

Developing Standards for the Structure and Content of Health Records: Workshop Report

A project co-ordinated by

Health Informatics Unit, Royal College of Physicians of London

Funded by

NHS Connecting for Health

Table of contents

Foreword	3
Introduction	4
Approach	4
Findings	5
Conclusion	7
Recommendations	8
Organisations signed up to the recommendations	9
Appendix 1 List of attendees	10
Appendix 2 Workshop programme	13
Appendix 3 Workshop breakout groupings	15
Appendix 4 Workshop questionnaire feedback	17
Appendix 5 Collated comments from breakout groups	18
Appendix 6 Feedback from individuals via completed forms identifying priority areas for developing standards for the electronic patient record	32
Appendix 7 Feedback from individuals via completed forms identifying methods for generating consensus	38

NHS Connecting For Health

NHS Connecting for Health (NHS CFH) has been pleased to work with the Royal College of Physicians to support the development of standards for patient records which have been agreed by the Academy of Royal Colleges, representing the whole medical profession. I thank the Royal College of Physicians for organising the workshop to share their experience with other Healthcare Professional Bodies and publishing the outputs from the workshop in this report. It is very encouraging to see the number of professional bodies represented at this workshop across the clinical spectrum and their willingness to contribute to this important work.

The development of multi-professional standards supports the objective of high quality care for all patients set out in the NHS Next Stage Review by Lord Darzi. Standardisation in record keeping is required in order to address the variation in clinical practice that creates such a challenge for clinical safety. It also ensures services can compare outcomes in a meaningful way. The introduction of the Electronic Patient Record offers the opportunity to implement these standards, delivering reduced variability and risks to clinical safety. I see this as part of an ongoing relationship of NHS Connecting for Health with professional bodies to deliver patient record standards to improve patient care. I also look forward to the next step, which will be a continued collaboration between NHS CFH, clinicians and suppliers to incorporate the new standards into electronic records.

Martin Bellamy

Director of Programme and Systems Delivery
NHS Connecting for Health

Multi-disciplinary Record Standards Workshop Report

Introduction

On 22nd October 2008, the Health Informatics Unit of the Royal College of Physicians of London (RCP) hosted a multi-disciplinary workshop to broaden professional engagement in the development of clinical record standards. Standardisation of medical records has been shown to improve quality and safety of patient care and is essential for electronic patient records (See RCP Health Informatics Unit Record Standards programme reports and publications - <http://www.rcplondon.ac.uk/clinical-standards/hiu/medical-records/Pages/Overview.aspx>).

The specific objectives of the workshop were to:

- Increase and broaden clinical engagement in the standardisation of records to support the Electronic Patient Record (EPR) development programme
- Invite the clinical professions to identify priority areas of the EPR for their profession (e.g. nursing notes, clinic notes, day case, specialist procedure notes, etc)
- Disseminate the methods adopted by the HIU for reflecting the consensus view of the profession
- Encourage the professions to identify the best methods for developing the consensus view of their profession.

Approach

Presidents and Chairs of Medical Royal Colleges, Specialist Societies and relevant clinical professional organisations were invited to nominate a representative for their organisation to attend the workshop (see Appendix 1 for list of attendees). The aims of the workshop were clearly stated and the organisations were referred to the work of Health Informatics Unit Record Standards programme.

A Clinician's Guide to Record Standards was distributed to representatives. The guide explains the rationale and methods used (Part 1), and it describes evidence and consensus based standards for the structure and content of hospital admission records, and handover and discharge documentation (Part 2). Copies can be ordered or downloaded from <http://www.rcplondon.ac.uk/clinical-standards/hiu/medical-records/Pages/clinicians-guides.aspx>

The workshop programme is attached at Appendix 2. After a scene setting plenary session, breakout groups addressed the specific tasks of identifying priority areas for clinical record standards and methods by which consensus could be gained from the practitioners of each profession and specialisation. Attendees were distributed between six breakout groups broadly defined by clinical profession. Each person was invited to list the priority areas for which their profession or specialty would like standard structures for the clinical record, and identify those areas where these have already been established. They were also requested to record views on matters pertinent to gaining consensus on standards from professional colleagues by answering a number of specific questions:

- How would you aim to get the consensus view of your profession or specialty?
- Do the necessary resources exist within your specialty's professional body? If not, what is missing, the presence of which would enable the process to go forward?

- What would the obstacles be to gaining a consensus view from your specialty or profession?

The intent is that the professions and specialties will lead the development of record standards for their own professions.

Findings

Ninety-three professional organisations were invited to send representatives to the meeting. A total of 70 nominated representatives from 50 royal colleges, specialist societies and professional regulatory bodies, 40 individuals (including clinicians) from NHS Connecting For Health and related organisations, and representatives from 3 system suppliers attended the workshop.

The six breakout groups were composed of representatives from:

- 1 Maternity & Child Health
- 2 Surgical specialties
- 3 Physician specialties
- 4 Psychiatry & Mental Health
- 5 Pathology & Clinical Scientists
- 6 Nursing & Allied Health Professions.

See Appendix 3 for total number of representatives and professional bodies represented within each breakout group.

Increasing and broadening clinical engagement in the Electronic Patient Record (EPR) development programme

The workshop was characterised by widespread enthusiasm, interest and engagement with the issue of professional standards for clinical records. Ninety-five percent of respondents found it useful or very useful (see Appendix 4).

There were common themes that emerged:

- There was general consensus that there should be standardised structure for clinical records.
- Clinical records should be person based – independent of (that is not determined by) location or clinician
- Records and the related structure and content standards should be able to follow a patient through stages of care. These stages of care extend beyond the tight definitions of some clinical pathways.
- There were frequent reports of well established (electronic) record systems in use which were not standardised across all locations.
- Most representatives identified areas and specific types of clinical encounters where standardised structure was thought to be of benefit.
- The desire for standardised structures was frequently mentioned in the context of multi-disciplinary records.
- There was frequent mention of information that extended beyond clinical/medical information – that is in relation to social circumstances, physical abilities and lifestyle.

- There was also frequent mention of the need to consider information and communications to and from patients and their carers. Training also needs to be considered.
- A frequently mentioned concern was the breadth and number of specialties and sub-specialties who would need to be engaged in the process of generating consensus and meeting best professional practice.
- There was general enthusiasm and support for the RCP approach to generating consensus and the standards that have been developed in the HIU Record Standards Programme.
- There was frequent mention of process standards, and some technical standards, which were not in scope for the subject of the conference.

See Appendix 5 for the detailed reports from the breakout groups.

Inviting the health professions to identify priority areas of the EPR for their profession (nursing notes, clinic notes, day case, specialist procedure notes, etc)

The professional groups identified many different areas of their clinical activity which would benefit from standardisation of structure and content. The following table displays the most frequently cited areas identified by representatives who completed the feedback forms:

	Priority areas	No.
1	Discharge and treatment summaries	30
2	Admission/ Initial assessment	28
3	Outpatients, including multidisciplinary treatments and therapies records	28
4	Records and care plans that span the care pathway including continuation records	21
5	Transfers and transitions of care	16
6	Procedures	16
7	Referrals	13
8	Consent	10

See Appendix 6 for details of individual feedback on priority areas.

Encouraging the professions to identify the best methods for developing the consensus view of their profession

The method of generating and gaining consensus agreement developed by the Health Informatics Unit of the RCP was highly regarded and widely seen as a model that could be developed or adapted by many of the professional bodies represented. The exceptions were a few professional groups that already had well organised professional structures and processes for addressing professional matters.

There was a general view that consensus would be possible within professional groups but the expectations of breadth of coverage of all membership of a professional group varied. Most professional groups did not have existing structures to support a consensus generating process and nearly all identified a lack of available resource to support this. However there were some specialties and professional groups that showed well organised and structured

processes that could be used. Indeed there were some specific groups who were ready to embark on a process immediately.

The most frequently cited concerns were lack of structures or resources to support a consensus generating process. A few groups anticipated apathy and lack of interest and engagement from their professional colleagues.

See Appendix 7 for details of individual feedback on gaining consensus.

Conclusions

There were five key features that characterised the workshop which has been seen as having been a highly successful event.

- 1 There was clearly widespread enthusiasm and interest in professional standards for structure and content of clinical records. The extent of interest and engagement was both surprising and encouraging. It is likely that this degree of interest reflected the principle that underpinned the design and conduct of the workshop – that professional standards should be developed, agreed and owned by the profession for which they are generated.
- 2 The focus on the development of professional standards that would be implemented in partnership with NHS Connecting for Health was acknowledged and seen as logical and acceptable.
- 3 There were eight suggested priority areas that had broadest support across the groups. In addition, surgical specialties identified steps in patient pathways, before during and after surgery, for which structure and content standards could be developed.
- 4 There was widely expressed eagerness to 'get on with the job', and since the workshop the HIU has received several requests for collaboration or comment on specific proposals from a number of professional groups.
- 5 If the process of developing record structure and content standards is to be successful, then there must be a determined effort to get the programme underway. There will be a significant risk of disillusion and disengagement if momentum is lost.

A key success for NHS Connecting For Health and the RCP HIU was the enthusiasm for and acknowledgement of the success of the record standards programme so far.

Recommendations

The professional bodies which took part in this workshop are committed to the implementation of a patient centred multi-professional care record which is underpinned by professionally developed and agreed standards for structure and content, and will enable interoperability of information technology systems across the NHS and Social Care.

