DRAFT – POLICY IN DEVELOPMENT

NORTH EAST LONDON
SUSTAINABILITY & TRANSFORMATION PLAN

Transformation underpinned by system thinking and local action

Delivery Plan 8 of 8:

Digital Enablement

Contents

Initiative map

Our approach

There are a wide range of programmes that support our aim of supporting the delivery of care and reduction in use of services through the use of digital technology. These are outlined in our narrative plan for north east London. As the three Local Digital Roadmaps (LDRs) come together we have agreed the best level at which each programme should be led and delivered within the health system. This process has begun based on the partnerships and scale required to best implement the specific programmes, using the following rationale for choosing to progress an initiative at a particular level:

1. There is a clear opportunity / benefit in doing it jointly (which is above and beyond what would be achieved through a local programme), to deliver improvement in terms of enhancing the offer, finance, quality, or capacity;
2. Doing something once is more efficient and offers scale and pace;
3. Collective system leadership is required to make the change happen.

We set out these different levels below.

NEL STP Level

- Patient access to records is in some ways down to GP and provider level but public awareness and NEL level communication plans can be co-ordinated
- As Shared Care Records systems mature they will be joined and provide benefits across the STP and feed into the wider London information exchange

Local Area Level

- Shared care records are currently being achieved at LDR level, although WEL and C&H have connected their primary sharing systems (HIE) and are increasingly working as a single digital footprint
- Population health plans currently exist at LDR level although again WEL and C&H are working on the same programme (Discovery), while BHR is developing its Health Analytics product

CCG / Borough Level

- BHR CCGs act as one collaborative organisation for Digital. GPIT decisions are made at CCG level, although combined where economies are available
- Individual organisations make their own investment decisions for IT systems, bearing in mind the LDRs

London-wide

- Sharing EoL care plans across London (Coordinate my Care)
- Patient consent
- Elements of patient access to their record, such as a common consent model
- Citizen identity
- N3 replacement
- Digital mental health

Delivery plan on a page

Vision

Digital Technology will:

- *Support initiatives to help health, social and community care providers meet the needs of local people through shared records and access to information, built around the needs of local people*
- *Enable the development of new, sustainable models of care to achieve better outcomes for all; focused on prevention and out of hospital care*

Background and Case for Change

As laid out elsewhere in this document, transformational change is key to providing health and care services in NEL over the coming years. The NHS has accepted the challenge of being paper-free at the point of care by 2020. We will accord priority to quickening the pace of appropriate digital technology adoption within our organisation, realigning the demand on our services by reducing the emphasis on traditional face to face care models. We will explore new digital alternatives that will transform our services, with the aim of shifting the balance of care into our communities, enabling new integrated digital outpatient services and providing our patients with the information and resources to self-manage effectively, facilitating co-ordinated and effective out of hospital care. We will continue to build on advanced analytics population health management technologies, utilising opportunities for real time, fully interoperable information exchanges to provide new, flexible and responsive digital services that deliver integrated, proactive care that improves outcomes for our patients in a more sustainable way.

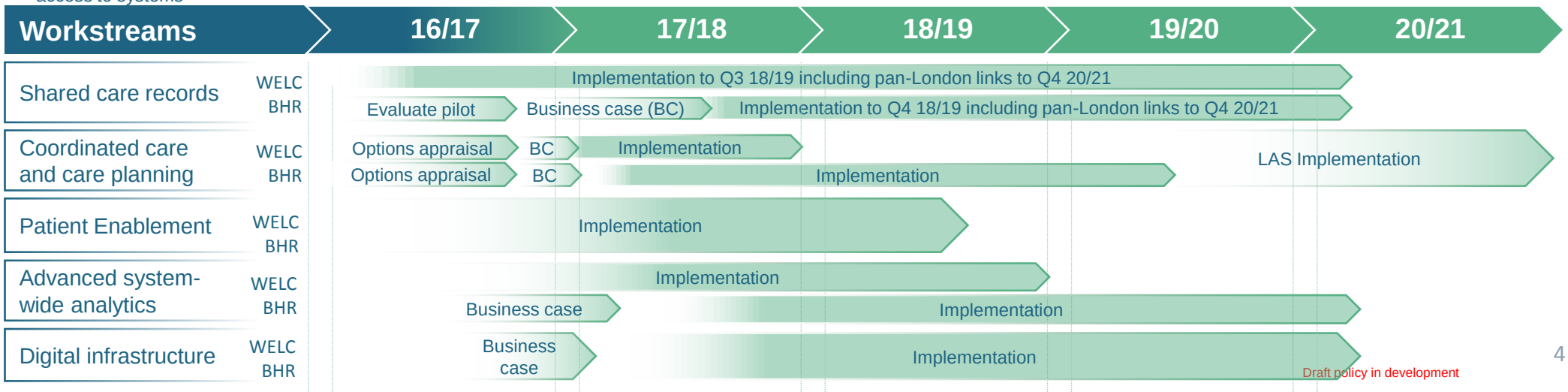
Priorities and Objectives

- **Shared care records** enhancing collaboration - Providers will collaborate with health, social and community care. Systems will therefore need to be interoperable to allow for providers from primary, community, social and secondary care to work together
- **Coordinated care and care planning** to enable more efficient transfers of care, reduce safeguarding risks and support safer and improved management of patients in crisis.
- **Patient Enablement** - Patients require the ability to view their own health records and care plans, book appointments with their GP and, eventually, the wider health and care system, and have greater access to services online.
- **Advanced system-wide health analytics** is needed to provide insight and prompt early interventions to enable informatics driven health management programmes; Population Health. Our health system will need to be proactive at preventing patients from escalating ill health and our interventions will need to be evidence-based. At present, each CCG has separate BI tools which are generally used for analysing corporate performance. This initiative will provide game changing health data analysis
- Ensure that the **digital infrastructure** across the footprint is up to the job of supporting reliable, fast access to systems

Expected Impact

It is recognised locally that the ability for professionals and patients to view and share patient information across the various care settings, leads to improved:

- Patient safety – supporting, safer more informed treatment by providing health and social care professionals with timely access to accurate and up to date information.
- Efficiency – reducing the time, effort, cost and resources required to obtain relevant information regarding patient care, e.g. reducing repeat tests, and transfers of care.
- Effectiveness – supporting appropriate care to patients, elimination of duplicate or unnecessary testing and unnecessary paperwork and handling.
- Patient experience & engagement– reducing the need for patients to recall or repeat their medication information and supporting people with difficulties communicating, and helping patients to be better engaged in their care.



Draft policy in development

Detailed plan – Work stream 1: *Shared care records*

Vision

All health and social care professionals will have access to all of the information directly relevant to the care of the patient or person with whom they have a legitimate relationship.

