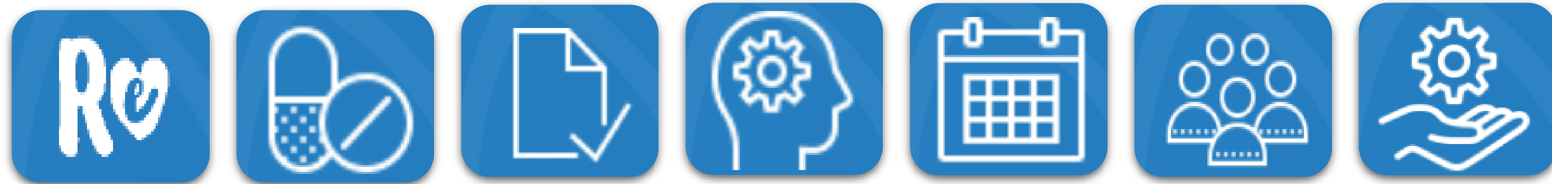
Bath and North East Somerset,
Swindon and Wiltshire Partnership
Working together for your health and care

BSW Integrated Care Record



Contents

What is the ICR?

What data is available?

What is it used for?

BSW ICR - What is it and what does it do?

ICR is a secure, electronic shared health and social care record in BaNES, Swindon and Wiltshire. The ICR brings together existing health and social care information (primary care, acute, mental health, community and social care).

ICR Capability	Example
Direct Care	ED consultant can view MH crisis plan on presentation at ED
Care Planning	End of Life Care Plans can be co-developed and viewed across multiple professionals and organisations
Population Health Management and BI	Aggregate analysis of health and social care usage of a cohort of population stratified by condition, age, deprivation

BSW Data Feeds

Live
Underway

* 1 GP outstanding & 1 out of scope

Data Feeds – what is shared

GP Data

(85 out of 87 BSW practices are live)

Nightly Feed of data recorded locally:

- ✓ Demographics
- ✓ Immunisations
- ✓ Medications
- ✓ Referrals
- ✓ Active & Past Problems
- ✓ Allergies
- ✓ GP results
- ✓ GP Encounters
- ✓ Contraindications
- ✓ Operations
- ✓ Radiology
- ✓ Investigations
- ✓ Family History
- ✓ Pregnancy, Birth & Post Natal
- ✓ Contraception & HRT

AWP

Real Time Feed:

- ✓ Demographic information
- ✓ Allergies
- ✓ Inpatient stays – Admission, Transfer, Discharge and Leave events
- ✓ Referrals to community teams
- ✓ Appointments – Planned and past
- ✓ Care Coordinator name and contact details
- ✓ Crisis, Relapse and Contingency Plans

Overnight Transfer:

- ✓ Perinatal Care plans
- ✓ Inpatient Discharge Summaries

Community – WHC & Swindon:

Nightly Feed:

- ✓ Inpatient Activity (wait list, admissions, transfers)
- ✓ Outpatient Activity (referral, appointments, attendance)

Swindon Community Only:

- ✓ Discharge Letters and other correspondence

Medvivo OOH

Real Time Feed:

- ✓ Demographics
- ✓ Medications
- ✓ Notes
- ✓ Activity:
  - Consultations
  - Clinical Codes
  - Cases
  - Case Questions
  - Informal Outcomes

Community – BaNES

Nightly Feed:

- ✓ Demographics
- ✓ Immunisations
- ✓ Diagnosis
- ✓ Medications
- ✓ Referrals
- ✓ MIU Data (Paulton)

Data Feeds – what is shared: Acute (Real Time Feed)

Type	RUH	GWH	SFT
Inpatient Activity - Wait List, Admissions, Discharges, Transfers	✓	✓	✓
Outpatient Activity - Referrals, Appointments, Attendances	✓	✓	✓
Emergency Activity – Attendance and Discharge	✓	✓	✓
Pathology Results	✓	✓	✓
Radiology Reports	✓	✓	✓
Discharge Summaries	✓	✓	Phase 3
Clinic Letters	✓	✓	
Flexible cystoscopies	✓	✓	
Colonoscopies	✓	✓	
Gastroscopies	✓	✓	
Flexible Sigmoidoscopies	✓	✓	
Maternity Notes		✓	
Cardiology Reports			Phase 3

