

Project Identification No: OGC 503

TITLE OF PROJECT

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

OGC Gateway review: Gateway 3b Implementation preparedness

Status of report: Final

Senior Responsible Owner: <Text Redacted>

Review Date: March 29 – April 2 2004

Review team:

<Text Redacted>



Office of Government Commerce

1 Background

- 1.1 The aims of the NHS Care Records Service (NCRS) Programme are to give:
- patients a modern IT-enabled NHS, which will directly impact on the care they receive;
 - frontline NHS staff access to safe, fast modern IT to support them in their work; and
 - managers, researchers and other professionals not involved in direct patient care access to high quality, confidential information.
- 1.2 Delivery will take place in three phases, by the end of 2004, 2006 and 2010 respectively.
- 1.3 Phase One will allow doctors to book outpatient appointments on line, send emails and browse the internet and view information relating to their patients. The latter will include laboratory and radiology results and some clinical correspondence, for instance GP referral letters. Phase One will offer simple functionality and make best use of existing and interim systems.
- 1.4 Phase Two will give doctors and health professionals access to a more detailed patient record, which will include specialist results, the GP prescribing record, and hospital discharge summaries. These services will be supported by telemedicine and digital imaging. Phase Two will also computerise all referral, requests and orders and all hospitals will have Picture Archiving and Communication Systems (PACS) support in place.
- 1.5 Phase Three will incorporate the advanced features necessary to fully integrate care across both health and social services. This will include decision support software, screening, community wide prescribing and clinical documentation, to include assessment and care planning
- 1.6 The NCRS programme together with the infrastructure programme, e-Bookings and the Electronic Transfer of Prescriptions comprise the National Programme for IT (NPfIT). The driving force for the programme is the policy paper "Delivering 21st Century IT Support for the NHS", which focuses on a patient centric approach. Ultimately, NCRS will replace the myriad of computer systems currently in use in the NHS with national applications supported by robust standards and implementation will be conducted through six projects. The first will provide a national infrastructure and the others will deliver application services in five regional clusters of Strategic Health Authorities (SHAs).
- 1.7 This is a Gateway 3B review carried out in respect of the prospective implementation of the Wave 1 clusters, London and the North East. The SRO for all elements of the implementation programme is <Text Redacted> for London and <Text Redacted> for North East.

2 Purpose and conduct

- 2.1 The purpose of this review is described in Appendix A. In view of the slightly unusual nature of the review, the Review Team felt that the most helpful way to structure the report was to adopt a subset of issues covered as part of a Gateway 3 Review:
- 2.2 The review was carried out from March 28 til April 2 in London and Leeds as part of a combined review of both clusters in Wave 1 of the NCRS LSP projects. We have taken into account the conclusions reached in the Gateway 3A reviews and the

recommendations made in so far as completion of the related actions has a bearing on the readiness for the next phase for the Wave 1 Local Service Provider Projects.

- 2.3 This report covers our findings in respect of the London and North East Clusters.
- 2.4 Those interviewed are listed in Appendix B at the back of the report. The review team would like to thank everyone involved for their support and openness, which contributed to the Review Team's understanding of the project and the outcome of this review. We are particularly grateful for the help and support of <Text Redacted> for organising a demanding interview and visit schedule and for their rapid responses to our various requests.

3 Common Conclusions

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

4 Conclusions: London

- 4.1 The Review Team finds that:
- 4.1.1 There is strong top management and clinical commitment to the success of the London programme. An active Cluster Programme Board has helped to establish strong commitment from SHA and Care Community leadership.
- 4.1.2 There is great clinical and professional enthusiasm for the adoption of an integrated approach to patient data, to developing best practice process design and to the adoption of common solutions across London. This enthusiasm has, if anything, grown in the period since the completion of the procurement phase.
- 4.1.3 Arrangements for clinical engagement in the implementation programme are growing, and are more extensive than during the earlier procurement phase.
- 4.1.4 The Cluster core team is seen as highly competent.
- 4.1.5 There is a good plan for the development of some 19 Best Practice process teams. It is being driven by the Modernisation leads for London, which is a welcome widening of what is often an IT dominated process. We think this is a comprehensive approach to the issue of building and sustaining a robust single design and change authorisation process, well anchored in the NHS community.
- 4.1.6 The placing of an experienced contract manager in the cluster team has increased confidence that the programme will be implemented with due regard to the complexities of the contracts involved.
- 4.1.7 The implementation phase is starting out with several strongly positive winds behind it: strong clinical enthusiasm, a successful procurement phase and a strong and supportive Programme Board.
- 4.2 However, there are shortcomings in the London programme which need to be addressed in order for the programme to have a greater chance of success:

- 4.2.1 The Service Provider CCA has been slow to get up to speed and is seen to be more reactive than pro-active. This is improving, but is in contrast to proactivity shown by the LSPs in the North East Cluster.
- 4.2.2 The Cluster core team is resourced well below planned levels and there have been significant delays in the agreement for funding for staff. As of today there are 36 vacancies in a planned cluster team of 80, although only 4 of these are stated as being immediately on the critical path.
- 4.2.3 The Cluster core team is regarded as being very competent, but with a highly centralised approach that focuses on delivering its outputs rather than the needs of the trusts in preparing for implementing.
- 4.2.4 The Cluster core team seems to be more confident of solving issues than is merited. For example in the question of the early adopters (see below), or on filling out the team, or on best practice deadlines (see below). CCA should also be playing a more pro-active role here in highlighting and addressing emerging issues early.
- 4.2.5 Many of the Best Practice design groups have got some early, tight deadlines to meet, from June to September 2004. Our view is that they are unlikely to meet these deadlines.
They will only meet them if the process is highly circumscribed and driven towards very basic first cut solutions: we have heard little evidence that this is to be the case. There is a further risk that expectations of clinicians joining these groups are falsely set too high and will not be met.
We do, nevertheless, fully support the setting up of these groups and the very valuable role they will play over the next 2-4 years. We believe it is possible to make this structure work, given a more tightly specified approach in the short term and appropriately experienced design team leads.
- 4.2.6 Benefit realisation plans are very limited, and structures and plans are not in place. A benefits coordinator has recently been appointed for London, which we welcome, but has little structure or material to work with.
- 4.2.7 There is a specific issue related to the early adopters of the e-booking solution. Whilst this is not a review of e-booking, most participants expect that this deadline will be perceived as a first result for the NpIT programme generally and thus also for NCRS. There is confusion on the state of preparedness, caused partly by excess secrecy within the National e-booking team on what the key dates are. We are concerned that the reputational risks to NCRS arising from early adopter failure are not sufficiently appreciated.
- 4.2.8 Neither the risk log nor the risk register reflect the main risks expressed to us by interviewees.
- 4.2.9 Programme control appears to be more administrative than functional in the cluster.
- 4.2.10 Legacy system modification and interface complexities will need careful attention. This is being approached with a good central focus for e-booking and early adopters but will become a larger issue.
- 4.2.11 Communications from the Cluster reflect the need to achieve certain outputs, rather than the needs of the audience
- 4.2.12 Despite these shortcomings, none are so severe as to prevent the project from proceeding: quite the opposite, risks would be greatly magnified by delaying implementation. Consequently, we believe that the project should proceed along the current plan, but taking account of the recommendations set out below
- 4.3 An **exemplar** of good practice is the comprehensive and inclusive approach to best practice process design.
- 4.4 **Status of Project is RED.** This takes into account the more demanding task set by London of developing common pan-cluster best practice processes. The red status does not mean in any way to delay the project. It means that the principal recommendations need to be acted upon promptly or else there will be a lower chance of success of the programme.

5 Summary of recommendations: London

The following recommendations should be addressed in the short term:

- 5.1 The Cluster team, CCA and the Modernisation leads should urgently prepare a detailed approach and plan for managing the short timeframe period they face to meet the Best practice process deadlines, focused on realistic deliverables and responsibilities. They should be very explicit on the limited result that it is realistic to achieve.

The same Group should give careful choice of best practice group leaders – whichever organisation they come from, as this is a very demanding task to achieve a useful outcome.

The more extended role over time of the best practice groups should be agreed and communicated to clinicians at the time of formation of the groups

- 5.2 The Cluster team should give higher priority to benefits realisation and tracking: (1) Defining just how benefit maximisation should inform their regular decision making and (2) Establishing a benefits management and tracking strategy and detailed plans, including individual responsibilities, for achieving and measuring the identified benefits, and (3) Aligning the Cluster plan with the strategy emerging from Professor Halligan's role as SRO focused on benefits.
- 5.3 The Cluster leadership should meet, together with the CCA leadership and the SRO, to consider
- How CCA can become more proactive in the programme
 - Placing CCA teams earlier in the Care Communities
 - Possible overconfidence in some key areas and how best to address it.
 - Faster arrival of Cluster staff
 - How better, as a group, to recognise and address emerging issues early
 - Focusing more on local needs for implementation
- 5.4 In order to enable faster arrival of team members, the SRO and the RID need faster approval processes for the recruitment of Cluster team members: both for the best practice process roles and for the other tasks of the programme
- 5.5 The National e-booking leader should share the key dates and overview planning chart for the early adopters more widely. The RID should ensure that he is fully informed of the readiness of each Early adopter team.

