

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

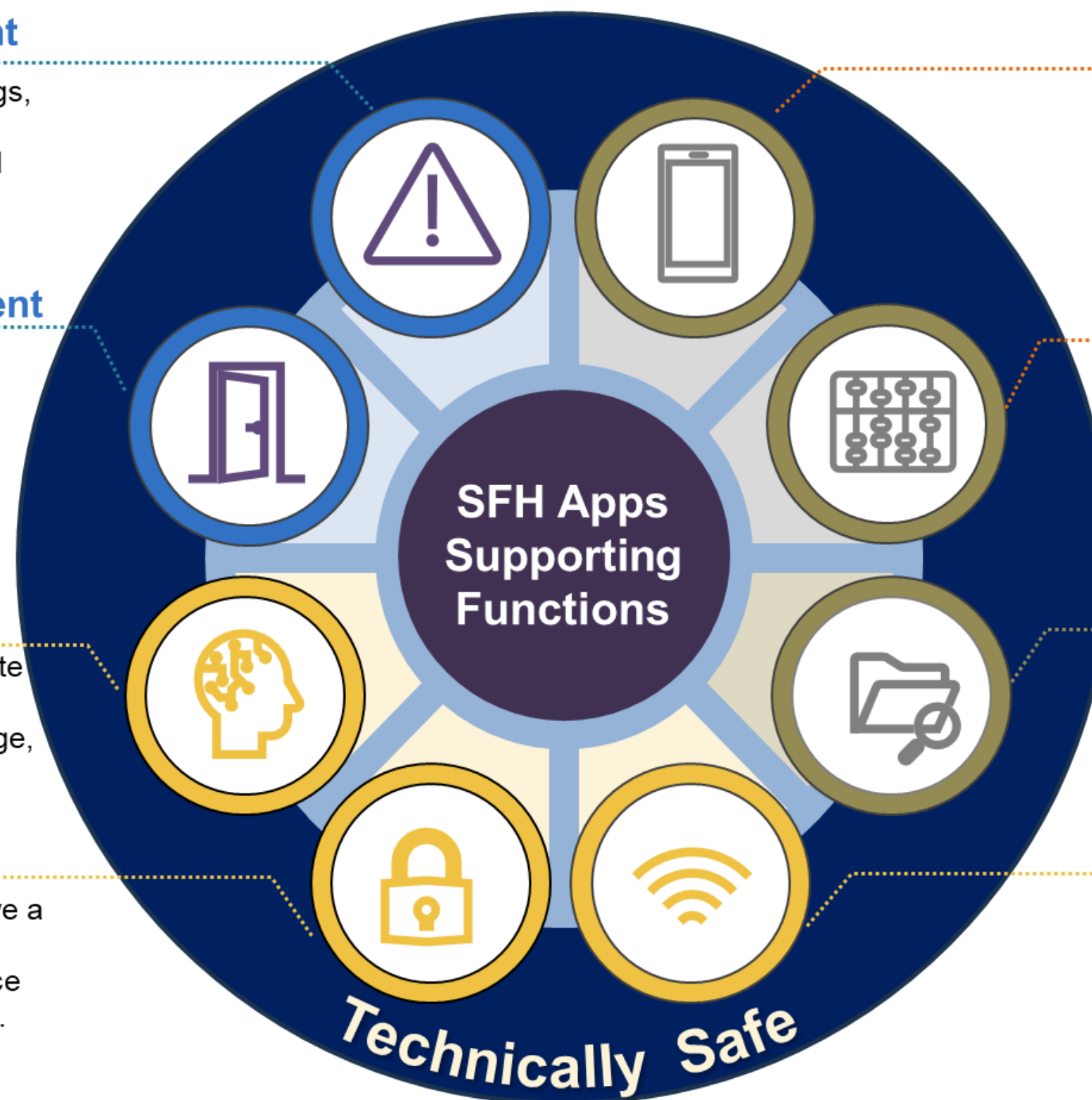
Applications are accessed easily, without compromising safety and role-based proportionality. Authentication and authorisation processes meet best practice standards

AI 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.



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

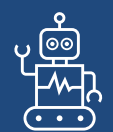
Data from applications is shared to business intelligence teams as coherently, efficiently and trustworthily as possible, with data quality issues quickly resolved.

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)

Patient systems

Portal PKB	Kiosk check-in Intouch
Virtual Consultation Attend Anywhere	Pre-op Lifebox (Definition)
Patient Comms Telephonetics	Labs booking Swiftqueue

EPR Scope category

In scope for replacement by EPR

In scope for integration with EPR

To remain live but not replaced or directly integrated

TBC

Other App caveats

Pre-EPR project to upgrade / implement / replace like-for-like

Associated risk

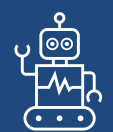
Discussion / pre-work required

Departmental systems

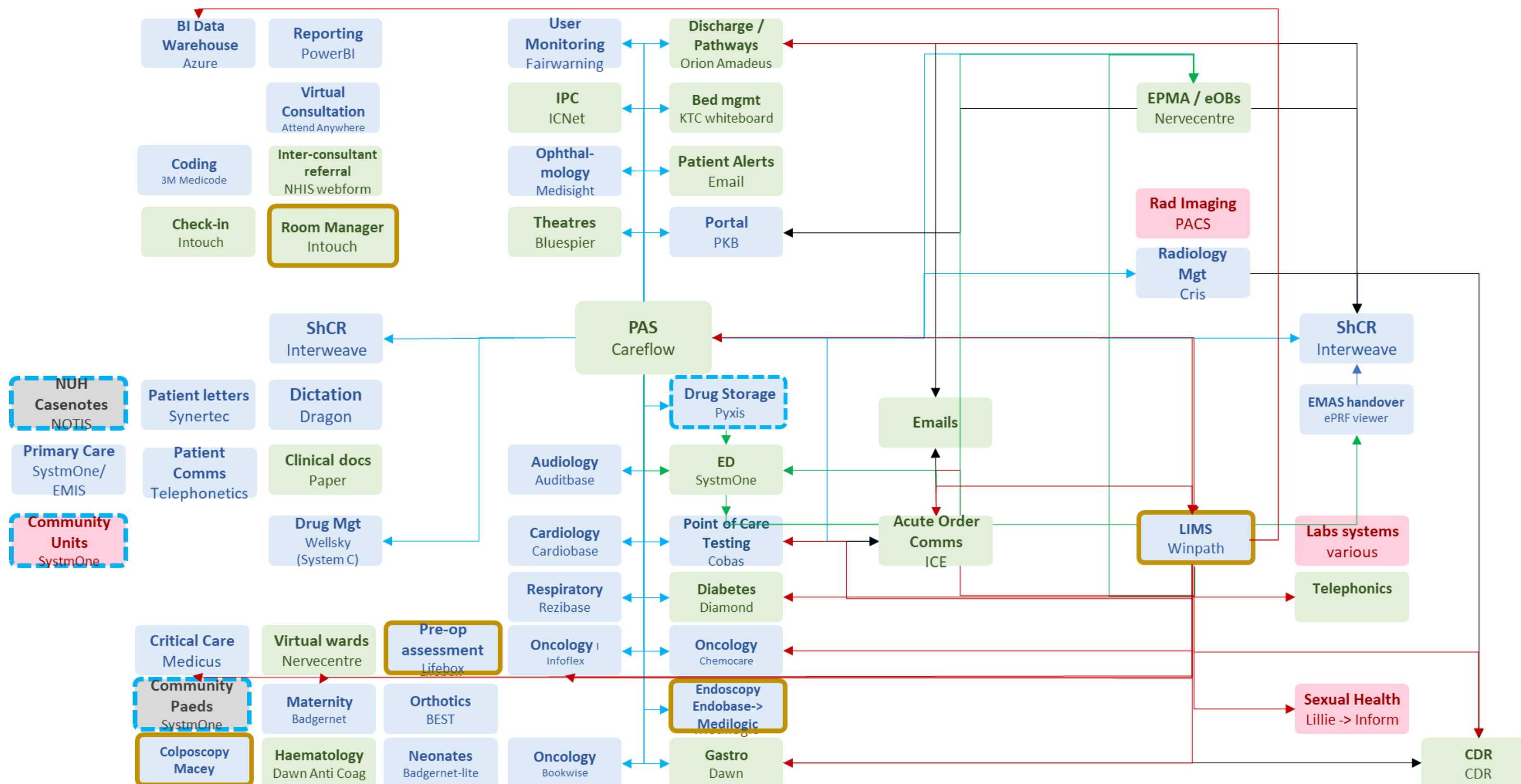
Audiology Auditbase (Auditdata)	Cardiology Cardibase	Digi Path Halo	Colposcopy Macey	Critical Care Medicus (Mela)	Community Paeds SystemOne (TPP)
Community SystemOne (TPP)	Dermatology images Orion	Diabetes Diamond (Hicom)	Cell Path Cirdan	Drug Mgt Wellsky (System C)	ED / SDEC SystemOne
Endoscopy Endobase-> Medilogik	Gastro Dawn (4S)	Haematology Dawn (4S)	LIMS Winpath Enterprise	Maternity Badgernet (Clevermed)	Neonates Badgernet (Clevermed)
Oncology Bookwise, Infoflex	Ophthalmology Medisight	Orthotics BEST	Radiology Mgt Cris (Magentus)	Respiratory Rezibase	Safeguarding SystemOne (TPP)
Theatres Bluespier (System C)					

ICS/System wide systems

Non-acute Order Comms ICE	Oncology Chemocare
NUH Casenotes NOTIS	Primary Care SystemOne/ EMIS
Rad Imaging PACS (GE)	Sexual Health Lillie -> Inform
ShCR Connecting Care (Interweave)	

