

Programme Title: NHS Care Records service: Local Service Provider – London Cluster.

OGC Gateway™ Number: 503.

Privacy Marking: Restricted:Management

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OGC Gateway™ Review 4 – Readiness for service

Version number: Final Draft

Date of issue to SRO: 19 July 2005

Department: DoH.

Agency or NDPB: Connecting for Health (CfH).

OGC Gateway™ Review dates: 11 July – 14 July 2005.

OGC Gateway™ Review Team Leader: <Text Redacted>

**OGC Gateway™ Review Team Member:
<Text Redacted>**



Office of Government Commerce

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Background

The aims of the project:

The National Programme for IT (NPfIT) is a long term (ten year) programme for the development of IT in the NHS to improve patient care and services. NHS Connecting for Health (CfH) has been established as the single national IT provider for the NHS, delivering NPfIT for the future and ensuring the maintenance, development and effective delivery of the IT products and services delivered by the former NHS Information Authority while these products and services are still required.

NPfIT consists of many elements, which are evolving at a rapid pace. They include:

- The NHS Care Records Service (NCRS);
- Choose and Book (CAB)
- Electronic Transmission of Prescriptions (ETP)
- The infrastructure to support the New National Network (N3)
- National Applications Service Provision (NASP, generally referred to as SPINE)
- Picture Archiving and Communication System

The exploitation of information and communications technology is an essential component of delivering the NHS Plan and the development of new patient focused services. The benefits from implementing information systems and technology should include underpinning and enabling the achievements required in the Delivery Plan Priority areas and supporting the achievement of the following:

- Patient Choice
- Integrated care
- Co-ordination and collaboration planning
- Informed service users
- Accessible services
- Evidenced based care
- Quality assured services
- Efficient service

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Delivery of the NPfIT programme for England is being achieved through five Clusters. The concept of Clusters is a unique structure not replicated elsewhere in DH/NHS management structures. Statutory accountability runs from the DH to the SHAs. Clusters are groupings of SHAs that come together to act as one for the purposes of NPfIT.

The London Cluster comprises 5 SHAs covering Greater London. .

The procurement status:

The LSP Contract for the London was awarded to BT Capital Care Alliance in December 2003.

Current position regarding OGC Gateway™ Reviews:

Gate 3 reviews were carried out of all Clusters in October 2003, followed by Gate 3b reviews in April 2004 to assess progress in the period following Contract Award.

Purposes and conduct of the OGC Gateway™ Review

The primary purposes of an OGC Gateway Review 4 are to confirm that contractual arrangements are up to date, that necessary testing has been done to the client's satisfaction and that the client is ready to approve implementation.

Appendix A gives the full purposes statement for an OGC Gateway Review 4.

This OGC Gateway Review 4 was carried out from 11 July to 14 July 2005 at the NHS office, 50 Eastbourne Terrace, London. The team members are listed on the front cover.

The people interviewed are listed in Appendix B.

The review team would like to thank the SRO, the acting Regional Implementation Director, members of their staff and of the local care community for their valuable time, support and openness, which contributed to the review team's understanding of the programme and to the outcome of this review.

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Conclusion

1. With its strategic decision to implement a single integrated Care Records System (CRS) for the capital based on clinical best practice, the London Cluster uniquely set itself an even more significant challenge than that faced by the other four clusters.

2. In overall terms delivery of CRS has been a major disappointment so far due in the main to poor supplier performance, although satisfactory progress has been made on the other elements of the overall Connecting for Health (CfH) programme. At this time the programme has no commercially supported and agreed plan for the delivery of CRS products to meet the urgent business needs of Acute Trusts. The LSP CRS product is as yet unproven as its development will not be completed for 3-4 months. This represents an overall delay in the programme of some 12 months,

3. The development phase has been further exacerbated by the considerable effort involved in endeavouring to develop the Common Solution with the Southern Cluster and in establishing a set of Common Working Arrangements. Southern Cluster's decision to withdraw from this arrangement has created a sense of relief in London.

