Outcomes from Supplier Group meeting 18th March 2016

Objectives and outcome of the meeting

The objectives of the meeting were to:

1. Agree and recommend a set of principles to be followed when determining the approach to setting standards for interoperability between systems in the UK
2. Recommended specific approaches to some pressing issues that have been raised within the NHS interoperability community.
3. Agree how to progress

Representatives were present from Cerner, Intersystems, EMIS, Orion, IMS Maxims, Black Pear and Endeavour Health.

There was unanimous agreement on the following principles and specific recommendations:

Principles

1. Evolution

When introducing and evolving new standards, an evolutionary approach should be taken. Big bang "swap overs" should be avoided.

2. Visibility of data held in systems

For each category of entry within the systems, the content definitions should cover all of the relevant data held within the relevant systems. Limiting data element definitions to that required in a single use cases can result in the frequent need for revision. Also, early visibility enables innovation as it often becomes clear that data can be used for benefits that were not envisaged by the initial formal requirements.

3. Simple questions first

The projects should concentrate on answering straightforward questions first, whilst building in extendibility and scalability from the start. Do not over-engineer or overcomplicate as this leads to unnecessary delay and increases the risk of overall failure. (For example, a question of whether a system has a record for a patient (yes or no) is an example of a straightforward approach. Discovering the allergies, medications, conditions and observations relating to a patient is straightforward)

4. Leverage use of current fit for purpose standards

Avoid jumping to the next new shiny thing when there is a standard in use that meets the use cases.

5. Openness, sharing and collaboration

All proposals should be openly shared from inception through to delivery. Publication for comment should be contemporary to the work being done and should not wait for finalisation before publication. Collaboration environments should be established and should involve all stakeholders

6. Technical assurance and accreditation

Automation should be established as the basis for assurance. The public provision of evidence by system suppliers that their systems have adhered to a set of openly visible tests cases with independent testing tools should be the basis of accreditation.

7. Clinical Validation

Clinical validation should be undertaken by appropriately trained clinical informaticians and that strategic encouragement should be given to the establishment of informatics as main stream within the clinical community.

Scope of work

The group recommended and agreed to incorporate the 3 interdependent categories of work which are:

1. API definition, profile definition covering clinical and administrative use cases
2. Security and IG issues that relate to technical design and implementation
3. Macro-Technical architecture, such as the services that are needed to support local and national use cases and the different local configurations. For example this would include standards support for point to point interactions and hub and spoke interactions, as well as support for common record repositories and distributed records, the nature of which will be determined by local NHS organisations.

Specific proposals

1. Real time transactional granular data exchange

FHIR is recommended as the base standard for data content. England or potentially UK profiles can be derived from the DSTU(2) resources.

2. Clinical Document format (report and transfer of care)

CDA Level 3 should continue be supported and new templates should be added in rather than jump immediately to FHIR.

FHIR based structures should be developed as an alternative and strategic direction of travel, and made optional, but in doing so free to use bidirectional transforms should be made available so that systems can send or receive in either standard.

At least 1-2 years notice should be given before any standard in live use is superseded and effort should be made to enable backward and upward compatibility.

3. Record locator services

Record locator services should be extendable to hold additional metadata items covering the type of data present in the particular instance of the patient record.

Access to the Record locator service should be via a set of standard FHIR APIs in line with the IHE policy to support FHIR.

A National Record locator service would be ideal, but the most important thing is that whether local or national, the API definitions are the same.

4. Authentication, and authorization

It was recognised that the NHS local communication communities can take responsibility for assigning a trusted status to end systems and organisations based on the confidence that they conform to data sharing agreements.

In that context suppliers should support TLS-MA as the mechanism for server to server communication within a trusted environment.

The recommendation for federated authentication and authorisation was to incorporate support for Oauth 2 and openID Connect for client interaction with authorization servers.

Future engagement

It was recommended that all interested suppliers should be proactive in helping accelerate the creation and implementation of standards and not wait for central standards bodies to publish standards.

It was agreed that the suppliers at the meeting will be proactive in helping accelerate the implementation of those standards subject to commercial barriers being removed.

There should be closer and broader engagement between suppliers and NHS England on the design of the collaboration environments and the on-going standards setting processes.

Next meeting Friday 15th April