	Family history 	Investigation results 	Investigations requested 
Examination findings 	Pregnancy status 	Assessments 	Formulation 	Risks 	Allergies and adverse reactions 
Medications and medical devices 	Equipment and adaptations 	Plan and requested actions 	Care and support plan 	Contingency / safety plans 	Additional support plans 
End of life care 	Documents (including correspondence, audio and images) 	Key:  Data always available to the care professional  Data not required for this PODAC care setting			

We anticipate that access to the full PRSB CIS will be a technical capability for all services during their implementation development programmes, consequently these decisions can be reviewed and modified as clinically applicable going forward.

Figure 2: Optometry use of PRSB CIS

“My grandma has macular degeneration, and she cares for my granddad, who has dementia, (which) my grandma's (also) getting. She must go to get her eye injections, but she's house bound. She doesn't know what day it is. ...unless I go to the optometrist with (her) she struggles to make the appointment or would not provide the correct recent medical history and is at risk of being discharged from the service. Would it provide the optometrist more information in regard to how to support her?”

- Patient Representative

3.2.3 Dentistry

“I'm aware at the moment the summary care record is predominantly the medical information but would also be useful would be that dental information as well. ... I think there's a case there for dental practise”

– Clinical Lead, OCDO

Due to the nature and complexity of dentists' involvement in care and treatment, it was determined that there would be broad access that a fully qualified dentist could appropriately justify in determining the correct course of action for any patient they can individually identify











































Dentistry has a range of services provided by specific levels of staff. The information needs of those staff groups varies. For instance, a dental receptionist may need nothing more than an address, GP and advisory information on a patient's immediate care needs or issues, whereas a dentist being asked to assess the dental health for a patient recently discharged from hospital will benefit from having wider access to discharge notes, medical history, prescriptions, and allergies.

The purpose of the PRSB CIS assessment was not to map the information needs to specific dentistry roles, but to determine whether access to the various elements of a shared care record could be justified to improve the care that is provided to individuals.

Through workshops and consultation exercises (see Appendix A), it was determined that access to a shared care record will allow for better decision making, better signposting and better all-round care provision, reducing service user's stress, improving organisational efficiency, and improving overall NHS service provision for every service user. It was also noted that access to a common shared record should complement and enhance existing innovative processes such as electronic prescribing into dentistry to maximise opportunities for an efficient and effective process. Safety is a key factor to every PODAC setting.

The appropriate access for Dentistry is outlined in figure 3 below.

The consensus reached through this project was that Dentistry (as a care setting) does not have a reason to access "Primary Support Reason" or "Formulation" from a shared care record therefore these would be excluded by the Dentistry IT system and not retrieved from the shared care record.

Dentistry service appropriate access to Shared Care Record					
 					
PRSB CIS sections:					
Personal demographics 	GP practice 	About me 	Individual requirements 	Alerts 	Legal information 
Safeguarding 	Professional contacts 	Personal contacts 	Participation in research 	Referral details 	Contacts with professionals 
Admission details 	Discharge details 	Future appointments 	Vaccinations 	Problem list 	Procedures and therapies 
Social context 	Services and care 	Primary support reason 	Family history 	Investigation results 	Investigations requested 
Examination findings 	Pregnancy status 	Assessments 	Formulation 	Risks 	Allergies and adverse reactions 
Medications and medical devices 	Equipment and adaptations 	Plan and requested actions 	Care and support plan 	Contingency / safety plans 	Additional support plans 
End of life care 	Documents (including correspondence, audio and images) 	Key:  Data always available to the care professional  Data not required for this PODAC care setting			

We anticipate that access to the full PRSB CIS will be a technical capability for all services during their implementation development programmes, consequently these decisions can be reviewed and modified as clinically applicable going forward.

Figure 3: Dentistry use of PRSB CIS

“Patients are treated without there being any risk to them falling through the gaps” – Dentist

3.2.4 Ambulance services

“We’ve looked to identify the least amount of information that should be made available. However, given the nature of the type of work that’s done, it was felt that with a few exceptions where it should be based on consent, wherever possible most data should be made available from the core information standard.” - PODAC ambulance professional lead/paramedic/CCG Director

Due to the nature and complexity of ambulance services involvement in care and treatment, it was determined that there would be no limits to the access that qualified staff (of an Ambulance Trust) could appropriately justify in determining the correct course of action for any health or care needs.

999 and NHS 111 services already have effective systems in place to identify patients to ensure that they are dealing with a specified named individual, including long standing access to the NHS Patient Record. Extending their access to the wider information available from a shared care record would enhance and improve their ability to provide both close, and distant, care.

Their long-standing work practices already comply with RBAC and extending this to shared care records could well be seamless. Through workshops and consultation exercises (see Appendix A), it was determined that access to a shared care record will allow for better decision making, better signposting and better all-round care provision, reducing service user’s stress, improving organisational efficiency, and improving overall NHS service provision for every service user. Safety is a key factor to every PODAC setting.

The appropriate access for Ambulance services is outlined in Figure 4 below

Ambulance (999, 111 and PTS) access to the Shared Care Record



PRSB CIS sections:					
Personal demographics	GP practice	About me	Individual requirements	Alerts	Legal information
Safeguarding	Professional contacts	Personal contacts	Participation in research	Referral details	Contacts with professionals
Admission details	Discharge details	Future appointments	Vaccinations	Problem list	Procedures and therapies
Social context	Services and care	Primary support reason	Family history	Investigation results	Investigations requested
Examination findings	Pregnancy status	Assessments	Formulation	Risks	Allergies and adverse reactions
Medications and medical devices	Equipment and adaptations	Plan and requested actions	Care and support plan	Contingency / safety plans	Additional support plans
End of life care	Documents (including correspondence, audio and images)	Key: Data always available to the care professional Data not required for this PODAC care setting			

In this project we have included 111 in scope of Ambulance and recognise that there are other providers of 111 services.

Figure 4: Ambulance (999, 111 and Patient Transport Services) use of PRSB CIS

"The ambulance control centre did not have access to patient records. The person responsible for categorizing the final call wrongly graded the priority a 4 as opposed to a 2 which had a lengthier call-out time. However, there were no crews available even within that prescribed time target and the call "fell off" the bottom of the computer screen, compounded by a shift changeover. Tragically, if the call had been correctly categorized there was an ambulance literally round the corner on standby, which was equipped and reserved for higher priority calls i.e., heart attack, stroke, etc. Additionally, the PFD notice issued by the coroner addressed the fact that when a seriously at-risk caller is on the line, the handler should do everything to keep them on the line until crew are on the scene." Anonymous Relative – Detail Provided by PRSB

3.2.5 Community services

"... that falls are incredibly common and it's also multifactorial by nature. There's a lot of causes for it, whether it's vision, mobility and so forth. So, it's a good vehicle to explore the complexity in the community."

– Occupational therapist/Community lead – PRSB PODAC/Data lead - Royal College of Occupational Therapy

Due to the nature and complexity of community services involvement in care and treatment, it was determined that there would be no limits to the access that qualified community staff could appropriately justify in determining the correct course of action for any health or care needs.

Community Health has a range of services provided by specific levels of staff. The information needs of those staff groups varies. For instance, a clinic clerk would only require nothing more than an address, GP and supporting information on a patient's immediate care needs or issues upon visit. A community healthcare professional will benefit from having wider access to discharge notes, medical history, prescriptions, and allergies, if being asked to assess an individual recently discharged from hospital.

The purpose of the PRSB CIS assessment was not to map the information needs to specific community roles, but to determine whether access to the various elements of a shared care record could be justified to improve the care that is provided to service users.

Through workshops and consultation exercises (see Appendix A), it was determined that access to a shared care record will allow for better decision making, better signposting and better all-round care provision, reducing service user's stress, improving organisational efficiency, and improving overall NHS service provision for every service user. Safety is a key factor to every PODAC setting.

The appropriate access for Community Nursing services is given in Figure 5 below.

Community Nursing appropriate access to the Shared Care Record

PRSB CIS sections:







































Personal demographics 	GP practice 	About me 	Individual requirements 	Alerts 	Legal information 
Safeguarding 	Professional contacts 	Personal contacts 	Participation in research 	Referral details 	Contacts with professionals 
Admission details 	Discharge details 	Future appointments 	Vaccinations 	Problem list 	Procedures and therapies 
Social context 	Services and care 	Primary support reason 	Family history 	Investigation results 	Investigations requested 
Examination findings 	Pregnancy status 	Assessments 	Formulation 	Risks 	Allergies and adverse reactions 
Medications and medical devices 	Equipment and adaptations 	Plan and requested actions 	Care and support plan 	Contingency / safety plans 	Additional support plans 
End of life care 	Documents (including correspondence, audio and images) 	Key:  Data always available to the care professional  Data not required for this PODAC care setting			

Figure 5: Community use of PRSB CIS

“The identity of the patient, the GP, then, individual requirements and alerts. Brilliant. Fantastic, one. thing that took me a good while to find, and I thought would have been a bit higher up in this hierarchy, is a list of medications and medical devices.” – Patient Representative

3.3 Recommendations

3.3.1 Implementation recommendations

- Transparency is essential to maintain the trust of people about whom data is being shared which will require each care setting having clear communications with their service users about the benefits in terms of care and service user safety that wider, but appropriate, access to the record can bring.
- Implementation pilots must explore the ethical, liability, safeguarding and contractual (for example the dentistry contract) challenges of making a wider dataset available at point of care
- Information Governance guidance is required, ideally at a national level, for how non-NHS organisations can establish Valid, Ethical and Transparent sharing of data (access to shared care records)
- To align and incorporate existing innovative processes such as electronic prescribing into dentistry to maximise opportunities for an efficient and effective shared care record
- Upon implementation, the access to historic data as well as current data will need to be considered. GP and Shared Care Record access may give different insights to history especially for long term conditions where things change over time.
- When considering implementation in an IT system it is unlikely to be helpful to have a single screen with all the data over all time displayed – the usability of the data needs to be considered (and explored through pilots)
- It was recognised that the [Gillick competency and Fraser guidelines](#) should be adopted for children under the age of 16 with the NHS. It was noted that implementation projects (pilots or otherwise) must include a review of processes, training and governance to maintain and ensure safe, effective and authorised use of shared data.

The workshop and its findings do not change the determining of this project; but does highlight the need to implement pilot projects to support the workshop findings.

The overriding opinion was that access to shared care records leads to better and safer care but that the implementation is not trivial and must be given careful consideration.

Further work to document the lessons and benefits from existing integrations (such as community pharmacy and ambulance services) should be carried out and shared to support implementation in the other PODAC settings, optometry and dentistry in particular.

3.3.2 CIS Update recommendations

- Maintain explicit alignment between PRSB CIS and the International Patient Summary (IPS) standard
- As detailed in 3.1 iv a) above, clear, and expanded explanations of terms should be a pre-requisite going forward
- Make sure that each section of the PRSB CIS is checked to ensure broad applicability across all care settings for example “equipment” to be any equipment from any provider not just a specific care setting.
- Reorder the sections of the PRSB CIS to a meaningful order. Continue to ensure there is a tight correlation between the sections of the implementation guide, the information model, and the actual model of the standard in the modelling tool.

