National Audit Office

The National Programme for IT in the NHS: Progress since 2006

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL | HC 484-I Session 2007-2008 | 16 May 2008

SUMMARY

1 Launched in 2002, the National Programme for IT in the NHS (the Programme) is designed to reform the way the National Health Service in England uses information, and hence to improve services and the quality of patient care. The Programme is not just an information technology programme but part of a wider change programme within the NHS. It will involve substantial organisational and cultural change to be successful, and is dependent on the deployment of systems in a highly and increasingly devolved NHS. In addition, the context within which the Programme is being delivered is complex and constantly changing, with new requirements arising from policy and operational changes in the NHS.

2 The Programme is managed at national level by NHS Connecting for Health, part of the Department of Health, and the Chief Executive of the NHS is the Senior Responsible Owner for the Programme. Since 2007 responsibility for delivery has been shared with the local NHS, with the Chief Executives of the ten Strategic Health Authorities responsible for implementation and benefits realisation in their part of the NHS.

3 This is the second report by the National Audit Office on the Programme. Our first report, in June 2006[1], was followed in March 2007 by a report by the Committee of Public Accounts[2], to which the Government responded in July 2007[3]. We have carried out this further study to review how the Department has responded to the Committee's conclusions and recommendations and to examine more generally the progress being made in delivering the Programme.

4 This report, Volume 1, sets out our main findings, together with our conclusions and recommendations. It is supported by a Volume 2 of 'project progress reports', which provide details of the development, deployment, service availability, usage and costs of each of the main components of the Programme. Details of our study methods are set out in Appendix 1.

Our key findings on progress in delivering the Programme

Progress against time

5 At the outset of the Programme, the aim was for implementation of the systems to be complete and for every patient to have an electronic care record by 2010, although the timetable from 2006 was described as tentative. While some parts of the Programme are complete or well advanced, the original timescales for the Care Records Service – one of the key components of the Programme – have not been met.

Summary Care Record

6 Implementation of the Summary Care Record is in the early stages. Deployment began in five 'early adopters' in March 2007 after a delay of just over two years. At 31 March 2008 two of the five early adopters (Bolton and Bury Primary Care Trusts) were uploading their patient records to the system; the remaining three had public information campaigns underway but had not yet begun to upload records. An evaluation of the early adopter programme will inform the national roll-out of the Summary Care Record to the remaining 147 Primary Care Trusts.

1 *The National Programme for IT in the NHS* (HC 1173, Session 2005-06).
2 *Department of Health: The National Programme for IT in the NHS* (Twentieth Report of Session 2006-07, HC 390).
3 Treasury Minute on the Twentieth Report from the Committee of Public Accounts (Session 2006-07), Cm 7125.

Detailed Care Records

7 To support the creation of Detailed Care Records, the Local Service Providers (BT in London, Fujitsu in the South and CSC in the North, Midlands and East) are implementing electronic care records systems in a series of releases. The scale of the challenge in developing and deploying these systems in the NHS has proved far greater than expected, and the timescales the Local Service Providers originally agreed with NHS Connecting for Health proved unachievable.

8 In London and the South, early releases of Cerner's Millennium product provide some of the functions required, with more clinical functionality planned for later releases. In the North, Midlands and East, development of iSOFT's Lorenzo system has taken much longer than originally planned and the first release is now expected to be available for deployment at three early adopter Trusts in summer 2008, with full roll-out planned from autumn 2008. In the interim, the Local Service Provider is implementing an existing care records system, upgraded to meet the requirements of the Programme.

9 The new care records systems are being deployed in Trusts, but at a slower pace than originally planned. At 31 March 2008, a total of 128 deployments had taken place, including 34 in Acute Trusts **(Figure 1)**. While the most deployments have been made by CSC in the North, Midlands and East, these are of the interim systems that will be used until Lorenzo is available.

