The following pages contain the responses to the various questions that have been raised with regard to the EPR FBC. In order to make it easier to follow the documentation your questions have been numbered sequentially in line with your letter.

1) It is clear from the business case that commissioners have been kept informed during the process; however evidence of formal commissioner support for the case and the preferred solution is required.

Embedded documents reflecting formal support from our primary commissioners; although at this stage they have not been formally advised of our proposed choice as it remains confidential until the formal notice of award has been issued to the supplier.


Letter to Steve Gregory re electronic


FW EPR Business Case Feedback.msg

2) It is currently unclear how the Trust reviewed and evaluated the initial long list of options before selecting the option of a PAS from outside of the national programme. The group requires evidence of the evaluation of options identified at OBC stage. Without this the Capital Investment Group cannot assure itself that the Trust has fully evaluated all available options to reach an informed decision.

Set out below is the reporting to the Trust Resource & Performance Committee where the subject matter relates to the EPR; this committee is a formal sub-committee of the Board. We have previously discussed the internal assurance process and can supply all the minutes of the IM&T Steering Group; EPR Project Team, EPR Project Board if you require them.

For completeness the appropriate extract from the minutes is included in the following pages along with the evaluation of the OBC options report to the Resource and Performance Committee.

Item	Committee	Meeting Date
Patient Administration System (PAS) Update Report	Resource & Performance Committee	26 NOVEMBER 2012
Patient Administration System (PAS) Replacement	Resource & Performance Committee	30 JULY 2012
IM&T Steering Group Minutes	Resource & Performance Committee	1 JULY 2013
Electronic Patient Record Project	Resource & Performance Committee	30 SEPTEMBER 2013
EPR Tender Briefing Document (includes embedded OBC options report)	**Resource & Performance Committee**	**28 OCTOBER 2013**
Resource and Performance Committee Report to the Board	**Board**	**21 NOVEMBER 2013**

Information Management & Technology	Resource & Performance Committee	9 JUNE 2014
Matters Arising Action Log	Resource & Performance Committee	29 SEPTEMBER 2014
Electronic Patient Record Tender Process	Resource & Performance Committee	26 JANUARY 2015
Matters Arising Action Log	Resource & Performance Committee	23 FEBRUARY 2015
Matters Arising Action Log	Resource & Performance Committee	23 MARCH 2015
Business Development and Service Transformation Report	Resource & Performance Committee	27 APRIL 2015
EPR Draft Business Case	Resource & Performance Committee	26 MAY 2015
EPR Outcome of Selection Process for recommendation to Board	Resource & Performance Committee	27 JULY 2015

RESOURCE & PERFORMANCE COMMITTEE MINUTES

26 NOVEMBER 2012:

4.2 Patient Administration System (PAS) Update Report

TW presented a paper on the Replacement Patient Administration and Clinical System and the following points were noted:

- It was noted that this paper had not been adopted by the relevant Director for this Committee. The paper had been presented and fully discussed at the IM&T Steering Group meetings held on 9 October and 13 November.
- The National position has changed and is more favourable. An agreement with Lorenzo Regional Care CSC has been issued for any Trust who wishes to engage in an appraisal process to identify potential impacts of implementation with no cost involved. This offer funds application costs and is restricted to the first ten Trusts who sign up to Lorenzo Regional Care. It was noted that at this stage the Trust would not be contractually committed.
- The software is acute focussed and does not include mobile working. TW commented that the upgrade would be 85% of functionality. SR said that standalone software would have to be purchased at an additional cost. The Trust would save up to a maximum of c £200k on payments to SATH which would offset the funding for disconnected working.
- It was noted that there will be no capital outlay; additional resource costs will be in the sum of £291,500 with existing resource costs of £707,070.
- CB would like to see broad cost benefits and how they fit into the Trust's service strategies and CIPs for the next 5 years. TW replied that benefits would be based on what functionality the system would provide. CB would like this linked to the CIPs/QIAs and Telehealth so the benefits and timescale on items such as productivity can be seen. TW will include in paper.

ACTION: TW to include Benefits Paper re Service Developments and CIPs.

- CB commented on interoperability and the need to understand that it would be compatible with other systems.
- AN commented that the Trust was moving to a paperless system and this would be a huge cultural change and shift for clinicians.
- In answer to MR's question SR confirmed that there was no guarantee of national support, but if all benefits were received the Trust would avoid costs in the first year. Also licences would be funded until 2016. With regard to long term running costs the current spend is £400k per annum this would be between £200/300k subject to 'add ons' to improve the system.
- TW agreed to check with his team with regards to the implementation at South Staffordshire and report back to the Committee.
  ACTION: TW to update the Committee on comments received from SS.
- CB queried compatibility with EMIS.
  ACTION: SR to check with IM&T Team compatibility with EMIS.
- It was agreed to engage with CSC and a summary of benefits to be presented to the February or March Resource & Performance Committee.

The Resource & Performance Committee agreed to engage with the supplier of Lorenzo Regional Care (CSC) with a view to completing an exhaustive appraisal of the system to identify potential impacts of implementation with a view to commencing following a satisfactory outcome of the appraisal.