3.3.3 Pharmacy

Community pharmacists have already demonstrated the ability to provide safer care and signpost to other primary and secondary care NHS funded services through having access to an individual's summary care record; "In June 2015 it was announced that community pharmacists across England will be given the opportunity to access the SCR. National roll out is expected to commence in October 2015 and could take a period of around 18 months to complete. A recent pilot carried out in around 140 community pharmacies showed that pharmacists were able to help people who needed access to essential medicines by using the SCR, avoiding an unnecessary visit to their GP. In 92% of encounters where SCR was accessed, the pharmacist avoided the need to signpost the patient to other NHS care settings. 56% of these encounters would have been signposted to the GP practice, 22% to GP out of hours or NHS 111, and 1% to A&E.³ Pharmacists involved in the pilot were also able to provide safer care with a reduction in the number of avoidable medicines errors. 73% of pharmacists who responded to the questionnaire agreed that using the SCR has helped them avoid medication related errors." (http://systems.hscic.gov.uk/scr/library/poc_report.pdf)

Pharmacists should have full read and write access to the patient health record to improve patient care and patient safety. Information is key to delivering more effective pharmaceutical care to patients, improving medicines adherence, and reducing the medicine related errors which contribute to unplanned admissions to hospital.

Access to the patient health record will allow pharmacists to make more informed clinical decisions, in partnership with patients and other health and social care professionals, about the pharmaceutical care that patients receive. It will support improvement in the treatment of individual patients and help the NHS to maximise the value of the significant investment it makes in medicines.

Pharmacist access to the patient health record will improve patient care by enabling pharmacists to play an even greater role in the provision of safe and effective unscheduled care, treating common clinical conditions and responding to emergency requests for medicines.

Read and write access by pharmacists will enable other healthcare professionals to be aware of interventions made by pharmacists, to get a fuller picture of medicines dispensed and to know which medicines patients are purchasing over the counter in pharmacies.

Each healthcare professional records important information about a patient's care. Currently, these separate records cannot be accessed by other healthcare professionals. A single patient record would enable more informed and safer health decisions to be made by practitioners and patients.

Currently the most complete record available of a patient's healthcare is that kept by their GP. This record is not routinely shared or accessed by other health professionals. If a patient requires healthcare advice when their GP practice is closed or in an emergency, it can be difficult for other healthcare professionals, including pharmacists, to access the critical medical information needed to make clinical decisions. In a hospital, pharmacists routinely access a patient's hospital health record, laboratory results and information about previous medicines to safely advise and input into a patient's care. This information is not currently available to community pharmacists who also need to advise and input into patient care on a regular basis. Hospital and primary care computer systems are not compatible causing issues of continuity of care when patients migrate through the healthcare system.

"One single patient health record where all essential information is stored. All registered health and social care professionals involved in the patient journey to have appropriate access to the patient health record with the patient or their designated carer's explicit

consent.” (Pharmacist access to the Patient Health Record, Royal Pharmaceutical Society, September 2015)

3.3.4 Ambulance Trusts

We have considered the Ambulance Trust to cover 999, 111 and non-emergency Patient Transport Services (PTS) appreciating that this is not universally true for all Ambulance Trusts. Implementation pilots should focus on each part of an Ambulance Trust separately. There is further complexity for an Ambulance Trust as they work with multiple commissioners and are therefore likely to need to integrate with multiple shared care records.

3.3.5 Community Services

The project recognised the vast and diverse scope of Community Services. Implementation pilots need to focus on specific Community Care settings and optimise the implementation for that specific service.

4 Benefits identified through the project

There are significant benefits in using the PRSB CIS to both those accessing care and those providing care in the five PODAC settings. Being able to use the standard will complement NHS/Department of Health strategies and requirements going forward including:

- Data Saves Lives strategy
- ICO Data Sharing Code of Practice
- The publication of Local Digital Roadmaps in 2016 across the NHS and Local Government

Whilst the project was focused on the feasibility of a professional care practitioner being able to access data from a shared care record in each of the PODAC care settings, it became clear in interviews and workshops that there were also many benefits for the recipients of care.

The definitive version of the Data Saves Lives national data strategy was published³ during this project. Shared care records feature extensively throughout the strategy and the PRSB CIS was identified as a foundational building block for the strategy. The work undertaken through this project will have a beneficial impact on the implementation of the strategy.

There may be further benefits that would accrue from the way in which data is presented to both individuals and carers, The scope of this project was specifically what data should be made available, not the presentation nor navigation of that data.

“Digital technologies can prevent avoidable delays in diagnosis, unnecessary repeat tests and reduce clinical uncertainty that can slow down the speed at which people are able to begin to receive the treatment and care they need. They can help better co-ordinate an individual’s care from across multiple health and social care organisations, whilst supporting

³ <https://theprsb.org/core-information-standard-v2-0/s-lives-reshaping-health-and-social-care-with-data>

us in better connecting people with support that is available to them” (Farenden and Singh: 2018).

“The NHS Five Year Forward View set out that the traditional divide between hospitals, primary care, community-based care, and social care is increasingly a barrier to providing personalised and joined up services to people. About technology, it emphasises that nationally we should focus on the systems that provide the ‘electronic glue’ that enable various parts of the health and care service to work more effectively together.” (Farenden and Singh: 2018).

“The complex landscape of clinical systems in place across the NHS uncovers gaps in patient care where patient data is not connected. A true Shared Care Record is one that is connected and reliant upon data locked in disparate systems. The MIG [Medical Interoperability Gateway] using national standards makes this simple by joining up any patient data from any clinical system in real-time. This ensures every healthcare professional can access accurate patient data in their native system, improving patient care pathways.” (Healthcare Gateway: 2021)

“Shared records are completely transformational. If you deploy a shared record correctly, then it saves lives, improves patient care, it has massive impact on the service, it is a driver for transformation” (Bolton 2021)

4.1 Benefits primarily focussed on individuals accessing care

The potential benefits of implementing the standards, to be delivered through this project, are:

- Creating standardised access (in terms of data available) to the shared care record, to have better access from a wider range of care settings than is currently the case, so that professional care practitioners benefit in greater information sharing between disparate, geographically separated care professionals. This may improve outcomes through ensuring information about the person is available to the professionals caring for the person.
- Providing greater ability for professionals to identify issues with data and are alerted to any safeguarding issues.
- Current initiatives suggest that sharing information across organisations:
 - Improves people’s experience by avoiding the need for them to provide the same information to different health and care professionals repeatedly.
 - Improves health and care professionals understanding of an individual’s condition, which enables an individual to be provided with a personalised treatment plan.
 - Improves safety by reducing the need for unnecessary repeated tests.
 - Improves safety and experience by making comprehensive and reliable allergy, medication, diagnosis, and social circumstance information readily available across all health and care settings, for example in A&E or when an ambulance is called.
 - Prevents unnecessary admissions to hospital by giving health and care professionals more information about the individual when making their professional decisions.
 - Saves time by reducing the need to manually request information.
 - Saves money by avoiding duplicate tests or assessments.
 - Improves people’s engagement in their own care and adherence with medications and care plans by providing individuals with access to shared records.

-
- Supports safeguarding by sharing alerts across multiple care settings for both adults and children.
 - Supports more accurate understanding of local populations, allowing services to be designed more effectively around individuals' needs" (Farenden and Singh: 2018).

4.2 Benefits primarily focussed on people delivering care

- Health and care professionals involved in a person's direct care will have access to the information they need that is accurate, up to date and increasingly available in 'real time'.
- It supports the standardisation, integration, and accessibility of vital information to improve care.
- It mitigates the need for informal workarounds.
- It avoids the requirement for care professionals to access multiple systems or ask the person repeatedly about their history.

4.3 Benefits for the national data strategy

- The national data strategy seeks to establish *"a world where every person and the health and care professionals involved in their care can draw information from, or put information into, the same shared care record in a safe and straightforward way."* The use of the core information standard can aid that in the pharmacy, optometry, and dentistry primary care settings as well as more broadly in ambulance and community services.
- Providing access to a single source of data, which has timely, accurate and comprehensive information about service user's complements NHS Health and Care strategies and will help underpin improved services and individual safety:
 - Individual care (real-time sharing of personally identifiable information) - Health and care professionals will be able to access an individual's integrated, care record, to support the delivery of care by having visibility of the care being delivered in other NHS and partner organisations, making use of clinical decision support systems, and to flag eligibility for preventative initiatives such being reviewed by a multidisciplinary team.
 - Whether through the local health and care records solution or via a separate personal held record (PHR) solution we expect individuals will be able to read, download and annotate their care record, update their personal details with appropriate quality controls and be able to support or link to a personal health record where users can upload data from wearables and apps.
- Individual care (near real-time sharing of personally identifiable information) to support care planning and co-ordination for individuals by optimising how they are directed through health and social care services along their pathway of care, with the ability to support real time logic applied to populations and individuals to flag interventions.
- Intelligence (near real-time information availability of de-personalised information) to understand the needs of the population, monitor the effectiveness of health and care delivery, and support the operation of the health and care system.
- Intelligence (longer term studies of de-personalised information) to review health and care service provision, identifying relevant population cohorts to reduce health inequality and gaps in care, design new risk stratification approaches, and identify future population care needs and services.

5 Correlation of PRSB CIS with the generic GP record

From discussions during and external to the workshops it became clear that much of the CPRSB CIS is theoretically already available in current GP systems. Accessing the coded information already in shared GP systems may accelerate the adoption of data sharing across the different care settings.

As noted in the key findings, “there is a viable option to begin implementation using the GP record and that, subject to implementation and piloting outside the scope of this project, this could leverage national infrastructure as opposed to the various current shared care records.”

5.1 Correlating the individual data categories

We conducted an exercise to map GP record fields with the PRSB CIS model

There are 38 data categories in the CIS, which were reviewed against national specifications that are used for interfacing with General Practice systems, and this showed that there are 20 categories which contain most of the required data in a structured format. The assumption in this evaluation is that coding practices and data quality are standardised for the purpose of this exercise when measuring data availability.

A table showing the cross matching is given in Figure 6 below.