Data Feeds – what is shared: Local Authority

Type	BaNES LA Adults	Wilts LA Adults
Demographics	✓	✓
Referral	✓	✓
Event Data including Assessments, Safeguarding, DOLS	✓	✓
Care Plans	✓	✓
Service Provision including non-plan service provisions	✓	✓
Alerts	✓	✓
Disabilities	✓	
Practitioner	✓	✓
Classification i.e. support reason	✓	✓

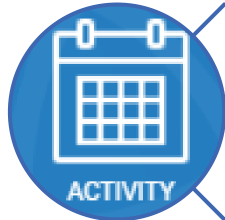
What do I use it for?

Virtual Ward

Is my patient on a virtual ward?

Direct Entry Care Plans

What are my patient's end of life wishes?



Two Week Wait Tracker

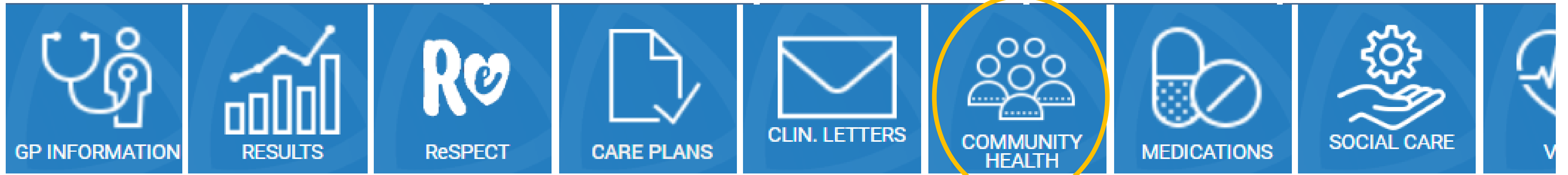
(Primary Care)

Use Cases in Primary Care

What do I use it for? – Virtual Wards

Virtual Ward

Is my patient on a virtual ward?



Community Care

Please note - Encounters and Appointments are not supplied by BaNES Community Health

Updates nightly

Click to see Referrals
Click to see Activity (Encounters and Appointments)

Community Care

Please note - Encounters and Appointments are not supplied by BaNES Community Health

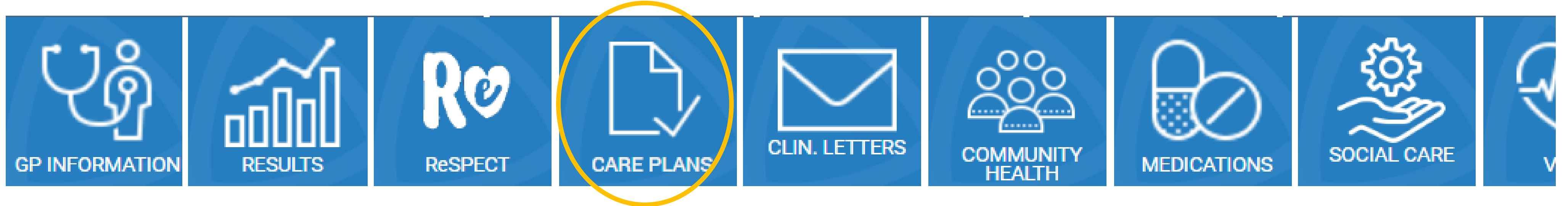
Open Referrals 5 items

Open Referrals 4 items

Showing 1 - 4 of 4 items. Click to see more items.