10 Following the transfer of accountability for implementation to the local NHS in April 2007, the Strategic Health Authorities and Local Service Providers have been developing plans for future deployments, with the aim of scheduling a rolling annual programme. Revised outline plans are now in place for London and the North, Midlands and East, with the plans for the South under discussion. Taking the country as a whole, the final releases of the care records software are scheduled to be deployed from 2009-10 to 2014-15.

Other elements of the Programme

11 Some other elements of the Programme are now fully deployed across the NHS and some have been delivered ahead of schedule. Volume 2 of this report sets out details of the progress made on each element of the Programme.

12 The N3 network and releases of the Spine, which together form the infrastructure of the Programme, have been deployed on or ahead of schedule. For example, 18,000 NHS sites were connected to N3 by January 2007, two months ahead of target. Similarly, deployments of the variety of other systems, which have been added to the scope of the Programme, have met the planned timescales. For example, all Acute Trusts now have the Picture Archiving and Communications Systems for digital X-rays and other images.

13 As well as the Care Records Service, the original scope of the Programme included an electronic booking service, which became Choose and Book, deployment of which is nearly complete. In addition, an electronic prescription service now enables the majority of GPs and pharmacies to issue electronic prescriptions. Paper prescriptions will continue to be required, however, until the second release of the software is deployed, which cannot begin until GP and pharmacy systems have been accredited.

1 Deployments of electronic care records systems under the Programme at 31 March 2008

		Acute Trusts		Mental Health Trusts		Primary Care Trusts	
Area	Local Service Provider	Number of Trusts	Number of deployments	Number of Trusts	Number of deployments	Number of Trusts	Number of deployments
London	BT	31	4	10	6	31	20
South	Fujitsu	41	9	14	1	31	7
North, Midlands and East	CSC	97	21	35	13	90	47
Total		**169**	**34**	**59**	**20**	**152**	**74**

Source: NHS Connecting for Health

NOTES

1 Two of the deployments in Acute Trusts in London pre-date the Programme but have since been integrated into the Programme, with services now provided by the Local Service Provider.

2 The deployments in the North, Midlands and East are of iPM, the interim solution, to be replaced later by releases of Lorenzo, the strategic solution, which will require Trusts that take iPM to implement a further deployment once Lorenzo is available.

3 This Figure does not include deployments of GP systems, which were not the focus of this report.

Our conclusion on progress against time

Current indications are that it is likely to take some four years more than planned – until 2014-15 – before every NHS Trust has fully deployed the care records systems. Until Lorenzo is available and has started to be deployed, there remains a particular uncertainty over timing in the North, Midlands and East. Good progress is being made with other elements of the Programme.

Progress against cost

Estimated cost of the Programme

14 The estimated cost of the Programme is currently £12.7 billion (at 2004-05 prices) **(Figure 2)**. As well as central costs paid and recorded by NHS Connecting for Health, the total includes estimates of the local costs incurred in deploying the systems. There remains some uncertainty around the estimates of local costs, however, principally because they are taken from business cases compiled by Trusts in 2003-04. The Department collects information on local expenditure via an annual survey of the NHS, though the survey does not distinguish between expenditure on the Programme and other investment in IT. The Department is to supplement the survey for 2007-08 with research at a sample of local sites, and for future years it will work with the NHS to develop an improved approach to capturing information on local expenditure.

15 The estimate in our first report on the Programme was £12.4 billion. Though the £12.7 billion in this report is still an estimate, there is now better information on costs. A reconciliation between the figure in our first report and the current estimate is shown in Figure 7. More detailed information on costs is also set out in Figures 6 and 8 and Volume 2 of this report. Since the start of the Programme, there has been an increase of £678 million (11 per cent) in the value of the core contracts, due mainly to the purchase of increased functionality, though there have been no increases in the cost of individual elements purchased under the original contracts. The remaining increases on the core contracts have resulted from supplier and sub-contractor changes. There have also been reductions in some cost estimates as costs have become more certain.

Expenditure to date

16 At 31 March 2008, spending on the Programme totalled £3,550 million. Spending on the core contracts of £1,933 million was 44 per cent below what was originally profiled (£3,428 million), reflecting the slower deployment of the care records systems described above.

