Freedom of Information Request

Reference Number: EPUT.FOI.20.1570
Date Received: 1st July 2020

Information Requested:

1. How many people are employed by your organisation, including full time and part time?
   Approximately 6700

2. What is your current intranet solution? (Sharepoint, Wordpress, Invotra, etc)
   SharePoint

3. How long have you been using this intranet solution?
   Over 10 years

4. When is your intranet contract up for renewal?
   April 2021

5. What is your annual intranet budget?
   There is no development budget for this Intranet

6. Do you share an intranet/IT services with other organisations, if so who?
   No

7. Which team and/or individual(s) are responsible for managing your intranet internally?
   Application Management Team and Communications Team

8. Are you using the Office 365 suite? If so, which applications from the suite are in use?
   Only cloud based offering provided by NHS Digital: Email, Teams, Office Online

9. Which team and/or individual(s) are responsible for your intranet’s procurement within the organisation?
   Information Management and Technology Directorate

10. Is your Active Directory hosted on-premise, or in the cloud?
    On premise

11. Could you provide us with a link to your Digital Workplace Strategy?
    Please see attached IMT Strategy 2017-2022

Publication Scheme:

As part of the Freedom of Information Act all public organisations are required to proactively publish certain classes of information on a Publication Scheme. A publication scheme is a
guide to the information that is held by the organisation. EPUT’s Publication Scheme is located on its Website at the following link https://eput.nhs.uk
IM&T STRATEGY
For
Essex Partnership University NHS Foundation Trust
2017-2022
V2 with updates September 2019
EXECUTIVE SUMMARY

1.1 Document purpose
As a new organisation EPUT inherits the success and challenges of its parent organisations. Looking forward, the Trust is faced with complex structural changes in the regional health and social care system; radical policy changes; increased demands for healthcare and associated information; ongoing financial challenges; and the need to merge the clinical model and cultures of the previous two organisations.

The purpose of this document is to outline the IM&T Strategy for Essex Partnership University NHS Foundation Trust (EPUT) for the next five years.

This document has been written to bring together the two approaches that were being taken by SEPT & NEP into a unified approach for IM&T.

The implementation of any strategy is a journey which is impacted by many factors. EPUT wants to achieve the benefits of historical and current investments but there are some key influencing factors:

1.1.1 Firstly we have the immediate challenges that we face from the technical integration of two very different organisations.

1.1.2 Secondly there are internal challenges faced by the IM&T team in planning and implementing complex technical solutions into a mental and community healthcare service during a time of organisational change.

Whilst there is no one NHS England document detailing the NHS IM&T Strategy, NHS England have published a number of papers giving guidance on how streamlined efficient services should be supported by IM&T. These include:

- The Five Year Forward View – new models of care (Oct 2014)
- The Forward View into action: Paper-free at the Point of Care – Preparing to Develop Local Digital Roadmaps – April 2016
- Next Steps on The Five Year Forward View – March 2017

In addition the publication of the National Contract (17/18 and 18/19) includes a number of changes, detailed below, which must be delivered through IM&T as part of the CCG contracts.

The Role of the Sustainability and Transformation Partnership (STPs) via the Local digital Roadmap, measurement of Universal Capabilities and the Digital Maturity Assessment tool, also places demands on IM&T, which may impact on access to significant funding streams and compliance with commissioner contracts.

How fast and how far we achieve success with our strategy will depend on the management of these influencing factors.

1.2 The role of IM&T in the Merger

IM&T has already played an important role in the merger and creation of the new Essex Partnership Foundation Trust.
As the multiple sites which make up the new organisation are separated by geographical distance there are significant challenges to achieving jointed up working and effective communication. IM&T can enhance and improve communications and jointed up working through modern IT systems and standardised systems.

The two organisation that have come together to make up Essex Partnership have different cultures, and processes. These can be enhanced and changed through IM&T systems and associated processes.

It is not the role or responsibility of IM&T to lead the change however they do have a key role in identifying enabling solutions, delivering technology and applications and then supporting and educating on possible changes to process. To deliver savings in this area requires more joined up working with the Trust transformation agenda.

1.3 The IM&T Strategy for Essex Partnership
The IM&T strategy for Essex Partnership is based on nine themes:

- **Interoperability of systems** – developing systems that interact with each other and that are intuitive so that data and information is in one place and can be found and viewed easily.

- A modern integration and highly functional and resilient **IT Infrastructure** that supports unified data management and electronic communications

- **Clinical systems** - to deliver **electronic patient records** based on maximizing the utilisation of existing investment and supporting improved patient safety and clinical efficiency. The impact of the integration on this area will involve a high degree of standardisation and over time rationalisation.

- To support **corporate services** through standardisation of systems and provision of solutions to provide more effective ways of working by improving process

- **Staffing needs** – using technology to support staff in the way they need and wish to work. Making technology simple and easy to use and available when it is needed. For example to allow staff to have more immediate access to information in an electronic format wherever they are located, that the information is complete and up to date, to reduce duplication in re-requesting information and to enable the sharing of information which means all staff are working with the same information.

- **Supporting** the national and STP agendas towards increased digital maturity and the sharing of clinical information and records across the local community. To share such data as safely and effectively as possible with our partners in health and care, and to encourage people to be more confident in doing so, and for them to share their data with us in return

- **Patient access** - encouraging patients to take a more active part in their care giving them access to their electronic records and providing the facilities for elements of self-care and regular feedback. Creating systems that give patients and carers the information they need and the ability to self-refer where service pathways allow.

- **Systems to support managers** – access to systems that provide managers with the tools and information to manage their services better. Turning data and
information into intelligence and bringing information into one place and providing reports that are intuitive and timely.

- **Information security** - There is a rapidly growing emphasis on cyber security in response to both a growing reliance on ICT, but more acutely, the threat of successful attack is far more complex and isn’t just a disruption to service, the threat now is ransom and data loss.

### 1.4 The Vision

Our vision is to deliver to the Trust an integrated set of IM&T applications that support and enhance the day to day working of all staff. These applications will be based on a modern and robust IT Infrastructure that provides a fast, safe, mobile and effective solution for access to information in the right place on demand.

To ensure we meet national best practice and the requirements of the CQC, NHS Digital, NHS England and NHS Improvement. By focusing on the above essentials, the Trust should:

- Remain compliant with CQC’s fundamental standards
- Increase our Digital Maturity in line with expectations of NHSD and NHSE

In summary the objective of the IM&T service and this strategy is to provide the knowledge, skills, technology and tools that enable information to be collected, managed, used and shared to deliver excellence in healthcare.

The strategy allows for a range of developments to take place, as resources become available, provided that they continue to fit within the Local Digital Roadmaps and provided they fit within a broad envelope of industry and NHS standards for IT. The standards are not fixed, but will change to adapt to industry trends and the emergence of new products and services. As described, the strategy is not affordable according to current financial assumptions. Bids for discretionary funding will need to be made to NHS England, and these will only be supported if they are signaled in the three local economy STPs, plus a further three where we have footprint, and Local Digital Health and Care Roadmaps.

### 1.5 IT Infrastructure – Investment and Integration

IT infrastructure is the foundation on which to deliver electronic services. It is a key enabler to the whole strategy and without it then effective and modern solutions cannot be implemented.

There are a number of areas where investment is required to deliver a modern IT infrastructure which will support modern technology. Due to the ageing IT infrastructure at some NEP sites which has not had the appropriate historical investment there are technical risks associated with legacy infrastructure that need to be addressed.

There is the additional challenge of delivering a fully integrated IT infrastructure which will support the new organisation.

The IT integration includes:

- A joined network for the whole organisation
- A single email system
- A single active directory (electronic directory of all users and assets)
1.6 Clinical Systems

This programme is designed to provide EPRs and associated systems which support best clinical practice and the new Clinical Model. The systems need to ensure that wherever care is delivered it can be safely supported by electronic systems.

1.7 Corporate Systems

This programme of work is focused on rationalisation and integration of corporate systems (standardising on a single system that serves the whole organisation). This programme of work has the potential to deliver efficiency savings for the trust and to support standardisation of process.

1.8 Information Security

The ICT management have matched each of existing practices against the good practice guides published by NHS Digital. Each one offers recommendations on the controls for delivering good Information security and are not explicitly to combat cyber security or malicious attack.

The IT department have produced a document that identifies the current position/compliance level/score and recommendation on how to achieve full compliance. This document will be used to monitor progress against the good practice guide.

1.9 Costs

Each year a financial plan will be developed to detail anticipated expenditure on capital, revenue pay and non-pay – please see Appendix D.

As every project will have a business case identifying predicated financial savings associated with the investment and these will be developed in detail within the individual project business cases.

1.10 Delivery

The IM&T strategy will rely on a number of changes to effectively deliver IT including:

- Reviewing the on call process within the IM&T team to support 24x7 working across the Trust alongside the increased reliance on electronic records
- Standardising governance arrangements for IM&T projects including Senior responsible owners for all IM&T projects
- Better identification, management and tracking of benefits relating to IM&T projects. Clear identification of benefit owners and responsibility for delivery. Close working with the transformation service to deliver business change.

1.11 Risks & Challenges
Particular risks and challenges for this strategy and the IM&T work programme have been identified as:

- **Financing:** Any new initiatives that need additional revenue finance will need to be self-supporting or bring external discretionary funding to support them (e.g. Vanguards, bids to the NHSE Technology Fund). While we have access to capital this year, each capital investment brings with it a revenue consequence. We expect the financial environment going forward to remain challenging.
- **The recent WannaCry ransomware attack demonstrated that there are vulnerabilities to cyber-attack that are being addressed.**
- Across clinical and corporate services there is a growing understanding and appetite for the use of digital approaches to support service transformation, but we need to work harder with Divisions to maximise the capabilities we have whilst tempering the desire for innovation with an understanding of the preparatory work that has to be done.
- **The lack of IT architecture alignment could lead to a failure to realise benefits that have been identified which can be delivered but only with an integrated IT infrastructure.**
- **User resistance to standardisation and rationalisation of systems.** It is recognised that across EPUT, staff represent a very wide range of IT abilities and diverse backgrounds, however we have a culture of ‘asking the expert for help’, instead of ‘can I find out how to do this myself’. Because of this and other factors, the IT team spend too great a proportion of their time on ‘keeping the lights on’ and reacting to user requests for help, and there is a consequential shortage of effort for proactive developments. This acts as a brake on the ability of IT to be an enabler for the customers of the IT services, i.e. the staff and the Trust. IT will encourage frontline innovation and support the workforce in utilising technology and systems to deliver improved performance and care.
- **Technical data migration issues in moving to single systems**
- **Managing legacy data which is in different formats.**
- **Suppliers of technology and systems are moving towards solutions that are based on revenue funding models which may not be affordable for the Trust in the longer term.**
- **Risks associated with major infrastructure and system changes where the likelihood of implementation issues is high within the CSU contract (North only).**
- **Resources for delivery – having the right staff with the right skills whilst maintaining existing IT infrastructure and systems.**
- **Expectations:** The majority of end users often ask why the IT they have to use if not as easy or powerful as Google, Amazon and Facebook. The answer is multi-faceted, but 4 factors are self-evident:
  - A lack of investment in applications that deliver an intuitive experience
  - The need to be realistic about the constraints of finance and supplier capabilities
  - The complexity of the data that we collect and what we have to do with it; and
  - The regulatory environment in which we operate, which attaches a very high value to maintaining the privacy and confidentiality of our patients’ data.

These risks and challenges will be managed through the governance arrangements which are already largely in place under the management of the IM&T Strategy Group.

There are further risks associated with the synergies and savings associated with this programme of work which are:

- Lack of governance and decision making process relating to possible efficiencies.
- Business and clinical ownership and engagement.
- Process for sign off of the benefits.
- Lack of effective and agreed transformation for change e.g. formalised agreement to enforce the use of electronic records keeping.

Agreement is required as part of the Transformation agenda on how we manage these risks.
This IM&T strategy supports EPUT in achieving its strategic objectives and is aligned with the wider challenges set out by the STPs and National strategic agendas.

