Ashford and St. Peter's Hospitals NHS
NHS Trust

TRUST BOARD
25th February 2010

TITLE	**IM&T Assurance Review**
EXECUTIVE SUMMARY	An external report on the Trust's IM&T function was recently commissioned. The report has now been finalised and is being shared with Trust Board for information.
BOARD ASSURANCE (Risk) / IMPLICATIONS	The BAF highlights certain risks to the Trust's operating efficiency posed by potential network resilience and infrastructure issues.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Information is a key asset for various stakeholder groups: Clinicians, Patients, Commissioners and corporate users. Modern patient care demands modern information systems.
EQUALITY AND DIVERSITY ISSUES	None identified.
LEGAL ISSUES	Significant body of legislation around data protection.
The Trust Board is asked to:	Note the findings of the IM&T Assurance Review
Submitted by:	John Headley, Director of Finance & Information.
Date:	11th February 2010.
Decision:	For Noting.

TRUST BOARD
25th February 2010

IM&T Assurance Review

Background

As discussed at the January Board meeting, an external review of the IM&T function has been commissioned from Mike Haynes, an experienced Information consultant who has worked with over 40 NHS organisations.

The Information Management and Technology function at ASPH covers all aspects of health information, specifically:

- Information Technology
- Major systems including the Patient Administration System (PAS)
- Data Quality
- Clinical coding
- Corporate and Health records
- Information Management
- Information governance

The reasons for commissioning the external review were to assess the capability and strategic direction of the function at a time when ASPH is moving towards its vision of being one of the best healthcare trusts in the country - against a challenging economic backdrop. Pressures on public spending have accelerated the demise of the National Programme for IT (NPfIT) and there will be no further centrally funded system replacements for acute trusts in the near future. This means that ASPH like many acute trusts is now at a cross-roads and must determine its own strategic direction for IT.

The full report is included here for the Board's information.

The report highlights areas of good practice together with some areas for improvement, and makes a number of urgent recommendations. Some changes and a new impetus are now required to strengthen the contribution of the IM&T function to the Trust. Key recommendations are listed below.

Recommendations in the report

1. Adopt the term "Health Informatics" for the IM&T function.
2. Raise Health Informatics leadership at all levels across the Trust.
3. Relaunch the Information Strategy Steering Group (ISSG), with new TOR, new members, and with a clinician as chair.
4. Shift from tactical to long term planning.
5. Re write the strategy, 5 year vision and investment plan and bring to Trust Board for discussion.
6. Restructure and strengthen IM&T department to meet current challenges
7. Develop informatics capability and capacity in the workforce
8. Work out what do with PAS (our Patient Administration System, supplied by iSOFT)
9. Require business managers to take a central role in realising benefits

Next Steps

The report has already been discussed by the middle managers within the IM&T function, generating engagement and a desire to improve. Mike Haynes will present his findings and recommendations at TEC on 26 February - which is important in terms of clinical engagement.

An action plan for implementation of Mike's recommendations will be prepared and brought to the March Board meeting.

The Trust Board is asked to note the findings of the IM&T Assurance Review.

Submitted by: John Headley, Director of Finance and Information

Date: 11th February 2010

Paper 7.3

Ashford and St. Peter's Hospitals NHS
NHS Trust

Ashford and St Peter's Hospitals NHS Trust

IM&T Assurance Review

December 2009 – January 2010

February 2010

Acknowledgements

This work has been completed in a relatively short timescale. IM&T staff made the reviewer welcome; they have provided excellent support and help throughout the review process. Extreme weather conditions during the course of the work caused some difficulty and delay. Acknowledgement is made for the considerable help received from Judy Trafford who had to constantly re-arrange interviews to overcome adverse weather conditions affecting people travelling to work. Finally, thanks go all those who made time available to be interviewed and contributed their ideas.

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Executive Summary

This document reports the findings and recommendations following a high-level assurance review of IM&T conducted in December 2009 and January 2010.

