Professional Record Standards Body

COMMUNITY PHARMACY STANDARD

IMPLEMENTATION GUIDANCE

NOVEMBER 2020

1.1 Introduction and background

The pharmacy information flows standard was developed to enable information about person-centered services provided by community pharmacists to be recorded in community pharmacy and transferred in a safe and efficient manner into the patients record, held by their GP practice, providing a more complete record of care to support better, safer, and more connected care.

Following the successful pilot with the transfer of flu vaccination data in the winter, the ambition remains to deliver full interoperability for community pharmacy services. The current standard represents 6 use-cases for specific services and the transfer of information for those services from pharmacy to GP (for the patient record). The implementation of the standard for all these use-cases by the pharmacy systems suppliers is a key stage in the overall adoption. However, with limitations on what GP suppliers can support restricting the initial messaging to just 2 of the use-cases, pharmacy system suppliers have only implemented individual use-cases as required rather than the standard as a whole.

The benefits of the project are expected to include:

- Consolidation of the existing use-cases into a single community pharmacy standard to reflect existing service provision under the Community Pharmacy Contractual Framework (CPCF).
- Consolidation of the existing standard to reflect other standard developments that have been undertaken since the publication of the pharmacy information flows standard that either relate or contribute to this work e.g., dose syntax, clinical referral standard etc.

1.2 Purpose

This document is intended to provide high level guidance for those implementing the Pharmacy Information Flows standards. It contains information relevant to both industry and clinical practice. The intended audience is broad, encompassing all involved in the design, development and implementation of IT solutions which are deploying the standards, including those developing learning resources. The guidance was developed during the development of the standards; it is therefore not able to provide definitive advice as it will be refined in response to findings and feedback during actual implementation.

2.1 General guidance

a) It is not anticipated that all headings will need to be recorded or communicated in all circumstances, only where they are relevant to a specific patient. Headings should not be included in an electronic communication (referred to in this document as a ‘message’) where there is no data recorded/available.

b) The section headings are intended to support navigation around the record and are clinical groupings of related subheadings, rather than having any semantic meaning.

c) Where there is a heading and a subheading with the same name, there is no need to display the heading as well as the subheading in a message.

d) It is not anticipated that local systems will need to change the display of data to comply with the pharmacy information models; local terms and ordering can be maintained as long as they are mapped to the pharmacy information models and associated technical specifications for communication outside the organisation. The order in which headings appear in a message can be agreed locally.

e) Data quality and accuracy of coded data entry needs to be monitored and implementers will need to ensure sufficient training concerning recordkeeping.

f) Each pharmacy record entry must have the date and time recorded and the identity and role of the person making the record. This information should be recorded in an electronic record automatically, by date and time stamping each record and associating it with the personal identification of the individual recording it (e.g., General Pharmaceutical Council (GPhC) number, Spine Directory Service (SDS) identifier etc.). The audit trail needs to be available on the pharmacy system but does not need to be communicated in the message.

g) Information should be auto populated in the pharmacy system, where appropriate, for example from the Personal Demographics Service (PDS). This will reduce the amount of data that has to be re-keyed by pharmacy teams at the point of care, and optimise the usability of the standard. The expectation is that, in time, auto-population will include supply of appropriate SNOMED CT codes, for example by using pick lists of terms from SNOMED CT, and by deriving some data from barcodes (after the implementation of the Falsified Medicines Directive [FMD]).

h) Where contributions are provided by multi-disciplinary team members, not just an individual clinician, the local system should retain an audit trail of the provenance of all contributions.

i) User interfaces should not restrict the order in which clinicians enter data, so that clinicians can navigate forwards and backwards to complete or partially complete sections as information becomes available. This does not negate the rule which stipulates that communication cannot be sent unless all MANDATORY sections are completed (see below for definitions of mandatory, required, and optional).

j) Pharmacists should always use professional judgment to determine what information should be communicated. Just because the system records information does not always mean that it would be relevant to send it to others. Systems should support this by enabling a review of communications by clinicians prior to them being sent.

