URGENT REFERRAL FROM CARE HOME TO HOSPITAL

Implementation Guidance v 1.0

OCTOBER 2020
Acknowledgements

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

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Revision History

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<th>Date</th>
<th>Summary of Changes</th>
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<td>1.0</td>
<td>20/10/2020</td>
<td>Approved version for publication (in draft)</td>
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Approved by

This document was approved by the following:

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<tr>
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<td>30/09/20</td>
<td>0.3</td>
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<tr>
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<td>Advanced Decision to Refuse Treatment</td>
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<tr>
<td>BIA</td>
<td>Best Interest Assessor</td>
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<td>CHI</td>
<td>Community Health Index</td>
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<tr>
<td>COVID - 19</td>
<td>Corona virus disease – 2019</td>
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<tr>
<td>CSP</td>
<td>Care and support plan. Used interchangeably with DCSP</td>
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<td>DCSP</td>
<td>Digital care and support plan. Used interchangeably with CSP</td>
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<tr>
<td>dm+d</td>
<td>Dictionary of medicines and devices</td>
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<td>DoLS</td>
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<td>EPR</td>
<td>Electronic Patient Record</td>
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<td>FHIR</td>
<td>Fast Healthcare Interoperability Resources</td>
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<td>GP</td>
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<td>HL7</td>
<td>Health Level 7</td>
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<td>LPA</td>
<td>Legal Power of Attorney</td>
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<td>MCA</td>
<td>Mental Capacity Assessment</td>
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<tr>
<td>Metadata</td>
<td>A set of data that describes and gives information about other data</td>
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<tr>
<td>MHA</td>
<td>Mental Health Act</td>
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<tr>
<td>NICE</td>
<td>The National Institute for Health and Care Excellence</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NHSE/ NHSEI</td>
<td>NHS England/ now NHS England Improvement</td>
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<td>Acronym</td>
<td>Description</td>
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<td>--------------------------------------</td>
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<tr>
<td>NRLS</td>
<td>National Record Locator Service</td>
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<td>ODS</td>
<td>Organisation Data Service</td>
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<td>PDS</td>
<td>Personal Demographic Service</td>
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<td>PRSB</td>
<td>Professional Record Standards Body</td>
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<td>SCCI</td>
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1 Introduction

1.1 Purpose of this document

This document provides guidance to support the implementation of the urgent referral from care home to hospital information standard.

It provides general guidance as well as guidance for each specific part of the standard.

PRSB has carried out a clinical safety review in accordance with DCB0129, which is detailed in the clinical safety case and accompanying hazard log. This guidance should be used in conjunction with section 2.4 Risk Mitigation.

This guidance should be used in conjunction with the final report for the digital social care standards.

1.2 Background

NHS Digital is delivering the Social Care Pathfinder programme; funding 16 local programmes to implement innovative technology and information solutions to improve sharing of information between social care and health care. The local programmes will deliver national outputs to support wide-spread national adoption. The outputs include the development of new, or changes to existing, information standards and the Professional Record Standards Body has been commissioned to support this.

One of the areas identified for a new information standard is in support of the work of the Sutton and South Gloucestershire pathfinders in their further development of Sutton’s existing ‘Red Bag’ initiative. The red bag contains important information and items that care home residents need when they are transferred into hospital in an emergency. The information is contained in printed documentation and includes a checklist of what has been included in the bag as well as:

- CARES Escalation Record
- Older Persons Assessment Form
- ‘This is me’ leaflet
- MAR sheet / chart

The items also included in the red bag could be medications and belongings such as glasses, hearing aids, dentures, clothes, toiletries and valuables. The contents of the bag are tracked from the care home into hospital and back to the care home using the checklist.

The ‘Red Bag’ Hospital Transfer Pathway was developed by the Sutton Homes of Care Vanguard in 2015.

The Hospital Transfer Pathway (often called the ‘Red Bag Pathway’) aims to ensure that every care home resident has a red bag containing their personal information documents, medications, belongings, and clothes for travelling.
By April 2019 the Sutton Demonstrator project showed that two older people’s care homes could send electronic ‘Red Bag’ documentation direct into the local hospital’s Electronic Patient Record system which would normally be transported by paper.

There are different levels of implementation of the concept of the ‘Red Bag’ nationally. In some areas, patients may be admitted with a GP referral letter or only an ambulance assessment and admission proforma. Not all residents are transferred with a red bag and when they are the contents can be incomplete. Contents vary from the resident’s physical possessions to only documentation. It is hoped that by developing a national standard information sharing can improved.

This national information standard builds on the work of Sutton by defining a national information standard to support the transfer of information during an urgent referral from care home to hospital.

The standard reuses existing information components defined by the PRSB as part of other standards to ensure the information is interoperable. The information included in the ‘Red Bag’ was widely consulted on resulting in the final information standard. The approach to consultation is described in the final report.

1.3 Implementation guidance development and updating process

This guidance was developed on the basis of extensive consultation described in the final project report. However, it will be refined and updated regularly as it is anticipated that there will be further findings and feedback as the standard is implemented in practice.

1.4 Audience – who is this document for?

This guidance is intended for anyone implementing and using the urgent referral from care home to hospital information standard. This will include health and social care professionals, IT system suppliers, developers, and implementors.

