

Information for Quality Programme (IfQ) – Managing Risks

| | | | |
|------------------------------|--|---|--|
| Strategic delivery: | <input checked="" type="checkbox"/> Setting standards | <input checked="" type="checkbox"/> Increasing and informing choice | <input checked="" type="checkbox"/> Demonstrating efficiency economy and value |
| Details: | | | |
| Meeting | Audit and Governance Committee | | |
| Agenda item | 5 | | |
| Paper number | [AGC (09/12/2015) 477 NJ] | | |
| Meeting date | 9 December 2015 | | |
| Author | Nick Jones, Director of Compliance and Information | | |
| Output: | | | |
| For information or decision? | For information | | |
| Recommendation | The Committee is asked to note this update | | |
| Resource implications | None as regards this update; Programme resource position set out in paper. | | |
| Implementation date | In Progress | | |
| Communication(s) | Extensive stakeholder communication | | |
| Organisational risk | <input type="checkbox"/> Low | <input checked="" type="checkbox"/> Medium | <input type="checkbox"/> High |
| Annexes | <ol style="list-style-type: none"> 1. GDS 18 Standards 2. Website / CaFC Project – DH Assessment Recommendations 3. Clinic Portal Project – DH Assessment Recommendations | | |

1. Introduction

- 1.1.** The Information for Quality (IfQ) Programme encompasses:
- The redesign of our website and Choose a Fertility Clinic (CaFC) function.
 - The redesign of the 'Clinic Portal' (used for interacting with clinics) and combining it with data submission functionality that is currently provided in our separate EDI (Electronic Data Interchange) system (used by clinics to submit treatment data to the HFEA)
 - A revised dataset and data dictionary which will be approved by the Standardisation Committee for Care Information (SCCI)
 - A revised Register of treatments, which will include the migration of historical data contained within the existing Register
 - The redesign of our main internal systems that comprise the Authority's Register and supporting IT processes.
- 1.2.** This report updates the Audit & Governance Committee (AGC) on the progress of the Information for Quality (IfQ) programme, specifically in the areas covered by the AGC terms of reference.

2. Progress update

- 2.1.** The IfQ Programme continues to make good progress since last update to AGC, achieving a significant milestone with the completion of the 'Alpha' phase. The IfQ Programme is now transitioning to Beta phase, in which the proof-of-concept work completed during Alpha will be iteratively built upon to produce a functioning 'beta' version of IfQ's 'minimum viable product.'
- 2.2.** The Website and CaFC, and Clinic Portal projects have now concluded initial 'proof-of-concept' clickable wireframe and design prototypes for a range of key pages. These pages have been user tested, with the results currently being considered - within the context of the HFEA's strategic priorities - in order to refine the deliverables to be produced during the IfQ Programme's Beta phase.
- 2.3.** Good progress continues to be made in the 'Internal Systems' work, the foundations or technical architecture. Additional specialist resources to our in-house team are in place as planned.

- 2.4.** The work on register data cleansing continues, with the Register and IT teams making good progress on identifying and cleansing records. Test register data has now been successfully extracted from the current register database structure to the new database structure, an important proof of concept stage of the data migration strategy.

3. Approval to proceed and expenditure for Beta

- 3.1.** As advised in the last IfQ update to AGC, the IfQ business case and associated digital expenditure controls for IfQ were conditionally approved by the Department of Health (DH) and the Cabinet Office's Government Digital Service (GDS) on 28 April 2015.
- 3.2.** For digital expenditure (covering the front facing aspects of the Website, CaFC and Clinic Portal), DH and GDS granted conditional approval for £180,000 expenditure for the Alpha Programme phase only. As previously advised, expenditure beyond Alpha phase required a subsequent formal DH led approval process.
- 3.3.** The first stage of this approval process has been met, with the IfQ Programme being granted approval to proceed by DH on the basis of a very positive assessment of the proof-of-concept deliverables from Alpha phase. This assessment comprised a thorough review of the IfQ's Alpha phase deliverables against the 18 Government Digital Service Standards, which can be found at [Annex 1](#), for members' interest.
- 3.4.** As with any assessment several recommendations have been made by DH, which we must consider during Beta phase. These can be found at [Annex 2 and 3](#)¹. Receiving DH endorsement in this approval phase is a significant achievement that underscores the quality and viability of work produced during Alpha. The team put in considerable work and received management team's gratitude.
- 3.5.** There is another approval stage. The Cabinet Office's Government Digital Service (GDS) must now approve Beta *expenditure* of c £290,000, in the light of DH's decision that IfQ has met their assessment criteria. This second stage approval from GDS is expected to follow within the next four weeks.
- 3.6.** In view of the risk attached to delaying the commencement of Beta, the IfQ Programme Board has taken the decision to proceed 'at-risk' to Beta phase in advance of GDS final stage approval. With the alternative being to stop work, and having passed the rigorous DH assessment during the first phase of this approval, the IfQ Programme Board's view is that this is the appropriate approach.