SRO:	*Terry Huff, Accountable Officer, Waltham Forest CCG*
Delivery lead:	*Anita Ghosh, IT Enabler Programme Manager, Homerton* *Bill Jenks, TST Programme Manager, TH CCG* *Simi Bhandal, Project Manager, BHR CCGs*

Case for change – Digital supports these STP initiatives:

- Lack of a joined up view leads to inefficiencies
- Without a complete picture patient safety can be compromised
- Many tests are ordered that have already been completed recently but are not visible in discrete system
- Patients are repeatedly asked for information that another part of the system already has leading to inconsistent data sets, frustrated patients and wasted time
- Records visible across Social Care and Primary Care is crucial to help avoid the need for acute care

Objectives

- Improved patient safety – supporting safer and more informed treatment by providing clinicians with timely access to accurate and up to date information
- Greater efficiency – reducing the time, effort and resources required to obtain relevant information regarding patient care, e.g. avoiding repeat test requests
- Greater effectiveness – supporting the delivery of appropriate care to patients
- Better patient experience – reducing the need for patients to recall or repeat their medication information and supporting people with difficulties communicating
- Real-time alerts in A&E
- Paperless results reporting
- Improved safety, efficiency and effectiveness for cross-border patients

	Initiatives	Enablers	Benefits and Metrics	Deliverables
1	Shared care records enhancing collaboration	• Stakeholder engagement: to ensure NEL wide agreement and take-up • Technical delivery by suppliers • Create and sign data sharing agreement to cover all providers so maximising availability of information • Publish fair processing notices • HLP Digital Programme	• Improved levels of care and patient safety through having a more complete picture • Efficient use of resources, especially around repeat testing and referrals • More satisfied patients because they've experienced a more efficient and effective system	• NHS bodies implement interoperable standards based systems • Connect all health and care providers in WELC to the eLPR (HIE/MIG) • Connect the London Ambulance Service via the HLP solution • Maximise interconnectedness of BHR providers and connect eLPR in WELC to key BHR systems • Implement sharing of structured data rather than web pages to allow automated actions to be taken • Connect WELC and BHR systems to HLP health and care information exchange • Electronic ordering of diagnostics and access to diagnostic results across NEL
2	Electronic ordering of diagnostics access to diagnostic results	• Stakeholder engagement: to ensure NEL wide agreement and take-up • Technical delivery by suppliers	• Faster and more reliable ordering • Reduced cost and reliance on paper	
3	eDischarge Summaries to GPs	• Stakeholder engagement: to ensure NEL wide agreement and take-up • Technical delivery by suppliers	• Improved levels of care and patient safety through having a more complete picture • Reduced cost and reliance on paper	• GPs receive discharge summaries more reliably and faster, directly into patient record
4	Child protection alerts for unscheduled care setting & social care	• Stakeholder engagement: to ensure NEL wide agreement and take-up • Technical delivery by suppliers	• Reduced chance of failing vulnerable children	• National CP-IS system implemented in all relevant organisations

Detailed plan – Work stream 2: *Coordinated care and care planning*

Vision

Patients receive the best care in the ways that they wish, especially towards the end of life and when multiple care providers are involved.

SRO:	*Terry Huff*
Delivery lead:	*Anita Ghosh, IT Enabler Programme Manager, Homerton* *Bill Jenks, TST Programme Manager, TH CCG* *Simi Bhandal, Project Manager, BHR CCGs*

Case for change – Digital supports these STP initiatives:

- Patients have a single care plan shared with professionals involved in their care, resulting in fewer avoidable hospital admissions
- Level of calls to 111 unnecessarily high
- Level of visits to GP Primary Care unnecessarily high
- ED conveyances from other areas too frequent
- Levels of frequent callers unnecessarily high
- Implementation of one platform for End of Life (EOL) care records accessible across all providers

Objectives

- Professionals able to view and amend care plans for all patients that require them
- Key health professionals able to create care plans with patients and their carers
- Shared care plans extended to social care professionals
- Patients and their carers able to view care plans online

	Initiatives	Enablers	Benefits and Metrics	Deliverables
1	Implementation of one platform for sharing of EOL care records accessible across all providers in London	• Stakeholder engagement: to ensure NEL wide agreement and take-up • Technical delivery by suppliers • Create and sign data sharing agreement to cover all providers so maximising availability of information • Publish fair processing notices • HLP Digital programme	• Fewer avoidable hospital admissions • Reduced level of calls to 111 and 999 • Reduced level of visits to GP Primary Care • Reduced ED conveyances from other areas • Reduced monthly levels of frequent callers • Supports multidisciplinary team working; improve quality of care and experience by service users	• Decision in WEL around best approach • Continuing business change activities in BHR and C&H to maximise use of Health Analytics and CMC respectively • Alerts and sharing of care plans in UEC settings • Practices sign-up to sharing agreements where necessary • Coordinate My Care or similar functionality provided co-authored plans
2	Sharing care plans directly into users normal clinical or social care system			• Easily used information in professionals main IT system which they can update and share with all other relevant people
3	Patients have a single care plan shared with health and care professionals involved in their care			• Multi-authored care plans that make a real difference to the care of patients at key stages of life

Detailed plan – Work stream 3: *Patient enablement*

Vision

That patients will become more engaged in their own health care through having more information, leading to better outcomes, and that the provision of services such as appointment booking and ordering repeat prescriptions will reduce costs and increase efficiency in General Practice.

SRO:	*Terry Huff*
Delivery lead:	*Anita Ghosh, IT Enabler Programme Manager, Homerton* *Bill Jenks, TST Programme Manager, TH CCG* *Simi Bhandal, Project Manager, BHR CCGs*

Case for change – Digital supports these STP initiatives:

- Need to improve patient satisfaction levels especially around the ease of making GP appointments, the ability of the NHS to meet demand including evenings & weekend access; reduce A&E attendances and reduce variation of service
- Care plans not visible to or changeable by patients
- Personalised budgets need patient access to care plans
- Need to improve access to unbiased information to make choices about care
- Patients don't have the tools, motivation and confidence to take responsibility for their health and wellbeing
- Low levels of self referral to e.g. IAPT services
- Patients are not empowered to remain healthy and don't feel connected to others and to support in their local community

Objectives

Summary of objectives from the work stream level plans:

- Access to detailed coded GP records actively offered to patients who would benefit the most and where it supports their active management of a long term or complex condition
- Patients who request it are given access to their detailed coded GP record
- Patients can book appointments and order repeat prescriptions from their GP practice
- Usage of online booking extended through enhanced mobile applications availability
- Patient can send electronic messages to GP via clinical systems
- Patient Owned Data (POD) updates to patient records increasing self-management and patients having greater control over the management of their own care.
- Patients have access to whole record of care - health and social care
- Improved management of capacity within primary care