Updated September 2019:
Work has continued and will continue with the three STPS. The most advanced is Suffolk and North Essex, who are working with Cerner HIE as their core interoperability platform. Since this utilises the same technology as EPUT’s Tiani HIE, integration is simplified with Health and Social Care partners across this Health economy and is schedule to form part of a pilot in 2019/20. Mid and South Essex STP are now aligning to Cerner HIE which will support EPUT integration. West Essex and Herts STP are planning on using Graphnet but this has not progressed across the economy. Integration with Graphnet and Cerner/Tiani HIE will form part of an East Accord wide agenda.
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1. **BACKGROUND AND CONTEXT**

2.1 Introduction

This document outlines the IM&T strategy for Essex Partnership University NHS Foundation Trust for the next 5 years. It describes the approach to IM&T following the merger of North Essex Partnership NHS Foundation Trust and South Essex Partnership NHS Foundation trust. There is a growing appetite with most staff wanting to embrace technology and use it to improve their working practice; quality of care given and help address some of the challenges they face. However the strategy must provide solutions that give confidence to the workforce and avoid the frustrations of inadequate or unreliable technologies. The new strategy and plan needs to have a clear focus on quality, improvement and efficiency, whilst ensuring that security, safety and business continuity are maintained.

The geographical characteristics of Essex provide a number of challenges and impact on the focus and delivery of the IM&T strategy. The number of dispersed operational bases provided to deliver local services, is central to those challenges. A lack of good quality 3G and 4G connectivity across the County in some areas has brought additional challenges. There are also further critical elements of service delivery and the external environment that impact on the Trust and its IM&T Strategy including:

- An increasing mobile workforce that needs to balance good quality care with an effective and efficient service
- The paramount importance of data quality and completeness and timely recording to support service delivery and manage clinical risk.
- The importance of communication and information sharing between the Trust and all stakeholders in care, including its partners in the health and social care community, ensuring compatibility and interoperability with local and national systems.
- The ability to respond and move quickly in a competitive market to operationalise and deploy services, particularly under such contracts as any qualified provider (AQP) and Accountable Care Providers (ACPs).
- The importance of immediate access to a wide range of information relevant to the enhancement of care and administration, together with analysis tools.
- The potential impact of information availability and analysis on enhancing the effectiveness of management and planning.
- Increasing implications of regulatory compliance, particularly concerning information storage and availability (e.g. the Data Protection Act and Freedom of Information Act) in the more general context of archiving and records management;
- Increasing requirements for internal and external reporting to NHSI, NHS Digital Commissioners, Care Quality Commission (CQC), Trust Board and Board of Governors. Increasing emphasis on the exploitation of information.
- The need for engagement from staff to ensure that system and software potential is maximised and benefits realised.
- A rapidly growing emphasis on information security in response to both a growing reliance on ICT, but more acutely, the threat of successful attack is far more complex and isn’t just a disruption to service, the threat now is ransom and data loss.

2.2 Where are we now?

IM&T was used as an enabler to support improved clinical care and drive efficiencies in both NEP and SEPT and this is reflected in the level of complexity and maturity; each Trust procured different systems for the vast majority of elements of IM&T. Whilst the majority of NEP systems and services
were outsourced, reflecting in a significantly smaller IM&T department, SEPT chose to insource most functions reflected in lower external costs but a much larger IM&T directorate, with correspondingly higher internal staff costs and associated infrastructure investment. It should also be noted, that in addition to Mental Health services, EUPT includes three Community Services, which utilise SystmOne for their core clinical record. SystmOne is supported within SEPT meaning that SEPT had two separate EPRs.

Neither of these approaches is right or wrong but the challenge of a merger of two organisations within this scenario is how to best support joint working of clinical and operational teams when the IM&T service delivery model is so fundamentally different. In order to respond to this challenge, the IM&T Workstream needs to be informed by the other Workstreams to understand the level of joint clinical and operational working that is expected in each of the different timeframes – Day 1, Year 1, Years 2 and 3, Years 4 and 5. For example, any plans for joint working of clinical services would ideally require a single EPR; whilst this is not possible for Day 1 or even years 2 to 3, given the length of procurement and implementation (not to mention the associated costs), there are pragmatic ways in which IM&T can support joint clinical working. This pragmatism is reflected in many of the proposals for mitigation of joint working.

The table below identifies the different IT systems deployed across the Trust and documents the activity that has already been undertaken prior to Day 1 of the merger to reduce the associated risk of disparate systems:
<table>
<thead>
<tr>
<th>System/Service</th>
<th>Current position</th>
<th>Risks</th>
<th>Mitigation Day 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prime Clinical Systems</td>
<td>NEP use Remedy (Paris) SEPT use Mobius and SystmOne for Community.</td>
<td>Joint working across MH services. That clinicians need access to both organisations EPR to deliver patient care. That NEP do not have sustainable use of EPR</td>
<td>Use Health Information Exchange (HIE) to access Patient Summary from each system</td>
</tr>
<tr>
<td>Appointments</td>
<td>NEP use Remedy (EPR). SEPT use Qnomy linked to Mobius plus SystmOne for...</td>
<td>Joint working</td>
<td></td>
</tr>
<tr>
<td>Intranet</td>
<td>The 2 Trusts have different intranet systems which have different underlying</td>
<td>Corporate identity, access to phone numbers hired to keep separate</td>
<td>Landing page for all staff with ability to link to re-skinned separate existing intranets *</td>
</tr>
<tr>
<td>Drug &amp; Alcohol (STARS)</td>
<td>Provided by Essex CC as part of contract</td>
<td>Lack of continuity of care across dual diagnoses</td>
<td>None</td>
</tr>
<tr>
<td>Patient apps</td>
<td>SEPT has IAPT app and is developing further apps. NEP has no patient apps</td>
<td>Opportunity for Nep to use apps subject to novation</td>
<td>None</td>
</tr>
<tr>
<td>eDRMS</td>
<td>Limited in NEP. Laserfiche a key part of Mobius and other storage in SEPT, plus</td>
<td>Records not available across new organisation</td>
<td>None</td>
</tr>
<tr>
<td>Intranet</td>
<td>WinDip used for historical documents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient apps</td>
<td>SEPT has IAPT app and is developing further apps. NEP has no patient apps</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Historic databases</td>
<td>Both organisations hold historic information on a variety of databases</td>
<td>Not accessible across merged organisation</td>
<td>None</td>
</tr>
<tr>
<td>Undocumented 'systems'</td>
<td>Both organisations may hold unknown systems e.g. locally developed Access</td>
<td>Unsupported patient records - risk to loss, breach and ATR requests</td>
<td>Continue to monitor and document</td>
</tr>
<tr>
<td>Speech recognition and digital dictation</td>
<td>NEP use 4 different systems incl Dragon and Philips; Sept. use Dragon and Olympus</td>
<td>Multiple solutions - lack of efficiency</td>
<td>None</td>
</tr>
<tr>
<td>Records</td>
<td>NEP holds paper records in multiple stores. All SEPT paper records are archived.</td>
<td>Separate policies and procedures.</td>
<td>Review policies and procedures. Assess NEP records stores</td>
</tr>
<tr>
<td>IG</td>
<td>Each Trust has a Level 2 on the IG Toolkit</td>
<td>That the two organisations have interpreted the IG Toolkit in different ways</td>
<td>Detailed analysis of the 2 toolkits and escalate issues to Integrated Governance</td>
</tr>
<tr>
<td>IT Support model</td>
<td>NEP uses the CSU whilst SEPT uses an in-house Helpdesk</td>
<td>Confusion. Potential 2 tier model. Lack of continuity. Missing potential savings</td>
<td>None</td>
</tr>
<tr>
<td>Service Desk / Service delivery</td>
<td>NEP use the CSU service desk. SEPT are migrating all staff to the Internal Service</td>
<td>Confusion for staff and lack of control/ownership of issues</td>
<td>Agreement between CSU and new organisation</td>
</tr>
<tr>
<td>Clinical Coding</td>
<td>does not have dedicated staff to code or validate</td>
<td>IG Toolkit may be impacted</td>
<td>Continue as is</td>
</tr>
<tr>
<td>Mail Services</td>
<td>NEP use NHS Mail. SEPT use internal email which must be accredited to continue.</td>
<td>Single distribution list, calendar access, Corporate identity</td>
<td>2 separate emails with the new organisation in the address</td>
</tr>
<tr>
<td>Room Bookings</td>
<td>NEP use SharePoint through the intranet. SEPT use Assure Software Resource</td>
<td>No centralised room booking</td>
<td>None</td>
</tr>
<tr>
<td>Telephony</td>
<td>2 separate systems</td>
<td>Increased cost, different main phone numbers</td>
<td>None</td>
</tr>
<tr>
<td>Mobile Telephony</td>
<td>Each organisation has contracts with EE</td>
<td>Potential savings not realised</td>
<td>None</td>
</tr>
<tr>
<td>Active Directory</td>
<td>2 separate systems - NEP CSU, SEPT internal.</td>
<td>Joint working - Staff cannot access files etc. across the geography</td>
<td>Access control list *</td>
</tr>
</tbody>
</table>
## Underpinning Infrastructure
- Each Trust uses N3, has separate datacentres, use different wi-fi and video conferencing. NEP has 5 year life model for PCs - SEPT has 3 year life model.
- Joint working - may not be able to access files, wi-fi or virtual meetings. Increased cost for DCs. Inequality of PCs.
- Open up firewalls.

## Other Communications
- Both Trusts use SMS for Appointment reminders - part of the same National contract. SEPT has instant messaging from Cisco and uses WebEx for meetings - NEP do not have this facility.
- Missed potential discounts for SMS and divergent solutions for instant messaging and video conferencing.

## Asset Management
- Each Trust uses a completely different system.
- No single view may impact discussions re: external licencing.
- None.

## Mobility Service
- NEP VPNs are provided by the CSU. SEPT’s are internally hosted.
- Confusion over new starters. Realisation of savings if single solution.
- None.

## Access controls/RBAC
- Provided by internals team in each Trust. NEP model is restricted by patient within.
- NEP current IG guidelines do not support access to Unified Record.
- Change in policy.

## Unified Comms
- Software is different for each Trust. In addition SEPT has a Contact Centre already used by NEP and utilises Snapcomms and Electronic signage which NEP does not.
- Opportunities for centralisation and discounts.
- None.

## System Management
- For remote monitoring, maintenance etc. Both use the same system but NEP is CSU.
- Any alignment is part of IT service model.

## Finance
- 2 separate systems.
- Joint working.

## HR
- 2 separate systems.
- Joint working.

## Procurement
- 2 separate systems.
- Joint working.

## E-Rostering
- Both Trusts use Allocate. Different stages of implementation. Linked to Payroll.
- Joint working - that staff cannot be rostered across the geography.

## Pharmacy Management System
- Both Trusts use Ascribe.
- None.

## Corporate MI
- Qlikview and Crystal used by NEP. SystmOne and Qlikview used by SEPT.
- Joint reports cannot be produced as easily.
- Continue with both processes.

## Risk Management
- Both Trust use Datix - 2 separate systems.
- Joint working and reporting.
- Merge both systems.

## Estates / Security
- NEP uses 4 different systems. SEPT uses a different system.
- Joint working.
- Implement SEPT system across trust.

## Members
- 2 different systems.
- Corporate identity. Single communications.
- None.

## Training and supervision
- NEP uses ESR and the intranet. SEPT uses an in-house built tracker via OLM.
- 2 separate systems, processes and controls. Shared course may not work.
- SEPT putting in competencies but will require manger on line to work. Sharing.

## Expenses
- NEP is paper-based whilst looking to migrate to Serco e-expenses. SEPT uses.
- 2 separate systems, processes and controls. NEP may implement a
Historically IM&T and Business Analysis and Reporting have been under separate directorates within both organisations. Following the recent staff consultation the two divisions fall under one directorate with single line management. This will ensure that information processes are developed to meet clinical and business needs and will increase resilience between the team to meet the needs of operational services.

This development of the Business and Analysis and Reporting service supports the development of the use of big data technologies and techniques:

- Through the availability of real-time data across multiple datasets
- Through the use of automation to support accurate, timely reporting
- Through the delivery of treatment pathways to support operational services in decision making and use of best practice
- Through the use of analytic technology and predictive modelling

2.3 The Role of IM&T in the Integration

IM&T has an important role to play in the integration of EPUT.