k) Communications should be brief, where possible, containing only pertinent information, rather than duplicating information which the recipients (e.g., GPs) already have access to in their own records. The system should not require the pharmacist to key in the information if the information can be pulled from other patient medication record (PMR) system data fields.

l) The extent to which information can be taken into the recipient system in structured/coded format will depend on the capabilities of the recipient system. Local decisions need to be made about what information is imported into recipient systems in a structured coded format and what information is attached as a document. Systems should have or be implementing structured and coded recording using SNOMED CT and the NHS Dictionary of Medicines and Devices (dm+d).

m) For inclusion in GP records, the message needs to indicate that it contains information about a new medicine service, medication review, appliance use review or other CPCF services that, if configured by the receiving system, could be either:

   - automatically entered into the receiving system without user intervention
   - added to workflow for clinician review to enable a clinical decision as to whether or not to enter the information into the record

n) Recipients should be able to read all the content (i.e., any coded data should be carried with a human readable term and any associated free text).

o) In the recipient system, the information in the message can be displayed in any format as designed by the end user and supplier. The standards provide a common structure for the communication, not a style guide. Different IT systems can display the same information in diverse ways, but the meaning should remain the same.

p) As part of the implementation, trading agreements will need to be drawn up at a local/regional level (e.g., clinical commissioning groups [CCG]), including:

   - Details of the information to be communicated, including which optional sections will be utilised.
   - The sequence of sections.
   - Which fields will be coded and which textual, depending on the capabilities of the sending and receiving systems.
   - Mapping from local headings/fields to those in the standard should be done by a system supplier clinical lead once for all instances of their system. Where the system allows local configuration, the mapping should be owned by a clinician in each organisation.
   - Requirements for receipt of the communication, e.g., use of a generic mailbox.
   - New work processes for producing and receiving the communication. This will require professional input from local professional leaders.

2.2 Structure of the PRSB standards explained

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

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

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

Information Components	Model Description
Section	A section groups together all the information related to a specific topic e.g., 'Medications and medical devices' and 'Person demographics'. It is the highest level to logically group data elements that may be independent or related. For example: - 'Legal information' includes a set of independent elements or information items, grouped in a logical section. - 'Medications and medical devices' include sets of related elements with dependencies between the elements.
Record entry	A record entry within a section is used where a set of information is repeated for a particular item, and there can be multiple items. For example, for each medication there is a set of information associated with that medication. Other examples are allergies or adverse reactions and procedures.
Cluster	This is a set of elements put together as a group and which relate to each other; e.g., medication course details cluster which is the set of elements describing the course of the medication.
Element	The data item. An element can appear in one or more sections e.g., name, date.
Information model rules and instructions	**Explanations**
Description	This is the description of the section, record entry, cluster, or element. For an element, it describes the information that the element should contain in as plain English as possible.
Cardinality	Each section, record entry, cluster and element will have a statement of cardinality. This clarifies how many entries can be made i.e., zero, one or many entries. The number of records expected and allowed are displayed as: 0……* = zero to many record entries are allowed 0……1 = zero to one record entry is allowed 1……1 = one record is expected 1……* = one to many records are expected For example, the 'Medications and medical devices' section may have zero to many medication item records in it and is displayed as 0…… *.

Information model rules and instructions	Explanations
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 applies 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.
Value sets	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

