Professional Record Standards Body

Better records for better care

DAPB4086 Wound Care Information Standard

(DAPB4086 Amd 60/2022)

High Level Implementation Guidance v1.0

10 November 2023

Data Alliance Partnership Board

The Data Alliance Partnership Board (DAPB), which holds delegated authority from the Secretary of State for Health and Social Care, has approved a new information standard for publication under section 250 of the Health and Social Care Act 2012.

Assurance that this information standard meets the requirements of the Act and is appropriate for the use specified in the specification document has been provided by the Data Standards Assurance Service (DSAS) and endorsed by the Data Alliance Partnership Sub Board (DAPSB).

This information standard comprises the following documents:

- Information Standards Notice (ISN)
- Requirements Specification
- High Level Implementation Guidance (this document)

An Information Standards Notice (DAPB4086 Amd 60/2022) has been issued as a notification of use and implementation timescales. Please read this alongside the documents for the standard.

The controlled versions of these documents can be found on the NHS England website. Any copies held outside of that area, in whatever format (e.g. paper, email attachment), are considered to have passed out of control and should be checked for currency and validity.

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Document Management

Revision History

Version	Date	Summary of Changes
0.1	25.05.2023	First draft
0.2	21.06.2023	Updates following DSAS review
0.3	28.06.2023	Updates after further review
0.4	21.08.2023	Updated templates and formatting (After DAPB approval)
1.0	07.11.2023	Minor corrections - preparation for publishing

Reviewers

Reviewer name	Title / Responsibility	Date	Version
Martin Orton	Senior Programme Manager, PRSB	06.11.2023	0.4
Sarah Furnell	Data Standards and Assurance Service (DSAS) – Publications, NHS England	07.11.2023	1.0

Approved by

Name	Title/Responsibility	Date	Version
Mike Watson	NWCSP Lead	25.05.2023	0.1

Glossary of Terms

Term / Abbreviation	What it stands for
CIS	Core Information Standard
DAPB	Data Alliance Partnership Board
DAPB4086	The Wound Care Information Standard
FHIR	Fast Healthcare Interoperability Resource. A method for exchanging healthcare information electronically.
ISN	Information Standards Notice.
NWCSP	National Wound Care Strategy Programme
PRSB	Professional Record Standards Body
Refset	In the context of this Standard, a Refset is a group of SNOMED clinical terms that is represented by a single reference, rather than a list of all the terms contained therein.
SNOMED CT	Structured clinical vocabulary for use in an electronic health record. SNOMED CT has been adopted as the standard clinical terminology for the NHS in England.
TRUD	Technology Reference Data Update Distribution. The standard references (eg) NHS Data Dictionary and SNOMED CT terminology. System suppliers are expected to update their products via TRUD or via the Terminology Server.

Contents

1 Purpose

The purpose of this document is to provide guidance on the implementation of the Wound Care Information Standard.

This stage covers the information to be recorded in all systems used for wound care and wound care records. Technical specifications are under consideration with NHS England which, through a further release of DAPB4086, will allow providers and their systems to be able to share information in the future.

This High Level Implementation Guidance is to be read alongside documents outlined in section 1.3 of the DAPB4086 Wound Care Information Standard Requirements Specification.

2 Implementation checklist

The following is a sequence of steps, set out to help organisations understand the implementation process, enabling them to ask the right questions and engage with the right people within their respective organisation.

Step 1: Read the Information Standards Notice (ISN)

This is the official notification of the Information Standard, published on behalf of the Data Alliance Partnership Board (DAPB). It provides an outline of the approved Standard and timeframe for compliance.

NB: Compliance with Information Standards will normally be included in contracts between NHS Providers and their system suppliers; review your existing contracts with system suppliers to confirm this is the case. If unsure, it is recommended that you liaise with your system supplier to establish what their intentions are regarding implementation of the DAPB4086 and the timescales they are working to (as per Step 4, below).

Step 2: Read the Wound Care Standard documentation

Documents (high level implementation guidance and the requirements specification) will be published alongside the ISN and will be linked to from the PRSB webpage.