	Initiatives	Enablers	Benefits and Metrics	Deliverables
1	Communications campaign	• Stakeholder engagement: to ensure NEL wide agreement and take-up • Technical delivery by suppliers • HLP Digital Programme • National Patients online programme • CCG Communications departments	• Patients are provided with more information enabling them to be more engaged in their own health care (leading to better outcomes), and that the provision of services such as appointment booking and ordering repeat prescriptions will reduce costs and increase efficiency in General Practice • More satisfied patients as measured by patient satisfaction surveys • Reduced DNAs through easier access to cancel and amend appointments • Richer and more complete patient record through recording of patient owned data	• Communications plans • Patient awareness raising activities • Advice and best practice guides to practices in terms of levels of appointments offered online and ways of engaging patients • Business change activities in general practice
2	Practice engagement to increase available appointments			• More GP appointments available on-line
3	Practice engagement to encourage take-up of access to patient online services			• Communications plans at the most beneficial level • Positive participation by GPs and Practice staff
4	Implementation of phone / appointment systems integration			• Patients able to book, amend and cancel appointments in appointment systems via the phone
5	Web based tools to aid initial consultation			• Web based pre-consultation software implemented in practices that can best utilise it

Detailed plan – Work stream 4: *Advanced system-wide analytics*

Vision

A Learning Health System that improves the health of individuals and populations by generating information and knowledge from data captured and updated over time and sharing and disseminating what is learned in timely and actionable forms that directly enable individuals, clinicians, and public health entities to separately and collaboratively make informed health decisions.

SRO:	*Terry Huff*
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Case for change – Digital supports these STP initiatives:

- To predict or anticipate individual health needs from algorithms running in real time (or as near as possible) and to deliver the insight gained directly into the patient's record across the whole of their pathway thus creating the opportunity to improve or prevent adverse outcomes.
- To expand the existing informatics driven improvement programme in east London in primary care to all health and care sectors.
- To enable the real time reporting of programmes supporting clinical improvement
- To provide patients with real-time information

Objectives

Summary of objectives from the work stream level plans:

- To predict, anticipate or inform individual health needs from algorithms running in real time (or as near as possible) and to deliver the insight gained directly into the patient's record across the whole of their pathway, whether in primary or secondary care or elsewhere, thus creating the opportunity to improve or prevent adverse outcomes.
- To expand the existing primary care informatics driven population health programme in east London, led by the Clinical Effectiveness Group at Queen Mary, to all health and care sectors
- To enable the real time reporting on programmes by providers and commissioners supporting clinical improvement and new payment mechanisms. This would involve reporting on either a pseudonymised or identifiable cut of the clinical data, as appropriate
- To use data by third parties (commissioners, public health, and academics) to support research, development and planning, whether on consented identifiable data, or the pseudonymised dataset. East London would thus become a research enabled community. BHR currently use linked datasets for research purposes, e.g. Health1000
- To support the development and delivery of outcome based care

Initiatives		Enablers	Benefits and Metrics	Deliverables
1	Implement Health Analytics in BHR	• Stakeholder engagement: to ensure agreement and take-up • Technical delivery by suppliers • Create and sign data sharing agreement to cover all providers so maximising availability of information • Publish Fair Processing notices	• Patient level alerts provided with more intelligence behind them that directly impact on professional decision making • The ability to receive accurate and immediate feedback on redesigned patient pathways • High quality and timely information at a population level on which to plan the health and care system	• Complete implementation of Health Analytics in BHR, building on progress and investment already made • Options appraisal on how Health Analytics and Discovery can be used in complementary ways, avoiding duplication but utilising best features or recommending a move to one system
2	Implement Discovery in WELC			• Complete implementation of Discovery in WELC, building on progress and investment already made
3	Provide real or near real-time reporting			• Clinicians and managers receive real time information and knowledge on which to base decisions
4	Write back functionality to patient / citizen record			• Professionals across care settings (with systems able to process them) receive alerts that enable them to make better or more timely decisions with their patients
5	Link BHR system (Health Analytics) and WELC system (Discovery)		• Information sharing for patients receiving cross boundary care'	• Connected systems sharing relevant and appropriate data

Detailed plan – Work stream 5: *Digital infrastructure*

Vision

A wholly reliable technical infrastructure with the capacity and capability to deliver the information required securely when and where it is needed across multiple care settings.

SRO:	*Terry Huff*
Delivery lead:	*Anita Ghosh, IT Enabler Programme Manager, Homerton* *Bill Jenks, TST Programme Manager, TH CCG* *Simi Bhandal, Project Manager, BHR CCGs*

Case for change – Digital supports these STP initiatives:

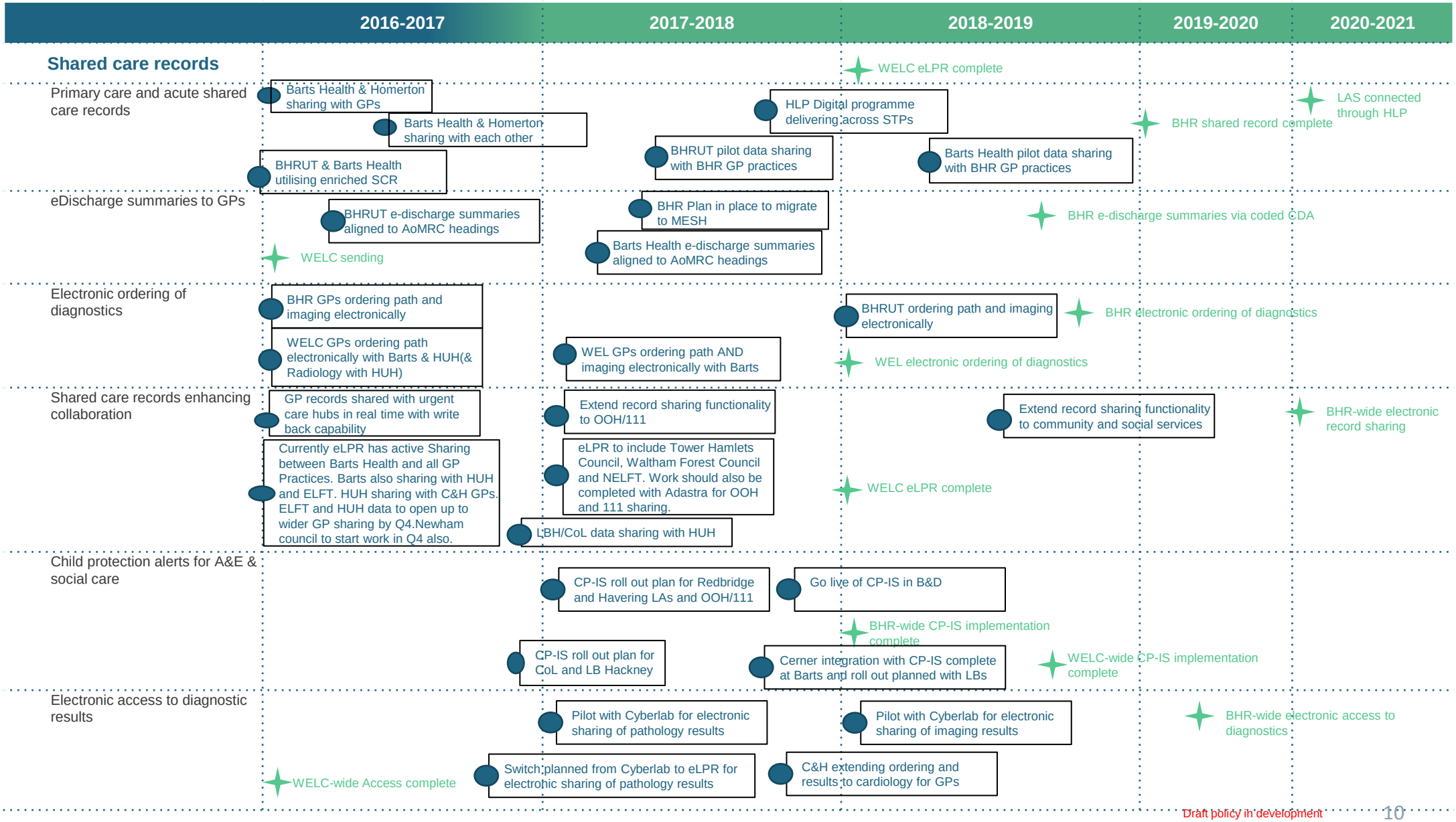
- Having a fit for purpose infrastructure provides the platform on which all else can be delivered
- Reduced outpatient appointment waiting times through use of telephone or video consultations
- Reduced back office costs
- Better patient engagement through Wi-Fi provision

Objectives

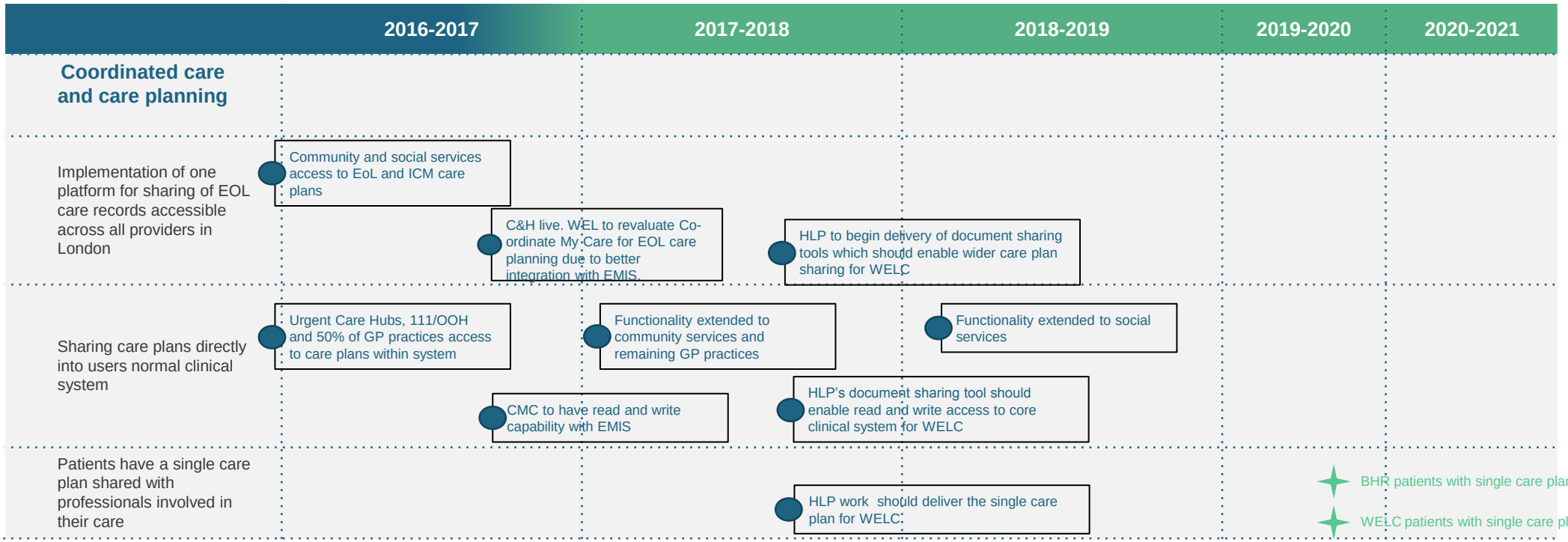
- Public have free Wi-Fi access from all GP surgeries
- Public have free Wi-Fi access from all NHS premises
- Improve Barts Health network to support other initiatives required to meet FYFV goals
- Offering all GP patients e-consultations and other digital services including e-referrals
- Support delivery of digital services
- Allow access to host systems via partner organisation Wi-Fi across NEL
- A Hackney network for care professionals and citizens - Hackney Devolution
- DoS - up-to-date and comprehensive - signposting to services including local services
- Re-procure wide-area network services

	Initiatives	Enablers	Benefits and Metrics	Deliverables
1	Barts Health infrastructure	• Stakeholder engagement: to ensure agreement and take-up • Technical delivery by suppliers • Pan-London N3 replacement • HLP Digital programme	• Stable platform over which all other initiatives can run (99.99% reliable clinical access)	• Fit for purpose infrastructure in Barts Health allowing use of technology such as video consultations
2	Telehealth expansion		• Reduced pressure on acute outpatient departments • Reduced travel for patients	• Outpatient shift utilising voice and video
3	Replace N3 network		• The ability to connect systems as required (no infrastructure blocks to progress)	• New wide-area network serving all NEL sites
4	Shared Wi-Fi access and free public access Wi-Fi (including Hackney network including mobile working - Hackney ambition)		• More flexibility in ways information is accessed (100% of staff able to work from other public sector sites) • More engaged patients/citizens (at least 20% accessing detailed record in 2018)	• Wi-Fi survey complete in all sites and Wi-Fi enabled for patients • Sharing required information to allow professionals to utilise Wi-Fi in other organisations • Area-wide citizen Wi-Fi to support Hackney devolution
6	DoS improvement	• NHS Digital DoS improvement project	• More effective e-referral system • Better sign-posting for patients	• NHS Digital to provide more effective Directory of Services tool

