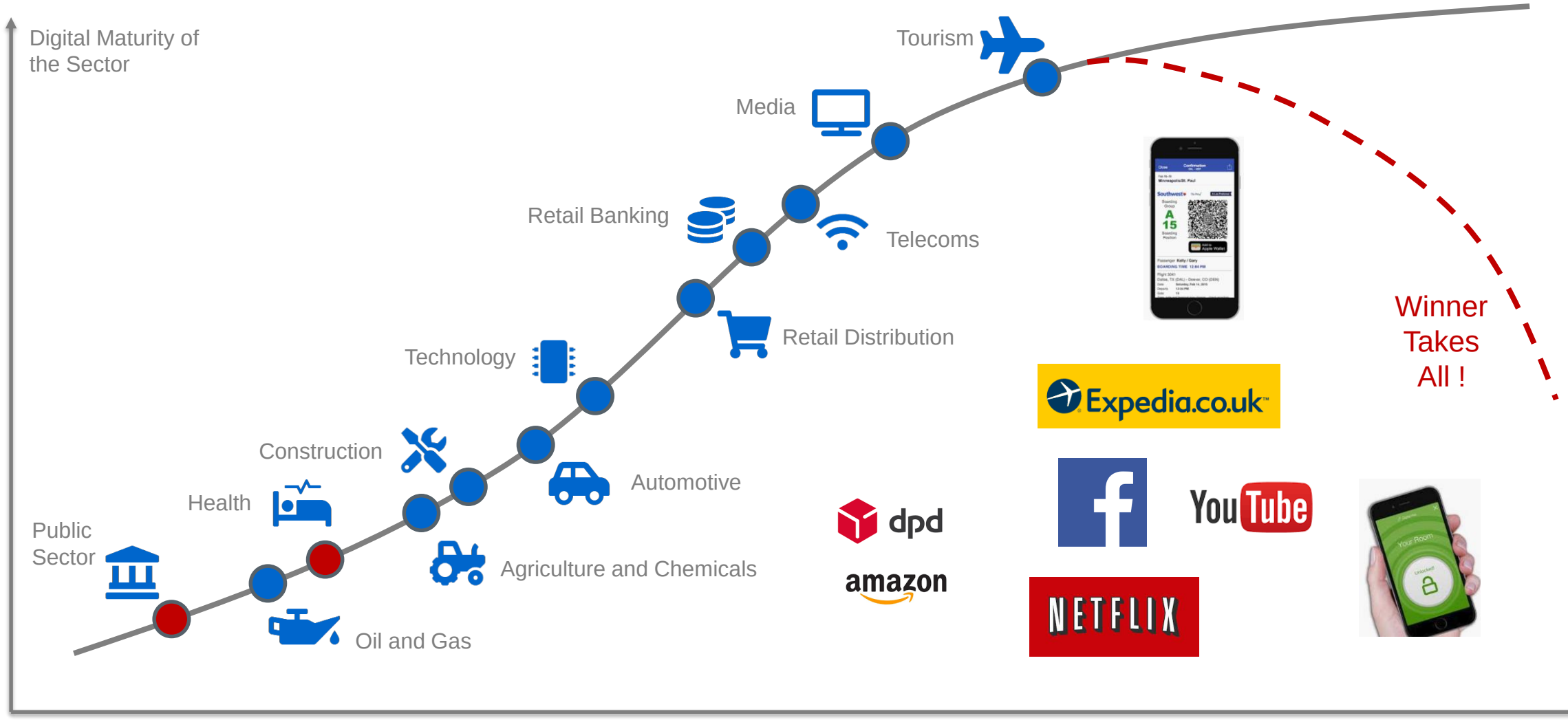
Staffordshire and Stoke-on-Trent STP Digital Programme Overview and Update

Agenda

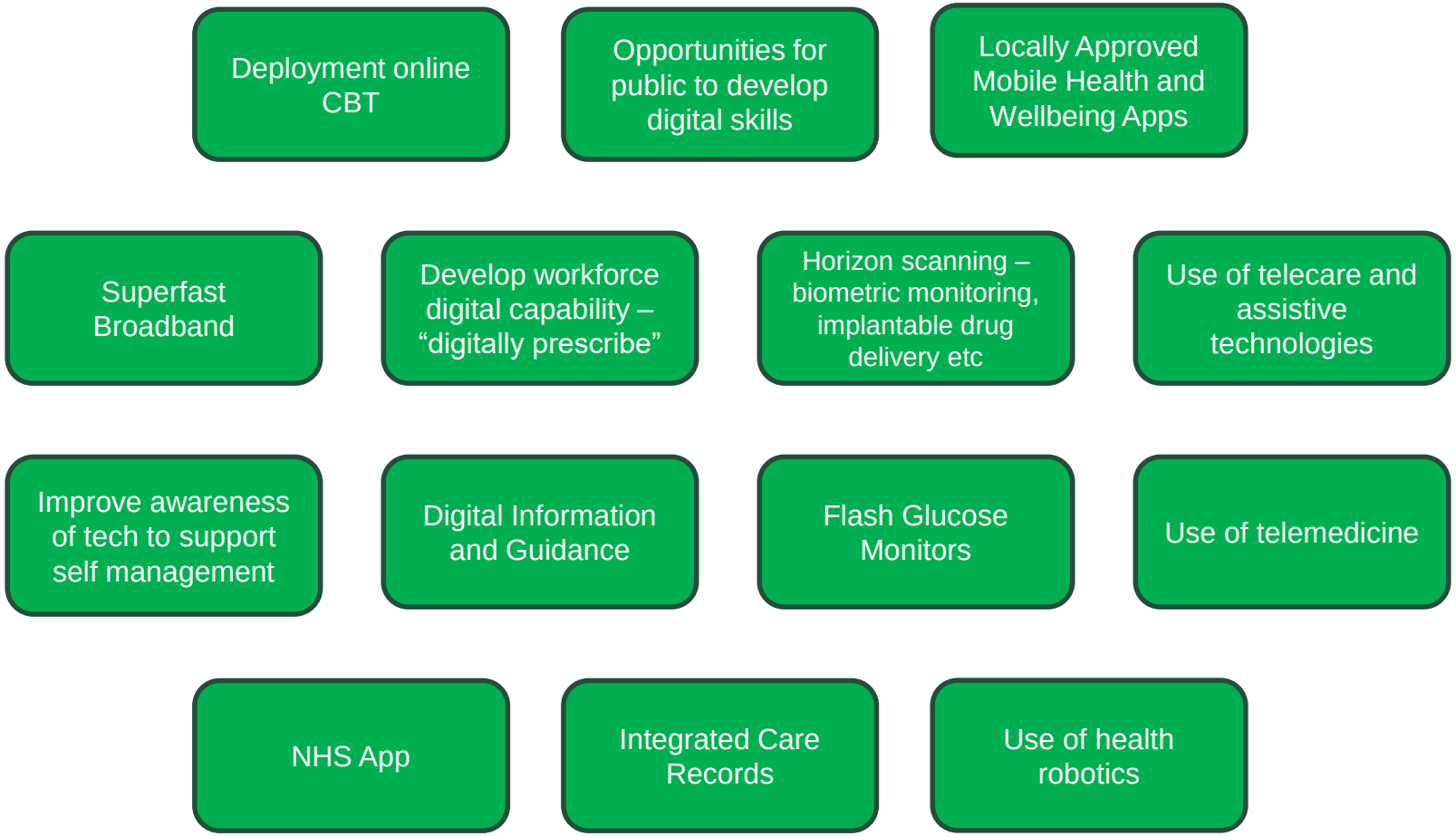
- Introduction
- Digital Strategy
- Delivery Programme
- Key Project Updates
  - Integrated Care Records
  - Technology Enabled Care Services

Digital Transformation

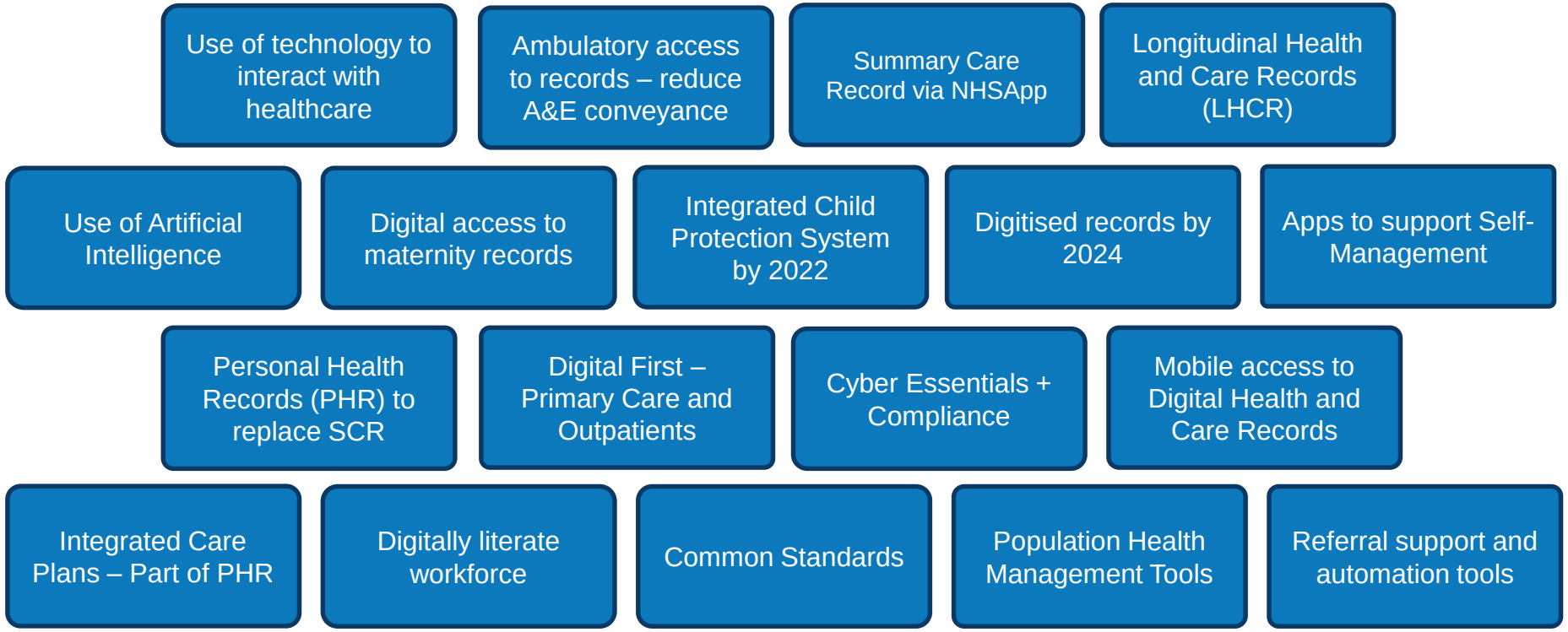


Source: McKinsey

Director of Public Health – Annual Report



NHS Long Term Plan



50+ Digital Commitments in the NHS Long Term Plan

Digital Vision

Context

EMPOWERED PATIENTS

We will place patients at the centre of their own health and care by adopting technologies that help citizens stay in their homes for longer, open new digital avenues into health and care services and promote shared care through 2-way information sharing, utilisation of apps and connectivity to wearable technology

DIGITISED CARE

We will ensure that all health and care information is recorded electronically to a high standard and digital tools are available to make health and care professionals lives easier. We will implement a range of new technologies aimed at improving the efficiency and effectiveness of health and care including the use of artificial intelligence.