To build on the progress described in this report, subsequent feedback from professional bodies, and discussion with NHS Connecting For Health, the following is recommended:

- 1 The rationale for professionally agreed record standards should be incorporated into pre- and post-registration educational curricula, and continuing professional development, as soon as possible.
- 2 The standards agreed for the medical admission record, and handover and discharge communications should be disseminated widely and incorporated into the induction training of junior doctors as soon as possible.
- 3 Professional bodies with responsibilities relevant to health and social care should work with NHS CFH to take forward the development of standards for the structure and content of records appropriate to their own profession, specialty or discipline.
- 4 Full patient participation should be ensured.
- 5 The medical record headings developed for hospital admissions should be extended in scope to cover all care settings in the NHS and defined at an appropriate level of detail.
- 6 This work should develop evidence and consensus based record standards for individual clinical specialties, care processes, and settings according to agreed priorities.
- 7 An overarching approach should be taken to ensure compatibility of the standards developed, and interoperability of records when the standards are implemented
- 8 Meetings involving key stakeholders should take place as soon as possible to discuss the approach, method, resources and priorities for implementing these recommendations. There is an urgent need to maintain the momentum and professional enthusiasm that has been generated.

Organisations signed up to recommendations

British Association of Dermatologists
British Association of Stroke Physicians
British Cardiovascular Society
British Society for Rheumatology
College of Emergency Medicine
College of Occupational Therapists
Faculty of Occupational Medicine
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health
Royal College of Pathologists
Royal College of Psychiatrists
Royal College of Speech and Language Therapists
Royal Pharmaceutical Society of Great Britain
The Royal College of Radiologists
Society of Chiropractors and Podiatrists
The Association of British Neurologists
The Association of Medical Microbiologists
The Society Of Chiropractors & Podiatrists
UK Renal Registry
British Association of Paediatric Surgeons
The Royal College of Surgeons of Edinburgh
Royal College of Midwives
Royal College of Nursing
Nursing & Midwifery Council
Chartered Society of Physiotherapy
NHS National Services Scotland
The British Dietetic Association
*British Association for Sexual Health and HIV
*British Geriatrics Society
*British Orthodontic Society
*British Society for Allergy and Clinical Immunology
*British Society of Gastroenterology
*Faculty of Pharmaceutical Medicine
*Renal Association
*Royal College of Physicians and Surgeons of Glasgow
*Society for Endocrinology
*The Nutrition Society
*The British Association of Urological Surgeons
*Royal College of Surgeons England
*Society for Cardiothoracic Surgery in Great Britain and Ireland
*British & Irish Orthoptic Society

* Unable to attend workshop

APPENDIX 1

List of attendees

Organisation Represented	Attendee
Association for Clinical Biochemistry	Dr Ian Watson
Association for Palliative Medicine of Great Britain & Ireland	Dr Bill Noble
Association for Palliative Medicine of Great Britain & Ireland	Dr Julia Riley
Association of British Neurologists	Dr Heather Angus-Leppan
Association of Microbiologists	Dr Steven Barrett
Association of Microbiologists	Dr Michael Kelsey
Audit Information and Analysis Unit Audit Information and Analysis Unit	Genevieve McCourt
British & Irish Orthoptic Society	Shelagh Baynham
British Association for Parenteral and Enteral Nutrition	Marinos Elia
British Association of Audiovestibular Physicians	Dr Sebastian Hendricks
British Association of Dermatologists	Dr Sheru George
British Association of Oral and Maxillofacial Surgeons	Mr Ian C Martin
British Association of Paediatric Surgeons	Mr Simon N Huddart
British Association of Stroke Physicians	Dr Hamsaraj Shetty
British Cardiovascular Society	Sarah Clark
British Cardiovascular Society	Iqbal Malik
British Orthopaedic Association	Professor Angus Wallace
British Society for Human Genetics	Carol Gardiner
British Society of Rehabilitation Medicine	Dr Charlie Nyein
British Society of Rehabilitation Medicine	Dr Diane Playford
British Society for Rheumatology	Clive Kelly
British Society for Sexual Health and HIV	Dr Anatole Menon-Johnsson
British Thoracic Society	Dr Ivan Le Jeune
College of Emergency Medicine	Nigel Brayley
College of Occupational Therapists	Chris Austin
ENT-UK	Richard Wight
Faculty of Occupational Medicine	Dr Moira Kelly
Faculty of Occupational Medicine	Dr I Madan
Faculty of Public Health	Dr Richard Turner
East of England, London & South East Coast SCGs	Maria Yeomans
Informing Healthcare	Dr Robin Mann
Informing Healthcare	Dr Martin Murphy
Informing Healthcare	Jan Williams
Intensive Care Society	Dr Jane Harper

National Programme for IT (Clinical Lead Mental Health)	Dr Hashim Reza
NHS London Programme for IT	Mary Maconachy
NHS London Programme for IT	Mr John White
NHS National Services Scotland	Dr Lorna Ramsay
NHS National Services Scotland	Lee Davies
NHS Education South Central	Steve Murray
Nursing & Midwifery Council	Michelle Lyne
Nursing and Midwifery Council	Martine Tune
RCM UK Board for England	Pat Gould
RCP GP Committee	Dr Jonathan Shribman
Renal Association UK Renal Registry	Dr CRV Tomson
Renal Information Exchange Group	Dr Annette Neary
Royal College of Anaesthetists	Mav Manji
Royal College of General Practitioners - Health Informatics	Dr Libby Morris
Royal College of Midwives	Jeanne Roberts
Royal College of Nursing	Jackie Cheeseborough
Royal College of Nursing	Ian Hulatt
Royal College of Nursing	Alison Wallis
Royal College of Obstetricians and Gynaecologists	Edward Morris
Royal College of Paediatrics and Child Health	Dieter Dammann
Royal College of Pathologists	Dr Ian Bailey
Royal College of Pathologists	Jem Rashbass
Royal College of Psychiatrists	Dr Martin Baggley
Royal College of Psychiatrists	Dr Harm Boer
Royal College of Psychiatrists	Dr Suren Govender
Royal College of Psychiatrists	Michele Hampson
Royal College of Psychiatrists	Michael Kingham
Royal College of Radiologists	Dr Joss Adams
Royal College of Speech and Language Therapists	Jane Mackenzie
Royal College of Speech and Language Therapists	Linda Ridsdale
Royal College of Surgeons of Edinburgh	David Birnie
Royal Pharmaceutical Society of Great Britain	Cheryl Way
Society Of Chiropodists & Podiatrists	Kay Blowe
Society Of Chiropodists & Podiatrists	Christopher Hunt
The Association of Cancer Physicians	Dr Rob Stein
The British Dietetic Association	Ingrid Darnley
The British Dietetic Association	Sue Kellie
The British Psychological Society	Dr Sarah Newton
The Chartered Society of Physiotherapy	Sue Parroy

The Chartered Society of Physiotherapy	Andrea Peace
Unite/CPHVA	David Munday
RCP Patient Care Network	Jennifer Dewhurst
RCP Patient Care Network	Liz Goodier
RCP Patient Care Network	Margaret Hughes
RCP Patient Care Network	Robert Jackson
RCP Patient Care Network	Angela Stones
NHS Connecting for Health (Clinical Lead for the Clinical Content Service)	Dr Tony Shannon
NHS Connecting for Health (National Clinical Lead for AHPs)	Yvonne Pettigrew
NHS Connecting for Health (National Clinical Lead for GPs)	Dr Manpreet Pujara
NHS Connecting for Health (National Clinical Lead for Hospital Doctors)	Dr Robert Pitcher
NHS Connecting for Health (National Clinical Lead for Medication Management)	Sharon Hart
NHS Connecting for Health (National Clinical Lead for Mental Health)	Dr Joe McDonald
NHS Connecting for Health ((National Clinical Lead for Paediatrics and Child Health)	Dr David C Low
NHS Connecting for Health (National Clinical Lead for Public Health)	Miss Parul Desai
NHS Connecting for Health (Care Pathways)	Katy Stainsby
NHS Connecting for Health (CUI)	Dr Mike Bainbridge
NHS Connecting for Health (CUI)	Dr Peter Johnson
NHS Connecting for Health (Digital Information and Health Policy Unit)	Magi Nwolie
NHS Connecting for Health	Andy Carr
NHS Connecting for Health	Beverley Harvard
NHS Connecting for Health	Richard Hatton
NHS Connecting for Health	Rowena Herbert
NHS Connecting for Health	Helen Hood
NHS Connecting for Health	Ken Lunn
NHS Connecting for Health	Dr Munish Jokhani
NHS Connecting for Health	Jo Nash
NHS Connecting for Health	Mona Pal-Singh
Audit Commission	Duncan Eastoe
Audit Commission	Elizabeth Lawrence
Cerner	Wale Lawal
Cerner	Simon Wallace
CSC	Paul Clark
CSC	Chris Orme
CSC	Dr Robert Morris
Deloitte MCS Limited	Dr Ronald Agble

APPENDIX 2

Workshop Programme

Developing standards for the structure and content of health records: A multi-specialty and multi-disciplinary workshop

Date: 22nd October 2008

Time: 8.55am – 4.30pm

Venue: Royal College of Physicians, London (Seligman Theatre, Main Building)

Chairs: Professor John Williams and Professor Iain Carpenter

The objectives:

- Increase and broaden clinical engagement in the EPR development programme
- Invite the clinical professions to identify priority areas of the EPR for their profession (eg nursing notes, clinic notes, day case, specialist procedure notes, etc)
- Disseminate the methods adopted by the HIU for reflecting the consensus view of the profession
- Encourage the professions to identify the best methods for developing the consensus view of their profession.

