**BUSINESS CASE TEMPLATE**

|  |  |
| --- | --- |
| Section 1 – Summary | |
|  | |
| **Name of Business Case** | Maternity Electronic Patient Record |
| **Directorate/ Clinical Group** | X |
| **Delivery Lead (Scheme Owner)** | X |
| **PMO Reference Number** | X |

**Table of Contents**

[Section 1 – Summary 1](#_Toc487468460)

[Section 2 – Business Need (Why Do We Need To Change?) 3](#_Toc487468461)

[Section 3 – Options Analysis 6](#_Toc487468462)

[Section 4 – Proposed Solution 12](#_Toc487468463)

[Section 5 – Risk Assessment 16](#_Toc487468464)

[Section 6 – Benefits Analysis 17](#_Toc487468465)

[Section 7 – Sensitivity Analysis 18](#_Toc487468466)

[Section 8 – Funding 19](#_Toc487468467)

[Section 9 – Project Delivery 20](#_Toc487468468)

[Appendix 1 - Stakeholder Management 23](#_Toc487468469)

|  |
| --- |
| Section 2 – Business Need (Why Do We Need To Change?) |
|  |
| **The Business Need – why do we need to change?** |
| X Hospital provides maternity services for women across X and the wider region. Currently it does not have an electronic patient record in place across the full pathway. X is used in the intrapartum period but paper is still used for the antenatal and postnatal periods with some basic details recorded on X.  X is now working with X to deliver an improved maternity service across the STP area X. X has implemented X as their EPR. This system is also used by other surrounding trusts. Key to the delivery of the improved service model is a single EPR across the patch. Therefore X is looking to procure X so that it can be implemented in time for the launch of the new clinical model in April 2018. |
|  |
| **The Current Situation And Existing Arrangements** |
| The maternity service currently uses a mixed economy of paper and electronic systems to record the women’s pathway during pregnancy, birth and the postnatal period. The Trust uses the Perinatal Institute’s “green notes” to record the women’s pathway. This is supplemented by an electronic system during the intra-partum period, X.  The maternity record is currently fragmented for care professionals, which means that they may not be assessing or treating the woman based upon the most up to date information. For community midwives they need to be able to access the woman’s record remotely and this has not always been achievable.  Under the National Tariff Payment System, the maternity pathway is split into three stages; antenatal, delivery and postnatal. The current electronic system allows capture of data in the intra-partum area and does not fully support the PbR dataset. The process requires intervention by community midwives to complete a paper form to capture the missing information. There are issues with the accuracy of the data that is being captured by the community midwives which we believe is impacting upon the payments that the Trust received through the National Tariff Payment System.  A report published by X in February 2015 identified a number of recommendations that required action by the Trust in order to recover lost revenue.  A further review published in August 2015, highlighted that there were still issues with the data collection and that further fields were being requested to be contained in the paper forms.  There is a national maternity dataset in place which has to be submitted, this is difficult and data comes from a variety of sources including manual collection. The national clinical director for maternity has indicated that the dataset will expand and he is working with EPR suppliers to ensure that they are able to meet the requirements. There is an expectation that all trusts have an EPR in place. Without this our ability to meet the information requirements will be compromised.  X is an outlier locally in not having a maternity EPR as neighbouring trusts have already implemented systems. Data on the casemix for antenatal pathways for X compared to X Hospitals and X shows a marked difference. X looks as though it cares for less complex women. This is not in line with expectations. Discussions with X and commissioners have identified that the implementation of an EPR has improved the data collection and this has meant more women being put on an intermediate pathway.    In summary:   * The current system uses paper and electronic systems which creates a fragmented record, with key information potentially difficult to locate. * Losing paper records means clinicians may not always have the most accurate information in order to inform decision making and treatment. * Patients are asked the same question a number of times creating a negative perception of services * Information reporting is challenging, with the need to collate information from disparate sources. * Missing PbR information and inconsistently recorded data means that money is under-claimed, and opportunities for financial recovery are not maximised. * Community midwives do not always have access to the up to date record * Inability to share information across providers about women.   Current maternity process |
|  |
| **Fit with the Trust’s Strategic Objectives** |
| Delivery of maternity services is a core part of the Trust’s strategy. In conjunction with partners we are working to improve services across the STP area. The aim is to improve the quality of care and outcomes for women and babies. The clinical model is based on working across the Local Maternity System (LMS) and having consistent guidelines and standards in place. Key to delivery of these changes will be a shared patient record across the LMS. X already use X and so to ensure delivery of the objectives within the programme X must implement the same system.  The Trust is currently working to deliver the requirements of the national strategy for hospitals to be paperless by 2020. The approach being taken is to use a portal approach which brings together a range of systems in one place with all the information about a patient. The current portal, X, does not meet the needs of a maternity EPR and the procurement of a specific tailored maternity system is needed. This will then form part of the portal.  There is an increasing move to share patient information across organisations for the benefits of patients. Locally X has seen GP records being shared with hospitals. The use of X will allow sharing of information across the STP, and potentially wider in the future, which means that the full record is available wherever a woman chooses to receive her care. |