POPULATION HEALTH

We will provide a range of tools and data sources and support these to be sensitively utilised in new and innovative ways so as to directly and indirectly benefit the health and care offered to the citizens of Staffordshire and Stoke-on-Trent.

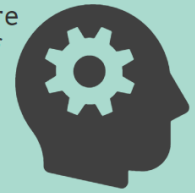
INFRASTRUCTURE & SERVICE

We will provide health and care professionals with an infrastructure that simplifies access to the right resources using appropriate devices to the highest possibly cyber security standards. We will provide staff with high quality digital support services at a time and place convenient to them and in accordance with industry level standards.

Programme

CAPABILITY & INNOVATION

We will seek to develop the digital capability of both our workforce and the wider population to ensure the digital initiatives stand the highest chance of success. We will develop and embed innovation at the heart of how we operate ensuring that we are constantly exploring how cutting edge technologies can benefit the local population.

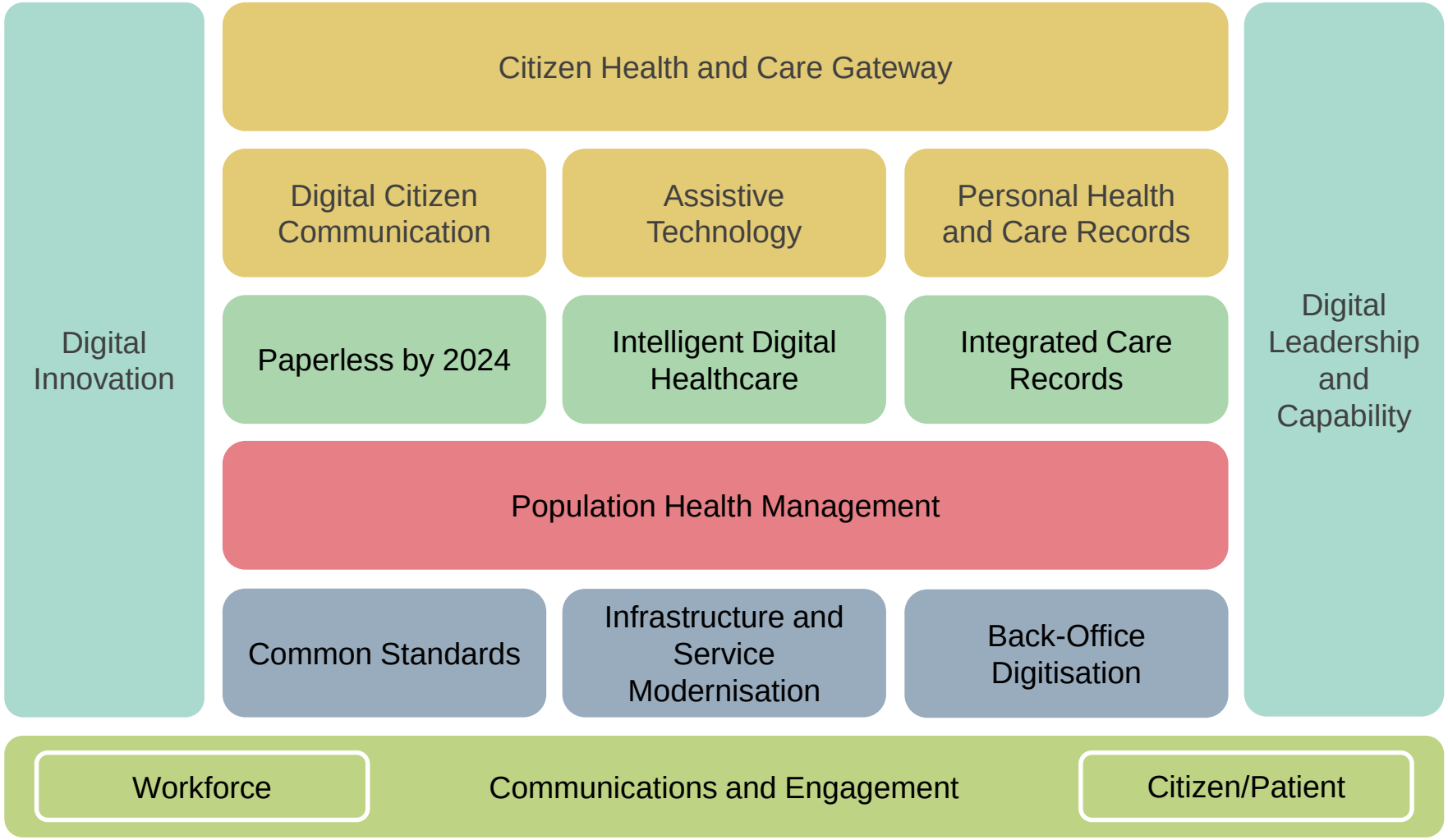


INVISIBLE BOUNDARIES

We will ensure that all residents of Staffordshire and Stoke-on-Trent are able to receive the same high quality health and care by ensuring that professionals outside of the immediate geography are as informed as those within it. We will routinely collaborate with local partners to share ideas and deliver digital technology faster.

Priorities

Digital Programme – Delivery Workstreams



Digital Programme – Delivery Workstreams

Citizen Health and Care Gateway

Citizen Health and Care Gateway:
Provide patients, carers, citizens etc with a single simplified point of access into all digitally enabled health and care services regardless of who provides them. Drive a channel shift towards the Citizen Health and Care Gateway by including as many services as possible within this..

- Integrated Patient portal
- NHSApp
- Digital first (outpatients and primary care)
- NHSLogin Compliance
- Staffordshire Apps Store

Digital Programme – Delivery Workstreams

Citizen Health and Care Gateway

Digital Citizen Communication

Digital Citizen Communication:
Create a series of pro-active digital engagement channels with citizens ranging from appointment reminders through to 2-way personalised communication.

- Bi-directional citizen/professional health and care communication
- Unified appointment reminders
- Electronic Patient letters
- Pro-active alerting and health promotion

Digital Programme – Delivery Workstreams

Assistive Technology:
Implement a range of assistive technologies aimed at keeping people in their homes for longer, improving quality of life and preventing illness.

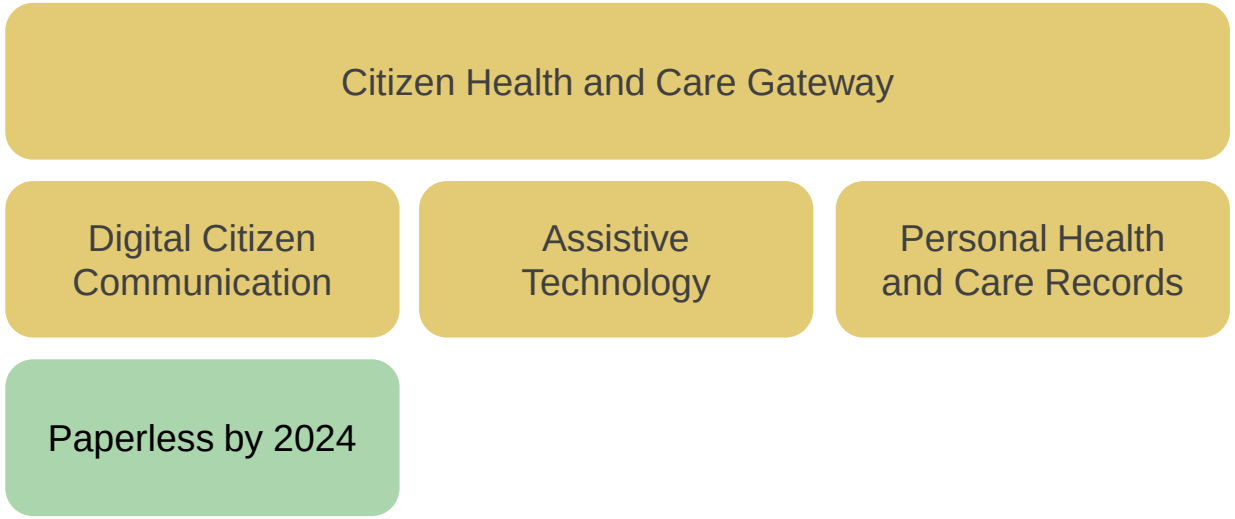
- Home health monitoring
- Citizen assistive technology

Digital Programme – Delivery Workstreams

Personal Health and Care Records:
Ensure citizen's health and care information is readily accessible to them and where appropriate they are able to records their own health and care information..

- Personal digital maternity records
- Personal health record tools
- Citizen sourced information
- National eRedBook deployment

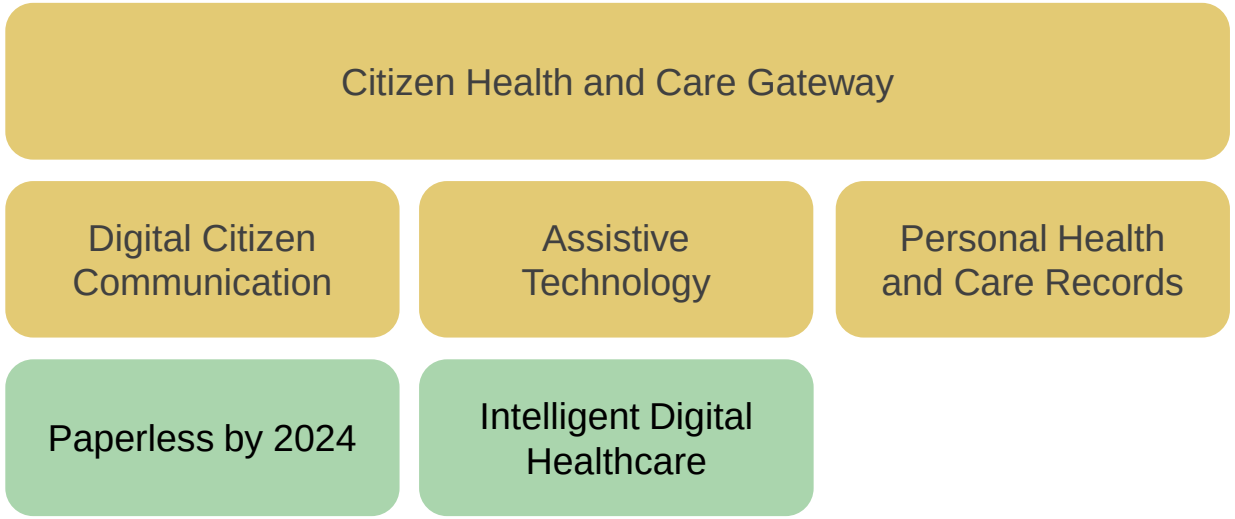
Digital Programme – Delivery Workstreams



Paperless by 2024:
Remove all paper records for all partner organisations and ensure that all health and care information is recorded electronically.

