Graphnet
Integrating Care

CareCentric

ICS ready, fully integrated solutions – designed to transform care across communities

Graphnet is part of

SystemC & Graphnet
Care Alliance

Graphnet is the UK's leading provider of integrated care solutions which join up services across entire health and care communities.

Our solutions seamlessly link information from multiple systems into meaningful, unified shared records; support cohort identification, enrolment and management for prevention and intervention programmes; enable personalised care and support planning across multi-disciplinary teams; provide personal health records and remote monitoring tools to support patient engagement and virtual care; and include comprehensive reporting and analysis capabilities.

All of which combines to fully support Integrated Care Systems to join-up health and social care; tackle health inequalities; reduce hospital admissions; provide better patient access; prevent major health issues; and lower waiting times.

We have been collaborating closely with our customers to design and implement systems that are built specifically for ICSs. This is enabling them to achieve 'what good looks like,' and to meet the goals laid out in the NHS 2022/2023 priorities document.

Our CareCentric solution is also delivering the National Immunisation Management System for Covid-19 and flu.
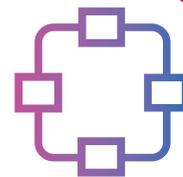
Our solutions cover

20 million people
Our shared care solutions hold records for 20 million people.

100%
Managing Covid and flu vaccination data across the whole of England.

2,300
We bring together information from over 2,300 NHS and social care systems

20,000
Around 20,000 patient care encounters are assisted by the use of our shared record every day.

17.3 million
17.3 million citizens benefit from planned care using our population health management.

50,000
Remote monitoring over 50,000 citizens.

Shared Care Records

Our market-leading **CareCentric shared care record solution** safely and securely collects and combines health and wellbeing data from the multitude of systems used across care communities. This is presented to clinicians and care teams in meaningful views, available in real-time at the point of care, supporting better informed, more timely decision making.

Individuals and patients also have secure access, using NHS Login, to their shared care record via the **myCareCentric Personal Health Record**. Localised and intuitive signposting to relevant care and wellbeing services, and embedded third-party content, are included. Our PHR also supports real-time sharing of information with care teams, e.g., 'About Me' details, Emergency Information and Contacts.

Interoperability and the Cloud

Fully interoperable and specifically designed to build on existing investments, CareCentric connects to all the major health and social care IT systems being used in the UK.

The solution can be embedded in third party systems so users can launch the shared record in patient context via Single Sign-On.

We have a package of open APIs (which use FHIR-based standards) available to enable enhanced sharing of data.

CareCentric is also cloud-based, providing a secure, scalable and resilient environment.

Releasing time to care

" *It's significantly reduced the time spent chasing up appointments. We rang at least 7 times in a week and were on hold around 10 minutes each time. We also use it to find what wards patients are on. This saves us about 15-30 minutes each time by ringing the ward direct.* **Administrator, GP Practice**

Improved outcomes

" *The access to information aids and avoids duplication of our services and therefore helps to avoid hospital admissions and re-admissions by having discharge information to hand. The shared record makes us effective and gives us the ability to achieve more timely outcomes for patients and service users.* **St Helens Contact Cares Advisor**
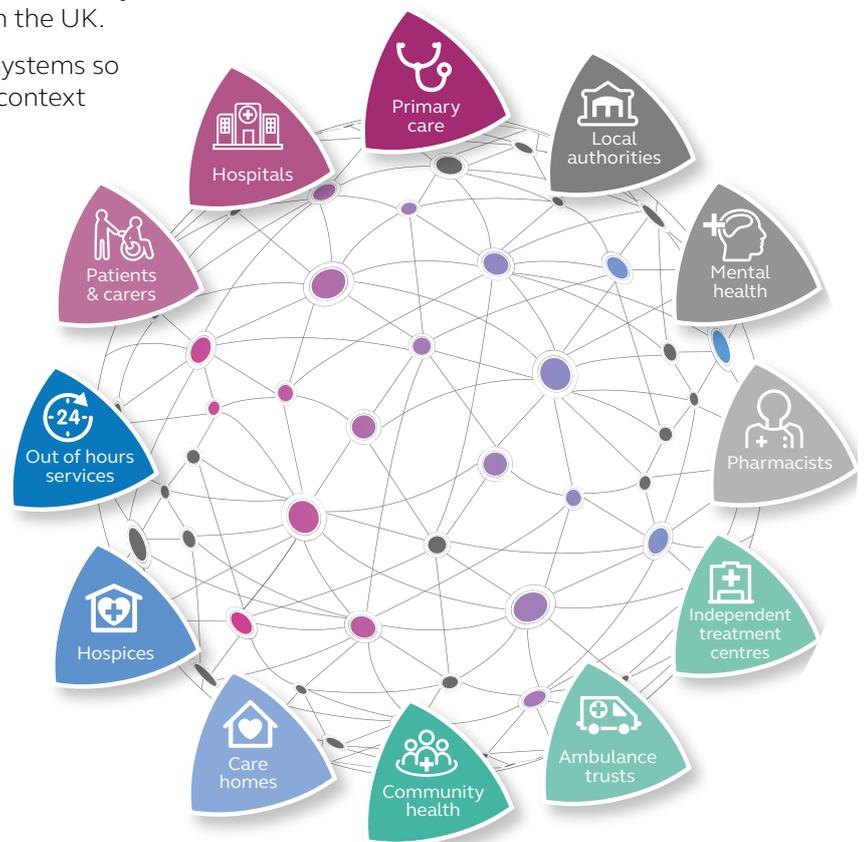
Sharing the right information, at the right time, for better, faster and more joined-up care.