30 JULY 2012

13. Patient Administration System (PAS) Replacement

AEC joined the meeting to present the Replacement Patient Administration (PAS) and Clinical System report and the key points were noted:

- Noted a PAS Replacement Board with clinician input was formed in February 2012 and produced a recommendation document that was presented to the IM&T Steering Group on 10 July and culminated in this report.
- It was noted that the PAS system is not fit for purpose and two approaches have been described; active formal tendering process to March 2013; and passive outcome of NPfIT negotiations.
- The cost to the organisation for replacement of this system is between £1.2m and £1.7m. CB commented on funding included in the LTFM for PAS replacement. SR said the Trust has assumed £0.5m in total each year for investments. There was a further discussion on the other potential impacts of replacing the PAS system.
- Noted this does not link into transformation and concerns were expressed on the funding implications and the skills to identify, support and deliver the product.
- AEC confirmed he had spoken to a number of organisations and had obtained a detailed specification from Kent which would form part of the process for tendering. This document would be shared with the project team and clinicians to make sure it was fit for purpose.
- Following a detailed discussion TW agreed to take the following actions back to the PAS Replacement Board. To understand exact system requirement; explore and exhaust options for a joint venture; tender preparation documents and funding potential; the proposal needed to be clearer about the benefits realisation in terms of service benefits, functionality and improvements in data quality compliance; considered alongside other potential projects and consider the opportunity costs of not doing the others, also review what other Community Trusts are doing. This

would then go to the Executive Team for agreement before being presented back to this Committee for approval.

The Resource and Performance Committee noted the contents of the recommendation document and requested the PAS Replacement Board explore the points above for discussion at Executive Team prior to Committee approval.

1 JULY 2013

10. IM&T Steering Group Minutes

The Committee noted the Information Management & Technology Steering Group minutes from the meeting held on Tuesday 7 May 2013.

CC updated the Committee on the Electronic Patient Record (EPR) system. The Trust was working very productively with Procurement and an agreed specification and procurement route would be in place by 25 July 2013.

30 SEPTEMBER 2013

11. Electronic Patient Record Project

TN presented the Electronic Patient Record Project report and the following key points were noted:

- MS wanted clarification on a few points specifically where the report stated that approval was given in November 2012 for the Trust to go out to market testing, the minutes of 27 November committee state the committee agreed to engage with the supplier of Lorenzo regional care specifically and did not involve the agreement to spend any money. The Trust should not be agreeing to anything that will commit to spending money on this project and a decision can't be made with two days' notice.
- TN could only speak from her time with the Trust and upon starting was advised that it had been agreed the Trust will go through the procurement process for a new EPR system, the driver being that the current system switches off so doing nothing is not an option. She was advised there would be a cost estimated at £3m to purchase a new system and that central funding via the "safer hospital" initiative was being explored and the Trust had made bid, which is being considered as part of the National process. The feeling was that Trust systems are far behind modern technology and a new system needs to be in place. It was noted that the safer hospital bid was for £1.5m which has to be match funded by the bidding organisation. The next stage in this process is a conference call which has been arranged for this week by DH leads. It is understood there are approximately one hundred and twenty bids against the fund and all will not be approved. At this stage the Trust is not actually committed to any specific expenditure on the project.
- RL confirmed a debate took place as the Trust has to do something, but the committee felt the Trust should look into a cheaper solution as £3m is not affordable and it was suggested that ideally a solution involving a partner might be identified.
- MS was concerned that the Trust doesn't have the resource to manage a project

of this scale and suggested alternatives need to be looked at.

- It was confirmed that continuing with the safer hospital bid isn't committing the Trust to any spend. MS felt in light of the current criticism over the business case for the Ludlow Health Facility Project the board via Resource and Performance Committee would need reassurance of any benefits and the affordability of the scheme. RL agreed, a deep dive into Lorenzo as previously suggested may not work but the Trust needs to be sure there isn't a more economical option. MS confirmed this committee cannot support a spend to this scale without having seen a full business case and he felt the Executive Team should consider all options to see if there is a way to utilise someone else's contract, e.g. Shropdoc. MB confirmed that using RIO the Mental Health system is not an option. MS wanted confirmation that the Trust cannot get into commitment without approval from the Board.
- TD asked for clarity, is the committee suggesting the planned teleconference for this week doesn't go ahead even though it won't mean a commitment to spend funds on the project and it might be an opportunity lost. MR's view was that no commitment is to be made or any decisions that may significantly further reduce the organisations reputation. MB felt the Trust needs to remain mindful that there is a lack of money available so this may present a good opportunity to receive £1.5m. It was agreed the Exec team should agree the way forward in relation to the bid.
  ACTION: Executive Team to determine the way forward.

The Resource & Performance Committee received and noted the contents of the electronic patient record project report.

15. Risk Assurance Update

EPR replacement may need to be added as a risk if the system is really to be switched off leaving the Trust without an alternative.

28 OCTOBER 2013

13.2 EPR Tender Briefing Document

TD presented the Electronic Patient Record tendering process briefing update and the following points were noted:

- RL referred to clinical visits where the topic of conversation always turned to hand held devices and commented that there must be other organisations that use tablets that we could benchmark against. TD confirmed that areas were being explored.
- TD clarified that the Trust's information system iPM at present cannot receive data electronically which is a barrier and whilst solutions are required this is currently outside the Trust's control. TD confirmed the IT department are approaching the system provider to clarify potential to change the system to accept electronic feeds. JD said timeframes around this are urgently required and should be developed through the IM&T strategy.
- TN confirmed that we are clear the EPR process must be an open system that will talk and interconnect across all systems and also with the local authority.
- MS referred to the iPM product used by therapist nurses and the child health system both of which will be unsupported from June 2016. It was noted that

this affects all district nurses and is linked to the SEMA system.

