Leicestershire Partnership NHS
NHS Trust

LEICESTERSHIRE PARTNERSHIP NHS TRUST

Digital Plan 2020 - 2024

Published: October 2020

DOCUMENT CONTROL SHEET

LEICESTERSHIRE PARTNERSHIP NHS TRUST

Digital Plan

Document control sheet

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CHANGE HISTORY

Version	Date	Author	Issued To	Reviewer Comments
0.1	22.11.2019	Ian Wakeford		Initial Document Created
0.2	07.02.2020	Ian Wakeford		First Draft Completed
0.3	10.06.2020	Ian Wakeford		COVID-19 response
0.4	20.07.2020	Ian Wakeford		Finances Updated post N365 decision
0.5	15.09.2020	Ian Wakeford		Finances Updated to include e-roster system and statement on annual revision of finances to reflect Capital CRL.
0.6	23.09.2020	Ian Wakeford		More explicit Update of care in the home using Telemedicine for CHS
0.7	16.10.2020	Ian Wakeford		Preparation of Document for Public Board

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1. EXECUTIVE SUMMARY

This plan is written as a response to the next exciting stage in the development of the NHS, to deliver more digital enabling technologies to support the first half of the NHS Long Term Plan. LPT in 2020 is in an excellent place in terms of its digital maturity. It is not without weaknesses, but this is mostly about affordability and not ambition.

The greatest external driver will be the increased national interest in centrally driven innovation through NHSX. Plus the higher profile role of the single CCG from 2021 and LLR working as an Integrated Care System.

The plan identifies asks and associated actions of the local healthcare system, understands the transformations that are planned and how the digital plan can respond with enabling technology. Within the Trust the plan makes challenges to modernise, increase sustainability and makes calls to accelerate a channel shift to a digital service for user access to records and perform administrative and clinical transactions because our population now demands it.

Section 4 details the 59 strategic objectives that LPT would like to support. These are either new since 2018, or we are reconfirming that these objectives need to continue.

The plan calls for £11.7 Capital and £2.8m Revenue over the next 4 years from April 2020 until March 2024, which is a reducing capital figure after 21/22 due to the Single EPR project completing but an increasing shift to revenue.

Note to reader – all statements made in **BOLD** are strategic objectives this plan is looking to deliver upon.

2. INTRODUCTION & CONTEXT

a. Why the need to have a Digital Plan?

It is important for LPT to have a long-term planning document that sets out at a high level how IM&T will support and enable the Trust and its partners to deliver upon its business objectives. The plan does not always describe how things will be done but puts down clear markers of what needs to be done and why it is important. This is for the prioritisation of resources within the Trust and to identify the linkages with other strategic drivers and plans.

b. The development of this Plan

As with the prior strategy this Digital plan has been developed by a combination of listening exercises within the organisation, understanding the direction of travel in the local health economy and also incorporating mandated national requirements. As an internal engagement exercise and within the local health economy the plan is very much written from understanding what the business needs to happen and only think about the technological potential once that this been established. The 2018 Strategy concentrated significantly on the decision to reduce to a single EPR within the Trust and supporting clinicians to have greater access to trusted information in an agile working context. It also looked to have greater clinical engagement with IM&T and strengthen clinical safety of IM&T systems. This plan has a slight change of emphasis as by mid-2020 LPT will be on a single Clinical System platform. It will be in a strong position digitally, now needing to concentrate efforts on making LPT part of a greater system consuming on onward sharing patient information along care pathways.

c. IM&T Strategic Principles

The plan will ensure that the following principles run through this document: -

- To ensure that service users are central to this plan both in terms of their safety, but also access to their information, how we communicate with them and how they transact with them.
- To support care professionals and support functions by being able to access the right information to do their job, but any time, any place, anywhere.
- To support the commercial business of the Trust by enabling them to retain existing business, extend their offering into new clients and also to develop and successfully run new services.
- To move to having an appropriate shared view of a patient record along a pathway of care regardless of organisational boundaries.

- To ensure that IM&T does not act as an inhibiter to cross sector working in the local health economy.
- To ensure that good governance exists for the information we hold and also for the investments we make.
- To support innovation internally and best practice elsewhere
- To fully exploit existing systems and investments made under the previous plan.

d. Previous IM&T Strategy

It is important to understand the foundation that this new plan is building upon. The 2018-20 IM&T Strategy was a mix of system consolidation, improving organisational weakness and supporting National and LLR System priorities. Key deliverables were:-

- To have a single EPR system – TPP SystmOne contracted to deliver.
- To consider if Medicines Management system should be replaced or integrated into the EPR.
- To migrate from Tiara Therapy System into Single EPR.
- Evaluate next generation Digital Dictation and workflow for dictating services.
- Staff recruitment challenges re SmartCard – especially with Agency and Bank.
- Data Entry at the point of care, NerveCentre rollout into AMH
- Linking Estates, IT and Service provision to share planning and seize opportunities.
- Business Intelligence Tools platform review.
- Information Support function to engage with deep dive audits to improve data quality.
- Ensuring that the IT Infrastructure was modern and up to date, mitigating cyber security threats.
- GDPR implementation
- Paper records management digitisation
- STP IM&T leadership
- Digital Offer – Wellbeing Portal and Correspondence App.
- Clinical Safety Officer Network

3. BUSINESS DRIVERS FOR CHANGE

a. National Context

Prior to 2019 National IM&T Strategic direction was regularly refreshed but there was not a long-term strategic plan for the NHS to contextualise the digital projects. In January 2019, the NHS published the NHS Long Term Plan (LTP) and within that document over 135 “asks” were made to the Digital agenda. At a National level these priorities and the associated transformation required, where digital is an enabler, are now finding their way into National requirements being demanded of the IM&T community.

The commitments made in the LTP was that there would be:

- Comprehensive digitisation of the Health and care system
- Locally based shared records supporting high quality care
- Digitally skilled workforce, supported by those with transformation skills
- Centrally delivered capabilities, where necessary
- Enabling a digital ecosystem
- Digital care plans and Personal Health Records available to patients

The new NHS organisation tasked with setting that National Digital Strategic direction is NHSX. It will be tasked with:

- Becoming a single team to lead the digitisation of Health and care.
- Bringing together expertise from multiple Arm’s Length Bodies.
- Providing consistent and coherent digital policy.
- Leading the development of strategy, programme and project delivery.

This new organisation is establishing itself, drawn from the NHSE/I/D IM&T community. NHSD will continue in a reduced role as a delivery organisation where certain tasks need to be completed at a National level. Work where best suited to local delivery will be managed through NHSE Regional Office or tasked to ICSs to ensure local system delivery.

NHSX has already described the missions it will strive to deliver and in the local context we must ensure that we consider these criteria when evaluating local investment or bidding for resource. **The NHSX Missions are:**

- Reduced burden on staff, so they can focus on patients
- Citizens have tools to access information and services directly
- Clinical information can be safely and digitally accessed

- Improvement of patient safety across the NHS
- Increased NHS productivity

b. COVID-19

The sudden arrival of COVID-19 initially provided a significant challenge to the IT services that LPT utilise, particularly in supporting clinical services to continue while operating but virtually and supporting large amounts of enabling staff to work from home. The positive side of COVID-19 has been that it has enabled considerable transformation to occur in a very short time, stress tested the Trusts Business continuity plans and beyond their usual level and exposed where greater resilience is required. As the NHS recovers and restores it will take the opportunity to reset how the services provided are offered and IM&T with play a major tole in supporting these activities.

c. Local Health Community Context

In the 2020/21 financial year there is much transition in the local NHS that is evolving in terms of ambition, structure and regulation.

Locally, the Health and care systems are being required to work in an increasingly co-ordinated way at a strategic level, all key stakeholders are working together to develop and implement change via the Sustainability and Transformation Partnership (STP) for Leicester, Leicestershire and Rutland (LLR). This partnership has an IM&T work-stream which develops a system wide response to support delivery of the STP priorities and has produced the latest version of the STP local digital roadmap which was published in April 2019.

Our three clinical commissioning groups have agreed to move to a single senior management team to enable a move to closer collaboration of commissioning activities. These will be formalised into a single commissioning vehicle CCG, within the ICS on the 1st April 2021 after the three CCGs are abolished.

The LTP also described the formation of Primary Care Networks (PCNs), which will act as local mini providers across LLR gradually developing new roles not traditionally seen at a local level. There are 25 PCNs in LLR who plan to improve and extend the range of services that are available in the community and join up the care that is provided from different organisations.

These local changes could be a threat to some of the services that LPT provide but LPT is also well placed to act a cornerstone organisation supplying resource to these new arrangements. The enhanced digital maturity of LPT and the single EPR and the hosting of the Health Informatics Service also means that LPT is seen as a digital mainstay of the local health economy.

The local digital ambitions of the ICS are currently evolving as the Digital lead for the single CCG has now been appointed and will join the system level governance for IM&T.