The NHS sees technology as a major enabler underpinning service transformation, improvements in patient safety, gains in efficiency and modernisation. The Operating Framework 2010/11 requires each Trust to develop health informatics capability and capacity in the workforce.

Good information is an essential ingredient contributing to the future success of the Trust, achieving financial balance and realising Foundation Trust Status. Good information is intrinsically linked with good patient care and the patient experience.

The Trust is now at a cross-road in terms of its Information Technology (IT) development. The National Programme for IT (NPfIT) is changing and the Care Records Service (CRS) is most unlikely to be deployed to acute trusts in the Southern Cluster in the foreseeable future. This means the legacy Patient Administration System (PAS) will not be replaced by a nationally provided solution.

The Trust needs to shift up a gear from tactical to long term planning for its future patient and clinical information systems. It will need to fall back on its own resources to deliver solutions and work out what to do about replacing the PAS. There are clear signals that no additional central money will be made available to Trusts for this purpose.

The Trust needs to rethink its approach to '*health informatics*' – adopting this umbrella term for the function will usefully signal a change to the organisation and raise the profile of this important enabling area. The Trust will need to develop a new health informatics vision, strategy and plan reflecting the national change in direction.

The IM&T department will need careful restructuring and strengthening to meet the new challenges that lie ahead. The Information Services Department is not satisfying the needs of some of its customers and this area needs attention.

There are good foundations on which to build. There are some good skills in the IM&T department but their full potential needs to be realised. There are some good IT assets to sweat. The Trust has a history of innovative development. There is a strong culture of ambition, especially amongst clinicians, to exploit modern technology to improve the delivery of patient care.

A corporate approach will be essential: leading, organising, planning, prioritising and delivering a health informatics programme of work that will benefit patients and those who care for them. The ISSG (or its successor) has a key role to perform in this respect.

The Trust Board will need to consider the investment profile necessary to support implementation of modern health informatics and enabling technology in this new world. Realising benefits from this investment is essential and will require determination and effort from business areas.

1. Introduction

This document reports the findings from an external review of Information Management and Technology (IM&T), the 'IT function' at Ashford and St Peter's Hospitals NHS Trust (ASPH). The requirement was for a quick high-level assessment to inform judgements about assurance. The statements and recommendations contained in this report are therefore of necessity broad. These can be used by the Trust to frame the scope and terms of reference for more detailed work and study in areas such as strategy development, IM&T and ISSG restructuring, IT systems and the management of change.

2. Information as an Asset

Modern healthcare delivery in a modern-day acute hospital is both highly complex and fast moving. Healthcare Professionals (HCP) need ready access to accurate and timely information in order to provide the best possible care for their patients. The Trust, especially in the current economic climate, needs to make efficient use of its resources. Patient safety is at the top of the national agenda. Getting paid and maintaining financial balance is vital to the Trust's success and its aspiration to attain Foundation Trust status.

Information underpins all these areas. Information needs to be at the top of a forward-thinking Trust's agenda and to be managed actively from the Trust Board downwards.

Modern patient care demands modern informatics. Modern technology (IT) should be exploited to enable, wherever possible, the replacement of traditional paper-based information systems such as the health record and nursing documentation and to move towards increased use of automated clinical coding.

The Operating Framework for the NHS in England 2010/11 states: '*Ambitious and innovative approaches to digital technology underpin the delivery of strategic business and service objectives*'. The Strategic Health Authority Informatics Planning guidance states: '*The SHA expects to see evidence of informatics planning as an enabling component of all service transformation*'. This report makes the assumption that ASPH also aspires to these national aims.

3. National Context

The National Programme for IT (NPfIT) was launched at the beginning of the decade as a major government initiative to invest in modern IT systems for the NHS. The programme is managed by Connecting for Health and delivered through appointed Local Service Providers (LSPs). In 2008 the contract for the LSP (Fujitsu) for the Southern Cluster was terminated. Although contract novation has occurred for some established areas such as Picture Archiving and Communication System (PACS) there has been considerable uncertainty since the termination.

