ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
E2
Scheme name
IT and Data Sharing
What is the strategic objective of this scheme?
The strategic objective of this scheme is two-fold: 1. Information Management &Technology (IM&T) is an important enabler of our plans particularly in supporting provision of safe, integrated care for people with Long Term Conditions and the elderly (shared records etc.); in driving innovation in service delivery (telehealth, telecare, telemedicine, mobile working etc); and in the use of 'big data' in support of risk stratification and other targeted interventions. IM&T can be used to transform virtually every aspect of healthcare delivery: how and where it is delivered, by whom and, when. 2. Making information regarding services available in the local area accessible to the whole population through an integrated IT infrastructure
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The scheme is an enabler; the work delivered within this scheme will target patients that access/receive both health and social care services, to ensure there is coherence and one unique identifier for each individual's health and social care record. Patient cohort is likely to be the elderly and those with long term conditions. Improved information and case management systems will drive efficiencies through allowing practitioners to have access to shared records, promoting "tell us once"; this will improve the patient/user experience of the health and social care system. Having sufficient information and advice accessible to the whole population will promote an individual's ability to self-help and receive information prescriptions, in turn reducing the reliance of health and social care services.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The existing Leicester Leicestershire and Rutland IM&T Delivery Board is being used to support Better Care Together (LLR 5 year strategy). During 2014/15 the work stream will have: • Produced plans to a 'quick win' around implementing a patient clinical records sharing service for primary and secondary care across LLR. The service will

allow clinicians from different 'provider types' across the health economy to view each other's clinical records

- Produced a report and plans which:
  - Identify major gaps in current services or plans
  - Setting out best practice from elsewhere that could be bought in or replicated
  - Outline short-term and longer-term options for closing identified gaps

The groups short-term work plan is to focus on primary Care Records Sharing Implementation using MIG, including work with MIG to expand the solution, for example to include social care.
In the short to medium-term we will:

- Produce a LLR-wide information sharing specification to support integrated care
- Create single care planning standards to enable co-production / sharing
- Introduce real-time spine links for social services / EMAS / UHL to obtain NHS numbers

In the medium term we will:

- Issue a care planning specification and amend associated templates
- Continue to progress initiatives to pilot and widen patient access to general practice systems
- Further develop the 'Digital first' initiative.

Longer term we will:

- Develop an LLR-wide patient-centred (not organisation-based) integrated digital care record with shared and inter-operating systems as appropriate
- Consider further development of clinical portal functionality for the sharing of UHL, LPT, social care, EMAS, and primary care out-of-hours data
- Review clinical codes used within NHS provider organisations
- Introduce a 'Clinical Contact Service Centre'
- Develop 'clinical analytics' to allow patients, the public, commissioners and care providers access to comparative performance information spanning all health and social care activity.

Locally, as part of Rutland's transformation team there is a cross cutting work stream – "IT". This work stream will lead on local delivery to ensure our plans are coherent with the bigger LLR picture whilst continuing to maintain momentum at a local level. Key programmes of work led by the Rutland IT and information and advice work stream will include:

Project	Task	Timescale	Local Lead
1. NHS Numbers – ensuring that initially at least 50% of	For initial data loading we will use a service called MACS (Migration Analysis Cleansing Service) to "batch match" client data against a database that	By 31st March 2015	Jason Haynes

patient records on social care systems contain the NHS number	holds the details of every patient who was registered with a GP on 1st January 1991 or who has been born since that date.		
2. Developing our social care case management system to ensure it is compliant with the Care Act /supports integration	Improving data quality and reporting functionality within our existing system (supports project 1 & 2) Understand whether the existing system (RAISE) is future proof i. Decide whether procurement for a new system is necessary ii. Procure new system	By 31st March 2015	Colin Pennington
3. Developing an integrated information service - improving methods of information and advice with residents and service users through IT	i. Recruit information development officer to update and maintain customer facing information systems ii. Procure system/database that stores a directory of services about local health, social care and other services available iii. Put in place a process that encourages "information prescriptions" iv. System in place and live	By 31st March 2015	Katy Lynch
4. Minimum data set	i. Implement the minimum data set to enable the safe transfer of patients between care settings across University Hospital Leicester, ii. Expand discussions to Peterborough Hospital to ensure process is in place at this setting	By 31st March 2015	Julia Eames

Key providers in the delivery chain will include:

- Care Management system provider i.e. currently RAISE but might change to ensure system is compliant
- Health providers i.e. Community health services and acute providers

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There is an urgent need to create a single coherent set of care plan standards and templates shared across the LLR care organisations according to patient consent. This is essential to avoid delay and duplication when multiple services are involved in a patient's care and is a major gap currently.

