

**TITLE OF PROJECT**

**NHS Care Records Service: Local Services Provider  
Wave 2 Cluster: East and East Midlands**

**OGC Gateway review: Gateway 3b Implementation preparedness**

**Status of report: Final Report**

**Senior Responsible Owner: <Text Redacted>**

**Review Date: 26 – 30 April 2004**

Review Team:

<Text Redacted>



## 1 Background

- 1.1 The aims of the NHS Care Records Service (NCRS) 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 anonymised high quality, confidential information.
- 1.2 Delivery will take place in three phases, by the end of 2004, 2006 and 2010 respectively.
- 1.3 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.
- 1.4 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 Picture Archiving and Communication Systems (PACS) support in place.
- 1.5 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
- 1.6 The NCRS programme together with the infrastructure programme, e-Bookings and the Electronic Transfer of Prescriptions comprise the National Programme for IT (NPfIT). 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. Ultimately, NCRS will replace the myriad of computer systems currently in use in the NHS with national applications supported by robust standards and implementation will be conducted through six projects. The first will provide a national infrastructure and the others will deliver application services in five regional Clusters of Strategic Health Authorities (SHAs).
- 1.7 This is a Gateway 3B review carried out in respect of the prospective implementation of the East and East Midlands Cluster within Wave 2. The SRO for all elements of the implementation programme is <Text Redacted>

## 2. Purpose and conduct

- 2.1 The purpose of this review is described in Appendix A.
- 2.2 The review was carried out from 26 – 30 April 2004 in Hatfield as part of a combined review with the North East and Southern Clusters within Wave 2 of the NCRS LSP projects. We have taken into account the conclusions reached in the Gateway 3A reviews and the recommendations made in so far as completion of the related actions has a bearing on the readiness for the next phase for the Wave 2 Local Service Provider Projects.

- 2.3 Those interviewed are listed in Appendix B at the back of the report. The review team would like to thank everyone involved for their support and openness, which contributed to the Review Team's understanding of the project and the outcome of this review. We are particularly grateful for the help and support of <Text Redacted> and their teams for organising a demanding interview and visit schedule and for their rapid responses to our various requests.

### **3 Conclusions of national relevance**

- 3.1 While the conclusions in Section 4 are complete for this Cluster, a number of them require national rather than Cluster action, either entirely or in part. These specific issues will be drawn together, along with those of a similar nature raised in the other four recently completed gateway reviews, in a single document to the national SROs' representative.

### **4 Conclusions**

- 4.1 The Review Team finds that:
- 4.1.1 There is strong top management and clinical support for the success of the EEM Cluster programme. This support is reflected across the whole spectrum of interviewees.
  - 4.1.2 Effective governance structures and protocols have generally been established down to and including the Statutory Trust Boards
  - 4.1.3 There is strong ownership of the programme in the SHA and Local Health communities and numerous examples of Trust CEO's chairing local programme boards.
  - 4.1.4 Clinical engagement is strong in the Early Adopters and PAS Early Implementers
  - 4.1.5 There is increasing Cluster clinician involvement in the design and development of LSP deliverables. Potential problems due to the EEM Cluster being contractually committed to sharing a common LSP deliverable solution with the NE Cluster who had already had the opportunity to make early input to the deliverable design have been well managed.
  - 4.1.6 The LSP has mobilised quickly and effectively. The LSP has delivered its manpower build commitments with quality resource and established good working relationships at all levels including the Trusts
  - 4.1.7 The placing of an experienced Commercial Manager in the Cluster team has supplemented existing resource with experience from the procurement negotiations and strengthened the confidence that the programme will be implemented with due regard to the complexities of the contracts involved
  - 4.1.8 There is good support across the Cluster for the appointment of Professor Aidan Halligan which it is believed will add momentum to the change from a necessarily centrally focussed procurement organisation to one which is devolved and committed to improving the quality of care across the service.

