Advisory Board Meeting Minutes, 30 January 2019

Venue: British Computer Society, 1st Floor, The Davidson Building, 5 Southampton Street, London, WC2E 7HA

Meeting Chair: Prof Maureen Baker (MB)

Present:		
Afzal Chaudhry (AC) PRSB	James Reed (JR) RCPsych	Philip Scott (PSc) HL7
Alannah McGovern (AMG) PRSB	Julian Costello (JC) RCGP	Rachel Scanlan (RS) RCM
Brendan O'Brien (BOB) FN NI	Karen Selby (KS) RCOG	Rebecca Cook (RC) FN Wales
Chloe Adams (CA) BDA	Kathryn Moyse (KM) RCSLT	Ross Scrivener (RSr) RCN
David Watts (DW) ADASS	Keith Strahan (KSt) CSW	Sandip Kaur (SK) PRSB
Don Redding (DR) NV	Lorraine Foley (LF) PRSB	Sarah Jackson (SJ) PRSB
Don Payne (DP) PRSB	Marlene Winfield (MW) PRSB	Sean Brennan (SB) IHRIM
Euan McComiskie (EMC) CSP	Martin Orton (MO) PRSB	Ross Scrivener (RS) RCN
Graham Fawcett (GF) BPS	Maureen Baker (MB) PRSB	Sandip Kaur (SKa) PRSB
Helene Feger (HF) PRSB	Michael Thick (MT) TechUk	Stephen Goundrey-Smith (SGS) RPharmS
Holly Kearn (HK) PRSB	Mike Andersson (MA) BCS	Steve Casson (SC) PHE
Iain Carpenter (IC) PRSB	Nick Booth (NB) FCI	Suzy England (SE) RCOT
Iain Moppett (IM) RCoA	Obi Amadi (OA) CPHVA	Upeka DeSilva (UD) CID
Ian Thompson (IT) FN Scotland	Peter-Marc Fortune (PMF) Resus	
Guests:		
Alastair Grenfell (AG) NHSD	Kenneth Harris Jones (KHJ) NHSD	Philippa Shelton (PS) UPD
Jan Hoogewerf (JH) RCP	Lyndsay Dytham (LD) HIU	Stephanie Strachan (SS)
Jo Reeder (JRe) NHSE	Masood Nazir (MN) NHSE	Susan Kennedy (SK) HEE
Apologies:		
Ajay Aggerwal (AA) RCR	Ian Rodrigues (IR) RCOphth	Martin Tully (MTu) eHealth Ireland
Alastair Henderson (AH) MTW	Ian Turner (ITu) CPA	Matthew Curl (MC) AHP Scotland
Alexia Tonnel (AT) NICE	James Sanderson (JS) NHSE	Mohit Khurana (MK) BOS
Amir Mehrkar (AM) INTEROPen	Jason Broch (JB) Leeds CCG	Natalie Koussa (NK) CID
Ben Bloom (BB) RCEM	Joe McDonald (JM) CCIO Network	Neelam Dugar (ND) RCR
Catriona Davenport (CD) PRSB	Joe Noar (JN) BOS	Nicola Strickland (NS) AoMRC
Claire Curtis (CC) PCHC	John Williams (JW) RCP	Paul Miller (PM) FN Scotland
Darren Wooldridge (DWo) HIU	Judith Brodie (JBr) PRSB	Phil Koczan (PK) PRSB
David Riley (DRi) NHSD	Kasmyn Chen (KC) PRSB	Raymond Nethercott (RN) RCPCH
Debbie Brown (DB) QNI	Kim Bellis (KB) IHRIM	Stephen Childs (SCh) NECS
Derek Felton (DF) PRSB	Laura Cameron (LC) AHP Scotland	Steve Van Wagenen (SVW) KLIMT
Dev Chauhan (DC) NHSE	Libby Pink (LP) NHSD	Tom Hughes (TH) RCEM
Gareth Thomas (GT) PRSB	Lucy Butler (LB) ADCS	Victoria Tzortzious Brown (VTB) RCGP

Haroldas Petkus (HP) HIU	Luke Readman (LR) INTEROPen	
Harpreet Sood (HS) NHSE	Mark Simpson (MS) PRSB	

1. **Welcome**

The Chair (MB) welcomes everyone and thanks the British Computer Society for hosting us.

The Chair Welcomes everyone on the phone – SE, MA, SB, RC, BOB, AG, SKa, PMF, JR, MT, EMC, SC.

The Chair also welcomes new joiners and those attending their first meeting.

Thank you and good luck to GF (BPS) who will be focusing on work overseas and Mark Simpson one of our clinical advisors who is moving to Australia.

No declarations of interest.

2. **Minutes, actions of the last meeting and matters arising**

The minutes were accepted.