4. Because of these problems the Cluster and CfH have found it necessary to sustain a strong emphasis on the development of its core LSP product. This focus on IT has been at the expense of strong engagement with the customer, of creating a readiness in the Trusts for deployment and of developing greater emphasis on benefit management. The Cluster has yet to make the attitudinal switch from development to deployment.

5. There is still wide support in the NHS for the original strategic vision of a single integrated CRS solution but repeated slippage of milestones and the failure to deliver a core CRS product have resulted in significant tensions and losses in confidence and trust between both the NHS and the suppliers and the NHS and CfH.

6. Given the problems the CRS element of the programme has encountered, the stakes for the next immediate phase are very high indeed. We see three key milestones which are critical to the future success of the London programme:

- Establishment of an agreed plan by September for deploying CRS to Acute Trusts in the short term which is commercially underwritten and has the informed commitment of all stakeholders

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- A successful deployment of the CfH CRS solution at QMS in November 2005
- Successful roll-out of CRS to an agreed number of Acute Trusts by March 2006

A summary of recommendations can be found in Appendix C.

Status

The overall status of the Project is Red - as defined below.

Red – To achieve success the project should take action immediately.

Amber – The project should go forward with actions on recommendations to be carried out before the next OGC Gateway Review of the project or by an earlier specified date, if the time to OGC Gateway Review 5 is protracted.

Green – The project is on target to succeed but may benefit from the uptake of recommendations.

All the recommendations of the previous review have been implemented except where discussed further in this report.

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Findings and recommendations

Business case and stakeholders

Stakeholder Support

7. Notwithstanding the progress that has been made by the Cluster in deploying a number of CfH projects, notably PACS, AltGP and Child and Community Health Interim Application (CHIA) the 12 month delay to the delivery of an LSP-based CRS product has caused great frustration across the care community. While the commitment of the Programme Board to the project remains intact their resilience and that of the Cluster management has been seriously tested over recent months.

8. Although the NHS in London remains committed to the CRS vision for the capital we have observed significant scepticism amongst members of the care community regarding how and when that vision will be delivered. Much of this doubt has been directed at the suppliers, BT and their principal sub-contractor IDX.

9. Unfortunately since CfH are perceived to have agreed the delivery dates forecast by the suppliers these same delays have undermined the trust between CfH and some segments of the NHS in London. There is a sense today that neither the Cluster nor the NHS has been sufficiently involved in current discussions on future CRS deployment.

10. This breakdown is also reflected in views that Cluster management has not been sufficiently customer focussed. We have heard questions as to whether the proposed Cluster restructuring will better meet customer needs and we would encourage the Cluster team to ensure full transparency across the whole care community in taking the new arrangements forward.

Benefits Realisation.

11. We have seen little to suggest either the Cluster or the NHS are giving thought to the benefits that will accrue from the successful implementation of a CRS product or indeed the other products that are currently being deployed. There is no Benefits/Change Manager in post in the Cluster team, a PEx sub-group on benefit realisation has only recently begun to establish itself, and we believe that only one SHA has appointed a benefit lead. We have no sight of an effective benefit realisation network being established in Trusts across the Cluster.

12. There is a view that the work on benefits realisation undertaken at national level to date has had little impact, indeed we understand that the

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Cluster benefits sub-group is developing its own local framework which will then need to be linked with the output from ISIP.

Recommendation 1. We recommend the Cluster team appoints a suitably experienced Benefits Manager and actively pursues the establishment of a Benefits Management network, setting a clear lead across the Cluster, identifying pockets of expertise, and enabling best practice to be shared.

Review of current phase

General progress

13. Progress over the 15 months since the last Review, and particularly with the core CRS element of the programme, has been disappointing: milestones have repeatedly been missed and re-set, and the LSP is still 3-4 months from delivering an operational system in an acute hospital. The general view is that this represents an overall delay in the programme of some 12 months.

14. Whilst there will have been many reasons for these delays, the management team believes that the principal root causes have been an under-estimation of the scale and challenge of the task by the suppliers (particularly the work required to 'anglicise' an American software product) and ineffective project management on the supplier side.