|  |
| --- |
| Section 3 – Options Analysis |
| **Long list of options** |
| Option 1: Do nothing and continue with existing mixture of paper and electronic systems.  Option 2: Explore expansion of current systems to cover whole pathway  Option3: Implement full maternity EPR - X |

|  |  |
| --- | --- |
| **Excluded Options** | |
| **Option** | **Reason for Exclusion** |
| Option 1 – Do nothing | While there is no up-front cost with this option, the significant issues created by the fragmented record would remain, including:   * Largely paper records in place - the digital and interoperable record by 2020 would not be met * Losing paper records means clinicians may not always have the most accurate information in order to inform decision making and treatment. * Patients would continue to be asked the same question a number of times * Information reporting would continue to be difficult to quantify and qualify. * Data quality would continue to suffer, and * Continuation of incorrect or missing PbR information, with no check and balances. * Opportunities to maximise revenue would be missed. * Increased effort in information recording and retrieval remain, missing opportunities for new ways of working. * The Trust would remain the only organisation regionally without a full electronic maternity record, setting it at a disadvantage against other Trusts. * Manual data entry and resultant effort from reporting would be required. * We would not be able to fully implement the X model across the LMS.   For these reasons, this option has been discounted. |
| Option 2 – Explore expansion of current systems to cover the whole pathway | X currently uses the X system as its Patient Administration System for Maternity. In addition, within Obstetrics the X system is used. While there are clearly benefits of a single EPR across the organisation, it is unlikely that this option could meet the service needs for the following reasons:   * As it stands, the X EPR system does not provide ‘out-of-the-box’ Maternity functionality. While it is possible to purchase enhancements, there is no clear roadmap for the system in providing full functionality required to support Maternity Services, so it is likely additional systems would have to be purchased anyway to complement X. * X was initially purchased by X – the contract for which end in July 2016. Any additional functionality now must be procured by the Trust in an open process. * X is a nationally hosted and pooled system. This makes adaptations to meet X’s needs difficult, and complicates the governance process around change requests. * X is currently contracted with X until 2019. While options to extend the system beyond that date exist, there is the potential that if X opts to change system, it would not be possible to make a return on investment for the additional maternity functionality in less than 3 years. * Significant time and effort was invested over recent years in attempts to extend the X system. Ultimately these were unsuccessful and the Trust withdrew from this work.   For these reasons this option has been discounted, however it is essential than any system implemented is able to integrate with X as the Trust’s Primary Record. |