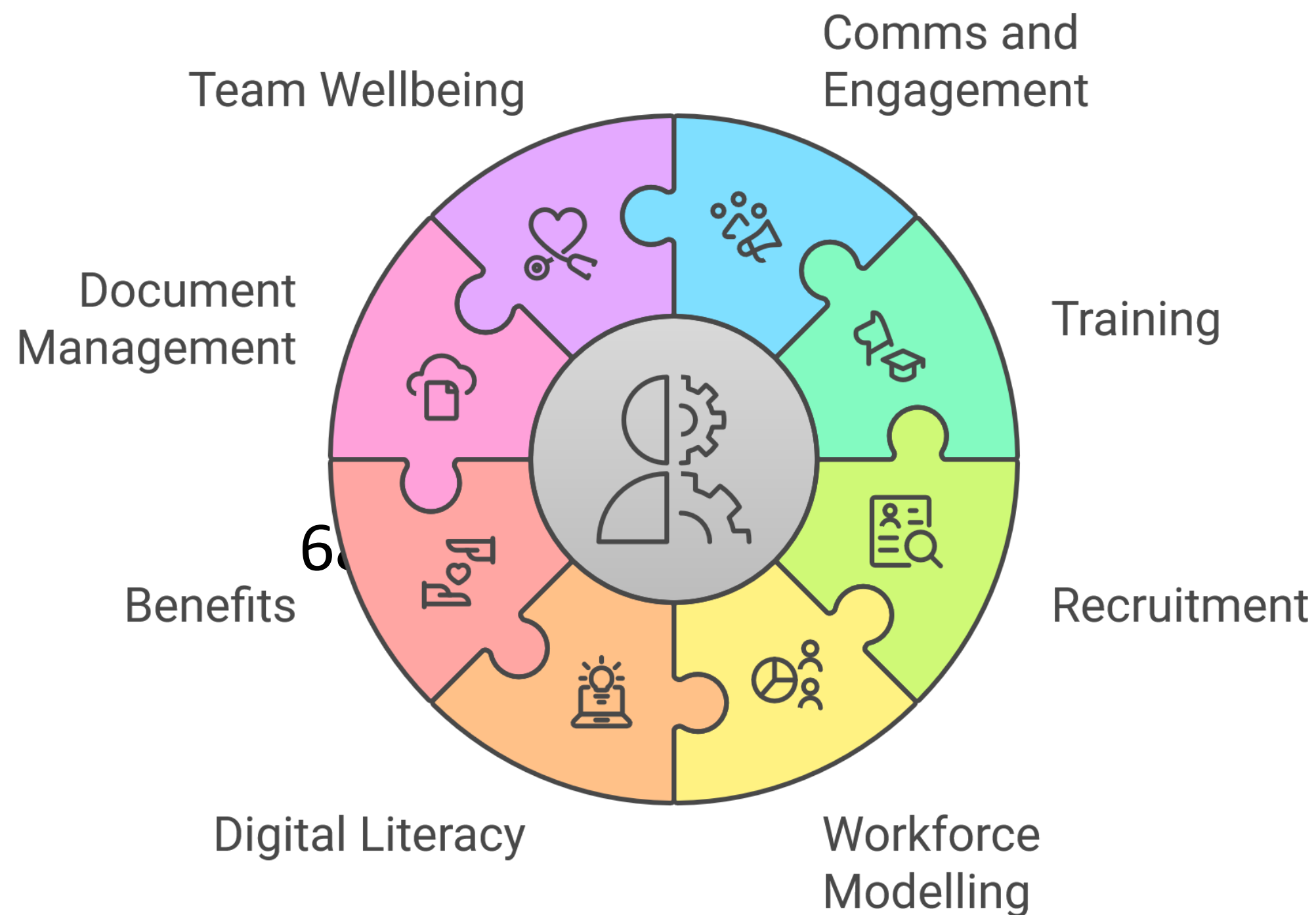


Our existing integrations



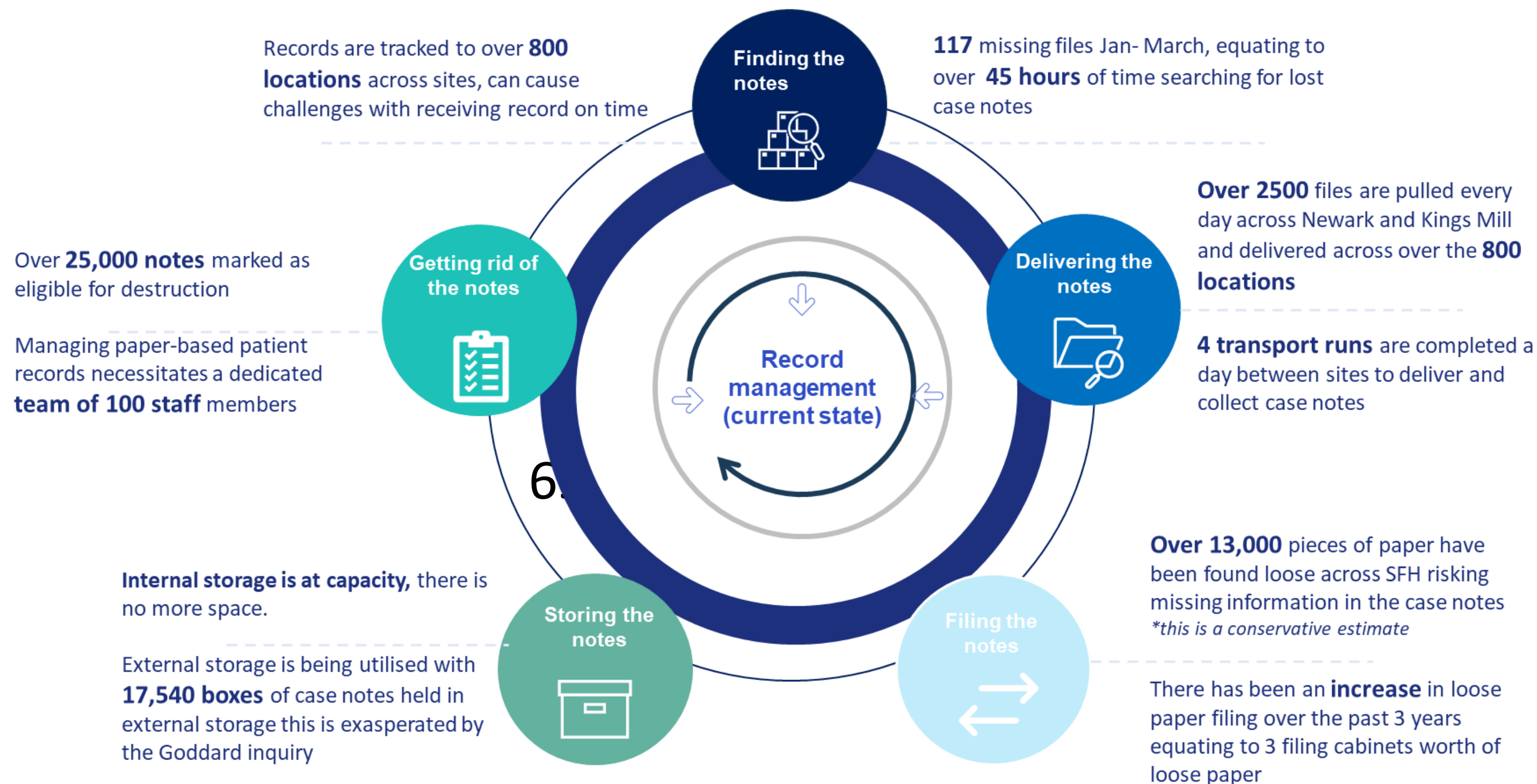


My role as Head of People





Transitioning from paper to digital



Key themes:

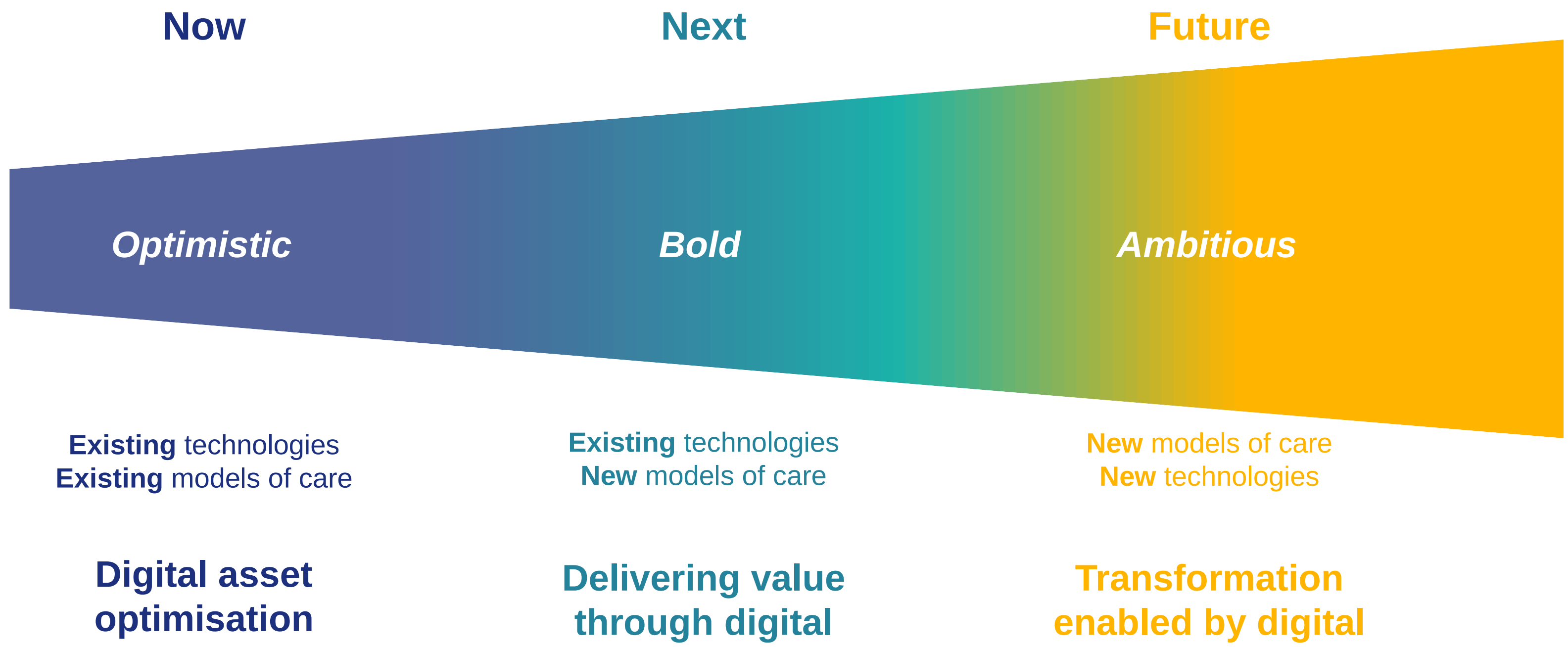
Storage is at capacity

Issues with missing records

Issues with availability of notes

Poor working environment for Medial Records team

The digital revolution is in our hands...



