



**Professional  
Record  
Standards  
Body**

**Better records  
for better care**

# Community Pharmacy Standard General Implementation Guidance

## Document Management

### Revision History

Version	Date	Summary of Changes
0.1	25/08/2021	First draft as general "Guidance for all PRSB standards"
1.0	02/02/2022	First version after incorporating reviewer comments
1.1	25/05/2022	Updated for changes to how provenance data is held in PRSB information models
1.2	17/03/2023	Updated with specific information relating to the Community Pharmacy Standard
1.3	30/03/2023	Updated following feedback from project team
1.4	26/04/2023	Updated following feedback from Assurance Committee and Project Team
3.0	22/05/2023	Changed to V3.0 to match the overall version of the standard
3.01	19/06/2023	Updated matrices to include the Discharge Medicine Service
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Project Board	05-04-2023	1.3
Assurance Committee	13-04-2023	1.3

## Glossary of Terms

Term / Abbreviation	What it stands for
ABPM	Ambulatory Blood Pressure Monitoring
CPCF	Community Pharmacy Contractual Framework
DAPB / DCB / SCCI	Data Alliance Partnership Board, formerly Data Co-ordination Board and Standardisation Committee for Care Information. Acts on behalf of Secretary of State for Health and Social Care to approve health and care data and information standards
dm+d	Dictionary of medicines and devices
EPR	Electronic Patient Record
FHIR	<a href="#">Fast Healthcare Interoperability Resources</a>
GP	General Practitioner
HL7	Health Level 7
Metadata	A set of data that describes and gives information about other data
NHS	National Health Service
NHSDD	<a href="#">NHS Data Dictionary</a>
NHSE/ NHSEI	NHS England/ now NHS England Improvement
NICE	The National Institute for Health and Care Excellence
NRLS	National Record Locator Service
ODS	Organisation Data Service
PDS	Personal Demographic Service
PRSB	Professional Record Standards Body
SNOMED-CT	Systematized Nomenclature of Medicine - Clinical Terms

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# 1 Introduction

## 1.1 Purpose of this document

This document provides general guidance to support the implementation and use of all PRSB standards.

Specific implementation guidance for specific standards at section and element level is available as part of the information model for that standard.

In addition, each standard will have a safety case and hazard log developed and approved in accordance with the DCB0129: Clinical Risk Management standard. This guidance should be used in conjunction with section 0 Risk Mitigation.

## 1.2 Audience

This guidance is intended for anyone implementing and using PRSB standards. This will include health and social care professionals, IT system suppliers, developers, and implementors.

# 2 General Guidance

## 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 titles of Description, Cardinality, Conformance and Valuesets.

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

Information Components	Model Description
Section	<p>A section groups together all the information related to a specific topic e.g. 'Medications and medical devices' and 'Person demographics'.</p> <p>It is the highest level to logically group data elements that may be independent or related. For example:</p> <ul style="list-style-type: none"><li>- 'Legal information' includes a set of independent elements or information items, grouped in a logical section.</li><li>- 'Medications and medical devices' includes sets of related elements with dependencies between the elements.</li></ul>
Record entry	<p>A record entry within a section is typically 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.</p> <p>A record entry has contextual information associated with it. The data model for the context information is determined by the information type</p>

	<p>of the record entry. There are two information types used: “Record” and “Event.Record”.</p> <p>For “Record” entries, the provenance data includes the person recording the data, and the time it was recorded. For “Event.Record” entries, details of the performer of the event, the location, and the time the event happened are also included in the provenance data.</p>
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	<p>The data item.</p> <p>An element can appear in one or more sections e.g. name, date.</p>
<b>Information model rules and instructions</b>	<b>Explanations</b>
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	<p>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:</p> <p>0.....* = zero to many record entries are allowed</p> <p>0.....1 = zero to one record entry is allowed</p> <p>1.....1 = one record is expected</p> <p>1.....* = one to many records are expected</p> <p>For example, the ‘Medications and medical devices’ section may have zero to many medication item records in it and is displayed as 0.....*.</p>
Conformance	<p>Conformance defines what information is ‘mandatory’, ‘required’ or ‘optional’ and applies to sections, record entries, clusters and elements.</p> <p>The IT system must be developed to be able to 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.</p> <p>The following set of rules apply to enable implementers to cater for the end users (senders and receivers) requirements:</p> <ul style="list-style-type: none"> <li>❖ <b>Mandatory</b> – the information must be included</li> <li>❖ <b>Required</b> – if it exists, the information must be included</li> <li>❖ <b>Optional</b> – a local decision is made as to whether the information is included</li> </ul>

	<p>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.</p> <p>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.</p> <p>Assessment Section – Required – i.e. its important information you must include if you have it.</p> <p>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.</p> <p>Assessment elements – Conformance set on the normal basis of which elements for an assessment are mandatory, required or optional.</p> <p><b>NB:</b> 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.</p>
Valuesets	<p>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).</p> <p>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.</p>

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', its 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' so 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.

