

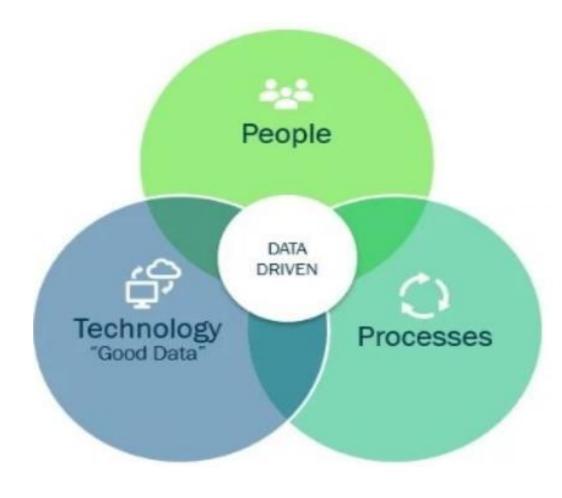
Data Environment

Loretto Grogan National CNMIO

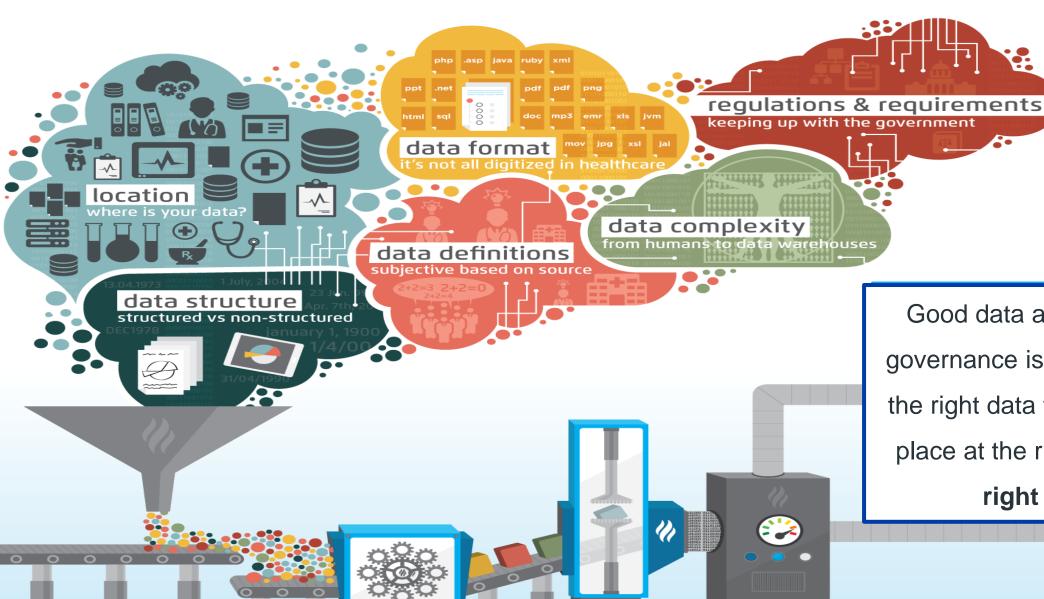


HE What is Digital Health

- Refers to the use of information and communication technologies (ICT) in health products, services and processes, combined with organisational change in healthcare systems and new skills to improve health, efficiency and productivity in healthcare delivery
- It is about the digitalisation of health services and processes so that the RIGHT DATA about the right patient is in the right place and at the right time to ensure SAFE and efficient provision of care services.



WHY HEALTHCARE DATA IS DIFFICULT



Good data and information governance is fundamental for the right data to be in the right place at the right time for the right person

Patient journey can be complex





IPPOSI citizens jury (2021):

Our patients want us to have good data and information



We need a connected, quality, digital health information system

We need citizens to be the owners of their own information

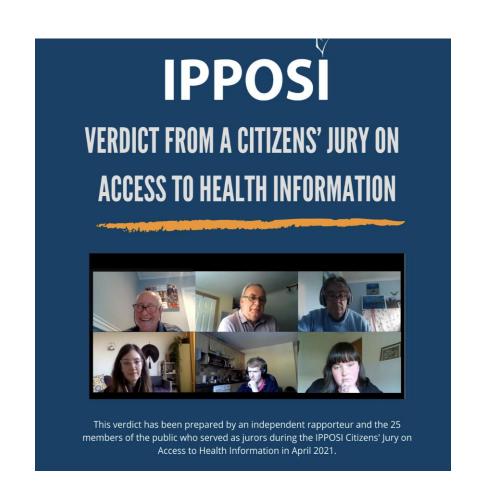
We have a collective responsibility to do the right thing