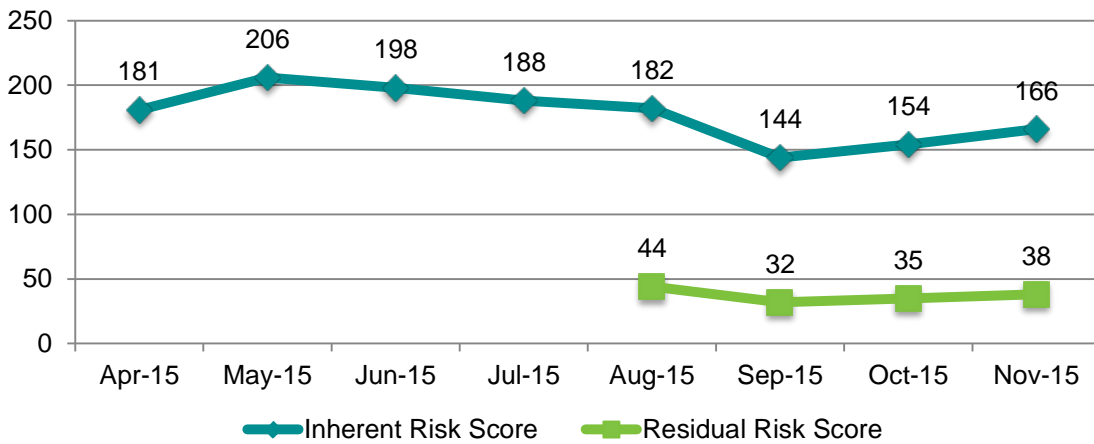
¹ Please note in relation to [Annex 2](#): HFEA are discussing with DH, regarding *user needs and assisted digital* recommendation 2 be amended to note the HFEA will be providing patient ratings and not actually free text or similar commenting feature.

4. Governance

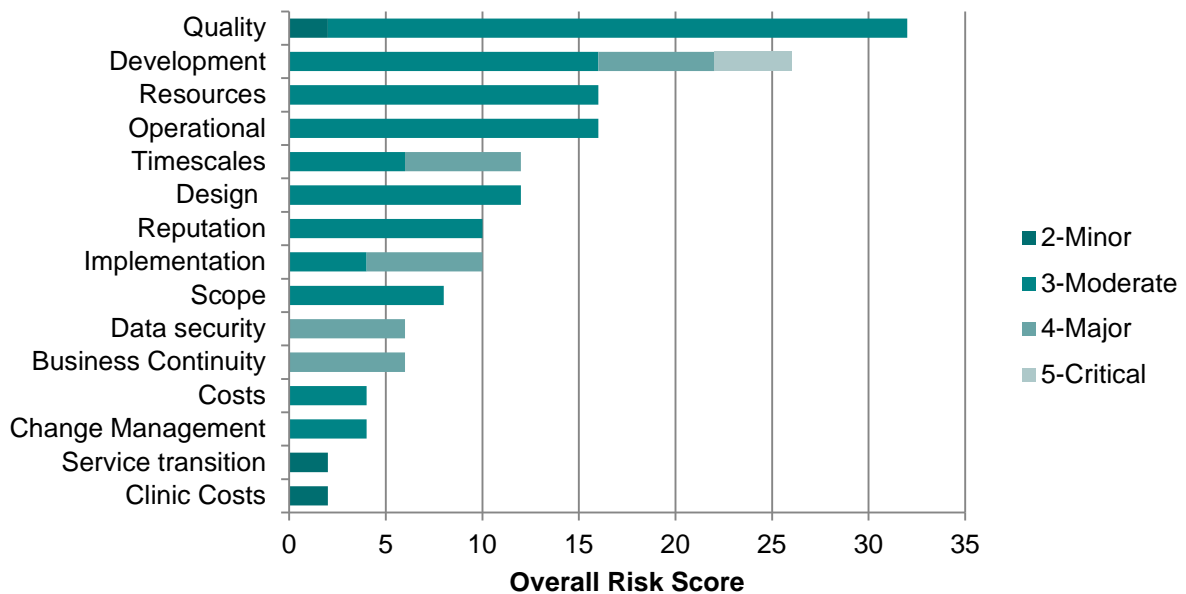
- 4.1.** The IfQ Programme Board has continued to meet and has reported progress on a monthly basis to the Corporate Management Group (CMG). An item regarding IfQ is presented at each meeting of the Authority, the latest on 7 October 2015.
- 4.1.** The IfQ Programme is supported by a dedicated Programme Manager, appointed in October 2013 to set up the Programme and establish an effective framework for delivery of the Programme so that it could be taken in house at an appropriate time. The IfQ Programme is now making arrangements to effect a smooth transition to HFEA's in house programme management office, having developed a succession plan for a handover at end December 2015.

