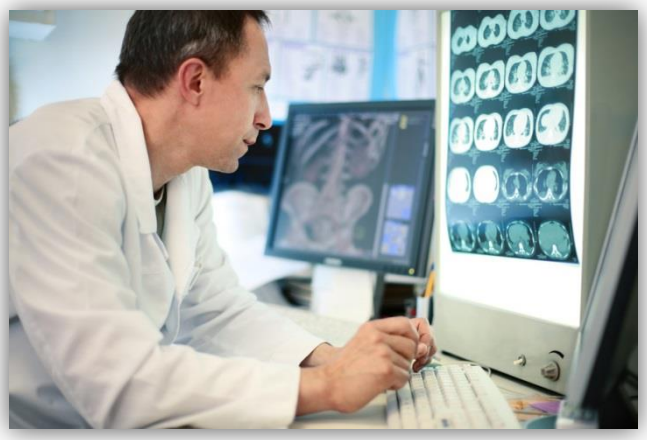
States of Jersey
States Assembly

États de Jersey
Assemblée des États

Public Accounts Committee



Health and Social Services Integrated Care Records Programme

Presented to the States on 17th July 2014.

PAC.2/2014

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Chairman's Foreword

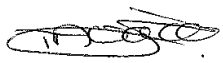
In recognising the demands placed upon the Public Sector for reform and change, there is one key message I would like to be taken forward without delay. Serious attention needs to be given to project management across the States of Jersey so as to reap dividends going forward.

Should the organisation keep its focus firmly on the customer, on achieving viable outcomes and strives to achieve value for money while delivering those outcomes, then Island residents should begin to see a real step-change in performance.

The evidence my committee obtained during this review indicated a little too much focus on ticking boxes and drawing up Gantt charts. Key project management principles were perhaps not fully understood and embraced as much as they could have been. That needs to change.

It is also important to place emphasis on the requirement for realistic timescales in respect of the ability for implementation of large-scale projects. The lack of evaluation and follow-on from previous changes made could create ambiguous and misinformed representation of newly formed policies and create a higher risk of not delivering original intentions.

The Health and Social Services Department has a vitally important remit and the biggest budget. It is therefore vital that project management in Health is of a high standard. Looking forward, the Department intends to spend heavily on the future hospital programme and on the IT that the Department believes it needs to bring service delivery up to 21st Century standards. In this regard, we will be inviting the reconstituted PAC to keep a close watch on the execution of these projects through 2015 and beyond.



Deputy T.A. Vallois

Chairman

Key Findings

1. In 2006, the Health and Social Services Department (HSSD) committed to an ambitious strategy of transitioning to fully integrated care records (ICR) via a single major programme and within a timeframe of less than 5 years.

2. HSSD sought and obtained £12 million capital funding in support of its ICR programme without having first produced an outline business case and without the Minister for Health and Social Services giving the States Assembly an accurate and meaningful summary of the intended use to which the £12 million would be put.

3. The HSSD-dominated ICR Programme Board was too slow to accept that it could not achieve even the majority of the ICR programme specification given the financial and other resources available.

4. During 2009, the ICR Programme Board fundamentally de-scoped the programme aims and objectives and re-wrote the ICR programme business case without the formal endorsement of the Minister for Health and Social Services. Neither did the Minister formally notify the Council of Ministers or the States Assembly, notwithstanding that all three had been party to the decision to fund the programme.

5. The de-scoped ICR programme concluded in the summer of 2011, having overrun by some 18 months. £11.97 million of the total programme budget was spent. The primary objective – an integrated care record spanning all health and social care settings – was not achieved.

6. Some material service improvements and cash savings were achieved by the programme but the cash savings were negated by a significant overall increase in IT-related operating costs. The majority of planned non-cashable efficiency savings were not realised.

7. The ICR programme was not closed by way of a formal and thorough evaluation. This may have affected the ability of the department to learn from experience. It may also have

impacted the accuracy of data used in the production of the subsequent 2012 white paper ‘Caring for each other: caring for ourselves.’

8. HSSD has launched a second major programme to complete the work started by the ICR programme. The Department expects to require additional funding in the sum of £12 million approx. during the period 2016 – 2018 in order to execute this second programme in full.

9. Although there are indications that some lessons have been learned from the ICR programme, there remains scope for HSSD and the States as a whole to improve their general approach to project management.

Recommendations

1. To assist the Audit Committee to track the progress of individual internal audit reviews, regular internal audit plan progress reports submitted to the Audit Committee should clearly record the current status of each review relative to the status reported to the Audit Committee at its previous meeting. (see page 23)

2. The Corporate Management Board must ensure that Ministers are suitably briefed on and have formally endorsed their departmental capital programme bids before they are submitted to the Council of Ministers for consideration as part of the Medium Term Financial Plan. (see page 27)

3. The Corporate Management Board must ensure that a thorough and objective evaluation is undertaken and is documented either at the conclusion of every capital project or whenever the capital budget allocated by the States to a specific project is deemed to require supplementation. (see page 33)

4. Outline business cases produced in support of capital funding bids must, as a minimum, specify clearly the anticipated funding requirement, the purpose of that funding and appropriate measureable outcomes. (see page 36)

5. The Chief Executive should, within 8 weeks, present to this Committee a written report explaining what actions are or have been taken in response to the recommendations made by the C&AG in her report R.118/2013. (see page 37)

6. The Treasurer of the States must ensure that all project descriptions included within future Medium Term Financial Plans and Budget Statements provide a clear and accurate summary of the purpose of funding allocations and measurable outcomes to allow for departments to be held to account. (see page 39)

Executive Summary

HSSD has been pursuing the goal of a fully integrated electronic health and social care records system since 2001. As of July 2014, HSSD remains some way short of achieving its goal.

The rate of progress towards the integrated care records (ICR) vision was limited until early 2004, when HSSD learned that its primary IT service provider was planning to exit the British healthcare systems market. This development forced HSSD to begin actively searching for replacement core systems.

At some point during the period 2004 - 2005, the project to replace the existing core IT systems became a constituent part of a more ambitious programme, supported by external consultants, to deliver ICR in support of a new overarching health and social care strategy.

Funding for the ICR programme was obtained in September 2006 when, as part of the Annual Business Plan 2007, the States endorsed a proposal of the Council of Ministers to award the capital sum of £12 million to HSSD over 4 years. The States were given a poor written summary of the use to which the £12 million would be put. This poor summary would later affect the ability of the States to hold HSSD to account for delivery of the ICR programme.

The decision to award £12 million to the ICR programme was made in the absence of an outline business case. Besides being late, the outline business case had several material weaknesses. Risk and benefits realisation analyses were not of high quality. There was neither proper recognition of, nor an action plan to address, a suspected (and later confirmed) mismatch between the ambitious programme scope and the available budget.

The ICR programme management structure struggled with the complexity of the programme. Insufficient resources were allocated to the procurement process at the outset. Some fundamental governance and risk management failures occurred.

Organisational change readiness was overestimated. There was insufficient focus on programme benefits realisation.

During August 2007, a new Director of Information Services was employed by the Chief Minister's Department to oversee corporate IT service provision. The new Director articulated various technical and programme management related concerns to the HSSD dominated ICR Programme Board at an early stage but was unable to materially influence the direction of the programme.

Procurement had been due to conclude by November 2007. This key milestone was missed by over 18 months. The Programme Board was too slow to accept that none of the bidders identified would deliver even a majority of the specification within, or near, the available budget. Programme Board minutes indicate that the procurement over-run may have accounted for as much as £1 million of the total programme cost by 2011.

It was not until mid-2008 that HSSD began actively considering the possibility that neither procurement negotiations nor the faltering New Directions strategy would close the funding gap. HSSD's remaining options were to bid for more money through the Annual Business Plan process or to de-scope the programme. After further indecision, the Programme Board opted for de-scoping.

We have seen no evidence that the Minister for Health and Social Services, the Council of Ministers or the States Assembly were ever formally notified of, or asked to ratify, the de-scoping of the ICR programme. Political oversight was compromised by this omission.

In June 2009 the ICR Programme Board approved a reworked full business case. This second business case confirmed the de-scoping. It divided both systems procurement and implementation into 2 realigned phases. Phase 1 was to replace existing obsolete systems, implement digital radiology solutions and provide limited additional systems only, using the full £12 million capital allocation. All outstanding elements of the ICR Programme were repackaged as an unfunded phase 2. Contracts with service providers were eventually signed in July 2009 on the basis of this second business case.

Given that many savings opportunities were contingent upon a full ICR implementation (i.e. both phase 1 and the unfunded phase 2), the de-scoped 2009 business case caused a number of savings opportunities to be deferred. Although the digital RIS / PACS radiology systems implementation was achieved in phase 1, the savings it generated (over £300,000 per annum cash savings, together with related staff reductions) were delayed by a year because of the procurement overrun.