- Care homes
- Enhanced maternity system
- Primary care network enablement
- GP IT Futures
- Lloyd George notes digitisation
- Localised care digitisation
    - EPR

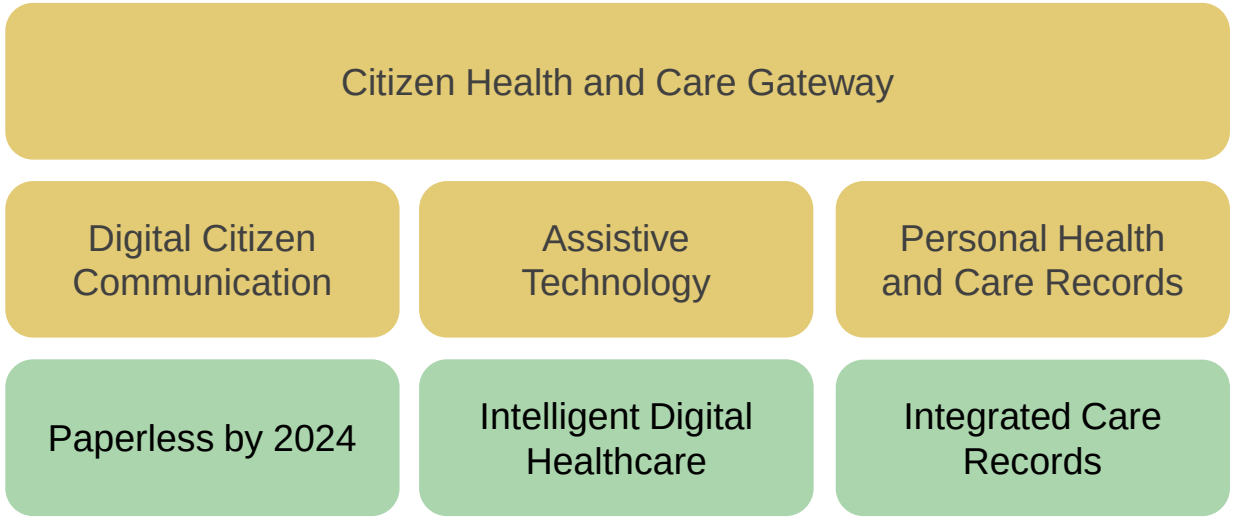
Digital Programme – Delivery Workstreams



Intelligent Digital Healthcare:
Digitally augment and improve how health and care is delivered and managed by identifying and implementing the latest digital tools and techniques into health and care settings.

- Streamlined referral and discharge
- Use of AI and Decision support
- AI enabled patient self-referral
- Patient flow management

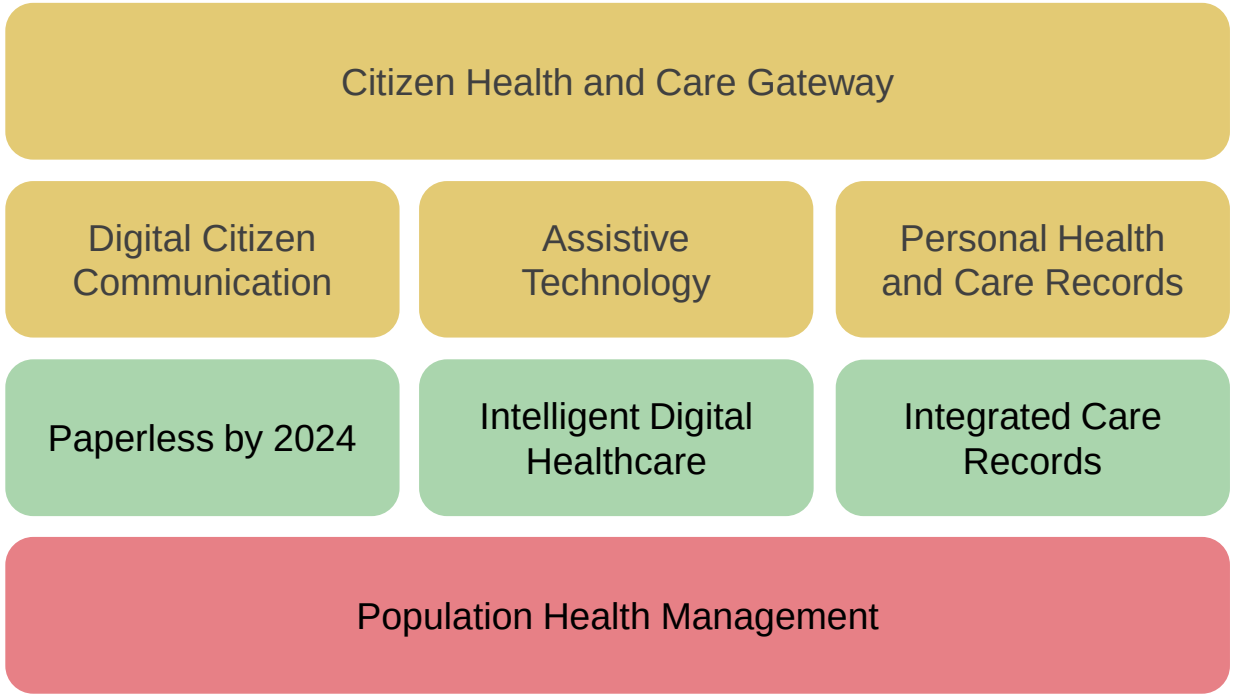
Digital Programme – Delivery Workstreams



Integrated Care Records:
Develop and implement a solution to amalgamate health and care information into a single repository to improve the delivery of health and care.

- Integrated care record and viewer
- Local health and care records (LHCR)
- Integrated Care Plans
- EPaCCS System Deployment

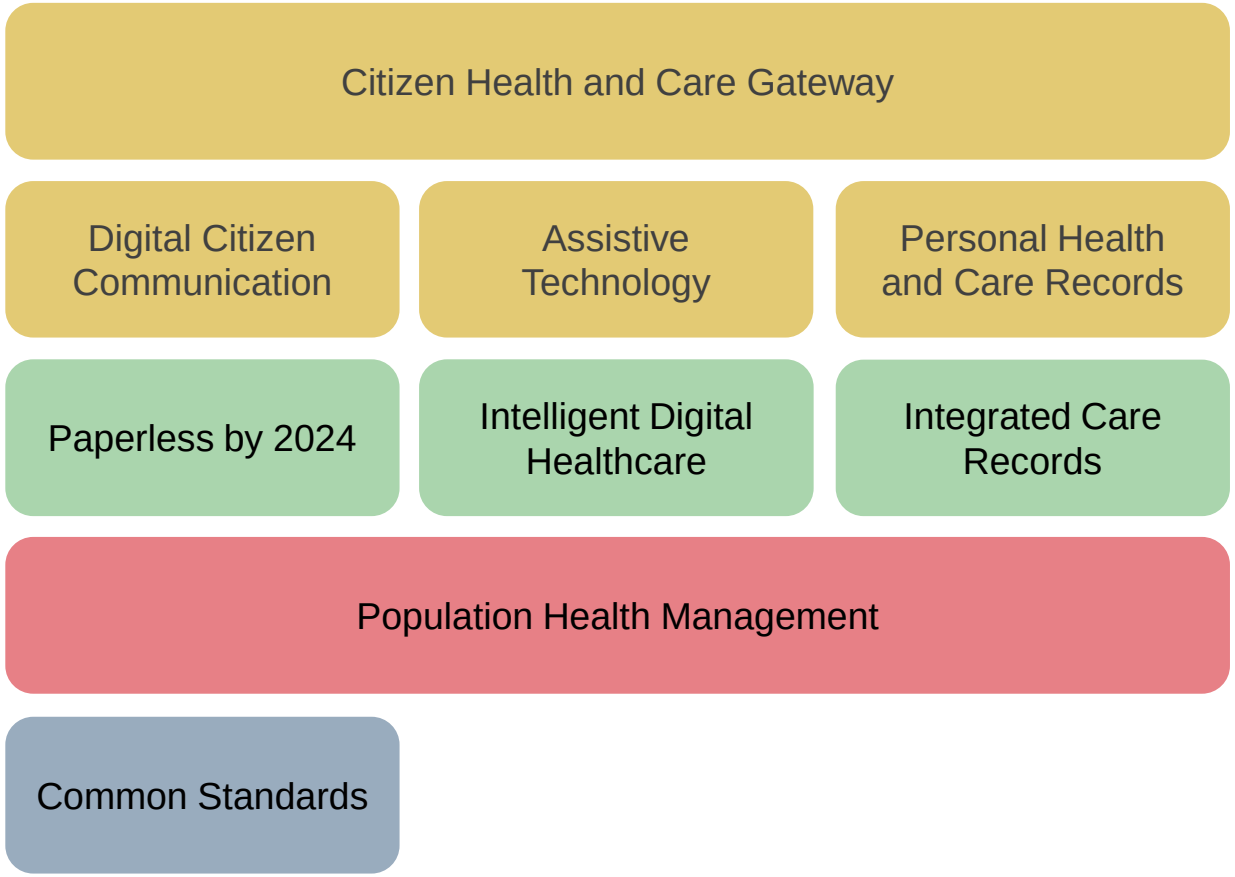
Digital Programme – Delivery Workstreams



Population Health Management:
Evaluate a range of current PHM pilots and implement a PHM toolkit comprising an enterprise wide core PHM system and smaller niche applications to amalgamate health and care information into a single repository to improve the delivery of health and care.

