

Programme Title: NHS Care Records Service: Local Service Provider – East and East Midlands Cluster.

OGC Gateway™ Number: OGC635.

Privacy Marking: UNCLASSIFIED

OGC Gateway™ Review 4 – Readiness for service

Version number: Final Report

Date of issue to SRO: 24 June 2005

Department: DoH

Agency or NDPB: Connecting for Health (CfH)

OGC Gateway™ Review dates: Monday, 13 June – Friday, 17 June 2005.

OGC Gateway™ Review Team Leader: <Text Redacted>.

OGC Gateway™ Review Team Members:

<Text Redacted>



Office of Government Commerce

Version 2.1 (Issued)

4th November 04

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Background

The aims of the project:

The National Programme for IT in the NHS (NPfIT) is a long term (ten years) programme for the development of IT in the NHS to improve patient care and services. NHS Connecting for Health 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 Record Service (NCRS);
- Choose and Book (C&B)
- Electronic Transmission of Prescriptions (ETP)
- The infrastructure to support the New National network (N3)

The development of information and communication technology is an essential component of delivering the NHS plan and the development of new patient focused services.

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

Delivery of the 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 Eastern Cluster comprises 5 SHAs covering the East of England from Derbyshire in the north to the counties of Hertfordshire and Essex in the south.

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The Eastern Cluster shares the same Local Service provider (LSP) and the same technical solution as the North East Cluster. Although there are two contracts the LSP is providing one solution across the two clusters. Whilst the implementation arrangements are separate this means that the two clusters are working very closely together sharing experience, and agreeing similar requirements. A review of the North East Cluster has been undertaken concurrently with this review.

The procurement status:

The LSP contract for the Eastern Cluster was awarded to Accenture in December 2003 following the award, also to Accenture of the contract for the North East Cluster.

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

Purposes 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.

Conduct of the OGC Gateway™ Review

This OGC Gateway Review 4 was carried out from 13 June 2005 to 17 June 2005 at the Prince's Gate, Leeds and the Eastern Cluster Office, Hatfield. 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 Regional Implementation Director, members of their staff and those in the Essex SHA and local health economy 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. The review team finds that since the last OGC Gateway review in April 2004 considerable progress has been made.
2. The programme has over the past 15 months transitioned from essentially a start-up phase to being on the verge of a wide-ranging deployment with the capability to improve fundamentally the delivery of health care to the local community. This is the result of substantial commitment and effort from members of the Cluster programme team, the National Programme and individual stakeholders across the Cluster.
3. Relationships with Accenture appear proven and robust and capable of delivering future success.
4. The review team has found wide recognition for what has been achieved and a strong belief that overall the approach is correct and a number of valuable lessons are being learnt. Deployment has been managed through a rigorous Agreement to Proceed procedure which has delivered a confidence building service to the users.
5. Although it is recognised there is much still to be done both clinical engagement and benefit realisation capability within the Cluster have been strengthened over recent months and we have sensed a noticeable improvement in the attitude of clinicians towards the programme.
6. Whilst a number of significant deployments have been successfully made the technology delays, especially on the delivery of the SPINE, have curtailed the scope and functionality of systems delivered. Based on original go-live plans the programme has slipped some 7 months. These delays have been the source of much frustration in the health community.
7. As is to be expected in a project of this size and complexity it remains exposed to a number of major risks, the impact of many of which cannot be quantified at this time but which will need to be carefully managed as the programme accelerates. These risks will also need to be reflected in the development of a bottom up service led deployment plan for 2006/7.

A summary of recommendations can be found in Appendix C.

Status

The overall status of the Project is **AMBER** - 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

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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

8. Since the last Gateway review the Cluster has successfully commenced deployment of a range of technology products including Choose and Book, PAS, SAP and a Phoenix based GP system upgrade. These implementations have demonstrated a capability to introduce change on a wider and larger scale.

9. However, there have been delays caused by technical problems, notably the timeliness, reliability and capability of the SPINE. This has meant progress to date has in some instances been achieved tactically rather than strategically through the replacement of obsolete and ageing systems and meeting contract closure deadlines with essentially like for like systems offering only limited additional functionality.