The Wound Care information model (version 1.0) provides a detailed description of the data requirements including explanations about the data items, definitions, formats and values which can be recorded. It also includes implementation guidance at section and element level primarily for system suppliers and providers implementing the standard. There are further supporting materials on the PRSB website including the clinical safety case, examples, an implementation toolkit for providers, and in future there will release notes for updates to the standard. These should be read alongside the Wound Care information model.

Step 4: Familiarity with the Core Information Standard (CIS)

It is highly recommended that providers are aware and familiar with the PRSB Core Information standard (CIS) which underpins shared care records.

The sections of CIS most relevant for Wound Care are listed below, although other sections may also have useful and relevant information:

- About me
- Individual requirements

- Care and support plan (also part of the PCSP)
- Contingency plans (also part of the PCSP)
- Additional supporting plans (also part of the PCSP)
- Problems List (other relevant conditions or diagnoses)
- Medicines and medical devices
- Allergies and adverse reactions

Detailed descriptions and specifications supporting implementation are hosted on the PRSB webpage Personalised Care and Support Plan (PCSP) standard.

Step 5: Discuss with current IT Systems Supplier

If a commercial system is in use, discuss with the supplier to confirm the timescale for any necessary changes to the system. In most cases these changes will be part of your Service Level Agreement (SLA). Ensure any future SLAs, via re-procurement or contract refreshes etc, cover adherence to ISNs impacting your service.

Discussions with systems suppliers should help inform subsequent steps.

Where an in-house solution is in place, discussions need to start early to ensure all changes can be incorporated within the implementation timetable.

Step 6: Stakeholder Engagement

It is essential to engage with those who are involved in collecting, recording and subsequently using the data items detailed within DAPB4086.

For example, you may find it useful to share the contents of this guidance document, and other documents relating to DAPB4086 including (but not limited to) the information model and section-level implementation guidance, with all staff groups and organisations directly impacted, such as frontline staff, commissioners and representative groups for people with lived experience.

Step 7: Check current state of readiness

Providers should check the current state of readiness for implementation of the information standard. This includes (but is not limited to):

IT Systems (Software)

- Many of the Elements in the Wound Care Standard may already be recorded electronically
- Check what changes are required to meet the new standard. For example, does the IT system require any additional fields?

It is recommended that providers identify whether:

- There are any changes required to clinical/business processes in order to implement DAPB4086.
- There are any additional training needs for professionals to be able to implement and use DAPB4086.

Step 8: Plan implementation

Each provider's approach to implementation may vary to suit their individual circumstances. At a high level, the following factors should be considered when assessing and enacting any business change:

- Scope of change
- Finance
- Change governance
- Change manager requirements
- Change resource requirements
- Timescales
- Key milestones
- Benefits
- Training requirements/resource
- Key stakeholder engagement
- Key risks/barriers to change
- Success measures.

3 Implementation plan

Compliance must be achieved no later than **September 2025**. Compliance is a prerequisite for the planned next release of the information standard to support sharing of the wound care information.

Section 1.3 of the requirements specification details the supporting documents for the standard, including links to access them.

Implementation of the information standard will follow a phased approach, identifying early adopters and publishing the results of trials to embed learning ahead of the planned full compliance date:

Action	Date
Communicate the DAPB4086 standard (this standard) to providers (including to all relevant suppliers)	Autumn 2023
Identify early adopters	Summer 2023
Work with early adopters	Sep-Dec 2023
Publicise findings	Jan – Apr 2024
Relevant suppliers conformant	March 2024
Full compliance date	September 2025

It is envisioned that the work with early adopters (above) may result in additional guidance that will need to be incorporated within the PRSB implementation guidance and the implementation toolkit from Q3 (Oct-Dec) 2023 onwards.

NB – The timescales for the next release of DAPB4086, in terms of detailing the mechanism of interoperability; ISN publication; and provider implementation, are currently to be defined. It is possible that data flows may be required in later releases of DAPB4086.