2 Estimated cost of the Programme at 31 March 2008 (at 2004-05 prices)

Category	£ million	£ million
Core contracts	6,805.5	
Products added to the scope of the Programme	665.8	
Other central costs	1,599.0	
Total central costs		9,070.3
Local costs		3,585.9
Total		**12,656.2**

Source: NHS Connecting for Health

17 Suppliers are paid only when services are proven to have been delivered and working, and in some cases they have not been paid for over 12 months after the deployment of systems in NHS Trusts. In the South, where there have been the most deployments in Acute Trusts of the first release of the strategic (i.e. not interim) care records system, the Local Service Provider has yet to be paid for over half of the deployments.

18 The Programme's contracts were based on the assumption that all Trusts would take the new systems at some point. In the event that the Local Service Providers do not receive the expected revenue for reasons solely due to the Department (for example, where a Trust elects not to deploy the system), the Department has to make a payment to the supplier. At 31 March 2008, payments totalling £36.1 million had been paid under these arrangements. Of this, £30.3 million related to care records systems in London and the North, Midlands and East (of which £29.1 million will be deducted from the charges if the deployments subsequently go ahead, with the remaining £1.2 million irrecoverable) and £5.8 million related to the Picture Archiving and Communications Systems in the North, Midlands and East (all irrecoverable).

19 If suppliers miss key milestone dates, they incur 'delay deductions', which they can earn back. From the start of the Programme to 31 March 2008, deductions of £26.3 million were made. Of this, the Department retained £9.5 million and suppliers earned back £10.1 million. The remainder was still available to be earned back.

Our conclusion on progress against cost

The estimated total cost of the Programme is broadly unchanged. The cost increases that have occurred are mainly due to the purchase of increased functionality. It remains difficult to produce a reliable estimate of local costs. Expenditure to date has been less than was profiled.

Progress in realising benefits

20 The Department published the first annual benefits statement for the Programme, for 2006-07, in March 2008, later than the Department's commitment to the Committee of Public Accounts to publish by the end of 2007. The statement drew on information from some 20 per cent of NHS organisations where the Programme's systems were in daily use and the deployments were sufficiently mature to start to draw conclusions. The statement reported:

- estimated financial savings to 31 March 2007 of £208 million, over 90 per cent of which related to the N3 network; and
- estimated annualised recurrent savings of £119 million, which would result in total savings of £1.1 billion over the 10 years to 2013-14.

21 The main aim of the Programme was to improve services rather than reduce costs, but the Department expects that the total savings will prove to be considerably higher than the current estimate of £1.1 billion as more of the Programme's systems are fully deployed across the NHS, although there is no baseline against which to assess the benefits that are in due course achieved. It is developing its approach to measuring the benefits and the first statement was being put together at the same time as we carried out our work for this report. The statement has not yet been subject to audit.

22 At Trust level, the Picture Archiving and Communications Systems have yielded the most tangible benefits to date, for example in helping to reduce diagnostic waiting times. The Programme has also brought wider benefits, such as improved IT skills among NHS staff. There is a large amount of work now to be done on benefits realisation, in particular to drive benefits from the new care records systems at local level where the Strategic Health Authorities and Trusts have so far focused largely on the practicalities of getting the systems deployed.

Our conclusion on progress in realising benefits

Some benefits from the Programme, including financial savings, are starting to emerge. Work to identify and measure all actual and potential benefits systematically is at a very early stage.

Technical performance of the systems

23 NHS Connecting for Health monitors the performance of suppliers against targets for service availability, response times (i.e. how quickly the system responds when it is being used) and the time taken to fix problems. Over the 18 months to March 2008, suppliers achieved most of the service availability targets (most commonly for a service to be available for 99.9 per cent of the time).

24 If performance falls below the level specified in the contract in any month, the supplier incurs performance deductions. The deductions are earned back if the supplier rectifies the performance failure for the subsequent three months; otherwise the Department keeps the money. From the start of the Programme to 31 March 2008, performance deductions of £14.2 million were incurred (three per cent of the total service charges). Of this, the Department retained £5.7 million and suppliers earned back £1.8 million. The remainder was still available to be earned back.