3. **Chair and CEO Updates**

Chair update

NHS Long-term plan

The Chair commented on the 10-year plan which has now been published. MB remarked that work force capacity is one of the biggest risks to the fulfilment of the long-term plan and that PRSB's purpose is really engaging clinicians, professionals and patients in the digital agenda. MB emphasised the importance of building our Chief Information Officer (CIO) and Chief Clinical Information Officer (CCIO) Network, making sure that they are aware of our product and agenda.

Funding and future of PRSB

Discussions with NHS Digital who hold PRSBs main contract has taken a lot of attention this period. It is important that a small organisation such as the PRSB is funded to a level which is sustainable and enables us to be effective. PRSB have been in constructive discussion on this with NHS Digital and there is increasing acknowledgement of the wider value of the role we play to the system at large. We are grateful to the Academy in supporting our cause to Secretary of State and elsewhere and this has been helpful in elevating the profile of PRSB's work.

KHJ NHS Digital recognise the challenges and said NHS Digital are keen to ensure ongoing support to the PRSB and recognise its important role. KHJ confirmed we are in constructive discussion and on course to resolve this.

NHS X

MB spoke about the new board NHSX which has been announced with remit to streamline and rationalise the health and care informatics function across NHS England and NHS Digital. PRBB will be observing with great interest as we expect new structures will be in place for the start of the financial year. Leadership of the health and social care informatics agenda structure is going to change, the Chair emphasised the importance of determining how the leadership want to engage and what role PRSB can play in relation to them.

CEO update

LF highlighted PRSB's status as a UK wide body. Issues raised at the last advisory board with the pharmacy information flows and applicability in Scotland have been resolved and LF is particularly pleased that a colleague from Scotland is one of the clinical leads on the NHS England commissioned Interoperable Medications project.

SGS reiterated LFs comments regarding ensuring our work is relevant in Scotland and all UK nations.

The CEO spoke about PRSB's priority of involving people and social care as equal partners. LF mentioned some of the ways PRSB's intend to continue doing this through consultation, working with personalised care teams and encouraging care providers to get on board with the digital agenda through engagement and the PRSB support service.

KSt remarked that NHS Digital has provided funding for the members of the Care Provider Alliance to deliver a new sector-led service which will offer digital support for social care providers.

LF noted that the Royal College of Physicians Health Informatics Unit will cease from end of March. LF took the opportunity to extend her personal thanks and the thanks of the board for the fantastic work of the HIU Director, Professor John Williams, Jan Hoogewerf and the whole team for the excellent work they have undertaken over the years an which has been key to our success. The advisory board added their thanks and good wishes for the future to the team.

LF noted that PRSB has increased internal capacity over the last year to ensure we are well placed to continue the work.

4. **Member items**

Journal of Innovation in Health Informatics
PSc informed the advisory board about a BCS and BMJ co-produced journal and PSc wanted to bring this to people's attention. Submission is free initially, before May 2019, so members are encouraged to take this up.

Speech recognition workshop
PSc outlined an opportunity with a provider of speech recognition. This is of interest in terms of how SNOMED can be interpreted from speech and support the clinical workflow. There are several other providers of this type of software. Nuance (the provider) would like to convene a group of clinicians to look at this with them if there is interest. PSc clarified that PRSB is not endorsing this product over any other.

PMF queried this product and whether there were other better ones.

MB said this type of product would be very beneficial so it is appropriate to explore and see what can be learned.

SGS said RPharmS had similarly been approached and suggested that PRSB would benefit from a policy to guide such matters. IT reiterated this point and said that any resulting software would need to be formally assessed for safety. PRSB to consider if we should note these on the web site for transparency.

SS commented on safety issues from this type of thing that she has seen.

MW queried whether there is a case for standards in this area.

Action: LF to ensure PRSB develop a policy for this type of issue.

5. LHCRs

SJ, Programme Director, gave an overview of the initial work we have done to define a standard core longitudinal record working with the 5 exemplar sites.

Patient and Public Engagement with LHCRs in Thames Valley and Surrey

DR of National Voices gave an overview of their work to date and future plans with the Thames Valley and Surrey LHCR who they are partnering with.

Long term plan includes great emphasis on digital but doesn't make it explicit how this relates to and links with personalised care. How do we enable citizens to have 'care planning' conversations and ensure their needs are recorded? DR highlighted that it is not just about having good information governance rules but how this works in practice on a case by case basis. PRSB need to take a learning approach.

Philippa Shelton, Understanding Patient Data (UPD)
UPD is an independent initiative to support better conversations around health information.

PS welcomed the important support that PRSB have provided over the last 2 years, the ground breaking work on animations and for spreading the word through networks. They have been approached by a number of the LHCR sites and sit on some of their boards, doing important work to build confidence in delivering messages, something which is vital to ensure transparency with patients and support for the programme.

