



Digital and Analytics update for ICB Board

October 2022



Executive Summary

Background & Context

- As a health and care partnership we are committed to using technology to help health and care professionals communicate better and enable people to access the care they need quickly and easily, when it suits them.
- Digital innovation is a key priority of our Integrated Care System, it has the potential to provide higher quality care with fewer barriers to access, allowing our workforce to operate at the top its license
- Frimley ICS has been at the forefront of digital innovation with the Health and Care sectors since 2015 and it underpins our approach to transformation.
- This is often best known through our leadership of the Connected Care Programme, although significant progress has been made across a broader scale than this alone
- This update to the Board focuses on four key areas:
 - The Shared Care Record & Remote Management Capabilities
 - Resident Facing Digital Services
 - Primary Care Digital Transformation
 - Connected Care Analytics
- This is not the totality of the work which we are leading in the digital space – further opportunities will be made available to provide additional information should this be requested.



SHARED RECORD & REMOTE MANAGEMENT



Shared Care Record

A Berkshire-wide digital and data architecture which enables the sharing of clinical data between health and care services

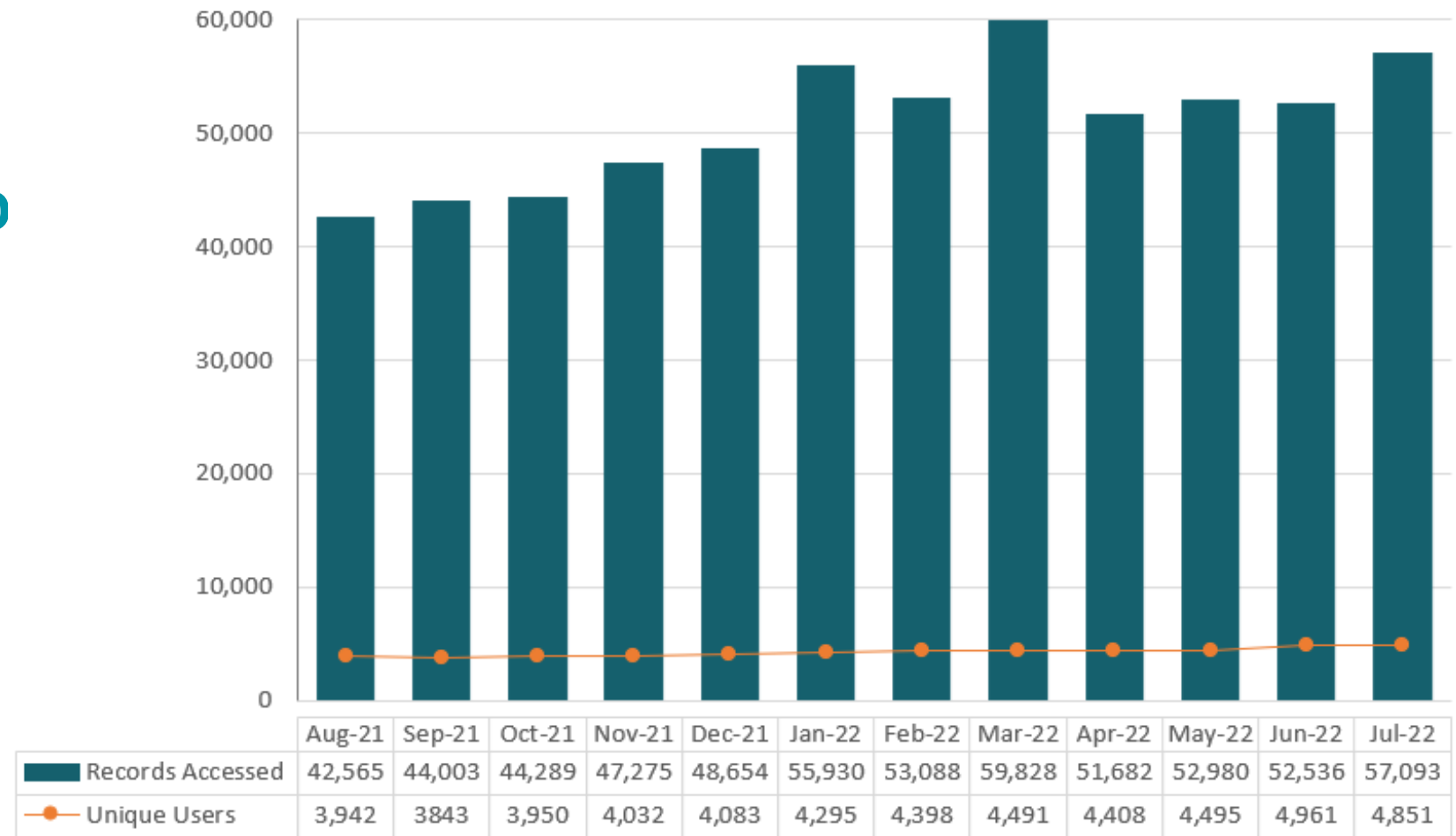
- As health and care services are working more closely together to provide a joined-up service to meet resident needs, the sharing of real time and accurate data between organisations is critical.
- Working collectively on this approach improves the quality of care because the clinicians and other professionals involved in treatment have the best information on which to base their decisions.
- It removes the need for patients and residents to repeat their story to different care professionals, thereby saving time and frustration. It also makes the services themselves more efficient and improves quality of outcomes and experience.
- In order to achieve this goal, it is important that clinicians and other health and care professionals involved in a person's care are able to view the relevant records as and when appropriate.
- Anonymised treatment data is also used to help monitor and improve the quality of the services which are provided.
- There are very strict rules to control how and when records are used, we have dedicated Information Governance professionals working together to ensure these rules are followed.
- Frimley residents and health and care professionals benefit from this real time data flow and contribute to improved delivery of health and care services