25 All the Trusts we visited had experienced some technical problems with the new care record systems, and there had been some dissatisfaction, especially in the period following a deployment, as is often the case with IT programmes. Many staff had come to prefer the new system to the one it had replaced, though some continued to be dissatisfied, for example where issues they had raised had not yet been dealt with.

Our conclusion on technical performance of the systems

Suppliers have largely met the targets for service availability and performance deductions have been applied where there have been service failures. Trusts have experienced some technical problems in using the new care records systems, especially in the period following a deployment.

Our key findings on the challenges to be managed for the successful delivery of the Programme

Challenge 1: Achieving strong leadership and governance

26 The Chief Executive of the NHS is the Senior Responsible Owner for the Programme as a whole. Though all the Programme's major components have been procured centrally, much of the implementation has to be locally driven. In October 2006 the Department initiated the 'National Programme for IT Local Ownership Programme' to strengthen local ownership and governance, and re-position the Programme as part of mainstream NHS business, and in April 2007 the ten Strategic Health Authorities became accountable for implementation of the Programme and realisation of its benefits for their part of the NHS.

27 The Local Ownership Programme has been widely welcomed by people working in the NHS and other stakeholders, although its impact has in the main yet to be felt. In the highly devolved NHS, the practical reality for the Senior Responsible Owner for the Programme and for the Strategic Health Authorities' accountability in their areas is not straightforward. So, for example, decisions about when a new care records system should be deployed lie with Trust Boards and their Chief Executives, rather than with the Strategic Health Authorities.

28 On a Programme of this size and complexity and in such a highly devolved environment, clear, realistic communications about attributes of the Programme such as progress against time and cost, and system performance, are especially important. Large volumes of data are available to help manage the Programme, though communications have tended, to date, to focus on achievements rather than what remains to be done. Our difficulty, in producing this report, in collating the Programme's current position to a reasonable degree of precision, reinforced our impression that reporting and communications about the Programme could be improved, particularly in relation to the deployments by the Local Service Providers. To this end, since November 2007 NHS Connecting for Health has been developing an electronic tool which is intended to provide a 'roadmap' of progress across the Programme.

Our conclusion on achieving strong leadership and governance

Local accountability for delivery of the Programme has been strengthened, though the new arrangements are still bedding in. Reporting and communicating progress on the Programme as a whole is challenging because of the volume of data and difficulties in clearly collating the state of play on every attribute of the Programme's various elements.

Challenge 2: Maintaining the confidence of patients that their records will be secure

29 In January 2007 the Department appointed a Patient Lead for the Programme to raise the profile of patient engagement work, where the main focus at present is the introduction of the Summary Care Record. The Record will be accessible to NHS staff involved in a patient's care anywhere in England, though patients can choose not to have a Record created or for it not to be shared. Early indications from the early adopter areas are that only very small proportions of patients are choosing not to have a Summary Care Record or for it not to be shared.

30 A key factor in whether patients choose not to have a Summary Care Record will be whether patients and GPs are confident that data will be secure and handled appropriately. NHS Connecting for Health has set out policies on secure processing, transmission and storage of patient data, and a range of controls have been put in place to prevent unauthorised access to data. For example, the N3 network and NHSmail system are protected by multiple security measures and communications are encrypted to protect the transfer of patient data.

31 Security also depends on the actions of the NHS and individual members of staff. To help provide assurance about data security and confidentiality, the Department and the NHS have developed a 'Care Record Guarantee', setting out the principles that will be applied in handling electronic care records. Access to care records is controlled through Smartcards and passcodes, and individuals are granted access to information based on their role and level of involvement in patient care. Inappropriate use of health records may lead to disciplinary measures and possibly legal proceedings, and access can be audited. In the light of concerns about public sector data protection and the security of information being transferred between locations and organisations, the Strategic Health Authorities are conducting a detailed review of all aspects of data security across their part of the NHS.

