Rewired

March 23

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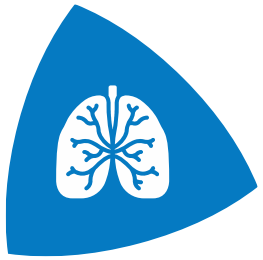
System C
Connected Care

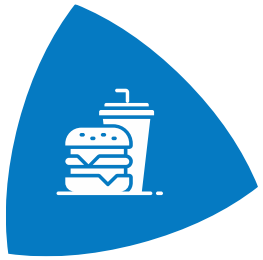
SystemC&
Graphnet
Care Alliance

High-level challenges and opportunities in Health and Social Care

Aging Population

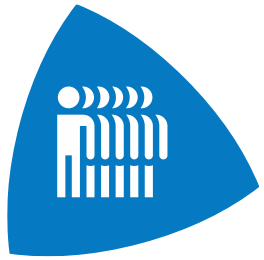


Long Term Condition
(1 in 4 People)



Lifestyle Related
Disease

Health
Inequality



Elective Backlog
(1 in 6 People)

COVID

Unprecedented demand

Escalating Costs

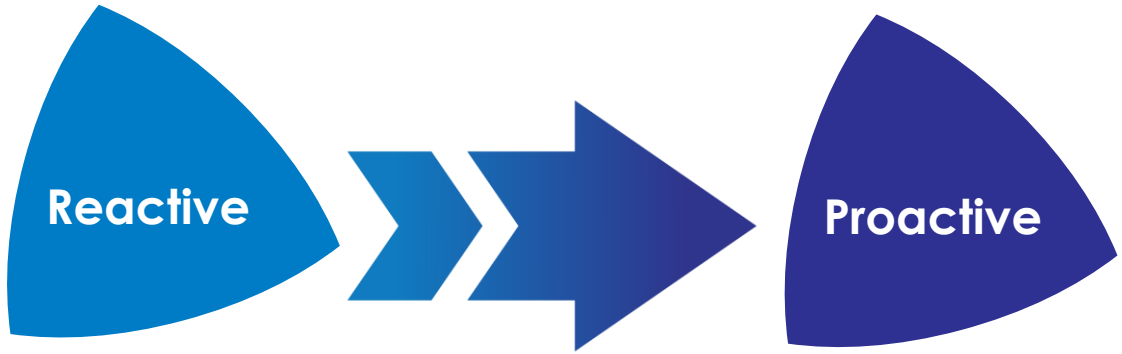
Exhausted Staff

Lack of
Staff/Capacity

System C