- It was noted that CSC Computer Science Corporation is the national programme local service provider who have declined to take part in the current tendering exercise.
- Noted CAMHS want to be a part of the EPR/PAS tendering process – a lot of work has been undertaken with a huge amount of clinical engagement. Alison Parkinson from children's division has a level of confidence that people have had their say towards the tendering process.
- TN commented that the Trust needs to be careful that we are not confusing the hardware solution with the software solution. We need a hardware solution that the software works with; the hardware will solve some problems before EPR is introduced. TN had spoken to IM&T to enquire when we can purchase smart pen/tablets so that staff do not have to keep going back to base. It was recognised that there are vast areas of the county where there is no signal but calls from a hotspot could be made just as much about common sense as technology. When going through tendering need to know there is a solution.TN chairs the EPR project group and explained operational and clinical involvement is in place.
- Systems used by other providers had been identified as part of the project and were listed within the briefing
- JD very recently went through a similar process and recognises most systems on the list. Some are bespoke and you buy extras as an upgrade, but if clear on what we have to have, and what is extra, through a tendering process, and narrow down through a timeframe we will get results.
- JD confirmed the need for clinical input at the point of delivery but we also need to be absolutely sure we have addressed the business elements.
- MS felt it would be better to utilise an out of the box solution.
- MS was more assured following discussions on the EPR approach and project and had made a suggestion that maybe an extended committee meeting could be held, attended by NEDs, to thoroughly understand the detail of the tendering exercise – MS felt that a cost of £3m was high for such a small organisation and queried whether we can partner with another to reduce costs.
- MB we had a presentation from CSC at Executives Team.
- A representative from Leeds Community Trust presented their lessons learnt to the TMG/SLF; the major point was to purchase the system first before the hardware.
  ACTION: MS/TD will explore options of a mini workshop to update the Committee on the EPR project

The Resource & Performance Committee received and noted the EPR Tender Briefing Report.


Enc 12 - Front Sheet EPR.docx


Enc 12 - EPR Report v2.doc

9 JUNE 2014

11. Information Management & Technology

11.1 EPR

TD tabled an action recorded in the minutes of the EPR Project Board held on

6 May 2014 for the Resource and Performance Committee to accept the recommendation for the Trust to not accept the offer of Lorenzo from CSC under the out-going National Programme for IT contract and for the Trusts' OJEU procurement process for the new Electronic Patient Record to be taken off hold and continue to completion.

The Resource & Performance Committee ratified the above recommendation of the EPR Project Board held on 6 May 2014.

29 SEPTEMBER 2014

5. Matters Arising

Action Log

- EPR paper on the outline functionality and business case – circulated to members on 22 September – Closed.

See embedded documents above (re-issued on the 22nd Sept 2014)

26 JANUARY 2015

8.3 Electronic Patient Record Tender Process

AEC joined the meeting and presented the Electronic Patient Record Tender Process and the following points were noted:

- MS referred to the competitive dialogue stage and questioned the final functionality. AEC confirmed that one to one meetings were being held with suppliers to discuss their delivery mechanism and their way of working. Suppliers will come back with a description of their preferred approach; generally this seems to be a phased approach (typically 9 months to first service go live). This process also identifies the respective responsibilities of the Trust and the suppliers.
- Mobile disconnected working is a mandatory requirement. Inter-operability does not mean integration, effective and efficient messaging between the respective systems is the optimum requirement. Discussions around messaging will also need to be held with GP System suppliers and Shropdoc. Also with SaTH and North Staffs regarding Pathology and SaTH; RJAH; Hereford; Wye Valley regarding the PACS systems; and both Social Care services with regard to their systems. The whole system is required to tie together and whether any single supplier can tick all the boxes will not be known until we have undertaken this process. Some functionality will be mandatory however some suppliers might come back and say they can only achieve 95%. If this is the case we will have to go back to clinicians to see if all of the functionality is required. This is why it is essential to go through the dialogue process.
- The initial technical specification is already in existence and has been refined over a number of months, and will be finalised once the dialogue phase is complete, this is to take account of any changes to the specifications that arise from the dialogue process.
- The Trust invited the 6 suppliers that had successfully completed the Pre-Qualification Process to take part in the dialogue process; 2 suppliers have decided not to proceed with the dialogue process, which leaves 4 suppliers

in the running.

- MS asked if decisions are agreed with clinicians on items to be left out of the final specification could the Trust Board be made aware of the direction the organisation is going. AEC replied that during the three years build-up of the programme there had been considerable clinical engagement and this would continue; everyone involved in the programme has an eye on the future and one of the criteria is that the chosen solution must be flexible.
- MS said the next Resource & Performance Committee is scheduled for 23 February and asked if members could be notified in summary form on the outcome of the discussions.

ACTION: AEC to notify Members as soon as information is received.