Date:	21-Jul-2023	Care Setting:	Community Data (for Swindon and Wiltshire)
Urgency:	Next Day	Reason:	Wound Care
Referred To:	Chippenham Community Team Nursing	Specialty:	NURSING EPIS[illegible]E
Referred By:	Carer/Relative		
Received:	21-Jul-2023	Accepted:	
Date:	20-Jul-2023	Care Setting:	Community Data (for Swindon and Wiltshire)
Urgency:	Routine	Reason:	Cardiac Conditions
Referred To:	Wiltshire Hospital at Home Service	Specialty:	ALLIED HEALTH PROFESSIONAL EPISODE
Referred By:	RUH Inpatient Ward		
Received:	20-Jul-2023	Accepted:	
Date:	08-Jun-2023	Care Setting:	Community Data (for Swindon and Wiltshire)

What do I use it for? – EOL Care



Direct Entry Care Plans

What are my patient's end of life wishes?

Integrated Care and Support Planning

Contacts Form — Has Main Carer: / Carer for Others: / Care Coordinator / Lead Professional Recorded: No / Other Personal and/or Professional Contacts Recorded: No / LPA(s) Recorded: No — Click to View / Edit / Add >>

About Minnie — Click to Start >>

Lifestyle & Environment — Click to Start >>

Care & Support Plan (Goals & Activities) — Review Date: 31-Oct-2019 — Activities & Actions Recorded: 0 — Click to View / Edit / Add >>

Contingency Plan — Click to Start >>

End of Life (EPaCCS) — Review Date: — Diagnosis: Dementia — CPR Status: — Click to View / Edit / Add >>

MDT Meetings — Click to Start >>

Care Planning: Supporting Documents — Click to Start >>

Frailty — Click to Start >>

ReSPECT — Recommended Summary Plan for Emergency Care and Treatment — Click to Start >>

Plans/Actions — Click to Start >>

End of Life (EPaCCS)

CONSENTED	LAST UPDATED	NEXT REVIEW	ADVANCE CARE PLANNING
11-Dec-2023	11-Dec-2023 12:19	Not Set	View the joint statement on advance care planning

Consent · GP ACP · Diagnosis · Special Req's · Pref Place of Care · Pref Place of Death · Adv Care Planning · Anticipatory Meds · CPR · Life Sustaining Tx · Other Concerns · After Death · MDT GSF Review · Next Review

GSF STAGE - GREEN Since 11/12/2023	STAGE CHANGE BY	ROLE
	mc	GP

Consent to Create and Share

The person giving consent understands an EPaCCS record will be created and shared with those involved in the provision and coordination of the end of life care. Also that personal identifying data will be shared when notifications are sent to the contacts included on the record via the contacts chosen method of notification.

ReSPECT — Recommended Summary Plan for Emergency Care and Treatment

Click HERE for ReSPECT Resources

Care Centric Digital Version 3.5

1. This plan belongs to:

Full Name:	Testing EOL2
D.O.B:	02-Feb-1961
Address:	300 Any Road, Any Town, Any County, PC12 9PC
NHS/CHI/Health and care number:	999 111 1117 / 999 111 1117
Preferred Name:	Tom
Form Completed:	22-Feb-2023

The ReSPECT process starts with conversations between a person and a healthcare professional. The ReSPECT form is a clinical record of agreed recommendations. It is not a legally binding document.

2. Shared understanding of my health and current condition

Summary of relevant information for this plan including diagnoses and relevant personal circumstances:

Ischemic heart disease, severe frailty.
Alzheimer's disease

test

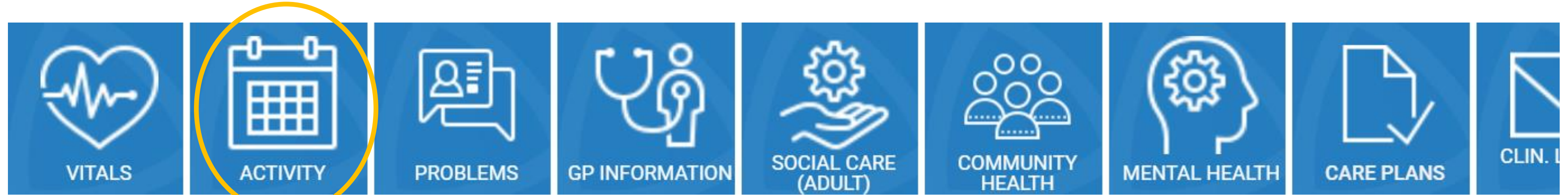
Details of other relevant care planning documents and where to find them (e.g. Advance or Anticipatory Care Plan: Advance Decision to Refuse Treatment or Advance Directive, Emergency plan for the carer):