15. There has been more success with some of the discrete components of the programme. PACS is judged to be progressing well, with 1 system already operational – the first in the national programme – with 9 further business cases approved.

16. We have found general satisfaction with the performance of the PACS product despite some disappointment with the level of support from the suppliers – BT and Philips – and a lack of understanding in the Trust of the exact capability of the system being procured. It is clear that a number of valuable lessons have been learned and there is a willingness in the lead Trust (Hillingdon) to share them.

17. Thirty eight GP surgeries have gone live (albeit with a number of problems related to service levels). Some of this progress (and that which is to come) is only being achieved by adoption of interim solutions: for example the GP surgeries are using Alt GP, and in the Mental Health area there has been a decision to deploy the Rio product.

18. This expediency is enabling the programme to maintain momentum in the short term but it does introduce new risks:

- Bringing in new suppliers inevitably causes perturbations to the management of commercial issues and contractual relationships.

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- There is the potential for greater disruption (and call on resources) when the interim solutions are eventually superseded by the original design.
- Depending on the duration of the interim phase – and particularly if the interim solutions were to be considered fit for the longer term – the approach also has the potential to undermine the coherence of the strategic, long term design vision.

19. These risks do not feature in the current Cluster Risk Register.

The demise of the Common Solution

20. All those we spoke to expressed relief at the decision to terminate the Common Solution and its formal tie with the Southern Cluster, conscious that, irrespective of the potential benefits offered by the approach, the complexities it introduced into the design, development and management processes were proving a major overhead and threat to successful delivery.

Cluster management

21. We noted the plans to re-shape the organisation of the Cluster team to reflect a new common structure being adopted by all Clusters. Whilst there are still a number of management issues to be addressed before the new structure is fully up and running, we believe it will greatly help to focus on core priorities and will more closely reflect the needs of the programme as it moves from development into delivery.

22. There is a perceived need in the Cluster for greater commercial authority to be delegated to it and we understand this will be provided by the new arrangements.

23. The absence of an established RID for a few months has clearly presented additional challenge but there was widespread support for the way in which Martyn Forrest was filling the role, albeit on a temporary basis, and we understand that regular candidates for the post are in the process of being interviewed.

24. We sensed that establishing closer links between the Cluster Team and both the National CfH team and the wider NHS community, which is one of the objectives of the Cluster re-refresh exercise, will be of great benefit in providing greater transparency and building effective working relationships, so that all parties are working to a common plan and set of priorities.

25. Members of the Programme Board and Programme Executive felt that both bodies were proving effective in practice, although there was a view that a smaller Board might be better able to focus on key issues and have the

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agility to respond to rapidly changing circumstances. There was also a sense that communications between the Board and the PEx had improved over recent months with the latter more effectively fulfilling the role of an executive arm of the Board.

University College London Hospital (UCLH)

26. Within the context of a major PFI development for a major new build, UCLH awarded a contract for a Care Record System in September 2003, some 3 months before the National (NPfIT) LSP contracts were awarded. Unlike the LSP contracts, UCLH elected to place their contract directly with a software supplier (IDX) in order to engage more closely with the application development activity. Although this work has formally taken place outwith the London Cluster/LSP framework, UCLH have maintained close liaison with both the Cluster and National CfH teams, to mutual benefit. The initial UCLH operational capability went live on 20 June 2005. This provides a functionality that is broadly comparable with the planned London solution for acute hospitals although there a number of differences in system architecture and design philosophy.

The forward plan

27. As a consequence of the various delays, there is at present no established plan to take the core CRS programme forward, which will therefore remain in serious jeopardy until a new commercially supported plan has been agreed. The customers seen to be most at risk are the Acute Trusts, and the LSP has been invited to develop a new proposal which would equip 10 such Trusts by the end of March 2006. Each Trust would be supplied with a system based either on the UCLH solution (which is now operational) or that of Queen Mary Hospital, Sidcup (QMS), which would be more closely aligned with the overall London design.

