The extra narrative on the long list to short list process provides a good overview of the timeline of events. It would be helpful to have a brief bit of narrative or a table detailing the key pros and cons of each option and reasons for discounting.

The response to this question is framed within the context of the option appraisal being carried out during 2012, and a retrospective assessment of the reasoning being applied to the options taking place 3 years later. This retrospective narrative is displayed in "***bold italic's***" to emphasise that it is written a few years after the decision point; and did not form part of the original documentation that has previously been submitted.

It should be born in mind that the considerations that were applied to the options; and the options themselves were related to what was known at that point in time. In 2012 the future direction of the National Programme for IT, and how the contractual arrangements would transform into future products and support arrangements was still being discussed at a strategic level, with very little engagement with the operational level of the NHS.

Option 1 Stay with the existing PAS ('do nothing' option).

iPM is kept available to the Trusts beyond 2015. iPM may be kept beyond the cut off date for iPM. In 2016 the National Programme is scheduled to end and Trusts are expected to take over the cost of the PAS. The Trust would be left with a system that was not *'fit for purpose'*.

Pros	Cons
Currently using the product	Product not fit for a Community service No certainty at the outcome of the project. Contractual arrangement beyond standard agreements would need to be agreed Unknown costs

Discounted Option 1 primarily because the iPM product is not fit for purpose in the context of supporting Community based services; it has a number of significant weaknesses that are currently being managed by workarounds where possible; however it does not support mobile disconnected working. Also the contract comes to an end.

Option 2 Keep the existing PAS and extend it using a third party Electronic Patient Record.

A third party EPR, providing clinical functionality, which would work with uni-directional messaging into iPM. This has been rolled out in South Staffs and at the Robert Jones and Agnes Hunt. On-going issues with updates to iPM and messaging have proved problematic. It does not resolve the issue of iPM being unsupported in 2015.

Pros	Cons
Lower costs for the application (virtually free). Ability to form the system to match the Trust. Potential for greater stakeholder position in future developments.	Higher development costs for the Trust requiring more staff input especially from clinicians. No certainty at the outcome of the project. Extended timeline. Contractual arrangement beyond standard agreements would need to be agreed

Discounted Option 2 primarily because the inherent problems within the iPM product remain; the updates and messaging within the core product have proven to be problematic. Getting a 3rd party supplier to maintain the necessary linkages into what will become an unsupported product will be difficult, and potentially expensive.

Option 3 Implement a replacement PAS under the National Programme for IT, although the programme itself is under contract negotiation.

TPP/Rio is available under NPfIT. TPP in the Community may still be available under the National Programme, and could be implemented through CSC with the direct implementation costs and annual costs covered by the contract until 2016, after which the Trust would have to take over the costs, these costs have not been agreed.

It must be noted that this will leave Child Health using HSW and additional functionality, such as Community Hospitals, would have to be implemented separately and at cost to the Trust.

There is a small chance that RIO may come available to the Trust under the National Programme but this has yet to be confirmed. RIO would be able to provide a holistic patient administration system to include Child Health and Community Hospitals.

Pros	Cons
Established product which will be supported through implementation. iPM will not be de-supported and a gap left before TPP roll-out. Established process and partner organisation.	Lack of choice. Some experience of TPP in Prisons has highlighted grave concerns about reporting and other systems issues. TPP under the programme does not give the Trust a full suite of applications (e.g. Community Hospitals) will need buying separately. Tied into TPP from 2016 and beyond with no certainty of costs.
Reduction in cost due to 'economies of scale'. Increased functionality across organisations (e.g. Sharing of patient details and migration of patients in and out of the Trusts system.	Limited geographical partners. Uncertain discount through limited 'economies of scale'. May still involve a tendering process which in turn will delay deployment. Agreement, throughout project lifecycle, with partner organisations may extend the project timeline.

Discounted Option 3 primarily because of the uncertainty around the future of NPfIT, and what if any services would be available to choose from. The only Community offering at that point in time was TPP which still left a significant gap in the service provision, which would have to be filled using another supplier at potentially significant cost.