Our conclusion on maintaining the confidence of patients that their records will be secure

Greater sharing of patient records brings new risks. Ultimately security depends on the actions of individual NHS staff, and there are a range of controls and protections in place. The NHS potentially has superior knowledge of who has accessed care records than it had prior to the Programme.

Challenge 3: Securing the support and involvement of clinicians and other NHS staff

32 The most recent survey of NHS staff, carried out in May 2007, found increases in levels of familiarity with the Programme and most staff – including 67 per cent of nurses and 62 per cent of doctors – thought the systems would improve patient care. Staff having access to patient information when they need it was rated as the most important of a series of potential benefits. The survey also found that, aside from information managers, less than 30 per cent of the other groups of NHS staff had had an opportunity to shape decisions about the new systems, although the majority did not consider they had a lot to contribute to the planning of IT changes.

33 In the last two years NHS Connecting for Health has taken steps to strengthen its mechanisms for clinical engagement, including appointing a Chief Clinical Officer to enhance clinical leadership of the Programme. In addition, the network of National Clinical Leads, who act as advocates for the Programme and facilitate communication between NHS Connecting for Health and NHS staff, has been expanded. NHS Connecting for Health has also involved clinicians and other NHS staff directly in the development of the Programme's systems to help ensure the products are fit for purpose. For example, a team of NHS staff has been established to assist with developing the Lorenzo care record software.

Our conclusion on securing the support and involvement of clinicians and other NHS staff

The arrangements for engaging with clinicians and NHS staff, and involving them in the development of the systems, have been strengthened. The latest survey indicates that most NHS staff expect the Programme to improve patient care and patient safety. There is, however, still progress to be made before all staff are convinced of the benefits of the Programme.

Challenge 4: Managing suppliers effectively

34 The three Local Service Providers told us that the scale and complexity of the Programme made it extremely challenging. They described how it can be difficult to plan and deploy resources where progress relies on many decisions necessarily made at local level, and how they cannot make progress simply by 'working to the contract' but need to be highly flexible to meet NHS requirements. All have boosted capacity since the outset, in part prompted by NHS Connecting for Health. In addition, the contracts with BT and CSC have been reset to reflect changing circumstances (including the novation of the contracts for the North East and the East from Accenture to CSC) and the need for greater flexibility than originally envisaged. The resetting has established more realistic timetables for deploying the care records systems and has incorporated cost changes arising largely from the purchase of increased functionality. The contract with Fujitsu is in the process of being reset.

35 Relations between NHS Connecting for Health and the Local Service Providers have been maturing, with both sides gradually developing the confidence in each other to work together to deal with the uncertainties and changes that arise during system development and deployment. Both described a relationship that is increasingly collaborative and based on partnership, with aligned objectives to deliver the Programme. Under the Local Ownership Programme, relations between the NHS and the Local Service Providers are still relatively immature but improving. Across the country, the NHS Trusts we visited commented positively on the working relations they had enjoyed with Local Service Provider staff during the deployment process.

Our conclusion on managing suppliers effectively

Relationships between NHS Connecting for Health and suppliers have matured, bringing much needed flexibility to the Programme. Until the process of contract resetting is complete, there remains a degree of uncertainty in relation to the South.

Challenge 5: Deploying and using the systems effectively at local level

36 Implementing a new care records system in a Trust entails substantial additional work, and places an inevitable burden on both clinical and administrative staff. During our visits we saw that NHS staff are demonstrating huge effort and commitment to make deployments go as smoothly as possible, and we saw clear evidence of Trusts learning from the experience of others.

37 Planned 'go live' dates had been missed in most of the Trusts we visited, in some cases on more than one occasion, usually as a result of over-optimism about the time required to prepare. Drawing on experience, Local Service Providers are now expecting the planning, preparation and testing with the Trust and Strategic Health Authority prior to the 'go live' date to take on average around a year, depending on the complexity of the deployment.

