Welcome to the 2nd EPR Summit: Translating the National Mandate into Local Success







Hadleigh Stollar Chief Executive Officer -Healthcare Innovation Consortium (HIC)







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Derm Ryan Director of Digital Transformation, Transformation Directorate - NHSE







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Janet Young Deputy Chief Information Officer - Lancashire Teaching Hospitals NHS Foundation Trust







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Jackie Edwards

Chief Clinical Digital Engagement Officer - Worcestershire Acute Hospitals NHS Trust

Daniel Hastie

Corporate Lead for Advanced Clinical Practice - Worcestershire Acute Hospitals NHS Trust







NHS George Eliot Hospital NHS Trust



Worcestershire Acute Hospitals South Warwickshire University NHS Foundation Trust

Jackie Edwards - Chief Clinical Digital Engagement Officer Dan Hastie - Consultant Nurse, Advancing Practice Programme Lead

Benefits Realisation Review: Understanding and maximising the qualitative impact of **introducing Sunrise Electronic Patient Record (EPR) system on Tissue Viability (TV)** management

Collaborative Working and Meeting Digital Goals

This benefits realisation review was undertaken by Worcestershire Acute Hospital Trust, working in collaboration with Health Care Innovation Consortium and Altera digital health. This review was a qualitative multi method review over 6 weeks was carried out in October–November 2024.

Motivated by Trust digital transformation goals to:

- streamline clinical workflows to reduce administrative burden on staff, improving operational 1. efficiency
- improve documentation that can support improvements in patient outcomes 2.
- enhance data accessibility to promote better quality data to empower its use by clinicians in care 3.

and the National Wound Care Strategy Programme (NHSE) goal to: 4. reduce variations in care







Project Overview

Purpose: The Sunrise EPR implementation project was initiated to evaluate its impact on Tissue Viability Management (TVM) and to identify areas for further optimisation.

Context: TVM at Worcestershire Acute Hospitals NHS Trust plays a critical role in patient care, with a particular focus on preventing, diagnosing, and treating pressure ulcers and wounds.

Strategic Alignment: The Trust is committed to the goals of the National Wound Care Strategy Programme (NWCSP), commissioned by NHS England, which seeks to enhance wound care management across the NHS through improved prevention, diagnosis, and treatment protocols.

Scope: Our assessment covered qualitative benefits, challenges, and strategic recommendations for system improvements.





NHS







NHS Worcestershire Acute Hospitals

Methodology







NHS George Eliot Hospital NHS Trust

NHS South Warwickshire University **NHS Foundation Trust**

-0



NHS Wve Vallev NHS Trust

NHS NHS NHS South Warwickshire Worcestershire George Eliot Hospital Acute Hospitals NHS Trust University **NHS Trust NHS Foundation Trust**

Key Findings – Benefits Realised

The discovery phase revealed significant advancements in patient care and workflow efficiency since the introduction of the Sunrise EPR system. Key benefits realised include:





60% of survey respondents said it was easy to document and access patient information related to tissue viability using the EPR system



52% staff reported a positive impact on administrative tasks Real time access at critical data points for governance investigations . *"which not* only saves time but supports continuity of care and risk reduction."

> South Warwickshire University NHS Foundation Trust

George Eliot Hospital NHS Trust

Worcestershire Acute Hospitals NHS Trust

Key Findings – Challenges Identified

The discovery phase also revealed significant challenges and pain points throughout the Tissue Viability workflow that still exist despite EPR implementation. These are the key challenges stakeholders identified:

58% of survey respondents feel that the EPR has had no impact on managing pressure ulcers



Not being fully digitalized (SSKIN bundle) meaning an increase the length of a ward round by 2-2.5 time with 24% staff recommended that clearer referral process in EPR would support adoption

Manual processes are still in use, causing inefficiencies and delays in patient care updates despite the digital system.

Incomplete data capture in referrals, resulting in timeconsuming searches and potential gaps in patient data.

Fragmented system integration requires staff to navigate multiple platforms, disrupting workflow efficiency.

Insufficient EPR training and adoption, hindering optimal use of the system and reducing staff confidence.





58% of survey responders expressed underutilisation or unmet expectations regarding the capability and impact of EPR on managing pressure ulcers.