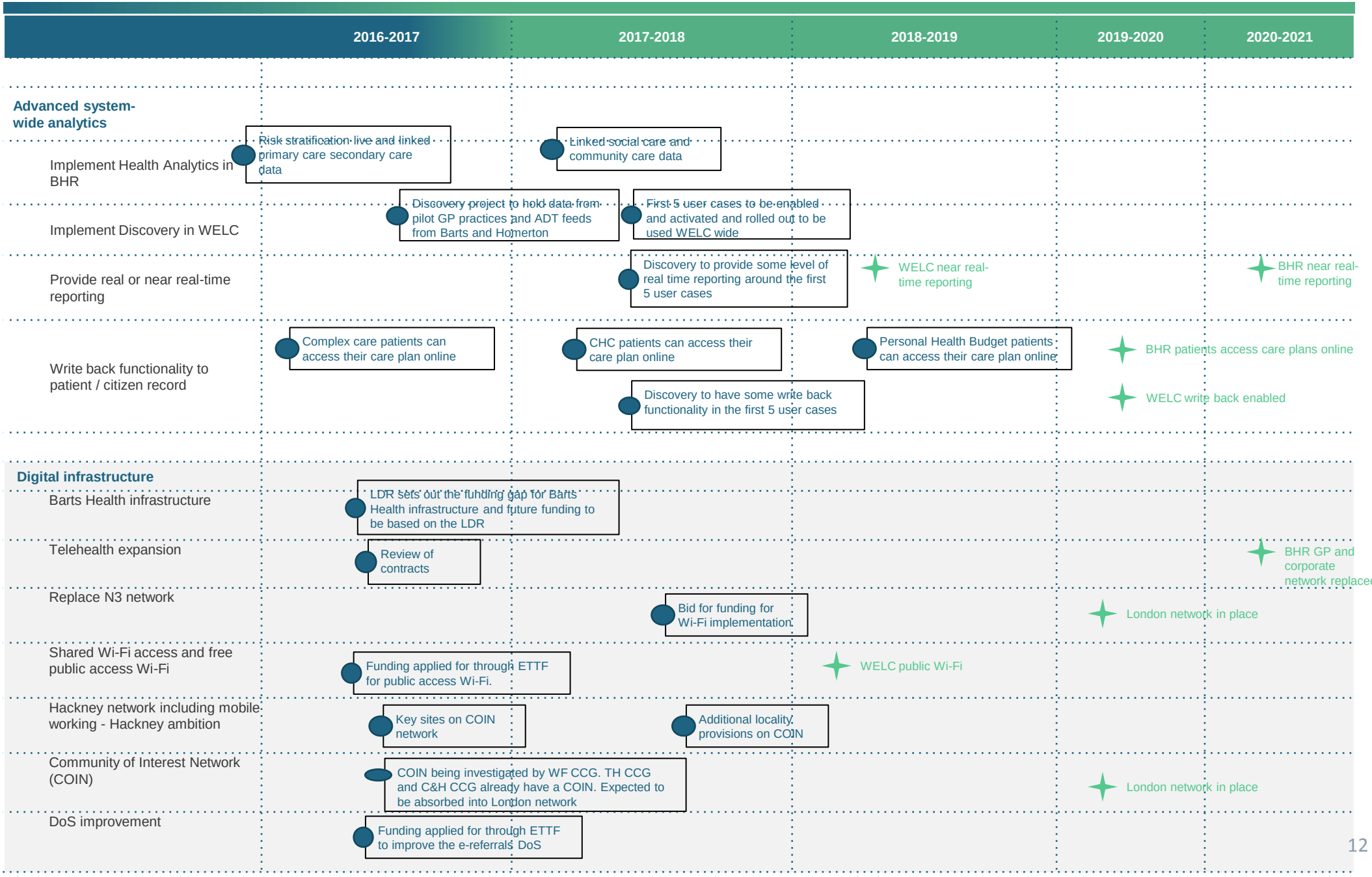
Route map (1/4)


2016-2017
2017-2018
2018-2019
2019-2020
2020-2021
Shared care records
Primary care and acute shared care records
Barts Health & Homerton sharing with GPs
Barts Health & Homerton sharing with each other
BHRUT & Barts Health utilising enriched SCR
HLP Digital programme delivering across STPs
BHRUT pilot data sharing with BHR GP practices
Barts Health pilot data sharing with BHR GP practices
WELC eLPR complete
BHR shared record complete
LAS connected through HLP
eDischarge summaries to GPs
BHRUT e-discharge summaries aligned to AoMRC headings
WELC sending
BHR Plan in place to migrate to MESH
Barts Health e-discharge summaries aligned to AoMRC headings
BHR e-discharge summaries via coded CDA
Electronic ordering of diagnostics
BHR GPs ordering path and imaging electronically
WELC GPs ordering path electronically with Barts & HUH(& Radiology with HUH)
WEL GPs ordering path AND imaging electronically with Barts
BHRUT ordering path and imaging electronically
WEL electronic ordering of diagnostics
BHR electronic ordering of diagnostics
Shared care records enhancing collaboration
GP records shared with urgent care hubs in real time with write back capability
Currently eLPR has active Sharing between Barts Health and all GP Practices. Barts also sharing with HUH and ELFT. HUH sharing with C&H GPs. ELFT and HUH data to open up to wider GP sharing by Q4.Newham council to start work in Q4 also.
Extend record sharing functionality to OOH/111
eLPR to include Tower Hamlets Council, Waltham Forest Council and NELFT. Work should also be completed with Adastra for OOH and 111 sharing.
LBH/CoL data sharing with HUH
WELC eLPR complete
Extend record sharing functionality to community and social services
BHR-wide electronic record sharing
Child protection alerts for A&E & social care
CP-IS roll out plan for Redbridge and Havering LAs and OOH/111
Go live of CP-IS in B&D
BHR-wide CP-IS implementation complete
CP-IS roll out plan for CoL and LB Hackney
Cerner integration with CP-IS complete at Barts and roll out planned with LBs
WELC-wide CP-IS implementation complete
Electronic access to diagnostic results
Pilot with Cyberlab for electronic sharing of pathology results
Switch planned from Cyberlab to eLPR for electronic sharing of pathology results
Pilot with Cyberlab for electronic sharing of imaging results
C&H extending ordering and results to cardiology for GPs
WELC-wide Access complete
BHR-wide electronic access to diagnostics

