Graphnet
Integrating Care

Patient engagement

Graphnet is part of

SystemC&Graphnet
Care Alliance

Our patient engagement solutions set out to use leading technology to help redesign care pathways and improve the quality of life for patients with or at risk of long-term, complex or life-limiting conditions. This is achieved at the same time as delivering efficiency and cost-saving opportunities for care providers.

Our solutions include personal health records, record sharing, electronic workflows and collaboration, and clinical dashboards – and are combined with remote monitoring, alerting, condition-specific apps and wearables to support new models of care for specific groups of patients.

Our patient engagement solutions build on our integrated care record and portal platform to support redesigned care pathways and the transformation of care delivery.

The base building block is the CareCentric shared record. This brings together information from GPs, social care providers, acute, mental health and community trusts into a single, unified record and provides care planning support.

It is this shared record that enables new partnerships such as Integrated Care Systems (ICSs), Multispeciality Community Providers (MCPs) and Primary Acute Care Systems (PACS) to work in tandem, as outlined in the NHS Five Year Forward View.

Patients are able to access, view and contribute to their records and services through the myCareCentric Personal Health Record.

The myCareCentric range of condition-specific mobile apps enable patients and other service users to contribute information in a range of innovative ways, including:

- Wearable technologies automatically gathering personal data such as sleep patterns, exercise, heart rate and temperature.
- Telehealth monitoring devices (e.g. blood pressure cuffs)
- Other health and lifestyle apps
- Personal goal setting, reminders and detailed personal content that meets and exceeds PRSB guidance
- Customised condition/problem specific assessments and forms, symptom diary, questionnaires, mood assessments, dietary information and medication compliance.

This is combined with standard shared care record data such as test results and visit outcomes so patients can be monitored and managed remotely. Teams are alerted when conditions change and care plans can be set or amended accordingly.

Example groups of patients for new models of care applications are patients with epilepsy, congestive heart failure, diabetes, frailty, COPD, obesity, undergoing cancer treatment and mental health problems such as dementia and depression.

For care professionals

Our patient engagement solutions enable care professionals to use risk stratification to identify groups of patients with specified conditions, or they can load existing registers.

Those patients can then be recruited onto revised programmes of care which combine information from wearables and other telehealth devices with data entered by the patient. This is added to information from various systems across the care community, and held in a single care record.

Patients can be monitored remotely and clinicians alerted to changes in a patient's condition using machine learning and clinical dashboards.

Treatments and levels of intervention can be managed remotely and patients only called in for consultation when necessary.

Benefits for clinicians

✓ Manage and monitor a patient's condition and general health remotely (including information collected from wearables and telehealth devices such as weight, pulse, sleep patterns, exercise).

✓ Reduced pressure on services – reduction in regular check-ups

✓ More time released for care

✓ Ability to respond immediately to any changes in condition and take preventive action (e.g. modify drug dosage).

✓ Set alerts for pre-defined events – e.g. when a patient presents for an unscheduled admission.

✓ Proactive, fast decisions could help ensure appropriate treatment, reduce length of stay, or avoid unnecessary admission.

✓ Communicate directly with the other care professionals e.g. call on the expertise specialist or acute-based teams, or plan care with community and social care workers.

✓ Involve patients actively in the management of their condition, in order to help keep them healthier longer or contribute to a successful recovery.
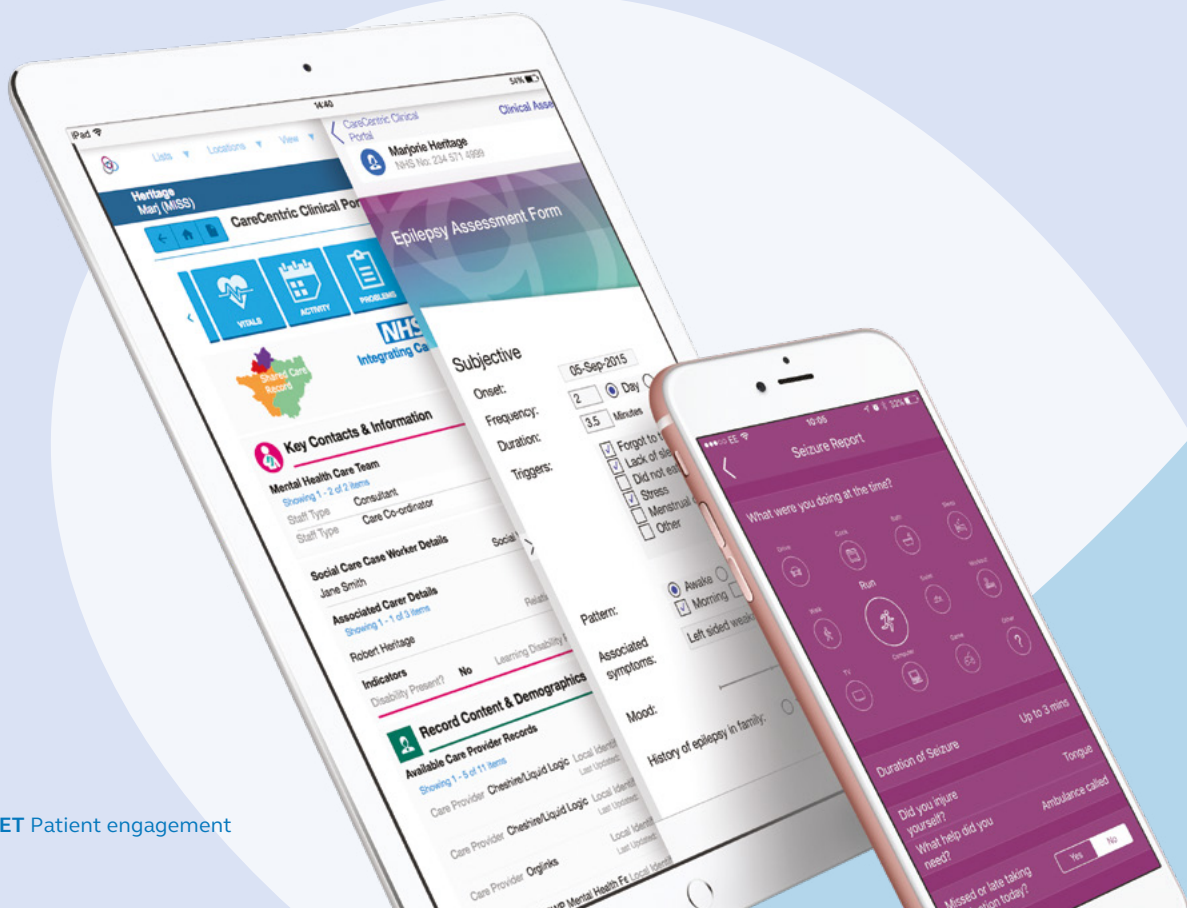
For service users