28. Given the problems the programme has encountered since its launch, the repeated slippage of milestones and the failure so far to deliver core product, our view is that the stakes for this next immediate phase are very high indeed; its success is critical for the overall London programme. The key will be in setting an end-March target which is challenging yet achievable. Undue pessimism would miss the opportunity to ramp up effort and deliver capability; over-optimism would almost certainly result in failure.

29. The intention is to work up an outline Change Control Note (CCN) to implement this proposal by 31 July and a detailed CCN by the end of September. We understand the proposal is being developed with the engagement of the National and Cluster CfH management teams as well as

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representatives of SHAs. In our discussions with NHS stakeholders, it was clear there are a number of factors which should shape this plan:

- The mix of ‘UCLH’ or QMS based solutions
- The capacity of the supply side to gear up for such an intensive delivery phase
- The ability of Trusts to prepare themselves at relatively short notice
- The ability to maximise the transfer of knowledge and experience from UCLH and QMS to those Trusts embarking on the process

30. We return to these issues under ‘Readiness for Next Phase’ below, but we believe that the key to success for this immediate phase will be the establishment of a realistic plan, with clear ownership. The plan must also have the support of all parties in the full knowledge of the contributions to which they will be committing.

Recommendation 2. We recommend that in determining the core CRS plan for the short term, every effort is made to ensure that the plan is realistic (challenging but genuinely achievable), has clear ownership, and has the explicit and informed support of all stakeholders.

Risk management

31. Although a risk management policy and process is in place for the project an examination of the latest risk and issues registers suggests that the system is not as effective as it could be in alerting the Board to the most critical current risks facing the project. Many of the topics raised with us as crucial today by senior players in the project did not seem to feature as such in either of the registers.

Recommendation 3. The Cluster needs to examine the manner in which its existing Risk Management system is being used in order to assure the Programme Board that it is addressing the highest risks and issues at each meeting.

Readiness for next phase

32. Given the general poor health of the programme, there are clearly many issues to be addressed if it is to be driven forward in a timeframe that meets customer needs and enables the benefits to be delivered successfully. In our view the CfH teams at Cluster and national level have a good grasp of these issues although there is a great deal of work to be completed in a short period of time. The priority is the establishment of a clear short term plan for CRS deployments to Acute Trusts; this then needs to be incorporated into an integrated Cluster plan which can be used to direct and manage these wide-

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ranging activities and keep all stakeholders engaged. There are component plans in place for many of the workstreams but in order to concentrate effort and attention where it would bring most benefit we highlight the following areas:

- Customer capacity and readiness to implement CRS
- Supplier capacity
- Ensuring that the lessons of hard-earned experience are re-applied
- Clarity of roles on the customer side
- The customer-supplier relationship

Customer capacity and readiness

33. There are serious concerns in all quarters as to the capability of Acute Trusts to mobilise resource to match such a programme of deployments. From a range of NHS sources we have heard estimates that two to five deployments may be the best that can be achieved by the end of the current financial year.

34. We therefore believe that careful assessments should be made of the scale of effort required (by Acute Trusts in particular) for customer organisations to receive and implement a CRS solution. Whilst much of the groundwork for this has been completed it was made clear to us that in many cases there is only a partial understanding of the investment of time and resource required, particularly by senior management, in order to see an installation through to successful roll-out. Given the many demands on executive teams' time, it would be sensible to ensure that this issue is well understood and that Trusts are provided with clear and effective guidance which minimises the burden and maximises the prospects for success. We understand that at least one SHA, as well as the Cluster team, is in the process of developing such guidance; at the same time it is clear that other SHAs are unaware of this work – but would welcome the product.

Recommendation 4. We recommend that the Cluster makes a careful assessment of the readiness and capacity for Trusts to implement the CRS solution and ensures that, through SHAs, clear and effective guidance is made available, tailored to the needs of each organisation.

Supplier capacity

35. Given the disappointing performance of the LSP to date there have to be serious questions about the ability of both BT and IDX to support the forward CRS programme as it gears up for delivery. Following a series of interventions by top management on the customer side, both companies have taken steps to reinforce the expertise and capacity of their organisations, but

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much of this has been fairly recent (new Programme Directors, for example, have only been in post for 6 weeks) and it is too soon therefore to see any evidence of improved performance.