1. Registration	All	8.30am
2. Welcome from the president of the Royal College of Physicians	Professor Ian Gilmore, President, Royal College of Physicians	8.55 am
3. Background, aims and objectives of the day	John Williams, Director, Health Informatics Unit	9.00 am
4. Progress of the clinical content service	Rowena Herbert, Programme Manager, NHS CFH	9.25 am
5. Developing the structure of Electronic Health Records	Tony Shannon, Clinical Lead, Clinical Content Service Clinical Content Service NHS CFH	9.45 am
6. The computer says no: a patient's perspective on clinical records	Margaret Hughes, Member of the RCP Patient Carer Network	9.55 am
<i>Coffee break – 15 min</i>		10.05 am
7. What will it look like? Future vision and Common User Interface	Mike Bainbridge	10.20 am
8. Recent Experiences: Renal-specific information systems in the UK	Charlie Tomson (15 mins)	10.30 am

Nursing Record Standards - whose responsibility?	Alison Wallis (15 mins)	
Learning Lessons from the PbR Data Assurance Framework 2007/08	Duncan Eastoe (10 mins)	
9. Gaining consensus on record standards	Iain Carpenter	11.10 am
10. Open discussion and introduction to working groups	Iain Carpenter/ John Williams	11.30 am
11. Work groups session 1: working together to produce national standards Delegates will be split up into work groups and asked to identify priority areas for the development of standards from which 5 top areas would be selected for further work. Seligman Theatre (Lower Ground Floor), Dorchester Library (1 st Floor)		12.00 pm
<i>Lunch break & View Demonstrators – 45 min</i>		12.45 pm
12. Feedback & Summary (Seligman Theatre)	Iain Carpenter/ John Williams	1.35 pm
13. Work groups session 2: working together to produce national standards In the same groups as the last session, the delegates will be asked to decide how each group would gain consensus for clinical standards for record content and structure standards in their area. Seligman Theatre (Lower Ground Floor), Dorchester Library (Main Building, 1 st Floor)		2.15 pm
<i>Tea break – 15 min</i>		3.15 pm
14. Feedback & Summary (Seligman Theatre)	Iain Carpenter	3.30 pm
15. Open Discussion		4.00 pm
16. Conclusion	John Williams	4.30 pm

APPENDIX 3

Workshop breakout groupings

Group	Organisation	Number Attended
Group 1	Royal College of Midwives	1
	Royal College of Obstetricians and Gynaecologists	1
	Royal College of Paediatrics and Child Health	1
	NHS Connecting for Health	3
	RCM UK Board for England	1
	Unite/CPHVA	1
Group 2	British Association of Oral and Maxillofacial Surgeons	1
	British Association of Paediatric Surgeons	1
	British Orthopaedic Association	1
	ENT-UK	1
	Intensive Care Society	1
	NHS Connecting for Health	2
	NHS London Programme for IT	2
	RCP Patient & Carer Network	1
	Royal College of Anaesthetists	1
	Royal College of Surgeons of Edinburgh	1
Group 3	Association of British Neurologists	1
	Association for Palliative Medicine of Great Britain & Ireland	2
	British Association for Parenteral and Enteral Nutrition	1
	British Association of Audiovestibular Physicians	1
	British Association of Dermatologists	1
	British Cardiovascular Society	2
	British Society of Rehabilitation Medicine	2
	British Society for Rheumatology	1
	British Society for Sexual Health and HIV	1
	British Thoracic Society	1
	College of Emergency Medicine	1
	Deloitte MCS Limited	1
	Faculty of Occupational Medicine	2
	Faculty of Public Health	1
	NHS Connecting for Health	7
	NHS Education South Central	1
NHS National Services Scotland	2	

	RCP GP Committee	1
	RCP Patient & Carer Network	1
	Renal Association UK Renal Registry	1
	Renal Information Exchange Group	1
	Royal College of General Practitioners - Health Informatics	1
	Royal Pharmaceutical Society of Great Britain	1
	Society Of Chiropodists & Podiatrists	2
	The Association of Cancer Physicians	1
	The British Dietetic Association	2
Group 4	NHS Connecting for Health	2
	RCP Patient & Carer Network	1
	Royal College of Nursing	2
	Royal College of Psychiatrists	5
	The British Psychological Society	1
Group 5	Association for Clinical Biochemistry	1
	Association of Microbiologists	1
	Audit Information and Analysis Unit	2
	British Society for Human Genetics	1
	Information & Analysis Unit for London, Kent, Surrey, Sussex, Essex, Beds & Herts	1
	NHS Connecting for Health	1
	RCP Patient Care Network	1
	Royal College of Pathologists	2
	Royal College of Radiologists	1
Group 6*	British & Irish Orthoptic Society	1
	College of Occupational Therapists	1
	NHS Connecting for Health	2
	Nursing and Midwifery Council	2
	RCP Patient & Carer Network	1
	Royal College of Nursing	1
	Royal College of Speech and Language Therapists	2
	The Chartered Society of Physiotherapy	2

- Group 6 had approximately double the number of expected representatives on the day of the workshop

APPENDIX 4

Workshop questionnaire feedback

How useful did you find this event?			
Extremely Useful	Useful	Fairly Useful	Not Useful
49% (21)	47% (20)	4%(2)	0%

Positive Comments:

“Very interesting, useful event, and a very important area. Hopefully, this will generate the impetus for ourselves to impress upon our respective colleagues/bodies to engage and contribute to this process to ensure a quality service for our patients, and useful working tool for professionals”

“Networking & exchanging views very valuable we now need to move this forward & get our colleagues on board - this needs both top-down & down-up approach.”

“Happy to contribute more & liaise with BCS re: this important piece of work”

“Well organised & productive day. Remarkable consensus at this level but will be more difficult as we drill down”

“Excellent, thank you!”

“Looking forward to receiving the written report from the event & the 'what next' action list & how NHS CFH foresee this work stream moving forward”

“Very useful having the debate within the workgroups about standardisation/commonality”

“This is long overdue and welcomed.”

“This project is very important. We need a project team – multi-disciplinary & enthusiastic”

“Breakout sessions very interesting & useful”

“Good, concise, snappy presentations building towards discussion groups where the “work” truly happened. Overall a thought (and action) provoking day”

Other Comments:

“The timescales & funding available were not very clear, in order to achieve this objective”

“Timetable against which we are working would be useful- perhaps to drive the process forward more quickly”

“Much of the discussion repeated many of the issues that we have wide experience of in General Practice - perhaps some background of 'lessons learned' could inform this process”

“Medical schools need to address documentation pre-qualification NOT addressed well in my experience & it won't necessarily solve it”

“I feel the task I am being asked to undertake is quite daunting and am concerned about the resource (or lack of it) that is available to accomplish this”

“I did wonder if the scope of what we are trying to do has increased tremendously & whether this will delay implementation”

“Very strongly behind this idea and the idea of integrated, combined, patient driven EPR. Though I appreciate the need to involve as many professional societies as possible at this early stage, I would like to have seen this meeting take place once the "lego building blocks" were invented and in place.”

“Would have liked to have this work done BEFORE contacts were signed with suppliers whose systems do not and will not meet these standards. Unless mandated by law/DSCN with enforceable data this will not happen in current systems”

APPENDIX 5

Group 1: Maternity and Child Health

Session 1: *Priorities for standardised records*

1. Standard Electronic Maternity Record
 - Use of electronic records is widespread, but not currently standardised
 - Scotland have a standard model they follow
 - England have a maternity data set but not a standard form
2. Subset of (1) – Handheld Maternity record for mother
 - Needs to have input from all specialities the mother comes into contact with
 - All information is already recorded but not in a form that's easy to transfer
 - Important to gather this from secondary care providers – this may be in the community
 - This form should be independent of location or clinician
 - This doesn't currently exist
 - This should take into account social elements also
 - Maybe this should look at family and not just mother
3. Child Health follow-on record
 - Similar to the “Red book”
 - This should be fed from the maternal notes and “kicks off” the child's notes
 - Important to include any neonatal information in there especially if the child has had acute care
 - Currently this is done reasonably well for “special babies” i.e. those who have been ill, but not so good for “well babies”
4. Standard template for the Child Health Programme
 - Child Health Promotion Plan was signed off this year
 - Standard programme exists for 0-5 and one for 5-16 – needs to have a standard format
 - Need to include social aspects e.g. maternal smoking, alcohol
 - Whoever has the information should fill it in rather than have allocated sections
5. Admissions/Handover/Transfer/Transition template
 - This should be independent of who fills it in – sometimes it is the midwife, sometimes not.
 - Hospital based practice in child health differs from that for adult care.
 - The standards (headings) approved by the Academy of Medical Royal Colleges, developed by the RCP HIU, should be the model, but will need to be adjusted to match practice in maternal and child health

Session 2: *Gaining consensus*

Summary of discussion

1. Is it consensus that we need or credibility?
2. Process identified
 - Identify local need/idea
 - Submit to college
 - Gain expert opinions
 - Consult with stakeholders
 - Pilot
 - “Tweak” and share
3. All group members believed this was the right way to produce consensus on clinical content
4. Barriers
 - Communications hurdles
 - By the time information about consultation is disseminated it's too late.
 - Low response rate
 - Time required to implement and consult
 - Lack of resources
 - Lack of clarity of vision
 - Vision is sometimes too far into the future
 - Disenchantment
 - Unrealistic timeframes
 - Fear
5. Consultation routes available
 - Internal Informatics group
 - Membership of college
 - Monthly presidents bulletins
 - Regulatory bodies
 - Newsletters
 - Website – on line questionnaires
 - Special Interest Groups
 - Clinical Exec's/Clinical Directors/Networks

Group 2: Surgical Specialties

Session 1: *Priorities for standardised records (actually considered as process through care)*