And the recommendations below should be addressed before the next review:

- 5.6 The SRO, the Board and the RID should agree the maximum amount of delegation by the Board to the SRO, so that she can progress most matters directly with the RID
- 5.7 The new joint SROs present a clear view of just how the new SRO arrangements re benefits realisation and clinical engagement are expected to translate into practical organisation.
- 5.8 The cluster should take the opportunity of the co-location with CCA as from June to do a thorough review of Programme Control operation across the Cluster and CCA and put an integrated set of improved arrangements in place
- 5.9 The Department of Health or the SRO clarify to the NpfiT programme that the funding arrangements are firm
- 5.10 The Cluster RID and the Programme Board members should each direct someone to work directly with the MA to orient MA staff towards filling NpfiT vacancies

- 5.11 Central legacy system management for e-booking should be extended for the NCRS programme, and the Cluster/CCA deployment checks be very detailed in respect of legacy and interface needs of trusts
- 5.12 Risk and issue management documentation should be thoroughly reviewed to ensure that it fully reflects current risks and their impact.
- 5.13 The Project Management Team carries out a comprehensive assessment of Lastword/ Carecast implications, and concludes quickly on the preferred route forward.
- 5.14 The London and South Cluster teams should decide in the near future on the criteria for early joint working and the conditions in which it would be better to separate.
- 5.15 The Cluster takes steps to ensure that each SHA is planning necessary action in relation to user authentication and smart cards.
- 5.16** The cluster communications lead, in consultation with SHA and Trust representatives, should develop and implement a communications activities plan: not a 'plan for a plan'.
- 5.17 Learning should be made explicit, eg from the early adopter experience, such as by nominating an individual to gather up the learning from key events such as early adoption.

6 Detailed Findings – London Cluster

6.1 Governance and management controls

6.1.1 Cluster Programme Governance. The Programme Board has recently been expanded to include the 14 Care Community Chief Executives. We view this as a very positive move, as it brings the leadership of the level at which implementation is focused – the Care Communities – directly into the programme direction setting. It will also help the Cluster team by giving them a stronger leadership voice in the Care Communities. We formed a view of the Programme Board as a confident Board that was enthusiastic about its responsibilities. Our sole concern is that such a Board is excellent for inclusiveness but harder for decision making. **We recommend that the SRO, the Board and the RID agree the maximum amount of delegation by the Board to the SRO, so that she can progress most matters directly with the RID.**

6.1.2 National Programme Governance. We have concerns that the new Governance structure, with <Text Redacted>as joint SROs, risks that parallel structures are set up for Benefits realisation/tracking and Clinical engagement. We think that this would be a mistake, and **we recommend that the new joint SROs conclude on this at an early stage and present a clear view of just how the new SRO arrangement will translate into practical organisation.**

6.1.3 Project Management Team. The Cluster project team is viewed as being highly competent. There are however some areas of concern:

- The cluster core team resourcing has been significantly delayed for some months, since before the last Gateway review. We understand that this has been due to issues of obtaining central funding. The last Gateway review team was informed that most London Cluster positions would be filled before contract award. The consequence is that the very ambitious programme of best practice process development and other main activities has been delayed. Today, the resourcing is still well below planned levels. The current plan is for 80 positions in the cluster: of these 36 are currently vacant, of which 4 are on the immediate critical path. This is placing heavy stress on some of the programme management team, and hampering the deeper external engagement referred to below. Recruitment of resource seems to take considerable time. **We recommend that the project management team obtains necessary approvals to fast track the standard HR recruitment process.**
- The Cluster approach is seen as being highly centralised. Part of this is in the nature of the London cluster: it is intended to be the driver of a common process approach across London, in contrast to other clusters. However, it also appears to be the style of the team. The focus is felt to be on 'outputs' rather than engaging with the needs of the trusts in implementing. Some communities perceive many central groups, some in the cluster and some in the National team, seeking to project manage parts of their activities whilst the overall accountability for delivery is at trust level. This approach can easily become a more inclusive, engaged one, and there are trend in this direction, for example the involvement of modernisation leads in the best practice work.
- The cluster core team seems to display a greater confidence in solving issues than we feel is merited: for example in the question of early adopters, or on recruiting the team, or on best practice deadlines. **We recommend that the cluster leadership team, CCA and the SRO meet to consider this observation and how best to address it.**