We need to be supported to grow trust and confidence in the State

We need to partner with citizens to design our health information future

We need to treat data as a national resource

We have to make consent the cornerstone of everything we do







Data and information at the core of healthcare delivery

10 systems to get to here



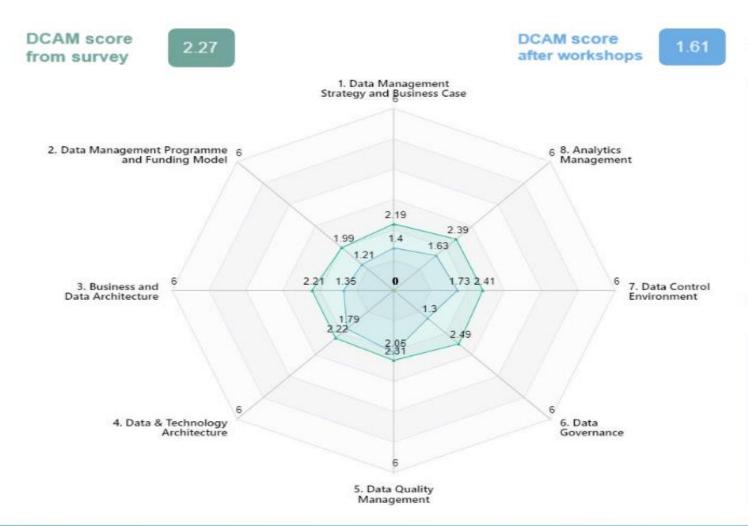
Healthcare professionals along the patient journey



Integrated Care



Data Maturity of the Organisation



Survey

- Most services have no DM initiatives in place or in the early 'conceptual' stages of establishing a limited set of capabilities.
- There are some services where efforts are in the 'developmental' stage for some key data management areas.
- Most of the survey comments indicate critical data management gaps and its impacts and risks for the HSE.

Consensus Workshops

- Workshop participants agree that there is no DM efforts centrally and this is a significant gap.
- The scores observed as part of the survey has been consistently seen as higher, when considering organisation level maturity for capabilities.
- There is a need for joined up thinking and efforts to initiate DM across the organisation.

HE 10



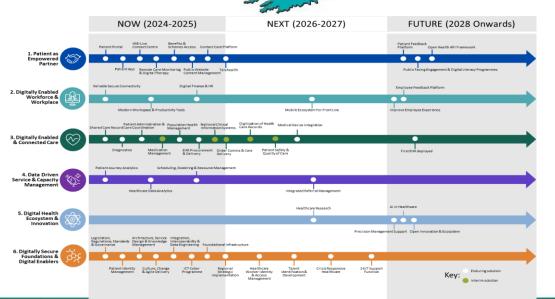
Context





Digital for Care — A Digital Health Framework for Ireland





HE

Establishment of Regional

Health Areas



What is the European Health Data Space

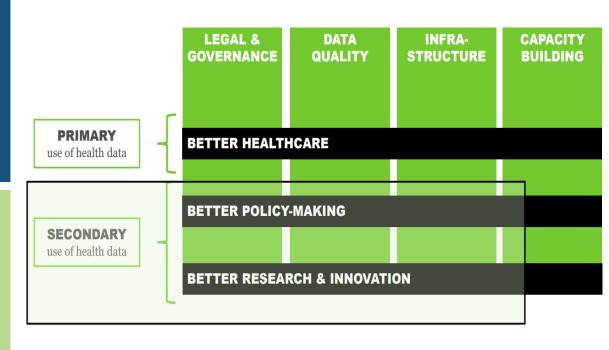
Two new infrastructures will support access to electronic health information

•MyHealth@EU

 standardised and interoperable Electronic Health Records within the EU.

•HealthData@EU

 A consistent, trustworthy and efficient set-up for the use and re-use of health data



Through MyHealth@EU – each person will have access to their personal health records for medical treatment (in Ireland and EU).

Through **HealthData@EU** – access to health datasets for public interest uses.