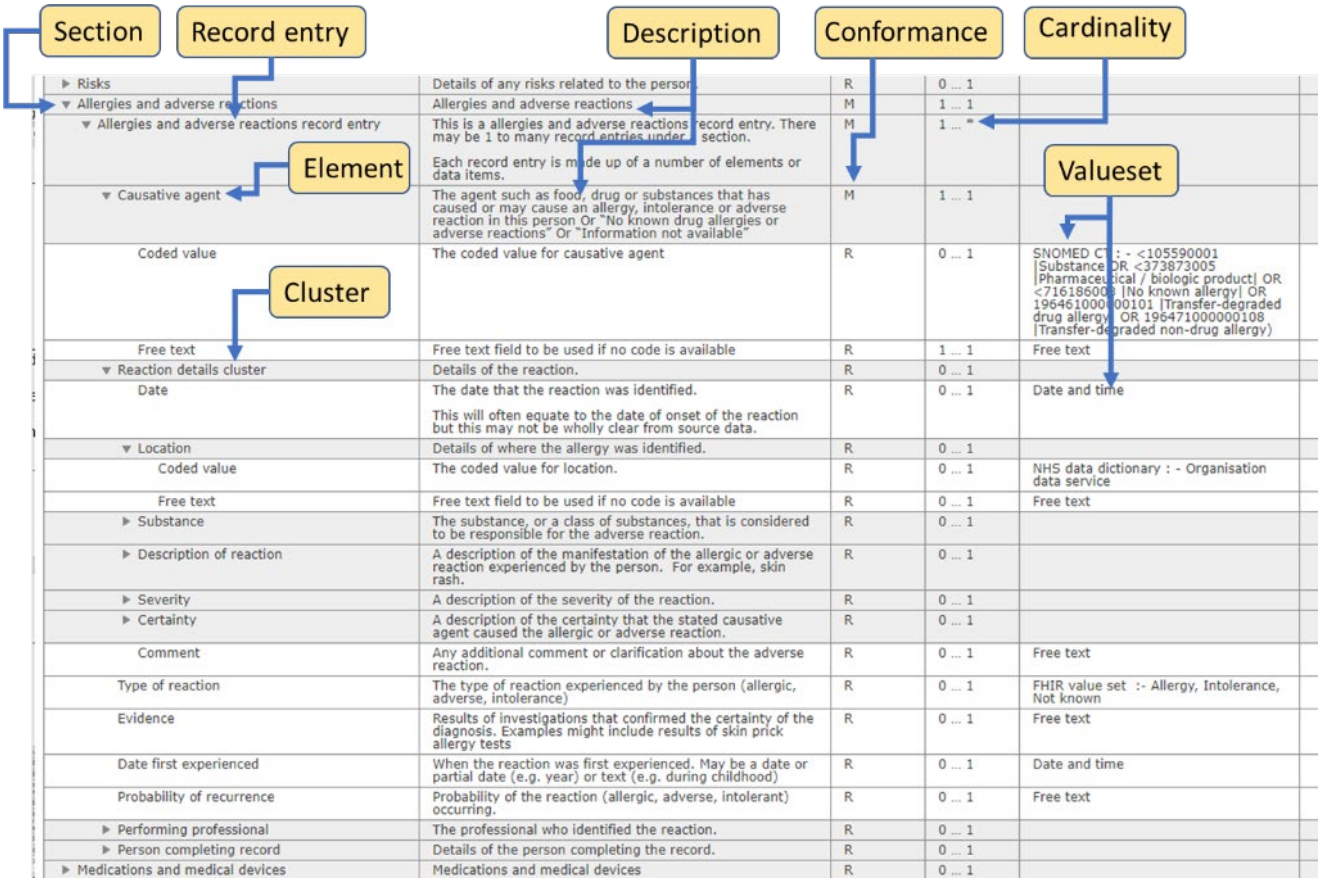
In the annotated example shown below for Allergies:

- The Core Information Standard has a section for 'Allergies and adverse reactions', it's conformance is 'mandatory' and the cardinality is '1 only' (or 1...1) i.e., there must be just one allergies section

- It has a record entry to allow for multiple allergies, which is also 'mandatory' but with a cardinality of 1 to many (or 1...*). The record entry contains a set of elements, i.e., the set of information for each allergy and there must be at least 1 record entry.

- The record entry also includes a cluster (reaction details cluster), which groups the reaction details together.

- Each element has a description, conformance, cardinality and valueset. e.g., Causative agent, which is mandatory with a cardinality of 1 only (or 1…1) and a valueset with two options, coded value with a constrained set of SNOMED codes (including an option for "No known allergy") or free text if coded values are not available. Other elements are required in this example. i.e., the set of information for each allergy or adverse reaction must have a causative agent, and where available should have the other information such as reaction details, substance, severity etc.