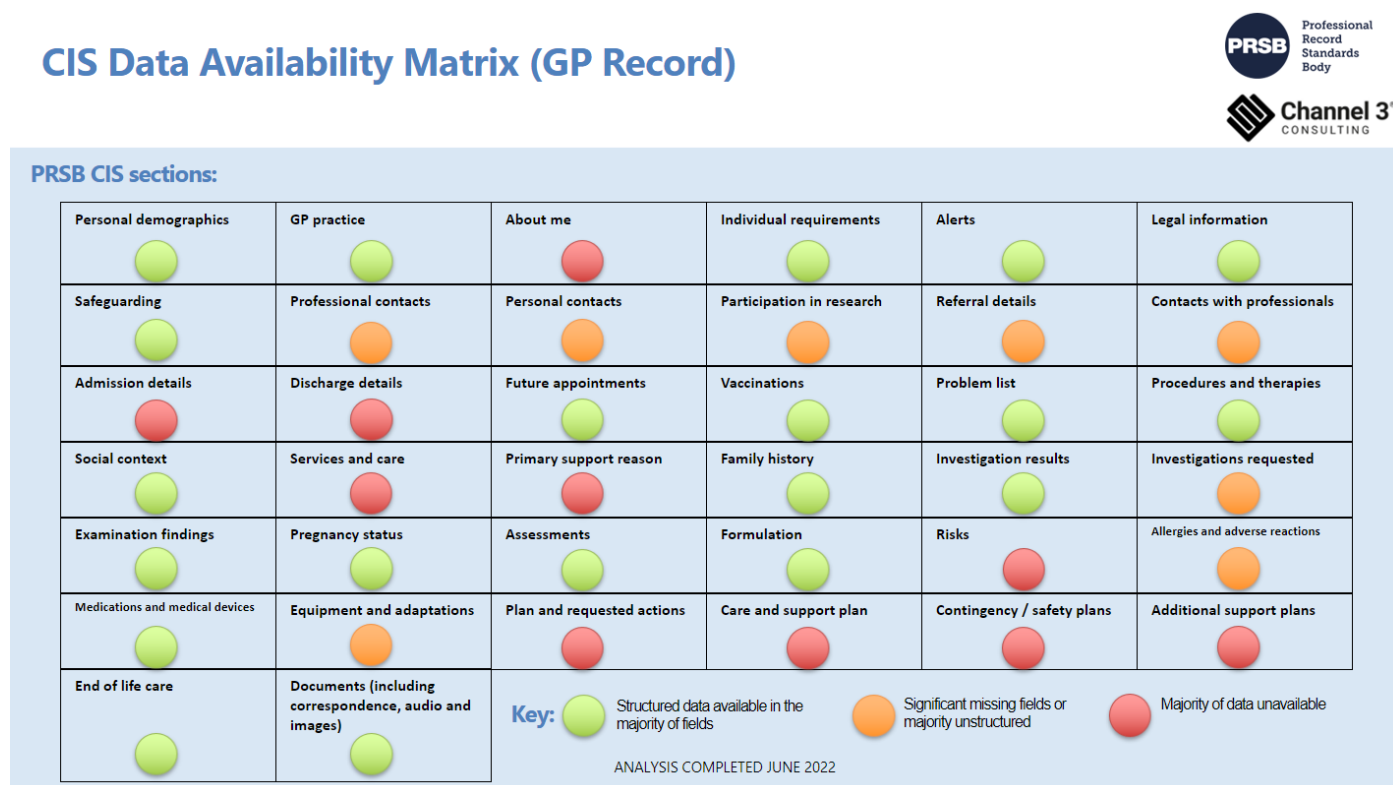


Figure 6: Correlation of PRSB CIS and a GP record

The remaining eighteen data categories have significant amounts of missing fields or are only available as unstructured data.

General practice (GP) records contain approximately 74% of the overall core information standard as structured data or within document content across the thirty-eight data categories. This is shown in Figure 7 below.

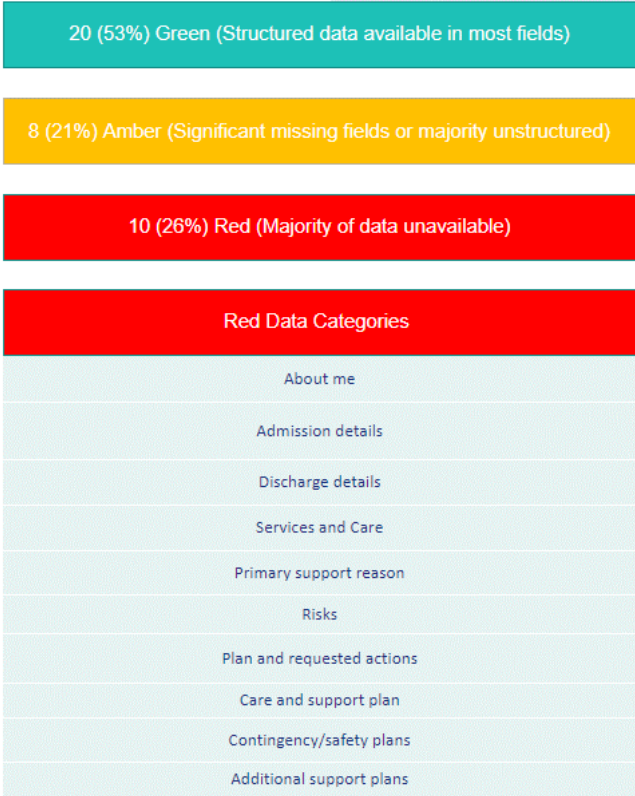


Figure 7: GP Record Coverage of PRSB CIS

Social and care planning have least availability as well as interactions with acute services.

Challenges:

Where the data category has been marked as amber or red this is due to data being unlikely to be coded in the GP record even with SNOMED CT UK coding is available or where a system other than the main electronic patient record system is used for data entry.

It is likely this data will be contained in the contents of a document that may be available attached to the patients record in an unstructured format.

6 Scope

The PODAC settings and scope of this project are defined in Figure 6: Scope:

Sector	In scope	Out of scope
Community pharmacy	Community pharmacy providers <ul style="list-style-type: none"> Independent contractors, multiples and online pharmacies that provide NHS services 	<ul style="list-style-type: none"> Hospital pharmacy (acute, community and mental health) Retail and private services
Optometry	General Ophthalmic Services providers <ul style="list-style-type: none"> Independent contractors and multiples that provide NHS services 	<ul style="list-style-type: none"> Hospital ophthalmology services
Dentistry	General Dental Service providers <ul style="list-style-type: none"> Independent contractors and dental corporates that provide NHS services Community dental services In-hospital and community-based 	<ul style="list-style-type: none"> Acute dental services Private dental services
Ambulance	NHS ambulance trusts	<ul style="list-style-type: none"> Air ambulances Private ambulances
Community health	CCG commissioned community services <ul style="list-style-type: none"> Focused on community NHS trusts and Community Interest Company (CIC) providers 	<ul style="list-style-type: none"> Local authority commissioned community services The considerable number of small and medium sized community providers, including the voluntary sector

Figure 6: Scope

In addition to adult's data, children's data, both including safeguarding, is also in scope for this project, a consultation was held with an NHS Safeguarding lead, who gave guidance on what information should already be considered across all PODAC settings.

Recommendations have been included in relation to safeguarding.

This project is equally applicable to all four nations. The survey and the two workshops published on Eventbrite were actively promoted to the three devolved nations. Eventbrite is a common Web site used to publish and register for public events and meetings.

Whilst private provision is outside the formal scope of this project, it has been noted during consultation that in some care settings (notably optometry and dentistry) both private and publicly funded care may be provided by the same organisation. Future projects must consider the access to NHS data during private practice in PODAC care settings, this is especially relevant in Optometry and Dentistry. It should also be noted that Air Ambulance is excluded from the Ambulance scope of PODAC.

6.1 Health and Social Care settings

Figure 7: Relevant Health and Social Care settings below (supplied by NHS Digital) identifies the target health and social care settings relevant to this work and its potential impact on these settings (see Figure 8: Care setting potential impact definitions below or the definitions of potential impacts).

Ref	Service	Target	Potential Impact (see definitions)	Ref to Note
S01	Primary Care - General Practice	Yes	Min	
S02	Primary Care - Dentistry	Yes	Mod	
S03	Primary Care - Pharmacy	Yes	Mod	
S04	Primary Care - Optometry	Yes	Mod	
S05	Primary Care - Out of Hours	No		
S06	Other Primary Care setting	No		
S11	Secondary Care - Ambulance	Yes	Mod	
S12	Secondary Care - Emergency	No		
S13	Secondary Care - General/Acute	No		
S14	Secondary Care - Maternity	No		
S15	Secondary Care - Mental Health	No		
S16	Other Secondary Care setting	No		
S21	Community Care - Child Health	Yes	Mod	Scope of Community to be agreed as work starts
S22	Community Care - End of Life	Yes	Mod	
S23	Community Care - Mental Health	No		
S24	Community Care - Rehabilitation / Aids & Adaptations	Yes	Mod	
S25	Community Care - Treatment / Therapies	Yes	Mod	
S26	Other Community Care setting	Yes	Yes	

Ref	Service	Target	Potential Impact (see definitions)	Ref to Note
S31	Public Health - Health Promotion	No		
S32	Public Health - Immunisation & Vaccination	No		
S33	Public Health - Infection Prevention/Control	No		
S34	Public Health - Screening	No		
S35	Other Public Health setting	No		
S41	Social Care - Advocacy services	No		
S42	Social Care - Disabilities services	No		
S43	Social Care - Domiciliary care	No		
S44	Social Care - Needs assessments	No		
S45	Social Care - Residential care	No		
S46	Social Care - Safeguarding	No		
S47	Other Social Care setting	No		
S51	Genomics	No		

Figure 7: Relevant Health and Social Care settings

Impact Definitions	
Min	The revised or newly created information standard could have a minimal but identifiable impact upon the current provision of care settings within this setting
Mod	The revised or newly created information standard could have a tangible and measurable impact upon the current provision of care settings within this setting
Sig	The revised or newly created information standard could have a substantial and disruptive impact upon the current provision of care settings within this setting

Figure 8: Care setting potential impact definitions

6.2 Exclusions from scope

Milestone 3 has been inclusive of all PODAC care settings (Version 1.0 of the Project Initiation Document had a smaller scope but the project team was able to accommodate all five care settings earlier than expected). The only exclusion is that the project scope does not include secondary care settings (providers of hospitalised care), or coverage at this stage of non-NHS Services.

7 Methodology and consultation approach

The project management methodology was Agile, as much of the activities were front loaded with key dependencies on deliverables, as mentioned above. The nature of the deliverables was dependent on consulting fora with primary care professionals and appointed experts, and to direct a way forward through consensus with the central aim to standardise shared care record accessibility.

7.1 Project Objectives and Scope

The key milestones (also outlined as critical factors to success, please see section 3.2 above) are shown in the table below (Figure 11)-

Milestone	Date
Milestone 1 Project Initiation Document (PID) and Outline Communications Plan (OCP) generated. Note: A single PID for the project and a single communications plan for all stakeholders had been generated, however, it was recognised that some stakeholders, such as Royal Colleges, were engaged in more than one PODAC care setting.	End February 2022
Milestone 2 Draft Information Standard and evidence review indicating the applicability (or not) of the PRSB CIS to each care setting, and proposal to use PRSB CIS. Note: The Clinical Safety Case and Hazard log at this point are the already published documents for the PRSB CIS	End March 2022
Milestone 3 demonstrable engagement with stakeholders for the development of standards Note: The scope of Milestone 3 will be determined by the evidence review and stakeholder conversations in Milestone 2 (applicability of PRSB CIS)	End June 2022
Milestone 4 draft standard(s) if required including information model ready for endorsement as part of subsequent M5	End July 2022
Milestone 5 Endorsement (as per stakeholder list) and record of stakeholders.	End August 2022

Figure 9: Project Milestones

7.2 Consultation approach

Through consultation we evaluated and confirmed that the CIS is suitable for those working in pharmacy, optometry, dentistry, ambulance, and community services (primary care settings).