- At the Pre-Qualification Questionnaire stage 2 suppliers failed as they could not meet the requirements.
- RL asked if the remaining 4 suppliers would meet all the requirements. AEC replied that the suppliers may or may not meet all of the requirements and this would be determined by the process.
- TD commented on the TDA approval process for a project of this scale. A query had been raised with the TDA to confirm whether they want the whole life project cost across capital and revenue or just the capital cost as the test against the delegated level. If approval is required it will be pursued.
- RL questioned why Graphnet and Child Health could not be included in the exercise? AEC replied that as the OJEU advert did not specify Child Health it could not be selection criteria. If a supplier has a product that comes with Child Health functionality included then although that element cannot form part of the scoring there is nothing to stop us implementing it as part of the chosen system. Graphnet can be included if the functionality for CAMHS is in the chosen solution.
- Timing with HSW Child Health is difficult as we are waiting for national guidance from the commissioning side.

The Resource & Performance Committee noted the content of the report.

23 FEBRUARY 2015

4. Matters Arising

4.1 Action Log

- EPR Tender Process – dialogue meetings with potential suppliers were completed last week, none of the shortlisted suppliers were able to offer a solution to cover all Trust needs. Some suppliers were over ambitious with the description of what they could offer. The specification is to be revisited with clinicians to decide what is mandatory for the Trust. AF to meet Andy I'Anson (AI'A) to work through the process and sign off a specification. The process may take a few weeks so the timetable needs to be revisited. A Full Business Case needs to be completed to be signed off by the Trust Development Authority (TDA) and the Trust. There are many Trusts in a similar position, the TDA are looking to address business case approvals within their monthly cycle to meet Trust timescales. AF will circulate a revised timetable and confirmed there is some capacity within the existing timetable, so interim support is not currently required to be purchased from the current supplier – Open.

23 MARCH 2015

4. Matters Arising

4.1 Action Log

- EPR Tender Process – noted that none of the shortlisted suppliers provided an option to meet all requirements in the original specification. AF agreed to review the specification to provide clarity on mandatory elements and circulate a revised timetable to Members of the Committee. MS requested reassurance that the project was not running late and that functionality was not being jeopardised. AF agreed to complete a refresh for the next Committee.

27 APRIL 2015

8. Business Development

8.1 Business Development and Service Transformation Report

- Electronic Patient Record – the revised schedule of the current programme timetable (appendix 3) was noted by the Committee and will be presented as an update to future meetings until the end of August. The timeframe had slipped from the original schedule with the start date moving from June 2014 to July 2015 however the overall implementation date had not changed. The Trust is working with the TDA to develop the full business case and this will then be presented to Resource & Performance Committee. AF confirmed that the EPR Programme Board would sign off the functionality element.

The Resource & Performance Committee noted the current position of the T/W MSK Tender; the unsuccessful outcome of the Walsall school nursing tender; the update on Future Fit/ Urgent Care Centre development; the latest position with ICS and Discharge to Assess initiatives; reviewed the schedule for the EPR project and noted the key milestones; the current status of development of the urgent care performance dashboard; reviewed and commented on the worked example of the broad tests for considering a business development opportunity, linked to the new business investment policy presented at last month's meeting; the addition of a horizon scanning section of the paper and associated updates.

26 MAY 2015

9. Business Development

9.2 EPR Draft Business Case

AF presented the draft EPR Full Business Case which is being refined over the coming weeks to reflect the requirements of a 'checklist' provided by the TDA. There are a number of assumptions in the draft version that may be subject to change due to the tendering process.

AF reported that the timetable had slipped by 4 weeks to take account of information from visits; advice from procurement regarding the tender document and to allow organisations a significant time period to respond.

PP expressed concern around the level of risk, in particular, the timescale and affordability. AF highlighted that the timescale was to a degree fixed in that the current system will cease to be supported in July 2016 so we have to have a

new system in place by then. The contingency is that we would seek to roll forward the existing system, however the costs associated with this are very high. In terms of the costs, we have yet to receive proposals from suppliers.

MS commented that the draft Business Case was not fit for purpose and in its current state would risk the credibility of the organisation if reviewed externally. AF reminded the Committee that the draft was presented on the basis that there would be a further iteration but that it would be useful to have initial views from Members as the timescales would be very tight for submission when the next version comes to the Committee. Also there was an opportunity to get advice from the TDA about how much additional work was required. MS made reference to the lack of detail behind benefits and in particular the financial benefits that would offset the substantial investment. MS agreed to provide AF with specific recommendations to strengthen the Business Case.

The Resource & Performance Committee reviewed the draft Full Business Case and agreed that further work should be undertaken before submitting an initial draft to the TDA.

The Resource & Performance Committee reviewed and agreed the draft Full Business Case prior to its submission to the Trust Development Authority (TDA), subject to the previous statement about the assumptions made and the ongoing refinements that will be made to the Full Business Case (including the financial assumptions) before the final version is submitted to both Resource and Performance Committee, and the Trust Board for approval; prior to a final submission to the TDA.

Part I Minutes of the Resource and Performance Committee held on Monday 27July 2015

10.3 EPR Outcome of Selection Process for recommendation to Board

AF introduced and AC presented the EPR Outcome of Selection Process for recommendation to the Board. The details discussed were commercially confidential and are set out in Part II of the minutes.

STRICTLY CONFIDENTIAL

Part II Minutes of the Resource and Performance Committee held on Monday 27 July 2015

10. Business Development

10.3 EPR Outcome of Selection Process for recommendation to Board

Andrew Ferguson introduced the paper before handing over to Andrew Crookes.

