

Informatics Strategy 2012-2017

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1 Introduction

In May 2009 the Northern Devon Healthcare NHS Trust (NDHT) approved the current Informatics strategy which covered the period 2009-2011. Since the publication of the strategy there has been significant developments both locally and nationally which have significant implications for the future of the Trust. It is, therefore, appropriate that the Trust takes stock of the progress that has been made and plans for the future.

The drivers for change that have emerged during the last two years are of a scale that could be described as major and, in no particular order are;

- The decision by the Trust's main application supplier HP to cease development of the products unless directly funded by the current users. Most existing users are planning to replace the current applications by 2013 presenting a potential 'last man' standing scenario for the Trust. This will, in turn, create operational, financial and support issues for some of the Trust's key business applications – Patient Administration System (PAS), Pharmacy, A&E and Maternity.
- The Trust's ambition to realise opportunities to provide safer, more efficient care through the introduction of order communications, electronic prescribing technology and Clinical Decision Support.
- The need for additional informatics capability and capacity to fully exploit new and existing technology in an increasingly challenging financial climate e.g. telehealth and telemedicine.
- The breakdown of the *Additional Supply Capability and Capacity (ASCC)* initiative. This process replaced the former National Programme for IT (*NPfIT*) and was meant to deliver a number of proven applications with central funding to cover licence costs. The process which started in 2009 has now 'timed out' with only limited delivery of any solutions.
- The potential formation of GP Consortiums and the informatics support necessary to support these new structures.
- The Trust's ambition to become a Foundation Trust is now moving rapidly ahead and a proven IM&T capability is a key element for a successful application.
- The dramatic increase in the size and complexity of the Trust following the absorption of a large part of the former Devon Provider Services following the *Transforming Community Services* initiative and the need to leverage increasing economies of scale and efficiencies from the IM&T infrastructure of the merged organisations.
- Re-procurement of applications obtained under the National Programme eg PACS/Radiology.
- The emergence of a large and specialized range of community-based services across Devon. There is currently little or no informatics support for many of these services and there is an urgent need for data to support clinical care, resource management and commissioning.

- The Trust requires an informatics strategy which can address the above demands and also provide a sound foundation to meet the challenges of the future. The Trust must be able to exploit the opportunities that will present over the next five years.

The strategy covers a five year period from March 2012 until April 2017 and will be subject to an annual review and refresh.

2 Previous Strategy

The Trust's previous strategy approved in 2009 noted the failure of the implementation of the national programme's Care Record System but noted the opportunities presented by the Additional Supplier Capacity and Capability (ASCC) initiative. With the benefit of hindsight this has proved a less than successful option for replacing the Trust's key software applications.

There were, however, some benefits obtained from the programme notably;

- PACS; Digital X rays
- Map of Medicine
- Choose and Book – Patient/GP direct bookings to Acute Hospitals.

In addition a number of local developments were delivered within the former strategy's 2009/11 window;

- Replacement of 3 older applications with the *Patient Management System*.
- Updating of the electronic Discharge Summary system.
- Introduction of SWiftPlus white board.
- Introduction of Chemo Care the Chemotherapy Prescribing system.
- Implementation of the Lilie Sexual Health system
- Development of a software development capability including programming and interfacing.

So although benefits were derived from the introduction of these applications the central requirement to replace the current HP applications with a modern *Integrated Patient Record, (IPR) including a clinical portal, order communications and electronic prescribing* has not yet been achieved.

The Trust is currently undertaking an extensive consultation exercise with key staff groups to validate the current and future strategic direction within Informatics.

3 Strategic Vision

The Trust Board's decision to seek Foundation Status following *Transforming Community Services* resulted in a review of the Trust's vision and future plans. The review took place during September 2011 and the outcome was a new vision;

We will be an integrated health and social care Trust and underpinning everything we do will be the provision of safe, high-quality care. We will support the population to be as healthy and as independent as possible.

To support this vision a number of key service development plans were identified;

- **Supporting independent living and well-being** – Helping patients manage their illnesses or injuries at home or in the community means they do not end up in hospital unnecessarily. However, when hospital care is needed, we will ensure it is available promptly with the right clinical expertise. Once in hospital, we will continue reducing delays to discharge and ensuring that services are joined-up for patients when they leave hospital.