Section	Record entry	Description	Conformance	Cardinality	Valueset
▶ 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.	M	1 ... *	
▼ Causative agent	Element	Each record entry is made up of a number of elements or data items.	M	1 ... 1	
Coded value	Cluster	The coded value for causative agent	R	0 ... 1	SNOMED CT : - <105590001 [Substance OR <373873005 [Pharmaceutical / biologic product] OR <716186009 [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	

## 2.2 Version Numbering

PRSB standards published with the detailed implementation guidance in the information model use a 3-segment version number, e.g. V3.01.02, while older standards published before the detailed implementation guidance was put into the information model retain the previous 2-segment version number, e.g. V2.02 until their next maintenance release or revision.

2-segment version numbers take the form of major version.minor version, e.g. V2.02 where the information model is major version 2 and minor version 01.

3-segment version numbers use the format Va.bb.cc where:

- a - is the major version number of the information model, incremented on significant revisions or enhancement of the information model
- bb – is the minor version number of the information model, incremented on minor updates such as changes or issue resolutions
- cc – is the implementation guidance version number, incremented whenever the implementation guidance is updated, which can be with or independent from an information model update. At a major revision of the information model this will restart at version 01.

## 2.3 Dependencies

The implementation of PRSB information standards is often 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 (Fast Healthcare Interoperability Resources) profiles (to support the transfer of information between 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.

## 2.4 Risk Mitigation

We recommend system suppliers and local implementers apply further risk mitigations when implementing PRSB standards by addressing the risks that have been flagged in the clinical safety case report and hazard log for each standard. Suppliers and implementors should aim to reduce the risk scores to 2, or better, when carrying out clinical risk assessments and developing safety cases for their implementations 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 has published a national [Information Governance framework](#) which needs to be considered when planning implementation.

Local agreements should be drawn up between organisations to define information requirements for communication.

## 2.6 Data Quality

Data quality and accuracy of coded data entry should be managed in local 'source' systems to ensure that information shared with people and professionals through other systems is dependent on the source data quality.

## 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 specified by the "information type" of the data item in any PRSB 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. In some situations, the action or event may be performed by the patient or a device. In these situations, a Performing Person or

Performing Device may be recorded. Alternatively a more generic “Performer” may be specified with the same content model as “Performing Professional”.

- **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.
- **Author** - is the person, device or application 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 2.7).

Note that although both ‘Performing professional’ and ‘Author’ 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, an information type of “Event.Record” or “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.

The provenance information model is published on the PRSB website [Provenance data – PRSB \(theprsb.org\)](https://www.theprsb.org)

## 2.8 Time stamp and audit trail

It is important that an audit trail is recorded for every item of information recorded or 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. PRSB record standards do not define all these possible links. It is expected that the local areas will define the requirements for accessing other records or documents, and where applicable 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 PRSB standards 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 primary clinical coding schemes in use in the NHS.

## 2.12 Accessibility

The design of user interfaces for health and care record systems should follow guidance for specific PRSB standards and 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 Specific Guidance for the Community Pharmacy Standard

## 3.1 Valuesets

In situations where both the context column and the valueset column are populated in the standard, it is recommended to use the valueset in the context column over the valueset in the valueset column. This is because the context column valueset is typically more refined and specific to the context of community pharmacy, compared to the more general valueset in the valueset column.

## 3.2 Other Community Pharmacy Contractual Framework (CPCF) Service Provided

Before completing the record, the user should be presented with a section that allows the user to select whether another CPCF service is being provided. For example, a patient may attend the pharmacy to use the contraception service and be offered a blood pressure reading, which they accept. The section should provide a drop-down list of the potential services and, upon completion of the current record, should create a new record for the additional service with the appropriate data items included.

## 3.3 Service-Specific Conformance/Cardinality Exceptions

Whilst in most cases the conformance and cardinality of data items will remain consistent across different services, there are some exceptions. This is due to some data items in the standard being core to the provision certain services, whilst being less core to others. Use the table below to ensure that the correct conformance and cardinality is used for specific data items/sections and services.

Section/Data Item	CPCF Service	Conformance	Cardinality
Presenting complaint or issue	New medicine service	M	1...1

### 3.4 History and Problem List Sections

The History and Problem List sections show similar information about the person's medical history, and both are necessary in this standard. The Problem List section captures inbound information from 111 referrals to the Community Pharmacy and will typically detail more recent relevant history. The History section captures any relevant history, which may have happened from the person's contact with the professional right to birth.

Both sections will capture important information about the person's medical history, and it is important that information is not missed by the professional viewing the record. Therefore, we suggest that these sections are presented together when implementing the standard to allow a holistic view of the person's history.

## 4 Matrices

The matrices provide a visualisation of which data items are recorded and shared between systems for the different community pharmacy services. Some services will require data items that are not needed in other services, and so it is important to use this resource to ensure that the right data items are being included in each services record.

There are three different matrices:

#### 1. The Pharmacy Record

This matrix shows the different community pharmacy services and which data items are captured in the pharmacy record. This should be used as a guide for which data items should be included in the records for the different services offered.