5. Risk and Issues update

- 5.1.** The IfQ Programme continues to manage risk and issues proactively, with Product Owners and the IfQ Programme Manager maintaining risk and issue logs. These are reported on at the IfQ Programme Board on a monthly basis, and are also reviewed in the context of IfQ Project and Programme highlight reports. IfQ risks are integral to the HFEA strategic risk register, covered under a separate item at this meeting.
- 5.2.** As reported in the previous update to the AGC, key areas of risk for the IfQ Programme remain centred on data migration work, in particular regarding decisions about timing for cleansing and migrating 'must' and 'should' data, and striking an appropriate balance against key programme milestones and with achieving sufficient quality.
- 5.3.** The graph below represents two different risk scores for the IfQ Programme. Risk scores are applied to each individual risk for different dimensions of that risk (e.g. probability and impact). The risk scores for the IfQ Programme have increased over recent months, relating primarily to the risk of delayed beta commencement having impacts on key milestones and programme budget.
- 5.4.** The two summary risk scores represented are:
- The sum residual risk score for all risks currently active.
 - The overall IfQ risk score, which combines impact and probability all active risks.



5.5. The bar graph below expands upon the current IfQ risk score for 166, showing those scores against IfQ Programme risk categories. This graph illustrates that the most significant areas of risk, considering perceived impact and likelihood, remain related to quality issues (with a focus on Data Migration work), and development related issues (as part of the Internal Systems work).



6. Internal Audit

- 6.1.** As previously advised, the IfQ internal audit programme is to observe deliberations as regards the data migration strategy and implementation. A member of the internal audit team has now observed a March and September IfQ Programme Board. The IfQ Programme Board continues to manage the key risk areas identified by the IfQ internal audit programme, which relate primarily to data migration work.

7. Contract matters

- 7.1.** As previously advised a (completed) contract awarded as part of the programme was subject to dispute. This minor (non-financial) dispute is closed, following confirmation from the supplier that it is taking no action.

8. Standing Instructions – Contracts Awarded

- 8.1.** In accordance with Standing Financial Instructions the Committee is asked to note that no contracts have been awarded since the last meeting.