- Existing PHM pilot evaluation
- PHM Enterprise Solution
- PHM Niche Tools

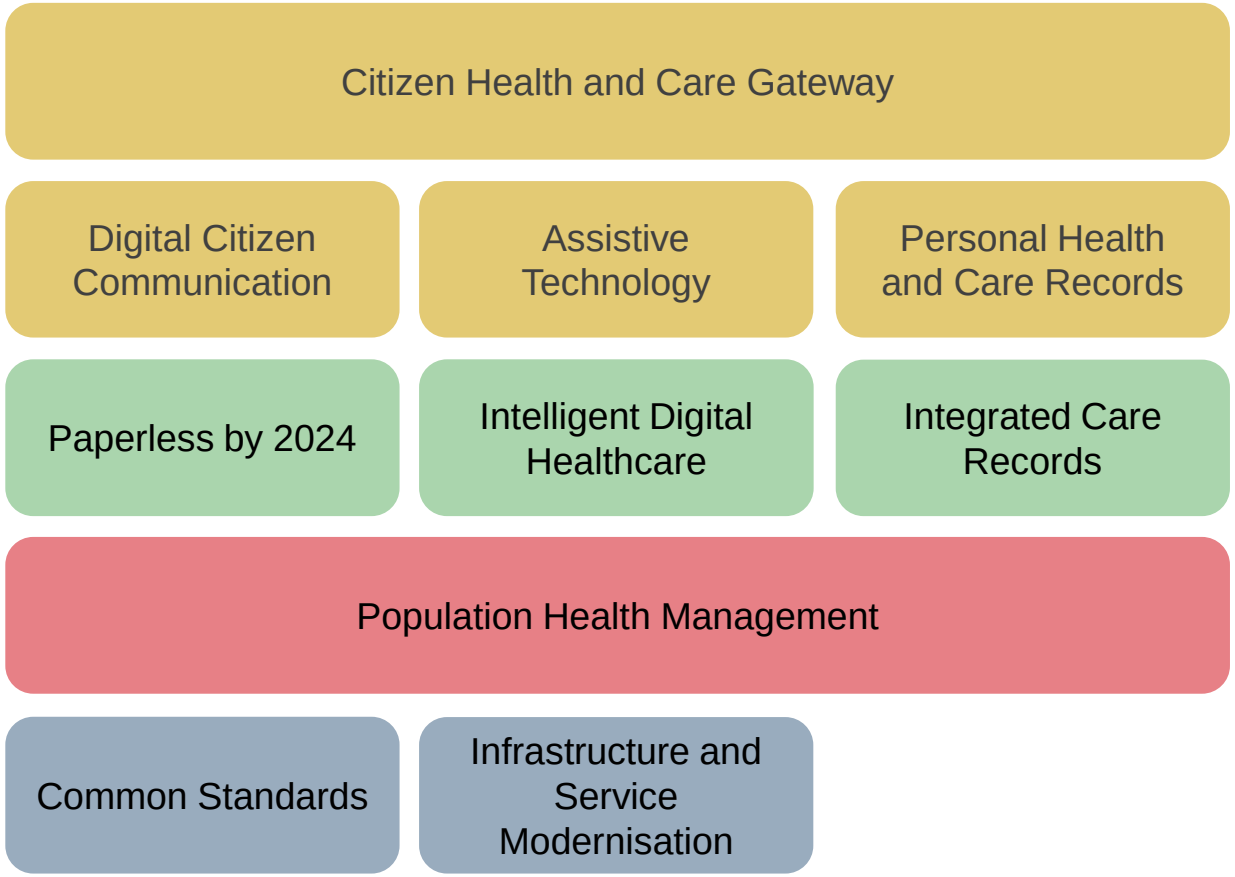
Digital Programme – Delivery Workstreams



Common Standards:
Ensure digital is a key enabler of change and delivers comparable, high quality information by adopting and embedding consistency and standardisation of digital tools and technologies throughout the Health and Care partners.

- Information sharing gateway
- Common Datasets
- Digital Commissioning
- Common Digital Standards

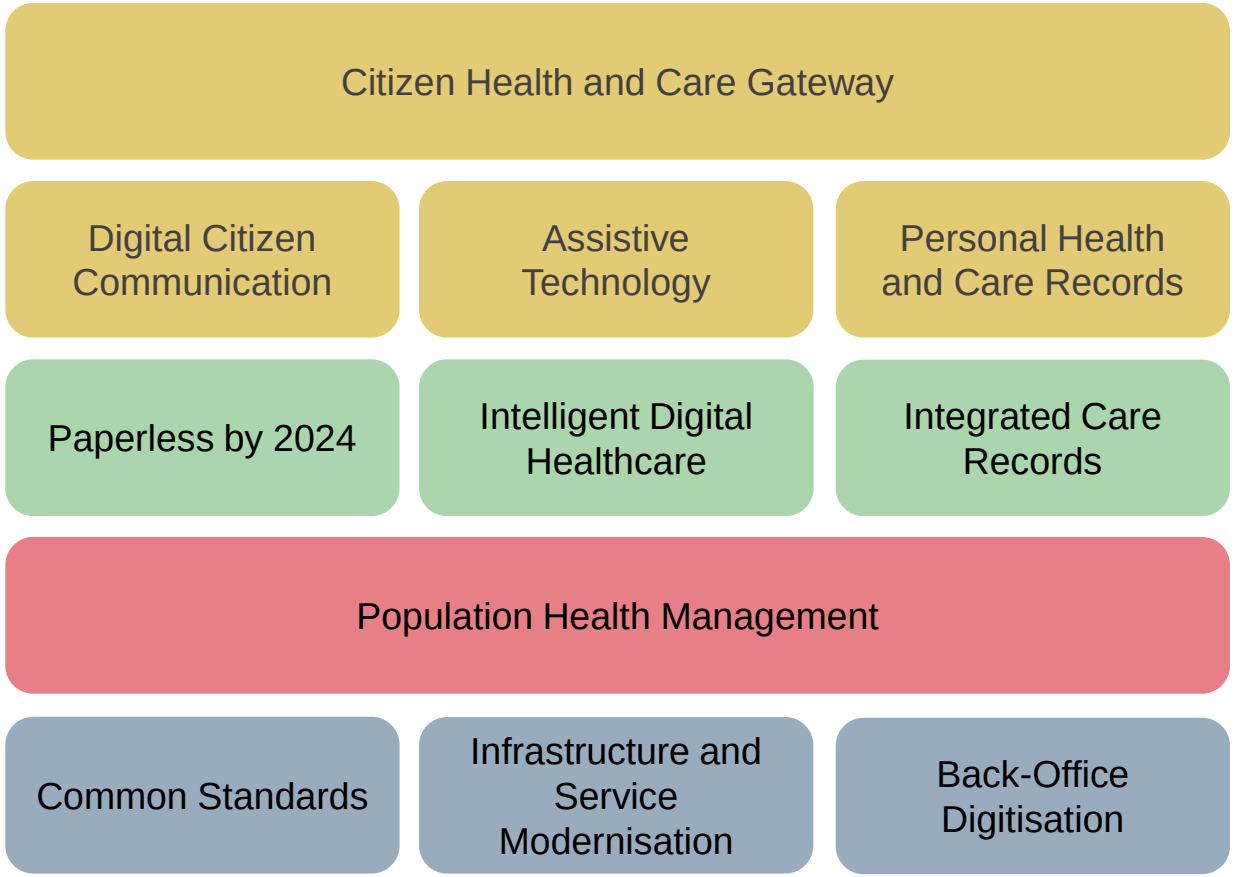
Digital Programme – Delivery Workstreams



Infrastructure and Service Modernisation:
Design and create a modern infrastructure and supporting services allowing simple, assured and portable access for all required users.

- Common Infrastructure Model
- Infrastructure automation and security
- NHSMail for care homes and hospices
- Unified IT Service Model
- User mobility

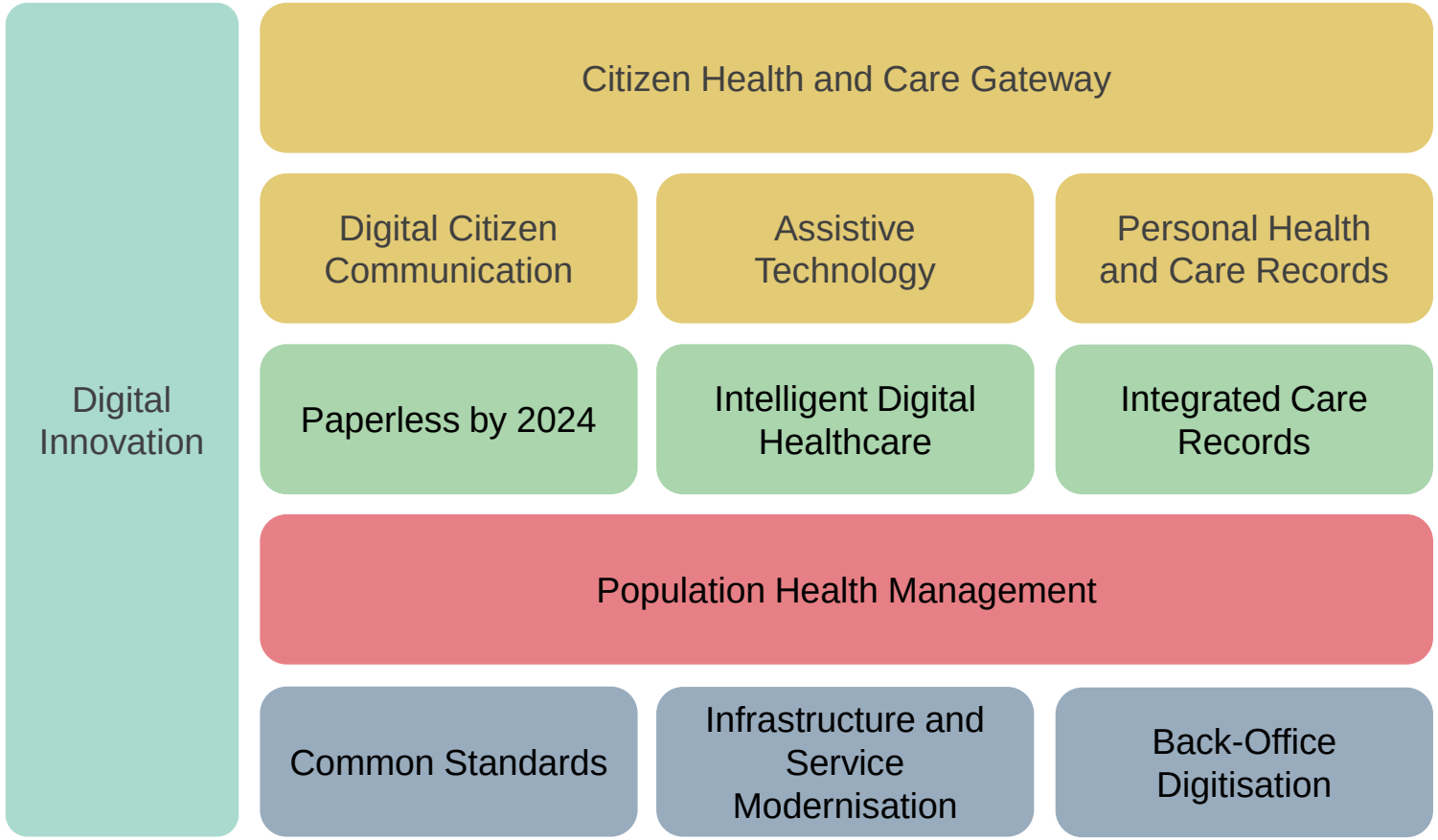
Digital Programme – Delivery Workstreams



Back-office Digitisation:
Support and promote back-office efficiency and effectiveness improvements by identifying and implementing opportunities for digital efficiencies.