6.1.4 Independent local solutions. We have found no evidence of parts of the London community looking to develop independent solutions. Quite the opposite, there is

great clinical and professional enthusiasm for the adoption of an integrated solution to patient data and acceptance of the need for a reduction of local variations in order to achieve this goal. The enthusiasm has, if anything, grown in the period since the completion of the procurement phase

- 6.1.5 Programme control.** Programme control appears to be more administrative than functional in the cluster. Documents appear not to be of reviewed quality, and timeliness, eg to Programme Boards, seems to be poor. Programme Control in CCA has already been found to be poor. **We recommend that the Cluster takes the opportunity of the co-location with CCA as from June to do a thorough review of Programme Control operation across the Cluster and CCA, and put an integrated set of improved arrangements in place.**
- 6.1.6 Prioritisation within Trusts and Care Communities.** We found that the NCRS programme had a high priority in the organisations of all those we interviewed.
- 6.1.7 Contract management.** A good structure is in place, whereby overall contracts management is centralised in Leeds and contract managers from that group are placed full time in the cluster. It is positive that this person is organisationally linked with the overall Npfit contract manager in Leeds and those in similar positions in the other clusters. Given the complexity of the contractual terrain this is a good move and one that has been welcomed by the RID. The contractual arrangement does mean though that there will be multiple opportunities for contractors to seek to enlarge their envelope of work and conditions.
- 6.2 Continuing support for the project**
- 6.2.1 Funding.** The granting of the £84 million by the Department of Health has made an immense difference to the London cluster, whose share of this is £13.5 million. It has ended the protracted delay to the funding of the cluster team, and brought funds to enable clinical and support involvement in SHAs and Care Communities. As a result the Cluster recruitment is going ahead. We have noted a concern that these funds may not be so firm as was initially declared, and **we recommend that the Department of Health or the SRO clarify to the Npfit programme that the funds are firm.**
- 6.3 Development and Implementation plans**
- 6.3.1 Lastword and Carecast.** Following contract award, the LSP has introduced the possibility of implementing using Carecast, the most recent version of IDX software. This proposal has very significant implications, including functionality, training and phasing and funding of implementation. **It is recommended that, based upon a firm LSP proposal, the Project Management Team carries out a comprehensive assessment of Lastword/ Carecast implications, and concludes quickly on the preferred route forward.**
- 6.3.2 Modernisation agency.** We understand that the future role of the Modernisation Agency and the deployment of its existing resources and the modernisation teams are under discussion. There is an opportunity here for SHAs and Trusts to obtain trained resources. **We recommend that Cluster RIDs and the Programme Board members each direct someone to work directly with the MA to orient MA staff towards the Npfit programme**
- 6.3.3 Legacy systems and interfaces.** Some interviewees observed how legacy system modification and interface complexities often derail large IT implementations. This issue is being addressed for the e-booking early adopters, via a central resource, albeit under-resourced. There was no evidence that this issue was being given particular consideration in the cluster programme as a whole. **We recommend that the legacy system management for e-booking be extended for the NCRS**

programme and that the CCA deployment checks be very detailed in this respect.

6.4 Business preparedness

- 6.4.1 **Preparedness of the LSP.** The LSP, CCA, has been slower to mobilise than expected. They had also brought in a mix of people that was seen not to be fit for purpose. This has resulted in delay in producing the plan, in numerous rejected documents, in poor CCA programme office performance, and an initial loss of credibility of CCA that is to be regretted. In addition:
- CCA are felt not to be visible in Trusts or Care Communities.
 - We would be expecting CCA to be pushing on the deadlines and the action needed to achieve them, and on emerging issues and this was felt not to be the case.
 - We have heard of plans to co-locate the CCA deployment teams (Perot) in the Care Communities, which we welcome, but nobody we spoke to from these communities had any awareness of this. **We recommend that this be done promptly, as it is having a major beneficial effect in the NorthEast LSP.**
 - CCA staff were perceived as claiming knowledge and expertise that front line staff felt was unwarranted, eg on business change. This looked like a case of the wrong CCA people coming to meetings. Business change resource is a critical issue for trusts and was flagged in the last gateway review.