Primary care

Hospitals

Local authorities

Mental health

Patients & carers

Pharmacists

Out of hours services

Independent treatment centres

Hospices

Care homes

Community health

Ambulance trusts

Better decision-making with complete information

" *Our social work professionals can make better decisions because they are presented with the complete view of a person. The information that social care now has access to is terrific. The information which health has access to is phenomenal.* **Mike Roberts, Central Systems Support Team Manager at St Helens Council**
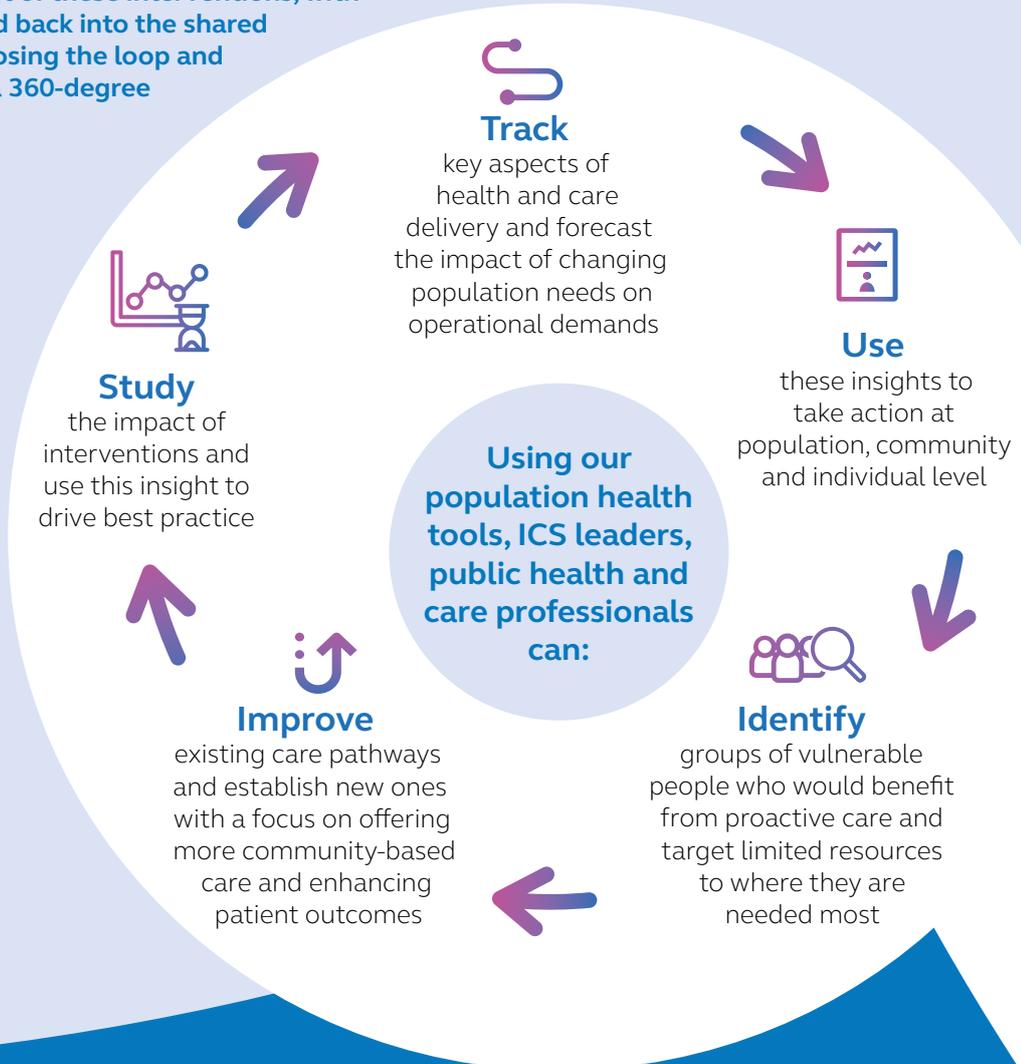
Providing actionable insights for the resilience, reset and recovery of health and care economies.

