Report of roundtable and member survey:
Re-imagining health and care services following COVID19

Revision History

Version	Date	Description
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0.2	11.08.20	LT completed first draft
0.3	13.08.20	JH added material from survey summary report and responded to LT queries
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Executive Summary

The Faculty of Clinical Informatics (FCI) undertook this study, to engage its membership in identifying responses to the COVID19 pandemic and making recommendations for action at both a local and a national level. This report is intended to inform policy makers and professional bodies to provide input to consideration of future plans for re-imagination of health and social care services in light of the pandemic.

The study was undertaken through an online survey of members seeking views of the impact of COVID19 and suggestions for addressing the issues and continuing service improvements that had started during the pandemic. This was followed by a roundtable of multi-disciplinary health and social care informaticians from the Faculty.

Our thanks to all those Faculty members who participated and to Cerner for their support for this project.

While many of the recommendations and views expressed in this report are not new, the COVID19 pandemic has placed a spotlight on the successes, the gaps, and the ways in which information communication technologies can strengthen the response.

This report sets out recommendations for action at a local and national level that emerged from the survey and the high-level principles discussed at the roundtable. The recommendations are as follows:

1. **Use informatics to increase capacity**.
   - Some technology trends have accelerated within health and care through the pandemic and should be rolled out widely and developed further to increase capacity. Examples are outlined in the report.

2. **Rationalise the infrastructure and promote interoperability**.
   - Electronic care records should be made available across regions to all health and care professionals as a matter of urgency.
   - Existing regionally federated approaches, such as those in North West and North East England, should be made available as a minimum.
   - Shortfalls, particularly in the social care basic infrastructure, need to be addressed by national investment to enable the access needed to support individuals effectively.

3. **Shift from 'nowcasting' to forecasting**. Efforts to date have focused on observing and reporting the pandemic as it unfolds (now-casting) rather than forecasting.
   - Develop an approach to forecasting what services are likely to be disrupted by the pandemic, for resource allocation.
   - Use of electronic care records by Sustainability and Transformation Partnerships (STPs) to enable dynamic evaluation in real time of care pathways, outcomes, adverse events, and processes at the system- and person-level.

4. **Patient and public engagement in all approaches**
   - The patient and public perspective should be involved from the start in all developments.
   - Make COVID19 data available more widely to the public at locality level. Engage the public and Local authorities in the design of case tracking and surveillance.
   - Giving the public better access to read and contribute to their own records should be a priority for system developers and policy makers.
   - Approaches to ensure digital inclusion must be part of every digital development.

5. **Share best practices in an accessible and referenced way**. The opportunities are fewer for cross-pollination of ideas during the pandemic and there are scattered outputs with varying accessibility to the lessons learned. To address this:
   - Local projects and initiatives should establish a regular practice to include access to audio / video of webinars, transcripts, etc. and a searchable registration of ongoing projects, similar to clinical trials registration.
   - At a national level, an innovation forum should be created to provide a searchable register of projects, to discuss and resolve problems, unblock barriers, and share local and national feedback, including from patients, carers and service users.

- A taxonomy of key terms should be developed to support the creation of a set of usable, referenced resources.

6. **Upskill and motivate the health and social care workforce in clinical informatics.**
   - More time should be dedicated to staff training in clinical informatics across all organisations, making use of FCI's recently published Core Competency Framework.
   - This should take a two-pronged approach for practicing health and social care professionals, and within their training curricula as a means to foreground issues of safety and quality care coupled with the capabilities to develop, critique and apply technology in practice.

The FCI aims to advance the health of the public through concerted efforts to promote inclusion in clinical informatics core training, provision of guidance on health and care information systems development, education and training and development of informatics professional standards. During COVID19, this has seen the FCI working towards:
- Improving trust in digital ways of working and information sharing.
- Members training and mentoring staff.
- Sharing innovations via virtual networks and a webinar programme.
- Evaluation of the safety of new digital ways of working.
- Developing digital skills in workforce including specialist skills.
- Helping to identify examples of best practice.

The FCI will help to develop and disseminate best practice via ongoing webinars and commissioned work. This includes collating and sharing projects that members have been working on in response to COVID19. This could provide the basis for a national innovation forum for digital responses to COVID19.