- AC referred to the Full Business Case and explained that this document was a requirement for the TDA who would sign off the proposal following Board approval. The TDA have received a draft copy of this document but are aware that it is still a 'dynamic' document.
- Three suppliers reached the final stage of the process and subsequently were subjected to a very rigorous, focussed and clinically driven evaluation process.
- The papers state a number of key areas where the preferred supplier delivers a higher level of functionality than the others. With Disconnected Mobile Working, Supplier 2 haven't developed their "app" across all of the potential operating systems and we would be restricted as to the type of device would be able to deploy.
- Ultimately all of the systems are clinically safe; however we want to deploy the best product for our organisation. This is an opportunity to transform the way staff work and to have the ability to share patient information in real-time.
- PP queried as to how the organisation would decide on what data was taken over to the new system. AC replied that a review would take place with each service as they came on board and a decision made over the length and range of data that is carried over.
- PP asked why Capita withdrew from the process. Al'A explained that they are not working at a community level at the moment. They were proposing a 'design and build' product in conjunction with another company. When they were challenged around the timescales for the product delivery they decided that they would not be able to meet our requirements.
- KS stated that she has some concerns over the recommendation and that by rejecting Supplier 2, a negative message is being sent to GP colleagues. She added that she felt that some of statements made about this product, particularly around Bed Management, Clinical Records and MIUs were incorrect. A large part of the workforce (District Nurses) is already familiar with the product and as integration with other systems is a key factor, this product already does it.
- KT and HB both supported Supplier 2 from a familiarity viewpoint, however, HB added that from a functionality perspective then Supplier 1 was superior.
- JC stated that the site visits had been a crucial part of the process and following these visits both systems could be implemented, however, from her perspective Supplier 1 would be the most adaptable.
- AP added that both systems are able to do the job. Supplier 2 is very good as a consultation system whereas Supplier 1 has a more fluid and flexible way of working. If people work in a consultation way, then they would like Supplier 2.

- JD asked whether the panel felt that the process was fair, how the weighting was decided on and whether the panel was assured that the process would capture the usability of the system/clinical view. AP replied that the technical specification has been reviewed many times and very clear guidance has been provided by Procurement as to the process we have had to follow.
- PA explained that the OJEU competitive dialogue process provides richness through the evaluation and the dialogue with the suppliers. JD asked whether the process captured the clinical conversation as well as the technical conversation. AC confirmed that there was not an opportunity to weight the external factors as part of the evaluation process as they were subjective. AI'A clarified that the scores were taken from the supplier responses to the questions. Supplier 2 had a lot more negative responses to the questions. PA explained that if the Trust decided to go with the second supplier, then it may be subject to a legal challenge.
- PP referred back to the site visit and asked whether this enabled us to get a good judgment as to whether the system would work. JC replied that it allowed us to see how the system would be able to be implemented within our services. The organisations were very open about their experiences and it was a very open clinician to clinician discussion.
- Supplier 1 has the market share within Community Trusts.
- SL sought clarity regarding the system used within GP practices compared to the one that could be deployed within the Trust. AI'A confirmed that they are two separate products. A separate Bed Management module is being talked about but there are no firm timescales around this.
- One of the key areas is around data and reporting. Supplier 2 is not an acute PAS and therefore does not contain A&E coding. This is something that is required for our clinical coding and reporting, they also cannot support reference costs, data capture for the tariff and HRG coding.
- PP asked whether during the timescale the Trust is working to, if there are any other organisations implementing at the same time. AC replied that across the country a lot of organisations are coming off iPM at the same time as it will cease to be available as of 7 July 2016. All of the suppliers have stated that the timescale is very challenging; however, they all are accepting it.
- An implementation plan is being created and the first services will start to move to the new system from the end of November. The Operations Directorate have agreed a deployment plan for all services to be off iPM by the end of March 2016. This will allow us a couple of month's leeway. It is anticipated that the SEMA PAS users will move between April and September 2016.
- Risks will be built into the normal project working and will be monitored. There are some milestones within the contract and there are consequences of not meeting the milestones.
- The draft Full Business Case has gone to the TDA, and JD asked whether the format of the document is acceptable. AF confirmed that the document is based on a template and we don't anticipate there being any issues.
- SL stated that from a financial perspective the 'Do Nothing' option exceeds the cost of any of the other options and asked whether we are absolutely certain that the 'Do Nothing' costs are correct. AC confirmed that the CES Account Manager has provided updated costs today although they are slightly different to what was originally quoted; it has not affected the overall outcome.
- The Committee was asked to note that for whichever solution is

implemented, then the capital is in place. The important cost is the incremental costs to the Trust. The Trust is looking at spending £3.1m revenue over five years. This would impact on our CIP and the 2016/17 value is estimated at £4.2m which is extreme and challenging to deliver. The 'Do Nothing' option would also increase the CIP to a similar extent.

The Resource and Performance Committee agreed to the proposed recommendation and agreed to put the proposal forward to Trust Board for approval.

Extract from the Trust Board Meeting on the 21st November 2013

Summary Notes from Resource & Performance Committee held on 28 October 2013

Accountable Director: Trish Donovan, Director of Finance, Contracting & Performance ;

Mike Summers Non Executive Director (Committee Chair)

Author: Trish Donovan, Director of Finance, Contracting & Performance

Purpose of the report

To advise and provide assurance to the Board on the main matters discussed at the meeting of the Resource & Performance Committee held on 28 October 2013.