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SHARED CARE RECORD Utilisation

Records Accessed By:	July
Royal Berkshire FT	16,892
Berkshire Healthcare FT	16,091
Frimley Health FT	14,222
CCG & Primary Care Monitoring Services	2,959
Councils	2,919
OOH GP Services	2,564
Surrey & Borders	705
GP Practices	414
HCRG Care Group (virgin care)	150
Care Homes	84
Hospices	78
South Central Ambulance	15





What We've Accomplished

Depth

- FHFT moved to EPIC and data feeds replaced with single feed, including Frimley Park ED data and addition of allergies
- BHFT Progress Notes now LIVE and available in the Shared Care Record
- Upgrade of Connected Care to support National Opt Out Compliance
- Pathology Inter-op now LIVE and enhanced to include request viewing
- Social Care Adults Data Feed now LIVE
- GP Information shared with TVS
- HRCG Data Feed (Community) feed now LIVE

Uptake & Access

- FHFT System Wide SSO now LIVE to allow direct access to Connected Care from EPIC
- Further Care Homes now viewing and connected in securely

Transformation:

- Learning disabilities dashboard
- Enhancements to SMI (Severely Mentally Ill) Dashboard
- Embedded TCN GP report enhanced to include location and presenting complaint

What we are working on.....

Depth

- BHFT Progress Notes final validation
- BHFT Assessment Form data
- RBFT Enhanced Feed
- TPP Primary Care data feed
- BHFT Assessment Forms
- Additional Children's Social Care
- Further sharing information with TVS
- Out of Hours Provider Data Feeds

Uptake & Access of Connected Care:

- Additional Nursing Homes
- Pilot Community Pharmacies

Transformation:

- Care Plans – Advanced Care Plans including ReSPECT
- Careflow
- Key Information Tile
- Further remote monitoring systems and opportunities
- Real time data visibility of patients waiting in ED for other clinical services



Rapid deployment of remote monitoring/management to support complex patients who are at risk of deteriorating this winter. This will compliment the work ongoing with care homes and to support respiratory, heart failure and diabetes.

Process

Identification

- Population Health Driven lists of red patients
- Provided to Docobo to import directly into Doc@Home
- Out of Hours Call Centre initial contact to opt patient in

- Agree cohort and whether triage necessary
- Mechanism to export into Docobo template and send

Onboarding

- Clinical Hub will contact the patient and equipment will be provided if required
- Bring your own device model
- Distribute necessary equipment

- What are we monitoring / is it the same for all?
- What equipment will be needed?
- Logistics of purchase and distribution?
- Are we using both providers and how so we divide the work (BPC only in hours)

Monitoring

- patient records readings and answers question set at defined parameters

- Agree question set and breach parameters
- Do some patients e.g. AIRS team need different thresholds?

