

**Health System Led Investment in Provider Digitisation**

**Prospectus**

**August 2018**

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1. **Introduction**

**Context**

* 1. The NHS Five Year Forward View, published in October 2014, promoted digital technology as a key enabler of the changes required to make the NHS sustainable in the long term. It made a commitment to ‘fully interoperable electronic health records so that patient’s records are paperless’.
	2. In September 2016, an independent review, led by Professor Robert Wachter, published ‘Making IT work: harnessing the power of health information technology to improve care in England’. The review concluded that “To those who wonder whether the NHS can afford an ambitious effort to digitise in today’s environment of austerity and a myriad of ongoing challenges, we believe the answer is clear: the one thing that NHS cannot afford to do is to remain a largely non-digital system. It is time to get on with IT”.
	3. The national digital programmes and services being delivered over the coming years have been mapped across five pillars which align to ‘Next Steps on the Five Year Forward View’: empower the person; support the clinician; integrate services; manage the system effectively; create the future; supported by investment in live services and infrastructure.
	4. Against this national strategy we have already invested in:
* Empowering patients with public access wifi in every GP surgery, enhancing and opening up of NHS Choices as nhs.uk, creating the NHS apps library and investing in an NHS app to be launched this year and apps to support the Five Year Forward View priorities.
* Supporting clinicians with the Global Digital Exemplar and fast Follower Programmes and the commencement of work to upgrade GP systems – the GP Futures Programme.
* Integrating services to provide a shared clinical record across health and care through the Local Health and Care Record Exemplars.
* Moving towards a ‘single source of truth’ database and dashboards to improve consistency and lower cost of NHS management information.
* Building the future with our work to integrate genomics, create safe, rapid innovation around predictive algorithms and AI and enable research through the Digital Innovation Hubs.
	1. We are now in a position to announce the release of a further £412.5m of funding is to be allocated to the provider digitisation programme over the next three years to invest in the digitisation of acute, ambulance, community and mental health providers.
	2. Having set the direction of travel with the Global Digital Exemplar and Fast Follower programmes and the framework for interoperability with the Local Health and Care Record Exemplars, we are seeking to encourage system-wide working around information and IT by allocating this money to ICSs and STPs on a capitated basis, to be locally allocated within the national priorities.

**Provider digitisation**

* 1. Provider digitisation will see patient information being recorded once, digitally, at, or close to, the point of care. Clinicians working will be alerted promptly to key patient events and changes in status, supported by knowledge management and decision support tools. Digital technology will support the improved management, administration and optimisation of medicines, increased availability of assets, effective staff rostering and mobile working for community-based staff. Transfers, referrals, observations, medications, pathology results, diagnostics, dates and schedules, orders, results, alerts, notices and clinical communications will be passed digitally based on common terminology from and to providers, on a timely basis and avoiding bureaucracy and duplication. Patient information recorded in one care setting will be available in other settings. By delivering these capabilities, provider digitisation will have made a significant contribution to the challenges identified in the Five Year Forward View, and in particular, closing the finance and efficiency gap.
	2. Increasingly, provider digitisation will underpin new models of care. Information will flow seamlessly across organisational boundaries, supporting the delivery of coordinated, patient-centred care, seven days a week. Digital systems will guide clinicians along defined clinical pathways, standardising practice and minimising variation across provider chains, ICS boundaries or STP footprints. Mobile technologies will support delivery of care outside traditional settings and closer to home. In enabling these new care models, provider digitisation will make a significant contribution to the challenges set out in the Five Year Forward View, and in particular, closing the care and quality gap.
	3. The digitisation of providers will be a foundation for further technology-led innovation in care models. Digital data captured in a direct care context will be subject to advanced analysis, enabling population health management and a shift from reactive to proactive care, and will support the development of bespoke treatments and medicines at the level of an individual. Opening up the digital record to allow patients to view, understand and contribute will increase patient activation. This in turn will be leveraged in patients utilising digital tools and applications for care planning and shared decision making, education and access to resources, monitoring and feeding back on their health and wellbeing, and administering their personal budgets. In so doing, digital technology will make a significant contribution to the Five Year Forward View challenges, and in particular, closing the health and wellbeing gap.