40% staff are not leveraging all functionality of TV workflow due to lack of awareness and understanding of the system – 42% poor confidence in EPR

> NHS South Warwickshire University

NHS **George Eliot Hospital** NHS Trust

NHS Worcestershire Acute Hospitals NHS Trust

Success Criteria – Key Quality Priority

Objective	Success Criteria	
Enhance Patient Outcomes	Reduction in pressure ulcer rates through complete and accurate assessment and documentation of all at risk patients	Target red ulcers; 24- admission
	Real-time decision-making enhancements	Percentag treated pro decision s
Streamline Clinical Workflows	Reduction in manual processes with the potential for eventual total removal	50% decre Time savin document
	Optimised handovers	Percentag handovers accuracy i
Reduce Administrative Burden on Staff	Time saved on administrative tasks	Measured data retrie defined ba
Improve Data Accessibility for Governance and Reporting	Improved data accessibility	Time to ac Percentag uploaded i
	Enhanced compliance and safety protocols	Completic Percentag reposition
Training and Adoption at Ward Level	EPR training and adoption across all wards	Completic models; in 1 year; Co









Measurement Metrics

- uction in hospital-acquired pressure -hour assessment rate post-
- e of high-risk patients flagged and omptly through automated alerts and upport features
- ease in manual referrals within 1 year;
- ngs in digital handovers and ation
- e of departments using digital
- s; Compliance audits on data
- in patient records
- reduction in time for referrals, wound val and administrative tasks, from a
- eval and administrative tasks, no
- aseline to a specific target
- cess historical wound data;
- e of wound images and notes
- in a timely manner
- on rate of SSKIN bundle assessments;
- e of compliance with patient
- ing reminders
- on rate of essential EPR/TV training ncreased staff confidence levels over
- mpliance scores from quality audits

Worcestershire Acute Hospitals NHS Trust George Eliot Hospital

South Warwickshire University NHS Foundation Trust



Conclusion: Digital Clinical Engagement is like developing a garden

 The choice of approach depends upon the desired outcome and given environmental factors which directs choice and approach.

 This approach has offered a meaningful process for digital and clinical staff

 Opportunity to deep dive into a key quality priority important to patient safety and outcome



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Morning Break & Networking





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Jennifer Dunne EHR Programme Director - Betsi Cadwaladr University Health Board







The importance of pre-market engagement and testing to ensure a successful procurement

Jennifer Dunne, Consultant EHR Programme Director

EPR Summit, 12th February 2025



Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Great care, every time



EHR procurement is high stakes!

Poor decisions can impact clinical workflows, operational efficiency and patient outcomes



Why pre-procurement market testing is essential

Done well

Pre-procurement market testing mitigates risks and ensures the right solution is selected

Done poorly...

Pre-procurement market testing can take a lot of time and resource, lead to ambiguous outcomes, confuse the market and lead to a less than effective procurement

- **Key topics for today:**
 - The right procurement support
- 2. Knowing what you need
- 3. Stakeholder involvement

1. PROCUREMENT SUPPORT



The right procurement support: Have the team done it before?

Experience matters:

- Complex EHR procurements require a mix of procurement, digital, clinical, legal and operational expertise
- Teams with relevant experience can avoid common pitfalls and work together to maximise the prospects of success, informed by their collective perspectives



So that...

Informed vendor assessments knowing which vendors can deliver the stated requirements

Efficient contract negotiations ensuring compliance and fair pricing

• **Risk management -** minimising delays, unexpected costs and the risk of procurement challenge

Procurement success and failures - examples

Procurement success:

- Cross-Trusts stakeholder engagement to agree requirements
- **Cross-market pre-procurement** engagement to establish which suppliers had the capacity and capability to deliver the requirements
- Requirements in tight pass/fail criteria to ensure that only capable suppliers tendered. Suppliers who could not didn't waste valuable resource on a tender which could not succeed

Cancelled procurement:

'In-procurement' realisation the Trusts had not reached consensus about their requirements, or the capacity and capability required of suppliers to deliver them

Poorly constructed pass/fail criteria

Therefore, unable to conduct effective, justifiable and compliant assessment of the tenders received from a wide range of suppliers with very different profiles

2. KNOWING WHAT YOU NEED



Defining requirements Business case and preferred option



Start with the business case

- Clear investment objectives and CSFs: Why do you need the new EHR?
- What problems must it solve?



Preferred option analysis

- Identify the features that align with organisational goals
- Balance between clinical, operational, and cost

Risks of poorly defined requirements:

 Over-purchasing or under-purchasing system capabilities

 Incompatible solutions with existing infrastructure

Steps to define what you need 1 2 3 4 5 5

Map current clinical and operational workflows



Steps to define what you need

3

4

5

Map current clinical and operational workflows

1

Identify critical pain points



Steps to define what you need

3

4

5

Map current clinical and operational workflows

1

Gather multidisciplinary stakeholder input

Identify critical pain points



Steps to define what you need 5 3 2 4 1 Map current Gather multiclinical and disciplinary operational

workflows

stakeholder input

Identify critical pain points

Develop a list of "must-haves" vs. "nice-to-haves"



Steps to define what you need

3

Map current clinical and operational workflows

Gather multidisciplinary stakeholder input Reflect all the above in your requirements on an iterative basis

5

Identify critical pain points

2

Develop a list of "must-haves" vs. "nice-to-haves"