|  |
| --- |
| **Short List of Options** |
| The only option that has been shortlisted is to implement a full maternity EPR and the other long listed options do not address either the risks identified or meet the strategic objectives.  The do nothing option has been included as a baseline against which to assess the option.  In 2016 a full procurement exercise was carried out which identified two potential solutions. At that time a business case was taken to Investment Committee for approval. However, whilst the need for an EPR was supported, it was felt that it wasn’t the right time to be making a decision on which solution. At that time the work across the LMS was just starting to be explored and the potential to move to one solution across the LMS was considered a possibility and so any decision needed to be taken in that context.  X is now a key workstream for the STP and both X and X are committed to delivery.  The X model will see maternity services across the two organisations working together to deliver maternity services. There will be consistency in approach and all women will access services through a single point of access.  The diagram below sets out the clinical model:    The clinical model work stream has stated that a single EPR is critical to delivery of the clinical model. |

|  |  |  |
| --- | --- | --- |
| **Option Description** | **Option 1 Do Nothing / Minimum** | **Option 3** |
| **BENEFITS** |  |  |
| Additional Income *(Note1)* | 0 | X |
| Estimated Savings / efficiencies | 0 | X |
| Other quantifiable benefits | 0 | X |
| **Total Benefits** | 0 | **X** |
| **COSTS** |  |  |
| **Revenue** |  |  |
| One off revenue investment | 0 | X |
| Specialty Costs | 0 | X |
| Other recurrent costs (e.g. support services) | 0 | X |
| **Capital** |  |  |
| Capital costs | 0 | X |
| **Total Costs** | 0 | **X** |
|  |  |  |
| **Net (Costs) / Benefits** | 0 | **X** |
| **Net Present Value (NPV) 5years 3.5%** | 0 | **X** |
| **Payback period (year)** | 0 | **X** |
| **Increase / (decrease) to Service Line contribution** | 0 | **X** |

Estimated savings/efficiencies relate to savings on current systems and paper and consumables. Other costs relate to system charges from supplier and a Band 4 systems support.

Note 1

It is anticipated that the EPR will improve data quality both in terms of recording all relevant clinical data to determine coding but also to ensure all bookings are captured. The price differential between a standard booking and an intermediate booking is £X. The table below shows the potential income that could be recoverable:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Baseline activity**  **(2016/17)** | **Number of bookings** | **Price 2017/18 (including MFF)**  **£** | **Movement in bookings to cover recurrent costs** | **Movement in bookings to match HEFT/SWBH** |
| Ante-natal standard | X | X | X | X |
| Ante-natal intermediate | X | X | X | X |
| Ante-natal intensive | X | X | X | X |
|  | **X** |  | X | X |
| **Additional income** |  |  | X | X |
| **Payback** |  |  | 4 years | 1 year |

The table shows that if there was a small change in casemix, shifting by only 181 bookings (3%) between Standard and Intermediate the annual costs would be met. If we saw a much larger shift more in line with X and X then there is potentially significant additional income available.

| **Impact on Activity** |
| --- |
| The implementation of an EPR will not lead to additional activity as the current model in terms of bookings is driven by the woman’s GP. The EPR will improve productivity and this along with the new model of care may lead to the ability to care for more women who may not live in the area but wish to receive their care from X. In particular this may be women who will give birth at X but are currently classified as out of area. At this stage no additional activity has been assumed. |

**Evaluation of options**

| **Option Description** | **Option 1 Do Nothing/Minimum** | **Option 2** |
| --- | --- | --- |
| Evaluation Criterion | **Raw Score *(1-5)*** | **Raw Score *(1-5)*** |
| Strategic fit  (*See Strategy scoring section below)* | **1** | **4** |
| Achievability  *(See Achievability Scoring section below)* | **5** | **3** |
| Risk of doing  *(See Risk Assessment Scoring section below)* | **2** | **4** |
| Financial Viability  *(See Financial Viability section below)* | **1** | **4** |
| OVERALL SCORE  (SUM TOTAL) | **9** | **15** |

**Strategy Scoring**

Rank the options against each of the below objectives of the Trust. A raw score of 5 for example would mean that the option has a high strategic fit, whilst a 1 is a low strategic fit.

