Project Identification No: OGC 394

NHS Integrated Care Records Service (ICRS) Programme

OGC Gateway review: Gateway 2.5 – Procurement Strategy

Status of report: Final

Senior Responsible Owner: <Text Redacted>

Review Date: 2nd to 6th June 2003

Review team:

<Text Redacted>

Office of Government Commerce

Background

1. The aims of the Programme are to give:

    - patients a modern IT-enabled NHS, which will directly impact on the care they receive;
    - frontline NHS staff access to safe, fast modern IT to support them in their work; and
    - managers, researchers and other professionals not involved in direct patient care access to high quality, confidential information.

2. Delivery will take place in three phases, by the end of 2004, 2006 and 2010 respectively.

3. Phase One will allow doctors to book outpatient appointments on line, send emails and browse the internet and view information relating to their patients. The latter will include laboratory and radiology results and some clinical correspondence, for instance GP referral letters. Phase One will offer simple functionality and make best use of existing and interim systems.

4. Phase Two will give doctors and health professionals access to a more detailed patient record, which will include specialist results, the GP prescribing record, and hospital discharge summaries. These services will be supported by telemedicine and digital imaging. Phase Two will also computerise all referral, requests and orders and all hospitals will have PACS (filmless X-rays) support in place.

5. Phase Three will incorporate the advanced features necessary to fully integrate care across both health and social services. This will include decision support software, screening, community wide prescribing and clinical documentation, to include assessment and care planning

6. Ultimately, ICRS will replace the myriad of computer systems currently in use in the NHS with national applications supported by robust standards.

7. The driving force for the programme is the policy paper "Delivering 21st Century IT Support for the NHS", which focuses on a patient centric approach.

8. The ICRS programme together with the infrastructure programme, e-Bookings and the Electronic Transfer of Prescriptions comprise the National Programme for IT (NPfIT).

9. The position of the Programme in the procurement process is that Preliminary ITN (PITN) and Output Based Specifications (OBS) have been issued.

10. The Gateway 1 report was delivered in October 2002.

Purpose and conduct of the review

11. Purpose of the review:

- Confirm the outline business case.
- Ensure that the procurement strategy is robust and appropriate.
- Ensure that the project's plan through to completion is appropriately detailed and realistic.
- Ensure that the project controls and organisation are defined, financial controls are in place and the resources are available.
- Confirm funding availability for the whole project.
- Confirm that the development and delivery approach and mechanisms are still appropriate and manageable.
- Check that the supplier market capability and track record is fully understood (or existing supplier's capability and performance).
- Confirm that the procurement (or acquisition approach) will facilitate good client/supplier relationships.
- Confirm that appropriate project performance measures and tools are being used.
- Confirm that quality procedures have been applied consistently since the previous review.

Conduct of the review:

12. The Gateway 2 review was carried out from 2nd June 2003 to 6th June 2003 at Leeds and London. The team consisted of:

<Text Redacted>

13. The people interviewed are listed at the Appendix.

14. The team would like to thank the Programme Team for arranging the interviews and providing portable documentation, their legal advisors for providing the accommodation for the review and the interviewees for their cooperation and candour.

Conclusions

15. There is widespread support for the aims and objectives of the ICRS. Much of the effort so far has been based on a view of this as an IT programme whereas it is really much more to do with fundamental business change; the means to deliver this are now being put in place but are not yet mature.

16. ICRS has its own Programme Board and programme-level documentation. It is not clear what added value these provide as they do not reflect the way the programme is being run.

17. The critical recommendations made in the Gateway 1 Review have for the most part been implemented with the exception of stakeholder engagement and change management, neither of which has yet produced beneficial outcomes. Since that Review there have been substantial changes in the shape of the programme and in the resources to deliver it. The necessary disciplines for programme management and control are now being established but it is too early to say how well this has been delivered.

18. The programme has a very aggressive timescale, which is positive in terms of driving the programme forward, but brings with it risks that have to be managed; there appears to be no contingency plan.

19. The affordability of the programme is as yet unresolved.

20. The Review Team concludes that the programme status is AMBER, but will revert to RED if certain recommendations are not implemented (see paragraphs 62-64).

21. This is a mission-critical high-risk IT enabled programme, being implemented in a modular / incremental manner, although the first phase of the local systems is substantial.

22. From 1st July Gateway Reviews will check that a responsible Minister has been identified, that the SRO and PM assessments have been undertaken and that there should be an Accounting Officer note of assurance regarding common causes of failure. This requirement does not yet apply but the Accounting Officer is aware of it.