- 4.1.9 Early deliverables from the LSP have generally been on time and of a suitable quality, notwithstanding the tight timescale. Some re-working, most notably in the Detailed Implementation Plan, has been necessary due to insufficient understanding on the part of the contractor during drafting or in order to reach a position acceptable to both parties on issues with commercial implications. To date the LSP response to concerns has been good.
- 4.2 However there are a number of areas in the EEM Cluster which need to be addressed in order for the programme to have a greater chance of success:
- 4.2.1 Despite sharing the same LSP with the NEC and being committed to common design solutions no formal protocols exist between the two Clusters to cover acceptance and sign off on those solutions.
- 4.2.2 Clinical engagement has accelerated rapidly in recent weeks and there is good involvement in LSP deliverable design and development. That said there is a strong sense across the Cluster that this programme of engaging clinicians needs to accelerate further. No definitive plan is in place to achieve such acceleration.
- 4.2.3 There is uncertainty in some areas of the respective responsibilities of the LSP and the Authority during the process of PID development. Given the importance of this activity for setting the right foundations for taking each component of the programme forward it is important that all customers are made aware of their role.
- 4.2.4 There is a level of concern across the Cluster at the magnitude of the task and the availability of NHS resource to support it. The proposed fully integrated Cluster plan, on which agreement to its development has now been reached with the LSP, will be fundamental to monitoring progress in the multiplicity of projects across the Cluster and whether or not they are adequately resourced.
- 4.2.5 Specific concerns have been expressed in terms of the availability of experienced resources in the areas of project management, training and business change management. We have seen no evidence of systems in place to make an early assessment of the validity of these concerns.
- 4.2.6 Delivering training is seen to be a particular challenge since it involves not only releasing quality trainer resource but also the people to be trained. Apart from the Early Adopters and Implementers, training needs have yet to be identified or quantified. We have seen no evidence of plans to identify the full scope of this emerging issue.
- 4.2.7 There is a great commitment across the Cluster to the strong SHA centric management approach. The Cluster organisation views itself largely a facilitator and quality assurance organisation.
- 4.2.8 This devolved approach is reflected in two specific ways:
- 4.2.8.1 There has been no focus in the organisation for the standardisation of clinical or business practices. While this approach is acceptable for Phase 1 Release 1 it will lead to the loss of opportunities to achieve significant business and clinical care improvements at the time of Phase 2 releases to the long term benefit disadvantage of the EEM care communities.
- 4.2.8.2 A group of Cluster clinicians have recently advised of their preference not to establish a CCAG but to continue to operate through well established and effective formal and informal networks. Consideration should be given as to whether assigning the Cluster Lead Clinician a formal governance role would be advantageous to the overall management of clinical issues in the Cluster.

- 4.2.9 As implementation gets underway and the full scope of the task at Cluster level emerges we, like the RID, see a need for additional resource in the Cluster team notably the recruitment of a Business Development Manager and staff to supplement planning activities with Accenture and to assure high standards of project management deliver in the LHCs
- 4.2.10 Despite a number of recent high profile communication events there is a widely held view at all levels across the Cluster that only the surface of the challenge of wider NHS stakeholder engagement has been scratched. Little effective communication has been done to address the awareness needs of the bulk of the NHS stakeholders. Tight control of the release of information during procurement has not changed significantly. It remains hard to get approval for strategic information release and this of itself limits initiatives and requests. A Communications and Stakeholder Engagement Strategy has however been recently jointly developed with the LSP and reviewed with the CPB.
- 4.2.11 Cluster is aware of delays in the planned delivery dates on the NASP Spine. These delays are impacting through the dependency chain on the LSP and delaying his solution testing schedules. Relief has been granted nationally on interim delivery milestones and as yet the final delivery date for system go-live is not threatened. The contractor is currently eating into his contingency and absorbing additional costs.
- 4.2.12 There is strong ownership in the SHAs to define the scope of their legacy system upgrades. They are receiving support from Cluster management in negotiations with local legacy suppliers and nationally with the larger suppliers. The SHAs still await national advice on the specification for upgrade requirements. We strongly endorse the Cluster decision to allocate specific Cluster resource to support the effective management of these activities in their SHAs
- 4.2.13 There is a problem in ensuring the LHCs deliver acceptable data quality standards when migrating information into the new NPfIT systems since there is no clear guidance as to the quality the data needs to meet.
- 4.2.14 Benefit realisation plans in the LHCs, where they need to reside, are very limited. Although work has been done on benefit realisation methodologies and consulting resource for benefit realisation, development has been made available in the organisation. A number of those interviewed a felt that current guidance needed to be more directly usable in the Trusts, especially as they move into developing PIDs.
- 4.2.15 The Status of the Project is Amber