**Digital maturity**

* 1. Between September and December 2017, all secondary care providers completed the second round of the Digital Maturity Self-Assessment (DMA). Results were shared with individual providers in February 2018 and can be made available to STP/ICSs via the DMA website on request.
	2. The results show that local investment over the last two years has delivered some increase to overall levels of digitisation, but that there are still significant gaps which this funding can help address.
	3. It also highlights a number of common characteristics across those organisations that have made greatest progress to date. In all cases, this included strong leadership from the top of the organisation (clinical and non-clinical), regular engagement with staff at all levels and investment in the underlying IT infrastructure required to deliver high-quality, reliable digital services. From a functional perspective, these organisations had also consistently made significant progress implementing digital systems to support effective observations and vital signs monitoring, medicines prescribing and administration, bed management and patient flow, and order communications. In most cases staff also had easy access to these via a single log-on or interface.

**Initiatives supporting provider digitisation**

* 1. 16 acute and 7 mental health trusts are being supported to become Global Digital Exemplars (GDEs). Each of these organisations are also supporting the accelerated and cost-effective advancement of digital maturity in other organisations through supporting ‘Fast Follower’ organisations and developing blueprints. Three ambulance trusts are also participating in the programme. A business case for the expansion of the GDE programme is under development.
	2. 5 areas have been identified to participate in the Local Health and Care Record Exemplar (LHCRE) programme. Together, these areas cover over 40% of the population of England, with each area made up of one or multiple STPs. Each area will receive funding to put in place a normalised longitudinal care record to enable the delivery of joined up care (direct care) and citizen access and contribution to their record. This support for direct care and also population health management being a key enabler of Integrated Care Systems. A business case for the expansion of the LHCRE programme is under development.
	3. Lord Carter's recent review of efficiency in hospitals suggested how large savings can be made by the NHS. In recognition of the role of digital technology in enabling efficiency savings, funds have been secured for targeted investment in key digital capabilities. In February 2018, the Secretary of State announced that £75m would be made available for provider trusts over 2018/19 to 2020/21 for electronic prescribing and medicines administration (ePMA). Further funding to support the development of system wide eRostering and Bed Management / Patient Flow exemplars is being progressed. The ePMA initiative is being launched in parallel to this provider digitisation programme. The exemplar programmes will be announced shortly.
	4. The initiatives outlined above are likely to impact on how an STP chooses to direct its allocation. As these initiatives are targeted at selected providers and systems, some STPs will be impacted more than others.
	5. Health System Led Investment in provider digitisation will bring outcomes that won’t be delivered through the various initiatives outlined above. It will explicitly align with local STP aims and ambitions, be prioritised against local circumstances, and will see investment across all STPs. The combination of GDE and Health System Led Investment will see financial support for digital leaders (to then support others), and for less mature organisations to help them get ready for future enterprise-wide digitisation.
1. **Health System Led Investment in provider digitisation**
	1. Funding has been secured for a Health System Led Investment programme to deliver the following objectives:
* Advance the digital maturity of secondary care providers
* Enable information to be shared across local healthcare systems, laying the foundations for integrated care
* Allow STP/ICSs to harness digital technology to help realise their transformation goals
* Catalyse STP/ICS-level leadership of the digital agenda at a local level.
	1. At a national level, the funding available for Health System Led Investment in provider digitisation is profiled below:

|  |  |  |  |
| --- | --- | --- | --- |
|  | 2018/19 | 2019/20 | 2020/21 |
| Capital | £104.0m | £92.4m | £216.1m\* |
| Revenue | - | - |

\* The mix of capital and (non-recurrent) revenue for 2020/21 remains to be confirmed