Within LLR there have been 10 expectation set in the post-COVID context, which will place an additional opportunity for IM&T to play a part on delivering. These are:-

- Safety First
- Equitable Care for All
- Involve our patients and public
- Have a virtual by default approach
- Arrange care in local settings
- Provide excellent care
- Enhanced care in the community
- Have an enabling culture
- Drive technology, innovation and sustainability
- Work as one system with a system workforce

d. Leicestershire Partnership Trust Context

Leicestershire Partnership NHS Trust has developed Quality Improvement Plan in 2019 which has been drawn up with input from staff, service users, carers and other key stakeholders.

It sets out ambitious plans over the next three years moving beyond some initial short term actions in response to a recent CQC report to a more strategic approach making a real difference to service users and staff delivering high standards of care, improving quality, safety and a commitment to continual service improvement.

This can be best described using a strategic objective and priority matrix.

Strategic Objective	Priorities
Safe **- Deliver safe, effective, patient centred care every time.**	**High Standards** Improve standards of safety and quality 
	Trust-wide QI Implement a Trust wide approach to Quality Improvement 

	Access to Services Make it easy for people to access our services	
Partnership **- Partner with others to deliver the right care in the right place at the right time**	**Patient Involvement** Involve our patients, carers and families	
Staff **- Staff will be proud to work here and we will attract and retain the best people**	**Equality, Leadership, Culture** Improve Culture equality and Inclusion	
Sustainability **- Ensure sustainability**	**Transformation** Transform our mental health and community services	
	Well Governed Be well governed and sustainable	
	Environments Environments will be welcoming, clean and safe	
	Single Patient Record Implement single electronic patient record	

One of the sustainability objectives specifically deals with the ambition to consolidate the Trust down to a single EPR, however there will be underlying IT enabling projects that will support strategic improvement in key areas of clinical work. These will enable LPT to: -

- Improve patient experience in their involvement and receipt of agreed care.
- Improve accessibility for patients of their care records.
- Improve experience of staff in the use of technology such as an efficient, effective and safe EPR system that supports clinical safety and service delivery.

- Improves and supports the efficiency and effectiveness of service delivery to deliver care in a timely way, right care, right place, right person, right time.
- Improves intra-professional and integrated working between primary, acute and secondary care across physical and mental health.
- Improves the delivery of interventions through other mediums such as digital channels.

Leicestershire Partnership NHS Trust is organised into corporate and clinical directorates, the clinical elements of these are separated into three services, delivering the following range of community based clinical services across Leicester City, Leicestershire and Rutland:

- Community Health Services
- Family, Young People and Children's and Learning Disability Services
- Adult Mental Health Services.

e. Community Health Services (CHS)

The future priorities for the Community Health Services will be to support providing more care closer to people's homes, and integrating with primary care and social care, leading to the design and agreement of a new model of community services. This work has set out a five-year plan from 2019/20 to transform community health care. The significant transformation of community services will be structured into the following service models:

- Community nursing and therapy teams: aligned with PCNs, providing both a same day urgent and routine, planned response. Where required, a two-hour response time will be delivered.
- Staff will work as part of integrated neighbourhood teams with PCNs working with primary care and social care will enable a focus on population health, at both neighbourhood and place.
- Home first services will be an enhanced 'step up and step down' services offering crisis response nursing and therapy as part of an integrated team offer with social care reablement and crisis response. Home First services will be commissioned and delivered at 'place' level, responding to different population needs and social care structures in each of the LLR local authority areas.
- Locality decision units will be created proving a single access point into multi-disciplinary triage, assessment, care planning and treatment for Home First services in each local authority area, as well as access to community hospital and health reablement beds.
- A shift towards population health management and integrated teams focused on supporting the needs of their local populations and crucially avoiding unnecessary hospital admissions.

To successfully deliver the LLR vision, CHS will need to address workforce and organisational development challenges which in turn will place IM&T challenges upon LPTs IM&T Provider (LHIS) to support new models of care and working. The new model supports the delivery of integrated working at the level of PCNs. This model is based on four 'building blocks' of integrated care

- Risk stratification as part of a population health management approach.
- Multi-disciplinary team working including care planning, with a focus on frailty and multi-morbidity. This will support the delivery of anticipatory care.
- Care co-ordination for patients with complex needs, particularly those at highest risk of admission, or recent discharge from hospital.
- A proactive and preventative offer supported by a local prevention offer and social prescribing.

Successfully embedding this approach to integrated team working will require a significant level of collaboration from partners in the system but also will require information systems to be aligned or the same for them to be successful.

This very much depends on whether it is a shared care model or a transfer of care model. Other services which form part of the wider out-of-hospital model such as core generalist teams will work with the specialist community services including heart failure and respiratory services, and how these can be more integrated at a local level.

CHS will be seeking to agree and deliver a consistent model of mental health support for integrated neighbourhood teams. There will be a change in the way that hospital-based staff work, moving to a model where specialists, consultants and acute therapy staff are seen as part of the community teams, and contribute to the continuity of care for people in the community, rather than only being concerned with patients once they are admitted or referred into secondary care. In 2020 CHS will focus on integrated therapy services and geriatrician support to the Home First model.

The model of care in care homes is delivering positive interventions which are supporting reductions in admissions from care homes (16% reduction in the first half of 2019/20). Proposals to address remaining gaps, including arrangements for each care home to be supported by one practice, are being developed in 2019/20. A shared EPR between care homes and practices will also support that initiative, which is an active project within LLR.

Sitting alongside these transformation programmes is a requirement for community providers to tackle workforce and information challenges in community services.

- Full usage of the mandatory **Community Services Data Set (CSDS) from quarter 4 of 2019/20 allowing for 2-hour urgent care and 2 day access to intermediate/reablement care to be recorded from 1 April 2020**.
- Getting **data sharing agreements and information governance arrangements signed and implemented between community health providers and Primary Care** (and wider partners such as voluntary sectors and Councils).
- Ensuring provider and commissioning arrangements include regular review and update of local **Directory of Services (DoS) to ensure transparency of information about community services, prioritising those for Urgent Community Response services** and consider wider inclusion of the voluntary and social care sector services (where appropriate).
- **All community services are recording their activity and notes onto a clinical system that has full interoperability with General Practice systems.**
- Introduction of **e-rostering and e-scheduling (TPP Autoplanner) for all clinic and home visiting staff by 2021** as per the NHS Long term Plan and Long-Term Plan Implementation Framework.

- The acceleration of remote monitoring of patients so that care can be provided within the home first as a supported option. This will require **further identification and deployment of Telemedicine Products for specific cohorts of patients** likely to respond well to this approach.

f. Families, Young Persons and Children and Learning Disabilities (FYPC/LD)

The future priorities for the FYPC/LD Health Services will be to support our work focused on 4 main areas: -

- The public health and prevention agenda which has involved a redesign of the local delivery of the National Healthy Child programme in line with the changing levels of public health grant. It delivers identification and early intervention for a population of 237,500 children and young people across LLR with approximately 12,500 births a year. The school age immunisation service continues to deliver the immunisation programme with the implementation of new initiatives.
- A system level approach to the provision of mental health care to children and young people. Known as Future in Mind, this is being delivered through a system level approach within LLR to improve the provision of mental health care to children and young people. A key aspect is to improve the access so that care is provided at the time of need by the most appropriate professional. To reduce the waiting times for neurodevelopment assessments and to link in with a system wide approach for the pre and post diagnostic care of autism.
- A system level approach to looked after children (LAC) and special educational needs (SEN) where FYPC are working with the local authorities and commissioners to support their statutory duties to safeguard and promote the welfare of children in their care and those with SEN. This includes ensuring that their health needs are fully assessed and met and that they form part of a health care plan or an education Health and care plan (EHC) shared with education and social care. The number of LAC in LLR continues to rise including an increase in unaccompanied asylum-seeking children coming into care in LLR. There is also work to improve the transition of young people into adult provision linking in with the need to deliver SEN services through to age 25.
- Transforming care for people with learning disability and autism is one of the key priorities for LPT and FYPC are working with adult LD and the wider system to reduce the number of unnecessary admissions to inpatient units and to provide positive behavioural support to young people closer to home through schools, home and care settings.

All of this work is reliant on the ability to gather and share population level data that supports reporting to national data sets and improves local delivery and local IT systems are being configured to support this ambition.

g. Adult Mental Health (AMH)

AMH employs about 1,100 people and provides services for those with acute and enduring mental health conditions – such as bi-polar disorder, schizophrenia, severe depression, personality disorder, dual diagnosis and asperger's/autistic spectrum. It currently provides 140 acute beds across 7 wards, 16 psychiatric intensive care beds, 68 mental health rehabilitation beds, 12 low secure beds and 12 beds for people with Huntington's disease. However, the vast majority of care (150,000 contacts per year) is provided in the community through various community mental health teams, psychological therapy and day care services.