## **5. Summary of recommendations**

- 5.1 The following recommendations should be addressed as a matter of priority:
- 5.1.1 A formal protocol should be established with the NE Cluster to define how the two Clusters should work together in the most effective way, given their common solutions and LSP, to the mutual advantage of both customer and supplier.
- 5.1.2 A plan to accelerate clinician engagement should be developed in conjunction with the SHA CAGs, incorporating early feedback on the e-booking Early Adopters supported by the national ebs team.
- 5.1.3 There should be strong encouragement across the Cluster for greater priority to be given to the identification of training needs in order that the consequences for funding and the release of staff can be planned with sufficient notice.

- 5.1.4 The extent of delays in relation to the NASP spine should be clarified as soon as possible so that any adjustments necessary to the NCRS schedule can be made with the minimum of impact to the LSP programme.
- 5.1.5 A clear understanding of the status of various legacy systems should be developed across the Cluster that identifies all dependencies and the contribution of each organisation, especially where this represents a contractual obligation by the Authority under the NPfIT contract.
- 5.1.6 The Cluster should consider the benefits of the lead clinician being given a formal governance role.
- 5.1.7 The opportunity should be taken to use the Phase 2 releases to deliver greater standardisation of business and clinical processes.
- 5.1.8 Given the importance and challenge of delivering real business benefits, the Cluster should ensure that Trusts are provided with clear guidance that is relevant to their needs. This should be further reviewed when national guidance is issued.
- 5.2 The following Recommendations should be completed before the next Gateway Review:
  - 5.2.1 The Risk log needs to be updated and the resulting high risks discussed at the next Cluster Programme Board
  - 5.2.2 The Cluster should consider guiding SHAs to appoint full time [Business Change] Implementation Directors to their teams or release Modernisation Directors for this role by backfilling.
  - 5.2.3 The RID is looking to increase resource and we recommend these proposals be supported in order that the Cluster can properly fulfil its role within the overall governance structure.
  - 5.2.4 The Cluster should consider a communication initiative with the SHAs to clarify the process of PID development and endorsement and the respective roles of the Authority and the LSP to ensure genuine joint ownership.
  - 5.2.5 The skill requirements identified in the early PIDs should be used as a practical basis for scoping the magnitude of the NHS resource challenge.
  - 5.2.6 The Cluster should gain prompt commitment from SHAs and LHCs to implementation of the recently agreed Communications and Stakeholder Engagement Strategy.
  - 5.2.7 The Cluster should provide the national team with a clear statement of their needs in respect of data quality for cleansing in order that the national team can provide the necessary guidance.

## **6 Detailed Findings**

### **6.1 Governance and Management Controls**

- 6.1.1 The overall philosophy of a SHA-centric approach is well understood across the Cluster and being applied consistently. Responsibilities at various levels are clear and in operation.

