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Presenting a solution: ICT-supported pathways for integrated social and health care

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SmartCare – Summary

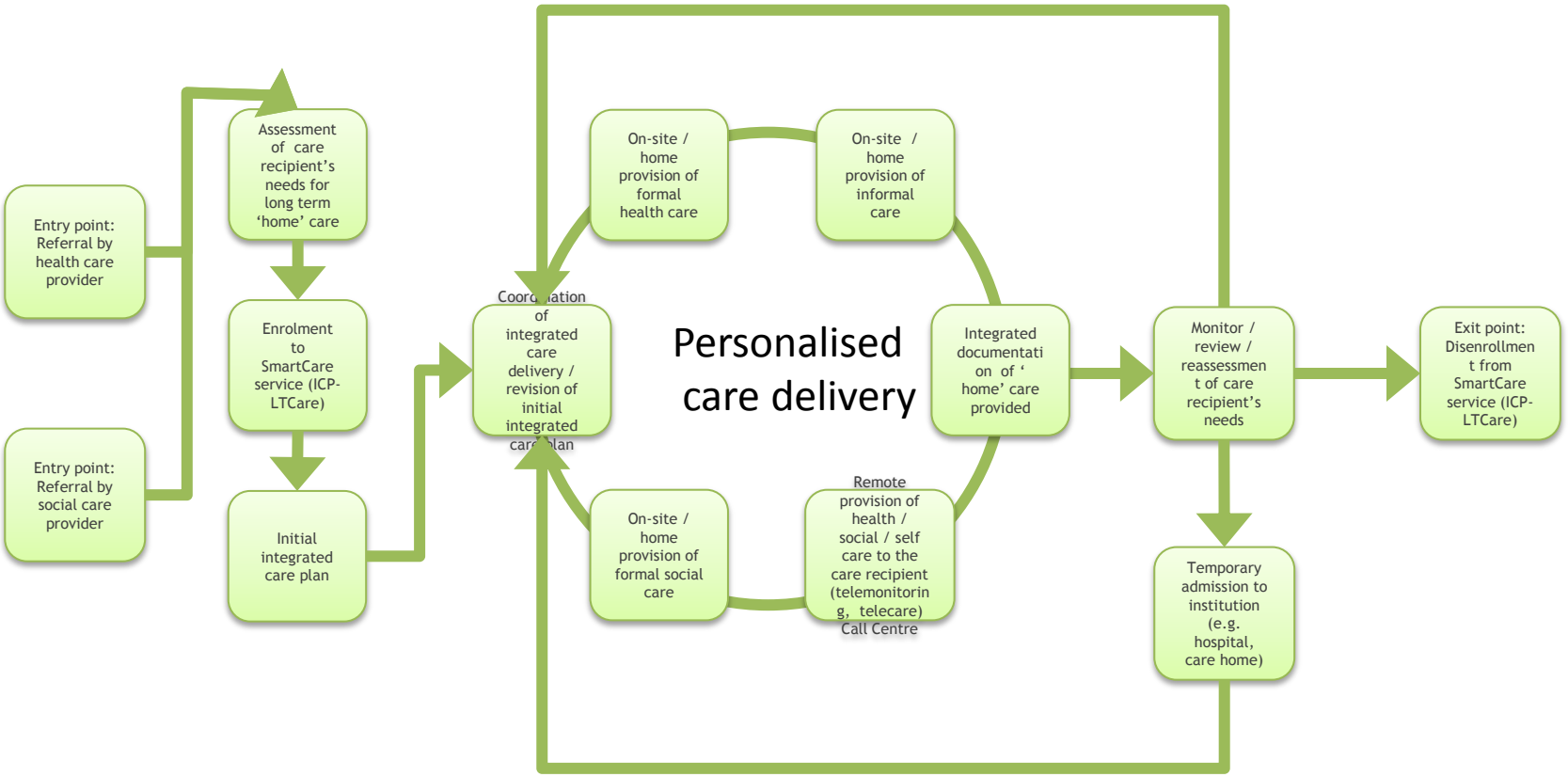
- Improve the care experience, quality of life and clinical outcomes for care recipients and carers
- Support and empower care practitioners and other staff in undertaking their work
- Improve the efficiency of current service delivery
- Promote service innovation - custom, practice, process and location
- Facilitate co-operation and co-production
- Provide economic analysis