AMH is finalising plans to transform many of the community services currently offered, with the new service models developed in partnership with many stakeholders, including patients, carers and staff. IM&T and digital innovations will lead to improvements in how patients and referrers access our services, and how long they have to wait to be seen Additionally, they will help us completely change how we engage and inter-act with patients. For example, our plans will see the **introduction of electronic referrals, use of App based technology will support patients and referrers to make appointments and receive information about their care, tele-consultations** will help improve access and allow our services to reach more people. IM&T in the context of the new single electronic patient record (TPP SystmOne) will **allow staff to be more agile** and efficient in providing care and will reduce the amount of time spent on paperwork. This will facilitate a more **collaborative approach to care planning with patients and carers.** We are also developing the case to invest in and improve our in-patient settings, which will support high quality care and better protect our patients' privacy and dignity. This will also present an opportunity to ensure our in-patient facilities are future proofed to take full advantage of IM&T advances over the coming years.

h. Estates

The triangulation between service transformation, estates and IM&T is a symbiotic partnership, where each need to inform each other of opportunities to be seized and assist in supporting that transformation. The 2019 LPT Estates Strategy is an important indicator to IM&T of the direction of travel and ambition of the Trust. Key objectives that need to be supported are: -

- To occupy fewer buildings and to locate non-clinical accommodation in non-clinical buildings – this will deliver better quality environments across the estate and reduce costs.
- To build on our network of space to facilitate agile working for staff.
- To use of space across the local health, social and local authority estates will also be considered where appropriate.
- To make sure staff do not feel isolated by agile working. This will mean ensuring solutions are in place **to manage or book desks**, properties are safe, secure, easily and readily accessed and have appropriate support facilities, have adequate car parking (or proximity to good public transport links).
- Increased agile working will lead to less reliance on the traditional need for a permanent base within the estate and therefore provide further opportunities for re-use or rationalisation of the estate.
- To continue to participate in Local authority 'One Public Estate' initiatives to ensure we take advantage of all opportunities offered – we will also seek to partner with other organisations (such as District Councils) to explore opportunities to locate relevant community service provision into suitable accommodation (such as Physio clinics into leisure centres etc..) and thereby release estate for disposal.
- The provision of a new facility at the Bradgate site which is subject to Strategic Outline Case (SOC) and ultimately Full Business Case (FBC).
- A review of the **facilities management services** and the future delivery options and opportunities that may present where IM&T may need to support a more **digital focussed solution in the delivery model.**

4. IM&T STRATEGIC OBJECTIVES

This plan sets out the objectives in terms of what needs to be achieved and has attempted to read across the complex set of business objectives within LPT to cluster them over-arching strategic objectives.

a. Partnering with Health and Care in LLR

LPT recognises that to deliver the strategic principle of a joined up electronic record not only within the Trust but beyond in the wider Health and Care system, supporting the patient journey, involving service users, it must work within a wider set of aims that the STP and ultimately the ICS will try to deliver. LPT is currently playing a leadership role in the IM&T workstream of the STP. By listening to the clinical workstreams of the STP and also analysing the NHS Long Term Plan, 100 individual projects or developments were specified as required to either act as a pre cursor enabler to a transformation or to support the success of that transformation.

To make some sense of these “asks” they were aggregated into themes where they could sit within an over-arching strategic objective where a common group of IT and clinical expertise could exercise direction over that work. The 5 strategic objectives and how the Trust can play a part in these, are described below:-

b. LLR Business Intelligence and Research

At the LLR system level there is now an agreement to establish a collaborative approach to Population Health Management. For LPT this means that the Trust will need to support developing capability of analytics staff to support population health management and also to focus resource in reporting at system, place and neighbourhood. Organisational Development Resource will now be focussed on engaging BI/Analytics staff in all partner organisations, but including LPT, to ensure that staff start to think about using population health analytics to support service delivery decisions.

The challenge will be the shift from utilising scarce analytics resource away from routine reporting to predictive analytics on population health, which is traditionally the domain of Public Health Medicine (PHM) only. It is also planned that LPT and LHIS are contributing to this process in the planning stage, but the expectation is that the 100 analytics staff working in these roles across 8 teams in LLR will begin to form peer group working, sharing tools, capacity and capability as the ICS matures.

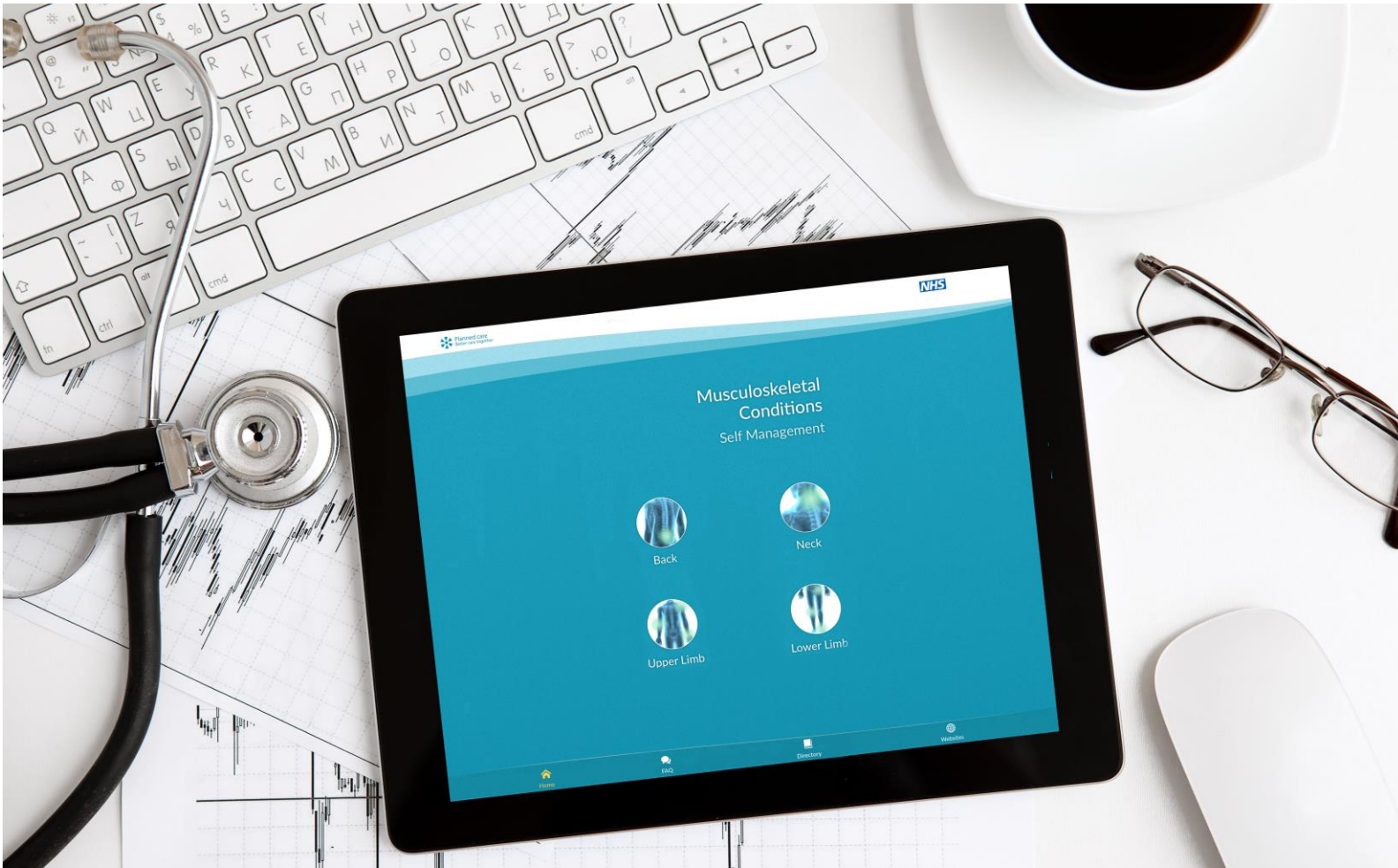
LPT will fully support the intent to develop a multiagency analyst peer group across LLR as part of the BI Strategy and PHM approach and support a wider East Midlands PHM Analyst network which LPT analyst representatives will participate in a collaborative approach to sharing secondary use data for the purposes of public health, research and service redesign for the benefit of the wider community.

c. Digital Self care

In many other sectors Digital Self Service is now the norm for consumers of a service, it offers benefits of choosing the time and place to interact that best suits the consumer, using a digital service to perform that transaction, such as an app or a web site portal. It can also extend further into devices connected to a cloud-based service that can interact or monitor. Health and Care have been very slow to adopt these technologies, mainly due to the lack of supply and the ability to prove the business case for adoption.

The critical part for this to succeed with Health and Care is the ability to interact with the main EPR systems used in LLR and the ability to workflow information into the mainstream administrative business processes that are actively monitored. There are undoubtable benefits for Health and Care too, i.e. to channel shift activity to a digital channel where a patient chooses to do so.