IT asked how we can ensure this LHCR work is applicable to the whole UK and also how National Voices can work with third sector organisations working to influence health and social care policy. IT indicated that he was happy to try and make these connections to help support the voices of citizens and patients.

DR confirmed that National Voices have a good relationship with the Health and Social Care Alliance but is less well plugged with the Welsh Social Care and Wellbeing Alliance.

LF stressed that whilst the work is funded and the drive has come from England, the core record and the consultation we are about to enter into is open to everyone in England (LHCR and non-LHCR alike) as well as Scotland, N Ireland and Wales.

DW in social care, we are frequently dealing with very small and sometimes transient care providers and we have to take account of how we engage with them. They also don't have the financial and infrastructural resource to be able to play. We should ensure that we are also bringing in social care through ADASS as UPD's work is clinician based.

Information governance video

HF stated PRSB recognises that the volume of information is likely to be really significant and immediately people ask how they can be assured that this information will be shared safely. It is not the role of the PRSB to create that information governance, but we thought it would be helpful to show that this work is going on elsewhere

A video was shown highlighting the work on information governance and the framework being developed which is key in this and which is being addressed at national LHCR programme level.

GF said the most citizens spend a tiny fraction in hospitals. Let's not let projects off the hook which start in the hospital and claim they will later deploy into the community. Do we have an architecture that includes more than just the state actors? Private contractors etc. How can we extend PRSB's reach to the entire landscape not just the state landscape?

LF confirmed that the project is not hospital centric but thanked GF for the caution. LF reminded everyone that there is a big consultation coming up – like no other and PRSB welcomes any thoughts as we recognise the record and it's use are important.

Open for ongoing input, discussions, queries via Sarah or info@prsb.org.

6. **RCP e-discharge training resource implementation review**

LD and SS of RCP described the work they had undertaken and the supporting tool to encourage uptake of the discharge standard and high-quality completion of it.

Tool is available now and is free. Members are asked to support and encourage its use.

SS said implementing the standard was tricky and the implementation needs to be considered.

Action: SS and Lorraine to talk through the details of the problems this highlighted.

KSt stressed the importance of discharge summaries for social care. We know that this is posted to nursing homes. This isn't just for GPs it's for all sorts of organisations. When writing the template, we must consider: what does the carer need to know?

DW welcomed this. Will the NICE standard around hospital discharge be updated to include this resource? The redbag project is a visual way to make sure the right information travels with people between different care settings and there is a push for national implementation.

MB informed us that physician associates have really engaged with this and are going to use this for their UK wide training.

SS said they were tasked with looking at the electronic discharge summary. Even though the majority of discharge seems to be non electronic. Data dump when a patient comes in. How could GPs incorporate this info into their records – so that good information is transferred? A key concern is that HIU is closing. Its not clear who will take this forward. There needs to be examples that this can be transferred to other departments.

JH happy to travel to different colleges etc to try and get engagement. Happy to cover this at other meetings.

LF remarked that putting in the technology is not enough and that defining the standard is important but then the hard work starts.

MT questioned whether we could incorporate the guidance into Electronic Patent Records and learning materials?

7. **Academy survey**

HF described the planned work with the Academy to survey medical staff regarding their experiences and needs to use digital effectively. We intend that this should be extended to all care professions in due course. The intent is that the survey leads to co-produced action plans that target the issues and opportunities identified by the survey and which enable clinicians to engage more effectively with digital.

The following points were fed back from members on the draft survey questions:

Is the terminology accessible? e.g. digital agenda
Ensuring the potential benefits are articulated
Test how it would be received in each setting e.g. 2-man GP practice/organisation - plan to test it with each
What does digital bring that's better/worse?
How could digital enable transformation rather than just automation?
NB - looser definition of technology that enables people to think e.g. why do junior doctors use WhatsApp?
Have you go the basic tools to do the job?
Clarity - what went well - for who? The staff, the system
Safe environment to use these kind of tools
Guidance note/narrative
What do they need? - e.g. how can the system be user friendly – users can use amazon but not clinical systems

MO encouraged clinicians to link with digital leaders

SK spoke about the topol report out on 11th Feb, to prepare, create and support a future workforce. I would echo the comments about useful guidance accompanying the questions. SK encouraged the advisory board to look at the report which covers education, training and retention of staff, when it is published.

8. Standards

Interoperable Medications Information Sharing

MN introduced this important area of work on standards
MN outlined the historical problems with standardising medications information - too difficult to fix. We are now tackling this with all the benefits that will confer for safety and better patient care.