Our patient engagement solutions engage patients as a proactive partner in their own care process.

They are able to participate in, and control, their care management to fit better with their own wishes and individual needs.

Benefits for service users include:

✓ Active and direct engagement in their own care.

✓ Links to health education information that aims to encourage and assist them in maintaining compliance with their care pathway.

✓ Assessment against their personal targets.

✓ The ability to share their goals and successes with a chosen network of family and friends.

✓ Responsive care, provided when it is needed rather than according to a prearranged cycle of appointments and check-ups.

✓ Security and quality of life improvements associated with having mobile, real-time electronic clinical support.

“ *As a first step towards this ambition we will improve the information to which people have access – not only clinical advice, but also information about their condition and history."*

“ *Second, we will do more to support people to manage their own health – staying healthy, making informed choices of treatment, managing conditions and avoiding complications."*

“ *A third step is to increase the direct control patients have over the care that is provided to them."*

Source: NHS Five Year Forward View
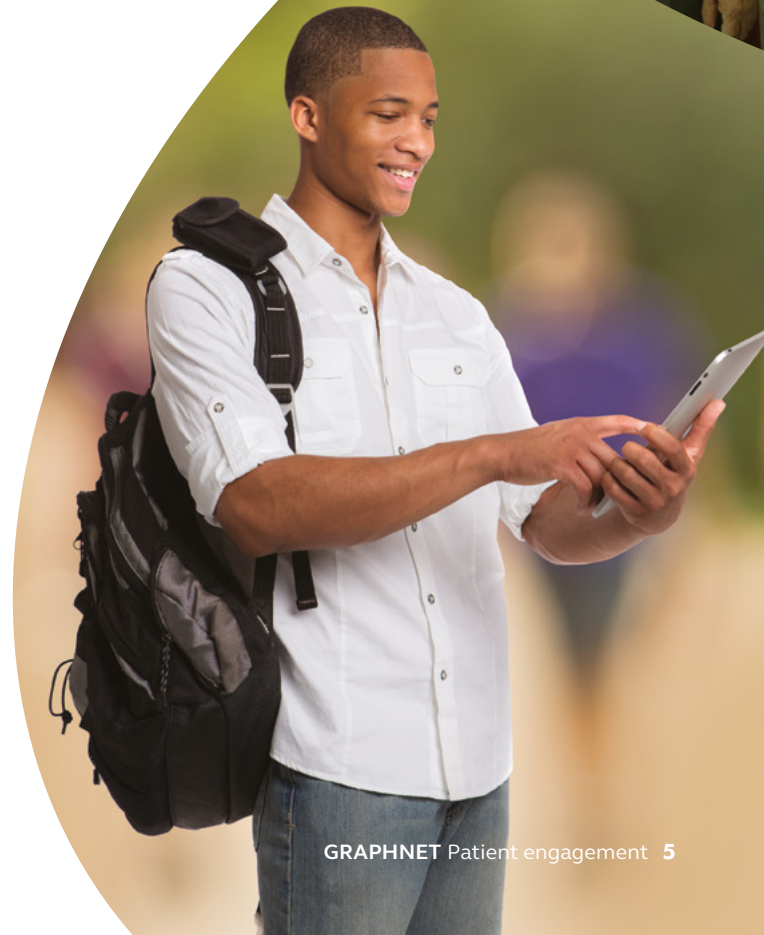
Patient engagement – case studies

myCareCentric Epilepsy is in use across Dorset, revolutionising the way in which epilepsy sufferers, their family, friends and clinicians work together to improve treatment and the quality of life.

myCareCentric Epilepsy is the first solution of its kind to integrate data from wearables, smartphones and portals with clinical records, and to share the enhanced record in real-time with patients, their families and clinical teams.