Connected Care

A seismic shift is needed

We need to shift from
Reactive to Proactive Care



We need to understand the whole
person and join up care

Digital is a key enabler to make this shift

Convergence as a way of joining up care

Model A: One EPR across the ICS

80% of patient flow are across different care settings

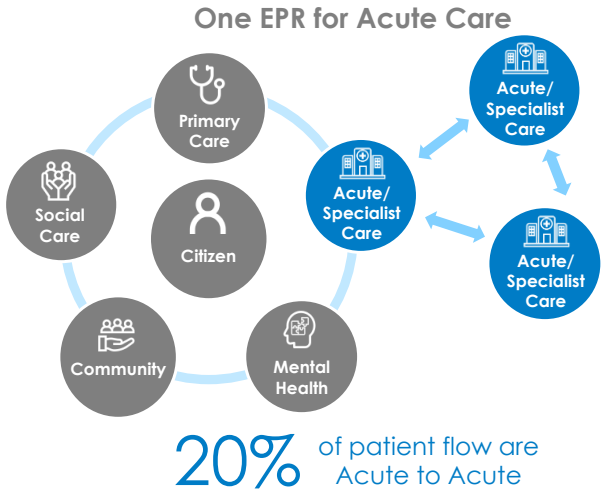
Unrealistic

Model B: One EPR for Acute Care

20% of patient flow are Acute to Acute

Realistic but only joins up part of the landscape

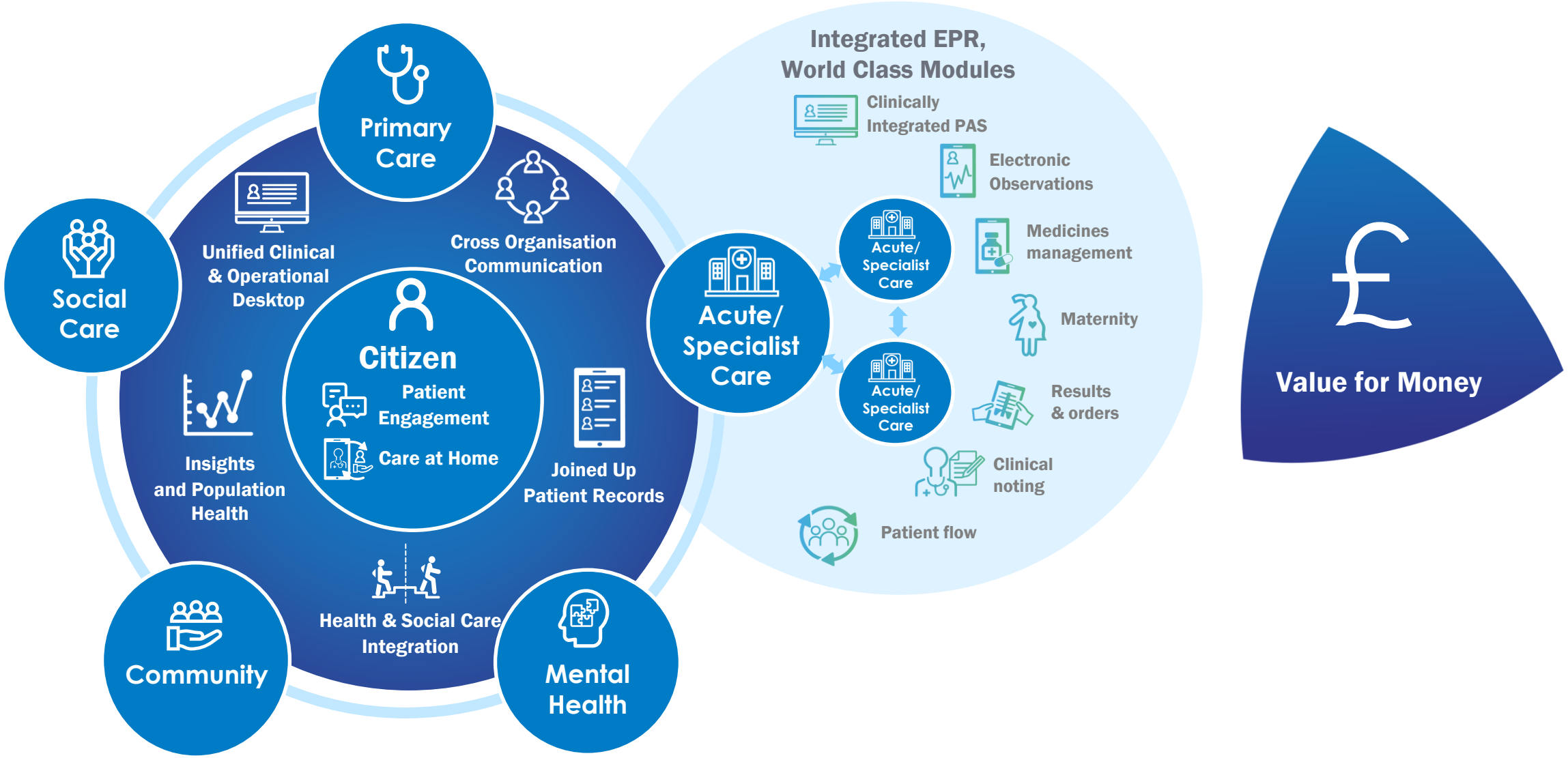
Should you “rip and replace” or super charge what you have ?