The challenge is to mainstream this as an additional choice for patients where the majority already have the ability to utilise digital services, should they choose to do so.



The STP IM&T workstream has now initiated the formation of a Digital Innovation Hub which LPT as a partner has access to and indeed hosts on the behalf of the system. LPT engages in this offer via representatives on the Steering Group that prioritises the workload and indeed benefit from the products they will deliver.

LPT will support the Digital Innovation Hub and will route appropriate service delivery challenges requiring digital innovation towards the service, who in turn can develop business cases for investment.

d. Record Sharing between all Health and Care

This benefits patients and practitioners by ensuring that they are all viewing the same Health and care information about a patient and where required can also contribute to that shared record for others also involved in that care to see, to make informed decisions within that context. This can include key clinical and social information about the patient which the patient could contribute to, the ability to plan their care which could be in collaboration with other Health and care providers. It also must give all those involved within that care the ability to pass actions between each other in that shared care model.

The ability to support this model is critical to the successful delivery of Integrated Locality Teams transcending Primary, Secondary, Community and Social Care.

In LLR, decisions have now been made that will effectively reduce the estate down to almost three EPR systems over the next 2-3 years, SystmOne in Primary Care, Community and Mental Health/LD, Liquid Logic in Adult Social Care and Nerve Centre in UHL.

LPT will be fully supporting this STP ambition and the trust decision to consolidate down to a single EPR acts as a catalyst to encourage other partners to follow suit.

There is also a National drive to establish a Local Health and Care Record (LHCR) service in the East Midlands, which will allow a regional view of a patient's interactions and medical history. It will also provide data to support analytics and insights into actually what the population need is and what is actually going on in the health of the population and service delivery to that population. **LPT will support** this project through membership of **the LHCR development project** and will also look to be a consumer of the patient records and analytics to provide better services to patients. The target date for completion of this project is 2024.

To complete the ambition to have a single source of information for medical and administrative staff to use in LPT and to share that information beyond the

boundary of LPT, two further projects will remain after the completion of the single EPR project in June 2020.

i. Electronic Prescribing within the EPR

As highlighted in section 4.2.1, prescribing and administration of drugs is supported on a separate computer system called WellSky. This system is a well-respected system and the configuration is considered to be safe for use by clinicians and pharmacists alike. As part of the Single EPR project an initial evaluation of the functionality in TPP SystmOne versus WellSky there were some functionality gaps so this product will continue to co-exist as a separate system. This will necessitate the integration of WellSky into SystmOne so that it can be contextually launched by SystmOne and also return prescribing history including TTOs on discharge back into the EPR. At a point **where additional functionality from SystmOne matches WellSky then this will be reviewed and remain as part of the strategic work IM&T work programme for the trust after the Single EPR project is complete**. The objective remains that **prescribing will be undertaken within the single EPR and the history of that prescribing for that patient to be held in the EPR, not only for LPT staff to view, but also the wider Health and Care Community who have access to TPP SystmOne.**

ii. Mobile Outcomes and Assessment

LPT within the Community Hospitals and Adult Mental Health and Learning Disability uses a product called Nervecentre which allows a practitioner to collect observations and capture assessment information at the bedside. This fully supports the principle that information about the patient should be captured contemporaneously about the patient but cuts across the decision to have all the information about a patient to be held within a single EPR. Although Nervecentre during 2019 was extended out further into other inpatient settings in AMD/LD, TPP have now developed an equivalent product. After an initial pilot in CAMHS and subject to a successful evaluation in February 2020 **LPT may choose to replace NerveCentre with the TPP mobile assessment App**. The two benefits this will bring will be that the assessment information will be integrated into the EPR system, and there is no additional charge by TPP, as it is included within the main contract, it will save supplier costs to LPT.

In addition Nervecentre is used within UHL and several of the surrounding large acutes, the ability to integrate observations captured within NerveCentre and transfer them correctly into SystmOne is now technically possible and a **request has been made**

to UHL to implement a NerveCentre records transfer from the trust transferring out a patient into the community setting.

e. Supporting Patient Pathways

Sharing information along a Pathway from one clinical system to another can only be achieved if information is consistently collected, regardless of the source system so the next service in the patient journey receives reliable and complete information, without further requirement to refer back to the sender and also that information is targeted at the correct service.

This can best be achieved by giving clinicians pathway navigation tools, ensuring they collect consistent and complete information to hand over to the next clinician in the pathway. Thus, inbound referrals are completed correctly and navigated correctly into the Trusts services, leading to the referral being right first time with no delays in the patient experience.

In LLR the agreed pathway tool that GPs utilise to refer into providers is PRISM.

LPT will commit to full coverage of PRISM for all pathways requiring a referral to be completed by March 2021 and will establish this initiative on a project footing during 20/21 to add an additional 40 pathways to the existing 31 on the system from LPT.

There is a contract requirement for LPT to receive all in-bound referrals electronically for all first Outpatient appointments by 1st April 2020, whether this is via the central Electronic Referral System (ERS) or just electronic using a shared EPR has yet to be clarified by NHS England, but at this stage as long as it is electronic end to end will meeting the requirement. **Moving to a single EPR and 100% PRISM coverage will facilitate this target being met.**

f. Standards

The strategic emphasis from NHSX going forward is for a dynamic ecosystem of innovative suppliers of product for Health and Care to use, but only within an environment of standards. These standards fit into different categories which going forward LPT will have to ensure the systems it uses or procures align with.

i. Clinical Coding

SNOMED CT stands for the 'Systematized Nomenclature of Medicine Clinical Terms' and consists of comprehensive scientifically validated content. SNOMED CT is available in more than fifty countries and has been adopted as the standard clinical terminology for the NHS in England. It is specified as the single terminology to be used across

the health system in 'Personalised Health and Care 2020: A Framework for Action'. SNOMED CT has the advantage that it had codes for Diagnosis, Procedures, Interventions, Allergies, Adverse Drug reactions and Medications all within one coding system. The benefit is that data passed between systems not only at a national level but international level will have a common currency of understanding. LPT will ensure that all its clinical systems will either use SNOMED CT or directly map to SNOMED CT by the 1st April 2020 target date. This process will be enforced via the supply chain, ensuring that suppliers either commit to this standard or their systems are changed to supplier that will comply. TPP SystmOne and WellSky (ex-JAC) pharmacy system will be compliant, Servelec RIO is in assurance with NHSX and is being replaced in June 2020.

SNOMED has within it the NHS dictionary of medicines and devices (dm+d) which represent medicines and devices in use across the NHS. The dm+d contains a huge variety of information, including for drugs; whether a product will be reimbursed by the NHS and the status of the product in term of whether it has been withdrawn from use, for devices it contains for instance the unit of measurement. Again, **LPT will ensure that the e-prescribing system it currently uses will be dm+d compliant by 1st April 2020.**

ii. Procurement

NHS England has decided that NHS organisations need to be able to access IT suppliers that have committed to the interoperability standards that it currently expects from NHSD, but also any future standards it will publish. To this end a new framework contract has been constructed for future EPR-type systems to be procured through. **LPT will move its existing contracts at suitable breakpoints to the HSSF framework** contract to ensure its suppliers going forward, (TPP, WellSky and potentially NerveCentre) to ensure supplier compliance.

iii. Interface Standards.

Although the Trust by June 2020 will be on a single EPR and therefore will be able to directly share information within its boundaries it is also important that it can share beyond into UHL, General Practice, Social Care and at Regional level. Much of this is dependent on agreed access and patient consent, but at a technical level LPT would wish to commit to sharing information wherever possible via the prescribed NHS Digital. Fast Healthcare Interoperability Resources (FHIR). Developed by Health Level Seven International (commonly known as HL7), is an interoperability specification for the exchange of healthcare information electronically.

FHIR will standardise the exchange of healthcare information, enabling sharing of patient information even when they're using different software systems. **LPT will look to implement the supply of information out and the consumption of information from other NHS organisations via FHIR standards and will ensure that all suppliers are capable over time of supporting this standard.**

g. Service User Empowerment

As stated earlier one of the key missions that NHSX will be looking to gain traction on in the next five years is giving patients much more control, tools and access to information and services that they receive from the NHS. COVID-19 has also taught us that the ability for the patient to perform some tasks that previously would had been carried out face to face, is much more acceptable if not demanded by both service users and clinicians alike. In the LPT context this means making sure patients can: -

- Understand what services LPT can provide and how to gain access to them.
- Have access to the information that LPT holds on them, such as their clinical record where appropriate.
- Perform some level of clinical encounter digitally as not all encounters need to be physically face to face and indeed due to social distancing should not be face to face by default without PPE.
- Transact digitally some administrative tasks rather than using traditional methods such as paper/post.

i. Web Site

To deliver upon helping patients and referring clinicians understand what services LPT offers and how to gain access to them is being managed by several approaches. The Trust has recently redeveloped its public facing web site so that the service directory offer to the public and how to contact is clearly visible. **Information for service users about more detailed guidance to support them through their journey through LPT will also be brought online via a dedicated online resource for service users which will be available April 2020.** For referring clinicians into LPT on the behalf of service users LPT this is addressed under section 4.1.4 of this document.

ii. Digital Patient Empowerment

Through the NHS Long Term plan there is a significant emphasis to drive patient empowerment up the NHS' digital agenda so that there is channel shift to digital certain types of patient encounters. This could take the form of: -

- Assessment questionnaires,

- Consent and authorisation,
- Digital instead of physical face to face outpatient appointments,
- Viewing a health record,
- Performing administrative transactions digitally.