We recognise that the analysis is quite high level and that further research is needed to develop more detail, for example, in the following areas:
- Evaluation of approaches to local shared health care records.
- Rapid knowledge sharing approaches
- Standards to enable electronic information flows related to point of care testing.

Background to the study

Countries around the world have been busy responding to the COVID19 pandemic and the health IT sector has been busy supporting health and social care organisations in meeting the challenges safely and effectively through rapid deployment of new technologies and timely provision of information.

At the start of this project, in May 2020, the number of cases of COVID19 in the UK was starting to plateau and there was a need to rapidly plan for recovery. Recovery includes recovery of systems, recovery of patients and citizens, of health and care staff and of displaced care processes. There are many aspects to recovery including the obvious catchup of supressed clinic and outpatient appointments, elective procedures and so on, but also, the need to establish vulnerable and at-risk populations that had not had access to health and care facilities in the response phase. This included key cohorts like cancer patients that had not been diagnosed or had been diagnosed but could not

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3

access treatment, people that could have had heart attacks and strokes but were not yet well managed, people with mental health concerns that may have been destabilised, and so on. There was a need for community reach out and prioritisation of activity to the unknown need as well as the known need.

Moving on from the recovery phase, as we continued into July 2020, there was a rapid movement towards a time to "re-imagine" how to manage potential future waves and future pandemics. There is a need to retain and extend successful new ways of working and be better prepared with supporting health IT, more ready to cope.

This is a huge opportunity to change the models and ways of working in health and care; there is no need to default back to more traditional ways when we are learning how much care can be provided for in different settings by different staff or with video media and other technologies, for example. The "re-imagine" phase of COVID19 is an opportunity to innovate and re-model future care provision models.

The FCI COVID19 informatics survey and roundtable discussion, in partnership with Cerner, explored the current informatics landscape in light of the unfolding global pandemic. The goal was to capture emerging initiatives in health and care practice with a view to highlight emerging trends, best practices and gaps in knowledge as a precursor to re-imagining a way forward to better health and care in the UK.

Methods

1. A survey was developed and distributed to members of the UK FCI. The survey's aims were as follows:
   - To support the recovery effort from the COVID19 pandemic by collating and sharing members ideas.
   - To identify top priorities for recovery by describing the biggest challenges and how they could best be tackled, drawing on the use of informatics and experience gained during the pandemic.
2. Results from the survey were collated and summarised in a report.
3. Analysis of the survey results informed planning of a roundtable event to re-imagine health services following the pandemic.
4. FCI members who represented a diverse spread of professions and experiences were identified and invited to attend.
5. The discussions in the roundtable have been analysed to identify themes which are presented and discussed in this report.
6. Results of the roundtable analysis have been used to provide recommendations for next steps and what the role of the Faculty could be in these.

Recommendations

The six recommendations below were developed following the results of the COVID19 recovery survey and subsequent discussions in the COVID19 re-imagine roundtable. Where relevant, recommendations are followed by further details drawn from the survey and roundtable.

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4

Recommendation 1:

Use informatics to increase capacity.

The health and care future state will involve people working in distributed locations, bridging across traditional hierarchies. The following solutions highlight a selection of technology trends that have accelerated within health and care which can be further adapted to best-effect in re-imagining health and care:

i) Testing and results management

- Reviewing imaging requests, reviewing clinical information on the EHR, followed up by telephone or video consultations with patients to ensure that imaging is really necessary.
- Point-of-care testing (POCT), linked to lab and other systems. POCT data are often not linked to NHS systems, so data are lost. Agreeing standards for POCT devices to export data to the Laboratory Information Management Systems (LIMS) would address this issue.

ii) Consultations

- Retain remote consultations in primary and secondary care, where appropriate, but also recognize some need to be face-to-face.
- Retain and develop use of telehealth monitoring. This needs integration into the health and care protocols so that it works effectively. People and professionals need training in the new processes supported by telehealth and integration with electronic health record systems is needed.
- Triage patients to determine priority and the most appropriate consultation method (needs access to joined up information to do so).
- Identify what is lost in negotiating an environment where close proximity increases the risk of COVID19 transmission. Consider where proximity for reassurance and providing care is a beneficial aspect of care provision and trust.

iii) Consent

- Arrange for consent to treatment to be obtained remotely prior to coming into hospital and where possible for remote pre-operative questionnaires and assessments. Digital remote consent is being trialled successfully in a number of sites, allowing surgical and oncology treatments to resume at an increased capacity.

iv) Integrated care

- Improved transfer of care supported by secure messaging and use of shared portals to share information and monitor progress. Use of NHSmail by care homes was mentioned as an enabler.
- Multi-disciplinary rehabilitation teams crossing organisational boundaries and sectors of care, supported by integrated electronic health records.

v) Data access and authorization

- Patient-facing user interface that allows patients to both read and write access to their medical records.
- Auto-identification has revolutionized laboratory requesting, reporting, and medicines management. Its use can be extended to other areas.

