Centre of Excellence for Information Sharing

Bristol, North Somerset and South Gloucestershire:

Connecting Care overview

Connecting Care is the interoperability programme for health and social care services across Bristol, North Somerset and South Gloucestershire [BNSSG]. The programme is dedicated to using technology to support better information sharing between local health and social care organisations, and ensuring that the people who are providing care have the information they need, when they need it.

BNSSG Connecting Care programme

Our common vision is that, by sharing information securely and effectively, we will make a lasting contribution to the health, well-being and opportunity of our population.

The vision for the Connecting Care programme is to use technology and share information better to support the changes needed across the health and social care system. For the programme manager, this means "making Connecting Care the backbone of the changes we make [to the sector in our region]." The vision was developed in partnership with over 60 stakeholders in the programme during the summer of 2015, once they had successfully tested the concept during the pilot stage.

How the conversation started

In 2011 a number of BNSSG agencies[1] aired concerns about how the different systems being adopted by local health and social care organisations were operating in silos. This led to clinicians and practitioners not having the information they needed to make informed decisions about a patient's care, experiencing frustrating waits whilst requests for this information were requested (often by fax), and making potentially risky decisions about appropriate courses of action without the information that enabled them to evaluate these risks.

There were national drivers for change too, including reviews into systemic Child Protection failures such as the Laming Report, and Caldicott guidance on better cooperation and information sharing to integrate health and care services. A report from the Care Quality Commission in 2009 concluded that "Joined-up care is better for everyone. It gives people a better experience of care, helps them to stay healthier for longer, and to recover better if they are ill."[2]

At the same time, there was a growing realisation across the place that sharing information electronically could save not just time but money, by removing duplication and reducing administrative costs of maintaining separate records. As departmental budgets became ever tighter, some organisations could see the financial benefits of integrating their systems to provide joined-up care.

Building a case for change

The BNSSG partners quickly realised that they had a shared interest in trying to improve the flow of information between these systems, and wanted to investigate ways of achieving this by creating a shared care record for the region. By starting small and thinking big, a number of determined officers with technical expertise were able to drive these ideas forward, attending monthly meetings to work through important operational and strategic issues in a spirit of innovation and collaboration.

Recognising that funding for the programme would be significantly limited until the case for change was proven, the management group decided early on that they needed to take a two-stage approach. In the first stage, a limited system was rolled out to 500 users to support unplanned and urgent care needs. This first stage would be carefully evaluated and time would be spent establishing the impact, benefits and learning from the initial development. This allowed programme leads to build a convincing proof of concept in order to bring others on board.

[1] A full list of partners working on the Connecting Care programme is included in the programme outline at the end of this overview.

[2] See http://www.cqc.org.uk/content/benefits-joined-care

As a result, a business case could be written for the second stage of development. This next stage involves scaling the programme up to an additional 2,000 users per year across many more disciplines; including GP practices and specialist community care services, social care and other hospital settings. Ultimately the second stage will extend the breadth and depth of information sharing with an additional 10,000 users of Connecting Care over the next five years.

Programme challenges and benefits

The key question that programme leads found that they needed to answer was how to get 17 partners to work collaboratively, especially when there are dwindling resources and increasing pressures on people's time. Strong local leadership was needed to ensure that the small group of 'early adopter' partner agencies were able to keep momentum going in the initial months of the programme. For the programme manager, the challenge was to win hearts and minds by "making sure they give something as well as get something, keeping things people-focused." As a result her team was able to develop strong connections across the region, and learned to build on these connections to reach out to new partners.

New projects – such as the Children's Safeguarding project the team is now working on – throw up different challenges. In this project, the team realised that the system needed to enable users to monitor risks as well as manage care, requiring different security profiles and more depth of information against particular elements, such as legal and family relationships of children in need. Building on their role-based access approach, the team are adding new requirements to meet the needs of the current project; for instance, further consideration of appropriate levels of information in each area of the system, and how this information is accessed by different types of social workers.

The benefits for an integrated digital care record vary depending on the interpretations and priorities of a local place. During the pilot stage of the BNSSG Connecting Care programme, partners realised that sharing information electronically could save not just time but money – removing duplication and reducing administrative costs of maintaining separate records.

Examples of the possible savings which Connecting Care could realise, based on actual impacts identified in the evaluation of the pilot stage, include:

- Admissions prevention – The pilot illustrated that savings were possible. This could equate to annual savings of £1,036,288 from admissions. (Figures based on 10,000 people using information in Connecting Care at a cost of £1,436 for an unplanned admission – Dept. of Health reference cost 2012/13).
- Time savings – Annual savings of £155,278 of 'people time' as Connecting Care users spend less time calling other organisations for information. (Figures based on evidence from the pilot and on the calculation that if only one call per week saved using salary cost savings for a medium salary between NHS bands 7-8).
- Reducing home visits – Annual savings of £68,000 on stopping unnecessary home visits as a result of 10,000 people using information in Connecting Care. (Figures based on £60 average cost of a face to face assessment by a Community Nurse, Dept. of Health reference cost 2012/13, and savings realised assuming the same rate of stated home visits prevented during the pilot stage).