This will fundamentally create an environment where the patient feels more empowered and in control of their information and their interaction with the NHS locally.

If you enable patients some self-empowerment over their health, it promotes better outcomes for patients, and channel shifting to digital reduces demand on Health and care services. The challenge for LPT in the wider system discussion about service redesign is always to seek the opportunity to digitally supported care models where patients have input to that digitally supported pathway.

The NHS has attempted to start this process with the NHS App, which presents the GP Record to patients in a limited form and allows some basic transactions with general practice. It also has introduced the

concept of a validated National identity login which is verified by NHS Digital. However, provider data unless it exists in the GP record as part of a Transfer or Care structured data transfer will not appear in NHS App. It also will not allow any transactions between LPT and the patient being focussed on the GP/Patient relationship.

This leaves LPT with a choice of four approaches going forward: -

- To wait and see if National developments eventually extend the NHS App into the provider space, however this is currently not on the development roadmap, and likely to be at least 2024 before another national development offers viewing of provider data.
- To develop its own suite of products to digitally share information and allow transaction with service users.
- To capitalise on the single EPR platform and extend the TPP Airmid App out to service users, so they can see their LPT records as well as allow transactions with the Trust.
- To review the commercial market of third-party apps that exist which re-present data from EPR systems out to service users and have limited transactional capabilities.

To answer this question the STP IM&T Strategic workstream has commissioned a technical evaluation of the TPP Airmid App and undertaken a desktop comparison exercise of the NHS App, the LPT Digital Offer products and the market leading third party App; Patients Knows Best (PKB). This evaluation has been presented to the LPT IM&T Committee. Airmid in July 2020 was passed by the LPT Clinical Safety Officers as fit for purpose to use within the Trust and therefore can be deployed where required. The functionality of Airmid versus other products in use or commissioned by LPT will be reviewed in September 2020. However, LPT will be **introducing digital platforms for service user appointment management, correspondence, questionnaires, virtual consultations, consent and medical record access during the lifetime of this plan.**

It is recognised nationally through the Government's Digital Inclusion Strategy and the NHS and wider health care system initiatives that online services have had a huge impact in transforming almost every aspect of the population's lives. Although there has been great progress in internet access and use of online services, there are still a significant number of people who do not make use of digital services to benefit their Health and care needs.

11.5m people in the UK lack the basic digital skills they need to use the internet effectively and 4.8m people are believed to have never been online at all. There are also particular cohorts of the population who are more likely to be digitally excluded than others, many of which who could most benefit from digital health services.

The additional opportunities created by the channel shift will eventually hit a ceiling of service users that will engage and the factors driving the ability of that engagement are listed below.

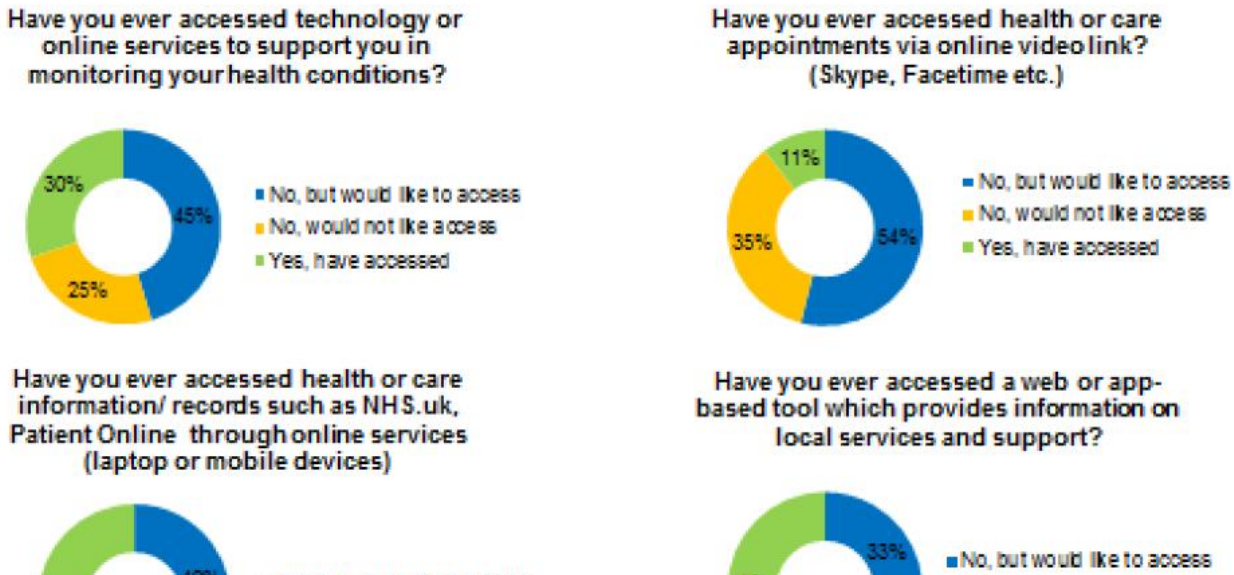
- older people – 51% of digitally excluded are over 65
- people in lower income groups – 45% of digitally excluded earn less than £11.5k a year
- people without a job – 19% of digitally excluded are unemployed
- people in social housing – 37% of digitally excluded are social housing tenants
- people with disabilities – 56% of digitally excluded have a disability or long-term condition and 27% of adults with a disability (3.3m people) have never been online
- people with fewer educational qualifications - 78% of digitally excluded left school before 16
- people living in rural areas
- homeless people
- people whose first language is not English

Looking at the list above it is likely that these people will proportionality be overrepresented as service users of LPT thus acting as a barrier to a complete channel shift. However not attempting to channel shift because of the excluded minority would also be a lost opportunity.

The balanced path would be to **work in partnership with other partners in LLR to increase the opportunity for the excluded population to engage. To encourage the existing STP partners to establish a dedicated digital engagement workstream.**

Figure 1 below is based on a recent survey In Nottinghamshire who are not dissimilar in socio-economic profile to LLR. The conclusion it leads to is that it is the digital offer from the NHS to our population that is holding back online access services, not the public's willingness to engage, as that path has already been established by banking, retail and travel already. It being likely that 70 to 80% of the population would readily channel shift to digital channels if provided with tools to do so for certain activities.

Figure 1. Survey of Public attitude to accessing Health Care online.