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

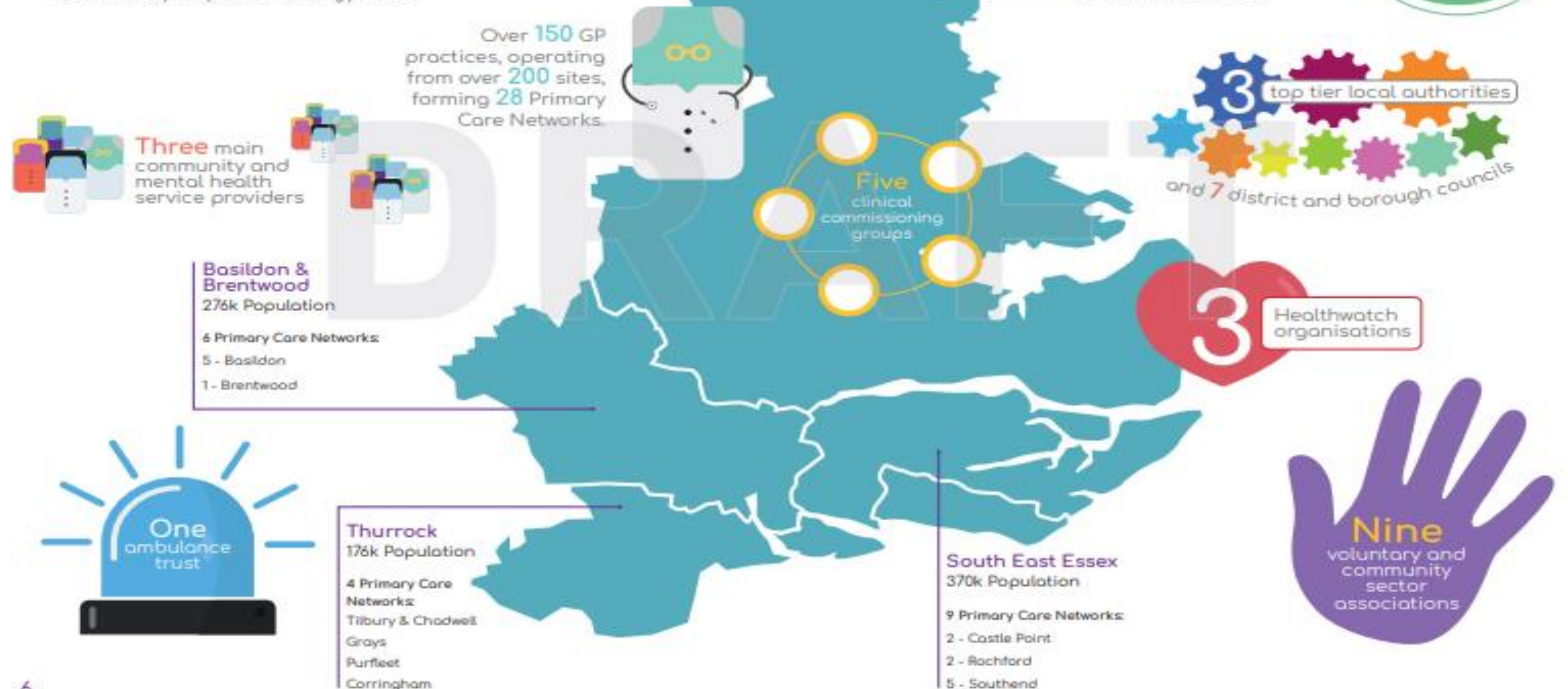
Sam Neville, Chief Nursing Information Officer (CNIO)
and Clinical Safety Officer (CSO)



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

The Mid and South Essex Health and Care Partnership serves a population of 1.2 million people, living across Braintree, Maldon, Chelmsford, Castle Point, Rochford, Southend, Thurrock, Basildon and Brentwood.

Our Partnership comprises the following partners:



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



~3 Million Population
Patients & Residents



2,948 Beds



~140 GPs in MSE



84 Main Sites
(200 total sites)

Currently 10
Electronic Patient
Record Systems
Moving to



1 Unified Electronic
Patient Record
System



Collaborative partnership

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

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

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.

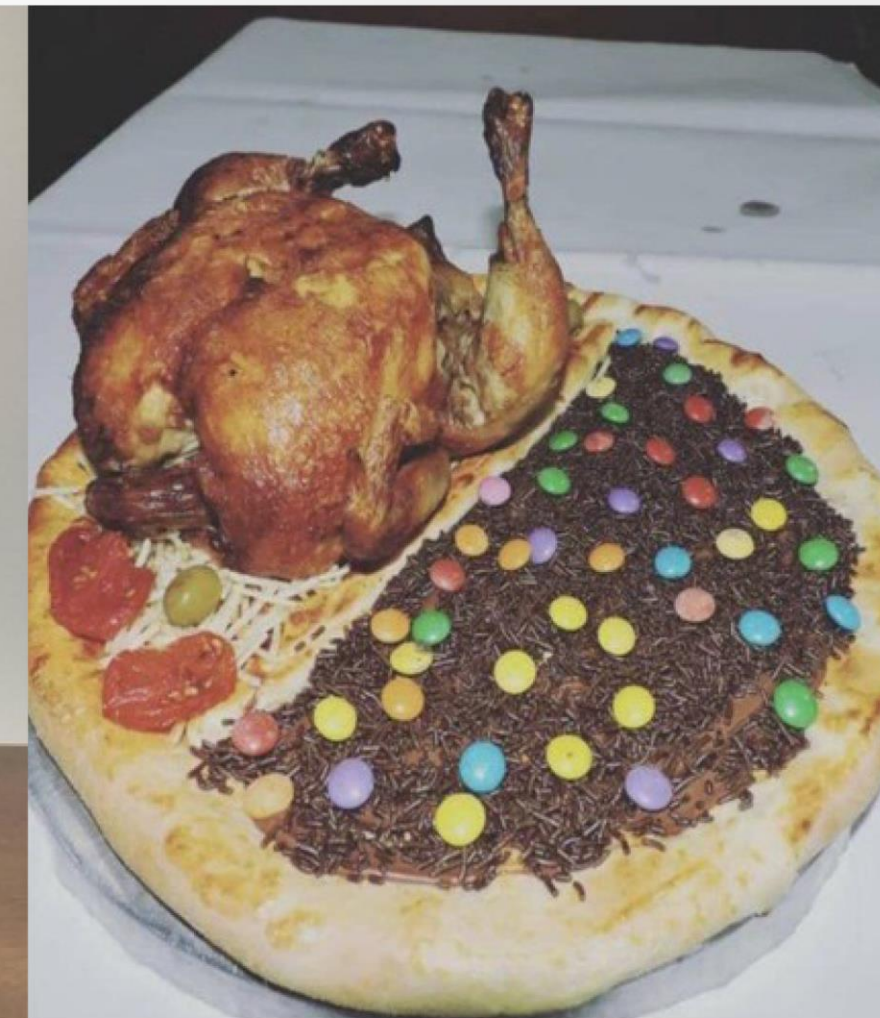
We will describe the change as a journey to our people. We will design the change around our people and their purpose.

We will support teams to:

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



Design



Clinically Led | Better for Patients

EPR – Sophie's Story - CRISIS

17-year-old female Sophie known to ED/IT with anorexia nervosa. Sophie collapsed at home and was brought in by ambulance.

EPR – Sanjay's Story - Frailty

Sanjay, an 87-year-old male known to GP with increasing frailty. His family has recently become worried about physical and nutritional status. He lives with his wife and daughter.

