NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire's Local Digital Roadmap (LDR)

Health and Wellbeing Board, 13th July 2017

Stuart Bell CBE, Gareth Kenworthy and
Lukasz Bohdan


North


North East


Oxford City


South East


South West


West

Glossary

5 Year Forward View – NHS strategy document published in 2014 setting out a new shared vision for the future of the NHS

LDR, Local Digital Roadmap – a local plan for making patient records digital and interoperable by 2020

OCS, Oxfordshire Care Summary – single electronic view of specific, up-to-date, clinical information from your GP record and other records supporting your care in NHS organisations in Oxfordshire

STP, Sustainability Transformation Plan / Partnership – originally plans, now partnerships, involving the NHS and local government in 44 areas covering all of England, to improve health and care. Each area has developed proposals built around the needs of the whole population in the area, not just those of individual organisations. Oxfordshire is part of the **(BOB) Buckinghamshire, Oxfordshire and Berkshire West 'footprint'**

Universal Capabilities – technology "must dos" for NHS to deliver during 2017/18 e.g. online GP and repeat prescription bookings

Our aim for this briefing is to build a common understanding of the Oxfordshire Local Digital Roadmap…

More specifically, we will:

- Explain the national context and look at Buckinghamshire Oxfordshire Berkshire West (BOB) Sustainability Transformation Partnership (STP) Local Digital Roadmap (LDR) priorities
- Explain "Universal Capabilities" we must deliver in 2017/18
- Explain what it all means for Dot – an Oxfordshire resident – and those involved in her care…

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The LDR is a national process introduced by NHS England in September 2015 to make sure patient records locally are digital and interoperable by 2020

The Five Year Forward View and Personalised Health and Care 2020 describe the commitment by the health and care system and the government to use information and technology and make sure patient records are digital and interoperable by 2020.

'Digital' has a significant role to play in sustainability and transformation, including for example delivering primary care at scale, securing seven day services, enabling new care models and transforming care in line with key clinical priorities.

Last year local health and care systems produced Local Digital Roadmaps, which set out how they will achieve these commitments