Steps to define what you need

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Identify critical pain points

2

Develop a list of "must-haves" vs. "nice-to-haves"

4

Clearly define your pass/fail criteria so you can encourage the right suppliers to deliver your requirements to bid and be honest with those who are not as well placed


Steps to define what you need

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Clearly define your pass/fail criteria so you can encourage the right suppliers to deliver your requirements to bid and be honest with those who are not as well placed

6

Engage the market about requirements and your procurement plans

> Reflect engagement outcomes in your procurement documentation

8

3. STAKEHOLDER INVOLVEMENT

Engaging clinical and operational stakeholders



Why collaboration matters

- Clinicians and operational staff are end users they know what works
- Lack of engagement leads to poor adoption and ineffective workflows (some) EHR procurements have been delayed for further engagement)



Who to involve

• Physicians, nurses, digital teams, finance departments, administrative staff



Benefits of engagement

- Solutions that align with real-world needs
- Higher user adoption rates
- Reduced resistance to change and greater buy-in to procurement outcomes

How to collaborate effectively



- Workshops Gather feedback on specific clinical needs
- **Prototyping** Demonstrate system workflows and gather feedback
- Feedback loops Continually refine requirements through user input
- Building organisational consensus Sharing perspectives across the organisation - the perspectives of clinicians, administrators and technical staff can be very different, and they need to be ironed out pre-procurement (as opposed to potentially delaying a procurement, or worse!)

4. WHY INVEST IN PRE-MARKET ENGAGEMENT?

What happens without effective pre-procurement market testing?



- Misaligned expectations between vendors and the organisation • Systems that don't integrate well with existing infrastructure
- High post-implementation costs (fixes, customisations, delays) and poor value for money
- Low user satisfaction or adoption
- Delayed procurements
- Procurement challenges
- At worse, procurement failure and reputational damage

5. KEY TAKEAWAYS

44

Key takeaways

- Use experienced procurement teams
 informed by real-world EHR experience to
 drive better outcomes
- Get clear requirements to reduce risks and avoid costly surprises
- Engage stakeholders to ensure the system fits operational and clinical workflows

Pre-procurement market testing is your safeguard for success











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Jason Jones Global Customer Manager, Healthcare - Rackspace Technology







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Andy Prior Senior Technical Product Manager - IGEL







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Lunch & Networking





Hadleigh Stollar Chief Executive Officer -Healthcare Innovation Consortium (HIC)







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Jo Hutchinson Head of EPR Applications & Orlagh Aiston – Head of People (EPR) - Sherwood Forest Hospitals NHS Foundation Trust





Prepare Today, Succeed Tomorrow: Early Transformation for a Seamless EPR Implementation

Jo Hutchinson – Head of EPR Applications Orlagh Aiston – Head of People (EPR)





You can realise benefits before implementation







Implementation



Stabilise

Optimise

Reinforce compliance & adoption

Structured approach to realising benefits built into BAU



2

OBC submitted to NHSE

October 23

Supplier agnostic activity:

- current state mapping
- detailed applications and architecture review
- exploratory work for a **document management** solution

OBC approved by Cabinet Office September 24

- Refine transformation opportunities:
 - **Outpatient productivity**
- Speech recognition
- **Paperless pathology and radiology**

Re-imagine our future ways of working and develop new models of care enabled by our EPR.







We have maximised time and funding to ensure EPR readiness and reduce our future implementation timeline.



Implementation start January 26

Preparing across all areas is key

People

- Communicate and engage effectively
- Workforce modelling







Process

- Understand our current state
- Re-imagine our future state

Technology

- Understand our starting point for applications
- Understand our data quality

What we've learned



There is a **heavy** reliance on paper...

Process

 $\diamond \leftarrow \circ$

↓ Ŏ→□

...with co-existence of paper and digital across the departments...

and a lack of system interoperability...

place

Engagement

>1()()

staff members interviewed and engaged

Key Activities

- ✓ 1.1 interviews
- ✓ Validation workshops

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Paper Documents

paper documents reviewed across the pathways

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...which means information not accessible in one However, there is a high appetite for change

Team members

Collaboration between Channel 3 പ്പും and SFH staff



Digital Systems

Digital systems used across the department



Insightful foundation for success

Critical Care

♦←○

Ŏ→□

Process

- Over 30 documents used monitor patients
- Predominately paper-based processes with 3 paper folders filled per patient. This reliance on paper leads to increases risk to patient safety, and notes being lost and illegible.
- Delays in retrieval of paper case notes often result in patients receiving care outside of their agreed care plan
- Data points from medical machines are manually transcribed onto A1 observation chart
- Manual transcription from digital systems onto paper to centralise information

Move to ePMA

Review paper docs purpose, utilisation, and duplication

ENT Outpatients

Clinic outcomes depend on paper reconciliation slips, leading to potential errors and missing outcomes

