REPORT TO:	Health Policy & Performance Board
DATE:	9 June 2015
REPORTING OFFICER:	Chief Officer, NHS Halton CCG
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Information Management & Technology (IM&T) Strategy 2015-18
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To provide the Board with the 2015-2018 IM&T strategy for Halton.

2.0 **RECOMMENDATION: That Members of the Board:**

i) Note the contents of the strategy
ii) Note the Year 1 priorities within the strategy

3.0 **SUPPORTING INFORMATION**

3.1 **Background**

The development of the document was carried out in collaboration with a number of key stakeholders including:

- St. Helens and Knowsley Teaching Hospitals NHS Trust (StHK)
- Warrington and Halton Hospitals NHS Foundation Trust (WHHDF)
- 5 Boroughs Partnership NHS Foundation Trust (5BP)
- Bridgewater Community Healthcare NHS Trust (BW)
- Halton Borough Council (HBC)
- St Helens and Knowsley Health Informatics Services (HIS)
- Voluntary sector
- Academic Health Science Networks (AHSN)
- Strategic Clinical Networks (where applicable) (SCN)
- Police Services
- Urgent Care 24 (UC24)
- North West Ambulance Service (NWAS)

The above stakeholders were invited to a number of engagement sessions and meetings to ensure that we could understand the

wider healthcare economy priorities and how these align with our local priorities in Halton so that we are not duplicating efforts and are making the best use of our local resources.

Following engagement with stakeholders the strategy aimed to identify what both our local priorities are in relation to IM&T and also the wider healthcare economy priorities which span a number of organisations and which are likely to span the life of the strategy.

The workstreams were identified by first specifying the need that was not currently being met and then identifying the possible solutions that could meet this need. Their potential impact on outcomes and also their ease of implementation was also mapped.

The strategy was presented to the CCG Service Development Committee in February 2015 and was approved via the Governing Body in March 2015. The workstreams are now being developed into a number of detailed project plans to be progressed over the coming months.

3.2 **Strategic context and Governance**

A number of workstreams within the IM&T strategy are also part of and have been influenced by a number a wider strategic CCG programmes currently being undertaken:

- Prime Ministers Challenge Fund
- Strategy for General Practice
- Emerging 'One Halton' programme

In addition a number of workstreams have been identified as a priority across a number of stakeholders. In order to ensure that these are progressed effectively, they have also been incorporated into the Health Informatics Service (HIS) operational workplan and will be monitored via the HIS Operational Group, who provide IM&T support for the CCG and a number of out neighbouring CCG's.

Locally, we have a Halton IM&T working group who will be responsible for monitoring the progress of the strategy implementation, including both the local priorities and also oversight of the wider health economy projects via feedback from the HIS Operational Group. The IM&T group will provide quarterly updates to the Information Governance Committee.

3.3 **Current position and next steps**

The identified workstreams within the IM&T strategy are now being planned in collaboration with the relevant stakeholders and detailed project plans being developed. These will form a monitoring dashboard that will be discussed monthly at the IM&T working group

and form the basis for the quarterly IG Committee report.

4.0 **POLICY IMPLICATIONS**

4.1 In line with NHS England, 2014, *Five Year Forward View*.

4.2 In line with NHS England, *Prime Minister's Challenge Fund: Improving Access to General Practice*, NHS England, 2014.

5.0 **FINANCIAL IMPLICATIONS**

5.1 Within existing CCG resources.

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Children & Young People in Halton**

None

6.2 **Employment, Learning & Skills in Halton**

None

6.3 **A Healthy Halton**

Embedding IM&T into existing practices and across organisations will ensure that clinicians have access to the appropriate and necessary clinical information when required which will both improve and support the clinical management of a patient, with the aim of improving health outcomes for our population.

6.4 **A Safer Halton**

None

6.5 **Halton's Urban Renewal**

None

7.0 **RISK ANALYSIS**

7.1 A number of the priorities identified within the strategy require cross-organisational working. As such there is a risk that competing organisational priorities may result in delays to implementation.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None

9.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF**

THE LOCAL GOVERNMENT ACT 1972

9.1 None under the meaning of the Act.

NHS Halton Clinical Commissioning Group IM&T Strategy Report

2015-2018

Contents

Executive Summary

NHS Halton Clinical Commissioning Group (HCCG) has a clearly stated intention to use transformational technologies (Priority Area 4 HCCG Five Year Strategy) to meet the needs of its patient population, users and staff; the CCG also sees Information Technology (IT) as a method for maximising the benefits from change.

This report highlights the system needs and proposed technologies that can be used to improve patient care, reduce barriers to communications and improve access to information. The needs and technologies referred to in this document have been identified and developed via extensive engagement, designed to understand the operational issues and barriers in relation to information management. This document outlines potential solutions to the issues identified as part of the engagement work, some of which are direct technological solutions are some of which are the supporting processes that need to be in place.

Two of the proposed solutions have been assessed and prioritised as having the greatest potential impact on service provision:

1. Interoperability between clinical systems
2. The Integrated Clinical Environment (ICE)

The deployment of these solutions is dependent on an associated relative ease of change. In this regard interoperability and ICE are assessed as being the high impact solutions that can be implemented and used by a wider group of staff over the life of the strategy.

The scope for deployment of all the solutions is wide and based on HCCG's expressed desire for transformational change and service development. The solutions outlined in this document can be applied to all care sectors:

- Primary
- Community
- Secondary
- Mental Health and
- Social Care

Adopting new, or expanding existing technologies to additional groups of staff and users will make a major contribution to all of the CCGs patient-centred Priority Areas, as well as realising the benefits of harnessing transformational technologies to bring about improving healthcare delivery.

Stakeholders are asked to note the contents of this strategy document and support the development and extension of the key priority areas over the next year, and to support the proposals for the use of IT to enable healthcare provision, across the CCG, over the subsequent 2 years, until 2018.