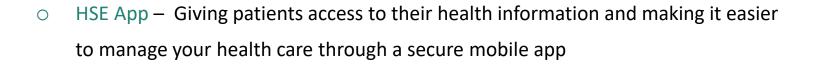
An Roinn Sláinte Department of Health



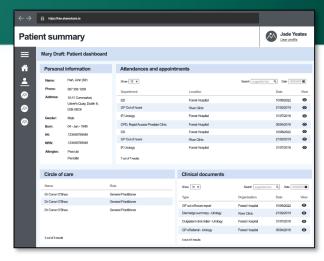
MyHealth@IE Programme

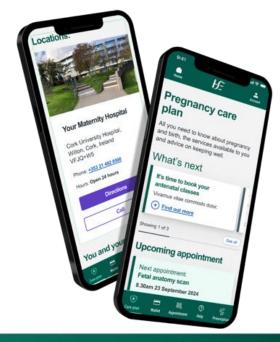
The MyHealth@IE Programme will deliver three important things:

 National Shared Care Record – A new system to bring together health information from lots of different Health Service IT systems, GPs, Hospitals, Community Services, Primary Care Reimbursement Service (Medical Cards), Pharmacies.



Open NCP/MyHealth@EU – Making the shared care record and HSE App work
with other health service systems across Europe. Good for patients when you
travel and good for people when they visit Ireland.





Currently CAMHS









Overview of CYPMHS Pathways of Care Documentation under review for Data Standardisation to realise Integrated Care

CYPMHS Pathway Documentation Discovery Overview

THVAYS	TITLE / PATHWAY STEPS	ELEMENT(S)							1									\vdash	-	\longrightarrow			₩
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Overview of CYPMHS Pathways of Care

A closer look at one document: CYPMHS Approved Centre Referral



= Standardised fields



= No Standardisation:

requires review against clinical requirements, governance and standards data requirements, governance and standards etc.

		ata Type	Source Standard / Conforms To K			Type of Term	Format	Length	CAMHS Required # Mandatory # Optional #	AKA	Where Used 8	Reference & Supporting Information	ion Link
Referral Details Referral Details	Hospital Speciality/service		- :		A health facility providing secondary or to The specialty or services within the hosp	rtiary care tal to which the referral is directed			Required at the time of referral Required at the time of referral	Name address or multiples of refer	ontact details of a altreciepinsts	unit	
Referral Details Referral Details	d consultant mealthcare practitioner Has the patient has previously attended the	w hospitalito v	shich this referral is directed.		A specific or named consultant to which A field used to indicate if the nation! has	the patient and referrer would like to dis- reviously attended the hospital to which	ot the referral this referral is directed		Required at the time of referral Required at the time of referral, Selection. Required at the time of referral				
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	Summary of Referral												
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Patient Details Patient Details	Preferred Name Preferred Promount Address Date of Batch Gender of parent or quardum (# appropriate) Communication				The location to be used to contact or co Date of birth indicating the day, month an Gender identity is a person's sense of ide	rrespond with the patient. This would no digear when the patient was born	rmally be the patient's usual home	eddress	Required at the time of referral	Residence, abod	, domicile		
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Patient Details	Nationality Ethnicity				This is the ranguage that the patient paint	and continuous axes axes				r in cyanangaay	r, spokemangse	ge, mouner compar.	
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Referrer Details	Signature of Referrer				The fax number of the referrer. The mobile telephone number of the refe The referrer's signature	rrer.			Conditional – either the referrer's mobile r Required at the time of referral.	umber or telephor	e number should	be supplied at the time of referral.	
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Consultant CAN Clinical Information	Name Examination findings				In the case of referral by Adult/Liaison/Pi The findings noted by the referrer it is stre	ivate Consultant Psychiatrists*, agreed ingly recommended findings after exam	CAMHS Consultant Psychiatrist to ination of the patient Referring GPs	whom the care and to should supply sufficie	reatment of the child I young person upon t not information to give a clear picture of the	their discharge from	n the Approved (Sufficient inform	Centre will revert to ation should be included so that the secon	ndary care do
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Clinical Information	record State of Chall Young Present About recent weight About recent weight About recent weight dear About recent weight dear About recent About About About recent About A				Individual work, FBT, SFT, Dietician, CB Medication that the patient is prescribed	T (CBT-E), other or taking at the time of the referral. The	referring doctor may have knowled	ige of fover the count	er' medication used by the patient and sho seutio intervention. This section should inc	uld also supply this	information		
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	Cther Agencies Involved Agencies Involved Contact Details				September and seek of septembers								
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Forensio History	Charles	Checklist											
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For hospital use For hospital use	Date sent for triage Date returned from triage			-									
For hospital use	Date returned from triage Date returned from triage Triage outcome (priority) Date of new attendance Consultant Clinic			-									
For hospital use For hospital use													



What our clinicians tell us......