- 6.1.2 There is strong commitment at SHA leadership level. The SHA Programme Implementation teams appear to be adequately resourced for the current phase. However we are concerned that the demands of the implementation will overstretch the availability of Modernisation Directors and CIOs to lead the business and IT side of the implementation. **We therefore recommend that the Cluster consider guiding SHAs to appoint full time Implementation Directors to their leadership teams, or release Modernisation Directors for this role by back filling.**
- 6.1.3 Responsibility for formal authorisation of PIDs has been moved from Trust Boards (which generally meet 2-monthly) to Local Community Programme Boards. This pragmatic move should provide greater agility and responsiveness and is strongly supported by the Review Team as a elegant solution
- 6.1.4 The EEM Cluster is tied (contractually) to common design with the NE Cluster. Initially, given the earlier start to their programme, a number of design decisions were taken by NE which EEM had little option but to agree to after the event, but there is now greater alignment of the two programmes and both organisations are working more closely together to harmonize their approach. **We recommend there would be advantages in taking this ad hoc arrangement a step further and formalising it. The approach should be one of a light touch rather than an additional bureaucratic overhead, but there would be considerable benefits and efficiency gains for both customer and supplier, for example if the design approval process could be carried out once rather than twice on each occasion.**
- 6.1.5 In keeping with the SHA-centric approach, EEM have opted not to establish a Cluster Clinician Board and instead have an individual (a former GP, available for 50% of his time) carrying out the role of Cluster Lead Clinician. Given the need to achieve pan-Cluster harmonization on a range of clinical issues, **We recommend consideration should be given to the benefits of the Lead Clinician being given a formal governance role.**

## 6.2 Continuing Support for the Project

- 6.2.1 There was widespread support for the NPfIT programme across the Cluster, at all levels and an enthusiasm for the new opportunities it would produce. NPfIT is seen as the top priority for the SHAs and there is a will to see it succeed and deliver the benefits to the NHS and its patients. There were many examples of Trust CEOs chairing Programme Boards.
- 6.2.2 A set of principles for clinical engagement across the Cluster have been promulgated and adopted. The Clinician community generally is showing great interest and enthusiasm, providing an effective expert input to the design/development process.

## 6.3 Development and Implementation Plans

- 6.3.1 All managers felt that funding was extremely tight, some (particularly CEOs) that they had an overall deficit. The challenge is likely to rise as cost estimates become more robust. At the SHA level the view was that overall the national programme was probably under-funded at present and that various inter-programme adjustments would be needed in order to meet all its commitments. They were committed to protecting NPfIT delivery and brokering funds to achieve to that end.

6.3.2 Agreement has recently been reached that the LSP will lead on the generation of a Cluster-wide Integration Plan, showing how the overall Cluster programme and its constituent parts relates to the various other NHS programmes and initiatives, identifies the scope of each programme and who is responsible for delivery, and also shows the relationship with the various Legacy systems across the Cluster. **The Review Team sees this as a very positive step forward.**

#### **6.4 Business Preparedness**

6.4.1 Since Contract signature, both the Cluster and the LSP have made encouraging progress through some intense periods of activity and have sustained the momentum that was successfully generated in the procurement phase. The programme remains on track, although it is only now that the scale of change that it will introduce is beginning to be appreciated, notably in the Local Health Communities and the Trusts.

6.4.2 The Cluster team is almost up to strength, having recently been reinforced by the addition of a Contract Manager and currently awaiting the appointment of a Business Development Manager, which will complete the current team (9 perm staff + 2 KBR). The team now includes a Contract Manager (and support) covering both the EEM and NE Clusters, which represents expertise that is likely to be key to successful management of the Cluster(s) as commercial pressures rise. The RID is looking to reinforce his team to increase capacity for Planning and Programme Mgt and to set best practice project management standards across the Cluster. **We recommend support is given to the RID proposals**

6.4.3 Development of PIDs for each implementation is now well under way for Early Adopters and is seen as a key step in clarifying the responsibilities of the respective parties and establishing the appropriate management arrangements. The lead for this activity is being taken by the LSP, working in partnership with each customer, but there was some evidence that the context for this activity is not yet properly understood by some organisations and **we recommend that a communication initiative be undertaken to clarify the role of the Authority and the LSP during the PID development and endorsement process.**

6.4.4 Coping with such a compressed programme is presenting a real challenge for many organisations, especially the Trusts, who find it difficult for example to turn around documents in the time needed. At worst, some stakeholders felt there was a danger they might be bounced into rushed decisions, although they made clear that the LSP was not seeking to take advantage.