Stakeholders

Due to the wide ranging role that technology can play in health and social care delivery, this strategy has taken a health economy approach and as such will be shared with our wider stakeholder group, who have also been engaged in this process. This includes:

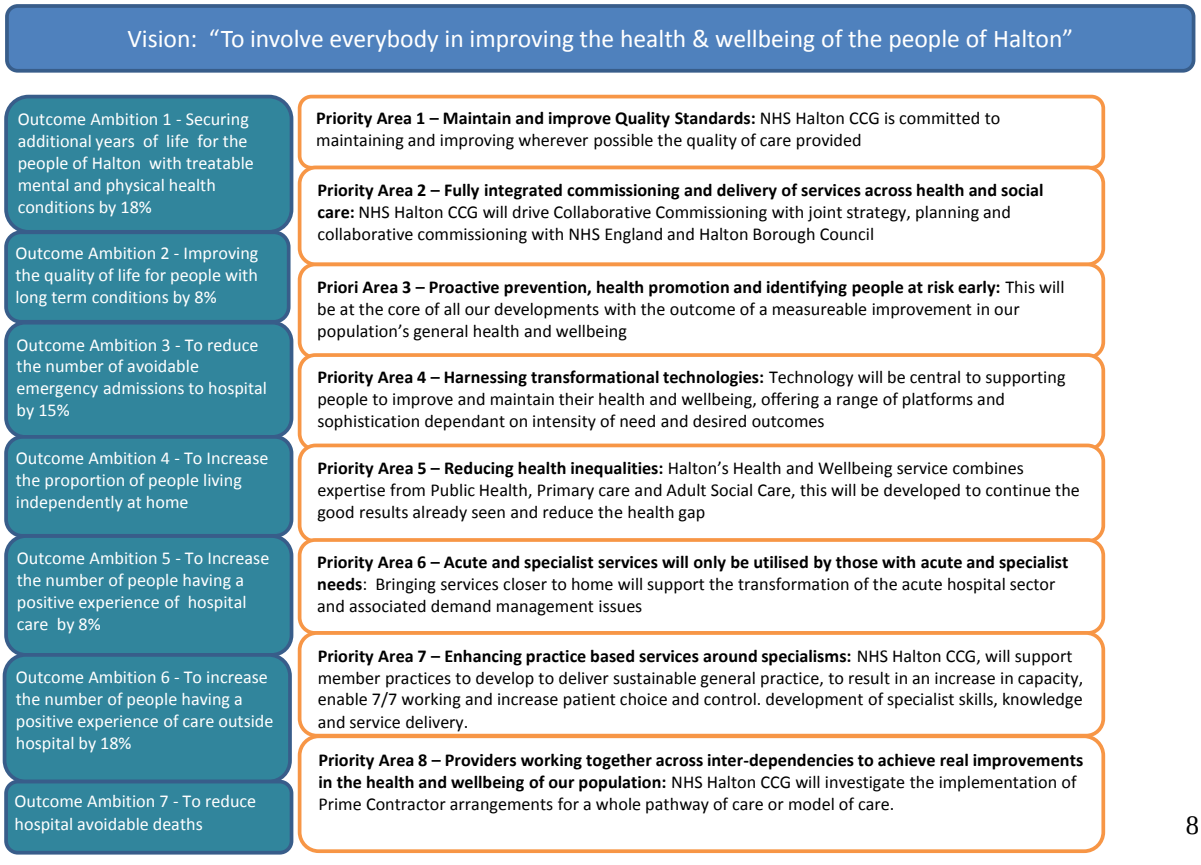
- St. Helens and Knowsley Teaching Hospitals NHS Trust (StHK)
- Warrington and Halton Hospitals NHS Foundation Trust (WHHDF)
- 5 Boroughs Partnership NHS Foundation Trust (5BP)
- Bridgewater Community Healthcare NHS Trust (BW)
- Halton Borough Council (HBC)
- St Helens and Knowsley Health Informatics Services (HIS)
- Voluntary sector
- Academic Health Science Networks (AHSN)
- Strategic Clinical Networks (where applicable) (SCN)
- Police Services
- Urgent Care 24 (UC24)
- North West Ambulance Service (NWAS)

There are a number of priorities identified in this strategy document that will be reflected in local organisational policies as such it will be necessary to establish cross organisational steering groups in order to manage the governance required for projects of this scale.

Background

NHS Halton CCG set out a five year plan and operational strategy in 2014. To achieve health improving outcome ambitions, the CCG has defined 8 Priority Areas for action; Priority Area 4 makes specific reference to making best use of technologies that will transform, improve and maintain health and well-being.

Having completed the 'Five Year Strategy and 2 Year Operational Plan 2014-2019' in October 2014, there was a need to develop the IM&T strategy bearing in mind NHS England's six characteristics of a high quality sustainable health and care system; this ensures a local and national context for the IM&T solutions that comprise the strategy.



NHS England's six characteristics of a high quality sustainable health and care system are:

1. Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care
2. Wider primary care, provided at scale
3. A modern model of integrated care
4. Access to the highest quality urgent and emergency care
5. A step-change in the productivity of elective care
6. Specialised services concentrated in centres of excellence (as relevant to the locality)

And as integrated care is a central feature of current health planning and direction, this early strategy work has been based on consultation with a multi-disciplinary team of staff drawn from across both health and social care.

Wider Considerations

Strategy for General Practice

Over the last 12 months, NHS Halton CCG has been developing a strategy for General Practice in partnership with local practices, clinicians, public, partners and providers. We have undertaken extensive engagement to develop the strategy and from this, a new model of care has emerged that brings all providers of health and social care, statutory and non-statutory, together to focus on improving out of hospital care and the wider preventative agenda.

This work emerged as we recognised that the demands on General Practice on out of hospital care, have never been greater, and our out of hospital workforce is changing, particularly as significant numbers of GP principals are nearing retirement age. There is also the need to extend and improve access to services and at the same time ensure a focus on prevention.

The driving concept of the new approach is to strengthen services in the community, wrapping them around local people; ensuring needs are met through an integrated health and social care delivery model. Essential to this is that the future model of General Practice fits in to the overall system.