Population Health Analytics

Our CareCentric population health platform uses the rich data held in our shared care record, combined with Secondary Uses Service (SUS) data and public data sources, to produce in-depth intelligence at population, cohort and individual level.

For ICSs, this combined intelligence is central to understanding where to target resources and interventions. Data and analytics provide the timely insights ICS partnerships and NHS Boards need if they are to take action and meet the new triple aim - improve outcomes, tackle inequalities and enhance productivity.

This intelligence can drive actions such as enrolling identified individuals into a remote monitoring programme, where clinicians can drill down into the shared care record and patients self-record into their integrated personal health record. In addition, analytical tools measure the impact of these interventions, with results fed back into the shared record, closing the loop and creating a 360-degree solution.

Using our population health tools, ICS leaders, public health and care professionals can:

Track
key aspects of health and care delivery and forecast the impact of changing population needs on operational demands

Use
these insights to take action at population, community and individual level

Identify
groups of vulnerable people who would benefit from proactive care and target limited resources to where they are needed most

Improve
existing care pathways and establish new ones with a focus on offering more community-based care and enhancing patient outcomes

Study
the impact of interventions and use this insight to drive best practice

Using shared care and personal health record data intelligently, ICSs will be able to operate in a more agile way, adapting and scaling up new services as demands change.

Integrated Care Solutions

Our Integrated Care Solutions are designed to transform the delivery of care across communities, radically improving services and the experience of both professionals and the people they care for.

Enabling safe, pro-active and efficient care planning, monitoring and management of patients both in and outside of the hospital.

Personalised Care and Support Planning

CareCentric provides PRSB and SCCI1580 compliant Personalised Care and Support Planning for long-term conditions, complex needs and those approaching end of life. Users benefit from having access to the wider data held within the person's shared care record and all relevant care professionals can view and contribute, as required. Individuals also have the opportunity to contribute to their care plans via their Personal Health Record.

Our frailty management solution provides care teams with the ability to assess, monitor and manage frail individuals, including tracking frailty scores, plans and actions. Updates are available in real-time, providing a single up-to-date record which can be shared across care settings.

Benefits of using DOC@HOME across Bexley, Sussex and Kent:

60% ↓ **reduction in GP visits**

35% ↓ **reduction in A&E visits**

69% ↓ **reduction in hospital admissions**

40% 🕐 **community matron time saved**

65% ↓ **reduction in conveyance**

Care@Home and Remote Monitoring

Graphnet and Docobo offer a range of tailored monitoring solutions which provide safe, targeted management of patients outside of the hospital. Designed to empower individuals in self-care and support virtual ward initiatives, our proven toolsets are used by care home residents, in maternity care and to manage long-term conditions such as COPD and hypertension, as well as Covid-19.

Data collection tools range from simple, customisable forms to device and wearable integrations. They include our DOC@HOME® CAREPORTAL® an easy-to-use Class IIa Medical Device for those less familiar with technology.

Our Population Health tools support cohort identification, enrolment and management for our remote monitoring programmes, including real-time dashboards which highlight out-of-range observations, deteriorations, etc. These are further complemented by proactive notifications to care teams. Text and video messaging to support remote consultations between clinicians and patients is also available, reducing the demand for home visits and freeing up valuable clinician time.

myMaternity Care App is being used in Greater Manchester by pregnant women identified as being at risk of pre-eclampsia. Women are provided with blood pressure and glucose monitors, and an app, to record their readings at home, without needing to attend hospital or clinic as frequently. Readings and comments are then accessed in real-time by their midwives – via the Greater Manchester Care Record - and any remedial actions can be taken.

Care Coordination: Supporting ICS wide collaboration with secure and mobile care communications

CareFlow Connect meets all care communication and collaboration needs on one secure platform.

Available on any mobile or web device, CareFlow Connect brings together messaging, workflow and health and social care data to allow care teams to co-ordinate services more effectively across multiple providers.

ICSs are using CareFlow Connect to create cross-community networks and co-ordinate care. It is already helping them manage complex workflows across the system.