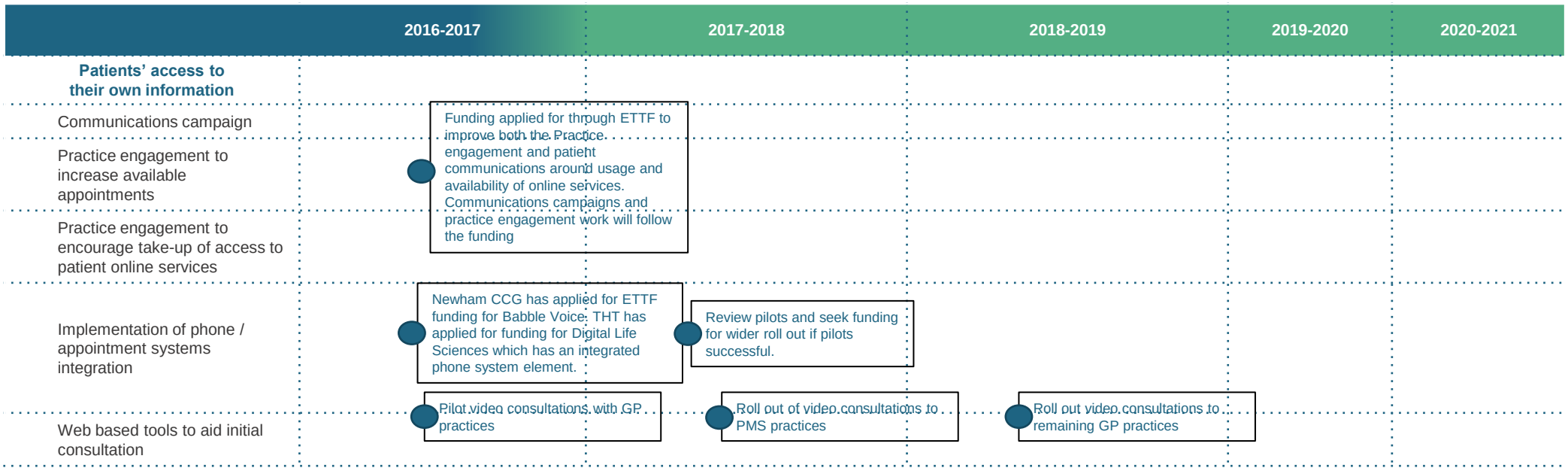
Route map (2/4)



Route map (3/4)


2016-2017
2017-2018
2018-2019
2019-2020
2020-2021
Advanced system-wide analytics
Implement Health Analytics in BHR
Risk stratification live and linked primary care secondary care data
Linked social care and community care data
Implement Discovery in WELC
Discovery project to hold data from pilot GP practices and ADT feeds from Barts and Homerton
First 5 user cases to be enabled and activated and rolled out to be used WELC wide
Provide real or near real-time reporting
Discovery to provide some level of real time reporting around the first 5 user cases
WELC near real-time reporting
BHR near real-time reporting
Write back functionality to patient / citizen record
Complex care patients can access their care plan online
CHC patients can access their care plan online
Personal Health Budget patients can access their care plan online
BHR patients access care plans online
Discovery to have some write back functionality in the first 5 user cases
WELC write back enabled
Digital infrastructure
Barts Health infrastructure
LDR sets out the funding gap for Barts Health infrastructure and future funding to be based on the LDR
Telehealth expansion
Review of contracts
BHR GP and corporate network replaced
Replace N3 network
Bid for funding for Wi-Fi implementation
London network in place
Shared Wi-Fi access and free public access Wi-Fi
Funding applied for through ETTF for public access Wi-Fi.
WELC public Wi-Fi
Hackney network including mobile working - Hackney ambition
Key sites on COIN network
Additional locality provisions on COIN
Community of Interest Network (COIN)
COIN being investigated by WF CCG. TH CCG and C&H CCG already have a COIN. Expected to be absorbed into London network
London network in place
DoS improvement
Funding applied for through ETTF to improve the e-referrals DoS

Route map (4/4)



Expected benefits & metrics

Note: Integrated outcomes and measures will be established in line with NHS E national metrics and current best practice guidance

This section provides a summary of high level benefits at Delivery Plan level:

Benefit description (Health & wellbeing, care & quality or financial)	Measurement (metric)	Current performance	Target performance	Target date (default 2020)	Linked work streams
New models of care can be developed, achieving better outcomes for all; focused on prevention and out of hospital care	Other delivery plans supported to deliver new models of care	TBC	TBC	Incremental to 2020	Advanced system-wide analytics, Digital infrastructure
Provide the information needed to enable organisations to work in partnership to commission, contract and deliver services efficiently and safely	Clinically significant information available where requested and agreed by Discovery board	TBC	TBC	2020 in BHR 2018 in WELC	Advanced system-wide analytics
Improved patient safety – supporting safer and better informed treatment by providing clinicians with timely access to accurate and up to date information	Number of serious incidents found to be as a result of lack of information	TBC	TBC	Incremental to 2020	Shared care records, Coordinated care and care planning
More efficient care –reducing the time, effort and resources required to obtain relevant information regarding patient care, e.g. avoiding repeat test requests	Amount of repeat testing	TBC	TBC	Incremental to 2018/19	Advanced system-wide analytics, Shared care records
Better patient experience– reducing the need for patients to recall or repeat their medication information and supporting people with difficulties communicating	Patient satisfaction rating	TBC	TBC	Incremental to 2018/19	Shared care records, Patient enablement
Intervention for individual patient prompted by analysis of broad set of data	Reduced incidence of specific life events	TBC	TBC	Commencing 20017/18	Advanced system-wide analytics, Shared care records
Patients take more active role in their own wellbeing	Accessing ‘patient on-line’ functionality	4%	20%-30%	2017/18	Patient enablement