38 To realise the benefits of a new care records system Trusts need to understand how it will affect their work processes, and if necessary redesign them to get the most out of the system. Training is also important in ensuring benefits are realised and was most effective where it was tailored to reflect specific roles. The value of training was, however, diminished by the fact that the training environment provided to Trusts differed from the live system they were deploying.

39 Deploying a new care records system has a large operational impact, and an important lesson has been the value of having high level clinical and managerial leadership of the change. All the Trusts we visited recognised the importance of engaging staff and had involved clinicians in the deployment process. Although increased functionality is planned for later releases, the limited clinical functionality provided to date had made engagement more difficult.

40 The NHS Connecting for Health Service Desk, run by Fujitsu, deals with technical issues that cannot be resolved at local level. During our visits, feedback was that the performance of the Service Desk was universally poor. NHS Connecting for Health and Fujitsu recognise there have been problems with the operation of the Service Desk and are taking steps to improve performance.

41 While the Choose and Book system is now nearly fully deployed, utilisation has been lower than expected, with 6.7 million bookings, against an original forecast of 39 million, by January 2008. Usage has been rising, and around half of new outpatient appointments are now being booked through Choose and Book, though there is wide variation in utilisation rates between Primary Care Trusts, ranging from over 90 per cent to below 20 per cent.

Our conclusion on deploying and using systems effectively at local level

The original unachievable timescales for the Care Records Service as a whole have been mirrored in the deployment of the care records systems at local level, and raised unrealistic expectations at times. Implementing the new systems entails substantial extra work and Trust staff are demonstrating high levels of commitment. NHS staff and Local Service Providers are learning from experience to make each new deployment go smoothly.

Our overall conclusions

The Department is taking action to progress all the recommendations which it accepted from the Committee of Public Accounts report.

All elements of the Programme are advancing and some are complete, though delivering a nationally specified Programme into the highly devolved NHS continues to be an enormous challenge. For the Care Records Service, the original timescales proved to be unachievable, raised unrealistic expectations and put confidence in the Programme at risk. While the Programme costs have largely held, the timetable for the Care Records Service has slipped.

The original vision for the Programme nevertheless remains intact and still appears feasible. The major outstanding challenge is to finish developing and deploying the care records systems that will help NHS Trusts to achieve the Programme's intended benefits of improved services and better patient care.

Our recommendations

42 We make the following recommendations outlining the actions that we consider necessary to realise the Programme's vision, while also achieving value for money.

a **There is considerable uncertainty about when the care records systems will be fully deployed and working across the country.** It is important that timelines for deploying the systems are realistic, and based on accumulated experience and evidence of what is achievable. NHS Connecting for Health and the Strategic Health Authorities should communicate the deployment plans that are being developed, drawing a distinction between firm commitments in the near future and the less certain timelines that apply further ahead.

b **The North, Midlands and East area does not yet have the strategic system to support its care record service because of the time taken to develop Lorenzo.** The delays in developing Lorenzo make it even more important to get the product right and win the confidence of NHS staff. Current plans are to have the first release available for deployment at three early adopter Trusts in summer 2008, with full roll-out planned from autumn 2008. Given the experience of deploying other care records systems within the Programme, however, this timeframe may prove over-ambitious. Before the system is rolled out to the rest of the North, Midlands and East, NHS Connecting for Health and the Strategic Health Authorities should carry out rigorous testing to ensure the system deployed in the early adopters works as required, and make the lessons learned from the deployments visible to NHS staff.

c **It is difficult to report reasonably precisely the state of play on the many different elements of the Programme.** For reporting within the Programme, NHS Connecting for Health should develop regular reporting on system development, deployment, cost and performance, based on some of the information presented in this report and covering the amount of work remaining to be done as well as progress to date. As part of this reporting, the Local Service Providers and the NHS should agree and regularly update the schedule for future deployments of new care records systems in each of the three areas. Communications with NHS staff and externally to Parliament and the public need to draw on the same information, and focus more on the Programme's central component, the Care Records Service.

