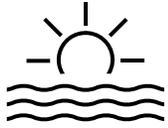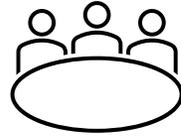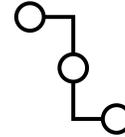# Digital CGA: Ingredients for success

System-wide horizon scanning for a versatile, **integrated** IT system across all settings, including acute, primary, community, social care and care homes

Identify what each setting needs to **collect**, **see**, **access** and **edit** in particular focus on the **acceptability** and **accessibility** for care homes

Understand how the CGA links into **anticipatory care** and **advance care** planning is it signposted in the digital solution and map key fields and pull through key demographics to reduce repetition
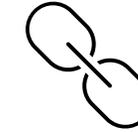
Integration with other care plans (anticipatory, advance, end of life, personalised care support plans) – no need to duplicate, consider which fields can be pulled into different "views"
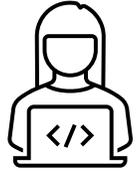
Information governance is not a barrier, work together to agree a **pragmatic** approach (1)
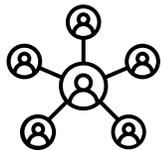
Creation of a single point of information recording/access, ideally providing patient/carer/family having access, utilising centralised care records where possible to inform their decision making e.g. Dorset Care Records, Care Health Information Exchange (CHIE)
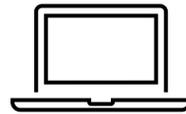
Develop a solution that enables tasks to be assigned to different staff groups and outstanding assessments identified and escalated
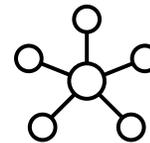
Develop a solution that enables the CGA and frailty support plans to be included in discharge summaries
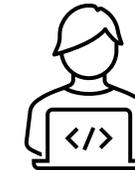
Develop a digital solution that allows you code the intervention of a CGA to aid population health stratification for frailty and to audit and identify who has had a CGA or requires a CGA

Explore best practice resources at British Geriatrics Society ICGA

(1)Explore resources such as From Data to Wisdom Dorset Intelligence Insight Service (DiiS) - FutureFest - Bing video , information: Digital service helps link health and social care as response to the pandemic | HSJ Partners | Health Service Journal)

Building a digital CGA approach
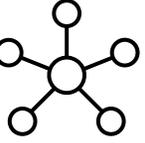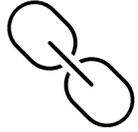
- Use the Wessex guiding principles and recommendations to build a best practice CGA process within your organisation; this will aid the development of a **consistent** approach (to include CGA templates and guidance on completion and who should complete what)
- **Start** a conversation within your organisation and then take the conversation wider into your local health and care system*. For each setting identify what key information needs to be shared to each stakeholder/setting
- **Build** on the technology you have in house to access and share information across settings. Consider how colleagues can best access key information? Do all relevant staff have access? How do staff know that the plans are they and/or have been updated?
- In the absence of integrated technology, **agree** a **pragmatic** approach with partner organisation(s)? Can the CGA be discussed at face to face or virtual MDT discussions?
- Understand how your partner organisations access and share information, can this be built upon? What is the system wide appetite for digital integration?
- **Build** relationships with colleagues in other settings, can processes be put in place to scan documents that others can view? How is the MDT used, could opportunities for sharing plans be considered? What other opportunities could be utilised?
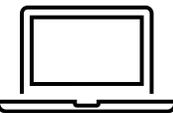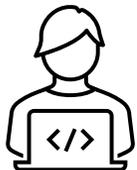
*acute, primary, community, care homes

Foundations for developing a digital solution: University Hospital Southampton Foundation Trust

Figure 1

2017-2018: Development of admission proforma including elements of the CGA by lead geriatrician

2018-2019 15 PDSA cycles trialling proforma within Acute Medical Unit setting and Medicine for Older People

2020-2021 Collaboration with the Trusts' IT department to dovetail into inpatient digital development

Key aspects of the CGA included in data collected via Doctors Worklist including CFS, MDT interventions, plans and goals

Production of a discharge summary which includes CFS and key aspects of CGA – accessible internally and .pdf sent to GP and care homes

Key information in from CGA accessible from CHIE and consideration of including a frailty flag to let colleagues know that the CGA is available

Fast adopters in Neurosurgery – planned rollout **July 2021**

2022+ Review and plan further roll out

"Looking to the future, a person or their carers/family could complete and update their 'This is Me' document from home, digitally, and that the data collected in this could be used to populate/inform other care planning documents. The hard bit of achieving this is mapping how the data and information should flow and in shifting the culture to one in which patients routinely do contribute data to their health records

I think that the only other thing that I would point to is that one of the challenges is that all organisations are starting from different places with their digital infrastructures and systems architectures. Sometimes, foundational work needs to be done first to bring partner systems to a place where they can be interoperable through the use of standardised messaging structures or other interventions. If that isn't in place to begin with, then the information sharing is much more difficult if not impossible. Importantly, that doesn't mean that everyone needs to use the same systems – simply that everyone commits to investing in a systems architecture which keeps integration and interoperability at its heart. With that in place, this flow of information so that the right information (including scheduling of contacts, enabling user-initiated contacts across systems, and managing MDT tasks/actions) is in the right place, at the right time becomes possible."

Jennifer Head of Benefits and Clinical Engagement Digital Services – Dorset County Hospitals