Gathering key data for national reports and audits is time consuming, and incomplete or inaccurate slips compromise the quality of data used for reporting. *If patient notes or key documents* are missing, appointments can be cancelled as not enough detail in the clinic letter

Referrals and letters held digitally are printed and added to the patient notes to centralise information

> **Review and optimise** current paper processes

Review options for digitalising the reconciliation slip

Gastro **Outpatients**

- Patient information is not in one place, within clinic clinicians having to use multiple systems and paper notes.
- There is no platform or method to communicate across the outpatient pathway, preventing collaboration and impeding on patient continuity of care.
- Referrals and letters held digitally are printed and added to the patient notes to centralise information
- Systems used do not integrate leading to duplication of data entry

Review and optimise current paper processes





ED Majors

- Digital systems do not integrate, which can lead to duplicated and siloed information.
- 9 different referral forms competed within majors and logged differently
- Information is not in one place with staff having to flick between systems and paper to get the latest information
- No established handover SOP across staff groups due to the mixed economy of paper and digital which can impact patient care

Review and optimise their current paper processes

Patient status dashboard



We have identified 3 priority areas with significant benefits realisation potential

Outpatients productivity

- £25k in paper cost savings
- £250-500k efficiency savings
- £500k-£1m staffing savings
- Adverse event reduction
- Improved patient experience
- Enable behavioural change to support EPR workflows

Transformation opportunities **£1.5m-£3m**

Speech recognition

- Options appraisal work to determine best option and potential value.
- Expected savings in non-clinical staffing costs and reduction in staff inefficiency.





Paperless radiology and pathology

£25-50k in paper cost savings
£250-500k efficiency savings
£50k staffing savings
Adverse event reduction
Improved diagnosis waiting times
Improved patient experience
Enable behavioural change to support EPR workflows

Technology

Our enabling foundations

Clinical Risk Management

Applications have robust hazard logs, safety cases and can demonstrate DCB0129 and 0160 compliance; all overseen by local clinical safety specialists.

ID and Access Management

Applications are accessed easily, without compromising safety and role-based proportionality. Authentication and authorisation processes meet best practice standards

Al and Innovation

The Trust's approach to, and appetite for, AI and novel innovation is calibrated with its capacity for change, uncertainty and risk.

Security

Applications (and data in them) have a range of protections in place to maximise safety from, and resilience to, attack, loss, breach and misuse.

SFH Apps Supporting Functions

echnically Safe

9999

8981





Device Compatibility

Application functionality is continually calibrated with our devices' capacity to support them. Hardware changes are pre-emptively planned to ensure optimal use of paid software functionality.

Business Intelligence

Data from applications is shared to business intelligence teams as coherently, efficiently and trustworthily as possible, with data quality issues quickly resolved.

Information Governance

Robust documentation and governance processes are in place to ensure data is used and moved in accordance with relevant laws and policy.

Application Connectivity

Staff can trust applications to connect to other data sources when and where they need to, in order to deliver the right care to patients at the right time.



Our scope

Cross-cutting systems

Room Manager Intouch	OP mgmt KTC whiteboard (Orion Health)	Clinical docs Paper	Dictation Nuance Dragon	eOBS Nervecentre	EPMA Nervecentre
IPC ICNet	Acute Order Comms ICE (Clinisys)	PAS Careflow (System C)	Pathway Support Orion Health	Patient lists NHIS/Intranet	Patient letters Prism (Synertec)
Point of Care Testing Cobas (Roche)	Virtual wards Nervecentre	User Monitoring Fairwarning (Imprivata)	BI Data Warehouse Azure(MS)	Reporting PowerBI (MS)	Coding Medicode (3M)

Departmental systems









Our existing integrations

Technology









People







Transitioning from paper to digital

People



records

capacity





117 missing files Jan-March, equating to over **45 hours** of time searching for lost

> **Delivering the** notes

> > -Ø

Over 2500 files are pulled every day across Newark and Kings Mill and delivered across over the 800 locations

4 transport runs are completed a day between sites to deliver and collect case notes

Over 13,000 pieces of paper have been found loose across SFH risking missing information in the case notes *this is a conservative estimate

There has been an **increase** in loose paper filing over the past 3 years equating to 3 filing cabinets worth of loose paper

of notes

Poor working environment for Medial Records team



The digital revolution is in our hands...



Digital asset optimisation

Delivering value through digital





Future

Ambitious

New models of care New technologies

Transformation enabled by digital Outstanding Care, Compassionate People, Healthier Communities

Thank you



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UK'S SECOND EPR SUMMIT

Sam Neville

Chief Nursing Information Officer (CNIO) and Clinical Safety Officer (CSO) - MSEFT and NH England Eastern Region Mid and South Essex NHS Foundation Trust







Making It Happen – Clinically Led Implementation & Change Management Nova | EPR

Sam Neville, Chief Nursing Information Officer (CNIO) and Clinical Safety Officer (CSO)







Mid & South Essex Health & Care Partnership - who we are

The Mid and South Essex Health and Care Partnership serves a population of 12 million people, living across Braintree, Maldon, Chelmsford, Castle Point, Rochford, Southend, Thurrock, Basildon and Brentwood.