#### 2. The GP Record

This record shows which data items from the pharmacy record should be transferred to the patient's GP for each service. There may be data items for a service included in the pharmacy record that should not be transferred to the GP record.

#### 3. The Inbound Record

This matrix shows which data items are being transferred in referrals into the community pharmacy from the discharge medicine service, as well as through 111 referrals.

Use this information to help with interpreting the matrix:

- Y - In the pharmacy record, it indicates data that should be captured. For the GP record, it is the subset being sent to the GP.
- An empty cell - Data not captured in the pharmacy record and should be blank in the GP record.

Please note that the matrix does not detail conformance or cardinality. Use the conformance and cardinality used in the standard, unless stated otherwise in section 3.2

## 4.1 Pharmacy Record Matrix

Dataset	New medicine Service	Appliance Use Review	Vaccination Administration	CPCS Emergency Supply	CPCS Minor Illness	Smoking Cessation	Blood pressure Check Service	Contraception	Hepatitis C
<b>Person demographics</b>									
Patient name	Y	Y	Y	Y	Y	Y	Y	Y	Y
Patient preferred name	Y	Y	Y	Y	Y	Y	Y	Y	Y
Patient address	Y	Y	Y	Y	Y	Y	Y	Y	Y
Patient telephone number	Y	Y	Y	Y	Y	Y	Y	Y	Y
Date of birth	Y	Y	Y	Y	Y	Y	Y	Y	Y
NHS number	Y	Y	Y	Y	Y	Y	Y	Y	Y
Sex	Y	Y	Y	Y	Y	Y	Y	Y	Y
Gender	Y	Y	Y	Y	Y	Y	Y	Y	Y
Ethnicity							Y		Y
Other identifier	Y	Y	Y	Y	Y	Y	Y	Y	Y
Patient email address	Y	Y	Y	Y	Y	Y	Y	Y	Y
Communication preferences	Y	Y	Y	Y	Y	Y	Y	Y	Y
Relevant contacts	Y	Y	Y	Y	Y	Y	Y	Y	Y
Place of birth									Y
<b>Referrer details</b>									
Referrer details	Y	Y	Y	Y	Y	Y	Y	Y	Y
Referral Type	Y	Y	Y	Y	Y	Y	Y	Y	Y
Reason for referral	Y	Y	Y	Y	Y	Y	Y	Y	Y
Date and time of referral	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>Contact with professionals</b>									
Date and time of contact	Y	Y	Y	Y	Y	Y	Y	Y	Y
Service	Y	Y	Y	Y	Y	Y	Y	Y	Y

Dataset	New medicine Service	Appliance Use Review	Vaccination Administration	CPCS Emergency Supply	CPCS Minor Illness	Smoking Cessation	Blood pressure Check Service	Contraception	Hepatitis C
Contact type	Y	Y	Y	Y	Y	Y	Y	Y	Y
Consultation method	Y	Y			Y	Y	Y	Y	Y
Organisation name	Y	Y	Y	Y	Y	Y	Y	Y	Y
Organisation address	Y	Y	Y	Y	Y	Y	Y	Y	Y
Organisation contact details	Y	Y	Y	Y	Y	Y	Y	Y	Y
Location of event	Y	Y	Y			Y	Y	Y	Y
Reason for service	Y	Y	Y	Y	Y	Y	Y	Y	Y
Reason for non-provision of service	Y	Y	Y	Y	Y	Y	Y	Y	Y
Reason for service discontinuation	Y					Y			
Clinician name	Y	Y	Y	Y	Y	Y	Y	Y	Y
Role	Y	Y	Y	Y	Y	Y	Y	Y	Y
Professional identifier	Y	Y	Y	Y	Y	Y	Y	Y	Y
Professional identifier type	Y	Y	Y	Y	Y	Y	Y	Y	Y
Outcome of contact	Y			Y	Y	Y	Y	Y	Y
Person accompanying patient	Y	Y	Y	Y	Y	Y	Y	Y	Y
Chaperone	Y	Y	Y	Y	Y	Y	Y	Y	Y
Person collecting the medicine				Y	Y				
<b>Future appointments</b>									
Date of appointment	Y		Y			Y	Y	Y	
Appointment status	Y		Y			Y	Y	Y	
Reason for appointment	Y		Y			Y	Y	Y	
Clinical urgency of appointment	Y		Y			Y	Y	Y	
Location of future appointments	Y		Y			Y	Y	Y	
Specialty	Y		Y			Y	Y	Y	
<b>Dataset</b>	<b>New medicine Service</b>	<b>Appliance Use Review</b>	<b>Vaccination Administration</b>	<b>CPCS Emergency Supply</b>	<b>CPCS Minor Illness</b>	<b>Smoking Cessation</b>	<b>Blood pressure Check Service</b>	<b>Contraception</b>	<b>Hepatitis C</b>