The Francis report called on the NHS to make better use of technology to improve safe, effective care with a particular focus on electronic prescribing linked to digital patient records. The benefits of e-prescribing are many and include reducing illegibility; providing warning and alert systems which reduce medication errors; reducing or eliminating phone calls and faxes to pharmacies; streamlining authorisation processes; and increasing patient compliance

Better Care Together programme has defined 5 clinical focus areas - CVD, Mental Health, Respiratory Disease, Dementia & Cancer - each of these areas should be subject to a detailed analysis of workflow and information flow throughout all common patient journeys across LLR care organisations. This will inform future IM&T developments (and will also be useful for the redesign of pathways and services)

Developing an integrated information service has gained political support as a result of the People First review. Consultation with residents and partners has identified a significant gap in information provision about local services available.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Year	Investment required
2014/15	£63k
2015/16	-

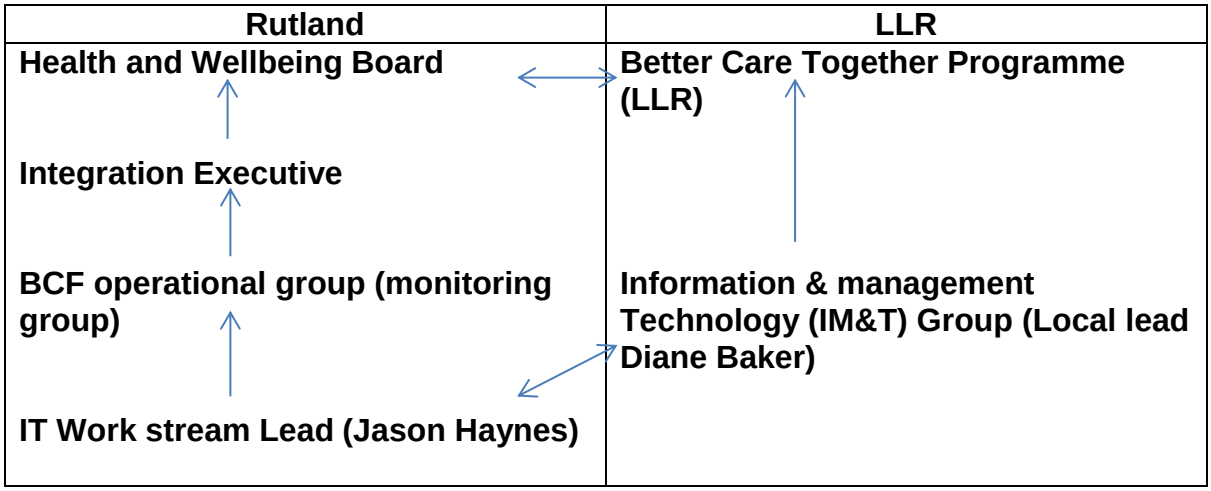
Investment for 2014/15 will explicitly link to improving data quality within social care systems so that data matching with health can take place before 31st March 2015.

Any further IT Investment required in 2015/16 will be allocated through the Care Act enabler scheme (£110k) and will be linked to procurement. (Please see the relevant Annexe).

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

During 2013/14 clinical, therapeutic and social care partners worked together to agree a minimum data set to enable the safe transfer of patients between care settings. Across LLR agreement has been reached to implement the tool currently being used electronically by South Warwickshire Foundation Trust this has delivered a three day reduction in processing time for discharging older adults, and has smoothed transitions generally across health and social care boundaries. Plans are in place to use the tool across University Hospital Leicester in 2014/15.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?



Key: **Feedback loop/reporting lines**

The BCF operational group will have representation from each scheme lead; the IT work stream lead will therefore report in on progress so that monitoring and plans for evaluation can be determined.

What are the key success factors for implementation of this scheme?

Sufficient Investment

Data quality

Information sharing protocols

Organisational buy-in

Partner buy-in into the 5 year strategy

Operational/front line engagement to enable roll out of system change

Compliance with statutory requirements (Care Act)