**6.4.5** The discipline of developing the early PIDs is highlighting some real difficulties in resourcing Project teams with sufficient numbers of staff of the requisite quality.

6.4.6 There are general concerns across the Cluster about the ability of organisations to man the NPfIT programme notably in the areas of project management, business change management and training. As with finance, NPfIT will be given the requisite priority; but this will cause a knock-on effect either by depriving other programmes of staff or withdrawing them from regular (ie non project) occupations, backfilling where possible. **It is recommended that requirements for these key skills identified in the early PIDs be used to scope the magnitude of this challenge**

6.4.7 In most cases (ie apart from the Early Adopters and Implementers), training needs have yet to be identified and quantified. There is a widespread recognition that this is likely to represent a significant challenge, in terms of both funding the training and releasing staff to attend courses. **We therefore recommend that the whole topic of training be given greater priority in order that the scale of the problem is identified as soon as possible and the appropriate planning can be put in place.**

- 6.4.8 The LSP, Accenture, is generally making good progress – despite having won two contracts. Milestones have been met, and resource build-up is on track in terms of both numbers and quality (2 rejections out of 600). Most people have been impressed with the positive approach.
- 6.4.9 There is a real sense of partnership expressed by a number of customers ('we succeed only if you succeed'), although those more experienced recognise that it will take time for mutual trust to be developed.
- 6.4.10 Early deliverables from the LSP have generally been on time and of a suitable quality, notwithstanding the tight timescales. Some re-working has been necessary due to insufficient understanding of the clinical environment on the part of the contractor or in order to reach positions acceptable to both parties on issues with commercial implications, but overall performance has been good.
- 6.4.11 The LSP is generally pleased with the relationships at all levels, having been through some testing discussions. The engagement is seen as very good at SHA level – a strong relationship with the key players. The LSP sees the next step as establishing similar links with Trusts/LHCs. PID development should flush out many issues and help raise understanding of the realities.

## 6.5 Risk Management

- 6.5.1 The current Risk Management Log prepared by the Cluster gives an unrealistic statement of a number of risks. It does not represent an accurate picture and therefore lacks credibility. **The Review Team recommends that it be updated and the risks be discussed at the Cluster Programme Board.**

### 6.5.2 Dependencies and Technical implications

- 6.5.3 The Cluster is aware of delays in the planned delivery dates on the NASP Spine. These delays are impacting through the dependency chain on the LSP and delaying the solution testing schedules. Relief has been granted nationally on interim delivery milestones and as yet the final delivery date for system go-live is not threatened. The contractor is currently eating into his contingency and absorbing additional costs. **The Review Team recommends earliest national clarification of expected SPINE delays which will bring stability to this situation and provide both a basis for any necessary revisions to critical delivery milestones and a platform for helpful and reasonable advice to the SHAs and LHCs**
- 6.5.4 Until now the Cluster team have not been taking an active role in managing the issues arising from legacy systems, acting primarily as a conduit between the coalface and the national programme. **The Review Team recommends a change in approach: the need is to develop a clear understanding of the status of various legacy systems across the Cluster, to appreciate the issues they each raise, to assist organisations where lessons learned can be shared, and to hold and manage the overall plan for the way forward. Such a plan should identify all dependencies and the contribution of each organisation, especially where this represents a contractual obligation by the Authority under the NPfIT contract.**
- 6.5.5 There is a clear case for greater guidance on the policies to be adopted when migrating legacy data to the new system. It is understood that the national team have undertaken to provide a policy covering this issue but can only do so in response to a clear statement of requirement by the organisations concerned. **It is recommended that the Cluster team provides a clear statement of data cleansing needs to the national team in order that they can provide relevant guidance**