By providing the individual with timely expert guidance and support, myCareCentric Epilepsy aims to overcome many of the challenges that people with epilepsy face, including the loss of independence and isolation that can go hand in hand with the unpredictable nature of epileptic seizures.

At the same time, it gives clinicians real time access to patient data. The diagnosis and treatment of epilepsy are recognised as being extremely challenging and depend on the availability of accurate, complete patient information and specialist knowledge at the point of care.

The aim is that novel clinical pathways, including real-time pre-emptive interventions, will help reduce the costs of care and improve the treatment of the condition.

The clinician view

" *This project is all about delivering better care for patients",* said Dr Rupert Page, consultant neurologist and clinical lead for the Dorset Epilepsy Service.

"It enables us to focus resources on those patients who need support, and at their time of need.

"The novel visualisation tools enable us to see critical details at a glance, releasing more time to care", he added. *"And by using wearables, monitoring and notification technology – combined with secure communication to clinical systems – we are providing patients with an electronically-enabled safety net.*

"This level of direct engagement helps clinicians monitor and understand the nature of someone's epilepsy and seizures and respond immediately with alterations to drugs, for example. This has significant quality of life benefits for the patient, and cost benefits to the health service by reducing outpatient and emergency department visits, preventing hospital admissions and cutting medication bills."

**Dr Rupert Page,
Consultant neurologist, Poole Hospital**

The patient view

" *The one key thing for me is about being able to have a safety net and a support system so I can actually regain my independence. What tends to happen now, particularly if I am out on my own, is that I end up back in an ambulance or in A&E. I hope to get better control of my seizures and ideally to get the life back that I used to have."*

Sean Hamilton, patient

Integrated care and support plans

Created and designed to help multi-disciplinary teams protect those people most at risk and dramatically improve their care outcomes. Unnecessary admissions can be avoided by use of the multiple contingency plans that are created and held within the main care and support plan; allowing many different scenarios to be catered for and easily accessed by care professionals as required during times of crisis.

The integrated care and support plan combines the CareCentric shared care record with a care and support planning application.

Within Greater Manchester it gives authorised professionals immediate, on-the-spot access to the records of 6,000 patients identified as being at risk of unscheduled or unplanned care.

At present, data is combined from three acute Trusts, 90 GP practices, and Manchester City Council's social services department. Plans are in place to deliver records from Manchester Mental Health & Social Care Trust and North West Ambulance Service later in the year.

Manchester Care Record – Benefits and Outcomes
Case studies

Benefits – Case Study 1

Prior to MCR
A 71 year old man lives at home alone, is a frequent faller and often calls 999. The patient is invariably shaken and upset, doesn't want to be alone and insists on attending hospital.

Now
- The patient's GP asks for consent to give him a shared health and social work record, therefore giving him a designated keyworker. The patient agrees and a keyworker goes to visit patient and agrees a current and crisis plan.
- The patient explains that he is scared of going to hospital but when he falls he is extremely frightened and feels he has no option. keyworker engages with patient's next of kin.
- When the patient next has a fall and calls 999, the ambulance driver reviews his care plan which suggests he should call his daughter if he has had a fall and is uninjured but shaken. The ambulance driver assesses the patient, calls the daughter and stays with the patient until she arrives.

Outcome
Admission is avoided. The patient is happy to remain at home and feels safe in the care of his daughter.

Benefits – Case Study 2

Prior to MCR
An 81 year old lady with dementia, who also has COPD and asthma, was attending hospital on average once a week. The patient was becoming increasingly upset and troubled each time she had to go to hospital.

Now
- The patient's GP put together a care plan in liaison with the patient and her daughter.
- The patient was then assigned a keyworker. As part of the overall care plan a crisis plan was created. Rather than the patient's carer or daughter immediately calling 999 when the patient's health deteriorates, she is now in most cases managed at home by the keyworker and/or family – unless she is unable to breathe.

Outcome
The patient has remained out of hospital for 5 weeks now and the keyworker continues to work closely with patient and the family.

Graphnet Health is the UK's leading supplier of shared care record software to the NHS, social and care services.

Its CareCentric software combines a shared record with community-wide assessment, workflow, care planning, and specialist apps for long term conditions. It also supports patient engagement through the use of the myCareCentric Personal Health Record and population health management.

Graphnet is part of the System C & Graphnet Care Alliance, a strategic alliance offering integrated IT solutions to the UK health and social care market.

Together we are:

- ✓ No. 1 supplier in **shared care records**
- ✓ No. 1 supplier in **social care**
- ✓ No. 1 supplier in **electronic observation systems**
- ✓ No. 1 supplier in **child health**
- ✓ A leading provider of acute **electronic patient records** systems, **clinical care**, **maternity** and **business intelligence**

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