Benefits include:

✓ Stops valuable time being wasted in inefficient communication and releases time to care

✓ Real-time alerts support cross-organisational collaboration, e.g., a care worker could ask to be alerted if a citizen attends A&E, is admitted, discharged or deteriorates

✓ Improves workflow by simply allowing care givers to communicate, share files/photos/videos, and discuss their patients/citizens. This results in: reduced admissions, faster discharge, improved health outcomes and improved patient/citizen satisfaction

✓ Digital handovers enable continuous and fast updates between teams and across shifts

✓ Easy to install, set-up and maintain

> " *Now we laugh when we think about the old way of doing things. Using CareFlow Connect has become the norm. Because it allows group task allocation, and secure messaging – in real-time – we can collaborate with pharmacists and other healthcare professionals, wherever they are.*
> **Rick Cooper, Lead Pharmacist Clinical Informatics at UHBW**

National Immunisation Management System

The National Immunisation Management System (NIMS) is the IT software provided by the System C & Graphnet Care Alliance that supports the management of the influenza and Covid-19 vaccination programmes across England.

It supports almost every aspect of the national vaccination services, from identifying prioritised patients to be vaccinated, through to recording vaccinations as they are given. As the National Immunisation System of Record, NIMS provides data for Public Health England, NHS England and at ministerial level.

Graphnet's population health solution provides the NIMS reporting and analytics dashboards which are used to manage local vaccination programmes.

Customer Stories

Using actionable data intelligence to reduce health inequalities

CIPHA (Combined Intelligence for Population Health Action) is an award-winning population health management programme, established in three months across Cheshire and Merseyside, to help the health and care system manage the Covid crisis and to drive its recovery.

The programme supported early mass testing and the world's first insights into voluntary testing for people without symptoms.

Its success has led to a national expansion to a population of over 17m citizens and CIPHA is now showcasing and blueprinting some 42 use cases for adoption and adaption by other ICS areas. It is also building the collaborative research platform 'CIPHA Trusted Research Environments' for researchers to access sensitive data in a secure way, whilst still having access to the software tools they need.

An integrated, 360-degree approach to Covid Oximetry@Home

Frimley Health and Care ICS and Berkshire West ICP are using the rich data insights from their CareCentric shared care record and population health analytics to identify and reach out to those most at risk from Covid-19 complications.

Under the Covid Oximetry@Home / Virtual Ward programme, patients record their pulse oximetry readings and symptoms using their myCareCentric Personal Health Record (PHR) app. As the app integrates with the shared record, professionals can access the latest recordings as they are taken, targeting care to where it offers the greatest benefit.

Accelerated deployment of the Greater Manchester Care Record (GMCR)

Health and care organisations across GM fast-tracked implementation of the GMCR for 2.8m citizens to provide frontline professionals with vital information in the fight against Covid-19. It has become a major digital asset for the city and region and almost 11,000 frontline users access the GMCR each month to support the delivery and planning of care.

De-identified data from the GMCR is also being used for research and planning purposes to gain a greater understanding of Covid, how best to tackle it and the type of services that needs to be in place. Studies underway include: examining the risks of contracting Covid for cancer patients and the impact of Covid on those seeking help following self-harm.

> " *The success of CIPHA is the result of a strategic collaboration between clinical teams, academia, health and commercial partners developing products and technology.*
> **Joe Rafferty, Jim Hughes, Professor Iain Buchan, joint article in HSJ**

> " *I had a 45 year old male of BAME background with underlying diabetes and Covid. We enrolled him in the pulse oximetry programme and after day 11 his symptoms suddenly deteriorated from 95% to 80% saturations. He was taken straight into hospital and he had a covid-related pulmonary embolism. Without the pulse oximetry programme, we wouldn't have known he had deteriorated and this has saved the patient's life.*
> **Dr Priya Kumar, Connected Care**

> " *Frontline staff love it, the system loves it, and the patient needs it.*
> **Guy Lucchi, Health Innovation Manchester & Greater Manchester Health and Social Care Partnership**

Benefits of using Covid Oximetry@Home across Frimley ICS

28 lives saved

Up to **50%** reduction in mortality for hospitalised patients

Median length of stay in hospital cut by 2 days

Graphnet is the leading provider of shared care solutions for integrating services across whole health and care communities.

We are part of the System C & Graphnet Care Alliance, bringing together five of the UK's most innovative and experienced providers of integrated IT solutions for the health and social care market: System C, Graphnet, Liquidlogic, Docobo and CareFlow Medicines Management.

Together we are:

- No. 1 supplier in shared care records with over 20m citizens' data held
- The national provider of the Covid and flu vaccination system NIMS
- Fastest growing supplier in social care with 60% of councils
- No. 1 supplier in population health analytics with over 17.3m citizens covered
- A pioneer in electronic observations with over 38 trusts using our system
- A leading supplier in acute EPRs with 30 NHS trusts
- No. 1 supplier in child health (covering over 6.4m children)
- Remote monitoring over 50,000 citizens
- Supporting £5bn+ / annum medications across 350+ hospitals in the UK and abroad

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