- 6.5.6 The Cluster is not proactive in promoting business or clinical process standardisation, leaving individual organisations to decide for themselves how the introduction of standard processes will affect their operations and how the new technology can best be exploited. Whilst this approach may suit P1R1, later releases will offer far more scope for business enhancement. **We recommend that the Cluster gives a stronger lead on this front, encouraging more proactive thinking and facilitating the sharing of best practice.**
- 6.5.7 On a related issue, both the LSP representative and some senior customers made the point that the real challenge with business change will be in getting practitioners to understand that commonality and standard processes are going to be imposed as part of the national solution. There is a need to be working now on hearts and minds to get the principle accepted which will represent a major cultural change. There is a general view that individuals may understand the vision but not its implications.

## 6.6 Benefits Management

- 6.6.1 Benefit realisation plans in the LHCs, where they need to reside, are very limited. Some work has been done on benefit realisation methodologies, and consulting resource for benefit realisation development has been made available in the organisation. Nonetheless a number of those interviewed felt that current guidance needed to be more directly usable in the Trusts, especially as they move into developing PIDs. **It is recommended that such a framework be developed promptly, which should be further reviewed when national guidance is issued.**
- 6.6.2 Clinical engagement has accelerated rapidly in recent weeks with road shows, identifications of champions, network mapping and involvement in LSP deliverable design and development. That said there is a strong sense across the Cluster that this programme of engaging clinicians needs to accelerate further. No definitive plan is in place to achieve such acceleration. Prompt feedback from the First Wave Early Adopters and Implementers is seen as a central part of such an acceleration programme **It is recommended that a specific plan is put in place to ensure these experiences are captured and fed into the SHAs and LHCs by the national e-bookings team and this is incorporated in a local plan designed to promptly accelerate clinician engagement.**

## 6.7 Communications

- 6.7.1 Despite a number of recent high profile communication events, there is a widely held view at all levels across the Cluster that only the surface of the challenge of wider NHS stakeholder engagement has been scratched. Little effective communication has been done to address the awareness needs of the bulk of the NHS stakeholders. Tight control of the release of information during procurement has not yet changed. It remains hard to get approval for strategic information release and this of itself limits initiatives and requests. **It is recommended that the Communications and Stakeholder Engagement Strategy, jointly developed with the LSP and reviewed with the CPB in March, is converted into a specific actionable plan in conjunction with the SHAs and delivered promptly.**
- 6.7.2 The Cluster is giving a low priority towards the realisation of business benefits from the investment in NPfIT, leaving individual organisations to decide for themselves how the introduction of standard processes will affect their operations and how the new technology can best be exploited. Whilst this approach may suit P1R1, later releases will offer far more scope for business enhancement. **We recommend that there is a need for the Cluster to give a stronger lead on this front, encouraging more proactive thinking and facilitating the sharing of best practice. The national appointment of Aidan Halligan may be an additional spur on this issue.**

**6.8 Next review**

- 6.8.1 The next Gateway will be a Gate 4 review. We recommend that this take place around April / May 2005

## APPENDIX A

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### **Purpose of Gateway 3B: Implementation (a subset of the Gateway 3 list)**

- Ensure that management controls are in place to manage the project through to completion.
- Ensure there is continuing support for the project.
- Confirm that the development and implementation plans of both the client and the supplier or partner are sound and achievable.
- Check that the business has prepared for the development (where there are new processes), implementation, transition and operation of new services/facilities.
- Confirm that there are plans for risk management issue management and change management (technical and business) and that these plans are shared with suppliers.
- Confirm that the technical implications, such as 'buildability' for construction projects and (for IT-related projects) impact of e-government frameworks such as e-GIF, e-business and external infrastructure have been addressed.

**APPENDIX B**  
**List of Interviewees for the East and East Midlands**

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