10. Since the last review there has been a clear improvement in clinical engagement. While it is recognised that there is still more work to do we have seen evidence that clinicians are getting involved in many aspects of the programme with a demonstrable enthusiasm to contribute.

11. Clinical reference groups have been established, with three of the five SHAs fully up and running. A pilot has been developed whereby clinicians will be able to contribute to those topics in which they are interested.

12. The decision to expand the model community from one location to four is widely seen as a positive step which will provide easier access and so enable more clinicians and others to see solutions earlier, to understand them and contribute to their successful deployment.

13. The use of model communities, the physical delivery of products and the time for further discussion and reflection as a result of the delays to the programme mean that GP's in general are now less vocal in their comments on the programme and key issues, such as the approach to security, are believed by those to whom we spoke to be more accepted.

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Review of current phase

14. Our overall impression of the Cluster organisation and its management of the programme is of a team that is well led and performing very creditably in managing a complex programme in a complex and volatile environment.

15. Some reservations were expressed to us as to the effectiveness and efficiency of the Programme Cluster Board, whether it has a good sight of major issues and strategic challenges and the time to debate them. Meeting frequency and make-up were also questioned. It is therefore timely that work is in hand to consider governance, the role of the Board and its composition.

16. In terms of controlling the programme of work we found the Cluster operates a rigorous and effective sign off process as work proceeds through the programme life cycle. Authority to Proceed (ATPs) are agreed at seven points in the cycle and a dialogue involving all impacted parties is a mandatory part of the process, notably at the go-live decision point. The Cluster will review with the project manager, the SHA programme manager and others that technical readiness is in place along with training, completed data migration and any agreed software fixes. The process is well documented as part of the contractual arrangements with the LSP and authority for sign off is clear and well understood.

17. Procedures for specifying and agreeing work and then taking this forward have been developed to meet the needs of the programme to-date. This is now being refined and improved. PIDs are drafted and approved as the method for agreeing the scope, timing, resource requirements and benefit deliverables for each project. The format of these documents is now being revised in a national PID template. There is widespread belief that this new template will bring more emphasis and focus to benefit realisation.

18. We have heard that delays in the delivery of ASRs (Additional Service Requests) and uncertainties as to exactly how they should be raised and progressed has caused some frustration. Work in hand to deliver a framework which clarifies this situation should be completed and resource should be available in the Cluster to ensure they are managed more effectively in the future.

Recommendation 1. A framework detailing the function and protocols for the use of ASRs should be developed and the necessary resource for its management established in the Cluster.

19. The Cluster team are working to an integrated plan covering both LSP and NPfIT deliverables. This is fit for purpose today. There is an intention to extend this plan so in future it will also incorporate benefit realisation plans. We would endorse this approach.

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20. Similarly we understand that the health community at both SHA and LHC levels are working to plans which reflect all of the projects they are responsible for delivering be they LSP, NPfIT or other NHS related opportunities.

Governance

21. We understand that the role and structure of the five Clusters has been reviewed, with the aim of deriving a common structure that is more appropriately geared to the needs of the programme and reflects the major operation which must be directed at Cluster level as the pace of roll-out picks up. Whilst the outcome of the review is unlikely to result in any change to the SHA-centric nature of the programme, there will be a shift of some management responsibilities from the national level to the Cluster. At the same time the resources of the Cluster will need to be strengthened considerably to handle this increased functionality. We strongly support this initiative, and at the same time we would encourage the governance arrangements at national and cluster level to be revised to reflect the following objectives:

- Giving the Cluster the authority, expertise and resources to direct the LSP in day-to-day issues and in its management of the forward programme
- Ensuring proper coordination and integration, across the Cluster, of the implementation of the LSP programme alongside the various components of the national projects such as Choose and Book and Electronic Transmission of Prescriptions
- Maintaining the integrity of the overall technical design across NPfIT and the coherence of the various workstreams
- Providing a strong communications focus so that all stakeholders across the Cluster are fully informed about the programme and the role they need to play in it

22. We understand that a parallel review has been commissioned with Portico to consider roles, relationships and specific governance arrangements in the Eastern Cluster. We assume that the outcome of this Portico review will be absorbed and reflected in Eastern Cluster's adoption of this revised structure.