The proposed model will see GP practices working better together in a more integrated way. As well as working better together, practices will also work even more closely with Community, Mental Health and Wellbeing, Social Care, Urgent Care, Children's Services, the Voluntary, Community and Social Enterprise (VCSE) sector and Pharmacy services all wrapped around Community Hubs. This concept resonates with NHS England's Five Year Forward View and the description of a Multispecialty Community Provider (MCP).

We must ensure that the use of information and information technology to improve patient care, access to care, the patient experience, delivery of clinical outcomes, health record keeping and value for money should be, and will be, a fundamental part of all future of General Practice.

Therefore, using and embracing technology to improve communication and interoperability of systems between practices and providers is essential, as is the development and use of Assistive Technologies to support the self-care agenda.

The overarching IM&T strategy needs to support this direction of travel and promote and encourage the use of technologies to realise the full potential of the new model of care.

Medicines Management

Information Management and technology is an integral part of medicines management and any IM&T element will need to interact with other clinical systems particularly those within Primary Care. NHS Halton CCG currently utilise the ScriptSwitch system which interoperates with GP clinical systems to assist with prescribing decisions and adherence to local guidance. We are contracted with this system until 31st March 2015. The intention is to extend this contract to allow a review of the requirements of this service and explore new technologies and solutions or additional functionality within the current system to match our specification.

NHS Halton CCG also currently utilise Webstar. Webstar is designed to help commissioners manage the administration of our minor ailments service within community pharmacy enabling focus on services rather than administration. This contract expires on 31st March 2016. It will be necessary over the next 12 months, to review our service requirements to ensure that we are adopting the most appropriate solution. There may also be opportunities for collaborative working with our Local Authority team to gain some economies of scale.

External Funding

In order to support the workstreams identified within the strategy, NHS Halton CCG have identified a number of potential funding streams that align with the strategic direction which include the Prime Ministers Challenge Fund and NHS England capital schemes. These potential funding opportunities will be confirmed in Q1 2015/16 and if successful, will be used to support a number of the programmes below, in particular:

- Interoperability
- Mobile working
- Patient centred media
- Predictive and Preventative Care Technologies

Process and approach to the solution proposals

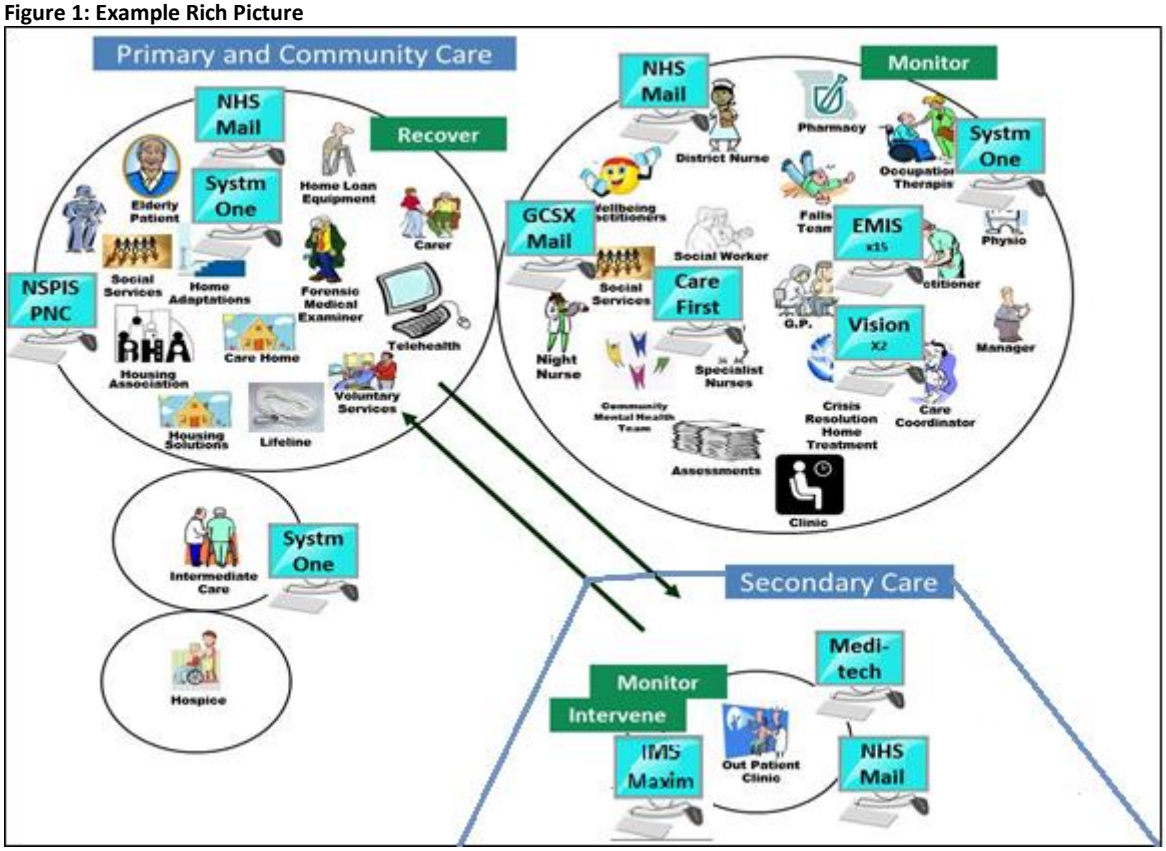
To engage with stakeholders as part of the IM&T strategy development, two workshops were held, one in October 2014 and a follow-up event in November 2014. The workshops were attended by staff from all sectors of the health and care community.

The workshop groups were tasked with defining problems and opportunities for improvement through six care streams; Present, Diagnose, Prepare, Intervene, Recover, and Monitor. Attendees were divided into three over-arching pathways to build a ‘Rich Picture’ for each of the following settings:

- Planned Care
- Unplanned Care and
- Mental Health

The groups constructed a picture and considered current working problems and solutions in terms of People, Process and Technology. This report focuses of the technology elements of their thinking.