23. Exemplars of good practice are:
    - The imaginative sequencing of tasks for suppliers in a very tightly timetabled procurement
    - The extensive market analysis that preceded the procurement strategy
    - The quality of the OBS

Summary of recommendations

24. The Review Team recommendations are all critical before next review in that they must be actioned before the next OGC Gateway review:

Recommendation 1: The ICRS Programme Board layer should be removed and absorbed within the National Programme (para 36)

Recommendation 2: Establish and implement a National Programme Benefits Delivery Strategy (para 39)

Recommendation 3: Funding stream assumptions need to be confirmed and strategies developed to address inconsistencies (para 46)

Recommendation 4: Review the timespans set out in the business case, proposed contract duration and for technology refresh (para 47)

Recommendation 5: Develop a formal mechanism for clinical input (para 51)

Recommendation 6: The risk management process should include regular risk identification workshops with participation from key stakeholders from outside the programme team (para 57)

Recommendation 7: Prepare a strategy to deal with the creation of Foundation Trusts (para 58)

Recommendation 8: Each cluster SRO should be asked to formally note their assessment that the CIO (or local implementation project manager) is capable of delivering the local implementation (para 61)

Recommendation 9: Put in place a hard internal decision gate to confirm that the necessary conditions to release the FITN and OBS2 have been met (para 64)

Potential for success

25. There is extensive stakeholder support for the principles of an integrated care record vision. There is a broad base of support for the programme, including political will and significant funding.

26. The OBS development has incorporated lessons from many previous OBS documents and has undergone extensive consultation resulting in widespread ownership.

27. There has been a focus on delivery of infrastructure rather than business benefit; however the approach invites imaginative proposals from suppliers including business change and user engagement.

28. The procurement route and analysis of options of sources of supply have been particularly well thought through.

29. There is a very strong management drive and a capable management team working to a challenging timetable, but it remains to be seen whether that can be met.

30. The breakdown of the programme into a national spine and 5 local clusters underpins the phased/ incremental approach.

31. Success depends on the local management of change underpinned by IT rather than delivery of IT supported by some change management. (Change management is mostly outside the programme as it is currently defined)

32. The London cluster, in the first wave of implementation, appears highly engaged and motivated. It is not clear if this is mirrored in the other first wave cluster.

Review of current phase

Programme organisation

33. The programme management structure is complex in that the ICRS programme is part of NPfIT under the aegis of the National Programme Board and the Operational Management Team (OMT) led by the DG/IT. Within the ICRS there are several projects to deliver the national spine and local components (the five clusters), the latter involving the Strategic Health Authorities (SHA) and Trusts as key agents in delivery of the system and the crucial business change.

34. In practice, the focus has been on the definition of the ICRS spine and the procurement of the ICRS, Local Services (LSP) and spine (NASP), and in this sense ICRS is working more as a procurement project than a programme.

35. In discussions with representatives from the London cluster and others, it is quite clear that they consider detailed negotiation and subsequent implementation as very much the business of the cluster, with no more than co-ordination expected from NPfIT. Implementation is therefore a substantial 'programme of programmes', which sits most naturally at National Programme level rather than ICRS level. This is because the scope of the implementation is broader than just ICRS and therefore the level of authority and input needs to be at the top level across the whole scope of the National Programme rather than limited to a single (though large) development stream.

36. This reflects the way the programme is being run currently and the way the decision making bodies (National Programme Board and OMT) actually operate. For example, it is recognised that cluster implementations are programmes by having Programme Managers assigned to them. It is far from clear what added value the ICRS Programme Board provides. It has also clouded the issue that each of the projects needs its own SRO and business case.

Recommendation 1: The ICRS Programme Board layer should be removed and absorbed within the National Programme.

37. In implementing this recommendation, the NASP and the cluster-based programmes would each report directly to the National Programme Board and have their own SRO (such as a SHA CEO). This does not preclude retaining the ICRS label.

Benefits Delivery

38. The ICRS programme has focused on the delivery of the specification and procurement of technology and services as underpinning infrastructure. Responsibility for implementation and benefits delivery lies with the clusters. They in turn will look to the Modernisation Agency (MA) to support them in exploiting the ICRS technology to deliver new processes and hence benefits.