Our Partnership comprises the following partners:

Over 150 GP practices, operating from over 200 sites, forming 28 Primary Core Networks.



6

hree main community and mental health service providers



Basildon & Brentwood

276k Population

6 Primary Care Networks

- 5 Basildon
- 1-Brentwood



Thurrock 176k Population 4 Primary Care Networks Tilbury & Chodwell Grays Purfleet Corringham

Ive clinicol ommissioning

- 2 Costle Point
- 2 Rochford
- 5 Southend

Our 5 Year Strategy & Delivery Plan



Mid Essex 390k population

9 Primary Care Networks:

- 3 Chelmsford
- 2 Brointree
- 2 Moldon/ Chelmsford
- 1 Maldon/Braintree
- 1 Braintree/Cheimsford

One hospital group with main sites in Southend, Basildon and Chelmsford



and 7 district and borough council

Healthwatch. organisations

voluntary and

community

sector

associations

South East Essex 370k Population

9 Primary Care Networks:

Nova

The Nova Electronic Patient Record (EPR) programme is a ground-breaking digital transformation programme that is a **first in type** in the UK.

Essex Partnership University NHS Foundation Trust (EPUT) and Mid and South Essex NHS Foundation Trust (MSEFT) are united in an ambitious partnership programme driving substantial improvements in quality, safety, and patient-centred care.

Our Trusts will redefine the way we use technology to shape better patient **outcomes** by embedding a unified Electronic Patient Record programme.

This will be the biggest transformation programme the Trusts will experience.







The scale of the ask



2 Trusts



5 Integrated Care Systems

22,620 Staff

8 6-8

0 0 0 0

~3 Million Population Patients & Residents

2,948 Beds

~140 GPs in MSE

84 Main Sites (200 total sites)









Collaborative partnership

- **Transformation programme not an IT Project** ullet
- Do 'once for both' •
- Recruit internally first, develop and grow our people lacksquare
- **Clinically led** ullet
- Safety throughout ullet
- Partnership agreement 'pre nup' in 3 phases ullet







Learn from those gone before

Over 200 lessons learned recorded,

Lessons learned condensed, themed and aligned across the programme and shared with programme leaders

- Executive ownership
- **Clinical engagement**
- Training
- Testing
- FADA (HIVE Manchester)
- Post go live sustainability (PAH Harlow)
- Research & Development \bullet





Continuous Learning & Build support

- We are leading EoE EPR sync collaborative
 - Share learning
- NHSE EoE support on issues eg 3rd party suppliers • Keep money in the NHS family
 - Invite more Trusts to join



Our commitment

Our programme will be a transformational programme not an IT project.

It is clinically and operationally led,

digitally enabled.

We will describe the change as a journey to our people. We will design the change around our people and their purpose.

We will support teams to:

- Let go of the past ways of working
- Work hard in the present
- Look to the future









Clinically Led | Better for Patients

EPR - Sophie's Story - CRISIS



NHS

Mid and South Essex Essex Partnership University

NHS

Described benefits for patients and staff







Change & Engagement Curve





Based and adapted from Kubler Ross

Stakeholder Matrix Programme Initiation



Clinical Leadership at every stage

Our Programme will have the clinical voice throughout

Digital Clinical leadership in a collaborative loop from day 1. Our 4 workstreams have a CCIO or CNIO dedicated to the work to deliver the vision, the outcomes expected. Above all to ensure the programme is safe





VOIC

JAKE II

HEARD

Knowing our clinical stakeholders

- Understand **people and purpose**. Working with our clinical stakeholders teams to share the vision, map 'As Is ' process help them lead the way for their service



Train for the change – Develop MDTs of EPUT & MSEFT

clinicians and ops. Key to provide SME commentary on service, sign off workflows and SOPs for their services. Help to train their team for the change. MDTs of Clinicians who will act as change agents. Trustworthy authority style



Stakeholder Matrix DIGITAL WILL Our key Stakeholders & Networks, to activate & engage FNABLE US TO MOVE FORWARD ...



EPR Strategic Groups Triangle

Nova | From As Is To Future State





Nova | Progress in engaging with our staff





Summary of NE Specialist Community Treatment Team (Colchester

& Tendring)

ve Colchester Specialist Mental Health Team (CSMHT) and the Tendring Specialist Mental Health eam (TSMHT) provide assessment and treatment for individuals who are registered locally with a iP and experiencing a Serious Mental Illness (SMI). Each team covers each borough within the iortheast Essex region, Colchester and Tendring.

