

TITLE OF PROJECT

NHS Care Records Service: Local Services Provider – Wave 1 Cluster - North East

OGC Gateway review: Gateway 3b Implementation preparedness

Status of report: Final

Senior Responsible Owner: <Text Redacted>

Review Date: March 29 – April 2 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 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).

This is a Gateway 3B review carried out in respect of the prospective implementation of the Wave 1 clusters, London and the North East. The SRO for all elements of the implementation programme is <Text Redacted> for London and <Text Redacted> for North East.

2 Purpose and conduct

- 2.1 The purpose of this review is described in Appendix A. In view of the slightly unusual nature of the review, the Review Team felt that the most helpful way to structure the report was to adopt a subset of issues covered as part of a Gateway 3 Review:
- 2.2 The review was carried out from March 28 til April 2 in London and Leeds as part of a combined review of both clusters in Wave 1 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 1 Local Service Provider Projects.

- 2.3 This report covers our findings in respect of the London and North East Clusters.
- 2.4 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 <Text Redacted> for organising a demanding interview and visit schedule and for their rapid responses to our various requests.

3 Common Conclusions

- 3.1 While the conclusions laid out in Sections 4 and 5 are complete for each individual cluster, a number of significance are common, if not identical:
- Little real progress has been made in establishing effective benefit realisation plans
 - Stakeholder communications have lacked content and impact
 - The complexity of delivering legacy system upgrades has been underestimated
 - Potential e-Booking Early Adopter timing risks and their impact on programme reputation are significant
- Recommendations in respect of these appear in both the London and the NorthEast recommendations sections below.

4 Conclusions: North East

- 4.1 The Review Team finds that:
- 4.1.1 There is strong top management and clinical commitment to the success of the North Eastern Cluster programme backed by a competent and professional Regional Implementation team. An active Cluster Programme Board has established strong commitment from SHA and Trust CEOs and CIOs. Governance structures are generally effective, well supported and providing timely direction to the programme.
- 4.1.2 There is clinical and professional enthusiasm for the adoption of an integrated approach to patient data to give health care professionals easier and safer access to patient information. We found evidence of strong support to the project across the wide spectrum of people we spoke to.
- 4.1.3 Clinical engagement is strong in the Early Adopters and Early Enablers. The recent creation of a Clinical Advisory Team involving a number of committed champions will further strengthen this situation as will the establishment of the Project Boards in the Trusts where PIDs are currently being written.
- 4.1.4 The Local Service Provider has mobilised quickly and effectively. The LSP has delivered his manpower build commitments with quality resource and established good working relationships at all levels including the Trusts. LSP resource is now collocated in all 5 SHAs where in all cases it is collocated with the SHA project implementation staff. LSP early deliverables have with one exception been of acceptable quality and produced to schedule.
- 4.1.5 Enthusiasm in the Early Adopters and Early Implementers reflects the effort dedicated to their selection through the use of a comprehensive Readiness Assessment Tool. Strong support is being provided by the Cluster organisation to the Early Adopters to ensure they are ready to come on line on schedule.
- 4.1.6 The mobilisation success of the LSP and the manner in which communications and relationships have been established have served to sustain the momentum in the project generated by a successful centralised procurement activity which has

demonstrated that size and complexity need not slow down a fast and highly professional procurement.