Figure 1: Example Rich Picture



Key Problem Domains

During the IM&T strategy workshops, nineteen key problem domains were described. Upon review, it was established that the problems span five of the six key care phases; presentation, diagnosis, preparation, recovery, and monitoring. No problems were identified which related exclusively to the intervention phase although it is likely that improvements in other areas would have positive influence on this area. The problem domains were groups into phases and settings of care for further analysis:

Figure 2: Key Problem Domains

Presentation and Diagnosis (Primary and Community care):
1. Information sharing 2. Access to services 3. Access to information 4. People 5. Patient 6. Duplication 7. Technology
Recovery and Monitoring (Primary and Community)
8. Patient flow 9. Access to information 10. Technology 11. Resources 12. Information sharing: Discharge

13. Access to information: Discharge
Diagnosis and Preparation (secondary, planned care):
14. Information sharing: Handoff to acute 15. Access to information
Recovery and Monitoring (Secondary, planned care):
16. Access to Information: Discharge
Presentation, Diagnosis and Preparation (Secondary, unplanned and planned entry routes)
17. Handoff to acute (services) 18. Access to information: Handoff to acute 19. People

Below is some further verbatim feedback the workshop sessions; they too can be categorised as problems relating to communications and access to information, and access to services.

Figure 3: Narrative from workshop sessions

Service User identified problems:
"I know the police will respond straight away so in future they are my first port of call." "I have to tell my story over and over as I am handed off through the service."
Referrer concerns:
"The Mental Health pathway is so complex and dense (and is only one of many) it is not possible to fully understand choice." "Social and domestic referral services are not as well identified as clinical referral services." "Access to GPs can be problematic and cause crises requiring police intervention." "GPs find it difficult to refer because of the time it takes to write/phone for referral." "Social perception of available care does not match reality." "Mental health issues present in subtle ways (repeat calls to police) and so can be difficult to identify." "As a referrer I have no assurance that what I am asking to happen will happen consistently." "There are too many access points causing multiple referrals for a single person." "The lines of communication between professionals are too formal and process-bound to nurture or develop good relations and share information." "There are no informal networks through which decision support can be gained, what would you recommend?" "Crises occur due to referrals to secondary care which are not appropriate and cause lengthy waiting lists."
From Service Providers:
"Referrals can keep bouncing back and forth if they are sent to the wrong place." "There is no single view available for all stakeholders." "Patient journey relies on the good will of the staff that make the pathway work."
Problems relating to referral methods:
"Sending info from a secure system to a secure system is difficult because not all staff have secure email across organisations."

"No one single view to all stakeholders means small pieces of the jigsaw can't be put together." "Response targets are fixed and for some it is too long causing unnecessary crises and police intervention."
Regarding assessments:
"Secure mail systems are more difficult to access (because they are secure) and so people tend not to use them."
General observations:
"So many people and organisations [are] involved who don't have all the information causes communications just to other providers for info." "Inconsistent relationships between staff [using the care] pathway has an impact on quality of service, better relationships [will provide a] better service."

These observations and comments by staff can be broadly summarised as problems relating to:

- Inter-disciplinary communications, including access to information
- Access to services by patients and healthcare professionals

Interdisciplinary communications and access to information were identified as being acute in all but the Intervene phase of care. Notably communications are most challenging at the points of patient care transition; between services and providers and at the point of discharge.

In relation to access to services, particularly for patients, there is also a need to ensure that we are effective utilising the way technology can improve our communications with patients to give them increased ownership of their healthcare. There are a number of programmes already in progress which aim to address this need, for example patient online access which aims to promote and support the programme of self-care and it is necessary to build on this platform as part of this IM&T strategy, the intentions for which are detailed below.

It is also clear from the key problem domains that there is huge potential to improve IM&T function within primary and community care. Primary care rely on a number of systems and processes to support their daily functions making it essential that they are efficient and practical with its use and the necessary support is available where needed. This will also ensure that they are utilising best practice and sharing learning across the health economy.

Proposed solutions

The workshops culminated in proposed solutions to each of the problem areas identified above and in some cases one solution was able to address a number of issues. The solutions were considered in terms of:

- **Need/outcome:** What need is this solution addressing and what is the expected outcome?
- **People:** What is required of staff and/or patients
- **Process:** The process or processes that need to be followed
- **Technology:** The supporting and assisting information technology that will enable staff to meet their obligations and execute the process

The range of 19 IT-related solutions proposed is outlined below:

Figure 4: Proposed workplan

Need	Solution	Outcome(s)
To be able to share relevant health and social care information across settings, initially prioritising the sharing of end of life data sharing in line with national requirements.	Interoperability technical solution (e.g. Clinical Portal) to be informed by business case. Hospice transition onto electronic patient system	• Improved patient pathway via more effective handovers • Reduced duplication • Increased opportunity for shared care
Inability for staff teams to efficiently order appropriate tests	Increased access to Integrated Clinical Environment (ICE)	• More efficient service for patients • Increased efficiency for staff, in particular community nursing teams
Variation in utilisation of supporting technology	Increased training and support to be provided as part of IM&T support contract	• Improved productivity and efficiency • Potential to increase direct patient contact time.
Opportunity for earlier discharges, improved access to services and to support mobile working	Telehealth Telemedicine Assistive technology Embed technology into the discharge checklist	• More accessible services for patients • Potential for reduced length of stay in hospital care • Improved efficiency for staff • Improved patient quality of life
Standardised route of referral and standardised supporting documentation to streamline referral	e-Referrals Standardised referral form for all services Electronic assessments	• Improved pathways into secondary care • Reduced patient delay

process	Culture of forward referrals	
Ability for staff to be mobile when visiting various care settings, including Care Homes	Smart card and supporting hardware facilities to allow access to patient systems Reliable Wi-Fi, and devices Bring your own device (BYOD)	• Increased efficiency whilst undertaking mobile working • Improved access to necessary clinical information • Future opportunities for shared care/GP coverage
Improved electronic communications to patients	Multimedia including: email, Text, Skype, VizBuzz, Facebook (Patient-centred Media), patient online access	• Better informed population and use of healthcare resources
Robust and secure information sharing across settings	Shared technology/controlled infrastructure Develop shared care agreements	• Improved patient care via sharing of key health and social care information
Appropriate IM&T support and guidance	Review IM&T support and supporting functions including Information Governance.	• Robust workplan in place • Appropriate levels of support and guidance available
Increased IM&T functionality within primary care	Docman workflow, Utilisation of the Hub, Spine, NHS.net	• More efficient primary care services
Provide access (view only) to cross-sector systems. Role based for easy access	Smart card and supporting hardware facilities to allow access to patient system	• Improved pathways or care across organisational settings • Improved access to necessary data
Access to up to date prescribing guidance and advice within primary care Streamlined prescribing processes	Review of current specification requirements of and options appraisal of available technologies	• Clinically appropriate prescribing decisions • Cost effective prescribing • Efficient prescribing process from the patient perspective • Reduced administration