When asked how BNSSG's system supports the wider integration agenda, programme leads point to the Five Year Forward Review which strongly articulates a vision for greater integration of care records in the future. They are keen to quote the Chief Executive of NHS England, Simon Stephens, who argues in this document that the UK has been too "slow to recognise and capitalise on the opportunities presented by the information revolution…the result has been systems that don't talk to each other and a failure to harness the shared benefits that come from interoperable systems…in future we intend to take a different approach.[3]"

[3] NHS (October 2014) Five Year Forward View, p. 31

Some important learning from phase one of the Connecting Care programme

Start small and build relationships at all levels

The approach taken to building relationships in BNSSG was one of starting small and 'going where the energy was', so the initial partnership of four to five partners was not made up of a pre-determined group, but rather consisted of those organisations that were enthusiastic about the scheme and wanted to be part of it at the start. The growth from this initial group to a partnership of 17 organisations was driven at first by informal relationship building activity, focused on building trust and mutual respect. Communicating what the Connecting Care partnership was doing also played a key role, helping to build enthusiasm for the programme and reaching out to other local organisations.

As it was accepted that not everyone was at the same point in this journey, the project team used a phased approach to building relationships. This meant that local organisations were able to take up a 'place at the table' in partnership meetings without a requirement to commit funding or invest in technological development. As the partnership grew, and the programme entered a procurement phase, the act of doing the procurement provided focus for further, formal relationship building, strengthening existing partnerships and generating good relationships across board, project team and technical levels. The team is always looking for reciprocal ('win: win') opportunities to build trust.

Communicate proactively to build enthusiasm

In order to support communications with GP practices, BNSSG developed materials to help communicate about the project and to explain the difference between local and national data sharing initiatives. The materials were designed to support GP Practices to respond to any questions they might receive about links with the local data sharing scheme and the different types of 'opt-outs' from Connecting Care available to individuals.

National drivers for technological change in the sector have also affected the timing of communications about the Connecting Care programme. For instance, BNSSG hadn't implemented the National Summary Care Record as early as other areas, so when they were advised to issue a letter very quickly to warn residents about these changes, they used the opportunity to tell them about Connecting Care as well. Even though they had brought their communications plans forward, the team discovered that people were happy that they had been told about the changes at the same time.

Engage inclusively with partners, providers and patients

When engaging with partners it is important that the shared outcomes expected for patients and citizens are at the forefront of every partner's mind. In BNSSG, they actively sought to 'encourage a non-organisationally-centric approach' when it arose, and encouraged partners to talk about the aims or benefits of the programme in terms of 'what's in it for the greater good of the patient'.

GP engagement was, and is, an important element. Before starting to engage local GPs in BNSSG, the partners spoke to the Local Medical Council (LMC) and the three local Clinical Commissioning Groups (CCGs) to ask for advice on the best ways to engage GPs and how they should do this. Locality managers within the three CCGs held meetings for GPs in geographical clusters of practices and one-to-one follow up meetings (either in person or on the phone) were organised in response to queries. This direct engagement was supported by the use of partners using existing newsletters to GPs to provide information about Connecting Care and the GP meetings being organised.

Outline of BNSSG's Connecting Care programme

The aim of the Connecting Care programme was to provide an integrated care record for people in Bristol and the South West. The first stage of the programme focused on urgent and unscheduled care. As a result of successful testing of the programme during this stage, the team delivered a business case to extend the breadth and depth of Connecting Care during the current second stage.

Current partners of the programme are:

- Bristol Clinical Commissioning Group (CCG)
- North Somerset Clinical Commissioning Group (CCG)
- South Gloucestershire Clinical Commissioning Group (CCG)
- North Bristol NHS Trust (NBT)
- University Hospitals Bristol NHS Foundation Trust (UHB)
- Weston Area Health Trust
- Bristol City Council
- North Somerset Council
- South Gloucestershire Council
- Bristol Community Health (BCH)
- North Somerset; Community Partnership (NSCP)
- South Gloucestershire Community Health Services (Sirona)
- Brisdoc (and OneCare)
- NHS England (Area team) for BNSSG (Bristol, North Somerset and South Gloucestershire)
- GP practices in Bristol, North Somerset and South Gloucestershire
- Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
- The West of England Academic Health Science Network (WEAHSN)
- South Western Ambulance Service NHS Foundation Trust (SWAST)
- NHS South, Central and West Commissioning Support Unit (SCWCSU)

Following a formal procurement process, the Connecting Care delivery team started working with Orion Health in March 2013 and Connecting Care went live in December 2013. Evaluation of the programme began in January 2014 and stage two was launched in September 2014.

Since going live, Connecting Care has been announced as a 'National Exemplar' site for clinical systems interoperability and has won two E-Health Insider (EHI) awards.

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