As the multiple sites making up the new organisation are separated by geographical distance there are significant challenges to achieving joined up working and effective communication. IM&T can enhance and improve communications and joined up working through modern IT systems and standardised systems. However the service delivery model in North Essex is dependent on the CSU which creates inconsistencies and challenges to delivering an integrated approach.

Also the two organisations that have come together to make up Essex Partnership have different cultures, and processes. These can be enhanced and changed through IM&T systems and associated processes which provide a more standardised approach.

It is not the role or responsibility of IM&T to lead this however they do have a key role in identifying enabling solutions, delivering technology and applications and then supporting and educating on possible changes to process. To deliver savings in this area requires more joined up working with the Trust transformation agenda and governance on how this will be achieved.

2.4 Vision, Values and Strategic Objectives

As a mental health and community services Trust it is our ambition to provide high quality services to the population we serve. Our vision is therefore to work to improve people’s lives, and we will do this through living our values of ‘Compassionate, Empowering and Open’.

As a new organisation we have four strategic objectives to support the delivery of our vision. A summary of the Trust’s vision, values and strategic objectives is shown in Figure 1.
Each year our Board will review these to ensure they remain valid, connected to our vision, and the behaviours we expect all of our staff to exhibit in everything they do.

This IM&T strategy aligns to all of the strategic objectives.

To support the delivery of the strategy the following frameworks are in place:

- Information Governance framework

This framework has an associated action plan.

The detailed business and clinical strategies for the new organisation are still being developed but there are some key themes that we understand which must be supported by IM&T.* Updated September 2019
<table>
<thead>
<tr>
<th>Corporate Objective:</th>
<th>Role of IM&amp;T</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Drive our quality agenda</td>
<td>1. To work in partnership with clinical colleagues towards ensuring the trust's EPRs support clinical practice and information collection for internal and external purposes. Plan for Trust EPRs to be developed to support CQUIN and KPI collection and to support evolving clinical models. 2. Evaluate options for consolidation of the Trust's EPRs. 3. Dashboard project to deliver appropriate information. Benchmarking exercise against national standards. To provide appropriate access to online information to support performance monitoring 4. To support clinical colleagues in increasing the uptake of technology via Clinical Change Management and Training programmes</td>
</tr>
<tr>
<td>2. Advance our Research and Innovation Strategy</td>
<td>To support the Research and Innovation Strategy through the continued exploitation of technology</td>
</tr>
<tr>
<td>3. Maintain a 'Good' CQC rating and progress towards 'Outstanding'.</td>
<td>1. To continue support the Local Health Economy in the migration from N3 to HSCN and to support the ongoing service via the ICF. 2. To provide a secure environment to hold the Trust’s clinical and non-clinical electronic records in line with NHS Digital expectations. To develop a detailed plan for the Cyber Security team to achieve the targets set by NHS Digital. 3. to complete the development of electronic discharges and outpatient letters and to implement these with CCG support 4. To evidence a well-led directorate 5. Telephony - to present and implement a strategic review of the Trust’s 7 disparate and in some cases unsupported systems. 6. Contact centre - to replace the legacy system</td>
</tr>
<tr>
<td>4. Be an employer of choice</td>
<td>Provide Performance report and supervision and training trackers.</td>
</tr>
<tr>
<td>5. Successful completion of our CiP and transformational programmes.</td>
<td>To provide IT solutions that support and enable efficiencies. To provide consolidated information to support transformational programmes</td>
</tr>
<tr>
<td>6. Achieve contract targets and objectives.</td>
<td>To continue to develop Systems to support operational services in the collection of KPIs. To produce Performance reports and dashboards in a timely manner</td>
</tr>
<tr>
<td>7. Participate as a valued partner in the STPs.</td>
<td>Actively participate in each STP with the support of the Executive Operational team. To work with each STP using HIE technology i.e. Graphnet with mid and south and Cerner HIE with Suffolk and North. To play an active role in the East Accord</td>
</tr>
<tr>
<td>8. Transform services through the use of new clinical models and pathways and technology</td>
<td>Plan for Trust EPRs to be developed to support evolving clinical models. Dashboard</td>
</tr>
</tbody>
</table>
### 2.5 Alignment with the Trust’s Quality Strategy priorities

Information and technology can play a fundamental role in supporting the delivery of quality services. The Trust’s 5 quality domains describe a range of delivery targets for the coming years are outlined below with a summary of the IM&T solutions that could support delivery:

<table>
<thead>
<tr>
<th>9. Drive our Commercial Strategy.</th>
<th>To support the Commercial Strategy through the continued exploitation of technology</th>
</tr>
</thead>
</table>

- Benchmarking exercise against national standards. Attendance at Transformation meetings, as appropriate.

- Project to deliver appropriate information.
Quality strategy governance framework

The table below sets out the quality objectives that we will achieve together, the frameworks that will support our work and how we plan to measure progress.

**Strategic Objectives 1-4**
Patient-safety, experience and outcomes

**Quality Domain**
- Caring
- Safe
- Effective
- Well led
- Responsive

**Quality Objective**
- person centred care
- planning and improved written communication
- enhance patient safety
- regulatory compliance
- robust mortality review process
- reduction in harm
- better patient outcomes
- reduce variation
- most efficient use of resources
- embed trust values
- motivated workforce
- reduction in temporary staff
- culture of openness
- improve access
- new clinical model
- continual Quality Improvement culture
- use of technology

**Enabler**
- people experience framework
- end of life framework
- risk framework
- sign up to safety framework
- clinical audit framework
- children's services framework
- secure services framework
- HR & workforce framework
- people experience framework
- HR & workforce framework

**Measure**
- patient survey
- number of Friends and Family Test complaints
- level of incident reporting
- serious number of incidents
- clinical audit
- clinical audit
- patient outcome measures
- staff survey
- vacancies, staff turnover & sickness
- safe staffing data
- performance data
- always event data
2.6  Alignment with the Trust’s Estates Strategy

The IM&T Strategy supports EPUT’s High Level Interim Estates Strategy:

<table>
<thead>
<tr>
<th>Estates Strategy</th>
<th>IM&amp;T Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 That culture of building use and staff expectations of offices, fixed desk and</td>
<td>Standardising on PC builds, networks and service delivery model</td>
</tr>
<tr>
<td>touchdown space is standardised across the Trust as soon as possible</td>
<td></td>
</tr>
<tr>
<td>2 That Worksmart principles are fully understood by staff and ‘policed’ to</td>
<td>Tightening of Worksmart processes to support hot-desking etc.</td>
</tr>
<tr>
<td>eliminate desk personalisation /’same desking’ and ‘contamination’ of touchdown</td>
<td></td>
</tr>
<tr>
<td>areas</td>
<td></td>
</tr>
<tr>
<td>3 The need to work with multiple stakeholders to achieve strategic</td>
<td>Joint working in the wider health economy to share networks (HSCN) and records</td>
</tr>
<tr>
<td>alignment</td>
<td></td>
</tr>
<tr>
<td>4 Promotion of Trust expertise &amp; leadership in agile working, space planning</td>
<td>Exploiting existing investment in infrastructure</td>
</tr>
<tr>
<td>estate management &amp; capital projects</td>
<td></td>
</tr>
</tbody>
</table>

2.7  National Context

In this section, the external factors and expectations that have been considered are summarised. These are described in more detail in Appendix B.

There is no single NHS England document containing a National Strategy for IM&T. NHS England have published a number of papers giving guidance on how streamlined efficient services should be supported by IM&T. The key points in relation to this strategy are:

- The Five Year Forward View – new models of care (Oct 2014):
  - By 2020, there will be “fully interoperable electronic health records so that patient's records are paperless”.

- The Forward View into action: Paper-free at the Point of Care – Preparing to Develop Local Digital Roadmaps – April 2016
  - Every local health and care system will be expected to make early progress on 10 universal capabilities, demonstrating clear momentum between now and the end of March 2017 and substantive delivery by end-March 2018. The universal capabilities are:
    - Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions *
    - Clinicians in urgent and emergency care settings can access key GP-held information for those patients previously identified by GPs as most likely to present in urgent care and A&E*
    - Patients can access their GP record
    - GPs can refer electronically to secondary care *
    - GPs receive timely electronic discharge summaries from secondary care *
• Social care receive timely electronic assessment, discharge and withdrawal notices from acute care
• Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly
• Professionals across care settings made aware of end-of-life preference information *
• GPs and community pharmacists can utilise electronic prescriptions
• Patients can book appointments and order repeat prescriptions from their GP practice
* relevant to EPUT
See Appendix C for a detailed analysis of the Universal Capabilities

• Next Steps on The Five Year forward View - March 2017
  • Electronic Referral System (ERS) – providers will only be paid for the resulting first outpatient attendance where the GP referral was made through ERS. Oct 2018 Health and Social Care Network – the replacement of N3 Data security – successor framework to the Information Governance Toolkit.
  • Outpatient clinic letters – requirement for electronic transmission of clinic letters, as structured messages using standardised clinical headings, will take effect from 1 October 2018.
  • Discharge summaries – From 1 October 2018, transmission of both clinic letters and discharge summaries to general practices must be via direct electronic transmission, not via email.

• The National Data Guardian for Health and Social Care, alongside the CQC, was commissioned by the department of Health to undertake a review of Information Security. On 12th July 2017, the DoH published a response to the NDG and CQC reviews under a publication titled “Your data: Better security, better choice, better care” which supported the introduction of 10 new data security standards grouped into 3 leadership obligations: People, Process and Technology. 

2.8 Digital Maturity Index

In spring of 2016, as part of the creation of the Local Digital Roadmaps, all trusts were required by NHSE to undertake a self-assessment of Digital Maturity. Over 150 criteria, North Essex scored at 38% overall, which is a lower quartile response over all trusts’ responses; South Essex scored 77% overall – the fifth highest scoring Trust out of 239 in total. There were three main headings covering readiness, capability and infrastructure. These headings comprised the following attributes:

• Readiness – Leadership, governance, investment, change & benefit approach, resources, programme & change structure, programme assurance
• Capabilities – Path to paper free, deployment schedule, status and optimisation against the Universal Capabilities
• Infrastructure – Information sharing, mobile, security, technology assurance.
Of the 236 trusts that provided data, the Trust scored as follows:

<table>
<thead>
<tr>
<th></th>
<th>Readiness</th>
<th>Capability</th>
<th>Infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>46</td>
<td>28</td>
<td>52</td>
</tr>
<tr>
<td>South</td>
<td>96</td>
<td>69</td>
<td>89</td>
</tr>
</tbody>
</table>

This exercise has been repeated for EPUT in August 2017 with an additional section relating to Business Intelligence. We await the publication of the scores but in the meantime it is clear that the overall result will be somewhere between those achieved by the two previous Trusts in 2016:

- The initial scores for the South were high partly due to the functionality SystmOne provides e.g. prescribing, referral, discharge etc. By adding the North Remedy system to the equation, these scores will be lowered proportionally.
- Improved functionality in Remedy, forms part of this strategy.
- Electronic order communications, results reporting and e-prescribing are part of the strategy which will also include technology supported redesign of clinical services
- The Strategy supports the role of a Chief Clinical Information Officer
- Electronic referrals are part of the strategy.
- Single sign on to our different application systems will be explored within the strategy.
- Cyber Security assurance will be provided to the Board.
- The Strategy includes patient access to their digital care records
- A full review of the IT Service Model will provide the level of resilience previously delivered by SEPT.

If we are to be viable partners in our local health and care economy, we will need to address the points above. A major part of this strategy is to plan to address all of the above.

We are proposing that we target moving back into the upper quartile when Digital Maturity is measured during 2020-2021. While we cannot predict how other Trusts will improve over that period, or how the metrics comprising the Index will change, if we achieve all that is set out in this document, it is a reasonable aspiration to achieve the upper quartile.

2.9 Public's expectations

As the National Information Board notes in Personalised Health & Care 2020: “In other parts of our lives, we see the benefits of technology: in the way we book our travel and holidays, manage our bank accounts and utility bills, buy groceries, connect and communicate with our friends and family. Digital technologies are changing the way we do things, improving the accountability of services, reducing their cost, giving us new means of transacting and participating. This is more than an information revolution: it puts people first, giving us more control and more transparency”.