1.5 Purpose of the urgent referral from care home to hospital standard

A care home resident could be urgently referred to hospital after a GP has seen the resident (during normal working hours). In this case a GP referral letter would typically be transferred with the resident. If a resident must be treated and admitted urgently, and a GP cannot be contacted (out of hours), the care home staff would call an ambulance.

This standard sets out the clinical, demographic and social information that needs to be available to the clinicians (and other professionals) in hospital in order to care for and support the patient during their hospital stay – some of this information will need to come from the care home, some may be better sourced from other records (e.g. the GP record).

This standard has been designed from the perspective of the information needs of the clinicians in hospital caring for the patient which may differ for example between a geriatrician and a nurse working in A&E. It is therefore important that the information is displayed in a way that allows the different end users of the information to be able to easily access the information they need quickly (particularly in an emergency
situation) with the ability to access other / more detailed information should they need it.

It is recognised that although care homes will hold much of the information they will not necessarily hold all the information (for example all the relevant medical history), for their residents and that some of the information may be better sourced elsewhere e.g. the GP record or the Summary Care Record. It is also recognised that there are different approaches to sharing the information in different areas. Some areas will share information using a shared care record and others will transfer information between systems. It is likely that a combination of information from the care home and information from other sources will be necessary. For example, the most recent information related to the referral should come from the care home and/or GP such as:

- reason for referral
- relevant medical history
- information about how the presenting complaints and issues have been managed
- recent relevant assessments and observations (so that clinicians can use this as a baseline to assess the current condition and determine what level of improvement they should be aiming for)
- medications administered (this is useful information for the clinician so they can see the pattern of medications taken over the previous 24 – 48 hours which may be erratic if the patient is unwell)
- information about day to day dependencies (including mobility needs) and behaviours (e.g. behaviour support plan)
- legal information held by the care home such as Deprivation of Liberty Safeguards

Other important information may be held in other records and/or by the care home and it is important that the latest and complete information is made available to the hospital team caring for the patient. This includes:

- preferences and wishes (including end of life e.g. Advance statement, DNA-CPR)
- legal information such as lasting power of attorney, mental health act status, mental capacity assessment
- personal and professional contacts
- individual requirements - reasonable adjustments that must be made by the health and care services so that the person can access services
- medications
- allergies and adverse reactions
- problems/diagnoses
- procedures
- assessments
- investigation results
- social context
- risks such as risk of self-harm, risk from others, risks to others, risk of accidents, risk of infection
- safeguarding concerns

Use of this standard is not designed to add additional burden onto already busy care home staff as it is anticipated that this information would be held electronically and could be extracted and shared digitally. However, it is recognised that the volume of information is a concern particularly as only about 25% of care homes are digitised and it is more difficult to supply paper-based information because with digital systems the system can be either designed to pre-populate forms directly from the record or information can be exchanged between systems digitally. To support this there are very few mandatory sections within the standard, however software suppliers would be expected to build the capability to support the standard in its entirety into its solutions. There is an urgent need to develop the digital capability of care homes if information sharing is to improve between health and social care.

1.6 Definition and scope of the urgent referral from care home to hospital standard

This standard defines what information should be available to clinicians and professionals in hospital when receiving an adult patient from a care home in an emergency. It is intended to be used across the UK.

1.6.1 What it is:

The urgent referral from care home to hospital standard is:

- a definition of the information required by the hospital team to holistically continue the care and treatment of an adult patient when admitted from a care home to the hospital in an emergency
- applicable to urgent referrals from all care home types – nursing (e.g. for people with severe learning or physical disabilities) and residential
- IT system agnostic
- designed to support the digital sharing of information

1.6.2 What it is not:

The urgent referral from care home to hospital standard is not:

- a definition of how information should be presented to professionals
- a definition of how the information should be captured / sourced

1.6.3 How it works:

The standard includes a core set of information that is directly related to the referral and identifies other important information pertaining to the person, for example an end of life plan, which should also be accessible to the professionals in hospital caring for and treating the person. This additional information may be held in the care
home, by the GP or in other records and may be in the form of structured data or documents.

Documents may be communicated as attachments or be made available from other records.

2 General guidance

This section describes general principles and rules covering this standard in its entirety. Section 2.1 outlines how the standard is organised and the rules governing how the information is entered and utilised; section 2.2 considers external dependencies affecting implementations, sections 2.3 – 2.12 cover general implementation guidance and principles.