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5

Recommendation 2:

Rationalize the infrastructure, promote interoperability.

Whilst the pandemic has led to progress towards putting in place the infrastructure needed, there are still shortfalls, particularly in the social care basic infrastructure. These gaps contribute to poor access to health and social care records needed to support individuals effectively. National investment is needed to address this disparity.

The pandemic has highlighted the urgency of the availability of electronic care records across regions to all health and care professionals, whether working face to face or virtually. Regionally federated systems such as those in use in the North West and North East of England are a minimum requirement as soon as possible. The key to progress is to emulate, rather than reinventing.

Regions should be working toward a platform approach to combine operational, health and social care records, financial data, and analytics. The technology does not need to be the most advanced, it needs to be accessible via a straightforward and uncluttered interface to all users within a bounded system. This minimizes the connections and integrations required for cross-organization collaboration.

The streamlined connections render data and information flows more visible and simplify information governance and data-sharing, which are still necessary. They more closely align practice and care agreements at the level of provider to provider (i.e. primary, secondary, community and social care) and may improve the transparency, accountability, and care communications.

The example of sub-optimal information flows between health and social care IT systems surfaces repeatedly. Clear definitions of the information flows and associated technical documentation to enable interoperability between systems is key and a whole systems approach is needed to achieve this, including information governance, terminology, information and technical standards and process change. This needs leadership at both a national and local level, supported by requirements in IT systems contracts.

Information flows

There is nothing novel about the data flows, but there is something novel about the people and organisations who have been placed within the flows. Within this, a desire was expressed for simple and uncomplicated information flows to support prioritization and decision-making.

The issue of long turnaround times following COVID19 testing was discussed. Clear, published documents that describe what information should flow where would have been beneficial and insights could have been provided from those with experience in testing protocols, such as in Pathology, Laboratory Medicine, Epidemiology and Public Health.

The example of the digital city, Leeds, and the "Left Shift' approach, toward prevention and early intervention, was cited as an example of leading from the top, bottom and across all strata. During the pandemic, Leeds worked with the NHS and City Council to help the Third Sector deliver essential

services[1]. Caution about the dual-pronged unknowns regarding recovery and rehabilitation following COVID19 highlighted the need to effectively partner with rehabilitation and social care partners including care homes. Valuable progress in aligning financial, operational, care outcomes, and trust in health and care may also be gained by deliberate attention to working data collaborations[2] within STPs as has been seen with city-level data[3].

> *"why does everything have to go through the GP? Why does a dentist have to see the GP summary care record rather than go direct to the patient? Empower patients with their own data – this is the opportunity for reports to go direct to patients really efficiently. And reports need to get to GPs too."*

> *"If we work together, we could use the data that we're getting from other services that would probably contribute to better prevention, more home care and delivering services, not in the way that we're so used to doing. At the moment, we are very reactive – dealing with the problem when it happens – we don't prevent it from happening."*

Joined up information across professional disciplines could also improve decision making about patients with complex needs, vulnerable patients, who should be shielding, who needs to be seen in person, by phone or by video. To achieve joined up working there is a need for social care parity: funding, a digitally skilled workforce, digital community of practice, digital specialists and investment in digital records which can operate in an integrated way with health records.

> *"we have to address illness and inequality from a systemic perspective, rather than just an NHS-centric perspective"*

Recommendation 3:

Shift from 'now-casting' to forecasting.

Efforts to date have focused on observing and reporting the pandemic as it unfolds (now-casting). Developing an approach to forecasting what is likely to be disrupted could prove to be advantageous for resource allocation. We should identify the sources of disruption[4], directly relevant to healthcare, whether direct or indirect. (COVID19 acute morbidity and mortality excess deaths, delayed cancer care, delayed care for other non-COVID19 related conditions, post-COVID19 rehabilitation, pros and cons of remote consultations clearly described.)