This list of solutions demonstrates that staff see a great deal of value and benefit from using IM&T, in some cases without having to invest in new technology. Proposals such as improving the Docman workflow, making better use of Spine service and the NHS.net and Bring Your Own Device are good examples of pragmatism.

Appendix 1 of this report documents the corresponding care stream, problem and proposed solution.

Two solutions were repeatedly identified as contributing towards a number of problems and thus appear to have the potential to make the greatest impact on the current situation; the solutions are:

- Interoperability between clinical systems
- Integrated Clinical Environment

Defining the greatest impact solutions

Interoperability between clinical systems

Identifying an interoperability solution to be delivered locally, connecting any healthcare system within a healthcare economy is a key priority. This will give users secure access to the whole-life health records. By mobilising this data via an interoperability solution, healthcare providers are able to deliver safer, more efficient care, based on a fuller understanding of a patient's medical records. There are currently a number of providers within the local health economy that have deployed an interoperability solution, the learning from which should be incorporated in the planning of this project. In additional there is a national focus on data sharing in relation to End of Life records and the requirement for increased coverage across England of an Electronic Palliative Care Coordination System (EPACC's) so it is intended that palliative care would be the initial focus of the interoperability agenda, taking into account the local hospice transition onto an electronic patient administration system.

Providing access to primary care records from Mental Health services (such as the Child & Adolescent Mental Health Service and Substance Misuse Teams) and acute services (such as Outpatients and Pharmacy) and at primary and community health units (such as the Urgent Care Centres and community nursing service) will allow clinical staff the opportunity to better assess patient care needs and contribute to improved outcomes, based on the diagnosis, care and medication records.

A key element of the interoperability agenda is to ensure a mechanism by which data can be linked and as such it will be a requirement for all Providers to ensure the use of NHS number as the prime identifier. It is also acknowledged that the planning for this programme will need to incorporate a number of stakeholders and it will be more realistic for this to be part of the wider health economy IM&T strategy for which NHS Halton CCG are engaged with via the current IM&T support contract and neighbouring CCG's.

Clinical portals would also be a consideration within this workstream as they are virtual electronic patient records, with information being presented within the portal as an assimilation of available information from other clinical information systems. Users have an authenticated single sign on and are able to view information and access other IT systems, based on their role and permissions.

The contents of clinical portals varies but a portal developed for NHS Halton CCG, in cooperation with primary, secondary, tertiary, community and mental health services could provide a point of access to many other software applications, as well as providing users with up-to-date information about a patient (information such as blood results, pending appointments, discharge summary information, single assessment scores).

The options for this will be explored via an options appraisal working collaboratively with neighbouring CCG's as appropriate.

Integrated Clinical Environment (ICE)

ICE, provided by Sunquest, is a portfolio of products that enables pathology and radiology requesting and reporting. ICE is used within primary and secondary care services and is central to GPs making pathology and radiology requests online, and being able to see the results.

Benefit from providing ICE to a broader range of staff, particularly in primary and community services, is that information sharing will be easier; all users, with appropriate access rights, will be able to view the latest patient pathology and radiology orders and results, acting on them to provide the most appropriate level of care.

Prioritising solutions for deployment and considerations

Although the 2 solutions above appear to present the greatest impact and opportunity to resolve operational problems, their priority for implementation is affected by the relative ease by which they can be implemented.

There is also a need to consider the supporting arrangements and infrastructure which sit under not just the 2 key priorities but also the other solutions identified above. This will be key in ensuring that robust Governance arrangements and an over-arching Information Sharing Agreement are in place. In order to provide assurance for providers these will be developed jointly seeking support from our Local Medical Committee's (LMC). This need has been incorporated into the Year 1 planning outline below.

In addition an IM&T Strategy Group will need to be established or incorporated into existing structures to develop plans in relation to each of the solutions identified within this report, with particular focus on the Year 1 deployment recommendations, and define work streams to deliver the solutions. It will also be necessary to consider and plan for the corporate governance necessary to meet the strategy, building on governance work already in place at the CCG

Priority Matrices

The Priority Matrices below illustrate the solutions impact against the ease of implementation.

