Professional Record Standards Body

Better records for better care

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DIGITAL CARE AND SUPPORT PLAN STANDARD

CLINICAL SAFETY REPORT

Professional Record Standards Body
32-36 Loman Street,
London, SE1 0EH.
www.theprsb.org

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Document Management

Revision History

Version	Date	Summary of Changes
0.1	28.11.2017	First draft created by Haroldas Petkus
0.2	04.12.2017	Updated by Jan Hoogewerf
0.3	11.12.2017	Reviewed by Dr Neill Jones (CSO) and Claire Buchner

Approved by

This document must be approved by the following people:

Name	Signed off?	Date	Version
NHS Digital Clinical Safety Group	Signed off	19/01/2018	0. 3

Related Documents

These documents will provide additional information.

Ref no	Title
[1]	Standards for the Clinical Structure and Content of Patient Records http://theprsb.org/publications/bible-sets-out-the-latest-agreed-standards
[2]	Generic Editorial Principles for the Development of Standards for the Structure and Content of Health Records https://www.rcplondon.ac.uk/projects/outputs/editorial-principles-development-record-standards
[3]	Clinical Documentation and Generic Record Standards (CDGRS) Clinical Safety Report 2013 v1
[4]	Clinical Risk Management: its Application in the Manufacture of Health IT Systems SCCI 0129
[5]	Clinical Risk Management: its Application in the Deployment and Use of Health IT Systems SCCI 0160

Contents

1. Executive summary and safety statement

This document provides a clinical safety case for the digital care and support plan standard project. The project has delivered information models and implementation guidance which will be used by NHS Digital to develop technical standards for structuring, coding and sharing care and support plan information, with a view to incorporating it into standard clinical IT contracts to facilitate better access and interoperability.

12 potential hazards were identified and mitigated and 8 deemed implementation issues. The mitigated hazards include information that should be addressed by implementers. All hazards were identified through the consultation steps carried out to develop these standards. The consultations consisted of a multidisciplinary workshop, online survey, review of draft information models and implementation guidance (by clinical informaticians and system suppliers) and an expert user group meeting. These workshops, surveys and communications included patient representatives as well as professionals from Royal Colleges, specialist societies, nursing, midwifery, social care, allied health professions, health informatics professionals and vendors (see Appendix B).

At each step of the consultation hazards were identified, reviewed and mitigations/actions considered. Nevertheless, some risk is inherent in the standards but most has been:

(A) mitigated by the development of the standards

(B) or the residual risk has been transferred (with guidance) to the implementers.

Certain hazards were deemed system implementation matters. The hazard log (a separate document) provides guidance for system developers and implementers. It is important that this guidance in relation to these hazards become requirements for implementation.

N.B: This clinical safety report is necessarily limited in its scope because it is neither directly related to software development nor to deployment. Suppliers developing software to implement these standards will therefore still be expected fully to apply SCCI0129. Organisations involved in the deployment of such software will still be expected fully to apply SCCI0160.

2. Introduction

NWL Collaboration of CCGs commissioned this project in collaboration with the Healthy London Partnership and NHS Digital. Further stages of work, through to implementation, will be commissioned by NHS Digital. The Professional Records Standards Body (PRSB) was commissioned to consult with citizens, healthcare professionals, suppliers and public health professionals to ensure that the standard meets their needs. The work was conducted in partnership with the Royal College of Physicians (RCP) Health Informatics Unit (HIU). Clinical leadership was provided by the Royal College of General Practitioners (RCGP) Royal College of Nursing (RCN), Adult Social Care and the RCP Patient and Carer Network.

The following approach was taken to develop the project deliverables:

- An evidence review identified existing models including international care plan models (e.g. 'Contsys'), the NHS D 'Using SNOMED CT in care planning' document, NWL and other local care and support plan documents, which were mapped to the PRSB/AoMRC headings.
- A multidisciplinary consultation workshop was held with key stakeholders, including patients and carers, front line health and care professionals, informaticians and industry representation to review the draft requirements. Outputs from the meeting were used to inform an updated version of the draft deliverables.
- An online survey was used to seek wider consultation and to obtain the views of frontline clinicians, patients and carers on a number of identified issues.
- Outstanding issues were consulted on by an expert user group. The outputs of this meeting informed the final draft deliverables.
- Final draft deliverables were disseminated to the project board for their official sign off.