Programme management shortcomings resulted in ICR implementation being affected by many of the same risks that had been highlighted early in the life of the programme. An added complication was the sudden departure of the original programme sponsor, the then Chief Officer, HSSD. The replacement Chief Officer and her newly appointed Hospital Director were instrumental in securing improved programme performance during 2010 - 2011.

What became ICR phase 1 was finally completed in mid-2011. This was some 18 months later than the original completion date for the full programme. HSSD maintained that the ICR programme came in under budget, citing a declared cost of £11.97 million. It would be more appropriate to record that de-scoping and utilisation of other budgets prevented the programme budget from being exceeded.

Certain de-scoped elements have since been delivered via separate projects. The recently commissioned GP central server project was one such example. Up to £1 million of the GP central server costs were instead drawn from the Health Insurance Fund via propositions P.36/2010 and P.125/2010.

ICR phase 1 delivered a core suite of systems that can be built upon to achieve a full ICR solution in the years to come and following significant additional investment. This is a manifestly different outcome to the achievement of digitised and fully integrated care records. Various sections within HSSD continue to rely on physical client records and associated paper-driven processes.

We have seen no evidence to suggest that a formal programme evaluation was undertaken at the conclusion of ICR phase 1. This omission may have impacted HSSD's ability to learn constructively from experience. It may also have impacted the quality of data on IT service provision that informed HSSD's revised service delivery strategy of 2012.

HSSD has since developed a new Informatics Strategy 2013 – 2015. This effectively advocates the execution of ICR Phase 2, updated with input from the gap analysis carried out by an external consultant. Funding for the Informatics Strategy is to be built into the next draft Medium Term Financial Plan, which the States will debate in 2015.

The absence of a full programme evaluation has not prevented some lessons from being learned. Revised Treasury rules on expenditure and new IT project management guidance from Information Services, Chief Minister's Department appear to give Information Services more scope to exercise influence over change programmes with a significant IT component. The HSSD senior management team of 2014, in conjunction with the Treasury and Resources Department, has developed and shared several draft outline business cases to support bids for future IT funding. Those draft outline business cases require more detail and stop short of setting out measurable outcomes.

PAC considers that more lessons could be learned from the ICR programme. The Comptroller and Auditor General's report R.118/2013 identified fundamental issues with the broad approach to project management across States departments, while her report R.94/2014 indicates a need for greater thought to be put into systems implementation. HSSD's Informatics Strategy confirms that the risks affecting that strategy are not all that different to those that affected the earlier programme. Full delivery of the ICR vision will require a step change in the quality of risk management, business case development, project management practice and governance, particularly at the political oversight level.

Accepting that the ICR vision remains as relevant now as it was in 2001, HSSD's Informatics Strategy indicates a need for a further £12 million funding over the period of the next Medium Term Financial Plan. This allocation would be additional to the monies

already set aside for the new hospital. A full ICR implementation is therefore likely to cost broadly double the figure originally discussed with the Council of Ministers in 2006. In this regard, when the States Assembly debates the next Medium Term Financial Plan, they may be well advised to take a close interest in the proposed allocation of monies to the Informatics Strategy and the description of what they can expect to see delivered.

1 Introduction

1.1 On 25th September 2013 the Comptroller and Auditor General (C&AG) presented to the States her report entitled 'Management of Major Property Transactions: Learning from the proposed acquisition of Lime Grove House.' (R.118/2013). Whereas the unsuccessful property transaction had provided the starting point for the C&AG's work, R.118 explored the broader issue of States-wide project management standards. The C&AG's findings indicated that the States of Jersey would do well to devote time and resource to the delivery of more structured and consistent project management.

1.2 Paragraph 2.1 of R.118/2013 offered the following guidance on maximising the chances of delivering a successful major project –

> *'No major project is guaranteed to succeed. But success can be enhanced by:*
>
> - *appropriately assessing the risk associated with the project and allocating the right skills and resources to it;*
> - *preparing a robust and comprehensive business case to support the project;*
> - *thoroughly evaluating alternatives in a structured way;*
> - *establishing robust arrangements for project management;*
> - *identifying the need for professional advice and then both requesting and obtaining the advice in writing in accordance with recognised professional standards;*
> - *establishing appropriate governance arrangements that involve politicians on a timely basis and provide appropriate evidence of their involvement.'*

1.3 At the time the above report was published, we had begun reviewing documentation sourced from the Health and Social Services Department (HSSD) regarding that department's major Integrated Care Records (ICR) programme. Certain concerns had been raised with the Committee regarding perceived issues with the execution of that programme, which was understood to have concluded in 2011.

1.4 Given that HSSD was, in 2013, beginning to execute a subsequent related programme of work, we considered that this topic offered an ideal opportunity to benchmark the historical and current approaches of a major States department to the management of a major project against the good practice described in the C&AG's report.

2 Strategic Context

2.1 The Health and Social Services Department (HSSD) has been pursuing the goal of a fully integrated electronic health and social care records system since 2001.

2.2 In 1999, HSSD operated a limited suite of ageing IT systems known collectively as the Integrated Health System ('IHS'). Electronic Data Systems ('EDS') supplied and supported the majority of IHS systems. IHS serviced core hospital needs from outpatients through to operating theatres but it was manifestly not a fully integrated electronic patient care record system. Numerous services operated by HSSD at that time were still paper-driven.

2.3 In December 1999, HSSD engaged external consultants to review the department's IT provision. An updated Information and Communications Technology (ICT) Strategy 2001-2005 was produced, which proposed that HSSD prioritise development of a new array of health and social care applications built upon a centralised digital database of client data. This approach would allow data to be accessed, collated and utilised more efficiently and effectively, thereby offering scope to benefit service delivery.

2.4 Other jurisdictions had electronic healthcare records on their agenda at that time. The National Health Service (NHS) in England was developing what would, by 2002, become its National Programme for IT (NPfIT).

2.5 Although both NPfIT and HSSD's ICT Strategy 2001 – 2005 were focussed on centralised electronic client records, there were key differences between the two strategies. NPfIT was designed for a more integrated primary and secondary health care services environment with primarily external social service provision. Jersey's HSSD provided both secondary health care and social care services but primary health care provision was (and remains) managed by a network of private GP's. Informational awareness and systems implementation within HSSD also lagged behind the United Kingdom.

2.6 What to do with the existing IHS system was arguably the primary technical issue raised in the ICT Strategy 2001–2005. IHS was mission-critical. The hospital would all but cease to function without IHS or an equivalent system in place, yet IHS could not serve as the core of the integrated client records system without fundamental reworking. Given that EDS' appetite for product development was not known to HSSD at that time, it was envisaged that work to replace IHS might need to begin in less than 2 years. In this regard, the strategy made provision for a detailed IHS review but stopped short of prescribing an outline funding requirement for systems replacement.

2.7 The ICT Strategy 2001 – 2005 advocated: infrastructure development; improved information management; ICT process improvement; applications development; and, implementation workstreams, at an estimated cost of £4.7 million. A further £3 million would be needed if the planned IHS review was to find that EDS supplied systems needed replacing. As HSSD did not have funding set aside to pay for major IT projects, the new strategy would form the basis for a new capital funding bid.

2.8 During the first 3 years of its life, the ICT Strategy 2001 – 2005 achieved limited change. Some discrete elements (e.g. server upgrades) were actioned but progress toward the primary goal of an Electronic Client Record was minimal. HSSD monitored NPfIT related developments. The question of what to do about IHS was nevertheless left unanswered until January 2004.

2.9 EDS was one of the companies bidding for English NPfIT contracts. By January 2004, EDS had seen its contract to provide a system known as NHSmail terminated and had been unsuccessful in securing other NPfIT work. These developments reportedly caused EDS to advise HSSD that it would cease development of the systems supporting IHS and withdraw from the British healthcare systems market in due course.

2.10 As both Guernsey and the Isle of Man were also EDS customers at that time, the NPfIT contract outcome forced all the Crown Dependencies to act. In this regard, Guernsey and the Isle of Man had a head-start. Although differences in the islands' respective approaches to capital funding and procurement were relevant factors, the

islands' respective starting points were also different. Guernsey and the Isle of Man had already set about acquiring a key digital system in the form of a Picture Archiving and Communications System (PACS) for their radiology functions. Jersey maintained a manual film-based system. Neither Guernsey nor the Isle of Man were working to a strategy that called for full integration of health and social care records in the medium to long term.

2.11 The EDS announcement convinced HSSD that it needed to replace IHS by 2008, else it would be left with obsolete systems that would cost more money to keep running.

2.12 Appendix 1 to this report continues the chronology of events from the beginning of 2004, when the need to replace existing obsolete systems became clear, through to mid-2011, when the ICR programme effectively concluded (see page 41).