Escalation

- if an alert is generated, the Monitoring Hub will trigger appropriate escalation
- 2 hour urgent response
- Primary Care
- Secondary Care
- Integrated Teams

- Agreed escalation model
- SOP in place

Evaluate

- Data in population health used to assess effectiveness

- Indicators such as reduction in admissions

Other Dependencies

- IG in place for all partners
- Clinical Safety Sign Off
- Finance



RESIDENT FACING DIGITAL



Achieved

Next steps

	Wait Well	Resident Portal	Apps/ digital support tools	Comms
Achieved	<ul style="list-style-type: none"> GP text signposting those waiting for an operation to self help resources MVP design prototype for self help personalised plan 	<ul style="list-style-type: none"> MVP design prototype developed, and internal testing of logic completed for personalised health/wellbeing recommendations via a 'quiz' Future design vision prototype created 	<ul style="list-style-type: none"> MSK app agreed with system partners Maternity app - Export to pdf function completed and app live in app stores ORCHA – further development with BHFT 	<ul style="list-style-type: none"> Further work on resident facing communications and engagement activities
Next steps	<ul style="list-style-type: none"> Engagement planning for stakeholders, residents & professionals Branching logic for MVP 'quiz' element MVP delivery end June Phase 2 of resident portal integration discussions (NHSLogin and EMIS as priority) to improve personalisation 		<ul style="list-style-type: none"> Resident view of remote monitoring services - working with remote monitoring workstream (adapting language, understanding patient journeys etc) 	<ul style="list-style-type: none"> Comms and engagement plan will be developed over the Summer / Autumn
	<ul style="list-style-type: none"> Digital Inclusion planning – working with system partners to have a consistent response 			



PRIMARY CARE DIGITAL

Access points



Website blueprint

70% of practices live/soon to be live that support accessibility needs, a consistency front door and patient behaviours on signposting as well as



Social media

NHS App



85% of practices on Advanced Telephony

Significant improved in resilience of telephony supporting patient access and supporting agile models.



Online consult.

8 PCNS moving to new platforms that utilise AI/algorithms to support streaming of patients to support access.



Email/mail

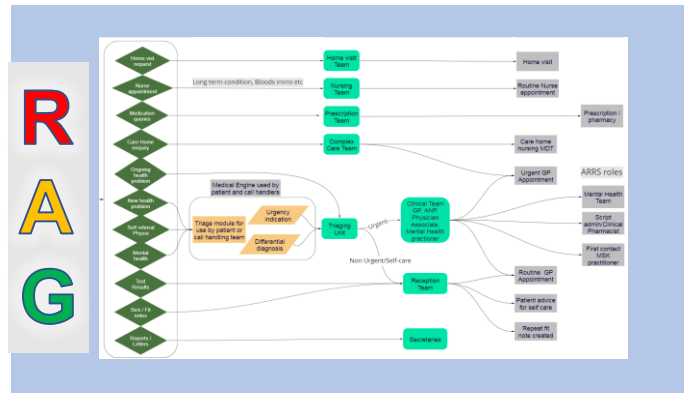


Walk ins

Care navigation training support.

Where we are now at a glance

- **OC that supports care navigation and streaming of patients**
- **EMIS segmentation to support care navigation models and streaming of patients.**
- **Automated health checks to support LTC management.**



- **Video consultation in place and no change to supplier; minimal utilisation compared to other routes.**



Telephony hub examples for centralised and external/overflow models. Slough and Bracknell Forest; SH development in progress.



eHub model examples from BF as well as external to Frimley.



Use cases of how AccuRx/Sym1 being used to support LTC management as well as better use ARRS roles.



What else is going on/of interest... Admin hubs, prescribing hubs, automation.

Next steps/areas of focus

- **Joint work to refresh hub/at scale model(s) blueprint and support enablers refresh** – case studies/sharing examples/learning key to this.
- **VOIP** – finish roll out and embed/optimize VOIP through Redmoor and supplier recovery/training.
- Building on case studies of LTC to support mixed
- Refresh of segmentation with recent PNG work.
- **Digital championing & literacy** to support workforce and resident adoption and confidence to support new models.
- EMIS PCN /enhanced access functionality review and mapping against models
- Resource summary pack and training to support social media and online presence work including NHS app promotion focus.
- Focus on embedding Video Consult and potential for VGC from regional/national case studies. Exploring system alignment potential.
- Online consult sharing of learning and feedback.