This has particularly affected plans for deploying the Care Record Service (CRS). This system was intended to replace the existing Patient Administration System (PAS) and to provide a fully integrated administrative and clinical system including

areas such as electronic requesting and reporting of diagnostic tests and procedures.

During the course of this study, it became clear that the CRS will not be deployed in Southern Cluster trusts in the near future, if at all. It is also clear that central money is unlikely to materialise to assist acute trusts procure locally, as priority is being given to mental health and community trusts. It is difficult to put a value on the loss of the CRS deployment to the Trust but this is probably in the region of £8m to £10m. Trusts will need to fall back on their own initiative and resources.

There has also been a national shift from 'ruthless standardisation' through the deployment of centrally imposed and paid-for solutions such as Cerner Millennium to an approach based on national standards to which trusts are obliged to adhere. Examples given in recent guidance include the need to ensure interoperability and information sharing (both across the Local Health Community (LHC) and internally between systems) and to deliver the so-called Clinical 5 (integration, scheduling, order communications, e-discharge and e-prescribing).

The implications for ASPH are immense and this review is timely. Like most trusts across the country, ASPH has been engaged in tactical planning to keep legacy systems going (such as the PAS) until the CRS is deployed. ASPH now needs to shift gear from tactical to long term planning for its future patient information systems.

The Trust is now at a cross-road: this means new strategic thinking and redefining aspects of the role of the IM&T department. Durable strategic IT decisions need to be made now as solutions selected are likely to serve the needs of the Trust for the next 10 years.

The Trust Board will need to consider the investment profile necessary to support implementation of modern health informatics and enabling technology in this new world.

4. Overview of Findings

In spite of delays with the national programme and the planning frustrations this has caused, the Trust has managed to move forward IT developments in a number of areas and innovate. There is a positive culture amongst clinical staff and an appetite for change in using new technologies to improve the delivery of patient care.

The main overarching issue and a major concern emerging from the review is a perceived lack of corporate control over the IM&T Agenda. There are multiple projects and initiatives, many laudable in their own right with individuals and departments pushing ahead with local agendas. The effect of this silo approach is to fragment and dilute corporate effort and resources, compartmentalise project development and cause a loss of direction.

There is frustration across the Trust about the absence of a clearly articulated, succinct and shared IM&T vision to provide a sense of direction and maintain coherence.

There are some good technical skills in the IM&T Department and these have been employed to overcome the limitations of the legacy systems and NPfIT delays and to deliver a number of innovations including the widely used In-Patient List (IPL) and electronic discharge.

Operational demands for information are not being fully satisfied and there are issues about inconsistent reporting.

Although information problems are solved in innovative ways that enable communication and sharing of information, the solutions are often largely text based (for example the IPL) thus creating information 'islands'. These add to the problem of duplicate entry which is widespread across the Trust.

Finally, the Trust has invested in a number of good quality products such as the Ardentia data warehouse and the cardiology PRISM products. The Trust is not realising the full benefits from these assets.

5. Detailed Comment and Recommendations

This section develops the themes identified in the overview. Each section summarises the issue and provides a recommendation.

5.1. Terminology

Use of the term IM&T as a name to describe the function is no longer in general use across the NHS in England. National guidance and the Operating Framework generally use the modern terminology of Informatics or Health Informatics (HI).

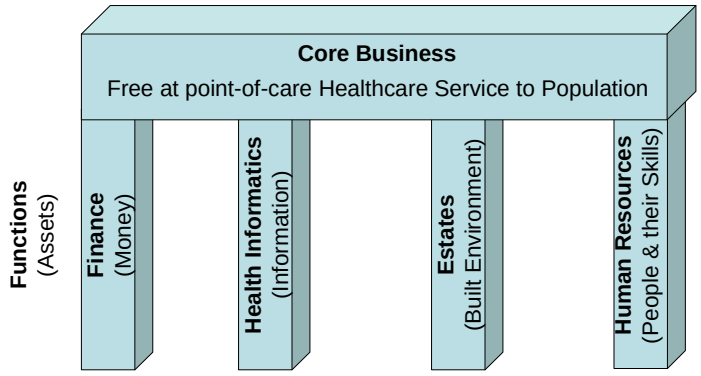
The nationally accepted definition of health informatics is: *'the knowledge, skills and tools which enable information to be collected, managed, used and shared to support the delivery of healthcare and to promote health*'.