This document provides the final report of the work done to manage identified clinical safety risks associated with the emergency care discharge summary project. The project has produced professional standards, as such the full application of SCCI0129 (Amd 39/2012) cannot be applied, as the professional standards themselves are not manufactured health IT systems. However, the guidance within SCCI0129 concerning clinical risk management and appropriately governed hazard assessment has been considered. Compliance to requirements from SCCI0129 are summarised in section 12.

3. Clinical safety governance

The NHS Digital Clinical Safety Group (CSG) operates a full Clinical Safety Management System (CSMS) that encompasses integration with Health Organisations and professional bodies. The CSMS gives particular consideration to the integration with the Information Standards Board and the process in which professional standards are developed in the CSMS framework. The essential structures of a CSMS have been implemented in this project by engagements with the following organisations:

- RCP

- RCGP
- RCN
- RCP Patient and Carer Network
- Association of Directors of Adult Social Services
- Digital Care and Support Plan project board
- Digital Care and Support Plan expert user group
- NHS Digital terminology team
- NHS Digital messaging team
- NHS Digital clinical safety group
- Other Royal Colleges and specialist societies
- The professional bodies of nursing, midwifery and the Allied Health Professions
- Involvement of patient representatives

However it should be noted that this clinical safety report is necessarily limited in its scope because it is neither directly related to software development nor to deployment. Suppliers developing software to implement these standards will therefore still be expected fully to apply SCCI0129. Organisations involved in the deployment of such software will still be expected fully to apply SCCI0160.

4. Safety organisation structure

The role of a Clinical Safety Officer (CSO) is to review the Clinical Safety Case using his/her clinical experience to judge the appropriateness and effectiveness of the risk management strategies and mitigating actions. The CSO should monitor the execution of the Clinical Safety Case and ensure that clinical safety obligations are being discharged.

5. Hazard identification & assessment approach

The first step to preventing harm to patients through the use of these standards is to ensure a good development process that results in standards fit for purpose.

Activities that have been carried out to clarify and address this potential include:

- Initial patient safety assessment carried out with input from stakeholders attending a consultation workshop
- Production of a hazard log for the project and revised through consultation with stakeholders
- Review of the hazard log following online consultation on the headings and any safety risks associated with any of the headings
- Review of mitigation of risks as part of the development of the standard headings and the implementation guidance
- Clinical safety mitigation of the project deliverables and confirmation of risks to be passed to implementation / maintenance stages identified
- Final draft of hazard log, standard headings and clinical safety report
- Drafting of safety report (approaches to mitigating the risks identified)

- Review and updating of safety report.
- NHS Digital clinical safety report review and approval.

The patient safety risk assessment approach that was used was:

- What could go wrong? (likelihood and consequence) [See Appendix A for risk matrix]
- Possible main causes
- Most likely consequences / potential clinical impact (i.e. for patient safety)
- Mitigations (and recommendations to improve patient safety) leading to a reduced residual risk
- Clarification regarding actions required and risk transferred to implementers.

The full hazard log comprises:

- Hazard name and description
- Potential causes
- Potential patient safety impact
- Initial hazard rating including likelihood and consequence
- Dependencies and assumptions
- Proposed mitigation
- Revised hazard ratings
- Summary of actions and approvals

Risk assessment was undertaken using the risk matrix and scoring tool shown in Appendix A. Note that for these standards, consequences were interpreted in terms of impact on outcomes including the person's experience of care.

6. Consultation stakeholders

Consultation stakeholders are listed in Appendix B.

7. Hazard log

The full hazard log is detailed in a separate document. A summary of hazards identified, including those deemed implementation issues is included in the following section.