2.1 Structure of the PRSB standards explained

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

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

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

<table>
<thead>
<tr>
<th>Information Components</th>
<th>Model Description</th>
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<tbody>
<tr>
<td><strong>Section</strong></td>
<td>A section groups together all the information related to a specific topic e.g. ‘Medications and medical devices’ and ‘Person demographics’. It is the highest level to logically group data elements that may be independent or related. For example:</td>
</tr>
<tr>
<td></td>
<td>- ‘Legal information’ includes a set of independent elements or information items, grouped in a logical section.</td>
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<tr>
<td></td>
<td>- ‘Medications and medical devices’ includes sets of related elements with dependencies between the elements.</td>
</tr>
<tr>
<td><strong>Record entry</strong></td>
<td>A record entry within a section is used where a set of information is repeated for a particular item, and there can be multiple items. For example, for each medication there is a set of information associated with that medication. Other examples are allergies or adverse reactions and procedures.</td>
</tr>
<tr>
<td>Cluster</td>
<td>This is a set of elements put together as a group and which relate to each other; e.g. medication course details cluster which is the set of elements describing the course of the medication.</td>
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<td>---</td>
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</tr>
<tr>
<td>Element</td>
<td>The data item. An element can appear in one or more sections e.g. name, date.</td>
</tr>
<tr>
<td>Information model rules and instructions</td>
<td><strong>Description</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Cardinality</strong></td>
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| | **Conformance** | Conformance defines what information is ‘mandatory’, ‘required’ or ‘optional’ and applies to sections, record entries, clusters and elements. The IT system must be developed to be handle all the information elements that are defined in the Standard but not all the information is required for every individual record or information transfer. The following set of rules apply to enable implementers to cater for the end users (senders and receivers) requirements:  
- Mandatory – the information must be included  
- Required – if it exists, the information must be included  
- Optional – a local decision is made as to whether the information is included  
These rules apply at all levels and give the flexibility to allow local clinical or professional decisions on some |
information that is included, while being clear on what is important information to include.

For example, a person subject to a referral may have many assessments, but not all of these will be relevant to the referral. The conformance can be used to allow just relevant assessments to be included.

Assessment Section – Required – i.e. its important information you must include if you have it.

Record entry level – Optional – allows a local decision on what assessments are included, so only relevant ones are included based on clinical or professional needs.

Assessment elements – Conformance set on the normal basis of which elements for an assessment are mandatory, required or optional.

**NB:** It is permitted to upgrade a conformance rule but not to down grade one. For instance, a section that is classed as optional in the standard can be upgraded to required or mandatory in local implementations. However, one that is classed mandatory or required cannot be downgraded to required or optional.

<table>
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<tr>
<th>Valuesets</th>
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| Valuesets describe precisely how the information is recorded in the system and communicated between systems. This is required for interoperability (for information to flow between one IT system and another).

The information can be text, multi-media or in a coded format. If coded it can be constrained to SNOMED CT and specific SNOMED CT reference sets, NHS Data Dictionary values or other code sets.

| Table 1: PRSB information standard data structure |

In the annotated example shown below for Allergies:

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

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

- The national and local Information Governance frameworks which will determine information access and sharing controls and legitimate relationships between health and care provider organisations.

- Technical messaging standards e.g. FHIR profiles (to support the transfer of information between local health and care systems).

- The availability of other sources to access some of the person’s care information such as the national record locator service (NRLS), GP records and shared care records.

- For digital implementation of the standard to support interoperability between systems care homes require digital systems in place that can capture information about the resident and share information with other systems.
2.3 End user requirements and user interface principles

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

- All the information in the referral standard should be available to the receiver. How this is achieved will depend on the maturity of local systems to share information. As set out above, the information may come from a variety of sources not just the care home.

- The information should be from the source where possible. For example, records of recent GP consultations should be from the GP record, records of recent A&E attendances should be from the hospital record and records of problems / diagnoses should be from the GP record and hospital records rather than from the care home, if the information can be accessed.

- Local agreements will need to be drawn up between organisations, including details of the information to be communicated, including which optional sections will be utilised; and the order in which sections appear for example.

- The sections are intended to support navigation around the record and are clinical groupings of related sub-sections and elements.

- The information can be displayed in any format as designed by the end user and supplier. The standard provides a common structure to the record, not a style guide.

- Communications should be brief, where possible, containing only pertinent information.

2.4 Risk Mitigation

We recommend system suppliers and local implementers apply further mitigations when implementing the urgent referral from care home to hospital standard, by addressing the risks that have been flagged in the accompanying clinical safety case report and hazard log in order to reduce the risk scores to 2, or better than human transcription alone when carrying out clinical risk assessments and developing safety cases with respect to DCB0129 and DCB0160.

2.5 Information Governance

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

2.6 Data Quality

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

It is vital for use of the data that all contextual information is maintained and should not be lost on exchange or import of information. For example, if a frailty assessment was undertaken at the care home 2 days before the individual was admitted to hospital it is important that the full context of the information is known (where and when the assessment was done and by whom).

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

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

- **Location** - the place in which the activity took place e.g. observations were made.

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

- **Person completing record** - is the person that recorded the information and has various attributes; name, role, speciality and organisation and the date the record was completed. This is expected to be automated and linked to audit trail (see section 2.8).

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

The principle applied in the information model is that where it is important (from a professional perspective) to know who undertook the activity and who recorded the activity, ‘Performing professional’ and ‘Person completing record’ will be included in the model. For every item of information shared it is important that an audit trail is recorded (even if not explicitly stated in the information model). This is set out below.

2.8 Time stamp and audit trail

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

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

The person may have multiple detailed records or documents held on local systems, e.g. there may be a mental health record for a person at a particular trust or shared care records such as an end of life care plan. The National Record Locator Service will, in due course, hold the links to the person’s records that reside in multiple different systems. This information standard does not define all these possible links. It is expected that the local areas will define the requirements for accessing other records or documents, where applicable and provide access through the shared care record for authorised professionals.

2.10 Use of terms

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

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

Some clusters such as referrer details have elements for one or more of specialty, team, service and department. This is to allow for all situations across health and care where different terms are required. Where possible specialty and service should be used and coded as detailed in the value set for the element.