39. The relationship between this infrastructure and its subsequent exploitation is through parallel and as yet unlinked activities within NPfIT and the MA, which already has a significant agenda. Without a delivery-focused benefits strategy, there is the risk that at best benefits delivery will be un-coordinated between clusters and, at worst, not take place at all. Exploitation of ICRS requires an over-arching benefits delivery strategy which is currently missing.

Recommendation 2: Establish and implement a National Programme Benefits Delivery Strategy

40. This calls for creation of a project whose terms of reference will be to develop the strategy and provide the appropriate formal linkages between NPfIT, the MA and individual cluster stakeholders. This project should be led by a delivery-focused executive and include clinical input.

Business case

41. The Approval to Proceed (1) document (AtP1) that serves as the OBC for the ICRS programme is less well developed at this stage in the procurement than would normally be expected. The development of the OBC has not followed the standard business case approach. A process has recently been put in place between the programme, DoH and Treasury to support an iterative approach to the formal approval of AtP1. Notwithstanding this adopted approach, there are a number of products that must be completed and factored into the AtP1 before this approval can be confidently expected. A number of workstreams have been proposed to deliver these products for AtP1 by the deadline set out in recommendation 9.

42. The costs in the business case are based on a consolidation of individual NHS Trust EPR business cases for different types of NHS Trust. The plan calls for responses from suppliers, within 5 weeks, to the PITN indicative charge model, which is aimed at trying to understand the quantum of cost.

Funding streams

43. The level and phasing of the additional funding for NPfIT secured in the SR2002 for the three years to 2005/6 is clear (£2.3 billion). Recently completed local development plans prepared by SHAs and their local health communities should also indicate the level of local IM&T investment over this three year period.

44. The proposition that ICRS will be delivered through a managed service or outsourced solution implies a payment stream that will be predominantly revenue based. Accordingly a key issue to be resolved is the flexibility available for the additional funding quantum to be used for revenue expenditure given its original allocation as capital funding. The NHS Director of Finance recognises ownership of the issue, however the review team believes it must be demonstrably resolved before contract structures can be finalised.

45. Future funding settlements and allocation decisions should recognise the cost implications of contracts entered into in support of the ICRS programme.

46. The review team has a concern that assumptions made at the programme level regarding the funding of implementation costs at the local cluster level do not accord with IM&T investment assumptions within local development plans. An analysis of this issue needs to be undertaken as a priority.

Recommendation 3: Funding stream assumptions need to be confirmed and strategies developed to address inconsistencies.

Consistency of timescales

47. The programme as currently configured is based on a business case that covers 10 years, with a proposed PPP contract for 5+2 years from first implementation and an intended technology refresh after 5 years. It seems clear that the benefits will

develop with time and the 10-year business case window may not capture all of these. The proposed contract would include provision for some lump sum payment but with the presumption that the supplier provides the initial funds for system acquisition; a five year-plus contract allows time to recover this investment. It is unclear how this would apply to the investment needed for the technology refresh and hence whether the proposed contract duration is consistent with this and with requirements regarding asset transfer.

Recommendation 4: Review the timespans set out in the business case, proposed contract duration and for technology refresh.

48. Note that this needs to be done in time for Recommendation 9.

Timetable

49. The plan timetable is recognised as very challenging. The review team supports the aggressive mindset, but there is a difference between driving hard to meet challenging milestones and letting the milestones distort the shape of the project and the quality of its deliverables. There is no documented contingency for delay. In the event that a conflict arises between quality of outcome, cost and target timescale, it would be sensible to revise the timetable.

50. The feasibility of achieving the very challenging timetable should become visible at the decision gate set out in recommendation 9.

Clinical input

51. There is no formal machinery for gaining clinical input to the programme, even though there has been formal clinical input to the strategy and the development of the national programme together with clinical members of the ICRS programme team. It is clear that clinical acceptability is critical to the delivery of programme benefits, but it should not be left purely to individual clinicians to determine acceptability during implementation. If Royal College or similar representatives are engaged in the evaluation process, then there will be a legitimacy that may help with local clinical take-up.

Recommendation 5: Develop a formal mechanism for clinical input.

Programme controls

52. Even though the OBS was produced to a very high standard, the majority of documents provided to the review team were of indeterminate status. This indicates a lack of programme control, which is now being corrected.