3.1 Support and maintenance

Where additional advice in implementing the standard is required, the PRSB support service can be contacted here. The PRSB is responsible for managing any updates to the information model and implementation guidance document through established assurance processes and release cycles (see section 7 below) at the PRSB and DAPB. If possible, please include "Wound Care ISN" in the subject header of your message so that it can be identified appropriately.

Maintenance releases for PRSB developed standards are currently planned for 3-year cycles, however these may be updated on a regular basis based on need and clinical and professional review. Issues raised may also affect the date for future releases.

The above email address can also be used should you have any suggested enhancements or amendments to any aspect of this standard. The management of such items is summarised in section 7, below.

4 General guidance for PRSB Standards

4.1 The structure of PRSB Standards

PRSB developed information standards are 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 Tables 1 and 2 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' includes sets of related elements with dependencies between the elements.

Information Components	Model Description
Record entry	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. A record entry has contextual information associated with it. The data model for the context information is determined by the information type of the record entry. There are two information types used: “Record” and “Event.Record”. 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.
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.

Table 1: PRSB information model structure

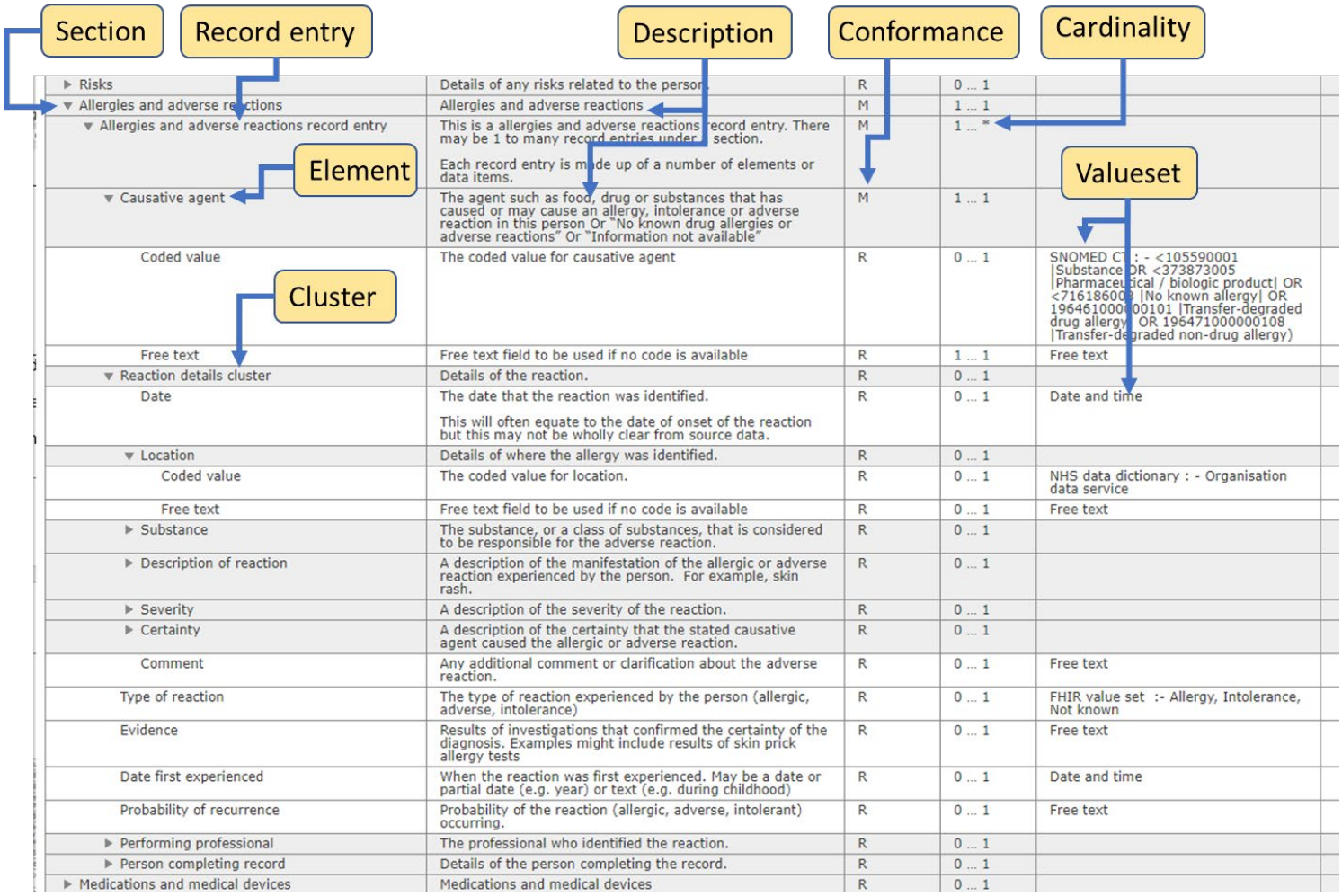
Information model rules and instructions	Explanations
Description	This is the description of the section, record entry, cluster or element. For an element, it describes the information that the element should contain in as plain English as possible.
Cardinality	Each section, record entry, cluster and 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 entries are allowed 0…1 = zero to one 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 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. The following set of rules apply to enable implementers to cater for the end users (senders and receivers) requirements: ❖ **Mandatory** – the information must be included ❖ **Required** – if it exists, the information must be included ❖ **Optional** – a local decision is made as to whether the information is included These rules apply at all levels and give the flexibility to allow local clinical or professional decisions on some information that is included, while being clear on what is important information to include. For example, a person subject to a referral may have many assessments, but not all of these will be relevant to the referral. The conformance can be used to allow just relevant assessments to be included. Assessment Section – Required – i.e. its important information you must include if you have it. Record entry level – Optional – allows a local decision on what assessments are included, so only relevant ones are included based on clinical or professional needs. Assessment elements – Conformance set on the normal basis of which elements for an assessment are mandatory, required or optional. **NB:** It is permitted to upgrade a conformance rule but not to down grade one. For instance, a section that is classed as optional in the standard can be upgraded to required or mandatory in local implementations. However, one that is classed mandatory or required cannot be downgraded to required or optional.
Valuesets	Valuesets describe precisely how the information is recorded in the system and communicated between systems. This is required for interoperability (for information to flow between one IT system and another). The information can be text, multi-media or in a coded format. If coded it can be constrained to SNOMED CT and specific SNOMED CT reference sets, NHS Data Dictionary values or other code sets.