* 1. The ‘fair shares’ allocations at STP/ICS level are derived from the 2018/19 CCG projected weighted population numbers.
	2. The purpose of this prospectus is to invite STP/ICSs to develop an Investment Proposal, setting out their plans for investing their allocations. The overall process that will result in funding flowing directly from DHSC to local providers to spend on provider digitisation projects is set out in sections 4, 5 and 6.
	3. The phrase ‘Health System Led’ signifies that the prioritisation of projects to receive investment should be undertaken at an STP (or ICS) level. Although the funding has been allocated to STP/ICSs on a ‘fair share’ basis, the subsequent allocation to providers is expected to follow a different principle. STP/ICSs are expected to facilitate local stakeholders to undertake a genuine prioritisation process, identifying how the resources should be distributed across providers in the footprint, informed by local STP/ICS priorities and digital maturity ambitions. Such local prioritisation will occur within a set of national eligibility criteria (see section 3), aligned to a set of national prioritisation guidelines (see section 4), informed by local and national intelligence (see section 5.6).
	4. Prioritisation will result in STP/ICS portfolios of provider digitisation projects that utilise this funding, potentially alongside other national and local funding. (Indeed, as the initial funding is capital only, revenue requirements for early projects will need to be funded from an alternative source). STP/ICSs will have discretion on the number of projects and number of providers represented in their portfolios.
	5. STP/ICSs should have the following in place early:
* An individual who is accountable to the STP/ICS leader for the Investment Proposal – this may be someone who has already been given the system leadership role for digital for the STP/ICS
* A governance mechanism to agree the priorities and Investment Proposal that engages the relevant stakeholders (see section 4.12) while still meeting the submission deadlines (see section 5.1) – this should include representation from the NHS England regional team
* A process to prioritise projects that aligns with the guidelines (see section 4)
* A ‘longlist’ of candidate projects (see section 4.1).
1. **Eligible investments**
	1. Where necessary, eligibility can be confirmed with NHS England before proposals are worked up in detail.

**What types of initiative can the funding be invested in?**

* 1. Investments of allocated funding should focus on the digitisation of mental health, community, acute and ambulance providers, and interoperability between them and primary and social care to support clinicians in delivering direct care.
	2. At the core of IT investment should be the NHS’s immediate challenges of managing very tight financial and capacity resources, reducing unnecessary acute admissions and length of stay, enabling community and ambulance services to keep people well and in the most appropriate location for their care, joining up care around the patient to optimise their experience and the quality of care they receive.
	3. Over the three years of the programme, we expect to see systems make progress against the following system digitisation priorities:
1. **Deploying EPR solutions at scale across systems** to allow provider digitisation to go further, faster, and more cost-effectively. Systems might look at short-term investments in year one to add additional modules to existing EPR solutions. Blueprints will become available, particularly from year two, to support accelerated progress. In addition, we are hoping that further investment will become available, mainly in years two and three, to expand the GDE / FF programme. This should be confirmed later in the year - it should therefore not impact the initial prioritisation undertaken by systems, although priorities may need to be revised in due course.
2. **Extending system capacity management** to improve hospital flow**.** Systems might look at short term investments in year one to provide a foundation of real time bed management. Years two and three would have the potential for a system wide strategic investment, informed by learning from the exemplar programmes that will be announced later this year.
3. **Improving system-wide staff rostering** to reduce agency use and increase flexible working. Systems might look at short term investments in year one to provide a foundation of better workforce visibility. Years two and three would have the potential for a system wide strategic investment, informed by learning from the exemplar programmes that will be announced later this year.
4. **Improving the completeness of information available in non-acute settings with real time, coded data collection in community, mental health** to facilitate better patient care and more efficient use of inpatient and domiciliary staff and resources.
5. **Improving ambulance and non-acute access to clinical information and support** such as technology to link paramedics in the field to support from an A&E clinician to reduce unnecessary transportation and hospital admissions.
6. **Sharing health and social care information** to create a shared view between health and care professions working in people’s homes to optimise the care that patients receive.
	1. In practice, individual projects may be focused on a Provider (e.g. mobile working for community-based staff, RFID tracking of high-value implants used during surgery), or may be at an ICS / STP level (e.g. sharing of admission and discharge data between secondary and social care, managing patient flow across the local system), or may be pan-ICS / STP (e.g. a longitudinal care record across secondary, primary and social care settings to enable a base level of information sharing at scale and laying the foundations for integrated care).
	2. Individual projects may focus on infrastructure if they enable clinicians to work in a new way (e.g. enabling mobile working across the community) or support the priorities detailed above (e.g. consistent staff identification across the system to enable information sharing). Infrastructure investment might be a particular consideration for year one. The funding is not a replacement for ongoing local capital investment in maintaining basic infrastructure.
	3. There should be a focus on standardising IT solutions across health systems to simplify data sharing, ease staff movement between providers and reduce the total cost of ownership. Investment in solutions that would result in the divergence of services, systems or infrastructure across the local health and care system should be avoided, unless a compelling rationale can be made. Specifically, EPR divergence in a local healthcare system will not be supported.
	4. Early investment in tactical solutions, for example proposals for point-to-point information sharing solutions when system-wide solutions may be available now or in the near future, should be avoided unless it addresses significant patient safety or business continuity risks.
	5. Funding will not be awarded for projects that are in receipt of awards from other current targeted digital investment programmes, such as the ePMA, LHCRE and GDE programmes. Neither can it be used for the match funding requirement of such programmes.
	6. Those programmes are ongoing. STPs may identify projects now that, in due course, overlap with future awards from these programmes. At that point, if the STP funding has not been committed by the Provider, then the STP will be expected to redirect it towards another project. Where it has been committed by the Provider, the award by the other programmes will be reduced and the balance made available to the STP for other projects.

