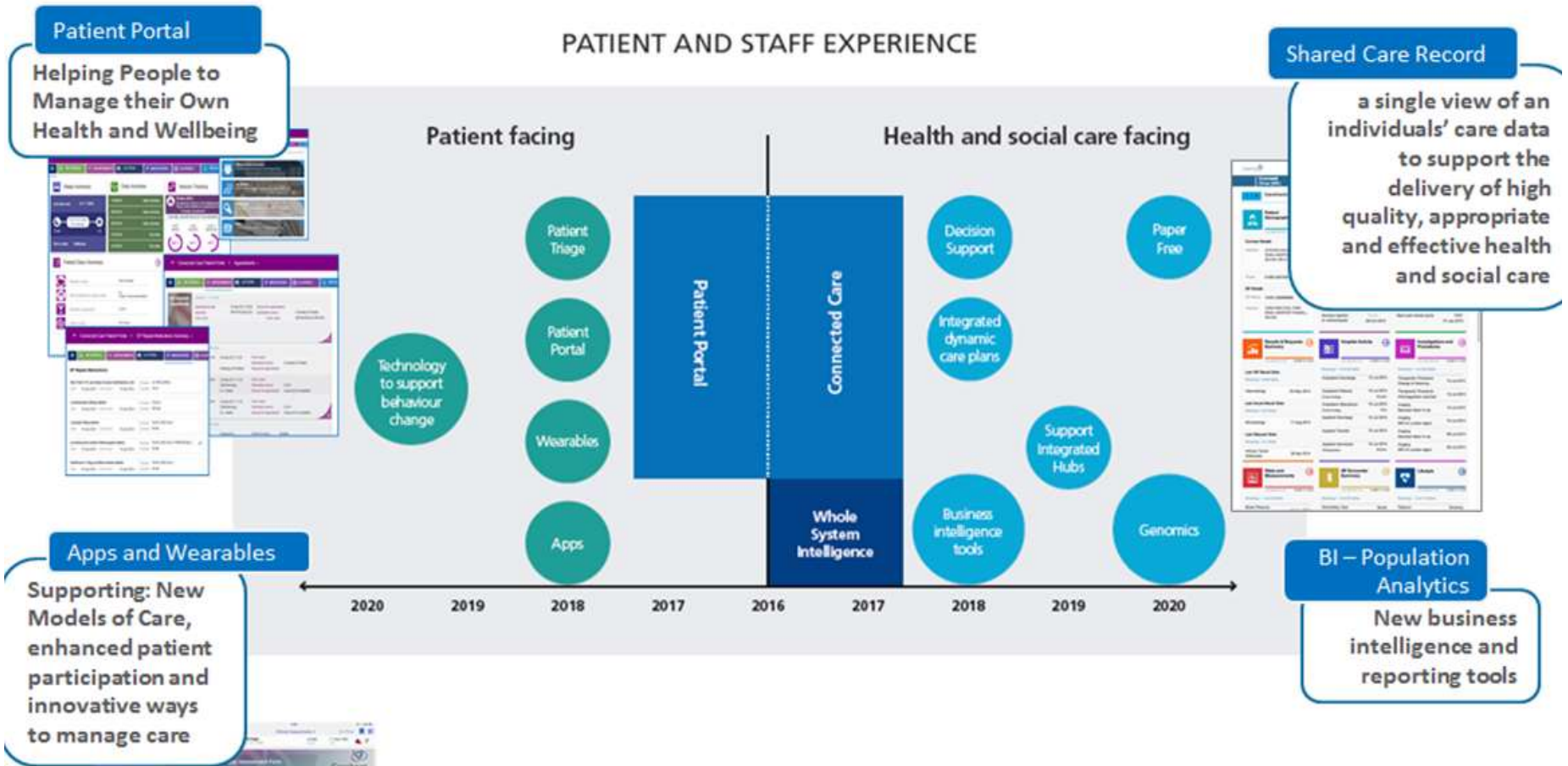


# Connected Care Vision

The continuation of a vision that has brought together record sharing, analytics and patient facing technology to support the ICS transformation agenda