EPR – Sean's Story Severe Mental Illness

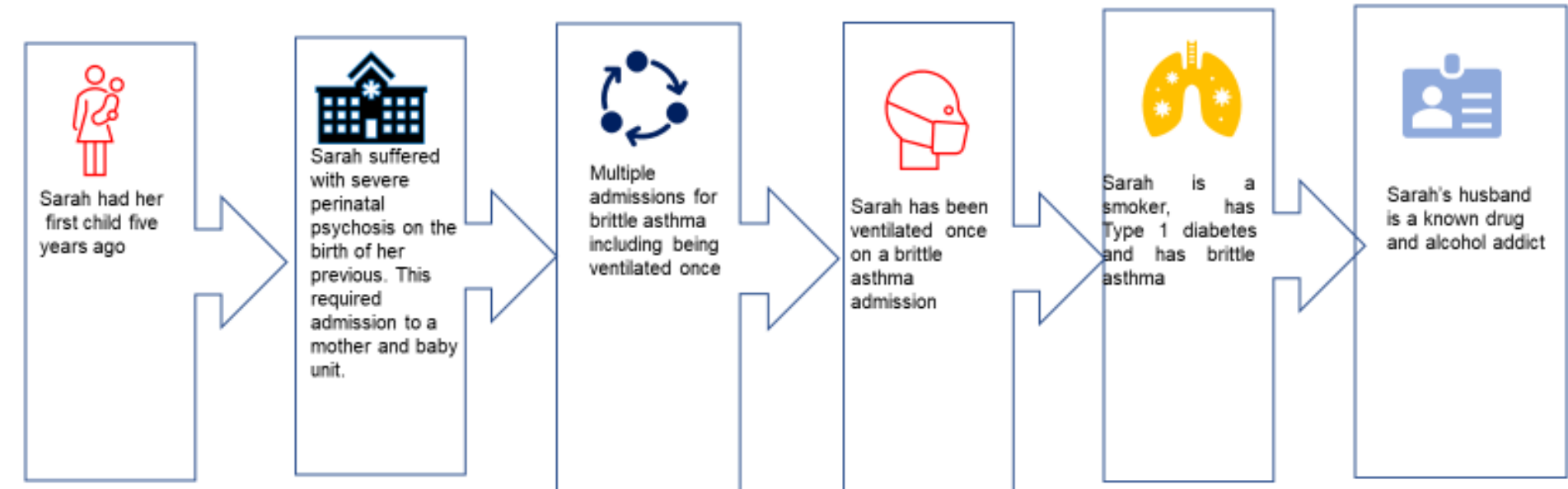
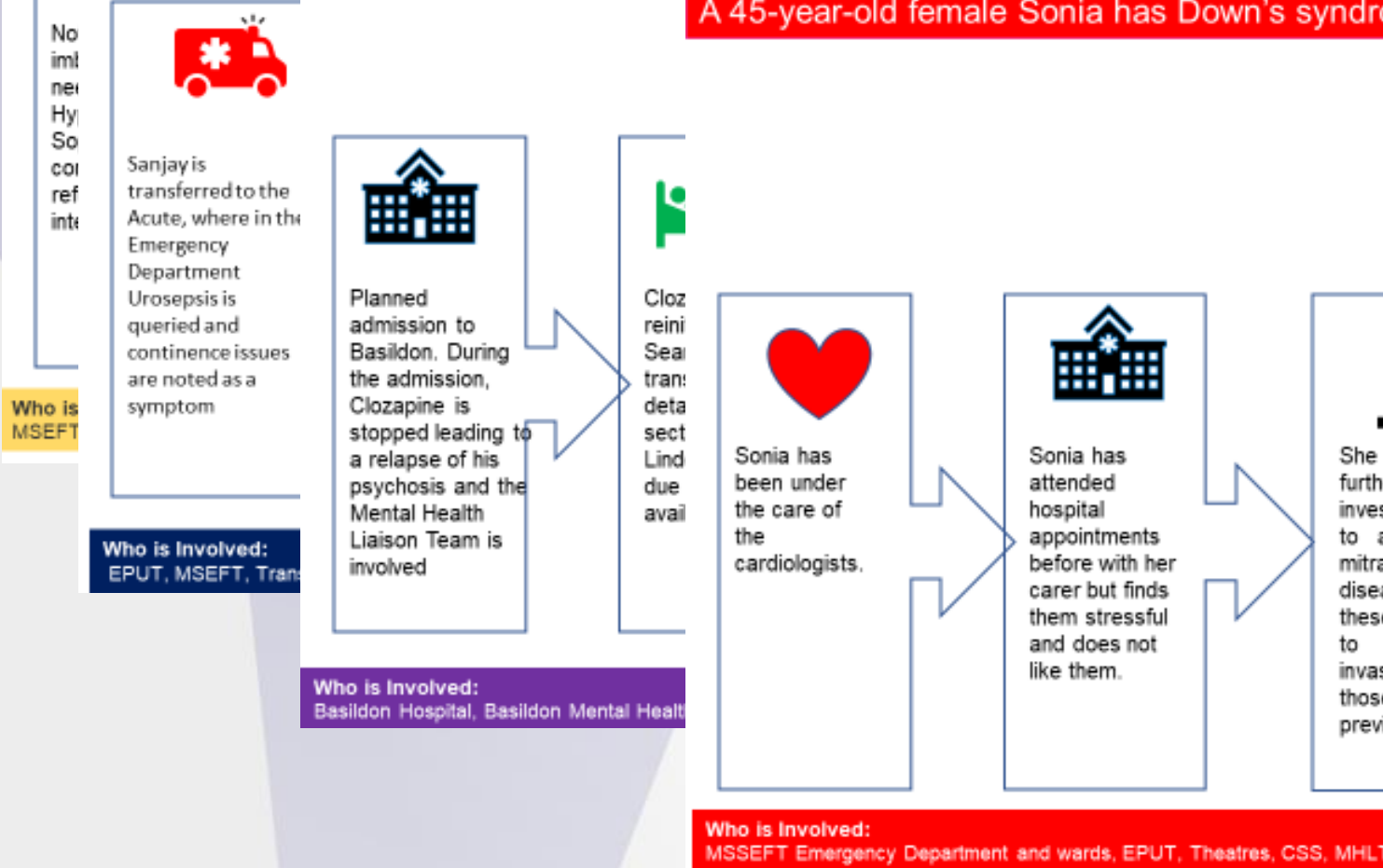
Sanjay sustains a fall at home and is brought to hospital. He has a diagnosis of Paranoid Schizophrenia, a general hospital for a planned admission to Basildon. During the admission, Clozapine is stopped leading to a relapse of his psychosis and the Mental Health Liaison Team is involved.

EPR – Sonias Story Management of Complex Conditions

A 45-year-old female Sonia has Down's syndrome. She has moderate to severe learning disabilities.

EPR – Sarah's Story Chronic Respiratory Disease

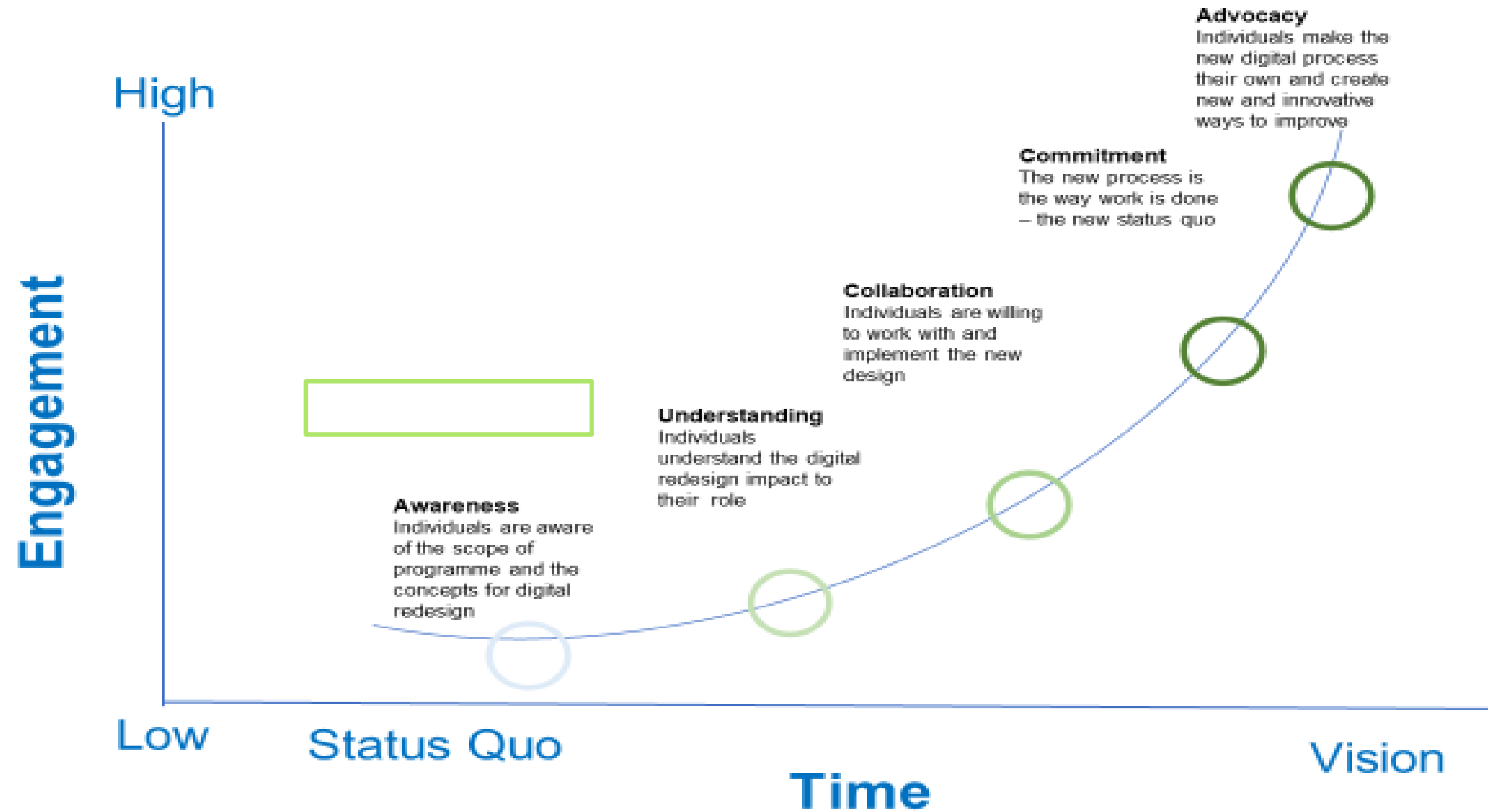
Sarah is 42 and is pregnant at 28 weeks.