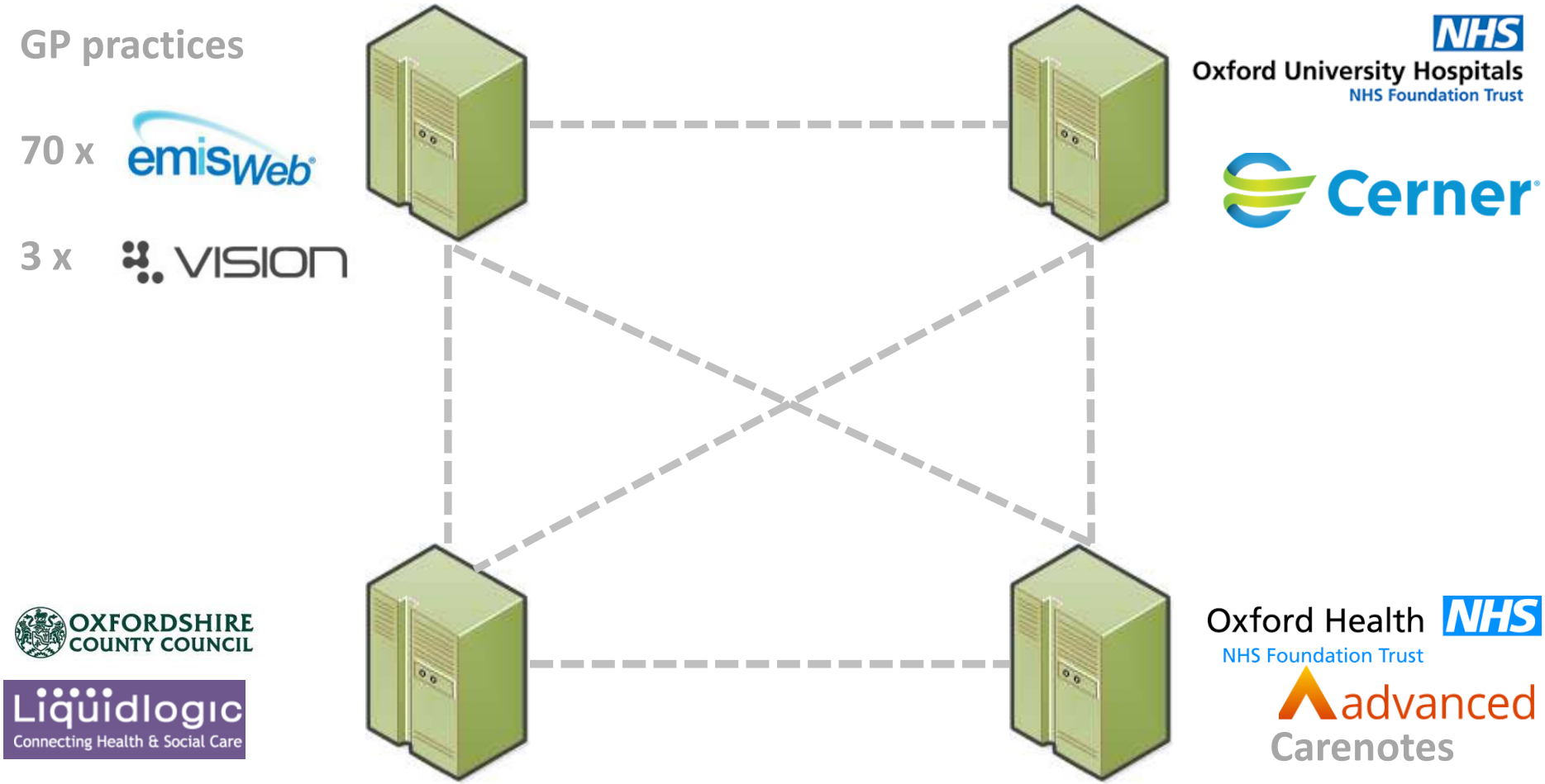
BOB LDR priorities

Five priorities have been agreed by the BOB Chief Information Officer (CIO) forum to deliver the Sustainability and Transformation Plan (STP) requirements. Co-ordinated workstreams will be set up locally and regionally to deliver these priorities

- **Records sharing**
- **Citizen-facing technology**
- **Whole system intelligence and real-time clinical intelligence**
- **Infrastructure and network connectivity**
- **Information Governance**

This is in addition to the NHS England requirement to deliver specific digital capability by the end of 2017/18. These are known as Universal Capabilities

Oxfordshire IT Map



Record sharing and transfers of care

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Vision	**To enable health and care professionals to have immediate and appropriate access to all relevant information about a person's care, treatment, diagnostics and previous history, including care plans and all necessary transfers of care information.**

Oxfordshire plan (2017/18)	▪ **Migrate the Oxfordshire Care Summary (OCS) to a new Cerner platform - Health Information Exchange (HIE) – main use for emergency care:**
	  ▪ **Maximise use of digital Proactive Care plans (End Of Life, Special Patient Notes)**
	  ▪ **Embed access to Oxford University Hospital (OUH) in GP system**
	  ▪ **Develop access to Social Services data and Oxford Health data in HIE**
	  ▪ **Develop access by Social Services and Oxford Health to HIE**
	▪ **Develop the Cerner HealtheIntent platform to provide an integrated shared care record platform:**
	  ▪ **Initially with Long term conditions (diabetes, asthma, COPD)**
	  ▪ **End of Life**
	  ▪ **Frailty**
	▪ **Mental health discharge summaries**
	▪ **OH orders and results**
	▪ **Child Protection Information System (CP-IS)**

