Member spotlight: introducing an electronic patient record at Calderdale and Huddersfield NHS Foundation Trust

Mandy Griffin, Managing Director of the Health Informatics Services and CIO at Calderdale and Huddersfield NHS Foundation Trust @THISNHSMandy

An electronic patient record (EPR) often lays the foundation for digital transformation in the NHS. It is essential infrastructure that is as important to a trust as the kits and wires, bricks and mortar, that enables safe, quality and effective care delivery. But just like a hospital rebuild, introducing a new EPR is complicated, expensive and involves many uncertainties. So, it will always require the full attention of the trust board.

In 2017 Calderdale and Huddersfield went live with its own EPR, Cerner Millenium. Three years on, the board and I are constantly asked about the lessons we learned along the way. As part of a Digital Boards peer learning "member spotlight" event organised by NHS Providers, my chief executive, Owen Williams, and I shared seven key learnings:

1. **Implementing an EPR is only part of the journey**.

We categorise our EPR deployment into four stages, starting with implementation. This took place over two years from 2015 to 2017, during which time we did the "go live". With hindsight this was much more challenging than we expected. After implementation, we entered a stabilisation period. During this time, we identified staff who were our EPR enthusiasts and those who needed more encouragement to engage. This gave us a better understanding of the ways in which the tool was being adopted and the obstacles to higher take up. Since 2019 we have been optimising the EPR, understanding the ways we can improve and get the most out of the system. We will then enter what we characterise as the final "full transformation phase", where we will begin to realise the true benefits of an EPR. We admit we're still not quite there yet, but we've come a long way on the journey.

2. **It's a culture change programme, not a technology roll-out** .

To begin with, the board didn't appreciate the extent of the wider change piece that was fundamental to the success of the EPR. What helps here is if the board really understands the organisation's current level of digital maturity, not just in terms of available technologies, but also the capability and attitudes across the workforce.

We talk of the four phases of our EPR journey, but a lot of the foundations were laid several years before we even decided to procure Cerner Millenium, when the board made the decision to significantly invest in core digital infrastructure. Alongside this investment came a recognition that the workforce would need to be engaged continuously during the trust's digital journey, with ongoing discussions, led by the board, on the new ways of working that the EPR would require.

3. **A new EPR needs the chief executive's attention and cross-board leadership.**

An EPR is too large to delegate to one leader and requires the entire board's focus. For a chief executive, it cannot be a passing interest. During the implementation phase it must remain one of the top two or three items in their in-tray. The chief executive also needs to understand how staff are using the tool. One of our four pillars at Calderdale and Huddersfield is "go see". The chief executive – and the rest of the board - must go and see the EPR in action.

4. **Understand your supplier.**

This is of course easier said than done and it requires the trust to have a strong "client side", and not just during the implementation period. Trusts will want to focus on collaboration rather than lengthy contract negotiation with their EPR supplier, but to reach this relationship maturity, it will be important for the board to consider the following questions:

- What is the supplier's business model? When and where are they making their money; is it in upfront costs or further down the line in terms of development and licensing? It is important for boards to understand lifetime costs.
- How does the supplier make decisions? Who is authorised to make decisions and what is the process?
- When can the supplier help you and when will they *not* have the answers? And equally, when they want something from you, what will be the cost to the trust?

5. **Engage staff with openness and honesty.**

Engaging your staff on the new EPR seems obvious, but is something we underestimated. There is a significant hearts and minds piece that goes alongside an EPR, and the board must constantly demonstrate that leaders are listening and acting on feedback from staff. It is imperative that staff trust the process during the EPR journey. The board must manage expectations and be honest. Even if you're unable to address some of their concerns, you must

remain sincere about feedback. As CIO I made sure I was known right across the organisation, spending nightshifts with staff to ensure I heard the views of all. To this day clinicians still email me directly with their challenges and ideas.

The importance of staff training also can't be overemphasised. We realised in retrospect that during the deployment we did not do enough user testing with staff which would have informed our training programme. We focused on EPR training by function: doctor, nurse, porter. But we should have also trained by workflow to better understand the patient journey and their touch points with the EPR. Since we introduced our EPR we have adopted a "digital ways of working" methodology within the trust which would have made our implementation a lot easier if we had started with this.

6. **Calculating benefits is hard.**

The landscape and what you think will happen almost changes immediately after go-live. An EPR is first and foremost about improving patient safety and quality of care, rather than financial efficiencies. We initially thought the financial benefits would come in the first six months. The truth is, it was the clinical benefits that materialised much faster at Calderdale and Huddersfield, driven by the fact staff could access data much more quickly. It's really taken three or four years for the financials to improve, and even then, the gains haven't been huge.

7. **Keep the regulators engaged and updated throughout.**

It will make it easier when things go wrong. We knew from the get-go that our EPR journey wouldn't be plain sailing. For example, we quickly identified that people would have workarounds once we had introduced the new system. That's why we're still only in our optimisation phase, and we're clear that this is an ongoing, iterative optimisation. For this reason we'd encourage boards to bring in the CQC right from the outset, even before go-live. The regulators will be justified in asking how staff are using the new system and how it is improving care, and therefore will quickly discover if the EPR has simply digitised existing processes and had little impact on patient care. Sometimes they can even help solve some of the operational challenges you're facing (for example they helped our team develop new patient letters).

Conclusion

Introducing an electronic patient record across a large organisation is a lengthy, complicated process. It will never be without its risk, but the board must be confident and seek evidence that risks are being properly managed

throughout this journey. We’ve learnt a lot as we’ve progressed through each stage of our EPR roll-out. Most fundamental of all has been the need for the whole board to champion the opportunity that an EPR represents to improve the safety and quality of care, and to engage all staff from the outset.