Resources & delivery structure

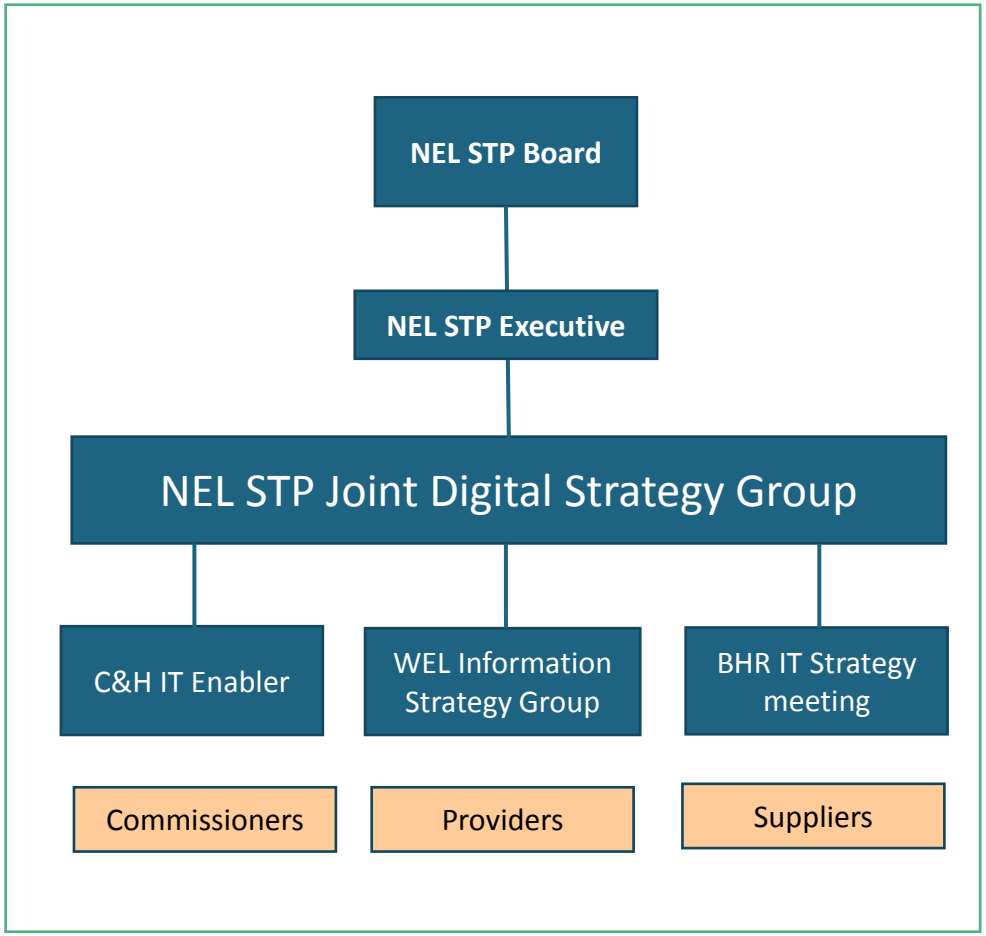
6.1 Resources

Delivery Plan	SRO	Delivery Lead
Shared care records	*Terry Huff, Accountable Officer, Waltham Forest CCG*	*Anita Ghosh, IT Enabler Programme Manager, Homerton* *Bill Jenks, TST Programme Manager, TH CCG* *Simi Bhandal, Project Manager, BHR CCGs*
Coordinated care and care planning		
Patients' access to their own information		
Advanced system-wide analytics		
Digital infrastructure		

In addition to the SRO and delivery needs named above, Luke Readman, CIO, WEL CCGs is taking the lead for Digital Enablement across NEL STP. Rob Meaker (Director of Innovation, BHR CCGs) and Niall Canavan (Director of IT, Homerton), along with Luke Readman in WEL, continue to provide digital leadership across their respective LDR footprints, working ever closer.

As ever, much of the delivery on the ground is provided through individual IT departments, change facilitators and suppliers which will need augmenting / paying for specific projects.

6.2 Delivery structure



Risks

Risks			
Work stream	**Description and impact**	**Mitigating action**	**RAG**
All	Finance – much of the Digital programme for the STP is unfunded and is reliant on successful bids to technology funds	Successful bids to Estates Technology Transformation Fund (ETTF) and other upcoming funding streams	**R**
All	Premature consolidation of BHR and WELC LDRs would potentially halt or even reverse progress that has already be made	Take time to consider real benefits verses risk before creating a single LDR	**A**
Digital infrastructure	Poor infrastructure in key areas	Successful technology bids allowing improvement programmes to be launch	**A**
Shared care record, Coordinated care and care planning	Compatibility of systems that haven't yet been connected	All systems use or soon will use recognised interoperability standards. Close supplier engagement underway	**A**
Shared care record, Coordinated care and care planning, Patient enablement	HLP Digital Programme failing to deliver the products they have committed to	Successful ETTF bid and ongoing funding streams secured	**A**
Patient enablement, Digital infrastructure	Progress would inevitably slow if GPIT re-procurement results in a new provider being selected	Careful consideration as to how and when any new service is brought on stream	**A**

This is a list of the highest-rated risks. Additional risks identified at a lower mitigated risk rating

Dependencies, constraints and assumptions

This section provides a summary of the key benefits that we expect to achieve through the implementation of this Delivery Plan level:

Dependencies, constraints & assumptions (in order of impact)			
Workstream	**Type: Dependency/ constraint/ assumption**	**Description**	**Actions / next steps**
Shared Care Record, Advanced system-wide analytics	Dependency	New Information Sharing Agreements and fair processing notices need to be in place before significant further steps can be taken	IG groups across NEL to collaborate on process and gain approval from all relevant parties
All	Assumption	Sufficient funding will be made available to deliver the transformational digital systems required. Current national (short term) bidding system for IT doesn't allow for good planning	Continuing to make the case for investment in Digital, bidding for monies from funds as they become available
All	Dependency	All suppliers deliver on their commitments	Continue existing good supplier engagement
Patient engagement	Constraint	Concerns from GPs about the effectiveness of patient on-line objectives and patient indifference / lack of awareness	Clinician and public engagement exercises
Patient engagement	Dependency	GP promotion of service to patients and willingness to publish appointment slots on-line	Clinician and public engagement exercises
Advanced system-wide analytics	Dependency	Engagement to determine where to focus initial efforts. Commitment to use information supplied	Continue discussions with clinicians
All	Dependency	Workforce appropriately skilled and engaged to take advantage of new ways of working enabled by Digital Enablement	Engage with Workforce team to ensure full understanding
Coordinated care and care planning	Assumption	Willingness for professionals and patients to use care plans	Fully engage with professionals and patients once clear on delivery mechanism
Digital infrastructure	Dependency	Provision of sufficient facilities for IT in new or refurbished buildings	Fully engage with estates and facilities teams where physical It assets need housing

Dependency map

This dependency map highlights where this delivery plan is linked to another delivery plan within our STP

	Prevention	Access to care close to Home	Accessible quality acute services	Infrastructure	Productivity	Specialised Services	Workforce
Shared care records							Workforce appropriately skilled and engaged
Coordinated care and care planning		Willingness for professionals to use care plans					Workforce appropriately skilled and engaged
Patients' access to their own information					GPs need to engage with the process of giving patients access		Workforce appropriately skilled and engaged
Advanced system-wide analytics	Engagement to determine where to focus initial efforts.						Workforce appropriately skilled and engaged
Digital infrastructure				Provision of sufficient facilities for IT			Workforce appropriately skilled and engaged

As an enabling delivery plan, Digital Enablement has few dependencies on other delivery plans

Summary of financial analysis

The basis for the financial modelling has been the five year Operating Plans prepared by individual NEL commissioners and providers, all of whom followed an agreed set of key assumptions on inflation, growth and efficiencies. The individual plans have then been fed into an integrated health economy model in order to identify potential inconsistencies and to triangulate individual plans with each other. In the June submission the starting point for this modelling was the 16/17 operating plans. This has since been refreshed to be the month 6 forecast outturn.