Consultation took a number of forms:

- Establishing a core team of professional and personal leads
- Running a series of workshops and discussions:
 - Two workshops with care professionals from the five care settings
 - An additional safeguarding and children's safety session was held
- A general (public) survey was conducted on behalf of PRSB from 9th May 2022 to 6th June 2022, aimed at professionals and service users working in or accessing health and care settings.
- Attendance at, and presentation to, the PODAC delivery groups

The PRSB assembled a team of PODAC “professional leads” (who deliver care) and “personal leads” (people who access care or support those accessing care). Channel 3 Consulting was engaged to facilitate the process and to produce the final Milestone 3 report

Initial assessment was whether new standards were required, or if existing PRSB CIS 2.0 would meet the needs of a care professional in a PODAC care setting accessing a shared care record. The team also considered if there any special considerations when handling children's data in each care setting appreciating that processes are already in place, especially with regards to safeguarding children and assuring adoption of codes of practice and regulatory and legal requirements are upheld. Whilst there are always implementation considerations for working with children's data (for example safeguarding, looked after children, and many more) the team determined that there were no additional considerations with respect of the standard being correct for children's data, but that implementation would consider the impact on operational processes and governance already in place to support handling of children's data.

The user cases used in the three workshops are provided as Appendix E.

7.2.1 Themes explored in consultation

PRSB workshop participants were health and care professionals working in community services, individuals who use services, system supplier colleagues, informaticians and others with a personal stake in quality information for health and care. In these workshops we looked at case studies and asked participants to feedback on the information that would be most important to access if delivering care in those scenarios. The first workshop included optometry focused scenarios, where the person also requires involvement from pharmacy, ambulance, and community services. The second workshop included dental focused scenarios, where the person also requires involvement from pharmacy, ambulance, and community services.

The project provided each care setting an overarching question “*Validate, explore, and evaluate the impact and appropriateness of using the PRSB CIS in each PODAC care setting on improvements to care as demonstrated through the user stories presented.*”

The key focus of each workshop was to consider addressing the following three questions -

1. *Is this the correct level of information available for the care professionals to effectively perform in their roles?*
2. *Were any safety issues to professionals and service users avoided or mitigated by professionals having access to the shared care record?*

3. *Is there any additional information required?*

PRSB invited care professionals and service users to complete a nationwide survey to determine the breadth of information professionals currently access and would like to access in the future, and the type of information that service users want and expect those caring for them to view and access (see Appendix D: Survey Results on page 59).

7.3 Communications

Communications with the project board was undertaken via fortnightly checkpoint meetings.

Communication with the wider PODAC teams (as standing agenda items) were through the PODAC delivery groups.

Communications with stakeholders participating in review of the CIS for each PODAC care setting or development of new standards (as required) was set out in the Communications and Engagement plan (separate document).

The Delivery Group Professional and Personal Leads also reached out to their own networks to ensure as wide a communication and engagement as possible.

8 Stakeholder engagement and endorsement

The following professional and patient organisations were identified as key stakeholders for this project.

- Royal College of General Practitioners
- Allied Health Professions Federation
- Chartered Society of Physiotherapy
- Royal College of Occupational Therapists
- Royal College of Speech and Language Therapists
- British Dietetic Association
- Community Practitioners and Health Visitors Association
- Queen's Nursing Institute
- Royal College of Nursing
- Royal Pharmaceutical Society
- Association of Directors of Adult Social Services
- Care Provider Alliance
- National Care Forum
- National Voices
- Patient Information Forum
- Shared Care Record Local Government Network
- British Dental Association
- College of Optometrists
- College of Paramedics

There is no requirement for new “endorsement” as this project has determined that no new standards are needed for PODAC care settings to access shared care records. However, as part of Milestone 5, the PRSB will share the outcomes of this project with all stakeholders who have endorsed the existing PRSB CIS 2.0 so that they are fully aware of how and where the PRSB CIS will be applied and used.

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The GM Care Record - Public - Health Innovation Manchester (2021)

10 Appendix A: Detailed findings

	Pharmacy	Optometry	Dental	Ambulance	Community
Themes <i>themes identified in consultation</i>	<p>“Validate, explore, and evaluate the impact and appropriateness of using the PRSB CIS in each PODAC care setting on improvements to care as demonstrated through the user stories presented.”</p> <p>1. Is this the correct level of information available for the care professionals to effectively perform in their roles?</p> <p>2. Were any safety issues to professionals and service users avoided or mitigated by professionals having access to the shared care record?</p> <p>3. Is there any additional information required?</p>				

	Pharmacy	Optometry	Dental	Ambulance	Community
Evidence <i>Literature review and discovery phase evidence</i>	Paula Russell (Pharmacy PODAC lead) reviewed the CIS and fed back that pharmacy would require 35 out of the 38 CIS sections. Admission details, assessments and participation were not considered as necessary to access for pharmacists to provide the highest level of care.	Janki Barai (Optometry PODAC lead) reviewed the CIS and fed back that optometry would require 36 out of the 38 CIS sections. Vaccinations and end of life care were not considered as necessary to access for optometrists to provide the highest level of care.	Shabir Shivji (Dentistry PODAC lead) reviewed the CIS and fed back that dentistry would require 36 out of the 38 CIS sections. Formulation and primary support reason were not considered as necessary to access for dentists to provide the highest level of care.	David Davis (PODAC ambulance lead) reviewed the CIS and fed back that ambulance would require all 38 sections of the CIS to provide the highest level of care possible in NHS ambulance services.	Suzy England (PODAC community lead) reviewed the CIS and fed back that community would require all 38 sections of the CIS to provide the highest level of care possible in NHS community services.

Findings
*Output of all
consultation
methods
summarised*

<p>Pharmacy requires 38 sections of the CIS for ambulance services to function as effectively as possible. Access to admission details and assessments by available to pharmacists, particularly community pharmacists will allow them to view what medication has been administered in hospital, prescribed upon discharge, and give pharmacists access to recent acute medical history.</p> <p>Enables less steps in pathways and the ability to assist with care to improve outcomes more quickly.</p> <p>Improved pharmacy care from having access to the shared care record.</p>	<p>Optometry require 36 sections out the 38 section CIS. Optometry does require admission details or assessments to provide the optimum level of care.</p> <p>Having the right information accessible for a service user that has a long-term illness that affects their cognition is beneficial for the delivery of care.</p> <p>Having the right information to refer service user to the most appropriate pathways, potentially reducing health inequalities and gaps in care.</p>	<p>Dentistry requires 36 sections out the 38 section CIS. Optometry does require primary support reason or formulation to provide the optimum level of care.</p> <p>There is no method of verifying a service user's knowledge of their own health.</p>	<p>Ambulance requires all 38 sections of the CIS for ambulance services to function as effectively as possible.</p> <p>If an individual had an underlying health issue or long-term condition and was not able to speak for themselves during a health or care intervention, the care professional would be able to take existing conditions into account when making split second decisions if they had access to all 38 sections of the CIS in the shared care record.</p> <p>Care professionals having access to carer information and contingency plans for individuals that have cognitive issues results in higher quality of care.</p>	<p>Community requires all 38 sections of the CIS for community services to function as effectively as possible.</p>
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	Pharmacy	Optometry	Dental	Ambulance	Community
Recommendations <i>Summary of recommendations</i>	<p>Provide access to assessments and admission details.</p> <p>The ability to filter the shared care record.</p> <p>Write as well as read access into the shared care record.</p> <p>Indications information made readily available.</p> <p>Access to medicine specific information regarding a service user's in-patient stay.</p> <p>A detailed implementation guide for each PODAC care setting to be provided to each care setting once the view of the CIS in each care setting has been agreed.</p>	<p>To provide access of the shared care record to the voluntary sector and have better access from all providers involved in community care to the shared care record.</p> <p>Access to an electronic patient care has given optometrists in Northern Ireland the ability to make proactive and more efficient care decisions. However, optometrists need see a filtered view of the shared care record, with a brief overview of clinical assessments, findings and history and a more detailed view of anything that would be relevant to eye health.</p> <p>To provide access of the shared care record to the voluntary sector and have better access from all providers involved in community care to the shared care record.</p>	<p>The right professionals need to have access to data sets. The integration between dentistry and GP systems must be secure to avoid information governance breaches.</p> <p>Dentists require a dental summary from previous dental assessments and treatments as well as medical history.</p> <p>The ability to use e-prescribing to update all services within PODAC care settings.</p> <p>SNOMED codes being standardised across primary care and dentistry.</p> <p>If dentistry has access to the shared care records it would mitigate the risk of patients falling through the gaps in the healthcare system.</p> <p>Private dentistry also require access to the shared care record.</p> <p>There is a necessity to order the CIS sections within the shared care record prioritising the sections that need to be accessed the most frequently.</p> <p>Health and care and outcomes need to be the focus when planning implementation of the shared care record across PODAC care settings: there needs to be less reliance on accessing medical information from the patient directly during assessment or treatment.</p> <p>The presentation of the shared care record needs to be easily readable to the clinician accessing it.</p>	<p>Extend the shared care record to local authority.</p> <p>Healthcare professionals having access to carer information and contingency plans for individuals that have cognitive issues.</p>	<p>A summarised view of the shared care record for care professionals in emergency and crisis interventions.</p> <p>Hierarchical order of information presented in the shared care record.</p>

	Pharmacy	Optometry	Dental	Ambulance	Community
Risks <i>Identified risks raised</i>	Incorrect data being entered into the shared care record.	The scope of this work is only covering NHS providers and not private healthcare providers.	Difficult to follow a patient journey with lots of settings overlapping	Care plans presenting information that was based on past assessments, however, at the point of the current health or care intervention the service user's condition has improved.	(No risks identified)

Pharmacy - Comments

Quotes from consulted participants

".... Given the new services that we are doing, which includes discharge medicine review, (where) you can just walk in without an appointment...I would argue that we also would need to access assessments, because then I can see it's across here on this table...as well as admission details." – National Pharmacy Association/Pharmacist

"... what I'm thinking is coming out of hospital issues like bandages, enough medication. We're going to be doing the Discharge Medicines review and so on." – National Pharmacy Association/Pharmacist

"I think... I agree with the previous point about assessments and findings it is important prior to arrival into the community pharmacy that we know what's happened in that current episode of care, because that might have some influence. ... social care contacts are important. ... that's certainly the driver in Scotland ...one last point to make is that the direction of travel is to have every pharmacist being an independent prescriber. (so) we really need to reflect on the information that they will need." - Pharmacist

"So, I think assessments is key as well. I would agree with all the colleagues on that." - Pharmacist/PRSB PODAC pharmacy lead

"To reinforce other comments (from Helga and John) that the admission details and assessments are going to be hugely useful. Off the work I've done for PSNC, the community pharmacy body, we get constant feedback about not having that type of information for the new services and even the information that is available in summary care records, of course is not live, the shared care record is a lot more live. It's critical that pharmacists have the proper information." - Pharmacist

"Admission information availability is important to pharmacy to give context to the discharge information that is available" - Pharmacist

"The message here I suppose is this is the core information standards and there are to be discussions ongoing and in the implementation guidance with regard to the filtering." - Pharmacist/PRSB PODAC pharmacy lead

"It would be quite helpful to also have read/ write access, again, building on the common set list said so that anything we notice, anything we see, we will be able to have that dialogue. Of course, the patient, the carer, is fully aware of it. So it is, with their own consent, which I'm sure they would want us to address in a bit of a timely manner, particularly coming over the weekend where we see most of these urgent cases come to us really." - National Pharmacy Association/Pharmacist

Pharmacy – Comments (continued...)

Quotes from consulted participants

“Where would indications be found - this was an important aspect also picked up in relation to overprescribing. Absolutely crucial to understand why medicines are prescribed. This info is not in the Medications and medical devices data.”

