Minutes of C4H Interop supplier subgroup

15th April 2016

Present:	Paul Cooper (PC)	IMS Maxims, C4H interop community board member
	Amir Mehrkar (AM)	Orion, C4H interop community board member
	Dougal Fleming (DF)	Orion
	Yossi Cohen (YC)	Intersystems
	Jon Payne (JPE)	Intersystems
	Ben McAllister (BM)	Cerner
	David Hunt (DH)	Cerner
	Yossi Cohen (YC)	Intersystems
	John Parry (JP)	TPP
	Ian Townend (IT)	NHS England
	Richard Kavanagh(RK),	HSCIC, C4H interop community board member
	Jonny Rylands (JR)	Endeavour
	David Stables (DS)	Endeavour Health, Chair
Apologies	Shaun OHanlon, EMIS	
	Manuel Reyes, EMIS	

		Discussion	Action
1		**Introductions and group status**	
	1.1	JP Proposed formal minutes should be taken and this was agreed. DS would minute this meeting in the absence of administrative support.	DS
	1.2	AM restated that the group is inclusive of all suppliers. It was agreed that invitations will be sent under the Code4Health community banner via techUK to all techUK suppliers to join the group. All health and social care IT suppliers will be welcomed also	AM,PC,DS All
	1.3	AM and PC expressed concerns that any formalisation of this group would be unhelpful at this stage and that this group was evolving.	
	1.4	JP requested clarification on the relationship between this action group, Code 4 health community and GP-Connect, and other initiatives in order to avoid duplication, and that transparency is vital. All agreed that activities and documents relating to group meetings and activities would be open and transparent and made available. All agreed that this group is inclusive and not exclusive to suppliers.	All
	1.6	There was a discussion and agreement that this group is convened to provide leadership for, and carry out specific work, in relation to the establishment of technical interoperability standards All group members will put aside commercial interests and commercial considerations are not within the group remit.	All
	1.5	DS,IT, RK highlighted that this group is seen in a positive light by NHS England /HSCIC as it is accepted that a supplier driven interop agenda is essential and consistent with NHS Policy. Feedback to NHS England and HSCIC will be via IT and RK	IT/RK
2		**Review of Outcomes document of 18th March meeting**	
		All attendees from the last meeting agreed that the document summarised the principles established at the last meeting. DS proposed to maintain the document updated as a working document alongside the minutes	DS
3		**Web site and new resource**	

	3.1	BM pointed out C4H interop community appeared opaque to suppliers and all concurred and that the current Web site was not fit for purpose. IT updated the group on progress towards a new resource DS suggested that if there were any obstacles to using the NHS domain then a new domain could be established on Azure or Amazon. IT indicated that NHS England can provide administrative support for this and DS offered Endeavour resource also. JP highlighted the need to make sure this resource could be trusted as single version of the truth. AM suggested that there can never be a single version but the site must be updated with all relevant information. DS suggested that suppliers needed to have confidence that this is main stream. Agreed to take this forward as a matter of urgency	IT, DS, RK
4		**Report on C4H board meeting**	
	4.1	AM PC and RK reported on inaugural C4H board meeting	
	4.2	IT reported on the likely routes by which the NIB channelled funding may be made available and how the activities of C4H fed into this process PC and others expressed the view that it was essential to link funding to a standardised approach to interoperability as previous funding mechanisms have led to isolated and non-replicable outcomes	
5		**Clinical validation and standards authority**	
	5.1	AM and DS reported that approaches had been made to PRSB to ask if they wish to become the authoritative body for the final validation of the standards that this group is helping to establish. This would require the early incorporation of clinical validation by independent clinical informaticians. AM and DS reported that PRSB at their recent board meeting have expressed willingness to take on this role subject to negotiation and appropriate funding. Further engagement between this group, the PRSB and NHS England will be undertaken to establish the feasibility of clinical validation as part of the core process.	AM, IT,DS
6		**General commitments and further principles**	
	6.1	All suppliers agreed to contribute technical and clinical resource to the work streams that are decided by the group	All
	6.2	All suppliers agreed that the suppliers are best placed to drive forward the technical agenda and that this group will not be dependent on any NHS outputs in order to progress. All suppliers agreed that the clinical validation and professional authorisation is important, timescales will not be dependent on these activities	All
7		**Specific activities**	
	7.1	There was a consensus that the establishment of FHIR profiles and real time FHIR APIs will be the primary initial focus of the group work	All
	7.2	RK reported on the current GP-Connect project	
	7.3	There was a consensus that isolating interoperability work within GP domain is unhelpful and counterproductive and that cross domain engagement between suppliers is vital. The main domains identified were GP, community nursing, acute and mental health (acute and community) BM Commented that it should be possible to establish a set of domain independent FHIR profiles. JR described the inheritance approach recommended by FHIR which can support a generic profile with specialised profiles for particular areas. There was interest expressed that the group should seek to establish pan domain profiles and where necessary specialised profiles.	
	7.4	JP highlighted the fact that TPP were actively engaged with HSCIC in the GP connect program and thus as well as being counterproductive to have two work streams, this would result in duplication of effort. There was a group discussion and the consensus was that a proposal will be made to NHS England/HSCIC to a) Extend GP-Connect to include both sender and receiver suppliers (Senders= GP,	RK, IT