**Frimley Health ICS**

**Berkshire West ICS**

East Berkshire CCG

Berkshire West CCG

NHS NE Hants & Farnham  
Clinical Commissioning Group

NHS Surrey Heath Clinical  
Commissioning Group

Bracknell Forest Borough  
Council

Slough Borough Council

Reading Borough Council

Wokingham Borough Council

Royal Borough of Windsor and  
Maidenhead

Surrey County Council

West Berkshire Council

Hampshire County Council

Frimley Health NHS Foundation  
Trust

Royal Berkshire NHS  
Foundation Trust

Berkshire Healthcare NHSFT

Southern Health NHSFT

Surrey and Borders NHSFT

Sussex Partnership NHSFT

South Central Ambulance Service NHSFT

North Hampshire Urgent Care

South East Coast Ambulance Service NHSFT

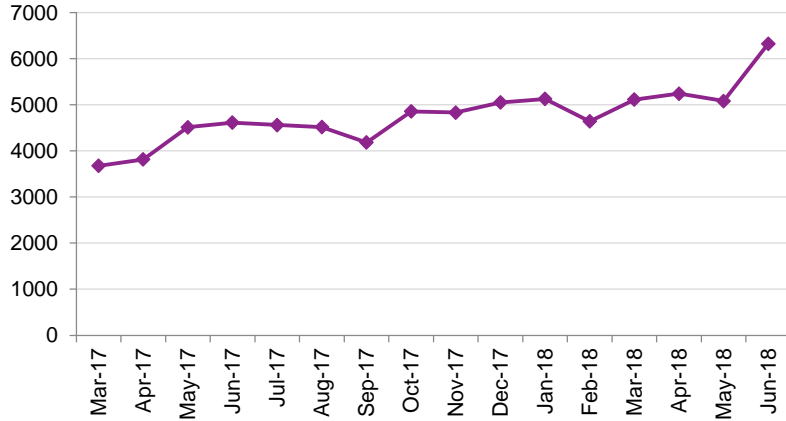
**Citizen / Patient / Service User – 1.3 million**

**Two core objectives:**

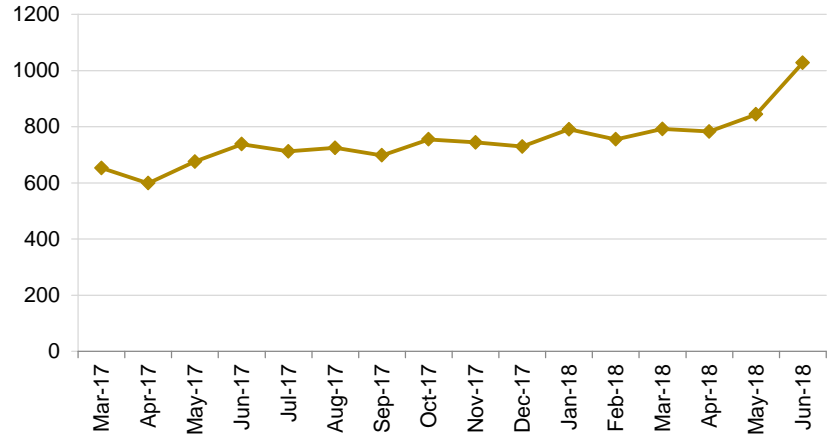
- 1. Interoperability and information exchange between health and social care organisations**
- 2. Having a person held record (PHR) for health and social care for the citizens of Frimley & West Berkshire ICS**