1. Day case assessment form
2. Pre-operative Assessment: Elective Surgery
3. Admission form: Emergency Surgery
4. Pre-admission anaesthetic assessment
5. ASA grade
6. Consent form and patient education
7. Anaesthetic documentation before the procedure (can be automated for vital signs)
8. Procedure note
9. Continuation/ Progress note
10. Recovery/ Post-operative care
11. Discharge /Handover/transfer documentation
12. Recording of Outpatient clinic

Issues arising during the breakout group discussion

- There are multiple surgical specialties
- Adequacy of coding/terminology: classification of anatomical site and distribution of disease not covered by terminology.
- The system needs to enable both clinical and administrative workflows to ensure financial payments data is available.
- Maternal and child notes should be linked at birth or copied across to child but at what age such link should be removed.
- There needs to be an efficient way of recording consent in electronic environment which is valid legally. Medico-legally clinicians must have a document to show to GMC.
- System should allow recording in multimedia e.g. video, audio to provide flexibility to clinicians. There are storage memory implications to this approach as video files can be very large around 5-10mb.
- Dentistry should be included in the scope as well.
- What information you give to patients?
- Gynaecological Screening **

Session 2: *Gaining consensus*

Summary of discussion:

- Purpose, process, people
- To use specialities and sub-specialities for assurance
- Use admission/transfer and discharge headings of RCP standards in each speciality to test if that works for different specialities.
- There should be a lead speciality and they should invite others.
- Web based questionnaire approach (as per RCP HIU led programme)
- Champions needed in specialities and need to report through colleges and speciality associations.
- Create generic template for each process step (see below) followed by specific templates for each speciality. *Process steps:*
 - Definition of problem (outpatients)
 - Decision Making: elective or emergency
 - Consent
 - Procedure
 - Recovery/ post-operative care
 - Discharge /handover/transfer documentation
- Assurance group should be multi-disciplinary and multi-speciality

Issues arising during the breakout group discussion

- NHS trusts are producing their own documentation and therefore need to be informed and made aware that this activity is happening at national level. Their engagement is vital. They have to see benefits to release trust staff for this activity
- Paper based back up is required when EPR goes down for couple of hours
- Need to involve Allied Health Professions, HP, ODP and theatre staff. Many groups don't have professional associations.
- System should be able to track every bit of data i.e. who has entered as audit trail.
- Theatre episode: difficult to log in and out for so many professionals in a short period of time in theatre.
- How to identify professionals? Use GMC number and professional registration numbers.
- There should be national standard for identifying amendments to a record and an audit trail is required in EPR. Clinical systems need to replicate paper practice of crossing out and signature to correct data items.
- In paediatric surgery it is difficult to identify who did what in the operation: can look at how cardiac surgery works.

Group 3: Physician Specialties

Session 1: *Priorities for standardised records*

1. Outpatients
2. Ward round notes
 - o To produce problem lists
 - o Pre-population of follow-up forms
3. Formalised noting of discussions within multi-disciplinary discussions
 - o Multi-Disciplinary records:
 - o What should be shared with social care?
4. Referrals
5. Information Sharing concerns between outside agencies i.e. Education / Local Authority etc.
6. Home visits – maybe parallels across specialities
7. Training patients / prep / dialogues
 - o What should be shared with social care?

Issues arising during the breakout group discussion

- There was discussion around many specialty related record priorities. These included discussion on requirements for particular services. For example:
- Palliative care the aim is to keep the patient at home and it may therefore be that the clinical records have particular requirements
- Some services have specialty specific referral information requirements
- Some treatments have wide ranging impact for patients who are referred or admitted to other services e.g. some disease modifying drugs in rheumatology
- Soft data needs a home in the record – context important
- WHO International Classification of Function (<http://www.who.int/classifications/icf/en/>) could be used for the recording of discussions and also recording soft demographic data.
- Environment classification, community access
- Patient reported outcomes
- Accounts of nursing care delivered
- Secondary and primary care interface
- Pre-procedure assessment (Major Heading), Infection Control sub-heading?
- Patient responsibilities (encourage sharing of responsibility hence empowering patients, could be difficult, needs to be tailored to each and every patient.)
- Could patient be in charge of this?
- Responsibility to be shared – this should be identified
- Patient diary with reminder prompts
- Who does what?
- Patient to be copied into correspondence? (part of patient preferences)
- Patient preferences (as DNR)
- Assessment for fitness to discharge including discharge planning.

Session 2: *Gaining consensus*

Summary points of discussion:

- Consultation – all have professional bodies – not all well-structured. Including trainees who don't always belong to societies; trainees need to be part of the consultants.
- Many of the delegates have offered to take this work to their associations at this juncture
- Experiment as much as possible; people need wording e-models to play with
- Patient groups: patients needs to be involved
- Online Questionnaires
- Funding is a barrier.

Group 4: Psychiatry & Mental Health

Session 1: *Priorities for standardised records*

1. Care programme approach – needs standardising
2. Risk assessment (including Mental Health Act status)
3. Initial assessment (instead of admission)
4. Case summary
5. Discharge documentation
6. Discussion with patient on how to use information.

Issues arising during the breakout group discussion

- Felt inspired by the HIU record standards programme methods and products
- Developmental history/ record
- Standard record of how far info can be shared
- Care plan and CPA (risks & warnings)
- Development history, Educational history
- Risk assessments – which would only be valid for that incident.
- Handover form – handover of care.
- Status: Child protection, Vulnerable adults
- Multi-agency matters: Probation, prison, alerts
- Progress notes standards
- Carers
- Informed consent needs to be part of system

Specifically in relation to the RCP HIU led project standards:

1. Admission:
 - Initial assessment, 1st episode team, rather than an actual admission
2. Key missing aspects were:
 - Mental Health Act status
 - Medico-legal complexities given
 - The type of patient
 - Confidentiality + consent
 - Multi-agency communications – probation, prison services, criminal legal system, police, social services.
 - Carers – where will information about carers be kept?

Session 2: *Gaining consensus*

Summary of discussion:

1. Consensus issues

- Consensus needs to be across specialty
- There is no single representative body for some of the involved professions:
 - Clinical psychologists – BPS, Therapists family, British Association of Behavioural & Cognizant Psych, Association for Family Therapists
 - RCN, Nurses belong to a number of organisations (e.g. Unison)
 - Social workers who work in mental health have different record keeping standards
 - New roles under Mental Health Act, how do they fit-in
 - BAOT, British Association of Occupational Therapists

2. Process issues

- Mental Health is a multi-professional agency group
- Singular Professional groups
- Patient involvement at each level
- ? Model eg. RCP, informatics team in Royal College to lead this work, pulling consensus together between all mental health professional bodies. Get groups together and a leader will emerge
- Multi-disciplinary groups – therefore, difficult to assume that infrastructure/ email lists already exists.
- Involve the Health Professional Council
- Who will have final sign off/on document?
- England / Scotland / Wales and Ireland impact on countries e.g. The Mental Health Act is different between the countries.
- Joint work around quality outcomes and indicators.
- They don't have the time or money to resource
- How do we stay in connection with other work so they don't work in ?solo.
- Next step was to meet with their groups to together to take 5 areas forward and set a steering group.

Group 5: Pathology & Clinical Scientists

Session 1: *Priorities for standardised records*

Test catalogue

1. Standardisation of results across centres
2. Internal lab data, exchange, preservation standards
3. Interoperability: requests, results, knowledge
4. Pathologists opinion: Clinical support (LAB, MDT)

Issues arising during the breakout group discussion

- Need a national test catalogue – consistent across organisations. Problem arise when a test is requested not in the catalogue
- Standard process for sending tests out, back and forth
- Exchanging data and technical information within or between laboratories, and with reference labs
- Internal standards, internal standards for data storage/archiving
- Interoperability – data into and out of computers
- Capture pathologists' opinion as well as clinical data – information presented to the clinician is often just the results. The pathologist could make available a lot more helpful information – Only a sub set of the information is passed on (microbiologist) - opinion of what is safe and useful is important
- Data preservation (big issue in genetics/ tissue storage also – HTA)
- Screening

Session 2: *Gaining consensus*

- November - Policy – setting system in place; some are developing their system.
- NHS CFH said will not fund so college has started already
- Learned – need to engage in NHS e.g. ISB approval etc.
- Processes, how to get standards board sign-off?
- Can have poor quality electronic data
- Communication – needs to be clearly and well done; they could do better in communication for pathology and patients

Summary of discussion

1. Development of a Test Catalogue – already going on (NHS CFH owner)
 - Discussion about ownership, engagement activity
2. Standardisation of results
 - Standardisation of results: e.g. Range: some work going on local variation
 - Modernisation agenda (who owns the agenda? The profession?)
 - DH Harmony workstream
3. Communication:
 - Take to Gifford Batstone, WCH CHF
 - Better communications strategy professions and patients
 - ? Patients involved with RCPATH / ACB
4. International / Data manager / Preservation Standards
 - HPA – Rehearsal levels
 - Preservation labs – HTA – Consent with implication for family members. Need to deal with the individual.
 - Owner RCPATH has guidance on maintenance and preservation of results
 - Clinical Genetic Society keep notes for > 30 years
5. Interoperability Standards
 - Requests, Results, Knowledge (NHS CFH – ACB/ RCPATH)
 - System Interoperability – NHS CFH, SNOMED
 - GP Pathology messaging (order comms)
 - Equipment suppliers
 - Lord Carter – end to end connectivity: wider publicity so that professions know what is going on.
 - NHSIA – regular events letting you know what was happening
 - Observation – probably lots going on but we need to be communicated to. Need communication strategy from NHS CFH NCH for Pathology.
6. Pathologist's Opinion / Clinical Support (LAB/ MDT)
 - System process design issues (no linking – generating a report with this working).
 - Criteria note in laboratory record but not linked – usually post-operative.
 - Who owns the problem - ? NHS CFH raises awareness
 - Data linkage between systems
 - RCPATH does not create standards
 - ? Patients involved with RCPATH / ACB