**Which organisations can the funding be invested in?**

* 1. Providers eligible to directly receive provider digitisation funding and to lead projects in the STP provider digitisation portfolio include all NHS Trusts and Foundation Trusts. In addition, from 2019/20, major providers of community and mental health services from the voluntary, community and social enterprise (VCSE) sector will be eligible with the support of their ICS/STP.
	2. STPs may wish to pool funding to invest in providers who serve multiple footprints – typically ambulance, specialist or mental health trusts.
	3. The Digital Maturity Assessment has identified providers with low readiness and infrastructure scores, who may not have the foundations in place for the effective and extensive deployment of digitally enabled capabilities. Similarly, the NHS Improvement Single Oversight Framework identifies providers facing challenges in leadership and improvement capability. Such organisations should be considered eligible for funding, but STPs will want to give careful consideration to such investments, and look to prioritise areas where there are potential patient safety or business continuity risks, or where the digital maturity of one organisation is acting as a brake on the whole system. Investment in simple and proven solutions will enable these organisations to build a track record of delivery and essential capability in key areas of digitally enabled change, such as clinical leadership, business transformation and informatics expertise.

**How can funding be spent?**

* 1. Funding is only available initially to be spent on items that can be classified as capital expenditure according to the recipient’s local accounting rules. Funding awards can be spent on hardware, software, infrastructure and costs associated with project management, implementation and business change, to the extent that these costs can be capitalised. Where VAT cannot be reclaimed on a procurement, the award can be used to cover this.
	2. Organisations who receive provider digitisation investment must own any assets procured with the funding, and will be responsible for any consequential costs arising from their award and any ongoing costs arising from the initial investment. Such costs may include capital charges and depreciation. Funding awards cannot be used to cover such costs.

