Northern, Eastern and Western Devon Clinical Commissioning Group

IM&T Strategic Vision Statement for Service Transformation 2014/15 -2017/18



Engagement Process:

1st July 2014 – reference group comment and document amended

Health and Wellbeing Boards – share and seek feedback – dates to be confirmed – S Mclean

Healthwatch – share and seek feedback by 4th September 2014 – S Mclean

Commissioner input:

Locality input – circulate to commissioning teams for feedback by 4th September – S Mclean

GP Forums in all localities – attend and share document – obtain feedback by 4th September S Mclean

Primary care input:

LMC – A Benny to meet with Mark Sanford-Wood and Angela Edmond to agree plan for engaging primary care – by mid July

Devon wide practice managers' forum – A Benny to share and ask for feedback after their next meeting on 21st August

Provider input – all CIOs committed on 1st July to taking the document to the relevant people within their organisation and to feedback by 4th September 2014

NHS England – A Benny to work with Julia Cory and shape document by 31st July

Kernow CCG, SD&Torbay CCG, Somerset CCG – share at next four CCG meeting and also contact CIO for each organisation for feedback – 17th July 2014

HSCIC – S Mclean to share with Tim Magor and seek feedback by mid July

Sign off process:

Final draft - Mid September

Endorsement from stakeholders – last two weeks in September

CCG governing body – October 2014

Date: 11 July 2014

Version: 0.8

Status: Draft

Document History

Date	Version	Status	Author	Summary of document revisions
03/06/2014	0.1	Draft	Zachary Swann	Initial Draft, Roadmap still needs to be completed
11/06/2014	0.2	Draft	Zachary Swann	Document restructured following feedback from NEW Devon CCG, Roadmap completed
18/06/2014	0.3	Draft	Zachary Swann	Following feedback from NEW Devon CCG strategic requirements broken into “core” (must do) driven by national priorities and “additional” (aspirational) driven by local priorities.
29/06/2014	0.4-0.6	Draft	Lisa Shotton	Document restructure and QA
11/07/2014	0.7	Draft	Shirley Mclean	Changes following feedback from IM&T Stakeholder event held on 2/7/14
11/07/2014	0.8	Draft	Annette Benny	Addition of engagement process and comments within governance arrangements.

Document Reviewers

Name of Reviewer	Job Title	Organisation	Date of review	Outcome
Shirley Mclean	Programme Manager	N.E.W. Devon CCG		

Document Approver

Name of Approver	Job Title	Organisation	Date of approval	Signature
Annette Benny	Managing Director for Delivery	N.E.W. Devon CCG		

Table of Contents

1. Executive Summary

NEW Devon CCG is a large and influential player in the delivery of health and social services in Devon. It aspires to continue to improve that delivery in terms of citizen experience, health outcomes and value for money. It recognises that a key success factor will be working in partnership with other organisations within its community, whilst aligning its activities with national best-practice standards.

NEW Devon CCG's draft Strategic Plan 2014/15 – 2018/19 recognises the role of IM&T as a key enabler of its 5-year strategic priorities and associated transformational change. This IM&T Strategic Vision statement demonstrates how IM&T will not only fulfil that corporate expectation over the next three years, but will also establish NEW Devon as an exemplary CCG in the delivery of national targets and programmes.

This document explores both the national and local strategic contexts for IM&T and also engages with the needs and aspirations of partners and stakeholders, expressed in a preparatory consultation exercise.

The strategic vision for IM&T in NEW Devon consists of:

- A single digital record for every citizen containing information integrated and summarised from every care interaction across NEW Devon, accessible by care providers and citizens themselves subject to security and confidentiality constraints;
- Information to support clinical, management and commissioning decision-making and for research purposes, derived from operational data, made available in appropriately anonymised/pseudonymised form with self-service access to analytical tools and reporting;
- Efficient and flexible working and new models of care supported through the innovative use of IT, such as telehealth and telecare.

This document sets out five key strategic objectives and the governance and organisational requirements needed to create an environment for their delivery. It also demonstrates the synergy between the achievement of national targets and fulfilment of NEW Devon's own strategic priorities and how interoperability and compatibility between partner IM&T services can leverage additional benefits for the local community from the effort applied to national initiatives.

SO1. To ensure that high quality clinical information is accessible in an **integrated, shared clinical record**, in real time, at the point of care; so that in future citizens only need to tell their story once;
SO2. To provide **citizen access** to that record and to enable them to contribute information and preferences.
SO3. To support the continuous improvement of the services we commission by **using information** available to us; and
SO4. To improve the value for money of services we commission by **using IT innovatively**;
SO5. To develop a **governance framework** to ensure that the IM&T programmes of the providers are fully aligned to meet the clinical and business needs of the clinical commissioning group.

Following an assessment of the current situation and progress to date, this document explores strategic options and sets out a road map to achieving the vision.

2. Introduction

NEW Devon CCG is a large and forward-looking CCG with substantial expertise and experience in using technology to improve care outcomes, to drive our strategic business aims and to encourage innovation and collaboration with our partners in the delivery of successful health and social care.

This document sets out NEW Devon CCG's high-level vision for the future of IT within health and social care in Devon for the next 3 years, and the strategic objectives to be achieved in order to fulfil that vision.

This document completes the action entitled "An outline IT Strategy and road map" taken by the CCG at the Devon health and social care community – IT workshop on the 27th February 2014.

This IM&T Strategic Vision statement demonstrates how IM&T will not only fulfil corporate expectations of IT as an enabler of transformational change in service delivery over the next three years, but will also establish NEW Devon as an exemplary CCG in the delivery of national targets and programmes.

This strategic vision statement has been produced based on the following inputs:

- the published notes from the Devon health and social care community – IT workshop held on 27th February 2014;
- extensive strategic documentation, including the published IT Strategy documents for the acute providers;
- interviews conducted between 19th and 22nd May 2014. This captured the views of 40 individuals from 13 different stakeholder organisations across the three localities of the NEW Devon CCG (a full list of participants is included in appendix B).
- a workshop on the 1st July to review the first draft by a reference group comprising the individuals from both the above workshop and the interviews. Their feedback has be incorporated into the document.

The target audience for this document includes:

- Senior managers responsible for the delivery of Information Management & Technology within New Devon CCG and Devon County Council;
- Senior primary and secondary care clinicians within Devon's Northern, Eastern and Western localities;
- The participants who attended the Devon health and social care community – IT workshop of 27th February 2014;
- The participants in the information gathering exercise, which was conducted during the third week of May 2014, as part of the preparatory work for this document.

3. Strategic context

This IM&T Vision addresses both the national requirements for IT development and the capability specifically needed to underpin delivery of NEW Devon's draft five-year Strategic Plan.

3.1 National Context

The Care Act 2014 will require health and social care to be more integrated, with joined plans and personalized budgets. This will require much more sophisticated IT systems than those currently deployed.

The CCG must fulfil the following 3 strategic objectives in order to meet the requirements as specified at the national level by NHS England and the Health and Social Care Information Centre (HSCIC).

3.1.1 Putting patients first

The aim of Digital First was to reduce unnecessary face-to-face contact between patients and healthcare professionals by incorporating technology into these interactions. This aim was picked up and developed further in Putting Patients First: The NHS England business plan 2014/15 – 2016/17[1]. This states:

> *"…we will give people control over their own health information to help them say what kind of care they want. This…will lead to improved outcomes for every citizen."*

and

> *"They (citizens) need to be able to make use of the latest digital technologies to improve the safety, outcome and experience of care."*

3.1.2 Paperless

In January 2013, the Health Secretary Jeremy Hunt challenged the NHS to become paperless by 2018.

- Everyone who wishes will be able to get online access to their own health records held by their GP.
- Adoption of paperless referrals - instead of sending a letter to the hospital when referring a patient to hospital, the GP can send an email instead.
- Clear plans in place to enable secure linking of these electronic health and care records wherever they are held, so there is as complete a record as possible of the care someone receives.
- Clear plans in place for those records to be able to follow individuals, with their consent, to any part of the NHS or social care system.
- Digital information to be fully available across NHS and social care services, barring any individual opt outs.

3.1.3 Joined up data

In July 2013, NHS England issued its guidance on 'creating an integrated digital care record' (IDCR). The guidance described this record as:

"the ability of local health and care services to use digital technology to ensure that vital, citizen related information and clinical decision and support tools can be viewed by an authorised user in a joined-up manner in any single instance."

It also stated that to make progress, systems would need to meet "national standards in vital areas such as data security and interoperability with other systems"; starting with a renewed focus on the NHS Number so that "records can be related to one person."

[1] http://www.england.nhs.uk/wp-content/uploads/2014/04/ppf-1415-1617-wa.pdf

3.1.4 Mapping National Targets against Strategic Context

The following table identifies seven national targets and shows how these support the national strategic guidance. The first six targets are taken from Mandate 6 of the NHS England Mandate 2014/15-2016/17[2] (use technology to help people manage their health and care) and the seventh comes from the Electronic Prescribing Business plan.