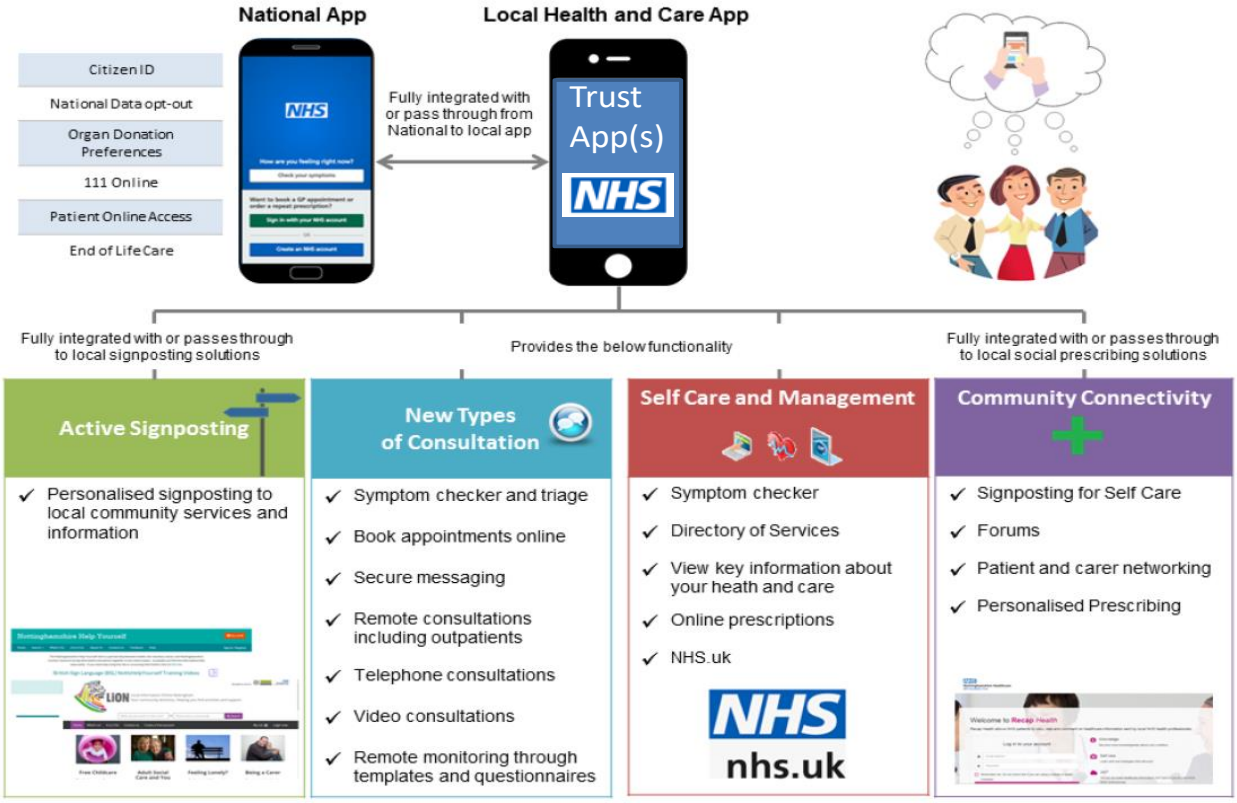


In terms of what that digital offer should contain, no one product will satisfy all the needs of the population and LPT recognises that from a transactional perspective, most healthcare interactions are with Primary Care; this will be serviced by the NHS App ultimately using the NHS Login. However, this product does not provide all the information and transaction capability that a patient needs if they are in contact with a provider, therefore additional offers need to be made in the medium term. This will be until the NHS App offer increases its scope or an alternative NHS Digital programme (the Local Health and Care Record – LHCR – see section 4.1.3) are deployed and can provide a broader service to patients.

In figure 2 below it shows that signposting people to services and describing how they access those services is important, coupled with the ability to connect to alternative provision, such as social prescribing. Many of these information and directory services should be offered to the population in a manner that provides a comprehensive set of information and interactions rather than each organisation establishing stand-alone data silos. LPT should aim to encourage LLR partners to work together, seizing the Primary Care Network opportunity of new local service provision, **to develop a roadmap of system level signposting to services.**

With regards to self-care, it may be appropriate for LPT to recommend, **in a form of digital prescribing, apps that will support self-care**. The most appropriate way to share this information would be via the LPT Web Site. As stated above, LPT will need to ascertain how it wants to transact with service users, once LPT moves to a single EPR there is a strong argument to directly link those transactions to the EPR, rather than use a standalone unlinked App, as this will require more work to support and more cost to maintain. The TPP AirMid product is free of charge and supported within the contract with TPP included in the current contract, if this product proves to be safe and secure to use then this would probably be the default approach for LPT.

Figure 2. Types of Digital Services potentially available to the population.



iii. Supporting care in the home

The connecting of home-based and wearable monitoring equipment will increasingly enable the NHS to predict and prevent events that would otherwise have led to a hospital admission. This could include a set of digital scales to monitor the weight of someone post-surgery, a location tracker to provide freedom with security for someone with dementia, and home testing equipment for someone taking blood thinning drugs. Already available technology can enable earlier discharge from hospital and transform people's lives but only really has an impact if this information is monitored where it is out of tolerance and integrated into the NHS' services provision model for supporting care in peoples homes. **LPT will actively engage with supporting digital advances** in these changing care models as demanded by the NHS Long Term plan which will no doubt result in further major work **to further digitise community services.** This will also include expanding the scope of the existing Community Dataset to standardise information across the care system and integrate it with Local Health Care Records (LHCRs – section 4.1.3).

iv. Friends and Family Test (FFT)

This is a national requirement that all NHS Organisations must comply with. There is a minimum standard of question that must be asked and is subject to change. LPT will ensure that the minimum standard questionnaire is proactively offered to as many service users as practicable using event triggers based on their passage through the service that LPT offers them. LPT has decided to implement a commercial FFT solution which will target service users **highlighted from the single EPR with SMS invites providing a universal patient trust wide satisfaction survey.**

h. Investing in our IT Infrastructure

The trust needs to ensure that the IT Infrastructure that it uses is capable of working within acceptable tolerance to the staff and is protected from outages and disruption. IT equipment is built to fundamentally perform to a very small failure rate up to the maximum warranty period. After this the equipment is more likely to fail catastrophically. This is usually around after 5 years of use. But there are also external influence over the IT Infrastructure which includes using obsolete software that is no longer supported by the manufacturer and also the Cyber Security threat which is an increasing threat to the NHS. To reduce the risks described above the following ongoing commitments are required within the Plan: -

- To **ensure that there is a rolling replacement programme** of IT hardware and that funding is adequate to ensure that minimum performance and reliability tolerances are maintained. The ambition is to replace desktop PCs in their 6th year of service, laptops in their 5th year of service and servers in their 7th year of service. Network Infrastructure will also be replaced based on an assessment of failure but likely not to exceed 7 years as a maximum. COVID-19 has also demonstrated that shared IT equipment is an infection risk and that many staff who were previously office based can work at home perfectly well as a supported option. This will require additional financial support to ensure that the COVID-19 response to allow staff to work from home safely, also in parallel meets the demands to replace additional old equipment which was due for replacement but unfortunately the laptop stock for the 20/21 RPP was issued to support COVID-19.
- The proliferation of smart phones to act as tools for clinical staff to use beyond the capability of a normal mobile telephone has brought great benefit to LPT staff to work in an agile manner on wards and in the community. However, there is no rolling replacement programme for these devices and due to their low value cannot be replaced from a capital allocation which favours equipment over £250. The Trust mobile phone contract does not automatically upgrade these devices, they are bought and are used until they break, where upon a budget holder must

be found to replace them. These devices should be replaced after a maximum of 3 years usage, as general wear and tear and battery deterioration makes them sub optimal to use. **It is recommended that a sustainable solution to this issue implemented informed by an analysis of the options available to the Trust.** The current mobile phone contract ends in March 2021 requiring this analysis completed and implemented for the 2021/22 Financial year. Under the current contract a three year cycle of phone replacement would cost an additional £282k revenue per annum for a basic smart phone handset.

- To ensure that the IT estate **does not use software that is no longer supported by the manufacturer** which could potentially expose vulnerability for cyber-attack or simply become incompatible with other software and affect its performance. NHS Digital have agreed with Microsoft that Windows 7 will continue to be patched until January 14th 2021. The immediate priorities are to migrate from Windows 7 to Windows 10 and Windows 2008 Server to Windows 2016 Server by December 2020. The trajectory discharged LHIS to deliver upon for LPT will be 66% by June 2020 and 100% by December 2020. At time of writing this figure is 40%.
- **To migrate** from MS Office 2010 and locally hosted email **to Office 365 and cloud based secure email** during the 2020 – 22 period for all LPT staff.
- **To create greater resilience and capacity in the IM&T Infrastructure,** which is primarily design to support an office-based workforce to a very agile and semi home-based workforce who have a primary connection to the Internet. This will mean a shift to delivering an “Internet First” delivery model over the next few years, so that applications and data can be safely accessed over public networks. The best way to achieve this is VDI, which also creates the opportunity for lower specification equipment which do not need card readers or lots of memory or high-speed processors (see section 4.n). This will also require extra capacity to support greater access from outside LPT, into LPT.

i. Cyber Security

From April 2018 the department of Health and Social Care demanded that NHS England ensure that organisations within the NHS implement the ten data security standards recommended by Dame Fiona Caldicott in her July 2017 report. In summary they are as follows: -

- Each organisation must have a SIRO, in LPT this is the Director of Finance, Business and Estates.
- Each Trust must complete the DSP toolkit whereby progress towards the ten security standards will be measured.

- GDPR actions to ensure and maintain compliancy must be completed by May 2018.
- Ensure that all staff undertake data security and protection training on an annual basis. The current compliance rate for LPT staff is just under 92%, in a range of 88% to 95% between Directorates, the target being 95% expected of NHS Trusts.
- CareCERT alerts from NHSD must be enacted within 48 hours, these tasks are undertaken by LHIS on the behalf of LPT and assured by the Data Privacy Officer.
- Continuity planning takes place to respond to data and cyber security incidents. In the Trust there is an annual exercise to develop responses and develop and update plans.
- All data security incidents and near misses are reported.
- Unsupported software, hardware and applications are either removed, or there is a plan to mitigate or manage the risk.
- To undertake cyber and data security assessments and to act on the outcome of that assessment.
- To ensure that suppliers of IT system have the appropriate certifications in place or are on framework contracts that have as a level of entry security certification.