9. Recommendation

- 9.1.** The Committee is asked to note this report

Nick Jones
Director of Compliance and Information



Digital Service Standard

- 1** Understand user needs. Research to develop a deep knowledge of who the service users are and what that means for the design of the service.
- 2** Put a plan in place for ongoing user research and usability testing to continuously seek feedback from users to improve the service.
- 3** Put in place a sustainable multidisciplinary team that can design, build and operate the service, led by a suitably skilled and senior service manager with decision-making responsibility.
- 4** Build the service using the agile, iterative and user-centred methods set out in the manual.
- 5** Build a service that can be iterated and improved on a frequent basis and make sure that you have the capacity, resources and technical flexibility to do so.
- 6** Evaluate what tools and systems will be used to build, host, operate and measure the service, and how to procure them.
- 7** Evaluate what user data and information the digital service will be providing or storing, and address the security level, legal responsibilities, privacy issues and risks associated with the service (consulting with experts where appropriate).
- 8** Make all new source code open and reusable, and publish it under appropriate licences (or provide a convincing explanation as to why this cannot be done for specific subsets of the source code).
- 9** Use open standards and common government platforms where available.
- 10** Be able to test the end-to-end service in an environment identical to that of the live version, including on all common browsers and devices, and using dummy accounts and a representative sample of users.
- 11** Make a plan for the event of the digital service being taken temporarily offline.
- 12** Create a service that is simple and intuitive enough that users succeed first time.
- 13** Build a service consistent with the user experience of the rest of GOV.UK including using the design patterns and style guide.
- 14** Encourage all users to use the digital service (with assisted digital support if required), alongside an appropriate plan to phase out non-digital channels/services.
- 15** Use tools for analysis that collect performance data. Use this data to analyse the success of the service and to translate this into features and tasks for the next phase of development.
- 16** Identify performance indicators for the service, including the 4 mandatory key performance indicators (KPIs) defined in the manual. Establish a benchmark for each metric and make a plan to enable improvements.
- 17** Report performance data on the Performance Platform.
- 18** Test the service from beginning to end with the minister responsible for it.

Health Digital Service Assessment

HFEA website and clinic finder tool

The HFEA website provides information for patients, donors, donor-conceived people, professionals working in clinics, researchers and the media. The redesign project aims to better meet user needs and upgrade an outdated infrastructure.

The clinic finder is a tool for patients and clinics to get impartial, unbiased information about clinics, the treatments they offer and how successful they are. The redesign project aims to give users a greater understanding of treatments and data.

| | |
|------------------------------|---|
| Department / Agency:□ | Human Embryology and Fertility Authority (HFEA) |
| Date of Assessment: | 12 November 2015 |
| Date of Original Assessment: | N/A |
| Assessment Stage:□ | Alpha |
| Lead Assessor:□ | L. Scott |
| Result of Assessment: | Pass |
| Assessors: | D. Sheldon |
| Service Manager:□ | Trisram Dawahoo |
| Digital Leader: | Adam Bye |

Assessment Report

The HFEA website and clinic finder has been reviewed against the 18 points of the Service Standard at the end of alpha development.

Outcome of service assessment

After careful consideration the assessment panel has concluded the HFEA website and Find a clinic tool is on track to meet the Digital by Default Service Standard at this early stage of development. We now expect the service team to address the recommendations made, course-correcting development where necessary, to ensure that the project remains on track and adheres to the Standard as it moves through beta.

We enjoyed meeting the service team and would like to extend thanks for the frank answers to our questions. We were impressed with the dedication, passion and hard work across the whole team, supported by their organisation, to change their working practices, embrace the Standard, and develop a product and service to meet user needs.

We were particularly struck by the quality of the user research, the user researcher's attitude and approach to identifying, validating and meeting user needs, and making user research a team sport.

Reasons

The service was assessed against all [18 points of the Digital by Default Service Standard](#). We asked questions from the prompts and evidence for assessors, supplied by GDS. This document has questions and the evidence sought for alpha, beta and live phases. We asked questions from the alpha section.

The service currently meets the requirements of the standard for an alpha service. Observations made below reflect some of the narrative about the service that we uncovered in the assessment. Recommendations are made later in this report.

User needs and assisted digital

The service team has carried out 28 1:1 interviews with current and prospective users of the service. We noted that the team had addressed feedback following their discovery phase about the suitability of previous research methodologies chosen. The panel is now confident that the service team has elicited a deep understanding of their range of users, and their top priority needs.

We were struck by the empathy the whole service team displayed towards their users, and their commitment to meeting those users' needs well. The team has ensured that this user insight is spread across the rest of the organisation, eg informing communications and content strategy.

The team identified no assisted digital users in their research, and demonstrated evidence that their user base has a higher level of digital capability than the national average. They plan to use an existing channel to provide assisted digital via phone, with a support team trained to take users through the service. They have also engaged with charities and support groups who may be able to provide a face to face channel.