Relevant National IT Targets	Strategic Context		
	Putting Patients First	Paper-less by 2018	Joined up data
1. By March 2015 – in 95% of GP practices patients will be able to order repeat prescriptions online, book appointments online and have online access to GP records	✓	✓	
2. By end of December 2014 – a third of A&E departments, NHS 111 providers and ambulance trusts will have access to primary care records	✓		✓
3. By end of January 2015 - 95% of Trusts to be using the NHS number as primary identifier in clinical correspondence	✓		✓
4. By end of January 2015 - E-Referrals will be available for patients and health professionals for all secondary care referrals	✓	✓	
5. By September 2017 - 100% of secondary care outpatient referrals will use the e-referrals service	✓	✓	
6. By end of 2017 – significant progress will have been made in the availability of telehealth and telecare[3]	✓		✓
7. By end of March 2015 – 50% of all GP Practices will be using Electronic Prescription Service (EPS)		✓	✓

Although specific targets do not exist for CCGs within Putting Patients First: The NHS England business plan 2014/15 – 2016/17, the CCG is also required to promote the use of following national systems/programmes:

- GP Systems of Choice (GPSoC) 2;
- Summary Care Record;
- GP2GP.

[2] http://www.england.nhs.uk/wp-content/uploads/2014/04/nhse-mandate-wa.pdf

[3] Telecare and telehealth services use technology to enable citizens to live independently at home and include personal alarms and health-monitoring devices. They are especially helpful for people with long-term conditions, giving them and their relatives the peace of mind that they are safe in their own home and that their health is stable, without the need for regular visits to the doctor's surgery. They can also help them live independently in their own home for longer, so that they can avoid a hospital stay or put off moving into a residential care home.

3.2 Local Context

In addition to meeting the national strategic targets, NEW Devon CCG has its own ambitious plans for service transformation. These are embodied in its draft five-year strategic plan and its two-year commissioning intentions statement.

3.2.1 Using technology as a key enabler to changing working practices

Underpinning the CCG's draft Commissioning Framework 5 year Strategic Plan and 2 year Commissioning Intentions 2014-2016, is the use of technology as a key enabler.

Figure 1 - NEW Devon CCG Strategic Plan 2014/15 – 2018/19 (Draft)

Technology will be required to support changes in working practices to bring about: improved outcomes; greater levels of citizen and staff satisfaction; more efficient, coordinated, cost effective and accessible services. Over the next 2 years, the CCG is expecting technology to have an impact on Urgent Care, Long-term Conditions (by facilitating "House of Care"), Frail Elderly and People with Learning Disabilities.

The technologies which will be used to support changes in working practices to deliver these improvements should be readily available. Examples of such technologies are well described in the QIPP Digital Technology and Vision: Enabler Library[4] and include: telehealth and telecare, digital dictation, mobile working and SMS appointment reminders for citizens. These are considered later in this document where relevant.

[4] http://www.networks.nhs.uk/nhs-networks/qipp-digital-technology-and-vision/enabler-library

3.2.2 Local IT Priorities

From information gathering sessions with the CCG's stakeholders the following set of five local IT priorities emerged:

1. Implementation of the **Integrated Digital Care Record** in Acute Trusts to improve the clinical digital maturity of these organisations
2. **Patient/citizen-controlled records** to improve self-management, promote choice, facilitate personal budgets empowering citizens by putting them in charge of their own records and letting them decide what is shared and with whom.
3. **Primary care record viewer** to give clinicians access to care records 24/7 to avoid unnecessary intervention, treatment or dispensing that does not benefit care.
4. **Improved workflow and task management** between secondary and community care and primary care to reduce the resources consumed in dealing with paper in GP practices
5. **Shared care plans** to improve the coordination between services and reduce unnecessary interventions.

4. Strategic Vision

The following strategic vision is informed by both national and local imperatives. It will be used to enhance the programme designed to deliver national mandatory requirements, incorporation of objectives to support the CCG's business plans to enable changes to working practices and to meet the aspirations of partners and stakeholders.

The strategic vision for IM&T in NEW Devon consists of:

- A single digital record for every citizen containing information integrated and summarised from every care interaction across NEW Devon, accessible by care providers and citizens themselves subject to security and confidentiality constraints;
- Efficient and flexible working and new models of care supported through the innovative use of IT, such as telehealth and telecare;
- Information to support clinical, management and commissioning decision-making and for research purposes, derived from operational data, made available in appropriately anonymised/pseudonymised form with self-service access to analytical tools and reporting.

We have identified five key strategic objectives (SOs) to achieve that vision:

SO1. To ensure that high quality clinical information is accessible in an **integrated, shared clinical record**, in real time, at the point of care; so that in future people only need to tell their story once;

SO2. To provide patient/citizen **access** to that record and to enable them to contribute information and preferences.

SO3. To support the continuous improvement of the services we commission by **using information** available to us; and

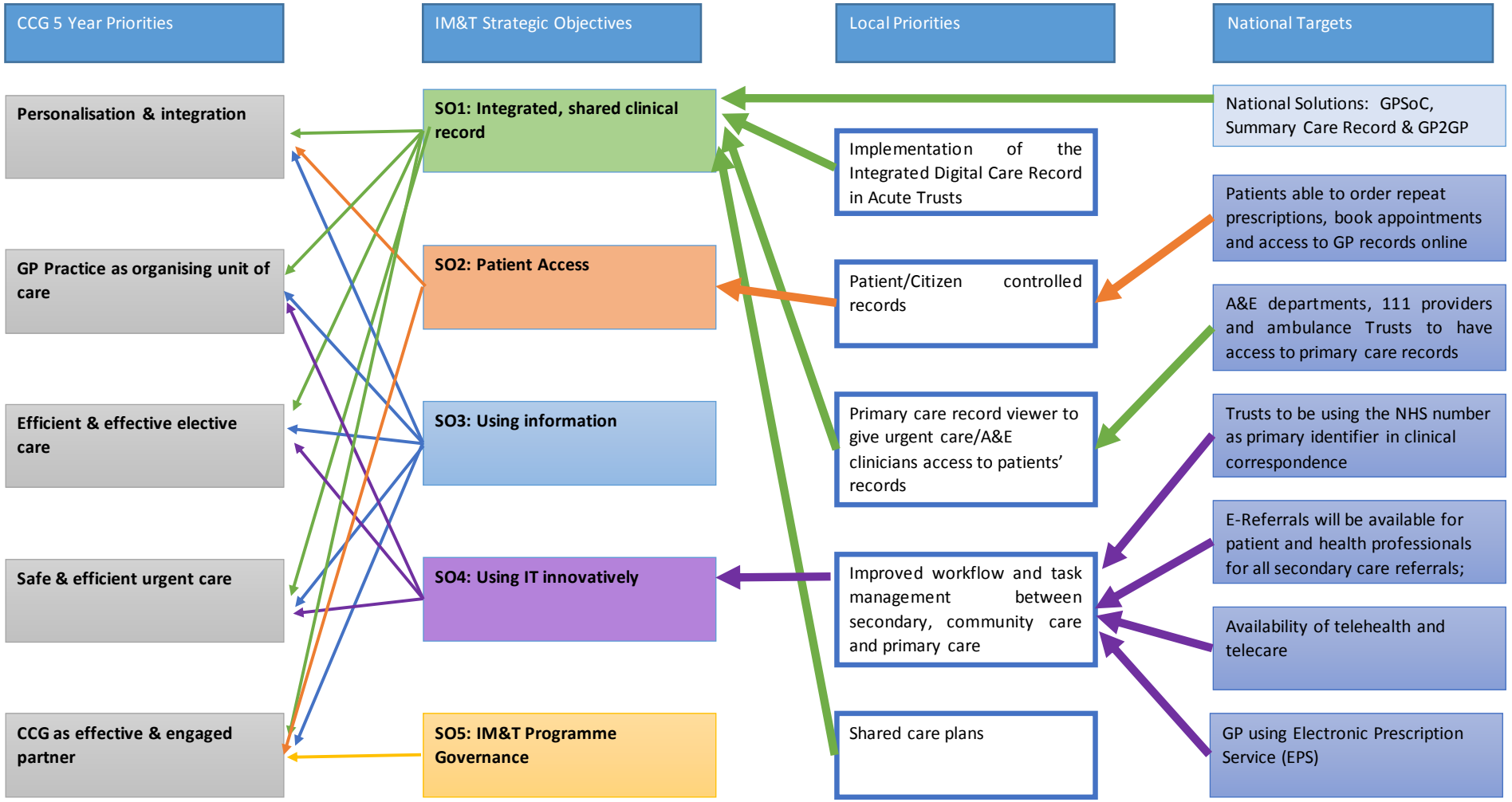
SO4. To improve the value for money of services we commission by **using IT innovatively**.