Please note: **The mitigations we have taken to address clinical safety risks are largely in relation to the design of the structure and description of the content of the headings. Further mitigations will be required when the headings are implemented in electronic health record systems. We have flagged some risks relating to implementation in this report, but expect that further mitigations will be identified as clinical risk assessments and safety cases are developed by vendors and sites during the implementation.**

8. Hazards

This section sets out identified hazards.

Hazard Id:	1	**Hazard Name**	Critical data absent as not recorded	**Residual risk:**	2
Hazard Description:	Critical data absent because it is not recorded.				
Hazard Causes:	Critical data not entered in the system, e.g. because clinician is not prompted for it or forgets to record it.				
Potential Clinical Impact:	Incorrect treatment or advice may be given based on incomplete clinical information				
Mitigation:	Include headings and fields to capture critical data. Guidance to implementers: This issue/risk might arise in use or misuse of our product. Mitigated by design. Training in good recording practice.				
Hazard Id:	2	**Hazard Name**	Inconsistent use of headings	**Residual risk:**	2
Hazard Description:	Inconsistent use of headings. i.e. The names and definitions of headings need to match between different sites/systems.				
Hazard Causes:	Inconsistencies in data transfer between systems.				
Potential Clinical Impact:	Incorrect data transfer, so that the data is presented under an inappropriate heading, resulting in it being missed or misinterpreted by the care professional.				
Mitigation:	Include heading and field definitions. Guidance to Implementers: Implementers have to ensure they have the most up to date version of the headings, and that the headings are correctly implemented in their system(s). Mitigated by design				
Hazard Id:	3	**Hazard Name**	Headings are not understandable to the patient	**Residual risk:**	3
Hazard Description:	Patients/carers with access to their records are unhappy with the content as they cannot understand it.				
Hazard Causes:	Headings are not understandable to the patient or patients are not happy with the clinicians population of the headings.				
Potential Clinical Impact:	Patient dissatisfaction, reducing engagement with their treatment.				
Mitigation:	Patients have been involved with the design of the headings to ensure they are understandable and appropriate from a patient perspective. Headings use terms that are comprehensible to patients. Train clinicians to record information appropriately.				
Hazard Id:	4	**Hazard Name**	Blank fields	**Residual risk:**	1
Hazard Description:	Lack of clarity over what a blank field signifies (i.e. not recorded, not assessed, not present etc).				

Hazard Causes:	Due to the design.				
Potential Clinical Impact:	Recipients will have insufficient information to make appropriate clinical decisions.				
Mitigation:	Implementation guidance states for optional fields that if a field is left blank the heading should not be communicated in the message. If a field is mandatory, the implementation guidance includes coded text for what should be recorded. System design should reduce this.				
Hazard Id:	5	**Hazard Name**	Misidentification of patient	**Residual risk:**	2
Hazard Description:	Correct patient may not be identifiable from the information provided.				
Hazard Causes:	Unique identifier unknown or entered incorrectly e.g. NHS number entered incorrectly.				
Potential Clinical Impact:	If patient is misidentified they may not receive appropriate treatment.				
Mitigation:	The National Patient Safety Agency (NPSA) recommends that the NHS number is used to correctly identify a patient. System should be linked to the patient demographic service (PDS) to obtain NHS number. Clinicians encouraged to use the patient demographic service to identify the patient.				
Hazard Id:	6	**Hazard Name**	Lack of alignment with other standards	**Residual risk:**	2
Hazard Description:	The standards may not be consistent with the latest version of related standards e.g. SNOMED CT subsets, etc.				
Hazard Causes:	As existing standards are updated they may be misaligned to the headings.				
Potential Clinical Impact:	Lack of standardisation across health/care records used in different sites.				
Mitigation:	Maintenance of the standards is the responsibility of the PRSB and changes must be possible for integration with relevant data standards as they change.				
Hazard Id:	7	**Hazard Name**	Lack of clarity about required actions	**Residual risk:**	2
Hazard Description:	Recipients of the care and support plan are unclear about what is expected of them for the ongoing care of the patient.				
Hazard Causes:	Clinicians completing the care and support plan with the patient do not clearly specify who is responsible for required actions.				
Potential Clinical Impact:	Patient receiving incorrect or no treatment as clinician fails to act upon the required actions described in the care and support plan.				
Mitigation:	Include heading and subheadings in NHS, GP and social care systems. Mitigated By Design. Training in system use should be an essential part of practice setting induction.				