|  |  |  |
| --- | --- | --- |
|  | Option 1 Do Nothing / Minimum | Option 3 |
| X Objectives |
| Delivery high quality, safe services to every woman, baby and family | *1* | *4* |
| Ensure every woman, baby and family is made to feel special | *1* | *3* |
| Fully embed a culture of safety, underpinned by openness and transparency | *1* | *4* |
| Recruit, Develop & Empower every member of staff to be the very best they can be | *1* | *4* |
| Maximise innovation through our partnerships and strength in Research & Development to improve outcomes for women, babies and families | *1* | *3* |
| Play a lead role in developing models of care for women, babies and families across X, the X region and beyond | *1* | *5* |
| TOTAL SCORE | *6* | *23* |
| SCORE FOR INSERTION IN SUMMARY TABLE (DIVIDE TOTAL BY 6 AND ROUND TO NEAREST WHOLE NUMBER) | *1* | *4* |

**\***New trustwide strategic objectives will be in place September 2017

**Achievability Scoring**

| Criteria | Option 1 | Option 3 |
| --- | --- | --- |
| Achievability | 5 | 3 |

For achievability, a score of 1 means that the investment requires significant change management, reorganisation and additional capacity and resources, and there is no / limited evidence of similar projects delivering success.

A score of 5 means that there is existing capacity and capability within the organisation and the timescales and scope are realistic and achievable.

**Option 1** requires no change management

**Option 3** will require significant change management within the Directorate, as they will be moving from a paper system to either a paper–light or paperless system. This project cannot be achieved without significant time and effort dedicated to the project from the directorate, as well as support in terms of business and culture change. The project will require a dedicated midwife resource to assist within the project and to facilitate the change required, and to assist with system localisation. Within the resource requested there is an assumption of dedicated clinical time and business change resource to support the implementation.

**Risk Assessment Scoring**

For risk, a consequence score of 1 indicates there is a high risk, whereas a score of 5 indicates a low risk to the Trust.

**Option 1** provides the greatest risk to the Trust, by doing nothing the Trust risks the Trust needs an electronic system to improve the data quality required and achieve wider Trust strategies.

**Option 3** does provide an element of risk in their deployment, however the benefits of implementing are greater, and the Trust will be in a far better position to achieve the strategic objectives and goals of X.

|  |  |  |
| --- | --- | --- |
| **Risk Assessment Results** | **Option 1 Do Nothing/ Minimum** | **Option 3** |
| Measurement of Consequence (1 to 5) | 4 | 2 |
| Measurement of Likelihood (1 to 5) | 4 | 2 |
| Raw Risk Assessment (i.e. Consequence x Likelihood) | 16 | 4 |
| Overall score from above divided by 5 and rounded to nearest whole number | 3 | 1 |
| **Score given** | **2** | **4** |

**Financial Viability Scoring**

Give each option a raw score from 1 to 5 under each criterion using the principles in the table below;

| Criteria | Option 1 Do nothing/Do minimum | Option 3 |
| --- | --- | --- |
| Financial Viability | 1 | 4 |

The costs of the system from the supplier are based on a revenue model and there is a charge of £X per birth. There are no upfront costs from the supplier. Given this is a revenue based system and therefore there is no asset the implementation costs will need to be charged to revenue. The Early Adopter Funding received for X will be used to cover these costs. This can be broken down as follows:

|  |  |  |  |
| --- | --- | --- | --- |
| **Implementation costs** |  | **Year 0** | **Year 1** |
| Midwife - B7 |  | X | X |
| Project manager - B7 |  | X | X |
| Configuration specialist - B6 0.6WTE |  | X | X |
| Integration expertise |  | X | X |
| Consultant 0.2wte |  | X | X |
| Mobile technician B4 |  | X | X |
|  |  | **X** | **X** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Options Evaluation | | | | |
|  | **Option 1 Do Nothing/Minimum** | **Option 3** |  |  |
| Options Evaluation Score | 9 | 15 |  |  |
| Ranking | 2 | 1 |  |  |
| Proposed Solution? (Yes / No) | No | Yes |  |  |
| An explanation should be provided here where the proposed solution is not the option with the highest score. | N/A | | | |