Different front doors points and maturity of digital enablers across each practice and PCN creating varied patient experience and access points.



Each practice/PCN...

- Working slightly different.
- A different look and feel to their 'front door' often wordy, complex to navigate websites where patients either go straight to phone numbers or econsult button.
- Minimal engagement and change with residents on the newer digital access routes.
- Varied robustness and costs of telephony.
- Varied usage of eConsult.
- National/regional/local development of hubs and care navigation model priorities.
- Focus over winter to provide the digital enablers alongside wider offers of support to help with pressures – mixed uptake rates – little chance to embed/mature how used and how fit with maturing models.

WAF enablers

- Website blueprint
- Telephony improvement
- EMIS XA and place based analyst.
- Automated Health Checks
- CPCS

Care navigation enablers

- EMIS XA and segmentation.
- SMS
- Website blueprint.
- Healthwatch review.
- Digital access survey.
- Hub /at scale model workshops and feedback survey.

DFD/I&U enablers

- Online Consultations
- SMS
- Video consultations.
- N365
- Automated Health Checks
- Redmoor.

Digital enablers to support at scale/hub/PCN collaborative models

- Consistent 'front door' for those on **website blueprint** that supports signposting, filtering requests to centralised resources and patient education.
- Improved **telephony** that will support better patient experience as well as directing calls in line with care navigation/hub models – reduced cost pressures for those aligned on suppliers.
- **Online consultation** solutions aligned at PCN level to support potential ehub models as well as 'AI/algorithms' that support care navigation and sign posting.
- **EMIS XA** investment alongside maturing **place based analyst** model to enable analytics supported model development and segmentation to support care navigation.
- **Automated Health Checks solutions** that can support use of ARRS/PCN & practice roles in different ways alongside segmentation/ACG.
- **Maturing website blueprint** with support in global comms, more localised content on specialist areas and wider training on CMS.



CONNECTED CARE ANALYTICS

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There is a strong foundation of existing tools using Connected Care as well as a pipeline of development work that is aimed at providing increasing support for decision making

Some examples of work in recent months supporting the ICS

Tool	Overview	Relevant case studies	Development priorities	Overview
Live ED view for Primary Care	Identify patients to GPs that are currently attending ED	<ul style="list-style-type: none"> Bharan practice 	POC – developing requirements	<ul style="list-style-type: none"> Outputs supporting urgent / on the day demand are developing rapidly, with a focus on data or operational challenges that could impact rollout Outputs supporting proactive care are well established and being actively used in some parts of the system. Key priorities are to increase breadth of usage to support proactive ways of working and unlock full potential
System Insights	Population Health system	<ul style="list-style-type: none"> Fuel Poverty 	New interface to support mass adoption	
Segmentation	Segmentation (red, amber, green) to support ED & Primary Care			
Health checks evaluation dashboard	Achievement of 68 different LTC care processes and treatment targets across 14 different conditions	<ul style="list-style-type: none"> Hypertension and Diabetes sprint 	Live - Expanding indicator set and providing more regular comms to Places around insights	
Primary care pressures analysis	Tracks volume of activity, staff and complexity of patients to identify trends that could indicate increasing pressure	<ul style="list-style-type: none"> Overview for Berkshire West 	POC - Feedback and endorsement from Primary Care on usability of the insights	
Diabetes dashboard	Achievement of diabetes care processes and treatment targets as well as patient case finding		Live – focus on embedding in CC and expanding usage	
Patient insights	Proactive case finding, providing patient lists for defined use cases	<ul style="list-style-type: none"> Community remote monitoring Sym/AccuRX Live bed view (Castle Ward) Hypertension 	Live – focus on adding more lists and expanding usage for new initiatives	

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Embedded analysts into each Place

Place	Status	Next Steps
Slough	Analyst in place	Scope additional joint working opportunities with Places and PCN Clinical Directors
Windsor and Maidenhead	Analyst in place	Scope additional joint working opportunities with Places and PCN Clinical Directors
Bracknell Forest	Analyst in place	Scope additional joint working opportunities with Places and PCN Clinical Directors
Surrey Heath	Analyst in place	Scope additional joint working opportunities with Places and PCN Clinical Directors
North East Hampshire & Farnham	Analyst in place	Scope additional joint working opportunities with Places and PCN Clinical Directors