Hazard Id:	8	**Hazard Name**	Headings are not appropriate for patients with mental health care needs	**Residual risk:**	1
Hazard Description:	Care professionals are unfamiliar with the language used in the headings and clinical descriptions				
Hazard Causes:	Headings and clinical descriptions are not those that are used in mental health care services.				
Potential Clinical Impact:	Important information is missing or entered in the wrong place leading to inappropriate care. Inappropriate clinical language may cause distress to patient and relatives.				
Mitigation:	The language in the headings and descriptions and implementation guidance are appropriate for patient with mental health care needs and the service needs. Guidance for implementers.				

Hazards specific to digital care and support plan standard

Hazard Id:	9	**Hazard Name**	A structured document can inhibit people in recording what is important to them	**Residual risk:**	2
Hazard Description:	Care professionals and patients/carers may want to record information in a different format, e.g. use free text to record additional detail.				
Hazard Causes:	Tension between structured information and free text recording in practice.				
Potential Clinical Impact:	Important information may be omitted.				
Mitigation:	The care and support plan standard should be piloted and evaluated prior to wider rollout. Guidance provided on what should be recorded under each heading and examples provided of how the care and support plan structure can be used in different care settings and for people with different health conditions.				
Hazard Id:	10	**Hazard Name**	Safeguarding information	**Residual risk:**	2
Hazard Description:	Care and support plan may include safeguarding information				
Hazard Causes:	Safeguarding information has the potential to be included in care and support plan as well as in a printed copy kept by the patient. The safeguarding information may be seen by abusive partner/relation etc.				
Potential Clinical Impact:	Potential patient harm due to safeguarding issues				
Mitigation:	Guidance to implementers - care and support plan should not contain safeguarding information. This needs to be reinforced by training.				

Hazard Id:	11	**Hazard Name**	Information needed in a crisis is not easily found	**Residual risk:**	1
Hazard Description:	Information needed in a crisis is not easily found in the care and support plan				
Hazard Causes:	Headings are not prominent enough.				
Potential Clinical Impact:	Potential patient harm and incorrect care provided due to lack of information				
Mitigation:	Separate contingency plan is recommended so that the detail is not lost in the care and support plan and so that urgent and emergency care staff can find the information they need quickly. Mitigated By Design.				
Hazard Id:	12	**Hazard Name**	Important information about an individual's preferences is lost in the care and support plan	**Residual risk:**	1
Hazard Description:	Important information about an individual's preferences is lost in the care and support plan				
Hazard Causes:	Headings are not prominent enough.				
Potential Clinical Impact:	People don't get a good experience with their preferences taken into consideration and are distressed				
Mitigation:	'About me' is part of care planning process and includes such information. Mitigated By Design - prominence of the About me section. Training in where to look for the information.				

9. Hazards transferred to implementation

These are issues that are out of scope of these projects but need to be addressed by system developers and implementers. These issues should be taken into account by system vendors and sites when implementing the headings.

Hazard Id:	13	**Hazard Name:**	Unavailable information	**Initial risk**	3
Hazard Description:	Information missed out as system already implemented is too structured/ inflexible to include headings.				
Hazard Causes:	E.g. Already structured systems, which cannot be changed or only at high cost.				
Potential Clinical Impact:	Incorrect treatment as a result of insufficient information.				
Hazard Id:	14	**Hazard Name:**	Electronic system failure	**Initial risk**	3