3 Evaluation

The Business Case

3.1 The first – or outline – ICR Programme business case of 2006, although lengthy, was neither robust nor comprehensive. It was also late.

3.2 On the basis that the March 2004 Health and Social Services Committee meeting represents the genesis of the ICR programme, it took over 2 years to complete the outline business case. For an IT-focused programme launched in response to the potential loss of critical systems support in the medium term, this was simply too long.

3.3 The absence of an outline business case before December 2006 meant that neither the Treasury and Resources Department nor the CMB could reassure the Council of Ministers that HSSD was offering a systematic explanation of the rationale for the ICR programme and a framework for completing the necessary work on time and within budget. Neither could the affordability question be answered. The fact that the Council of Ministers and the Corporate Management Board backed the capital bid anyway is worthy of note.

3.4 Although the outline business case was late, it was still further advanced than the overarching New Directions strategy it was intended to support. This inevitably meant that the objectives the ICR programme was aiming to deliver were less than fully fixed. In fact, New Directions foundered in 2009 without achieving green or white paper status.

3.5 The outline business case was built on several high-risk planning assumptions. It was assumed that there existed a largely integrated solution that could meet the critical requirements set out in the OBS. By January 2008, the Programme Board would be advised by consultants that the concept of an ICR was relatively untried and that HSSD's aspirational programme had tested the healthcare market Other assumptions were made regarding the availability of resource. In fact various critical internal and external resourcing issues would be flagged throughout the life of the programme.

3.6 The risk assessment in the outline business case was flawed. Programme affordability was not flagged as a primary risk, yet the first few pages of the business case made it abundantly clear that there was a probable capital funding shortfall in the region of £4 million. There was no obvious plan to manage the funding gap.

3.7 Although lack of experience in procurements of such broad scope and complexity was cited as a risk, the business case stopped short of acknowledging that trialling competitive dialogue procurement might exacerbate that risk, irrespective of its relative suitability in principle. In the event, expert external assistance was required to manage the procurement. There was no clear recognition of the risk arising from the need to manage a series of consultants with differing briefs. One paragraph claimed that organisational capacity for change was a very probable risk with major scope for impact. An adjacent paragraph then claimed that HSSD had '*significant experience over recent times of changes occurring and managing through this.'* This was not so much a mitigation strategy as a contradiction of the original assessment.

3.8 Finally, when the realities of the procurement became inescapable, the outline business case was superseded by a second – or full – business case that reflected what the Programme Board believed it could deliver. There is, however, no record of this major development having been endorsed or even noted by the Minister for Health and Social Services, the Council of Ministers or the States Assembly.

Risk Management

3.9 Standards of risk management remained poor for the duration of the ICR programme. This is evidenced by the degree of repetition in successive reports by various third parties.

3.10 Substantive development of the ICR programme began in response to the major risk of imminent and terminal failure of the business critical but obsolescent systems that made up the IHS. In the circumstances, HSSD could reasonably have commissioned a tighter, faster programme to replace core systems with a modular solution that would have

enabled future ICR development (which is almost precisely what the de-scoped programme became). Instead, HSSD tried to execute a much broader and complex programme of work. This decision added significant complexity and risk at the procurement phase and exacerbated the risk that procurement would overrun. The original risk of IHS systems failure was therefore compounded.

3.11 We have already explained that the risk assessment within the outline business case of 2006 was flawed. In truth, a number of the risks facing HSSD in 2006 were not markedly different to those flagged in the original ICT Strategy 2001 – 2005. The earlier document acknowledged issues with: funding, organisational capacity for change; disjointed management processes across the organisation; and, structural and resourcing issues within the department's own IT section. Each of these issues impacted the ICR programme in some way after 2006.

3.12 The inadequacy of the initial risk assessment was exacerbated in the months that followed. The OGC Healthcheck of March 2007 observed that the programme risk log was not being updated and that relevant information was missing. Various other risks were cited by the OGC. Remedial measures put in place following receipt of the Healthcheck improved risk identification but had insufficient impact on management of more critical risks. Successive consultants' reports invited consideration of funding issues, bidder capability and departmental capacity for change.

3.13 A draft internal audit report produced in May 2008 offered a new perspective on broadly identical risks. It described the ICR programme as *'too large and complex to be capable of being delivered in a single "project" structure.'* It called for a '*more focussed approach'* and a suitable process for escalation and capture at programme level.

3.14 The Programme Board minutes indicate acceptance of the report's findings, although the management response indicated that each discrete project within the ICR programme was going to have its own governance structure. In addition, a written comment on the report submitted to the Board by the Programme Manager indicates that the Programme Manager had challenged the author's experience of the health and social

care business sector and was convinced that the existing procurement process offered the necessary degree of risk mitigation.

3.15 The ICR programme internal audit report was never finalised. This was unusual. No formal explanation for this omission has been forthcoming. The practical consequence may have been a reduced likelihood of its contents receiving a broader circulation, including to the Audit Committee of the day. Given the important observations made in the draft report, this was quite a troubling discovery.

> **Recommendation 1** – To assist the Audit Committee to track the progress of individual internal audit reviews, regular internal audit plan progress reports submitted to the Audit Committee should clearly record the current status of each review relative to the status reported to the Audit Committee at its previous meeting.

3.16 The second OGC Healthcheck effectively corroborated significant sections of the earlier internal audit report. Supplier resourcing and internal staffing of the programme team, the change management team and the technical services team were all highlighted as key risks in urgent need of attention. Programme Board minutes and other supporting documents indicate that some of these risks were developing into material issues as the programme progressed.

Options Appraisal

3.17 Several options appraisals were documented during the course of the ICR programme. None adopted a systematic approach of the type discussed in R.118/2013. There was no obvious evidence of scoring or weighting.

3.18 The lack of a finalised New Directions strategy may have affected each appraisal. Prospective ICR programme solutions could only be measured against a combination of possible or probable high level business objectives.

3.19 One relevant options appraisal was dated July 2005 and was included within background documents given to the producer of the OBS. It considered 4 prospective solutions –

(a) a bespoke solution;

(b) an off-the-shelf NHS Local Service Provider solution;

(c) an off-the-shelf NHS Local Service Provider solution with Jersey customisations; or

(d) an existing solution offered by another major system supplier.

3.20 Solution (a) above was effectively discounted on account of high anticipated costs, reliance on a single supplier and lack of relevant HSSD experience. Solutions (b), (c) and (d) were each considered potentially able to meet the needs of the department, albeit that option (b) would inherently have been more difficult to align with programme objectives because of the different approaches to primary and social care in the UK.[1] The eventual solution was arguably closest to option (d), with an element of option (a). This was something of a departure from the original systems replacement approach discussed with the Health and Social Services Committee in March 2004.

3.21 The most notable subsequent options appraisal was conducted in June 2008 by HSSD with the support of external consultants, after the preferred bidder confirmed that they were no longer prepared to act as a prime contractor with responsibility for delivering all aspects of the ICR programme. Again, 4 options to move forward were outlined. These were –

[1] HSSD Request for Proposal June 2005 – Para 2.2.2 page 7

i. Do nothing
ii. Purchase a full ICR system from the preferred supplier
iii. Purchase an EDS replacement system from the preferred supplier –
    a. With an option to take clinical modules at a later point in time, or
    b. Procure clinical modules at a future date via a new procurement.
iv. Start the procurement again.

3.22 Option 3a was recommended, with option 3b serving as a fall-back option.

3.23 Although the June 2008 appraisal was not quite a scored and weighted assessment against specific criteria, it did at least follow a rationalised consideration of cost, effort requirements and impact. The problem was that the appraisal continued the practice of setting aside the funding shortfall. Evidence suggests that the funding consideration was set aside because the consultant was working on a base assumption, given by the programme management, that the extra money would be found somehow. A fully systematic appraisal might nevertheless have encouraged a more thoughtful debate at Programme Board level and an earlier realignment of the programme.

Use of Consultants

3.24 We found no evidence that consultants appointed to assist the ICR programme in various different roles failed to fulfil their terms of reference. There were nevertheless several problems with consultancy support in this case.

3.25 First, additional cost was incurred to correct shortfalls in HSSD's understanding of its own business activity. To improve that understanding, the Programme Board planned to pay for the successful bidder to map and re-engineer the department's existing business processes before selling the Department some new IT systems and implementing those new systems to support the re-engineered processes. Consultants were to be engaged separately to quality assure the resulting change plan produced by the successful bidder. When the preferred bidder declined to undertake the change

management work, HSSD obtained assistance with that element of the programme by way of a separate consultancy contract.

3.26 Secondly, consultancy fees were incurred for rather longer than should have been necessary. Extending the procurement stage by 18 months meant that procurement consultants were needed for much longer than planned. There was also an associated coordination issue in that the procurement consultant had a different reporting line to those of other consultants, albeit that costs appear to have been recharged to the ICR Programme. The draft internal audit report of May 2008 found inadequate controls in place to mitigate the risk that unnecessary work might be undertaken by consultants being remunerated on a time and materials basis.