Option 4 Source a replacement PAS from outside of the National Programme

Deploy a PAS which is outside of the NPfIT. RIO and a number of other PAS could be considered under this option. This would broaden the number of potential suppliers but would require a full appraisal and tendering process; this would take the longest time to implement

Pros	Cons
Wide range of products. Enabling a better fit both strategically and functionally. Most flexible procurement option (capital vs. revenue).	Prolonged tender and appraisal process. Market cost.

Chose Option 4 primarily because of the control over the functionality and costs and the product choice that would be available.

The following additional points were also considered at the EPR project boards during 2012, and as can be seen there is some discussion around the deployment of the TPP SystmOne solution, which was potentially still on offer via NPfIT at that stage; although this in fact never materialised.

It does demonstrate the discussion and considerations that we having locally with regard to the EPR process; and the state of confusion that was arising from both the termination of the programme and a lack of a clear roadmap for the operational services.

Additional considerations

- The Trust is currently assigned to take TPP which includes the Community module as part of the national contract. Unfortunately, the Community Hospitals module does not form part of this contract and will cost approximately £350k.
- For a completely integrated system the Child Health and Palliative Care modules would also need to be purchased (the Prisons module is already deployed). TPP has been deployed in a wide range of settings and we are aware of its shortcomings. Rio is deployed in the south of the country and has its own positives and shortcomings. All modules are included in the package but the financials are unknown at the moment.
- By deploying another system, the Trust would be walking away from the national contract and all costs would have to be funded by the Trust. It is worth noting however, that the national contract runs out in a couple of years and the maintenance costs will have to be paid by the Trust regardless of which product it goes with. A Project Team has been assessing both TPP and Rio focussing on a high level set of comparators.
- There is no further information available regarding the National Contract and the IT Strategy is not being issued until the Autumn. CfH haven't defined what the situation is regarding funding from 2015 and therefore it is difficult for organisations to complete their financial planning
- The IM&T Steering Group agreed that as a new entity, the Trust is in position to decide exactly how it would like to move forward, particularly as it is aiming for FT status. It is the perfect opportunity to deploy an integrated PAS system across the Trust. At some point a decision will need to be made whether to wait for the national contract to be agreed or to proceed outside of the contract.
- It was reported that there is still no feedback nationally and therefore the Trust has nothing to lose by scoping the requirements for a replacement PAS system although the Trust is still down to take TPP as a replacement for Lorenzo.
- It was explained that TPP is a modular product and the Trust is down for the Community module. The Community Hospitals (CoHo) module is not part of the national deal. The Prisons module has been bought by the Home Office and there are also modules for Hospices and Child Health. In summary, TPP will deliver a high degree of functionality but potentially cost quite a bit of money.
- Lorenzo is not currently fit for purpose and is unable to work on a mobile basis and Rio is a complete package but will probably have quite a high price tag equal to TPP as will all similar products with that functionality.
- The group noted that Lorenzo does not allow a clinical record to be created and shared with other agencies. It is felt that if there was a system in place which worked well from a clinical perspective and allowed mobile working, it would be well received and used by clinicians.
- It is likely that the two front runners for the Trust, if there are funds available, will be TPP or RiO. In addition, there will also be lots of other potential suppliers but this has the downside of there being little or no potential for integration.
- The questions that the Trust needs to consider are whether it wants to have a single unified solution, what the business requirements are and are the financials available?
- In the interim, the Trust will continue as business as usual. All the clinical systems that are currently in place are still viable. With regards to timeframes, the lead time for any system is approximately 14 months.
- Service line reporting will become increasingly important as the Trust moves forward

Please could you provide an updated timeline for implementation (previous one attached which had a 1st Nov go live).