Who is involved: MSEFT Emergency, Maternity, Mother and Baby Unit, EPUT, Theatres, CSS, MHLT, Community services, CPIS

- 5 patient scenarios
- Captured pain points
- Described benefits for patients and staff

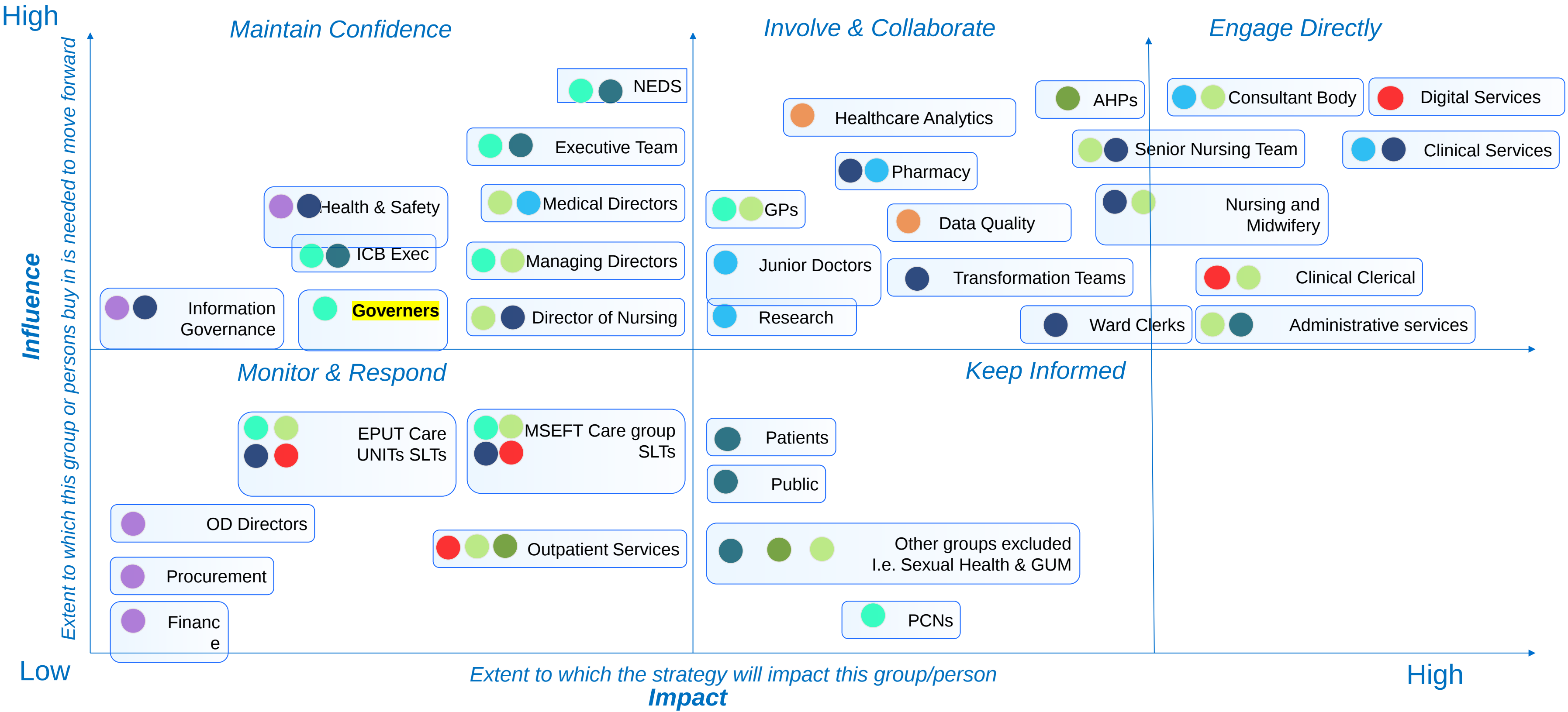
Change & Engagement Curve



Based and adapted from Kubler Ross

Stakeholder Matrix Programme Initiation

Our key Stakeholders & Networks, to activate & engage



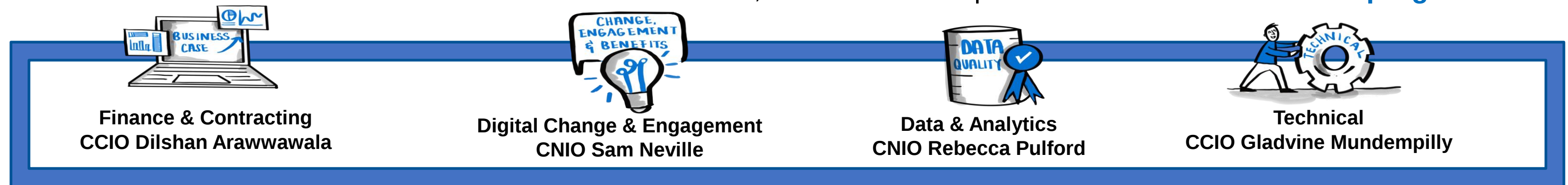
Who must be in contact with the stakeholder group?

- Prog Dir
- SROs
- CNIOs
- Lead CCIOs
- CIOs
- CCIOs all
- Change Lead
- CSO

Our Programme will have the clinical voice throughout

1

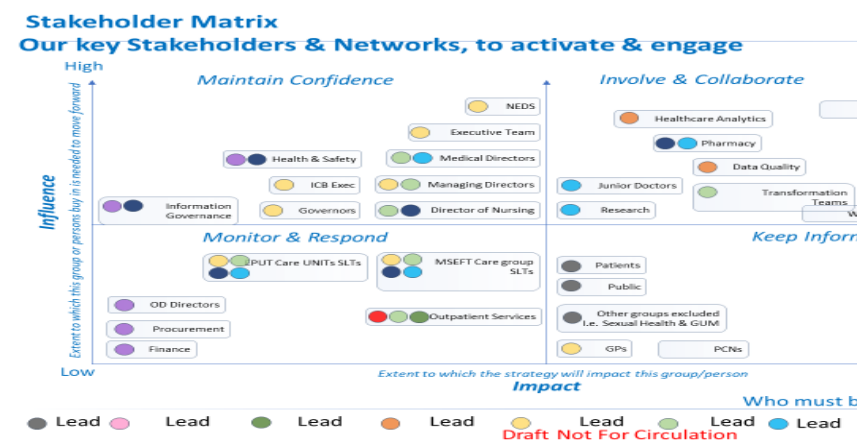
Digital Clinical leadership in a collaborative loop from day 1. Our 4 workstreams have a CCIO or CNIO dedicated to the work to deliver the vision, the outcomes expected. Above all to ensure the **programme is safe**



2

Knowing our clinical stakeholders

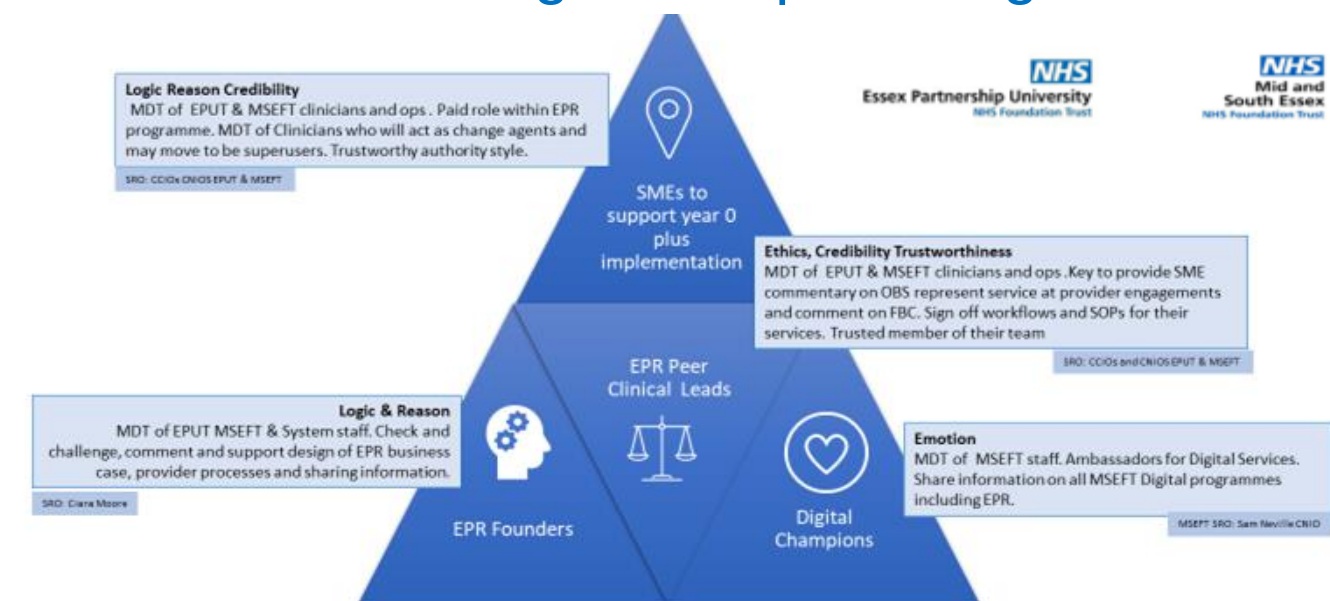
— Understand **people and purpose**. Working with our clinical stakeholders teams to share the vision, map 'As Is' process help them lead the way for their service



