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NHS Trust

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Dear Richard

TDA EPR additional assurance questions

I am writing in response to your email to Sarah Lloyd regarding additional assurance around the processes and evaluation of our EPR Business case and Procurement. I have set out the information to address six areas:

1. Commissioner Support
2. The process used to progress from the Long list to Short list
3. Cost differential
4. Financial Benefits
5. Financial Comparison
6. Assessment of robustness of approach by new Director of Finance

The following sections deal with each area in greater detail with the aim of providing you with both the clarity and assurance that you are looking for.

1. Commissioner Support

The majority of the Trust income is secured through a block contract and although activity monitoring is still an important feature it is less so than for tariff based services. The Trust has positive relationships with its commissioners and we have their general support in taking positive action to improve our patient record keeping and data quality as this supports better quality of care and reduce clinical risk across the interfaces of our services. Our plan is to share our implementation plan with them in advance and we would anticipate having a constructive dialogue with them in the event of any circumstances that meant we were unable to provide the agreed datasets on time.

As part of our project planning we will identify any areas of potential risk, and should data availability be considered as a potential issue for a particular service area, then we would engage with the commissioner to ensure that the appropriate mitigations are in place. Our implementation plan is designed to progress through service blocks and we will therefore be sure that activity information can be delivered in a specific area before the project moves on to the next this will limit the scale of the risk.

2. Long list to Short list

The Trust first identified that a PAS replacement would be needed in late 2011, this was prompted by the forecast end of the National Programme for IT. As a consequence of this a PAS Replacement Board was established in February 2012. The PAS Replacement Board reviewed potential ways forward and submitted a report to the IM&T Strategy Group in July 2012; this was subsequently received by the Resource and Performance Committee of the Board in July 2012.

The July 2012 Resource and Performance Committee discussed a range of options these were:

1. Stay with the existing PAS ('do nothing' option).
2. Keep the existing PAS and extend it using a third party Electronic Patient Record.
3. Implement a replacement PAS under the National Programme for IT, although the programme itself is under contract negotiation.
4. Source a replacement PAS from outside of the National Programme

The Trust had ruled out an option to develop an in-house EPR as it does not have the capability or capacity to do so. The meeting agreed to develop the tender documents and prepare to follow the procurement process but identified further work to be undertaken before embarking on a full procurement. The process was then "paused" until CSC and HSCIC provided clarity around the legacy position of NPfIT. Between July 2012 and October 2013 the Resource and Performance Committee looked in more detail at the options including holding a workshop with Non-Executive Directors present.

In October 2013 this review period concluded with a paper received by the Committee setting out the work that had been undertaken to date. At that point a further discussion was held with the existing supplier to consider if they could offer an appropriate solution. Those discussions concluded in May 2014 and in the June 2014 Resource and Performance Committee it was agreed to follow the procurement route by restarting the process that had begun earlier.

The PQQ process was completed by November 2013 and the subsequent stages progressed leading to formal proposals from three suppliers. Those proposals were considered by the EPR project board. In May 2015 the results were reviewed by the Resource and Performance Committee at a meeting that had been expanded to include additional clinical representation. That meeting endorsed the preferred option and recommended submission to the Board.

Although, looking back over the recording of proceedings there are gaps in terms of evaluation and perhaps evidence of objective scoring used to move from a long list to a short list, there is enough organisational memory left held with non-executive directors in particular who can assert that they had full and frank discussions based on the information made available at the time, which as is outlined above, was an ever changing context and less than ideal to be making clear, sequential decisions.

This particular issue was addressed at our recent Resource and Performance Committee (dated 26th October 2015). An extract from the minutes are enclosed with this letter for your reference.

3. Cost differential

A number of discussions (detailed below) took place before the proposal went to the

Trust Board; following the extensive assessment process the Award Notice was constructed and submitted to the EPR Project Board.

A meeting of the Project Board on the 9th July was structured on a "challenge and response" basis and was specifically designed to provide the Project Board with assurance that the evaluation process was fair and transparent, and had been conducted appropriately. Reviewing the price differential was an integral part of that discussion.