The team have identified user needs they are unable to directly meet due to legislative remit, eg recommendations for best clinics, and cost. We had some concerns about other user needs that the team were aiming to meet via this product (eg general

information about problems conceiving), which could be better served by directing users to trusted sources of this information elsewhere.

User research plans and skills are comprehensive for the next phase with research built into the cycle. The user researcher will be upskilling the in-house service team, and expects to see them helping to run research in the next phase.

The team

The service works as one, co-located team with most of the recommended roles in place throughout alpha. Extra skills (eg policy, medical, clinical, stats) are accessed via in-house and stakeholder expert groups. Although the team has access to a content strategist, the content is produced by the Comms team. The in-house team are taking steps now to fill some of the deep technical skills gaps currently met by their supplier. They anticipate some ongoing support from interim contractors.

The team took a proactive approach to the move to use agile methodologies. They have invested time training themselves and others and also fostering the kind of organisational culture change that this shift necessitates.

The team has changed their working practices following retrospectives, eg a closer collaboration between developers and the product manager over story crafting.

The team showed some great examples of transforming governance. They use agile techniques to show rather than tell, via presentations to senior staff and weekly communications. They showed how this gives their executive team confidence in the project, meaning the service development team is freed up to continue delivering against user needs.

Security, privacy, tools and standards

The team have chosen their existing in-house technology suite, justified by their skillset and their confidence that it meets needs. They acknowledged their challenges around integrating their CMS with the clinic API, and the changing world of internal systems within the organisation. Story cycle time is standard at this stage of development and they are planning for more automation during the deploy cycle.

The service captures no user data as yet. They have researched potential threats to the service, and the risk is deemed low.

They plan to make the code open, and see a potential use for it by other governments. They are using open standards in development, and have made contact with other parts of government providing a similar offering, eg NHS Choices. We'd expect to see greater

ambition here to collaborate with other parts of government as the project develops. We understand that some uncertainty around future plans for the NHS.UK alpha project has delayed collaboration.

The team have identified where they need to explore to better meet needs via the clinic finder tool, eg users found the initial information too overwhelming. There are significant challenges in data presentation, and the team are exploring adding patient feedback to help users make an informed decision over clinic choice. The team have engaged with NHS Choices about this approach. The panel suggests this approach is rethought (see recommendations.)

Improving the service

The team had evidence that users were broadly successful in using the website unaided. They identified areas for improvement, eg navigation, and are exploring how to surface user support throughout the journey. The team explained how some users take a different route from what research had led them to anticipate, eg choice of clinic sometime precedes choice of treatment, and they are working to address this.

The clinic finder revealed more areas for improvement and evidence from research suggested the team needed to rethink the primary navigational approach (eg filter by treatment). We'd expect to see continued rigorous research to inform the development of the tool during beta.

Design

The team have not so far used the recommended best practice approach of sketching in code, testing and iterating (rather they are designing visuals first in mockups and wireframes).

The team are using their house style guide, developed alongside other style guides used in the health family. They are exempt from the visual branding of GOV.UK. However the GDS design patterns still stand as an accepted starting point for evidenced best practice in service design and user interaction standards. The team have not used these, and showed willingness to adopt them during the next phase of development.

Again, the GDS content style guide should be used as starting point for patterns (even if the service is exempt from technical style guide adherence) as to how users will successfully engage with a government service.

Analysis and benchmarking

The team are working with the Communications team who responsible for the offline channel – a booklet printed and distributed to clinics. They have identified where content is meeting needs that are best met on the digital product. They are engaging with clinics that disseminate the printed material to actively encourage users to go to the website. They are measuring channel shift and aim to reduce this printed channel, although they have no plans to cease it.

The team are using Google Analytics and will continue to do so as they build the beta. The team have a good understanding of how they will measure success, including a reduction in customer enquiries. They are already measuring performance on the performance platform.

Testing with the Minister

The team have engaged their most senior board member who has seen the service. They have no plans as yet with the current minister with portfolio for this area.