Service	Y		Y			Y	Y	Y	
Professional to see person	Y		Y			Y	Y	Y	
<b>Admission details</b>									
Date of admission						Y			
Reason for admission						Y			
<b>Gp practice</b>									
GP practice identifier	Y	Y	Y	Y	Y	Y	Y	Y	Y
GP name	Y	Y	Y	Y	Y	Y	Y	Y	Y
GP practice details	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>Consent</b>									
Consent for treatment record	Y	Y	Y	Y	Y	Y	Y	Y	Y
Consent for information sharing	Y	Y	Y	Y	Y	Y	Y	Y	Y
Consent relating to child	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>Allergies and adverse reactions</b>									
Causative agent	Y	Y	Y	Y	Y	Y		Y	
Description of reaction	Y	Y	Y	Y	Y	Y		Y	
Type of reaction	Y	Y	Y	Y	Y	Y		Y	
Severity	Y	Y	Y	Y	Y	Y		Y	
Certainty	Y	Y	Y	Y	Y	Y		Y	
Evidence	Y	Y	Y	Y	Y	Y		Y	
Probability of recurrence	Y	Y	Y	Y	Y	Y		Y	
Date first experienced	Y	Y	Y	Y	Y	Y		Y	
Comment	Y	Y	Y	Y	Y	Y		Y	
Date recorded	Y	Y	Y	Y	Y	Y		Y	
<b>Dataset</b>	<b>New medicine Service</b>	<b>Appliance Use Review</b>	<b>Vaccination Administration</b>	<b>CPCS Emergency Supply</b>	<b>CPCS Minor Illness</b>	<b>Smoking Cessation</b>	<b>Blood pressure Check Service</b>	<b>Contraception</b>	<b>Hepatitis C</b>
<b>History</b>									

Relevant past medical, surgical and mental health history	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>Medications and medical devices</b>									
Medication name	Y			Y	Y	Y	Y	Y	
Form	Y			Y	Y	Y	Y	Y	
Batch number	Y			Y	Y	Y	Y	Y	
Site	Y			Y	Y	Y	Y	Y	
Route	Y			Y	Y	Y	Y	Y	
Indication	Y			Y	Y	Y	Y	Y	
Total amount of medication supplied	Y			Y	Y	Y	Y	Y	
Dose directions description	Y			Y	Y	Y	Y	Y	
Matters identified during the discussion	Y			Y	Y	Y	Y	Y	
Reason for supply request				Y	Y		Y		
No supply reason				Y				Y	
Additional instructions	Y			Y	Y	Y	Y	Y	
Supply type	Y			Y	Y	Y	Y	Y	
Date/time	Y			Y	Y	Y	Y	Y	
Prescription exemption category	Y	Y	Y	Y	Y	Y	Y	Y	Y
Prescriptions intercepted	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>Information and advice given</b>									
Information and advice given	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>Referral details</b>									
Referral to	Y	Y	Y	Y	Y	Y	Y	Y	Y
Clinical urgency of referral	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>Dataset</b>	<b>New medicine Service</b>	<b>Appliance Use Review</b>	<b>Vaccination Administration</b>	<b>CPCS Emergency Supply</b>	<b>CPCS Minor Illness</b>	<b>Smoking Cessation</b>	<b>Blood pressure Check Service</b>	<b>Contraception</b>	<b>Hepatitis C</b>
Expectation of referral	Y	Y	Y	Y	Y	Y	Y	Y	Y
Reason for referral	Y	Y	Y	Y	Y	Y	Y	Y	Y

Date	Y	Y	Y	Y	Y	Y	Y	Y	Y
Person Referral Reference	Y	Y	Y	Y	Y	Y	Y	Y	Y
Journey ID				Y	Y				
Referral Type								Y	
<b>Plan and requested actions</b>									
Actions for healthcare professionals	Y	Y	Y	Y	Y	Y	Y	Y	Y
Actions for patient or their carer	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>Appliances</b>									
Appliance name		Y		Y			Y		
Product order number		Y		Y			Y		
Manufacturer		Y		Y			Y		
Batch number		Y		Y					
Size		Y		Y					
Weight		Y		Y					
Colour		Y		Y					
Route		Y		Y					
Site		Y		Y					
Quantity		Y		Y			Y		
Indication		Y		Y			Y		
Matters identified during the discussion		Y		Y			Y		
<b>Vaccinations</b>									
Vaccine product			Y						
<b>Dataset</b>	<b>New medicine Service</b>	<b>Appliance Use Review</b>	<b>Vaccination Administration</b>	<b>CPCS Emergency Supply</b>	<b>CPCS Minor Illness</b>	<b>Smoking Cessation</b>	<b>Blood pressure Check Service</b>	<b>Contraception</b>	<b>Hepatitis C</b>
Vaccine procedure			Y						
Manufacturer			Y						
Batch number			Y						