|  |
| --- |
| Section 4 – Proposed Solution |

|  |
| --- |
| **Project Scope** |
| In Scope |
| The project will procure, configure and implement and EPR system for Maternity Services in X, it will include:   * Setting up the system to ensure that it meets the needs of maternity services * Training staff to use the system and ensuring business and cultural change work that supports the systems use is in place * Ensure that adequate reporting is in place to maximise income opportunities. * Ensuring adequate benefits monitoring is in place * Ensuring that adequate hardware devices are in place to allow staff to access the system in a way that supports their work. * Ensuring community based staff can access the system. * Ensure appropriate processes are in place to allow patients to access their information.   The current target date for implementation is 1st April 2018. This is to be in line with the launch of X. In reality this will mean some elements of the record being in place by 1st April with the full implementation taking 12 months. The exact timing and specifications will be agreed as part of the planning and in conjunction with the clinicians and the supplier. |
| Out of Scope |
| The patient portal element of the record will be excluded from the initial roll out but form part of the full implementation. |

**Stakeholder Mapping Template**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Stakeholder Mapping Template | | | | | | |
| Stakeholder Group | Perceived Benefits | Changes Needed | Perceived Resistance | Negative | Neutral | Positive |
| Patients | Improved care through improved information sharing. Ability to access records electronically | Understand benefits | Potential resistance through withdrawal of green notes. |  | C | R |
| Community Midwife | Ability to see up to date information and share with other providers | Move from paper based system | That the new system will not work for them, leading to poor data quality.  Non-use of the system reverting to paper processes  Their concerns and needs not addressed | C |  | R |
| Inpatient Midwife | Ability to see up to date information and share with other providers | Move from paper based system | That the new system will not work for them, leading to poor data quality.  Non-use of the system reverting to paper processes  Their concerns and needs not addressed | C |  | R |
| Outpatient  Midwife | Ability to see up to date information and share with other providers | Move from paper based system | That the new system will not work for them, leading to poor data quality.  Non-use of the system reverting to paper processes  Their concerns and needs not addressed | C |  | R |
| Consultant Obstetrician & Junior Doctors | Ability to see up to date information and share with other providers | Move from paper based system | That the new system will not work for them, leading to poor data quality.  Non-use of the system reverting to paper processes  Their concerns and needs not addressed | C |  | R |
| Information & Contracting | Improved data quality | Understanding of dataflows for internal and external reporting | Initial setup will be time intensive but lead to benefits |  |  | CR |
| Clinical Director | Improved reporting and ability to interrogate data | Understanding of what is available  Ability to champion the system with other clinicians | Time constraints |  |  | CR |
| Head of Midwifery | Improved reporting and ability to interrogate data | Understanding of what is available  Ability to champion the system with other clinicians | Time constraints |  |  | CR |
| Radiology | Ability to see up to date information and share with other providers | Move from paper based system | That the new system will not work for them, leading to poor data quality.  Non-use of the system reverting to paper processes  Their concerns and needs not addressed | C |  | R |

***C= CURRENT COMMITMENT, R= REQUIRED COMMITMENT***

***Negative = Stakeholder is against the change or is passively negative about the change***

***Neutral = Stakeholder is neutral; he will allow the change to happen, but have no strong feeling for or against***

***Positive = Stakeholder understands the benefit and will help facilitate the change or is actively promoting the change***

|  |
| --- |
| **Stakeholder Analysis** |
| See appendix 1 for stakeholder analysis |