Recommendations

User needs and assisted digital

1. Continue to identify any users with [assisted digital](#) needs. [Carry out research](#) with users with assisted digital needs to test that journey.
2. Investigate alternatives to providing the facility to comment and feedback on clinics. This is a significant undertaking and we do not believe the service is equipped to run this facility at present.
3. Two possible options are a) provide the clinic data to NHS Choices who could then use their existing comment/feedback facility; b) provide the clinic data publicly and work with others (e.g. <https://www.patientopinion.org.uk/>) to provide the facility to patients via a third party.
4. Re-engage with NHS Choices to determine where the informational content for the public is best placed. As the team acknowledged, users seeking information about 'problems conceiving' are less likely to visit HFEA in the first instance, and more likely to turn to NHS and third parties.
5. There may be other types of user needs better addressed elsewhere. A key principle should be to not duplicate and instead signpost users to the best place to meet their needs. A re-think on this is required and the service team should not assume that its own website is the place for everything.

The team

1. We strongly recommend the addition of a [content designer](#) on the service team. They should also engage with the [cross government content design community](#), adopt the [GDS content style guide](#) for patterns, and contribute back to that community with findings.
2. We expect to see a plan underway during beta to ensure the in-house team is capable of [continuous iteration](#) across the whole product to ensure this project does not stall after the 'design and build' phase.

Security, privacy, tools and standards

1. Look at using a content delivery network. This will help the website to scale when necessary and reduce load on the servers.
2. Develop the service to work regardless of browser capability. Follow the Service Manual [guidance on progressive enhancement](#) and ensure the menu and all other elements work with Javascript switched off.

Improving the service

1. Be considered with the amount of customisation and integration for the product in Umbraco and keep components loosely coupled. This will give you more flexibility and reduce any exit costs.

Data and open standards

1. Provide the list of clinics as a public register via an API and variety of different standard representations.
2. Engage with Paul Downey at GDS to discuss the cross-government registers work, and [re-use the code](#) or [build their register](#) to the standards GDS are setting.
3. Work closely with NHS Choices to provide the clinic data to their service finder.

Design

1. Ensure the design of the website is capable of iteration. The design should not be frozen once prototyping and transfer to Umbraco templates is complete.
2. Use the [GDS design patterns](#) and [GDS style guide](#) as starting point, even if you are exempt from adopting the visual style.
3. Test page length and sentence length with users to make sure the content density isn't detracting from comprehension.

4. The clinic finder [makes use of icons](#) which detracts from service design recommendations. These should be researched and thoroughly tested before making a decision to use them.
5. We discussed a simple search for the clinic finder based on the top things people want to filter the list by. As discussed in the assessment, the current treatment-based search is not working.
6. Stop printing specific URLs in the printed booklet - content may change.
7. Ensure that [no link is left behind](#) - we briefly discussed plans for URL redirection and we'd like to emphasise the importance of this.

Digital by Default Service Standard criteria

| Criteria | Passed | Criteria | Passed |
|----------|--------|----------|--------|
| 1 | Yes | 2 | Yes |
| 3 | Yes | 4 | Yes |
| 5 | Yes | 6 | Yes |
| 7 | Yes | 8 | Yes |
| 9 | No | 10 | Yes |
| 11 | Yes | 12 | Yes |
| 13 | No | 14 | Yes |
| 15 | Yes | 16 | Yes |
| 17 | Yes | 18 | Yes |

Health Digital Service Assessment

HFEA clinic portal

The clinic portal allows clinics to submit, obtain and manage clinic information and allows HFEA to give clinics performance data.

HFEA are redesigning the clinic portal to combine existing and enhanced functionality and make it easier to use by: improve the quality of data submitted to HFEA; reduce the “burden” associated with data submission; provide added utility; provide an improved user experience of accessing information and submitting data.

| | |
|------------------------------|---|
| Department / Agency:□ | Human Embryology and Fertility Authority (HFEA) |
| Date of Assessment: | 12 November 2015 |
| Date of Original Assessment: | N/A |
| Assessment Stage:□ | Alpha |
| Lead Assessor:□ | L. Scott |
| Result of Assessment: | Pass |
| Assessors: | A. Grimley |
| Service Manager:□ | Chris Hall |
| Digital Leader: | Adam Bye |

Assessment report

The HFEA clinic portal has been reviewed against the 18 points of the Service Standard at the end of the alpha development.