**How could / should proposed projects be scoped?**

* 1. The annual total allocation for an STP must be spent (by Providers) in-year, it cannot be rolled over. (Note that this is not requiring projects to ‘go live’ by the end of the given year, although clearly, procuring assets without deploying them for a number of months is not appropriate).
	2. Projects can be multi-phased, and spend funding in multiple years.
	3. National investment needs to be match funded locally. In practice, this is likely to take the form of investment in kind, for example in the form of released staff time to support implementation.
	4. Each project in an STP portfolio must have a single lead provider who will be accountable to NHS England for the project approach, spend and outcome delivery. Some projects, particularly around information sharing, may be cross-organisation (or even cross-STP), but a lead provider must be identified and will be held accountable. This will require sufficiently inclusive governance arrangements to support delivery of the project. Organisations impacted by a project may extend beyond those eligible to receive provider digitisation funding, as defined above. For example, a project would be valid that introduces electronic discharge notices from an NHS secondary care provider to a for-profit private provider of community services, a local authority social care team and private care homes, although provider digitisation investment could only go towards assets owned by the NHS secondary care provider. The lead provider may set up arrangements to provide services or ‘lease’ assets to other local organisations.
	5. Individual projects may be part of broader transformation programmes, but awarded funding cannot be used for other capital investment priorities beyond digital.
	6. Projects in the portfolio should be scoped to incorporate any business change, implementation and support activities required to deliver the associated potential benefits. Providers should, where appropriate, fully exploit any opportunity to capitalise project related costs.
1. **Prioritisation and phasing guidelines**
	1. STP/ICSs are anticipated to start the process with a long-list of potential projects, which may arise from local transformation plans, Local Digital Roadmaps and digital maturity assessments.
	2. STP/ICSs should undertake a multi-year prioritisation exercise. However, we accept that priorities will evolve in the future, partly driven by learning and blueprints coming out of the exemplars. We also appreciate the need for funding to start flowing as soon as possible. Therefore, we are prepared to accept Investment Proposals that, while identifying a firm set of projects for year one and a provisional set for years two and three, only need to provide value, transformation and delivery confidence justifications for the year one projects. We will ‘lock down’ the following year’s plans prior to the start of each financial year.
	3. STP/ICS footprints should avoid defaulting to a ‘fair share’ allocation approach across providers within the footprint. Local prioritisation is likely to require some challenging conversations and difficult decisions.
	4. The prioritisation criteria to be applied by STP/ICSs to determine where to invest their allocations fall under the following headings, and should be given equal weighting:
* strategic alignment
* financial return on investment
* broader value considerations
* delivery confidence.
	1. Considerations of strategic alignment should reflect alignment with the six national priorities for system digitisation set out in section 3.4, and with STP/ICS plans, strategies and performance targets across themes such as productivity, transformation, operational resilience, acute care collaboration and performance against the A&E standard. For STPs, consideration should also be given to the contribution towards developing the core capabilities required to become an ICS.
	2. Financial return on investment (FROI) considerations cover both the scale of the projected return and the level of confidence. FROI is the average annual cash-releasing savings arising from the project divided by the total investment in the project, expressed as a percentage.
	3. Broader value considerations include potential clinical outcomes, patient safety, patient experience and financial non-cash-releasing benefits (both significance and confidence), and the degree to which the investment can be leveraged to benefit others in the local health and care system.
	4. Considerations of delivery confidence include quality and credibility of plans and costings, informatics leadership, clinical leadership of the digital agenda, maturity of programme and project management, confidence in (rapid) procurement approach, capability and track record of digitally enabled transformation, commitment to leveraging support from others, complexity of what is proposed, and maturity of infrastructure. Where delivery confidence is initially low, STPs may want to challenge or broker support to increase confidence, particularly for projects that are ranked high from the other perspectives.
	5. Each of the four headings should be scored out of 4, and combined to give a total score out of 16 for each proposal. For projects seeking 2018/19 funding, only those that score at least 10 out of 16 should be put forward in the Investment Proposal. (For any projects that are seeking funding only from 2019/20 and currently score lower than 10, further work will be required to improve the score to the threshold before funding is released – this will likely be more detail around financial return on investment and/or delivery confidence). Scoring guidelines for STP/ICSs to apply are included in Annex A.
	6. STP/ICS portfolios must be designed so that the allocated funding is spent in the allocated year. Additionally, to minimise the risk of losing funding due to project delays, in their Investment Proposal, STP/ICSs should identify contingency proposals to the value of approximately 20% of their annual allocation – these may include extending existing projects, accelerating future projects or investing in other projects that can procure solutions rapidly.
	7. A clear and compelling narrative should be provided, setting out how the portfolio will support transformation of the local health and care system.
	8. The process should involve all secondary care providers in the local system, and there should be significant participation from senior clinicians.