NO other ACP documents

Click to View and Upload Supporting Docs

What do I use it for? – Two week wait referral tracker

Two week wait referral tracker



Hospital Activity

Outpatient Activity
Showing 1 - 2 of 4 items

Outpatient Referral 25-Nov-2015 14:45	Specialty: COCOC Outpatients Clinician: Dr R Whitehall	Referrer: Dr M Clarke	Florence Nightingale NHS FT
Outpatient Discharge 15-Oct-2015 15:00	Specialty: Clinician: Dr R Whitehall	Referrer: Dr C Hughes	Florence Nightingale NHS FT

Inpatient Activity
Showing 1 - 3 of 5 items

IP Admission 26-Oct-2015 07:00	Specialty: Upper GI Oncology Surgery Clinician: Dr P Giles	Location: Spencer Ward	Florence Nightingale NHS FT
IP Admission 22-Dec-2015 13:00	Specialty: HCOOP Clinician: Dr P Dawes	Location: Spencer Ward	Florence Nightingale NHS FT
IP Discharge 22-Dec-2015 14:15	Specialty: Clinician: Dr S Wright	Location:	Florence Nightingale NHS FT

Emergency Activity
Showing 1 - 2 of 2 items

AE Attendance 23-Jul-2018 06:41	Clinician: Dr FG Odding	Location: Minors string	Florence Nightingale NHS FT
Emergency Attendance 02-Sep-2018 11:41	Clinician: Ms KY Fisher	Location: Resus 4G	Florence Nightingale NHS FT

Check patient record for hospital appointments (Activity nav tile and Clinic Letters)

Update the two-week wait tracker.

What do I use it for? – Primary Care Additional Use Cases

Primary Care Use Cases

Scenario	80yo patient discharged from hospital confused about several new medicines for a gastrointestinal condition but no discharge summary
What usually happens?	Duty doctor and admin spend lots of time trying to speak to discharging ward, chasing doctors on ward and trying to get discharge summary emailedemailed
What happened	Care co-ordinator accessed the discharge summary (immediately available on ICR) in 3-clicks, reassured the patient
	ACTIVITY · PROBLEMS · GP INFORMATION · SOCIAL CARE (ADULT) · COMMUNITY HEALTH · MENTAL HEALTH · CLIN. LETTERS · SUMMARY · TIM

Scenario	65yo newly registered with surgery in urgent need of medication for complex conditions including cardiomyopathy. Records not yet transferred.
What usually happens?	Duty doctor, pharmacy team and admin spend significant amount of time chasing previous GP and pharmacy
What happened	Within 3 clicks, duty team was able to access previous medicines, vitals and clinic letters, ensuring patient safely continued medicines.
	ACTIVITY · PROBLEMS · GP INFORMATION · SOCIAL CARE (ADULT) · COMMUNITY HEALTH · MENTAL HEALTH · CLIN. LETTERS · SUMMARY · TIM

What do I use it for? – Primary Care Additional Use Cases

Primary Care Use Cases

Scenario	3yo child with rapid onset unilateral swollen eye. Known safeguarding concerns on record. Likely orbital cellulitis/allergy but want PAU review to exclude non-accidental injury
What usually happens?	Good practice is to ensure patient has attended for review on PAU after being referred, usually requiring duty doctor or admin to call PAU to check.
What happened	Within 3 clicks, Duty doctor was able to check attendance to inpatient unit via “Activity” tab, and Discharge Letter was already available to view too.
	ACTIVITY · PROBLEMS · GP INFORMATION · SOCIAL CARE (ADULT) · COMMUNITY HEALTH · MENTAL HEALTH · CLIN. LETTERS · SUMMARY · TIM