“It is interesting to hear the support for ‘admission’ details. That was not the feedback I got from colleagues who are more junior jobbing pharmacists than the representatives here! I think it might be a ‘nice to have’ because pharmacists like to have everything but suspect if we interrogated how often it is used, we might find it will be rarely used. Thinking about it, it might possibly be useful to see if / why meds might have been changed following an admission to hospital – but that info would be available elsewhere in the CIS record.”

- Pharmacist/PRSB PODAC pharmacy lead

“I think it might be useful to understand the information that is recommended as a minimum for the Discharge Medicines Service (DMS)”

There has been a lot of complaint by community pharmacy about the information they are accessing from hospitals for the DMS. I therefore suspect that some of the comments about admissions information may be informed / influenced by these ongoing complaints e.g., it would ‘provide context to the DMS.’

If community pharmacies were to receive the recommended DMS information as below, I think that would provide sufficient ‘context,’ but the issue is they are currently only accessing what hospital systems give them! However, it is easy to include admissions information if that is what they want.

DMS referrals from Trusts should contain the following information, as a minimum:

- *The demographic and contact details of the person and their registered general practice (including their NHS number and their hospital Medical Record Number).*
- *The medicines being used by the patient at discharge (including prescribed, over the counter and specialist medicines, as there may be medicines interactions), including the name, strength, form, dose, timing, frequency, and planned duration of treatment for all and the reason for prescribing.*
- *How are the medicines taken and what they are being taken for?*
- *Changes to medicines, including medicines started or stopped, or dosage changes, and reason for the change; and*
- *Contact details for the referring clinician or hospital department, to use where the pharmacy has a query.”*

- Pharmacist/PRSB PODAC pharmacy lead

Pharmacy – Comments (continued...)

Quotes from consulted participants

"I worked with the Community Pharmacy Leadership when 111 Pharmacy Lead and at that stage when we wanted to address an important issue because of a coroner's section 28 using a flag on the summary care record. They said that they don't always look at it! So, it is moot as to whether the jobbing pharmacists will look at much of this information and may well complain further down the line that there is too much! The implementation guidance will likely be important for this. - Pharmacist/PRSB PODAC pharmacy lead

"...we have been working quite blind and I think as pharmacists move into work to GP practices and work in community, they have recognized how much more information they could have access to and that would enable them for more in Community pharmacy. So, this is very much about enabling Community pharmacy to help patients there and then, and gateway another journey where it is possible to another care service"

- Pharmacist/PRSB PODAC pharmacy lead

"I had an experience with a patient like Dorothy coming in and regretfully had to send them to the to the GP because I couldn't rule out the nausea as being possibly caused by the digoxin, So, this is a real-life example of where access to additional information could have been very helpful in in helping the patient and negating that need for an additional journey and there and then." - Pharmacist/PRSB PODAC pharmacy lead

"Pharmacy access to the record is needed to provide proper care including NHS111 referral, NHS discharge medicines service, management of long-term conditions." - Pharmacist

Optometry – Comments

Quotes from consulted participants

“... would that be if the patient was on an end-of-life care pathway or the details of that end-of-life care pathway because it could have an influence on referral decision making. If you’re referring a patient for complex eye surgery but they only have a matter of weeks to live that may not be in their best interests.”

- Optometrist/Clinical director at the Association of Optometrists

“The end-of-life care decisions may not be completely relevant to an Optometrist; it is important to streamline information for Optometrists meeting demands in a busy practice. However, it can be helpful to understand the individual requirements if they are visually comfortable and to give access to palliative care notes when deciding if to refer for further intervention in secondary care. Although we wouldn’t need to know the end-of-life care decisions, we would want to know if the patient were terminal and potentially how long they might have.”

- Optometrist/PODAC Optometry Lead – PRSB

“I worked on this project a few years ago. I have access to a bespoke view of our entire Northern Ireland electronic care record, ... we have a substantial number of our primary care workforce now accessing it on a regular basis, not just to look up relevant history and medication, but certainly, as regards all their ophthalmic information that’s available in there. It is a, it is a tailored view, so professionals don’t see a full view of radiology, screening results, or anything that’s not directly relevant to their area of clinical practice. Optometrists in Northern Ireland have described it as a complete game changer; for them to be involved and able to make better decisions. Referrals are visible through it. Optometrists certainly feel much more integrated with the wider system prior to that we’re always reliant on trying to find out information through general practitioners or ringing clinics. Whereas now they can look it up proactively. Consent is a big part of it absolutely. There is a consent process with it but our optometrists value it. It’s right up there with an important innovation for them locally.”

- Optometrist

“The sight loss charity I work for are the link between health and social care ..., some of this information is so valuable to community groups such as voluntary organisations because we often are the buffer (with)the NHS, ... often, when people get referred or find out about us, it can be at an extremely confusing time. So, in the case of Dorothy, we have absolutely no information about any of this to support her. if we had this information beforehand, not only can we get a better idea of what support she might need and what appropriate support is available, but actually we would know that we wouldn’t be wasting anyone’s time as well. The voluntary sector is a real gap in the service provision

- Chief Executive Officer - West Sussex based sight loss charity

“In Dorothy’s case, she would be monitored under NHS Optometry care in practice. We would want to monitor her sight considering how prone she may be to falls and the medications she takes. We would want to provide her with the best vision possible. It could be difficult to rely on her subjective responses and I believe the NHS would support regular sight tests to monitor from an objective perspective.”

- Optometrist/PODAC Optometry Lead – PRSB

“My grandma has macular degeneration, and she cares for my granddad, who has dementia, (which) my grandma's (also) getting. She must go to get her eye injections, but she's house bound. She doesn't know what day it is. ...unless I go to the optometrist with (her) she struggles to make the appointment or would not provide the correct recent medical history and is at risk of being discharged from the service. Would it provide the optometrist more information in regard to how to support her?”

- Patient Representative

“I believe this is exactly the sort of patient journey we could help with shared care records. As the population is ageing, there is going to be more demand on all care settings treating age-related conditions. For example, the treatment for wet macular degeneration is 1-2 monthly injections which could be performed locally in a community care setting. This would provide better access to care for the elderly population as well as support family members working full time and wanting to attend appointments with their parents or grandparents.”

- Optometrist/PODAC Optometry Lead – PRSB

“The Federation of Ophthalmic and Dispensing Opticians (FODO) is a leading professional membership and insurance organisation that represents eye care providers..... a substantial proportion of the population are not entitled to free NHS site tests and are therefore excluded from this program and (it) could be argued, are discriminated against.”

- Director of Regulatory Affairs

Dental – Comments

Quotes from consulted participants

“As a GP knowing what people are on but also if they have been referred, perhaps for potential oral cancer would be a big move forward. Current GP/dental problems and prescribing information sharing don’t exist, and patients aren’t always certain.” - GP

“My big concern with all this is the access. I mean, what's on the information is absolutely fine, but how do dentists get the access? ... are dentists going to be registered under a list that can be given out? ...we must have a specific high security connection within practices to get this and no practices, I know, have this (level of connection) now”

- General Dental Practice Committee exec member

“I'm aware at the moment the summary care record is predominantly the medical information but would also be useful would be that dental information as well. ... I think there's a case there for dental practise”

- Clinical Lead, OCDO

“So, they keep a record of what they put into you, who's giving it, when and why not.”

- Patient Representative

“Whilst the recommendation, absolutely we should be taking forward, is shared knowledge of any prescribing for a patient, whoever happens to be involved, but you could facilitate that by having an e-Prescribing for certain (issues) making sure that you enter once, and it references to all the relevant records. So even if you didn't have dental practitioner access to the patient care summary, you would automatically get an update into that.” - CDO England

“I think alerts is a really tricky area - alerts can range from anything (I think PRSB gives dangerous dog as an example) to more focussed type clinical alerts. Currently in my experience they mostly come across as free text rather than SNOMED coded (I believe in GP systems they are mostly recorded as alert-able problems).”

- Product Director

“50% of dentistry codes are used in primary care”

- Information Architect

“Patients are treated without there being any risk to them falling through the gaps”

- Dentist

“Now there's a massive proportion of dentistry done outside the NHS. They still have patients that are NHS members, so they have access to secondary care being referred in. So, I think to sort of completely dismiss half, maybe more of the dentistry being done and not having access to this is that is a bad idea, really.”

- General Dental Practice Committee exec member

“Various other things should be prioritised. Like someone was mentioning in the chat that there's a lot we don't want too much information. It needs to be relevant information. You're going to be swamped.”

- General Dental Practice Committee exec member

Ambulance – Comments

Quotes from consulted participants

"We've looked to identify the least amount of information that should be made available. However, given the nature of the type of work that's done, it was felt that with a few exceptions where it should be based on consent, wherever possible most data should be made available from the core information standard."

- PODAC ambulance professional lead/paramedic/CCG Director

"Has the daughter been offered a carer's assessment and where does the local authority fit into these core standards in terms of shared care record?"

- Patient representative/Bristol North Somerset ICS

"What we did talk about were the types of use cases where carers perform a vital role. And, where carers are present as that leads a third party to need to have other arrangements put in place. ...that's why care and support planning information and contingency and safety plans were felt important to be made available."

- PODAC ambulance professional lead/paramedic/CCG Director

"This type of case study represents a very common type of call to the ambulance service. It reflects the type of complexity that is the reality of people with long term conditions presenting in the community. And we've thought carefully about each type of interaction that might be had in the ambulance service in this context."

- PODAC ambulance professional lead/paramedic/CCG Director

"We need to remember that this is a complete look at the data, and not every data item will be looked at for every case presentation you deal with. Info you don't get from the patient/carers, but you want to know, this is what you'll look up. Access to data should be selective and needs to be driven at the time of care delivery"

- Pharmacist

"How do you then go back and address care plans that you've set up for somebody where you're looking at the worst-case scenario for the health? How do you then change it to reflect the fact they've got better?"

- Patient Representative

Community – Comments

Quotes from consulted participants

"Unless that there was a summary or some key, information that I need ASAP and can view in a few minutes."

-
- Nurse/PRSB lead assessor for suppliers

“The identity of the patient, the GP, then, individual requirements and alerts. Brilliant. Fantastic, one. thing that took me a good while to find, and I thought would have been a bit higher up in this hierarchy, is a list of medications and medical devices; the first questions is usually are you on any medication, because care professionals tend to want to know about that before they prescribe you something that might have serious repercussions.”

- Patient Representative

“... that falls are incredibly common and it's also multifactorial by nature. There's a lot of causes for it, whether it's vision, mobility and so forth. So, it's a good vehicle to explore the complexity in the community.”

“It’s really important that as AHP Informatics leads that we keep on supporting AHPs to structure their information in a way that enables it to flow into a shared care record.”