Expiry date			Y						
Serialisation code			Y						
Site			Y						
Route			Y						
Indication			Y						
Dose amount			Y						
Dose Sequence			Y						
Date/time			Y						
<b>Presenting complaint or issues</b>									
Presenting complaint or issue					Y	Y	Y		
Chief complaint					Y	Y	Y		
<b>Clinical narrative</b>									
Clinical narrative	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>Investigations</b>									
Investigation performed						Y			Y
Investigation results						Y			Y
Investigation method						Y			Y
Performing professional						Y			Y
Date and time						Y			Y
<b>Signpost record</b>									
Signpost details	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>Dataset</b>	<b>New medicine Service</b>	<b>Appliance Use Review</b>	<b>Vaccination Administration</b>	<b>CPCS Emergency Supply</b>	<b>CPCS Minor Illness</b>	<b>Smoking Cessation</b>	<b>Blood pressure Check Service</b>	<b>Contraception</b>	<b>Hepatitis C</b>
Clinical urgency for signposting	Y	Y	Y	Y	Y	Y	Y	Y	Y
Reason for signposting	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>Smoking record</b>									
Set quit date						Y			

Smoking status						Y	Y	Y	
Smoking status details						Y	Y	Y	
Nicotine replacement therapy						Y			
Varenicline or other pharmacotherapy used						Y			
E-cigarettes used						Y		Y	
Treatments and interventions and changes made to treatments						Y			
Date stopped smoking						Y			
Self-reported quit						Y			
<b>Family history</b>									
Family History							Y	Y	
<b>Examination findings</b>									
Observations					Y	Y	Y	Y	
<b>Safeguarding</b>									
Safeguarding concerns	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>Procedures and therapies</b>									
Procedure								Y	
Anatomical site								Y	
Laterality								Y	
Complications related to procedure								Y	
Specific anaesthesia issues								Y	
<b>Dataset</b>	<b>New medicine Service</b>	<b>Appliance Use Review</b>	<b>Vaccination Administration</b>	<b>CPCS Emergency Supply</b>	<b>CPCS Minor Illness</b>	<b>Smoking Cessation</b>	<b>Blood pressure Check Service</b>	<b>Contraception</b>	<b>Hepatitis C</b>
Comment								Y	
ABPM declined							Y		
Reason ABPM declined							Y		
Contraception type	Y			Y		Y	Y	Y	
Contraception start date	Y			Y		Y	Y	Y	

Contraception end date	Y			Y		Y	Y	Y	
Contraception review date	Y			Y		Y	Y	Y	
<b>Problem list</b>									
Problem					Y	Y			
Onset date					Y	Y			
End date					Y	Y			
Severity					Y	Y			
Body site					Y	Y			
Laterality					Y	Y			
Stage of disease					Y	Y			
Problem status					Y	Y			
Problem priority					Y	Y			
Problem on discharge					Y	Y			
Primary palliative care diagnosis					Y	Y			
Description of palliative care diagnosis					Y	Y			
Comment					Y	Y			
<b>Pregnancy status</b>									
Pregnancy state	Y		Y	Y	Y	Y	Y		
Expected delivery date	Y		Y	Y	Y	Y	Y		
<b>Dataset</b>	<b>New medicine Service</b>	<b>Appliance Use Review</b>	<b>Vaccination Administration</b>	<b>CPCS Emergency Supply</b>	<b>CPCS Minor Illness</b>	<b>Smoking Cessation</b>	<b>Blood pressure Check Service</b>	<b>Contraception</b>	<b>Hepatitis C</b>
Feeding status of the baby	Y		Y	Y	Y	Y	Y	Y	
<b>Red flags</b>									
Red flags	Y	Y	Y	Y	Y	Y	Y	Y	Y
Red flag detail	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>Documents</b>									
Date							Y		

Document location							Y		
Document name							Y		
Comments							Y		
<b>Discharge details</b>									
Date of discharge						Y			
<b>Assessments</b>									
Assessment type						Y			
Assessment summary						Y			
Structured assessment						Y			
Comment						Y			

## 4.2 GP Record Matrix

Dataset	New medicine Service	Appliance Use Review	Vaccination Administration	CPCS Emergency Supply	CPCS Minor Illness	Smoking Cessation	Blood Pressure Check Service	Contraception	Hepatitis C
<b>Person Demographics</b>									
Person name	Y	Y	Y	Y	Y	Y	Y	Y	Y
Person's preferred name									
Person's address	Y	Y	Y	Y	Y	Y	Y	Y	Y
Person's telephone number	Y	Y	Y	Y	Y	Y	Y	Y	Y
Date of birth	Y	Y	Y	Y	Y	Y	Y	Y	Y
NHS number	Y	Y	Y	Y	Y	Y	Y	Y	Y
Sex	Y	Y	Y	Y	Y	Y	Y	Y	Y
Gender									
Ethnicity							Y		Y
Other identifier	Y	Y	Y	Y	Y	Y	Y	Y	Y
Person's email address									
Communication preferences									
Relevant contacts									
Place of Birth									Y
<b>Referrer Details</b>									
Referrer details									
Referral Type									
Reason for referral									
Date and time of referral									
<b>Contact With Professionals</b>									
Date and time of contact	Y	Y	Y	Y	Y	Y	Y	Y	Y
Service	Y	Y	Y	Y	Y	Y	Y	Y	Y
Contact type	Y	Y	Y	Y	Y	Y	Y	Y	Y

