**KENT AND MEDWAY SHARED HEALTH AND CARE ANALYTICS BOARD (SHCAB)**

**15th March 2021, 11am-1pm**

**Actions**

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| **Action Date** | **Who** | **Action** | **Progress** |
| **16-11-20** | **Marc Farr** | Invite Nick Plummer and Nigel Lowther to business planning deep dive. | **Paused because of delay to business planning cycle** |
| **16-11-20** | **Simon Bailey** | Come up with a regional approach to recording standards and data quality. |  |
| **16-11-20** | **Valerie Elderkin** | Work out a Maternity Funding Model. | **Completed** |
| **08-01-21** | **Morfydd Williams** | Raise the issue of linking in care home data to the Kernel and what IG will need to be in place for that. | Ongoing |
| **13-01-21** | **Peter Gough** | Confirm that the EMPI as proposed by Graphnet is suitable for our plans at Kernel - for SHCAB. | **Completed** |
| **18-01-21** | **Marc Farr/Emily Lloyd** | Confirm funding agreement from each SHCAB member. | Hold until Morfydd presentation |
| **18-01-21** | **Marc Farr** | Change the TOR to include both Maternity (Digital Maternity Steering group) and IG working group.  | **Completed** |
| **18-01-21** | **Abraham George** | Pick up the linked Police data project and apply to NIHR. | Action |
| **18-01-21** | **Morfydd Williams** | Arrange meeting with JJ to go through investment strategy for Kernel. | Completed |
| **18-01-21** | **Marc Farr** | Develop a deck for MW to take to CEOs on the business case for Kernel. | Completed |
| **18-01-21** | **Helen O’Neill** | Helen to liaise with Marcus Green to explain our IG approach. | Completed |
| **18-01-21** | **Abraham George** | Invite Marcus Green to weekly IG meetings. | Completed |
| **18-01-21** | **Marc Farr** | To contact Sam Page, Morfydd's PA to join nest LMC meeting re SHCAB. | Completed |
| **18-01-21** | **Marc Farr/Morfydd Williams/Rachel Jones**  | Have a call to discuss Kernel business case. | Action |
| **15-03-21** | **Marc Farr/James Jarvis** | Open up a clinical coding working group, to try and align more closely clinical coding across our organisations. | Action |
| **15-03-21** | **Marc Farr** | Add the coding working group to the TOR | Action |
| **15-03-21** | **Marc Farr** | Send out official KID governance letter | Action |
| **15-03-21** | **Marc Farr** | Project creating an AI tool for the early detection of lung cancer, study will go ahead subject to the SHCAB. Ask SHCAB if happy for this to go ahead. | Completed |
| **15-03-21** | **Marc Farr/Chris Farmer** | Talk about how to get access to the GP data for care home research. | Action |
| **15-03-21** | **Marc Farr/James Jarvis** | Improve collaborative clinical coding using KFRS and accidental fire admissions as an initial starting point. | Action |

**Minutes**

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| **Minute no** | **Notes** | **Action Owner** |
| **1** | **11.00 – Chair Opening Remarks** **MF -** * Have had some funding available (from HSMI). We’re going to employ a CSU to do some consultancy, rearticulating what we’re doing with the kernel, how the KMCR links to the kernel etc. Need to get the data linked and all the IG in place.
* Going to form some groups in response to the digital white paper to think about how we’re going to respond locally. Would we organise our data differently? It may affect how we are organised.
* Data is starting to flow out of trusts into the KMCR, once we have all the IG in place, we will have more data to be used for planning, research etc. We’re currently doing a regional piece of work on Covid, if other trusts want to provide data or use the results for studies, let us know. Currently published data for the whole period, in the next week or so we’re hoping to get some published data weekly between March-February. To see the difference in trusts in admissions, mortality, ward stays etc.
* CCG projects – talking about the level of data linkage. Bronze – primary care data, silver will be data from the council, gold will be data outside of the NHS eg. policing data. This will enable to use for planning and research.
* Outcome based health care – needs a linked data set to serve it.
* 16 million project won with Kings College health partners, starts with medical imaging, but it will go onto use AI to analyse pathways eg. can we predict patients stay?
* Graduate management trainee scheme is now open, you can take analysts through this program. You may or may not want to apply.
* JJ and MF have been talking about clinical coding, they want to align what’s happening in terms of coding eg. the coding around Covid. We have to make sure we’re recording in the same way. MF and JJ to open up a clinical coding working group, to try and align more closely clinical coding across our organisations.
 | **MF** |
| **2** | **11.15 – Research** **AG -** * There was a research study around Public Health research system. Lindsay and colleagues have joined the department in Public health temporarily to see how to promote research culture.
* Kent was successful in a NIHR application to unlock data – there are now opportunities into linking data in terms of health.
* In terms of data access requests – KID governance has changed. Want to extend the governance for the KID for another year.
* One project is with the Health economics unit about developing an algorithm to detect heart failure.
* Another project creating an AI tool for the early detection of lung cancer. There has been overwhelming support around it, so the study will go ahead subject to the SHCAB.
* Haven’t had any formal request forms filled yet.
* Going forward there was a bid to the health foundation around developing an innovation hub, it was unfortunately unsuccessful. We can recycle the bid for future applications of similar interest.
* Funding application around AI. Funding closing date next month.
* IG Group will become the formal IG group which will manage and process data access requests for the KID and Kernel. Policy for operating procedure almost completed.
* Had a meeting with LMC, which was agreed we need more GP champions on our SHCAB group.
* Patient master index, almost there with an application. It is a short-term solution; a future solution will be linking data between NHS and non-NHS data. It will take a long time to approve.
* Senior analysts and officers are collaborating to do modelling and surveillance work for covid. It has been successful and has helped in decision making. Have used the modelling to help with additional body storage capacity. There are about 19 other models being developed in the South East.
* Doing some ethnicity analysis, need to be monitoring vaccination uptake by ethnicity.
* We have been sharing testing data across trusts.
* Currently working on the roll out of the level 7 systems apprenticeship standard and is now ready for roll out.