Major efforts have been made by both the Cluster and the CCA lead in the last two months to address this, and the problem is now on the way to being resolved. Nevertheless, a lot is riding on the quality and drive of the CCA team, and the senior leadership on both sides need to have a stronger framework for addressing issues early. **We recommend that the SRO, the RID leadership team and the CCA team meet to decide how best to be more effective in highlighting and responding to emerging issues.**

- 6.4.2 **Best Practice Process design.** A key feature of the London Cluster plan is the development of common best practice processes for all major processes. This is now taking shape, with plans for some 19 groups to be set up. Each will have a design team and a steering group, that will set Terms of Reference and scope. There is a best practice steering committee sitting over the groups, which will sign off the designs via a clinical reference sub-group, and also a number of wider pan London groups of clinicians against whom the design will be tested. This is a large structure, but has the advantage that it will draw a wide spread of clinicians into the design and subsequent revisions.

This structure is being jointly driven by the Cluster team and the Modernisation Leads in the SHAs, which in itself is a welcome widening of the Cluster's broadening into the business side of the NHS.

We think that this is a positive development, but believe that the process groups have a much wider benefit to London than just the immediate design. They will have a role in agreeing modifications to the design as time and experience accumulates, and can serve as the permanent source of authority on future changes. This role is at least as important as that of providing immediate input into the first design. **We recommend that this more extended role be discussed/agreed and communicated to clinicians at the time of formation of the groups.**

On the negative side: most of the practice groups are not yet formed, the lead person has not yet been recruited, terms of reference have not yet been drawn up, and the process steering groups have not yet been established. We do not believe that they will complete initial design within the planned timeframes.

In addition, there is confusion over how the groups will function. Some believe it will be a process of developing and comparing current versus the desired process. Some think CCA will drive the process, others think it will be the Cluster lead.

In order to have any chance of meeting the early deadlines, there needs to be a restricted scope, and the process needs to be tightly time managed. It may be that a way forward is to base the first solution on a simple interpretation of the most generic configuration in the CCA software.

We recommend that the Cluster team, CCA and the Modernisation leads prepare a detailed approach and plan for managing this short timeframe period, focused on realistic deliverables and responsibilities. We recommend that they be very explicit on the limited result that it is realistic to achieve.

We further recommend that the same group give careful consideration to selecting who will lead the design groups, as this is a very demanding task to achieve a useful outcome.

- 6.4.3 Early adopters.** There is a specific issue related to the early adopters of the e-booking solution. Whilst this is not a review of e-booking, most interviewees expect that this milestone will be perceived as a first result for the Npfit programme generally and also for NCRS. We have found widely conflicting views of “what will be delivered when”, both from people close to the specific projects and more senior managers. As we first understood the plans, it seemed impossible that the June 30 deadline can be met. Having talked with the e-booking head it seems that it is tight but possible, if the delivery dates for each of the many related systems are met. Our concern is twofold: 1) There has been poor or negligible communication with some of the parties who need to be informed. We do not understand at all why the dates should be treated as highly confidential, and 2) Awareness of the reputational risks arising from failure do not seem to be widely appreciated. **We recommend that the e-booking leader should share the key dates and overview planning chart for the early adopters more widely. The RID should be fully informed of the readiness of each Early adopter team.**
- 6.4.4 **Learning.** There should be many opportunities to capture learning and disseminate in this programme. An example is the use of the early adopters as a test of how this complex multi project multi location programme is operating. However, learning is usually lost unless the gathering of it is made explicit. **We recommend that this be made explicit where there is a wish to learn, such as by nominating an individual with a one week project to gather up the learning from a few such key events by interviews, and then disseminate the outcome across those whom it may help. This would be a useful function at national level.**
- 6.4.5 A number of interviewees commented on how limited the cross cluster learning was. There are cross cluster meetings, such as that chaired by Norman Houghton with suppliers, but no-one seems aware of them and they seem to be focused more on issues of common interest than learning.

6.5 Risk Management

- 6.5.1 The recent risk log, and undated risk register attribute high scores to a number of risks which were not given prominence by our interviewees. On the other hand, key issues, such as credibility and reputation damage, which could arise from P1R1 slippage, are not included. Neither are the risks associated with the potential earlier than planned adoption of the latest adoption of IDX software (Lastword to new version Carecast)

It is not clear that the risk log is up to date. Consideration of current key risks is essential to inform the Programme Board's assessment of the health of the project. **We recommend that risk and issue management documentation is thoroughly reviewed to ensure that it fully reflects current risks and their impact.**

- 6.5.2 As the Cluster has not yet approved CCA's detailed implementation plan, it cannot yet have the necessary degree of confidence in the associated continuity and contingency plans, to minimise business risks.