Dataset	New medicine Service	Appliance Use Review	Vaccination Administration	CPCS Emergency Supply	CPCS Minor Illness	Smoking Cessation	Blood Pressure Check Service	Contraception	Hepatitis C
Consultation method	Y	Y		Y	Y	Y	Y	Y	Y
Organisation name	Y	Y	Y	Y	Y	Y	Y	Y	Y
Organisation address	Y	Y	Y	Y	Y	Y	Y	Y	Y
Organisation contact details	Y	Y	Y	Y	Y	Y	Y	Y	Y
Location of event	Y	Y	Y	Y		Y	Y	Y	Y
Reason for service	Y	Y	Y	Y	Y	Y	Y	Y	Y
Reason for non-provision of service	Y	Y	Y	Y	Y	Y	Y	Y	Y
Reason for service discontinuation	Y					Y			
Clinician name	Y	Y	Y	Y	Y	Y	Y	Y	Y
Role	Y	Y	Y	Y	Y	Y	Y	Y	Y
Professional identifier	Y	Y	Y	Y	Y	Y	Y	Y	Y
Professional identifier type	Y	Y	Y	Y	Y	Y	Y	Y	Y
Outcome of contact	Y			Y	Y	Y	Y	Y	Y
Person accompanying patient	Y	Y	Y	Y	Y	Y	Y	Y	Y
Chaperone	Y	Y	Y	Y	Y	Y	Y	Y	Y
Person collecting the medicine				Y	Y				
<b>Future appointments</b>									
Date of appointment	Y		Y		Y	Y		Y	
Appointment status	Y		Y		Y	Y		Y	
Reason for appointment	Y		Y		Y	Y		Y	
Clinical urgency of appointment	Y					Y		Y	
Location of future appointments									
Specialty									
Service									
Professional to see person									
<b>Admission Details</b>									
Date of Admission						Y			
Reason for admission						Y			

Dataset	New medicine Service	Appliance Use Review	Vaccination Administration	CPCS Emergency Supply	CPCS Minor Illness	Smoking Cessation	Blood Pressure Check Service	Contraception	Hepatitis C
<b>GP Practice</b>									
GP practice identifier	Y	Y	Y	Y	Y	Y	Y	Y	Y
GP name									
GP practice details									
<b>Consent</b>									
Consent for treatment record	Y	Y	Y	Y	Y	Y	Y	Y	Y
Consent for information sharing	Y	Y	Y	Y	Y	Y	Y	Y	Y
Consent relating to child	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>Allergies and Adverse Reactions</b>									
Causative agent	Y	Y	Y	Y	Y	Y		Y	
Description of reaction	Y	Y	Y	Y	Y	Y		Y	
Type of reaction	Y	Y	Y	Y	Y	Y		Y	
Severity	Y	Y	Y	Y	Y	Y		Y	
Certainty	Y	Y	Y	Y	Y	Y		Y	
Evidence	Y	Y	Y	Y	Y	Y		Y	
Probability of recurrence	Y	Y	Y	Y	Y	Y		Y	
Date first experienced	Y	Y	Y	Y	Y	Y		Y	
Comment	Y	Y	Y	Y	Y	Y		Y	
Date recorded	Y	Y	Y	Y	Y	Y		Y	
<b>History</b>									
Relevant past medical, surgical and mental health history	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>Medications and Medical Devices</b>									
Medication name	Y			Y	Y	Y	Y	Y	
Form	Y			Y	Y	Y	Y	Y	
Batch number	Y					Y	Y	Y	
Site	Y			Y	Y	Y	Y	Y	
Route	Y			Y	Y	Y	Y	Y	
Indication	Y			Y	Y	Y	Y	Y	

Dataset	New medicine Service	Appliance Use Review	Vaccination Administration	CPCS Emergency Supply	CPCS Minor Illness	Smoking Cessation	Blood Pressure Check Service	Contraception	Hepatitis C
Total amount of medication supplied	Y			Y	Y	Y	Y	Y	
Dose directions description	Y			Y	Y	Y	Y	Y	
Matters identified during the discussion	Y			Y	Y	Y	Y	Y	
Reason for supply request				Y	Y		Y		
No supply reason				Y				Y	
Additional instructions	Y			Y	Y	Y	Y	Y	
Supply type	Y			Y	Y	Y	Y	Y	
Date/time	Y			Y	Y	Y	Y	Y	
Prescription exemption category									
Prescriptions intercepted	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>Information and Advice Given</b>									
Information and advice given	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>Referral Details</b>									
Referral to	Y	Y	Y	Y	Y	Y	Y	Y	Y
Clinical urgency of referral	Y	Y	Y	Y	Y	Y	Y	Y	Y
Expectation of referral	Y	Y	Y	Y	Y	Y	Y	Y	Y
Reason for referral	Y	Y	Y	Y	Y	Y	Y	Y	Y
Date	Y	Y	Y	Y	Y	Y	Y	Y	Y
Person Referral Reference	Y	Y	Y	Y	Y	Y	Y	Y	Y
Journey ID				Y	Y				
Referral Type									
<b>Plan and Requested Actions</b>									
Actions for healthcare professionals	Y	Y	Y	Y	Y	Y	Y	Y	Y
Actions for patient or their carer	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>Appliances</b>									
Appliance name		Y		Y			Y		
Product order number		Y		Y			Y		