SO5. To develop a **governance framework** to ensure that the IM&T programmes of the providers are fully aligned to meet the clinical and business needs of the clinical commissioning group.

These objectives will be delivered in a structured governance environment, with clear roles and responsibilities, and underpinned by best-practice programme/project management. Interoperability of systems will ensure full benefit realisation for all stakeholders.

4.1 Mapping of IM&T Strategic Objectives

The diagram below shows how the IM&T Strategic Objectives are related to the CCG's five year strategic priorities and to the local and national targets:



5. Current Situation

A detailed analysis of the current situation by care setting is contained within Appendix A – Background Information. A summary of progress towards national and local targets is shown below.

5.1 Progress against National Targets

The following table summarises the current situation or starting point against the CCG's National IT Targets:

Target/Programme	Status	Rational/issues
1. By March 2015 – in 95% of GP practices patients will be able to order repeat prescriptions and book appointments online and have online access to GP records	Green	Practices that are using the up-to-date hosted versions of their clinical system have the capability to meet this requirement in full. They are currently enabling patients to order repeat prescriptions and book appointments online but have yet to roll out online access to their records
2. By end of December 2014 – a third of A&E departments, NHS 111 providers and ambulance trusts will have access to primary care records	Red	There is currently no universal solution to this issue in NEW Devon CCG. There are a number of potential solutions such as TPP EPR Core, which is being implemented in A&E in Plymouth, but this will not provide universal coverage for all practices in the locality or the CCG. Alternative options such as using a record viewer linked to an information/integration gateway or a clinical portal must be considered as a priority
3. By end of January 2015 – 95% of Trusts to be using the NHS number as primary identifier in clinical correspondence	Not known	This measure needs to be quantified as a priority and progress monitored by the CCG.
4. By end of January 2015 – E-Referrals will be available for patient and health professionals for all secondary care referrals	Green	The first release of e-Referral system which replaces Choose & Book will be released in November. Assuming this deadline is met then this target should be achievable
5. By September 2017 – 100% of secondary care outpatient referrals will use the e-referrals service	Green	The current utilisation of Choose and Book is over 80%. This gives the CCG 2 years from the release of e-Referral for it to close the gap and achieve the 100% target
6. By end of 2017 – significant progress will have been made in the availability of telehealth and telecare	Amber	There are currently no examples of telehealth or telecare being used systematically in the CCG. However, the technology is available and the end date is 2½ years away
7. By end of March 2015 – 50% of all GP Practices will be using Electronic Prescription Service (EPS)	Green	By the end of June 2014 there will be 47 practices (38%) using EPS. With the appropriate resourcing and project management the target of having 50% of practices live on EPS by March 2015 is achievable

The following table summarises the CCG's current situation or starting point against the other key national programmes (see section 3.1.4).

National System	Status	Rational/issues
1. GPSoC 2	Green	GP Systems of Choice 2 represents an opportunity for the CCG to promote federated working amongst GP Practices and deliver benefits to patients such as extended access. This is beginning to have an impact on practices' choice of clinical systems, because to federate effectively a group of practices needs to share the same hosted clinical system. To federate, the practices must have common hosted GP Clinical Systems and these can be acquired through GPSoC 2 when the contract for a practice's current system comes up for renewal. At the local level, practices are already starting to converge on either EMIS Web or TPP SystmOne.
2. Summary Care Record	Green	By the end of June 2014, 59% of practices (72) will have the ability to upload a summary care record. In comparison, across the southern region 44% of citizens have had a summary care record created. Given the high number of practices with access, the CCG is in a good starting position
3. GP2GP	Amber	60% of practices (73) are live on GP2GP. The low uptake is explained in part by GP2GP only working on the latest versions of the GP Clinical Systems. This restricts the number of practices where it can be rolled out. There are also issues with the functionality of the current version, which restrict its use and value to the GP Practices. These issues will be fixed with version 2.2a5. This version is being piloted (outside of the CCG) in June 2014 and there is currently no intelligence on when it will be available for roll out

5.2 Current progress against local IT targets

Although the timeline for delivering the full vision and the more aspirational requirements is longer than the three-year time frame for this strategy document, the CCG already has a head start. Areas where progress is being made are as follows:

[5] GP2GP Version 2.2a supports transfers of unlimited file sizes and with an unlimited number of attachments. It has no restrictions on the file types it can transfer and it sends a confirmation message that the receiving practice has successfully integrated the citizen's record electronically via GP2GP

Target/Programme	Status	Rational/issues
1. Implementation of the Integrated Digital Care Record in Acute Trusts to improve the clinical digital maturity of these organisations.	Green	Although the acute Trusts are all starting at different points on the Clinical Digital Maturity Index (CDMI)[6], they all have strategies in place to achieve integration across all care settings within and beyond their organisations by 2017/18. As acute Trusts embark on implementation of their strategies, it is important that the CCG engages and influences them; so that the CCG's strategic requirements are addressed.
2. Primary care record viewer to give clinicians access 24/7 to patients records to avoid unnecessary intervention, treatment or dispensing that does not benefit care.	Amber	The CCG is looking to put in place capability to support a number of scenarios including virtual clinics and extended access to primary care.
3. Improved workflow and task management between secondary & community care & primary care to reduce the resources consumed in dealing with paper in GP practices	Amber	Further investment is required in training and infrastructure to enable paperless solutions.
4. Shared care plans to improve the coordination between services and reduce unnecessary interventions	Red	A range of business scenarios, architectural patterns and interoperability specifications will need to be considered as part of a NEW Devon implementation plan. This will include potential use of existing National solutions.
5. Patient/Citizen controlled records to improve self-management, promote choice, & facilitate personal budgets; empowering people by putting them in charge of their own records & letting them decide what is shared and with whom.	Red	NEW Devon CCG aspires to enable and support record access, transactional services, etc. via a 'Digital Front Door' for residents in Devon. There is potential, with support from the NHS England Personal Health Record (PHR) programme, to deploy a PHR on a pilot basis. GPs in Devon are already working with Public Health & NHS England, to explore change behaviour messages delivered directly to citizens, particularly those with Long Term Conditions.

6. Implementation of the IM&T Strategic Objectives

A programme to deliver the IM&T strategic objectives will be implemented which will consist of the following elements:

[6] The CMDI is a benchmarking tool developed by EHI Intelligence that focuses on the adoption of electronic citizen records and related digital healthcare technologies within an acute trust. The CMDI assessment results in a ranking of all trusts in England from 1 to 160, with 1 being the most developed to 160 being the least well developed.

6.1 Development of an integrated, shared clinical record (SO1)

A shared, integrated clinical record across the CCG and its local care providers is at the heart of the vision for IM&T across the CCG. There are several technical architectural options for achieving this vision, ranging from a single, centralised database platform which is fed by all the constituent provider systems (primary care/GP systems, acute EPR systems, community, mental health and social care systems, etc.) through a locality-based model whereby integration is achieved locally centred around the acute Trust's systems, to a very light touch model whereby a minimum dataset of health and care information can be requested and shared on a need-to-know (or "pull") basis through an interoperability portal.