Each team has a Multi-Disciplinary Team comprising of Mental Health Nurses, Occupational Therapists, Social Workers, Psychiatrists and Support Workers. All the staff work collaboratively with service users to define needs and goals, working with service user's own strengths.

Additional Information



EPUT | Commenced May 2024

Milestone	No. completed	% complete
Service contacted	218	100%
As-Is mapping meeting booked	42	19%
As-Is mapping meeting completed	156	72%
Pending QA review	49	22%
As-Is map QA approved	10	5%
Rapid Design Group (RDG) set up	0	0%









Nova | Progress in engaging with our staff

We have engaged lead clinicians in our programme

We have created a digital champions network and have recruited over 150 people in EPUT and 1200 in MSEFT

Our EPR founders community has 400 members



Our Digital Champions play a critical role to improve patient care and better work practices for our staff.







Become an EPUT Digital Champion

You don't have to be an IT whizz, but have an interest and passion in enhancing patient and staff experience through digital technology.

Scan the QR code to register or email epunft.digitalchampions@nhs.net

Nova | Building a Digital Academy

- The Nova Academy offers access to an innovative and inclusive programme of learning to equip staff with the essential skills for navigating change and driving digital transformation.
- We will empower individuals to upskill, reskill, and connect with likeminded peers, supporting a culture of adaptability and growth.
- Designed on the core values of the Nova EPR Programme, it will foster a collaborative and supportive environment that will transform healthcare delivery, promoting safety, efficiency, and holistic patient care.
- It is based on 7 core modules which will be delivered in a blended approach of eLearning and face to face.



















UK'S SECOND EPR SUMMIT

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UK'S SECOND EPR SUMMIT

PROACT

Darius Virabi Head of Healthcare - Proact IT

Gary McAllister Healthcare CITO & Former NHS CIO & CTO









Delivering better patient experiences...

An EPR journey together

Wednesday 12 February 2025

www.proact.co.uk/healthcare

in D F Y



Speakers



Darius Virabi Head of Healthcare Proact IT UK



Gary McAllister

Healthcare CITO Dell Technologies

In partnership with

Delivering better patient experiences...

Understanding the EPR journey

Key considerations to choose the right digital platform

Hearing from BWCT on key lessons learned

Sharing critical success factors of a successful EPR programme

Agreeing future EPR programme priorities

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PROACT

Gary McAllister Healthcare Chief Technology Officer @ Dell Technologies Former NHS CIO & CTO

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What makes an EPR Architecture?

Clinical and Operational Modules

Integration Services

Core Infrastructure



Clinical and Operational Modules



Clinical Docs

Emergency

Specialist Modules

Integration Services



Integrated Engine

Data and Analytics

Diagnostics (Labs, Rad etc.)

Specialist Modules

Theatres



Observations & Prescribing







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Technologies

PROACT



Types of EPR

- Best of Breed Different Modules delivering a total outcome •
- Hybrid Core modules delivered by a single vendor with peripherals ulletprovided elsewhere
- Big EHR A single system that tries to do everything. ullet

Lessons Learned

- Best of Breed Can be difficult to manage and clinically unsafe •
- Hybrid Is safer for managing the core journey but still required integration ullet
- Big EHR Safer but depending on vendor can provide a legacy experience. ullet

Will never cover everything – and the way we are delivering healthcare is changing

Infrastructure findings

- Best of Breed Lots of different systems, enhanced infrastructure need. •
- Hybrid Consolidated infrastructure, but will still require best of breed ulletservices, just at a lower scale.
- Big EHR Check DR requirements and ensure that these are robust. ullet

A 50% cost saving for hosting EPIC on managed, 3rd party infrastructure

- It is often better to have managed environments than try and 'do it ulletyourself'. Modern EHRs require enhanced certification (ODB, Specialist patching etc.).
- As IT systems grow and evolve the complexity of skills needed to manage \bullet these platforms will be out of reach of NHS budgets without leveraging economies of scale.

The Future

As we move towards a wellness health system we will begin to see;

- Monitors and trackers in the home. ullet
- Care traffic control services monitoring the health of individuals. ullet
- Genomics screening and real-time disease diagnosis. ullet
- Enhanced stem-cell treatments and cures. ullet
- Personalised medicine and treatments. ullet

This will transform the current health system, centring on the patient:

"A future health system will be a patient managed system, enabled and delivered with digital technology"

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Technologies

PROACT

Darius Virabi Head of Healthcare @ Proact IT UK





Delivering better patient experiences...