2.11 Coding

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

2.12 Accessibility

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

3 Guidance for specific sections and sub-sections

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

3.1 Person demographics

3.1.1 Person Identifiers

This section contains the person’s demographic and contact details including key identifiers e.g. name, date of birth, NHS number, address etc.
The PDS (Personal Demographics Service) should be used as the source of this information.

NHS number (or equivalent, e.g. CHI number in Scotland), is the primary person unique identifier however existing national guidance should be followed, including how to handle patients without an NHS number, for example, overseas visitors. Verification of the NHS number is required.

The person’s correct address can be a potential source of error. Include the person’s current place of residence as the primary address (this will be the care home address). There can be multiple addresses associated with a person including temporary and correspondence addresses.

3.1.2 Sex and Gender

Displaying ‘sex’ and ‘gender’ data items, in the demographic model, may cause accidental disclosure of gender reassignment of the person, during use of the referral standard. Having both fields on display may show a difference and therefore disclose gender reassignment without consent. It is unlawful to disclose, without consent, a person’s gender reassignment with or without a gender reassignment certificate. Please refer to current national guidance.

This risk can be mitigated by appropriate implementation; refer to the clinical safety case report and hazard log. Two options are proposed, either ‘sex’ can be left out or ensure the design of the standard, including its Information Governance model, reduce this risk to an acceptable level. For example, move ‘sex’ from the demographics to under clinical as it is classed as clinical concept.

3.1.3 Telephone number

The person’s telephone number and other contact details should be the details for reaching them at the care home.

3.1.4 Photograph

The photograph of the person is intended to be used by staff in hospital caring for and supporting the care home resident in hospital as a clear understanding of the how the person normally is and looks enable some parameters to be measured. This includes stress, anxiety as well physiological markers. It is important that the photograph is kept up-to-date.

3.2 About Me

This section supports sharing of information that the person thinks is important to share with professionals. This could include information about their needs, preferences, concerns and wishes. For example, it could include that a person is a carer and so the person they care for will need help were they to go into hospital.

‘About me’ should be prominently displayed in the record as it is important information about the person relevant to all care and support providers. This information may be available in multimedia formats e.g. jpeg, mp3 etc. These documents are likely to follow a variety of formats but should be transferred in their entirety.
Care will need to be taken in local implementations to differentiate between ‘About me’ and things like ‘Advance Directives’ and preferences and wishes expressed in other care plans such as end of life plans.

See separate implementation guidance on ‘About Me’.

3.3 GP practice

This section contains details of the GP practice where the person is registered. This information would be sourced from PDS. This will include the GP practice identifier code. In situations where a person is not registered with a GP practice, the GP practice identifier would contain the appropriate code to indicate this.

This section would also need to accommodate details for temporary GP where the patient is registered away from their usual place of residence.

3.4 Legal information

This section identifies whether there is legal or formal documentation relating to the care of the person. This includes Lasting Power of Attorney (LPA), Deprivation of Liberty Safeguards (DoLS), Advance Decision to Refuse Treatment (ADRT), Mental Capacity Assessments (MCAs) and Mental Health Act (MHA) status.

The documentation may be available centrally as part of shared care records or held locally by the care home. How the documentation should be stored / shared is a local implementation decision. The standard allows for documents to be attached with the message alternatively a URL/address for where the document is located could also be shared (e.g. potentially using the National Record Locator Service in due course).

3.4.2 Deprivation of Liberty Safeguards (DoLS)

Although a request for authorisation for deprivation of liberty would be made by the care home and hospital separately (related to the specific need) it is important for the hospital receiving the care home resident to know whether the care home has or had a deprivation of liberty request authorised for the resident.

3.4.3 Mental Capacity Assessments

There should be provisions for more than one mental capacity assessment to be shared. If sharing the outcome of a mental capacity assessment it is important to record to which decision it relates.

The mental capacity assessment is based on one of the following Acts:

- Mental Capacity Act 2005 (England and Wales)
- Adults with Incapacity Act 2000 (Scotland)
- Mental Capacity Act 2016 (Northern Ireland)
3.4.4 Mental Health Act

Similarly, there can be more than one record of ‘Mental health act status’ (a record of a decision to detain the person diagnosed with a mental disorder under the Mental Health Act or equivalent.

3.5 Safeguarding

This section includes any concerns in relation to safeguarding. Appropriate policies and technical solutions need to be in place to insure there is appropriate and timely access to this information.

3.6 Individual requirements

This section allows for the sharing of any individual requirements the person may have, such as to support accessibility requirements, cognitive impairment or mobility issues when they are not unwell such as identified during a moving and handling assessment.

3.6.1 Reasonable adjustments

Within individual requirements there is a section to record reasonable adjustments. These are adjustments that must be made by the service, to enable the person to access the service, to comply with the Equality Act 2010.

For example:

- Reading Braille
- Using a hearing aid
- Using visual aids for communication
- Needing an interpreter
- Requiring a hoist when transitioning from a wheelchair
- Requiring help to stand up or balance

SNOMED codes should be used for this where a code exists. This set of codes is being updated regularly. If a code doesn’t exist for a particular adjustment, free text should be used to define the adjustment.

In line with existing systems such as the Summary Care Record the adjustment is defined as a coded item and supporting free text.

The code may be specific or generic and the free text may be blank (the code alone tells the story) or rich where a very specific adjustments is recorded against the generic code.