# Delivery and utilisation

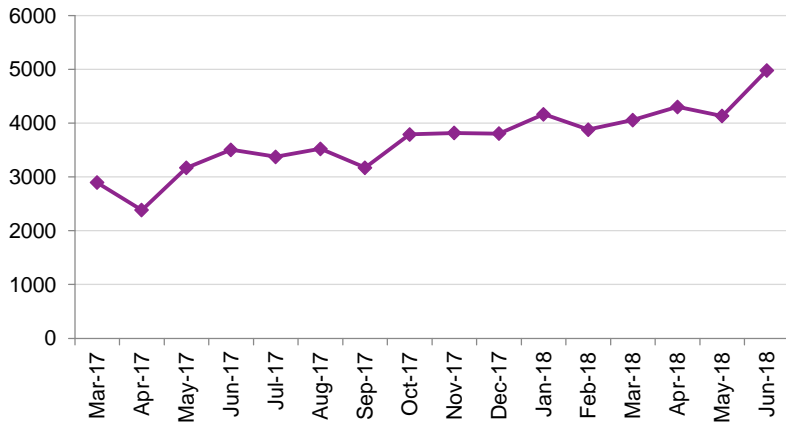
**Patients Records Accessed 2017/2018**



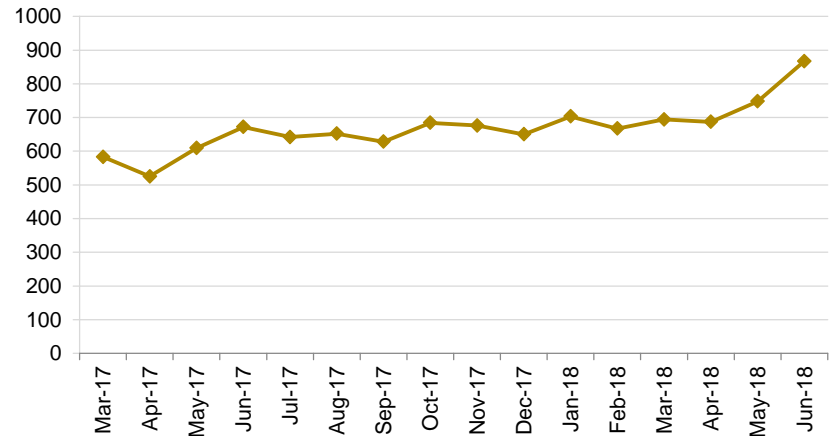
**Unique Users 2017/2018**



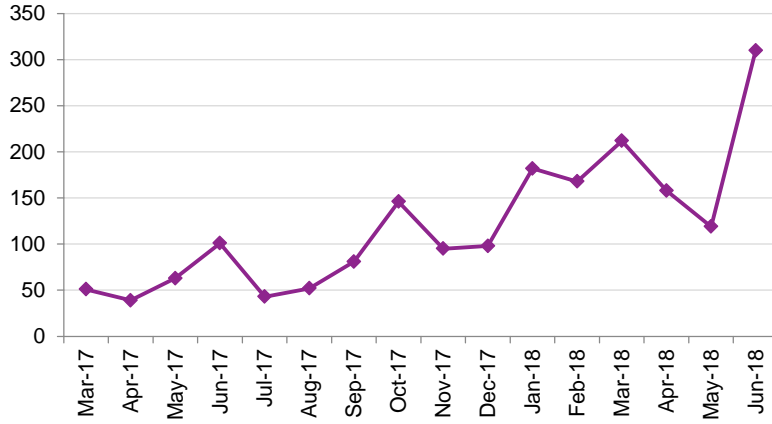
**Patients Records Accessed By Community & Mental Health Services**



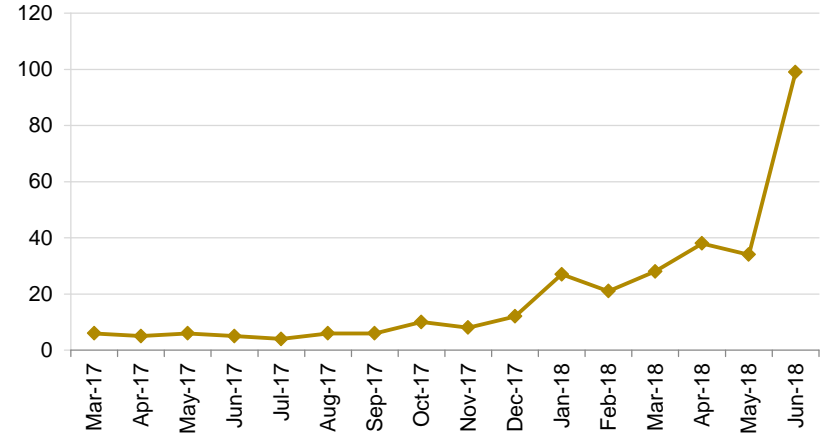
**Community & Mental Health Services - Unique Users**