- Robotic process automation
- Workforce engagement App
- WMAS corporate record digitisation

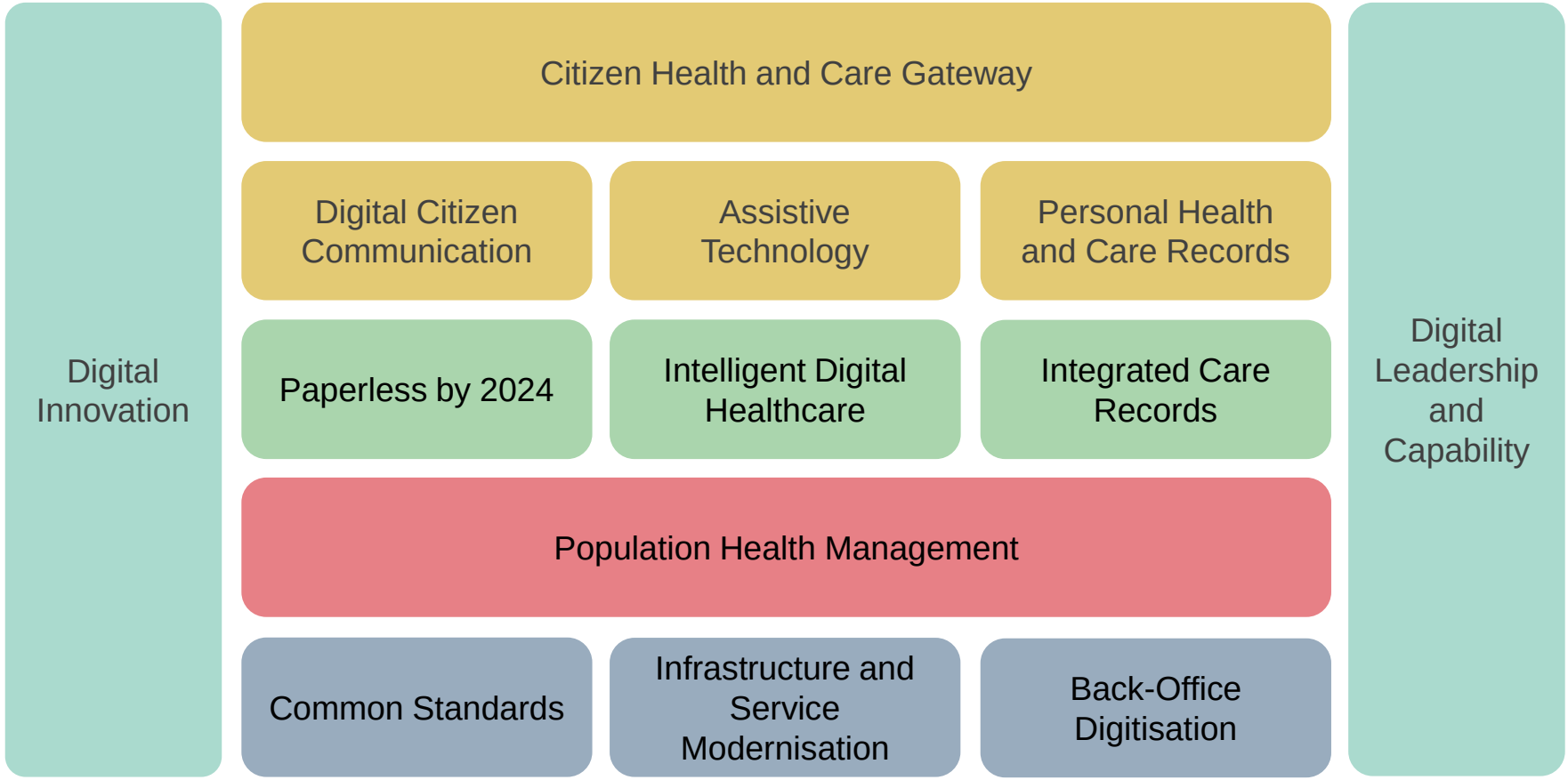
Digital Programme – Delivery Workstreams



Digital Innovation:
Create and foster a culture of digital innovation and engage the wider workforce and stakeholders in developing digital ideas to improve health and care delivery.

- Unified Digital Innovation Process
- Ideation and Engagement Hub
- Digital Innovation Centre

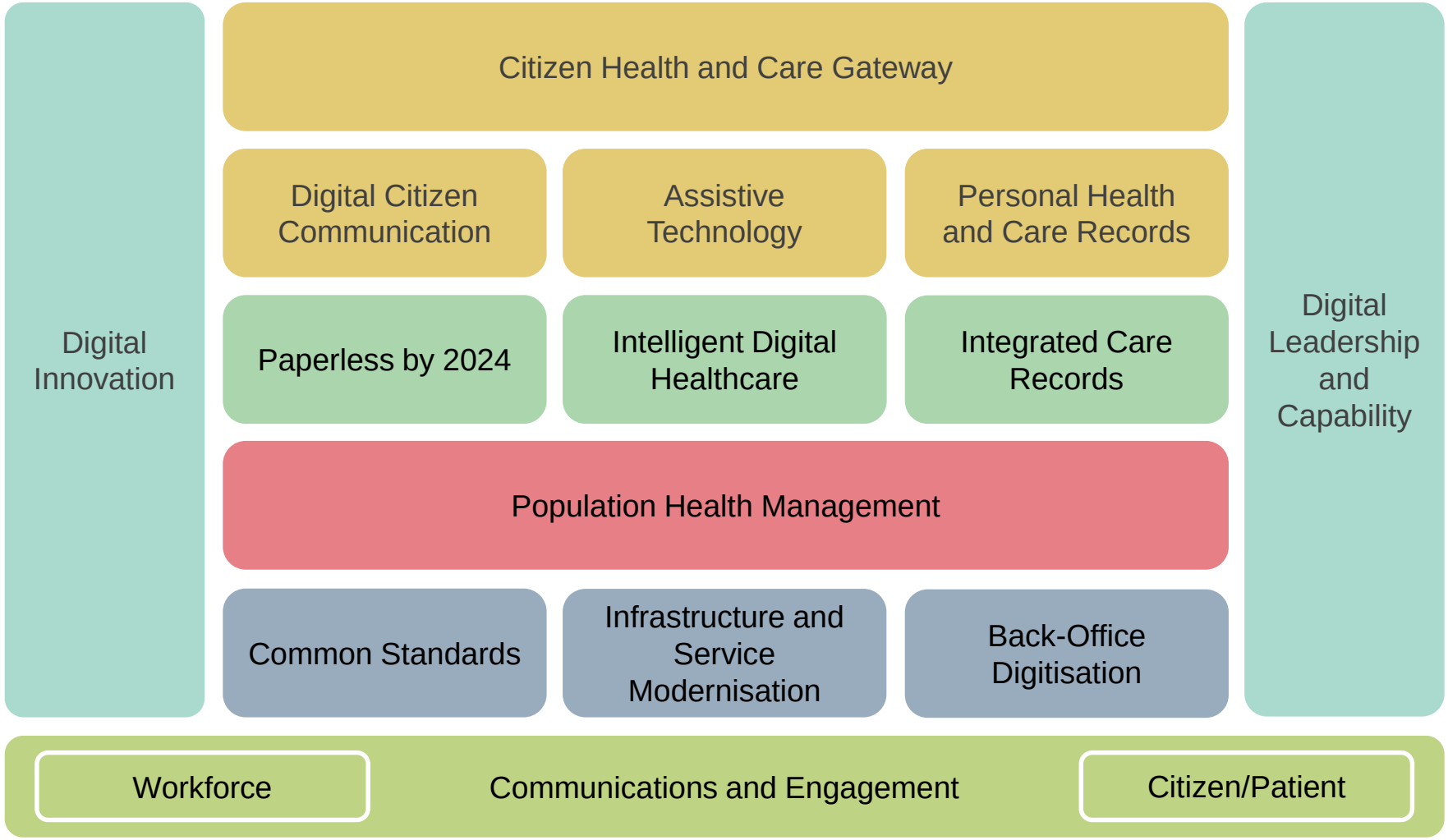
Digital Programme – Delivery Workstreams



Digital Leadership and Capability:
Develop the digital capability of staff and citizens whilst improving the wider digital leadership capacity to embrace and lead the future changes required.

- Public Digital Inclusion
- Digital Apprenticeships
- Clinical Digital Upskilling
- Digital Development Networks
- Digital Leadership Programme

Digital Programme – Delivery Workstreams



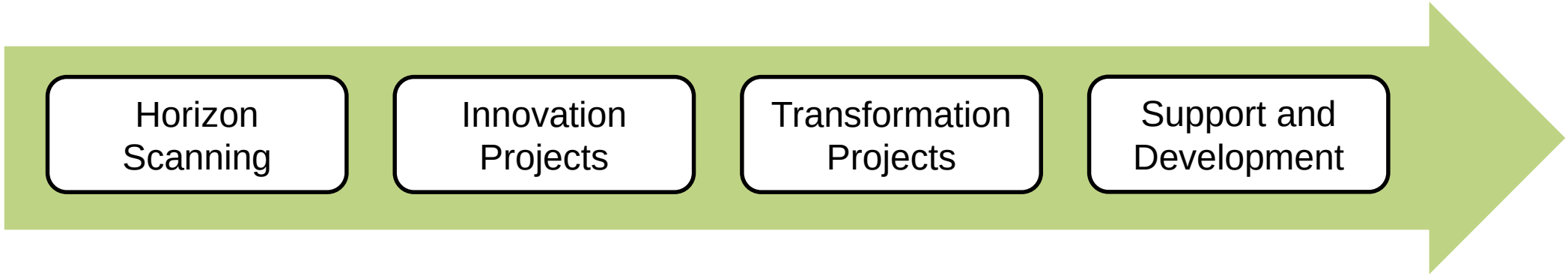
Communication and Engagement:
Integrated planning and approach to communications and engagement.