Figure 5: Prioritising high impact solutions

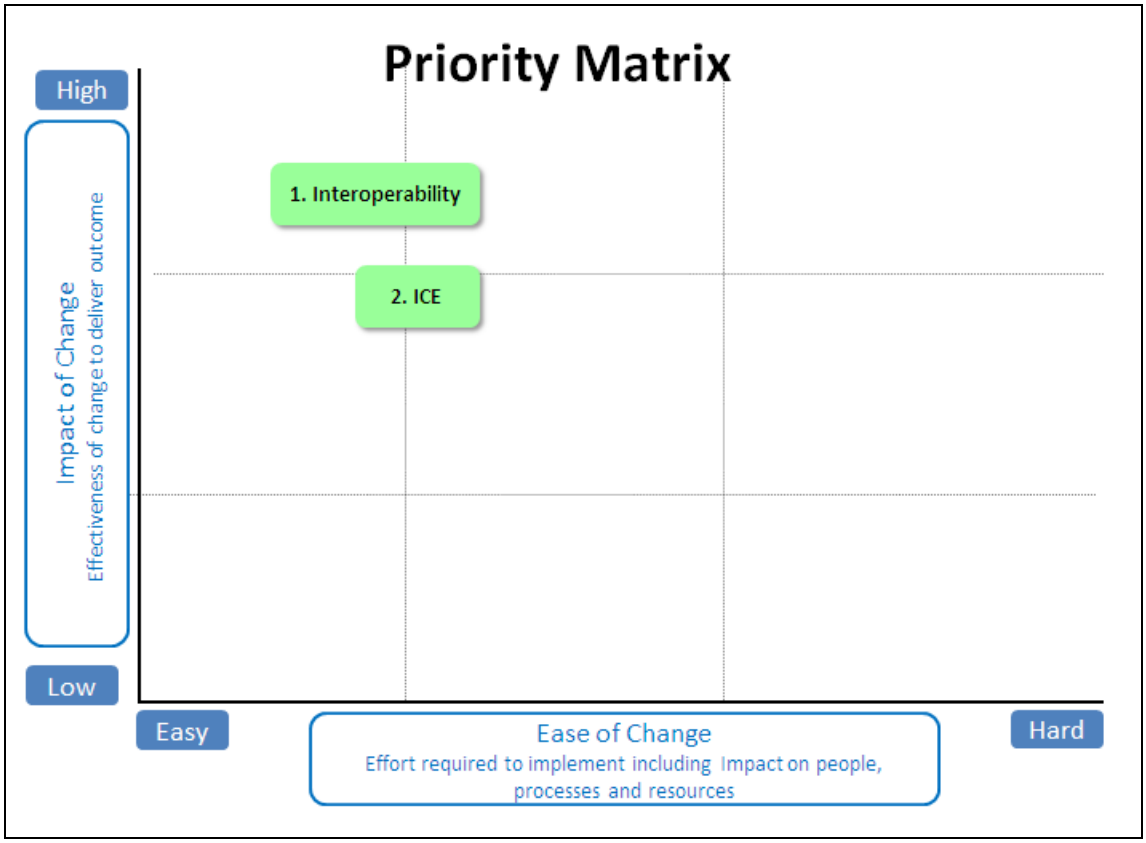
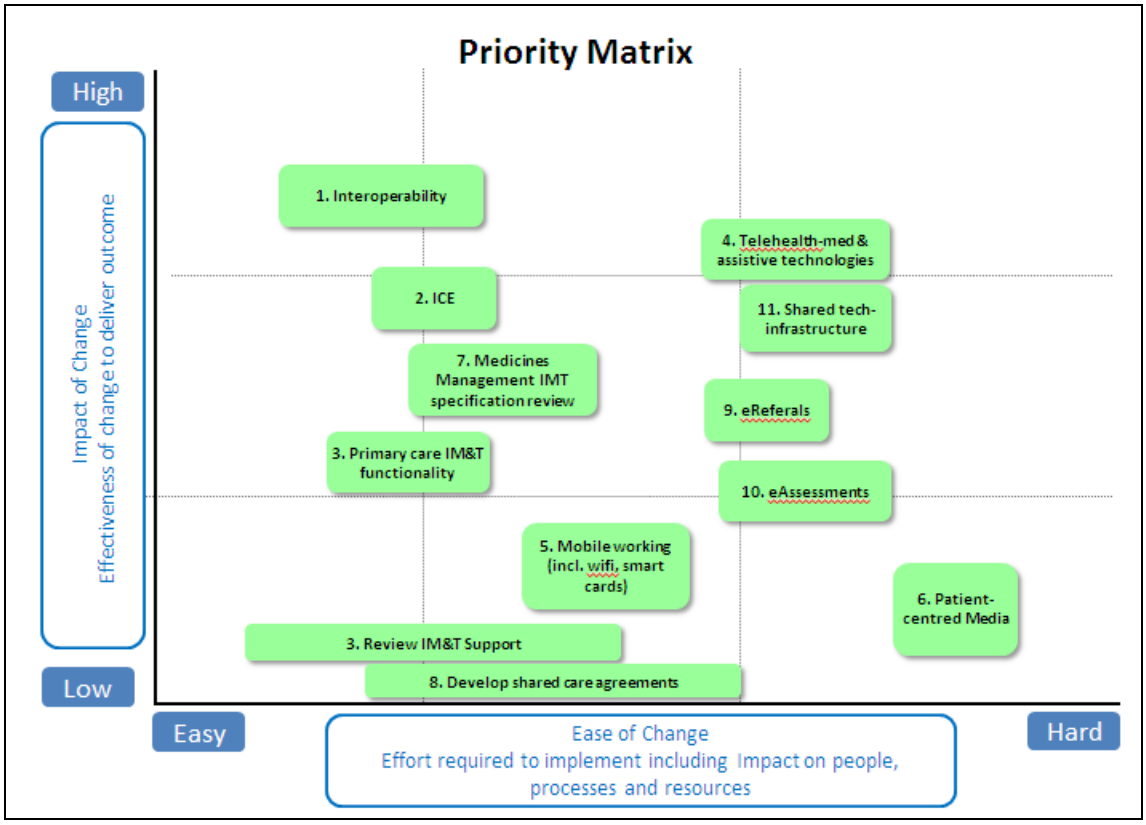


Figure 6: Prioritising all solutions (numbers correspond to 3 year planning below)



A number of dependencies became apparent when reviewing the solutions; for instance allowing the use of staffs own devices (BYOD) can only be enabled once a reliable Wi-Fi network has been established. Similarly eReferrals and eAssessments may only be fully achievable once a technology platform, such as SharePoint has been set-up. As such the below pages provide a proposed 3 year plan in line with the interdependencies and what is achievable.

Year 1 Planning

In relation to the 2 key priority areas, ICE is an existing solution and there are technical solutions available to support interoperability; with agreement to the benefit and use of each solution, these provide the earliest opportunities to use the technology to improve patient care. They will also contribute to the national priority of managing access to A&E services and avoiding unnecessary admissions in line with the Five Year Forward View.

The use of both solutions by a wider group of staff could be affected by the end of 2015 pending the appropriate information sharing agreements developed and agreed by all relevant parties as outlined above.

It is envisaged that a clinical portal may take longer to develop; specifications will need to be defined and a commercial partner found to build, configure and test the product. A proposed implementation date is March 2017.

