Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Meeting of Governing Body meeting

Date: Tuesday 3rd December 2019
Time: 13:30pm
Location: Clevedon Hall, Elton Road, Clevedon, North Somerset, BS21 7RQ

Agenda Number :	**6.1**
Title:	**Integrated Care Bureau (ICB) Digitalisation**
Purpose: For Information	
Key Points for Discussion:	

- Following several workshops, interviews, process mapping across the service and reviews of products on the market, we have worked in partnership across our three councils, three acute trusts and community providers to develop our digital requirements and submitted a proposal to develop a scalable, cost-effective multi-agency approach to reducing length of stay and delayed transfers of care for complex patients.

- On 20th November 2019 we were awarded £330k to develop national blueprints for our work and develop our digital solutions that will provide:
  - Real time communication between social care and health teams
  - Notifications patients have been admitted to hospital
  - Up-to-date information on progress of package of care in real time, capacity and tasking
  - Create a single version of the referral form
  - Provide real performance data showing impacts to support local and national investment
  - Build blueprints including minimum data sets and specifications; compliance with national standards; and standard messaging protocols that can be implemented with the technology partners of choice in any Health System

- At each stage of the process, the ICB teams through the joint Health and Social Care Task and Finish group have been making improvements to the service, workflows and use of the digital tools they have.
- The proposal was based on enhancing existing systems in place
- Due to changes in the ICB model following the award of the community contract and on-going improvements to service deliver, we will undertake a review before agreeing the final solution although work is already underway to:
  - To improve the existing referral forms and create a single version
  - Create notifications when a patient that is admitted to hospital that has previously had a Single referral form or has a package of care with the council

Recommendations:	To note, consider and take feedback
Previously Considered By and feedback :	• Healthier Together Integrated Care Steering Group • Local Authority Strategic Group • Healthier Together Digital Delivery Board
Management of Declared Interest:	N/A
Risk and Assurance:	There is a risk that the major programme of merging three community health providers into a single organisation and contract by 1st April 2020 will impact resource availability. There is a risk to go-live and fully automating a solution that the partners technical teams and providers do not have sufficient resource time.
Financial / Resource Implications:	£330K of funding has been provided through NHS Digital and further £165K has been provided through national funding to improve communication tools. Licencing costs for future software will need to be agreed between providers before final commitment to long term solutions.
Legal, Policy and Regulatory Requirements:	Information Governance is managed through the Connecting Care Partnership Information Group that has been established for more than 7 years and jointly funded by all Social Care and Health organisations across BNSSG.
How does this reduce Health Inequalities:	Improving the work flows for the existing service and building the capability for notifications of patients that may have complex conditions and improving planning of discharge may reduce inequalities
How does this impact on Equality & diversity	An assessment has not been completed, due to the work supporting the existing service
Patient and Public Involvement:	The programme of work has been focused on improving the Integrated Care Bureau existing processes and patient and public involvement has not been required although we have used nine patient stories the service has created and over 200 staff members have been involved in creating the requirements for the service.
Communications and Engagement:	The Integrated Care Bureau Task and Finish Group will continue to lead the work, with regular updates to the Integrated Care Steering Group and Local Authority Strategic Group
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Sponsoring Director / Clinical Lead / Lay Member:	Deborah El-Sayed Director of Transformation BNSSG CCG

Agenda item: 6.1

Report title: Integrated Care Bureau (ICB) Digitalisation

1. Background

In October 2018, BNSSG implemented the Integrated Care Bureau to develop cross-agency collaboration between health and social care providers to affect faster complex discharges where patients need rehabilitation and/or reablement before packages of care or new residential requirements are started or restarted.