Outcome of service assessment

After consideration the assessment panel has concluded the clinic portal service is on track to meet the Digital by Default Service Standard at this early stage of development.

Reasons

The service was assessed against all [18 points of the Digital by Default Service Standard](#). We asked questions from the prompts and evidence for assessors, supplied

by GDS. This document has questions and the evidence sought for alpha, beta and live phases. We asked questions from the alpha section.

The service currently meets the requirements of the standard for an alpha service. The comment below reflect some of the observations we made during the discussion. Recommendations are listed later in this report. We now expect the service team to address the recommendations made, course-correcting development where necessary, to ensure that the project remains on track and adheres to the Standard as it moves through beta.

Thanks to the service team for answering questions frankly and contributing to the discussion. We were encouraged to see the appetite the team have to build a product according to the Standard and to meet user needs.

User needs and assisted digital

The service team used a blend of information gathering and observational research at 12 clinics, expert groups and analysis of customer feedback to establish the top user needs for the clinic portal. They have spoken to a range of staff as clinic size impacted who their main user would be, rather than role type. The team used personas developed during a discovery period of user research. We'd encourage the team to keep these updated as new finding about users are identified.

The team have identified needs which they have ambition to later meet, but are not in scope for this phase of development, eg giving users instant feedback re: compliance when they submit reports.

The alpha prototype has tested solutions to address 3 top user needs: a compliance task list, updating clinic details, and submitting a self-assessment risk questionnaire. the structure of the rest of the microsite has been wireframed.

The team have not found users with assisted digital needs. IT skills are higher than average.

There is a user researcher assigned to the service team and research and testing is planned into the sprint cycle. The team are considering a pilot with a private beta for more focussed research and testing. Clinics are all aware of the project and are actively encouraged to feedback and engage with the project team via the service manager.

The panel was encouraged to note the team's focus on user needs in designing the process rather than simply automating the current forms.

The team

The team is currently well resourced with the skills required to develop the service. They also seem to be managing the dependencies between user needs, front end development and underlying databases and infrastructure although this has led at times to refactoring effort.

The service team contains all the recommended roles at this stage of development. Gaps in the in-house team are infilled with support from the supplier. One important omission is a content designer working alongside the service team - copy is provided by HFEA staff.

There is a high dependence on external skills and expertise but no evidence of a structured and measurable plan to transition some of the skills in-house. We heard that interims are asked to transfer skills via pair programming and in-house code review. It's not yet clear how confidence and capability can be accurately measured. This will inevitably limit potential to continuously improve the service in future.

The team is using scrum and carries out agile ways of working. Alongside the dedicated delivery manager who joins the team from the supplier, the role of scrum master is rotated to upskill the in-house team. Although the team is not fully co-located, suppliers join the rest of the team for important sessions such as planning and design, and connect via remote working tools otherwise. The team use retrospectives to address ways of working, eg they now have pre-planning and sprint goals, and use agile techniques to prioritise the most valuable tasks.

Current technical capability and business processes have influenced how possible it is to meet some needs in a more bold way, eg allowing users to explore the data behind the reports, and having one licence application instead of many. The team have ambitious plans for the future. The current development is focussed on an MVP replica of the existing service, focusing on increased usability. This will allow the team to deliver an improved service at pace, incorporating a data cleanse and migration.

The team have used agile techniques to transform governance - eg programme board processes to approve budgets etc. A shared understanding of a prioritised list for the migration project is now in place, along with clarity.

Security, privacy, tools and standards

As an organisation, HFEA are well-versed in the IG implications of the services they maintain and address these diligently. They demonstrated their understanding of the nature of likely threats and appropriate responses. There is very low user impact of the service being unexpectedly offline.

The tool chain and technical stack they have adopted are widely used and understood although the choices made were largely influenced by the existing in-house skills. This is understandable but can limit detailed assessment of the trade-offs that are implied in a technology choice leading to a service outgrowing its stack. They have researched likely end-user configurations and are optimising the service in this regard. They have the considerable advantage of being able to mandate minimum requirements for the end users' technology.

Although they are aware of touch points with other services, such as the national directories of services, they have decided not to integrate with them.

Improving the service

The team can spin up identical environments for testing.

While they have not carried out specific research into browsers and device use, the team are aware of the IT setup of their users, and will be developing with this in mind. We learned that many clinics are running outdated systems with unsupported browsers.