3

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

EPR Strategic Groups Triangle



Nova | From As Is To Future State



Mid and South Essex
NHS Foundation Trust



Essex Partnership University
NHS Foundation Trust

Analyse service needs and requirements to identify key features and functionalities

Evaluate clinician workflows to ensure safe patient care and clinician efficiency

Understand how usability and user interface design drives safety, accessibility and clinician efficiency **including system partners**

Pre Discovery

Solution design

Development

Deployment & Go Live

Post deployment

As Is Mapping

Service Event

Set up EPR Rapid
Design Group
Group

Optimise the
now

Design future
state

Sign Off future
State

Go Live

Benefits
Realisation

Each Service EPR Rapid design group will act as the change agents for their service

Lessons Learned :

'Choose a clinician who you trust to look after your family, they will make the system safe'

Nova | Progress in engaging with our staff





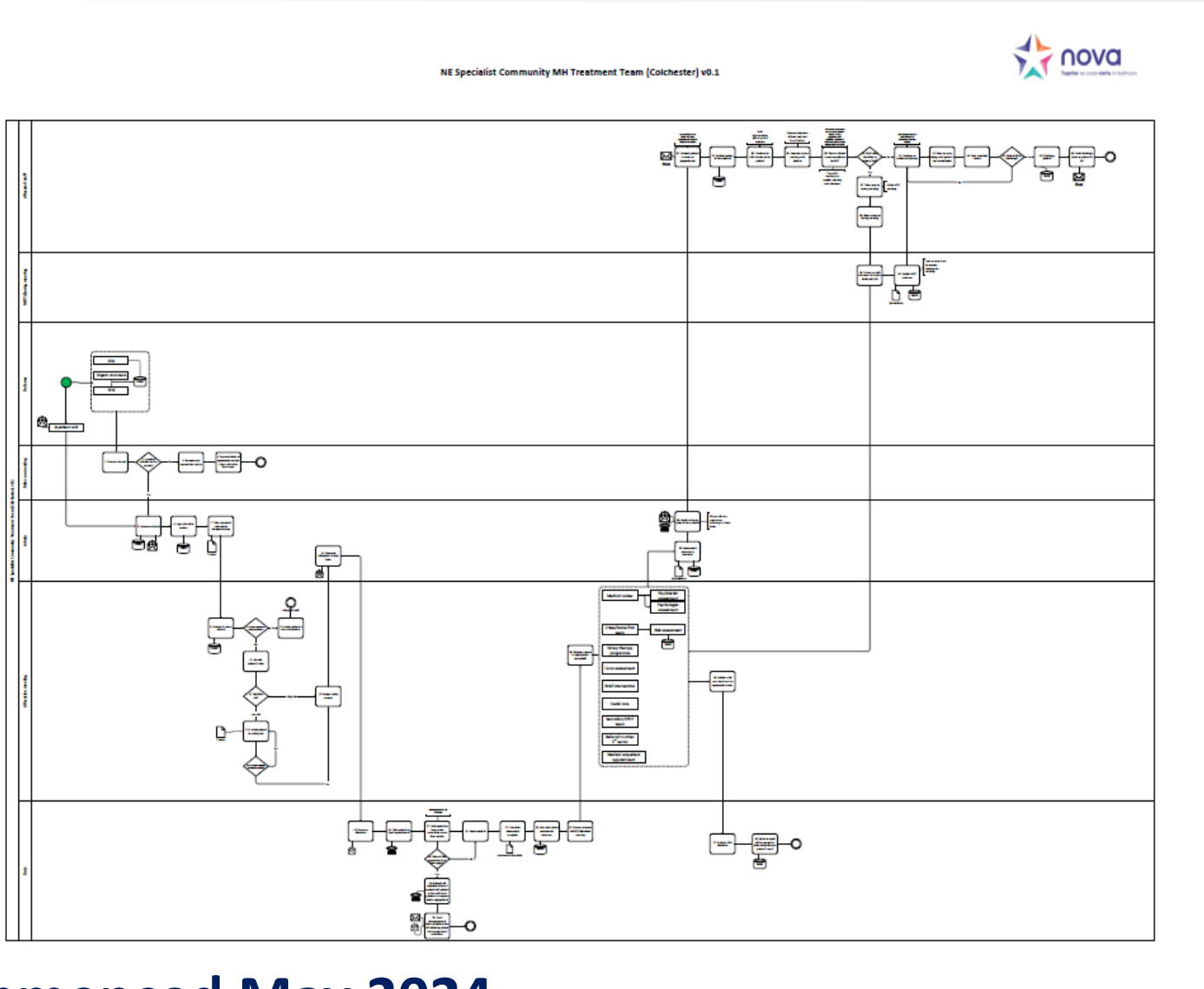
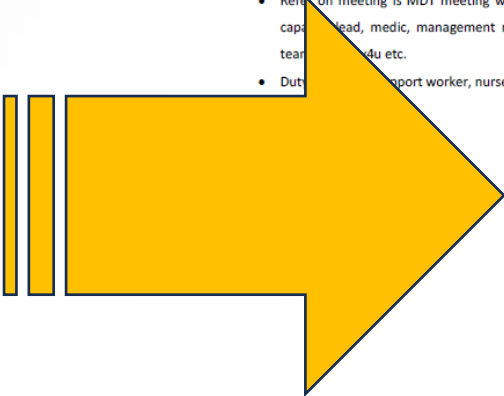
Summary of NE Specialist Community Treatment Team (Colchester & Tendring)

The Colchester Specialist Mental Health Team (CSMHT) and the Tendring Specialist Mental Health Team (TSMHT) provide assessment and treatment for individuals who are registered locally with a GP and experiencing a Serious Mental Illness (SMI). Each team covers each borough within the Northeast 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

- Referral meeting is MDT meeting where referrals are discussed attended by flow cap, lead, medic, management representative from specialist community MH team etc.
- Duty support worker, nurse, occupational therapist, or social worker.



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

Become an EPUT Digital Champion

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

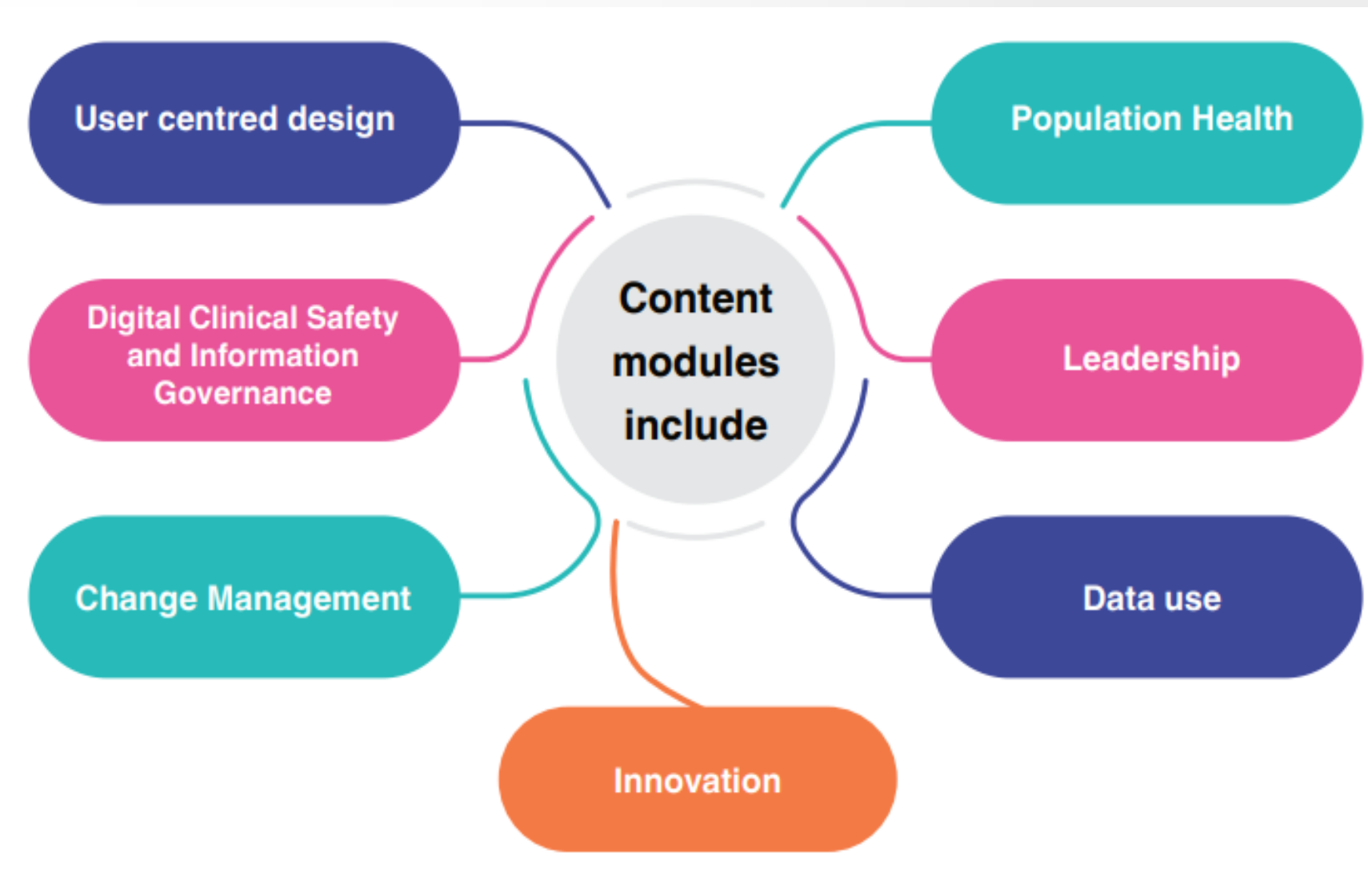
You don't have to be an IT whizz, but have an interest and passion in enhancing patient and staff experience through digital technology.