Table 2 below provides examples:

<table>
<thead>
<tr>
<th>Code</th>
<th>Free text</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires written information in at least 24 point sans serif font</td>
<td></td>
<td>Little or no free text needed as the coded items should be detailed enough?</td>
</tr>
</tbody>
</table>
Requires Reasonable adjustment  |  James will have a meltdown if he sees anyone in a white coat so please do not wear one. All coloured uniforms appear to be ok but please be aware.  |  Bespoke adjustment code used – indicates its reasonable adjustment of some sort and the detail of the bespoke tailored adjustment is in the free text.

<table>
<thead>
<tr>
<th>Impairment</th>
<th>Equality Act definition of disability – Impairment</th>
<th>Code description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autism</td>
<td>Autistic Spectrum Disorders (ASD)</td>
<td>Impairment related to autism (Equality Act 2010)</td>
</tr>
<tr>
<td>Developmental conditions (excluding autism)</td>
<td>Developmental conditions (excluding autism), such as dyslexia or dyspraxia</td>
<td>Impairment related to developmental conditions (excluding autism) (Equality Act 2010)</td>
</tr>
<tr>
<td>Dementia</td>
<td></td>
<td>Impairment related to dementia (Equality Act 2010)</td>
</tr>
<tr>
<td>Learning disability</td>
<td>Learning disability</td>
<td>Impairment related to learning disability (Equality Act 2010)</td>
</tr>
<tr>
<td>Mental Health Condition</td>
<td>Mental health conditions with symptoms such as anxiety, low mood, panic attacks, phobias or unshared perceptions</td>
<td>Impairment related to mental health condition (Equality Act 2010)</td>
</tr>
<tr>
<td></td>
<td>Eating disorders</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bipolar affective disorders</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Obsessive compulsive disorders</td>
<td></td>
</tr>
</tbody>
</table>

Table 2: Example use of codes and free text for reasonable adjustments

Key points:

- Users must use specific codes when they exist so that systems can functionally respond to the adjustment e.g. Automatically print letters in 28 point font OR prompt the system user to do this. They must comply with the accessible information standard – not just put text against a bespoke adjustment.
- Systems that do not use accessible information codes must use the equivalent free text rubric – see DCB1605 for the model we follow for all codes. The implementation of DCB1605 is our model.

3.6.2 Impairments

In addition, there is a section for impairments which records the impairments for which reasonable adjustments are required. There is currently no SNOMED reference sets for impairments therefore local codes are used. These should be recorded as per table 3 below.
<table>
<thead>
<tr>
<th>Physical disability</th>
<th>Produced by injury to the body, including to the brain.</th>
<th>Impairment related to physical disability (Equality Act 2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensory disability - such as sight, hearing or verbal</td>
<td>Sensory impairments, such as those affecting sight or hearing;</td>
<td>Impairment related to sensory disability (Equality Act 2010)</td>
</tr>
<tr>
<td>Long-term condition</td>
<td>Impairments with fluctuating or recurring effects such as rheumatoid arthritis, myalgic encephalitis (ME), chronic fatigue syndrome (CFS), fibromyalgia, depression and epilepsy</td>
<td>Impairment related to long-term condition (Equality Act 2010)</td>
</tr>
</tbody>
</table>

Progressive impairments such as motor neurone disease, muscular dystrophy, and forms of dementia

Auto-immune conditions such as systemic lupus erythematosus (SLE)

Organ specific conditions including respiratory conditions, such as asthma and cardiovascular diseases, including thrombosis, stroke and heart disease.

There is specific guidance in relation to HIV, cancer or Multiple Sclerosis

Patient would prefer not to say

Patient prefers not to share impairment

Not currently recorded

no code

Table 3: Recording of impairments
3.7 Professional contacts

This section should include current details of health and care professionals, teams or organisations involved in the care of the person. Third sector organisations can be included.

For example, the name and contact details of the person’s current care coordinator, a person’s Independent Mental Capacity Advocate (IMCA), key worker, local authority liaison, care home manager, community learning disability team, the local authority’s Best Interest Assessor (BIA) should be included here.

3.8 Personal contacts

This section includes the personal contacts (e.g. family, friends, relatives etc.) including informal carers. Relationship type should be used to share information such as if a particular contact is a carer, Next of Kin, Nearest Relative, emergency contact, Lasting Power of Attorney, dependent, etc.

3.9 Participation in research

This section should include details of research the care home resident is actively involved in if it involves medication or treatments e.g. a clinical trial. If the research involves medications it is very important to know about as it may have resulted in the reason for the referral to hospital and / or it may affect the diagnosis or treatment.

It is not used to record a personal preference to participate in research.

3.10 Referral details

This section includes a record of the current referral from the care home to the hospital.

3.10.1 Referrer details

This information should include the details of the professional, team or organisation making the referral. Contact details are mandatory to enable the hospital to contact the referrer if there is a need for additional information.

3.10.2 Referral to

If known, the professional, team, specialty, service or organisation the care home resident is being referred to should be included.

3.10.3 Return response to

This can be used where the outcome of a referral needs to be directed to a specific professional or team within the referring organisation. Systems should allow this field to be automatically completed and default to the care home. Systems should also allow for it to be potentially turned off. A decision should be made locally about how it is used.
3.11 Reason for referral

This section is used to record the health problems that have led to the urgent referral, information related to each problem including the development and characteristics of each problem, information about how the problems have been investigated and treated and how the person has responded to any treatment.