Hazard Description:	If the headings are only designed for use in electronic systems, there is a risk that there is no fall back if the system is not available.				
Hazard Causes:	Critical problem of system.				
Potential Clinical Impact:	Inability to record patient data.				
Hazard Id:	15	**Hazard Name:**	Confidentiality issues	**Initial risk**	2
Hazard Description:	There may be some information (such as sexual health information) that patients do not want recorded on a shared record.				
Hazard Causes:	Auto-population of sensitive information or failure of clinician to discuss what information was acceptable to be included.				
Potential Clinical Impact:	Violations of privacy may cause great distress to the patient.				
Hazard Id:	16	**Hazard Name:**	Cross boundary interpretation	**Initial risk**	3
Hazard Description:	Incorrect interpretation/ translation of clinical information.				
Hazard Causes:	Incorrect interpretation/ translation of clinical information.				
Potential Clinical Impact:	Incorrect clinical information.				
Hazard Id:	17	**Hazard Name:**	Incomplete exchange of information	**Initial risk**	3
Hazard Description:	Different coding systems used in different sites will limit exchange and re-use of data.				
Hazard Causes:	Different coding systems used in different sites.				
Potential Clinical Impact:	Incorrect clinical information.				
Hazard Id:	18	**Hazard Name:**	Refusal to adopt the standard	**Initial risk**	4
Hazard Description:	Services may refuse to use the record standard.				
Hazard Causes:	Lack of support for the standard.				
Potential Clinical Impact:	If some services do not adopt the standard there will remain a lack of interoperability between services.				

Hazards specific to digital care and support plan standard

Hazard Id:	19	**Hazard Name:**	Ensuring information is up to date	**Initial risk**	4
Hazard Description:	Using outdated information / inappropriate review interval				
Hazard Causes:	No review recorded / inappropriate review interval / delay in review				
Potential Clinical Impact:	Incorrect decisions or actions as a result of out of date/ insufficient information.				
Hazard Id:	20	**Hazard Name:**	Understanding what is a digital care and support plan	**Initial risk**	2
Hazard Description:	Care professionals have different understanding based on their practice				
Hazard Causes:	Variation in use of digital care and support plan in practice.				
Potential Clinical Impact:	Incorrect care provided as a result of insufficient information.				

10. Summary safety statement

12 potential hazards were identified and mitigated and 8 deemed implementation issues. The mitigated hazards include information that should be addressed by implementers. All hazards were identified through the consultation steps carried out to develop these standards. The consultations consisted of a multidisciplinary workshop, online survey and an expert user group meeting. These workshops, surveys and communications included patient representatives as well as professionals from Royal Colleges, specialist societies, nursing, midwifery, social care, allied health professions, health informatics professionals and vendors.

During the consultation hazards were identified, reviewed and mitigations/actions considered. Nevertheless, some risk is inherent in the standards but most has been:

(A) mitigated by the development of the standards

(B) or the residual risk has been transferred (with guidance) to the implementers.

Certain hazards were deemed system implementation matters. The hazard log (a separate document) however provides guidance for system developers and implementers. It is important that this guidance in relation to these hazards become requirements for implementation.

11. Document control and post standard approval maintenance

Maintenance arrangements for the headings that constitute these standards are specified in the Generic Editorial Principles for the Development of Standards for the Structure and Content of Health Records (a separate document). Future governance of development and maintenance for all professional record standards is the responsibility of the PRSB.

12. SCCI 0129 compliance matrix

The table below summarises the compliance status of this safety case for digital care and support plan standard project.

Requirement	Compliant (Y/N)?	Comments
4 General requirements for effective clinical risk management	Y	See section 3
4.1 Clinical risk management process	Y	See section 3
4.2 Management responsibilities	Y	See section 3
4.3 Competencies of personnel	Y	See section 3 & 6
4.4 Clinical risk management planning	Y	See section 3 & 4
4.5 Clinical risk management file	Y	This document in its entirety, including supporting evidence and the standard in full.
4.6 Clinical safety case	Y	This document in its entirety, including supporting evidence and the standard in full.
5 Clinical risk analysis	Y	See section 5
5.1 Clinical risk analysis process	Y	See Section 5
5.2 Intended use and identification of characteristics related to the clinical safety of the health software product	Y	See section 2
5.3 Identification of hazards to patients	Y	See section 5
5.4 Estimation of the clinical risk(s) to a patient for each hazardous situation	Y	See section 8
6 Clinical risk evaluation	Y	See section 5
7 Clinical risk control	Y	See section 8
7.1 Clinical risk reduction	Y	See section 8
7.2 Clinical risk control option analysis	Y	See section 8

