Update on CRS upgrade

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<th>Trust Board Meeting – Part 1</th>
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**Purpose of the Report:**

FOR: Information ☒ Assurance ☐ Discussion and input ☒ Decision/approval ☐

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**Risk Implications – links to Assurance Framework or Corporate Risk Register:** T.IMT009 BAF Principle Risk 4

**Link to Relevant Corporate Objective:** Links to Strategic Objective 1 Quality of Care and 5 Well Managed and Governed

**Document Previously Considered by:** Executive Management Team 16<sup>th</sup> September 2013

**Recommendation & Action required by the Trust Board:**

The Trust Board is asked to review this paper and the proposed way forward and agree whether there are any further actions required.
Update on CRS Upgrade

Executive Summary

Introduction

The Board will remember that the Trust was due to go live with an upgrade to its Care Records System (CRS) in June 2013 under the national programme for IT contract with BT. At its last meeting (July 2013), the Board was informed that BT had been unable to deliver a workable system as it could not resolve problems with the reporting aspects of the functionality. This meant that the Trust could not go live as planned. Following the delay, BT, the Department of Health (who hold the contract) and the Trust worked together to resolve the issues and re-plan the go live. Once BT resolved the problems they had experienced and were able to deliver a functioning product, a new date was set. Unfortunately, at the end of August 2013, just before the Trust was due to go live; the DH informed the Trust that it would not support the additional costs the Trust would have borne due to the delay. The Trust has taken the upgrade but has not been able to roll out the new clinical functionality. This means that BT has been paid, but the Trust is not able to deliver the anticipated benefit for patients. This paper gives an outline of the situation, looks at the risks this situation has exposed and proposes a way forward.

Key Points

1. The Trust is reviewing possible options for rolling out the new functionality in the summer of 2014. This will require the support of BT and the DH and there is not yet certainty that this will be available. Further work is underway on this and an update will be provided at a future meeting.

2. There are three main options/implications in continuing with the programme:
   - Continuing with the planned upgrade to expand clinical documentation in 2014/15, under the national contract, which would place the Trust in the same situation in the future if there was further failure and no appropriate compensation.
   - Exiting quickly from the national programme which would be more expensive but which would enable delivery of the Trust’s strategy and may be cheaper than the current situation. In order to ensure this is a possible option, the Trust has started the process for exiting out of the contract.
   - Remaining in the national programme until the contract ceases in 2015, with no further deployments, which whilst saving service management costs, would delay implementation of the Trusts IT strategy.

3. The paper outlines plans the Trust has taken to minimise losses and exploit opportunities

4. This has exposed the following risks:
   - The Trust is working under a legacy contract for its IT systems over which it has no leverage if there is a failure (including deployment or service failures). This could result in significantly increased costs.
• A further upgrade of functionality, in the form of a maintenance release is planned for February 2014. If this is delayed this could impact on income received.
• The potential for similar issues to arise with other legacy contracts.

5. **Action proposed**

The following actions are proposed. Updates on progress will be given at the November 2013 Board meeting:

• Review of options for rolling out functionality for clinical documentation and e-prescribing, dependent upon support from BT and the Department of Health.
• A full review of options to take place on continuation with the national programme
• The issue with legacy contracts (around deployment and service failures) would be added to the risk register and consideration given as to whether there are any mitigating actions that might be taken.
• Review of plans for the next upgrade of functionality due to take place in February 2014, to identify risks and mitigation in the event of delays.
• Review of other legacy contracts that could place the Trust in a similar position.

6. **Recommendation**

The Trust Board is asked to review this paper and the proposed way forward and agree whether there are any further actions required
Introduction

1. The Board will remember that the Trust was due to go live with an upgrade to its Care Records System (CRS) in June 2013 under the national programme for IT contract with BT. At its last meeting (July 2013), the Board was informed that BT had been unable to deliver a workable system as it could not resolve problems with the reporting aspects of the functionality. This meant that the Trust could not go live as planned. Following the delay, BT, the Department of Health (who hold the contract) and the Trust worked together to resolve the issues and re-plan the go live. Once BT resolved the problems they had experienced and were able to deliver a functioning product, a new date was set. Unfortunately, at the end of August 2013, just before the Trust was due to go live, the DH informed the Trust that it would not support the additional costs the Trust would have borne due to the delay. The Trust has taken the upgrade but has not been able to roll out the new clinical functionality. This means that BT has been paid, but the Trust is not able to deliver the anticipated benefit for patients. This paper gives an outline of the situation, looks at the risks this situation has exposed and proposes a way forward.

