Advisory Board Meeting Minutes, 17 July 2019

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

Meeting Chair: Prof Maureen Baker (MB)

Present:		
Alannah McGovern (AM)	Dr John Williams (JW)	Kathryn Moyse (KM)
Ben McAlister (BM)	Dr Julian Costello (JC)	Laura Fulcher (LFu)
Chloe Adams (CA)	Dr Karen Selby (KS)	Lorraine Foley (LF)
David Watts (DW)	Dr Keith Strahan (KSt)	Marlene Winfield (MW)
Debbie Brown (DB)	Dr Laszlo Igali (LI)	Martin Orton (MO)
Don Redding (DR)	Dr Michael Thick (MT)	Mike Andersson (MA)
Dr Brendan O'Brien (BOB)	Dr Peter-Marc Fortune (PMF)	Prof Maureen Baker (MB)
Dr Cheryl Battersby (CB)	Dr Philip Scott (PS)	Rebecca Cook (RC)
Dr Iain Carpenter (IC)	Dr Steven Casson (SC)	Ross Scrivener (RS)
Dr Ian Rodrigues (IR)	Dr Tom Hughes (TH)	Sophie Randall (SR)
Dr Ian Thompson (IT)	Euan McComiskie (EMC)	Stephen Goundrey-Smith (SGS)
Dr James Brown (JB)	Helene Feger (HF)	Suzy England (SE)
Dr James Reed (JR)	Holly Kearn (HK)	
Guests:		
Dr Anoop Shah (AS)	Henrietta Mbeah-Bankas (HMB)	Kenneth Harris Jones (KHJ)
Dr Emma Davis (ED)		
Apologies:		
Alexia Tonnel (AT)	Dr Nicola Strickland (NS)	Mohit Khurana (MK)
Andrew Mitchell (AMi)	Dr Phil Koczan (PK)	Myer Glickman (MG)
David Riley (DRi)	Dr Rhidian Hurle (RH)	Natalie Koussa (NK)
Derek Felton (DF)	Dr Timothy Yates (TY)	Obi Amadi (OA)
Dr Afzal Chaudhry (AC)	Hannah Farndon (HFa)	Pippa Mccabe (PM)
Dr Amir Mehrkar (AMe)	James Freed (JF)	Prof Sue Hill (SH)
Dr Ben Bloom (BB)	Jane Gregson (JG)	Russ Charlesworth (RCh)
Dr Iain Moppett (IM)	Kim Bellis (KB)	Sarah Jackson (SJ)
Dr Jeremy Bewley (JBr)	Laura Cameron (LC)	Steve Van Wagenen (SVW)
Dr Joe Noar (JN)	Lucy Butler (LB)	
Dr Neelam Dugar (ND)	Luke Readman (LR)	

1. Introduction

Colleagues from RCGP presented our chair with a gavel to help her call order to the group. This was much appreciated.

New joiners were welcomed: Pippa McCabe - Allied Health Professions Northern Ireland (who we will meet at the next meeting), Dr Cheryl Battersby - Royal College of Paediatrics and Child Health, Ben McAlister - HL7 UK and particularly Dr James Brown as it has been some time since we have had a Royal College of Surgeons representative and we are delighted to have them.

Guest speakers were welcomed: Dr Emma Davis - NHS South, Central and West CSU, Henrietta Mbeah-Bankas - Health Education England, Dr Anoop Shah - University College London.

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

Corrections:

- LF NHS Digital item
- SGS suggested a correction of wording re pharmacists and medications. To be agreed with SGS.
- IC pointed out error in 2nd paragraph - inhabited rather than inhibited

Minutes approved.

Matters arising

IC queried feedback from West Suffolk about testing of interoperable medications guidance.

MO said that the pilot in Taunton is progressing well and work is ongoing in Suffolk. MO agreed to keep the advisory board posted.

3. Chair and CEO updates

NHSX and business plan

MB and LF spoke about the important launch of NHSX and the effect of this on PRSB. They mentioned that core funding previously came from NHS Digital but that reorganisation within the NHS means that PRSB are currently working from reserves. There is a meeting scheduled on Tuesday with Matthew Gould which will hopefully resolve this issue.

LF also added that this has been a good prompt for us to act more independently and attract other sources of income. LF mentioned a number of ideas that are in discussion: partnering with other organisations that have synergy with us, exploring service lines and new business areas and accreditation of services.

EMC offered PRSB support from the Chartered Society of Physiotherapists. He suggested reading HSJ document which discusses NHSX and its unique position to deliver on standards.