Strategic Partnership

5-Case **Business Case** c. 25% Saving

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Enable Innovation



Secure by Default





Fully Managed 24/7/365



Optimal Sustainability

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A message from Prof. Daniel Ray (Chief Technology Officer @ Birmingham Women's and Children's NHS Foundation Trust)







Prof. Daniel Ray (CTO @ Birmingham Women's and

Children's NHS Foundation Trust)

NHS **Birmingham Women's** and Children's idation Trust



Top 5 Tips for other Trusts

Clear Vision

Get 'buy in' from the organisation to deliver change Resourcing

Where do the people come from? Culture

Overt, not covert... support with transparency **Clinically Led, Operationally Driven**

Not an IT project

Leadership

Whole organisation, wide and deep

Delivering EPR Transformation...





Cyber Protection



24x7 Management & Support

D&LLTechnologies PROACT

Operational Resilience

Key takeaways from us...

- **1.** Early partnerships 'outside view' | experience | capability | capacity
- 2. Early readiness people | engagement | resourcing | data | technology
- 'Right' leadership style gardener not chess master 'start with why?'
- Tackle complexity through transparency & by building a change network
- Genuinely learn engage & collaborate with other Trusts & FDSO
- **6. Focus your team on the 'uniques' -** where does your team add most value?

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Technologies
 PROACT
How I can help you next...

Stop by 'Proact Corner'

Contact for Slides & Top EPR Tips





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Email for Future Queries



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Tracy McClelland Chief Clinical Information Officer - Dedalus







Dedalus Orbis Regional EPR Used Case



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Corina Hulkes

Chief Nursing, Midwifery & AHP Information Officer - London North West University Healthcare NHS Trust







Realising Benefits

February 2025

Corrina Hulkes, Chief Nursing, Midwifery & AHP Information Officer (CNIO)

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What can Digital do for you?

- At what point are benefits identified OBC? FBC?
- Who is involved in agreeing benefits? Who owns them?
- Cash releasing to fund the EPR? How easy is it to articulate these, some easier than others
- Is there a realistic timeline for achievement? How are you going to track them?
- Generic benefits often included e.g. reductions in patient mortality, reduced LOS, reduced medication errors, reduced spend on paper documents, reduction of pathology tests, improved workflows for clinicians.....



Cash Releasing, Non-Cash Releasing, or Non-Financial and Societal?



Benefits management approach



- Measuring change
- Benefits plan
- Benefits process:
 - Benefits identification
 - Benefits mapping
 - Statement of planned benefits
 - Benefits categories
 - Benefits criteria
 - Benefits tracking
- Benefits governance including roles & responsibilities



Key takeaways

- The EPR should be continuously improved throughout its lifecycle.
- EPR optimisation is not just about configuration, you need to pay attention to human dimensions of change.
- The benefits set out in an EPR should be realistic, measurable and aligned with available resources.
- It can take 5-10 years for benefits to be realised from your EPR.
- Some benefits are unintended or cannot be known from the outset.

Making the most of your electronic patient record system. NHS Providers, Public digital, Health Education England. January 2023. **BE REALISTIC** EPR business cases tend to contain unrealistic expectations.

As a board it is important to be realistic about the benefits you expect to see in a business case. But it will also require board leaders to understand that transformation benefits can take a long time to fully realise – in some instance five to ten years.

Non-Financial and Societal benefits

Case study

Digital and data as an enabler to service transformation

The biggest benefits [from a shared instance across four trusts] are going to be the fact that the EPR is integrated both within our organisation and across the sector, so the data will flow across the modules which is very different to what we currently have, which is many IT systems with information not flowing. The benefits to staff are that they'll only need to enter data once and the information will be clearly visible, whichever part of the system you're in. Corrina Hulkes, CHIEF NURSING INFORMATION OFFICER, LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST

A big improvement from a converged EPR is that staff only enter information once and it is visible in all parts of the system. Key to transformation was engaging with clinical leaders, focusing on ensuring benefits are meaningful for them. As well as using data to inform improvement and service transformation, using improvement methods such as plan, do, study, act (PDSA) cycles to implement changes.

Baseline measurement

Gathering information – what is already available?

- Reporting re LOS, Sepsis
- Spend on paper documentation
- Spend on legacy systems
- Datix re medication errors
- Improving clinician workflows/releasing time to care?

What does the literature say with regards to improving clinical staff workflows?

- Much research has been generated in the States and focusses mostly on medical workflows.
- The studies present conflicting evidence re saving time and improvement of workflows.
- Much of the evidence assessing the impact of EPR adoption has been limited by the methodologies applied to discrete isolated activities.
- Nursing is the largest health workforce, and we need to evaluate the impact of EPR implementations, and the perceived saving of time on documentation – Releasing Time to Care?