While developments in clinical technology have had a revolutionary impact on healthcare over the last 30 years, the same cannot be said for the use of technology and data to improve health or the way health and social care services are delivered. The consumer experience of care services remains much as it was before the mobile phone and the internet became commonplace. For health and care professionals, from social workers to doctors and nurses, the arrival of the digital age has often been experienced not as a force for good but rather as an intrusive additional burden in an already pressured existence.

At the same time the technology industry is investing massively in consumer health products but these are not comprehensively linked to the formal health and care sector.

2.10 Technology Opportunities
Although technology should not be seen as a driver in setting strategy, the continuing churn of new developments needs to be assessed. While healthcare has historically lagged behind most other sectors of the UK economy, there is evidence that the technology contribution to detection, prevention and diagnosis is increasing rapidly through the use of wearables, implantable devices, mapping of the human genome and individually tailored drug therapies.

A literature review leads us to draw the following conclusions from the evidence base:

2.10.1 Within 3-5 years’ time, the keyboard will no longer the primary method of input for creating clinical records. Speech recognition and natural language processing have developed to the point where we can envisage that most records will be spoken not typed by 2020. The rate limiting factor here could be cost, or the willingness of staff to embrace new technologies or the speed with which our major application vendors can adapt their systems to cope.

2.10.2 The use of wearable technology by our patients will become more commonplace. The ability of such devices to record vital signs and to stream that securely into a data centre, allied with decision support algorithms, could be used to remotely monitor a proportion of our domiciliary patients, and to alert our clinical staff when an intervention by voice or video or by a visit was required.

2.10.3 The use of similar telemetry devices in peoples’ homes could likewise create an opportunity for some of our patients to be remotely monitored from a health and care perspective. The local authorities are actively developing Assistive Technology strategies to do that and we must collaborate with them to ensure minimum expenditure is made on basic communications infrastructure in service users homes.

2.11 Local IM&T context

Within our local area we have multiple developing and changing CCGs, STPs and ACPs with a complex mix of IM&T services and solutions.

The GPs across the patch are largely standardised on SystmOne with some EMIS presence. SystmOne presents its own challenges since it remains impossible to integrate with most other systems.

The Trust has existing electronic links with social and acute services but these need to be strengthened and enhanced.

2.12 Where do we want to get to?

The Trust values technology as a solution to some of the challenges it is facing. It continues to invest in technology and information development both directly through procurement and development of solutions, but also in its specialist workforce that provide the business support function within Information, Finance, Performance, clinical systems, Workforce and procurement services. Having the expertise within the Trust provides both a value for money service as well as flexibility and control over direction. The strategy recognises that value for money from investment and realising the benefit of change, is a measure of success. Having a well-developed plan that is prioritised and recognises dependencies and also quick wins will also be a measure of success. There needs to be a balance between the must do’s and the developments that will bring about positive change.

Key factors in the delivery of the Strategy cut across both service provision, receipt of care and demonstrating quality and efficiency. The Trust aspires to be the service of choice and will utilise technology to support:

- Quality provision of care
- Fast and efficient service delivery
• Choice of care delivery
• Inclusion of service users in their care and decisions about their care
• Provision of self-care options to service users where possible.
• Access to accredited information to empower service users
• The provision for staff to access and input information into the care record more flexibly
• Information Security Good Practice
• More effective services delivering significant efficiency gains
## 2.12.1 Original Plan

The table below has been updated to demonstrate progress against the plans in the original publication intended to reduce the associated risk of disparate systems and build on existing investment.

*Updated in September 2019 to show progress*

<table>
<thead>
<tr>
<th>System/Service</th>
<th>Current position</th>
<th>Risks</th>
<th>Migration Year 1</th>
<th>Migration Years 2 &amp; 8</th>
<th>Migration Years 4 &amp; 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prime Clinical Systems</td>
<td>NEP used Remedy (Paris) SEPT use Modulus and SystmOne for Community</td>
<td>Joint working across MH services. That’s clinicians need access to both organisations EPR to deliver patient care. That NEP do not have sustainable development model for Remedy</td>
<td>Extend the publication of joint docs to 6 key documents as determined by clinical workstream (including referral) from each org in HIE. Establish mechanism for consuming the “Top 0” documents in year 2*</td>
<td>Complete development of HIE pull/push. Evaluate options for use of a single system in Year 2/3 – clinical need dependent*</td>
<td>Implement preferred solution</td>
</tr>
<tr>
<td>Appointments</td>
<td>NEP use Remedy (EPR), SEPT use Gnomly linked to Modulus plus SystmOne for community</td>
<td>Joint Working</td>
<td>See Clinical systems</td>
<td></td>
<td>Part of Review which clinical system should be used.</td>
</tr>
<tr>
<td>Intranet</td>
<td>The 2 Trusts have different Intranet systems which have different underlying architecture’s</td>
<td>Corporate identify, access to phone numbers. Need to keep separate policies and procedures until review complete</td>
<td>Review and implement single Intranet*</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Drug &amp; Alcohol (Stars)</td>
<td>Provided by Essex CC as part of contract diagnoses</td>
<td>Lack of continuity of care across dual diagnoses</td>
<td>Review options</td>
<td>Implement single PMI</td>
<td>N/A</td>
</tr>
<tr>
<td>Patient apps</td>
<td>SEPT has JAPT app and is developing further apps. NEP has not patient apps</td>
<td>Opportunity for NEP to use apps subject to novation</td>
<td>Explore synergies and deploy across trust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>eDRMS</td>
<td>Limited in NEP. Laserfiche a key part of Modulus and other</td>
<td>Records not available across new organisation</td>
<td>Scan NEP HR records, Medical Records proposal for North</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
<td>Recommendations</td>
<td>Notes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>--------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Historic Databases</strong></td>
<td>Both organisation hold historic information on a variety of data bases.</td>
<td>Options appraisal undertaken pending future review of Clinical Systems*</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Undocumented 'systems'</strong></td>
<td>Both organisations may hold unknown systems e.g. locally developed Access databases.</td>
<td>Visible through merged Active Directories. May need to be consolidated</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Speech recognition and digital dictation</strong></td>
<td>NEP use 4 different systems incl Dragon and Philips; SEPT</td>
<td>Multiple solutions – lack of efficiency</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Records</strong></td>
<td>NEP holds paper records in multiple storers. All SEPT paper records are archived.</td>
<td>Establish position Optional appraisal* implement recommendation</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IG</strong></td>
<td>Each Trust has level 2 on the IG Toolkit</td>
<td>Produce NEP medical records proposal including scanning options*</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IT Support model</strong></td>
<td>NEP uses the CSU whilst SEPT uses an in-house helpdesk</td>
<td>Merge IG action plans. Secure external audit prior to submission for Year 1</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mobile Telephony</strong></td>
<td>Each organisation has contracts with EE</td>
<td>Review EE contracts Single contract</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Active Directory</strong></td>
<td>2 separate systems – NEP CSU, SEPT Internal</td>
<td>Plan a full active directory integration project to reduce administration, cost</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Underpinning Infrastructure</strong></td>
<td>Each Trust uses N3, has separate datacentres, use</td>
<td>Implement full active directory integration project to reduce administration, cost</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: N/A indicates information not available or not applicable.*
<table>
<thead>
<tr>
<th>Category</th>
<th>Issue Description</th>
<th>Recommended Action</th>
<th>Implementation</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Communications</td>
<td>Both Trusts use SMS for appointment reminders—part of the same National contract. SEPT has instant messaging from Cisco and uses WebEx for meetings—NEP do not have this facility.</td>
<td>Missed potential discounts for SMS and divergent solutions for instant messaging and video conferencing.</td>
<td>Review options for aligning datacentres* Establish HSCN Governance</td>
<td>N/A</td>
</tr>
<tr>
<td>Asset Management Access controls/RBAC</td>
<td>Each Trust uses a completely different system. NEP VPNs are provided by the CSU, SEPT are internally hosted.</td>
<td>No single view may impact discussions re: external licencing.</td>
<td>Implement recommendation</td>
<td>N/A</td>
</tr>
<tr>
<td>Mobility Service</td>
<td>Provided by internal teams in each Trust. NEP model is restricted by patient within team, SEPT model is open to all MHI patients.</td>
<td>Confusion over new starters. Realisation of savings if single solution.</td>
<td>Service cost model review and migrate to one solution*</td>
<td>N/A</td>
</tr>
<tr>
<td>Unified Comms</td>
<td>Software is different for each Trust. In addition, SEPT has a Contact Centre already used by NEP and utilises Snapcoms and Electronic signage which NEP does not.</td>
<td>Opportunities for centralisation and discounts.</td>
<td>Consolidate for discounts</td>
<td>N/A</td>
</tr>
<tr>
<td>Systems Management</td>
<td>For removed monitoring maintenance etc. Both use the same system but NEP is.</td>
<td>Any alignment is part of IT Services model</td>
<td>See IT Service Model</td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
<td>Joint Working</td>
<td>Dependent on Finance workstream</td>
<td>Dependent on Procurement workstream</td>
</tr>
<tr>
<td>-------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>----------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Finance</td>
<td>2 separate systems</td>
<td>Joint Working</td>
<td>Both Payroll contracts run to 2020 without break clauses. Finance to negotiate but VPD merge may not be until year 4. This will impact on ESR</td>
<td>Both Payroll contracts run to 2020 without break clauses. Finance to negotiate but VPD merger may not be until year 4. Will impact on ESR, e-Rostering, e-expenses</td>
</tr>
<tr>
<td>HR</td>
<td>2 separate systems</td>
<td>Joint Working</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procurement</td>
<td>2 separate systems</td>
<td>Joint Working</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e-Rostering</td>
<td>Both Trust use Allocate. Different stages of implementation. Linked to Payroll system which is part of Payroll contracts</td>
<td>Joint working – that staff cannot be rostered across the geography</td>
<td>Both Payroll contracts run to 2020 without break clauses. Finance to negotiate but VPD merger may not be until year 4. Will impact on ESR, e-Rostering, e-expenses</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Both Trusts are Ascribe</td>
<td>Join Working. Economics of contract incl. ePrescribing</td>
<td>Merge both systems</td>
<td>N/A</td>
</tr>
<tr>
<td>Management System</td>
<td>Crystal used by NEP, SystemOne and Olliview used by SEPT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate MI</td>
<td>2 Separate systems, processes and controls. NEP may implement a different system before Day 1</td>
<td>Review Options for joint data warehouse and streamlined PMI</td>
<td>Implement</td>
<td></td>
</tr>
<tr>
<td>Expenses</td>
<td>NEP is paper based whilst looking to migrate to Serco e-expenses. SEPT uses Allocate</td>
<td></td>
<td>Both Payroll contracts run to 2020 without break clauses. With Finance to negotiate but VPD merge may not be until year 4. Will impact on ESR, E-Rostering, E-Expenses.</td>
<td>N/A</td>
</tr>
<tr>
<td>Safer staffing</td>
<td>NEP uses Allocate. SEPT is looking to move this but currently uses a manual process.</td>
<td>None</td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>
2.12.2 Current Plan – September 2019

The plan shows the plans for the different IT systems and infrastructure as at September 2019:

<table>
<thead>
<tr>
<th>Programme</th>
<th>Project</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prime Clinical System</td>
<td>Evaluate options for streamlining 5 EPRs</td>
<td>Clinical safety and efficiencies</td>
</tr>
<tr>
<td></td>
<td>Deliver chosen solution</td>
<td>Clinical safety and efficiencies</td>
</tr>
<tr>
<td>Applications</td>
<td>Suffolk &amp; NE Essex HIE integration as per STP HSLI plan</td>
<td>Information sharing across Suffolk STP</td>
</tr>
<tr>
<td></td>
<td>RBAC</td>
<td>Development of RBAC model for HIE access</td>
</tr>
<tr>
<td></td>
<td>Consent model</td>
<td>To only consume data into HIE with patient consent</td>
</tr>
<tr>
<td></td>
<td>Publication from H&amp;J into HIE</td>
<td>Extracts from Excelcare</td>
</tr>
<tr>
<td>HIE</td>
<td>e-Discharge - MH community / MH inpatient / MH 24 discharge. Inc. first outpatient outcome letter</td>
<td>The ability to send electronic discharges directly from provider into GP system using a structure messaging format. One project - triggers - to be delivered by MESH (Message Exchange Social Care Health) / FHIR?</td>
</tr>
<tr>
<td></td>
<td>Structured messaging functionality</td>
<td>FHIR, MESH, HL7, HL7 FHIR</td>
</tr>
<tr>
<td></td>
<td>SystmOne Publication into HIE</td>
<td>To publish data from SystmOne into HIE using improved Strategic Reporting - working with NELFT</td>
</tr>
<tr>
<td>Category</td>
<td>Existing Functions</td>
<td>New Function</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Portal review</td>
<td>Publishing to S1</td>
<td>Integration with GPs</td>
</tr>
<tr>
<td>Paris</td>
<td>Paris upgrades</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Support CQIN, KPI and MDS</td>
<td></td>
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<tr>
<td></td>
<td>Paris programme</td>
<td>Form development</td>
</tr>
<tr>
<td>S1</td>
<td>Support CQIN, KPI and MDS</td>
<td></td>
</tr>
<tr>
<td>Mobius</td>
<td>Support CQIN, KPI and MDS</td>
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<tr>
<td></td>
<td>snomed</td>
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<tr>
<td></td>
<td>AEM</td>
<td>Continued support</td>
</tr>
<tr>
<td>ePrescribing</td>
<td>Develop single PMI and PSD</td>
<td>Data quality</td>
</tr>
<tr>
<td></td>
<td>Implement ePrescribing</td>
<td></td>
</tr>
<tr>
<td>Apps</td>
<td>Meds reminder, EIT</td>
<td></td>
</tr>
<tr>
<td>eReferrals</td>
<td>All GP referrals to be electronic via eRS</td>
<td>Will reduce reliance on appts office.</td>
</tr>
<tr>
<td>Artificial Intelligence (AI)</td>
<td>Understand and exploit</td>
<td>e.g. First Appointments, clinical coding, workflows etc.</td>
</tr>
<tr>
<td>Telephony</td>
<td>Produce a strategic review of Telephony options - 7 different systems in use and risk in the North of phone systems with no maintenance cover in place that use N3 LGS or Featurenet 1000 links</td>
<td>Implementation of a single telephony platform. Funding has been reduced by £138k in 19/20 to fund Cyber team</td>
</tr>
<tr>
<td></td>
<td>Risk to HSCN migration if HVS &amp; LGS services are not addressed.</td>
<td></td>
</tr>
<tr>
<td>Project</td>
<td>Description</td>
<td>Benefits</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Edge switch replacement</td>
<td>Switch replacements and Wi-Fi upgrades which are end of life and out of support (Cyber risk identified by NHSD)</td>
<td></td>
</tr>
<tr>
<td>Infrastructure refresh</td>
<td>SAN Replacement, Essex LDR - end of life replacements and growth for EPRs and North</td>
<td></td>
</tr>
<tr>
<td>Paris in-house hosting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bedfordshire data centre decant to Essex (Crystal Centre)</td>
<td>Lease arrangements currently in place for the Data Centre in Bedfordshire expire at the end of 03/20. Data Centre lease either needs to be renegotiated or Data Centre moved to an alternative location. Consideration of services provided in Bedfordshire needs to form part of the plan as only customer left will be VCL post 09/19.</td>
<td>To maintain a Disaster Recovery Data Centre for services hosted from Thurrock Data Centre, specifically Clinical Applications.</td>
</tr>
<tr>
<td>Unsupported application refresh</td>
<td>Identify and remove/migrate all unsupported applications in use across Trust services. Upgrade all PCs to Windows 10 as per Cyber Audit report by Dec 19</td>
<td>To mitigate any potential threat to the trust from unsupported applications. Allow compliance with DSP Tool Kit and Cyber Security+ Certifications</td>
</tr>
</tbody>
</table>
### EPUT IM&T Strategy

#### Contact Centre system replacement
- Provide a replacement Desktop Agent Application to support the call handlers with incoming service user contact.
- Review and replace aging/legacy hardware and software.
- To support the requirements of the Trust in delivering services to patients. In addition to support the requirements identified as part of the award of NHS 111 services for Mental Health patients. To mitigate any potential threat to the trust from unsupported applications and hardware.

<table>
<thead>
<tr>
<th>Service Delivery</th>
<th>Records</th>
<th>IG</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSCN</td>
<td>Replace N3 network with a suitable HSCN compliant solution</td>
<td>Flowz</td>
</tr>
<tr>
<td>Review and propose market options for replacing Cisco Contract provider (Intrinsic/Maintel)</td>
<td>Provision of Network Infrastructure Maintenance Provision</td>
<td>Data flow mapping</td>
</tr>
<tr>
<td>Support Office Moves</td>
<td>Various moves of staff/Teams as requirements arise</td>
<td>Records Storage</td>
</tr>
<tr>
<td>Remote consultations</td>
<td>Develop strategy and promote incl. internal functionality</td>
<td></td>
</tr>
<tr>
<td>PC deployment</td>
<td>Refresh of Aging Desktop Estate</td>
<td></td>
</tr>
<tr>
<td>Starters/Leavers process</td>
<td>Align to Trac and ESR</td>
<td></td>
</tr>
<tr>
<td>Single sign on</td>
<td>Relaunch of password self-service on Windows</td>
<td></td>
</tr>
<tr>
<td>MS Office refresh</td>
<td>End of Life and Cyber risk</td>
<td></td>
</tr>
<tr>
<td>Records Storage</td>
<td>Tender for consolidated records storage</td>
<td></td>
</tr>
</tbody>
</table>
**Informatics Strategy on a Page**

Our ambition is that, by 2022, each of our clinicians will be able to access the relevant health and care data about our services users, using intelligent, reliable and supportive technology tools.

<table>
<thead>
<tr>
<th>Best Care</th>
<th>Best Value</th>
<th>Provider of Choice</th>
<th>Great to work for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical records become paper light</td>
<td>Single Point of Referral to replace multiple SPAs, e.g. for Bassetlaw Physical &amp; Mental Health</td>
<td>Informatics support for new models of care as required by Accountable Care Systems</td>
<td>Steamedlined processes supported by reliable and intuitive IT</td>
</tr>
<tr>
<td>HIE provides consolidated view</td>
<td>Support to Service Improvement and Service transformation</td>
<td>Share patient data more readily and efficiently with partners through County wide Clinicians Portal and other tools</td>
<td>More liberal social media policy</td>
</tr>
<tr>
<td>Use of SNOMED codes</td>
<td>Support for Research, Clinical Audit &amp; Medicines Optimisation</td>
<td></td>
<td>Videoconferencing</td>
</tr>
<tr>
<td>Clinicians Dashboard and Outcomes</td>
<td></td>
<td>Alignment with People &amp; Culture Strategy</td>
<td></td>
</tr>
</tbody>
</table>

Ensure everything is underpinned by robust, responsive, secure infrastructure and that our staff are competent and confident.

- **Cyber Security**
- **Business Continuity**
- **People, Culture & training Strategy**
- **Reduce single points of failure**
- **Rolling Infrastructure Improvement Strategy**
- **Service Catalogue – informatics Offer to the Trust**
- **Innovation and collaboration opportunities**
3. THE IM&T STRATEGY FOR ESSEX PARTNERSHIP

The IM&T strategy for Essex Partnership is based on nine themes:

- Interoperability of Systems – developing systems that interact with each other and that are intuitive so that new views of information can be created by the user. That data and information is in one place and can be found and viewed easily.
- A modern integrated and highly functional and resilient IT Infrastructure that supports unified data management and electronic communications.
- Clinical systems – to deliver electronic patient records based on maximizing the utilisation of existing investment, ensuring best industry practice is adhered to and new technology is evaluated and exploited whilst supporting improved patient safety and clinical efficiency. The impact of the integration on this area will involve a high degree of standardisation and over time, rationalisation.
- To support corporate services through standardisation of systems and provision of solutions to provide more effective ways of working by improving process.
- Staffing needs – using technology to support staff in the way they need and wish to work. Making technology simple and easy to use and available when it is needed. For example to allow staff to have more immediate access to information in an electronic format wherever they are located, that the information is complete and up to date, to reduce duplication in re-requesting information and to enable the sharing of information which means all staff are working with the same data.
- To support the National and Sustainability and Transformation Partnerships (STPs) towards increased digital maturity and the sharing of structured clinical information and records across the local community.
- Patient access – encouraging patients to take a more active part in their care giving them access to their electronic records and providing the facilities for elements of self-care and regular feedback. Creating systems that give patients and carers the information they need and the ability to self-refer where service pathways allow.
- Systems to support managers – access to systems that provide managers with the tools and information to manage their services better. Turning data and information into intelligence and bringing information into one place and providing reports that are intuitive and timely.
- Information security - There is a rapidly growing emphasis on cyber security in response to both a growing reliance on ICT, but more acutely, the threat of successful attack is far more complex and isn’t just a disruption to service, the threat now is ransom and data loss.

3.1 The Vision

Our vision is to deliver to the Trust an integrated set of IM&T applications that support and enhance the day to day working of all staff and support the safe and effective care of patients. These applications will be based on a modern and robust IT Infrastructure that provides a fast, safe, mobile and effective solution for access to information in the right place on demand.

In summary the objective of the IM&T service and this strategy is to provide the knowledge, skills, technology and tools that enable information to be collected, managed, used and shared (both within and outside the Trust) to deliver excellence in healthcare.

3.2 What does this mean for staff?

The vision for the IM&T strategy needs to mean something to our staff who may not have a
technical understanding of some of the areas of this strategy. The following six messages convey what this should mean for staff:

- **Make it easy to access and fast** - easy for me to log on and gain access to the information I need.
- **Make it credible and reliable** - I trust the technology to work.
- **Give me one view** - All the information I need about a patient in one place.
- **Help me to change the way I work** - I use IM&T as part of my role – it helps me to reduce delays and provide better patient care. I use accurate and timely electronic information.
- **Help my work to become paper light** - Take the paper out of the organisation and my working day and help me to become more efficient.
- **Help me to join up healthcare** – allow me to work more effectively with my colleagues and health and social care partners through the transfer of electronic information, provide a better service to patients.

### 3.3 IT Infrastructure

A joined and integrated IT infrastructure is the key enabler to the IM&T strategy. Any IT application is dependent on the infrastructure that sits beneath it – the part of IT that you cannot see. An analogy would be the wiring within a house – you can’t see it, but without a modern efficient wiring system, the latest electrical equipment can fail to work. When you travel the electricity may be the same but the plugs are different so you need an adaptor.

For EPUT to function as an efficient, physically remote organisation there is a need for a scalable, resilient IT infrastructure to deliver on-demand services in tune with the growing reliance upon consolidated cloud based solutions. As a newly merged Trust it is possible to
provide an immediate reduction of IT cost through consolidation of services, reducing costs by maximizing existing investments. It is possible to ‘future proof’ technology to some extent – this approach requires more investment in the short term, but over the lifetime of this strategy, total costs would be lower.

The Department of Health is now publishing ‘standards’ which IT suppliers and systems must adhere to. This enables organisations to view consolidated information about patients/service users, both within the NHS and from external organisations e.g. Social Care.

In order to deliver a robust infrastructure we will:

- Consolidate on existing investments e.g. data centre, helpdesk
- Continue to deploy wi-fi across the Trust for both staff and patients.
- Migrate from the N3 network to HSCN with Essex wide colleagues.
- Deliver a standardised single unified email system
- Further explore single sign-on.
- Work towards a single IT helpdesk with a published SLA monitored by KPIs.
- Work towards the integration of the telephony system across EPUT.
- Continue to monitor software licensing and ensure that Disaster Recovery processes are fully documented and tested.
- Upgrade/update all applications and software to the latest release as soon as possible in accordance with NHS Digital and CareCERT guidance within the parameters agreed by the Trust Executive.
- Ensure that the Board is aware of the risks and mitigations against cyber-attacks and that the adopted processes are monitored and reported.
- Explore alternatives to Active Directory for user identification including smartcards, portable and wearable technology, biometrics (fingerprint, retinal etc.)
- Review IT support services to maximize value and quality and address the current two tier level of service.
- Adopt a common and standardised approach to file storage and back up that allows the Trust to build a cost effective, highly resilient, secure and fault tolerant solution for file management.
- Develop a robust Print Management Policy across the Trust to reduce risk and waster work collaboratively with the wider Essex Health and social care economy and beyond to maximise the Return on Investment and capability of new and existing infrastructure investments
- Commission expandable solutions – to meet the growth plan for EPUT
- Comply with the National standards as they are defined by the Department of Health to ensure interoperability.
- Support a mobile work force – both Worksmart for home working and remote working for Community staff

This presents the following challenges:

- The most significant issue is the length of contracts currently held due to contestability.
- Any infrastructure must be capable of disaggregation should individual or multiple service contracts be awarded to other organisations as a result of contestability.
- Infrastructure projects tend to be costly, both financially and in terms of resources. Return on investment measured of short contract terms is highly problematic.
3.3.1 The 2020 Wall

With 2020 fast approaching there is significant need to replace and redesign our basic toolsets. The Microsoft tools we have used for years are approaching end of life and support. In 2020 Microsoft Office 2010, Windows 7 and Server 2008 will no longer be fit for use along with all associated platforms of that age.