36. For the moment the matter of supplier capacity must remain a critical risk to the forward programme and we fully support the efforts of the national and Cluster teams which are directed at establishing a more robust commercial platform. Until evidence of an improved performance becomes apparent, it would be appropriate to ensure that roll-out plans are cautious in their expectations otherwise there is every prospect that the development phase experience of repeatedly missed milestones will be repeated during deployment.

Passing on experience and lessons learned

37. The management teams and staff of those organisations which were amongst the first to deploy any of the new CfH systems will have acquired considerable experience and learned many lessons in the process. Clearly the passing on of some of that knowledge to follow-on adopters would remove considerable risk from the programme and be of great benefit to the wider NHS community.

38. In talking to the UCLH management team we were impressed by the positive approach being taken to this concept. We would encourage the Cluster team to ensure that action is set in hand to identify the full scope of such opportunities and to put in place (or facilitate) processes to turn good ideas into action. Whilst the UCLH case probably represents the most immediate and significant opportunity for such an initiative, it should be possible to adopt a similar approach across the breadth of the CfH programme.

Recommendation 5. We recommend that the Cluster team, with key stakeholders, identifies the potential opportunities for sharing expertise and passing on lessons learned from early adopters (particularly in the case of UCLH) and puts in place processes to turn good ideas into action.

Clarity of Customer roles

39. Whilst the present NPfIT governance structure has been in place for some time, the series of difficulties with the London programme have called for a degree of flexibility in its application. As a result there is some uncertainty across the Cluster stakeholder community of the exact role of the national and Cluster teams on specific issues, which can be further complicated when SHA representatives are working in direct support of a particular initiative. Whilst the main effect of this uncertainty is usually limited to a degree of frustration or inefficiency (which would of itself represent sufficient grounds for action), at

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worse it could result in inappropriate guidance being given to a supplier – with potentially commercial implications. As the pace of activity picks up it is essential that the customer community speaks with a single voice, and we do not believe the present conditions act in this direction.

40. We understand that a new governance document is being prepared in order to reflect the roles and responsibilities of the new Cluster structure and we would encourage the Programme Board to ensure that this issue is addressed and the new arrangements are widely disseminated in order that uncertainties are removed.

Recommendation 6. The Cluster Board needs to be satisfied the new governance arrangements stress the importance of CfH, the Cluster team and the care community presenting a single face to the suppliers and that these arrangements are widely promulgated and understood.

The Customer-Supplier relationship

41. For any programme as significant and long-lasting as CfH, success will only be achieved through the establishment of a relationship between customer and supplier founded on trust and a desire to cooperate for the common good. Whilst a good deal of guidance exists on this subject, at the end of the day it is the senior management of each side who need to have a common desire to build a long term partnering-based relationship, and the will to make such a relationship work, if this approach is to succeed.

42. In our view this is the model which should undoubtedly be the goal of those managing – and delivering – the London programme, although we recognise it will be difficult to make much progress until the programme itself is showing stronger signs of recovery. Nevertheless we believe both customer and supplier should see this as the way ahead and start to signal an intent that, as and when conditions permit, it represent a direction of travel they intend to follow.

Recommendation 7. We recommend that the Cluster gives thought to the way in which a more partnering-based relationship with the LSP might be developed, when conditions make this possible, in order to lay a stronger and more effective foundation for the longer term programme.

Moving into Deployment.

43. Recognising the effort the Cluster has had to exert in managing the LSP through its major performance difficulties, and the critical importance of developing an acceptable CRS product, it is not surprising to find an organisation strongly focussed on its suppliers, on development activities and

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on technology. The Cluster now needs increasingly to shift its focus from suppliers to customers, from development to deployment and from technology to service led improvements in care.

44. Despite obvious commitment and dedication in CfH and Cluster management there is no sense across the care community that the CRS element of the project is being service led. CfH and the Cluster team feel like an organisation concentrating on developing a CRS product for delivery to a customer that is as yet not well positioned to receive it.