The Trust will continue to work within the ten data security standards and look to improve its annual rating in the DSP toolkit (DSPT) and the compliance rate for data security and protection training to nearer the 95% expected target for an NHS trust.

The other improvement that the Trust will seek to make is ensuring the main provider of IT Support, **LHIS is able to provide assurance of Cyber Essential plus or equivalent by June 2021 and that regular assurance of the risks to the core Network Infrastructure are understood. An assurance of the risk management of these threats are received and understood.** The greatest potential risk to the IT Infrastructure is via a PHISHing attack due to a member of start accidentally downloading a malicious payload by clicking on a link in an email or attachment. Only by repeated PHISHing simulation and drawing the attention to staff or their mistake can this be improved. There is an active process within LPT to heighten awareness to this vector of attack, but staff gullibility remains currently too high and probably **more Cyber security training needs to take place.**

It is acknowledged that not all Cyber-attacks can be prevented but it is the impact of that attack and the speedy recovery from it that is as critical as the prevention. Some risk mitigation may be within the gift of LPT also to deliver, such as **regular awareness communications and Phishing simulations.** A summary of **Cyber Safe do's and don'ts will also be introduced into staff induction for the Trust and brought to the attention of agency staff who are given access to LPT IT resources**. Previous Phishing exercises have flagged that it often new or inexperienced staff that are the greater risk which is why the reliance on annual completion of the Data Security Awareness module on uLearn needs to be strengthened.

j. Better Information

Information in LPT is generated by several routes, which can be standard reports, dashboards, scorecards and ad-hoc analysis. Information is primarily used by the management of the Trust to judge its performance and support decision making but it is also shared with commissioners and regulatory bodies such as the NHSE/I, CQC, and HEE. The performance information reported is scrutinised as KPIs are compared and triangulated to better understand how the Trust is performing. By listening to feedback from the Trust Information improvement fall into effectively two categories: Data Quality and Reporting.

i. Data Quality

There have been recent data quality improvements due to the fact that the Single EPR team project team have been correcting poor quality

data within the RIO EPR system, so that it will accurately land into TPP SystmOne in the right context. These are often quite minor issues, such as deceased patient not having a data of death entered onto the system nor being discharged but they have an impact on the accuracy of reporting both within and external to the trust. There is a risk that the single EPR team when it is wound up after the Single EPR go-live in June 2020 will obviously not be correcting data going forward so data quality will fall back within LPT. Therefore, the **configuration of SystmOne must maximise the ability not to opt out of entering certain data but data quality audit reports must be enacted within the services that routinely capture data into the EPR**. In the two previous IM&T Strategies for LPT a request has been made to establish a Data Quality Improvement Manager post which has not been actioned by the Trust. A piece of work needs to conclude on how LPT can best tackle the **ownership and responsibility of data quality and how best the Trust can assure itself that data quality is maintained and continues to improve**. This request within this plan to create focussed ownership of the performance management of poor data quality within LPT. The view that data quality is everyone's responsibility is not a sustainable one without an individual not working with front line services to improve the impact that poor data quality is having on patient safety, reported performance and potentially income.

ii. Reporting

By listening to service managers, they are more than prepared to use self-service tools to receive routine information necessary to run their service and ensure performance and patient safety. However, staff want to be able to trust the information they receive without having to challenge back to the Information department, who in turn may have to look into data quality issues. These staff also want to be able to interpret the information themselves for what it means. A combination of improving data quality as per section 4.10.1 and **introducing more self-service tools either direct from the new single EPR or secondary use next generation BI tools**, will free up the burden on scare information analysis resource.

k. Records Management and Compliance

In the areas of Records Management and Compliance, the following are seen as strategic priorities in supporting the Trust with innovation and quality improvement:

- With the successful accreditation against BSI BIP10008:2014 the focus on scanning of archived records (on request from storage) supporting the cultural shift towards the use and management of electronic records is

the next natural phase. **The exploration of developing an Internal Scanning Bureau** to support the process of scanning of records still held in local service areas assisting the repurposing of the estate. This also requires the **identification and integration of an appropriate Electronic Document Management System** from where clinicians can easily retrieve the clinical information they require to support decision making with their patients/service users, this should ideally be the context of the patient from within the Single EPR system. As there is an attachment size limit in TPP SystmOne of 10 MB and the Trust paper records in many cases would scan to a file size greater than that, it would be advised to make these **attachments available in secure cloud storage**, so that any onward sharing of the TPP SystmOne record to another NHS Trust, that would allow secondary sharing of that paper record, but only from within legitimate access to the patient electronic record.

- Supporting the development of the LLR Integrated Care System whereby shared records support the integration of health and social care services, with the LLR STP Information Governance Delivery Group supporting workstreams to achieve this against the Five-Year Plan.
- **Extending the reduction in the reliance of paper**, through the exploration of electronic communications with service users. Adapting to the world in which our service users live their lives, transacting with them in more familiar ways such as email and other forms of messaging in a secure manner.

I. Supply of IM&T Services

Outside of its internal IM&T staff, LPT receives IM&T Services from a blended approach of NHS Shared Services and Private Supplier. In this section of the plan is a position statement on the future usage of this arrangement.

i. LHIS

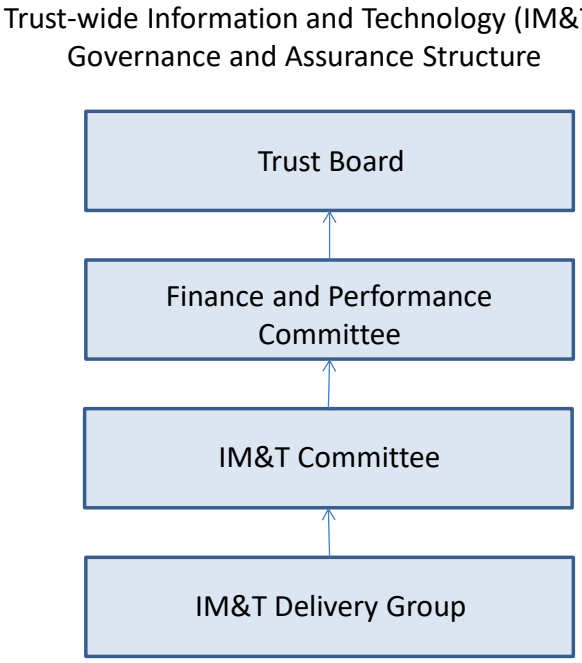
IM&T Services supporting LPTs function is provided by the Leicestershire Health Informatics Service (LHIS). The SLA that is currently in place finishes on 31st March 2021. LPT does not directly commission the service from LHIS but is instead a member of a consortium along with ELR CCG, LC CCG and WL CCG. The consortium exists to risk share and exercise high level governance over LHIS, which is constructed as a shared service vehicle. In return the core IM&T SLA that LHIS operates within is recharged out at cost, back to the consortia members. **The LHIS consortium agreement during 2020 will need to be reviewed with the movement to a single CCG from 1st April 2021.**

m. Governance

Within LPT IM&T Governance forms part of the overall assurance process for the Trust. Beneath the Trust Board, the Finance and Performance Committee (FPC) receives a highlight report ranking the level of assurance that key issues, risks and associated actions are being managed. These are created by the IM&T Committee which is the highest IM&T group within LPT. Its role is to set the strategic direction of IM&T within the Trust and manage the investment of resource to support that programme, owning the Digital Plan for the Trust. The delivery of the work programme of IM&T projects and management of, operational risks and issues are managed through an IM&T delivery group, which reports into the strategic committee. See Figure 3.

Clinical Safety of IM&T system was called for in the 2018 Strategy through the establishment of the Clinical Safety Office network. This has worked well in assuring that Clinical IM&T systems are only changed or configured with clinical sign-off of trained personnel and **LPT confirms that it would want continue with this governance approach of a CSO network going forward.** Although it is important to show good governance to provide upward assurance to the Board, the focus of the **IM&T Committee must also be a forward looking Committee, ensuring that all decisions are tested for strategic fit against this plan, challenge for value for money and benefit is robust and IM&T is supportive of service transformation**, not a barrier.

Figure 3.



n. Sustainability post COVID-19

Although many of the strategic objectives mentioned in this plan will have an impact on sustainability, it is worth noting the principles that **LPT will aim to seek in any IM&T project or technically supported transformation to ensure that sustainability agenda is supported and that previously considered unachievable working practices pre COVID-19 that offer a sustainability and productivity gain are kept as the default offer to staff.**

- To reduce service user and staff carbon footprint by reducing unnecessary mileage in a private motor vehicle and where that must take place to ensure it is performed in the most efficient manner.
- To stop creating new printed paper documents wherever possible, by holding meetings paper free, supporting digital signatures, removing faxes and using secure email, implementing workflow systems into EPR and enabling systems, such as Finance and HR.
- To continue to support agile working as a supported choice, making work about what you do and achieve, not where you go to perform it. This will no doubt extend to further make home working a supported choice for many people as COVID-19 has proved that LPT staff have generally adapted well to this as an option.
- To encourage greater use of collaboration tools, this will ultimately replace fully MS SharePoint and MS Skype for Business with MS Teams, under initially the 90-Day Microsoft Offer to the NHS during COIVD-19 to the rollout of Office 365 under the N365 National deal now it is signed. This can then lead to a Trust wide transformation of how LPT works at

the team level. The Trust has chosen to migrate to NHSMail and therefore will be migrating to an NHS Shared Tenant for the provision of Office 365. This will require a total investment of £1.3m until 30th April 2023.