The team are expecting desktop/laptop/tablet usage. Reports are printed out for dissemination to staff who are in the labs. The team have noted that printable content of reports is a currently unmet need that they will address.

The team learned through research that some of the navigation is not clear to users, including organisation of content and labelling. They are able to address this and test it in the next round of research.

Open source

Much of the technology stack is proprietary but the developed code is capable of being shared and will be, albeit in a limited way with third party commercial suppliers.

Design

The team are using their house style guide, developed alongside other style guides used in the health family. They are exempt from the visual branding of GOV.UK.

However the GDS design patterns still stand as an accepted starting point for evidenced best practice in service design and user interaction standards. The team have not used these, with the exception of form state and form layout, and showed willingness to adopt them during the next phase of development.

Again, the GDS content style guide should be used as starting point for patterns (even if the service is exempt from technical style guide adherence) as to how users will successfully engage with a government service.

Analysis and benchmarking

The team have relied almost exclusively on user research to gather evidence for user needs. They intend to connect with the business support team who manage the telephone enquiry line, though they have not used this feedback thus far.

The team have a target to reduce the time clinics take to complete certain tasks, and saving users 4hrs a week is a target, along with reducing error rates, reducing support calls, and increasing current satisfaction.

There was no evidence that the team had considered service metrics in any depth. We accept that some of the transactions can be complex and consist of multiple stages but looking at measurement can provide useful insights into actually reducing the complexity.

During the discussion we were able to identify a few areas which could be monitored, eg incomplete submissions, internal staff time taken, user support tickets which the team could put in place.

There is no offline competing channel, although most forms are paper only. The ambition is to digitise all paper channels.

The team cited evidence from research that their users expect and desire to use a fully digital service.

Testing with the Minister

The team have engaged their most senior board member who has seen the service. They have no plans as yet with the current minister with portfolio for this area.

Recommendations

User needs and assisted digital

1. Understand any potential users who would have needs met on the public facing website vs the clinic portal. Check the user journeys between the two are validated by research.
2. Continue to identify any users with [assisted digital](#) needs. [Carry out research](#) with users with assisted digital needs to test that journey.
3. [Analyse other evidence](#), such as customer feedback and user support, to identify any unmet or emerging needs.

The team

1. We expect to see a [plan underway](#) during beta to ensure the in-house team is capable of [continuous iteration](#) across the whole product to ensure this project does not stall after the 'design and build' phase. This should include objective-based training plans addressing both the technical stack and agile working methods, eg [junior-led programming](#) or guided solo programming.
2. We strongly recommend the addition of a [content designer](#) on the service team. They should also engage with the [cross government content design community](#), adopt the [GDS content style guide](#) for patterns, and contribute back to that community with findings.

Security, privacy, tools and standards

1. Recommend liaison with NHS 111 digital team to further investigate integration with other national services such as Directories of Service and Demographics/Patient identification.

Improving the service

1. Clarity on the primary aims and the minimum viable product to satisfy these - we heard great evidence that you are working to address the underlying needs identified by research rather than automating forms. This will discover new features and functions that you haven't yet envisaged - and you will need to know what 'done' looks like.

Design

1. Use the [GDS design patterns](#) and [GDS style guide](#) as starting point, even if you are exempt from adopting the visual style.
2. Ensure that [no link is left behind](#) - we briefly discussed plans for URL redirection and we'd like to emphasise the importance of this.

Analysis and benchmarking

1. Have a clear plan to work out how to measure whether your improvements have made things better or worse by establishing [clear and meaningful KPIs](#) for the service, as well as the 4 mandatory KPIs - that you can measure in the open on the performance platform.

Digital by Default Service Standard criteria

| Criteria | Passed | Criteria | Passed |
|----------|--------|----------|--------|
| 1 | Yes | 2 | Yes |
| 3 | Yes | 4 | Yes |
| 5 | No | 6 | Yes |
| 7 | Yes | 8 | Yes |
| 9 | No | 10 | Yes |
| 11 | Yes | 12 | Yes |
| 13 | No | 14 | Yes |
| 15 | No | 16 | No |
| 17 | Yes | 18 | Yes |