At the Resource and Performance Committee held on the 27th July the cost and benefits of each system were reviewed. The additional cost of the preferred option was discussed there were three specific issues highlighted through the discussion:

1. The additional functionality of the preferred option was significant enough to warrant considering the price differential as a direct consequence.
2. The procurement advice was clear that we had declared the evaluation approach at the outset and therefore if we chose to select a product that scored less in the combined quality and financial evaluation we would be open to legal challenge that could significantly increase the timescale.
3. The product that scored second highest (but was less cost) did not include some specific functionality that would need to be deployed this would mean that additional costs would be incurred to deliver that functionality.

The Award Notice highlighted the different costs of each system and that document was included as part of the discussion both at Resource and Performance Committee and Trust Board. However, the specific percentage difference in cost was not used as part of the evaluation.

4. Financial Benefits

The primary financial benefits will arise from the transformations in working practices that can be achieved from migrating from paper records / traditional ways of working to digital records / mobile working. The Trust plans to deliver CIPs to support the procurement. It was also noted that the proposed solution was a lower cost than the do nothing option. As a result the Business Case identified areas of financial benefit but did not place a financial value to these at this stage.

The Trust has revisited the work that was undertaken looking at financial benefits, that work is set out in the table below. It is proposed that this information is now included as an appendix to the Business Case.

Table 1 Financial Benefits of EPR

Item	Min potential saving	Maximum potential saving
Reduction in number of staff due to more efficient working practices (18 wte – 35 wte)	£530k	£1,000k
Less mileage for community based staff as return to base journeys are reduced	£75k	£150k
less transport costs eg. Reduction in transfers of physical records	£2k	£20k
reduced paper costs – digital record	£13k	£20k
reduced printer costs – less printers, less consumables	£10k	£15k
reduced postage as we transmit information to both the patients and other healthcare professional digitally	£15k	£30k

e-prescribing	£15k	£30k
Shared data with other health and social care organisations	£20k	£30k
Total for 1 year	£680k	£1,295k
Total for 5 Years	£3,400k	£6,475k

This work indicates that financial savings of between £680k and £1,295k could be achieved.

5. Financial Comparison

We understand from information provided by you that, in comparison with other Community Trusts our procurement cost is relatively high in terms of a proportion of Trust turnover. The procurement process we have adopted defined the system requirements and then sought competitive responses. It would seem that the only way to reduce cost would be to reduce functionality and ultimately the benefits that could be achieved. The Trust is convinced that the functionality that has been defined creates the best opportunity to radically change the way care is delivered which is the reason for following this route.

It is possible that the Trust size is also a factor in this calculation. The Trust is a relatively small NHS organisation covering a large geographic area. It has therefore recognised that investment in technology is key to its long term success.

6. Director of Finance Assessment

At the start of October 2015 Ros Francke joined the Trust as the new Director of Finance. Ros will be taking over responsibility for taking this implementation forward. The following are the points which she would like to draw your particular attention to;

- Adherence to the selection criteria used in the procurement process underpins the decision made by the Board and consideration of an alternate decision at this stage would mean the collapse of the process and require the Trust to go out to market again and the current procurement process is now in danger of becoming frustrated due to the time it has taken to gain the relevant approvals. The impact of which will be further additional costs of continuing to run legacy systems, unsupported, out of contract.

- The Trust recognises that this procurement is about effective relative investment. The 'do nothing' option will also significantly increase the cost base of the Trust and as such the key focus of the Board has been on addressing 'how' such an increase in overhead can be afforded in any event. The greatest risk to the organisation, whichever option is chosen, is the deliverability of future efficiencies, the maximum being at the level of the do nothing option.

- It is clear that whatever system the Trust procures it will have to pay for itself. In this case, it is my opinion the Trust were right to consider optimal functionality as the most critical factor to pursue in any replacement EPR system as this holds the most potential for maximising future workforce flexibility, more

effective and safe patient care and ultimately greater scope for future efficiencies. It has been a difficult balance to strike but I believe it is right for the Trust to challenge itself and be ambitious at this stage, as to have gone for a cheaper, less functional solution would have limited the scope to which these agendas could be pursued and only driven costs up in an unmeasured way to gain the same advantage they are seeking

I hope that the further information set out in this letter will provide the assurance you are seeking. The timescales the Trust is faced with mean that it is important to progress the procurement and subsequent implementation as a matter of urgency.

Yours sincerely

Ros Francke
Director of Finance

cc. Andrew Crookes

encl. Extract from RPC 26th Oct 2015