Recommendation 2. We recommend that as the plans for the revised Cluster structure are implemented, the opportunity is taken to adjust the governance arrangements at national and Cluster level to clarify roles, relationships and authorities as the programme moves forward.

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EEM/NE Coordination

23. In the review of the North East Cluster discussions with the Cluster team and stakeholders involved in delivering the programme, the review team formed the view that there will be instances where there could be benefit in staff from the two Clusters working even closer together, given that they share a common LSP.

24. Our sense is that much of this working together today happens on an ad hoc basis. We suggest that the EEM Cluster team explore with their NE colleagues the range of possibilities where such opportunities might present themselves.

25. Whilst the potential for such opportunities seems readily apparent when viewed from a distance, we recognise there may well be local factors which would reduce their benefit in practice. We therefore suggest that such an initiative should be approached incrementally, building on instances where there is a clear case for action.

Recommendation 3. We recommend that the EEM Cluster team examine, with their NE colleagues, opportunities where there would be mutual benefit in sharing experiences and working even more closely together in order that every benefit is drawn from their joint role as customers of the common LSP.

Commercial management

26. We formed the view that the relationship with the LSP is generally strong and robust. The programme is undoubtedly proving challenging for all parties and we understand that there have – inevitably – been some difficult moments for the supplier. Overall, the clear message which came through was that Accenture have made a genuine effort to adopt a partnering-based relationship with the customer and have been professional in their approach. Our view is that this relationship, which both sides have worked hard to build and sustain, represents a good foundation for the future, although it is one that will no doubt be further tested as future challenges materialise.

Benefit Realisation

27. The Cluster now has an increasing amount of resource committed to benefits realisation and have invested time in training and education and have started to establish a capability in this area.

28. The Cluster has identified and adopted an approach based on a process defined by the School of Management at Cranfield University- the Cranfield model. This has been cross-checked with the national team to ensure it meets national needs and requirements in terms of benefit management.

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29. To support and take this work forward at least one Cranfield workshop has been held in each SHA.

30. The Cluster team have encouraged the SHA and LHC teams to appoint benefit leads and with many of these now in or being put in place a benefits realisation capability is being built. To-date many of the current leads are IT focussed and this may need to change as the emphasis of the deployments moves to one of business change and service improvement. This has been recognised.

31. The Cluster has also encouraged clinicians and other users to use the Model Community to understand the opportunity for benefits from the solutions being developed. Significantly, clinicians have been able to revisit the P1R1 deliverables and redefine or revalidate the anticipated benefits areas.

Risk management

32. We found that the Cluster operate a risk management process which ensures risks are effectively managed at SHA and Cluster level and are reported upwards to the national Programme team.

33. As well as active management of Cluster level risks the programme management group monitors and reviews the top 5 risks from each SHA as well as from specific areas such as the Model Community. The PCM assures himself on a weekly basis that the risk register is reviewed, updated and progress is being made on all live entries.

34. The top 5 risks in the Cluster are available for review at each Cluster Programme Board meeting. The CIO sub group also considers the risk register on a monthly basis.

35. We also found evidence that the project teams at both SHA and Local Health level operated a risk and issues process and understood how their risks could be escalated to Cluster level.

Impact of National Factors

SPINE

36. The delays to the SPINE have had a significant impact on the deployment and have delayed the roll out both of P1 R1 and P1 R2. The net result is a delayed deployment with reduced functionality. Many GPs are simply replacing their existing systems with no additional functionality and no benefits from the SPINE. The position has been complicated by the large number of

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releases of the SPINE to the LSP with up to 6 releases in a year. In an attempt to stabilise the development environment and the cluster release programme it has been agreed that the release strategy for the SPINE will revert to two releases per year. We fully support the strategy of restricting SPINE releases and agree that this will provide a more stable environment for the LSP development and deployment although the timing and scope of the next release remains to be confirmed.