Recommendation: *The Trust adopts the term 'Health Informatics' to describe the vision, strategy, and information-related planning and programme activity. (The term IM&T could be retained for the department concerned with operational and technical project delivery).*

5.2. The Health Informatics Function

Health Informatics is not just about IT: it is concerned with information in any media; the way information is collected and managed; about the manner in which change is organised; and the way people work with information in a modern Trust. The diagram below illustrates HI as one of four functional pillars required to support the core business of healthcare delivery.

Functional Map



'Modern Informatics for Modern Patient Care'

Recommendation: *The profile of Health Informatics, as a structured functional business area (an outline model is provided in Appendix III) within the Directorate of Finance and Information, needs to be raised.*

The ISSG and IM&T department have crucial roles to play in shaping the function to meet the information requirements of the Trust.

5.3. Trust Board and Senior Management Team

Given the major changes to the NPfIT, the investment implications and the importance of information to the success of the Trust, it is vital that the Trust raises the profile of Health Informatics and provides leadership at Trust Board and senior management levels. The Operating Framework and Informatics Planning guidance identify informatics as an enabler for service transformation and modernisation.

Recommendation: *The Trust Board and Senior Management Team provide strong leadership and routinely review and consider HI matters at meetings.*

5.4. IM&T Strategy Steering Group (ISSG)

All interviewees expressed concern about the effectiveness of ISSG as a decision-making and leadership body. There is good representation from user areas within the membership.

Recommendation: *ISSG in current form is disbanded and replaced by a strengthened HI Programme Board with terms of reference that include: developing strategy, maintaining direction, setting priorities, approving all projects, assigning project resources, leading change and directing a programme of work. Preferably, the Board should be delegated overall control of the HI capital budget. Ideally, the Chair of the Programme Board should be a senior clinician. (The Programme Board would <u>not</u> have responsibility for overseeing day-to-day operational activities of the IM&T Department).*

5.5. Health Informatics (IM&T) Vision, Strategy and Annual Plan

The versions of these documents reviewed as part of this assurance exercise were prepared before recent changes in the NPfIT and do not take account of the need for the Trust to adopt a long-term planning approach. As part of strategy development the Trust will now need to undertake a detailed options appraisal for PAS replacement or development.

Some major developments such as records scanning, e-prescribing, development of patient centre, pathology order communications, introduction of bar-coding technology and wireless infrastructure seem to be locally determined and undertaken in isolation rather than an integral part of coherent strategic development.

Recent guidance emphasises the need for interoperability and connectivity and this is not addressed in the current version of these documents.

A succinctly articulated and corporately-owned vision for Health Informatics would be beneficial. This should be developed to provide the organisation with a sense of direction and the glue which holds a portfolio of projects together.

The strategy should be underpinned by a set of principles to guide developments and ensure coherence across projects. Examples include: '*Data will be collected once and used many times'*, and '*Wherever possible management and performance information will be produced as a by-product of operational systems*'.

In current form the vision, strategy and annual plan do not meet contemporary requirements and require further work to bring these important documents up-to-date.

Although this work may be led by the IM&T Department and signed off by ISSG, it is essential that it reflects corporate business needs with senior managers and clinicians contributing through a structured interview programme. In this way greater corporate ownership can be assured.

The annual plan should be used to create and inform a funded programme of work approved by ISSG.