53. The procurement timetable is being held firm, although the business case is late. There is clear evidence that normal project disciplines and controls were not in place, but in recent months these are being developed and implemented. There is now a clear weekly operational management team providing a high level checkpoint control. Dependencies are managed through a fortnightly cross programme meeting. Plans, risks and issues are now being brought into a controlled process of release and update***. The controls must be fully in place and seen to be working for the Gateway 3 reviews.***

54. Budgets to the total available NPfIT funding for 2003/4 (£375 million) have been developed, including the ICRS programme in the current year. These are being proposed to the OMT for approval and will subsequently be consolidated into

programme management reporting arrangements. This budget determination is also being integrated into standard DoH financial control processes.

Risk management

55. As with other project controls, a risk management process is being implemented to replace previous arrangements. This has yet to bed down. Although there has been a risk workshop the risks identified fell short of the expectations of the review team, e.g. risk of legal challenge, risk of Foundation Trust non-compliance, risk of suppliers not having the capacity to deliver. The review team saw no evidence of major risks being considered at the level of Operational Management Team or ICRS Programme Board. This may be a consequence of the pace of the programme outstripping the pace of the risk management process.

56. The scale of this procurement is causing the NHS IT Supplier market to restructure. Current suppliers that are unsuccessful have no prospect of further NHS business until the procurement is repeated and a number will withdraw from the market or may fail. The risk of a legal challenge by an unsuccessful supplier must be significant, because a number of suppliers will have nothing to lose.

57. This risk does not appear to be in the current register, although the degree of legal input and interviews with the team suggest the risk is recognised and is being managed. There may also be a risk that first wave clusters may cherry-pick suppliers with the preferred application suites.

Recommendation 6: The risk management process should include regular risk identification workshops with participation from key stakeholders from outside the programme team.

Foundation Trusts

58. It is not clear to what extent Foundation Trusts will be obliged or choose to participate in the ICRS and related systems. The prospective scale of Foundation Trusts is such that their non-participation would severely undermine the benefits achievable from the system; moreover there could be contract legacy issues if the Trust did not wish to continue with the ICRS cluster contracts it inherits. This risk is not on the risk register seen by the review team and the Programme Board needs to take this into account in preparing a strategy to respond to the creation of the Trusts.

Recommendation 7: Prepare a strategy to deal with the creation of Foundation Trusts.

59. This needs to be done by Gateway Review 3.

Local implementation

60. The success of the programme depends ultimately on clinical acceptability and the management of change at a local level. Currently, the programme seeks to engage local management through top team meetings (28 SHA Chief Executives), but principally through SHA Chief Information Officers. There is a mixed calibre of CIO population, so some local communities may not be as well prepared for implementing the procured LSP solutions.

61. Although SHA CEOs are accountable for successful implementations within their patch, the SRO for a cluster has a responsibility to ensure that this is integrated so as to ensure successful delivery for the entire cluster. This may be through the SHA performance management responsibility.

Recommendation 8: Each cluster SRO should be asked to formally note their assessment that the CIO (or local implementation project manager) is capable of delivering the local implementation.

Readiness for next phase – investment decision

Decision Gate

62. This current Gateway Review, which is of the programme rather than a specific project, does not occur at a distinct decision point. There is however an imminent key milestone with the issue of the Final ITN (FITN) and the revised Output Based Specification (OBS2) scheduled for 1 August.

63. It is clear that a number of things must be in place before the issue of these documents, such as:
    - Determination of the Contract Authority for NASP and cluster projects
    - Confirmation of the funding streams- from central and local sources
    - Agreed pricing model and the nature of PPP
    - Requirement and timescale for technology refresh
    - Exit criteria (both planned and early demise), including TUPE issues and asset transfer
    - Completion of due diligence regarding legacy assets
    - Confirmation that the cluster is ready to tackle its role with leadership, management, resources, commitments and agreements in place
    - Confirmation that the AtP process (covering the required Business Cases) is complete
    - Confirmation that Acceptance Criteria have been prepared and that there are milestones for their completion before contract placement
    - Confirmation that the definition evaluation process and associated weights are finalised

64. These and any other necessary conditions can be compiled in the form of a go/no-go checklist as input to short decision gate review in which all of the conditions must be met before proceeding.

Recommendation 9: Put in place a hard internal decision gate to confirm that the necessary conditions to release the FITN and OBS2 have been met.

65. Note that this recommendation is classified as AMBER, but a failure to implement it raises the overall status to RED.

The next OGC Gateway Reviews (gate 3) for the NASP and local clusters are expected in October 2003.

LIST OF INTERVIEWEES

<Text Redacted>