SmartCare – Summary

- Enable the creation, access and exchange of high quality information between all stakeholders
- Develop pathways that can evolve to reflect service/organisational change, technology advances, social expectations and legal/ ethical requirements
- Exploit existing ICT investment where appropriate
- Deliver new care workflow processes and procedures

Integrated Care

Integrated Long-Term Home Care Support



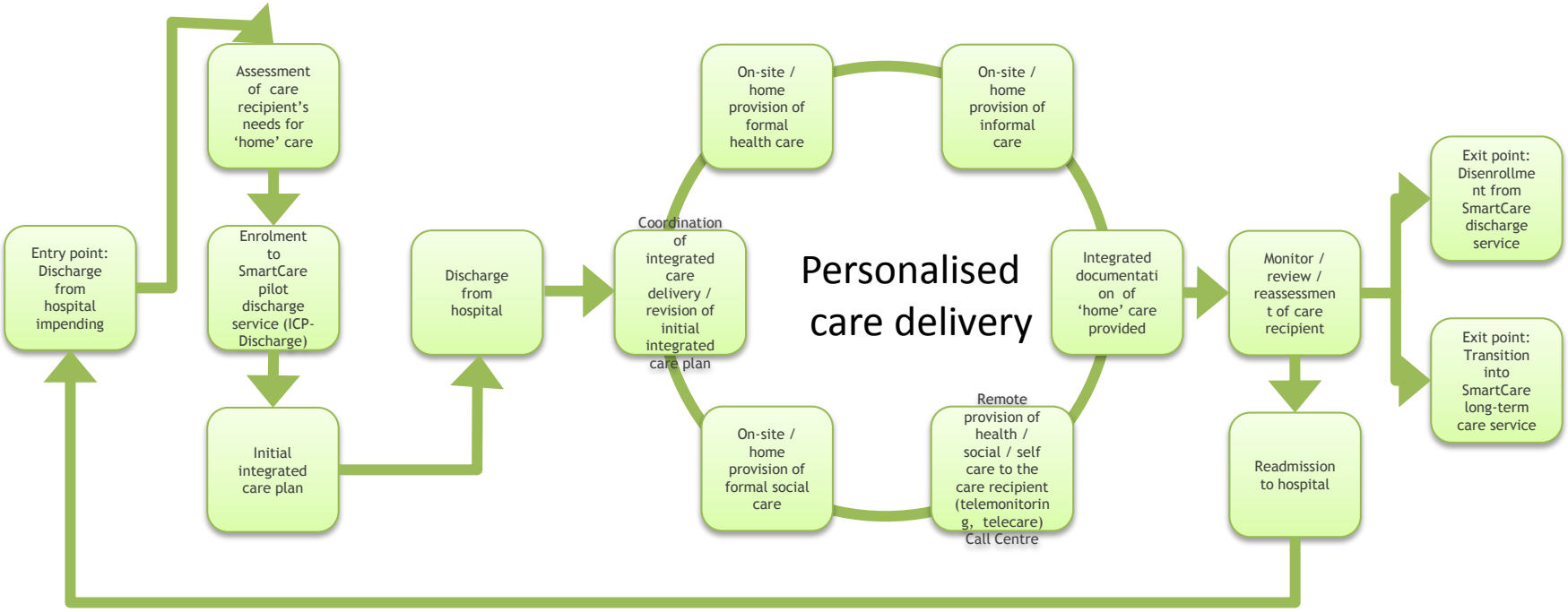
Personalised care delivery = interventions + co-ordination + integrated documentation

Onsite = care delivery setting including home

Pathway

Integrated Care

Integrated Home Support after Hospital Discharge



Pathway

Onsite = care delivery setting including home

Personalised care delivery = interventions + co-ordination + integrated documentation

SmartCare – ICT development process

- Creation of three pathway layers:
  - Information recorded and shared
  - IT infrastructure
  - Communication mechanisms
- Three pathway templates completed to provide:
  - Current situation
  - SmartCare ICT model

SmartCare – supporting key functions through ICT

- Information sharing
- Care co-ordination
- Joint, integrated assessment and care planning
- Support for self care and self management

Information sharing

- Communication
- Electronic, paper, verbal, evidence-based, anecdotal
- Right information, right place, right time, right person