Any speculative or working diagnosis / primary care reason should not be coded but included as narrative.

3.12 Contacts with professionals

This section is used for information about recent (for example within the last 12 months) contacts the care home resident has had with health and care services. Information about GP consultations and A&E attendances are important for the hospital teams to be aware of. It is important that this information comes directly from the source e.g. the GP record for information about GP consultations and the hospital record for A&E attendances. This information may need to be filtered to only display what is relevant for the professional’s discipline.

3.13 Admission details

This section is for information about recent admissions (for example within the last 12 months). Include the relevant site code according to the Organisation Data Service (ODS) codes. This information should come direct from the source e.g. the hospital record.

3.14 Problem list

This section allows for all relevant diagnoses, symptoms, conditions, problems and issues.

Although a care home may hold a problem list it may not be complete therefore ideally the problem list should come from the original source of the information e.g. the GP record, if available. If it is not available from the source, the information should be sent by the care home. The section is set to ‘required’ which means that if information about problems exist in the care home the section should be included however, at record entry level it is set to ‘optional’ to give local flexibility in what information is sent about problems from the care home depending on local availability of information from other records.

The problem list would include disabilities, including learning disabilities, and conditions such as autism where they fall into the above categories i.e. are diagnosed, seen as a problem by the person or are considered a condition or similar. Behavioural factors which are not formal diagnoses but could be seen as a problem for the person would also appear under this section.

‘Onset date’ should be included where available even if this is estimated in source systems.
When a diagnosis has not yet been made, the most granular clinical concept with the highest level of certainty should be displayed. This may be a problem, symptom, sign, or test result, and may evolve over time, as a conventional diagnosis is reached. For example, ‘dyspepsia’ may be the diagnosis when a patient first presents with indigestion, upgraded to ‘gastric ulcer’ when this is found at endoscopy, and ‘gastric cancer’ when biopsies reveal this.

Unconfirmed or excluded diagnoses should not be included in structured coded fields, but may be included in free text in the comments field. Thus, in the example above, gastric ulcer and gastric cancer may be in a list of differential diagnoses at presentation, but the symptom, dyspepsia, should be included in the diagnosis field. The differential diagnoses should only be included in free text in the comments field, and not in a coded diagnosis field until confirmed with confidence.

Comorbidities should be shown as separate diagnoses. For example, dementia may be recorded as a primary diagnosis by a psycho-geriatrician, but as a co-morbidity where a patient is admitted for a hip replacement. Local implementations will need to define what will be prioritised according to each use case.

In some situations, a diagnosis may need to be qualified by a number of attributes to give further detail. A generic approach to these attributes (such as grade; severity; distribution; behaviour; laterality etc.) has not yet been agreed. Until this is achieved it is recommended that these features are included as free text comments.

### 3.15 Procedures

This section includes details of procedures performed. Which procedures are communicated and visible to viewers of the information should be based on what they need to know for this referral. Procedures vary significantly between primary and secondary care and therefore different types of procedures are more or less relevant in different care scenarios.

Although a care home may hold some information about procedures, it may not be complete. Ideally the problem list should come from the original source of the information e.g. the GP record, if available. If it is not available from the source, the information could be sent by the care home. The section is set to ‘required’ which means that if information about procedures exist in the care home the section should be included however, at record entry level it is set to ‘optional’ to give local flexibility in what information is sent about procedures from the care home depending on local availability of information from other records.

Procedures include diagnostic as well as therapeutic procedures and will need to be clearly defined as such in local implementations.

Outcomes or results of procedures should be included in comments.

The record should include what was actually carried out, not the planned procedure as this may have been changed. The detail should be taken from the record of the actual procedure (e.g. operating note).
The procedure, anatomical site and laterality should be SNOMED CT coded wherever possible, with free text as an option where this is not possible.

There are specific elements for complications relating to the procedure and anaesthetic issues

The anaesthesia issues included could be, for example, “short neck, difficult to intubate” and the actual intubation grade or adverse reactions.

3.16 Social context

This section includes information about the social setting in which the person lives, such as occupational and educational history, and lifestyle factors. Social circumstances include the person’s social background, network and personal circumstances. ‘Smoking status’ should be shared using SNOMED CT rather than yes or no.

3.17 Care needs summary

Include a narrative summary of the person's care needs e.g. catheter/ continence/ stoma care, skin care (wounds, ulcers), tracheostomy, nutrition and fluids, behavioural care and support. Attach additional support plans that are relevant to the referral as required.

Aids (e.g. needs Zimmer frame) and adjustments required due to needs related to mobility, cognitive impairment, communication and culture will be recorded under ‘Individual Requirements’ and Reasonable Adjustments’.

3.18 Investigation results

This section includes details of the investigation results. Systems should allow copies of reports, scans, images related to the investigation results to be shared with the record. It allows for results in either structured format (e.g. blood tests) or unstructured format (e.g. genetic test with the result as a report). One or other of these should be used for the result. Investigation results received from laboratories may be imported into this section.

This information should come from the source (e.g. GP record) however, if an investigation is carried out in a care home e.g. a test for COVID-19, the results of the investigation can be sent using this section.