▸ Risks	Details of any risks related to the person.	R	0 … 1	
▾ Allergies and adverse reactions	Allergies and adverse reactions	M	1 … 1	
▾ Allergies and adverse reactions record entry	This is a allergies and adverse reactions record entry. There may be 1 to many record entries under this section. Each record entry is made up of a number of elements or data items.	M	1 … *	
▾ Causative agent	The agent such as food, drug or substances that has caused or may cause an allergy, intolerance or adverse reaction in this person Or "No known drug allergies or adverse reactions" Or "Information not available"	M	1 … 1	
Coded value	The coded value for causative agent	R	0 … 1	SNOMED CT : - <105590001 |Substance OR <373873005 |Pharmaceutical / biologic product| OR <716186003 |No known allergy| OR 196461000000101 |Transfer-degraded drug allergy| OR 196471000000108 |Transfer-degraded non-drug allergy\)
Free text	Free text field to be used if no code is available	R	1 … 1	Free text
▾ Reaction details cluster	Details of the reaction.	R	0 … 1	
Date	The date that the reaction was identified. This will often equate to the date of onset of the reaction but this may not be wholly clear from source data.	R	0 … 1	Date and time
▾ Location	Details of where the allergy was identified.	R	0 … 1	
Coded value	The coded value for location.	R	0 … 1	NHS data dictionary : - Organisation data service
Free text	Free text field to be used if no code is available	R	0 … 1	Free text
▸ Substance	The substance, or a class of substances, that is considered to be responsible for the adverse reaction.	R	0 … 1	
▸ Description of reaction	A description of the manifestation of the allergic or adverse reaction experienced by the person. For example, skin rash.	R	0 … 1	
▸ Severity	A description of the severity of the reaction.	R	0 … 1	
▸ Certainty	A description of the certainty that the stated causative agent caused the allergic or adverse reaction.	R	0 … 1	
Comment	Any additional comment or clarification about the adverse reaction.	R	0 … 1	Free text
Type of reaction	The type of reaction experienced by the person (allergic, adverse, intolerance)	R	0 … 1	FHIR value set :- Allergy, Intolerance, Not known
Evidence	Results of investigations that confirmed the certainty of the diagnosis. Examples might include results of skin prick allergy tests	R	0 … 1	Free text
Date first experienced	When the reaction was first experienced. May be a date or partial date (e.g. year) or text (e.g. during childhood)	R	0 … 1	Date and time
Probability of recurrence	Probability of the reaction (allergic, adverse, intolerant) occurring.	R	0 … 1	Free text
▸ Performing professional	The professional who identified the reaction.	R	0 … 1	
▸ Person completing record	Details of the person completing the record.	R	0 … 1	
▸ Medications and medical devices	Medications and medical devices	R	0 … 1	

2.3 Mandatory and optional

a) Within the standards, some of the headings which may be included in a message to a GP will be mandatory, but others will be optional. The information models define which headings may be included in a message to a GP, which of these are mandatory and which are optional.

b) MANDATORY sections must always be included. Other sections are optional. Where there is no information recorded in an optional section, that section should not be

displayed to the recipient, to avoid the recipient having to view communication with blank sections.

c) A distinction has been made between sections which are REQUIRED or OPTIONAL. The definition of each is given below:
    - REQUIRED: if there is information recorded it should be sent to the recipient.
    - OPTIONAL: a local decision as to whether information is sent to the recipient.

d) The project consulted with a wide range of stakeholders to gain consensus on whether the information to be included in a message to a GP should be mandatory, required, or optional. If a section is marked as MANDATORY or REQUIRED, it should not be 'downgraded' to OPTIONAL by local agreement. However, in some circumstances by local agreement headings can be 'upgraded' from OPTIONAL to either REQUIRED or MANDATORY. However, decisions should be made as part of a trading agreement between the parties involved (local GPs and community pharmacies).

e) For each applicable use-case, all sections in the standards must be supported by IT systems, i.e., it should be possible to record and communicate information in all sections. However, there should be flexibility as to which of the optional sections are included in local implementations. This means that all the sections should be available for local organisations to use, but there should be flexibility to allow local choice about which of the optional headings to use.