Example – Southern Denmark

Information sharing – shared care record – Southern Denmark

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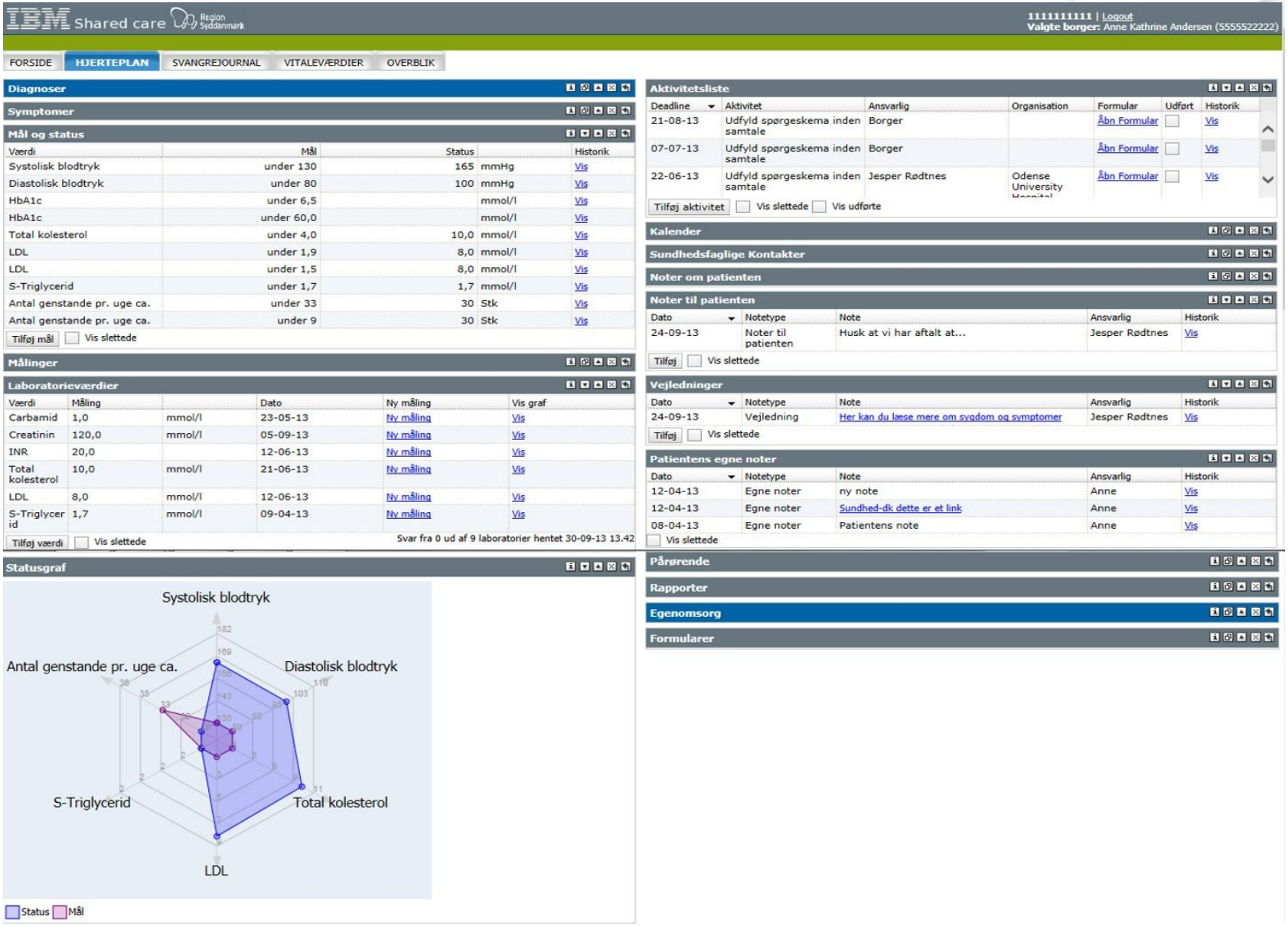

Care co-ordination

- Co-ordination of a care recipient's care undertaken by a care practitioner, the care recipient themselves, their informal carer
- Co-ordination through IT systems
- Role and function 'owner' can change

Example - Aragon

Care co-ordination – IT system focus model - Aragon

Joint, integrated assessment and care planning

- Joint development and ownership of assessment and care plans
- Flexibility to support scheduled and unscheduled monitoring and event management

Example Friuli Venezia Giulia

Self care and self management

- Telehealth and telecare
- Online patient and carer education programmes
- Person held record
- Appointments diary
- Care recipient networking
- Information resource
- Directory of services

Example - Scotland

Living it Up - Scotland

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