Table 2: PRSB information model content structure and definitions

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.



▶ 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 section. Each record entry is made up of a number of elements or data items.	M	1 … *	
▼ Causative agent	The agent such as food, drug or substances that has caused or may cause an allergy, intolerance or adverse reaction in this person Or “No known drug allergies or adverse reactions” Or “Information not available”	M	1 … 1	
Coded value	The coded value for causative agent	R	0 … 1	SNOMED CT : - <105590001 |Substance OR <373873005 |Pharmaceutical / biologic product| OR <716186003 |No known allergy| OR 1964610000000101 |Transfer-degraded drug allergy| OR 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	

Figure 1: Diagram detailing key terms used in the standard with the example for allergies and adverse reactions (taken from the Core Information Standard)

4.2 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 developed 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 (see under 'Record entry' in Table 1 above) in any PRSB developed 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 the audit trail (see section 4.3).

4.3 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.

4.4 PRSB reference library

The content of DAPB4086 is based on a reference library of components used for all PRSB standards, maximising reuse of existing components and ensuring consistency across standards to support interoperability between records, systems, professionals, and people.

4.5 SNOMED CT

This standard uses SNOMED CT coding where appropriate. Where this is not appropriate, national coding from the NHS Data Model and Dictionary has been used where available and appropriate. The supplier systems must be compliant with the SNOMED CTcodes set out within the Wound Care information model.

Compliance is based on the scope of the standard SNOMED CT SCCI0034.

4.6 Format

If national codes have been defined, then the format will match that of the NHS DataModel and Dictionary; this will be shown in the “Valuesets” column. The field describes the valid formats that will be accepted for this data item. For dates and times, it specifically refers to the exact formatting. For other data items it describes the data type required and the max/min field lengths.