Group 6: Nurses & Allied Health Professionals

Session 1: *Priorities for standardised records*

1. Way into the service
 - How has patient become known (e.g. self referral, referred by another professional)
 - Presenting issues and problems
2. Assessments
 - Objective assessment / assessment instruments
 - Observation
 - History
 - Context
3. Judgement/diagnosis
4. Care plan
 - Evidence for decisions, implementation
5. Review of outcomes
 - Objective –e.g. as shown by assessment instruments
 - Subjective view of patient
 - Subjective view of clinician
6. Discharge/transfer of care
 - Way out of the service

Issues arising during the breakout group discussion

- Some professions keep own records which are not visible to other professionals
- Complexity issues – best represented by a matrix with professions on one axis and care groups on the other (not professions and care groups mixed e.g. Rheumatology and OT on the same axis), as registered OT's work across lots of other specialities. This principle applies for all AHPs
- Should look at work done in Scotland
- Not re-do headings project – but build on it
- Need to see if can build on RCP work
- Common Assessment Framework needs to be considered
- Identify patient's abilities and contribution
- Matrix to make sure patient-centred
- Level of specificity/granularity must be defined
- Independent sector/voluntary sector all contribute to records
- Fluidity: will be required across organisations as patients move between them and staff may be employed in one organisation and deliver care in another
- Clear common terminology
- Professional regulation – each have own –therefore their own standards
- NSFs e.g. long term conditions – some useful work already done in defining core care standards that require documentation

- Concern: could these really support end-to-end care?
- Clarification and scope of future work is paramount
- Build in patient strengths
- Priority areas should be chosen that can be patient centred and multi-professional

Session 2: *Gaining consensus*

(Large group that decided to divide into two (Group A&B) for the session 2)

Group A

- Would need to start with a scoping to find out who signs-off this type of work within each professional body e.g. executive body.
- Need to consider Statutory (Regulatory bodies) vs. Professional sign-off.
- Small groups could potentially buddy up.

Summary of discussion

1. Challenges and obstacles

- Resources for smaller specialty groups. Community workers etc. Two way communications infrastructure is important.
- Who needs to be engaged and what infrastructures is in place
- Need to share resources e.g. RCP methodology
- Meetings – location and time issues. Need to utilise other methods.
- Clear/ Appropriate communication.
- Consistency across all care settings.
- Lack of clarity of 'sign-off' process. For all professional groups. Partnering of professions
- Collating examples of what has already been done.
- Review of existing data standards/ data sets /Headings project.

2. Resources – Potential Enablers

- Secondments
- Named lead for each profession – managing and/or clinical research experience, analytical background.
- Time & funding
- Utilising existing resources
- Project lead.
- Examples of good practice models to educate so that get informed opinions.

Group B

Gaining consensus

- Are there any situations where the Professional Body response could lead to litigation against the Professional Body?
- Does 'consensus' suggest to the public that the PB endorses a particular view?

- Should there be a greater focus on 'Champions' within each profession being enabled and supported to lead on consultations relevant to their area of specialist practice?

1. Consultation processes

- The Nursing Professions and Allied Health Professions (AHPs) have broadly similar mechanisms for reaching a consensus within their profession and responding to a national consultation. There is a continuum of complexity and comprehensiveness in the mechanisms used to respond to different consultations
- They rely heavily on speciality groups to obtain views
- Variety of approaches
- The healthcare professional body (PB) may be contacted directly by another agency, e.g. NHS Connecting For Health, may be alerted by a member to a national consultation, or become aware of a consultation because of the diverse contacts and activities of PB staff. An external request, or information about a consultation, may need to be passed to a different department or member of staff within the PB
- The process starts with a discussion and decision within the PB as to whether the consultation concerns a subject that is a priority for the PB. There may be a discussion with colleagues, or with members of a PB Board, committee or group
- Usually a PB officer (or sometimes a member who is an enthusiast and/or specialist practitioner, manager, educator, or researcher) leads on the process of obtaining a professional consensus and drafting a response for the PB. Whoever is leading may need to prepare a briefing paper that will explain the context and purpose of the consultation, the timescale for responding to the PB, and perhaps indicate the issues or views that the PB is considering expressing in the PB response. The draft briefing paper may need to be commented on and/or amended by a PB specialist group, committee or Board, before it can be circulated e.g. Professional Practice Board or IM&T Committee
- The consultation document(s) are circulated widely by various routes
 - Email circulation list of members
 - PB specialist groups or specialist sections
 - PB website or online forum
 - Newsletter or bulletin, electronic or paper
 - Informal professional networks both nationally and locally
 - Holding a workshop or other event
- Responses from members are collated and used to develop a collective response from members, reflecting the diversity of views and opinions. The PB officer will draft a PB response based on the views of members. This draft this may need to be shared with a PB Board, committee or group for discussion, amendment and endorsement. In some cases the final draft will need to be similarly amended and approved by the PB council, and then usually signed off by the chair of council
- Once approved, the official response is then submitted to the consulting agency, and posted on the PB website

2. Resources

- Resources are stretched and currently sufficient to respond to some national consultations, with a high quality approach being restricted to very few consultations – the most important ones only. PBs take a very pragmatic and streamlined approach to the majority on national consultations, perhaps receiving only a handful of responses from members to inform the official PB response
- An effective and 'quality-assured' approach to a consultation would need to consider a range of components, such as workshops, focus groups, phone interviews, conferences, web-based questionnaires etc. (Similar to the RCP-NHS CFH approach)

- Resources can be stretched because PBs have a UK-wide remit and receive requests for responses to consultations from Northern Ireland, Scotland and Wales, as well as from England. This can include social care and education as well as the NHS

3. Obstacles

- There are many obstacles to improving professional assurance by the PBs
- PBs can find it difficult to generate enthusiasm amongst members to respond to consultations, and the few who do may not be representative of all members
- PB officers and NHS staff face many conflicting priorities, which can inhibit their engagement with consultations, especially when there are so many consultations
- Understanding and reflecting on professional issues takes time, and can be assisted by opportunities to talk through the subject with colleagues. When time is not specifically set aside for these discussions then HCPs are unlikely to respond to consultations. This is essentially a funding issue
- Workshops and other consultation events require funds (Not currently available) to organise and hold them and to reimburse participants for their expenses and time
- PBs plan their work annually and can find it difficult to defer or cancel existing commitments in order to take on unexpected tasks, such as new consultations
- AHPs can work across organisational boundaries, both within the NHS, and collaborating with social care, education, employment and the prison service. There needs to be a common health language, and the foundations (Structure and embedded processes) for a single integrated electronic health record for each patient
- PBs vary in their access to dedicated online/electronic resources such as web pages, comprehensive email circulation lists, discussion forums
- HCPs vary in their access to electronic resources (Internet and email) whilst at work, e.g. ward nurses sharing a single access point in the ward office
- Some AHPs (And Healthcare Scientists) were not represented at this event. Was this because they chose not to attend, were due to attend but cancelled, or do not have the resources to send a representative and so are effectively excluded from national events such as this one?
- Need to clarify the scope of this project. Does it exclude: mental health, children's services, learning disabilities, community nursing, health visiting, 'community hospitals', and community-based rehabilitation

APPENDIX 6

Feedback from representatives via completed forms identifying priority areas for developing standards for the electronic patient record

Eight clinical contexts emerged as common priority areas:

1 = Discharge
 2 = Admission (initial assessment)
 3 = Outpatients
 4 = Care plan/continuation notes
 5 = Transfers
 6 = Procedures
 7 = Referrals
 8 = Consent

These are numbered for reference purposes (see column 2 in table below). The table shows the disciplines that identify these areas and the others that emerged.

Specialty	Common priorities code *	Other priority areas	Additional Notes
Maternity & Child Health	1,2	-Standardized ante-natal, intra partum, post natal records (except Scotland)	Universal child health record exists but not universally completed and paper based. Existing records aren't fit for full purpose (eg. Neonatal records) Need to be more comprehensive, multi professional, multi sectional - primary, secondary location. The biggest issue is around appropriate + universally understood language and woman + family focused (e.g. admission, discharge, handover, patient/client/user.)
Midwifery	1,2,5,7	-Maternity records: antenatal, roll post partum, intra partum, -Neonatal records. -Child health record.	
Obstetricians and Gynaecologists	1,3,6,8	-Standardized maternity record. -Standardized handheld maternity record -Standardized links between maternity record and child record, -Standardizing giving assessments, -Gynaecological oncology care records, -Records for fertility treatment, -Outcome measures / Quality of life, Screening Records, Risk Mgmt / NPSA/ CNST	
Paediatric Speech & Language Therapy	1,4,7,8	-Diff. Dx codes, -Packages of care -Outcomes	Many children seen are not "ill". Have close partnership working with education/ local authorities
Paediatric Surgery	1,2,5,6	-Obstetrics/ antenatal, -Histology	Specialist vs. General Paed. Surgery. Video/Still images.
Surgery	1,2,3,5,6,8	-Patient's problem (outpt app, emergency), -Decision making, education, -Pre-procedure / admission assessment, -Pre-operative care	E-consent, multi-discipl pathways, tailoring info to admission, coding, operation notes, day surgery, endoscopy, MDT
Oral & Maxfac Surgery	1,2,3,6,8	-Preop assessment, -Operative / GA/ Critical care, -Post-op discharge, -Multi-disciplinary integration	Exam/Investigation/Decision Making, Greater integration multimedia, photos, radiology, etc.
Trauma & Orthopaedic Surgery	1,3,6	-Outpatient decision making re: operation, Pre-operative assess, -Operation record, Immediate post-op care, -Later post-op rehab, -Post-discharge rehab.	
Lay Representative	3,4,5	-Patient instructions, -Self & shared management, inter-disciplinary discussions of physiological and rheumatological interventions	