		receives = others) and b) Include bidirectional exchanges(Sender – acute, receiver= GP) RK agreed to take this forward and IT agreed.	
	7.5	AM proposed that it was vital to show data actually flowing across these domains and that the scope of the data, whilst important, would come next. There was a debate as to whether to start with Medications, or Problems, or both and a further debate as to whether broader elements of the record should be included. It was agreed that the approach would be to start simple but not necessarily limit the scope. It was agreed to invite suppliers from all domains to join the group on the basis of commitment to contribute. The invitation will be issued via techUK to techUK members but not limited to techUK members.	PC,AM,DS
	7.6	AM proposed that the target for a demonstration of a multi-directional, multi-domain, real time care record data flows could be EHI November. Prior to that, a connectathon should be run in September to help prove the flows. Work will need to start now. All agreed	All
	7.7	There was a debate on data format for a particular API Get Record call JP proposed that HTML readable format and FHIR structured format should be included in the same response YC questioned the need for HTML at all if the structured data was present JP suggested that the HTML could be used to represent information that was not yet profiled DF raised a safety issue in that if data was present in HTML that was not present in the computable structure that could result in poor decision making PC suggested that XSLT could be used to generate HTML from the FHIR resource and thus no AM indicated that this was precisely the reason that clinical validation is necessary DS suggested that 3 methods might be supported (HTML only, FHIR structured profiles only, or mixed). HTML is needed at all. There was no consensus on these points. DS indicated that this debate needs to be had and concluded but should be had in the context of the work-streams themselves.	
	7.8	DS proposed that the FHIR Profile and API work could be use case driven AM proposed that initially it should be data model driven i.e. prove that the data present can be sent and received. The consensus was that a data model based approach should be undertaken in the first instance and that the use cases will inform but not constrain.	
8		**Architecture (infrastructure)**	
	8.1	IT Reported on the planned spine service proxy. A debate ensured as to the benefits or disbenefits of the approach. DF indicated that progress can be made quickly with point to point TLS/MA. JP expressed concerns that this could be another bottleneck preventing rapid progress. DS suggested that it was not an either/ or discussion and that both approaches are valid. There was a mix of opinions and no consensus on the value of this. There was a general consensus that with a federated architecture design, it is unnecessary to rely on a single national instance and that multiple standards based instances can be supported allowing localities to progress at different paces. Services can be offered under commercial or non-commercial terms.	

9		**Clinical modelling**	
		AM reported on his assessment of openEHR DS reported on a proposal to bridge FHIR with openEHR archetypes BM proposed that other initiatives be considered such as CIMI RK highlighted that the main benefit to clinicians was the modelling tool rather than openEHR. DS and AM proposed that clinical modelling tools should be developed that would directly enable FHIR as the transport mechanism between systems. There was unanimity that the suppliers in the room were unlikely to adopt openEHR. There was a view expressed that clinical modelling tools should be explored but that progress can be made without waiting for this DS and AM will explore further and RK will make introductions to some leading experts	DS,AM,RK
10		**Next meeting**	
		Next meeting set for 26th May at IMS offices Milton Keynes	PC