Citizen-facing technology

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Vision	**Support and enable people to be actively involved in managing and making decisions about their care, and provide a strong basis for well-being and prevention.**
Oxfordshire plan (2017/18)	**Working in conjunction with the prevention and citizen engagement transformation programme:** ▪ **Align portal plans.** ▪ **Audit existing approved apps (e.g. diabetes).** ▪ **Develop technical standards for connecting to integrated records.** ▪ **Develop processes for linking records/decision tools to guidance, prevention and self care advice.**

Whole system intelligence

NHS Oxfordshire

Vision	**Health and care professionals across communities, geographic and clinical, have the information & insights they require to run an efficient and effective service, including for care delivery, planning, targeting, monitoring, auditing, and research.**
Oxfordshire plan (2017/18)	**This is very much a green field development area.** **In Oxfordshire the intention is to build on the Population Health Management capabilities delivered by the Cerner HealtheIntent platform to develop.** ○ **Real time information to support responses to immediate pressures.** ○ **Trend analysis and rapid assessment of service changes.** ○ **Risk modelling to support targeting for care management** ○ **Predictive demand and capacity modelling across all settings of care.** ○ **Information to target of patients with services and care pathways appropriate to their need – e.g. diabetes patients.** **Across BOB the focus will be on integrated Cancer information working with the Thames Valley Cancer network.**

Infrastructure & network connectivity

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Vision	**To have a fast, reliable infrastructure, with shared connectivity, at a lower cost, with common ways of working that supports access to "home" systems across the footprint.**
Oxfordshire plan (2017/18)	**A BOB-level workstream to:** ▪ **Procure jointly: e.g. COIN, increased bandwidth** ▪ **Define common standards** ▪ **Align firewalls** ▪ **Enable user domain interoperability** ▪ **Connect Councils and Care Homes**

Information Governance

NHS Oxfordshire

Vision	**To put in place a common set of processes to appropriately and effectively use information in line with the expectations of patients and citizens, such that IG is an enabler, not a barrier, to care or planning or targeting or research.**
Oxfordshire plan (2017/18)	**A BOB-level workstream developing:** ▪ **Common consent models.** ▪ **Standardised data sharing agreement and processes.** ▪ **A common understanding of what data can be used for - that is signed up to across the STP area.** ▪ **Public engagement on data use.** ▪ **A joined up process for handling subject access requests and patient queries.**

Universal Capabilities

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The 10 Universal Capabilities

NHS England has identified 10 Universal Capabilities where there is an opportunity to exploit existing investments in healthcare technology and deliver real benefit within a short timeframe. These must be delivered by end of 2017/18

These are incorporated in the work streams: Record Sharing & Transfers of Care & Citizen-Facing Technology

a. Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions via OCS
b. Clinicians in Urgent & Emergency Care (U&EC) settings can access key GP-held information for patients previously identified by GPs as most likely to present (in U&EC) via OCS
c. Patients can access their GP record Digitally via EMIS/Vision portal - not used much
d. GPs can refer electronically to secondary care via Electronic Referral Service (ERS)
e. GPs receive timely electronic discharge summaries from secondary care All except MH
f. Social care receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care In plan
g. Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly March 2018 – reliant on OCC
h. Professionals across care settings made aware of end-of-life preference information via OCS
i. GPs and community pharmacists can utilise electronic prescriptions National EPS
j. Patients can book appointments and order repeats prescriptions from their GP practice Being rolled out by GP practices and GP system suppliers

Local priorities for these digital developments include:

- Urgent and Emergency Care:
  - Accident and Emergency (A&E)
  - Ambulance
  - Prevention….
- Long term conditions:
  - Diabetes
  - Asthma
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Prevention…..
- Maternity
- Frailty
- Mental Health
- Learning Disabilities

The Governance:

