National Information Systems Group
NISG Solution Stewardship

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NHS National Services Scotland

Minutes

Meeting of SCIMP working group

Date: **Monday the 4th November 2013**
Venue: **Crieff Hydro, Crieff**
Time: **18:30hrs to 20:00hrs**

Present:	**Paul Miller (PM)**	**Paul Hemsley (PH)**	**Karen Lefevre (KL)**
	Alison Forbes (AF)	**Colin Brown (CB)**	**Helen Maguire (HM)**
	Iain Cromarty (IC)	**Ian Thompson (IT)**	
	Rob Walter (RW)	**Lindsey Ross (LR)**	**Leo Fogarty (LF)**
	Paul Woolman (PW)	**Sam Patel (SP)**	**Ros O'Connor (RO)**
	Neil Kelly (NK)		
Skype:	**Ian McNicoll (IM)**		
Apologies:	**Jill Gordon (JG)**	**Bruce Thomson (BT)**	**Alastair Taylor (AT)**

1 Welcome, apologies and introductions

PM welcomed everyone to the meeting, introductions were made and apologies were noted.

2 Minutesfrom previous meeting – 4th September 2013

Minutes were agreed as an accurate record of the last meeting. Sam Patel is attending today's meetingas a guest.

3 Single prescriber ID – progress and review

ITdelivered a presentation to the group. With the introduction of SHIP the Scottish Government became interested in reporting on prescribing and reporting on individual prescribers. There was a whole chunk of the GP population it was difficult to do and this included the GP principals who work in more than one location. There has been some concern around the impact on revalidation so we were asked to try and complete this validation work. There are issues around validating a prescriber

to specific location in that around 0.5% of the total prescription volume has the wrong prescribing code. This is usually down to continued use of a code for someone that has left the practice. IT referred to the recent communication from RCHP which asked practices to remove out of date prescriber codes. Ken Truslove from the ePharmacy Project has put together a diagram which covers how information flows through the system. All of this information ends up in the prescribing information store, data warehouse and prisons. The problem is that we are not sending information for non principals. The idea is to switch to use professional code (GMC code) for prescribing instead of GP cipher code,and then we can start reporting on what is coming into the prescriber store. There are issues around Locum A being valid prescriber at practice B, and there have been some pragmatic fixes suggested: use the prescribercode of existing partner and if a valid prescriber code for that location appears they will presume it is a valid professional code. We discovered that there was a lack of clarity in the way the ePharmacy specification was written; both GP suppliers interpreted it differently. The RFC is currently with the Scottish Government to decide on how it will be funded. There is a potential costs saving benefit if this work is tied up with other prescribing work.

If we remove the names of locums from the past, does it affect historical data? IT confirmed that this data will be future only; we need to work out a way to persuade practices to create a unique user id for each Locum. This is a change in business practice for a lot of practices, promoting active user management if a Locum leaves. If this is managed carefully the practice data will become cleaner. IT would welcome advice from SCIMP members as to how we sell this to practices. Inactive users are not visible in EMIS.

PM summarised that the key points needing addressed are how weincentivise practices to change their business practices and how do we communicate these changes.

IT concluded that there are some ideas around what might happen for prescribing in the future, in terms of no need for a signature on paper and that this might be achievable but is not likely to happen in the very near future.

4 NHS Scotland Clinical Models – progress and review

PM discussed the Clinical models paper that was circulated recently. The main thing we are trying to do is establish a way to communicate clinical data effectively between information systems. We are also trying to build up a common model under the bonnet, eg if we want to represent a weight as a clinical concept we need to specify what the computer needs to define in terms of, date, description, place of value and units of measure. We are using the Open Air Ocean Informatics Clinical Knowledge Manager to deliver this and this is a web based interactive collaborative tool, to allow us to look at clinical models. In this system we call them archetypes. It allows clinicians and other users of systemsto contribute to reviews of these models. We are trying to create models to cope with adverse reactions and medications. We need to think about how the description meets the clinical and end user requirements of how we want things to be represented in our systems. An archetype is a container that has everything in it for the clinical model. A template is small form that has selected bits of information from the archetype (elements) and because they are all defined within the archetype; they will be the same structure when displayed in template format therefore they immediately interoperate. One of the challenges is understanding the interface and this is perhaps off putting for busy clinicians who cannot commit to a few hours learning and navigating the system.

If we have an agreed clinical computable model for adverse reactions and medications then we get to a point where we can exchange this information easily. There are around 30 people who have already signed up; there is interest from clinicians, technical people and suppliers. We are hopeful that suppliers will see the value of having an interoperable model it should make their job easier. Mike Robson from INPShas already contributed to this piece of work.

5 Closing the loop – dose syntax paper

With regards to hospital to general practice transition – we have an issue with hospitals doing dose based prescribing and GPs doing product based prescribing. We are currently trying to solve dose syntax and this is being driven by a few people. It is complex and what we are going to try and do if we can get funding is to teach people how to use it, get key people involved and educated, andkeep progressing medication archetypes. Presenting practical templates which will be easier to understand from a clinical context has been suggested. PM is doing a presentation on Day 2 on Medication modelling.

The structure has been agreed and it is virtually identical to the GP2GP model. There is some terminology work outstanding and once this is complete it will be fit to use. The archetype is the same, and at the time (4 years ago) the suppliers operating in that market agreed to support the archetype on their systems.There are two parts of the archetype that are inadequately populated by terminologies at the moment. One is the list of ingredients which is incomplete in dm+d and the other is a shared view of what constitutes a drug group. All suppliers recognise drug groups, and these came from the BNF.As they came at different points and were maintained differently they are not the same so they do not interoperate. Suppliers agreed in principle to combine a list of ingredients and drug groups and this piece of work did not happen. A meeting will take place in early 2014 between interested parties in Scotland and England and relevant suppliers (EMIS, INPS, Vision and First Data Bank) toagree a work package to fill out terminology lists and have the list maintained somewhere else.

6 AOCB

The BoSS document is now available and PM asked the group to read over the document and email him with any comments.

Next meeting – Wednesday the 15th January 2014, Gyle Square, Edinburgh