3.27 The 2006 business case envisaged a consultancy spend in excess of £4 million. We were advised that this large allocation reflected the anticipated costs of change management consultancy. When this element of the programme had to be taken partially in-house, the 2009 business case was adjusted to reflect a significantly lower consultancy spend. At the close of what became ICR Phase 1, consultancy expenditure had not been markedly disproportionate for a public sector IT programme of this scale. Other costs had nevertheless increased, such that there would be no overall saving.

Governance Arrangements

3.28 Governance failings were evident at the political level and within the programme management framework. Although the current Chief Officer, HSSD, accepts the need for political oversight of such programmes, processes before her arrival were less than robust.

3.29 Current rules indicate that the approval of a draft budget for forwarding to the Council of Ministers and the States should be recorded by way of a formal ministerial

decision.[2] Whether this applies to the approval of a £12 million draft budget for a capital programme is unclear. It nevertheless seems logical that a department wishing to have their Minister support their capital programme funding bid at the Council of Ministers table and, subsequently, in the States Assembly should first have to persuade their own Minister to formally endorse at least a summary of the relevant outline business case.

3.30 We have seen no evidence that the then Minister for Health and Social Services was asked to formally endorse his department's capital programme bid for the ICR programme in 2006. We find it hard to comprehend that a Minister could seem to be so unknowing of, and uninterested in, a major and critical capital programme like this within his department. Neither, incidentally, are we clear that all Ministers adopt such a practice today.

> **Recommendation 2** – The Corporate Management Board must ensure that Ministers are suitably briefed on and have formally endorsed their departmental capital programme bids before they are submitted to the Council of Ministers for consideration as part of the Medium Term Financial Plan.

3.31 When the Council of Ministers was finally given a briefing on the £12 million funding requirement, it learned that a major programme of systems expansion to improve efficiency and service delivery was intended and that integrated health and social care records were the intended outcome. The equivalent description in the draft Annual Business Plan 2007 regarding the purpose of the £12 million allocation was, however, materially different. It omitted to acknowledge the existence of the ICR programme and it indicated that straightforward systems replacement – rather than major systems expansion – was planned. As the States were not told about the high level objectives of the £12 million programme, they were not well placed to hold the Minister and the department to account for its delivery.

[2] R.C.80/2005 refers

3.32 Occasional written and oral questions from individual States Members in subsequent years gave successive Ministers opportunities to clarify the status of the ICR programme. They included written questions asked on 15th January 2008, 21st September 2009 and 3rd May 2011. None of the answers given to the States referred overtly to the de-scoping of the programme or its consequences.

3.33 We have not been able to identify any formal records that show the then Minister for Health and Social Services was formally briefed on and / or endorsed steps to secure the additional capital needed to close the ICR funding gap prior to de-scoping.

3.34 The Minister for Health and Social Services (who was then new in post) received a detailed briefing on the robustness of the ICR programme contracts before she signed them in July 2009. We nevertheless found no evidence that the same Minister was formally briefed on the circumstances of the programme de-scoping that occurred in the months before the contracts were finalised. Neither have we found evidence that the Council of Ministers and / or the States were formally apprised of the de-scoping either, yet they had proposed and approved the original funding allocation respectively. What is clear is that the Minister knew something of the de-scoping by 23rd December 2010, when she presented to the States an organisational and management improvement plan for her department (R.153.2010 refers). That document contains a brief reference to the change of plan at page 10.

3.35 Governance arrangements at the operational level were ostensibly robust. Programme organisation and governance arrangements were set out at an early stage in a Project Initiation Document. There was a desire to achieve PRINCE2 compliance. In this regard, a Programme Board and a dedicated Programme Manager were appointed. The Programme Board included HSSD's Clinical Lead on IT as the Senior User. The Director of Information Services, Chief Minister's Department took the role of Senior Supplier. The Chief Executive assumed the Senior Responsible Owner role. Change management and senior legal representation was nevertheless missing at the outset.

3.36 In practice, it was not always clear who was authorised to take either the key strategic decisions or those required on a day-to-day basis. One example of the lack of clarity was the decision in December 2007 to discontinue negotiations with all parties save HSSD's preferred bidder. This decision had strategic implications but it was effectively made below Programme Board level and put to the Board for ratification after the event.

3.37 Again, the most telling evidence of the state of programme governance at the operational level is the consistency of message in the OGC, internal audit and other consultants' reports. They repeatedly flagged similar risk management concerns over the lifetime of the programme, which indicates that the key decisions to address risk were simply not being taken.

Delivery Against Specification

3.38 Attempts to measure the success of the ICR programme are complicated by the relative lack of clarity as to what the programme was expected to deliver.

3.39 When assessed against the Annual Business Plan 2007, the conclusions are relatively positive. The programme delivered what the Business Plan entry called for and did so within the capital budget awarded, albeit that implementation was completed late and additional systems support costs of £1.2 million per annum were generated by 2011.

3.40 An assessment against the original programme objectives and the briefing given to the Council of Ministers leads to a different conclusion. Almost all of the £12 million capital allocation from 2006 was spent and there is evidence of other expenditure incurred outside of the £12 million allocation. Programme Board minutes suggest that departmental overtime budgets might have been called upon to fund programme related activity. The GP central server was part-funded by the Health Insurance Fund via propositions P.36/2010 and P.125/2010.

3.41 The ICR programme concluded without achieving a full ICR, notwithstanding that this was considered mandatory at the programme outset and that this was the vision outlined to the Council of Ministers. The systems analysis at **Appendix 2** (see page 53)

reveals precisely what was delivered by the summer of 2011. In summary, obsolete EDS supplied systems were replaced with modern alternatives that appear to be of good quality. New digital radiology systems and a limited number of additional components were implemented. A significant number of systems were nevertheless deferred for future implementation. Elements that were implemented were delivered late. The original programme objective will be complete only when the remaining systems are replaced or upgraded. HSSD needs to launch a new programme with a new budget to finish the job it originally set out to do.

Value for Money

3.42 Although a full-scale value for money assessment of the ICR programme would take many months and require significant specialist resource, it is possible to make four straightforward observations.

3.43 First, the pursuit of a full ICR programme (instead of a more straightforward replacement of obsolete systems with modular replacements) generated additional expense and stress-tested States' resources. Although it is arguable that HSSD could not reasonably have known until mid to late 2007 that the market was not in a position to deliver what the department was asking for at even a remotely affordable price, HSSD did not change course until 2009. Programme Board minutes indicate that the procurement over-run might have accounted for as much as £1 million of the final programme cost, not least because procurement consultants were required for longer than anticipated.

3.44 Secondly, the extended procurement process delayed the implementation of the RIS / PACS systems. The original business case concluded that RIS / PACS would save over £300,000 per annum and 4.7 full time equivalent posts. Had the procurement concluded on time, RIS / PACS might have been generating savings in 2008. Instead, it successfully went live in 2010.

3.45 Thirdly, the de-scoping of the programme in 2009 on affordability grounds resulted in the deferral of a majority of the other savings opportunities identified beyond RIS /

PACS, plus a number of quality improvements. Initial change management work conducted by HSSD's consultants found scope for £2.2 million cash savings and efficiency savings valued at up to £4.5 million – if the programme was executed in full. The value of the deferred savings was, therefore, significant. Additional quality benefits deferred in part or in full included –

- improved quality in terms of governance, safety and clinical care throughout the use of integrated care pathways
- improved productivity in terms of efficient processes, single source of data, communication
- improved support for the introduction of modern health and social care techniques e.g. PACS / MHAS
- improved data collection and reporting to support evidence based care provision
- improved resource utilisation through improved requesting, tracking and cost management
- continuity of service beyond the end of the EDS support contract.

3.46 Fourthly, savings achieved as a consequence of retiring obsolete systems and dispensing with associated support contracts were negated by the higher running costs of the new systems. Discontinuation of support contracts for the old systems saved over £200,000 but HSSD needed £1.2 million added to its base budget from 2011 to support the new systems.

Programme Management

3.47 Good programme management requires effective stakeholder engagement, allocation of clear roles and responsibilities, structured monitoring, active management and appropriate provision for escalation of issues as necessary.

3.48 How well the programme functioned in practice is discernible from the management of certain key challenges, including: the funding gap and subsequent de-scoping; OGC,

internal audit and consultants' findings and recommendations; resource management; and, relations between HSSD and Information Services.

3.49 The HSSD – Information Services relationship warrants additional comment. We found signs of tension between HSSD and the central Information Services function as early as 2007.