2.4 Coding

Snomed-CT and dm+d are now NHS standards. Please note:

- The receiving GP systems are due to migrate to SNOMED CT, in a phased approach, from April 2018.
- The ambition is for SNOMED CT and dm+d to be the only clinical coding schemes in use in the NHS by 2020.
- Not all information sent in structured/coded format will be displayed in this format at the receiving end. This will be dependent on the capability of the receiving end system and will vary across organisations. However, the structured coded data should be retained in the recipient system so that it can be migrated to a system that does understand the coding.
- There may be circumstances where the end user needs to be able to see the actual code rather than the text. This could be done in a variety of ways, for example, 'mouse over.'

2.5 Risk Mitigation

We recommend system suppliers apply further mitigations 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.

2.6 Time stamp and audit trail

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

2.7 Falsified Medicines Directive (FMD)

The Falsified Medicines Directive (FMD) is a patient safety feature, designed to thwart the introduction of counterfeit medicines into the legitimate supply chain, with tamper-evident seals and a unique identifier on every pack. The unique identifier is shared by the license holder with a European repository and then onwards to a national repository, allowing pharmacies to verify that the medicine they received is bona fide, through a verification check.

When the medicine is supplied to a patient or otherwise 'taken out of use', the unique identifier is 'decommissioned' to prevent nefarious re-use of the packaging. In the community pharmacy, the verification of the pack will take place when the pharmacist scans the barcode of the pack at the time of supplying it to the public (although pharmacy system suppliers are looking at several ways in which this might be implemented). The presence of the barcode allows the medicine to be identified through the Global Trade Identification Number (GTIN), and includes details of batch and expiry date, so offers the opportunity for accurate capture of this information through barcode scan, populating some fields that will support this standard. More information is available at https://psnc.org.uk/contract-it/pharmacy-regulation/falsified-medicines-directive/

3.1 Hospital discharge to pharmacy services guidance

The view from the PRSB consultation was that the full discharge summary which is sent to the patient's GP (https://theprsb.org/standards/edischargesummary/) should also be sent to the community pharmacy, rather than a subset. For further information see the Pharmacy Information Flows Stage 2 final report. The following additional implementation guidance has been identified for hospital discharge to community pharmacy services:

a) The selection of the community pharmacy should be based upon a patient's choice, rather than an automated selection, in order to allow for a range of patient requirements. Where patients have a registered pharmacy, this should be displayed, but it should be possible to select another pharmacy if the patient prefers to do so.

b) Pharmacy system design can be optimised to display the information from the hospital discharge summary, which is most relevant to the pharmacist, which would be beneficial both for good pharmacy workflow and clinical safety. It may be helpful if systems can re-organise the order of the information for display to pharmacy staff, based on pharmacy feedback, so that more valuable information is more prominent.

c) Where assessment scales are included in a discharge summary, the term has been used as it is generally understood; however, in order to allow values to be recorded under this heading (e.g., assessment scale score) the value set permissible under this heading should be an observable entity e.g., 447316007 | Mini-mental state examination score (observable entity), rather than 273617000 | Mini-mental state examination (assessment scale).

4 Section specific guidance

4.1 Person demographics

a) In England, Spine-compliant systems are needed to obtain traced NHS numbers. Pharmacy systems are spine-enabled for the electronic prescription service (EPS) so should always know the patient's NHS number and hence GP practice. Where an organisation does not have a system linked to the Personal Demographics Service (PDS), other demographics fields will need to be used, with local person identity matching software.

b) Pharmacists record patient demographics for their own records, but they only need to communicate to the GP practice the data items needed for record matching (i.e., NHS number and one other searchable item such as date of birth). NHS Number should only be used if NHS Number Status Indicator Code has value '01' (i.e., it has been verified against the Personal Demographics Service. For Status Indicator Code values other than '01' that the NHS Number should be reported as 'null'. NHS number (or equivalent, e.g., CHI number in Scotland) is required, but with the option to record 'Not Known' or 'Not Available'. Existing national guidance should be followed, including how to handle patients without an NHS number, e.g., overseas visitors, service personnel, prisoners. The 'other identifier' heading may also be used to record the pharmacy case number.

