

# Just some of our standards

- Terminologies
  - Read
  - CTV3
  - SNOMED CT
  - DM+D
  - Cross maps
- Classifications
  - OPCS
  - ICD10
  - Cross maps
- Data Dictionary
- User Interface
- Messaging
  - HL7 V3 for Spine
  - HL7 V2 for local integration
  - CDA + Templates
  - Commissioning Data Sets
  - Other data sets
- Content Modelling
  - Clinical Archetypes (CEN13606)
  - Content models for suppliers
- Logical Record Architecture

# NHS Connecting for Health deployment statistics (for w/c 3 March 2010)

- More than 21 million electronic bookings (21,890,744) have been made to date.
- During the week 3,527,916 prescription messages were transmitted using the Electronic Prescription Service (EPS)
- Over 300 million (306,774,292) prescription messages have now been transmitted electronically.
- 7,094 (85%) GP Practices and 9,392 (87%) Pharmacies have gone live with EPS Release 1 systems.
- There are 127 Picture Archiving and Communications System (PACS) from NHS Connecting for Health now live across England.
- GP2GP has now been used for 1,022,140 medical record transfers
- 1,243,911 Summary Care Records have now been created on the Spine.

# National Integration – The Spine

- Demographics service
- Summary Care Record
- Choose and Book
- Electronic Prescriptions
- GP2GP records transfer service

# National Integration Standards

- HL7 V3
- SNOMED CT
- CDA
- HL7 V3 templates
- Terminology Cross Maps

# Local Integration - ITK

# Local Integration Standards

- HL7 V2
- IHE Profiles
- CDA
- SNOMED CT / Read
- Terminology Cross Maps

# Secondary Use Standards

- OPCS
- ICD10
- Terminology to Classification Cross Maps
- Datasets
- Data Dictionary

# Barriers to Interoperability

- Multiple, overlapping and inconsistent terminologies
- Multiple, inconsistent information models that cannot easily map
- Information models that overlap and conflict with terminologies
- Inconsistent definitions of content

# The solution

- A single reference terminology
- A single reference information model
- A set of defined data entries expressed in the reference terminology and reference information
- A set of defined record entries made up from the data entries
- Rules and guidance on how to produce the reference data entries

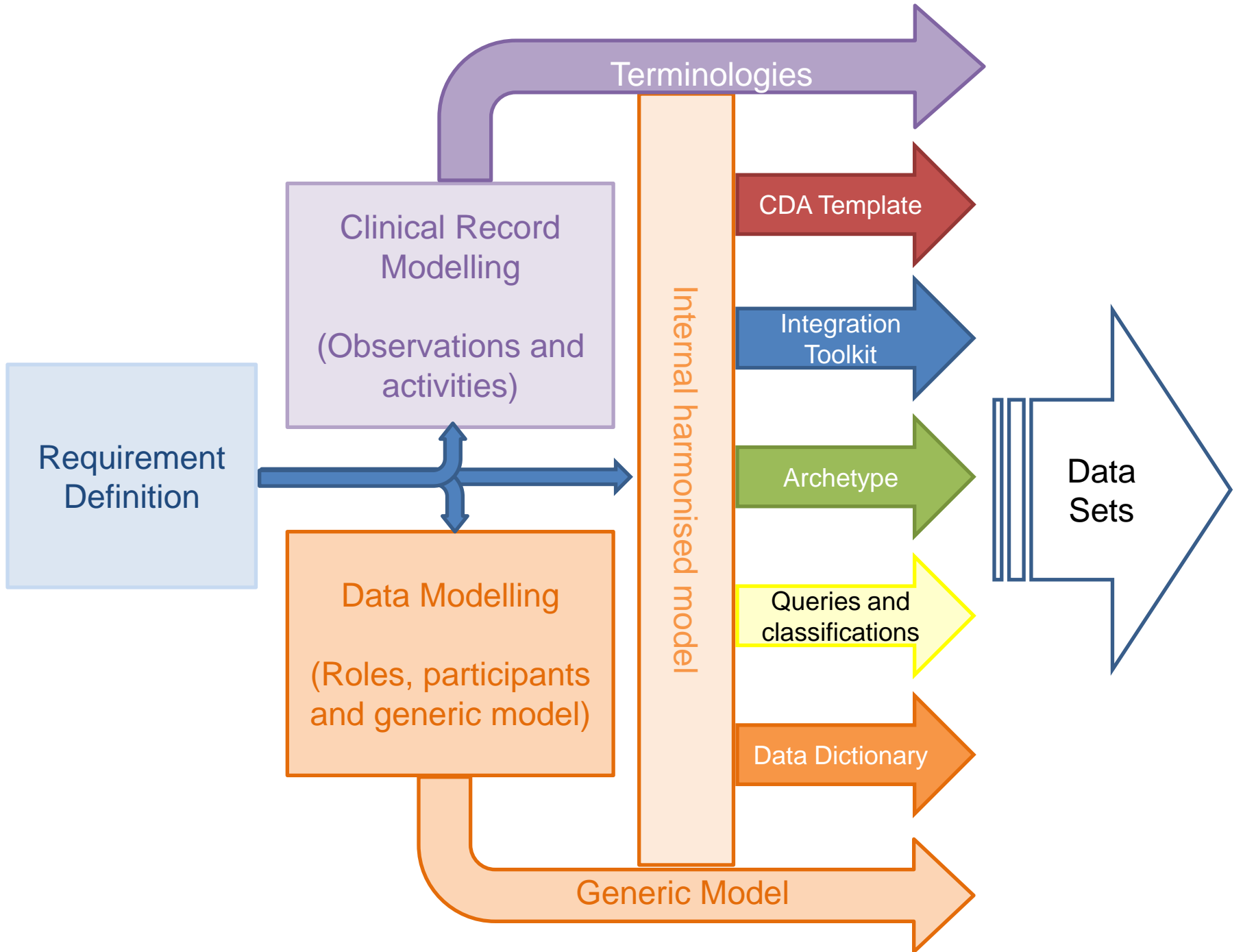
# Content is King



A standard structure is important, but ...

You need standard content to make it worthwhile





# The Challenges

- Which terminologies?
- Which information model?
- How do we derive classifications from the health record?
- Who defines the content?
- How do we govern this?