IT described the work underway on the project in more depth taking about the scheduled clinician/patient webinars and clinical informatician webinars, the scope of the work e.g. chemotherapy not in scope and posed questions to the members, the following responses were received:

Most people didn't understand what the problem was

Further clarity of what this means for lay folk

Early adopter NHS sites - who would be willing to pilot (speak Philip re simulation) - 2 first of type sites

Change management needed around this - this is huge, how can we help?

Vendors will use any inconsistency between clinicians to avoid acting

Medication errors in care homes - why is this not included in scope? Care providers should be added to scope - digital maturity is low but some have excellent systems and could test this - pursue with Keith, can we find some?

Scottish implementation opportunity?

How will we share this information with health and care professionals not working in a hospital?

What information do patients need?

How are we preparing the consultation for patients - what does the survey say?

What about new drugs not in the dictionary of medicines and devices (DMD) - implementation consideration. Improvement to DMD would be one of the pieces of work going forward.

What are the exceptions? What is automated, what isn't?

SC emphasised that getting this right might mean less wasted time for patients.

IT suggested that we are talking about a messaging standard – many places that this could be used. Provided the example of the GP who does the majority of prescribing, communicating to the carer or the patient. IT considered some ways of implementing this through using software as a service – office 365 product? Could a small prescriber subscribe to this? How do we identify health and social care professionals and the myriad of other people who might need access to this information (relevant to them)? This is very early stage development.

CA recommended that on a practical level – yourcareconnect could work in a primary care setting, there was a point when we could view GP records. AHPs are also now prescribing. CA compelled the group to think more widely as she thinks this could be used more efficiently in a multidisciplinary team.

MB said this is critical work and very high on Simon Eccles agenda but equally applicable across the 4 nations. MB also said that the work was undertaken in very short timescales without losing rigour and PRSB are managing to deliver this in very short order, learning that will be applied to future projects.

9. Work programme update

HF PRSB has launched a podcast. Members are asked to propose topics/speakers that will engage their organisations.

Action: members to propose - mail them on this

Digital Health Rewired and summer school - advise if you have topics or want to propose material for these.

Diagnosis recording

AC told the advisory board that the diagnosis recording work originated from looking at hospital episode statistics where 49% of dementia diagnoses appeared to have been resolved. Recording the most accurate and granular information on diagnoses is absolutely critical. PRSB with RCP have developed a set of guidance on recording of diagnosis. Current status - collating final comments on the consultation on the guidance. Buy in from all colleges will be important - some of this can be enforced through technology, but much is behavioural.

MB questioned how we might articulate this complexity to lay, public audiences (e.g. the complexity of a diagnosis) and thought it helpful to have a discussion in the public arena.

NB thought a providence model or metadata around the model detailing who made the original diagnosis, their role, who made the machine that recorded the diagnosis etc would be helpful.

AC reminded colleagues of the burden of an incorrect diagnosis. E.g. allergies

IT spoke about some challenges his team in Scotland noted: each supplier uses a different mechanism and there is no way of coding a mistaken penicillin allergy currently. How could we construct active and past conditions into a useful summary as a way of improving shared information across clinical settings?

AC emergency care data set – expected or confirmed diagnosis. No code for expected – can only be transmitted in free text. Pathological uncertainty v diagnosis uncertainty. Tissue diagnosis blood diagnosis etc.

Pathology coding

MO primary care requesting pathology tests – based on recodes. The system is frozen and can't be updated. NHS Digital are developing pathology coding in SNOMED CT, beginning with blood sciences and have asked us to assure these. PRSB are recruiting clinical informaticians to review how this can be tested and they will make up part of multidisciplinary teams.

Pharmacy Information Flows

MO PRSB have signed off the stage 2 final report and are about to start endorsement – meds review, appliance use review, draft pilot schemed, discharge to pharmacy, confirming existing information to pass on to pharmacies.

Endorsement

MO endorsement. Document Naming and Pharmacy stage 2 are currently out for endorsement. We are updating the child health standard via the maintenance release and we hope to maintain your endorsement. The PRSB are working to improve delivery and the endorsement process and make it more efficient by contacting the endorsement bodies at the beginning of the work, warning that we will be looking for them to endorse it at the end with the hope that we get the appropriate people involved and engaged to make sign off easier.

KHJ said that NHS Digital had received the first update report from your team, and that it was really informative. KHJ said he thought seeking endorsement early was a great idea.

AOB – none.

MB thank you for your attendance.

Actions from Advisory Board meeting – 30th January 2019

Date	Agenda Item	Action	By Whom	Status/Comments
30/01/2019	1	Create a vendor policy	Alannah and Helene	Completed – to be sent out in advance of the advisory board
30/01/2019	2	Lorraine and Stephanie Strahan to meet and discuss the	Lorraine	Completed

		problems Stephanie encountered when implementing the standard		
30/01/19	3	Mail members about contributing podcast ideas	Lizzie mails individual organisations about proposing ideas when timely	Completed