- Occupational therapist/Community lead – PRSB PODAC/Data lead -

11 Appendix B: Stakeholders

Details of those who participated in consultation events:

Workshop 1 – 27th May 2022

Job title	Company
Person with lived experience	(not applicable)
Person with lived experience	(not applicable)
Person with lived experience	(not applicable)
Person with lived experience	(not applicable)
Person with lived experience	(not applicable)
Person with lived experience	(not applicable)
Person with lived experience/ informal carer	(not applicable)
Volunteer	(not applicable)
Chief Executive	4Sight Vision Support
Deputy Superintendent Optometrist	Asda Opticians
Clinical Lead	Association of British Dispensing Opticians
Clinical Director	Association of Optometrists
CCIO	Birmingham and Solihull ICS
Consultant Ophthalmologist and CCIO	Bolton NHS Foundation Trust
Senior Enterprise Architect	Boots
Pharmacist	Boots
Chief Pharmaceutical Officers' Clinical Fellow	Care Quality Commission
Associate Product Manager	Cegedim Healthcare Solutions
Analyst	Channel 3 Consulting
Consultant	Channel3
Health Informatics Lead, Physiotherapist	Chartered Society of Physiotherapy
Director of Policy & Strategy	College of Optometrists
Lead Nurse	Devon Partnership NHS Trust
Hospital ePrescribing Lead	Digital Health and Care Wales, NHS Wales
Director	ELCI Primary Eyecare Company
Clinical Director	EMIS
Technical Director	EMIS Health

Services Director	Epsomedical Ltd
Chair	Faculty of Clinical Informatics
Director of Regulatory Affairs	Federation of (Ophthalmic & Dispensing) Opticians
Head of Policy and Public Affairs	FODO
Specialist research Optometrist	Guy's and St Thomas' NHS Foundation Trust
Person with lived experience	Humanity & Integrity in Public Sector Services
Architect and Cyber Security Lead	IDO Consulting Limited
Honorary Research Officer	Imperial College London
Project Worker	Irish Causeway Housing
Volunteer	N/A
Policy Manager	National Pharmacy Association
Service Development Manager	NHS 24
Associate Clinical Director	NHS 24
Deputy Medical Director	NHS 24
Clinical Lead for Digital Medicines	NHS Digital
Senior Project Manager – Digital - PODAC	NHS Digital
Project Manager	NHS Digital
Senior Policy Lead	NHS England
Head of Digital Transformation	NHS Somerset CCG
Clinical Service Manager	NHS Wales
Specialist Pharmacist in Diabetes and Endocrinology	North Middlesex Hospital
NHS Community Pharmacy IT Policy Manager	Pharmaceutical Services Negotiating Committee (PSNC)
Product Design Manager	Positive Solutions
Director of Delivery and Transformation	PRSB
Standards Assessor	PRSB
Director of Strategy, Communications and Engagement	PRSB
Standards Implementation Assessment Lead	PRSB
Communications Officer	PRSB
Membership and Stakeholder Manager	PRSB
Product Manager	Push Doctor

Clinical Representative Dementia	Royal College of General Practitioners
Paramedic and Head of Integrated Governance (999 & 111)	Southeast Coast Ambulance Service NHS Foundation Trust
Optometric Clinical Adviser	Strategic Planning and Performance Group, Department of Health, N. Ireland
Patient Representative	Tameside and Glossop Integrated Care Foundation Trust
Freelance Trainer	Thornfields

Workshop 2 – 31st May 2022

Job title	Company
Person with lived experience	(not applicable)
Person with lived experience	(not applicable)
Person with lived experience	(not applicable)
Person with lived experience	(not applicable)
Person with lived experience	(not applicable)
Person with lived experience	(not applicable)
Senior Enterprise Architect	Boots
Pharmacist	Boots
General Dental Practice Committee Executive	British Dental Association
Pharmacist Specialist	Care Quality Commission
Associate Product Manager	Cegedim Healthcare Solutions
Technical Product Owner	Cegedim Healthcare Solutions
Head of Information Governance	Cerner
Analyst	Channel 3 Consulting
Consultant	Channel3 Consulting
Head of Clinical Safety	EMIS
Product Manager	Healthcare Gateway
Community Involvement Worker	Healthwatch West Sussex
Person with lived experience	Humanity & Integrity in Public Sector Services
Honorary Research Officer	Imperial College London
Pharmacy Affairs Manager	McKesson UK
Volunteer	N/A
Policy Manager	National Pharmacy Association
IGARD Specialist Member	NHS Digital
Senior Project Manager - Digital PODAC	NHS Digital
Junior Project Manager	NHS Digital
Clinical Lead - Office of the Chief Dental Officer for England	NHS England and Improvement
Senior Programme Manager - Optometry and Dental	NHS England and Improvement
Local Dental Network Chair for Nottinghamshire	NHS England and Improvement

Digital Transformation Lead - Office of the Chief Dental Officer for England	NHS England and Improvement
Senior Policy Lead	NHS England and Improvement
Senior Dental Advisor CVD Prevention Lead, Office of the Chief Dental Officer for England	NHS England and Improvement
Chief Dental Officer England	NHS England and Improvement
Head of Dental Programme	NHS England and Improvement
Information Architect	NHS England and Improvement
Dentist	NHS England and Improvement
CT3 Anaesthetist	North Bristol NHS Trust
Product Director	Orion Health
Service Development Officer	Pharmaceutical Services Negotiating Committee
NHS Community Pharmacy IT Policy Manager	Pharmaceutical Services Negotiating Committee (PSNC)
Director of Delivery and Transformation	PRSB
Standards Assessor	PRSB
Director of Strategy, Communications and Engagement	PRSB
Senior Programme manager	PRSB
Membership and Stakeholder Manager	PRSB
Principal Pharmacist	Regional Drug and Therapeutic Centre
Dentist, Founder	Sermaur.ai Ltd
GP	Silverdale Medical Practice
Patient Representative	Tameside and Glossop Integrated Care Foundation Trust
Assistant Administrator	University of Plymouth
Innovation Manager	Well

Safeguarding and Children's workshop attendees – 13th June 2022

Job title	Company
Analyst	Channel 3 Consulting
Consultant	Channel 3 Consulting
Consultant	Channel 3 Consulting
Digital Nurse Specialist & Health Visitor	Sussex Community NHS Foundation Trust
Ex Dentist and Patient representative	Centre for Perioperative Care
Parent Carer	n/a
Membership and Stakeholder Manager	PRSB
Person with lived experience	n/a
Principal Pharmacist	Regional Drug and Therapeutics Centre

Paramedic and Head of Integrated Governance (999 & 111)	College of Paramedics
Senior Dental Advisor CVD Prevention Lead OCDO	NHS England and Improvement
Person with lived experience	n/a
Professional Advisor in Health Informatics	Royal College of Occupational Therapy
Person with lived experience	n/a
Director of Delivery and Transformation	PRSB
Senior Programme Manager	PRSB
Director of strategy, communications, and engagement	PRSB
Digital Transformation Lead	Office of the Chief Dental Officer for England at NHS England and Improvement

12 Appendix C: The PRSB CIS

The PRSB Core Information Standard (CIS) was initially published in 2019. It is now at version 2.0 as of August 2021⁴.

The 38 sections of the version 2.0 standard, and the ability to expand and collapse the detail with the right and down arrows, is available on the PRSB website⁵.

The PRSB also publishes an “Implementation Guide”⁶ which further expands on the purpose of each section and much more.

Name	Description
▸ Person demographics	The person's details and contact information.
▸ GP practice	Details of the person's GP practice.
▸ About me	About me
▸ Individual requirements	The individual requirements of the person.
▸ Alerts	Details of alerts.
▸ Legal information	The legal information relating to the person.
▸ Safeguarding	The safeguarding details of the person.
▸ Professional contacts	The details of the person's professional contacts.
▸ Personal contacts	The details of the individual's personal contacts.
▸ Participation in research	Participation in research
▸ Referral details	The details of the referral.
▸ Contacts with professionals	The details of the person's contact with a professional.
▸ Admission details	Admission details
▸ Discharge details	Discharge details
▸ Future appointments	Details of future appointments.
▸ Vaccinations	Details of vaccinations.
▸ Problem list	A summary of the problems that require investigation or treatment.
▸ Procedures and therapies	The details of any procedures performed. Includes both psychological and medical therapies and procedures (e.g. cognitive behaviour therapy, hip replacement)
▸ Social context	The social setting in which the person lives, such as their household, occupational history, and lifestyle factors.
▸ Services and care	The services and care provided for the person.
▸ Primary support reason	The primary support reason for social care.
▸ Family history	Family history

⁴ Homepage for the standard <https://theprsb.org/core-information-standard-v2-0/>

⁵ Sections of the standard <https://prsb2.vercel.app/page/core-information-standard> (Figure 12)

⁶ Implementation guide <https://theprsb.org/wp-content/uploads/2021/09/Core-Information-Standard-Implementation-Guidance-v2.0.docx>

Name	Description
▸ Investigation results	Investigation results
▸ Investigations requested	Details of any investigations requested
▸ Examination findings	Examination findings
▸ Pregnancy status	Pregnancy status of the person.
▸ Assessments	Details of the person's assessments
▸ Formulation	Details of the person's formulation.
▸ Risks	Details of any risks related to the person.
▸ Allergies and adverse reactions	Allergies and adverse reactions
▸ Medications and medical devices	Medications and medical devices
▸ Equipment and adaptations	Details of equipment/asset (or modifications) that the Local Authority has provided to the patient.
▸ Plan and requested actions	The details of planned investigations, procedures and treatment, and whether this plan has been agreed with the person or their legitimate representative.
▸ Care and support plan	This records the decisions reached during conversation between the individual and health and care professional about future plans and also records progress.
▸ Contingency/safety plans	These are the things to do and people to contact, should an individual's health or other circumstances get worse for safety.
▸ Additional support plans	Additional support plans
▸ End of life care	Information relating to end of life care. 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.
▸ Documents (including correspondence, audio and images)	Details about documents related to the person.

Figure 10: The 38 Sections of the PRSB CIS#

13 Appendix D: Survey Results

A general (public) survey was conducted on behalf of PRSB from 9th May to 6th June 2022, aimed at professionals and service users working in or accessing health and care settings.

The survey was: *“predominantly aimed at health and care professionals and service users to determine the breadth of information professionals currently access and would like to access in the future and the type of information that people who use services want and expect those caring for them to view and access.”*

The survey consisted of the following fourteen questions:

- Q1. Are you filling in this survey for yourself or for someone else?
- Q2. Where in the UK do you use or work in health and care services?
- Q3. In which capacity as your answering this survey?
- Q4. If you work in health or care, which setting do you predominantly work in?
- Q5. Do you have access to the following: Summary Care Record, Shared Care Record, GP record, local hospital record or other?
- Q6. Which IT systems can you access?
- Q7. The PRSB Core Information Standard defines a set of information that can be shared between systems in different sites and settings, among professionals and people using services. Will shared care records (which use the PRSB Core Information Standard) meet your information needs?
- Q8. Is any information missing that you need to access?
- Q9. Can the following people view your health records online: Dental professionals, Optometry professions, Pharmacy professionals, Ambulance professionals, Community professionals?
- Q10. Do you have to tell health and care staff your health and care history?
- Q11. What information do you think health and care staff should always have access to?
- Q12. What information should health and care staff should sometimes have access to?
- Q13. If you think health and care staff should only sometimes have access to your records, describe when they should have access and when they shouldn't have access.
- Q14. Is any information missing that you think these health and care staff should be able to see in your records?

There were 140 responses to the PODAC survey, 11 represented group feedback and 129 were personal, of these 128 were based in England, 14 Scotland, 9 Northern Ireland and 8 Wales.

As detailed above the first six questions focussed on who the respondents were, where they worked and what systems they could access.

