Benefits report: Adopting the Great North Care Record in Adult Social Care

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The case for change

Adult Health and Social Care is inherently people focused. To enable people to live independent lives for as long as possible, providing the right assistance and support when they need it.

Therefore, professionals dealing with these people need the most up to date information at the right time to inform their decisions. It is evident that many social care staff spend much of their time chasing information from health care colleagues in order to make informed decisions and to plan care packages.

The Great North Care Record (GNCR) Health Information Exchange (HIE) will enable people to receive care in a much more joined up way as a whole health and care record can be shared.

In the GNCR Vision document the future model of health and care provision is explained:

> "The Great North Care Record will help deliver significant change to create services which are firstly better coordinated with one another, and secondly, better integrated around the life goals and preferences of the individual."

Better coordinated services will be able to share information to reduce risk and to make better use of resources. They will do this by:

a) ensuring that important information about patients and customers is shared and available whenever and wherever it is needed

b) creating and using shared care plans which reflect the activity of many providers and which anticipate future needs

c) communicating more effectively across organisational boundaries to manage transfers of care

Better integrated services will be personalised. This means that care for those most in need will be assembled around the person, regardless of provider, taking into account the individual's own priorities, social context, and clinical need.

Rather than being passively moved along a care pathway, the individual, supported by expert advocates such as community nurses, social workers and care navigators, will actively build their own care packages and ensure that plans for the future reflect their own wishes and priorities.

Patients and customers, supported by professionals as needed, will be able to use information technology to:

- access their records and care plans and add to them
- access and change appointments
- monitor their own health

Better integrated services will be safer by design. Over time, we will be able to research and implement systems which are able to:

- give early warning of worsening health
- flag up risks to patient safety and offer intelligent feedback to care professionals
- automate routine tasks and decisions and reduce workload

Better integrated services will be better not only for those who use them, but also for those who work in them, on them, and lead them.

> These changes will not be achieved in a single leap. Our ambition is to build maturity over time. There are already examples of better co-ordination and integration across the region. The Great North Care Record will aim to accelerate progress.

> As its benefits spread through our communities, it will unlock the creativity and energy of leaders, service designers and professionals towards new solutions to the challenges of integrated care and support emerging models of care.

The National View

In the policy paper published in October 2018 by the Department of Health and Social Care entitled "The future of healthcare: our vision for digital, data and technology in health and care" it sets out a Technology Vision for Health and Social Care.

It states:

> "Our technology infrastructure should allow systems to talk to each other safely and securely, using open standards for data and interoperability so people have confidence that their data is up to date and in the right place, and health and care professionals have access to the information they need to provide care. Interoperable, connected health information in other countries has shown cost-and time-saving benefits, including enhanced care co-ordination and a reduction in unnecessary diagnostic testing. We need to replace legacy architectural decisions to keep up with modern technology."

This is where the GNCR can play a major part in achieving this vision.

NHS England is committed to ensuring both health and care records are joined up and accessible:

> "NHS England are investing in a number of Local Health and Care Record Exemplars that will enable the safe and secure sharing of an individual's health and care information as they move between different parts of the NHS and social care. The local health and care record exemplar programme is designed to support local areas that are already adopting best practice in the collection, protection and ethical use of health and care data to go further, faster and encourage others to follow swiftly in their footsteps.
>
> "At the same time, we are working to make sure that data can flow seamlessly between different IT systems across health and care settings.
>
> "Find out more about our system-wide move towards interoperability."

Other regions such as North West London, Yorkshire and Humberside and Bristol, North Somerset and South Gloucester have begun this journey with positive results being reported. In one evaluation report, a social worker stated:

> "Connecting Care is brilliant…I use it to triangulate information from service users, to find out about other services involved so that I can contact them to inform my assessments"

North East and Cumbria Local Authority Engagement

A consultation exercise has been undertaken with representatives from the majority of Adult Social Care services in the North East and Cumbria.

A GNCR workshop was held on 22 May 2019 to provide an update as to how GNCR is progressing and to discuss how it could be implemented in Adult Social Care.

An Amy's Page workshop then followed to look at what information would be useful to have access to, and the benefits this would bring for frontline staff and for service users and carers. Further information about Amy's Page interactive design workshops can be found on YouTube.

The author then collated the findings from the workshop. This then informed the one to one meetings with representatives from 10 local authorities to discuss in detail their working practices, current issues and the benefits GNCR could provide staff, service users and the organisation.

Findings

Cumbria Local Authority already have access to the MIG (Medical Interoperability Gateway) which is the precursor to GNCR, which allows the Adult Social Care staff to view GP information rather than having to ring or fax for it.

The benefits they have gleaned from this are time saved not chasing information, resources are freed up and service users are dealt with more quickly.