Subsequent waves of the pandemic will impact on health and care workers, support staff, and the public with predictable outcomes. Each Sustainability and Transformation Partnership (STP) needs to collect relevant local knowledge to identify key problem areas of unmet needs in order to improve population health outcomes.

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[1] https://www.digitalhealth.net/2020/07/leeds-city-digital-team-helps-third-sector-go-digital-during-pandemic/
[2] https://link.springer.com/referenceworkentry/10.1007%2F978-3-030-13895-0_92-1, as viewed 31 August 2020
[3] https://datasmart.ash.harvard.edu/news/article/case-government-investment-analytics, as viewed 31 August 2020
[4] https://sloanreview.mit.edu/article/the-11-sources-of-disruption-every-company-must-monitor/, as viewed 22 August 2020

Dynamic evaluation of care pathways, outcomes, adverse events, and processes at the system- and person-level is a key feature of applying digital technology to care. This has previously been done in a retrospective fashion via service evaluation and audit. With the opportunity to appreciate what is happening, can developing trends be made visible in real time, studied, and lead to timely direct interventions being made? This is the kind of capability being applied in tracking the virus, and can be extended to other areas of care. These ideas are meant to supplement rather than replace traditional research timelines

Work from Prof Amy Webb at Future Today Institute provides some short exercises to help disentangle the complexity and provide some clarity around describing assumptions, building evidence, and using knowledge to make a plan and pivot[5].

Public Health England (PHE) are collating information from COVID19 testing and now sharing it with local authority public health teams for use in dynamic outbreak control management. These teams should have access to relevant person-level and postcode-level test data. This can then be combined with other intelligence from local PHE colleagues such as outbreak notifications as well as the use of "trend over time" analysis using the "number of cases" data that are available on the national COVID19 tracker. These data allow modelling and simulation work to help understand and predict the impact of COVID19 over the coming months.

> *"it would have been helpful to have all of these data but also the capability and functionality to link them at a person level with other local NHS data, for example, from hospital admissions etc., to really paint a rich picture of the COVID pandemic with individual patients aggregated to a population"*

Recommendation 4:

Patient and public engagement in all approaches.

The patient and public perspective should be involved from the start in all developments.

Make COVID19 data available more widely to the public at locality level. Engage the public and Local authorities in the design of case tracking and surveillance.

The pandemic has helped to progress information sharing within health and care services, but to give patients confidence in how their data are being used and shared, giving the public better access to read and contribute to their own records should be a priority for system developers and policy makers. Patients should also be able to use local data to gauge personal risk and help them with personal risk-avoidant behaviour.

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[5] https://sloanreview.mit.edu/article/the-11-sources-of-disruption-every-company-must-monitor/, as viewed 22 August 2020

The transition to digital solutions means that members of the population who are digitally excluded are also more likely to have unequal access to health, care and adequate social support. Digital inclusion should be part of every digital development or initiative.

Public trust and engagement

If the public are to engage with efforts to limit the spread of COVID19 now, and in the future, there is a need to build trust in the approaches being taken. The public needs to have access to all data in appropriate forms to help them understand why decisions are being made and to tailor their own risk to the local threats that local data can describe or reveal.

"There is an issue around people really understanding how data are being used. If there was sufficient public understanding on this, with use cases of how data are being used which are widely cascaded and understood then there would be more trust"

This trust applies to the example of "track and trace" applications, where people can be asked to self-isolate for a period of time if they have been in close proximity to someone who later tests positive for COVID19.

"With track and trace we are trying to put things out really quickly and expect the entire population to trust a faceless app that tells them to isolate. People need to understand why and what decisions have led to it in order to trust those decisions. It is necessary to work with people and let them be concordant with understanding when they were unlucky with being in a particular place and agree to take themselves out of society for a week or 2. Otherwise people don't download it, use it or trust it."

"no current framework for people receiving care to understand how data are used clearly"

Confusion also continues to exist in the public around data sharing and deliberate efforts are needed to gain confidence and trust. Social care was identified as a particular space where improvements in data sharing and collaboration would be of benefit, and this is an area where an initiative like 'Understanding Patient Data' could improve understanding and trust.