In December 2018, on-going work from all partners started to identify the digital needs of the service and over the last year several improvements have been made including

- Referral forms created electronically in the hospital systems for North Bristol Trust and University Hospital Bristol, removing paper and pulling information already in the system into the record saving staff time.
- Referral forms are now available on connecting care
- Teams have access to Connecting Care to support assessment
- Improved connectivity with fast access to all clinical systems

2. Proposed solutions

To deliver the key outcome requirements identified in the engagement phase, the project will deliver solutions over several stages

- Real time communication between social care and health teams
- Notifications patients have been admitted to hospital
- Up-to-date information on progress of package of care in real time, capacity and tasking
- Create a single version of the referral form
- Provide real performance data showing impacts to support local and national investment
- Build blueprints including minimum data sets and specifications; compliance with national standards; and standard messaging protocols that can be implemented with the technology partners of choice in any Health System

2.1 Digitisation of the administrative processes

Digitisation of the administrative processes that support referral through the use of a full Single Referral Full as a record will enabling not only visibility of the record across the system as it is built in real time during the patient journey, but the ability to navigate patients earlier in the day allowing wards and community health and social care to start the process of discharging the patient earlier in the day. This in itself will reduce stays for many of these patients by a further day.

Two-way interoperability between the hospital, community and social care systems, will enable the SRF to become a current “live” document visible to the whole system.

2.1 Communication

We will use local communication tools to enable faster communication and a system of event-driven notifications and tasking enabling us to compress the time between admission and the declaration of fitness for discharge and ensure that delays such as those due to the availability of medication, transport and other causes of unnecessary delay can be eradicated by planning around the Expected Discharge Date (EDD) rather than after the patient is deemed medically fit for discharge.

2.2 Triggers, Notifications and alerts

We will build a set of triggers in the patient journey that will alert staff, whichever organisation they are in, to undertake tasks to support that patient's discharge. Some examples are already known to us but an in-depth analysis will uncover a web of interactions for different types of patient with different conditions and needs that can be built into standard workflows to speed up discharge. Examples of alerts include:

- Alerting the local authority when a patient known to them is admitted so a decision can be made about suspending their care package, and alerting them again when the EDD is entered onto the hospital system
- Alerting community providers already supporting the patient that they have been admitted. An example might be that the social work assessment of the patients' ability to return to their own home is done by their existing mental health social worker before their discharge date rather than being scheduled for a Local Authority social work assessment at or after the point of discharge
- Breaking the current cultural ways of working that mean assessments and other actions are arranged serially when they could be scheduled contiguously or in parallel

2.3 The Single Referral Form (SRF)

The SRF is under review with two main aims; to ensure it is compliant with the Care Act, and to review that it contains all of the information required not only to navigate the patient to the right pathway, but also to make an effective trusted referral to the right service(s).

We will then update the different versions in use across BNSSG and use a single version.

3. High-level Milestones

Milestone	Date
Revised Single Referral Form ICB Navigation Meeting Blueprint DPIA and DSAs Reporting and evaluation framework blueprint	Jan 2020
Engagement and design of triggers, notifications and tasking	Q4 2019/20
Implementation of triggers, notifications and tasking	Q2 & Q3 2020/21
New SOP Development	Q3 2020/21
Enhanced reporting/evaluation blueprint	Q2 2020/21
Implement reporting/evaluation suite	Q3 2020/21
Build Return of Investment Business Case	Q4 2020/21
Directory of Services development	Q4 2019/20 to Q2 2020/21
Full Product Release	Q4 2020/21

4. Financial resource implications

£330K of funding has been provided through NHS Digital and further £165K has been provided through national funding to improve communication.

Licencing costs for future software will need to be agreed between providers before final commitment to long term solutions.

5. Legal implications

There are currently no legal implications.

6. Risk implications

Ref No.	Risk/Issue Description	Action required	Responsibility
1	There is a risk that the major programme of merging three community health providers into a single organisation and contract by 1st April 2020 will impact resource availability	• The STP will provide the majority of the resource and engagement so far manes that all stakeholders agree the plan.	Integrated Care Steering Group
2	There is a risk that individual STP partner internal governance processes do not support the project.	• Clear escalation routes in place to STP Executive Group with Director level support from each organisational. • Fortnightly updates with operational ICB task and finish group. • Delivery Board and management group already established • Priority project for STP • Regular updates to Integrated Care Steering Group, Local Authority Strategic Group • Heads/Leads of Service included on Project Steering Group	Integrated Care Steering Group
3	There is a risk to go-live and fully automating a solution that the partners technical teams and providers do not have sufficient resource time.	• All products already in use across system and data sharing in place. • STP priority work stream and partner organisations agree priority project organisational work plans. • Engagement with all CIO • STP Digital Delivery Board fully support bid as a priority	Integrated Care Steering Group

7. How does this reduce health inequalities

Improving the work flows for the existing service and building the capability for notifications of patients that may have complex conditions or certain symptoms will support the ICB teams to work with the wards to support early planning for discharge and reduce inequalities.