Specialty	Common priorities code *	Other priority areas	Additional Notes
Clinical Oncology	1,5,6,7	-Chemotherapy toxicity + response assessment, -Radiotherapy toxicity + response assessment, -Treatment summary chemotherapy, -Treatment summary radiotherapy, -MOT discussion record	
Medical oncology	2,3,5	-Standardized assessment of fitness for treatment and of treatment toxicity, -Standardized recording of multidisciplinary meeting discussed + outcomes, -Cross site transfer of info for patients receiving specialty care at several sites, -Recording treatment outcomes	Recording of information needs of patient and of information given. Recording info for patients receiving multi-specialty follow up + surveillance,
Critical Care	2,4,5,6,7	-Comment/Mental capacity, -Transfer of patients (intra and inter hospital), -End-of-life care	
Acute / Respiratory Medicine	1,2,3,4,6,7,8	-Pre-populated forms for ward rounds, -Electronic drugs record/ Reconciliation, -Clinic letters, -MDT meetings, Pangut preferences, -Triage facility within admission documentation	Discharge summary with different aspects seen by GP, social workers, nurses, etc. Virtual clinics - reminders of things to follow-up, shared patient's daily, more speculated. Tailored Admission documents - select respiratory forms or preferable guidelines driven admission proforma. This needs selectable front sheets or interfaces which can populate a generic background form so that aspects will be accessible to and useful to other health care providers.
Emergency Care Incl. Pre-hospital	1, 2	-Summary of primary care record (Rx, Allergies, consults), -Pre-hospital episode	Current medication list, Mental capacity and End-of-life decisions/Advanced directives, Allergies, sensibilities, interactions, Ongoing primary care issues, Accessing quickly/ linking records from community using pt name / DOB (not NHS number). Social history - carers, dependants, support services assessed, Infection control, Medications administration pre-hosp, Reason for ambulance response / pt concern, Findings of ambulance crew, Current status (bp, ecg, spO2)
Emergency Medicine	5	Open ECG standard for NHS	Context - or Attendance, Transfer to tertiary care/ proformas, 'Lurkers', Application soft data entry
Acute / Emergency Medicine	1,2	-Pt. assessment, -discharge (similar to Dutch/ Danish model), -Outcomes	Interoperable nursing language, Implementation of SNOMED for nursing
Stroke Medicine	1,2,3,7	Acute admission - facilitation of thrombolysis. -Acute Stroke Unit, -Stroke Rehabilitation, -Stroke prevention / neurovascular clinics, -Communication with patients / carers.	
Cardiology	2,5,6	-Angioplasty, -Angiography, -Pacing (HR UK), -Rehabilitation, -Heart failure, -Echocardiography/ Non-invasive, -Heart attacks, -Daily problem sheet, -Inter hospital transfer.	EDC variable systems

Specialty	Common priorities code *	Other priority areas	Additional Notes
Cardiology	1,2,3,4,5,7	-GP referrals to out-pt clinic and in-pt clinic with relevant clinical fields. -Electronic referrals to procedures from DCTH cardiologist (similar to GP referral). -Preadmission assessment (e.g. Electronic procedures for angiogram, PCI, PPM. -Acute referrals (e.g. Primary care), -Ward rounds documentation (with some free text). -Bed mgmt system to allow LOS and discharge/ admission processing. -MOT's - who present / discussion / outcomes.	Diagnosis /Symptoms, Risk factors, Medications (what they are), Allergies, Abnormalities on examinations, Test referred & results, Reason for letter + instructions.
Rehabilitation Medicine	3,4,5,6,7	-Specialist mgmt procedures	Communications with pts, goal setting, scaling outcomes. Referrals & assessments for tertiary specialists in the London region. Goal attainment scaling.
Rehabilitation Medicine	3	-Multi-disciplinary meetings - including those with families, -Outcomes, - Patients reported outcomes, PROMS, clinician records	-Documentation / functional WHO Icf (provides focus point for multi-professional records), Liaison with social care (e.g. SAP)
Rheumatology Medicine (BSR)	1,3,7,8	-Monitoring of Drugs, -Annual Review Clinic, -Cross referrals	
Nephrology	3	-Ward rounds need sub-headings, -Current Review need sub-headings, -Multi-disciplinary team discussions	Discussion with patients/ 2 relatives.
Renal Medicine	3,4,6	-In-patient daily follow-up sheet, -12 patient-reported outcome measures, -12 Quality of life, -Drug treatments: medicine reconciliation, what drug treatments pt currently receiving rx and who from?	Virtual consultations includes patient referred: tests awaited from elsewhere, reminder system. Community visit to dialysis and non-dialysis patients-supportive care, Planning for renal replacement therapy. Castration of vascular accen for hemodialysis, Kidney biopsy, Placement of catheter for hemodialysis and for terkhoff catheters
ENT	1,2,3,5,6	-Outpatients episode (to include diagram + imaging), -Decision making (to include comment / multidiscipl), -Intervention /Procedure in OPD, -Preadmission assessment, -Operative/Procedure + process (prosthesis, tracking instruments), -Peri-operative care (includes HDV/ ITV), -Maternal Care triage, Multi-professional care (SLT audiology), -Emergency non-admitted care, -Emergency admitted non-procedural care.	
Gastroenterology	2,3,6	-Endoscopy, Specialist clinics: IBD, Hepatitis C, Transplant, Procedures (oesophageal function), Assessment, Dietetics	From discussion: ward rounds, MDT, info sharing - multidiscipl/social care, primary - secondary communication
Neurology	1,3,6	-Standardized summary care record, -Patient held record, -Pre-procedure/ Procedure checklist, -Standardised proforma: home visits + ward round notes	Follow-up forms, information sharing, summary care record, "Virtual consultations"
Palliative Medicine	4	-Preferred place of care (PPC), -Professional place of death (PPD)	Patients/ Carers access to healthspace: summary of care record and health space. Identify responsibilities in care plan: both health and social, Medications & syringes devices needs, DNR, Organ donation, equipment

Specialty	Common priorities code *	Other priority areas	Additional Notes
Palliative Medicine	3,4	-Drug List & History, -Multi-disciplinary team meeting record. -Carers/ Bereavement record	Patient's concerns list, Resus status/ preferred priorities of care, Information copy to Pt., Advanced Directive
Clinical Genetics	3,4,6,7,8	- Standardisation of information in clinic letters, recording of MDT meetings, - Standardised summary care record with management plan, - standardised proforma for pre-clinic assessments and home visits, - standardisation for recording results of procedures and investigations. - Standardisation of referral information. - Standardisation of consent for testing forms	- Service records patients with a unique patient identifier and a family identifier to link individuals together as family members
Molecular Genetics, Cytogenetics and Biochemical Genetics	6,7,8	- Standardisation of results. - Interpretation of reports and use of graphics. - Standardisation of referral for testing criteria. - Recording of patient consent for testing	- Standardisation of results. Interpretation of reports and use of graphics. Standardisation of referral for testing criteria. - Recording of patient consent for testing
Clinical Biochemistry		-Standardization of test units and ref. ranges. -Lab results to open data warehouse	Interpretation of reports. 5Correlation of labs & observations: use of graphics, query for any clinician access, GP requesting consistency, knowledge-based request
Pathology (Clinical Biochemistry)		-Catalogue of Tests, -Standardization of results across centres, -Onto lab data, discharge, preservation standards, -Onto operativity - regards, results, -Pathologist opinion - clinical support (LAB/ MDT)	
Audiovestibular Medicine	3,4,5,6	-Investigation, -Virtual consultation	Proforma history
Mental Health Nursing	4,8	- Care planning in relationship with career + family, -Risk Assess	Release signature
Mental Health	1,2,4	-Risk Assess, -Case summary	Developmental History
Psychiatrist	1,2,3,4,8	-Risk assessment & mgmt in CPA, -Clear screen for care planning and risk assessment / mgmt, -Multi-agency screens, legal issues (mental health as well as mental capacity), -Case summary for rolling and multi-disciplinary, for communication	Facility to conceal info from pt that is potentially harmful and to conceal sensitive/irrelevant info from clinicians who do not need to know. Electronic / Paper records
Psychiatry	1,2,4	-Risks, -Case summary	All needs to be multi-professional including local staff and social workers. Include prevention and promotion within screening, written information given to patient - not only verbal discussion.
General Practice	1	-Patient diary, -Palliative care summaries	Patient diary (eg. Blood) need to be done - this is available in GP systems but does not link into tasks and reminders for clinicians. 1 Discharge summaries - need to have links between clinical conditions, medications and reminders. Palliative care summaries can be linked to problems & avail as attachments.