Instead of waiting for people to become ill and need our services, we will also focus on providing information and support so that people can make informed lifestyle choices.
- **Responsive acute hospital services** – We will develop our acute services to be sufficiently flexible to accommodate all the patients who need them. Our hospital care will continue to bet clinical standards but we will invest in ensuring it is efficient and supports the independence of patients once they leave.
- **Protecting the rights of vulnerable adults when they have a physical illness or injury** – We will improve care for vulnerable adults by ensuring our staff recognise and assess their needs and take a holistic approach. We will also work hard to avoid unnecessary admissions for vulnerable adults where there is alternative, community-based support.
- **Networks and partnerships** – We will continue to work in clinical networks with our partners to ensure our services are local, safe and promote independence. We will also work with our patients to provide the best possible service and ensure they are equal partners in decisions about their care.
- **Estates** – Our goal is to ensure that our services are provided in buildings that are fit for purpose and help staff do their job efficiently.
- **Integrated patient record** – It is our plan to create an integrated patient record to ensure that there is a seamless transferring, recording and sharing of information across our services. Accurate documentation supports and enhances the delivery of high quality patient care.
- **Non-clinical services** – We will protect front-line clinical services by ensuring that our non-clinical services are as efficient as possible. We will review our contracts with suppliers to ensure that we are obtaining maximum benefit and deliver savings which can be reinvested in clinical services.

The Trust will procure an *Integrated Patient Record* which will sit at the heart of the Trust's delivery of care. It will ensure that relevant, timely and accurate information is provided to staff at the right time, in the right place and in the right format.

The patient record will support staff working in all settings and will support the care pathways in place and those being developed. Access to the record will be facilitated through innovative use of wi fi and mobile working solutions across the topography of the new organisation. In addition to the Integrated Patient Record

other technologies will be employed to ensure the delivery of safe healthcare. Intranet and extranets will support staff and will seamlessly link to the IPR as will specialist clinical systems.

The Informatics Strategy will support the Trust's vision outlined above. It is planned that by 2017 Informatics development will enable the Trust to be a 'paper-light' organisation through an information culture that has less reliance on hard copy documents and patients records.

This will lead to effective and consistent record keeping through an agreed format enforced through the application(s) user interface.

Clinical access to information will be available at the point-of-care through a variety of mobile and fixed devices. Wireless working will also be possible through extensive wi-fi capacity within Trust premises and through mobile phone networks to support truly mobile working within a community setting.

4 Road Map of Activities for the next 5 years

Describing the road map of replacements, interfacing and interoperation associated with the Trust's software portfolio is complex. One way that the activities can be better illustrated is through the use of the schematic in Appendix B '*Application Road Map*'.

The road map was further complicated by the organisational configuration that followed TCS which saw a number of applications transfer to Northern Devon Healthcare whilst the new services still looked towards the local IM&T supplier (Royal Devon and Exeter Foundation Trust) for support.

This strategy is based on a number of underpinning principles in relation to the future of these applications and services. These are;

- Applications will be supported where it is most cost effective to do so and this may result in hosting and support arrangements moving to a single or smaller number of locations.
- Where there are multiple instances of systems and applications they will be merged or replaced by a single application.
- The main acute provision, all community hospitals and community services will operate one enterprise-wide system which will support the pathway of care through the healthcare system.
- If possible this single system will also support community based activities and, in time, the delivery of social care.
- Where necessary the underpinning data structures will allow patient information to be shared,
- The Trust will retain the capacity to develop and interface applications as required.

These activities can be broadly divided into three distinct but overlapping phases;

- **Consolidation** – This focuses on transferring the management and support of applications used within the former Devon Provider Services to Northern Devon Healthcare NHS Trust. This transition is short in nature and the vast

majority of the tasks needed have been completed. The emphasis is ensuring that *business as usual* is not impacted

- **Transition** – During this phase applications and systems may be merged, expanded retired or replaced. This phase may also include the transfer of services provided under the Service Level Agreements by other organisations back to the Trust.
- **Acquisition and Migration** – This phase is linked closely with the procurement of an enterprise-wide Electronic Patient Record and the subsequent migration of the current PAS, Maternity and A&E applications to a new state-of-the-art application. This work will also encompass the development of a community system.

5 Deliverables

The delivery of new applications and new functionality is subject to an ongoing consultation exercise; however, for the purposes of this document we can describe this new functionality in broad terms.

Electronic Patient Record – The Trust needs to replace the current PAS, Maternity, Pharmacy and A&E applications because after 2013 they have an uncertain future. HP - the system supplier have made no commitment to develop the products after this and most of the current user base are looking at alternative options.

If the Trust does not take measures to replace the current HP supplied applications the full cost of operating these applications will fall to those Trusts still using the applications. In addition any developments needed to meet statutory or mandatory requirements will also fall to the remaining users.