35% of the respondents were Pharmacists/Pharmacy technicians (49), 18.5% (26) service users or their next of kin. The remaining 65 respondents covered a variety of disciplines and support services.

There were 132 responses from those identifying as working in health or care, just over 12% claiming to be predominantly hospital based. The remainder covered a variety of community locations including home care, primary care dentistry and care homes.

69 respondents claimed existing access to some form of care record, with the Summary Care Record most predominant, with 57 accessing it. Additionally, access was available to Shared Care records, GP Connect and local hospitals, with 8 respondents also detailing separate systems which they were connected to including one on the Ministry of Defence system, one on a patient demographic system and one on the SE London local care record. 87 respondents identified a primary IT system for their access with EMIS and “in house system” claiming the most users (21/20 respectively).

Question Seven asked whether respondents believed that the PRSB CIS could meet their needs in respect of shared data. 89 responses were received, of which 72 believed it could either fully or somewhat (34/38 respectively). 20 recipients did not know; only 2 believed that it could not.

Question Eight asked if there was anything missing that needed to be accessed. 90 responses were received, with 30 suggesting that there would be gaps. Of these 35 identified examples of what they believed would be lacking, including medicines dispensed, usual pharmacies, medical histories, recent GP consultations. The subsequent workshops were able to remove all these misconceptions, with the single exception of genomics, which is not currently applicable to PODAC NHS commissioned direct care. This led to the unanimous decision that the PRSB MIS COULD be used to enhance the development and delivery of a shared care record across the NHS.

Question Nine, asking who could access health records online, garnered just 26 responses, of which 13 were “don’t knows” ... 11 believed that Community professionals had access, 8 pharmacy, 5 ambulance and 4 each dental and optometrist.

Question Ten asked if health and care staff have to be told your health and care history. Again, there were only 26 responses, only one recipient said no, 11 saying sometimes, the remaining 14 yes. A variety of reasons were given for these responses, with no common theme arising other than “it depends on” circumstance

Questions Eleven and Twelve asked what information health and care staff should “always” or “sometimes” have access to. The respondents numbered between 26 and 24 of the 140 total. The table below summarises how they responded.

There were four options available in each case:

- A My Shared Care Record that many care providers can access and contribute to
- B Summary Care Record created from the GP record
- C GP record including information on medicines, vaccines, test results and communications
- D Only What I give them permission to see

SERVICE	A		B		C		D	
	ALWAYS	SOMETMES	ALWAYS	SOMETMES	ALWAYS	SOMETMES	ALWAYS	SOMETMES
Pharmacy	6	9	8	4	5	5	6	5
Optometry	5	10	8	3	4	2	5	8
Dentistry	8	9	6	3	9	5	2	4
Ambulance	10	10	8	5	6	6	2	2
Community	8	9	5	3	8	5	4	5

The results were rather inconclusive. During the workshops and related discussions some of the uncertainties were addressed, the conclusion being that the more access that could be arranged the better for all BUT RBAC must be prioritised in all cases.

Question 13 asked respondents to clarify the conditions they believed should apply for “sometime” access. 18 respondents gave answers ranging from health workers needing to understand the importance of confidentiality, to “explainable clinical reasons”.

Question 14 asked for details of any information which respondents believed to be missing. 12 positive responses were received, including a “best to ask them”. The findings were dealt with and addressed during the workshop sessions.

In response to Question 15 52 respondents asked to be included in future update on the project or from PRSB in general.

Conclusion

From the survey responses it was clear that there was support and endorsement for use of the Core Information Standard within PODAC care settings access Shared Care Records. However, there are certain factors which need to be considered during implementation pilots for example:

- ensuring confidentiality of a person’s shared care record data
- ensuring that the shared care record was only accessed when appropriate
- frequency with which a care professional has access to shared care records
- presentation of the shared care record data in a useable and useful manner in each care setting, and for each type of care professional
- ensuring that the timeliness of the shared care record data is understood by the care professional when making decisions based on the data
- the shared care record will (probably) be the largest data set accessed by the care professional and the organisations therefore will have an impact on operational processes and governance (or at least trigger a review)

These conclusions are in part endorsed by a comment provided for sharing in the free text space of the survey, from NHS 24 (the Scottish NHS 111 service) ... *“there is the potential to have too much data information within that record, which could potentially affect the amount of information processing undertaken by the professional. It would be beneficial if the record was developed in real time and adjusted according to the information a professional enters into the record and a ‘streamed’ edition of that record is tailored to meet the needs of the patient presentation in the out of hours period – thus providing the right amount and type of information for the professional, at the right time. It is likely that the Digital Prescribing and Dispensing Pathways Programme in Scotland will adopt the PRSB Medication standard that now forms part of the FHIR Medication Standard, and NHS 24 is supportive of this approach*

14 Appendix E: User Cases

During the online workshops a few user case scenarios were employed to test whether the identified access levels would be effective, utilised and timely.

Free and open debate and discussion was encouraged, with views being sought from participants, both verbally and within the “chat” environment available for each workshop.

These user cases are provided for both information, and to encourage further use as the deployment of the PRSB CIS for PODAC services is undertaken

For each workshop we focussed on the following, which built upon the information extracted from the user survey:

Questions specific to each PODAC care setting



- 1. Is this the correct level of information available for the care professionals to effectively perform in their roles?*
- 2. Were any safety issues to professionals and service users avoided or mitigated by professionals having access to the shared care record?*
- 3. Is there any additional information required?*

There are three examples of the user case scenario included within this appendix:

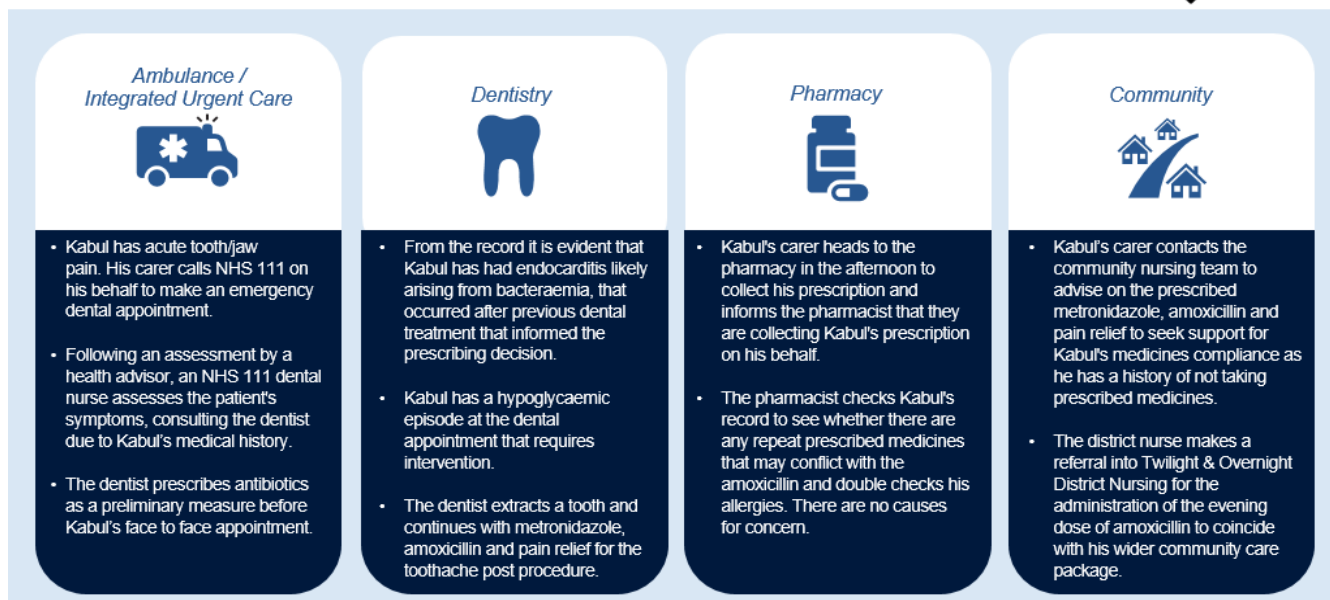
14.1 – Kabul’s story which was dentistry focussed

14.2 – Dorothy’s story which was ophthalmology focussed

14.3 – Stacy’s story which was focussed on children’s care and safeguarding

14.1 Kabul's story – Dentistry focussed

Kabul's story



Section 1: Ambulance (111) and Patient Transport services

- Kabul is a 36-year-old person, who is morbidly obese with a BMI of >60.
- He wakes up one Sunday morning with a throbbing pain at the back of his gum and lower jaw with some local associated swelling.
- During his morning visit his carer, Adriana, calls NHS 111 to seek advice on the management of his dental symptoms since he is not registered with a dentist. The call handler asks for permission to access Kabul's shared care record; he asks for the carer's details and can see they are saved under Kabul's personal contacts. He asks her to confirm Kabul's date of birth and address, which she does. The call handler sees an alert for Kabul's mobilisation difficulties and needs arising from his weight, which is also recorded under his individual requirements. There is an alert flagging that he requires bariatric beds and chairs at appointments.
- The NHS 111 call handler transfers Adriana to have a telephone assessment with a dental nurse based in the clinical assessment service. The dental nurse reviews Kabul's shared care record and can see that he has had previous heart problems (endocarditis caused by bacteraemia that occurred after a previous dental abscess). Kabul also has several co-existing co-morbidities, including grade 3 pressure injuries proximal to a chronic pilonidal sinus, unmanaged type 2 diabetes that requires insulin, and repeated and systemic localised infections.
- The dental nurse uses the directory of services to identify the urgent dental care telephone service. They mention the information regarding Kabul's bariatric needs on his patient record. The dental nurse requests for a dentist to call Kabul back within two hours, because based on his medical history, he may require provisional steps before his examination.

Section 2: Dentistry (NHS funded)



- Two hours later, Kabul receives a call from a duty dentist at the out of hours NHS dental service. The emergency dental service dentist checks the summary care record. The dentist can see that Kabul has a history of endocarditis that occurred following a previous dental abscess. The dentist prescribes prophylactic antibiotics as a preliminary step before Kabul's appointment and advises Kabul that he may require a surgical procedure based on his symptoms. The clinician can commence antibiotic treatment and pain relief and advises that he will need to be seen in 4 days at the community dental service which has bariatric facilities.
- Adriana contacts the community dental service which is based in a local hospital and run by the NHS community trust to request hospital transport for Kabul for his appointment scheduled for after he finishes his course of antibiotics, given his special requirements that includes a bariatric dental chair and wheelchair access.
- Kabul arrives at the community dental service surgery and whilst waiting in the reception area he starts swearing and acting aggressively, causing disruption in the waiting room and making other patients anxious. The receptionist checks Kabul's shared care record and can see that there is an alert on his record flagging to make appointments in the morning because he is prone to episodes of diabetic hypoglycaemia which can result in him acting volatile and appearing incoherent.
- The receptionist flags this with the dentist. The dentist requests that the receptionist accesses glucose (dextrose tablets) from the medical emergency kit for Kabul. Kabul is reassured and comforted by the dentist and receptionist; he settles down and becomes visibly more coherent after a few minutes.
- Upon examination, the Dentist can see he has a broken and a severely decayed tooth that had caused the abscess. As Kabul has already finished a course of prophylactic antibiotics, the dentist performs a tooth extraction procedure.
- The dentist prescribes Kabul with a further prescription for antibiotics and pain relief after performing the procedure. Kabul's dental record states that his carer is his primary contact. With Kabul's permission, the dentist calls his carer Adriana to ask her to pick up Kabul's prescription that day.