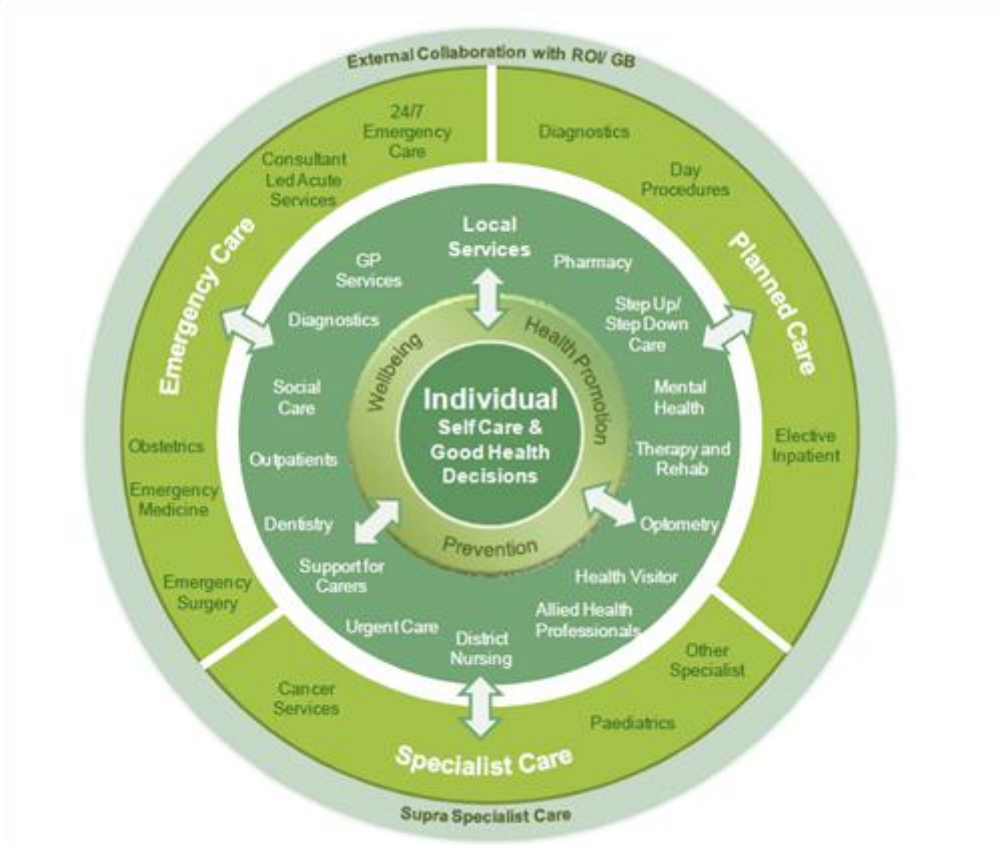


Figure 2: The patient at the centre

There are decisions to be made about whether GP systems should be connected together using the Medical Interoperability Gateway (MIG) supplied by Healthcare Gateway (or potentially an alternative product, subject to procurement) prior to the development of the wider interoperability solution.

The clinical data to feed the interoperability platform will be generated within provider systems.

The major systems replacement projects underway at each of the secondary care providers will be managed from within the Trusts. The GP systems consolidation project will be managed from within a separate work stream. However, both will develop an interoperability framework within which they will need to work and share data.

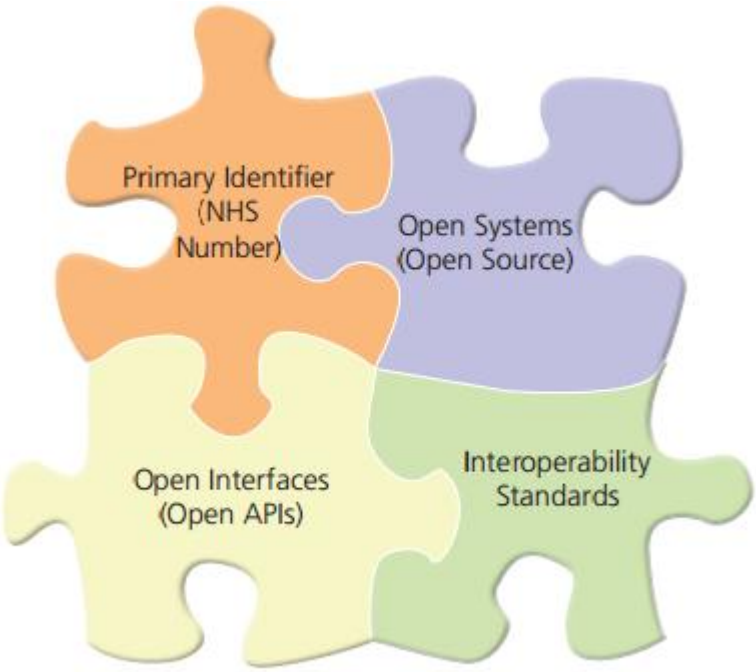


Figure 3: The Interoperability Jigsaw

In the short to medium term, there are four priority projects for this work stream:

P1. To produce an architectural design for interoperability. This will illustrate how interoperability will be achieved, explore architectural options and present a prioritised and costed plan to deliver it in a phased manner over 2 – 5 years. This plan will include projects to introduce new functionality and linkup existing and new provider systems as they come online. In the early years, this work stream will adopt and integrate existing projects as appropriate.

P2. Providing access to primary care records for A&E departments, NHS 111 providers and ambulance Trusts. The CCG will partner with one of the Acute Trusts, e.g. North Devon Healthcare Trust, and NHS 111 to bid against the Safer Hospitals, Safer Wards Technology Fund (round 2). The bid will be for the implementation of a clinical viewer/detailed care record linked to an information/integration gateway. This would enable the A&E department and NHS 111 to view primary care records.

P3. Consolidation of Primary Care Systems using GPSoC2: to evaluate options for moving towards shared GP systems across federated groups of practices, across localities or even across the whole CCG as a stepping stone towards achieving full CCG-wide record-sharing.

P4. Establishing the NHS number as the primary identifier for correspondence: To provide a firm foundation for sharing information across care settings, providing confidence in the correct identity of the citizen whilst maintaining confidentiality. In the first instance, this project will assess the levels of usage and then develop a work programme for improving levels and accuracy of use where required.

Other projects covered by this workstream will include:

P5. a mechanism for securely exchanging electronic correspondence between care providers;

P6. development of information sharing protocols to enable record sharing between health and social care;

P7. implementing e-referrals for all secondary care referrals;

P8. development of an interoperability framework to support the acute EPR implementation projects.

6.2 Enabling patient/citizen access & control of care records (SO2)

Technology solutions which provide citizens and their personal carers with the ability to access, update and contribute to their own records put them at the centre of their care and have been demonstrated to assist in self-monitoring, self-care and wellness. Successful applications of this technology allow care providers to share care plans and for people to be able to view their appointments, results and outcomes. Some applications enable citizens to input their own clinical measurements (e.g. blood sugar levels, weight, etc.) and to express their preferences for their treatment and care. This has the potential to be extended to enable citizens and care professionals to communicate online or via video conferencing.

Some applications can be populated with data directly from GP or secondary care solutions, whilst other designs rely on the sharing of data from the clinical portal or interoperability platform described in section 6.1 above.

Tactical solutions which can provide patients with access to their GP records will continue to be explored (eg. EMIS /TPP native solutions). Also, the use of SMS appointment reminder services, NHSmail services and other commercial solutions.

Projects included in this work stream are:

P9. To explore options for design of the patient/citizen portal. This will be based on the outcome of the work set out in section 6.1 but will be augmented by a market review of currently available products.
P10. Evaluate SMS Appointment Reminder Services.
P11. Evaluate tactical solutions for patient access to GP records

6.3 Support the continuous improvement of the services we commission by using information available to us (SO3)

NHS England identified that commissioner's need accurate, relevant and timely information to enable them to design and plan services and ensure that they are open, responsive and transparent. Specifically, they wish to:

- strengthen their knowledge of local health needs and the quality of services;
- lead clinical redesign through active clinical engagement;
- engage local communities to adopt improved services;
- improve quality of referrals into care pathways;
- drive citizen-centred service integration;
- improve the quality of primary care;
- innovate, adopt and spread emergent good practice.

NHS England has developed a Commissioning Intelligence Self-Assessment Tool to help CCGs to:

- understand how commissioning intelligence can be used to improve outcomes;
- identify any gaps in current provision and create a development plan to address these shortfalls;
- identify the commissioning intelligence services that they may then wish to procure.

This work stream will undertake an up-to-date self-assessment of CCG Business Intelligence services and identify actions to improve the use of information. The CCG's business intelligence team will promote the value of the data it collects from GP practices by presenting it back to decision-makers e.g. when evaluating various models of care for a particular condition, information on the outcomes could be fed back to the GPs as part of their continuous improvement cycle. This work package will be delivered using an Agile methodology using 4-week sprints and a backlog of requirements. This will allow the GP practices to refine their requirements as they gain more experience in using the data and the toolsets.

A project within this work stream will evaluate toolsets to provide GPs and other stakeholders with greater access to information, enabling them to match data with their own records, then query, accept or reject the changes if there is a discrepancy. In doing so, it will help to monitor utilisation and ensure accurate payment for services, potentially saving money and improving efficiency across the local health economy.

Risk stratification tools can help determine which people in a population are at high risk of experiencing outcomes, such as unplanned hospital admissions, that are simultaneously: undesirable for patients; costly to the health service; and potential markers of low-quality care. Also known as predictive risk models, these tools are used widely in the NHS, both for:

- analysing the health of a population ("risk stratification for commissioning"); and
- targeting additional preventive care interventions, such as the support of a community matron, to high-risk patients ("risk stratification for case finding").

More advanced analytical tools to support risk stratification, as well as clinical audit, data quality and information for research purposes will be explored during this strategic period.

Projects included in this work stream are:

P12. Completion of the Commissioning Intelligence Self-Assessment Tool and generation of an improvement action plan
P13. Evaluation of Business Intelligence/Analytical tools and development of an implementation plan to include training in the use of the information and development of an 'Information Culture'
P14. Extension of toolsets to cover more advanced analysis, such as risk stratification and modelling.

6.4 Innovative Use of IM&T to Improve Efficiency (SO4)

This work stream aims to improve the efficiency of citizen-facing and back-office services through the innovative use of technology.