c) System design should allow the display of separate sections for health/care contacts and personal contacts (e.g., family, friends, relatives etc.) under the 'relevant contacts' heading. This heading is where the patient's emergency contacts would be recorded.

d) The mandatory information in this section is person's name, date of birth, sex, and address. On the address, not all the fields have been made mandatory except for the 1st line of address, to allow the input of just enough of a person's address.

4.2 Referrer details

Referrer details (e.g., NHS111, healthcare professional referral) should be copied forward from the referral or transfer of care where possible. Coded text 'self-referral' should be used where the patient is not referred or transferred from a health/care organisation. Where 'self-referral' is recorded the referrer data items should be left blank. Referrals from NHS 111 to a CPCS attendance, the 'reason for referral' may include a diagnosis code and a symptom code.
This section is about who referred the patient to the pharmacy service whereas the 'referral details' section is to provide information to the GP about any referrals made.

4.3 GP practice

'GP practice identifier' does not need to be a displayed field, although the GP Practice Name should be displayed unambiguously to the pharmacist for lookup and selection. It is intended to be used to provide the GP practice details via lookup from national registers.

Many people will not offer a named GP. Only the 'GP practice details' heading would need to be completed in these situations. These details would be obtained by the PDS or via a look up file of Organisation Data Service (ODS) codes provided by NHS Digital.

4.4 Consent

A record of consent for service, consent relating to children and consent for information sharing should be captured in the clinical system. Please note these headings are included in a separate 'consent' section for this standard to reflect the way pharmacists work, however they are also included in the 'legal information' section.

4.5 History

The history section is intended to capture SNOMED CT and free text descriptions of patient history recorded by the pharmacist. This should only include history which is pertinent, for example contraindications, pregnancy, immunosuppression etc.

4.6 Allergies and adverse reactions

a) Patients may return to/contact the pharmacy if they experience a reaction at a later date in relation to a vaccination or supply of medicine. Further consideration should be given about how to notify GPs where an allergic/adverse reaction occurs after the patient has left the pharmacy.

b) Coded information on causative agents is important to GPs to enable safe operation of prescribing decision support. The model proposed here is being adopted across the GP domain to enable interoperable drug allergy information to support patient safety at transfer of care.

c) Existing allergies should not be duplicated. Allergies should only be recorded and communicated to the patient's GP where the pharmacist thinks that the allergy has been newly identified. In this situation a pharmacist must be able to record a full allergy record. Guidance on good practice recording of allergies and adverse reactions is provided by NICE (https://www.nice.org.uk/guidance/CG183/chapter/1-Recommendations). This relates to end systems rather than the transfer of care communication but is included here as its use should improve the quality of the information communicated.

4.7 Information and advice given

a) In some instances, specific information about the information and advice which was given to the patient (e.g., proper inhaler technique) may want to be communicated to the recipient. It is important that this is concise and is only information which it is pertinent for the recipient to be aware of.

b) Where patients are provided with literature (e.g., pamphlets) there is no need to provide details of the information contained in the literature e.g., simply state that the patient was provided with a pamphlet.

c) It is recommended that system design provides drop-down lists of common information and advice given to patients e.g., after care instructions, common side effects, leaflets provided etc.

4.8 Attendance details

a) Location of event should only be populated if the location differs from the organisation address e.g., vaccinations given in care homes etc.

b) Consultation method has been included to accommodate services provided remotely.

c) Pharmacists need to decide, on a case-by case basis, on the need to inform the patient's GP if a patient is not provided with the service and the reason for the non-provision of the service.

d) Reason for service is a required section for new medicine service, medication review and appliance use review, however, in emergency supply this should be configured as a mandatory

4.9 Eligibility Criteria

Eligibility criteria should be recorded in a structured way in the pharmacy system as it is required for contractual purposes. However, this information will be sent to the GP as free text. If the service does not have any specific eligibility criteria, this section should be left blank.