- 4.2 However, there are some shortcomings in the North Eastern programme which we believe need to be addressed in order for the programme to have a greater chance of success
- 4.2.1 The Cluster will need an integrated plan which captures all NPfIT and other related IT activities which they have a responsibility to manage. They have a plan to deliver this essential schedule by integrating non-LSP related activities into the LSP's planning and resource management tool. They are currently in discussion with Accenture on this proposal. The Cluster needs to satisfy itself and the SHA's that such an approach will indeed deliver something which is acceptable to all parties.
- 4.2.2 Additional experienced Contract Management resource has recently been added to the RID team but only on a shared basis. Recognising the need to implement the programme with due regard to the complexities of the contracts involved concerns exist as to whether even this existing resource if delivered on a fulltime basis will be sufficient to meet this need.
- 4.2.3 Concerns have been widely expressed on the capability of the NHS to deliver the resource they will need to deliver the programme as implementation ramps up. To date we have seen no examples of such shortcomings nevertheless a rigorous project management tool will need to be in place which accurately identifies NHS resource shortfalls in a timely manner (see 5.2.1).
- 4.2.4 There is a specific issue related to the early adopters of the e-booking solution. Whilst this is not a review of e-booking, most participants expect that this deadline will be perceived as a first result for the NPfIT programme generally and thus also for NCRS. There is confusion on the state of preparedness, caused partly by excess secrecy on what the key dates are. We are concerned that the reputational risks to NCRS arising from early adopter failure are not fully appreciated.
- 4.2.5 Benefit realisation plans in the SHA communities, where they need to reside, are very limited. While clear responsibility for delivering a strategy has been vested in the Deputy RID, who published an updated strategy document in March, a document which is still in draft. Little has been achieved in terms of tangible plans or commitments.
- 4.2.6 Programme communications across the Cluster are less than satisfactory. Despite a recent series of meetings at SHA level involving both NHS and LSP representatives, which we understand were well received by those who attended, little has been done of a general nature to address the awareness needs of the bulk of the NHS stakeholders. Tight control on the release of information by the national organisation during procurement has not changed. It remains hard to get approval for information release and this of itself limits initiatives and requests jeopardising the enthusiasm and commitment necessary for the programme's ultimate success. There is a generally held view that clinician engagement is not where the organisation would like it to be. Comms resource exists at both Cluster and SHA level but it seems focused on strategy and stakeholder mapping and is delivering little of real value.
- 4.3 Exemplars of good practice used are:
- The rapid co-location of the LSP and SHA teams
 - The use throughout the cluster of a proven readiness tool to assess Trust preparedness
 - The development of a 'mission control' project and resource management system which will be available to the joint project teams
- 4.4 Status of Project is AMBER.

5 Summary of recommendations: North East

The following recommendation should be addressed in the short term:

- 5.1 The Cluster team should give higher priority to benefits realisation and tracking: (1) Defining just how benefit maximisation should inform their regular decision making . (2) Establishing a benefits management and tracking strategy and detailed plans including individual responsibilities, for achieving and measuring the identified benefits, and (3) Aligning the Cluster plan with the strategy emerging from Professor Halligan's role as SRO focused on benefits.
- 5.2 Integrated plans reflecting the full scope of the programme should be produced as quickly as possible. The RID team should satisfy themselves that such a plan is not only adequate for their needs but also for those of the SHA teams.
- 5.3 The Cluster team develop a communication plan involving both the trusts and the SHAs, which builds on those real successes that have recently been achieved and is rolled out promptly into those trusts with early slots.

In addition, a focused programme to ensure clinical engagement needs to be initiated promptly.
- 5.4 Early consideration be given nationally to adopting a more open communications and approval strategy since this will encourage activities that are just beginning to happen in the field

The following recommendations should be addressed before the next review:

- 5.5 A schedule of authorities should be developed for the RID and his organisation.
- 5.6 The capacity of the newly assigned contract manager should be examined at an early date against the assessed size of the task within the cluster.
- 5.7 The Risk Register should be examined to add more detail and specificity to the risks and mitigating actions.
- 5.8 Early advice should be given to the SHAs on the specific of the £13.3M and their portion of it.
- 5.9 Learning opportunities be made explicit.
- 5.10 Early clarification of the extent of portal access to resolve confusion.
- 5.11 Ad hoc scope or contract related changes be recorded formally with the LSP as they are made, to avoid them being quoted out of context by the provider at some future date.

6 Detailed Findings - North East

6.1 Governance and management controls

- 6.1.1 The Programme Board and Project Management Group are seen to be working well. Roles and responsibilities are well defined. It is felt that similar organisational strength is being established in the Project Management Boards in the Trusts where PIDS are being developed where good governance is assessing the quality and experience of each Board and ensuring there is formal LSP membership. The governance system would be further strengthened if supported by a clear set of Delegated Authority levels defining the decisions that can appropriately be taken by the RID and his team and those requiring Board/Group/Project Board approval. **We recommend that a schedule of authorities be developed for the RID and his organisation.**
- 6.1.2 At an operational level, meeting structures appear to be working well. The RID organisation meets twice weekly with the LSP. Ad hoc meetings are easily arranged as Accenture have their headquarters in Leeds along with their Cluster management organisation. LSP personnel in the SHAs are in all cases collocated with their NHS counterparts. Relationships are seen to be effective across all parts of the organisation.
- 6.1.3 Independent local solutions. We have found some evidence of these but they had both been effectively handled by the RID by appropriate management of programme adoption slot timing.