Background

2. The planned upgrade included enhancements to the functionality of the Cerner system, a new reporting warehouse (as BT are no longer supporting the current reporting solution) and most importantly for the Trust the deployment of e prescribing and clinical documentation. Both of these aspects of new functionality are a key part of the Trust strategy to move to an electronic record for its patients and to improve the safety of care provided. E prescribing enables clinical staff to prescribe and administer medications electronically rather than using a paper based system. Not only would it have enabled the Trust to build in a number of elements that improve the safe prescribing and administering of medication for patients, but it would have formed the core of an electronic record. Clinical documentation enters patient information e.g. nursing assessments, directly into the computer record on admission of patients. This improves safety of patient care and is a key plank of our strategy to create an electronic record.

3. Clearly, there are risks as new functionality is rolled out. To mitigate those risks, only a few wards can take the new functionality at a time and therefore some wards would have been using electronic systems and others paper. As patients and staff move around the Hospital, this would have created risks due to dual operating systems.

   It was considered important that the roll out was completed before winter as the risks are greater when staff are required to manage an increasing workload.

4. From our experience and that of others within the NHS, the Trust has decided the best deployment model would be that of an intensive support team. This innovative model would provide just in time training undertaken on the wards with staff in their usual working environment rather than taking them away for training in a class room.
and then expecting them to recall that training later when the new functionality is deployed on their ward. The original plan for a June deployment was to deploy two wards at a time spending two weeks with each ward, the aim being to complete before the worst of the winter pressures hit at the Christmas break. Whilst an expensive model, the Trust was prepared to invest in this to ensure the safety of patients through the process and to enable a speedy and effective deployment. The costs were minimised by ensuring full recruitment was achieved so that Trust staff could be released to create the intensive support team. This has the additional benefit of developing a group of Trust clinical staff who are very familiar with the system who then become champion users in the longer term, supporting their clinical colleagues once the system was fully deployed.

5. The Trust invested significantly in preparing for this new upgrade, including recruiting additional staff, procuring new equipment such as tablet computers and developing and testing the new functionality and processes. The Trust would have been the first in London to take this new functionality under the national programme. The Trust has invested £2.8 million this year in the programme to enable this update, including £1.2 million for the intensive support team (which now may not be spent).

6. Following the delay caused by BT’s failure to deliver a functioning system, BT, the DH and the Trust worked together to re-plan. BT worked hard to resolve the problems that caused the new system not to function. Following some intensive re-planning a proposal that would enable the trust to deploy this year was developed and BT resolved the problems causing the delay in August 2013. The revised plan required the Trust to double the number of wards going live at any one time so that deployment was still complete by Christmas. This was possible, but required a doubling of the size of the intensive support team. As the Trust was not able to release any more staff, additional staff were sourced from external contractors and training for them was due to start on 27th August 2013. As the delay was caused by BT, the Trust had been undertaking discussion with BT (Ian Dalton, previously Deputy CEO of the NHS and now president of BT global) and with the new SRO of the programme, Tim Donohue, who is the lead at the DH for the contract with BT around funding for these additional costs caused by the delay. The additional costs amounted to around £2million (including the doubling of the intensive support team using external staff and additional project costs caused by the delay). On 19th August 2013 the DH offered the Trust £200K towards these additional costs. This was confirmed by e mail from Tim Donohue on 21st August 2013 who said “Having thought about this carefully and also having spoken to Ian Dalton at BT, I can confirm that we would find it impossible to justify and to source the additional funding.” This left the Trust with no option but to cancel the deployment. In order to minimise losses, the Trust took the upgrade to the functionality (so BT have been paid) but is not able to utilise the functionality so has gained no benefit to patient care.

**Actions taken by the Trust to find an alternative to cancelling the roll out**

7. Clearly, this decision was a surprise as both BT and the DH had been involved in the re planning and had not expressed reservations about the approach being taken. As the Trust has no visibility of the details of the contract such as compensation for
delay, it has no ability to apply leverage. The Trust provided the DH with a full explanation of the additional costs and suggested areas where costs could be reduced, together with an outline of the associated risks of each possible reduction. Unfortunately, there was still a refusal from the DH to support the Trust.