Updated implementation timetable

Stage	Date
Strategic Planning	September 2011
Project Start-up	February 2012
Scoping, Planning, Market Analysis	March 2012 –June 2013
OJEU Advert	July 2013
Pre-Qualification Questionnaire (PQQ)	Nov 2013
Assessment of Options	Dec 2013 – Dec 2014
Commence Dialogue with Suppliers	Jan 2015
Pre Deployment Evaluation Workshops	March – April 2015
Tender Submission and Contract Award	June – Nov 2015
Go-Live – early adopter	**Phase 1** (iPM services) MIU/APCS/Scheduled Therapies Feb 2016 **Phase 2** (iPM services) Children & Families Mar/Apr 2016 **Phase 3** (iPM services) ICS and IDT May/June 2016 **Phase 4** CAMHS July/Aug 2016 **Phase 5** Community Hospitals Oct/Nov 2016
Cessation of iPM Service	7th July 2016
Deployment completed	Nov / Dec 2016

In terms of the cost differential your letter referenced a paper to the 27th July Resource and Performance Committee around the differences and justification, please could you provide this.

Shropshire Community Health NHS
NHS Trust

SUMMARY REPORT	Meeting Date:	27 July 2015
	Agenda Item:	10.3
	Enclosure Number:	13

Meeting:	**Resource & Performance Committee**		
Title:	**EPR Draft Full Business Case**		
Author:	**Andrew Crookes, Head of Informatics**		
Accountable Director:	**Steve Gregory**		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/Recommendation from that Committee**
	Resource & Performance Committee	May 2015	Expansion of benefits description, and clarity of interworking with other systems.

Purpose of the report		
The content of the Full Business Case (including the financial plan) has been refined during the past couple of months to reflect the clarification points request at the May Resource and Performance Committee meeting; where the draft version of the Full Business Case was reviewed. Also a number of assumptions in the draft version have been refined during the dialogue with suppliers as the tendering process has progressed. In Summary the Trust needs to replace the three separate Patient Administration Systems (PAS) that supports inpatient, outpatient and community services with a single, modern service user record system. This Full Business Case: - a) Seeks approval to proceed to contract award and subsequent deployment stage with a proposed go live date for the Electronic Patient Record of November 2015 for the early adopter services b) Confirms the case for this deployment by following the NHS "five case model" – providing detail on costs, risks, benefits and project management arrangements c) Demonstrates the deployment of the Electronic Patient Record which: • meets the Trust's immediate requirement for PAS replacements • provides a reliable platform for strategic integration/interworking with other key clinical systems • provides a robust and sustainable pathway to a clinically rich deployment	**Decision/ Approval**	✓
	Assurance	✓
	Discussion	✓
	Information	✓

- provides significant financial savings over the “Do Nothing” option

Strategic Priorities this report relates to:

To exceed expectations in the quality of care delivered	To transform our services to offer more care closer to home more productively.	To deliver well co-ordinated effective care by working in partnership with others.	To provide the best services for patients by becoming a more flexible and sustainable organisation
	✓	✓	✓

Summary of key points in report

This Full Business Case (FBC) updates the Outline Business Case (OBC) discussed by the Trust Resource and Performance Committee in July 2012, and the draft Full Business Case which was discussed by the Trust Resource and Performance Committee in May 2015.

It recommends the preferred option which was selected following the agreed product selection and procurement process.

The product has been chosen on the basis of a clinically driven procurement; which placed the greatest significance on clinical functionality rather than price, although the product cost was a significant factor in the procurement process. There is clearly an attainment of value for money when comparing the preferred solution to the “Do Nothing” option.