### Patients Records Accessed By Hospitals



### Hospitals- Unique Users



# Feedback from Users

## **Senior Diabetes Specialist Nurse**

I had a referral from a GP a short while ago, the referral was in the form of a conversation over the phone.

The patient was elderly with sub optimal diabetes control, had also had a fall and recent fractured wrist.

The GP told me all the information, however I also had activated the connected care button to review further details whilst talking to the GP. I found that the patient has osteoporosis and was on a drug that is contraindicated in elderly patients and can cause bone fractures especially in patients with osteoporosis, this was vital information that the GP had omitted and could have had a detrimental effect upon the patient if not acted upon swiftly.

By activating connected care I had a fuller and safer picture of the patients medical history.

## **Podiatry Lead Diabetes**

I work in a MDT clinic at the RBH, our team find it very useful for seeing what medications have been prescribed by the GP, particularly antibiotics (often patients unsure of the name) and for any interactions or contra-indications to therapy.

When seeing NEW patients it's useful to see medical history if referral letters are lacking information.

## **Example from OOH GP where Rio Data will add value**

Several calls from a man whose wife passed away earlier this year...

He regularly turns up at West Berks or calls 111 looking for his wife because he's forgotten she has died, looking at his Rio notes there are some special notes saying he does this a lot, he forgets that she has passed away and that you just need to reassure him.

Without access to these notes I would have thought.. is he more confused than normal? It is so difficult to tell from his voice .. it's his previous memory that has gone, so I would probably have sent a doctor to visit him.

## **OOH GP**

Example of how Connected Care helped me.

A call came through for lab results showing a High glucose and that patient was unwell, no other information was provided.

I tried to contact the patient but no reply. I needed to know if she was known diabetic or not, as someone with a blood glucose as high as the result who is not known diabetic and feels unwell can mean we potentially have a life threatening scenario on our hands

I accessed Connected Care and saw that she is not diabetic which helped me decide she needed an ambulance which I arranged.

## **Specialist Children's Nurse**

I am the team Leader for Community Children's Nursing.

I have needed to use Connected Care whilst working a shift at the children's respite centre to clarify a medication dose that had been prescribed by the GP. Without this service it may have meant me making several phone calls and possibly the child not being able to attend respite.

When I have approached parents for their consent they have always been willing and think that this is a really good idea.