6.2 Continuing support for the project

- 6.2.1 We found strong evidence for commitment and support of the project across the wide range of interviewees we spoke to. However in order to maintain this we feel that communication must be improved as a matter of urgency (see 9.8 below).
- 6.2.2 As far as funding is concerned, we found that £13.3M has been allocated to the North East Cluster for non LSP activities out of a national £84M. Funds for the financial year 2004/2005 are judged to be adequate for planned non- LSP activities in the NEC. None of the SHAs are aware of the NEC Cluster specific allocation and this is raising concerns. **We recommend that early advice is given to the SHAs on the specific of the £13.3M and their portion of it.**
- 6.2.3 As far as project resources are concerned are findings are:
- 6.2.3.1 Although Contract Management resource has recently been added to the RID team, we believe the impact of this addition needs to be carefully monitored as further experienced help may be needed for a contract of this magnitude being managed across 5 SHAs. **We recommend that the capacity of the newly assigned contract manager is examined at the end of April to allow the new appointees time to assess the size of the task within the SHAs.**
- 6.2.3.2 No concerns have been raised as to the LSP's capability to deliver its resource plan
- 6.2.3.3 The inability of the NHS to deliver the resource plans as implementation pace quickens was a commonly expressed concern. The development of an integrated planning tool in conjunction with the LSP must be developed which is capable of identifying any shortfalls on any project in a rigorous and timely manner. See 9.3.1.

6.3 Development and implementation plans

- 6.3.1 There is currently no integrated plan in place at national or cluster level. Plans exist at both national and local level to produce integrated plans and we recommend that

these should be progressed as quickly as possible. **As part of this activity we additionally recommend that the RID team satisfy themselves that such a plan is not only adequate for their needs but also for those of the SHA teams.**

- 6.3.2 A 'Mission Control' web based monitoring system being developed by NE Cluster to go live on 10/05/04. From all we have heard this sounds an excellent development and an example of good practice that might be usefully replicated across the national programme as a whole.
- 6.3.3 Confusion exists in the minds of some people as to the target the programme has for the number of Accenture portals that will be available by the end of 2004. They believe the programme is committed to a goal of making access to the portals widely available. We understand this is not the cluster's aim and this needs clarification. **We recommend early clarification to resolve this confusion**

6.4 Business preparedness

- 6.4.1 The LSP, Accenture, have mobilised well. They have delivered or exceeded their committed resource build up plan. They currently have over 600 people on the ground in Leeds and 50 in the SHAs. The quality of the people is judged to be high. Only one has been replaced since contract award. The recruitment base is broad with some 60% of the build up coming from Accenture's own employees or established Accenture consultants. The balance is from UK contractors with experience of working with the NHS. There is no expectation that their resource build up will not continue to their summer peak requirement of 1000 employees. Their deliverables are acceptable both in terms of quality and timeliness. Only one document has been rejected.
- 6.4.2 The RID team have made use throughout the cluster of a readiness tool/methodology to assess the preparedness of early adopters. This has proved very successful and we would put it forward as an example of best practice.
- 6.4.3 Our interviews suggest the Early Adopters are ready. We found high levels of enthusiasm and commitment to the programme amongst these groups. That said there was a high level of concern that the national systems and legacy upgrades would not be completed in sufficient time to allow the EA's themselves to deliver their commitments on e-booking (see 8.6.1 below).
- 6.4.4 On clinical engagement, we are satisfied that there is adequate clinical engagement to deliver the early adopters and implementers. However, consistent with our findings on communications there has been no focussed programme in to engage clinicians generally across the NHS notwithstanding specific involvement in the development of best practices and design solutions. **We recommend that this is rectified promptly as a key element of 9.8.1.**
- 6.4.5 **Learning.** There should be many opportunities to capture learning and disseminate in this programme. An example is the use of the early adopters as a test of how this complex multi project multi location programme is operating. However, learning is usually lost unless the gathering of it is made explicit. **We recommend that this be made explicit where there is a wish to learn, such as by nominating an individual with a one week project to gather up the learning from a few such key events by interviews, and then disseminate the outcome across those whom it may help. This would be a useful function at national level.**

6.4.6 As far as clinical standardisation is concerned, the agreed strategy is one of evolution. The national systems, as installed, will establish a degree of standardisation but they have been also been designed to provide wide flexibility in terms of their specific application. The NEC approach is to initially provide “knowledge support” to the clinicians and then evolve to more decision based applications.