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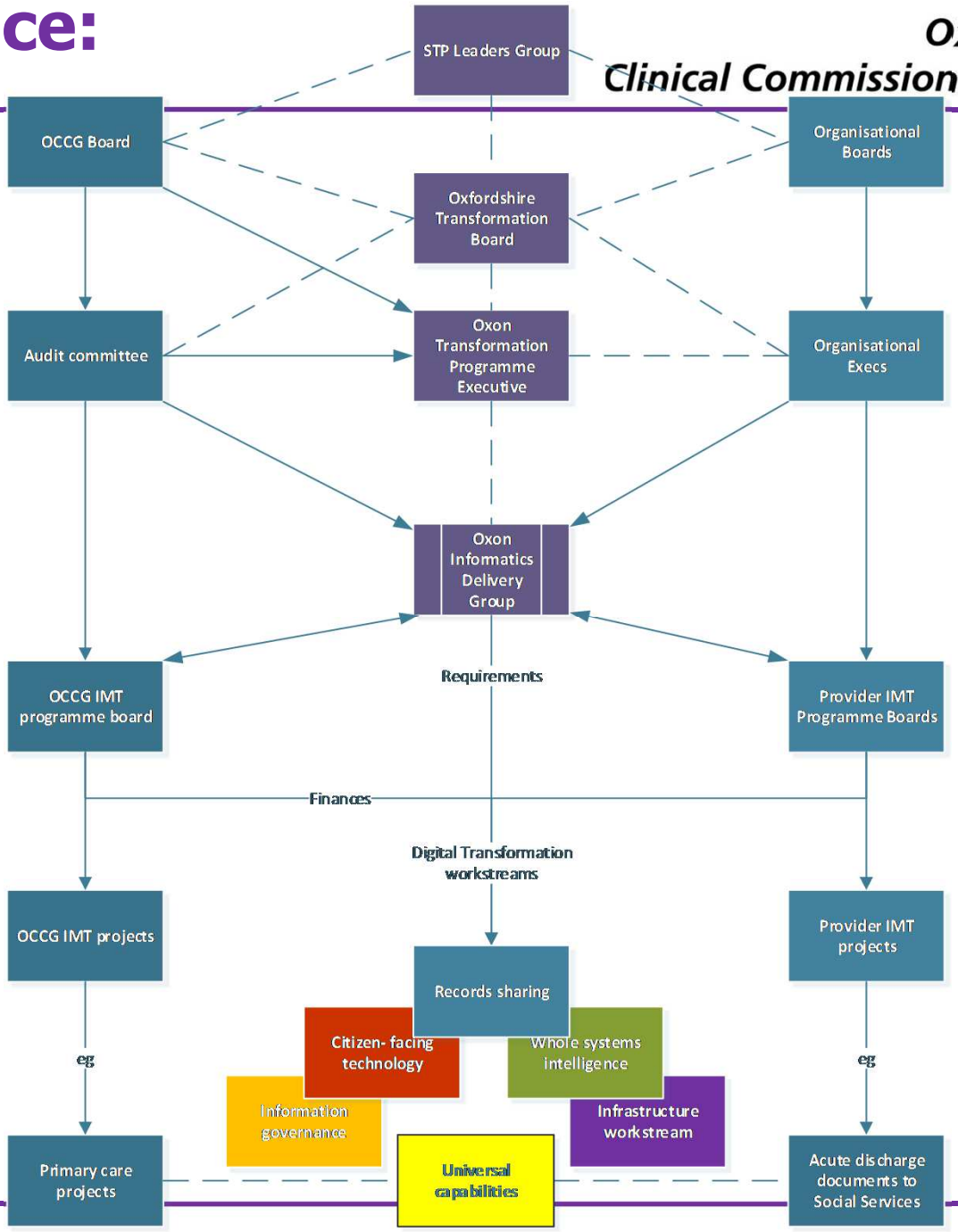
It's a complex landscape requiring effective governance…

This is the simple version



Why are we doing this?

Introducing Dot, an Oxfordshire resident…

"I get very worried about being by myself when my breathing gets worse. When I called NHS 111 the lady knew about my emphysema and said she was sending a paramedic to see me. He knew about my problems, that I smoked and the treatment I was taking, so I didn't have to keep telling everyone the same story when I went into hospital.