d **Some Trusts have still to be convinced of the benefits of taking up the Programme's care records systems.** Planning for future deployments has to take account of Trusts' concerns about the benefits of the new systems relative to the systems they currently have, the amount of organisational change required, and the impact the deployment may have on the ongoing operation of the Trust. To help produce plans that are realistic at the same time as driving the Programme forward, Strategic Health Authorities need to employ or draw on people with programme management skills who can work with Trusts and Local Service Providers to address these issues and develop deployment plans that meet Trusts' business needs.

e **The Programme's emphasis on benefits realisation is increasing but is not yet sufficiently comprehensive across the whole Programme.** Success of the Programme depends crucially on the commitment of all NHS staff, which will come more easily once more of the Programme's benefits are identified and realised. Throughout the Programme, the balance of resources should shift to place increasing emphasis on benefits realisation. For example, Strategic Health Authorities should appoint clinicians and administrative staff who understand all the Programme's elements to work with Local Service Providers and Trusts to establish how the systems can best support a Trust's operations and to maximise benefits after deployment. They should set up mechanisms to share knowledge on how best to realise the benefits.

f **Early experience with the Summary Care Record indicates that patients have a high level of confidence that their personal data will be secure, but security lapses could easily undermine that confidence and reduce the benefits of the Programme.** The Department and the NHS should give priority to data protection, monitor levels of public confidence and review how the levels are being influenced by its communications about the protections in place to secure and manage access to care records.

43 Successful implementation of the Programme's systems is dependent on the actions of individual NHS Trusts, and Trusts also rely on their Strategic Health Authority and the Department to provide support and manage aspects of the performance of the Local Service Providers. From our visits to Trusts we identified a range of actions – which some Trusts were undertaking and some of which echo NHS Connecting for Health's own guidance – to help improve the deployment and utilisation of the new care records systems. These actions are set out in the table opposite.

Improving the deployment and utilisation of the new care records systems

Recommendations for NHS Trusts

- Before starting a deployment, Trusts should undertake detailed planning, in partnership with the Strategic Health Authority and the Local Service Provider, drawing on experience of earlier deployments, to establish a realistic timeline and work programme that reflects the circumstances of the individual Trust.
- Every deployment should have full, joint commitment from the clinical and managerial leadership of the Trust. The deployments require change management across the organisation, and senior leaders need to champion the change.
- The resources required at Trust level for a deployment should be planned for, costed and continuously updated as the deployment proceeds.
- Prior to a deployment, Trusts should thoroughly map their work processes and adjust them where necessary to secure in full the potential benefits of the new system. Trusts should also plan the data migration carefully and consider whether it is more practical to reduce the amount of data that needs to be migrated by keeping older information in a separate database to be referred to as necessary.
- Trusts should establish in detail the advantages and disadvantages of the system being deployed compared with the one being replaced, and clearly communicate them to staff in order to manage expectations.
- Trusts should plan for refresher and further training to reinforce consistent working practices and maximise the benefits of the new system.
- Trusts should make clear to staff the importance of reporting all system performance issues through formal channels. They should secure progress reports on change requests from Local Service Providers and keep the staff who requested the changes informed.
- Trusts should rigorously apply the arrangements that have been put in place for handling care records and other patient data, including enforcing disciplinary procedures relating to unauthorised access or failure to keep data secure.

Recommendations for the Department and Strategic Health Authorities

- Strategic Health Authorities should support the transfer of learning from one deployment to the next through staff continuity, both in terms of their own staff and by encouraging Trusts who have been through deployments to share resources with other Trusts during planning and 'go live' periods.
- The Department should require Local Service Providers to provide Trusts with a training environment as close as possible to the system being deployed. For example, the training environment should reflect the different structures of a Trust's outpatient clinics, to reduce the risks associated with staff having to use a system that looks different from the one they trained on.
- The Department should check whether the planned improvements to the service provided by the NHS Connecting for Health Service Desk to NHS staff have been fully and effectively implemented.
- The Department should require Local Service Providers to have transparent processes for logging and dealing with system performance issues and for handling change requests, thereby enabling Trust staff to monitor progress.