

Improving the physical health of people with severe mental illness through interoperability

A step by step guide



Purpose

People living with SMI have a life expectancy of 15-20 years less than the general population. This disparity is due in part to physical health needs being overlooked. Knowing whether people with SMI have received all the physical health checks they are entitled to will require information sharing between primary and secondary care.

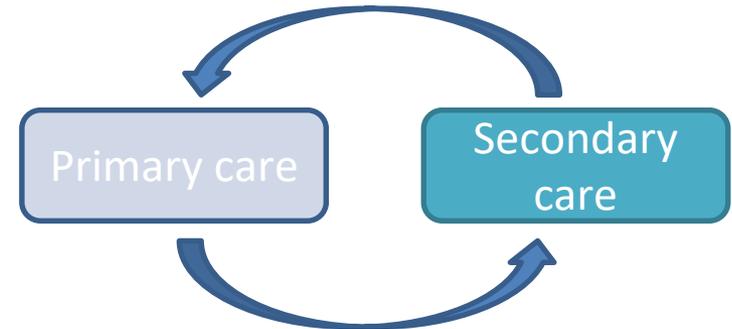
- There is good evidence to support the use of regular physical health checks to reduce chronic ill health and/or premature death for people with serious mental illness.
- Guidance for the implementation of these health is detailed in *'Improving physical healthcare for people living with severe mental illness (SMI) in primary care'* and supported by a national CQUIN, which requires patient care plans or comprehensive discharge summaries to be shared with GPs.
- This slide pack aims to:
 - Outline the principles of information sharing and how to achieve interoperability to improve the delivery of mental health services.
 - Provide a 'how to' guide to support information sharing on physical health checks between primary and secondary care.
 - Support the delivery of the national CQUIN, which will be assessed through internal audit by providers.

Interoperability: what is it and why is it important?

Interoperability: The ability of two or more computer systems to share information between them and to make use of this information.

Interoperability:

- Enables effective communication between different clinical systems, such as those in primary and secondary care
- Avoids assessments being repeated or missed
- Improves the care an individual receives and supports decision making
- Reduces burden of data entry
- Likely to release cost saving longer-term
- Empowers patients, families and carers to support self management and better involvement in their care



The [Lancashire person record exchange service](#) has provided a centralised system across health and social care organisations. It allows all professionals involved in providing care for an individual have access to the same information from GP records, acute and community healthcare providers. This has improved efficiency, allowing more seamless management of care and reducing the amount of time spent taking history and entering data about an individual.

Minimum requirements for interoperability

Fully interoperable systems:

- The health and care professional is able to both view and edit the information in their usual system and share changes with other systems

Partially interoperable systems:

- The health and care professional is able to view the information in their usual system but is unable to share changes through their system

Basic interoperability:

- The health and care professional can view through a third party system rather than their usual system

In order to be fully interoperable, two systems must implement Open APIs* able to both access and update information held by both those systems. This will be driven by an information sharing process for physical health assessments that has been agreed by clinicians. This process should include who can amend the patient record, where the information will be stored, whether and how the process will be reviewed, and who will be notified when the information is changed.

An **Open API is an Application Programming Interface – a set of definitions and protocols that specify how software/systems interact and share data.*

Step 1: identify the information you need to share and why

- How can better information sharing between settings and services improve your service and what is stopping this from happening?
- What specific information items you want to record and share?
- Will your information and IT systems allow you to share this information?
- What standards, if any, do existing systems have in common to support accurate sharing of information?

What information might you need to share to improve the physical health of people with SMI?

- Physical health risk factors identified
- Lifestyle and advice given
- Medical tests requested
- Medication prescribed

NHS England guidance asks that, as a minimum, standard templates (such as care plans) are in place to share information about an individual's health checks and care, between:

- The local health team
- The person living with SMI and/or their carer
- Their GP
- The local healthcare record - so the longitudinal patient record includes physical health checks for use in other care settings
- The population health management team to monitor trends and outcomes.