1. **Approval of prioritised investments**
	1. Systems should plan to submit their final Investment Proposals to the appropriate regional mailboxes from 1 September 2018 and by no later than 5 October 2018. This is not a competitive process. We will review STP/ICS plans as and when they are received, so that they receive endorsement within four weeks of their receipt. Early submissions will provide more project time before the end of the year and increase confidence that money can be spent wisely in year one. Endorsement of the Investment Proposal should give providers confidence that, subject to funding agreement and local business case approval, funding will be made available for their year one projects.
	2. The Investment Proposal will detail a portfolio of projects that will utilise the 2018/19, 2019/20 and 2020/21 STP allocations, with the total funding requested matching the allocation profile. The proposals can be indicative in future years and subject to further review.
	3. The submitted Investment Proposal must be endorsed by the STP/ICS leadership. Any additional local endorsement is at the discretion of the STP/ICS leader (or the person they have identified to lead the development process – potentially the STP/ICS digital lead or equivalent).
	4. A template for the Investment Proposal is provided alongside this prospectus. In summary, it consists of:
* a summary and descriptions of the projects in the portfolio
* a case for the portfolio as a whole delivering value and supporting transformation
* a set of responses to build delivery confidence in the portfolio, including details on local match funding
* a declaration for STP/ICSs to acknowledge funding rules, and reciprocal requirements and expectations.
	1. The Investment Proposal is not a business case. Further steps need to be navigated before funding is released for individual projects, including local endorsement of project level detailed business cases (see section 6).
	2. NHS England regional resources are available to provide challenge and support during the prioritisation and development process. This can ensure that the Investment Proposal submitted is aligned with the eligibility criteria and the portfolio-level requirements, and that the range of prioritisation and phasing guidelines are understood and considered. This should mean that formal approval of an Investment Case by the SRO can be secured quickly, based upon a recommendation from the NHS England regional team.
	3. NHS England regional teams will also help STP/ICSs access additional resources to support the development of Investment Proposals. These may include: provider intelligence (such as recipients of previous technology funding in the STP/ICS and their performance in its investment, or DMA scores); a blueprint pipeline; resources to support benefit analysis.
	4. It is anticipated that updated Investment Proposals will be requested, developed, and then submitted in March 2019. This would detail a portfolio of projects that would utilise the 2019/20 and 2020/21 allocations. It will re-confirm 2019/20 priorities, but also allow them to be updated from the original Investment Proposal. Further guidance will be provided in due course.
1. **The process beyond the Investment Proposal**
	1. Providers with projects that make it into the Investment Proposal should note that allocated funding cannot be rolled-over into a later year, so an early start on procurement processes may be appropriate.
	2. The Investment Proposal details a portfolio of projects. The subsequent steps detailed below are focused on a provider / project. Different projects in the portfolio can progress through these steps at different times, as long as the current year allocations are spent by the end of the financial year.
	3. Before funding draw-down can be requested by a provider for one or more specific projects in the portfolio, a Funding Agreement will need to be developed and agreed between the Provider and NHS England. This will identify the roles, responsibilities, contact details and commitments of all parties, the local governance arrangements, detail key milestones and funding drops, and for projects considered high-risk, identify any draw-down dependencies.
	4. Additionally, and also before funding draw-down is requested for a project in the portfolio, a corresponding detailed business case will need to be approved by the lead provider for the project, following its Standing Financial Instructions. It is expected that this will incorporate appropriate equality and health inequalities analysis, and be consistent with the Green Book guidance (see the Business Justification template, Template 5 of ‘Public Sector Business Cases using the Five Case Model: templates’, available to be downloaded at <https://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-governent>). It is also envisaged that STPs with maturing governance arrangements around the digital agenda will wish to endorse detailed business cases.
	5. The provider will also be expected to draw on the analysis of projected costs and benefits within the detailed business case to populate a standard value analysis template. Data from these can then be aggregated at STP, regional and national levels. Any significant discrepancies with the financial return on investment scoring previously undertaken within the prioritisation process (see section 4.6) will be challenged.
	6. The final requirement for funding draw-down is a PDC Award Agreement, signed by the Provider Director of Finance and DHSC’s Finance Director. This allows DHSC to set the appropriate funding limits.
	7. Once all these requirements are met, the Provider will be able to initiate draw-down following the standard procedure for accessing PDC. Funding should not be drawn down in advance of need. We will review these requirements in the future in line with ‘earned autonomy’ principles.
	8. Further guidance and templates for the requirements and processes above will be provided in due course, and in advance of the Investment Proposal submission window closing.
	9. Based on information in the Investment Proposal, Funding Agreement and the existence of an approved local business case, NHS England will seek to categorise projects. This will serve as a foundation for identifying future procurement support, and in segmenting projects according to the level of risk they represent, which in turn will inform levels of challenge and support to be provided by NHS England regional teams.
	10. For some projects, as they are further defined through the Funding Agreement and detailed business case, their viability or attractiveness may be reduced from what was anticipated in the Investment Proposal. Additionally, some projects may encounter issues around procurement or delivery slippage. Also, as set out in section 3.10, successful bids for funding from other targeted programmes may create capacity in the portfolio. In such circumstances, the STP may wish to rescope or substitute a project in the portfolio, thereby avoiding any underspend of their allocation. Any changes to the portfolio will be subject to the same rules and guidance set out in previous sections. As set out in section 4.10, some contingencies may already have been pre-approved as part of the original Investment Proposal.
	11. Capital funding will flow to NHS providers in the form of Public Dividend Capital, and to eligible VCSE providers as a capital grant.
2. **Reciprocal requirements and expectations for STP/ICSs**