**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.





Essex Partnership University
NHS Foundation Trust



Mid and South Essex
NHS Foundation Trust



Together

we create **clarity** in healthcare

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Darius Virabi

Head of Healthcare - **Proact IT**

Gary McAllister

Healthcare CITO & **Former**
NHS CIO & CTO



PROACT

**Delivering better patient
experiences...**

An EPR journey together

Wednesday 12 February 2025

www.proact.co.uk/healthcare



Speakers



Darius Virabi

Head of Healthcare
Proact IT UK



**Gary
McAllister**

Healthcare CITO
Dell Technologies

In partnership with
DELLTechnologies

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**

Gary McAllister

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



What makes an EPR Architecture?

Clinical and Operational Modules

Integration Services

Core Infrastructure

Clinical and Operational Modules

PAS
(inpatient and
outpatient)

Order Comms

Clinical Docs

Observations
& Prescribing

Theatres

Emergency

Data and
Analytics

Diagnostics
(Labs, Rad
etc.)

Specialist
Modules

Integration Services

PAS
(inpatient and
outpatient)

Order Comms

Clinical Docs

Observations
& Prescribing

Integrated Engine

Data and
Analytics

Diagnostics
(Labs, Rad
etc.)

Specialist
Modules

Emergency

Theatres

Other Things to Consider – When Running a Hospital

Operational Management

Incident

SLAs

OLAs

BC

Recovery

Clinical Management

DCB129

DCB160

Serious
Incident

Safety
Protocols

Training and
Adoption

Data, Income and Analytics

SUS

CDS

Analytics

Pop-health

Research

Core Infrastructure

Devices

Dell
Laptops

Dell
Desktops

Dell
Tablets

Dell
COWS

Mobile
Stuff

Networking, Cyber and Management

Wireless

Distribution

Core

NAC /
Firewalls

SIEM /
Detection

Data Centre

Dell
Servers

Dell
Storage

Hypervisor

Backup /
Recovery

Replication

Types of EPR

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

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
- Big EHR – Safer but depending on vendor can provide a legacy experience.

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 services, just at a lower scale.
- Big EHR – Check DR requirements and ensure that these are robust.

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 yourself'. Modern EHRs require enhanced certification (ODB, Specialist patching etc.).
- *As IT systems grow and evolve the complexity of skills needed to manage 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.
- Care traffic control services monitoring the health of individuals.
- Genomics screening and real-time disease diagnosis.
- Enhanced stem-cell treatments and cures.
- Personalised medicine and treatments.

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”

Darius Virabi

Head of Healthcare @ Proact IT UK



Delivering better patient experiences...



**Strategic
Partnership**



**5-Case
Business Case**



c. 25% Saving



**Fully Managed
24/7/365**



**Enable
Innovation**



**Secure
by Default**



**Optimal
Sustainability**

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)



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...



Key takeaways from us...

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

How I can help you next...

Stop by
'Proact Corner'

Contact for
Slides & Top EPR Tips

Email for
Future Queries



Darius Virabi
Head of Healthcare
dvirabi@proact.co.uk



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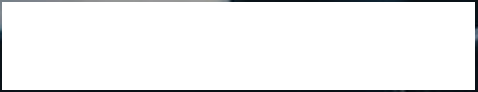
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Tracy McClelland
Chief Clinical Information
Officer - **Dedalus**





Dedalus Orbis Regional EPR Used Case

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UK'S SECOND

EPR SUMMIT

Corina Hulkes

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



Realising Benefits

February 2025

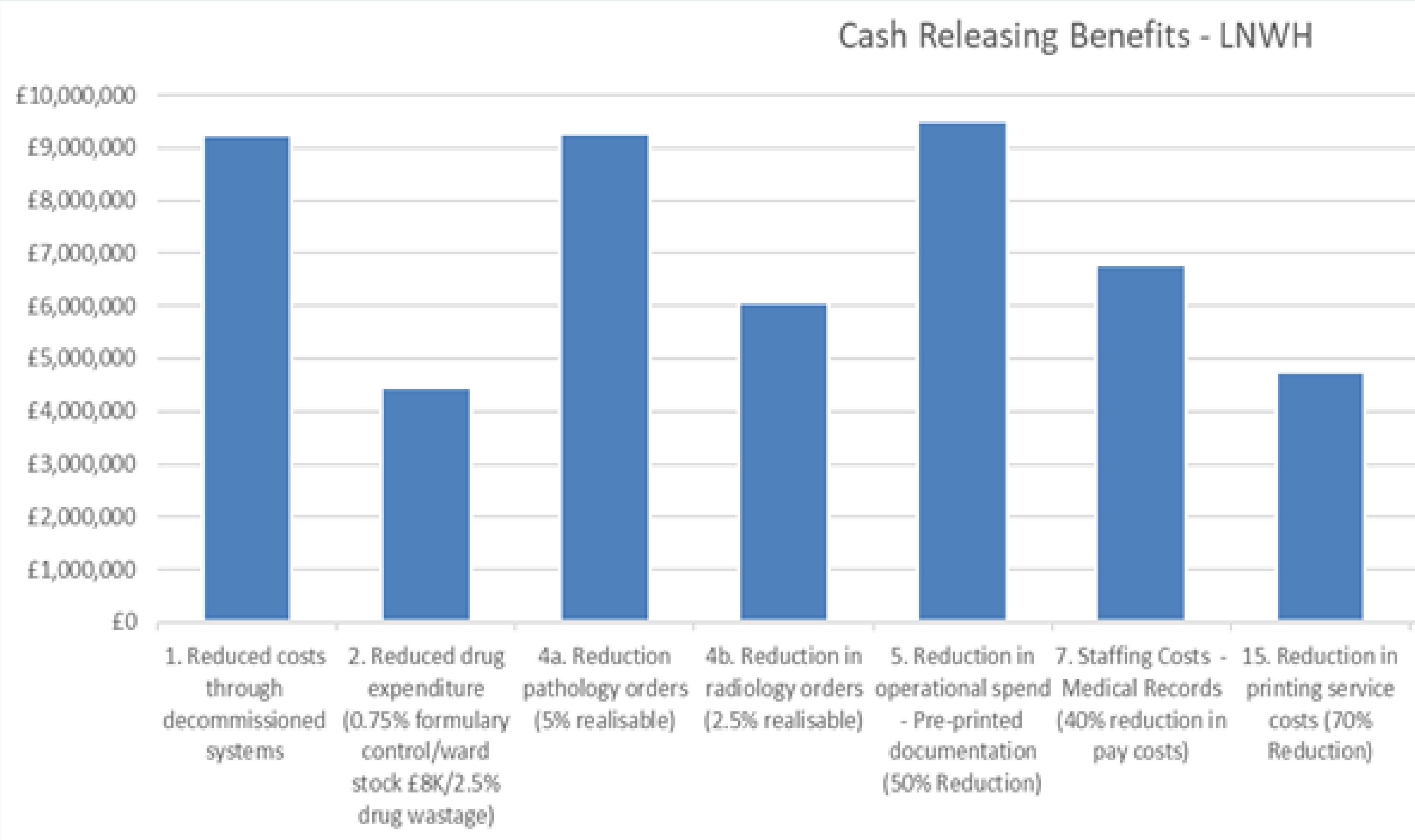
Corrina Hulkes, Chief Nursing, Midwifery & AHP Information Officer (CNIO)

corrina.hulkes@nhs.net

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

REVIEWING BUSINESS CASES AND REALISING BENEFITS

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.

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.

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, Treatment room	Patient	Face to face
Documentation	Nurse's station Bedside	Nursing alone	Permanent record
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