- Internal and external workforce
- Citizens and Patients

Key focus areas in behaviour change and public uptake of new technologies

Programme Approach

- Majority of the programme is not funded
- Approach
  - Prioritise deliverables
  - Define projects and business cases
  - Seek funding sources or alternate delivery approaches
  - Deliver
- Combination of centralised and localised delivery projects



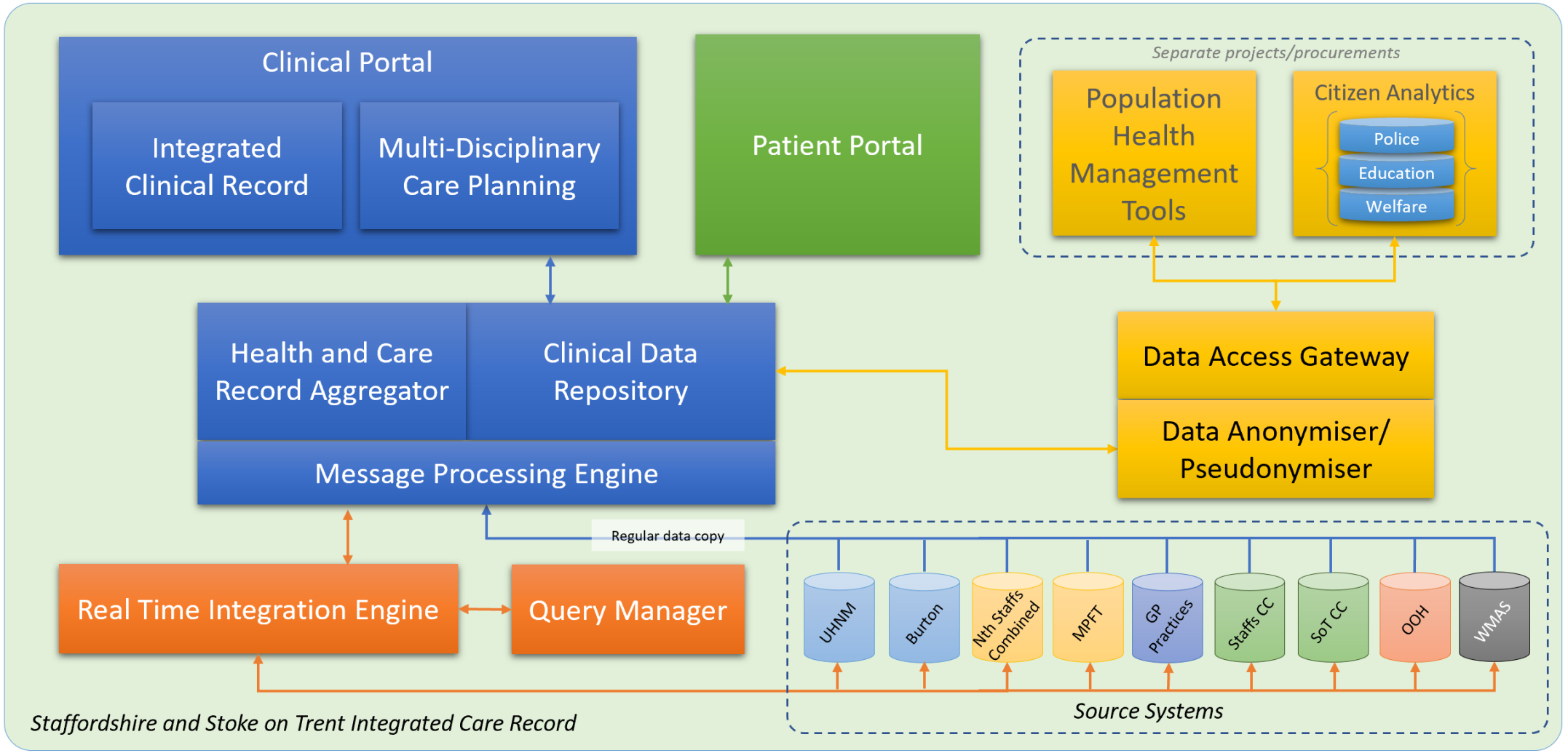
HealthandCare
ONE RECORD FOR BETTER HEALTH AND CARE

NHS

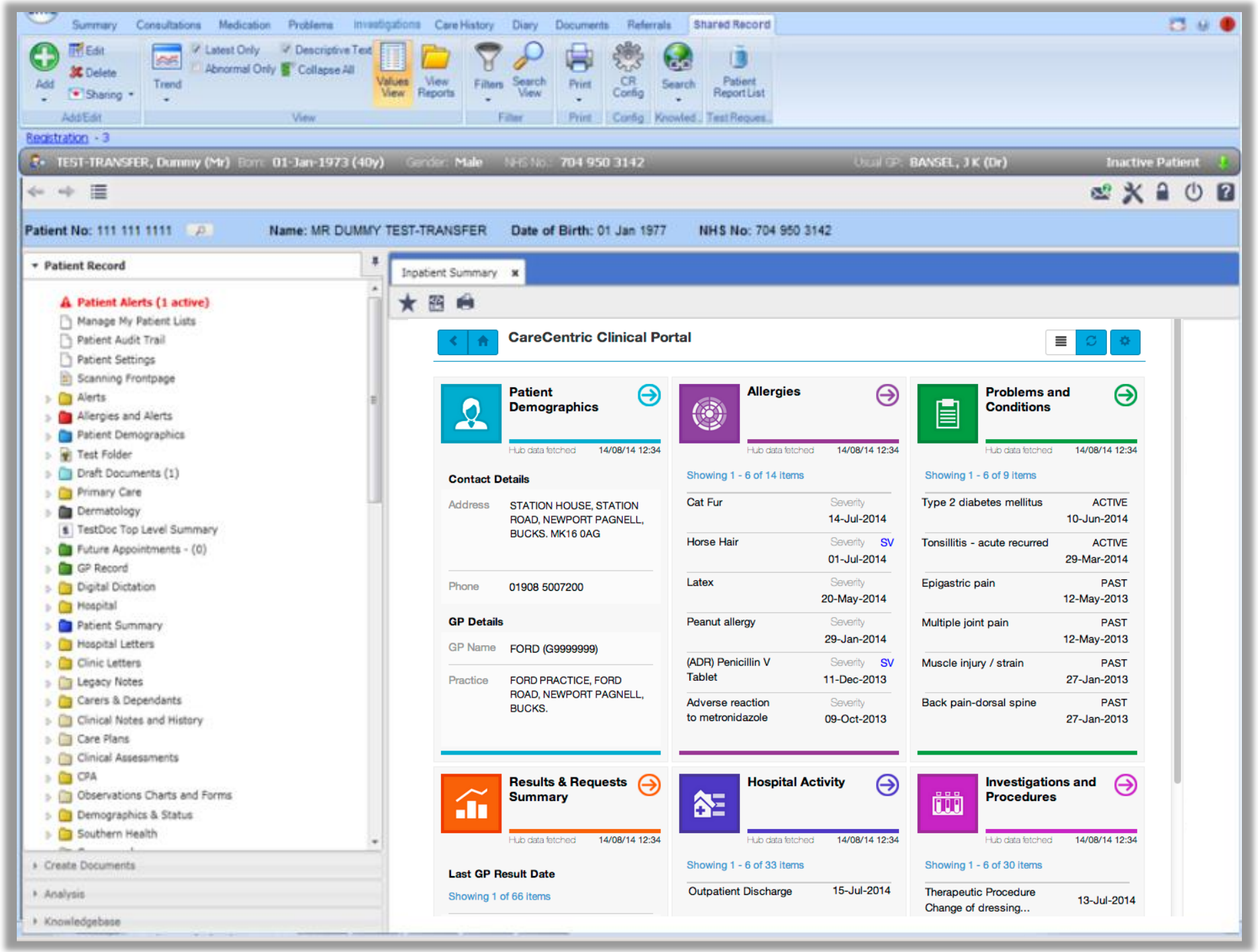
One Health and Care

One Record for Better Health and Care

Integrated Care Records - Overview



Information



HealthandCare
ONE RECORD FOR BETTER HEALTH AND CARE

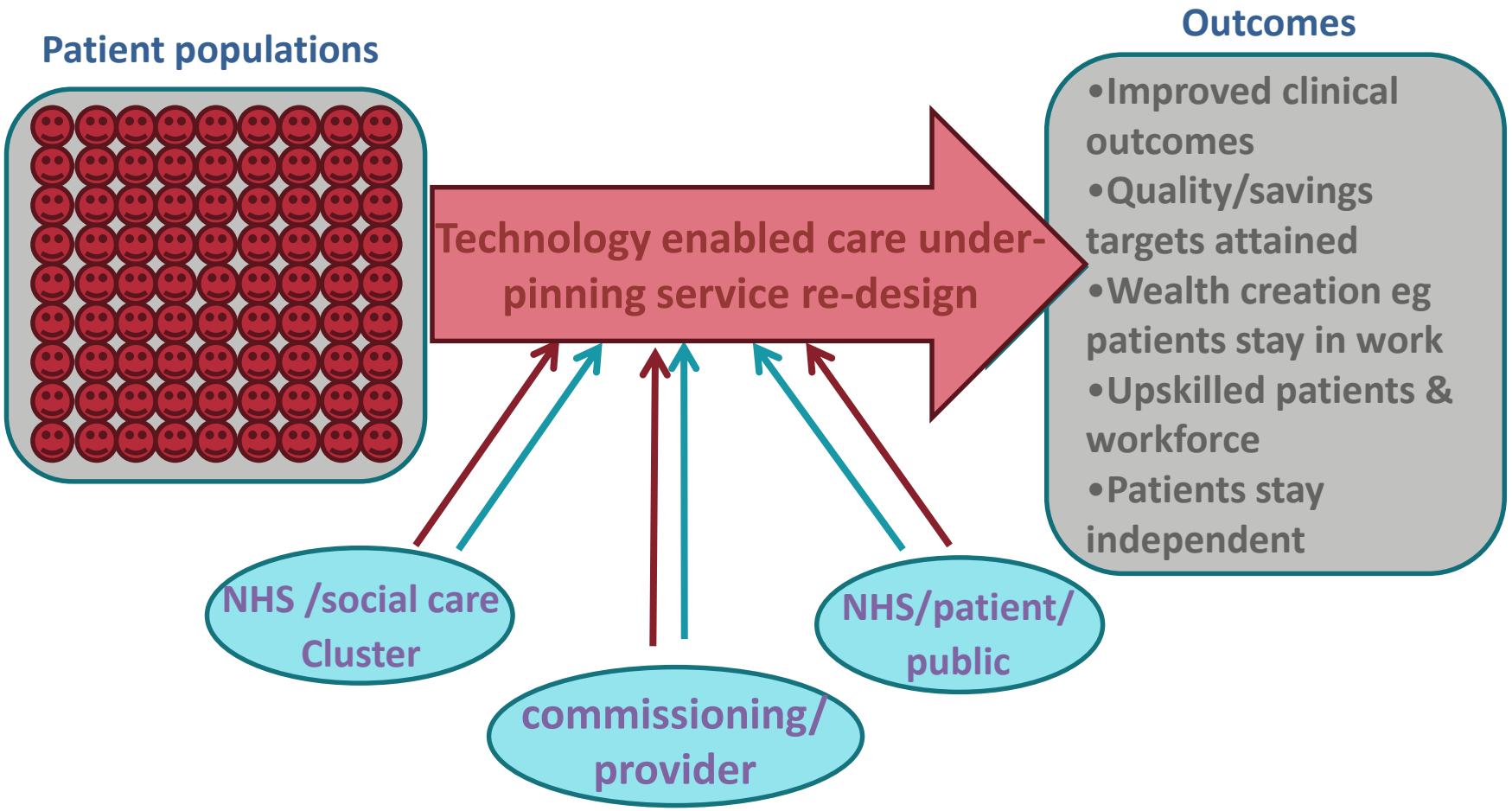
Progress to Date

- System procurement complete – contract awarded
- Agreements in place with all STP partners to share data
  - Information sharing gateway being implemented
  - Information sharing agreements currently being formally signed
- Test data messages complete between most partners and the integrated care record
- Fair-processing campaign complete
- Training material in development
- Anticipated live from April 2020 onwards
  - Go-live will be based on achieving a critical mass of information