(Minutes, once ratified, will be reported to the Board for information; this report provides an interim summary).

Attendees and summary of key issues and risks for board attention

Members Present :

Mike Sommers , Non-Executive Director (Committee Chair);
Rolf Levesley, Non-Executive Director
Peter Phillips, Non-Executive Director
Jan Ditheridge, Chief Executive
Trish Donovan, Director of Finance
Maggie Bayley, Director of Nursing & Quality
Tessa Norris, Director of Operations

Apologies: None

In Attendance :

Mike Ridley, Trust Chairman
Angela Saganowska, Non-Executive Director
Jan Cox, PA to Director of Finance

Key issues and decisions from the 28 October 2013 meeting:

- Information Management & Technology

  - IM&T Steering Group Minutes from the meeting held on 18 September 2013 were noted by the Committee.

- A briefing paper on the EPR Tendering process was noted by the Committee

Any key risks identified:

・ There were no new risks noted at this Committee, however the risk to delivery of the planned financial position by year-end remains a key issue.

Recommendation(s) to Board

The Board is asked to note the main issues discussed at the The Board is asked to note the main issues discussed at the Resource & Performance Committee meeting held on 28 October 2013.

3) The group expressed concern that the chosen supplier option (Rio) will cost approximately 45% more than the EMIS system, which based on the NPV valuation would rank in first place. The group requires further assurance of the benefits arising from this additional cost. It is expected that this would include identification of further cash releasing benefits relating to the features of the system described

This observation is only significant if the award is solely based on financial evaluation; however the EPR is a clinical system, and as such, and in line with best practice the award is based both upon the clinical functionality and the financial value; with the greatest weighting towards clinical benefits and functionality.

The respective weightings of 40% Finance and 60% Functionality are not unusual and were provided by our procurement service provider; it is possibly worth noting that some recent service tenders from NHSE have weightings of 35% Finance and 65% Functionality.

Therefore when the clinical functionality is taken into account the RiO product significantly outperforms EMIS for the functionality that our services require; across both the mandated and desirable areas.

The Trust has already supplied detailed information with regard to the clinical functionality that was accessed (included within the FBC at Appendix 11 – Award Notice); however for further assurance the table below (**Table 1**) shows the major areas of difference in mandated functionality between the two products. The mandated functionality was determined and classified in the largest part by our clinicians.

Additionally a further list of potential benefits; over and above those detailed in the FBC at Section 3.4 is shown in **Table 2** below, and although some of these benefits could be considered as cash releasing the majority are focused on improving efficiency, and thereby releasing clinical "time to care" or improving patient safety and the patient experience.

Table 1

Key Functionality Issue	Service Impact	Financial Impact
Bed Management and associated basic patient management functions	**This mandated functionality is not currently available in EMIS but is available in RiO:-** The system must have the ability to read machine bar codes from products and add the bar code to the printed medical records. The user must be able to print wrist bands for patients from the system which includes the NHS number and barcodes	Basic requirement for improved patient safety (GS1); not included in EMIS, available via a 3rd party application at an additional cost. "EMIS Bed management is in its first phase of release, and more future work is planned to extend into historical bed views, improved forward planning and integration to patient tracking partners."
Caseload management, including discharges	**This mandated functionality is not currently available in EMIS but is available in RiO:-**	This functionality is not available in EMIS, unknown if available via a 3rd party, if so would be at an additional cost.

	The user should be able to attach all relevant members of staff to theatre slots or procedures The system must provide a workforce planning module within the application software, to assist staff in managing their individual/team workloads. The system must be able to notify the user of all events relating to patients under their care, including contacts, assessments, Treatment plans, onward referrals, datix, RCA's, Complaints, discharges and death. The system should provide an overview for a given team, their current capacity vs caseload and highlights any risks to Service Users as a result.	
Clinical records management; including tracking and searching	**This mandated functionality is not currently available in EMIS but is available in RiO :-** The system must not show to unauthorised users that a record or partial record has been hidden. The user must be able to record on the system, other members of staff present at a patient appointment (e.g. if not registered on system, i.e. students). The user must be able to be logged into various systems simultaneously. Following a theatre procedure, each member of staff in attendance must be able to record who did what during the procedure in a patient record	This functionality is not available in EMIS, unknown if available via a 3rd party, if so would be at an additional cost.

	(this would include agency staff). The user should have the ability to apply additional character sets e.g. phonetic symbols The system must be able to send an alert to the Caldicott Guardian at any transaction point, managed by the rules engine	
Clinical records management : coding	**This mandated functionality is not currently available in EMIS but is available in RiO:-** The system must support OPCS coding and the ability to update these as new DSCNs are issued. The user should be able to record the HRG codes in a patient record.	EMIS does not at present cover all ICD10 or OPCS4 coding for non-community settings. This is a significant issue in terms of contractual elective and non-elective activity. It is possible to purchase 3rd party applications at an additional cost.
Minor Injuries functionality both clinical and reporting	**This mandated functionality is not currently available in EMIS but is available in RiO:-** The system must be able to create different units for different MIU locations. The service user must able to record a call no response (where a patient has been summoned for treatment but could not be located). The system must be able to record the priority of each patient (e.g. major, minor). The system must be able to record whether the patient has been accompanied to the unit. The system must be able to record the time elapsed since the incident occurred.	The current version of EMIS does not provide the necessary functionality that our clinicians consider the basic minimums. Nor does it allow the Trust to correctly account for monitoring waiting times in MIUs. A fully functional 3rd party product would be available at an additional cost.