Recommendation: *Revised versions of the IM&T Vision, Strategy and Annual Plan need to be prepared to reflect recent changes in the national programme and guidance. The revised version should include a clear vision statement, development principles, a 5-year financial and benefits profile and a coherent programme of work.*

5.6. IM&T Department

The IM&T department has undergone a number of major changes in recent years. Many health economies across England established shared services in the early part of this decade. This occurred in Surrey and a shared service was established to provide a full range of IM&T services to partner organisations in the health community. Subsequently this arrangement failed and during 2007/08 local IM&T departments were re-established. The creation and dissolution of the health community shared service has influenced the shape of IM&T in ASPH. These re-organisations and the need to re-absorb staff (and their grades) tended to drive structural arrangements rather than the needs of the organisation.

NPfIT deployment obligations imposed by CfH on Trusts required the establishment of a Project Team and resources. With the contract reset process and eventual termination of Fujitsu's contract these teams were stood down and the resources re-absorbed. This occurred in ASPH.

In 2008, there was pressure on the Trust to improve performance reporting, partly driven by the RTT agenda. In response 3 additional specialist senior information consultant positions were created and filled.

There is a small separate IT department in Pathology. Some business areas are employing their own analysts.

The current departmental form has emerged from a period of some turbulence. A strong and effective IM&T department serving the needs of business areas is vital if modern technologies are to be successfully deployed and benefits realised for users.

The changes in the national programme provide an opportunity, one of several at this cross-road in time, for a purposeful review of the IM&T function within the wider context of Health Informatics. Departmental form should follow function – a model is provided in Appendix IV. This example illustrates the typical functions of an information services department and similar models could be constructed for other IM&T areas. A detailed review would need to consider a number of questions including:

a) Should there be one IT department serving the needs of all departments?

b) Given NPfIT changes and the need for the Trust to plough its own furrow, what IM&T functions will need strengthening (such as Project Management and Applications Development)?

c) Could the professional skills of Information Services, using tools such as Ardentia, be better deployed to empower business managers to run their own reports rather than reacting to requests?

d) What shape should the relationship between Information Services and business areas take – should this be performance managed through a formal Service Level Agreement (SLA) process?

e) Should dedicated (named) Information Analysts be allocated to selected business areas?

f) Should a discrete business intelligence unit be established within the Information Service?

g) Should all data analysts employed by the Trust in different business areas come under the professional guidance of Information Services?

h) Given the natural relationship between coding and information should these areas be brought together?

i) Where do web content/services logically sit in the organisation?

j) System management is usually the responsibility of the business area owning and using the system (this arrangement usually leads to better data quality). Should Theatre system management be repatriated from Information Services to Theatres?

k) What structural arrangement will help to create a career framework and encourage staff?

Recommendation: *A full review of the IM&T function should be undertaken in the light of national developments and growing business demands for information.*

Recommendation: *as an interim measure, a named information support person should be attached to the office of the Chief Operating Officer to provide support for performance information.*

5.7. HI Capability and Capacity

National guidance (Operating Framework 2010/11 and Informatics Planning 2010/11) encourages Trusts to develop informatics capability across the general workforce (for example empowering managers to develop and run their own reports above) as well as strengthening the capacity of the specialist workforce (for example reviewing and strengthening the IM&T Department above).

Developing capability will enable the Trust to maximise benefits from investment in IT systems. Developing capacity will enable the Trust to exploit, implement and maintain new technologies which in turn will enable modernisation and more efficient working.

Recommendation: *The Trust should develop Informatics capability and capacity in the workforce and exploit the CfH framework to guide this process. www.hicf.org.uk/*

5.8. Clinical Engagement and Leadership

Modern information systems can bring enormous benefits for patients and the clinicians (doctors, nurses, therapists and scientists) who care for them. These systems have considerable impact on the way clinicians work and the way they work with information. It is important that those who are affected by these systems are involved and engaged. Clinicians need to be properly represented in the decision-making process, in the specification of systems to be used, in setting priorities, and in designing and leading change.

The obvious formal vehicle for this representation is through the ISSG (or its successor). However, each clinically-focused IT project needs to include a clinician as a Project Board member and identify clinical champions to advise and support delivery.