Scenario	Vulnerable blind elderly patient with significant appointment burden, strugglng to co-ordinate appointments including transportation
What usually happens?	Lots of stress for the patient, DNA to appointments, admin time used to find out appointment times and co-ordinate appointment/transport
What happened	Within 3 clicks, frailty team can see upcoming appointment times and support patient with planning attendance
	ACTIVITY · PROBLEMS · GP INFORMATION · SOCIAL CARE (ADULT) · COMMUNITY HEALTH · MENTAL HEALTH · CLIN. LETTERS · SUMMARY · TIM

What is ICR used for? User Feedback

Tom Bellfield, care coordinator for St Chads and the highest user of the ICR in primary care.

> “ICR invaluable in allowing a better more holistic view of the patient ”

Use Case: Tom manages a varied client list and takes referrals from clinicians and self referrals to manage non-medical issues. Finds the ICR invaluable in allowing a better more holistic view of the patient:

- Ability to locate patients
- Getting information before it lands in SystmOne (letters/documents). Normally any documents that go to primary care gets sent to scanning. This can lead to a delay of processing.
- Finding out more about a patient/client - which organisations are involved, how often do they access services etc.

Tom feels the most important part of the ICR is the documents section

Benefits:

- Using the ICR gives a better quality service to the patient
- Saves time phoning different organisations e.g. hospital
- Real world example of pharmacy calling the practice about a very vulnerable patient who hadn’t picked up their meds for 6 days. Normally this would have resulted in the practice trying to call the patient and if no response contacting the police. However by looking on the ICR they saw that he’d been admitted and saved an awful lot of time and hassle.

What is ICR used for? User Feedback

Nic Aplin, Community Frailty Nurse Practitioner for BaNES at Royal United Hospital

Use Case: Nic uses the ICR on daily basis via Millennium and finds it especially helpful for MDT meetings and supporting the residents in the care hotel. These individuals may have come from any area in BSW and are not always known to RUH. The ICR enables Nic to see all relevant information in one place:

- Quick and easy access to relevant information (meds, comorbidities, outpatient referrals, etc.), especially helpful for those patients who do not appear on Millennium
- Access to caseworker contact details which was not always possible previously.
- Having the information available on ICR means there is usually no need to log into the read only version of SystmOne separately and search for patients which takes time.

Benefits:

- Access to caseworker contact details has seen an improvement in MDT meeting attendance and in turn an improvement in quality of assessments and follow-up.
- Time saved by having information in one place and not having to log into SystmOne separately or phoning around for information means more time spent with the patients
- Easily compare comorbidities and meds, comparing RUH with GP data. Real life example: Nic was able to check on a specialist haematology med that was not on an RUH discharge summary and contact the appropriate clinician quickly and easily, potentially saving harm.

What is ICR used for? User Feedback

First Response Occupational Therapist Teams HCRG

Use Case:
The goal of the FRT is to **build a picture of the circumstances of the Service User in order to make an informed decision** as to the **most appropriate onward journey** – whether that be into third-sector organisations, Adult Social Care or Healthcare.

The ICR currently provides 'cues' to the FRT in terms of Service User's circumstances – such as whether the Reablement Team are/have been involved or whether the SU has recently admitted to hospital – **medications and problem lists** would improve this process

The OT team use the ICR to support the **adaptation assessment process**. Access to medication lists would support the decision making process around the introduction of a stair rail aid for example

Benefits:
Reviewing the ICR can be up to 24 hours faster than awaiting a GP summary from a practice. More if multiple GP summaries are required. This enables better and faster outcomes for service users

Avoids duplication and provides the most effective support for people at the earliest opportunity

Reduces Service User confusion, frustration and the frequency that they had to repeat the same story to a different person