During 2012/13 the Trust is planning to start a procurement process for an enterprise-wide EPR which may include the following functionality;

- **Order Communications (OCS)** – offers major benefits to the Trust including (but not limited to) electronic requests replacing paper-based systems principally radiology and pathology.
- **Pharmacy stock control and e-Prescribing** - This will promote safer and more efficient prescribing and administration of medicine.
- **Clinical Decision Support** – This functionality provides the latest evidence based best clinical management advice to clinicians electronically.
- **Clinical portal or Clinical Desktop** – This provides the clinicians with an overall view of their activity e.g. outpatient clinics, outstanding requests and/or investigations, results, inpatient lists, outliers etc. This facility can pull together data from a number of disparate applications.
- **Maternity** – Almost a ‘mini EPR’ for maternity services which links through to the full EPR.
- **Accident and Emergency (A&E)** – This is a departmental application which forms a module of the integrated patient record. In addition to utilising the order communications functionality it will provide specialist support to the Emergency Department

- **Document management** – The Trust will look at the potential for maintaining the balance between electronic and manually produced data using this bridging technology.

The key benefits of this combined technology are;

- Enable users to select multiple patients to view, saving time reviewing results.
- Enable users to set up manual lists of patients for follow up or for research; improving clinical care, and allowing more effective use of data.
- Reduce average length of stay as a result of the more effective management of patients; for example, easily identifying outliers from dynamic lists.
- Reduce average length of stay as a result of the more effective management of patients; for example, easily identifying outliers from dynamic lists.
- Patient centric views facilitates users to only use one system to see all results information, saving time and improving care decisions.
- Automatic flagging of abnormal results makes it quicker and easier for clinicians to diagnose problems effectively.
- Replacing paper results with electronic results view reduces resources to print and file results in patient notes.
- Reduction of time in high dependency areas, transcribing results into trend tables.
- Results available sooner, permitting earlier decision making which can lead to earlier discharge, average length of stay reduction and improved use of beds.
- More than one clinician can access the same results at the same time without waiting for another clinician to finish with the notes
- Results do not get lost during transit or use, improving patient care and reducing the risk of potential litigation. Additionally, Porter time and cost can be reduced.
- The ability to view order history enables clinicians to monitor the ordering of their house officers, leading to better clinical mentoring.
- Order entry on screen is faster than it is on paper, due to default values, carried forward information, order sets, etc. One Trust showed time saving of ½ hour per House Office per day in Medicine
- Reduce inappropriate orders and non-viable orders through the use of item messages
- Duplicate checking reduces unnecessary placing of orders
- Order sets help to standardise protocol-driven care, and promote best practice – improving clinical outcomes

- Electronic transmission of requests saves the lab and rad departments from (1) performing patient search in the departmental system and (2) keying in the order details
- Reduce the number of unnecessary repeat orders placed on the Pathology and Radiology departments because clinicians can view orders that have already been placed
- Improved data quality through the use of mandatory fields, dictionaries, etc means that there is less risk of the wrong test / examination being done, and less time spent chasing missing information
- Because clinicians can place orders from anywhere in the hospital, it saves them time
- Phlebotomists can review orders and generate work lists, streamlining their activities and workload planning
- Reduce the number of tests that cannot be performed due to specimens being collected in the wrong container
- Viewing of order statuses by clinicians results in a reduced number of telephone calls to the laboratory and radiology departments to check the statuses of requests
- Add specimen allows phlebotomists to add requests to an existing specimen saving on collection and container and (2) could lead to a reduction in duplicate tests.
- Reduced work for junior doctors assembling notes and accessing information to prepare for ward rounds.
- Supports complimentary technologies such as telehealth, telemedicine and condition/end of life registers.

Appendix C and D provide an example of the impact on individual departments and a recent survey of clinical staff showed strong support for this range of functionality.

The process for acquiring this infrastructure will depend on the likely value of the procurement. However, it seems likely that since the National Programme for IT (*NPfIT*) process has stalled the OJEU route is the most likely candidate although other options may be explored.

The Trust will consider partnership arrangements for the procurement providing there is a strong case to do so. Our neighbouring Trust the Royal Devon and Exeter Foundation Trust are also seeking a replacement PAS and there may be advantages in collaborative working during the procurement and implantation phases.

There is also a requirement that patient information needs to be readily accessible across the whole North, East and Mid Devon Health community. Joint planning at this stage will ensure that the existing flows are safeguarded and new care strategies can be supported.

The EPR will need to be able to respond to a rapidly changing service reconfiguration and provide the necessary patient information to healthcare professionals at the point of care. There will also be the potential to make key links to the national *Summary Care Record* which is currently being rolled out across Devon.

Specialist Applications

The Trust recognises the need for the retention of specialist clinical applications such as Endoscopy and Ophthalmology and these will continue to operate. The Trust's procurement approach will ensure that all new applications adhere to the current technical standards such as HL7 and will be *interoperable* with other applications.

Interoperability will allow the Trust to link key applications and pass data safely between them without the need for costly third party intervention. This allows legacy systems to be linked with new applications and with locally developed solutions. This provides a cost effective solution to managing the lifecycle of applications and their retirement/replacement.

Links will be made seamlessly via interface engine technologies such as MIRTH. Access to the applications will be simplified by rolling out Single Sign-On access to the whole organisation (a number of wards have just completed successful pilots).