3.50 At his first Programme Board meeting in September 2007, the new Director of Information Services observed that the procurement might benefit from a more service-based focus. His advice was noted but there was no obvious change of direction by the Board. The Director warned that the outcome of negotiations on terms of reference documents would need to be considered by Information Services as part of their ICT infrastructure development plans. These terms of reference documents were to specify, amongst other things: the ICR solution; the project plan; resource plan; and, the risk and issue logs that would operate in the post-procurement stages. It reportedly took until April 2008 for the Information Services senior management team to secure greater input and visibility into the signing off of those documents. By the time that greater input and visibility was achieved, Programme Board minutes and associated documentation were hinting at a possible problem regarding assumptions made about central provision of core IT infrastructure and support arrangements to underpin the ICR system. In this regard, we note that the 2009 business case identified a need for in excess of £1 million additional revenue funding.

3.51 The central Information Services section appeared to lose a degree of confidence in HSSD through 2008 and sought a greater degree of managerial control over the technical aspects of the programme. In turn, there are signs that HSSD resisted. Information Services would later put new managers in place with a view to maximising progress on ICR, whilst also seeking to mitigate risk by stripping back change elements and concentrating on technology implementation and successful data migration. We are pleased to see that the relationship between Information Services and HSSD appears to be more positive in 2014.

3.52 There is one other aspect of programme management that deserves attention and that is the manner in which the programme was closed. A full and formal programme review and evaluation was not conducted at the conclusion of what became ICR Phase 1. It therefore appears that an opportunity to clarify precisely what had been achieved and learn from experience was lost. Given the scale and cost of the ICR programme, this is unacceptable.

Recommendation 3 – The Corporate Management Board must ensure that a thorough and objective evaluation is undertaken and is documented either at the conclusion of every capital project or whenever the capital budget allocated by the States to a specific project is deemed to require supplementation.

4 Looking Ahead – the Informatics Strategy 2013 - 2015

4.1 With ICR Phase 1 concluded, HSSD concentrated on devising its new overarching service delivery strategy that would become the white paper 'Caring for Each Other, Caring for Ourselves' informed proposition P.82/2012 ('Health and Social Services: A New Way Forward'), which was adopted by the States Assembly. Better client records, better management information, underpinned by appropriate information technology, were seen as key to the new vision.

4.2 It seems, however, that there may have been a problem with the white paper. During the course of its review of the Health and Social Services Redesign, the Health and Social Services Scrutiny Panel was told by HSSD's Clinical Lead for IT that the white paper of 2012 had –

> *'... made assumptions about the state of informatics and information technology within Health and Social Services which were more advanced than where we actually were.'*[3]

4.3 The Clinical Lead for IT submitted that he had not been consulted about the informatics elements of the white paper during its development. He recalled having become involved after publication, when he met with the Director of Finance and Information and set out his concerns. This meeting reportedly influenced the commissioning of consultants to produce the Informatics Strategy 2013 – 2015, which the Clinical Lead believed defined the gap between the department's existing operational status and the vision and requirements specified in the 2012 white paper.

4.4 We have since been advised that the recollection of the Clinical Lead for IT does not accord with that of the Department. HSSD maintains the Clinical Lead was consulted on the informatics element of the white paper and that the Informatics Strategy 2013-2015 was a pre-planned piece of work to build on the white paper. We nevertheless observe

[3] Transcript of hearing with Clinical Lead for IT 14th April 2014 – page 2

that had what became ICR Phase 1 been closed by way of a formal and documented programme evaluation, the consultants assisting with production of the 2012 white paper might have been better placed to produce an accurate assessment of the IT position within HSSD.

4.5 The Informatics Strategy 2013 – 2015 does two things. It defines where the Department is now and describes how it should move forward.

4.6 Regarding where HSSD is now, the Informatics Strategy arguably attempts to fill the gap left by the absence of a proper ICR Phase 1 evaluation, despite containing only a few isolated references to the original ICR programme. In this respect, the strategy is weakened by a lack of detail on how the new systems are been utilised. The C&AG's recently released report on management information in hospital theatres[4] fills a vital gap in this regard. It demonstrates that HSSD has not yet made best use of its new theatre information systems. HSSD is not yet using the systems it bought via the ICR programme to measure the right things and the quality of data being added to the systems could improve, as could the Department's utilisation of that data.

4.7 In terms of moving forward, the Informatics Strategy describes a timetable spanning the period 2013 – 2018 and anticipates a cost of £14,667,000. An initial phase of the Informatics Strategy is currently underway, though the bulk of the anticipated spend is dependent on the securing of £12 million funding via the Medium Term Financial Plan 2016-2018. Provisional funding requests to support Informatics Strategy execution have already been submitted to the Treasury and Resources Department.

4.8 Reflecting on the areas where the ICR programme ran into difficulty, it would be reasonable to expect that HSSD can avoid repeating earlier mistakes when executing the Informatics Strategy. Notwithstanding the failure to properly evaluate the ICR programme in 2011, HSSD is now following an approved overarching strategy. It has a better

[4] R.94/2014 refers

knowledge of its full range of business activity as a consequence of the ICR programme, although the fragmented ICR implementation may have generated a requirement to revisit some of that work.

4.9 HSSD has produced some draft outline business cases for individual elements of its new strategy at a materially earlier stage. The latest drafts do, however, stop short of offering clear statements of funds required, purposes and measureable outcomes. They would benefit from more detail on how delivery will be achieved. As an example, one document refers to expanding '*acute TrakCare EPR and clinical modules'* without offering any detail as to which departments will be included or excluded. There is more work to do to ensure that the Informatics Strategy implementation can outperform the original ICR programme.

> **Recommendation 4** – Outline business cases produced in support of capital funding bids must, as a minimum, specify clearly the anticipated funding requirement, the purpose of that funding and appropriate measureable outcomes.

4.10 If HSSD still has some issues with project management capability and resource then this should not come as a particular surprise. The C&AG's report R.118/2013 explains that the States had some fundamental shortcomings in their approach to project management in 2013.

4.11 There are signs that R.118/2013 is encouraging positive change at the corporate level, from which HSSD should benefit. States departments are now being required to execute all projects with a budget in excess of £100,000 in accordance with PRINCE2 or another suitably structured project management methodology. The ongoing application of Lean methodology is reportedly beginning to improve business process awareness and the refinement of those processes across all departments, including HSSD. We nevertheless see a need for greater clarity and detail on how broader project management standards across the States are being raised and monitored. Our review of the ICR programme indicates that the intention to achieve PRINCE2 compliance was not sufficient to prevent some fundamental project management errors.

Recommendation 5 – The Chief Executive should, within 8 weeks, present to this Committee a written report explaining what actions are or have been taken in response to the recommendations made by the C&AG in her report R.118/2013.

4.12 There are reasons to conclude that Information Services' remit and relationship with other departments has more structure than before. Information Services is clear that its role is to provide assurance and governance around technical project delivery and project management. It believes that both Financial Directions and its newly published project management framework document will mitigate past concerns. Some reassurance in this regard might be beneficial in the finalised outline business cases that will inform funding requests submitted for consideration as part of the next Medium Term Financial Plan.

5 Conclusion

5.1 The ICR programme of 2004-2011 secured delivery of a core suite of systems that, with further work, can serve as the heart of a full ICR solution in the years to come. It did not, however, achieve the principal objective set in the period 2004 - 06. Paper records are still circulating widely within HSSD premises. Numerous records are being updated manually. Hard copy folders are having to follow clients around different locations.

5.2 Accepting that the ICR vision remains as relevant now as it was in 2001 and that the proposed dual-site hospital strengthens the case for fully digital integrated records, the States can expect to be presented with a strong case to fund the Informatics Strategy implementation over the period of the next Medium Term Financial Plan. Such an allocation, if approved, would be additional to the monies already set aside for the substantive hospital project.

5.3 The Informatics Strategy 2013-2015 identifies a number of the same risks that affected the preceding ICR programme. PAC has not yet received a clear explanation as to how, or how many of, these risks have been mitigated. Outline business cases will need to set out clear aims, objectives and success criteria for what is, again, a notably complex programme of work. Those charged with asking the States to fund such programmes in future would do well to satisfy themselves in advance that those business cases exist, that they are fit for purpose and, importantly, that they are going to be executed in accordance with a structured project management methodology that should become a fundamental part of the way the organisation works.

5.4 A full ICR implementation may cost broadly double the figure originally discussed with the Council of Ministers in 2006. In this regard, and given our findings in this report, we invite the States Assembly take a particularly close interest in the detail of the case made for Informatics Strategy funding before the next Medium Term Financial Plan is debated. In turn, we urge the Treasury and Resources Department to ensure that any such programme description included in the MTFP is rather more accurate and informative than that which was included in the Annual Business Plan of 2007.

Recommendation 6 – The Treasurer of the States must ensure that all project descriptions included within future Medium Term Financial Plans and Budget Statements provide a clear and accurate summary of the purpose of funding allocations and measurable outcomes to allow for departments to be held to account.