The main areas of mandatory functionality where there is a clear difference in the respective supplier products are around:-

- Bed Management and associated basic patient management functions
- Caseload management, including discharges
- Clinical records management; including coding, tracking and searching
- Minor Injuries functionality both clinical and reporting
- Mobile working
- Waiting list management

The replacement of the existing PASs with the Electronic Patient Record (EPR), meets the NHS “five-case” model required for NHS IM&T Business Cases as follows: -

- Strategic case – a good fit with local and national objectives
- Economic case – value for money
- Financial case – affordable with the injection of approved capital and one off revenue investment
- Commercial Case – the contract and procurement case has been covered in the OBC
- Management case – the project has robust programme, risk and benefits management arrangements

The Committee are being asked to:

1. Agree that the methodology utilised provides adequate assurance that a fair, transparent and robust process for the selection of an appropriate product was followed – **Appendix 1 Draft Award Report**
2. Agree that the methodology utilised provides sufficient assurance around meeting the competing demands of cost vs quality
3. Support the outcome from that process
4. Identify any further issues that are in the public interest that may need to be taken into consideration

Key Recommendations
• Review and agree this Full Business Case prior to its submission to the Trust Board for approval; prior to a final submission to the TDA.

Is this report relevant to compliance with any key standards? YES OR NO		**State specific standard or BAF risk**
CQC		
NHSLA		
IG Governance Toolkit		
Board Assurance Framework		

Impacts and Implications?	**YES or NO**	**If yes, what impact or implication**
Patient safety & experience		
Financial (revenue & capital)		
OD/Workforce		
Legal		

Appendix 1 Draft Award Report

Enc 13 - Appendix 1 EPR Contract Award

In addition could you review the attached to confirm if these are the key functionality differences between EMIS and Rio that you allude to in this section of the letter.

We can confirm that the key mandatory functionality differences between EMIS and RiO are shown in the table below.

Key functionality

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:-** 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.	This functionality is not available in EMIS, unknown if available via a 3rd party, if so would be at an additional cost.

	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 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	This functionality is not available in EMIS, unknown if available via a 3rd party, if so would be at an additional cost.
Clinical records management : coding	**This mandated functionality is not currently available in EMIS but is available in RiO:-** The system must support OPCS	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-

	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.	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 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	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.

	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 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	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.

	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.

We could also do with this confirming whether the Advanced Health and Care option included this functionality.

For Advanced Health and Care (AH&C) their product generally scored lower on the quality aspects of the award criteria; the specifics have been provided in the award notice. However some of the shortfalls are the same as EMIS; but there are other areas where AH&C could not meet our requirements where EMIS could e.g. Medicines Management and Prescribing, and other areas where they scored higher e.g. Minor Injuries and Waiting List Management.

Key Functionality Issue	**Service Impact**	**Financial Impact**
Bed Management and associated basic patient management functions	**This mandated functionality is not currently available in AH&C 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	Basic requirement for improved patient safety (GS1); not sufficiently developed within the product

	wrist bands for patients from the system which includes the NHS number and barcodes The system must fully support dynamic bed management including the number and location of "virtual" ward beds in situations where patients who are no longer occupying beds still require care and treatment in the ward. (For example patients transiting through Admission and Discharge Lounges)	No graphical representations of ward/bed environment at this point in time
Clinic management	**This mandated functionality is not currently available in AH&C but is available in RiO:-** The user must be able to 'bulk' move clinics to another date on the system.	This functionality is not available in AH&C, unknown if available or practical to implement via a 3rd party, if so would be at an additional cost.
Clinical records management; including tracking and searching	**This mandated functionality is not currently available in AH&C but is available in RiO:-** An authorised user must be able to override and view a hidden record or partial record i.e. A&E consultant The system must include instant messaging functionality, where a user can send an instant message to another user/users who are logged on The system must notify users on screen when a record is also being viewed by another user.	This functionality is not available in AH&C, unknown if available via a 3rd party, if so would be at an additional cost.
Clinical records management : coding	**This mandated functionality is not currently available in AH&C but is available in RiO:-** The system must support	AH&C does not at present support SNOWMED CT coding This is a significant issue.