7.3 Implementation of clinical risk control measure(s)	Y	See section 8
7.4 Residual clinical risk evaluation	Y	See section 8
7.5 Clinical risk/benefit analysis	Y	See section 8
7.6 Clinical risks arising from clinical risk control measures	Y	See section 8
7.7 Completeness of clinical risk control	Y	See section 1
7.8 Evaluation of overall residual clinical risk acceptability	Y	See section 1
8 Clinical safety case report(s)	Y	This document in its entirety, including supporting evidence and the standard in full.
9 Stage reports and pre-release clinical risk management process review	N	Not required for a professional standard.
10 Post-deployment monitoring	N	Not required for a professional standard.
11 Product modification	Y	See section 11

Appendix A – Risk matrix

Likelihood						
	Very High	3	4	4	5	5
	High	2	3	3	4	5
	Medium	2	2	3	3	4
	Low	1	2	2	3	4
	Very low	1	1	2	2	3
		Minor	Significant	Considerable	Major	Catastrophic
		Consequence				

Likelihood

Category	**Likelihood**
Very High	Unacceptable level of risk. Mandatory elimination or control to reduce risk to an acceptable level.
High	Unacceptable level of risk. Mandatory elimination or control to reduce risk to an acceptable level
Medium	Undesirable level of risk. Attempts should be made to eliminate or control to reduce risk to an acceptable level. Shall only be acceptable when further risk reduction is impractical.
Low	Tolerable where cost of further reduction outweighs benefits gained.
Very Low	Acceptable, no further action required

Consequence

Category	**Interpretation**	
	Consequence	**Patients Affected**
Catastrophic	Death	Multiple
	Permanent life-changing incapacity and any condition for which the prognosis is death or permanent life-changing incapacity; severe injury or severe incapacity from which recovery is not expected in the short term	Multiple
Major	Death	Single
	Permanent life-changing incapacity and any condition for which the prognosis is death or permanent life-changing incapacity; severe injury or severe incapacity from which recovery is not expected in the short term	Single
	Severe injury or severe incapacity from which recovery is expected in the short term	Multiple
	Severe psychological trauma	Multiple

Considerable	Severe injury or severe incapacity from which recovery is expected in the short term	Single
	Severe psychological trauma	Single
	Minor injury or injuries from which recovery is not expected in the short term.	Multiple
	Significant psychological trauma	Multiple
Significant	Minor injury or injuries from which recovery is not expected in the short term	Single
	Significant psychological trauma	Single
	Minor injury from which recovery is expected in the short term	Multiple
	Minor psychological upset; inconvenience	Multiple
Minor	Minor injury from which recovery is expected in the short term; minor psychological upset; inconvenience; any negligible consequence	Single

Appendix B – Consultation stakeholders

This appendix describes the stakeholders who participated in the workshop, online survey and the expert group review.

Workshop attendees (05 April 2017) by organisation

Organisation	Name
Patient Representative	Ann Heaton
North West London Collaboration of CCG's	Bill Sturman
Scottish Government	Blythe Robertson
The Coalition for Collaborative Care	Cally Ward
Think Local Act Personal Partnership	Caroline Speirs
Homerton University Hospital NHS Foundation Trust/ Royal College of Occupational Therapists	Catherine Atkinson
The Coalition for Collaborative Care / NHS England	Catherine Wilton
South London and Maudsley NHS Foundation Trust	Charles Comley
Royal College of Nursing	Claire Buchner
NHS England	Clive Prince
Royal College of Physicians	Darren Wooldridge
Patient Knows Best	David Boerner
National Voices	Don Redding
OLM Group	Ed Hagerty
Resuscitation Council (UK)	Federico Moscogiuri
Registered Nursing Home Association	Frank Ursell
Chelsea and Westminster Hospital	Gary Hartnol
Royal Pharmaceutical Society	Heidi Wright
Professional Record Standards Body	Helene Feger
Health Informatician / Accessibility	Howard Leicester
South Somerset Symphony Vanguard	Ian Wyer
Cerner	James Parrott
Royal College of Physicians	Jan Hoogewerf
Hertfordshire County Council	Jennifer McAteer
South Somerset Symphony	Joanne Cummings