How we are implementing Technology Enabled Care in Primary Care –across Staffordshire

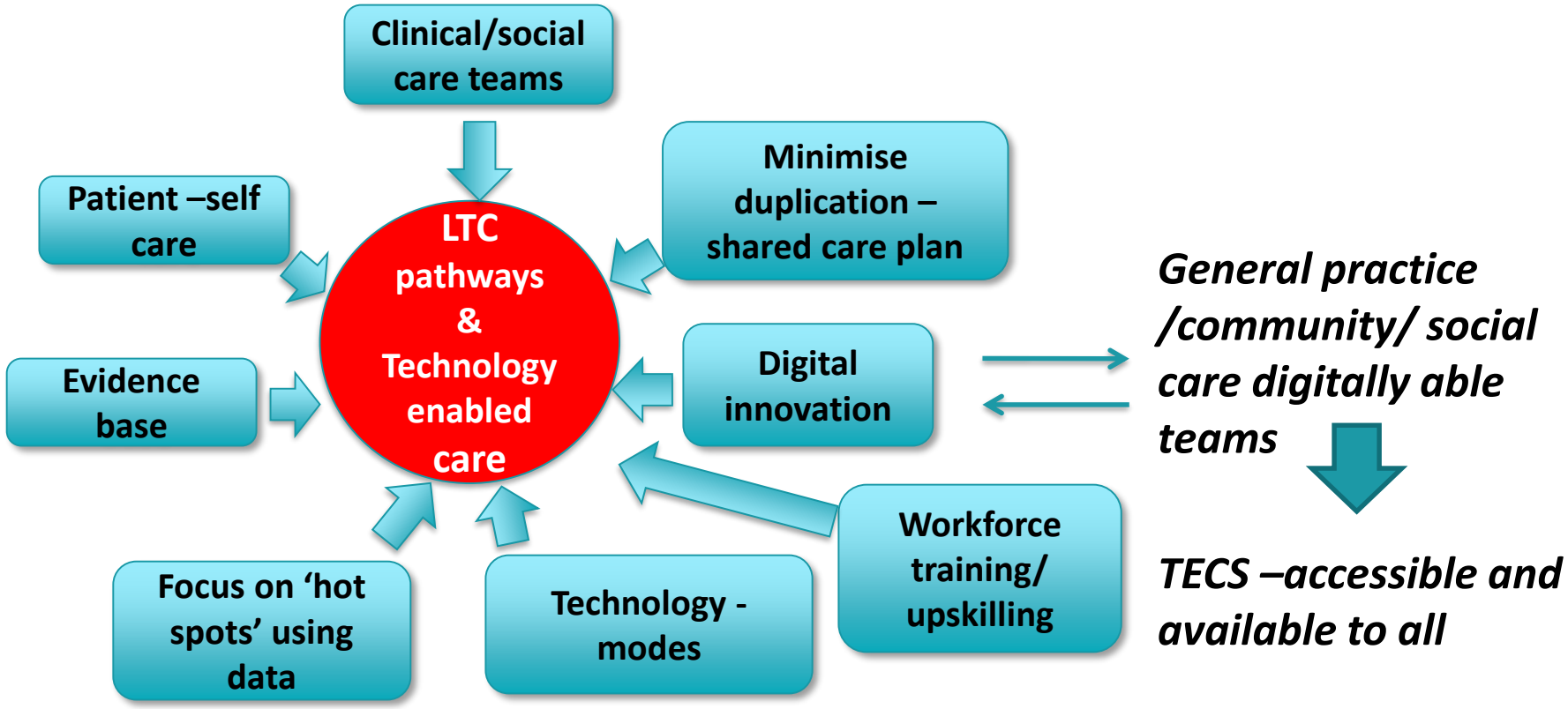
Dr Ruth Chambers OBE, Clinical lead for Staffordshire STP's technology enabled care services (TECS) programme, digital workstream board

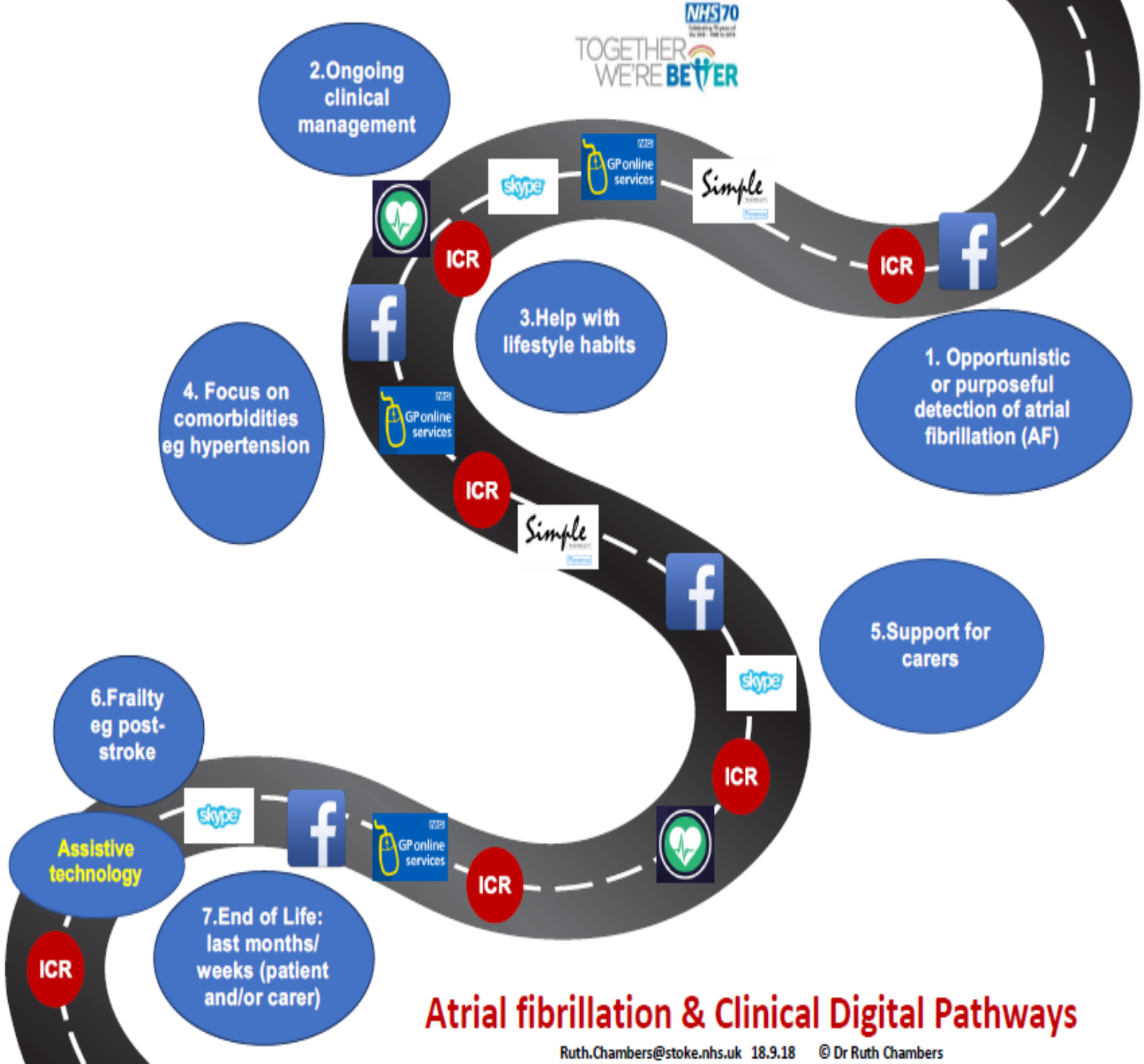
Technology enabled care at scale - the future



Digital Clinical /Social Care Champions

Developing confidence, competence, capability, continuity and capacity for delivery of technology enabled care





Atrial fibrillation & Clinical Digital Pathways

Ruth.Chambers@stoke.nhs.uk 18.9.18

Practice report: Opportunities for technology enabled care to underpin delivery of care for patients with key long term conditions and/or adverse lifestyle habits

GP practice: A2 CCG:

Modes of TECS practice currently uses as far as is known					
Lifestyle / long term condition indicator	**Practice**		**CCG**	**National**	**TECS opportunities**
	2016/17	**2017/18**	**2017/18**	**2017/18**	
COPD Prevalence	1.47%	1.60%	1.71%	1.91%	
COPD003- Percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months		97.67%	94.01%	89.69%	
COPD003 - Exception reporting		21.10%	16.83%	11.48%	
Atrial Fibrillation (AF) Prevalence	2.06%	2.30%	2.50%	1.91%	
AF007 – In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anticoagulation drug therapy	92.52%	87.90%	89.46%	90.04%	
AF007- Exception reporting		3.88%	4.61%	6.69%	
Stroke or TIA *Prevalence*	2.33%	2.28%	2.21%	1.75%	
STIA003 - Percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	94.70%	91.89%	85.89%	88.06%	
STIA003 – Exception reporting		5.13%	4.03%	4.46%	
STIA007 –Percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken	94.17%	99.04%	95.94%	97.37%	
STIA007 – Exception reporting		6.31%	4.30%	5.63%	

Atrial Fibrillation

- **AF prevalence**
  Average (1.9 – 2.5%) The number of your patients diagnosed and coded as having AF seems good being near your CCG's average prevalence rate. The CCG average is much higher than the national average as we've all worked so hard to identify and diagnose people with AF and might be partly due to the patient demographics locally- patients' age group, how many patients smoke etc. You could consider using technology enabled care to increase patients' awareness that they might have AF eg via your practice website or public Facebook messaging; or you could try screening patients not diagnosed as having AF or taking an anticoagulant at 'flu clinics or when they are attending for annual review of another long term condition or help with their adverse lifestyle habits.

- **AF007 – take a look at how your practice's exception reporting rate compares with the CCG average or national average too, when looking at the commentary on your practice performance.**
  You could promote GP Online to encourage patients to sign up and look at their own medical records and realise that they were diagnosed as having AF but at a stage when they were not anticoagulated as their CHADS2-VASc score was deemed too low to start anticoagulation. Obviously the practice team could do a records search every so often to pick up such patients if they might have been lost to follow up; then if their CHADS2-VASc score is ≥2 recommend they start anticoagulant medication. This could save more of your patients from having a stroke that might have been avoided.