Data sharing agreements are in place and to date there are no data breaches. The system is audited, and managers can see which members of staff have accessed the record and what was viewed. The Information Sharing Gateway is being used with positive results.

Cumbria have been viewing GP records since November 2018 and started with a limited amount of information to view, with the aim of building upon it.

There were several key themes that emerged from the consultations in the North East region:

- Staff in many sites are frustrated as they spend a large amount of time trying to determine the current clinical status of clients and who is involved in their care.
- The staff are often working without vital clinical information which could impact on care decisions.
- There is duplication of effort and waste as often social care arrange an intervention, and later find that NHS colleagues have already acted upon it.

Baseline information was collected from 2 sites (Gateshead and Sunderland) and some specific examples are below. Appendix 3 provides a summary of data collected via questionnaires in Sunderland City Council Adult Social Care team, along with estimated time savings if GNCR were to be implemented.

Gateshead referrals team stated that they spend an average of 45 minutes per case for mental health assessments and receive on average 15 per week. This equates to over 11 hours of time that could be saved per week in one team alone.

Mental health referrals are classed as functional or organic mental health conditions, thus determining the referral route. As the information is not at hand, incorrect referrals occur which impact waiting and correct treatment times.

Admissions to hospital via North East Ambulance Service often state a care package is required. Staff must ring round to determine if the client is on a ward or not. There are on average 65 cases per week taking 10 minutes per case, equating to almost 11 hours per week.

Approximately 65 police concerns received are signposted to GP practices. Currently the team must determine if a community psychiatric nurse (CPN), mental health trust or GP is involved. This would not be required as the information would be readily available to social care and clinicians.

There is an issue of the time delay in receiving faxed information from GPs, some not being received for a few days. GNCR would eliminate this wait therefore reducing risk to clients.

Often when occupational therapy (OT) assessments requesting equipment are received, it is processed then the team discover that it has been dealt with by a district nurse or community OT which is wasted time and resources. GNCR would allow the teams to view who is involved and the progress made.

Safeguarding teams currently spend time determining who else is/has been involved in a client's care. If that information was readily available it may reduce risk as trend and patterns can be identified e.g. 5 x A&E attendances, 10 x GP appointments etc.

Missed appointments in clinical settings are not viewable currently. If this was available, then social care could determine the reasons e.g. a chaperone required, and arrange it, resulting in better care and cost savings as there would be fewer DNAs (did not attend).

The staff were overall very positive about the potential change and could cite many examples of how risk could be reduced, and time saved.

If a more formal investigation of how much time could be saved across all teams was carried out this would add to the case for adopting the change.

Benefits Identified

This list of generic benefits can be used for any local authority. These have been devised from the information that staff provided during interviews.

The most relevant benefits would be agreed by the senior managers and the business change manager. Additional benefits for individual teams or locations could be devised if it is felt they will deliver a significant benefit. A total of 5-6 measurable benefits would be agreed upon, and qualitative benefits such as client or staff satisfaction could be measured using surveys.

Benefit	Results	Baseline	Annual saving
Improved efficiency as reduced time spent	Staff time redeployed	Example: Gateshead 1st point of	22 x 50 weeks = 1100 hours p.a.

chasing clinical information	Faster responses Client satisfaction	contact team– 22 hours per week spent	= 30 staff days p.a. saved approx.
Improved efficiency as time saved as wasted home visits will be prevented (e.g. client in hospital)	Staff time redeployed Faster responses Client satisfaction	2-4 visits per month wasted across teams in Sunderland	64.5 working days potentially saved if GNCR information is available
Reduced duplication as dual entry of data no longer required	Staff time redeployed Faster responses Client satisfaction	Mental health teams enter onto PARIS and social care systems	TBC
Improved efficiency as time saved not having to log into multiple systems	Staff time redeployed Faster responses Client satisfaction	Sunderland 30 cases per day @ 3 minutes per case = 7.5 hours per week	Equates to 50 working days per year
Increased safety as medication and dosage, and allergies can be viewed	Safer care		
Reduced risk (especially in vulnerable cases) as all clinical interventions can be viewed and trends can be spotted	Earlier interventions		
Improved level of care as the whole picture of health and care interventions is instantly available	Client satisfaction Service efficiency		
Improved client experience as person	Client satisfaction		

does not have to repeat their story	Staff time saved		
Reduced duplication and DNAs as appointments can be better planned around existing clinical appointments	Staff time saved Improved planning	DNA rates	
Improved security as information is accessed from one portal, lessens the need for paper, phone calls and other system access	Improved data quality	Measure data breaches	
Improved information flows as information will be shared using the Information Sharing Gateway	Improved data flows Security	Measure data breaches	
Improved care planning as admission and discharge information is available	Safer, more person-centred care		
Reduced summary care records (SCRs) as all information is available and shared with relevant parties	Cost saving Organisational benefit	The average cost of a SCR is between £4000 and £10 000	