**CF –** * In terms of the university we have prepared the DSP toolkit, it needs to be updated annually and we’re going to submit it the end of 2021/22.
* The database access committee have probably secured some funding to support a 50% FTE admin, currently looking to hire.
* In terms of DSP we were told it wouldn’t have a delay, as the sandpits are available around the 7th April.
* Have submitted an access request for the KID, its around baselining comorbidity at LSOA, need to link it to aggregated data. Quite a broad request around episode data in primary care and in particular prescribing. Wanted to look at the impact of pulse oximetry across Kent and Medway in relation to health inequalities. It’s an explorative project happy to currently do without specific funding.
* Strength in Places Bid – Began October 2019. About to hear whether we get an interview at the end of March. It delivers quite a lot of funding for data – biomed, computing and AI.

**MF –** * We currently have a digital care home project funded by NHSX. One of the aims in getting to ‘gold’ is to link in care home data. We are gathering the data in terms of practices and remote monitoring. We’d like to look at the geography data may get it from acute, care homes and we may get the data through the GPs.

**GA –** * Multi-morbidity and prescribing, we have already started a piece of work trying to get a standardised prescribing measure which gives us more insight than the current measures. We wanted to look at the epidemiology of multiple morbidity and the polypharmacy aspects associated with that. Especially in regards to care events, and possibly causes of premature death etc. Haven’t made as much progress as we would like to due to Covid. Already made a presentation to the local GPs who are sponsoring. Is there a possibility to work collaboratively?

**CF –** * We would be interested to collaborate.
* Hopefully what we’re doing will serve to help.
 | **CF/AG** |
| **3** | **11.35 – Kernel****JJ –** * Still have a group every other Thursday.
* PMI is a key building block.
* Preference for DID is to use the Nottingham uni tool until a national solution is developed.
* IG group have been developing the DPIA.
* Data warehouses are continuing to be built based on the original plan.
* Trying to use existing data in the warehouse for ease of use ahead of the timeline for the new version.
* We’ve tried to recast the phasing spreadsheet. Action – Marc to work through with all of the stakeholders on the phasing spreadsheet to confirm when they can make available capacity within their teams to do the testing work required to sign off the datasets
* Have been working with IC24 with their dataset and should hopefully be finished by the end of the month.
* HSLI funds – we have got 258k dedicated directly to this and the CCG have given us some more. We have extended some of the contracting resource, we have some priority over the maternity data set, commissioned beautiful information, allocate some money to the CCG around IG framework, commissioning the CSUs around the design, and the support for next year on call when we need it, put some money into the website, some spend for the data warehouse team etc.
* Almost spends all the money. Got quotes for a lot of them.

**MF –** * Is it still possible to get some funding for data quality work?

**JJ –** * It is still possible, can pay the money over to SB.

**SB –** * Giving that more thought this week. Deciding who’s best to come together to help.
 | **JJ** |
| **4** | **11.50 – Information Governance** **MF –** * Strategy is to build a linked dataset in the region. There are two projects in play that need this.
* Thinking about where the data can get linked eg. moving the care home data from the PMCR to the kernel etc.