Specialty	Common priorities code *	Other priority areas	Additional Notes
General Practice	1,3	- "Special notes" between primary, secondary and tertiary cases, - Soft data- such as patient preferences, - Palliative case summaries.	Discharge summaries- but some of them are hopeless, not enough information and too many pages with blank spaces. 'Special notes' for out of hours - live limited, produced for use in unscheduled case at week. Palliative case summaries already agreed & being piloted in Scotland in addition to emergency case summary.
General Practice	1,6	- Results of hospital investigations - Summary of GP record auth for other professionals. - Multi-disciplinary meetings, - Pre-procedure assessment. - GP & Pt requests for discharge.	Specific request for secondary care want primary to do. Patient's ideas, concerns, expectations.
General Practice	1		ID of patient, ID of clinician, Current medication, Main problem, Action required.
Occupational Medicine	3,5,7	OH Clinical notes (first consultation & review), -OH letters to HR/Managers/GP's/Specialist/ Patients/employees.	
Occupational Medicine	2,3,5,7	-OH first consultation record + review, - Referrals to OH from managers, - OH letters to HR/Managers, employees, patients/employed.	
Metabolic Medicine / Clinical Nutrition	1,3,4	- Discharge summary with care plans, - Nutritional screening, multi-disciplinary input	Continuity of care between primary + secondary care
Public Health	2	- Patient + clinician reported outcomes, - Patient compliance with recommended treatment	Cause of illness or accidents, Problems to be recorded as well on diagnosis, Flexibility to clinicians to enter "Research" data into the computer record for participant
Occupational Therapy	1,2,4	- Clinical assessment, - Care planning and care plan review, - Home visit assessment	
Physiotherapy	2,3,4,5,7,8	- Clinical assessment, clinical reasoning, - Agreed Outcomes, - care planning	
Speech & Language Therapy	1,2,3,4,7,8	- Case history, - Outcome measures (patient centred)	Diagnosis & prognosis of speech/ language difficulty, Other agencies involved - multidisciplinary team
Nursing	3	- Long-term condition support	Sharing across professions and care setting, Consistency/ Evidence-based care
Nursing	2,4,5	- Clinical decision making, - Outcomes	
Nursing / Community Primary Care	3,5	- Multi-disciplinary meeting notes, - Palliative care/ Management Plan	Accurate drug list to GP + back to GP or discharge, Sharing info with social care
Nursing	2,4	Outcome setting / measurement, Interventions, Patient views	
Orthoptics	2,4,7	- Summary letter after visits, - Record of home treatment,	Social/family issues

Specialty	Common priorities code *	Other priority areas	Additional Notes
Pharmacy	1,2	-Current Medication Prescribed, prescribed & purchased: allergies (inc. hospital administered meds), adverse drug reactions, linked conditions, Reasons (prescribing decisions, changes, stopping). -Patients concerns, -Discharge Meds, -Meds administered in hospital, -Med. linked tests - drug levels, path tests (Lipids, LP, RF), recent (last 4/52), -Acute medication, -Pharmacist Q's/concerns (requiring action/response)	
Pharmacy	1,2	-Medicines Reconciliation form, -Patient medication record (secondary to primary care), -Pharmacist intervention record, -Patient medication reminder chart (patient held).	
Summary Care Record	1,3	-Emergency Dept. Reports, -Clinic letters, -Out of hours reports	
Chiropody/Podiatry		-Shared (national record with both primary/secondary care)	Guidelines standards already exist (variance in selection)

APPENDIX 7

Feedback from individuals via completed forms identifying methods for generating consensus (session 2)

How would you aim to get the consensus view of your profession or specialty?	Do the necessary resources exist within your specialty's professional body? If not, what is missing the presence of which would enable the process to go forward?	What would the obstacles be to gaining a consensus view from your specialty or profession?
<ul style="list-style-type: none"> ▪ Usually through society wide request per feedback by the members 	<ul style="list-style-type: none"> ▪ Yes 	<ul style="list-style-type: none"> ▪ The potential obstacles would be many differing views, different agendas, some division between secondary and tertiary groups
<ul style="list-style-type: none"> ▪ Email distribution, UK members meeting Nov. 08 ▪ BAPS website 	<ul style="list-style-type: none"> ▪ Yes – good email list and website between only specialist paediatric. surgery 	<ul style="list-style-type: none"> ▪ % Feedback. ▪ No easy link to General Surgeon who also operate on Children
<ul style="list-style-type: none"> ▪ British cardiovascular society (inc carers non medics) ▪ Email + mail shot with a deadline ▪ Could make it a task for BCS or Heart improvement program ▪ Deanery 	<ul style="list-style-type: none"> ▪ Yes 	<ul style="list-style-type: none"> ▪ Choosing only 5 priorities would be difficult. ▪ Setting basics agree would be good ▪ Need to explain how IT would fit with BCIS / CCAD / BPEG/ HCC/ MINAP data + CRS ▪ Need to make it easier
<ul style="list-style-type: none"> ▪ Send drafts, emails, blue prints etc ▪ GP to RCGP college council ▪ RCGP college council. ▪ IT & JGP IT + users groups ▪ Suggest wider consultation via email ▪ In practice, the same small number of people replies ▪ RCAP will then sign off 	<ul style="list-style-type: none"> ▪ Yes 	<ul style="list-style-type: none"> ▪ A small numbers of people will reply but should be able to get agreement
<ul style="list-style-type: none"> ▪ Through email, through review of Medical Oncology ▪ Through the Joint Council of Clinical Oncology for the broader community of adult solid tumour oncology ▪ Through appropriate specialty groups for clinical haematology + paediatric oncology 	<ul style="list-style-type: none"> ▪ Yes – within medical oncology (and Clinical Oncology) ▪ Will need engagement from other professional groupings ▪ Unclear whether resources exist 	<ul style="list-style-type: none"> ▪ Fragmented nature of cancer medicine
<ul style="list-style-type: none"> ▪ Attend council of British Society Rheumatology 6 Nov ▪ Speak + on agenda, then addressing this. ▪ Will update Council on today's meeting and propose, develop and standard forms for new OPC letters and annual review. Recently recommended by NICE 	<ul style="list-style-type: none"> ▪ Yes ▪ Council – disseminate info to 4 subcommittees (esp. clinical affairs of which I'm Vice Chair) ▪ Suggest we (as Committed Members) tryout these and report back (via me) to Iain Carpenter et. Al. Will also attend BHPR (AHP allied to Rheum. Inclu. Neuro, Physio, etc) on Dec. 2nd 	<ul style="list-style-type: none"> ▪ Silent majority ▪ Inaction ▪ Time ▪ However spur to achieving this will be chance to shape future. Also, revalidation will be a useful tool – standard document will help both teams and individuals

<ul style="list-style-type: none"> ▪ Please provide a template for each of 8 stages. We will then circulate for sub-specs to modify. ▪ We need then pilot these in volunteering centres. 	<ul style="list-style-type: none"> ▪ Yes, we have a good website + good email communication ▪ We need financial support for one lead clinician 	<ul style="list-style-type: none"> ▪ If done properly, very few
<ul style="list-style-type: none"> ▪ Cumulative part 2 of the comment document to the ICS membership: BACCN, Critical care networks ▪ Trails of the notes would have to be undertaken 	<ul style="list-style-type: none"> ▪ The ICS has emailing list of – 2200 (multidisciplinary) membership which would include consultants from most UK-English units. ▪ Would need help & template & questionnaire & analysis ▪ For design: would need time and travel expenses for workshop 	<ul style="list-style-type: none"> ▪ Apathy, exclusion of non-membership
<ul style="list-style-type: none"> ▪ Work within framework of RCP ▪ Documents + populate on specialty/ sub-specialty. ▪ Basis specific fields (+ omissions) ▪ Through specialty association clinical effectiveness, committee + email (membership) 	<ul style="list-style-type: none"> ▪ More or less. Web-based questionnaire facilitation centrally for Tailoring by specialist associations ▪ Coordinate through Forum of Surgery (PAN UK) 	<ul style="list-style-type: none"> ▪ Apathy ▪ Culture ▪ Local trans., loyalties
<ul style="list-style-type: none"> ▪ Tier one: Patient involvement – multi-professional group for mental health, other medical specialties ▪ Tier two: Patient involvement – groups of single professionals (psychiatrists, nurses, OTs, psychology, Social workers) ▪ Tier three: Cascade to each professional group front-line. Clinicians by: email, online questionnaires, etc. for consensus 	<ul style="list-style-type: none"> ▪ Structures may lend themselves within re: psychiatrists ▪ But finance not available as it stands. ▪ Need to produce business case for money 	<ul style="list-style-type: none"> ▪ Difficult to obtain consensus: <ul style="list-style-type: none"> ○ Multiple sub-specialities, multiple disciplines. ○ Lack of “buy in” ○ Lack of time
<ul style="list-style-type: none"> ▪ Take to national body to coordinate consensus view of group 	<ul style="list-style-type: none"> ▪ Subspecialty systems exist (eg. BCS databases, MINAL, BPEG, etc) ▪ CCAP but not integrated 	<ul style="list-style-type: none"> ▪ Agreement between subspecialty groups! ▪ Reliance to complete this important piece of work albeit worthwhile
<ul style="list-style-type: none"> ▪ Professional journal, email circulation lists, specialty sections ▪ Focus groups, phys consultation + workshop, expert workshops – each AHP and then all together 	<ul style="list-style-type: none"> ▪ Partially – need allocated resources to respond to a small number of consultations ▪ Also, practitioners rarely respond to PB consultations unless there is a large campaign to publicize the importance ▪ Work = funds + online functionality (c.f. physicians) 	<ul style="list-style-type: none"> ▪ Publicize the campaign to promote the importance ▪ Resources for online questionnaires / phone interviews
<ul style="list-style-type: none"> ▪ Via society and multi-professionals/multi-disciplinary engagement ENT ▪ Set out own model pathway based on themes ▪ Map who needs to be involved 	<ul style="list-style-type: none"> ▪ Web-based questionnaire ▪ Use methodology so far ▪ Specialty – forum of surgery and then college 	<ul style="list-style-type: none"> ▪ Pick-up ODP
<ul style="list-style-type: none"> ▪ Marketing, Networking, Specialist groups, Working groups 	<ul style="list-style-type: none"> ▪ Use of email posting, e-zine, Website 	<ul style="list-style-type: none"> ▪ Resources, Time problems may arise through slow working program ▪ Important that work is done in collaboration