Organisation	Name
Manchester City Council	Joe Kelly
Healthy London Partnership	John Arnett
Imperial College Healthcare NHS Trust	John Kelly
Thames Valley Strategic Clinical Network	Julia Coles
Royal College of Physicians	Kajal Mortier
NHS Digital/Association of Directors of Adult Social Services	Keith Strahan
British Dietetic Association	Kiri Elliott
The Coalition for Collaborative Care	Kristi Adams
Arthritis Research UK	Laura Boothman
Northumbria Healthcare / Year of Care Partnerships	Lindsay Oliver
Oxfordshire Clinical Commissioning Group	Merlin Dunlop
NHS Digital	Munish Jokhani
Durham Darlington Easington Sedgefield Primary Care trust/ General Practitioner	Neill Jones
North West London Collaboration of CCG's/ General Practitioner	Nilesh Bharakhada
Hertfordshire Partnership University NHS Foundation Trust	Paul Bradley
Surrey Heartlands STP	Robert Smith
Professional Record Standards Body	Sarah Jackson
Royal Free London NHS Foundation Trust / British Association of Audiovestibular Physicians	Sebastian Hendricks
Royal College of Physicians	Sheena Jagjiwan
London Borough of Tower Hamlets, Principal Social Worker	Stella Smith
Civica	Stephen Hawkins
College of Paramedics	Steve Hatton
EMIS Health Ltd	Steve Roberts
Royal College of Nursing/ District Nurse	Susan Rayment
Oxfordshire CCG/ General Practitioner	Thomas Nichols
Cerner	Tim James
Private Healthcare Information Network	Vaibhav Joshi
North West London Collaboration of CCG's	Xavier Yibowei
ESP IT Consultancy Ltd/ Royal College of Nursing	Zabeda Ali-Fogarty
NHS Digital	Zac Whitewood-

Organisation	Name
	Moores

Workshop attendees (05 April 2017) by sector/role

Role	Number
Allied Health Professional	4
Commissioner	2
Industry	6
Informatician	4
Mental Health	2
Nursing	3
Other	6
Patient / carer	4
Pharmacist	1
Policy	1
Primary Care	7
Private Health	1
Professional Body	1
PRSB	1
Secondary care	2
Social care	6
Voluntary	4
Total	**55**

Online survey respondents (by role)

Role	Number	%
Allied Health Professional	110	18%
Commissioner	7	1%
Community nurse	30	5%
General Hospital Nurse	8	1%
General Practitioner	27	4%
Informatician	22	4%
IT System Supplier	16	3%
Manager	120	19%
Mental Health Nurse	4	1%
Patient / Carer / Service user	57	9%
Pharmacist	11	2%
Psychiatrist	4	1%
Secondary Care Doctor	42	7%
Social care worker	17	3%
Voluntary / Third sector worker	32	5%
Other	116	19%
Total	**623**	

Expert Reference Group attendees (20 October 2017)

Organisation	Name
NHS Digital	Adnan Azfar
Hillingdon CCG	Nilesh Bharakhada
Imperial College Healthcare NHS Trust	Gerry Bolger
Royal College of Physicians / Royal College of Nursing	Claire Buchner
Royal College of Nursing	Matt Butler
College of Paramedics	David Davis
NHS Digital	Michael Folan
Royal College of Physicians	Jan Hoogewerf
Royal College of Physicians / NHS Digital	Neill Jones (Chair)
NHS Digital	Munish Jokhani
Royal College of Physicians / Adult Social Care	Joe Kelly
Northumbria Healthcare / Year of Care Partnerships	Nick Lewis-Barned
Royal College of General Practitioners CCSP Network	David Paynton
Royal College of Physicians	Haroldas Petkus
Patient Knows Best	Shriti Rai
NHS Digital	Keith Strahan
Patient Knows Best	Shailesh Suri
Partnership in Care	Ian Turner
North West London CCGs	Xavier Yibowei