4.10 Vaccination

a) In future, vaccination information will be captured by scanning the GS1 barcode of the vaccine. Additional information on GS1 is available at https://www.gs1uk.org/support/our-standards/discover-gs1-standards.

b) The batch number and expiry date of the vaccination will be recorded in the pharmacy PMR system, but not shared with the patients GP.

c) GPs record vaccinations as procedures, thus it will be important for pharmacists to also record vaccinations as procedures in SNOMED CT, as well as recording the actual product using dm+d. Dose sequence will also be captured by the procedure code. This is important so that a flu vaccination can be recorded as both a clinical intervention and the supply of a medicinal product.

d) For inclusion in GP records, the message needs to indicate that it contains vaccination procedures that if configured by the receiving system could be either: ·

   - automatically entered into the receiving system without user intervention·
   - added to workflow for clinician review to enable a clinical decision as to whether or not to enter the information into the record

4.11 Medications and medical devices

a) Supply type is a heading which identifies the type of medication supply. The following value set has been proposed as part of the NHS Digital curation process: https://fhir.hl7.org.uk/STU3/ValueSet/CareConnect-MedicationSupplyType-1

b) In future, medication information will be captured by scanning the GS1 barcode of the medicine. Additional information on GS1 is available at https://www.gs1uk.org/support/our-standards/discover-gs1-standards

c) The ‘dose directions description’ can now be recorded in a structured way with free text an option for systems unable to manage structured data. Dose syntax should be unambiguous and avoid using confusing abbreviations.

d) In the future batch numbers will be captured from the FMD scan for prescription medicines; however, this does not need to be transmitted to the GP.

e) The total amount of medication supplied should be recorded in a structured format, as per common current practice.

f) Indication is defined as ‘reason for supply’ and should allow for both licensed uses and off-label uses of a medicine.

g) Site and additional instructions should be auto populated where possible to reduce burden on the pharmacist.

h) For inclusion in GP records, the message needs to indicate that it contains ‘medications prescribed elsewhere,’ that if configured by the receiving system could be either:
    - automatically entered into the receiving system without user intervention.
    - added to workflow for clinician review, prior to entry into the receiving system
    - or not entered in the record.

4.12 Plan and requested actions

The plan should make clear who is expected to take responsibility for actions following the encounter, e.g., the person receiving care or their carer; the GP or another heath care professional.
The pharmacy provided plan could be presented in several ways in the system to prompt complete information to be recorded e.g., table, best practice prompts, etc.

This section may include the date of the next planned review.

5 GP Messaging Implementation Guidance

The following table provides GP messaging applicability to the pharmacy information flow use-cases. The first column provides the dataset captured by community pharmacies and the additional columns indicated with a ‘Y’ shows the relevant information sent to the GP systems by use-case.

Dataset	New medicine Service	Medication Review	Appliance Use Review	Vaccination Administration	Emergency Supply	CPCS
Person Demographics						
Person name	Y	Y	Y	Y	Y	Y
Person preferred name						
Person's address	Y	Y	Y	Y	Y	Y
Person's telephone number	Y	Y	Y	Y	Y	Y
Date of birth	Y	Y	Y	Y	Y	Y
NHS number	Y	Y	Y	Y	Y	Y
Sex	Y	Y	Y	Y	Y	Y
Gender						
Other identifier	Y	Y	Y	Y	Y	Y
Person's email address						
Communication preferences						
Relevant contacts						
Referrer Details						
Referrer details						
Reason for referral						
Date and time of referral						
Attendance Details						
Date and time of contact	Y	Y	Y	Y	Y	Y
Service	Y	Y	Y	Y	Y	Y
Contact type	Y					
Consultation method	Y	Y	Y			Y
Organisation name	Y	Y	Y	Y	Y	Y
Organisation address	Y	Y	Y	Y	Y	Y
Organisation contact details	Y	Y	Y	Y	Y	Y
Location of event	Y	Y	Y	Y		Y
Reason for service	Y	Y	Y		Y	
Reason for non-provision of service	Y	Y	Y	Y	Y	Y
Clinician name	Y	Y	Y	Y	Y	Y
Role	Y	Y	Y	Y	Y	Y
Professional identifier	Y	Y	Y	Y	Y	Y
Person accompanying patient	Y	Y	Y	Y	Y	Y
Chaperone			Y	Y		
Person collecting the medicine					Y	Y