We must invest time and resources into delivering a sustainable platform post 2020. Even our most advanced current systems will be end of life by 2022, we should therefore embrace the challenge and adopt platforms with longer lives to ensure we invest once and deliver maximum benefit.

NHS Digital and NHS England, with the support of the CareCert program are defining standards that are likely to mandate the transition away from unsupported technology due to the security risk it may pose.

3.3.2 Interoperability Standards

The Trust has been working with the Department of Health and UK standards groups (IHE-UK and HL7-UK) for the past two years. The Trust is actively engaged in defining these standards through its membership of the IHE committees. Although recommended at this time the Department of Health strategy indicates that the use of agreed standards will become a mandatory requirement over time. We will continue to use the NHS number as the main identifier in all patient systems. We will work towards SNOMED coding supporting shared information e.g. structured discharge summaries.

3.3.3 Information Security

Following the Cyber attack in May 2017 the EPUT IT Department gained approval from the Executive team to establish a Cyber security team tasked with the mitigation, control and prevention of the identified security risks that the trust faces.

Following an in depth cyber security assessment against the Cyber Essentials Plus standards, a detailed action plan was written and prioritised. The delivery against this plan is reported up to the Trust Audit committee and has to date demonstrated significant progress. The initially identified 12 high priority areas of risk have been reduced to 1.

Notable achievements include:

- 95%+ Patch management assurance to all trust Laptops and Desktops.
- Enforced complex password policies
- Detection and prevention software on all laptops/desktops identifying any unauthorised software activity
- Staff education and training on their responsibilities to ensure best practice under cyber security.
- Legacy application and operating system eradication.
- Windows 10 deployment project to all trust staff currently 60% complete and expected to reach 100% by January 2020.
The Trust has put in place robust cyber security Business continuity plans to ensure that EPUT can respond effectively and efficiently in the event of another cyber security attack and is on track to achieve the Cyber essentials Plus certification by January 2021.

The Trust has measured itself against recommended best practice and National Guidelines and created a risk stratification based on the current position:

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Good Practice Guide</th>
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<tbody>
<tr>
<td>Extreme</td>
<td>Patch Management*</td>
</tr>
<tr>
<td></td>
<td>Securing data systems</td>
</tr>
<tr>
<td>High</td>
<td>Antivirus, Malware and Hoax Management</td>
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<tr>
<td></td>
<td>LAN Security**</td>
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<td></td>
<td>TCP/IP</td>
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<td></td>
<td>Access Control Lists</td>
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<td></td>
<td>Tablet and Smartphone Security</td>
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<tr>
<td></td>
<td>IDS/IPS***</td>
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<td>System Hardening</td>
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<td></td>
<td>Firewalls***</td>
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<td></td>
<td>Proxy Services</td>
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<td></td>
<td>Remote Access</td>
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<tr>
<td>Medium</td>
<td>Password Policy and Control</td>
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<tr>
<td></td>
<td>VLAN security</td>
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<tr>
<td></td>
<td>Site to Site VPN</td>
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<tr>
<td></td>
<td>Virtualisation</td>
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<tr>
<td>Low</td>
<td>Wireless Security</td>
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<tr>
<td></td>
<td>Network Address Translation</td>
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<td></td>
<td>Security Principles</td>
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<td>Data disposal</td>
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It has been agreed that a separate Information Security team will be funded and ring–fenced to implement a planned programme of work which reduces the above individual risk levels and thereby the total risk of Information Security to the Trust.

3.4 Records, Assessments & Plans

We will:
- Continue to support the organisation towards achieving fully electronic records across clinical and corporate services to support decision making, improve patient/service user experience and safety.
- Continue to develop HIE to facilitate patient record visibility across different EPRs within EPUT.
- (re)Develop EPR forms to support the new Clinical Model
- Work towards harmonising the presentation of eForms/templates across the two mental health EPRs to support consistent best clinical practice and simplify the move to a single EPR.
- Ensure that all performance metrics including national returns, commissioner KPIs etc. are collected within the clinical eForms/templates as part of the record keeping process.
- Continue the promotion of voice recognition (Dragon) as an effective and efficient mechanism for recording patient records.
- Develop a single Patient Master Index – PMI – to reduce the risk of duplication where there are multiple EPRs
- Develop a single data warehouse to support integration across the multiple EPRs, reduce the need to re-enter information and simplify the Information and performance reporting process.
- Converge our two Electronic Digital Records Management (EDRM) platforms.
- Evaluate options and implement a single Mental Health EPR.
- Deploy a single intranet across the organisation as a central point of communication, harmonised policies and staff contact directory.
- Fully utilise the technology in our EPRs and future systems to support patient alerts, automatic reminders for overdue actions, next steps on pathway, MHA deadlines etc.
- Promote and support clinical coding to industry standards
- Adhere to national standards for coded records and data
- Implement and exploit electronic prescribing in line with the national initiatives including the recording of administered drugs and the electronic delivery of prescriptions to local pharmacies.

3.5 Electronic communication and Information sharing with Health and Social Care partners.

The Trust does not exist in isolation but rather works closely with a large number of other organisations and agencies in order to provide effective patient care. It is essential that the IM&T strategy considers these interactions and how they can be supported by electronic solutions.

We will:
- Maximise the investment in existing technology e.g. HIE, Mirth etc. as a mechanism to securely communicate outside the organisation.
- Use current technology and exploit its potential to support electronic communication between clinicians both within EPUT and in the wider Health and Social Care Economy e.g. access to hospital pathology systems for test results and requests.
• Contribute and adhere to national standards to enable integration supporting the bi-
lateral sharing of patient information e.g. GP medication visible to EPUT clinicians.
• Deliver solutions that support consent models and that access to records is auditable
and appropriate.

3.5.1 Transfer of Care

Specifically mandated within the national contracts is the utilisation of eReferral and electronic
discharges and within the 10 Universal Capabilities is the sharing of assessments and
discharges with Social Care. We will deliver solutions against these mandates, wherever
possible utilising existing systems and exploring synergies across all EPRs to reduce costs
and deliver a consistent approach.

3.5.1.1 E-Referrals

The NHS e-Referral Service (e-RS) combines electronic booking with a choice of place, date
and time for first outpatient appointments. Patients can arrange their hospital appointment with
their GP during consultation, or independently either online or by telephone. NHS England has
developed the e-RS Commissioning for Quality and Innovation (CQUIN) for 2017/18 with the
aim of increasing the availability of services and appointments on provider e-RS systems as a
key enabler of, and in preparation for, the conditions set out in the NHS Standard Contract.

The NHS Standard Contract conditions for 2017/18 - 2018/19 are that, “with effect from 1
October 2018, the Provider need not accept (and will not be paid for any first outpatient
attendance resulting from) Referrals by GPs to Consultant-led acute outpatient Services made
other than through the NHS e-Referral Service.” However, the current National tariff does not
identify separate payments for the first appointment.

We will therefore work with colleagues in Business Development to ensure that all clinical
systems are able to interface appropriately with the national e-RS platform.

Update September 2019 – NHSD have delayed this deployment. We await further updates.

3.5.1.2 E-Discharge

In 2015/16 the NHS Standard Contract changed to include;

Service Condition 11.6 requires Acute and Mental Health NHS Trusts to send inpatient and
day case discharge summaries, subject to the 24 hour rule to GP practices electronically from
1 October 2015 onwards. In North Essex there is a project underway in 17/18 to facilitate this
through a module of Paris. In the South this is currently facilitated through a combination of
Mobius eForms and email.

This was the first step in a digital journey, in moving from paper to electronic transmission,
then moving to electronic structured messaging, in order to realise benefits around patient
safety, outcome and experience.

Further in 2016/17 the Standard Contract requires providers sharing inpatient and day case E-
Discharge summaries to implement the Academy of Medical Royal Colleges (AoMRC)
headings by 1st December 2016.

Update September 2019 – There remain ongoing challenges with this development due to lack of progression from the GP IT suppliers to receive the messages ad ongoing dialogue with NHSD re: codin standards. However EPUT is at the forefront of this development across the NHS and continues to engage with Commissioners re: progress.

3.6 Remote & Assistive Care

The latest technology can be used to interact with patients in many different settings, be that at home or in remote clinics. As demand for services increases and patients demand an ever more flexible service in terms of location and time of appointment, it not infeasible that our current resources will not cope logistically.

We will continue to exploit technology to promote patient access and support the demands of our clinical workforce including:

- Secure video communication (e.g. Jabber)
- Telehealth, teledicine and telecare
- Instant messaging, voice and video communication solutions and conduct a review into strategic video and meeting place services, which will support advances in community care and handling isolation in both patients and staff.
- Reminder services for patients through Text messaging.
- Providing patient apps and websites to support education and treatments
- Patient tools such as self-service check in, surveys, ability to book and rebook appointments on line etc.
- Partnership working with social care colleagues to exploit telecare technology.
- Continue to exploit and utilise the latest mobile technology including off-line working.

3.7 Business and Clinical intelligence

EPUT holds and is dependent on a massive amount of corporate data across Financial, HR, Training, Procurement, Contractual and many other disciplines. We will:

- Continue to develop data consolidation approaches such as dashboards including a customised, personal Management Dashboard, providing managers with the information required to effectively control their services. Information will include budgets, sickness, vacancies, training status and holiday planning.
- Provide access to this information in a user-friendly and easily disseminated manner.
- Support the appropriate sharing of data across the health care economy to support service design, research and patient care.
- We will continue to monitor and promote data quality.
- Support the deployment of Safer Staffing software in the South to provide a robust mechanism for delivering effective, safe care.

3.8 Corporate Systems

We will support our corporate colleagues in the integration of corporate systems including:

- Consolidating onto one Finance System
- Merging onto one Payroll including the impact on expenses
- Technical aspects of the rollout of the e-rostering system
- Merging onto one Pharmacy system
- We will deploy a single Room Bookings system across the Trust
4 Implementation of the IM&T Strategy

The proposed approach to delivery of the IM&T strategy is via a phased programme of projects each of which will be delivered over a 9-12 month period. The phase will consist of a mixture of small, medium and large projects to balance the capacity and resources available with the desired output.

This strategy outlines what we know at this point in time but technology changes rapidly and there is no doubt that new requirements and systems will be identified. The strategy is necessarily high level at the commencement of the 5 year period and will be revised and re-issued as investigative initiatives and associated business cases are completed. The plan is aligned to the timeframes in the national strategy.

The IT industry continuously evolves bringing new services and technologies to the market. This IM&T Strategy is based on current understanding, both within the organisation and partner organisations, of the ability of the latest technology to support the organisation in its strategic direction. The strategy includes the continual re-evaluation of market developments and will be revised to reflect these findings over the 5 year period.

An action plan that summarises all the recommendations and actions identified within this document will be developed once the Strategy has been signed off. It will be responsibility of the Chief IM&T Officer to oversee this action plan and report progress to the IM&T Board.

The Trust needs to deliver synergies and savings and there is an expectation that IM&T will support this work. A number of opportunities have been identified:

4.1 Single Approach to projects

Significant IIM&T projects delivered via a single team therefore saving money on procurement and project management.

An example of this is the recent procurement of an ePrescribing solution which can be deployed across all Mental Health services in the Trust. No further procurement costs are required.

4.2 Rationalisation

Rationalisation is required to help the organisation become more efficient. There are too many systems across the Trust and this leads to confusion, multiple pockets of information which is not joined up and increased revenue costs for the maintenance contracts.