GP Choice

37. The Ministerial announcement giving greater system choice for GPs has introduced a new set of risks and created uncertainty. This has resulted in a degree of planning blight in the forward programme, with many GPs who had been ready to commit now reviewing their options.

38. We understand that a project has been established to assess the impact of GP choice, in particular its effect on the programme and potential commercial implications.

PACS

39. Accenture has been unable to proceed with selecting a PACS supplier and awarding a contract for the NE and EEM Clusters because of a judicial review instigated by an unsuccessful bidder. We understand that this dispute has now been resolved and procurement action is able to continue. Until this contract is let and a deployment timetable agreed there will be a continuing state of uncertainty around the PACS product, and these delays will inevitably have an impact on benefits realisation.

40. The original deployment target for PACS was 100% completion by March 2007 with 80% deployed by March 2006, although we understand that some relaxation may be sought.

Other Factors

Data Migration

41. The time taken to achieve the successful deployment of the two GP installations (6 months and 3 months) requiring mass data transfer indicates the level of complexity and elapsed time (each migration takes three iterations) required. The Cluster and LSP have worked closely to identify suppliers to support this work and have recognised the need to start the process of migration earlier. How successful this approach will be remains to be proven and the future magnitude of this risk remains uncertain.

NHS Resource

42. It is not only at Cluster level that we found a requirement for additional resource. Currently, across all levels in the organisation there are either risks

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noted as significant and/or projects already flagged Red because of a lack of NHS resource. The exact magnitude of this risk as the programme accelerates also remains unquantified.

Benefit Realisation Capability

43. Benefits realisation will be crucial as the type of deployment switches from one of tactical system replacements to strategic implementation as the identified benefits of the overall Connecting for Health agenda have to be delivered. A benefit realisation capability is being established across the Cluster but its ability to deliver extensive service led improvements remains largely unproven.

44. Many of these factors have the potential to impact on the remaining deployments in 2005 as the rate of implementation accelerates. They will all need to be carefully considered as the Cluster prepares its 2006/7 deployment plan so this can reflect the expressed desire of the users for a “more realistic” delivery schedule.

Readiness for next phase – benefits evaluation

45. Without exception we have found enthusiastic support and demand for the programme across the Cluster.

46. Those in the local health community to whom we spoke, who have direct experience of the deployment process, see it as rigorous and professional, creating confidence in the likely success of their particular project. LHCs have felt able to dictate deployment pace so ensuring they are comfortable at “go-live”. They also believe there is an effective process in place to log problems and for them to be escalated should the need arise.

47. Despite the delays, and the frustrations they have caused, people are comfortable with the quality of the products they are now receiving. We heard positive comments on the value of product user reviews and that these have stimulated change management and benefit realisation activities prior to go-live.

48. There is a formal system in place, as part of the Eastern Cluster Programme Life Cycle, to capture lessons from the 137 deployments already successfully delivered. This Knowledge Management System also captures experience and learning from all other key elements of the Life Cycle Programme, notably their Model Community, data take on and training.

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49. The availability of NHS resource to support the significant ramp up in activity through the balance of this year and onwards, with 179 deployments planned in the Cluster over the next 12 weeks, is widely seen as a potentially significant constraint to the programme. We have heard of resource constraints today and of problems already seen as likely to emerge in the autumn.

50. We have heard from one local health community of plans to form a core team which will move location to assist in specific deployments. We have also heard of willingness at SHA level to broker resource availabilities and of the intention of establishing a Clearing House at national level in an effort to match experienced resource to demand. Notwithstanding the difficulties that exist in the service to release resource from individual trusts the likely magnitude of this constraint suggests that it should be given the highest focus.

51. The process for deployment initiation, technical readiness and competent training checks is well defined and understood along with the go-live support calls and the formal ATP signoffs. As deployment activities accelerate the Cluster perceives a need to transfer responsibility for management of the go-live process to the SHAs, whilst retaining a Cluster assurance and sign-off role. We have heard SHA support in principle for this approach but have not seen a plan which defines what each SHA will require to do to take on this role and by what time they need to be ready.