NHS Digital thanked us for our continued professional support and clinical input.

KHJ confirmed ongoing funding of PRSB. NHS Digital have been subject to the same funding pressures and uncertainty.

MB confirmed the enduring importance of the relationship with NHS Digital.

4. Education/Digital workforce.

Panel discussion to identify the work being done to tackle the issues around education and digital access identified by health and social care professionals.

Dr John Williams - Faculty of Clinical Informatics (FCI), Henrietta Mbeah-Bankas - Health Education England (HEE) and Euan McComiskie - Chartered Society of Physiotherapy (CSP) introduced themselves, their organisations and their work in educating the workforce re digital.

JW spoke about his time as a GP, involvement with BCS primary healthcare specialist group and the GP to GP project, the development of HL7, JGPIT group and RCGP Health Informatics Group. KW remarked that English general practise is such a long way ahead in terms of digital and interoperability due to these early initiatives.

JW thanked MB for her help in setting up the FCI, for which he is the Chair. The FCI is soon to become a charitable incorporated organisation. The FCI are developing core competency standards for clinical informaticians, this should deliver late spring. They also offer accreditation courses for professional leadership, developing a robust career structure for clinical informaticians.

HMB a mental health nurse and digital literacy project manager at HEE was passionate about leadership happening at all levels but stated that the evidence shows that it is board level leadership that most often leads to the implementation of a change agenda and HMB believes it is digital literacy and digital readiness that are pivotal to achieving successful implementation. HMB spoke about social media savvy health and care professionals that are assumed ‘digitally literate’ but are in fact less confident with content specific digital applications.

HMB alerted us to the below survey which is part of the HEE and NHSD commissioned project led by Social Care Institute for Excellence (SCIE) and the British Association of Social Workers (BASW), to develop and provide new guidance and a digital capabilities framework for social workers. There has been over 500 responses already, informing pre and post registration training:

https://www.basw.co.uk/media/news/2019/jun/basw-and-scie-survey-digital-capabilities-social-work.

HEE are also developing a self-assessment diagnostic tool so that practitioners can identify where they need more digital learning, the idea being is that the tool would then signpost people to where the required learning is. Development is also underway for an internal piece of work around personalised learning to increase competence. HMB additionally spoke about the importance of local championship and the capacity to supply the workstream.

EMC introduced himself as a clinical physiotherapist and informatician. EMC told us about the Chartered Society of Physiotherapists work around education and the digital workforce. CSP have set up the Digital Informatics Physiotherapy group, which gained its eightieth member last week. They are trying to put together learning opportunities for physiotherapists at all levels of their careers, aiming for evolution rather than revolution. EMC also spoke about the work of the Allied Health Professionals collectively who he describes as doing similar work to generate interest and drive informatics forward.

MO said we need digital to become part and parcel of everyone's job not just the interest of a self-selected few who are already tech advocates?

SGS said this will become even more critical with integrated working and integrated care records.

EMC said digital is the vegetables that you hide in your child's dinner, it's good for them but they almost don't know it's there.

IT asked if the training systems and bodies are addressing the issue of how professionals interact with digital and develop the skills to use digital in a day to day way and in consultation so that it doesn't dominate the discussion. Scottish Social Services Council (SSSC) have been exploring education theory around certain competencies and awarding badges. IT also made the point that we should not be forcing everyone to go through the core training if they already have skills but offering various skill appropriate levels of training.

PMF endorsed comments made about integrating IT and education. PMF challenged the prior comment about professionals as confident social media users but unconfident with digital in a clinical environment. PMF questioned whether this demonstrates incompetency or unintuitive and inferior systems. PMF said that NUANCE and EPIC have developed audio-based systems that avoids the problems that come with having a computer in front of you in consultation.

RS explained that RCN plan to build on the wok that NHS improvement published last autumn on a framework for careers in nursing and allied health professions. RS said that the RCN will publish this as a public facing web resource to advertise the digital roles emerging for nurses, and the digital work nurses are doing already. RS agreed with the need for informaticians, but also emphasised the need to engage across the board.

RS said that education needs to change, e.g action learning sets in primary care, focusing on solving an issue not promoting a technology.

PS and LFu spoke about their desire to join the FCI but as a nonclinical informatician and patient they are not eligible for the fellow and membership categories.

LFu questioned how patients are getting access to this kind of training and development, stating that the barriers are even bigger for them.