Recommendation: *The appointed Chair of ISSG should be a senior and respected clinician.*

5.9. IT Systems and Infrastructure

There was not sufficient time to undertake a detailed investigation of IT systems. Brief consideration was given to four areas: PAS and the Patient-Centre, major departmental systems (Pathology, Pharmacy and Cardiology), infrastructure (wireless) and servers. Alongside these systems a number of innovative applications have been developed including the widely used in-patient list and e-discharge systems.

Development of IT systems lacks cohesion and corporate connection. Decisions as to what to do next, where to invest and where to put effort seem to be taken locally to meet a local need rather than in the context of

a clear vision and strategy. Strong corporate leadership through a body such as ISSG is essential to avoid fragmentation.

The Trust's main patient-based IT system is the legacy (managed service) iSoft PAS. This is based on old technology and is character-based. The servers have recently been replaced. The PAS would have been replaced by the CRS under NPfIT. The PAS interfaces with a number of other systems to provide patient demographic and admission, discharge and transfer (ADT) feeds.

In spite of the age of the PAS, it has been exploited to the full and order communications implemented for radiology and pathology (although the latter has only seen limited implementation). However, users dislike both the 'clunky' nature of the user-interface and the way results are displayed.

iSoft has developed a modern 'front-end' for the product called Patient-Centre. Work is underway to evaluate this development with a view to implementing this product.

The Trust's main departmental systems are the Pathology Clinisys 'Winpath' (managed service) system, the Pharmacy 'Ascribe' system and the Cardiology PRISM system. In addition, the Trust has implemented the NPfIT PACS and CRIS radiology systems although these systems were not considered.

The pathology 'Winpath' system is in wide use across the NHS in England. Pathology is considering the Anglia ICE order communications system – particularly to support GP test ordering. Pathology has particular business requirements as a good proportion of their work comes from external customers.

The pharmacy Ascribe system is also a significant player in the NHS market. Pharmacy is considering the future of the Ascribe system. The Department would like to implement e-prescribing when the organisation is ready.

Cardiology has implemented the HD Clinical PRISM system. The Department has had the system in current version and its predecessor system for about 10 years. PRISM is a powerful application and is capable of supporting order communications. It is surprising that such little use is being made of this powerful tool. Benefits are not being realised from this investment.

The Trust is considering development of a wireless infrastructure. This technology is an essential building block to ensure access to clinical systems and their uptake by users. Queuing to access a PC or moving from bedside to a remote location desktop PC to access or record information will be unacceptable to clinical users. Wireless capability enables flexibility.

Servers are housed in a fire-protected secure room. Work is underway to introduce virtualisation although progress is slow. Resilience is being developed although the absence of a remote second site to develop a modern storage area network and fail-over functionality will limit the extent to which this can be achieved. Disaster Recovery is being put in place through a project led by IT.

The recommendations that follow are made on the assumption that the recommendation in Section 5.5 (revise the strategy and develop a vision) is a precursor and provides a framework to guide decision making.

Recommendation: *A full evaluation and options appraisal of the PAS, including the proposal to implement Patient-Centre, should be undertaken as a corporate priority before further development work is undertaken. This should include dialogue with the supplier as to their long-term intentions for the product. (This work should be undertaken in the context of: strategic direction; NPfIT changes; the requirement for a PAS that is fit-for-the-future; and with no central monies - affordability).*

Recommendation: *Review all existing IT systems (including cardiology and the data warehouse) to ensure the Trust is sweating these assets and maximising benefits to achieve strategic and business goals.*

Recommendation: *Develop investment plans for infrastructure building blocks: fully resilient split-site storage area network (Server Farm) based on virtualisation and modern blade technology; wireless infrastructure; and user interface devices (PCs and mobile devices).*

Recommendation: *Establish IT development, specification and procurement guidance to ensure future interoperability and integration, adherence to ISB Standard Contract Terms and Information Governance Privacy Impact Assessment (PIA) requirements.*

5.10. Benefits Realisation Planning and Tracking

Benefits realisation planning and tracking is done well in very few Trusts. ASPH is not alone in this respect. Most NHS organisations are in a constant state of flux and implementation of IT systems can take years. Both organisation and technology move on and attribution of quantitative benefits to a particular investment can be very tricky as often sight has been lost of the original business drivers or objectives. Soft qualitative benefits (for example better patient experience through reduced delay as a result of ready access to information by those providing their care; or improved patient safety benefits from e-prescribing) can be extremely difficult to track and demonstrate. Realising benefits requires dedicated effort.