6.6 Dependencies and technical implications

- 6.6.1 The Review Team received mixed messages on the readiness of the infrastructure across care communities, and on mechanisms necessary to ensure that readiness. The messages included the use of Perot to undertake pre-deployment certification and a recent decision to staff a cluster team to assure readiness. In the NorthEast these pre-deployment checks are already very well advanced.

- 6.6.2 A link between the LC and SC contracts has been established by the decision of Fujitsu to engage BT as a sub-contractor. Although we did not understand that any NCRS business need lay behind the decision, the two clusters are now proposing to jointly engage their respective clinicians in design processes. The Review Team were concerned that difficulties could arise as a consequence of this joint working (though recognising that benefits may also accrue). **Accordingly we recommend that the two cluster teams decide in the near future on the criteria for early joint working.**

- 6.6.3 Only one SHA in the LC was addressing the issues associated with user authentication and smart cards. Although not on the immediate horizon we recommend that the cluster takes steps to ensure that each SHA is planning necessary action.

6.7 Benefits realisation management

- 6.7.1 The team found little evidence of a framework for realising benefits, which could be deployed, in conjunction with the LSP, to influence the implementation strategy; nor that thinking about benefits maximisation is a driving influence on the rollout plan, which it should be.

Benefits thinking needs to be an integral part of project thinking rather than the later bolt-on that it now is becoming. For example, is the implementation plan being reviewed for maximising patient benefits (for example is there more patient benefit by preferring PCT implementation over acutes?)

We understand that the NPfIT programme is part of the NHS modernisation agenda, and have seen some high level success criteria for the latter. However, no clear linkage has been made, to demonstrate how the NCRS benefits, when defined and measured, will contribute to that. A 'discussion draft' had been prepared by the Modernisation Agency and the coordinator recently appointed in the Cluster team. The LSP had produced a benefits realisation paper and told us that a benefits steering group had been established' led by the LSP. The cluster team and other interviewees were not aware of this nor of any meaningful activity on this subject. We understand that the clinicians who are engaged with the project are keen to see some 'early wins'. However, it is not clear that the implementation plan will be configured to

accommodate this objective: if not, the consequence may be that these clinicians be less committed to the benefits realisation.

We recommend that the Cluster team give high priority to (1) Defining just how benefit maximisation should inform their regular decision making and (2) Establishing a benefits management and tracking strategy and detailed plans including individual responsibilities, for achieving and measuring the identified benefits, and (3) Aligning the Cluster plan with the strategy emerging from Professor Halligan's role as SRO focused on benefits.

6.8 Communications

- 6.8.1 The project is being taken forward within a very complex environment. Interviewees generally felt that communications from the cluster had a technical perspective, and reflect the need to achieve certain outputs: the trusts believed that they had received rather mixed messages. Improvements have been noted since the conclusion of the procurement phase, for example, a number of events for clinicians have been mounted. However, most of the initiatives appeared to lie with the SHAs and trusts who have held roadshows.

From a trust perspective, the feeling was that they were being project managed by groups of central people, that they lacked clear contact points and that promised explanatory documents had not been produced.

It is recommended that the cluster communications lead, in consultation with SHA and Trust representatives, develops and implements a communications activities plan: not a 'plan for a plan'. It is hoped that this plan will dovetail with an overhauled NpflT communications strategy, which should form the basis for far more open and effective communications across the NHS and other stakeholder groups.

APPENDIX A

Purpose of Gateway 3B: Implementation (a subset of the Gateway 3 list)

- Ensure that management controls are in place to manage the project through to completion.
- Ensure there is continuing support for the project.
- Confirm that the development and implementation plans of both the client and the supplier or partner are sound and achievable.
- Check that the business has prepared for the development (where there are new processes), implementation, transition and operation of new services/facilities.
- Confirm that there are plans for risk management issue management and change management (technical and business) and that these plans are shared with suppliers.
- Confirm that the technical implications, such as 'buildability' for construction projects and (for IT-related projects) impact of e-government frameworks such as e-GIF, e-business and external infrastructure have been addressed.

APPENDIX B List of Interviewees for both Clusters.

<Text Redacted>