'Digital First', a Department of Health initiative, set out to reduce unnecessary face-to-face contact between citizens and care professionals by incorporating technology into these interactions. This means using technology in healthcare where it can deliver the same high standards in a way that is more flexible and convenient for citizens, and at a lower cost. The benefits of Digital First were identified as:

- reducing unnecessary face-to-face interaction so that appointments can be given to the people who really need or would prefer them;
- fitting in with people's busy lives and delivering faster and more convenient services;
- improving citizen choice and satisfaction levels and enhancing quality of care;
- helping to deliver efficiency gains by reducing face-to-face interaction;
- empowering citizens to take control of their own healthcare needs and promoting self-care;
- improving collaboration across healthcare, social care and industry;
- helping to cut carbon emissions by reducing unnecessary travel to appointments.

In this work stream, we will also cover initiatives to improve the efficiency of non-citizen-facing interactions, such as supporting online meeting services/teleconferencing, etc.

Telemedicine can be split into three main categories: store-and-forward, remote monitoring, and interactive telemedicine. Store and forward telemedicine involves transmitting medical data from a patient to a doctor for assessment at a later time; remote monitoring uses devices to monitor people in a non-medical setting; and interactive telemedicine uses technology such as videoconferencing and telephones for real-time remote communication.

There is an appetite within the CCG area to explore telehealth solutions further as assistive technologies E.g. for the elderly, in cases of dementia to track the person's daily life etc. and to aid in mobile working.

The priority project for the CCG in this work stream is:

P15. **Availability of telehealth and telecare** is a priority for the CCG, because these technologies are not being used systemically across NEW Devon. The CCG will collaborate with the GP community to implement telehealth and telecare. Experience at the national level has shown that telehealth and telecare works best where it is targeted at the appropriate risk groups. Risk groups include patients with one or more long-term conditions, the frail elderly and those with learning disabilities. The project will be broken into five phases and will run initially as a pilot: Phase 1 - identify the risk group for the pilot; Phase 2 - identify the appropriate technology for the chosen risk group; Phase 3 - procure the solution; Phase 4 - implement the solution; and Phase 5 – evaluate the pilot. Assuming the pilot is successful, the solution will be rolled out more widely and more opportunities to use related technologies explored.

The rollout of national solutions also provides the opportunity to provide efficiency-related benefits. Specifically, these projects are covered by this work stream:

P16. **Roll out of GP2GP Version 2.2a**. The project will consist of 3 work streams:

- Work stream 1 – upgrade GP practices to versions of available primary care clinical systems which support GP2GP version 2.2a
- Work stream 2 –rollout version 2.2a of GP2GP to all practices
- Work stream 3 – engage and work with the practices on standardising the summarisation processes so that practices can be confident they do not need to re-summarise the patient's paper notes when they are transferred using GP2GP.

This project will maximise the use of a national system in order to deliver efficiencies for GP Practices and improve the sharing of patient records.

P17. **Utilisation of Electronic Prescription Service**
P18. **Roll out of the Summary Care Record**

This workstream will also contain projects covering the following areas:

P19. **Improved practice level decision support**
P20. **Care pathway redesign**
P21. **Digital dictation/digital pens**
P22. **Mobile working/Remote access**
P23. **Medicines Optimisation**
P24. **Pathology Optimisation**
P25. **Practice website development**

6.5 Development of an IM&T Governance Framework (SO5)

The table below summarises the advantages and disadvantages of four possible roles for the CCG in delivering its IM&T strategic objectives:

Option	Description	Advantages	Disadvantages	
1	Do nothing	• Neutral cost • Doesn't require any additional governance arrangements	• Passive • High risk that core strategic requirements will not be delivered • Opportunities to get collective benefits will be lost	Reject
2	Only use a commissioning led approach i.e. CCG defines and then puts the requirements to deliver the IT enabled service transformation into the contracts with the providers	• Makes use of CCG's primary lever for change i.e. commissioning. • Incentivises providers to deliver strategies that fit into and contribute to the overall CCG strategy	• High risk that core strategic requirements will not be delivered • Leaves the CCG in the role of facilitator • Long-term strategy because: 1. Requires commissioning to mature 2. Major providers are committed to IT programmes for the next 3-5 years which haven't been designed to deliver this strategy	Reject
3	Define, procure & implement an interoperability platform (based on interface engine, gateway and a portal or portals) across NEW Devon	• Core requirements would be delivered • Active, clearly puts the CCG in charge • Shortest time to market	• Would create competing solutions e.g. multiple portals i.e. one from the local Trust and one from the central solution • Not a value for money approach	Reject
4	Hybrid approach. Use a commissioning led approach and where appropriate combined it with components of a centralised or CCG level interoperability platform	• Core requirements would be delivered • Collaborative /Pragmatic - works with stakeholders and fills the gaps rather than trying to do everything • Initial components parts (e.g. the gateway) if implemented with a partner organisation would be eligible for central seed funding like Tech Fund • Maintains momentum whilst acute Trusts focus on EPR • Uses commissioning to reinforce the adoption of standards based approach to interoperability	• Requires upfront analysis to work out what component parts would be require where • Final solution will be more complex than a centralised CCG solution based on single component parts	Recommend

The recommendation is option 4, i.e. that the CCG takes a hybrid role where it incorporates its core and additional strategic requirements into its commissioning activities, whilst simultaneously working with other stakeholders to implement components of a centralised or CCG-wide interoperability platform.

The CCG will establish the appropriate governance to define, own and drive forward the IT Strategy. As a minimum, this will consist of an IT Strategy programme board, run using Managing Successful Programmes (MSP) and PRINCE2 principles. The IT Strategy programme board will have representation from CCG/Locality, Primary Care, Acute Trusts, Community Services, Social Care, the Academic Health Services Network (AHSN) and others. The programme board will own this strategy and oversee all strategic programme-related business cases and decisions. It is recommended that the programme board reports to the newly formed system wide programme board, NHS Futures, which is responsible for overseeing all elements of change required to deliver a sustainable economy for Plymouth and Devon. This will ensure attention at the most senior level and that the work is fully integrated with other change programmes.

In parallel with establishing the strategic governance framework, the CCG will initiate a programme to deliver the IM&T strategic objectives. This will require the appointment of an additional full-time programme manager and the support of the Programme Management Office (PMO).

The following actions will be taken forward into the implementation plan:

P26. **Build specific interoperability requirements into future contracts for services.** As stated in NHS England's document - The Integrated Digital Care Fund: Achieving integrated health and care records[7] "…the combination of primary identifier, open interfaces and standards … form the technical foundation for interoperability." Although the CCG does not currently own any of the systems which need to interoperate within Devon, it does have an important lever it can exert to bring about the behaviours which will make interoperability easier. It can specify within its contracts that systems must use:

a. The NHS Number as primary identifier
b. Open Application Programming Interfaces (APIs)
c. Interoperability standards as defined in the Interoperability Toolkit (ITK).

P27. **Adopt a CCG-wide approach to information governance and data sharing.** Other geographies/local health economies have put in place information governance and data sharing agreements e.g. Hampshire. Using these as a template, the CCG will construct a framework for sharing data between care settings. This work should also include an evaluation of the feasibility of giving the citizen control of their data and also incorporate NHS England best practice relating to risk stratification.

P28. **Engaging with internal and external stakeholders, including the public.** As was demonstrated by the number of clinicians who attended the information-gathering sessions for this document, the clinical community is well engaged in the process and supportive of the outcomes. The CCG has recently appointed a Clinical Chief Information Officer. Formal mechanisms for continuing this engagement will be put in place. The CCG will run a wider communications exercise, prompting feedback on this IM&T Strategic Vision Statement. This will focus on the benefits and how it complements commissioning intentions for the next 2 years, whilst seeking detailed feedback which can be used to develop the full IT strategy. The impact on patient experience should be at the forefront of the CCG IT Strategy and this will require engagement with patient groups either directly or through third parties like Healthwatch.

P29. **Organisational Development.** The DELT project, an entity that provides Information and Communication Technology (ICT) Services to both the NHS and Local Authority, has the potential to facilitate integration. This potential will increase as the number of partners expands.

P30. **Applying lessons learnt from previous programmes.** The lessons learnt from previous projects such as eSAP and the MIG pilot in North Devon will be applied to this programme.