**Interoperability Standards**

* 1. STP/ICSs must ensure provider organisations comply with national interoperability standards designed to enable the effective sharing of data across care settings. This includes the use of:
* Open APIs (i.e. the CareConnect profiles) to enable sharing of elements of the care record
* Transfer of care standards aligned with PRSB standards.
	1. This will support the Standard Contract requirements:
* By Oct ’18 that providers should have aligned their outpatient letters and inpatient, emergency care and mental health discharges to nationally published or have locally agreed plans in place to do so
* By Dec ’18 that providers should have enabled delivery of Open APIs using the CareConnect Profiles or have locally agreed plans in place to do so.
	1. STP/ICSs should ensure that provider organisations are working towards the key interoperability priorities, for which nationally published specifications will be provided:
* Sharing of structured basic observations
* Sharing of structured dates and schedules
* Sharing of structured basic pathology information
* Sharing of medications that are machine readable and interoperable
* Use of the NHS number at the point of care
* The use of a consistent set of terminology and diagnostic codes (SNOMED CT and dm+d)
* The use of a consistent staff identifier within any information exchange.

**Cyber Security**

* 1. All healthcare systems must also take active steps to reduce cyber risks and mitigate the effects of future attack. STP/ICSs should take a lead role in ensuring all parts of the system are addressing basic issues such as the use of unsupported software like Windows XP, and are compliant with the National Data Guardian’s 10 Cyber Security Standards, and that they have undertaken an online assessment and have clear plans in place to be Cyber Essentials + accredited.

**Data Submissions**

* 1. STP/ICSs are expected to secure local compliance with the submission of clinical datasets and statutory reporting to national systems – for example, Commissioning Data Sets (CDS) including critical care / maternity data tails where appropriate to SUS+. The content of data submissions are expected to be in accordance with national guidance, complete and submitted in line with national data submission timetables.