The NEL STP financial template summarises the:

- Latest financial gap projection
- The anticipated financial impact of the work streams on closing the gap
- The BAU effect on closing the gap
- The capital requirements for the STP
- The investment requirements including 5 year forward view investments

While substantial progress has been made on the financial and activity modelling for the NEL STP, the finance and activity plan for the October 21st submission should not be regarded as the final position. Further detailed worked-up analysis will follow over the coming months.

Work done since 30th June

- Expanded the Transforming Services Together capacity and activity model across the whole NEL STP footprint
- Updated the new capacity and activity model to include the BHR ACO schemes
- Refined the capital investment requirements
- Incorporated the estimated costs for the delivery of the 5 Year Forward View requirements
- Refreshed the underlying financial calculations to be based on month 6 forecast outturn
- Agreed the STP resourcing requirements
- Commenced detailed analysis of the financial and activity impact of the workstream initiatives
- Applied the capacity and activity model to calculate the capacity requirements for the Whipps Cross capital business case

Planned future work

- Update the new capacity and activity model to include Hackney Devolution pilot
- Identify opportunities to obtain additional funding from national investment funding sources (e.g. the Mental Health 5 Year Forward View)
- Undertake more detailed modelling of the financial and activity implications of workstream initiatives
- Reach agreement on the STP wide system control total (taking into account organisational control totals).
- Agree the implementation of the system control total, including handling of key dependencies (e.g. the NHS E specialised commissioning)

Contribution to our Framework for Better Care and Wellbeing

This delivery plan sets out how it will deliver improvements against the core areas of prevention, out-of-hospital care and in-hospital care.

Promote prevention, and personal and psychological wellbeing in everything we do

The Patient Engagement work stream supports patients to improve their own wellbeing through providing information to them and enabling them to provide information, e.g. from an activity tracker or mood score app, back to their clinician.
The Advanced System-wide Analytics work stream will provide prompts to clinicians to enable early intervention.

Co-ordinated Care and Care Planning will help patients receive the treatment and social care support they want where and when they want it, initially supporting end of life care. The Shared Care Record will give a sense to the patient that those involved in their care have a complete picture and have the confidence to act upon that information

There is clear evidence that multi-authored end of life care plans have a significant impact on the ability of patients to die in their preferred place. Wider multi-authored care plans enable all those involved in care to provide what is need in the right place and at the right time, involving carers as necessary. A full Shared Care Record can facilitate safe discharge from hospital but also help prevent admission and attendance at A&E because professionals have a full picture and can make more appropriate decisions based on that information

Promote independence and enable access to care close to home

Through the use of all of the Digital Technology described in this Delivery Plan and in the LDRs it is possible to reduce recourse to acute services because professionals and patients alike have a much richer picture of previous care, current conditions, risks and ongoing planned interventions. Such reductions in demand for acute services allows greater access for those that necessarily require them.

Ensure accessible quality acute services for those who need it

Addressing the 10 'Big Questions'

Q1. Prevent ill health and moderate demand for healthcare

- Greater patient engagement (slide 8 - work stream 3).
- Advanced system-wide analytics uses risk stratification and algorithms to alert clinicians to possible early interventions engagement (slide 9 - work stream 4).

Q2. Engage with patients, communities & NHS staff

- Greater patient engagement though access to their own record and digital interaction with professionals (slide 8 - work stream 3).

Q3. Support, invest in and improve general practice

- Greater patient engagement though access to their own record and digital interaction with professionals (slide 8 - work stream 3) can reduce workload on practice staff.

Q4. Implement new care models that address local challenges

- Advanced system-wide analytics can surface bottlenecks in the health and care system and support new models of care with early evidence of effectiveness (slide 9 - work stream 4).

Q5. Achieve & maintain performance against core standards

- Improved e-referral usage can make significant impact on overall system performance. The Local Digital Roadmaps describe how e-referral performance will be improved.

Q6. Achieve our 2020 ambitions on key clinical priorities

- Shared care record (slide 6 - work stream 1) and Coordinated care and care planning (slide 7 - work stream 2) generally support professionals delivering care by giving them a more complete picture.
- Advanced system-wide analytics will alert for early intervention (slide 9 - work stream 4).

Q7. Improve quality and safety

- Shared care record (slide 6 - work stream 1) and Coordinated care and care planning (slide 7 - work stream 2) support quality improvement by giving professionals a more complete picture
- Advanced system-wide analytics will alert for early intervention (slide 9 - work stream 4).

Q8. Deploy technology to accelerate change

- All work streams in this delivery plan involve the deployment of technology to accelerate change (see slides 6-10).

Q9. Develop the workforce you need to deliver

- Work streams 1,2&4 provide the tools required to support MDTs, for example.

Q10. Achieve & maintain financial balance

- The benefits sections of all work streams identify ways in which digital technology can improve efficiency and reduce demand.
- In addition to the identified work streams, digital is engaged with Carter review recommendations.

Addressing the 9 'Must Do's'

1. STPs

- This delivery plan outlines our agreed STP initiatives and milestones and the timeline for delivering them. We have also begun to map out the metrics against which we will measure our progress.
- Much more detail is included in the Local Digital Roadmaps.

2. Finance

- The Digital Enablement plan will enable the other delivery plans to achieve their financial targets.
- We are working collaboratively to develop a flexible / scalable back office service models where this will deliver value for NEL.

3. Primary Care

- Digital underpins primary care activity, as expressed in all of the work streams.

4. Urgent & Emergency Care

- Access to shared more complete records in NEL and across London, plus the ability to write back into records and care plans underpins changes needed in U&EC.

5. Referral to treatment times and elective care

- The digital capability is already in place to enable 100% use of e-referrals.
- The use of advanced analytics will provide key parts of the information required to streamline elective care pathways.

6. Cancer

- The Shared Care Record and the Coordinated Care And Care Planning work streams in particular, support the Recovery Package information requirements.

7. Mental health

- The Shared Care Record allows professionals to see what interventions have been tried or are ongoing outside of their own organisation.

8. People with learning disabilities

- Shared Care Records reduce the need to ask patients for information about allergies, previous treatments in other care settings, etc.
- Multi-authored care plans that are accessible by patients and their carers support community provision and avoiding admissions.

9. Improving quality in organisations

- The information provided by Advanced system-wide analytics can be used to drive up quality across the system.
- Access to fuller care record information from beyond own organisations enables professionals to take better decisions, driving up quality and reducing avoidable cost.