"if it is expressed in terms of "we plan to share your data", rather than "here is a clinical use case, and this is how we plan to improve your care, and by the way, we plan to share your data" – it is a completely different type of conversation."

There is scope to improve the way patients can enhance their own personal records. For example, the ZOE COVID19 symptom study app[5] may be of value to health and social care professionals in tracking illness and symptom progression and reviewing preventative measures.

Personal health information that the public could be encouraged to collect and monitor could include, for example: daily activities, diet and nutrition, social interactions, concerns and wishes, symptom and illness progression during acute illness. An approach such as this could increase the control individuals have over their health information and deepen involvement with their health improvement; holding health and care providers and organisations accountable for quality service provision.

"[There is] a need for streams of high-quality data on individuals, their behaviours and their movements - at risk populations are being underserved."

Digital inclusion

For patient or public-facing initiatives, there is an expectation that people have full capacity, a smart phone, and that no considerations need to be taken for different abilities and health conditions like dementia. More than 11 million across the UK are unable to use the internet effectively and people who are differently abled are less likely to have digital skills for everyday life[6].

The transition to digital solutions means that members of the population who are digitally excluded are also more likely to have unequal access to health, care and adequate social support. Taken together, digital exclusion and the rapid digital transformation potentially adversely magnify inequalities and health outcomes.

Recommendation 5:

Share best practices in a curated, accessible, and referenced way.

Although the communication infrastructure allows for asynchronous and remote working, the conversations and initiatives discussed in specialty forums and organizations remain locked in those applications and channels.

The opportunities are fewer for corridor conversations, cross-pollination of ideas, and networking. There are scattered outputs with varying accessibility to the lessons learned and initiatives underway. For local projects, collaborative initiatives and webinars, a regular practice should include access to the audio / video, transcript, and a searchable registration of ongoing projects, similar to clinical trials registration. Annotating the topics with major themes like 'infrastructure', 'integrated services', 'quality' and 'collaboration', in addition to 'COVID19' are another way to create a set of usable, referenced resources.

At a national level, there is scope to build an innovation forum to provide a searchable register of projects, to discuss and resolve problems, unblock barriers, and share local and national feedback, including from patients, carers and service users.

Some of the innovations will be more effective than others. Assurance of these developments is a priority to identify what to retain and extend as they improve the service to patients and service users and increase efficiency. Clinical safety of new developments should be included in this assurance.

Reviewing and not reverting back

Through the survey and roundtable, participants were clear that the momentum of change during the pandemic should not be lost. The UK health and care systems should take advantage

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[6] https://digital.nhs.uk/about-nhs-digital/our-work/digital-inclusion/what-digital-inclusion-is, as viewed 21 August 2020

of the rapid developments that have occurred and put measures in place to avoid reverting back to former ways of working where this would be inappropriate.

> *"There has been rapid innovation and adoption of digital technologies: much of this should become our new normal, not to let these advantages slip away by a return to the "old ways"."*

Any **changes need to be sustainable**; new ways of working need to be embedded and sustained in the workforce or rolled out further for sustained improvement. Initiatives must be stabilised and optimised to maintain benefit and reduce risk. Some of the innovations will be more effective than others. Assurance of these developments is a priority to identify what to retain and extend as they improve the service to patients and service users and increase efficiency.

> *"Thorough review of all changes in managing data made in pandemic."*

It is important to **keep sight of the importance of clinical safety of digital deployments** which have been developed at pace in the pandemic while much innovation is occurring. Subsequent to the critical pandemic phase, such rapidly developed digital deployments should be re-examined, to preserve the gains and eliminate safety compromises.

Recommendation 6:

Upskill and motivate the health and social care workforce in clinical informatics.

More time should be dedicated to staff training in clinical informatics across all organisations, making use of FCI's recently published Core Competency Framework[7].

Particularly important is the inclusion of training for nursing, allied health professionals and all those working in social care and primary care, where the bulk of care has shifted during the COVID19 recovery phase. The workplace is where people learn digital skills. Embedding clinical informatics theory and practice into general workplace training would go a long way to encouraging health and social care services to be more innovative. This could take a two-pronged approach for practicing health and social care professionals, and within their training curricula as a means to foreground issues of safety and quality care coupled with the capabilities to develop, critique and apply technology in practice. This fosters computational thinking about the exponential possibilities of using data and technology to improve care.