For the majority of data items, SNOMED CT is permitted as well as a free text option for those who are not yet SNOMED CT compliant.

4.7 National codes

If no SNOMED CT has been identified, then certain Elements provide a list of the valid formats that will be accepted for this data item (if there are any). For example, a field may only allow values of "Y", "N" and "X", which equate to "Yes", "No", "Don't Know".

For ease, the information model contains hyperlinks to referenced DataDictionary formats in columns: “National Codes (if applicable)” and “National Description (if applicable)”.

4.8 Free text fields

Free text will be available where there is a clear clinical requirement. It is also appreciated that many systems are not yet compliant with SNOMED CT and so the ability to use free text where SNOMED CT is not available has often been allowed.

Free text field size will be appropriate to support the clinical requirement. All free text documentation should be completed in accordance with professional record keeping standards, being clear and accurate.

4.9 Use of terms

The term ‘role’ has been consistently used rather than ‘designation’ throughout PRSB developed 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.

4.10 Dependencies

The implementation of PRSB developed 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 profiles (to support the transfer of information between systems).

N.B. information sharing is expected to be supported by the next version of this standard (v2.0) – see statement under section 3 above.

4.11 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.

5 Clinical safety

We recommend system suppliers and local implementers apply further risk mitigations when implementing PRSB developed 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.

As more practical implementation issues may vary from provider to provider, it is recommended that all providers implementing the PRSB developed standards must still follow their local clinical safety processes to assess the local impact.

6 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.

As more practical implementation issues may vary from provider to provider, it is recommended that all providers implementing the PRSB developed information standards must still follow their local information governance and security review processes to assess the local impact.

7 Future changes

7.1 Release cycles and governance

DAPB4086 will be enhanced as necessary based on need. Enhancements could be based on further clinical requirements, clinical safety feedback, technical SME feedback or supplier implementation findings (for example).

This information standard (including guidance) provides the structure and content for a Wound Care record; the sections and elements of the Wound Care information model define what information should be recorded. The need for data flows will be considered for later versions.

Throughout the implementation process, any lessons learned and feedback from implementers will be documented and used to influence future releases.

A formal log will be maintained and managed by the PRSB to analyse, assure and prioritise any enhancements or amendments elicited from the feedback channels detailed above. The information standard will follow a three-yearly release cycle by default. Ongoing feedback and review will take place throughout the implementation period through the PRSB support service. All feedback is reviewed on a quarterly cycle, and it is possible that enhancements are made to this information standard as a result of the assessment of the feedback on a regular basis.

8 References

DAPB4086 webpage:
Short URL: http://www.digital.nhs.uk/isce/publication/dapb4086
Full URL: https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dapb4086-wound-care

Health and Social Care Act (Section 250):
https://www.legislation.gov.uk/ukpga/2012/7/section/250

Information Governance Framework: https://transform.england.nhs.uk/information-governance/guidance/summary-of-information-governance-framework-shared-care-records/

National wound care strategy programme: https://www.nationalwoundcarestrategy.net/

PRSB Core Information Standard: https://theprsb.org/core-information-standard-v2-0/

PRSB Wound Care Information standard webpage: https://theprsb.org/standards/wound-care-standard/

PRSB Provenance data: https://theprsb.org/standards/provenance/

PRSB Personalised Care and Support Plan standard: https://theprsb.org/standards/personalisedcareandsupportplan/

PRSB support service: https://theprsb.org/standards/support/

SNOMED CT SCCI0034: https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/scci0034-snomed-ct

SNOMED CT Editorial Guide:
https://confluence.ihtsdotools.org/display/DOCEG/SNOMED+CT+Editorial+Guide

DCB0129 Clinical Risk Management: its Application in the Manufacture of Health IT Systems: http://www.digital.nhs.uk/isce/publication/dcb0129

DCB0160 Clinical Risk Management: its Application in the Deployment and Use of Health IT Systems: http://www.digital.nhs.uk/isce/publication/dcb0160