JW later explained that FCI are a new organisation and they have plans to ensure they have a patient and citizen voice guiding them. JW also explained that FEDip cater for the nonclinical informaticians and the reason the two organisations are separate is because of how the clinical and nonclinical workforce are regulated. JW noted that there are a number of faculty fellows in the audience and ensured that all comments made would be taken on board by the faculty.

HMB confirmed that HEE plans also include working with citizens.

DB from the Queen's Nursing Institute (QNI), did an explorative piece of work and found that clinicians were most frustrated by software, with 78 different systems were noted in one borough.

EMC believes multiple systems can work if the multiple systems are right and that one system only results in monopoly.

IT mentioned teaching methods needed to change and we should strive for more immersive learning, recommending Prof Shafi Ahmed speaking on virtual surgeons.

DW agreed, mentioning that social care is focusing on seeing the person at the centre and on asset based rather than deficit-based models to identify solutions. DW reiterated that there are many factors that enable someone to manage with more or less care and support and it would be impossible to code them or even draw conclusions from the uniqueness that you would try and code.

DW suggested that anyone wanting advice on co-production and user voice in developing their service/engagement should explore with TLAP
https://www.thinklocalactpersonal.org.uk/Browse/Co-production/National_Co-production_Advisory_Group/

MW agreeing with LFu, spoke about the frustration from patients and clinicians from lack of digital skills in health despite being digitally enabled in every other aspect of their lives. MW said that 15 years ago, with 3 GPs, they drew up a digital curriculum for students, which some medical schools are now interested in having a look at. MW asked the panel what input their organisations are having to medical schools, patients and users?

HMB has observed digitally enabled pockets and understands there is an impatience and desire for the technology to work in a certain way everywhere. She informed us that Plymouth university are signing all its students up to twitter and teaching them how to use it professionally.

JW argued that the FCI bringing together clinical informaticians that understand enough of the technology puts us in a good place to help develop better technology.

EMC, agreeing with JW, said that standards so the systems can talk to each other is the answer.

MB thanked our panel.

5. ReSPECT (recommended summary plan for emergency care and treatment)

To update on the progress with adoption of ReSPECT and development of electronic versions.

PMF representative for Resuscitation Council (UK), provided a brief summary of what ReSPECT is and explained frustrations in taking this forward. The ReSPECT process encourages people to have an individual plan to try to ensure that they get the right care and treatment in an anticipated future

emergency in which they no longer have the capacity to make or express choices. The ReSPECT process has been fully implemented on the national digital platform in Scotland and has had some successful local implementation in England. PMF explained that ReSPECT was soft launched in March 2017, where 86 centres fully adopted it. PMF thinks that there will likely be a national standard document.

PMF spoke about the small data set lending itself to digital piloting. The development team are keen to digitise it and make it universally available as they are very worried about paper-based version control. PMF informed us that the centres who have adopted ReSPECT have demonstrated an appetite for a digital version but typically, there are instant issues around interconnectivity.

JR asked how ReSPECT relates to things like Co-ordinate My Care and other End of Life standards.

PMF Co-ordinate My Care are quite clear on how they want to present their data however the data sets are the same as ReSPECT.

PS said there has been regional implementation in Hampshire.

ED highlighted work on this and current implementation in Isle of Wight.

PMF confirmed that the Royal College of Paediatrics and Child Health (RCPCH) were involved but did not formally sign off.

CB, RCPCH representative to pursue with RCPCH.

KHJ said this should be made an ISN.

LF said first step should be to assure as PRSB standard. However, we need to address the issue of consistency between different standards in this area first, so a clear message is sent.

The advisory board agreed there is a clear job to be done here to clarify the position and encourage uptake.

6. Clinical Decision Support

To explain the decision support research project and prepare the advisory board for the forthcoming consultation.

PS described his research project on clinical decision support, PRSB will be running the projects consultation.

Availability of more and more information means that professionals are presented with growing inputs to decision making and there is an important role for digital in enabling and supporting this.

Rather than decision support logic being hard baked into proprietary systems, PS explained that there will be a library of clinical biomedical knowledge (CBK) that captures this logic and enables machine learning and artificial intelligence.

PS is seeking input from the PRSB advisory board into scrutiny of management of the CBK, asking how we can determine what goes into the CBK and how can we assure its efficacy.

PS explained that we will be working closely with NICE on this to capture the synergy of alignment of NICE guidelines with the information requirements.

LFu said exploring how patients make decisions is also important, for example: when they decide to go to the GP and what they have a right to ask for.

SR asked how clinical decision support interfaces with shared decision making?

JR and JC both said they would like to get involved in the project.