- To move away from Capital Funded on-premise digital storage and locally installed applications to revenue funded cloud software as a service (SAAS) and hardware as a service (HAAS). This will include the delivery of applications increasingly over Virtual Desktop Infrastructure (VDI) which uses virtual machines to provide and manage virtual desktops created on a centralised server and deploys them to end-users on request regardless of equipment used.
- To create oversight and challenge of the same rigor for EPR systems, but to enabling service systems, so that the above contribution to sustainability can also take place.

o. Productivity

There are productivity gains that IM&T can deliver especially when combined with service transformation. These can exist either within LPT or based on broader learning within the NHS family, where there has been demonstrable productivity gain. The list below indicates the gains that LPT should be investigating and subject to a positive evaluation implementing to increase productivity.

i. Workforce

The LPT workforce has had to adapt over the years to using more technology, but from the level of support required to ensure that these staff are using the technology effectively and optimally suggests that with the right proactive support staff could be more productive by ensuring that:-.

- **New staff entering the workforce** have had significant exposure to digital platforms, such as e-learning during their training so they are **familiar with the sort of technology they are likely to be faced with**. As an example trainee nurses are very able with social media and smart phones, but they do not possess any typing skills nor understand why it is important to ensure record keeping on EPR systems is critical to safe patient care or the income of the Trust. This can be picked up via the link LPT has with De Montfort University.
- Digital skills are taught based on a person's role and the application they need to use to perform that role. Once taught their IT Training is not refreshed unless the application is changed, there is no continuous programme to enhance skills nor any measures in place to ensure that a minimum level maintained, however we expect this for clinical skills, but the digital skills underpin patient safety too. The ask here is for

workforce colleagues to look at how we can do better to **support our staff by continuous enhancement of these necessary skills.**

- Bank and Agency staff are still a challenge, the previous strategy was concerned about staff not actually having accounts set up and Smart Card procession. This has largely been removed as a barrier now, however moving to a single EPR, the Trust needs to ensure that the bank and agency staff it engages have the necessary skills and are deemed safe to use the EPR system. All bank staff will be trained as part of the single EPR project, but this will exclude agency staff, and once the training programme has completed the resource to train new bank staff will not be available. **LPT staffing service need to ensure that Bank and Agency staff can demonstrate a minimum attainment level before they use the EPR system, and also challenge the LHIS training service to offer e-learning via the Internet to avoid bank and agency staff having to attend training and be paid for that day**.
- As the NHS evolves and particularly with the transformation programmes in community services, new roles with new digital demands will evolve for healthcare staff. LPT must ensure that these **staff understand that digitally supported patient care will become the norm** and must also ensure that some of the challenges of working in **new provision models demanded by the NHS Long Term Plan can be digitally supported by the IT Services** necessary to deliver these new models.

ii. Smart Scheduling

The Trust has introduced smart scheduling not only for Bank staff but also for many community services, the principle is that availability, location and skill can all be taken into account by the computer system and it works out the optimal solution for a shift or visits. This moves away from a staff elected decision, to an automated decision. **With the single EPR project go-live post November 2020 this will create the opportunity for other services to move to smart scheduling technology within their service.** The ability to empower bank staff through their own dedicated App which allows staff to see availability, book vacant shifts and request annual leave or shift preferences is seen a huge additional benefit that the Trust would like to introduce into operation. This will require a shift to a cloud based platform to the current product used which is on-premise.

iii. Insights

This term fundamentally means in this context a real time view on how a system is working so that potential bottlenecks can be spotted in a system and pro-active action taken to avoid. **LPT** on its own cannot provide the system overview but **can supply information to allow the collective of partners in the local Health and care system to see in real time how the system is**

working and spot a problem. Early work has been undertaken in areas such as Manchester on this with reference to Ambulance crews choosing the right destination, but it could also extend to real time LLR views of bed states or numbers of patients flagged as ready of discharge, to allow the whole system to flow much better. Historically flow is not capable of being monitored between computer systems in real time. One of the objectives in the LHCR project in section 4.1.3 is to allow this to happen and also for every Health and Care provider to play their part in supporting it.

iv. Collaboration Tools

The Trust in its attempts to improve its sustainability will have to take greater advantage of **collaboration tools** as stated in section 4.8. However making products available and training on their usage has not changed significantly the culture within LPT of too many physical meetings when they could be done virtually. It is proposed that the Agile working project which is funded again in 2020/21 **relaunches this opportunity and where barriers to usage have deterred usage to concentrate effort removing those barriers.**

v. Automation

As a principle LPT needs to look at its end to end business processes where data is entered into one software product and potentially passed to another computer system (often via paper) to do something with. This is often not done in an automated manner and can require double data entry, manual authorisation and a high risk of human error either not to undertake a task or make data entry errors. Where data collection in one format requires re-entry by an employee into another system, on a case by case basis Robot Process Engineering (RPE) could be explored as an option. Additionally, for where data is collected in a set format requiring assessment or triage, technology is emerging to automate this process by using Artificial Intelligence (AI). It is likely that AI will enter the NHS through triage or diagnostic operational tasks initial, but it is predicted that before the end of this plan some elements of AI will be used with LPT, probably linked to the Single EPR system. It is recommended that **as part of the Transformation Committee in LPT, business process automation, RPA and AI where appropriate are initiated as subprojects. With specific reference to business automation this must be urgently looked at**, to firstly understand if the process is efficient, challenge any custom and practice audit opinion and aim to have a single workflow process for these business processes. A capital allocation in the 2020/21 Capital Programme has been bid for to pump prime this work initially.

5. FINANCE

The emphasis from the NHS centrally is to promote digital transformation to support the Health and care system integration. To do this NHSX will work with systems to define 'what good looks like' for a digitised Health and Care system. Care systems and providers within will be expected to set out clear plans to work towards the agreed ambitions by 2024. These expectations will now be embedded in the CQC inspection framework and the Single Oversight Framework. Early in 2020/21 NHSX will set out its approach to mandating technology, security and data standards across the Health and care system, which all systems and organisations will be expected to comply with. NHSX, with NHS England and NHS Improvement, will also set out how technology funding should work, including:

- Funding for the digitisation of providers will be targeted through a new digital aspirant programme and will not be split equally across all organisations.
- Clarity on who pays for what, defining technology costs providers will be expected to pay for themselves.
- Other programmes to improve outcomes and relieve the frustrations for frontline staff, for example on solutions which will reduce the time that staff spend logging onto different systems.
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In the meantime, NHSX will expect systems and providers to ensure an appropriate level of investment in digital to achieve full use of modern digitised technology in the Trust by 2024 and that the investment in technology is done in the right way, improves care, increases productivity, reduces the burden on staff. Freeing up more time to care, helps manage demand by enabling care to take place in the right setting and improving patient experience.

NHSX therefore want the NHS to invest in technology now, to realise the benefits throughout the period of the NHS Long Term Plan and meet for the coming standards of interoperability and cyber security. NHSX, with NHS England and NHS Improvement, will be engaging with LPT to determine if there is a minimum and optimal indicative benchmark level of technology revenue spend linked to digital maturity standards that are under development, what that level might be; and how they might move towards it over time.

Going forward there will also be opportunities to bid for non-recurrent monies, which will generally be Capital and will partly relate to the multi-year capital settlements to enable the halt to stop/start investment in IM&T at year end.

Therefore the environment LPT will be heading into will be one where the revenue spend starts to become a aspirant target, there will be some central deals done by NHSX, which in some cases may be gifted to the local economy but in others will probably be discounted but also advised to utilise. Where LPT or the system can

demonstrate an ambition that can probably be first of type and subsequent blueprinting of that learning is shared with the NHS, then non-recurrent monies can be bid for.

Digital services increasingly will not match with the Capital funding process, both for the rules that exist on the spend of the money and the establishment of more revenue and less capital would be the preferred model to be migrated to by 2024 as this will support service based IT services rather than owned digital assets, which depreciate and need to be replaced from Trust Capital. Between revenue and capital workstreams a figure of between 4-5% is the likely target of Trust turnover that should be invested in IM&T. LPT although by no means a poor investor in IM&T manages circa 2%.

This financial ask to deliver the Digital Plan will be subject to the annual Capital Resource Limit of the Trust and the Annual capital plan agreed by the Trust within that resource limit and the Revenue Budget setting process.