With clinical informatics competencies identified and published[7], this increases the scope for non-medical practitioners to develop informatics careers within the NHS, third sector, private, and other settings to better provide holistic health and care. The approach to re-imagine health and care is multi-disciplinary and involves digital technology partners from industry.

Communities of practice, whether digital (like the FCI), or discipline-specific (like the Royal College of General Practitioners), will remain important as spaces to set standards for practice, progression, and to explore emerging issues for inclusion in the canon. 'On-the-job' learning and practice will rise

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[7] https://facultyofclinicalinformatics.org.uk/core-competency-framework, as viewed 4 September 2020

in importance as the space to apply digital and informatics skills, further highlighting the importance of sharing best practices within learning frameworks.

Workforce: engagement, improvement and data quality

Health and social care staff burnout was identified as an issue, together with low morale and declining motivation, arising from the rate and frequency staff have had to continue to work through substantial change - in professional and often as much in personal life. Three themes were identified in relation to the health and care professional workforce:

i. Health and care professionals, including clinical informaticians, can contribute to decision making; they can often be an innovative part of management teams as they have the first-hand experience of working with patients.

ii. Frontline staff need to be engaged in manageable quality improvement projects, which need to be quick and easy to do. Their outcomes should be able to be shared nationally.

iii. Improving data quality, such as symptoms, diagnoses and treatments, is key to improved COVID19 monitoring. Staff are often unaware of the importance of care documentation in creating high quality data. There is a need for basic clinical informatics training for hospital staff, post-graduates, and undergraduates. Regular review of data in team meetings can lead to a virtuous circle of quality improvement through improved data quality from the frontline leading to better clinical understanding of care quality and personal professional development.

"Fear by leaders of not knowing what is needed now and not bringing in frontline workers to discussions."

"To roll out immediate at-scale deployment of a small agile Quality Improvement project using maybe "Plan-Do-Study-Act" cycles to help staff bite off chunks of improvement work that will help them now. Do this in a digital package that takes less than 15 mins to do, accessible via Teams and on mobiles so it's very easy to access and click through but is captured on a national platform for data analysis. This could work for small teams or at a service level, functional management or clinical speciality between eg AHPs or social workers."

Moving forward

The emergence of the pandemic has made the gaps and disconnections in services, information flows and resources more obvious between primary, secondary and social care. Putting together the type and scope of digital solutions being trialled and tested, together with the ongoing uncertainty and remaining questions, points to ongoing efforts to apply digital technology and informatics capabilities to connect across traditional healthcare spheres (i.e. primary, secondary, social care) to better effect and involving patients and the public.

Again, while many of these ideas and views are not new, the COVID19 pandemic has placed a spotlight on the successes, the gaps, and the ways in which information communication technologies form the grounding for success.

FCI COVID19 resources

The FCI aims to advance the health of the public through concerted efforts to promote inclusion in clinical informatics core training, provision of guidance on health and care information systems development, education and training and development of informatics professional standards.

During COVID19, this has seen the FCI working towards:
- Improving trust in digital ways of working and information sharing.
- Members training and mentoring staff.
- Sharing innovations via virtual networks.
- Evaluation of the safety of new digital ways of working.
- Developing digital skills in workforce including specialist skills.
- Helping to identify examples of best practice.

This is evidenced through the FCI Core Competency Framework[8], published in August 2020. The framework provides a robust structure of the necessary knowledge and skills-based competencies for clinical informatics across health and social care and makes explicit some of the theory and practice that could be embedded within workplace and core training informatics curricula.

The FCI webinar series[9] shares new thinking on topical digital health issues, such as how to fix a national clinical safety issue, computable biomedical knowledge, integrating electronic records with clinical trials, and an informatics approach to estimating excess deaths during COVID19.

Next Steps

This report will be published and shared widely with policy makers and professional bodies to provide input to consideration of future plans for recovery and re-imagination of health and social care services in light of the pandemic.

The FCI will help to develop and disseminate best practice via ongoing webinars and commissioned work. This includes collating and sharing projects that members have been working on in response to COVID19 (see Recommendation 1). This could provide the basis for a national innovation forum for digital responses to COVID19.

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[8] https://facultyofclinicalinformatics.org.uk/ccf-introduction As viewed 7 October 2020
[9] https://facultyofclinicalinformatics.org.uk/webinars As viewed 7 October 2020