|  |
| --- |
| Section 5 – Risk Assessment |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Summary Risk Table | | | | |
| **Risk Description** | **Score** | **Mitigation Strategy** | **Responsible Individual** | **Cost\* (£)** |
| The project and implementation of the system are not adequately resourced | L2 X C4 =  **8** | The business case needs to allow for sufficient funds to be freed to resource the project. | Project Executive |  |
| Inability to release staff for training on the new system | L2 X C4 =  **8** | A training plan needs to be put in place with the assistance of the Operational Managers and the e-Rostering system to facilitate this. | Head of Midwifery |  |
| Insufficient Stakeholder Engagement | L3 X C4 =  **12** | A project midwife will be recruited to lead engagement as well as a consultant with dedicated time in their job plan | Head of Midwifery |  |
| Insufficient attention to the Change Management within the project. | L3 X C4 =  **12** | A business change strategy will be developed which engages the key stakeholders in order to assess the level of change required based on the premise that this is about an electronic workflow not “digitised forms” | Project lead |  |
| The system does not meet the needs of the directorate | L3 x C4 = 12 | A detailed specification will be developed in order to evaluate available systems. Resource will be dedicated to configuration of the system to meet the service’s needs. | Project lead |  |
|  |  |  |  |  |

*\*Cost of dealing with the risk if it were to materialise.*

|  |
| --- |
| Section 6 – Benefits Analysis |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Summary Benefits Table | | | | | |
| **Ref** | **Critical Benefits** | **Measurement Basis** | **Base / current Value** | **Target Value** | **Target Date** |
| C1 | A single comprehensive record, available 24/7, to support the maternity pathway | Availability of the record | 0% | 100% | September 2018 |
| C2 | Improved income through more accurate coding at the point of care, and enhanced ability to report | Shift in casemix complexity | AN pathway:  Standard 60%  Intermediate 29%  Intensive 11% |  | April 2019 |
| C3 | Comprehensive access to the Maternity Record for staff working in the community | Full roll out of EPR | Nil | 100% | September 2018 |
| C4 | Improved Management reporting enabling service and transformational changes | Enhanced maternity dashboard for LMS | Existing dataset | As defined within LMS | September 2018 |
| **Ref** | **Additional benefits** | **Measurement Basis** | **Base Value / current** | **Target Value** | **Target Date** |
| A1 | Ability to introduce access to the record for patients and families | Patient access | Nil | Access available | September 2018 |
| A2 | Reduction in paper, consumables and manual data entry of paper forms | Cost of paper notes and existing databases | £X | £X | September 2018 |
| A3 | Enhanced data quality, and ability to rapidly audit information relating to maternity services | Enhanced data availability for maternity services | Maternity services minimum dataset | Additional dataset | September 2018 |

|  |
| --- |
| Section 7 – Sensitivity Analysis |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | ***Sensitivity Analysis:*** | **Base** | **Scenario 1** | **Scenario 2** | **Scenario 3** | | ***[year 2 assumed fye]*** |  | ***Delay in implementation*** | ***Increase in costs of 10%*** | ***Reduction in income*** | | Costs | X | X | X | X | | Benefits | X | X | X | X | | Net Costs / Benefits | X | X | X | X | | NPV | X | X | X | X | | Payback period | X | X | X | X | | Change in service line contribution | X | X | X | X |   In each of the scenarios above the annual I&E impact shows a positive impact on the service line contribution except for scenario 3, however, payback is not achieved over the 5 year period under scenario 3. |
| The table below explains each scenario chosen:   |  |  |  | | --- | --- | --- | | Scenario Number | Explanation | Why Chosen | | 1 | **Delay in the implementation of the system leading to an increase in capital costs and delay in benefits** | **This is a huge change programme and whilst we have tried to mitigate this risk through increasing the implementation resource it remains a risk.** | | 2 | **Increase in annual costs by 10%** | **Annual costs are significant and so it is sensible to model changes.** | | 3 | **Reduce potential income by 50% (change of only 2% in casemix)** | **To test robustness of model.** | |