Financial Benefits

Local Authorities can also consider the following potential cashable benefits when identifying the benefits for their locality:

- Travel costs saved from reduction in wasted visits
- Reduced costs as information may be visible via GNCR rather than paying for GP reports
- Direct payment reconciliations may be improved as customer whereabouts (e.g. admitted to hospital) can be checked and payments stopped

- Possible system licence savings from not needing access to multiple systems e.g. EMIS, SystmOne, RiO etc – this requires further investigation
- Reduced system support costs as multiple systems may no longer be required

Managing the Change

As each local authority is looking to upgrade their IT system this needs to be factored into the GNCR rollout plan.

The majority of sites wanted a small-scale rollout initially to ensure the system was properly managed and any issues were ironed out before rolling it out to all staff.

There are several areas to address:

- Standardised methods of recording information on the shared record. Data that could be misinterpreted needs to be redefined, so all users in health and care understand it.
- Joint work on Process mapping or new ways of collaborating to determine how each local authority and health services will work together and share information, and how to get the best use from it.
- An understanding by primary care and acute colleagues into the data requirements that social care requires, why it is required and how it is used. Joint working groups are key to ensuring the change is understood and implemented.
- NHS Number data matching to social care records is required but this will be an improvement as it will highlight any duplicated social care records (e.g. typos/aliases) and ensure only relevant information is recorded and stored.

Benefits Management Approach

As each site agrees their business case for GNCR, their specific list of agreed benefits should be added to the case, chosen from a list of generic benefits in this report.

The GNCR team will provide a benefits guide explaining how to collect baseline information before go-live.

Then three months afterwards, the first benefit measures will be recorded and reported on, using a benefits tracker provided by the GNCR team. This will continue quarterly to determine whether the GNCR has delivered the anticipated benefits. A benefits owner and a nominated person to report the measures must be established at each site.

Often benefits are not realised until much later, when new working processes are embedded, and staff are comfortable with the change.

Financial Commitment

In order to adopt the GNCR, a subscription fee is payable annually. This is currently a maximum of £20 000. However, as more services and sites begin to use GNCR the cost may fall.

This cost is for the GNCR implementation, training material and annual subscription. Local process change and change management would need to be resourced by the Local Authorities.

As there will be improved safety, time savings and possible savings from reduced system access requirements, this will be a valuable investment.

Conclusion

There is a strong case for this change to be adopted, as there will be significant benefits for service users, carers, the workforce and local authorities. From the sample of information collected from two teams, there are definite time savings and efficiencies.

It is recognised there is much preparatory work and a better understanding of how social care and NHS will work together but by using joint working groups and sharing protocols this can be achieved.

Recommendations

Directors are asked to consider the benefits identified in this report and commit to adopt the GNCR HIE.

Each Local Authority will then develop a business case for investment which this report can be used as a supplement.

Appendices

Appendix 1 Thanks to contributors
Appendix 2 Current systems
Appendix 3 Collated baseline data from Sunderland team

Appendix 1

Thanks go to the following colleagues who have offered their insight and knowledge into shaping the benefits identification work.

Local Authority	Name	Interview date
Gateshead	Carol Wilson Shannon Tumelty Sam Willis	22.5.19
Newcastle	Stephen Foreman	30.5.19
Hartlepool	Trevor Smith	31.5.19
Durham	Marion Ingleby	5.6.19
Sunderland	Emma Anderson Sunderland team questionnaire completion	6.6.19 25 - 28.06.19
Northumberland	Sarah Zarraga Elaine McKenna	6.6.19
Cumbria	Davina Jenkins	17.6.19
Darlington	Paul Neil Steven Bennett	1.7.19
Stockton	Helen Ruddick Angela Connor Kate Fulton	2.7.19
Middlesbrough	Neil Cave	4.7.19 – postponed until 17.7.19

Caroline Harper South Tyneside no reply
Catherine Murdoch Redcar & Cleveland no longer working on this – await new contact in IT team

Appendix 2

Current Systems:

- Newcastle OLM Eclipse
- Gateshead OLM CareFirst
- Durham SSID (Azeus from mid-2020)
- Northumberland OLM Swift
- Middlesbrough Liquidlogic
- South Tyneside Liquidlogic
- Sunderland Liquidlogic
- Hartlepool OLM Eclipse
- Stockton CareWorks

Most local authorities are seeking to change to newer systems over the next two years, which could impact on the implementation of GNCR and needs to be borne in mind.