Appendix 1: A Chronology of the ICR Programme

2004 – Programme Development Begins

The ICR programme effectively began with a meeting of the then Health and Social Services Committee on 3rd March 2004, when the Committee was briefed on the EDS announcement. It was advised that capital funding of the order of £10 to £15 million would be needed by 2007 to replace the IHS. HSSD advocated 'piggy-backing' on UK NHS developments to minimise the complexity and risk of new systems procurement and implementation. The Committee noted the position.

This was an anomalous briefing for several reasons. First, there was no consideration of the EDS issue in the context of the ICT Strategy 2001-2005 (which had been developed during the term of the preceding Committee and which should have been the point of reference for a decision). There is no evidence that the strategy was ever mentioned. Secondly, the funding requirement discussed with the Committee was significantly greater than the full electronic client records vision outlined in the ICT Strategy, yet the briefing had concerned a direct IHS replacement and not IT systems expansion. In fact, no mention was made of any plan to achieve a fully-fledged ICR system spanning the full range of health and social care services.

Notwithstanding the above, at some point after the March 2004 briefing, HSSD began executing a plan to replace the IHS as one part of a full-scale integrated electronic health and social care records programme. It did so at a time when the States were endeavouring to reduce the value of the overall capital programme by some £3 million per annum.

2005 – The Programme Scope is Confirmed

By mid-2005, HSSD was developing its ICR programme in parallel with an ambitious new overarching health and social care service delivery strategy, known as 'New Directions.' Integrated health and social care records were a prerequisite of that strategy.

The most notable ICR programme development during 2005 was the production of an Output Based Specification (OBS). This was prepared by external consultants, which had also been advising HSSD on the content of the ICR programme and on the likely ability of potential suppliers to deliver. This OBS described the scope of the substantive programme contract to be awarded and articulated HSSD's desired outputs in qualitative and quantitative terms. It was designed to offer potential bidders scope to be innovative in proposing solutions and systems.

Documents given by HSSD to the producer of the OBS described HSSD's requirements in the following high-level terms–

- *'An integrated care record*
- *Clinical applications*
- *Community and Social Care Applications*
- *Planning, Management and Performance*
- *Interface with the UK NHS Spine*
- *Integration with existing Primary Care Systems*
- *Interface to Jersey Government Corporate Systems*
- *Association ICT Services*
- *Change Management.'*

The documents confirmed that HSSD wanted a prime contractor to deliver the full specification by way of a fixed price contract. Delivery of a full integrated care records solution was to be a non-negotiable contract requirement. The successful prime contractor would need to map existing business processes, re-engineer them and then implement the revised processes, complete with supporting IT solutions where necessary. It would select suppliers for all the individual solutions needed, integrate those solutions into a coordinated offering and deliver them to HSSD.

2006 – Funding Secured and First Business Case Produced

It took HSSD some 21 months to obtain the capital funding it needed for the ICR Programme.

In April 2006 the Corporate Management Board (CMB) reviewed the draft capital programme for the forthcoming year. The CMB recommended to the Council of Ministers that HSSD be awarded £12m over the period 2007 – 2010 to secure replacement ICT systems. It did so without having seen a documented outline business case or documented evidence of the probable funding requirement.

The CMB recommendation was forwarded to the Council of Ministers for consideration – again without an outline business case or a summary of the same having been tabled. On 11th May the Council deferred its decision on the draft capital programme, having complained of a lack of information. HSSD addressed the lack of information by making an oral presentation to the Council on 25th May, during which the objective of fully digitising and integrating health and social care records in support of the New Directions agenda was explained. It was suggested that £15 million might conceivably be needed to fund the programme but the £12 million sum recommended by the CMB was accepted by HSSD until such time as it could produce hard evidence in support of the larger sum. No detail was given to the Council regarding the proportions of the budget to be devoted to business continuity, to service improvements or to invest to save spending.

The Council endorsed the £12 million HSSD capital bid and put the complete capital programme to the States for approval as part of the Draft Annual Business Plan 2007. The bid was recorded in the text of the Annual Business Plan as follows –

'REPLACEMENT HEALTH ICT SYSTEMS *£4,000,000* *2007*

£3,000,000 *2008*

£3,000,000 *2009*

£2,000,000 *2010*

'Department's Submission:

'Health ICT Systems: A new line of funding of £12 million is included from 2007-2010 to meet the lowest estimated cost of replacement Health IT systems.

'The company currently providing Health's ICT systems is leaving the market place. The situation was highlighted during last year's capital resource allocation process but at that time details on cost and programme were not well developed. Initial indications suggesting [sic] that the replacement cost could be in the region of £15 million. A sum of £12 million has been included in the forward capital programme, which represents the lower end of the cost estimate. The position will need to be carefully reviewed as more information is obtained and, if necessary, adjustments made to the future capital programme.

'As this item is of such value and significance to Health's business it has been shown separately from the Corporate ICT funding stream, but will need to conform to all Corporate ICT protocols and requirements.'

The above text indicated the £12 million was needed for straightforward IT systems replacement, not a major expansion of systems capability in support of New Directions.

Hansard records that when the Annual Business Plan 2007 was debated, only Deputy R.G. Le Hérissier of St. Saviour sought clarity regarding the ICR Programme funding allocation. The Deputy said -

'... I.T. as we all know, looking elsewhere, is one of the most difficult projects to manage and generally runs out of control ... with the Health programme, I know the doctors are continually complaining that there is not compatibility between their systems and Health and this presumably is one of the big efforts to overcome this. Is that ring-fenced or are we just pouring money into sort of a vast thing called I.T. with no real idea where it is going to end up?'

With the money allocated, an ICR Programme Board was established. The first Programme Board meeting was held on 2nd October 2006, at which meeting the decision was taken to procure the ICR solution via the competitive dialogue process. It is understood that no States department had ever used competitive dialogue before.

In December 2006, the Programme Board approved the outline business case. This anticipated a capital funding requirement of £16.3 million and an ongoing revenue funding requirement of £1.8 million per annum. It set out a procurement timetable that should conclude by November 2007, with implementation concluding at the end of 2009, before the final tranche of funding would arrive. Realisable savings were quantified at £0.6 million per annum, with the possibility of achieving £1.4 million non-cashable efficiency savings for absorption elsewhere in HSSD.

2007 – Procurement Begins

Programme Board minutes reveal that programme slippage began as early as March 2007. The Board was busy evaluating bids from 5 prospective suppliers. None of the bids was scoring well.

The United Kingdom Office of Government Commerce (OGC) was commissioned by HSSD to conduct periodic external reviews of the ICR programme. The first OGC Healthcheck report, published in March 2007, identified programme complexity and a lack of procurement resource as matters of concern. Various governance and management issues, risk management issues, organisational change readiness issues and benefits realisation issues were also found. A risk board was established. Evidence suggests that the commissioning of Best Practice Group ('BPG') as procurement consultants was also a response to the OGC report's findings.

By April 2007, analysis of bidders' submissions indicated either that the OBS was poorly understood by the companies bidding for the work or that there was a clear gap between HSSD's requirements and what the market was willing and / or capable of delivering at or anywhere near the available budget. New data on likely programme costs suggested that HSSD's full specification would cost significantly more than £12 million. Substantive action taken to address the funding gap seems nevertheless to have been limited to ongoing procurement negotiations.

In August 2007 a new Director of Information Services, Chief Minister's Department took up his post, which included a seat on the ICR Programme Board. Initial concerns expressed by the new Director were not dissimilar to the matters raised in the earlier OGC Healthcheck. The Director also expressed broader concerns regarding project management standards and related skills shortages across States departments.

Consolidation in the healthcare systems market further complicated the procurement. Two of the three bidders still engaged were acquired by other companies. There remained a lack of clarity regarding the remaining bidders' capacity to deliver the OBS in full. Consultants were telling the ICR Programme Board that the department's aspirations had tested the healthcare systems market. Bidders did not fully understand HSSD's business requirements. In turn, HSSD was unclear as to what potential bidders were offering. Remaining bidders wanted a more straightforward contract than that which HSSD was demanding.

Consultants BPG devised a series of terms of reference documents in consultation with HSSD that would shed light on programme requirements and product / service capability. These were intended to narrow the gap between HSSD's understanding of the market and bidders' understanding of HSSD's objectives.

By late 2007, funding was being cited in the Programme Board minutes as the primary risk, ahead of HSSD's own capacity to manage such a complex programme and suppliers' ability to meet the specification. Mitigation of the funding risk took the form of a belief either that New Directions could be used to source supplementary funding for the programme or that the procurement process would still push the cost down.