8. How does this impact on Equality and Diversity?

The current Single Referral Form takes account of how the patient would like to be addressed, their language and communication requirements, considerations of their sexuality, and their requirements for their emotional and spiritual wellbeing. It also addresses their capacity to

participate in decisions about their care and the details of people close to them if they require someone to act in their capacity.
By improving information sharing and enabling all professionals involved in the care of the patient access to the right information at the right time, we expect this cohort, some of the most vulnerable we support, to experience a more equitable, streamlined and effective health and social care support structure.

9. Consultation and Communication including Public Involvement and key out comes

The scoping of the programme of work started in early December after the ICB went live and early identification for technical support managing the new workflows. Over 200 users have been involved in developing the requirements for the service through a series of workshops,1:1 interviews, process mapping and surveys, representing system wide requirements and benefits for the public, Social Care and Health.

User	Identification and Engagement during Discovery Phase	Key outcomes and requirements identified from discovery phase	Implementation Phase
Operational and commissioning staff across Social Care and Health	85 surveys were completed and returned, comprising of 44 staff and 41 stakeholder questionnaires.	Streamlined process for discharge planning Improve quality of SRF and create one consistent version Currently the processes are paper and spreadsheet heavy and communications are at times patchy Improve rejection information Standardisation of referral process Improve communication and real time information	Continued co-design with ICB task and finish group sign-off each step of the way to ensure whole system wide feedback fortnightly Further workshops with operational teams to finalise process and interface Setting up of core testing team with representation from across teams to develop testing process and carry out user testing Technical working group with operational leads, all IT leads and external software vendors to ensure IT and operations are aligned with delivery plan Public user group to develop process and interface for communication Utilisation of existing communication channels with regular monthly highlight reports to Authority and STP Strategic Groups
Public/Patient representation	9 patient stories collected by service providers to support improvement	Ensure SRF includes information concerning patients concerns e.g. home oxygen, sufficient support capability to capture the 3 conversation model and Clarity of patients on-going needs and goals improved communication to family/care on discharge arrangements	
Joint Heath and Social Care workshops	45 Social Care and Health Staff involved in 5 x ½ day workshops 20 days processing mapping pathways and issues with operation (Brokerage/Acute/Community/intermediate Care) All three councils, three acute and three community providers represented across workshops	automated population of Single Referral Form from host systems into the SRF (e.g. Liquid Logic, AIS, Medway, EMIS, Lorenzo etc.) advanced referral analysis functionality to challenge the referral back to the sender	

Local Authorities Joint Strategic Group and individual 1:1	15 Senior social Care leads 1:1	Role Based Access to capacity and demand Capture of the 3 Conversation model Improved communication between Acute Ward and Social Care teams Improved information for Care Homes supporting discharge Improved tasking for teams	
Integrated Care Steering Group	35 members from Integrated Care Steering Group (representation from 13 Social Care and Health partners jointly chaired by BNSSG CCG and Community Provider CO	Dynamic Resource Management Automated Business intelligence on demand and blockerages	
GPs	5 1:1 with GP leads within CCG including Medical Director, CCIO and Integrated Care Medical Lead	Alerting patients are being discharged Discharge plans	
Integrated Care Bureau Task and finish Group	Fortnightly updates and discussion on proposal. Group includes the 9 key co-ordinating providers (3 x Councils, 3 x Acute, 3 x Community and CCG)		

Appendices 1

Glossary of terms and abbreviations

Blueprint	In this context, a description of the process of compiling and transferring data, messaging and communication protocols, and where appropriate messaging specifications and standards
ICB	Integrated Care Bureau The navigation and administrative function that uses the SRF to select the appropriate discharge pathway for the patient and affects the discharge
Navigation	The process of reviewing the SRF and selecting the correct discharge pathway for the patient
SRF	Single Referral Form A form that collects all information required to Navigate the patient to the correct pathway and that contains the information relevant to the discharge