This section is set to ‘required’ which means the section must be included. The record entry is set to ‘optional’ to indicate that only investigations carried out by the care home and relevant to the referral should be included which should be determined locally.

3.19 Examination findings

This section is a summary of key findings carried out as a result of an examination conducted by a healthcare professional. Each record of an ‘Examination finding’ should include a named examination and associated findings, which may include both coded and narrative elements.
‘Observations’ includes a record of essential physiological measurements, e.g., heart rate, blood pressure, weight, height, temperature, pulse, respiratory rate, oxygen saturation.

This section is set to ‘required’ which means the section must be included. The record entry is set to ‘optional’ to indication that only examination findings and observations relevant to the referral should be included (recent information) which should be determined locally.

Many care homes are now equipped to collect a NEWS2 score with baselines, history and current score at the time the call was made to healthcare professionals leading to the hospital admission. It is important for the hospital to have access to recent baseline information about the care home resident in order to understand what is normal for the individual and how rapidly they have deteriorated. This information should be sent from the care home where possible.

3.20 Current pregnancy

This information should be shared if the care home resident is currently pregnant.

Obstetric and gynaecological history, specifically any complications, would be shared in the problem list (history) for professionals that need and are authorised to have access to the information.

If a person is pregnant there should be an electronic shared maternity record and if professionals need, and are authorised to access it, they should be able to link to the more detailed record. This would be through the national record locator service.

3.21 Assessments

This section includes details of a person’s assessments allowing for unstructured, semi structured and structured outputs from the assessment. Some assessment outputs will be narrative and may come with their own sub-sections e.g. psychiatry (Presenting Problem, Personal/Family History, Mental State Examination etc.)

This section would also accommodate the results of any more structured assessment tools completed (e.g. screening tools/outcomes measures such as PHQ-9 or GAD-7). Numeric results of any assessments completed can also be included.

Care homes will have information about some assessments for example Waterlow, smoking and frailty assessments. Recent assessments (prior to the resident becoming unwell) relevant to the referral e.g. a frailty or Waterlow assessment is particularly important when a care home resident is referred into hospital because professionals need to know how the resident is on a typical day and how rapidly they have deteriorated.

The section is set to ‘required’ which means that if information about assessments exist in the care home the section should be included however, at record entry level it is set to ‘optional’ to indicate that only assessments that are relevant to the referral should be included.
3.22 Risks

Categories of risks are as follows: Risk to self, risk to others, risks from others, risk of accidents, risk of infection and other risks to cover anything else. Risks identified by the care home should be included but this information should be supplemented by risks identified by health and social care professionals in other settings from other sources (e.g. GP record).

There should be mechanisms in place to validate this information and for it to be reviewed regularly and if applicable ended.

3.23 Allergies and adverse reactions

Guidance on good practice recording of allergies and adverse reactions is provided by NICE (https://www.nice.org.uk/guidance/CG183/chapter/1-Recommendations).

A record should be provided of all allergic and adverse reactions relevant to the person. Coded information on causative agents is important to healthcare professionals to enable safe prescribing of medications.

When an individual is diagnosed with an allergy related condition (e.g. anaphylactic shock or urticarial skin rash) this will be entered in addition into the diagnosis field in the healthcare system and will need to be cross referenced into the problem list and prominently displayed there.

Where there is a diagnostic code for an allergy recorded in the system, the system should trigger an allergy entry. There is a significant risk to patient safety if allergies are not explicitly and prominently displayed.

Adverse reactions need to be treated in a similar manner.

Information about probability of recurrence may be included in the allergy comments element if this has been identified.

Care homes may hold some information about allergies and should send this information with the referral however, it should be validated against other sources of information e.g. the GP record.

3.24 Medications and medical devices

Please refer to the PRSB website to keep informed of the latest developments with the Medication information modelling for interoperability (https://theprsb.org/projects-2/digitalmedicationinformation/)

This section is for details of the medication the person is taking when referred to hospital. It allows for information about recent changes in medication and any medications that have been discontinued. It also allows for information about support the care home resident needs to adhere to the medication regimen.

Any medical devices not prescribed should be entered in the medical devices record entry.
Items such as hearing aids, spectacles, wheelchairs and walking sticks would be recorded as medical devices in alignment with the Medicine and Healthcare Products Regulatory Agency (MHRA)¹ and NHS Data Dictionary² definitions which states that a medical device includes items “for the purpose of... compensation for an injury or handicap”. The MHRA states that equipment intended for alleviation of, or compensation for a disability may or may not be considered as medical devices. The determining factor will be whether or not there is a direct link between the corrective function of the equipment and the individual concerned and that there is a stated medical purpose.

Equipment issued to support activities of daily living (that are not directly linked to an individual) such as alarms, keysafes, handrails etc. would not be considered medical devices and would be recorded in the ‘Equipment and adaptations section’.

A review will be carried out into the modelling of medical devices and equipment within the PRSB information models to determine whether it needs to change to better align with the clinicians’ and professionals’ expectations.

This section also allows for details of medications that have been administered (if the details are structured). If the Medication Administration Record (MAR) chart is not structured it should be sent as a document (see section 3.28).

Care homes may hold some information about medications and should send this information with the referral however, it should be validated against other sources of information e.g. the GP record. Information from the MAR chart should also be sent with the referral to provide information about medications administered recently to the care home resident.