[7] http://www.england.nhs.uk/wp-content/uploads/2014/05/idcr.pdf

P31. Better primary care clinical system training

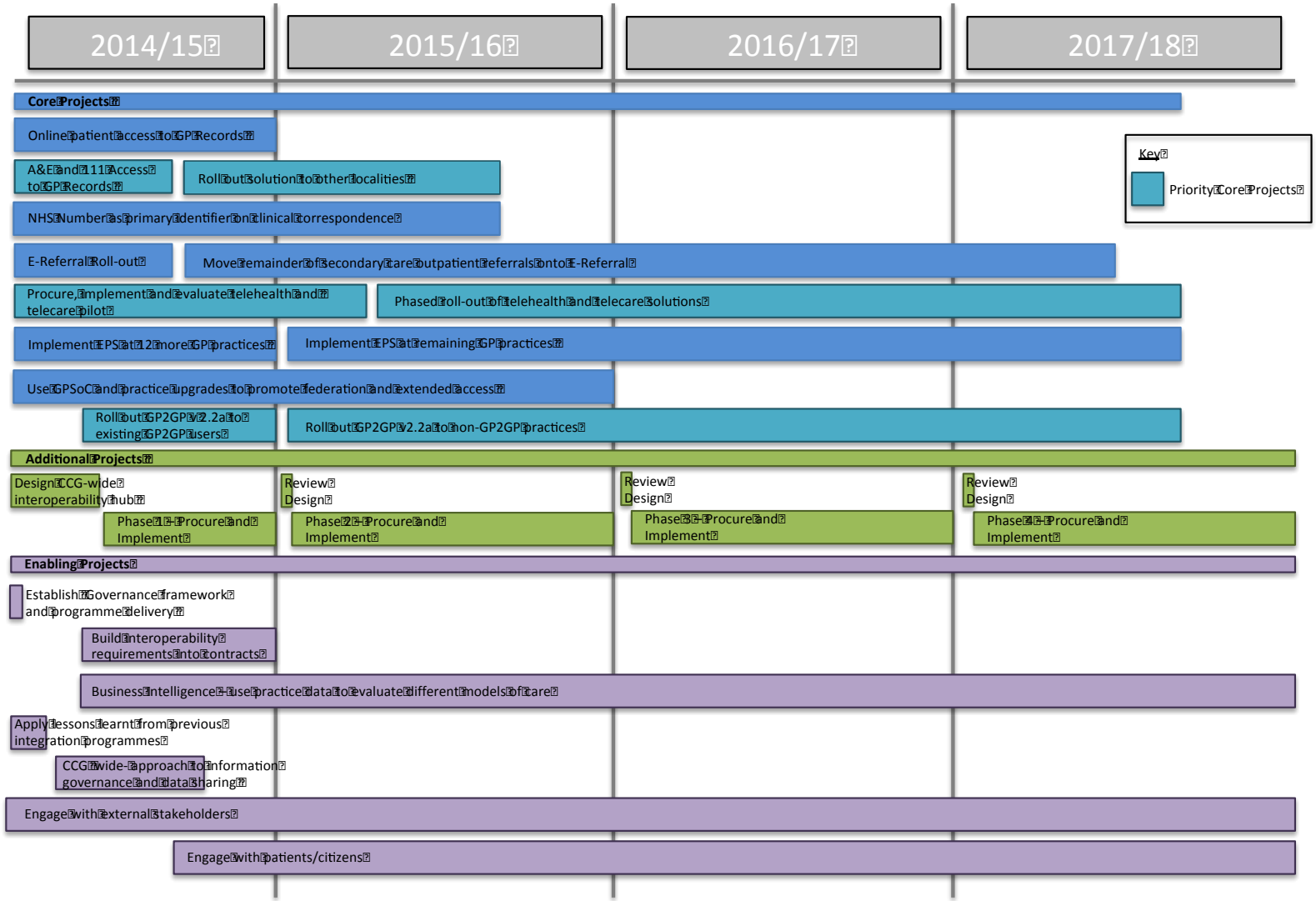
7. Sources of Programme/Project Funding

There is unlikely to be any additional long-term funding for health and social care IT systems and so any projects proposed by the CCG will have to be supported by business cases with sufficient benefits to demonstrate positive returns on investment.

There are two programme/project funding recommendations:

1. The CCG should look for opportunities to secure seed funding for its IT Strategic programme. As discussed above, solutions such as the Shared Care Record, linked to an information/integration gateway to enable A&E departments and NHS 111 to view primary care records, would be ideal candidates for the second round of Tech Fund. The CCG should take advantage of the fund to acquire solutions which could be used in one or more localities and contribute to the CCG-wide interoperability platform.
2. The CCG should establish a coordinated and equitable mechanism for GP practices to bid against central funds for local IT projects, thus supporting consistency in IT projects and procurements. Some of the money awarded to the CCG as part of their successful Challenge Fund bid, or additional funding that will be received through the next generation of GP System of Choice, could contribute to a fund that GP Practices could bid against for local innovative IT projects. Projects could include installing a WiFi in the practice, purchasing tablet PCs or iPads for GPs to use on home visits, installing dual monitors in consulting rooms to make consultations more efficient, purchasing enterprise search software to allow searches across a group of federated practices, re-designing a practice website to make greater use of social media and other web based health promotion sites such as NHS Choices.

8. Roadmap


2014/15
2015/16
2016/17
2017/18
Core Projects
Online patient access to GP Records
A&E and 111 Access to GP Records
Roll out solution to other localities
NHS Number as primary identifier on clinical correspondence
E-Referral Roll-out
Move remainder of secondary care outpatient referrals onto E-Referral
Procure, implement and evaluate telehealth and telecare pilot
Phased roll-out of telehealth and telecare solutions
Implement EPS at 12 more GP practices
Implement EPS at remaining GP practices
Use GPSoC and practice upgrades to promote federation and extended access
Roll out GP2GP v2.2a to existing GP2GP users
Roll out GP2GP v2.2a to non-GP2GP practices
Additional Projects
Design CCG-wide interoperability hub
Review Design
Review Design
Review Design
Phase 1 – Procure and Implement
Phase 2 – Procure and Implement
Phase 3 – Procure and Implement
Phase 4 – Procure and Implement
Enabling Projects
Establish Governance framework and programme delivery
Build interoperability requirements into contracts
Business Intelligence – use practice data to evaluate different models of care
Apply lessons learnt from previous integration programmes
CCG wide approach to information governance and data sharing
Engage with external stakeholders
Engage with patients/citizens
Key
Priority Core Projects

9. Appendix A – Background Information

This section provides further information on the current status of IM&T in each of the sectors:

A.1 Primary care

Primary care IT is the responsibility of NHS England and is commissioned through the NEW Devon CCG. The operating model is defined in NHS England's publication Securing Excellence in GP IT Services: Operating Model 2nd Edition (2014-16)[8]. The operating model is designed to give practices the flexibility to meet local needs, within the framework of a core IT offer and national information governance and security standards. The application of the revised operating model, particularly the approach based on equity for GP IT funding, has resulted in NEW Devon CCG becoming a net winner i.e. there has been an increase in funding for GP IT. The expectation of NHS England is that this money will be used to implement consistent high-quality value for money IT services with the aim of increasing digital maturity in primary care.

There has been a good uptake of five different clinical systems by GP Practices in NEW Devon CCG, leading to greater efficiency.

Breakdown of GP Practices by Clinical System

Clinical System	Number of Practices as at end of June 2014	% Total Practices	Total list size	% list size of total population as at the end of June 2014
EMIS LV	2	1.63%	6,664	0.73%
Microtest Evolution	25	20.33%	140,796	15.48%
INPS Vision	13	10.57%	140,939	15.50%
EMIS Web	31	25.20%	243,267	26.75%
TPP SystmOne	52	42.28%	377,729	41.54%
Total	**123**		**909,395**	

Figure 3. Showing a breakdown of Practices by Clinical System as at the end of June 2014

TPP SystmOne is the most prevalent system and although there has been some consolidation (particularly in Plymouth) to facilitate the federation of practices, the general consensus is that the practices will continue to use a range of different clinical systems.