- **Low (<89%)** The number of your patients who are taking an anticoagulant drug who have been diagnosed and coded as having AF with a CHADS2-VASC score of ≥2 seems a bit low, compared with your CCG's average rate. The CCG average is similar to the national average. You could consider using technology enabled care to increase patients' awareness of the importance of adhering to their medication eg via Flo telehealth interactive texting for medication adherence, or maybe try setting up a Closed Facebook Group for patients with AF who will benefit from peer to peer support and clinical input to encourage a healthy lifestyle.

AliveCor Screening across Staffordshire PCNs

The number of practices using AliveCor to screen patients for AF

113 out of **152**
practices are using **AliveCor** to screen their patients for AF

The national AF prevalence is 1.91%

Region	Practices Using AliveCor	AF Prevalence
North Staffordshire	25	2.49%
Stoke-on-Trent	31	2.00%
Stafford and Surrounds	11	2.50%
Cannock Chase	11	2.13%
South East and Seisdon	17	2.35%
East Staffordshire	18	2.06%

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Transforming health and care for Staffordshire & Stoke-on-Trent

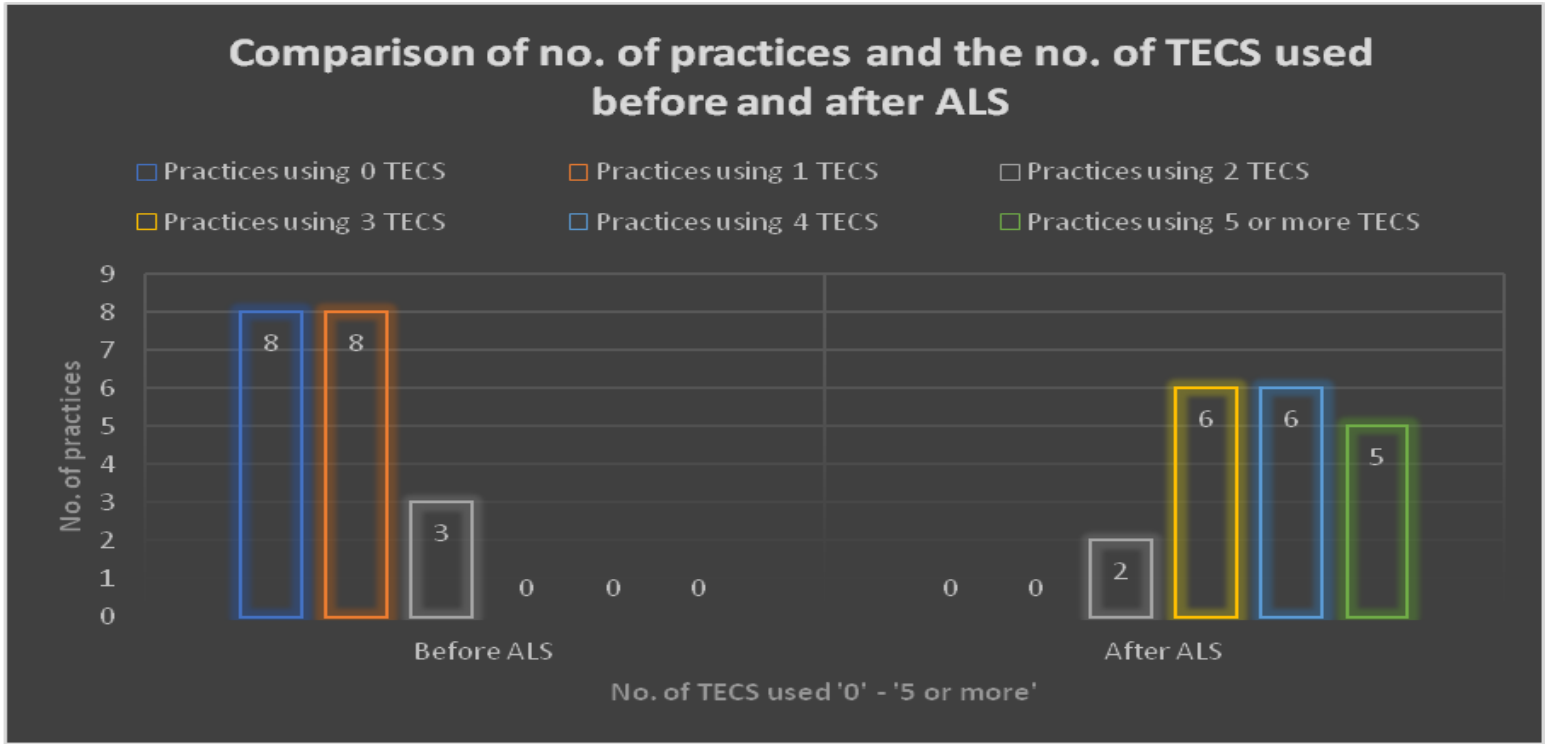
AF prevalence and achievement across 6 Staffordshire CCGs

2013/14	National	Cannock Chase	East Staffs	North Staffs	South East and Seisdon	Stafford and Surrounds	Stoke on Trent
AF prevalence	1.57	1.71	1.64	2.03	1.76	1.95	1.67
2014/15	National	Cannock Chase	East Staffs	North Staffs	South East and Seisdon	Stafford and Surrounds	Stoke on Trent
AF prevalence	1.63	1.83	1.71	2.12	1.86	2.04	1.73
2015/16	National	Cannock Chase	East Staffs	North Staffs	South East and Seisdon	Stafford and Surrounds	Stoke on Trent
AF prevalence	1.71	1.90	1.81	2.21	1.97	2.17	1.79
AF007	86.69	85.34	87.00	85.33	86.45	84.68	87.27
2016/17	National	Cannock Chase	East Staffs	North Staffs	South East and Seisdon	Stafford and Surrounds	Stoke on Trent
AF prevalence	1.84	2.06	1.97	2.40	2.16	2.40	1.91
AF007	88.41	89.05	90.61	86.88	86.69	88.29	89.56
2017/18	National	Cannock Chase	East Staffs	North Staffs	South East and Seisdon	Stafford and Surrounds	Stoke on Trent
AF prevalence	1.91	2.13	2.06	2.49	2.35	2.50	2.00
AF007	90.04	89.96	91.01	89.59	88.26	89.46	91.24
2018/19	National	Cannock Chase	East Staffs	North Staffs	South East and Seisdon	Stafford and Surrounds	Stoke on Trent
AF prevalence	1.98	2.26	2.13	2.64	2.46	2.60	2.08
AF007	91.09	91.03	92.51	91.19	89.59	89.97	91.73

AF007 - In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, % of patients who are currently treated with anticoagulation drug therapy

Case Study – Staffordshire STP TECS

Comparison of 19 practices where 24 general practice nurses participated in digital upskilling programme; modes of TECS used before and after their action learning set (ALS)



What do we seem to have achieved?

- Technology-enabled care services by general practice teams provided as routine patient care including via apps, video-consultation, telehealth, social media, GP Online.
- Expected / achieved benefits: enhanced productivity (practice teams); patient empowerment to self care and thus improved clinical outcomes; minimised unwarranted clinical variation; increased patient convenience.

Benefits vary according to the practice and their adoption of specific mode of TEC and purpose. By October'19, of 151 general practices across Staffordshire:

104 practices were using Facebook
21 practices undertaking video-consultations
28 practices using interactive Flo telehealth
41 practices promoting apps (probably more)
113 practices using 'AliveCor' for AF screening (smart phone compatible portable handheld ECG heart rate monitor)
23 practices undertaking online clinical consultation triage

Facebook and video consultations in Staffordshire

611 people are supported in closed Facebook groups in Staffordshire for long term health conditions

859 **video consultations** in North Staffordshire and Stoke-On-Trent between care homes and health professionals, such as GPs and nurses

9 care homes, 12 GP practices, and mental health nurses are participating in the pilot - with an expansion into **5 more care homes** and **5 more GP practices** before September 2019

859 video consultations
have occurred since June 2018

2,772 minutes
of GP travel time saved

706 miles
of driving saved

618 face to face visits
avoided

NHS

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Staffordshire practices' use of public facebook pages for population health messaging

The number of practices using public Facebook pages to promote population health messages

104 out of **152** practices **using facebook** in 23 PCNs

30	North Staffordshire
33	Stoke-on-Trent
5	Stafford and Surrounds
11	Cannock Chase
11	South East and Seisdon
14	East Staffordshire

OVER 13,750 LIKES on public facing **Facebook pages** across Staffordshire

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Extent of responsibility for delivery of integrated & connected care via TECS

1.Shared real time responsibility by ≥2 clinicians/ social workers, in different organisations/settings share TECS directly (same mode of technology or connected if different) for delivery of an agreed shared care plan of same patient/ same condition at same treatment phase (clinicians/ social workers have agreed responsibility via shared care plan agreed by patient, that optimises patient responsibility for their own care)

2. Shared sequential responsibility: ≥2 clinicians/ social workers, in different organisations/settings interface; so one **hands over** responsibility to the other for providing TECS directly (same mode of technology or different) for continuing care of same patient/same condition via agreed care plan.(This might be by the most senior/expert defining the patient pathway and endorsing the TECS protocol for others to provide with real time support eg advice in person/by email; with shared care plan agreed by patient, that optimises patient responsibility for their own care.)

3. Shared multidisciplinary protocol with one TECS operator: ≥2 clinicians/ social workers, of different disciplines, in same organisation or setting; sharing (delegated) responsibility for providing TECS directly (≥1 mode of technology) for continuing care of same patient/≥ 1 conditions via agreed care plan. (This might be by the most senior/expert defining patient pathway and endorsing TECS protocol(s) for others to provide with real time support eg advice in person/by email; with shared care plan agreed by patient, that optimises patient responsibility for their own care.)

4. Shared delivery by individual professional with patient/carer: TECS initiated & delivered by health /social care professional who updates other health/social care professional(s) or teams involved in the patient's care (ie giving information rather than interactive decision making between professionals). It might be that a patient requested the inclusion of their personal technology such as an app in their health or social care, that the initiating health/social care professional has adopted; with shared care plan agreed by patient, that optimises patient responsibility for their own care.

5. Person selects and purchases own technology to support or improve their own health and/or social care and/or lifestyle habits: they may include goal setting, reminders, records of feelings/bodily measurements etc, action plans, information about best practice. They may or may not share their personal information/record keeping generated by the technology (eg health app) with a health/social care professional.

Making digital delivery happen at scale in your workplace setting

Aim – Adopt technology enabled care as usual practice

Outcomes – Improve patient /clinical management of long term conditions/adverse lifestyle habits – efficiently and effectively

Scope – Which type(s) of technology will you use to achieve planned outcomes/ what LTCs and adverse lifestyle habits will you focus on/ what population health & wellbeing?

Resources – Who/what do you/teams need – infrastructure, equipment, competence, practical support, capacity, communication, integrated working, clinical consultation triage?