3.24.1 Medication item entry cluster

The medications section allows for using structured dose and timing information that is machine readable to facilitate the reading and transfer of medications information between systems and providers of care, through the structured dose direction cluster. Technical guidance for implementing the structured dose and timing in Fast Healthcare Interoperable Resource (FHIR) messaging is available from NHS Digital:


The free text Dose directions description is the form of dosage direction typically used in UK GP Systems.

Dose direction duration can be derived from the start and end dates if no other information is available.

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² https://www.datadictionary.nhs.uk/data_dictionary/classes/m/medical_device_de.asp?shownav=1
When sharing Dose duration direction, the following examples are provided to clarify definitions for two of the coded text items which appear similar. In both cases, these directions are not an absolute instruction. They are:

- ‘continue medication indefinitely’ - ongoing treatment planned for example when starting daily aspirin or a statin. There will be circumstances where you would stop them such as a GI bleed.
- ‘do not discontinue’ refers to medication where suddenly stopping could be dangerous, for example the abrupt withdrawal of long-term steroids.

3.24.2 Over the counter medications

All over the counter (OTC) medications that the person uses regularly which are not prescribed by a medical professional should be recorded and communicated. These may or may not be required for the treatment and management of their health condition(s). Examples include analgesics for pain relief (brufen tablets); topical anaesthetics (voltarol gel); vitamin and mineral supplements (folic acid and calcium); herbal medicines (St Johns Wort). Include details of reason for use, dose amount, frequency, start date and duration of medication.

These medicines will be recorded in the medication item entry with a flag to identify them. Any display of OTC medications should show them separately from prescribed medications for clarity.

3.24.3 Additional instructions

This may include guidance to the prescriber, person or person administering the medication including covert medication instructions. For example, include specific instructions such as does the person need a dosset box, do the tablets need crushing and to be given with food, what covert medicine is given and how etc... Other type of comment includes “Omit morning dose on day of procedure”, "for pain or fever", "Dispense weekly".

In some settings, specific Administration Instructions may be re-labelled as "Person advice’ or 'Dispensing Instruction’ to capture these instructions. It is important to share this information, so the person’s medicines are administered effectively.

3.24.4 Medication changed and discontinued by the hospital

The medication changes cluster and medications discontinued cluster are to ensure clarity of what medications have changed or been stopped in hospital.

3.24.5 Medical devices record entry

The Medical devices element is for medical devices that cannot be prescribed and do not have representation in the NHS dictionary of medicines and medical devices (dm+d). Whilst medical devices that can be prescribed in primary care are generally well represented in dm+d, there are other kinds of devices used in hospital care which may not be, therefore this section provides for this.
3.25 Contingency plans

This section includes contingency / crisis plans for those people who have specific and predictable risks associated with their health and wellbeing. It describes how disruptions to the care and support plan should be addressed.

A contingency plan sets out what should be done if the person’s condition or other circumstances get worse.

This section is set to ‘optional ‘to reflect the fact that not all contingency plans need to be shared, only those that are relevant to the referral.

3.26 Additional supporting plans

This section includes additional supporting plans, which may be linked to the person’s care and support plan. Examples of additional supporting plans include: The Asthma UK action plan, a mental health plan (for people that are supported by a Care Programme Approach package), tissue viability plans, nutrition plans, a falls prevention plan, an end of life care plan, a behavioural support plan, a hospital or other service transfer of care plan etc.

The format of additional supporting plans will vary according to the type of plan. Some may be structured and coded, others may include diagrams or images.

This section is set to ‘optional ‘to reflect the fact that not all additional supporting plans need to be shared, only those that are relevant to the referral. An example of an additional supporting plan that is likely to be relevant is a behavioural support plan.

Additional supporting plans, if relevant to the referral, should be available for others to view, but will only be created, updated and ended by the service creating the plan.

See the detailed guidance in the Digital Care and Support Plan for further information: https://theprsb.org/standards/dcsp/.

3.27 End of life care

This is not an end of life care plan, but this section contains information that would be expected in an end of life care plan. It provides details of a person’s end of life preferences and wishes including cardio-pulmonary resuscitation decision (CPR), advance statement, anticipatory actions, anticipatory medicines/equipment, preferred place of care and preferred place of death.

Note: professionals reviewing end of life care information should also refer to the Legal Information section as a record of an Advance Decision or Lasting Power of Attorney would be included there.

The information included in the standard is consistent with the end of life minimum dataset and SCCI1580. However, PRSB recognises that there is work to do to develop a nationally agreed information standard for an end of life care plan.

3.28 Documents

This section includes details for documents and images. It includes the metadata that is required for the document or image and a link to the actual document or image.
When displayed in a record, documents and images should be organised logically in date order. Local implementations will need to determine the best logical groupings for use here. It is expected that the care home will transfer the MAR chart if the information is not available in a structured format, a body map if available and other documentation relevant to the referral such as a weight chart or plans such as a behavioural support plan.

The section is set to ‘required’ which means that the documents section should be included however, at record entry level it is set to ‘optional’ to indicate that only documents that are relevant to the referral should be included.

3.29 Property and equipment

This section is to record personal items that are transferred to the hospital with the care home resident to ensure that they are sent back to the care home with the resident when they are discharged. This could include glasses, hearing aids and clothes.

4 PRSB support

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

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