Consensus view	Resources within your specialty or professional body	Obstacles to gaining a consensus
<ul style="list-style-type: none"> ▪ In England we have British Association of Stroke Physicians ▪ The multi-disciplinary UK Stroke Forum which has access to addresses/ emails addresses of large number of professional managing stroke patients. In Wales, there are similar groups (Welsh Association of Stroke Physicians and the Welsh Stroke Alliance) 	<ul style="list-style-type: none"> ▪ No. If there has to be a nation wide, multi-disciplinary consultation, there is a need for resources to perform such a process 	<ul style="list-style-type: none"> ▪ There are unlikely to be any major obstacles. ▪ The problem may be that the patient record may become too unwieldy if views of all disciplines are to be incorporated
<ul style="list-style-type: none"> ▪ Consent 80% Audio vest med ▪ BAPA, BAAP, SpR + Cons, NHS team leaders, BAA + scientist, Audiology nurses, RNiD, NDCS ▪ Proposal development ▪ Circulation ▪ Re-development ▪ Re-circulation 	<ul style="list-style-type: none"> ▪ Required: <ul style="list-style-type: none"> ○ Outline questionnaire + analysis ○ Space to meet / discuss via telephone ○ IT support ○ Academic support ○ Recognition by trust to undertake this work 	<ul style="list-style-type: none"> ▪ Lack of above ▪ Time scale
<ul style="list-style-type: none"> ▪ From on APM working partly linked to a London Pilot Project ▪ Coopt. Nurses, S.W's, ADPST National Charity organizations ▪ Consult whole membership 	<ul style="list-style-type: none"> ▪ Money 	<ul style="list-style-type: none"> ▪ The poor quality of IT provision in the voluntary hospice sector ▪ Concern about the case of changing to EPR + interface NHS
<ul style="list-style-type: none"> ▪ Through the Clinical Effectiveness Committee of College of E.M. ▪ IT subgroups ▪ Trainees 	<ul style="list-style-type: none"> ▪ Time and money to free up nurse/ doctors to develop PCR in ward rounds. ▪ Need 6/52 lead time 	<ul style="list-style-type: none"> ▪ Lack of application of importance of impact of IT work streams association with SCR ▪ Frustration of C/FL on functions? Recovery time, table
<ul style="list-style-type: none"> ▪ Cascade information via RCR membership (fellows + members). ▪ Other oncologists (medical, paediatric, haematological) may need topic-ing in other ways 	<ul style="list-style-type: none"> ▪ Access to lists of paediatric oncologists 	<ul style="list-style-type: none"> ▪ Not sure. Too many cooks spoil the broth!!
<ul style="list-style-type: none"> ▪ Through existing networks, specialist groups (i.e. information, clinical standards, policy, research, etc) 	<ul style="list-style-type: none"> ▪ No, not as a designated, discrete dept. or individual. This to be done well (& this is possible) with research i.e., time, facilities, skills + knowledge ▪ Measure need for marketing – importance to quality of care emphasis 	<ul style="list-style-type: none"> ▪ Some scepticism / fear ▪ Resources (sorry again, I am afraid).
<ul style="list-style-type: none"> ▪ National meeting of invitees – to disseminate: Pathology IT, printed statement ▪ This is an issue of communication across specialties, not just within specialty 	<ul style="list-style-type: none"> ▪ No. Need recourses to report clinical reference groups 	<ul style="list-style-type: none"> ▪ Lack of awareness, IT independence
<ul style="list-style-type: none"> ▪ Information in nursing group and other specialty forms ▪ The safety practitioners and other activist groups ▪ Bulletin, electronic WebPages: Ethernet program book, council, 4 counting e.g. NC wide 	<ul style="list-style-type: none"> ▪ Not funding for workshops ▪ Can do above 	<ul style="list-style-type: none"> ▪ Not given enough time ▪ Lots of consultations ▪ Consultation goes to wrong person (eg. Gets stuck in someone's email box) ▪ Business planning cycle

Consensus view	Resources within your speciality or professional body	Obstacles to gaining a consensus
<ul style="list-style-type: none"> ▪ Through patient support groups (i.e. National Association for Colitis & Chronic disease. etc. ▪ PCN network + other college PPI (Informed views cheapest) ▪ Communication through hospitals patients ▪ Local involvement networks (LINKs) ▪ National Patient Network 	<ul style="list-style-type: none"> ▪ Funding not existing 	<ul style="list-style-type: none"> ▪ General lack of knowledge and apathy
<ul style="list-style-type: none"> ▪ Policy/ Guideline producers – Joint Royal College Ambulance Liaison Committee. ▪ Paramedics – HPC (miss other pre-hosp. practitioners) ▪ Ambulance Service Association – will catch some non-NHS ambulance providers. ▪ British Paramedic Association – Not all paramedics + private/ NHS, others 	<ul style="list-style-type: none"> ▪ To catch NHS ambulance employees – direct to each NHS Ambulance Trust ▪ Starting with comparison of current forms. ▪ 	<ul style="list-style-type: none"> ▪ Engaging all practitioners. ▪ Funding people's time
<ul style="list-style-type: none"> ▪ Since national care is a multidisciplinary responsibility, the consensus could be established through BAPEN, which is multidisciplinary (doctors, nurses, dieticians, patients, etc) ▪ Test of prototypes using IT system 	<ul style="list-style-type: none"> ▪ The IT systems are not readily available 	<ul style="list-style-type: none"> ▪ Participation bias ▪ Consistent criteria needed for establishing criteria within & between disciplines ▪ PCT involvement needed (not just discipline based involvement) ▪ Need to examine how the specialty specific consensus works in the context of the integrated IT system
<ul style="list-style-type: none"> ▪ Would wish this to be multi-professional to ensure coordination. ▪ Also needs ongoing links with other specialties to support joined up care ▪ Plus multi-agency group, would need financial support. ▪ Would get high level agreement or non consult through each year 	<ul style="list-style-type: none"> ▪ No. To have formal support as per RCP ▪ Need lead organisation with strong multidisciplinary involved. ▪ National screening group 	<ul style="list-style-type: none"> ▪ Lack of resource hrs for involvement. ▪ Lack of IT infrastructure – so reluctance or clinicians to be enthusiastically involved unless this is addressed
<ul style="list-style-type: none"> ▪ Trail, Clinical Directors, Workshops. Travelling to units, Discuss with RCM. 	<ul style="list-style-type: none"> ▪ Not completely, there are a small number of interested parties. 	<ul style="list-style-type: none"> ▪ Enough people to spread the word, Money, Time
<ul style="list-style-type: none"> ▪ Multi-agency Storing Group Meeting to bid for NHS CFH funds 	<ul style="list-style-type: none"> ▪ No. We need NHS CFH support 	<ul style="list-style-type: none"> ▪ How do we remain connected to main record?
<ul style="list-style-type: none"> ▪ Use PRINCE2 approach! ▪ One project per consensus 	<ul style="list-style-type: none"> ▪ Finance, time & organization 	<ul style="list-style-type: none"> ▪ As above and as per group 6b notes
<ul style="list-style-type: none"> ▪ Profession Royal College: <ul style="list-style-type: none"> ○ Special interest groups, links with independent practitioners ▪ Specialities – children's services – more difficult, particularly those shareholders who are not NHS. (CAF, Contact Point) 	<ul style="list-style-type: none"> ▪ A paid officer/ lead ▪ Administrative support ▪ Analytical support ▪ Training ▪ Existing record helping standard 	<ul style="list-style-type: none"> ▪ Lack of knowledge and understanding of scope (this could be record by briefing, paper, workshops.

Consensus view	Resources within your specialty or professional body	Obstacles to gaining a consensus
<ul style="list-style-type: none"> ▪ Run an event for the branches of the profession 	<ul style="list-style-type: none"> ▪ Resources missing: knowledge of understanding, people dedicated to IT development 	<ul style="list-style-type: none"> ▪ Changes in the society, lack of dedicated staff, engagement of council and president
<ul style="list-style-type: none"> ▪ Build the tension for change – get support from DH/ SHA / PCT ▪ Consult Renal Association, British Renal Society, Nephrology trainees: ▪ With paper versions/ proformas using proposed headings ▪ With electronic systems allow web-based /email feedback ▪ Get CPH process analysts to observe + map the relevant clinical case process 	<ul style="list-style-type: none"> ▪ Time, money ▪ Project management ▪ Backfill ▪ Support from CPH on the ground 	<ul style="list-style-type: none"> ▪ Tension between how we do it now + how we might do it in future when supported electronic records. ▪ Disagreement between parts and the profession. ▪ 'Special notes' derailing the process ▪ Existing IT renal system makes it more difficult to imagine a different electronic solution.
<ul style="list-style-type: none"> ▪ Report back from this meeting to professional body and other professional groups ▪ Need to inform profession that this work is going on and why they need to get involved ▪ Get some groups together with examples e.g. Admission form to comment on ▪ Community pharmacy very different and separate from hospital which is multidisciplinary 	<ul style="list-style-type: none"> ▪ I don't know. I'd need to liaise with them. This work is being done by pharmacists written of it ▪ 'Informing Health Care' at present, not the professional body 	<ul style="list-style-type: none"> ▪ Large geographical area to cover ▪ Community pharmacy is very different from hospital pharmacy and would need to be done by experts from this area
<ul style="list-style-type: none"> ▪ A challenge could be through the regulatory body NMC and their structures 	<ul style="list-style-type: none"> ▪ No! ▪ Resources for NHS CFH would be needed 	<ul style="list-style-type: none"> ▪ Divided access varies organization so need to use the regulatory body