Time & Motion Proposal & Methodology

- The aim of the proposed study was to objectively measure nursing care delivery before and following the introduction of a fully integrated big bang Go-Live across 3 hospital sites in August 2023.
- The validated Work Observation Method by Activity Timing (WOMBAT) was to be applied to undertake a direct observational time and motion study of nurses' work immediately prior to and following the introduction of a full clinical EPR.
- Frequency and time spent on pre-determined tasks were recorded and included direct care, indirect care, documentation, medication-related tasks, communication (professional) and other tasks. Task interruptions and multitasking were also recorded.
- Descriptive statistics were used to summarise observations for the proportion of time for each task domain, average time to complete tasks and the number of tasks undertaken per hour from the WOMBAT work task classification.
- The survey content was built out utilising MS Teams forms to gather observational data in real time, collected by experienced clinical nurses who had no affiliation with the areas observed.

WOMBAT Task classification options

Task	Task location	Collaboration	Task conducted
Professional communication	Bedside	Patient	Face to face
Direct care	On ward, patient bedside,	Patient	Face to face
	Treatment room		
Documentation	Nurse's station	Nursing alone	Permanent record
	Bedside		
In transit	Off ward	Nursing alone	Face to face, paper documentation
Indirect care	On ward	Nurse to nurse/patient/relative/other professional/external care giver	Face to face, telephone, paper documentation
Medication	On ward, drug room, patient bedside	Patient, another nurse, doctor, pharmacist	Face to face, paper documentation/permanent record, telephone
MDT care	On ward, ward rounds, board rounds, MDT meeting	Nurses, Therapists, doctors, social workers, discharge planning team, community partners	Face to face, paper documentation, telephone, referrals sent
Waiting on response	On ward	Nurses, Therapists, doctors, social workers, discharge planning team, community partners	Face to face, paper documentation, telephone, bleep
Ward related other	On ward - Quality audits, daily checklists, daily safety checks, safer staffing audits, ward stickups, printing of paper documentation	Nursing alone	Audits, paper documentation, inputting into digital tools

Data Collection

- Data was collected by an observer in two-hour slots, Mon Fri, between the hours of 08.00 – 18.00.
- Data was collected using the MS Form that had been loaded onto designated iPads.
- Each site was covered by a different week due to the availability of auditors.
- To ensure consistency with the data review, on each site, two adult medical wards were chosen.

Initial Data Analysis

4. Task Working On

•	Direct Care	91
٠	Indirect Care	44
•	Patient administration of care	30
•	Medication	66
٠	Documentation	46
٠	Professional communication	44
•	MDT Care e.g. ward round, board round MDT discussions	9
٠	In Transit	7
•	Waiting on response	4
•	Ward related other e.g. ward audits, safety checklists	6





6. Task conducted



7. Task Location





8. Task collaboration

•	Nurse independently	71
٠	Nurse to Nurse	48
•	Nurse to patient	81
•	Nurse to relative	2
•	Nurse to external care giver	2
•	Nurse to Doctor	6
•	Nurse to Pharmacist	1
•	Nurse to Therapist	3
•	Nurse to Social worker	0
•	Nurse to Discharge planning	1
•	Nurse to Community Provider	1
•	Nurse to other Professional	8



Post Go-Live Time & Motion

- The original intention was to repeat the audit 6 12 months post Go-Live.
- But with regards to successful adoption, this has taken longer than anticipated.
- Therefore, the whole audit is yet to be repeated, even though we are 18 months post Go-Live.
- However, it has been possible to identify benefits in the form of time savings for nurses, by the introduction of the integrated spot monitors.

Results Post Go-Live – Recording of patient vitals signs and admitting a patient

	Pre Go-Live	Post Go-Live
Indirect Care;	00:44:12	
Documentation;	00:13:13	
Medication;	00:08:54	
Direct Care;	00:08:04	
Professional communication;	00:06:22	
MDT Care e.g. ward round, board round MDT dise	00:05:30	
In transit;	00:03:00	
Admission (TAU)	00:30:00	00:07:30
Full set of observation (TAU)	00:10:00	00:05:30
Full set of observation with admission (TAU)	00:40:00	00:12:00
Full set of observation with admission (Jenner)	00:20:00	00:04:05

Benefits Realisation references

- Blueprinting FutureNHS Collaboration Platform
- Planned Benefits can be misleading in Digital Transformation Projects: Insights from a case study of Human Resource Information Systems Implementation in Healthcare. Tursunbayeva et al, 2020.
- A longitudinal time and motion study quantifying how implementation of an electronic medical record influences hospital nurses' care delivery. Bingham et al, 2021. Int Journal of Medical Informatics.
- Benefits management NHS England Digital
- Making the most of your electronic patient record system





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Mr Bill Shields

CFO – Devon ICB | Interim CEO - Torbay & South Devon Healthcare Trust

Chris Monk

Deputy SRO for the Connect Programme - Sheffield Teaching Hospitals NHS Foundation Trust







Hadleigh Stollar Chief Executive Officer -Healthcare Innovation Consortium (HIC)







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