8. The Trust considered actions within its own control. These included using a different deployment model; this was ruled out as unsafe. Funding the additional costs was ruled out as it would require the Trust to find an additional £1.8million saving this year or fail its financial targets with the associated action from the regulator. It also sought to influence the decision of the DH by escalating within the DH, the TDA and NHS England. Changes to the governance of the national programme means there is no longer any ownership of difficulties caused by legacy contracts within the NHS. Escalation was unsuccessful. In addition, as the Trust is now a Foundation Trust, it can no longer look to the NHS for support and is expected to manage its own affairs. The Trust had no alternative but to take the difficult decision to stop deployment of the functionality this year.

Proposals for the way forward

9. There are two issues to consider. Firstly, whether the Trust can roll out the e-prescribing and clinical documentation functionality at a future date and secondly, whether the trust should continue with further planned upgrades under the national programme.

9.1 Roll out of clinical documentation and e prescribing

The Trust is reviewing possible options for rolling out the new functionality in the summer of next year. This will require the support of BT and the DH and there is not yet certainty that this will be available. Further work is underway on this and an update will be provided at a future meeting.

9.2 Continuation of the Trusts role in the national programme

- The Trust was due to take a further upgrade to expand clinical documentation in 2014/15. If the Trust was to continue with this plan, the deployment would still be under the national contract. The Trust could therefore find itself in the same situation in future, having invested considerable sums in a deployment with no leverage over BT if they fail to deliver and no support from the NHS or DH to ensure appropriate compensation.
- The Trust could move quickly to exit from the national programme. This would enable the Trust to place and manage its own contracts to continue the implementation of its strategy for an electronic record for patients. This would be more expensive for the Trust and would waste NHS resources that are committed to the national programme. However, it would enable the Trust to control the delivery of its strategy and may be cheaper for the Trust than the current situation where the Trust commits resources with no control over whether that commitment will deliver. In order to ensure this is a possible option, the Trust has started the process for exiting out of the contract.
- The trust could remain with the national programme until the contract ceases in 2015, but not undertake further deployments. This would save the trust money in terms of
additional service management costs until 2015, but would delay the implementation of the Trusts IT strategy.

9.3 A full review of these options will be undertaken and presented to the next meeting of the Board.

**Action taken to minimise losses and exploit opportunities created by the cancellation of this deployment**

10. Notification of a refusal to provide compensation for the additional costs of BT’s delay came very late. However, the Trust has sought to pull back capital expenditure and not place contracts for the additional external staff. This has enabled the Trust to act quickly to minimise the losses caused by the cessation of deployment.

11. Sunk costs such as testing of the functionality and development of the new processes have not been wasted as the Trust has taken the new functionality enabling it to deploy this functionality at a later date – either under the national programme or under its own contract with Cerner (if it were to procure from Cerner in the future).

12. This leaves the additional clinical staff that have been recruited to support the intensive support team. It is proposed that these staff are refocused on delivering high quality care to patients over the winter period and to enable the wards to release staff from clinical care to spend time working on improvements to patient care and safety.

**Reflections and Lessons Learnt**

13. This is a useful reminder that, as a Foundation Trust, the organisation is expected to effectively manage its own affairs and cannot expect support from the NHS or the Department of Health. The difficulty is caused by the fact that the Trust is working under a legacy contract for its IT systems over which it has no leverage if there is a failure. This includes deployment failures but also service failure. If the service went down for any period of time it would cause significantly increased costs to the Trust and there are no mechanisms to secure compensation for that loss. It is proposed that this issue is added to the risk register and consideration is given to whether there are any mitigating actions that might be taken.

14. A further upgrade of functionality, in the form of a maintenance release is planned for February 2014. This maintenance release contains significant changes to the format and content of commissioning data sets (CDS). CDS contains data on activity carried out by NHS Trusts reported centrally for monitoring and payment purposes. All NHS Trusts will need to ensure that they are in a position to provide the data by 1st April 2014. With the recent supplier delays on delivery, we are reviewing our plans for this work and looking at our risks and mitigations in the event that there are any delays. If there were delays it would mean we could not submit by the deadline and therefore would receive any income for the care delivered to patients from 1st April 2014.
15. The Trust should also review whether there are any other legacy contracts that could place the Trust in a similar position.

16. The Trust could have pressed harder for greater clarity over the availability of compensation when there was an initial delay at the end of June. This might have enabled the Trust to cease activity to continue the roll out sooner and avoided the additional work that has gone in over the last few months to reach a position where the Trust could deploy. Should the Trust find itself in a similar situation in the future, more formal action will be taken sooner.

**Recommendation**

17. The Trust Board is asked to review this paper and the proposed way forward and agree whether there are any further actions required.