Section 3: Pharmacy (NHS funded)



- Adriana travels to the pharmacy in the afternoon to collect Kabul's prescription and informs the pharmacist that they are collecting Kabul's prescription on his behalf.
- The pharmacist can verify this by looking at Kabul's record where the collection arrangements are noted.
- The pharmacist checks Kabul's record to see whether there are any repeat prescribed medicines that may interact with the antibiotics and double checks his allergies; there are no causes for concern.
- The pharmacist dispenses the prescribed medicines to Adriana with appropriate advice. She advises no alcohol when taking metronidazole.

Section 4: Community (District Nursing and Twilight & Overnight District Nursing)



- Kabul is under the care of district nursing with a care and nursing package in place that includes personal care, support with medicines administration, daily wound dressing for an ongoing pilonidal sinus and pressure injuries. Adriana calls the district nurse that regularly visits Kabul, to seek support for Kabul's medicines compliance as he has a history of not taking prescribed medicine. They agree to administer the oral medication during scheduled visits for wound care in collaboration with the care at home team.
- During the phone call with Adriana about the medicines management, it was noted that the district nursing service is not commissioned to visit service users more than twice daily, so would be unable to administer all doses prescribed each day.
- The district nurse makes a referral to twilight and overnight district nursing and care at home service operated by the same NHS trust to create a care plan to administer oral medication for 7 days, ensuring that Kabul has his third dose administered and finishes his course of antibiotics.
- The nurse makes the referral via telephone. She speaks to one of the twilight and overnight district nursing administrator, who loads Kabul's patient record after confirming his NHS number and date of birth. The administrator sees an alert and an individual requirement regarding Kabul's weight, as well as the fact he is prone to hypoglycaemic episodes early in the morning and late at night. The administrator flags this with the Nurse triaging the referral who allocates a two-person team to attend the visit, to ensure that appropriate care and team safety can be ensured.

14.2 Dorothy's story – Optometry focussed

Dorothy's story



Ambulance



- Dorothy has a fall at home.
- A paramedic is called out. Once Dorothy is stable, they have a collaborative clinical discussion with a care of the elderly admission avoidance service clinician via a phone call; to seek support on trying to manage Dorothy's needs in the community rather than at hospital. This is in line with Dorothy's wishes.
- A referral is made to a rapid response team by the paramedic, so Dorothy can be assessed and treated at home.

Community



- The rapid response team arrive at Dorothy's home.
- An occupational therapist provides some independence aids to minimise the risks of further falls. They also make a referral into community rehabilitation therapy for re-enablement.
- The rapid response on call clinician makes a referral to the virtual ward operating within the same NHS trust to keep Dorothy at home with medication and monitoring.

Pharmacy



- Dorothy is discharged from the virtual ward, then later has an episode of diarrhoea, headaches and blurred visions.
- Her daughter picks up her repeat prescriptions and asks her pharmacist for advice on whether Dorothy's condition is affected by her medication.
- The pharmacist checks her repeat prescriptions for allergies and potential side effects of prescribed medication.

Optometry



- Dorothy has an optometry appointment to rule out any health condition related to eye deterioration.
- The optometrist rules out any health-related eye conditions and prescribes distance vision glasses.
- The optometrist advises more regular visits to monitor any vision related side effects from her prescribed medication.

Section 1: Ambulance (999)



- Dorothy is an 81-year-old person who lives alone. Her daughter, Kate, lives a 15-minute walk away and cares for her full-time.
- One day whilst Kate is preparing her lunch, Dorothy has an acute episode whereby her cognition appears to be impaired, and as a result, trips down a couple of steps whilst walking into her garden.
- Kate calls 999 and an ambulance arrives on the scene promptly. The paramedic assesses her, she has no injuries and no impairment to her mobility. She is visibly confused but stable.
- After assessing Dorothy, the paramedic asks the daughter whether she has any health conditions they should be made aware of. Kate informs them that she has Alzheimer's and atrial fibrillation. The paramedic accesses Dorothy's shared care record and can see from her recent admission and discharge details that she has been admitted into hospital six times in the last year. Two of these were for acute delirium and the other four episodes were for urinary tract infections (acute urosepsis). The paramedic takes a range of physiological measurements and assesses that Dorothy's NEWS2 score is low. The paramedic then takes a urine sample and tests it with a dipstick. Dorothy's urine is cloudy and has strong odour. The dipstick tests showed positive to blood, white blood cells and nitrites, pointing towards a bacterial infection.
- The paramedic evaluates the information accessed on the shared care record. The information presented suggests that Dorothy could potentially be treated in the community which is in line with her pre-expressed wishes. The paramedic makes an informed decision to call the care of the elderly admission avoidance service, who make a referral into the local NHS rapid response service.
- The care of the elderly admission avoidance service's clinician makes a 2-hour urgent crisis response referral via the direct phone line for the local rapid response service, who can assess and treat Dorothy at home to avoid an acute hospital admission.
- The rapid response service clinician accepts the referral and confirms that a nurse and occupational therapist will arrive within half an hour. The on-call clinician accesses the shared care record to include the relevant detail on the referral form so that other healthcare professionals accessing the shared care record can see details of this acute episode.

Section 2: Community (Rapid Response, Virtual Ward & Falls Clinic)



- 25 minutes later the rapid response nurse and occupational therapist arrive at Dorothy's home with IV antibiotics and IV fluids as directed by the rapid response on call clinician.
- The nurse moves Dorothy somewhere more comfortable with the assistance of the paramedic, then check her vitals again, her catheter and performs a brief cognitive screen. The nurse records the clinical notes into the EPR system which updates Dorothy's shared care record.
- The occupational therapist can access the shared care record and finds out that Dorothy is quite frequently having slips and trips. The occupational therapist provides some independence aids, including a Zimmer frame, perching stool and chair raisers, to minimise the risks of further falls in the short term. Kate confirms that Dorothy is having problems with steps and edges. The occupational therapist discusses re-enablement goals with Kate, who is Dorothy's lasting power of attorney, then creates a personalised care plan on the EPR. The occupational therapist makes a referral into the community falls service for further assessment and advice on falls prevention. Dorothy is placed on the waiting list for an initial assessment.
- The clinician on call sees Dorothy's updated clinical notes on her record, they arrange a follow-up visit from the rapid response nurse that responded to the referral. They also allocate a health support worker in the service to visit that evening to take and record Dorothy's observations.
- The clinician on-call makes a referral into the frailty virtual ward operating within the same NHS community trust to administer IV antibiotics, IV fluids, and monitoring after the rapid response follow-up visit. Virtual wards support patients, who would otherwise be in hospital, to receive the acute care, remote monitoring and treatment they need in their own home or usual place of residence. Virtual wards provide acute clinical care at home for a short duration (up to 14 days) as an alternative to care in hospital.
- 3 days later Dorothy finishes her course of IV antibiotics and fluids and is discharged from the care of the virtual ward with a prescription for nitrofurantoin to be taken orally for another 7 days.

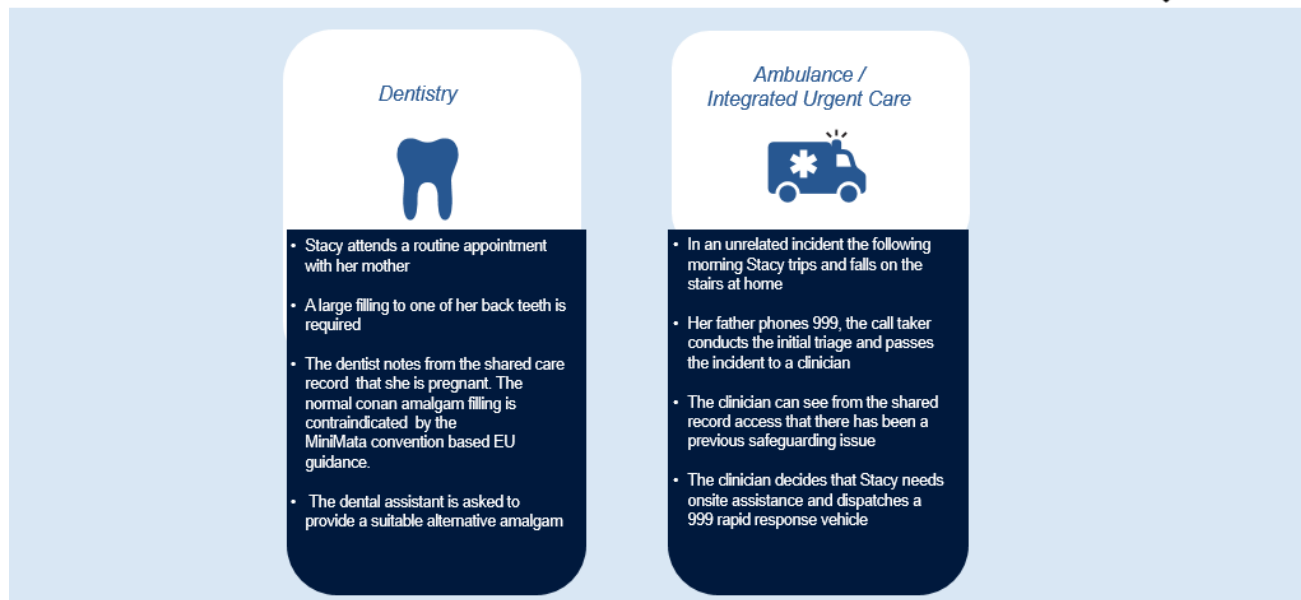
Section 4: Optometry (NHS Funded)



- The GP recommends that Dorothy stops taking the nitrofurantoin immediately as her UTI symptoms are no longer present, and she has taken most of the course.
- Dorothy has been accommodating to walking with a Zimmer frame following a history of numerous falls. She enjoys watching TV and watching her grandchildren play in the garden. She is more stable with a walking frame, but her daughter has noticed that since, she's still complaining about blurred vision. Dorothy has been walking into furniture and losing interest when watching TV. Kate makes an appointment at her local high street optometrist for the next day.
- The optometrist suggests distance vision glasses may help when she is walking around. A moderate myopia is found, and a prescription is arranged to address this. Distance glasses are prescribed and are to be dispensed in a week's time. A glasses chain is given to prevent the spectacles slipping if Dorothy is leaning over on her walking frame.
- Whilst updating Dorothy's optometry record, the optometrist notices that she is on digoxin and other medication that could potentially impact her vision. The optometrist advises that Kate book a regular eye tests with retinal OCT scans every 6 months for Dorothy.

14.3 Stacy's story – Child & Safeguarding focussed

Stacy's story



Stacy's story

Stacy is a 15-year-old who is pregnant and needs a large filling on her back tooth.

Her Mother does not know about her pregnancy but attends Stacy's dental appointment with her.

Stacy does not declare her pregnancy status at the appointment in case her mum finds out.

As Stacy is pregnant, and the Dentist is able to see this via the Core Information Standard, conan amalgam filling is contraindicated by the MiniMata convention-based EU guidance on the use of amalgam in pregnant women, therefore an alternative filling material is required and used.