Electronic Rostering

The Trust already makes significant use of the MAPS application to support nurse rostering and this will be expanded to support the timetabling of other staff groups including medical staff.

Community

There is currently no single application operating within the Trust's community services. There is an urgent operational, management and commissioning requirement to be able to measure the performance of these increasingly important services. To address this need there is a nationally mandated data set that community providers must be able to collect by April 2012.

The *Community Information Data Set (CIDS)* collects basic management data across a wide range of services. In order that the Trust can comply with this requirement an enterprise-wide application – ComPas – has been developed in-house which will be rolled out across the entire Trust.

This will form the first phase of the *Community Informatics Plan*. The second stage is to ensure that there is adequate clinical functionality within or linked to the EPR to meet the operational, clinical and management information needs of this sector.

It is recognised that post-National Programme for IT there has been a slow take up by suppliers to the challenge of the new organisational structures that are emerging following *Transforming Community Services (TCS)* and the White Paper. It is conceivable that a 'mixed economy' of applications may be needed to address the informatics requirements of community services until existing applications have been developed to meet these needs.

The Trust is also reviewing the options for collecting assessment data as required to support the *Single Assessment Process (SAP)*. The current system is expensive to support due to many of the original participating organisations having withdrawn

from the project. The Trust is considering alternatives but still based on the principals of a single assessment collected and distributed by electronic means.

The Trust also intends to improve the quality of data recorded for patients discharged from mid and eastern Devon community hospitals. This will be achieved through the implementation of the locally developed e Discharge summary application.

In addition to providing GP's with a more standardised and comprehensive discharge summary it will provide better source material for the clinical coding of this activity and more accurate *Payment by Results* data.

Re-procurement of PACS/RIS

With the current cluster-wide contract for PACS/RIS services coming to an end there will be a re-procurement requirement for these services commencing in 2012/13. The current approach is to work within a Peninsular-wide group to re-provide this service. This work is not part of the EPR procurement but will obviously have to link to the selected product's order communications capacity.

Pathology

Currently there are no plans to replace the existing application as part of the EPR procurement. There will be a review of future options undertaken during 2012/13. Service re-configuration may influence the direction and outcome of this review.

Sexual Health

The Trust is committed to the provision of a full range of sexual health services serving a large and diverse population. Following TCS there are now two instances of the same application (Lille) operating within the Trust.

From March 2012 work will commence to merge the databases to create a single organisation-wide instance of the application which will yield simpler, unified working practices and a saving on licence costs as well as providing clients with a better service.

In terms of the future the use of the EPR within sexual health services will depend on the supplier being able to reassure clinicians that highly sensitive data can be collected, stored and retrieved safely and confidentially.

Electronic Staff Record (ESR)

The Trust is planning to merge the two organisational instances of ESR (Northern Devon Healthcare NHS Trust and Devon PCT Provider Services 415 and 626 VPD).

In addition the Trust will implement manager and user 'self service'.

Finance Systems

The Trust is not planning to change its main Finance application –Integra - at this time.

Timescale

Appendix E provides an estimate of the suggested timescale for the individual elements of the strategy.

6 Information Provision

The provision of timely, relevant and accurate data where it is needed underpins the delivery of good healthcare. In turn, robust operational data will support effective and innovative service management. The Trust has developed an excellent Information function which supports a range of activities and utilises a range of technologies to extract, format and present this data. This development will continue and new tools will be utilised to meet the ever growing need for information.

Data Quality will become an important issue as performance measures become more sophisticated and poor data can give the impression of poor performance. Often clinical care is good but can be tainted by poor performance data. Transforming Community Services has also resulted in a number of new data collection systems being merged to produce the overall 'Northern Devon Healthcare NHS Trust' view at a national level. Some of these systems have not been subject to the same rigours as were previously applied to the former Northern Devon Healthcare NHS Trust pre April 2011 and need to be assessed and improved if necessary.

The Trust has ring fenced provision to focus on improving data quality across all of the Trust's activities.

7 Clinical coding

The Trust has already made a significant investment with the purchase and implementation of the 3M Clinical Coding tool to assist coders with the selection of the appropriate OPCS or ICD code as the selection of the correct code underpins the *Payment by Results* (PbR) process. This potentially has a significant impact on the Trust's finances. In addition the coded data when extracted from national databases such as the *Secondary Uses Service* (SUS) or *Hospital Episodes Service* (HES) form the basis of many national performance indicators e.g. mortality indicators.

The major impact for Coding over the next five years is the decision to replace the existing two coding systems – OPCS and ICS with the new international standard SNOMED. This is an integrated coding nomenclature which replaces the two existing systems. There are significant training implications. To meet this future challenge a re-structure of the department and an increase in management capacity is planned for 2012/13.