Dataset	New medicine Service	Appliance Use Review	Vaccination Administration	CPCS Emergency Supply	CPCS Minor Illness	Smoking Cessation	Blood Pressure Check Service	Contraception	Hepatitis C
Manufacturer		Y		Y			Y		
Batch number		Y		Y					
Size		Y		Y					
Weight		Y		Y					
Colour		Y		Y					
Route		Y		Y					
Site		Y		Y					
Quantity		Y		Y			Y		
Indication		Y		Y			Y		
Matters identified during the discussion		Y		Y			Y		
<b>Vaccinations</b>									
Vaccine product			Y						
Vaccine procedure			Y						
Manufacturer			Y						
Batch number			Y						
Expiry date			Y						
Serialisation code			Y						
Site			Y						
Route			Y						
Indication			Y						
Dose amount			Y						
Dose Sequence			Y						
Date/time			Y						
<b>Presenting Complaint or Issues</b>									
Presenting complaint or issue					Y	Y	Y		
Chief complaint					Y	Y	Y		
<b>Clinical Narrative</b>									

Dataset	New medicine Service	Appliance Use Review	Vaccination Administration	CPCS Emergency Supply	CPCS Minor Illness	Smoking Cessation	Blood Pressure Check Service	Contraception	Hepatitis C
Clinical narrative	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>INVESTIGATIONS</b>									
Investigation performed						Y			Y
Investigation results						Y			Y
Investigation method						Y			Y
Performing professional									
Date and time						Y			Y
<b>SIGNPOST RECORD</b>									
Signpost details	Y	Y	Y	Y	Y	Y	Y	Y	Y
Clinical urgency for signposting	Y	Y	Y	Y	Y	Y	Y	Y	Y
Reason for signposting	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>SOCIAL CONTEXT</b>									
Set quit date						Y			
Smoking status						Y	Y	Y	
Smoking status details						Y	Y	Y	
Nicotine replacement therapy						Y			
Varenicline or other pharmacotherapy used						Y			
E-cigarettes used						Y			
Treatments and interventions and changes made to treatments						Y			
Date stopped smoking						Y	Y	Y	
Self-reported quit						Y			
<b>FAMILY HISTORY</b>									
Family History							Y		
<b>EXAMINATION FINDINGS</b>									
Observations					Y		Y	Y	
<b>SAFEGUARDING</b>									
Safeguarding concerns	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>PROCEDURES AND THERAPIES</b>									

Dataset	New medicine Service	Appliance Use Review	Vaccination Administration	CPCS Emergency Supply	CPCS Minor Illness	Smoking Cessation	Blood Pressure Check Service	Contraception	Hepatitis C
Procedure								Y	
Anatomical site								Y	
Laterality								Y	
Complications related to procedure								Y	
Specific anaesthesia issues									
Comment									
ABPM declined							Y		
Reason ABPM declined							Y		
Contraception type	Y			Y			Y	Y	
Contraception start date	Y			Y			Y	Y	
Contraception end date	Y			Y		Y	Y	Y	
Contraception review date								Y	
<b>PROBLEM LIST</b>									
Problem					Y	Y			
Onset date					Y	Y			
End date					Y	Y			
Severity					Y	Y			
Body site					Y	Y			
Laterality					Y	Y			
Stage of disease					Y	Y			
Problem status					Y	Y			
Problem priority					Y	Y			
Problem on discharge					Y	Y			
Primary palliative care diagnosis					Y	Y			
Description of palliative care diagnosis					Y	Y			
Comment					Y	Y			
<b>PREGNANCY STATUS</b>									
Pregnancy state	Y		Y	Y	Y	Y	Y		Y

Dataset	New medicine Service	Appliance Use Review	Vaccination Administration	CPCS Emergency Supply	CPCS Minor Illness	Smoking Cessation	Blood Pressure Check Service	Contraception	Hepatitis C
Expected delivery date	Y		Y	Y	Y	Y	Y		Y
Feeding status of the baby	Y		Y	Y	Y	Y	Y	Y	Y
<b>RED FLAGS</b>									
Red flags	Y	Y	Y	Y	Y	Y	Y	Y	Y
Red flag detail	Y	Y	Y	Y	Y	Y	Y	Y	Y
<b>DOCUMENTS</b>									
Date									
Document location									
Document name									
Comments									
<b>DISCHARGE DETAILS</b>									
Date of discharge									
<b>ASSESSMENTS</b>									
Assessment type						Y			
Assessment summary						Y			
Structured assessment						Y			
Comment						Y			