	The system must be able to record triage status. The system must be able to record TTO and any given analgesia. The system must be able to produce a full data extract of the A&E quarterly monitoring dataset (QMAE) The system must be updated to incorporate any updates and changes to the A&E dataset The system must be able to notify Child Health Dept. of Children under 19 attendences (every one/each occasion). Including a count of number of attendences in total as a runnung record plus today's visit, the reason for attendance and if possible outcome.	
Mobile working	**This mandated functionality is not currently available in EMIS but is available in RiO:-** The system must notify any other users when accessing a record that has been "booked out' for remote use (e.g. briefcase). A user should be able to complete a blank assessment form remotely and upload it to a patient record when they are next online (visits to unexpected appointments). A user looking at a record offline must be able to see an audit trail of the last e.g. 10 times this Service User's record was taken offline by whom and synchronisation date times if any. The timestamp on this	The provision of this functionality is crucial in the Trust being able to achieve its modernisation and transformation agenda around having a truly mobile community workforce. A fully functional 3rd party product would be available at an additional cost.

	view is the synchronisation time. A user looking at a record online must be able to see an audit trail of the last e.g. 10 times this Service Users record was taken offline by whom and any synchronisation date times if any. The system must provide end user diaries, caseload, scheduling, assessments and necessary patient information in disconnected mode.	
Waiting list management	**This mandated functionality is not currently available in EMIS but is available in RiO:-** The user must be able to record projected event dates, proposed length of service provider intervention, start and end dates of actual interventions with coded information to support quality and service delivery to the patient. The system must prompt the user if a patient is about to exceed a waiting time threshold with a configurable lead in time. The user must be able to view from the patient record all waiting lists a patient is on.	It is unlikely that a 3rd party product would be economically viable to provide integration into the clinical record for this functionality.

Table 2 – Additional benefits

Potential Benefit	Impact
Remove the need to pre-print nursing and other medical documentation	Reduction in costs of paper, printers and consumables; also greater efficiency in the workflow process
Remove the need to print patient address labels for every piece of information entered into the patient medical record	Reduction in costs of paper, printers and consumables; also greater efficiency in the workflow process
Remove need to photocopy notes or episodes and send to requestors	Improved efficiency, faster response times, improved patient experience
Reduce time spent per nursing interaction documenting activity	Filing carried out electronically so improved efficiency, use of vital signs monitoring improves safety
Reduce cost of managing patient paper medical records	Filing carried out electronically so improved efficiency, electronic transfer rather than manual files improves efficiency and safety
Reduce number of printers in administrative and ward areas	Potential cash releasing, however the number of deployed printers is small so it will not be financially significant
Reduce cost of re- appointments due to information (notes) not available	Filing carried out electronically so improved efficiency, electronic transfer rather than manual files improves efficiency and safety, improved patient experience
Reduce the overhead on clerical staff of filing, locating and moving paper records	Potential cash releasing, however the number of Medical records staff is small so it will not be financially significant
Reduce posting overhead by sending electronically	The Trust is already doing this in Childrens services and these are part of our ongoing CIP programme; also improves service efficiency and can deliver an improved patient experience – subject to IG considerations
Reduce time spent per admission	Overall efficiency gain by reducing the “paper trail” only asking the patient once – improves patient experience
Reduce time spent completing nursing observations	Electronic recording at point of contact, real time, improved safety, and improved patient experience
Improved discharge process	Smoother and more efficient process improves patient experience – electronic discharge notification
Improved patient experience generates a reduction in complaints	Improved patient experience, given the relatively low number of complaints this is a reputational gain rather than directly financial
Reduce the time of normal consultations due to immediate availability of relevant information and reduction in amount of time taken per visit – less waiting due to time taken to find information, and shorter appointment times	Electronic storage and retrieval of clinical documentation improves efficiency of the process, improves patient safety, increases “time to care”, and improves patient experience.
Reduction in number of follow up appointments due to availability of shared data and changes in service delivery	Increased efficiency through sharing information across services, improves patient experience, however relatively low numbers so unlikely to be financially significant
Reduce failed contacts in community	Improved communication and sharing both internally and across organisations can improve the efficiency of service delivery, not sure that it would be financially significant, but it will improve the patient experience.

Reduce number of repeated pathology tests	Overall efficiency gain for the Pathology service provider
Reduction in number of duplicated tests due to better availability of previous results	Overall efficiency gain for the Pathology service provider
Reduction in time taken to acquire information to prescribe	Improved patient safety and increased efficiency, but relatively low numbers when compared to an acute trust.
Reduction in number of Acute prescriptions written due to timely letters to GP.	Improved patient safety and increased efficiency, but relatively low numbers when compared to an acute trust.
Individual log-ins and full audit trail when viewing results, protecting patient confidentiality	Access controlled via RBAC and NHS smartcard, improved security, audit, increases confidence around confidentiality and IG compliance, improves patient experience.

3 Cont) It would also be useful to understand how the Trust Board reached agreement that the additional expense was justified, especially in the context of local GP's using EMIS.