|  |  |
| --- | --- |
| |  | | --- | | Section 8 – Funding | |

|  |
| --- |
| **Funding Table** |
| The table below assumes a shift in case mix sufficient to cover the annual recurrent costs.   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | ***Phased I&E:*** | **2017/18** | **2018/19** | **2019/20** |  |  | | Income | X | X | X |  |  | | Expenditure | X | X | X |  |  | | **I&E surplus / [deficit]** | X | X | X |  |  | |  |  |  |  |  |  | | ***Cashflow:*** | **2017/18** | **2018/19** | **2019/20** | **2020/21** | **2021/22** | | Total Income: | X | X | X | X | X | | Expenditure: | X | X | X | X | X | | Pay: | X | X | X | X | X | | Non-Pay: | X | X | X | X | X | | Capital: | X | X | X | X | X | | **Total Expenditure:** | X | X | X | X | X | | **Net Cash in / [out] flow:** | X | X | X | X | X | | **Net Cash in / [out] flow [Accum]** | X | X | X | X | X |     The shortfall in Year 0 (2017/18) relates to the following costs:  System costs £X – this assumes that the system is in use from 1st March 2018 and all new antenatal bookings are registered on the system and so charged.  Capital charges £X  **Capital funding**  Capital funding required is £X. There is £X allocated within the 2017/18 capital programme for this. |
|  |

|  |
| --- |
| Section 9 – Project Delivery |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Project Delivery Table | | | | |
| Milestone Activity | **Responsible Individual** | **Start Date** | **End Date** | Time Requirement |
| Investment Committee Approval | X | *16th June 2017* | *16th June 2017* |  |
| Finance and Resource Committee (FRC) approval (if required) | X | *20th July 2017* | *20th July 2017* |  |
| Project Initiation | X | *1st August 2017* | *1st February 2018* | *6 months* |
| Implementation | X | *1st February 2018* | *31st July 2018* | *6 months* |
| Completion Date | X | *1st August 2018* | *31st August 2018* | *1 month* |
| Post Implementation Review 1 | X | *November 2018* | *December 2018* | *1 month* |
|  |  |  |  |  |

A detailed PID and project plan is currently under development. This will be agreed both internally with the clinical services and externally with the supplier.

Given the target to go live with the new service on 1st April 2018 the aim will be to have an antenatal record available by this date, the remainder of the pathway will follow. The exact specification and requirements will be determined as part of the initiation phase.

|  |
| --- |
| **Project Roles** |
| |  |  | | --- | --- | | Role | Responsibilities | | Senior Responsible Officer:  *TBC* | Ultimately responsible for the project, supported by Project Team.  Responsible for overall business assurance of the project – that is it remains on target to deliver products that will achieve the expected business benefits and that the project will be completed within its agreed tolerances for budget and schedule.  Ensures the project gives value for money, ensuring a cost conscious approach to the project, balancing the demands of business, user and supplier. | | Clinical Sponsors:  *Medical –* X  *Midwifery -* X | Responsible for the specification of the needs of all those who will use the final products, for user liaison with the project team and for monitoring that the solution will meet those needs within the constraints of the Business Case in terms of quality, functionality and ease of use.  The role represents the interests of all those who will use the final product(s) of the project, those for whom the product will achieve an objective or those who will use the product to deliver benefits. The Senior User role commits user resources and monitors products against requirements.  Supported by the Clinician and Midwifery based focus group. | | Accountable Manager:  X  X | Responsible for the work of the project team leading engagement within the directorate and ensuring that the system supplier delivers.  The system supplier will appoint an accountable manager who will be responsible for the delivery of the system. | | Project Manager:  X | Manages the project on a day-to-day basis.  The project manager’s prime responsibility is to ensure that the project produces the required products, to the required standard of quality and within the specified constraints of time and cost. | | Project Midwife  *TBC* | Responsible for providing input to the project relating to business process, business change, localisation, functionality, testing, and acting as a conduit to the clinicians within the directorate to provide decisions to the project when required. | | Project consultant  TBC | Responsible for providing input to the project relating to business process, business change, localisation, functionality, testing, and acting as a conduit to the clinicians within the directorate to provide decisions to the project when required. | |
| **Project Governance** |
| The project will be managed in line with the X ICT Project Management Standard Operating Procedure (SOP) and assigned a named project manager. A Project Board will meet at least monthly, chaired by the SRO and consisting of representatives from key stakeholders able to make decisions about the project with respect to their areas.  The Project Board will review progress and authorise key decisions. During the active phase of the project, a weekly operational project team meeting will be held chaired by the clinical lead or project midwife and consisting of all key project staff to monitor day-to-day progress.  A Project Initiation Document will be created to support project kick-off and regularly reviewed throughout it will include plans, risks and issues and other key project information. Monthly Highlight reports will be created and reviewed by the Project Board and used to progress report up to the ICT Strategy Board and X Programme Board. Key actions and escalations will be reported from ICT Strategy Board to the Trust’s Finance and Resources Committee monthly. |