HIMSS Level	HIMSS Level Components	CareFlow EHR & Care Alliance Components
7	Level 7: Analysing Performance	CareCentric/CIPHA Population Health Analytics
7	Level 7: Shared Data	CareCentric Shared Care Record
7	Level 7: Summary Data Continuity	CareFlow Clinical Workspace
7	Level 7: Physician Documentation And Cpoe	Cross CareFlow Capability
6	Level 6: Closed Loop Administration	Provided Within CareFlow Medicine Management
6	Level 6: Integration Of Emar, Cpoe, Labs Etc	Provided Within CareFlow Medicine Management
6	Level 6: Five Rights	Provided Within CareFlow Medicine Management
6	Level 6: Physician Docs: Protocols & Outcomes	CareFlow Vitals, Connect, Narrative
6	Level 6: Bring Your Own Device	Local Policy As Implemented
5	Level 5: Physician Documentation Using Templates	CareFlow Clinical Noting/Narrative
5	Level 5: Timeliness Of Orders	CareFlow Vitals And Careflow OCRR
5	Level 5: Intrusion / Device Protection	Security Features In all CareFlow modules
4	Level 4: Orders	CareFlow Order Communications
4	Level 4: Cpoe With Cds	CareFlow Clinical Workspace
4	Level 4: Nursing & Allied Health Documentation	CareFlow Clinical Narrative, Vitals And Care Planning
4	Level 4: National Or Regional Patient Databases	CareCentric Shared Care Record
4	Level 4: Basic Business Continuity	Local Policy As Implemented
4	Level 4: Evidence Based Medicine Protocols	Logic In Core CareFlow modules
3	Level 3: Nursing & Allied Health Documentation	CareFlow Clinical Notes, Clinical Narrative, Care Plans
3	Level 3: Emergency Department	CareFlow ED
3	Level 3: Role Based Access Controls	RBAC Across all CareFlow modules
2	Level 2: Integrated Data Stores	CareFlow interoperability/consolidated data storage
2	Level 2: Common Data Repository	Data dictionaries In CareFlow
2	Level 2: Internal Interoperability	Systems and data integrated With CareFlow
2	Level 2: Basic Security	Basic Security Policies and Capabilities
1	Level 1: Ancillaries	Existing Systems In Labs and Imaging

	Single EPR Vendor *Move existing EPR to single EPR*	**Mixed Model** *Build on what you have*
Shared care record	• Yes, for the Acute, but this only addresses 20% of the story • Still need anther ICS digital solution for 80% flows e.g. shared care record	• Delivered by other ICS digital capabilities e.g. shared care record
Aligned ways of working	• A single EPR with a shared configuration across two organisations forces a degree of clinical and technical process alignment	• Can be achieved without 100% EPR alignment. Provides greater choice for the different organisations to align at their own pace
Impact on staff	• High, requires staff re-training from one system to another	• Incremental as new capability is introduced
Value for money	• ~£10m migration costs +staff distribution • Incremental cost for capability the Trust doesn’t already have	• Minimal migration costs, leverage existing investment • Incremental cost for capability the Trust doesn’t already have
Time to value	• Transformation can only start post migration so at least 18-24 months away	• Start now

The Connected EPR



Conclusion

1. The outcome of the race to Digital Maturity is to **join up care** for the **whole person**

2. The **Acute EPR is a fundamental building block** and needs to go beyond the walls of the Hospital to **enable Citizen flow across the ICS**

3. Acute **EPR convergence** is one important way of joining up care

4. There are **different ways** to achieve the outcome of convergence which join up care across Acutes as well as **other care settings**

5. The focus therefore should be on the digital approach that maximises net benefit in the **most expedient and cost effective way**