	SNOMED CT coding	It is possible to purchase 3rd party applications at an additional cost.
Medicines Administration	**This mandated functionality is not currently available in AH&C but is available in RiO:-** The system must allow drug administration/ prescription within role based access controls. The system must be able to record the administration or supervision of a single or multiple medicinal products to patients, including administration of medicinal and non medicinal products through any route of administration.	This functionality is not available in AH&C, available via a 3rd party, would be at an additional cost.
Mobile working	**This mandated functionality is not currently available in AH&C 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). The Application is able to ask for confirmation of Legitimate Relationship for each record or set of records prior to a synchronisation. The Application automatically removes or allows the End User to remove locally held records on a mobile device where the End User has indicated that they no longer have a Legitimate Relationship. The system must has the	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.

	capability to queue the print request until connectivity is restored	
Ordering Test/Request	**This mandated functionality is not currently available in AH&C but is available in RiO:-** The user must be able to order pathology tests/ X-rays/ any other tests or investigations needed electronically via the system	A fully functional 3rd party product would be available at an additional cost.
Prescribing	**This mandated functionality is not currently available in AH&C but is available in RiO:-** The system must be able to support prescribing in all care settings and includes medication and changed medication details in the discharge communications at the point of transfer of care between organisations.	A fully functional 3rd party product would be available at an additional cost. This ties into Medicines management.

The financial benefits section is very useful, please could you confirm if these are the benefits of the EPR project in general or if any could not be realised with a system other than Rio.

The benefits we have described are generally attainable through moving to a fully functional EPR; providing the product fully supports mobile disconnected working, electronic data sharing across organisations; electronic prescribing; bed and clinic management etc.. Given our award criteria and assessment of the products we believe that the financial benefits can only be fully realised by the implementation of the RiO product; as the other two products fail to provide areas of mandated functionality, and consequently would not enable all of the potential benefits to be realised.

Also could you tie these into your original benefits table (also attached).

We have included the original benefits wording into the new categories to identify the respective potential savings; please note that the final 2 items, Single EPR and Digital Patient Access are shown in the original document but were not identified in the letter; these are now shown below; the Digital Patient Access has not had any financial benefit associated with it.

Item	Min potential saving	Maximum potential saving
Reduction in number of staff due to more efficient working practices (18 wte – 35 wte) To provide opportunities to simplify, standardise and improve existing clinical processes leading to improved patient experience and patient care, through analysing current processes and deploying "LEAN" methodologies in the process mapping and design phase, the patient/client pathway can be optimised - see FBC Fig. 1 – Potential impact of implementing electronic diaries – page 20 To improve bed and clinic management trust wide through using one co-ordinated bed and clinic management system, this will allow the trust to have an over-arching view of these resources and their availability, and will promote and enable effective resource planning including : • Better bed management from better predictability of bed availability • Bed Occupancy is visible across all sites • Delayed Discharges can be more effectively reported Delayed Admissions can be more effectively reported • All services are visible and this promotes effective transfers between services	£530k	£1,000k
Less mileage for community based staff as return to base journeys are reduced To provide opportunities to simplify, standardise and improve existing clinical processes leading to improved patient experience and patient care, through analysing current processes and deploying "LEAN" methodologies in the process mapping and design phase, the patient/client pathway can be optimised - see FBC Fig. 1 – Potential impact of implementing electronic diaries – page 20	£75k	£150k
less transport costs eg. Reduction in transfers of physical records To become "paper-light"; the deployment of the EPR will	£2k	£20k