|  |
| --- |
| **Benefits Management** |
| The benefits and data sources are set out in Section 6. The benefits realisation monitoring will be done jointly by the Directorate and the Informatics team. |

|  |
| --- |
| **Next Business Case Review Date** |
| August 2018 |

# Appendix 1 - Stakeholder Management

Stakeholder Identification

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Stakeholder Group** | **Stake in Project** | **Impact** | **What do we need from Them** | **Perceived attitudes/risks** | **How could they contribute** | **Risk if they are not engaged** |
| Patients | Co-design models of cares, and how the system can support this | Low | Understanding of what they require from their records |  | Looking at Models for Patient Portal | Their concerns and needs not addressed |
| Community Midwife | They will be the main users of the system and will need to be comfortable in its use particularly in remote situations, without impacting on patient care. | High | * Understanding of current processes. * Contribute to process design and testing | * Potentially not engaged in project * Non-use of the system reverting to paper processes. * Concern about using system instead of paper. | They can contribute to the new processes, involvement in workstream meetings | * That the new system will not work for them, leading to poor data quality. * Non-use of the system reverting to paper processes * Their concerns and needs not addressed |
| Inpatient Midwife | They will be the main users of the system and will need to be comfortable in its use particularly in Ward settings without impacting on patient care. | High | * Understanding of current processes. * Contribute to process design and testing | * Potentially not engaged in project * Non-use of the system reverting to paper processes. * Concern about using system instead of paper. | They can contribute to the new processes, involvement in workstream meetings | * That the new system will not work for them, leading to poor data quality. * Non-use of the system reverting to paper processes |
| Outpatient  Midwife | They will be the main users of the system and will need to be comfortable in its use particularly in the outpatient clinics without impacting on patient care. | High | * Understanding of current processes. * Contribute to process design and testing | * Potentially not engaged in project * Non-use of the system reverting to paper processes. * Concern about using system instead of paper. | They can contribute to the new processes, involvement in key meetings influencing the pathways | * That the new system will not work for them, leading to poor data quality. * Non-use of the system reverting to paper processes. |
| Consultant Obstetrician & Junior Doctors | They will be heavy users of the system and will need to be comfortable in its use without impacting on patient care | High | * Understanding of current processes. * Contribute to process design | * Potentially not engaged in project * Time and work constraints | They can contribute to the new processes, involvement in key meetings, influencing the pathways | * New system will not work for them * Non-use of the system reverting to paper processes |
| Information & Contracting |  | Medium | Understanding of reporting requirements | Lack of Involvement due to resource constraints | Involvement in workstream meetings for the project | Lack of comprehensive reporting from the new system leading to poor data quality and loss of revenue |
| Clinical Director | Will sponsor the project | High | Direction and Guidance within the project | Time and work constraints | Involvement in Project Steering Board, Regular updating meeting with project leader. | Lack of decision making for the project relating to current medical practice |
| Head of Midwifery | Will sponsor the project | High | Direction and Guidance within the project | Time and work constraints | Involvement in Project Steering Board, Regular updating meeting with project leader. | Lack of decision making for the project relating to current midwifery practice |
| Radiology | They will use the system and will need to be comfortable with the way it fits existing processes | High | * Understanding of current processes. * Contribute to process design | * Potentially not engaged in project * Time and work constraints | They can contribute to the new processes, involvement in key meetings, influencing the pathways | * New system will not work for them * Non-use of the system reverting to paper processes |