My GP came out to visit me when I came home. He knew everything that had happened to me in hospital and told me I would need to reduce the dose of one of my tablets next week. I am not very good at remembering things so the nurse is going to call me on my iPad to remind me and to check that I am alright."

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And all those involved in Dot's care ……

"As the **call handler** I know that Dot has a long-term problem with her lungs and that the nurse has been to see her at home three times in the past week. This information helps me decide that Dot needs someone to assess her at home and see whether she needs to be admitted to hospital. So I ask for a paramedic to be dispatched."

"As the **paramedic** attending Dot I can assess how much her current condition differs from when she was last seen by her GP. I can also see her previous blood results which lets me know her usual oxygen level and whether she is sensitive to treatment with oxygen. This means I can treat her safely."

"As the **A&E consultant** I can see that Dot was barely able to speak and was very wheezy when she was seen by the ambulance staff. She had a high temperature and very low oxygen level when she was first seen. I can compare the recordings taken in hospital with those taken by the paramedic and see that Dot has improved with the treatment she has received on the way to hospital. I can see that the chest x-ray she had done in A&E shows signs of an infection which wasn't there on her previous chest x-ray."

"As the **Respiratory registrar** I can see from Dot's previous hospital record that she was in hospital for 2 weeks last winter with a bad chest infection and took a while to recover. I can see the antibiotics she was given at that time so decide to prescribe the same ones. I am alerted that she has an allergy to this and when I look back at the notes from her last hospital admission I can see she developed a rash with the antibiotic, so her treatment was changed. Although she has not been in hospital for a year I can see from her GP notes that the nurse has been visiting her more frequently at home recently, as she has not been coping as well."

"Dot can't remember the name of all her medicines and inhalers. As the **hospital pharmacist** I can look at the information in Dot's GP record which tells me all the medications she usually takes so I can make sure these are prescribed. I can also see that Dot's GP prescribed her a course of antibiotics two weeks ago which she has recently finished, so I can discuss the best antibiotic treatment to give Dot while she in in hospital with the Respiratory Registrar.

I could see from Dot's care records that she hadn't had her annual flu jab. I administer Dot with a Flu jab and make a note on her care record."

"As the **discharge nurse** I can see from Dot's GP notes that she needed a lot of input after she was discharged from hospital last year and lost her confidence getting back on her feet after her chest infection. I speak to her daughter who lives 50 miles away. She is worried that Dot won't manage if she is discharged home quickly and she mentions that Dot has been struggling to get into the bath and to get out to the shops recently. I set up a conference call with her GP, the community hospital consultant, social services and Dot's daughter. We decide that Dot should go to the community hospital for a while once her chest infection is improving. I record the outcome of the meeting in Dot's shared care plan."

"When I see Dot in the **community hospital** I can see the treatment she had in hospital and review the assessments made by the physiotherapist. I can also see from the GP record that Dot has not been managing well at home for a few months and will need some additional care at home when she goes home. I notify social services of Dot's likely discharge date so they can make sure her new care package can be put in place. I update Dot's shared care plan.

I can see from Dot's care record that she has not yet received the latest stop smoking kit. I give her a kit and mark her down as having received one."

"As **Dot's GP** I can see that Dot had phoned NHS111, been seen by a paramedic and then admitted to hospital. I know which ward she was admitted to and who was looking after her.

Now that Dot has been discharged home I can see all the treatment she has been given from her hospital records and the note from the hospital consultant to ask me to reduce the dose of one of her medications in a week. I can see that social services have arranged for a carer to visit twice a week and that the first visit is due tomorrow.

I know Dot gets a bit anxious and sometimes forgets to take her medications. Dot's daughter has recently bought her an iPad so she can stay in touch with her more easily. I tell Dot the nurse will arrange to contact her regularly on Skype to keep an eye on her now that she is back home."

Questions?