8 Information Governance

The Trust will strive to maintain the current high standards of safe, effective and appropriate management of confidential data. The core to this is compliance across the new organisation with the Information Governance Toolkit Version 8.

The management structure supporting these activities has been strengthened during 2011 following the expansion of the Trust. Part of the re-configuration has been the recognition of the need for ring-fenced resources to promote and support excellent data quality.

9 Infrastructure

The infrastructure needed to support the strategic vision above is detailed within the accompanying document *IT Strategy 2012-2017*.

10 Costs

It is difficult to precisely identify what the cost of the informatics programme is at this point in time. Whilst the implementation of key applications can be costly there are many cash and non-cash releasing benefits that will form part of the overall business case. The reduction and/or repatriation of services provided through Service Level Agreements may also represent a reduction in operating costs.

The key is affordability and this will be tested by a robust business planning process and detailed business cases followed by a rigorous application of programme and project management methodologies.

The Board do have to recognise there has been a significant disparity in the investment made locally in IM&T when compared with other health communities. Benchmarking data suggests that a significant increase in levels of investment will need to be made to both continue providing existing services and leverage future investment opportunities.

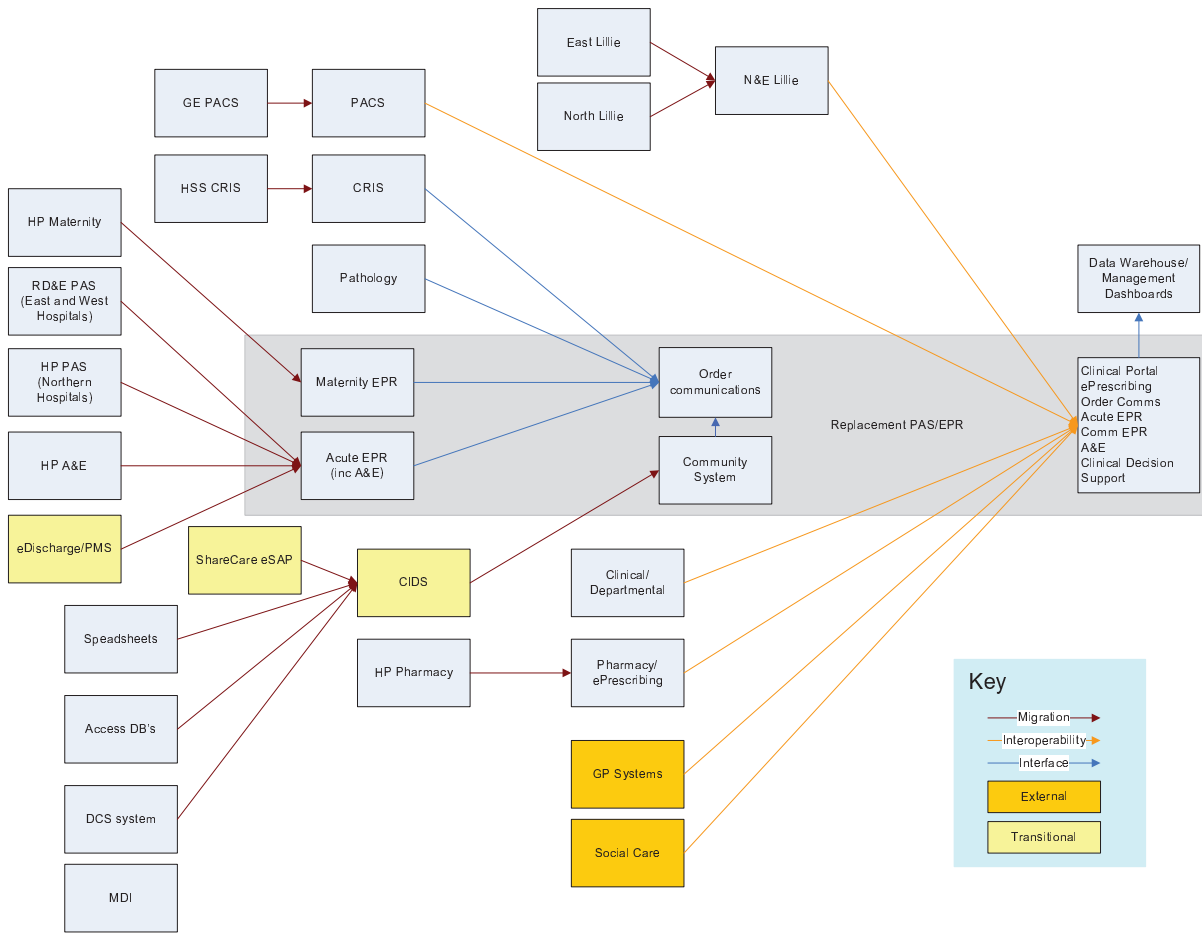
Table 1 outlines the indicative costs based on readily available commercial data. The benefits assumptions are based on some recent work by a potential supplier and some of the research that underpinned the *Shires Consortium* and *National Programme for IT* business cases.