Ongoing concerns regarding supplier capability resulted in the preparation of a paper that would invite the Board to close and restart the procurement after an evaluation. Having sought informal advice from the former Comptroller and Auditor General on the matter, the Programme Board abandoned competitive dialogue procurement in favour of negotiated procurement, then single bidder procurement. Efforts were concentrated on the supplier

that HSSD deemed most likely to deliver the majority of the OBS, albeit noting that the supplier favoured by HSSD would not take responsibility for change management.

When it became clear that the procurement phase would overrun beyond November 2007, extended support contracts were negotiated to keep the obsolete IHS in operation. Procurement consultants were also retained for longer.

In the intervening period, a new Minister for Health and Social Services had been appointed, which in turn prompted a status review of New Directions.

2008 – Preferred Bidder Negotiations and the Internal Audit Report

By February 2008 the Programme Board had awarded preferred bidder status to Intersystems, notwithstanding that revised costings were showing that the ICR programme remained unaffordable. Development of the New Directions strategy continued, which appeared to lead the Programme Board to conclude that it could secure a supplementary budget for ICR.

Having accepted that the preferred bidder would not undertake change management work, HSSD instructed the consultants initially engaged for the OBS to assist with taking the workstream in-house. The consultant's initial analysis identified scope for £2.2 million cash savings and up to £4.5 million efficiency savings – if the ICR programme was executed in full.

Negotiations with the preferred bidder over the new terms of reference documents were protracted. Documents received from the preferred bidder were reportedly late and not of good quality.

In May 2008 a draft Chief Internal Auditor's report on the ICR programme was produced in lieu of a second OGC Healthcheck. Its contents were not dissimilar to those of the first OGC Healthcheck. Of 13 areas of risk examined, 10 were described as having inadequate controls in place. Programme Board minutes of 22nd July indicate that the

Board 'signed off' the draft internal audit report but, unusually, the draft report was never finalised.

The programme funding gap was now being actively discussed by the Board. During one meeting the Board all but agreed to de-scope the programme. At the next, it reverted to full implementation and resolved to pursue £3.5 million additional funding.

A second OGC Healthcheck, executed in September 2008, highlighted the pressing need to address the funding gap and both supplier and HSSD resourcing issues. Contractual relationships between HSSD, the Information Services section of the Chief Minister's Department, the primary contractor and their local support provider were also discussed. Planned support arrangements were analysed, the conclusion being that the post-implementation support model for maintaining the new systems might need to be rethought.

2009 – From Procurement to Implementation

3.32 2009 was a notable year for 4 reasons.

First, a new ICR Programme Manager was appointed. The original officer moved to the post of Change Manager before changing departments later in the year. A programme status review was undertaken by the new Programme Manager, which in turn prompted new actions to achieve compliance with earlier recommendations on programme governance.

Secondly, the ICR business case was fundamentally reworked and de-scoped without formal political oversight. Although ostensibly identical in terms of scope and outcomes, the revised business case divided implementation into 2 distinct phases. ICR phase 1 would replace existing obsolete systems and supporting hardware. It would implement digital RIS / PACS radiology systems and add maternity and pharmacy systems using the full £12 million capital allocation. A notional £400,000 contingency would, if called upon, be funded from existing HSSD budgets. ICR phase 2, which was unfunded, would deliver the remaining systems needed to achieve the fully integrated care record, including new

supporting communication functionality. A break clause was to be inserted in the ICR contract so as to give HSSD the option not to proceed with phase 2 if new money could not be secured. Savings in radiology would be achieved in phase 1. Most other targeted improvements in quality, efficiency and costs would be achieved in phase 2.

Thirdly, the ICR contracts were finally signed in July. Intersystems would implement the majority of systems. GE Medical Systems would supply the RIS / PACS radiology solution. Contracts were signed with the funding gap left unresolved. Programme Board minutes indicate that the then Chief Officer, HSSD had been due to meet the then Chief Executive, States of Jersey to discuss the supplementary funding requirement. If there were any such meetings, they did not result in the Council of Ministers being asked to approve or recommend more capital funding.

Fourthly, the Chief Officer, HSSD announced on 28th September 2009 that he was resigning for personal reasons. Programme sponsorship passed temporarily to the Deputy Chief Officer, HSSD until a permanent replacement could be appointed.

2010 to 2011 – Implementation

Implementation of ICR Phase 1 progressed through 2010. RIS / PACS radiology systems were operating by February.

There remained problems in other areas. Although the immediate funding gap issue had been avoided by de-scoping, there was now a realisation that HSSD could not afford the ongoing running costs of the new systems. Whereas page 48 of the Annex to the States of Jersey Annual Business Plan 2010 had declared that technical support for the ICR programme had been fully funded, pages 65 and 66 of same Annex set out a requirement for a £1.2 million revenue growth bid for HSSD, payable from 2011, because the full-year running costs of the new systems had not been fully budgeted for. Efficiency savings being generated by the ICR programme were not sufficient to cover the increase in running costs that the more complex new systems were generating. This should perhaps

have formally alerted the Council of Ministers to the fact that all was not entirely well with the programme.

The above provisional growth allocation would later be formally added to the department's base budget via the Annual Business Plan 2011.

With RIS / PACS in place, the focus was now on implementation of the new TrakCare patient administration system (PAS). This was the discrete element of the programme that would replace the legacy EDS systems and form the core of the new ICR system. A new go-live date of October 2010 was targeted.

A new Chief Officer, HSSD and a new Hospital Director were in post by June 2010. The latter assumed the role of programme sponsor. Both were committed to achieving the earliest practical go-live date for PAS, so as to limit further costs, delays and , potentially, avoid the break-up of key teams. Confidential correspondence obtained by this Committee shows that the Hospital Director and the new Chief Officer, HSSD were instrumental in preventing the eventual PAS go-live date from slipping any further than the summer of 2011.

There was at least one further notable development before ICR Phase 1 concluded. During the States Assembly meeting of 3rd May 2011, the Minister for Health and Social Services answered a written question posed by Deputy R.G. Le Hérissier concerning progress on major HSSD IT projects. Hansard records that the Minister's reply included the following statements -

> *'...The target date for completion of the PAS project was originally October 2010 however due to a number of system developments and changes mutually agreed with supplier the current target "golive" date is now June 2011.'*
>
> *'... The change of date to June was in part dictated by the need to avoid peak times in hospital activity'*

...HSSD and the suppliers are currently in the final stages of negotiating additional clinical functionality which will deliver increased operational benefits.'

While none of the above statements were technically inaccurate or misleading in isolation, they perhaps gave the States a selective impression of the state of the programme. For instance, the *'original target date for completion'* was in fact selected sometime after the procurement overrun, after de-scoping and after the June 2009 final business case was approved. Confidential correspondence between HSSD and the supplier of the new PAS leaves this Committee in no doubt that peak hospital activity was merely one of several key factors that drove the change of date to June 2011. As for the statement regarding *'additional clinical functionality'* the functionality to be achieved was additional only when measured against the de-scoped programme.

ICR Phase 1 concluded some 18 months later than originally planned. £12 million had been spent, a supplementary £550,000 budget had been needed in 2011 and a growth bid of £1.2 million per annum had been needed from 2011 to support the new system. The de-scoped ICR Phase 2, with all its opportunities for savings, remained unfunded. Just over £330,000 per annum (derived in part from the loss of just under 5 full time equivalent posts) had been saved - but those savings were achieved behind schedule.

Appendix 2: HSSD Information Systems Analysis

SERVICE	SYSTEM	2006 BUSINESS CASE	2009 BUSINESS CASE	2011 ICR PROGRAMME CONCLUSION	2013 INFORMATICS STRATEGY PROPOSAL
Acute and General	Patient Administration System (PAS)	Full replacement of existing IHS system (EDS supplied)	Full replacement of existing IHS system (EDS supplied)	Systems replaced with TrakCare	Maintain and upgrade, refresh hardware. Implement electronic patient records (EPR)
	Referrals Index	Full replacement of existing IHS system (EDS supplied)	Full replacement of existing IHS system (EDS supplied)	Systems replaced with TrakCare	As per PAS (TrakCare) Review and address functionality
	Inpatients	Full replacement of existing IHS system (EDS supplied)	Full replacement of existing IHS system (EDS supplied)	Systems replaced with TrakCare	As per PAS (TrakCare)
	Outpatients	Full replacement of existing IHS system (EDS supplied)	Full replacement of existing IHS system (EDS supplied)	Systems replaced with TrakCare SMS text reminders enabled	As per PAS (TrakCare)
	Waiting List	Full replacement of existing IHS system (EDS supplied)	Full replacement of existing IHS system (EDS supplied)	Systems replaced with TrakCare	As per PAS (TrakCare)