[8] http://www.england.nhs.uk/wp-content/uploads/2014/04/gp-it-nhs-op-model.pdf

A.1.1 Common Issues

The common IT issues faced by Primary Care Practices are as follows:

1. **Training**. The practices meet their own training need internally. This can represent quite a large burden for the practice managers. However, effective training requires knowledge of the practices internal processes.
2. **Paper**. Although the practices are paper-lite or paperless internally, the majority of their communication with the external world involves paper.
    a. Use of NHSmail as the de facto communication tool. When providers do not have an IT solution which can interoperate with the GP's clinical system, or the GP Practice System is not capable of accepting an Interoperability Toolkit (ITK) compliant message, then communication is sent to the Practice's generic NHSmail address. To maintain the integrity of the inbound message, the practice is unable to cut and paste the content of the email message. Instead they have to print the email off, scan it back in and then shred the paper copy. This is very wasteful of human and material resources.
    b. Although GP2GP has speeded up the process of transferring patients between practices, (an electronic version of a patient's notes arrives in 2 weeks), a paper copy of the notes is still sent to the receiving practice, so that they can do their own summarization, because each practice has their own summarization standards.
    c. When a patient dies, the electronic record has to be printed off and then sent for storage in Exeter. For a patient who has had a long-term condition this can generate a lot paper.
3. **Information rather than data.** Although the Post Event Messages (PEMs) from the 111 Service were simplified at the beginning of 2014, GPs are still concerned that they are structured in such a way that it is difficult for them to work out what information is important and what follow-up action they need to take. It should be noted that this issue is not unique to Devon as the structure of the PEMs is agreed nationally.
4. **Infrastructure.**
    a. N3 network. Now that the majority of the clinical systems are web based and centrally hosted they are very susceptible to network bandwidth. If this drops then the system freezes. This happens in the urban as well as the rural practices.
    b. Wireless networks. Not all practices have wireless networks.
    c. Aging PCs and obsolete operating systems. It is not uncommon for practices to be using PCs which are 4 or more years' old running Microsoft Windows XP which is now out of support.
    d. Tablet devices. Where these are being used they are often the GPs' or Practice managers' own devices.
    e. Video conferencing. Although this technology is ubiquitous and accessible through consumer platforms like Skype, Microsoft Messenger and Lync, it not used by practices to reduce their travelling or interacting with citizens in their own homes. The reasons for this are concerns about the impact on available network bandwidth and information governance concerns.
5. **Getting a complete view.** Although practices have implemented innovations like virtual wards, the only way that they can get a complete picture of all the vulnerable adults in their care is to get everybody into a room for a Multi-disciplinary Team Meeting.
6. **Referrals.** The national Choose & Book system is used for referrals between primary and secondary care, but through a service augmented by Devon Referrals Support Service (DRSS). This service is used to make up some of the deficiencies of Choose & Book. Some of these deficiencies are inherent in the system i.e. it does not accept attachments to a referral which are larger than 1MB; whilst others are more organisational in nature e.g. people being booked into the wrong clinics because the service description of the clinic is not clear about its purpose. DRSS works well, but at an overhead to the CCG. Choose & Book will be replaced during 2014 by the e-Referral

Service. This will build upon the benefits and successes of Choose & Book and acknowledge its weaknesses.

7. **Special Patient Notes.** These are small nuggets of information, which are maintained by the patient's GP using the Adastra web access (AWA). These notes can include anything that the GP wants to share about the patient including problems, palliative care needs, care plans, etc. However, they have to be entered manually into the AWA by the GP. As the information is already available on the GP's Clinical System this is a waste of resource and the Special Patient Notes are often incomplete or out of date.
8. **Patient access.** Through their clinical systems there is widespread direct access by patients to functions like appointment booking, repeating prescriptions and changes of address. However, although most practices have systems capable of supporting access to their records this has not been rolled out. One the reasons holding the practices back are concern about giving citizens access to legacy data which was recorded in an era when standards were less stringent than they are today.
9. **Data collection, but no information.** The CCG currently collects data from the practices and feeds it into their data warehouse. However, the results are hardly ever fed back to the practices with a consequence that the loop is not being closed and information, which could be used as part of a continuous improvement process, is being lost.

A.1.2 Locality Specific Issues

The Western Locality Practices and in particular those using Microtest Evolution have an issue with the electronic discharge summaries being sent by Plymouth Hospitals NHS Trust. The solution implemented by the Trust utilizes the Sunquest Integrated Clinical Environment (ICE), which is widely used for GP pathology test requesting and reporting. This solution sends the discharge summary as a HTML file when most GP systems are expecting a PDF. HTML has two disadvantages over PDF. Firstly, viewing can be adversely affected by Internet browser version and settings in the practice (this is a particular issue for practices who are using older versions of MS Internet Explorer); and secondly, PDFs have the advantage that when they are received they can be integrated into the practice's clinical workflow. This allows the GPs to annotate the discharge summary and recode the content without having to print and scan the document back in.

A.2 Urgent Care

A.2.1 NHS 111

The NHS 111 service in Devon has identified the following major IT issues:

1. The patients' primary care record is the most valuable source of information, but this is generally not available outside the GP's system. Records may be viewable using technologies like the Medical Information Gateway (MIG) viewer.
2. Each treating service creates a record, tracking the treatment through the service to discharge. A discharge summary may be provided to the GP; however, much of the information generated may be lost in the transfer.
3. Currently SystmOne is the only GP Clinical system which is capable of receiving 111 Interoperability Toolkit (ITK) compliant messages. For the practices using the other clinical systems (EMIS, INPS Vision or Microtest Evolution) the 111 Service sends the message via NHSmail. The suppliers have all committed to becoming ITK compliant and the 111 service is at varying stages of testing with them. It is hoped that all GP system providers will be receiving and processing ITK 111 messages by the end of July 2014.
4. One of the possible outcomes of a 111 call is to refer to A&E. However, 111 Service is not obliged to routinely provide the A&E departments with details of 111 encounters. The OOH is currently working with the major A&E departments in Devon to explore whether this would help them and the best way of achieving this.

A.2.2 Out of Hours (OOH) - Devon Doctors (DDoc)

Devon Doctors is contracted to provide the county's urgent out-of-hours GP services. 111 is the gateway to the OOH Service with the majority of calls referred through this route. The service handles about 250,000 contacts per year.

The OOH service in Devon has identified the following major IT issues:

1. The OOH service, like 111, uses Adastra as its Clinical Management System and is largely paperless. The area where they are most reliant on paper is District Nursing
2. OOH creates an end-of-treatment summary at the end of the encounter. This is sent from the OOH Adastra to the GP practice via the Data Transport service (DTS). Although DTS is preferred by the GP practices over NHSmail, (because if appropriately formatted messages are sent through this route they can be picked up directly into the Clinical Systems workflow, saving the practice time and money), it has some limitations which would be overcome by using an ITK compliant message. The limitations of DTS are: firstly, messages are sent in periodic batches causing delay; and secondly, there is no message acknowledgement so the audit trail is incomplete. However, for this to happen, the Adastra OOH Module would need to be accredited to send ITK messages.
3. The Minor Injury Units (MIU) that is run by the OOH Service uses an out-of-date PAS, which cannot accept inbound messages.
4. The OOH service would benefit greatly from being able to refer seamlessly for admission into the acute hospitals.

A.3 Acute Care

A Comparison of the Clinical Digital Maturity Index (CDMI) scores for each of 4 acute trusts in Devon gives an assessment of the relative maturity of their current clinical systems as reported on 11/07/2014.

Trust	CCG	CMDI ranking out of 160 (where 1 is highest)
North Devon Healthcare NHS Trust	NEW Devon	91
Plymouth Hospitals NHS Trust		80
Royal Devon and Exeter NHS Foundation Trust		41
South Devon Healthcare NHS Foundation Trust	South Devon & Torbay	70

All of the acute trusts within Devon have strategies in place to move themselves up the Integrated Digital Care Records curve within the timescales indicated. This will put them at the top of the curve by 2017/18 (see figure 4 below).

The main issues for the CCG are how to: firstly support the acute trusts to ensure that they deliver to their respective programmes; and secondly, ensure that these locally determined solutions can interoperate, so that there is an integrated system across the whole of Devon.