Whilst the interoperability and ICE technological solutions are being brought into wider use it is proposed that a number of other solutions can be initiated in Year 1 based on the solutions identified in Table 3 (page 10), some of which will span the life of the strategy due to the complex nature of the projects. These have been highlighted below.

1. **Interoperability** (project brief above) – this will be developed in a phased approach and will span the life of the strategy.

2. **Integrated Clinical Environment (ICE)** (project brief above)

3. Review of current levels of **IM&T support** and need for further training to encourage more efficient use of technology, utilising current IM&T performance reports to inform primary care IT support SLA to increase levels of **functionality within primary care**. This should include (but is not limited to):
    - Docman workflow,
    - Halton Hub,
    - Spine,
    - NHS net,
    - Electronic patient prescribing (EPS)

4. Undertake review of current schemes and programmes being undertaken in relation to **telehealth and assistive technologies**, building on work undertaken by HBC and select

appropriate solutions for further rollout or exploration in addition to horizon scanning of what else is available across the region and through the Innovation Network.

5. Improved **mobile working** via:
    - Implementation of secure router into care homes to provide Smart card access to EMIS for mobile GP working
    - Extend reliable Wi-Fi and devices so that mobile working allows staff to make connections to clinical and social care systems when office bound and out in the community
    - Further develop SharePoint opportunities
    - Investigate BYOD as a real option

    This programme will span the life of the strategy via a phased rollout plan; however a number of elements will be scoped and progressed within Year 1, namely extending Wi-Fi and secure routers in care homes.

6. **Patient centred media -** Improved electronic communications to patients utilising existing multimedia including messaging services, Skype, VisBuzz, Facebook (Patient-centred Media), patient online access

7. **Medicines Management IMT specifications review –** During 15/16 a review will be carried out in relation to supporting Primary care prescribing and the associated administration. This will inform the commissioning decisions for 16/17.

8. Lastly, as part of the Year 1 solutions, the CCG will develop robust **shared care agreements**. These agreements will be useful in not only managing patient care and contributing to the commissioning and provision of integrated care but also defining or refining the IM&T strategy, within and beyond this three year view

Year 2 Planning

In year two (16/17) we propose that these solutions are focused on; they have a medium impact on the health economy and appear harder to implement; by moving them into year 2 of the strategy additional time is provided to lower barriers and increase the chances of operational and deployment success:

9. Develop **eReferrals** to support multidisciplinary working and integrated care provision and as part of this programme work towards developing a standardised referral form for all services

Year 3 Planning

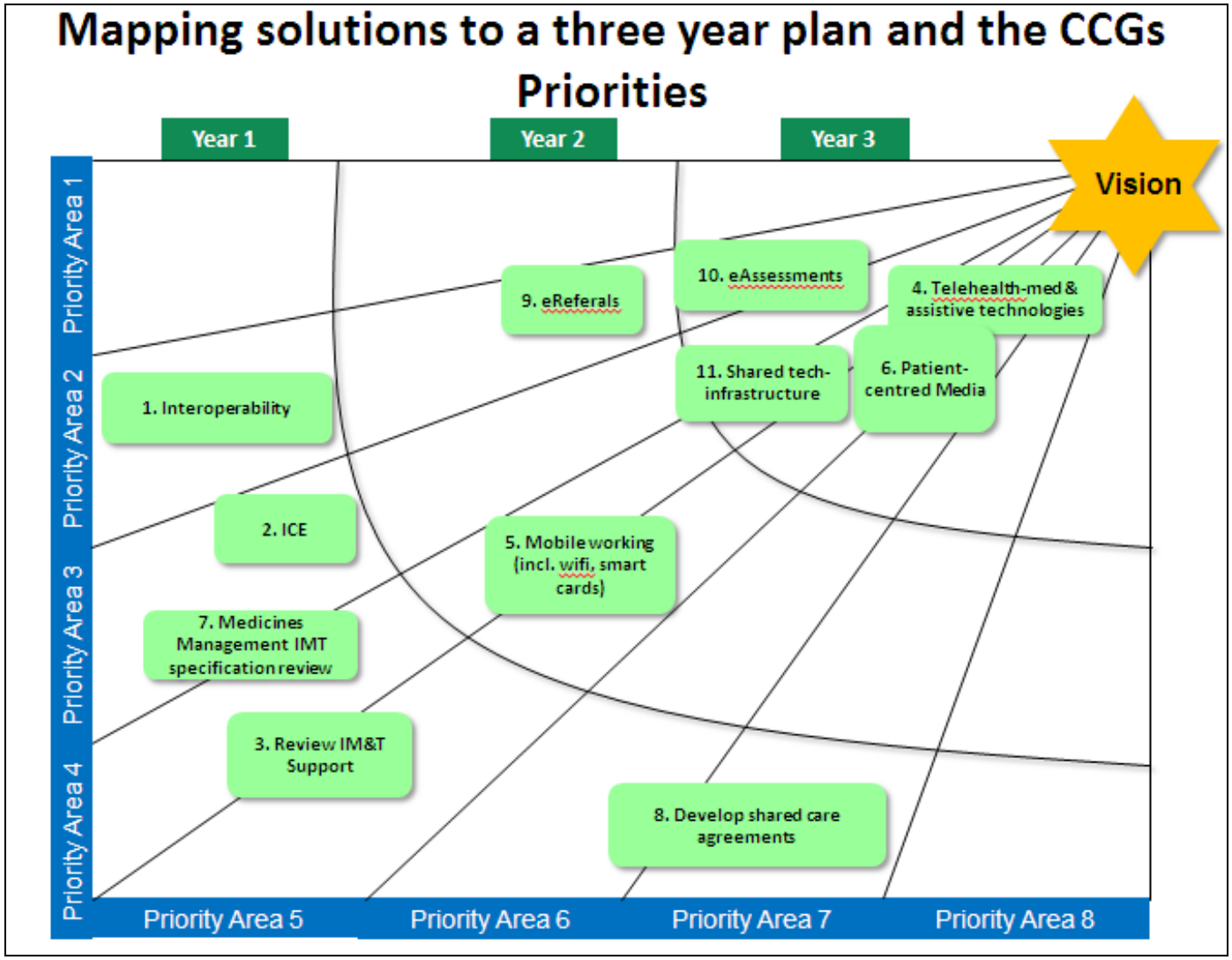
In the third year of the IM&T strategy (17/18), or sooner if practicable, we propose the harder to implement or dependent elements of the strategy be brought into use:

10. Implement **eAssessments**, building on the benefit of eReferrals

11. Providing information via a secure **shared technical infrastructure** will be important as services integrate care and need to share information on secure and common technology platforms. An infrastructure that connects primary, secondary, community, mental health and social care services will allow the information to be shared more freely whilst protecting it from misuse

Deploying the Year 1 solutions, increasing the use of existing technologies and developing shared care agreements will help the CCG to achieve the Priority Areas and Outcomes set out in the 'Five Year Strategy and 2 Year Operational Plan 2014-2019', October 2014. Driving the interoperability agenda will enable the CCG to share, and users to open, patient and service user information. In turn this will assist improved patient and service user management and the provision of improved quality standards, the delivery integrated services, the promotion of health and enable staff to identify people at risk of ill-health. In short, the technology will link to the CCGs Priority Areas.

Figure 7: Mapping the proposed solutions to the CCGs Priority Areas and a 3 year plan



Appendix 1 – Suggested work streams to bring the Year 1 solutions into use

Interoperability and increased functionality of ICE are intended to provide users with up-to-date patient information. As such, and in the first instance, it is likely that the same groups of clinical staff will want access to both applications. With this in mind it is proposed that the programmes are viewed as "opposite sides of the same coin", allowing the same team of staff to bring both into use, by a wider group of users, at the same time.

The advantages of this approach include:

1. Joined-up thinking about the benefits the applications will bring users and the patient care they manage
2. No duplication of effort; a possible consequence of two change and implementation teams working separately
3. Reduced training time for users – both applications can be introduced at the same time
4. Maximising the benefit to users – assuming that both applications go live with the new users on the same day, clinicians will be able access primary care notes and records, see pathology and radiology results and, if appropriate, request pathology and radiology tests and examinations
5. Maximising the preparation, consultation time and output-outcome collations from the work streams; simply, the same work streams can be used simultaneously to define, plan and complete the tasks necessary to achieve the applications go lives

With this latter point in mind the following work streams are proposed:

1. Project Management
2. Transformation and benefits realisation
3. Governance and information management
4. Technical infrastructure and set-up for deployment
5. Training
6. Finance management

An example plan for these work streams is shown on the next page.

Example work stream plan to deliver the MIG and ICE to a wider group of users in 2015-16

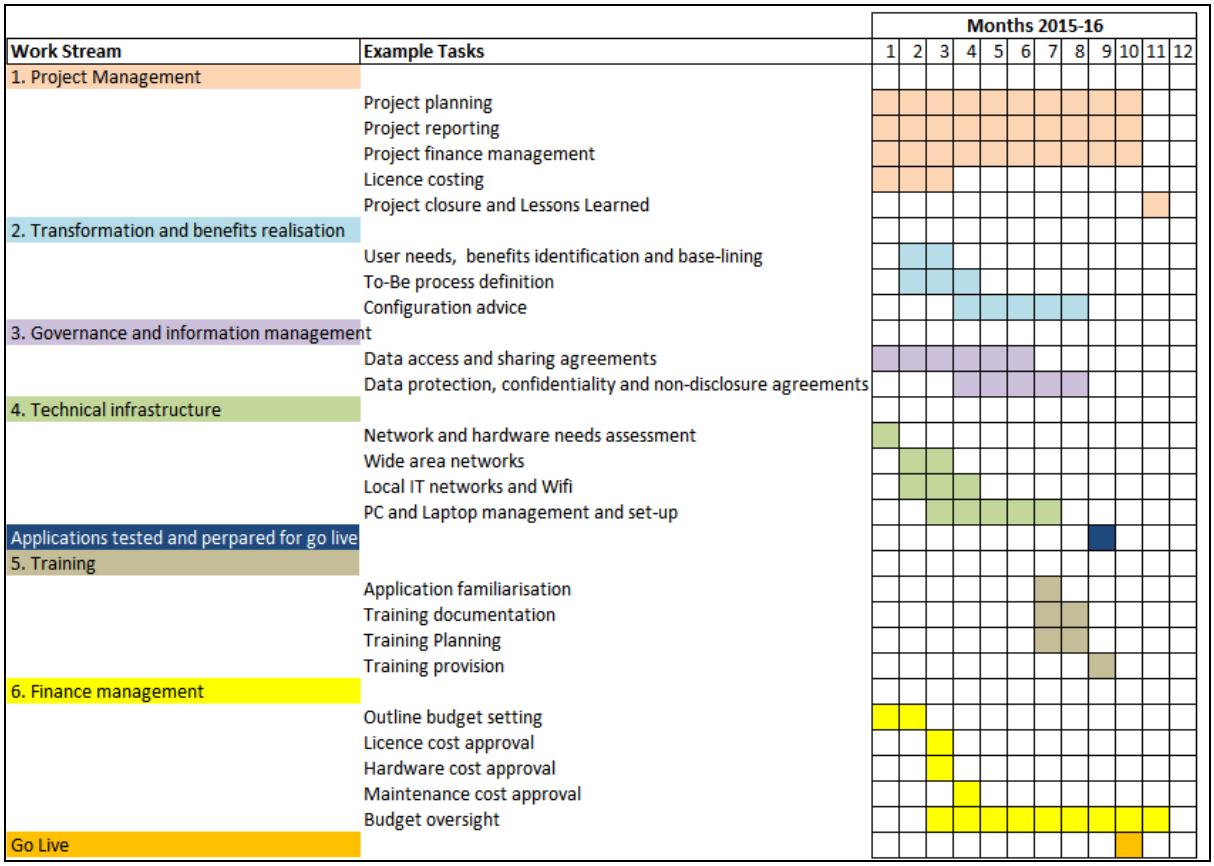


Figure 2: Example work stream plan