Benefits will largely come from changes in the way people work and more efficient processes. The ISSG and business managers have central roles to play in leading benefits realisation.

Recommendation: *Business managers should take the lead in ensuring benefits are realised from IT investment. They should ensure*

that IT Projects impacting their areas should have a named representative, responsible for benefits realisation, on relevant Project Boards. (The ISSG should continue to take the corporate lead for benefits realisation as per current TOR).

Recommendation: *Project documentation (business case, project initiation document, project plan etc.) should contain clear reference to benefits identification, planning and realisation.*

Appendix I

Terms of Reference

The Terms of Reference agreed with the Trust for this review were to:

a) investigate the IM&T vision and strategy and the current version of the Annual Plan; the review will assure the current roadmap against delivery requirements of national and Trust business requirements;

b) examine the clinical and patient administration IT systems in use, investment priorities and progress towards delivery of the Clinical 5 and an integrated electronic patient record;

c) review delivery arrangements including fitness-for-purpose of the IT management structure, IT resources and governance arrangements within the wider IM&T structure;

d) appraise clinician leadership, engagement and involvement in determining priorities and the degree of local business ownership in delivering change projects;

e) explore development requirements for IT leadership and management;

f) identify potential risks.

After these TOR were agreed, significant changes in the national programme for IT became evident. Account has been taken of these changes in the framing of the recommendations contained in this report.

IT staff development requirements and risk identification are covered in separate sub-reports.

Appendix II

Interviewees and Contributors

Vanessa Avlonitis, Deputy Chief Nurse
Raj Bhamber, Director of Workforce and Organisational Development
Mike Baxter, Medical Director
Julie Callin, Head of Therapies
Martin D'Arcy, IT Manager
Andrew Davies, Information Consultant
Laura Ellis-Phillips, IT Services Manager
Linda Fairhead, Infection Control Nurse
Peter Finch, Clinical Director, Consultant Imaging and Endoscopy
David Fluck, Clinical Director, Cardiology
Fern Freestone, HAS Manager
Robin Gammon, Head of Information Services
Melanie Grant, Health Records Manager
Victoria Griffiths, Chief Pharmacist
Suzanne Hatfield, Cardiology Department
John Headley, Director of Finance and Information
Valerie Howell, Chief Operating Officer
Elaine Inglis, Hospital Manager, Ashford Hospital
Cath Jago, Head of Information Services
Clinton Krynie, Information Manager
Andrew Laurie, Clinical Director, Pathology
Andrew Liles, Chief Executive
Steve Lomas, Business Centre Manager
Eileen Nolan, Associate Director of Maternity Services
Tracy Paton, Assistant Director, Financial Management
Peter Reynolds, Consultant Neonatal Paediatrician and Clinical Lead for IT
Barry Sellick, Clinical Director, Critical Care
Steve Shiel, Pathology Services Manager
Helen Sibley, General Manager for Children's Services
Julia Tudose, Clinical Coding Manager