Dataset	New medicine Service	Medication Review	Appliance Use Review	Vaccination Administration	Emergency Supply	CPCS
GP Practice						
GP practice identifier	Y	Y	Y	Y	Y	Y
GP name						
GP practice details						
Consent						
Consent for treatment record	Y	Y	Y	Y	Y	Y
Consent for information sharing	Y	Y	Y	Y	Y	Y
Consent relating to child	Y	Y	Y	Y	Y	Y
Allergies and Adverse Reactions						
Causative agent	Y	Y	Y	Y	Y	Y
Description of reaction	Y	Y	Y	Y	Y	Y
Type of reaction	Y	Y	Y	Y	Y	Y
Severity	Y	Y	Y	Y	Y	Y
Certainty	Y	Y	Y	Y	Y	Y
Evidence	Y	Y	Y	Y	Y	Y
Probability of recurrence	Y	Y	Y	Y	Y	Y
Date first experienced	Y	Y	Y	Y	Y	Y
Comment	Y	Y	Y	Y	Y	Y
Date recorded	Y	Y	Y	Y	Y	Y
Medications and Medical Devices						
Medication name	Y	Y			Y	Y
Form	Y	Y			Y	Y
Batch number						
Site					Y	Y
Route	Y	Y				
Indication	Y	Y			Y	Y
Total amount of medication supplied					Y	Y
Dose directions description	Y	Y			Y	Y
Matters identified during the discussion	Y	Y				
Additional instructions					Y	Y
Supply type					Y	Y
Date/time					Y	Y

Dataset	New medicine Service	Medication Review	Appliance Use Review	Vaccination Administration	Emergency Supply	CPCS
History						
Relevant past medical, surgical and mental health history	Y	Y	Y	Y	Y	Y
Information and Advice Given						
Information and advice given	Y	Y	Y	Y	Y	Y
Referral Details						
Referral to	Y	Y	Y	Y	Y	Y
Clinical urgency of referral	Y	Y	Y	Y	Y	Y
Expectation of referral	Y	Y	Y	Y	Y	Y
Reason for referral	Y	Y	Y	Y	Y	Y
Eligibility Criteria						
Eligibility criteria	Y	Y		Y		
Distribution List						
Name	Y	Y	Y	Y	Y	Y
Role	Y	Y	Y	Y	Y	Y
Grade	Y	Y	Y	Y	Y	Y
Organisation name	Y	Y	Y	Y	Y	Y
Team	Y	Y	Y	Y	Y	Y
Relationship to subject	Y	Y	Y	Y	Y	Y
Appliances						
Appliance name			Y		Y	
Product order number			Y			
Manufacturer			Y			
Batch number			Y			
Size			Y		Y	
Weight			Y		Y	
Colour			Y		Y	
Route			Y		Y	
Site			Y		Y	
Quantity			Y		Y	
Indication			Y		Y	
Matters identified during the discussion			Y		Y	
Date/time					Y	

Dataset	New medicine Service	Medication Review	Appliance Use Review	Vaccination Administration	Emergency Supply	CPCS
Plan and Requested Actions						
Actions for healthcare professionals	Y	Y	Y		Y	Y
Actions for patient or their carer	Y	Y	Y		Y	Y
Vaccinations						
Vaccine product				Y		
Vaccine procedure				Y		
Manufacturer				Y		
Batch number						
Expiry date						
Serialisation code				Y		
Site				Y		
Route				Y		
Indication				Y		
Dose amount				Y		
Date/time				Y		
Presenting Complaint or Issues						
Presenting complaint or issue						Y
Clinical Narrative						
Clinical narrative						Y