It should be noted that these costs will also be spread over the life of the programme which will be approximately 7-10 years from procurement starting to all the component applications being fully implemented.

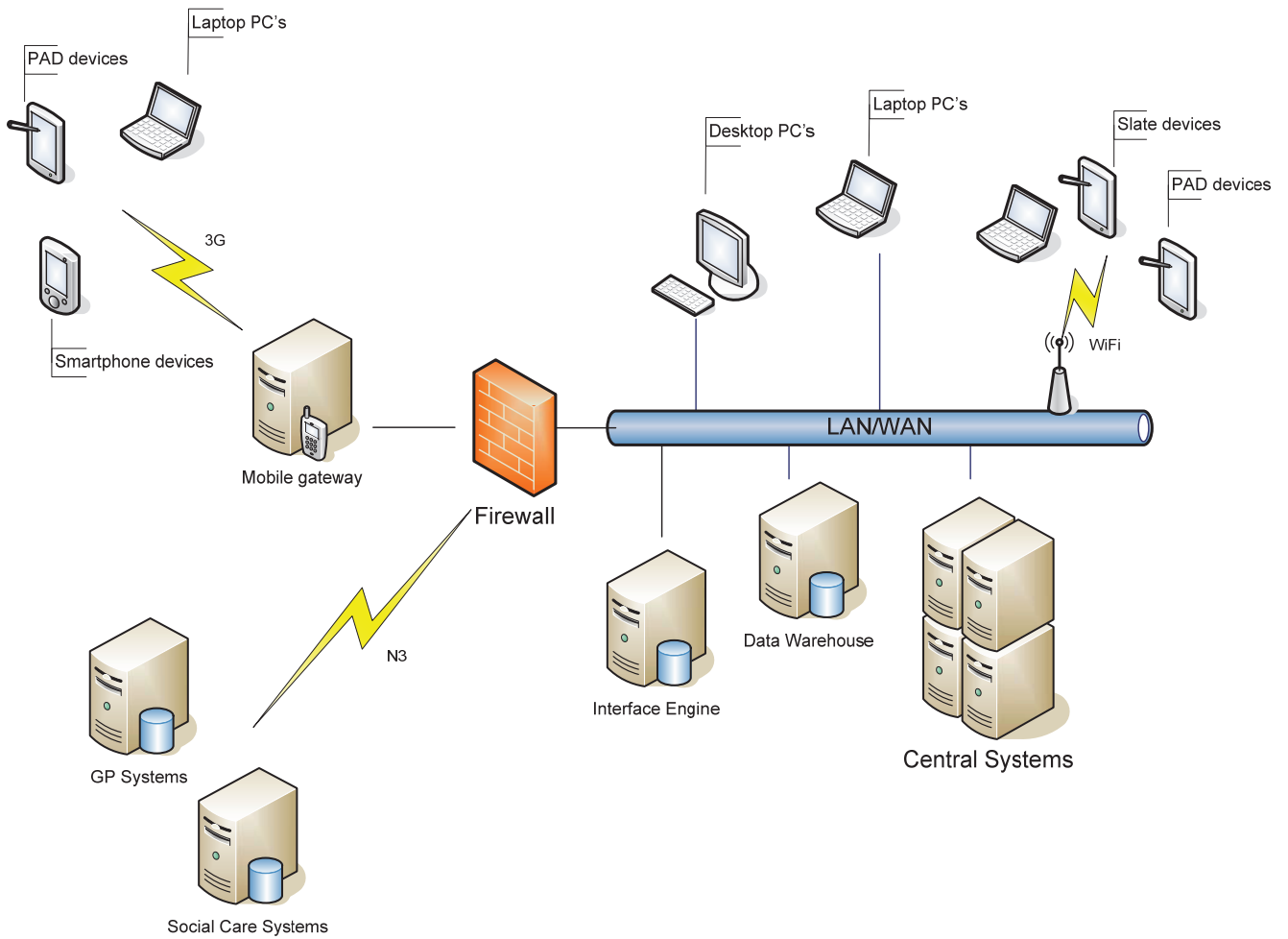
Table 1

Development/Application	Cost	Benefits (if realised)	Actual Cost
EPR inc A&E, Maternity, Order Comms, e Prescribing etc	£8 million	£3 million	£5 million
Pharmacy Stock Control	£250,000	n/a	£250,000
PACS/RIS re-procurement	£3 million	n/a	£3 million
Community/Social Care	£2 million	£500,00	£1.5 million
Pathology	Next review		
Electronic Staff Record	£250,000	£250,000	
e-SAP	£30,000 interim costs	Not known	
e-Rostering	TBA	TBA	TBA

Appendix A – Application Road Map



Appendix B – Infrastructure Schematic



Appendix C – Pharmacy Benefits

Benefits Discussion with Paul Cooper – Head of Pharmacy (21st October 2011)

The current situation at the North Devon District Hospital is a manual system with numerous physical checks which could be reduced and streamlined with the application of technology.