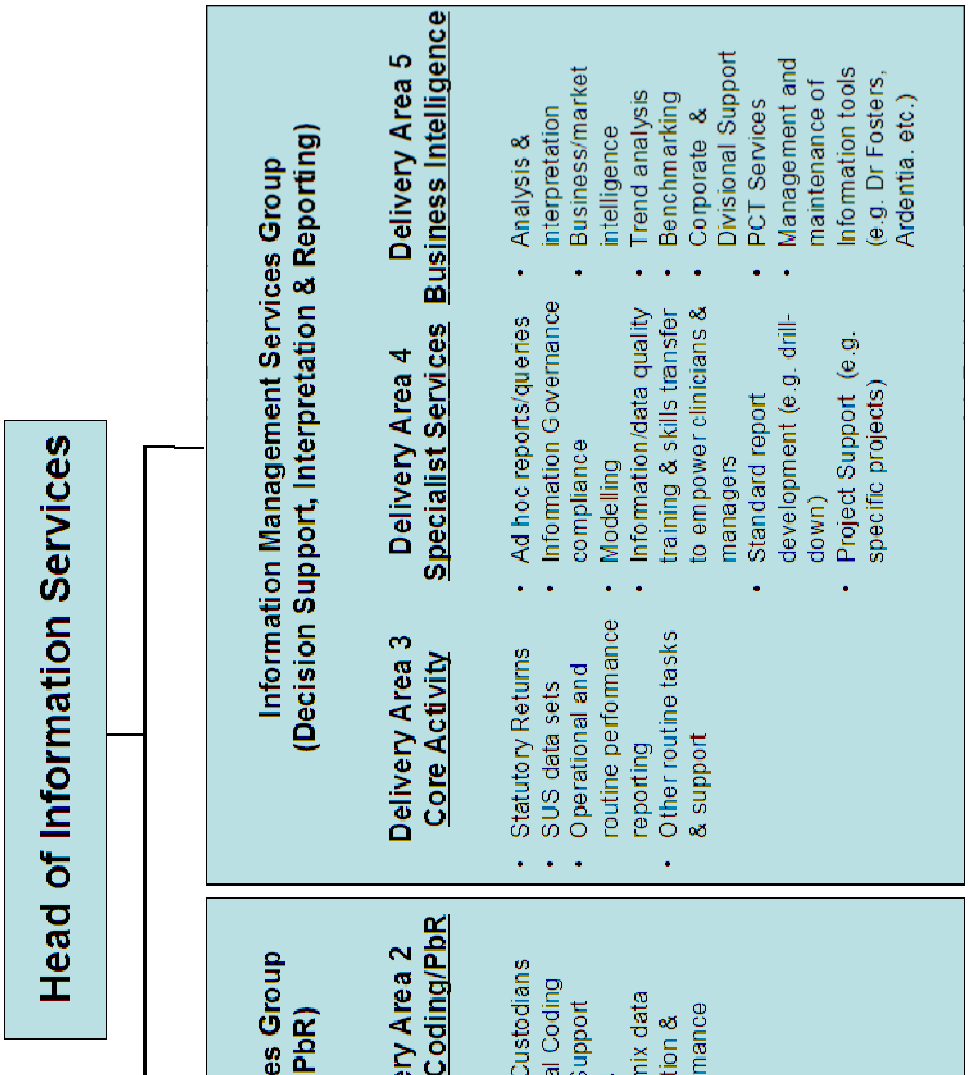
Appendix III

Model HI Functional Structure

- HI 'organisation'
  - Contains structure for all functional elements
  - Provides professional direction & leadership
  - Gives professional advice to the Trust Board
  - Maintains corporate cohesion & coherence
  - Develops corporate HI capacity & capability (with HR support)
  - Provides overall information management
- HI Programme Board
  - Has clinician leadership
  - Owns and delivers HI Strategy
  - Reviews HI-related Business cases – makes recommendations
  - Sets priorities against financial allocation
  - Leads change programme
- Information & IT Services
  - Gives technical advice & operational services
  - Contains all elements (coding, IS, IT, Health Records, IT training, IG etc.)
  - Sets standards for Data Quality (esp. patient admin staff)
  - Delivers technology (ICT) solutions against prescribed needs
  - Provides project management support for implementation, change & modernisation
  - Provides System Administration (technical)
- Service Directorates
  - Determine requirements
  - Realise benefits from Information systems (as (Users)
  - Manage systems (day-to-day updating)
  - Deliver Data quality

Appendix IV

Information Services Design Model



ISD Service Model – Map of Activities and Services