7. Diagnosis recording

To test with the advisory board our suggested approach for taking the diagnoses recording work forward with a few pilot organisations and to discuss plans to publicise this work amongst the clinical community.

AS summarised the important work on how diagnoses is recorded and problem lists are managed. This would enable more accurate and relevant diagnoses leading to better care and enable interoperability and research. It would also assist better communication between primary and secondary care. It includes guidance of persistence and maintenance of the diagnosis.

AS put some questions to the advisory board: will the guidance work in your area of practise? What errors are you aware of in the scope of your practise which could have been avoided by more consistent recording of diagnoses, systems or problems? In what areas of practise and where could we test this?

DB suggested the coding of social aspects for a person's health would also be helpful.

AS responded saying that social problems should be linked with consultations or other deeper analysis, linking these is the missing part.

MW queried whether diagnoses information might compromise patients' ability to get long term care or health insurance.

AS remarked that persistent diagnoses are important for long term care but marking conditions as resolved or changed is important.

KS said that allot of these issues came up when developing the maternity record standard. KS explained that from an electronic prescribing perspective, it is important to know a patient is pregnant, however they are not pregnant forever. Diagnoses and problem lists are important, confirming that these are correct is vital.

EMC brought up the challenges of persistent recording of sensitive conditions, as persistent conditions are the things that would influence other healthcare delivery. EMC proposed testing the guidance with a modern inter-disciplinary care team.

ED mentioned that there are conditions that you might want forgotten e.g abuse/ neglect cases – might not want to share these years later and with some departments.

LI asked about coding the guidance.

HMB gave an example of two different hospitals working on different diagnoses - gallstones or cancer with associated distress for patient.

JW said that GP's are more used to working with evolving problem lists.

LI reiterated this, saying that common grouping diagnoses are useful for an epidemiologist and GP but perhaps not for day to day treatment.

AS said that in SNOMED the hierarchy is programmed in, the same data could also drive a general diagnosis and patients' version. AS also proposed manual downgrading of old conditions to save time and flagging of sensitive items.

The advisory board agreed that the report is a good piece of work and is approved for publication. MO promised to report back at subsequent advisory boards and track progress of this work.

IT assured that any operational issues will be ironed out in the proposed next steps

MO thanked everyone for their support. Asked for volunteers and suggestions for where we might test the guidance, proposing it is tested in relatively small areas of scope as a first stage. MO also explained that AS will be developing implementation guidance.

Action: Advisory board members asked to suggest trial sites and areas.

8. Completed standards

To discuss outcomes and the benefits of this completed piece of work.

Core information standard (CIS)

HF informed the advisory board that the core information standard has been published and is available to view on our website.

HF explained that the work undertook to define a key set of information that could be shared across the whole health and social care system, was commissioned by NHS England and is to be piloted by the Local Health and Care Record exemplars. HF said that there has been wide support for this piece of work, but it needs a well thought out and through programme of support to drive implementation and PRSB have made recommendations for more work in certain areas.

HF said that PRSB are making important recommendations in six key areas about how this work needs to go forward including more work on the safety and policy and practice issues associated with more 'about me' information from patients, patients taking more control and accessing and updating their records. More work on information governance and how it will work in tandem with the record standard and more work to test out different aspects of the core standard to refine and improve it and ensure it works in practice.

LFu talked about her perspective on the CIS as a patient and how the focus is entirely different to that of health and care professionals.

LFu thinks future aspirations need to be prioritised and 'about me' information needs to be more structured to make it more useful. LFu is concerned with how patients can provide meaningful rather than tokenistic contributions to these developments.

LFu thinks this would be much better if other NHS organisations brought the kind of patient focus that the PRSB does. Patients should be on all boards etc.

ED spoke about the realities of implementing the core information standard, introduced herself as a GP and clinical lead for the Care and Health Information Exchange (CHIE), Wessex care record (WCR) and Southampton CCG.

CHIE has been in use since 2003, it crosses 8 CCGs and has 55,000 records accessed a month. The Dorset care record started last year. Specialisations are to cross over e.g. the Dorset care record feeds social care and mental health data into CHIE. ED explained they have data sharing agreements which have been standardised across the whole region. ED told us that they are going to try and go across the border with the WCR and data set generated by EMIS. The WCR is focusing on maternity, cancer and end of life.

ED explained that the core information standard gives them a base and is essential for getting a project started. When hospitals start overlapping, ED says, they will start to see more benefits.

ED said that recording what patients want from their medical direction is essential and that this needs a standard.