Three key areas where benefits would accrue were identified;

- Prescribing
- Supply
- Administration

Benefits include;

- Computerised entry and management of prescriptions
- Computerised links between hospital wards/departments and pharmacy and patient's integrated care record.
- Knowledge support, with immediate access to medicines information.
- Decision support, aiding the choice of medicines and other therapies.
- A robust audit trail
- Safer prescribing through more legible prescriptions, alerts for contra-indications and drug interactions. Guidance for inexperienced prescribers.
- More efficient processes through improved communications between departments, reductions in paperwork-related problems e.g. fewer lost of illegible prescriptions. Clearer and more complete audit trails of medication and administration, improved formulary guidance and management and appropriate recording.
- Ability to restrict certain drugs to authorised clinicians e.g. microbiologists.
- Provide a more clinically focused pharmacy service by reviewing patient data before visiting wards.
- Timing alerts for individual patients e.g. drugs to be administered at specific times with system alerts to remind staff.
- Makes the source data needed for prescribers available at the time of prescribing.
- Automatically populates the discharge summary with the patient's prescribing data.
- Manages stock control

Appendix D – Pathology Benefits

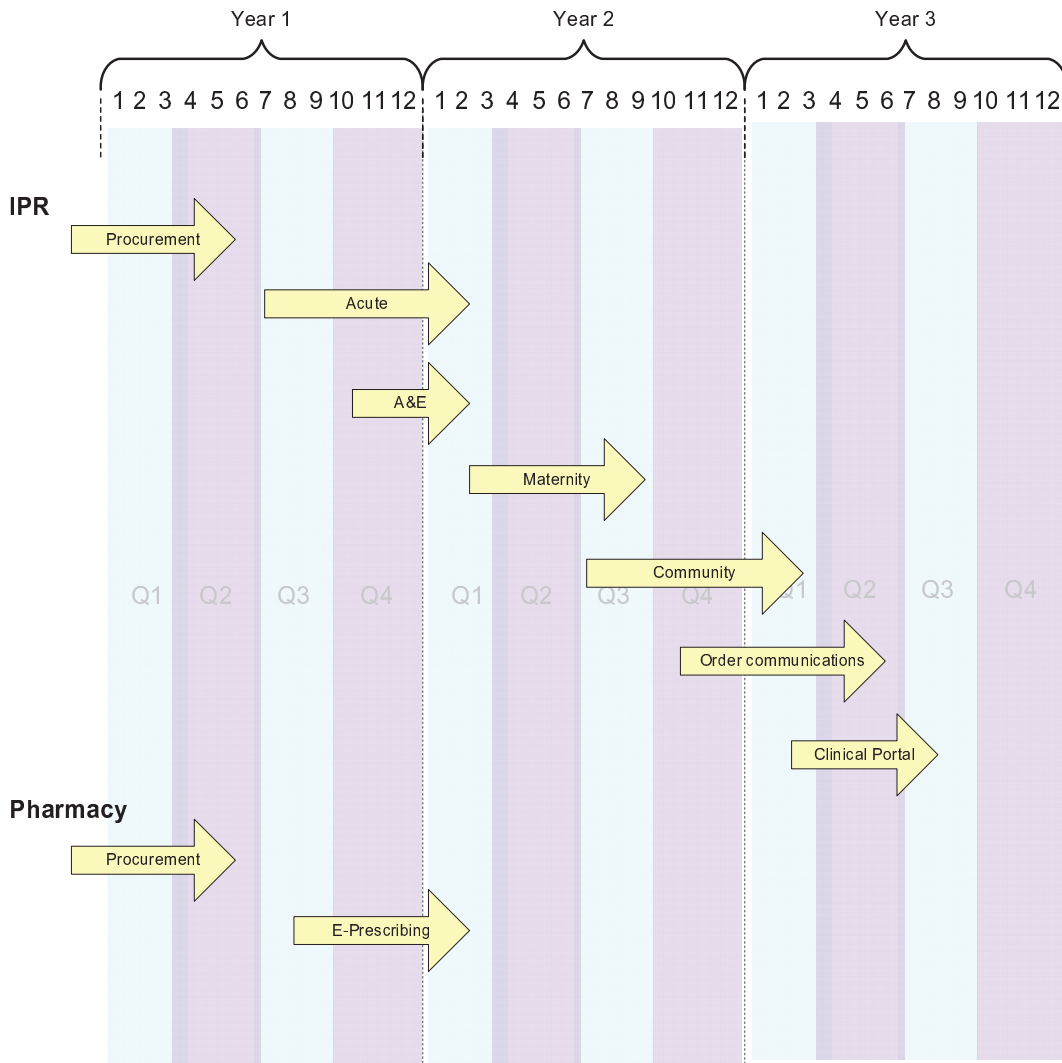
Benefits Discussion with Senior Pathology Staff (21st October 2011)

The department's current application – MasterLab – provides computerised results reporting to both internal requestors and General Practitioners. Replacement of the current application is not planned but there will be a need to integrate the application into the order communications functionality that will come with an integrated care record.