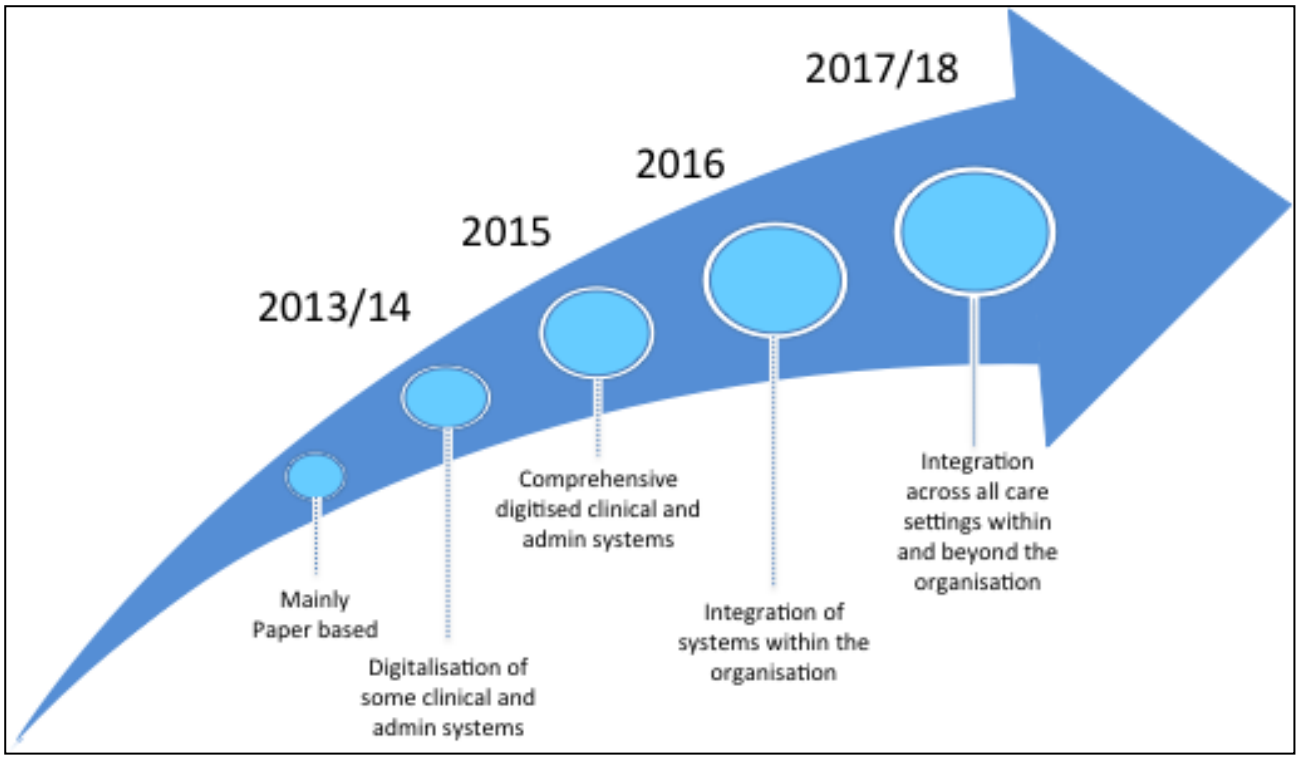


Figure 4: Integrated Digital Care Records

A.4 Social Care

Devon County Council provides the social care services within the boundaries of NEW Devon CCG. Adult social care uses Care First from OLM Systems, which provides a true single record and currently they use this system as the lead case recording system for common assessments. Social care shares the vision with health i.e. that data should be recorded once and shared. The delivery of this vision would allow the following issues to be handled: e.g. if a person with a package of care, or a carer for someone with a package of care, visits A&E, the staff in the A&E department need to know who and when someone from the social services is going into the citizen's home. With this information they can coordinate care more effectively.

The social care team in Devon has previous experience of working on the joint single assessment process (eSAP) project and Medical Information Gateway (MIG) pilot in North Devon. They learnt valuable lessons from these projects, which should be applied to any future IT enabled service transformation programme. These lessons were as follows:

1. eSAP
    a. Do not underestimate the number of people who need to be actively engaged;
    b. Forcing a single solution onto everybody is not the solution.
2. North Devon MIG Pilot
    a. The choice of pilot areas needs to made carefully and the professional groups/care teams in the pilot need to be engaged;
    b. Avoid areas which are supported by out of the box interfaces or viewers as creating bespoke interfaces/reviewers is time-consuming.

In addition to lessons learnt from previous experience, the social care team in Devon identified the following major IT issues that any IT strategy for service transformation needs to address:

1. Managers need to be able to look across the team; this is an issue if the team includes both health and social care workers because everyone uses their own system, which they bring from their employing organisation;
2. There is currently no off-the-shelf health and social care system which could be implemented;
3. Solution should be based on the systems that staff use to do their day to day work and the need to log on to another system to get a piece of information or perform a task should be avoided;
4. Unfortunately health and social care records break down differently. NHS records are coded and concise, whereas Social care records are more qualitative, contain greater volumes of information and include financial information including what is required in the package of care and who is paying for what;
5. Any potential solution should start off at the very simple end of the scale and have patient/citizen portals built into it from the beginning.

A.5 Mental Health

NEW Devon CCG commissions mental health care services from two providers: Devon Partnership Trust and Plymouth Community Healthcare.

A.5.1 Devon Partnership NHS Trust (DPT)

DPT provides all mental health and learning disability services for Devon except Plymouth. It has been using the RiO mental health system through the national contract with NHS Connecting for Health (CFH) for the last 3 years. RiO has been implemented to such an extent now, that it is practically paperless. The trust is currently part way through re-procuring its Mental Health System, because the contract with NHS CFH expires in 2015.

DPT's IT strategy is based on trying to emulate in the workplace the impact that technology, over the last 10 years, has had on home lives. The aim is to have a truly mobile workforce and reduce the budgetary spend on estates by using technology to enable staff to work more efficiently. The trust has recently purchased 200 tablet PCs through the Nursing Technology fund.

A.5.2 Plymouth Community Healthcare (PCH)

PCH is the community interest company, which delivers mental health and learning disability services to Plymouth. They share a common vision with the rest of organisations in Devon to ask people for information once. Their aim is to have systems where, with appropriate consent, health and social care workers can see the same record and triggers caused by changes in underlying data will be used to highlight to staff that there is something to which they need to respond.

PCH is currently replacing a legacy paper-based system with the mental health module of TPP SystmOne. Integration with GP practices will be achieved in 2 ways:

1. SystmOne Practices – directly via the inbuilt integration in the TPP product set;
2. Non-SystmOne practices (EMIS, INPS Vision and Microtest Evolution) – indirectly via the MIG.

It should be noted that option 2 is currently not available, as this would require the procurement, implementation and ongoing support of a Medical Information Gateway for Plymouth.

Integration with Plymouth Hospital NHS Trust is possible by utilising TPP's EPR Core Module. This would require the procurement, implementation and ongoing support of this module.

Integration with OOH and the Ambulance service would require an interface engine or MIG or combination of both. PCH has neither of these solutions currently.

Plymouth Council currently uses First Care like the rest of Devon for social care, but is considering using the social care module of TPP SystmOne. As with the GP Practices who use SystmOne, this would integrate

directly via the inbuilt integration in the TPP Product set. However, this would put them out of step with the rest of the county who will continue to use First Care.

PCH will be "flat out" implementing the community system until March 2015 and will not be looking at any of the integration issues until after this time.

PCH have learnt two important lessons, so far, from the implementation of the TPP SystmOne community module:

1. Getting the system configured is a challenge, but once this is done it is met with a very positive response from the clinicians;
2. It is a challenge to get the whole organisation to change the way it works.

PCH identified that Plymouth is a health economy in its own right and as such they are uncertain that they need to involve the whole of NEW Devon CCG to achieve its objectives.

A.6 South Devon and Torbay CCG

Although neighbouring Clinical Commissioning groups, NEW Devon CCG and South Devon and Torbay (SD&T) CCG are very different from each other. For instance, NEW Devon CCG covers a large mixed urban/rural geography, whereas SD&T CCG covers a smaller area dominated by a single urban conurbation. New Devon CCG has multiple competing providers whereas the three providers in SD&T are more vertically integrated and the CCG has co-terminus borders with the local authority. However, the two CCGs do share a common vision of using IT to: integrate care; support professionals in delivering care at the right time and in the right place; enable service provision that is value for money; and assisting research and continuous improvement. From this common ground there are two key aspects of SD&T CCG's approach from which NEW Devon can learn. These are as follows:

1. The importance of having the right governance in place; and
2. Basing any solution on a framework of integration standards which places the citizen at the centre.

Appendix B – List of participants

The following individuals were interviewed as part of the information-gathering phase for this document:

List of participants	Stakeholder organisations
James Short (Delivery), Shane Coe (Business Intelligence), Clare Doble (Information Governance), Nicola MacPhail (Partnerships), Clive Robb (111), Simon Kerr (Vice Chair *Eastern* Locality), Charlotte Ives, Dr Richard N… (GP, *Eastern* Locality), Dr Paul Hardy (Chair, *Western* Locality), Dr Tim Chesworth (GP, *Northern* Locality), Murray Heath (*Northern* Locality), Gail Irvine (IT), Dr Anita Pearson (Clinical lead partnerships directorate children and young people, Clinical lead for long term conditions *Western* locality), John Tovey (DRSS)	NEW Devon CCG
Dee Brown	Practice Manager, Northern Locality
Susan Stokes	Practice Manager, Eastern Locality
James Davies	Practice Manager (Representative), Eastern Locality (Mid)
Susan Smith, Sharon Kershaw, Darren Newland, Dawn Mainland, Chris Wade, Louise Killick, Wendy Ellis	Practice Managers, Western Locality
Julia Cory & Robert Knibbs	NHS England (LAT)
Graham Sykes	PCHT
Gary Hotine and Vanessa Dunn	SD&T CCG
Matthew McVicar	DDoc
Nick Hopkinson	DPT
Wendy Ware	RD&E
Mike Richards	LMC
Mike Jones	NDHT
Marisa Smyth & Freya Woodward	DCC
Miles Sibley	Healthwatch
Dr Ed Conley	SW Academic Health Science Network (AHSN)
Sue Bracey, Head of software development and integration	Plymouth ICT Shared Service (PHT)
Hugh van Wijk, Head of Business and Technical Architect	Plymouth City Council (PCC)