**AG –** * Key Issues are the common law of the duty of confidence, nationally we have a law around this, you have to get explicit consent for confidential data. NHS digital are able to link data for secondary use without having to get consent. Our warehouse has to get permission to link secondary data. It’s going to take some time to develop an application to do this. The short-term solution around the population health management program, Optum will undertake some analysis and pass it to local GPs to start to deliver the integrated care. We need to use NHS digital, it will all be synonymised data. All of this will flow into the Kent and Medway data warehouse, then optum will identify a list of high-risk patients. GPs will then receive this data.
* Redrafted a PMI application, if we get agreement we can submit the application quickly, they can process this quickly if our application is robust. Another option, the KMCR already has a PMI for primary care, have asked if we can use it for secondary uses.

**MF –** * Kent and Medway Data Warehouse is the Kernel.
* Is this specifically for this population health RJ is leading on?

**AG –** * Yes.
 | **HON** |
| **5** | **12.10 – Risk Stratification Work KFRS****RS –** * Currently doing a lot at looking at secondary research and the causes of fire and what puts people at risk, it’s not a well-researched field like the health sector.
* We recognise this is going to take a number of years because we still have to obtain the data.
* Looking at the relationship between health and fire risk.
* Eg. the quality of housing/deprivation
* The research we have done to inform this analysis was looking at secondary research to see the characteristics of people at risk of fire using old KID data.
* The research showed in an accidental fire (not arson) – for fatalities data is clearer because it is a coroner inquest. The non-fatal accidental injuries there is less data.

**NC –** * We have ended up with three cohorts – two looked at fatalities, the other at non-fatal.
* The first was looking at the fatalities of elderly and children under the age of 11. These were two very distinct groups across Kent. Another was around non-fatal such as males living alone (40-64).
* We were able to use the Kent integrated dataset to look at the distinct three populations.
* Some of the risk segmentation we undertook was around healthcare conditions, combining various long-term conditions eg. comorbidity and mental health. We also drew in the deprivation data, to see if it supported the assumption between deprivation and health and certain types of behaviours. There were some challenges in relation to identifying fatalities in households for children under 11. We were able to extract households with multiple children under the age of 18 which has been identified as a single parent household. We got less information out of this cohort.
* Using the KID data, we were able to look at the geographies at the LSOA level, we have access to the KFRS model. Initially we looked at the LSOA and the local authority level to see if we could establish to see if the populations are clustered in Kent.
* What was interesting was looking at the clusters around coasts, which gave us an indication of where we would expect accidental fires to occur where the populations are clustered together.

**JS –** * There was a strong correlation between males living alone and having accidental fires.

**NC –** * Deprivation played a key role.
* Levels of severe mental health and dementia were quite low – they may already be in a home. We’re talking about early stages where the diagnosis is yet to be made.

**AG –** * Did you quantify the extent of accidental fires on the impact on acute trusts in terms of how much hospital activity is generated as a result?

**NC –** * No, the focus was on safe and well visits and KFRS deployment.

**GA –** * Did a study previously and were unable to find a safe and well visit impact on the reduction of fire related incidents in terms of admissions. There were limitations with data quality. When we have a richer data repository, the capabilities will be greatly enhanced.

**AG –** * It’s indirectly linked to the clinical coding suggestion. Might be an opportunity to improve collaborative clinical coding.
 | **GA/NC/RS** |
| **6** | **12.30 – Unlocking data to inform public health policy and practice BSMS****MR –*** ARC is a 9 million
* Arc is all funded, and the idea is to develop regional partnerships between healthcare organisations.
* Got funding around public health, data scientists etc.

**LF –** * Background on medical text – different types of methodologies and results. A lot of clinical information is only found in text eg. Mental health records unstructured form, pathology reports, letters between clinicians etc.
* NLP analysts would love to turn unstructured data into structured data for statistical analysis at scale. They generally can’t get access to text because its stripped out before analysis. It’s unclear whether the public would be willing to give access to this text.
* Involving the public is important due to privacy.
* Reviewed everything we could find about electronic public health records, we found that between 70-80% were willing to share their anonymised data. They were worried about hacking, identity theft, judgement and work etc. Much lower trust in commercial organisations.
* Decided to commission a Brighton’s Citizens Jury. Felt that this was a complex issue so we needed time to inform the public and get an informed public opinion from them.
* We had presentations on what patient records are, how free text can be identified and the law. All of the panel were supportive. Slightly more cautious with text data than coding data.
* Gave us recommendations about safeguarding the data, and the option to opt-out should be clear.
* The public wanted to know what benefit is going to come from the research around using free text – some of the benefits are improving quality of care, observational research, drug prescribing safety etc.
* Have reviewed UK Governance models and looked at how the public were included.
* Wanted to bring questionsto give an initial view around public views of the Kernel.
* The publics opinion on the Kernel, advantages/disadvantages for them, type of projects prioritised, any concerns that could be mitigated, how best to communicate for inclusivity and transparency etc.
 | **LF/MR** |