## 4.3 Inbound Record Matrix

Dataset	E - Discharge Summary	111 Inbound
<b>Patient demographics</b>		
Patient name	Y	Y
Patient preferred name		Y
Patient address	Y	Y
Patient telephone number	Y	Y
Date of birth	Y	Y
NHS number	Y	Y
Sex		Y
Gender	Y	Y
Ethnicity		Y
Other identifier		Y
Patient email address	Y	Y
Communication preferences		Y
Relevant contacts		Y
Place of birth		
<b>Referrer details</b>		
Referrer details		Y
Referrer Type		
Reason for referral		Y
Date and time of referral		Y
<b>Contact with professionals</b>		
Date and time of contact	Y	
Service	Y	
Contact type		
Consultation method	Y	
Organisation name	Y	
Organisation address		
Organisation contact details	Y	
Location of event		
Reason for service		
Reason for non-provision of service	Y	
Reason for service discontinuation		
Clinician name		
Role	Y	
Professional identifier		
Professional identifier type		
Outcome of contact	Y	
Person accompanying patient		
Chaperone		
Person collecting the medicine		
<b>Future appointments</b>		
Date of appointment		
Appointment status		
Reason for appointment		
Clinical urgency of appointment		

Location of future appointments		
Specialty		
Service		
Professional to see person		
<b>Admission details</b>		
Date of admission	Y	
Reason for admission	Y	
<b>Gp practice</b>		
GP practice identifier	Y	Y
GP name		Y
GP practice details		Y
<b>Consent</b>		
Consent for treatment record		
Consent for information sharing		
Consent relating to child		
<b>Allergies and adverse reactions</b>		
Causative agent		
Description of reaction		
Type of reaction		
Severity		
Certainty		
Evidence		
Probability of recurrence		
Date first experienced		
Comment		
Date recorded		
<b>History</b>		
Relevant past medical, surgical and mental health history		Y
<b>Medications and medical devices</b>		
Medication name	Y	
Form		
Batch number		
Site		
Route		
Indication		
Quantity supplied		
Structured dose direction cluster		
Matters identified during the discussion		
Reason for supply request		
Additional instructions		
Supply type		
Date/time		
Anticipatory medicine/equipment		
Prescription exemption category		
Prescriptions intercepted	Y	
No supply reason		
<b>Information and advice given</b>		
Information and advice given		

<b>Referral details</b>		
Referral to	Y	Y
Clinical urgency of referral		Y
Expectation of referral		Y
Reason for referral		Y
Date	Y	Y
Person Referral Reference	Y	Y
Journey ID		Y
<b>Plan and requested actions</b>		
Actions for healthcare professionals	Y	Y
Actions for patient or their carer		Y
<b>Appliances</b>		
Appliance name		
Product order number		
Manufacturer		
Batch number		
Size		
Weight		
Colour		
Route		
Site		
Quantity		
Indication		
Matters identified during the discussion		
Date/time		
<b>Vaccinations</b>		
Vaccine product		
Vaccine procedure		
Manufacturer		
Batch number		
Expiry date		
Serialisation code		
Site		
Route		
Indication		
Dose amount		
Dose Sequence		
Date/time		
<b>Presenting complaint or issues</b>		
Presenting complaint or issue		Y
Chief complaint		Y
<b>Clinical narrative</b>		
Clinical narrative	Y	
<b>Investigations</b>		
Investigation performed		
Investigation results		
Investigation method		
Performing professional		

Date and time		
<b>Signpost record</b>		
Signpost details		
Clinical urgency for signposting		
Reason for signposting		
<b>Smoking record</b>		
Set quit date		
Smoking status		
Smoking status details		
Nicotine replacement therapy		
Varenicline or other pharmacotherapy used		
E-cigarettes used		
Treatments and interventions and changes made to treatments		
Date stopped smoking		
Self reported quit		
<b>Family history</b>		
Family History		
<b>Examination findings</b>		
Observations		
<b>Safeguarding</b>		
Safeguarding concerns		
<b>Procedures and therapies</b>		
Procedure		
Anatomical site		
Laterality		
Complications related to procedure		
Specific anaesthesia issues		
Comment		
ABPM declined		
Reason ABPM declined		
Contraception type		
Contraception start date		
Contraception end date		
Contraception review date		
<b>Problem list</b>		
Problem		Y
Onset date		Y
End date		Y
Severity		Y
Body site		Y
Laterality		Y
Stage of disease		Y
Problem status		Y
Problem priority		Y
Problem on discharge		Y
Comment		Y
Primary palliative care diagnosis		Y
Description of palliative care diagnosis		Y

<b>Pregnancy status</b>		
Pregnancy state		
Expected delivery date		
Feeding status of the baby		
<b>Red flags</b>		
Red flags		
Red flag detail		
<b>Documents</b>		
Document location		
Document name		
Comments		
<b>Discharge details</b>		
Date of discharge	Y	
<b>Assessments</b>		
Assessment type		
Assessment summary		
Structured assessment		
Comment		