Step 2: Get to know your local systems

- Is there a local digital strategy which can help with understanding local systems?
 - [Local Digital Roadmaps](#)
 - [Digital Maturity assessment](#)
- Review the systems which will need to share information:
 - How ready are your systems to share information?
 - How flexible are your system suppliers in making changes to support better sharing of information between systems?
 - What are the dates for renewal of licenses and contracts with your suppliers? These may affect your ability to introduce new requirements
- What sharing model/models fit your requirements best?
 - Single shared application – information is shared through a common data store
 - Click-through – a simple web link which allows a provider to view another computer system

Details of these information sharing models, and more, can be found in [the Interoperability Handbook](#)

Shared learning: in some areas standardised templates have been developed to support the development of interoperable systems, such as the [Bradford Physical Health Assessment Template](#).

Step 3: Engage your partners

- Work out who you need to partner with to share information
 - Aim to build close cross-institutional working relationships to develop a system of trust including joint expectations
 - Establish an Information Sharing Agreement
- Agree a governance structure, funding and resources
 - Encourage strong support and ownership from every stakeholder organisation
 - Ensure a clear, agreed shared care protocol with clarity on who is responsible for what
- Identify any cultural challenges, including resistance to sharing data
 - Maximise the role of GPs and other digital champions in leading engagement
 - Identify training needs in:
 - Understanding physical health check requirements
 - Use of new systems
 - Loading templates into primary care systems
- Test with clinicians and patients

Resources: Bradford standard template

- Bradford District Care NHS Trust has been working with Yorkshire and Humber Academic Health Science Network to design and implement a new physical health template with associated training, driving interoperability between the primary and secondary care to provide good physical healthcare for patients with SMI.
- The template created guides GPs to collect relevant clinical information relating to physical morbidity and health risks
- Ensures standardised physical health checks carried out and information passed easily between GPs and secondary care.
- Supports GPs with submission of QOF data without having to duplicate data entry
- For screenshots of information included in the template see www.tpp-uk.com/mhpr

Lifestyle advice and intervention

Smoking status

Lives with Smokers?

Alcohol intake Units/Week

Smoking cessation drug therapy

Alcohol consumption screening test declined

Health education - alcohol

★ ES Alcohol 2016/17

Current drug user

Drugs - health education

Smoking Cessation Advice

- Smoking cessation advice (Ua1Nz) QOF
- Seen by smoking cessation advisor (Xa1e) QOF
- Consent given for follow-up by smoking cessation team (XaXSVA) QOF
- Practice based smoking cessation programme start date (XaVDh) QOF
- Referral to NHS stop smoking service (XaQT5) QOF
- Referral to smoking cessation advisor (XaltC) QOF
- Referral to stop-smoking clinic (XaFw9) QOF
- Declined consent for follow-up by smoking cessation team (XaXS...) QOF
- Smoking cessation advice declined (XaRFh) QOF
- Smoking cessation programme declined (XaREz) QOF

Resources: Case studies and contacts

Challenge	Solution	Where is this happening?
Improving consistency in the delivery of physical health assessment	Standardised physical health template (with associated training)	Bradford and Airedale Kate Dale Kate.Dale@bdct.nhs.uk <u>Yorkshire and Humber, Academic Health Science Network</u>
Providing real-time electronic read-only access to joined up physical and mental health records across acute, community and primary care.	Integrated local care record	Lambeth and Southwark Partnership Dean Holliday, dean.holliday@nhs.net Nancy Kuchemann, nancy.kuchemann@nhs.net
Improving patient access to medical records	Care Information Exchange which will provide secure online access to medical records.	The Imperial College Healthcare Charity Stephen Janering stephen.janering@nhs.net

These case studies can be found in the [‘Improving physical healthcare for people living with severe mental illness \(SMI\) in primary care’](#) Supporting Annex

Resources: Other useful links

- [The Interoperability Handbook](#) – for in depth guidance on building interoperable systems.
- [Personalised health and care 2020: a framework for action](#) – for further information on the digital strategy for the NHS.

Examples of shared care records across primary and secondary care:

- [Lancashire Personal Record Exchange Service](#)
- [Hampshire Care and Health Information Exchange](#)

Trusts that are working to become leaders in digital health:

- [Global Digital Exemplars](#)
- [NHS Digital Academy](#)