1. Integrated Healthcare Prioritises the Patient:

To put patients at the centre, healthcare systems need standardised and integrated data to effectively use digital solutions. Data and processes must be aligned to ensure continuity, providing one care plan for each patient, avoiding siloed care experiences.

2. Safe and Effective Care is Clinician-Led and Technology-Supported:

Safe and effective care is driven by clinicians, not by introducing ICT solutions or software. Clinicians need to work in safe environments, have the right skills, and follow well-supported standardised workflows. Electronic Health Records (EHRs) should then enhance workflows and allow for greater efficiencies, greater clinical understanding and fundamentally better outcomes. Digital clinical infrastructure must be clinically sponsored, driven, and overseen to provide the necessary assurance to healthcare professionals who rely on them for patient care. In this context, EHRs act as tools to support—not replace—clinicians in delivering high-quality, patient-centred care.

3. National Standardisation is Urgently Needed:

Digital solutions should be built upon standard clinical workflows that apply across healthcare institutions. This requires national effort and ownership of leading standardisation, involving regulators and health service bodies, to ensure consistency in care delivery across the system.



The National Programme for IT in the NHS – A Case Study

The 1992 NHS Information Management and Technology (IM&T) strategy was the first truly nationwide NHS IT strategy, and identified five main principles for the use of information in the health service (Brennan, 2005):

- 1. Information should be person-based;
- 2. IT systems should be integrated;
- 3. Information should be derived from existing operational systems;
- 4. Information should be secure and confidential; and
- 5. Information should be shared across the NHS.

The 1992 IM&T strategy saw the introduction of a number of key pieces of infrastructure which still exist today, such as the NHS Number, shared NHS administrative registers (NHSARs) and the NHS-wide information network NHSnet.

Programmes initiated under the 1992 strategy included the EPR Programme, which ran from 1994-97 in Queen's Hospital, Burton, and Arrowe Park Hospital, Wirral. This six-level EPR system was a great success in the two hospitals covered, and enjoyed overwhelming 'buy-in' from stakeholders at both sites. However, the programme's full evaluation report was never made public, which may have led to later opposition to similar EPR systems elsewhere (Brennan, 2005).

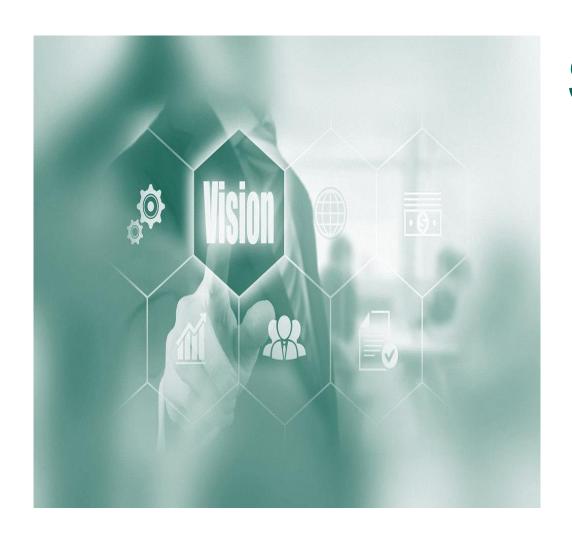
Aim of this case history

This case history of NPfIT investigates what went wrong with the programme, identifying three main themes:

- Haste. In their rush to reap the rewards of the programme, politicians and programme
 managers rushed headlong into policy-making, procurement and implementation
 processes that allowed little time for consultation with key stakeholders and failed to deal
 with confidentiality concerns;
- Design. In an effort to reduce costs and ensure swift uptake at the local levels, the
 government pursued an overambitious and unwieldy centralised model, without giving
 consideration to how this would impact user satisfaction and confidentiality issues; and
- Culture and skills. NPfIT lacked clear direction, project management and an exit strategy, meaning that the inevitable setbacks of pursuing such an ambitious programme quickly turned into system-wide failures. Furthermore, the culture within the Department of Health and government in general was not conducive to swift identification and rectification of strategic or technical errors.

Consequences of not standardising

- Impact successful implementation of our national health policies - Integrated care requires integrated information
- Patient safety clinical documentation and the data it is based on are foundational for successful clinical interactions and outcomes
- Professional risk to clinicians
- Overwhelm too much data in too many different places
- Different ways of representing what we do
- Documentation burden
- Decreased efficiency and accuracy
- Poor reporting, analytical and visualisation capability
- Poor research capability, quality measurement and performance benchmarking
- Interoperability problems
- Higher operational costs resulting in financial loss



Stand up a clinically led clinical data and clinical documentation standardisation programme

Thank you