45. Whilst this is understandable, the Cluster now faces the challenge of moving to a mode in which they are more engaged with their customer and better able to prepare the care community for the deployment of these new products. Their emphasis needs to move increasingly toward the delivery of benefits and service led change.

Recommendation 8. The Cluster Board, in conjunction with its key care community stakeholders, needs to ensure that the forward a programme for the Cluster gives more emphasis to customer engagement and service led priorities.

46. We suggest that a Gate 4b Review is held in March/April 2006. This would provide the opportunity to demonstrate good progress with the core CRS element of the programme and a successful transition to deployment mode.

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APPENDIX A

Purpose of OGC Gateway™ Review 4: Readiness for Service

- Check that the current phase of the contract is properly completed and documentation completed.
- Ensure that the contractual arrangements are up-to-date.
- Check that the business case is still valid and unaffected by internal and external events or changes.
- Check that the original projected business benefit is likely to be achieved.
- Ensure that there are processes and procedures to ensure long-term success of the project.
- Confirm that all necessary testing is done (e.g. commissioning of buildings, business integration and user acceptance testing) to the client's satisfaction and that the client is ready to approve implementation.
- Check that there are feasible and tested contingency and reversion arrangements.
- Ensure that all ongoing risks and issues are being managed effectively and do not threaten implementation.
- Evaluate the risk of proceeding with the implementation where there are any unresolved issues.
- Confirm the business has the necessary resources and that it is ready to implement the services and the business change.
- Confirm that the client and supplier implementation plans are still achievable.
- Confirm that there are management and organisational controls to manage the project through implementation and operation.
- Confirm that all parties have agreed plans for training, communication, roll-out, production release and support as required.
- Confirm that all parties have agreed plans for managing risk.
- Confirm that there are client-side plans for managing the working relationship, with reporting arrangements at appropriate levels in the organisation, reciprocated on the supplier side.
- Confirm information assurance accreditation/certification.
- Confirm that defects or incomplete works are identified and recorded.

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- Check that lessons for future projects are identified and recorded.

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APPENDIX B

Interviewees

<Text Redacted>

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APPENDIX C

Summary of recommendations

Red – Take action immediately.

Amber – Take action by the next OGC Gateway Review.

Green – Take action as required.

		Status
Ref. No.	Recommendation	R/A/G
1	We recommend the Cluster team appoints a suitably experienced Benefits Manager and actively pursues the establishment of a Benefits Management network, setting a clear lead across the Cluster, identifying pockets of expertise, and enabling best practice to be shared.	A
2	We recommend that in determining the core CRS plan for the short term, every effort is made to ensure that the plan is realistic (challenging but genuinely achievable), has clear ownership, and has the explicit and informed support of all stakeholders.	R
3	The Cluster needs to examine the manner in which its existing Risk Management system is being used in order to assure the Programme Board that it is addressing the highest risks and issues at each meeting.	A
4	We recommend that the Cluster makes a careful assessment of the readiness and capacity for Trusts to implement the CRS solution and ensures that, through SHAs, clear and effective guidance is made available, tailored to the needs of each organisation.	R
5	We recommend that the Cluster team, with key stakeholders, identifies the potential opportunities for sharing expertise and passing on lessons learned from early adopters (particularly in the case of UCLH) and puts in place processes to turn good ideas into action.	A

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6	The Cluster Board needs to be satisfied the new governance arrangements stress the importance of CfH, the Cluster team and the care community presenting a single face to the suppliers and that these arrangements are widely promulgated and understood.	A
7	We recommend that the Cluster gives thought to the way in which a more partnering-based relationship with the LSP might be developed, when conditions make this possible, in order to lay a stronger and more effective foundation for the longer term programme.	G
8	The Cluster Board, in conjunction with its key care community stakeholders, needs to ensure that the forward a programme for the Cluster gives more emphasis to customer engagement and service led priorities.	A

Add or delete rows as required.

NB: Full R/A/G definitions can be found in the status section.