The Trust board considered the recommendation of the Trust Resource and Performance Committee, (see Part II Minutes of the Resource and Performance Committee held on Monday 27 July 2015 included under a previous section), and agreed that the functionality of the RiO product would allow the Trust to reap the greatest benefits for both its patients; and moving forward with a transformational programme around clinical working in a community setting. So the Trust can realise the potential for the wide spread use of mobile working across community based services, without the dependence upon a particular hardware/software platform.

The use of EMIS by the GPs in the locality is not especially relevant, given that the RiO product can effectively message to all the existing GP systems that are deployed across the country.

Extract from Shropshire Community NHS Trust Board Papers 30th July 2015 (Part 2)

Minute No 2015.4.35 EPR Business Case

Mr Ferguson noted that the procurement of the new electronic patient record had gone through a well structured process; there had been engagement with staff, visits to sites where systems were in use and a process to identify benefits and allocate scores. Three systems had reached the final stage of evaluation. All could deliver technically but there were subtleties about their relative benefits. Emis and Rio were stronger and very close on scoring and costs. Clinician preference in the Trust was divided.

Rio emerged as marginally the preferred option taking all the analysis into account. However, GPs across the county almost universally use Emis and may therefore perceive the Trust choosing Rio as unhelpful to joint working. However, in reality, the Emis systems for GPs and for community are different, and the two would still need to be integrated.

Mr Gregory stressed that the new system would improve quality by giving better, faster access to patient information, removing waste and duplication. Some staff will struggle with new technology but generally staff recognise the need and the training will be provided.

Mrs Lloyd clarified financial details in the report. Purchase and implementation of the new system is estimated to cost the Trust £3.1m over five years. The capital investment is estimated at £1.4m, and we will fund this from our existing cash balance. Revenue costs will be funded through increasing the value of the cost improvement programme and next year's value is estimated to be £4.2m, although this is subject to change. The cost of implementing the Rio option is £180,000 less than the 'do nothing' option, since the latter would incur additional costs to keep the old system in use. Further detail was included in the full business case which had been considered by the Resources and Performance Committee.

In reply to questions from Dr Ganesh, Mr Ferguson confirmed that e-prescribing was included in the specification. In reply to questions from other members he explained that all the systems were technically capable of communicating with GP systems; the challenge was generally gaining consent from GPs for that to happen. There were national specifications for the transfer of data between systems and the three options met that requirement. Training was included in the package and two clinicians would be seconded to support training roll-out. Due diligence had been carried out via the procurement process.

Mr Philips noted the presentations from the companies which the Resources Committee had received; he and Mr Ridley asked for clarification of project leadership in view of Mr Ferguson leaving in October, and whether there was time for necessary Trust preparation. Ms Ditheridge said that responsibility would sit with Mr Gregory and new Director of Finance Ms Franke, with the Senior Responsible Officer probably being Ms Franke. Mr Ferguson noted that the implementation will be managed service by service to ensure delivery.

It was confirmed all systems include the capability to provide access to data via hand held devices, and that there was some compatibility with telehealth but the important factor for the latter was internet connection.

Mr Ridley confirmed that if the Board now agreed the business case with Servelec as provider, it would go to the TDA for approval; the Trust would then announce the decision at the next meeting after a stand still period.

Ms Ditheridge asked the Board if they were sufficiently assured about the possibility of GP concerns if Emis was not selected; the Board acknowledged the issue and agreed the Trust needed to be prepared to handle this risk. All members indicated they were in favour of proceeding with the recommendation.

Mr Phillips PROPOSED the Board approves the Full Business Case, and the preferred provider. This proposal was SECONDED by Mr Jones.

4) Further clarity in relation to contingency arrangements to manage the impact of any unforeseen additional costs in implementation is necessary.

As described in our Finance Case, the Trust has set aside funding for 2015/16; and it is anticipated that the balance of funding for the whole of the project life will be met through internally generated funds, based on delivery of our CIP programme.

The impact of any additional unforeseen costs will be managed through the Trust's contingency funds which equates to 0.5% of our turnover in 2015/16.

In the event that the additional costs are in excess of the contingency funds available, they will be met through an in-year increase to the CIP programme. Delivery of the CIP is driven and monitored in a number of forums including the CIP Delivery Group; Transformation & CIP Programme Board; Resource & Performance Committee and the Board; as well as through our electronic performance management system.

Additional Question) It would be helpful if you could confirm your own contractual timescales and key dates, including the potential impact of any further delays in approval.

The prices that have been supplied by the suppliers are valid for 120 days; therefore if they are not notified by 26th October we will have to ask them if they are willing to extend their offer price for an additional period of time, our procurement service are suggesting they would wish to write to the suppliers on or about the 14th October to request an extension.

If we suffer any delay beyond November; the planned delivery programme will become unattainable within the NPfIT exit timeframe; we will therefore have to ask CSC / HSCIC to extend our existing service. There are minimum timeframes that CSC will accept as extension periods and these currently cost £52K per month ; the minimum extension period is 3 months therefore we will incur additional charges of circa £156K for this delay.

The very last date for notification of Exit, or having a new contract in place, is 31st December 2015.

These additional charges would impact upon the Trusts ability to deliver the TDA stretch target.

Obviously if the potential delay is considered significant by the suppliers they may withdraw their offer; in which case we will have to restart the procurement programme.