# Transformation programme



## 32 Core Members from the partner organisations

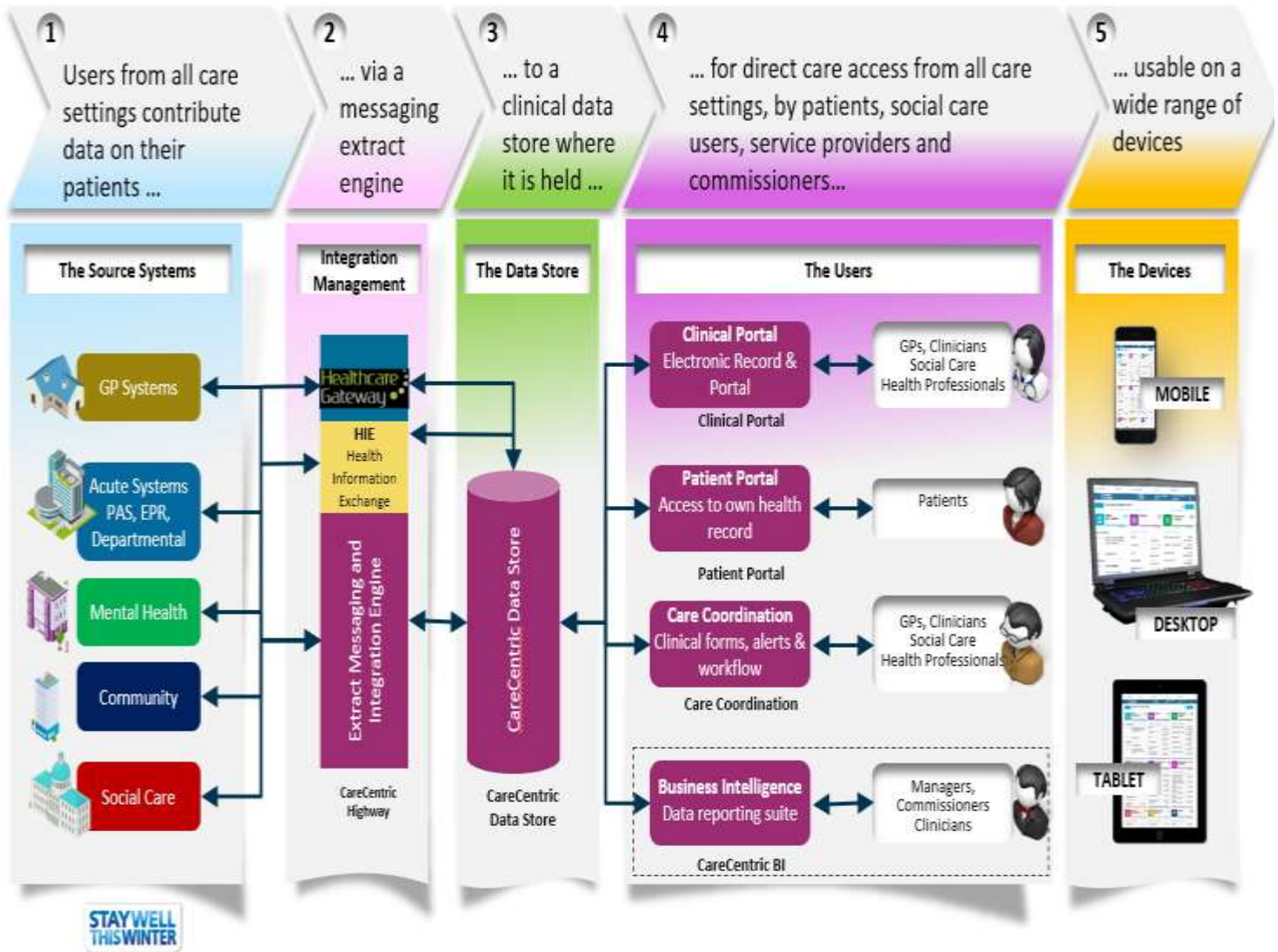
- Includes Consultants, Physiotherapists, Occupational Therapists, Pharmacists, Community Nurses, GPs and Social Workers.
- Additional 10 Subject Matter Experts within the subgroups
- Frimley Health and Care STP Programme Management
- Technical and project support from SCW



***Collaborating to deliver the Shared Care Record vision***



# Analytics repository



\*CareCentric BI is a separate database where data can be anonymised. It requires explicit consent for data loading if used outside direct care.

# Patient Health Record- Wearables pilot



## Completed

- IRAS Ethics & IG
- Volunteers
- Consent
- Handover meetings to set up participants with Garmin

## Technology

- Pilot patient portal
- Link between patient portal and Clinical Portal for remote onboarding
- Connection

## In progress

- Remote onboarding
- Summaries of wearable data back into pilot patient portal
- Anonymised access to



# PHR Next Steps

---

## Test the deliverables

If this is delivered, we will have a successful, scalable PHR



## Everything should be aligned to an overarching vision

Will it improve patient experience

Will it release time to care through increased efficiency

Will it empower residents to take greater ownership of their health & self-care



## Test through the development of several use cases

e.g. how can a GP consultation be supported through a PHR

e.g. how an outpatient appointment at Frimley Health can be supported through a PHR