**Obsolete Technology**

* 1. STP/ICSs must ensure that providers reduce and eventually remove their current reliance on out-of-date technology such as fax machines and pagers. Specifically, the Funding Agreements developed as part of this process will include a requirement to declare the number of fax machines currently in use; that these will be replaced by March 2020; and that all organisations will positively confirm to Dr Simon Eccles, NHS CCIO, when this is completed.

**Health System Led Investment**

* 1. Providers within an STP who receive provider digitisation funding will have direct obligations to NHS England, to be formalised through Funding Agreements, and administered through NHS England. STP/ICSs are expected to support the fulfilment of these provider obligations, which will encompass spending, reporting of progress and exceptions, record keeping, procurement, commitment to architectural and clinical safety standards, intellectual property rights, supplier contracting, acknowledgement, publicity and knowledge sharing. Awards may be withheld, reduced, suspended or required to be repaid if the obligations are not met.
	2. Informed by provider reporting of spending, progress and benefits, STP/ICSs should play a role in assuring funded projects. NHS England regional teams are likely to devolve much of this assurance to ICSs and the more advanced STP/ICSs, while retaining more of it for other STP/ICS s. A differentiated approach to assurance should be followed, based on the project risk level.
	3. Although lead providers for projects in the portfolio will be accountable for outcome delivery from their projects, STP/ICSs are expected to play a leading role in creating a benefit realisation strategy, potentially linked to the broader transformation programme. For example, for a saving of time for general ward nurses, influencing whether that should be realised as reduced agency spend, redeployment to other activities, or an increase in patient-facing activity.

**System-Level Leadership of the Digital Agenda**

* 1. STP/ICSs are expected to be working towards effective system-level leadership and governance of the digital agenda. This may encompass: a strategy for convergence of infrastructure, services, systems and contracts; system-wide functions of a design authority, a PMO and clinical leadership; shared specialist resources; pooling of budgets; common approaches to development, project management, business change and delivery assurance; and system-wide career development and succession planning. The approach should also align with the broader STP transformation programme.

**Equality**

* 1. STP/ICSs are expected to support compliance with the Equality Act 2010 and the Health and Social Care Act 2012 through overseeing the design of digital services and systems that are appropriate, accessible and meet the needs of diverse communities.

**Annex A – Scoring guidelines**

|  |  |  |
| --- | --- | --- |
| **Heading** | **Criteria** | **Scoring** |
| Strategic alignment (ref. 4.5 of the Prospectus) | * Strong alignment with the six national priorities for system digitisation
* Strong alignment with system digital plans / performance targets
* Strong alignment with system digital vision / strategy
* Strong alignment with other system plans / performance targets
* Strong alignment with other system vision / strategy
 | 4: fully meets3: mostly meets2: partially meets1: mostly does not meet  |
| Financial return on investment (ref. 4.6 of the Prospectus) | * Level of return projected >= 20%
* Calculation for projected return clearly set out
* Sources of cash-releasing benefits identified
* Strong evidence base for proposed solutions delivering significant returns
 | 4: fully meets 3: mostly meets2: partially meets1: mostly does not meet |
| Broader value considerations (ref. 4.7 of the Prospectus) | * Significant clinical outcomes, patient safety or patient experience benefits identified
* Significant non-cash-releasing financial benefits identified
* Strong evidence base for proposed solutions delivering identified benefits
* Significant proposals for leveraging value from the investment for others in the local health and care system
 | 4: fully meets3: mostly meets2: partially meets1: mostly does not meet |
| Delivery confidence (ref. 4.8 of the Prospectus) | * Project
	+ Clear and credible plans and costings
	+ Clear procurement approach that will conclude within the appropriate timescale
	+ Commitment to leveraging support from others
	+ Low to moderate complexity
	+ Fit for purpose underlying infrastructure
* Provider
	+ Strong informatics leadership
	+ Strong clinical leadership
	+ Mature project and programme management
	+ Track record of digitally enabled transformation
 | 4: fully meets3: mostly meets2: partially meets1: mostly does not meet |