New technology and systems that are part of this plan will replace functionality currently delivered by a number of the smaller systems or non-digital processes For example:

- Log on credentials should work in any location and allow to the requisite systems to provide patient care regardless of location.
- Using existing Laserfiche infrastructure to reduce costs of paper storage in the North
- Using the existing Patient Summary Database - PSD – to hold a central PMI and data warehouse for all EPRs reducing the complexity and cost of reporting and improving data quality.

4.3 Transformational change

It is known that transformation and the associated savings can be supported by IM&T developments. A good example of this is where a system allows work practices to change and become more efficient and effective. However the caveat attached to this is that it requires
effective change management to deliver the savings since often a parallel project is required to own the change and deliver and embed the process change.

The IM&T structures include Clinical Change managers who support and educate on possible changes to process, however in order to deliver savings in this area there must be joined up working with the Trust Transformation agenda and governance on how this will be achieved.

An example of transformational change is the use of Microsoft Outlook for booking meetings. If all staff used Microsoft Outlook for their diary and standards for meeting invites and diary management permissions were agreed that included management of availability and “keep free” time. This change in working practice would dramatically reduce the amount of time spent by secretaries and administrators to book meetings and meeting rooms. However this change requires agreement to a standard way of working that up to now the Trust has not been able to agree or implement.

We have recognised in the development of this strategy the three critical elements to delivering benefits and improvement from IM&T. They come from three sources:

- **IM&T** – delivering the solutions, providing the IT, the systems, the expertise in technical implementations and system integration
- **Information services** – management of the output from the systems and applications – delivery of the Trusts Information services – expert and owner of data meanings and data integrity
- **Transformation /Change** - providing leadership and support for the change management. Owning the benefits.

These three elements must work together and their overall co-ordination needs to be via the Transformation agenda.

### 4.4 Funding Allocation

All expected synergies and savings will be presented to the IM&T Strategy Group in individual business cases for each project.

IM&T in healthcare does not have the reputation for easily delivering savings from projects. This is because there are a number of risks and issues associated with such projects. The risks and issues that we have identified associated with this strategy and the targeted benefits and savings are:

- Lack of governance and decision making process
- Business and clinical ownership and sign off of the benefits
Lack of clinical engagement

Lack of effective and agreed transformation for change e.g. agreement to switch off paper.

These risks need to be managed through the Trust’s transformation agenda.

All procurement activities will be undertaken at the most appropriate level to allow for the most appropriate contractual relationships and allow for greatest value to be gained from our suppliers.

All of the Trust’s strategic suppliers will be managed in a way that allows effective collaboration and innovation leading to a better relationship between them and the Trust allowing for improved understanding of and response to the Trust’s needs. In order to optimise the use of the latest technology in a cost-effective manner to improve clinical and corporate efficiency, EPUT works with a variety of partners (e.g. Fortrus, Tiani) with appropriate skill sets. This provides resilience within EPUT.

4.5 Governance

In order to deliver this strategy secure governance must be in place. We will:

- Continue to harmonize structures, processes and cultures across the Trust following the recent merger.
- Regularly review the appropriateness of the governance structure for IMT decisions
- Follow Prince2 methodology. In accordance with this, risk registers are developed for each project to manage any relevant risks and reported to the IM&T Strategy Group. Any risks associated with this strategy are noted on the Directorate Risk Register, which is reported to the Executive Team on a bi-monthly basis and is reviewed by the IM&T Senior Management Board on a monthly basis. We will work towards adopting MSP (Managing Successful Programs) to support the successful delivery of programmes.
- Adapt processes and systems to meet the needs of the users to ensure maximum take up and therefore return on investment.
- Work with managers and other staff to ensure that any IT interface is appropriate to the model of care.
- Encourage the concept of ‘super-users’ and champions in clinical and corporate teams to improve utilisation of IT.
- We will attend clinical and corporate planning days to improve the understanding of the purpose of IT within EPUT.
- Improve accessibility to self-help tools to support utilisation of IT.
- Evaluate training needs for staff involved in the use of technology in the workplace.
- We will hold ‘Show and tell’ days to demonstrate the effective use of new technology across the Trust.
- We will present information in a way that is meaningful and relevant to the individual through the use of dashboards etc.

4.6 Information Governance

The Department of Health is clear that Information Governance should be used as an ‘enabler’ to safe and secure use of confidential and sensitive information. The Trusts’ Information Governance Team provides advice and guidance about the correct implementation of mandatory and legislative requirements in order to protect the confidentiality and security of personal information.

We will ensure that:

- EPUT is continually aligned with the National Policy as it is reviewed and updated (the new IG Toolkit)
• Information Governance is viewed as a safe enabler rather than a preventer to access to information, internally and externally.

4.7 Leadership

Good implementation and integration of technology relies on exceptional leadership from both within IM&T and the wider organisation. The role of the organisation in owning and leading the change cannot be under stated. It is very important that we have non IM&T staff heavily involved in the development and integration of systems.

4.7.1 Chief Clinical IM&T Officer (CCIO)

To comply with the Digital Maturity model it is recommended that EPUT should appoint or identify a Chief Clinical Information Officer (CCIO), monitoring emerging digital technology trends, engaging with clinicians and taking an active role in improving patient access to digital services whilst championing the use of technology to improve healthcare outcomes. This is a part time role that will be undertaken alongside clinical commitments.

The CCIO Leaders Network has been established to promote and develop current and future clinical information leaders across the NHS. The network is being developed in partnership with the Royal College of Physicians and the British Computer Society.

Updated September 2019: The Executive Medical Director has been assigned the role of CCIO.

4.7.2 Clinical Change Managers

The IM&T structure includes two full time Clinical Change managers who act as the main conduit between clinicians and IM&T ensuring that clinical needs are supported within any IT development and promoting the effective use of IM&T across clinicians.

4.7.3 Senior Responsible Owner

Successful health IM&T projects are owned and lead by operational and clinical staff who understand the context in which the technology is to be placed and operate. This approach has been proven in industry and other healthcare organisations.

Putting clinicians and operational leads into the driving seat (in the SRO role) for IM&T projects will allow EPUT to maximise the potential for achieving the benefits of information and technology that is reforming the world beyond the NHS. The SRO role provides the interface between the organisation and IM&T to ensure that solutions are well implemented and fit for purpose.

4.8 Innovation

Under SEPT the Digital Health Special Interest Group (DHSIG) met to discuss innovation. We are taking advantage of the new organisation to refresh the DHSIG as the EPUT LAB as a high profile stakeholder in the IM&T Strategy.

Over time it is possible that the EPUT Lab could replace the IM&T Strategy Group in terms of IM&T governance. The Lab will give clinicians the opportunity to present innovative ideas supporting improved care and efficiency delivering benefits against CIPs.

Updated September 2019: The EPUT Lab meets on a regular basis and is well represented by clinicians across all disciplines. The group has identified a number of initiatives which are now being piloted in EPUT prior to being reviewed by IM&T Strategy.

4.9 IM&T Culture
All IM&T Teams must understand and adopt a service based ethos. They must understand their part in the service chain and the impact their actions have on the reputation of IM&T, the availability of systems and the impact on patient care and the wider business.

4.10 Data Migration

Where services are migrating to a single system there will be particular challenges around migration including the management of legacy data. This needs to be factored into planning that is undertaken.

4.11 Communications and engagement programme

There is a key requirement for an ongoing communications and engagement programme to explain to all staff the IM&T strategy, the timescales and the implications on working practices.

4.12 Business Continuity and disaster recovery planning

An organisation that is more dependent on electronic systems to support corporate and clinical process becomes highly reliant on its IM&T infrastructure. There is a need to build in a high degree of resilience and fault tolerance into the IT infrastructure but also to have effective Business Continuity plans to continue working when systems are down for maintenance or fail.

4.13 Service Management and Implementation

The Trust will continue to evolve a mature approach to Service Management, aligning its approaches to best practice. This will be achieved by using the ITIL framework. There will be a formal sign off process that involves checking that all the critical success factors have been met. Confirmation of the projects delivery, testing and release must be agreed upon and signed off. Satisfaction surveys should be used to document what has been achieved. The sign off process to ensure a project successfully move into BAU needs to include:

- Post implementation review
- The identification of benefits achieved
- Provision for ongoing training
- Process for dealing with any outstanding project issues
- Provision of system management
- Knowledge transfer and local ownership
- Closure of the formal project arrangements.

5. Benefits Realisation

The main benefits associated with the EPUT IM&T Strategy are patient safety and quality of service. The Strategy will also support EPUT in the delivery of the Trust’s strategic objectives and contribute towards the Trust’s Cost Improvement Programme.

All projects will include a Benefits Realisation review determined by the project scope and objectives to include baseline metrics. Benefits to be measured will include:

- Reducing unnecessary face to face interaction so that appointments can be given to patients who really need them
- Fitting in with patients busy lives and delivering faster and more convenient services
- Improving patient choice and satisfaction levels and enhancing quality of care
Helping to deliver efficiency gains by reducing face to face interaction
- Reduction in DNAs
- Empowering patients to take control of their own healthcare needs and promoting self-care.
- Helping the environment by reducing carbon emissions through reducing unnecessary travel to appointments

This section illustrates the stakeholder benefits that we expect to achieve from the implementation of this strategy.

**Patients**
- Access to their own electronic information - giving them more understanding and control over their health care and data
- Ability to leave timely electronic feedback
- Ability to book healthcare services including one shop stop services meaning less visits to hospital as multiple appointments can be scheduled on the same day
- Providing more standardised care – improving patient safety
- More transparent processes – more reassurance

**GPs**
- More comprehensive and timely access to the Trust information about their Patient’s care.
- Options for receiving information electronically into their own systems and also using the Portal to view information in more detail.
- Able to more easily collaborate with specialists regarding the care of their patients so it can be shared and managed in different ways.

**Clinicians**
- Fast and easier to access information from any location – no more lost notes.
- Ability to see single contextual view of patient care – no need to log into lots of different systems
- Time savings in documentation of care
- Assurance of requesting and results – ability to see status and receipt of results
- Support for more comprehensive audit and research

**Nurses**
- Time released from processing paperwork to direct patient care
- Easier to access patient information from any location – no more lost notes
- Easier to request support services and see the status of those requests online
- Better able to plan and manage discharges through online collaboration with multiple agencies
- Less phone calls to the ward or required to check status of requested services

**Administration / Support**
- Less paperwork and more support for electronic workflow
- Automation of manual and paper based administration processes
- Less time spent on phone calls and chasing information, looking for case notes
- Reduce time spent liaising
- More able to spend time on effective patient communication and support

**Junior doctors**
- Faster and easier to access patient information from any location – no more lost notes
- Electronic alerts and checks to aid with decision making and completion of tasks
- Provision of alerts and online support/information resources to enable best practice
- Time savings – better management of time due to workflow and presentation of information
- Access to greater patient data set for audit

**Operational Management and Directors**
- Improvements to process and patient flow
- Greater efficiency and effectiveness
- Reduction in operating costs
- Standardisation of care
- Reducing risk
- Data security and assurance that information accessed on “need to know basis”
- Greater agility and flexibility in operational processes

There will always be problems with IM&T projects and this strategy is likely to have failures as well as successes. IM&T needs to learn from the well-developed processes we use in clinical service provision on dealing with significant issues. It is proposed to take the corporate process for root cause analysis and apply it to IM&T projects.
APPENDIX A: DEFINITIONS

IM&T can appear complex and like healthcare there is a prolific use of jargon and words that can be misinterpreted. Also some terms have different meanings in different organisations. This strategy has been written with a deliberate attempt to be non-technical. We hope it can be read and understood by all Trust staff and wider stakeholders. However sometimes technical terms and names have to be used. The following table explains these terms in a non-technical language:

<table>
<thead>
<tr>
<th>Terms</th>
<th>Our definition</th>
</tr>
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<tbody>
<tr>
<td>Electronic patient record (EPR)</td>
<td>The means by which we will manage and document patient care in an electronic format removing the need for a paper based case note.</td>
</tr>
<tr>
<td>Health Information Exchange (HIE)</td>
<td>The means by which we will share electronic information about patients with our health care partners such as GPs, community services, mental health, social services in order to improve patient care and provide a more seamless service.</td>
</tr>
<tr>
<td>Information Technology (IT)</td>
<td>The technical infrastructure we use at the Trust which includes networks, servers, desktop computers and printers.</td>
</tr>
<tr>
<td>Applications</td>
<td>Systems that store and process information required to support healthcare processes e.g. electronic prescribing supports the medication management within the hospital environment including the prescribing process and medication admission.</td>
</tr>
<tr>
<td>Information Management and Technology (IM&amp;T)</td>
<td>Information management and technology is the term used to describe the services covered in this strategy which include collection and application of Information Technology, Applications, Information Science, Business management and Project Management</td>
</tr>
<tr>
<td>IM&amp;T Strategy Group</td>
<td>Our executive level group with responsibility for the IM&amp;T agenda. Meets on a regular basis and includes a number of senior clinicians and nurses.</td>
</tr>
<tr>
<td>Prince 2</td>
<td>The project management set of standards used widely across the public sector and adopted by EPUT as the mechanism used to deliver all M&amp;T projects.</td>
</tr>
<tr>
<td>MSP (Managing Successful Programmes)</td>
<td>A programme is a group of related projects. MSP is the recognized standard across the IM&amp;T industry and EPUT will look to adhere to this standard.</td>
</tr>
<tr>
<td>Worksmart Principles</td>
<td>When registering for a laptop through Worksmart, it is assumed in line with the Policy, that a desk is not required and where one exists, it will be surrendered in order to work smarter. Estates are notified of any teams with Worksmart enabled staff in order for them to consider rationalising office space. In addition, any desktop computer that is predominantly used by a member of staff enabled for work smart will be considered for redeployment, options exist that can replace any desktop computer with a docking station for use as a touchdown.</td>
</tr>
</tbody>
</table>
APPENDIX B – NATIONAL GUIDANCE

This appendix outlines the different sources of national guidance that have been used within the IM&T Strategy:

a) The Five Year Forward View (October 2014)

The above publication states:

- An emphasis on prevention e.g. obesity, smoking, alcohol and the links between physical and mental health.
- New models of care based on multispecialty providers in hospital and community settings - the Multispecialty Community Provider.
- An equal response to mental and physical health, and towards the two being treated together. Parity of esteem between physical and mental health by 2020.
- 95 rather than 75 per cent of people referred for psychological therapies start treatment within six weeks and those experiencing a first episode of psychosis do so within a fortnight.
- Working more efficiently to close the funding gap
- Exploiting IT:
  - Focusing on key National Systems enabling different parts of the health service to work together
  - Other systems to be determined locally provided they meet nationally specified interoperability and data standards.
- Establishing a National Information Board (NIB) which will publish a set of ‘road maps’ identifying responsibilities for digital transformation including:
  - Healthcare apps
  - Comprehensive transparency of performance data – including the results of treatment
  - Fully interoperable electronic health records with patient access
  - Sharing of information across all care settings to support holistic care
  - By 2020, there would be “fully interoperable electronic health records so that patient’s records are paperless”.

b) The Forward View into Action : Paper-free at the Point of Care – Preparing to Develop Local Digital Roadmaps (April 2016)

The above publication states:

It is clear that ‘digital’ has a significant role to play in sustainability and transformation, including for example significant increases in primary care, securing seven day services, enabling new care models and transforming care in line with key clinical priorities.

In September 2015 a process began to allow local health and care systems to produce Local Digital Roadmaps (LDRs), which set out how they will achieve these commitments.

NHS England regional teams are working with these footprints to support the ongoing development of their LDRs – with a focus on Sustainability and Transformation Plan alignment, approach to information sharing, and universal capability delivery plans.

An LDR is expected to include the following elements:

- A five-year vision for digitally-enabled transformation
- A capability deployment schedule and trajectory, outlining how, through driving digital maturity, professionals will increasingly operate ‘paper-free at the point of care’ over the next three years
- A delivery plan for a set of universal capabilities, detailing how progress will be made in fully exploiting the existing National Digital assets
- An information sharing approach
Progress in delivering the commitments and aspirations in Local Digital Roadmaps will become embedded in commissioner and provider assurance, assessment and inspection regimes going forward.

In April 2016, CCGs will be required to submit their plans (local digital roadmaps) for how their local health and care economies will achieve the ambition of being paper-free at the point of care by 2020.

Every local health and care system will be expected to make early progress on 10 universal capabilities, demonstrating clear momentum between now and the end of March 2017 and substantive delivery by end-March 2018. * The universal capabilities are:

- Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions
- Clinicians in urgent and emergency care settings can access key GP-held information for those patients previously identified by GPs as most likely to present in urgent care and A&E
- Patients can access their GP record
- GPs can refer electronically to secondary care
- GPs receive timely electronic discharge summaries from secondary care
- Social care receive timely electronic assessment, discharge and withdrawal notices from acute care
- Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly
- Professionals across care settings made aware of end-of-life preference information
- GPs and community pharmacists can utilise electronic prescriptions
- Patients can book appointments and order repeat prescriptions from their GP practice

See Appendix C for a detailed analysis of the Universal Capabilities

NB EPUT is already making progress against these initiatives.

c) **Next Steps on The Five Year forward View - March 2017** reinforces the role of digital solutions in particular:

- Digital contribution to research
- The ability to collect, aggregate and analyse the data generated by the NHS is not only critical to delivering the triple aims of healthcare, but also underpins the NHS and wider life sciences research strategies. Interoperability will be key to successfully making use of NHS data to support the life sciences research strategy.
- The use of e-rostering and effective job planning to ensure right staffing at the right time
- Making it easier for patients to access urgent care on line.
- Simplifying and improving the online appointment booking process
- Making patients’ medical information available to the right clinicians wherever they are.
- Increasing the use of apps to help people manage their own health.
- The use of the e-referral service

d) **National contract – 17/18 and 18/19**

The National Contract includes a number of initiatives which are based around or impact the use of IM&T:

- Seven day services
- Electronic Referral System (ERS) – providers will only be paid for the resulting first outpatient attendance where the GP referral was made through ERS. Oct 2018 NB: This includes Mental Health.
- Self-care
Interoperable IT systems – from January 2019, key clinical data can be shared appropriately with healthcare professionals in other providers via interoperable IT systems.

Health and Social Care Network (HSCN) – the replacement of N3

Data security – successor framework to the Information Governance Toolkit.

Outpatient clinic letters – requirement for electronic transmission of clinic letters, as structured messages using standardised clinical headings, will take effect from 1 October 2018.

Discharge summaries – From 1 October 2018, transmission of both clinic letters and discharge summaries to general practices must be via direct electronic transmission, not via email.

Glossary


http://www.dh.gov.uk/health/2012/07/informatics-future/

The Forward View into Action: Paper-free at point of care


The Forward View into action: Paper-free at the Point of Care - Preparing to Develop Local Digital Roadmaps – April 2016


Next Steps on The Five Year forward View - March 2017

www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view


### APPENDIX C - UNIVERSAL CAPABILITIES

The following table outlines the Universal Capabilities as defined in the "Paper-Free at Point of Care" paper.

<table>
<thead>
<tr>
<th>Draft Guidance Universal Capabilities</th>
<th>Core Capability Group</th>
<th>Additional Information From guidance</th>
<th>Status</th>
</tr>
</thead>
</table>
| 1 Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions | Records Assessments and Plans | - Information accessed for every patient presenting in an A&E, ambulance or 111 setting where this information may inform clinical decisions (including for out-of-area patients)  
- Information accessed in community pharmacy and acute pharmacy where it could inform clinical decisions | In terms of the guidance, this applies only to Crisis and AMPH teams. Access can be achieved via smartcards from the summary care record (SCR.) this functionality is supported as part of the 1718 IM&T workplan. |
| 2 Clinicians in U&EC settings can access key GP-held information for patients previously identified by GPs as most likely to present (in U&EC) | Records Assessments and Plans | - Information available for all patients identified by GPs as most likely to present, subject to patient consent, encompassing reason for medication, significant medical history, anticipatory care information and immunisations  
- Information accessed for every applicable patient presenting in an A&E, ambulance or 111 setting (including for out-of-area patients) | In terms of the guidance, this applies only to Crisis and AMPH teams. Access can be achieved via smartcards from the summary care record (SCR.) this functionality is supported as part of the 1718 IM&T workplan. |
| 3 Patients can access their GP record | Records Assessments and Plans | - Access to detailed coded GP records actively offered to patients who would benefit the most and where it supports their active management of a long term or complex condition  
- Patients who request it are given access to their detailed coded GP record | GP software function – not applicable to the Trust. |
| 4 GP’s can refer electronically to secondary care | Transfers Of Care | - Every referral created and transferred electronically  
- Every patient presented with information to support their choice of provider  
- Every initial outpatient appointment booked for a date and time of the patient’s choosing (subject to availability)*  
- [By Sep 17 – 80% of elective referrals made electronically] | From SystmOne GPs to Community electronic referrals are already in place; this refers to using eReferral software which will form part of a Service Improvement project |
|   | GPs receive timely electronic discharge summaries from secondary care | Transfers Of Care | All discharge summaries sent electronically from all acute providers to the GP within 24 hours  
· All discharge summaries shared in the form of structured electronic documents  
· All discharge documentation aligned with Academy of Medical Royal Colleges headings | Applies to MH discharges. Will use Paris module and HIE with Mobius |
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</thead>
<tbody>
<tr>
<td>5</td>
<td>Social care receive timely electronic admission, discharge and withdrawal notices from Acute care</td>
<td>Transfers Of Care</td>
<td>All Care Act 2014 compliant Assessment, Discharge and associated Withdrawal Notices sent electronically from the acute provider to local authority social care within the timescales specified in the Act</td>
</tr>
</tbody>
</table>
| 6 | Clinicians in unscheduled care settings can access child protection information with Social Care professionals notified accordingly | Decision Support | · Child protection information checked for every child or pregnant mother presenting in an unscheduled care setting with a potential indicator of the child being at risk (including for out-of-area children)  
· Indication of child protection plan, looked after child or unborn child protection plan (where they exist) flagged to clinician, along with social care contact details  
· The social worker of a child on a child protection plan, looked after or on an unborn child protection plan receives a notification when that child presents at an unscheduled care setting and the clinician accesses the child protection alert in their record | Supported by Essex wide Child Protection initiative using SystmOne |
| 7 | Professionals across care settings made aware of end-of-life preference information | Decision Support | · All patients at end-of-life able to express (and change) their preferences to their GP and know that this will be available to those involved in their care  
· All professionals from local providers involved in end-of-life care of patients (who are under the direct care of a GP) access recorded preference information where end-of-life status is flagged, known or suspected | Approach to be established as part of the wider health economy – some limited SystmOne access available to a central register |
| 9 | GPs and community pharmacists can utilise electronic prescriptions | Medicines Management and Optimisation | · All permitted prescriptions electronic  
· All prescriptions electronic for patients with and without nominations - for the latter, the majority of tokens electronic  
· Repeat dispensing done electronically for all appropriate patients  
· [By end 16/17 – 80% of repeat prescriptions to be transmitted electronically] | For MH will form part of ePrescribing (Ascribe) as patient is discharged. For Community, SystmOne GPs can view information; EMIS GPs will view via HIE. |
|---|---|---|---|---|
| 10 | Patients can book appointments and order repeat prescriptions from their GP practice | Remote Care | · [By end 16/17 – 10% of patients registered for one or more online services (repeat prescriptions, appointment booking or access to record)]  
· All patients registered for online services use them above alternative channels | GPs only |
APPENDIX D – COSTS

The IM&T directorate has the following budgets allocated:

<table>
<thead>
<tr>
<th>£k</th>
<th>17/18</th>
<th>18/19</th>
<th>19/20</th>
<th>20/21</th>
<th>21/22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurring</td>
<td>12,820</td>
<td>13,410.25</td>
<td>13,358.00</td>
<td>13360.40</td>
<td>N/A</td>
</tr>
<tr>
<td>Non-recurrent</td>
<td>499</td>
<td>2,028.27</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>Capital</td>
<td>2,818</td>
<td>1,838 (at M12)</td>
<td>2,960 (at M5)</td>
<td>1,743</td>
<td>1,296</td>
</tr>
<tr>
<td></td>
<td>1,372 (at M12)</td>
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</table>

All access to capital funding will be subject to individual business cases submitted to IM&T Strategy to include Benefits associated.