SERVICE	SYSTEM	2006 BUSINESS CASE	2009 BUSINESS CASE	2011 ICR PROGRAMME CONCLUSION	2013 INFORMATICS STRATEGY PROPOSAL
Acute and General (cont.)	Order Communications (Pathology and Radiology)	Introduce new systems	**Deferred**	Renegotiated in 2011, then implemented.	Maintain and upgrade
	Order Communications (other)	Introduce new systems	**Deferred**	**Deferred** (With exception of Patient Transport)	Review scope for implementation in other services
	Tracer	Full replacement of existing IHS system (EDS supplied)	Full replacement of existing IHS system (EDS supplied)	Systems replaced with TrakCare	As per PAS (TrakCare)
Ambulance Tracking and Care	MIS ambulance system	Retain and interface existing system	Retain and interface existing system	Existing system retained and interfaced	Upgrade or replace existing system. Evaluate new / expanded functionality to achieve real time mobile EPR
Central Sterile Supplies	Scantrack management and tray tracking system	Replace or integrate existing system	Integrate existing system	Existing system integrated	Maintain and upgrade. Extend existing system to include high cost consumables in theatres

SERVICE	SYSTEM	2006 BUSINESS CASE	2009 BUSINESS CASE	2011 ICR PROGRAMME CONCLUSION	2013 INFORMATICS STRATEGY PROPOSAL
Clinical Decision Support	Evidence based care planning system	Introduce new system	**Deferred**	**Deferred**	Evaluate cost-benefit and consider case-by-case implementation of decision support systems
Clinical Investigation	Prism6 clinical system	Replace or integrate existing system	**Deferred**	**Deferred**	Integration with TrakCare in 2013. Maintain and upgrade, refresh hardware, implement EPR
Colposcopy	Colposcopy clinical support system	Replace or integrate existing system	**Deferred**	**Deferred**	Replace existing system and integrate with TrakCare
Community	Care in the community system	Implement new system – to include mobile working.	**Deferred**	**Deferred**	Implement new system – to include mobile working.

SERVICE	SYSTEM	2006 BUSINESS CASE	2009 BUSINESS CASE	2011 ICR PROGRAMME CONCLUSION	2013 INFORMATICS STRATEGY PROPOSAL
Community (cont.)	Community alarms system	Replace or integrate existing system	**Deferred**	**Deferred**	Replace / expand existing system to exploit telehealth / telecare solutions
Corporate Systems	Risk management system	Replace or integrate existing system	**Deferred**	**Deferred**	Existing system development to continue separately
	E-learning system	Introduce new system	Introduce new system	New system implemented	Maintain, upgrade or replace
	Livelink – scanning and archiving of inactive medical notes	Replace existing system	Upgrade and integrate existing system	Existing system upgraded and implemented	Replace paper medical notes with EPR over time. Conduct cost-benefit analysis / options appraisal for an organisation-wide document management system
Critical Care	Clinical audit software	Replace or integrate existing system	**Deferred**	**Deferred**	Integration with TrakCare during 2013

SERVICE	SYSTEM	2006 BUSINESS CASE	2009 BUSINESS CASE	2011 ICR PROGRAMME CONCLUSION	2013 INFORMATICS STRATEGY PROPOSAL
Drug and Alcohol	Integrated care planning and outcomes system	Full replacement of existing system	**Deferred**	Existing system replaced by FACE Integrated with TrakCare.	Maintain and upgrade. Review as part of Community System implementation
Information Services (Technical)	Ensemble integration engine	Retain or replace existing system	Upgrade existing system	Existing system upgraded	Evaluate cost / benefit of alternatives.
Maternity	Maternity Information System	Replace or integrate existing system	Replace existing system and implement EPR	Systems replaced with TrakCare. EPR implemented	Maintain and upgrade, refresh hardware
Mental Health	FACE mental health system	Replace or integrate existing system	Integrate existing system	Existing system integrated and deployed across more service areas	Maintain and upgrade. Consider place in new Community System.
Metabolic Medicine	Diamond diabetes system	Replace or integrate existing system	**Deferred**	Appts. managed in TrakCare. Resulting integrated with existing system	Maintain and upgrade. Review integration/ replacement options

SERVICE	SYSTEM	2006 BUSINESS CASE	2009 BUSINESS CASE	2011 ICR PROGRAMME CONCLUSION	2013 INFORMATICS STRATEGY PROPOSAL
Older Person's Care	Assessment and MI system	Replace or integrate existing system	**Deferred**	Existing system replaced by FACE	Evaluate options re new Community System.
Pathology	Pathology Information System	Replace or integrate existing system	Upgrade and integrate existing system	Existing system upgraded and integrated	Maintain and upgrade. Consider replacement
Pharmacy	Pharmacy stock system	Full replacement of existing IHS system (EDS supplied)	Full replacement of existing IHS system (EDS supplied)	Existing system replaced with JACS	Maintain and upgrade (4-6 year upgrade cycle)
	Robot	Retain and interface existing system	Retain and interface existing system	Existing system retained and interfaced	Maintain and upgrade
	E-prescribing system	Introduce new system	**Deferred**	**Deferred**	Implement e-prescribing module within existing JACS system.

SERVICE	SYSTEM	2006 BUSINESS CASE	2009 BUSINESS CASE	2011 ICR PROGRAMME CONCLUSION	2013 INFORMATICS STRATEGY PROPOSAL
Primary Care	GP practice systems (external systems / central server)	Integrate systems	**Deferred**	**Deferred** Social Security leading on GP central server project	Link with GP central server following implementation
Psychology	Psychology database	Full replacement of existing system	**Deferred**	**Deferred**	Implement new system as part of new Community system
Physio-therapy	Physiotherapy database	Full replacement of existing system	Full replacement of existing system	Systems replaced with TrakCare	As per PAS (TrakCare)
Public Health	Child health system	Replace existing system	Replace existing system	Existing system replaced	Maintain and upgrade

SERVICE	SYSTEM	2006 BUSINESS CASE	2009 BUSINESS CASE	2011 ICR PROGRAMME CONCLUSION	2013 INFORMATICS STRATEGY PROPOSAL
Public Health (cont.)	Breast / cervical screening database	Replace existing system	Replace existing system and integrate	Existing system replaced and integrated with PACS (but not TrakCare)	Maintain and upgrade. Integrate with TrakCare and SoJ Population Database
	Bowel screening system	n/a	n/a	n/a	New service using existing screening system. Maintain and upgrade. Integrate with TrakCare and SoJ Population Database
Radiology	Radiology Information System (RIS)	Introduce new dedicated RIS system. Replace existing appointment and attendance management via IHS system (EDS supplied)	Introduce new dedicated RIS system. Replace existing appointment and attendance management via IHS system (EDS supplied)	HSS CRIS system implemented as managed service. System integrated with TrakCare.	Maintain and upgrade, refresh hardware (4 yearly major upgrade cycle).

SERVICE	SYSTEM	2006 BUSINESS CASE	2009 BUSINESS CASE	2011 ICR PROGRAMME CONCLUSION	2013 INFORMATICS STRATEGY PROPOSAL
Radiology (cont.)	Picture Archiving and Communications System (PACS)	Replace existing manual film-based system with digital system	Replace existing manual film-based system with digital system	Implemented GE PACS system	Maintain and upgrade, refresh hardware (4 yearly major upgrade cycle)
Social Care	Social Care Information System	Replace or integrate existing system	**Deferred**	**Deferred**	Replace with new Community System. Extend FACE to include assessment of all Long Term Care clients. Integrate with Social Security system. Go-live July 2014
Theatres	PAS Theatre Module	Full replacement of existing IHS system (EDS supplied)	Full replacement of existing IHS system (EDS supplied)	Systems replaced with TrakCare.	As per PAS (TrakCare) . New endoscopy system implemented in 2013
	PAS A&E Module	Full replacement of existing IHS system (EDS supplied)	Full replacement of existing IHS system (EDS supplied)	Systems replaced with TrakCare. **EPR implemented**	As per PAS (TrakCare)

Appendix 3: Committee Membership

The membership of the Public Accounts Committee (as at the date of the presentation of this report) comprises:

States Members

Deputy Tracey Vallois (Chairman)

Senator Sarah Ferguson

Deputy Richard Rondel

Deputy Gerard Baudains

Independent Members

John Mills CBE

Ian Ridgway

Robert Parker

Appendix 4: Terms of Reference

To evaluate the following aspects of the Integrated Care Records (ICR) programme with reference to report R.118/2013 of the Comptroller and Auditor General -

(a) the strategic context within which the ICR programme was devised and executed;
(b) the identification of risks associated with the ICR programme and how these were mitigated;
(c) the original business case for the ICR programme and how that business case was modified over time;
(d) how alternative options for delivery of ICR were evaluated;
(e) the project management structure established to deliver the ICR programme;
(f) whether a requirement for professional advice was identified and, if necessary, executed appropriately;
(g) the governance arrangements put in place for the ICR programme;
(h) the extent to which the ICR specification has been met by the various systems deployed as at 2013; and
(i) whether the ICR programme has achieved value for money.