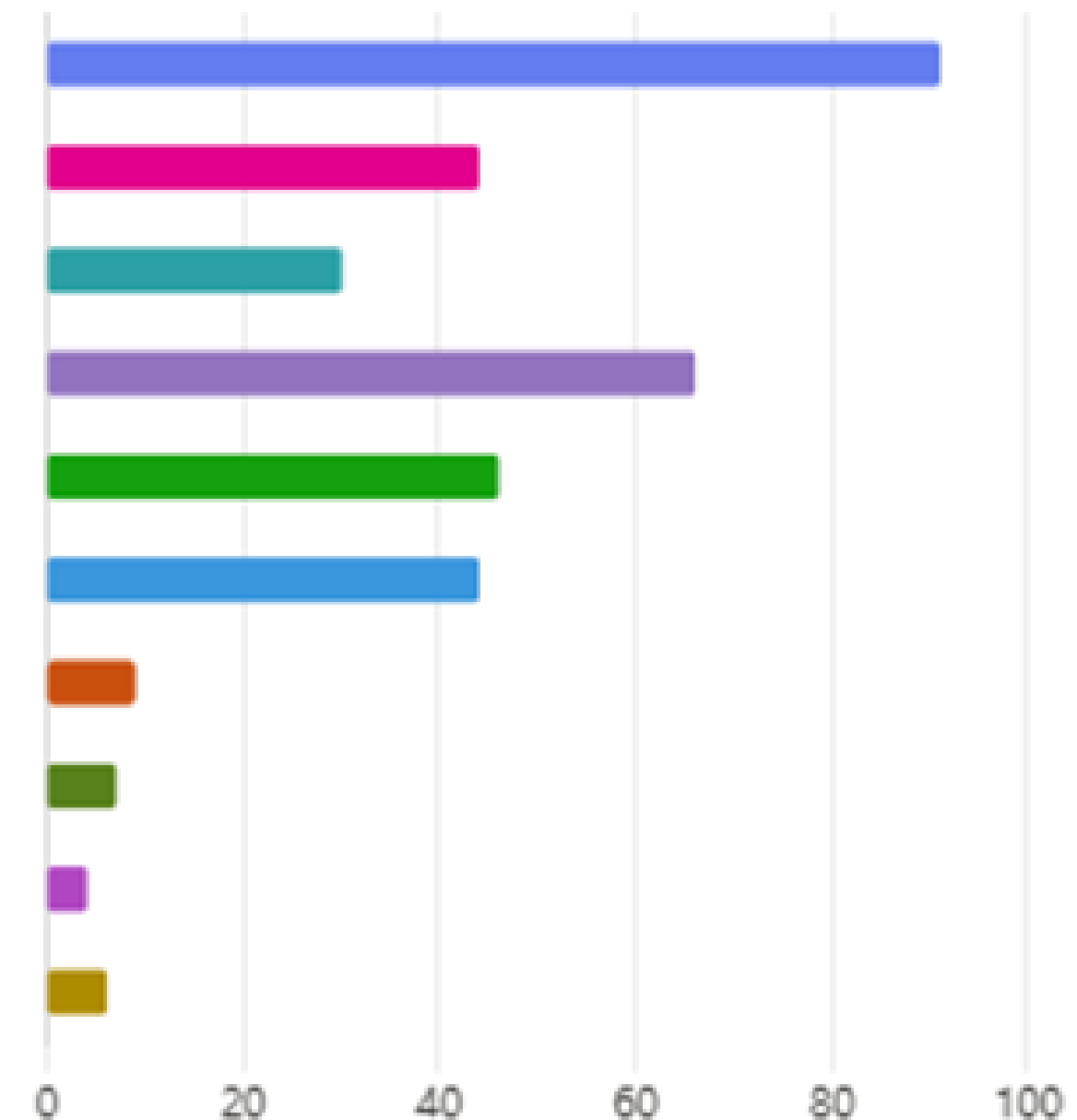
Data Collection

- 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

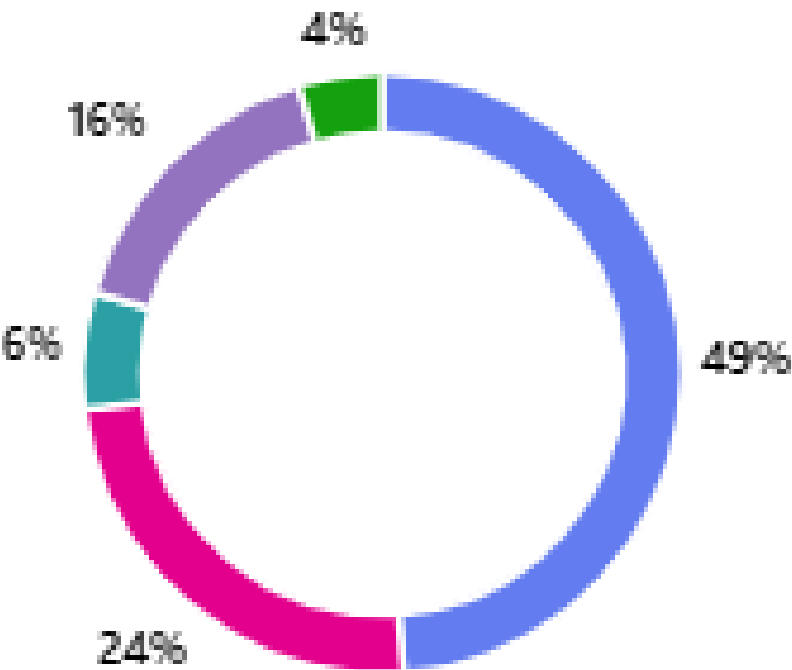
4. Task Working On

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



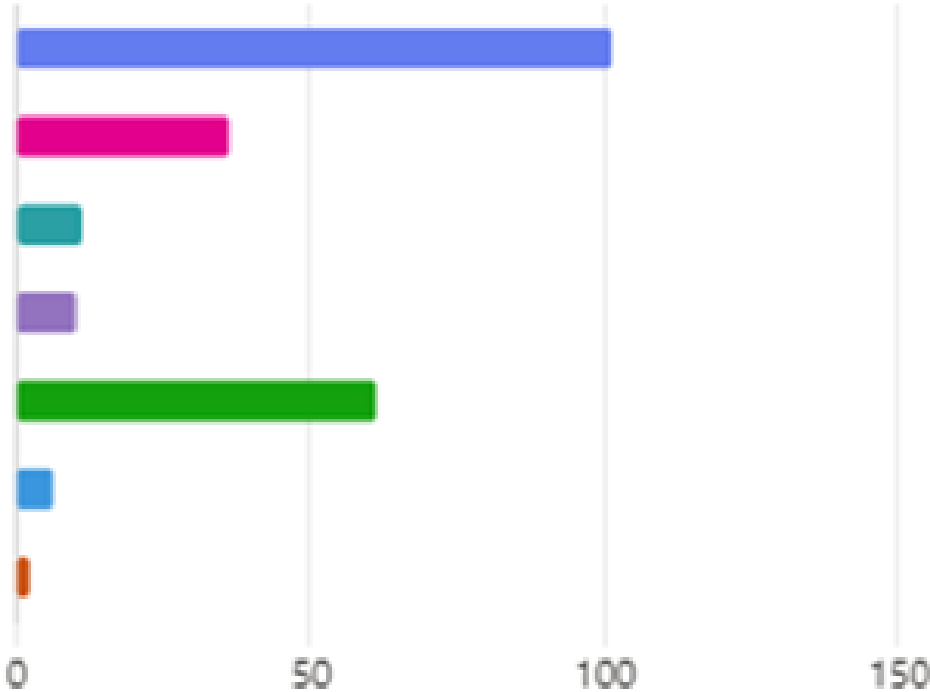
6. Task conducted

Single nurse patient administration of care	109
Face to face communication	54
Telephone	14
Paper documentation	36
IT system data entry	10

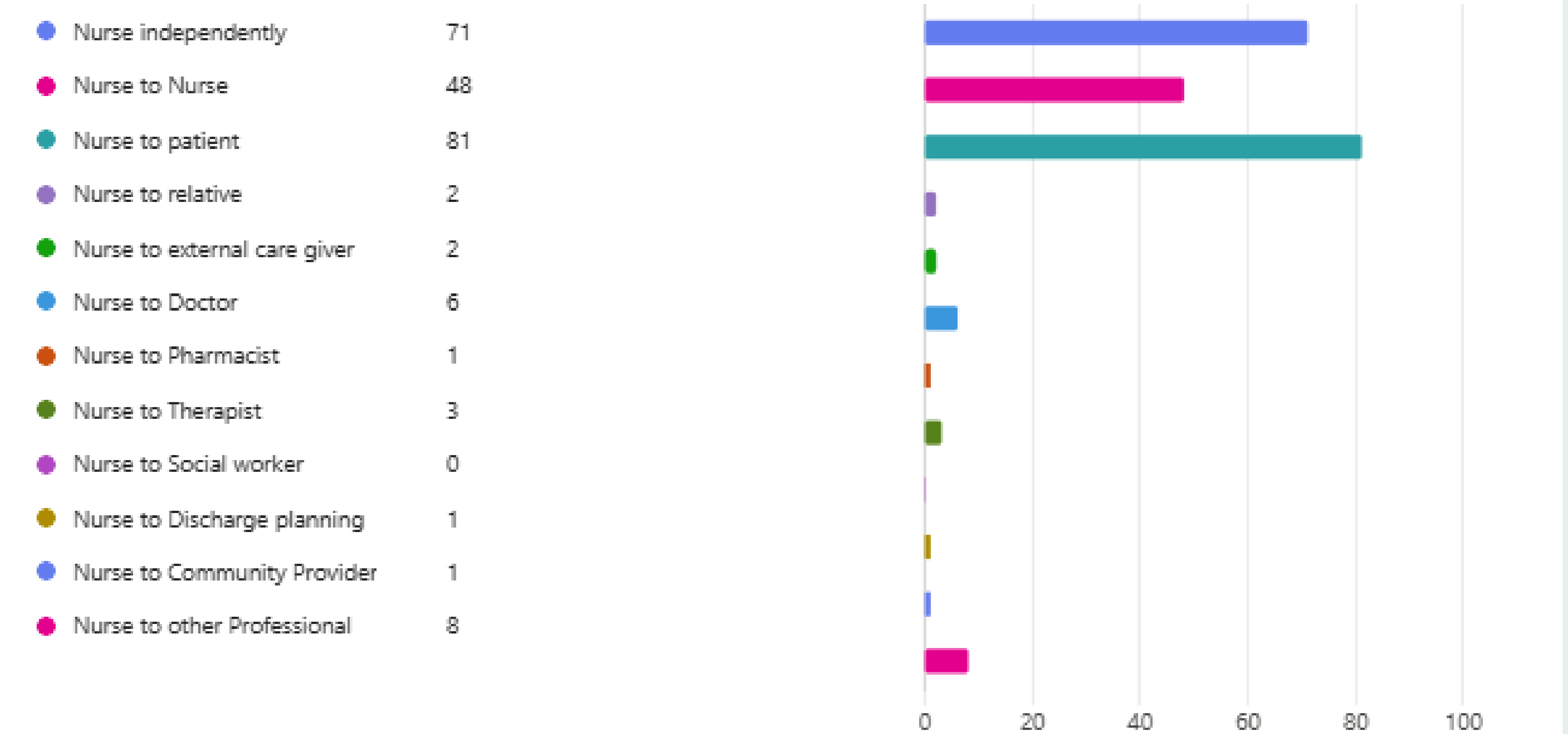


7. Task Location

Patient bedside	101
General ward area	36
Treatment room	11
Drugs room	10
Nurses station	61
MDT/ward seminar room	6
Off ward	2



8. Task collaboration



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 disc	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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