allow the trust to embark on the first stage of its digital journey; with the majority of new cases (and the record content) being held digitally rather than on paper, significantly reducing storage costs and improving retrieval times To enable the Trust to share electronic information across the local health economy and ensure the Trust is in a position to fully support the development of a local integrated care record and contribute to the LHE Digital Roadmap		
reduced paper costs – digital record To become "paper-light"; the deployment of the EPR will allow the trust to embark on the first stage of its digital journey; with the majority of new cases (and the record content) being held digitally rather than on paper, significantly reducing storage costs and improving retrieval times	£13k	£20k
reduced printer costs – less printers, less consumables To become "paper-light"; the deployment of the EPR will allow the trust to embark on the first stage of its digital journey; with the majority of new cases (and the record content) being held digitally rather than on paper, significantly reducing storage costs and improving retrieval times	£10k	£15k
reduced postage as we transmit information to both the patients and other healthcare professional digitally To become "paper-light"; the deployment of the EPR will allow the trust to embark on the first stage of its digital journey; with the majority of new cases (and the record content) being held digitally rather than on paper, significantly reducing storage costs and improving retrieval times To enable the Trust to share electronic information across the local health economy and ensure the Trust is in a position to fully support the development of a local integrated care record and contribute to the LHE Digital Roadmap	£15k	£30k
e-prescribing To enable the Trust to share electronic information across the local health economy and ensure the Trust is in a position to fully support the development of a local integrated care record and contribute to the LHE Digital Roadmap	£15k	£30k
Shared data with other health and social care organisations To enable the Trust to share electronic information across the local health economy and ensure the Trust is in a position to fully support the development of a local integrated care record and contribute to the LHE Digital Roadmap	£20k	£30k
Single EPR To provide a modern sustainable and well supported technical platform for a single integrated EPR, utilising	£55k	£55k

current generation technologies that are provided by a well-established clinical systems supplier, that has a proven track record in systems delivery and ongoing support To replace three separate PASs with a single modern EPR, with the consequent reduction in duplication and risk reduction that can occur when records transfer across systems		
Patient Digital Access To enable patients access to an electronic version of their records through utilising a "portal" approach; this element will be implemented in line with national requirements for patients access to their records		
Total for 1 year	£735k	£1,350k
Total for 5 Years	£3,675k	£6,750k

Original Benefits table

Benefits of the project

Goal	Deliverable	Description of Benefit	Financial		Non-financial	Tracked in benefits realisation plan	Value for Total benefits £000s
			Non-cash releasing	Cash releasing			
EPR Implemented	1. Single EPR	To replace three separate PASs with a single modern EPR, with the consequent reduction in duplication and risk reduction that can occur when records transfer across systems		£276,000		Y	£276
		To provide a modern sustainable and well supported technical platform for a single integrated EPR, utilising current generation technologies that are provided by a well-established clinical systems supplier, that has a proven track record in systems delivery and ongoing support			Y		
		To provide opportunities to simplify, standardise and improve existing clinical processes			Y		

Goal	Deliverable	Description of Benefit	Financial		Non-financial	Tracked in benefits realisation plan	Value for Total benefits £000s
			Non-cash releasing	Cash releasing			
		leading to improved patient experience and patient care, through analysing current processes and deploying "LEAN" methodologies in the process mapping and design phase, the patient/client pathway can be optimised - see FBC Fig. 1 – Potential impact of implementing electronic diaries – page 20					
		To enable the Trust to share electronic information across the local health economy and ensure the Trust is in a position to fully support the development of a local integrated care record and contribute to the LHE Digital Roadmap			Y	Y	
		To improve bed and clinic management trust wide through using one co-ordinated bed and clinic management system, this will allow the trust to have an over-arching view of these resources and their availability, and will promote and enable effective resource planning including : oBetter bed management f**rom** better predictability of bed availability o Bed Occupancy is visible across all sites o Delayed Discharges can be more effectively reported o Delayed Admissions can be more effectively			Y		

Goal	Deliverable	Description of Benefit	Financial		Non-financial	Tracked in benefits realisation plan	Value for Total benefits £000s
			Non-cash releasing	Cash releasing			
		reported o All services are visible and this promotes effective transfers between services					
		To become “paper-light”; the deployment of the EPR will allow the trust to embark on the first stage of its digital journey; with the majority of new cases (and the record content) being held digitally rather than on paper, significantly reducing storage costs and improving retrieval times			Y	Y	
EPR Implemented	Patient Digital Access	To enable patients access to an electronic version of their records through utilising a “portal” approach; this element will be implemented in line with national requirements for patients access to their records			Y	Y	