So the department considered the benefits that would accrue from the combined functionality of MasterLab and order communications. These were;

- Screen-based request ordering is faster than paper saving 30 minutes of junior doctors time a day.
- Item messages reduce/eliminate inappropriate orders.
- Automated duplicate checking reduces unnecessary orders
- The ability to add a request to an existing specimen reduces the need for repeat testing.
- Orders can be placed from anywhere in the hospital.
- Visible order status reduces calls to laboratory.
- The use of mandatory fields ensures all the necessary data is captured when the order is placed.
- Reduced print costs.
- Results available sooner.
- Improves patient safety when ordering and administering transfusion projects.
- Reduced need for reception staff.
- Provides safeguarding support e.g. has a patient has the required tests and/or investigations.
- Pre-agreed test sets ensure clinical safety and best use of resources.
- On-line decision support for staff ordering tests and investigations reduces inappropriate samples due to poor labelling.
- Identity management is simpler and more robust due to the integrated nature of the system.
- Clinical workstations/portals can be created for clinicians within Pathology e.g. Microbiologists, Haematologists etc.
- Reduced time in A&E for patients as results are available more quickly.
- Application could be made available on mobile devices such as PADS.
- Analyser results could be linked to the IPR reducing need for paper copies in notes that often get lost or are hard to find.
- Orders from GP's (60% of workload) could be automated.

Appendix E - Timescale



Appendix F - Equality Impact Assessment Screening Form

Equality Impact Assessment Screening Form			
Title	Informatics Strategy 2012-2017		
Author	Martin Scrace		
Directorate	Finance & Performance		
Team/ Dept.	Informatics		
Document Class	Document Status	Issue Date	Review Date
Strategy	Review	February 2012	February 2013
1	What are the aims of the document?		
	To set out the strategy for the delivery of Informatics developments over the next 5 years		
2	What are the objectives of the document?		
	To ensure that future Informatics developments are consistently implemented and comply with the guiding principles of reliability, availability, supportability, manageability and sustainability.		
3	How will the document be implemented?		
	<ul style="list-style-type: none"> The strategy will be implemented through the Informatics Business Plan 		
4	How will the effectiveness of the document be monitored?		
	Strategy will be subject to annual review to ensure it still complies with principles above.		
5	Who is the target audience of the document?		
	<ul style="list-style-type: none"> Trust Board 		
6	Is consultation required with stakeholders, e.g. Trust committees and equality groups?		
	Yes		
7	Which stakeholders have been consulted with?		
	<ul style="list-style-type: none"> Informatics Department Section Managers Clinical staff Head of IT Services Trust Executive Directors 		
8	Equality Impact Assessment		
	Please complete the following table using a cross, i.e. X . Please refer to the document "A Practical Guide to Equality Impact Assessment", Appendix 3, on Tarkanet for areas of possible impact.		

	<ul style="list-style-type: none"> • Where you think that the policy could have a positive impact on any of the equality group(s) like promoting equality and equal opportunities or improving relations within equality groups, cross the 'Positive impact' box. • Where you think that the policy could have a negative impact on any of the equality group(s) i.e. it could disadvantage them, cross the 'Negative impact' box. • Where you think that the policy has no impact on any of the equality group(s) listed below i.e. it has no effect currently on equality groups, cross the 'No impact' box. 			
Equality Group	Positive Impact	Negative Impact	No Impact	Comments
Age			X	
Disability			X	
Gender			X	
Race / Ethnic Origins			X	
Religion or Belief			X	
Sexual Orientation			X	
	<p>If you have identified a negative discriminatory impact of this procedural document, ensure you detail the action taken to avoid/reduce this impact in the Comments column. If you have identified a high negative impact, you will need to do a Full Equality Impact Assessment, please refer to the document "A Practical Guide to Equality Impact Assessments", Appendix 3, on Tarkanet.</p> <p>For advice in respect of answering the above questions, please contact the Equality and Diversity Lead.</p>			
9	<p>If there is no evidence that the document promotes equality, equal opportunities or improved relations, could it be adapted so that it does? If so, how?</p> <p>No</p>			

Completed by

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