6.5 Risk management

6.5.1 The Review Team has seen the most recent version of the Risk Log for the NE Cluster dated 9 March 2003 and a document entitled 'North Easter Cluster/Accenture Top Risks' dated 8 March 2003. On the whole most of the key risks to the programme we identified during the Review are listed in the risk register, albeit at a high and rather generic level, and some of the mitigating actions appear weak. The joint document (a good example of the close working between the RID team and the LSP) on the other hand although not structured in the same way, does contain more granular mitigating actions for the Accenture risks. **We recommend therefore that the Programme team examine the Risk Register to see if it is possible to add more detail and specificity to the risks and mitigating actions it contains.**

9.5.2 We have seen examples of where pragmatic and entirely appropriate judgements have been made at no risk to either timing or cost but outside of agreed contractual protocols. **We recommend that such decisions be recorded formally with the LSP as they are made to avoid them being quoted out of context by the provider at some future date.**

6.6 Dependencies and technical implications

6.6.1 We found a depth of concern within the early e-booking adopters and elements of the cluster organisation on the likelihood of the two national systems, the Spine and e-booking delivering on time.

6.6.2 Doubts over the national system deliverables along with similar concerns about national capability to facilitate the resolution of legacy modifications are causing at least one early adopter to question whether the risks of failure and the associated credibility and clinician alienation do not justify some flexibility in the 30 June target.

6.6.3 Having talked to the NpFIT e-booking head we have seen a draft high level delivery plan which contains milestones that suggest that the 30 June timetable may be feasible however, communication of this does not appear to have cascaded to the appropriate levels within the Trusts. **We recommend that the e-Booking team review its line of communication to the Trusts and the RID and ensures that key information is received by those implementing e-Booking in a timely way.**

6.6.4 These concerns are being addressed for the e-booking early adopters by a national resource albeit under-resourced. We saw no evidence that this issue was being given particular consideration in the programme as a whole other than for e-booking. **We recommend that the legacy management for e-booking be extended for the NCRS programme as a whole.**

6.7 Benefits management

6.7.1 Other than high level scoping for the business cases little or no work was done on this prior to signature of the contracts. Efforts post procurement have been to ensure mobilisation of the LSPs and acceptance of their deliverables. Consequently it is only recently that there has been any progress at cluster level on better defining a strategic approach to benefit delivery and to stimulating ownership of this effort in the SHAs. Specifically, a draft Benefits Realisation Strategy exists and the first steps have recently been taken to see that implemented in the SHA's. Training has also

been given in the Cranfield Benefits Management system and a Change Management Group has been established which met for the first time in February.

We recommend that the Cluster team give very high priority to (1) Defining just how benefit maximisation should inform their regular decision making and (2) Establishing a benefits management and tracking strategy and detailed plans including individual responsibilities, for achieving and measuring the identified benefits.

6.8 Communications

- 6.8.1 Although improvement was recommended at the Gateway 3A review, programme communications across the cluster remain less than satisfactory. While clinical engagement is building and is high in the early adopters and implementers, the cluster has failed to engage stakeholders generally. This will become increasingly important as implementation accelerates. **We recommend the Cluster team develops a plan involving both the trusts and the SHAs which builds on those real successes that have recently been achieved and is rolled out promptly into those trusts with early slots.**
- 6.8.2 Little information regarding the structure, benefits and timing of the national programme has been shared with NHS employees at all levels. During the procurement phase strong control from the centre was understandably exercised because of the need for commercial confidentiality. Frustration is growing at cluster, SHA and Trust level that approval authority levels have not changed following contract signature. At least one SHA has set up its own programme specific website, as have a number of trusts. This comment mirrors that made last year in the OGC Gateway 3A review. **We recommend early consideration be given nationally to adopting a more open communications and approval strategy since this will encourage activities that are just beginning to happen in the field.** Notably in the area of benefits identification, business change and engagement.

APPENDIX A

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 both
Clusters.**

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