Appendix 3

Collated responses from GNCR Baseline Questionnaire – Sunderland
Group 1 - 8 OTs, 1 OT Assistant and 1 Physio

Reduced duplication if GNCR information was available:

- Reduced duplication e.g. equipment already supplied by a district nurse but social care unaware
- Hospital staff refer people to falls team or stroke team and social care are unaware
- Duplicated appointments e.g. Recovery at home team and domiciliary care teams already involved
- Community nursing teams already in attendance when social care staff visit so social care must wait until they finish, leading to delays for next clients.

Wasted trips and travel time
From all responses the average is 2 visits per month wasted.
Average travel time wasted is 45 minutes per visit.
9 staff = 18 visits. 13.5 hours' time wasted per month. Plus mileage costs?
162 hours p.a. is **7.5 days wasted per year**

Top 3 benefits staff cited
For staff

- Less time wasted finding information, more reliable information
- Working together in a collaborative way and improved communication
- Less duplication

For clients

- Customers would only be referred to services that meet their needs instead of multiple referrals to agencies which can becoming frustrating for the customer
- More streamlined service for the customer
- Allow for the professionals involved in their care to collaborate timely and efficiently ensuring that all involved are "singing from the same hymn sheet"

Group 2 - 1 Manager, 8 Assessment and Review Officer and 1 Care Co-ordinator

Duplication
Reduced duplication e.g. if a District Nurse or CPN has referred for Telecare equipment and was not aware.

Wasted trips and travel time
From 5 respondents the average is 1 visit per month wasted.

Average travel time wasted is 45 minutes per visit.
5/8 staff reported wasted visit= 5 visits. 3 hr 45 time wasted. Plus mileage costs?
45 hours p.a. or **6 working days p.a**.

Time requesting GP information
Average 2 cases per person per day. 20 minutes average spent.
5 respondents = 10 cases per day = 3 hours per day wasted. Equates to 750 hours p.a. or **100 days wasted**.

Time accessing multiple systems
30 cases per day, average 3 minutes per case = 90 minutes per day/ 7.5 hours per week wasted. Equates to 375 hours or **50 days per year**.
If via nominated GP email route, it takes 2 days to receive the information.

Determining who is involved in the person's care

> "We often don't know which clinicians are involved in a person from the first instance. We are only aware of clinicians who are currently involved in the persons care when the referral comes to the hub."

Top 3 benefits staff cited
For staff

- Consistency, information quickly to hand when required
- Streamlined approach easier record sharing and time management.
- Having up to date information with who is involved when would mean more accurate record keeping.

For clients

- Safeguards customers, means they don't have to answer the same questions to different services
- More support for customers as staff would have more time. It would mean the most appropriate support in a timely way and avoid duplication of services
- Customers could be referred for services quicker where there is a need

Group 3: 6 Social Workers
Duplication
Not very often. Mostly with regards to telecare equipment if an OT may have also done the same. Sometimes the service user has not fully understood what is being ordered/recommended or been aware that this is the same thing that is being ordered.

Wasted trips and travel time:
From all responses the average is 4 visits per month wasted.
Average travel time wasted is 60 minutes per visit.
8 staff = 32 visits. 32 hours' time wasted per month. Plus mileage costs? 384 hours p.a. or **51 days p.a**.

Time requesting GP information:
Average 2 cases per person per week. 20 minutes to hours spent.

Time accessing multiple systems

> "One or two social workers who can access Meditech/ V6 (NHS) at Sunderland Royal.
> "I would have to call that worker if I need to find information and that can be time consuming."

> "Time to log in and out per case varies, it could be up to 10 times a day depending on case. Number of cases per day varies- I have to access RIO (NTW) to get information for MASH (joint work with police and safeguarding)-a colleague had 46 to check the other week (17/06/19). It is difficult as you can't copy from RIO to Liquid Logic (LL), you must copy information down by hand then transfer it to LL and that can take time."

10 minutes per case, approximately 10 cases.

Top 3 benefits staff cited
For staff

- Better assessments, using a holistic approach to health and social care needs. Wouldn't have to call people and request paper copies of their health assessments.
- Shared record would mean that we have access to up to date information for all involved in care and we are well informed of what's happening. Quick response.
- Being able to share and be aware of relevant information. Being able to make well informed professional decisions following this. Being aware of risks and completing effective risk management plans.**For clients**
- Experiencing less assessments with a streamlined system. Being able to access their information in fewer places.
- More person-centred care as information is shared.
- A shared system which would improve joint working partnerships from professional from different disciplines which would benefit the clients as it could minimise the amount of contact they receive from professionals whilst still ensuring that their concerns and issues are addressed by those involved.