Recommendation 4. The Cluster and the SHAs should agree a plan which transfers responsibility, in a timely manner, consistent with the build in deployment activities, for the management of the go-live process from the Cluster to the SHAs. The Cluster will continue to have responsibility for management of “ first of type “ go-lives, all ATP signoffs and retain an assurance role.

52. Now that the basic ATP processes have been proven we understand that thought is being given in the Cluster to streamlining these procedures to reduce the number of sign-offs. We believe that the necessary balance should be sought between operational standards and commercial prudence to deliver greater ATP throughput to match the pace of roll out. This will also facilitate the transfer of these approval responsibilities to the SHAs.

Recommendation 5. We recommend that, given the expected considerable expansion of roll-out volume across the sector, the ATP process is reviewed to examine any opportunities for streamlining, subject to ensuring that standards of operational capability and commercial prudence are not compromised.

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53. The Cluster is about to begin developing its deployment plan for 2006/07. There is a strong desire nationally, in the Cluster and in the wider health community, to ensure it is a more service led plan than in the past.

54. We are aware of work underway nationally on service implementation, both in the modernisation directorate and within ISIP (Integrated Service Implementation Project). We believe the Cluster should take the latest national guidance on service modernisation and use it in an appropriate way in assessing how best to develop their own bottom-up 2006/07 plan. This may result in an interim approach but even so the experience and learning could be of great value as they seek to progress to a fully integrated, service-led plan delivering local priorities and national goals.

55. Models and processes are being discussed across the Cluster as to how a service-led plan might best be achieved but as yet no plan exists to develop clarity on the process or processes through which this will be developed.

Recommendation 6. A plan needs to be agreed between the Cluster, the SHAs and the local health community as to how to achieve a more service led programme for 2006/7.

56. Much has been said about the consequences of the delays the programme has suffered to-date. Consistent with the resulting frustrations we have heard requests for future deployment plans to be “more realistic”.

57. Risk Management - Section 3 of this report details some of the risks to which the 2006/7 plan will be exposed. With the desire to develop a more service-led plan we believe the potential impact of such risks should be assessed, shared and agreed with key stakeholders in the health community prior to the development of the plan such that there is a good understanding of the plan assumptions for delivery capacity, timeliness and product range. This should assist in building realism into the overall programme along with focus on service priorities and the management of expectations.

Recommendation 7. Deployment plan capability in terms of volume, timing and product range should be assessed and agreed with key stakeholders in the light of known potential risks and constraints.

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The next OGC Gateway™ Review.

58. We suggest the next review be planned for approximately 18 – 24 months hence which should provide an opportunity to demonstrate benefits are being delivered as well as affording an overall assessment of progress.

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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.

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

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APPENDIX B

Interviewees

<Text Redacted>

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.	A framework detailing the function and protocols for the use of ASRs should be developed and the necessary resource for its management established in the Cluster.	G
2.	As the plans for the revised Cluster structure are implemented, the opportunity is taken to adjust the governance arrangements at national and Cluster level to clarify roles, relationships and authorities as the programme moves forward.	A
3.	The EEM Cluster team examine, with their NE colleagues, opportunities where there would be mutual benefit in sharing experiences and working even more closely together in order that every benefit is drawn from their joint role as customers of the common LSP.	G

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4.	The Cluster and the SHAs should agree a plan which transfers responsibility, in a timely manner, consistent with the build in deployment activities, for the management of the go-live process from the Cluster to the SHAs. The Cluster will continue to have responsibility for management of “ first of type “ go-lives, all ATP signoffs and retain an assurance role.	A
5.	With the expected considerable expansion of roll-out volume across the sector, the ATP process is reviewed to examine any opportunities for streamlining, subject to ensuring that standards of operational capability and commercial prudence are not compromised.	G
6.	A plan needs to be agreed between the Cluster, the SHAs and the local health community as to how to achieve a service led programme for 2006/7.	A
7.	The deployment plan capability in terms of volume, timing and product range should be assessed and agreed with key stakeholders in the light of known potential risks and constraints.	A

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