IC commended LFu for challenging the system, and said he was delighted that she finds PRSB a welcoming environment to be able to do this in as it has been a value from PRSB's formation. IC asked LFu what kind of organisation she thinks might fund the work she has been talking about?

LFu responded saying that she doesn't see why NHS wouldn't fund this as it should fit within the NHSX empowering the person agenda or potentially DWP.

SE said that RCOT would be willing to work with PRSB on a standard for structured 'about me' information.

HF presented the recommendations to the Health and Care Professional advisory group recently and it was the parts on about me that generated the most interest and excitement for forward work.

IT said Zahid Deen and Health and Social Care Alliance Scotland (HSCAS) have done a lot of good exploratory work on what patients think are important and produced a report which we should draw on.

SC asked whether patient contributed about me information could form part of the care plan? SC also wondered whether there might be an opportunity for standardisation around personal budgets?

DB, addressing LFu, said that at her trust they have the screens turned to the patient as it is capturing what is affecting them. DB also said that QNI would be interested in working with LFu.

PS addressed ED asked how often CHIE is used and what has encouraged this?

ED explained that they have been very prominent in communicating across the whole patch and that one clinician has been a real driving force. ED said agreeing a standard is another way to encourage use.

LFu said that most people don't have a care plan which needs to be considered in the scope of the care record. LFu said that facilitating more people to have care plans is important.

ED encouragingly said things are changing. That care plans haven't historically been used in GPs because they don't think people will look at them but when answering 111 calls, staff automatically check for care plans.

LF asked all advisory board members to promote our work around patients as a unique and distinguishing strength of ours.

LI spoke about the patient portal developed by an American private company who he used to work with, that is linked to their electronic patient records. LI said that he could probably get them to come and talk to us.

KS said we need to integrate digital and electronic records for the primary objective of aiding care.

10. Work programme update

To update members on key developments and to highlight forthcoming projects and developments for members consideration/action.

#thedoctorsdownload

HF explained that the PRSB, in partnership with the Academy of Medical Royal Colleges, has launched a UK wide online conversation, #thedoctorsdownload, to engage the whole of the medical profession in a debate about their digital experiences and expectations.

PMF asked why the focus is just on doctors?

HF explained that the nurses have already had similar engagement and that we have had conversations with the Allied Health Professionals to address other disciplines.

HF urged people to get involved, stating that it is a unique and timely opportunity to influence the system and have a say in how digital needs to be done differently to meet the needs of professionals. If this is done correctly for doctors in the first instance, it helps increase the pressure for all the other professions.

EMC confirmed that PRSB and AHPs have had good conversations about this and he thanked PRSB for supporting this discussion.

MB suggested that this block by block approach could give us richer data, avoiding specific professions perspectives getting lost.

ED suggested making this into an app to make it easier to complete and said that the text needs to be viewable in a stream.

Strategy and business plan

HF introduced the strategy and business plan, HF explained that this is subject to change, dependent on the discussions with NHSX and our changing business model.

Action: Advisory board members are asked to ensure the paper is reviewed in their organisations and to feed back any comments.

Work programme

MO outlined new areas of work coming up, which advisory board members will be asked to contribute to: pharmacogenomics and use and display of alerts; pre-primary care and use of accreditation of apps; international social care pathfinder standards; digitisation of GP Lloyd George Records and how this information is made accessible.

MO confirmed that we are not proposing accreditation of the detailed working of the artificial intelligence logic and assured the advisory board that we would see this as high risk and not within our core competence.

MO highlighted endorsements outstanding and on the horizon including the core information standard. MO explained that the formal endorsement request for the CIS is due to go out to organisations shortly, saying that hopefully the endorsement process is easier this time round as the organisations have received prior warning.

MO mentioned that there are some outstanding queries and questions related to the Ambulance work, however the plan is to go out for endorsement in early August.

Actions from Advisory Board meeting – 17th July 2019

Date	Agenda Item	Action	By Whom	Status/Comments
17/07/2019	7. Diagnoses recording	Advisory board members asked to suggest trial sites and areas.	AMG/ advisory board	AMG sent (24/07/19) request reminder to ab members in post meeting document detailing key points and actions.
17/07/2019	10. Work programme Strategy and business plan	AB members are asked to ensure the PRSB strategy and business plan is reviewed in their organisations and to feed back any comments.	AMG/ advisory board	AMG sent (24/07/19) the strategy paper to ab members, college Presidents and CEOs in post meeting document detailing key points and actions.